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Oculists in the Orient: A History of Trachoma, Zionism, and Global Health, 1882-1973

A dissertation submitted in partial satisfaction
of the requirements
for the degree Doctor of Philosophy in History

by

Anat Mooreville

2015

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ABSTRACT OF THE DISSERTATION

Oculists in the Orient:

A History of Trachoma, Zionism, and Global Health, 1882-1973

by

Anat Mooreville

Doctor of Philosophy in History

University of California, Los Angeles, 2015

Professor Sarah Abrevaya Stein, Chair

The dissertation considers how a wide range of actors—including physicians, scientists, hospitals, aid organizations, governments, and the public—understood the infectious eye disease trachoma and deemed eye health salient from political, economic, scientific and cultural perspectives in Palestine and Israel from the late nineteenth century through the 1970s. Even though the causative agent was not isolated until 1957, there was a strong consensus at the beginning of the twentieth century that poverty, unhygienic practices, and ignorance facilitated trachoma. This etiology allowed Jewish ophthalmologists to construct it as a disease that was receptive to biological, cultural, and social interventions. My dissertation explores the design and implementation of Jewish anti-trachoma efforts; how physicians produced biomedical discourses on trachoma that were entangled with cultural constructions of the Arab East; and the wide set of transnational developments and relationships that configure the story of ocular expertise in Israel.

Using a wide array of state and organizational archival papers, memoirs, and scientific publications, this study investigates what it meant for trachoma to be considered a “disease of the Orient” throughout three political regimes in Palestine and Israel, and the

social, ethnic, and political tensions the presence of trachoma raised about who was modern. During Ottoman and British Mandate Palestine, trachoma treatment instigated questions about the boundaries between Jews and Arabs, Middle Eastern Jews and European Jews, physicians and auxiliaries, biomedicine and folk remedies, and the health of the eye and the health of the nation. In the postwar period, when trachoma nosedived as an Israeli public health priority, trachoma instead illuminates how Jewish organizations and the State of Israel utilized their ocular expertise to make their mark on the Third World through technical solutions embodied as development aid, both to Jews in North Africa and non-Jews in sub-Saharan Africa. The history of trachoma not only highlights how important ophthalmology was in conceptualizing public health in the Middle East, but also creates new sites of global medical inquiry by linking Zionist social welfare practices, international Jewish philanthropy and postcolonial medical diplomacy.

The dissertation of Anat Mooreville is approved.

Hannah Landecker

Soraya de Chadarevian

James Gelvin

David Myers

Sarah Abrevaya Stein, Committee Chair

University of California, Los Angeles

2015

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I wrote this dissertation in multiple coffee shops over the years, my favorites being Espresso Profeta, Funnel Mill, Espresso Cielo, Andante Coffee Roasters and Zinque in LA; Shraga Cafe and Nocturno in Jerusalem; The Green Line, Hothouse Coffee, and Gryphon Cafe in Philly; and Konditori in Brooklyn. I’d like to think I have what it takes to open my own one day. I’ve also benefitted from working in wonderful libraries, including the Santa Monica Public Library, the New York Public Library, the Brooklyn Public Library, Ludington Library, Bryn Mawr College Library, and Haverford College Library. The West Hollywood Library, in particular, was a god-sent wifi-free refuge, providing sunlit views of the hills during my last year.

I have been fortunate to have had a long string of very special teachers who showed me that art, poetry and integrity can be a profound source of power and beauty in our lives, including Rita Ross, Susan Friedman, Tom McLaughlin, Harold “Doc” Gorvine, Susan Weisgrau, Catherine Imbriglio, Rick Benjamin, John Edgar Wideman, Josef Mittlemann, and Samantha Dunn. I first took an undergraduate seminar with Maud Mandel because it fit into my schedule; little did I know that she would usher me into graduate school in her field, and remain a trusted source of advice and feedback throughout.

Ishai and Mira were awesome, always calling me from across the country, sending me funny links, and greeting me with warm hugs whenever I came back East. You know how much I love you. Mom and Dad have supported my swervy path in whatever way it has gone.

Not only did they instill in me the value of meaningful hard work, but they also modeled the joy of partaking in life's simple pleasures: a walk in the neighborhood, reading good novels, and ice cream/gelato at every opportunity. I would not have been able to do this if you two did not have my back. Thank you for both loving me and each other.

I also thank my parents for introducing me to the strange, curious world of medicine. I am not sure what other families talked about over the dinner table, but our conversations when I was a kid were all about patients (and HMOs, but I didn't understand that part). Either Mom or Dad would start off by saying, "I saw this one patient today..." These stories were tragic and hilarious, aggravating and perplexing. My parents would often consult each other on their diagnosis decisions to make sure they had considered all of the possibilities. I realize now that all of those dinner table tales that I had thought had nothing to do with my interest in history and writing, in fact taught me how to make sense of human nature and interaction. Stories of patients are stories of lives and decisions taken, of trust, authority, vulnerability and hope. They helped me to understand, form, and fall in love with narrative. And I, kind of unconsciously, have taken it back around by trying to tell my own story—albeit an historical one—about physicians, patients, and disease.

I dedicate this dissertation to my grandparents, Hana and Iancu Shechter, who hosted me every time I was in Jerusalem, and who epitomize modesty, moral conviction, diligence, and compassion. They showered me with love, Shabbat meals, and wisdom that only nonagenarians have to give. Hana, who earned her doctorate in chemistry under much less favorable circumstances than I, has empathized with my setbacks and cheered me on to the finish line. They are very special people, and I am so glad I was able to spend part of this journey in their company. I know Jonas and Simsi Mooreville would also have been proud of this accomplishment.

I would be remiss if I did not acknowledge the city of Los Angeles. Anyone from the Northeast can attest to the fact that LA looms large in our collective imagination, slightly akin to a massive parking lot filled with inane blonde people covered in smog. We were wrong. I hiked once again to the Hollywood Sign along the unmarked ridge trails of Griffith Park, after the tourists had gone home. From the canyon crests at sunset, I saw this city's nerves sending electrical signals through parallel and perpendicular roadways, far from the dark mountains that towered above. I felt pockets of warm air rush up Mount Lee's back from the valley, as cold spurts brushed through the tall grasses from the city side. From this vantage point, I can see all of it: Los Angeles, with all of its contradictions and incompetence, with how it grows lax and almost hysterical under the benign sun. In her short story, "Wants," Grace Paley described the narrator's ex-husband this way: "He had had a habit throughout the twenty-seven years of making a narrow remark which, like a plumber's snake, could work its way through the ear down the throat, halfway to my heart. He would then disappear, leaving me choking with equipment."

From the ubiquitous birds of paradise, cyclamens, red hibiscus, foxgloves, and bougainvillea; Topanga's promise of a secret history, of bonfires and antics, of Moon Fire Temple rituals I wish I had seen; the stock image of myself cruising on street names that are larger than life: Sunset, Mulholland, the Pacific Coast Highway, with designer shades, the windows down, and the pop radio up, with every American peering to this little corner of the country for common culture, for the fancy, the vogue, the crazy rage, despite ourselves; from mid-century modernist dreams scattered on hillsides and Googie-inflected dingbats lining the flats, from the high desert's desperation and quiet deliverance under blooming ocotillos in the dusky light; to the enveloping beauty of the Santa Monica Mountains' sweeping panoramic landscapes dipping into the ocean below that have felt like home—that have been my home—since I first hiked them, I have learned to adore it all, a city that not only sunbathes its

summits and in-betweens, but that decrees the Santa Anas and explodes the wildfires through its dragon-breaths. I feel the plumber's snake halfway to my heart. At the end of the West, I am choking with equipment.

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The Traveling Oculist and the Jewish Hakim: Trachoma in Mandate Palestine
NYU Taub Center for Israel Studies Graduate Workshop, New York

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The Mass Trachoma Project: Jews and Global Health in Morocco, 1949-1956
Middle East Studies Association Annual Meeting, Denver

Trachoma in Palestine: The Very Idea
American Association for the History of Medicine Annual Meeting, New Haven

Thinking Beyond the Canon: New Themes and Approaches in Jewish Studies
Conference co-organizer, UCLA Center for Jewish Studies, Los Angeles

Introduction

Meir Gur-Arie, one of the most prominent artists of the Jerusalem Bezalel Art School in the early twentieth century, was most famous for his attractive black and white silhouettes depicting figures and tableaux of pioneer life in Palestine. The Bezalel artistic style was marked by so-called Oriental subjects in a romantic and idealizing tone. One postcard in particular, from a set of ten painted in 1933 that portray street scenes in Jerusalem, illustrates the prominent and public space of eye disease in the city's landscape. It is titled, "Eye Patients," and illustrates a line of patients waiting to see the ophthalmologist.¹ It is clear from their poses that they have been standing for a long time. The first, an elderly man wearing a turban, is hunched forward squatting on the ground, holding a staff in one hand to support himself, while a handkerchief sags in the other. The gentleman behind him wearing a fez is wiping his brow with fatigue, as his young son, also tired, leans against him. There are three sets of mothers clutching babies to their chests, while the rearmost patient even brought along a spread of pita and eggs to last through the predictably protracted wait. As a group, the patients look poor, desperate, and weary. And, according to visual tropes of the day, they are undoubtedly of the Orient.

Why eye patients? Why did Gur-Arie choose eye disease as the quintessential Jerusalem malady to complement his set of city moments that include "Water Supply," which depicts a line of Jerusalemites at the public spigot, and "Marhaba," a cafe scene of men smoking sheesha and drinking coffee?² Did this sort of scene—eye patients waiting in line—

¹ Meir Gur-Arie, *Eye Patients*, 1933. Yeshiva University Museum, New York.
<<http://museums.cjh.org/web/pages/cjh/Display.php?irn=14335&QueryPage=>>.

² Meir Gur-Arie, *Water Supply in Jerusalem*, 1933, Yeshiva University Museum, New York.
<<http://museums.cjh.org/web/pages/cjh/Display.php?irn=14337&QueryPage=%2FAdvQuery.php>>; Meir Gur-Arie, *Marhaba*, 1933, Yeshiva University Museum, New York.
<<http://museums.cjh.org/web/pages/cjh/Display.php?irn=14339&QueryPage=%2FAdvQuery.php>>.

have a particular socio-cultural resonance that was wholly familiar to residents and visitors during the first decades of the twentieth century?



Figure 1: “Eye Patients,” Meir Gur-Arie (1933)

These eye patients were most likely waiting to see the famous Dr. Albert (Abraham) Ticho, who had established a Jerusalem eye clinic in the impressive Ottoman Aga Rashid House in 1924. Before I embarked on this project, I had the chance to visit the Ticho House, which currently operates as a café and small art museum that exhibits his wife and assistant Anna Ticho’s artwork. I stopped by to get a cappuccino, but instead found myself captivated by the photographs of Ticho and his overcrowded waiting room: he developed an imminent medical reputation treating Jewish and Arab patients, including Emir Abdullah, the first King of Jordan; Haj Amin al-Husseini, the mufti of Jerusalem; and various other sheikhs from Saudi Arabia, Yemen, Iraq, and Egypt. Supposedly “Dr. Ticho” became the generic name for any eye doctor.³ Over the course of his career, Ticho performed no less than 25,000 surgeries,

³ Miri Debbi, *Ticho, the Story of a Family* (Tel Aviv: Reches Pub. House Educational Projects Ltd., 1994).

many related to trachoma and its complications.⁴ His name has retained some sticking power in Israeli popular culture in the modern Hebrew idiom “mi-yemei Ticho” (“from the days of Ticho”), figuratively meaning from the British Mandate days. A colleague on Ticho’s sixtieth birthday wrote that, “Dr. Ticho is beloved by everyone in the country, both Jew and Arab, and there is no doctor more popular than he.”⁵ Two questions from this experience spurred the beginnings of my research: Why did Ticho’s clinic come to signify an oasis of Jewish-Arab coexistence? How does an ophthalmologist become a celebrity?

To unpack these questions, I have attempted to trace trachoma—the disease Ticho treated most frequently—through a century’s worth of revamped regimes, medical doctrines, and global politics. Eye disease, and trachoma in particular, carried a huge amount of meaning in early twentieth century Palestine, and continued to retain a cultural and political salience well into Israeli statehood. This dissertation elucidates why trachoma commanded this distinct attention, and how this disease was constructed as an urgent medical, cultural, and scientific conundrum in the context of fluctuating worldwide interest. Physicians, scientists, travelers, patients and politicians all had a hand in framing the pursuit of healthy eyes as a civilizational struggle, an act of colonial benevolence, development aid, a research scientific triumph, and as a political entrée to the regional and global stage. Rather than hold fast to the myth of Ticho, I argue that trachoma was more likely to mark cultural differences between Palestine’s residents than unite them in tranquil tolerance. Trachoma was in concert an idea and an idiosyncratic illness, and the mobility of actors, agents and concepts were crucial in creating these cultural and clinical formations.

At the turn of the twentieth century, trachoma was widespread in practically every country in the world: whether in the United States’ “trachoma belt” through the Appalachian

⁴ Ephraim Sinai, *With the Entire Eye: The World of a Physician* [Hebrew], (Tel Aviv: Tzrikover, 1984): 106.

⁵ Ephraim Sinai, “Ticho on his Sixtieth Birthday,” *Harefuah* 24-25 (1943): 169.

mountains, the Jewish ghetto in Amsterdam, or villages along the Egyptian delta. Its prevalence led to the founding of the first eye hospitals in Europe and helped to launch ophthalmology as a specialty.⁶ Although trachoma is now known to be caused by the chlamydial organism, *chlamydia trachomatis*, its boundaries were in flux until the agent was isolated in 1957. Even so, eye doctors always identified trachoma by its telltale sign: the granular inflammation of the conjunctiva, the tissue lining the eyelid (that looks like little seeds, which is why the disease is called *garenet* [גרענת] in Hebrew, from the root word for “seed” [גרעין]). If it is left untreated after repeated infections, trachoma can scar the eyelids and corneas, and eventually cause blindness. The inflammation, combined with trichiasis—in which the eyelashes grow inwards—cause further damage by producing an opaque layer over the cornea. Originally cured with antibacterial copper sulfate and silver nitrate topical ointments, sulfonamide drugs, and later antibiotics, became standard care throughout the 1940s and 50s.⁷ Although trachoma is still cited as the leading cause of preventable blindness, it has all but been erased from public knowledge.⁸ The discrepancy between its global pervasiveness in the first decades of the twentieth century and its current obscurity—even if it still affects 146 million people in the world’s poorest countries—is one of the prevailing tensions and questions motivating my research.

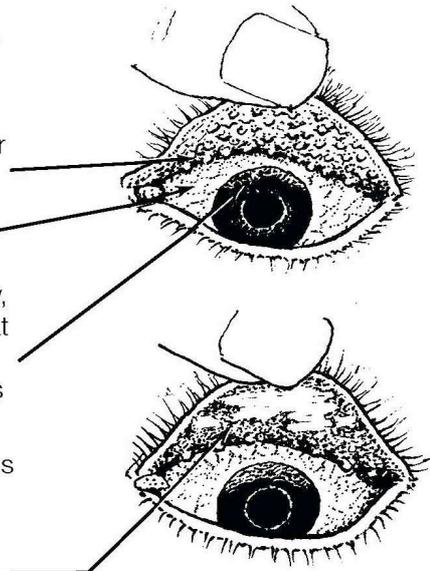
⁶ Hugh Taylor, *Trachoma : A Blinding Scourge from the Bronze Age to the Twenty-First Century* (Melbourne: Centre for Eye Research Australia, 2008), 19.

⁷ Julius Shachter, “Chlamydial Infections,” in *Bacterial Infections of Humans*. Eds: Philip Brachman and Elias Abrutyn, (New York: Springer, 2009) 221-247.

⁸ Julius Schachter and E. Russell Alexander, “Chlamydial Infections,” in *Bacterial Infections of Humans* (Springer, 2009), 221.

Signs:

- Trachoma begins with red, watery eyes, like ordinary conjunctivitis.
- After a month or more, small, pinkish gray lumps, called follicles, form inside the upper eyelids. To see these, turn back the lid as shown on p. 218.
- The white of the eye is a little red.
- After a few months, if you look very carefully, or with a magnifying glass, you may see that the top edge of the cornea looks grayish, because it has many tiny new blood vessels in it (*pannus*).
- The combination of both follicles and pannus is almost certainly trachoma.
- After several years, the follicles begin to disappear, leaving whitish scars.



These scars make the eyelids thick and may keep them from opening or closing all the way.

Or the scarring may pull the eyelashes down into the eye, scratching the cornea and causing blindness.

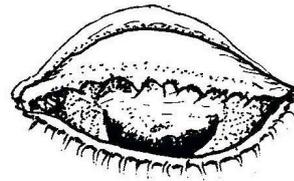
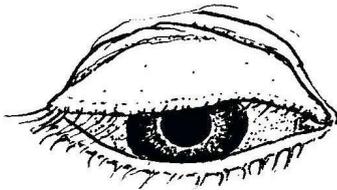


Figure 2: “Trachoma,” from *Where There is No Doctor: A Village Healthcare Handbook*, by David Werner (2011)

My dissertation reexamines this trajectory of decline through considering a particular Jewish history of trachoma that spans Palestine and Israel from the late nineteenth century through the 1970s. Rather than confined to that sliver of geographic space, tracking Jewish interest in trachoma mirrors important shifts in geopolitical developments, highlighting new areas of the globe with each decade: German medical and orientalist scholarship in the late nineteenth century, the rise of the American-sponsored Hadassah Medical Organization in the Mandate period, decolonizing North Africa in the 1950s, and sub-Saharan Africa in the postcolonial era. In so doing, I also hit the keynotes of trachoma’s prominence (or lack thereof) on the international scientific stage, which included debates concerning its etiology, epidemiology, and mass treatment. I argue that Jewish histories of trachoma embody the

broader strokes relevant to the global history of the disease, and in some instances were instrumental in formulating its contours.

Trachoma was not only endemic in late Ottoman Palestine—second only to malaria in importance to Jewish physicians—it was also one of its defining features. The eye disease was marked as the “blinding scourge of the Orient” due to high chronic incidence rates throughout the Arab East and North Africa; and at the same time, represented apathetic poverty, hygienic carelessness, and cultural backwardness owing to its particular etiology. Zionist health organizations were concerned that physical and spiritual regeneration would not be possible in a country where “not ten percent of the population have absolutely sound eyes,” propelling a forty-year treatment campaign managed by the Hadassah Medical Organization beginning in 1918.⁹ I argue that because of trachoma’s idiosyncratic biology and regional prevalence, it became a resilient site for Jewish physicians to create and contest cultural demarcations between modern binaries, including East and West, Jewish and Arab, and modern and primitive. Besides being a ubiquitous scene on the streets of the Jerusalem, Gur-Arie depicted a line of eye patients on a postcard because it fit into his conception of the Orient. Jewish physicians conceptualized trachoma as a disease of the Orient, the East, of the backward and uncivilized; and the anxieties concerning how and whether Jews fit into that category bubbled to the surface wherever trachoma manifested.

I investigate what it meant for trachoma to be considered a disease of the East throughout three political regimes in Palestine and Israel, and the social, ethnic, and political tensions the presence of trachoma raised about who was modern. During Ottoman and British Mandate Palestine, trachoma treatment negotiated, blurred, and set distinct boundaries between Jews and Arabs, Middle Eastern Jews and European Jews, physicians and

⁹ Theodore Harrison Butler, “The Clinical Features, Bacteriology, and Treatment of Acute Ophthalmia in the East, with an Analysis of 5,700 Cases,” *Royal London Ophthalmic Hospital Reports and Journal of Ophthalmic Medicine and Surgery* 17 (1907): 115.

auxiliaries, biomedicine and folk remedies, and the health of the eye and the health of the nation. In the postwar period, when trachoma nosedived as a national concern of public health, trachoma instead illuminates how Jewish organizations and the State of Israel utilized their ocular expertise to make their mark on the Third World through technical solutions embodied as development aid, both to Jews in North Africa and non-Jews in sub-Saharan Africa. A “disease of the East” was recast to highlight differences not only between Jews and Arabs, but between developed and developing, white and black, and purveyors and receivers of aid. Trachoma lends itself to a storyline that threads the politics of race and disease in the Yishuv, global health in postwar French Protectorate Morocco, and development aid in postcolonial sub-Saharan Africa into a coherent whole.

Literature

My research engages and brings together a range of sources, approaches, and topics that have customarily been approached in discrete terms. In particular, I aim to situate my work within the history of medicine, Jewish studies, Israeli history, and Middle Eastern studies. I argue that scrutinizing Jewish histories compels the historian of global health to rethink inherited binaries, and to follow alternative transnational experiences of disease, unofficial medical networks, and new comparative settings. Likewise, following trachoma wherever it ignites interest offers new chronologies and contexts for the Jewish historian, one that highlights oft-overlooked actors and political flashpoints.

An emerging history of the Jewish relationship to colonialism has argued that attention to Jews—a non-natural and liminal category that had been inscribed in divergent legal and imaginative frameworks throughout the colonial world—has the power to shift colonial studies away from standard subjects and chronologies.¹⁰ This approach has invited

¹⁰ Sarah Abrevaya Stein, “Jews and Modern European Imperialism,” in *The Cambridge History of Judaism: The Modern Period*, ed. Mitchell Hart and Tony Michels (Cambridge; New York: Cambridge University Press, Forthcoming).

new transnational subjects of inquiry that complicate our understandings of what the term “Jew” meant across time and space. This literature has focused on specific and local contexts, the use of new source material in various languages, and has situated itself firmly within Ottoman or Middle East studies to produce empirical scholarship in a field that had suffered from both a reliance on the modernization paradigm, and an over-theorization of identity politics.¹¹ Investigating the history of the Jewish stake in trachoma control through time periods often discussed separately and across the Middle East, I analyze complex ideologies, ethnic relations, migrations, and geopolitical relationships that are obscured when we employ traditional categories and periodizations.

Despite the recent proliferation of this critical scholarship, Jews have so far made a scant appearance within the histories of colonial and postcolonial medicine. As neither a Great Power nor the wronged native, Jews in the history of medicine have been relegated to internal narratives about Jewish pathology and modernization in Europe, or to Zionist constructions of disease and difference in Palestine and Israel.¹² A small cohort of historians have published superb scholarship on how healthcare structured social hierarchies by marking class, ethnic or racial differences between European Jews, Middle Eastern Jews, and Arabs in Mandate Palestine and Israel. Some members of this same group have also looked

¹¹ See, for example, Julia Phillips Cohen, *Becoming Ottomans: Sephardi Jews and Imperial Citizenship in the Modern Era* (Oxford: Oxford University Press, 2014); Orit Bashkin, *New Babylonians: A History of Jews in Modern Iraq* (Stanford, Calif.: Stanford University Press, 2012); Michelle Campos, *Ottoman Brothers: Muslims, Christians, and Jews in Early Twentieth-Century Palestine* (Stanford, Calif.: Stanford University Press, 2011); Emily Gottreich and Daniel Schroeter, *Jewish Culture and Society in North Africa* (Bloomington, Ind.: Indiana University Press, 2011); Joshua Schreier, *Arabs of the Jewish Faith: The Civilizing Mission in Colonial Algeria* (New Brunswick, N.J.: University of Rutgers Press, 2010).

¹² See, for example, Sander Gilman, *The Jew's Body* (New York, 1991); John Efron, *Medicine and the German Jews: A History* (New Haven, 2001); Mitchell Hart, *Social Science and the Politics of Modern Jewish Identity* (Stanford, 2000); Nadav Davidovich & Avital Margalit, “Public Health, Racial Tensions, and Body Politics: Mass Ringworm Irradiation in Israel 1949–1960,” *Journal of Law, Medicine and Ethics*, 36 (2008) 522–9; Dafna Hirsch, “‘Interpreters of Occident to the Awakening Orient’: The Jewish Public Health Nurse in Mandate Palestine,” *Comparative Studies in Society and History* (2008) 227–55; Nadav Davidovitch and Rakefet Zalashik, “Pasteur in Palestine: The Politics of the Laboratory,” *Science in Context* (2010) 401–25; Sandra Sufian, *Healing the Land and the Nation: Malaria and the Zionist Project in Palestine, 1920–1947* (Chicago, 2007).

westward, contextualizing the activities of Jewish health organizations in interwar Europe within broad frames, including those of the American Jewish Joint Distribution Committee, and the OZE/OSE (Society for the Preservation of the Health of the Jewish Population).¹³ These authors successfully use the history of medicine to illuminate a broader socio-cultural Jewish or Israeli history. I tell a Jewish tale of trachoma to rewrite a global history of medicine that questions the topics, actors, organizations, and geographies that have to date received attention.

A history of medicine in Israel does not have to be bound by state borders. In fact, the history of medicine and science demands a transnational view of Israeli politics and priorities that do not necessarily dovetail with the standard Israeli-Arab conflict timeline, punctured by one war after another. Although Yishuv and Israeli social and political circumstances indeed determined to some extent how trachoma was conceptualized and controlled, Zionist physicians adhered and contributed to the international language of science itself, with its own rules and trends. Leon Wulman, the executive director of the World Union-Oeuvre de Secours aux Enfants (OSE), best expressed how a particular scientific network mutually reinforced the importance of Jewish health in Israel and in the diaspora:

“The health-problems of the Jews in the Diaspora and in Israel are closely interwoven. Thanks to the presence of Israel on the various UN health commissions, the problem of Jewish health—not only in Israel, but the world wide over as well—has recently come to the forefront. I have mentioned before that the health of Jews in the Diaspora will closely affect health conditions in Israel. It is equally true that medical progress and scientific advances made in Israel—which has the double incentive of establishing a modern state and founding it on the soundest basis possible—can be an inspiration

¹³ See, Rakefet Zalashik, “The Anti-Favus Campaign in Poland,” *Polin* 27 (2015): 369–84; Rakefet Zalashik and Nadav Davidovitch, “Taking and Giving: The Case of the JDC and OZE in Lithuania 1919–26,” *East European Jewish Affairs* 39, no. 1 (April 1, 2009): 57–68; Nadav Davidovitch and Rakefet Zalashik, “‘Air, Sun, Water’: Ideology and Activities of OZE (Society for the Preservation of the Health of the Jewish Population) during the Interwar Period,” *Dynamis* 28 (January 2008): 127–49.

and an example to be followed by Jewish public health institutions in the Diaspora."¹⁴

Following the nature of this interaction requires moving beyond questions of the origins of the conflict, moral judgments of Zionism, or cultural histories of the everyday: it instead demands tracing how Jewish history and Israeli history could converge through global geopolitical trends: colonialism, internationalism, decolonization, the Cold War, and development. I argue that Israel's distinctive set of governing structures—and its connections to the Jewish diaspora—over the past one hundred years makes it all the more fascinating a site to create new conceptual models of “colonial” and “postcolonial” medicine.

This becomes clear when we broaden the scope of the literature on technical development, of which Israel and Jewish organizations have been completely excised. Microhistories of the American Jewish Joint Distribution Committee's (JDC) Mass Trachoma Project in Morocco and Israel's eye aid programs in sub-Saharan Africa fulfill several directions research scholars have encouraged. First, a focus on these projects moves beyond the US-Soviet binary, following new work that has evaluated how European and Asian modernizing projects unfolded in the Third World. Second, there is more known “about modernization as an intellectual framework than about modernization on the ground,” and interrogating local projects permits us to see how variegated practices intersected with professed ideologies.¹⁵ This approach also decenters the nation by explaining how individuals and organizations had great sway in how these projects were constructed and implemented. Third, I turn from the usual emphasis on behemoth technocratic projects to medical aid, which has been usually lumped with humanitarianism and excluded from the literature on foreign aid altogether. While the JDC was an American philanthropic organization

¹⁴ Leon Wulman, “Problems of Jewish Health in the Diaspora,” Box 1773, RG 494, OSE Collection, YIVO Archives, Center for Jewish History (CJH), New York.

¹⁵ David C. Engerman and Corinna R. Unger, “Introduction: Towards a Global History of Modernization,” *Diplomatic History* 33, no. 3 (2009): 375–85.

positioning itself as global health player on a par with the WHO in the 1950s, Israel's eye aid program in the 1960s represented a rather different kind of engagement with global health, one that was arguably not about health at all.

The history of medicine in the colonial world itself is varied and wide ranging, investigating how medical missions intersected with civilizing missions, how colonial discourses were used to explain disease prevalence, and the relationship between the metropole and colony in propagating certain medical theories and practices. This scholarship has wavered between social and cultural approaches, understanding the importance of cultural constructions but also of biological realities.¹⁶ In her plea for more comparative social studies of medicine, historian Ilana Löwy insists that “Diseases are transnational phenomena; medicine and public health are often global endeavors; medical practice is influenced by international rules and regulations, and by global economic and political trends; medical researchers and medical practitioners travel, as do their ideas, and developments in one country may affect those in other countries.”¹⁷ Fearful that the “transnational” approach to history will remove its critical political edge, Warwick Anderson reasserted his commitment to postcolonial analysis, which “means we recognize how modern science and biomedicine are put together, assembled, on the terrain that various sorts of colonialism have worked over—whether in Asia, Africa or Europe.”¹⁸ In as much as recent scholarship champions attention to global health—including to transnational comparisons and

¹⁶ See, for example, Richard Keller, *Colonial madness: psychiatry in French North Africa* (Chicago, 2007); David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley, 1993); Randall Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley, 1990); Megan Vaughn, *Curing Their Ills: Colonial Power and African Illness* (Palo Alto, 1992); Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, 1999). For a historiographical review, see, Warwick Anderson, “Postcolonial Histories of Medicine,” in Huisman F. and Warner J. Harley (eds), *Locating Medical History: The Stories and Their Meanings* (Baltimore, 2004) p. 285–306.

¹⁷ I. Löwy, “The Social History of Medicine: Beyond the Local,” *Social History of Medicine* 20, no. 3 (October 2007): 465–81.

networks, and to the role of international organizations, including the Rockefeller Foundation, the League of Nations and the World Health Organization—I argue that Jewish history can be a fruitful analytic frame in conceptualizing the colonial, international, and global together. By incorporating Jews and Israel into global health, how do we complicate existing historical narratives?

Perhaps most obviously, we can look to the Middle East, the region of the colonial world populated by the largest number of Jews. While historians of Africa and India have composed a large corpus of the literature on colonial medicine, it has not been sufficiently explored in the Middle East or North Africa. This is in part because imperialism in the Middle East was manifest in complicated and varied forms: economic penetration, diplomatic coercion, settler colonization, occupation, and protected states. A lack of language training, and a tendency to focus on “Islamic” science or medicine during its perceived medieval heyday also likely contributed to this shortage. Although a growing number of works have started to address this lacuna, it generally is not in conversation with a history of medicine audience.¹⁹ Despite the large Jewish minority in those places, they have rarely figured into these studies as a category of analysis. How can we reevaluate disease campaigns, conceptions of hygiene, health education, and the creation of scientific knowledge in the Middle East if Jews are not sidelined as besides the point?

¹⁸ Warwick Anderson, “Making Global Health History: The Postcolonial Worldliness of Biomedicine,” *Social History of Medicine*, 2014: 10.

¹⁹ Examples include, Nancy Gallagher, *Egypt’s Other Wars: Epidemics and the Politics of Public Health* (Syracuse, 1991); Amira El Azhary Sonbol, *The Creation of a Medical Profession in Egypt, 1800-1922* (Syracuse, 1991); Richard Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago, 2007); Timothy Mitchell, *Rule of Experts: Egypt, Techno-Politics, Modernity* (Univ of California Press, 2002); Hatem, Mervat F. “The Professionalization of Health and the Control of Women’s Bodies as Modern Governmentalities in Nineteenth-Century Egypt,” in Madeline C. Zilfi (ed.), *Women in the Ottoman Empire: Middle Eastern Women in the Early Modern Era* (Leiden: Brill, 1997); Khaled Fahmy, *All the Pasha’s Men: Mehmed Ali, His Army, and the Making of Modern Egypt* (Cambridge Univ. Press, 1997).

When we start shining a light on the Middle East, it is impossible to ignore that one disease was “practically universal.”²⁰ Trachoma has never been explored in the historiography of medicine and empire because it lacked the mortality rates, a requirement of quarantine, or weight in the colonial imaginary that would have made it of prime importance to administrators. Instead we have dozens of monographs on the same signature diseases: malaria, cholera, leprosy, syphilis, tuberculosis, bilharzia, typhus, and madness. Each disease biography unites a particular set of actors, institutions and anxieties, as “Disease is thus historically as much as biologically specific.”²¹ It is mind-boggling that trachoma, which affected 15% of the entire world’s population, has not hitherto received scholarly scrutiny. In general, the history of ophthalmology has not been “deinstitutionalized” and remains within the realm of practicing physicians, rather than professional historians.²²

Trachoma, however, proved to be indispensable to understanding public health in Palestine. This had everything to do with trachoma’s causes and mode of transmission. Since its agent was not isolated until 1957, the causes of trachoma remained a fluctuating conversation, from the 1914 Trachoma Conference in Palestine to the World Health Organization Second Expert Committee on Trachoma in 1956. However, it was decidedly a disease of poverty and unhygienic practices. To take care of the eye, then, always required a sort of variation on investigating social customs, home conditions, and intensive hygiene education. The restoration of sight and healthy eyes had to be accompanied by the

²⁰ A. F. MacCallan, “The Epidemiology of Trachoma,” *The British Journal of Ophthalmology* 15, no. 7 (1931): 378.

²¹ Randall M. Packard, *The Making of a Tropical Disease: A Short History of Malaria* (Johns Hopkins University Press, 2010), ii.

²² See, for example, George Gorin, *History of Ophthalmology* (Wilmington, Del: 1982); Daniel M. Albert and Diane D. Edwards, *The History of Ophthalmology* (Cambridge, 1996). The focus remains on its development as a specialty in nineteenth century Germany. However, a literature has developed on the dominance of vision in modern culture, including Jonathan Crary, *Techniques of the Observer: On Vision and Modernity in the Nineteenth Century* (Cambridge, Mass., 1992); Martin Jay, *Downcast Eyes: The Denigration of Vision in Twentieth-Century French Thought* (Berkeley, Calif., 1993); David Michael Levin, ed., *Modernity and the Hegemony of Vision* (Berkeley, Calif., 1993).

population's acceptance of modern hygiene. Trachoma became a sometimes obsessive locus of attention because the health of the body and the social environment were manifest in the health of the eye, whether in Palestine, Morocco, or Africa. To be an ophthalmologist was to be a practitioner of primary care and social medicine, in its myriad forms and ideals. That is why an eye doctor could become the most popular physician in Palestine.

Since the incidence of trachoma was so tightly connected to poverty, examining trachoma treatment and the practices of mass campaigns highlights the shifting boundaries of what was considered medical over an one hundred year period. Physicians oscillated between blaming the individual for his moral shortcomings, and a deeper sympathy that socio-economic conditions were beyond any one's control. In the name of both understanding and treating trachoma, then, ophthalmologists became experts of the Orient, development, and diplomacy, forming a distinctive configuration of producing knowledge. There existed consistent hope that a dogged investment in medical solutions could solve the trachoma problem, even if since the turn of the century physicians conceptualized poverty—rather than an agent—as the cause. Medical authority stood aside other types of social expertise, which were crucial to addressing a “social” disease.

By tracing trachoma, I tell a story that crosses Ottoman, British Mandate, and Israeli State rule that also pulls attention to non-normative political conjunctures. Trachoma was most often salient when the boundaries between modern and non-modern were in question. These moments were often pulled under the rug of Western victory, glossing over the period where it was unclear how certain relationships would unfold. This is true for Zionist ophthalmologists in Mandate Palestine who saw practicing medicine in Gaza as a form of pioneering, JDC healthcare workers who conceptualized their work in Morocco as development aid, and Israeli eye doctors in Africa who identified with postcolonial solidarity. In the postwar period, these sites push Israel into a global conversation about medical aid and

philanthropy, rather than into a simple story of nation building. Trachoma reveals the variegated Jewish relationships to empire, decolonization, and global health, as subjects, experts and state actors.

A Biography of Disease

The chapters are both chronological and geographic in focus, highlighting how trachoma was defined and what kind of problem it signified during each period. I first trace the story of Jewish ocular expertise and incidence through Egypt, Germany, and Palestine in order to delineate trachoma's significance on the cusp of World War I as the "Oriental problem," making colonial ethnography a key component of the ophthalmologist's craft. I explore the scientific uncertainties surrounding trachoma at the turn of the century, and how it became constructed as both a disease of poverty, and as a "scourge of the East," as a result of regional prevalence, travel narratives and historical research on Arabic ophthalmology (by Jewish ophthalmologist-orientalists). At the turn of the century, physicians in Palestine and throughout the world mulled over nearly every facet of trachoma: its causes, modes of transmission, diagnostic markers, and even the name itself. Even though trachoma was a fluid entity and global phenomenon, physicians in Palestine conceived of and conducted the one of the longest anti-trachoma campaign in the twentieth century. Why and how did this group of Jewish ophthalmologists, mostly European immigrants at the beginning of their careers, frame trachoma as an urgent medical, cultural, and scientific problem? Through interweaving narrative threads about the construction of trachoma as a disease of the East, the ambiguities of what trachoma was in the absence of an agent, and the historiography of ophthalmology, I show how Jewish physicians formulated eye health as integral to the cultural modernization of Palestine, as well as to its national scientific development. The crowning achievement of these efforts was the First Trachoma Conference in Jerusalem in

1914, where physicians created their own scientific principles on which they could design an anti-trachoma campaign.

Trachoma occupied its most notable place in Palestine during the British Mandate. This is true in all respects: the pages in Hebrew newspapers and medical journals devoted to its comprehension; the dollars donated to its mass treatment in the Yishuv; the tally of physicians and teachers rubbing silver nitrate on children's eyes; and the absolute number of residents infected. The British Mandate, however, was also a time of cultural ambiguities and political contradictions, which determined how these activities were conceptualized and implemented. I use two sets of sources—written and visual archival material of the Hadassah Medical Organization anti-trachoma campaign and memoirs of ophthalmologists in private practice—to illustrate how Jewish ophthalmologists in Mandate Palestine interpreted, negotiated, and produced their own visions of the relationship between Zionism and the Orient in this particular context. Unlike colonial rule in Africa or Southeast Asia, the mandate system was employed to give Palestine “proper guidance” before it could claim its own independence. During this period, however, the Zionist leadership spearheaded health, educational, and political institutions, jumpstarting their own civilizing missions and state-building endeavors, while the Palestinian Arab population were subject to British budget limitations. Within this peculiar political framework, the Hadassah Medical Organization, an American Zionist social welfare organization, operated as the proto-state Jewish Department of Health, seeking to inculcate a backwards place with modern and Western ideas.

Although at the start of the British Mandate, trachoma afflicted the entire population—including Ashkenazi skull-capped boys and pioneers in the Jezreel Valley—Middle Eastern Jews and Arabs bore most of its brunt. In Gur-Arie's postcard, Jews are indistinguishable from Arabs; indeed, we don't know what they are. A “new Jew” worthy of the ideals of the much hoped-for progressive and scientific Zionist state could not afford to

bear this mark, and the Hadassah Medical Organization put more money and manpower than anything else into treating this stigma. Yemenite Jews were already inscribed as inferior in their faces, and whether they could resolve this typological difference through digesting the rules of hygiene remained to be seen. Trachoma had become a “problem of hygiene,” and this was reflected in how physicians understood the disease’s etiology, and as a requirement for entry into modernity. To combat this entity required a mass campaign underpinned by mounds of statistics. The “traveling oculist” of the public health anti-trachoma campaign constructed the Yemenite Jew as a medical and cultural liability through scientific publications, reports, and correspondence, but also portrayed a complex epidemiological picture that indicated how social factors and the economics of health care—not just cultural deficiencies—contributed to Yemenite trachoma prevalence. The British Mandate Government’s Department of Health, which served the indigenous Arab population, also conceptualized trachoma as a disease of hygiene—but unlike Hadassah—contended with harsher summer bacterial eye infections in Southern Palestine (where Jews did not settle) that led to blindness.

Rather than just a disease of reproach, trachoma could also illustrate the Orient as “a metaphor for metamorphosis,” where Jewish ophthalmologists could set up shop in Gaza or Nahariya and become experts in Arab bodies, language, and customs. I use two first-person narratives to analyze how Jewish eye doctors navigated operating a private practice for Palestinian Arab patients and how they conceived of that enterprise in terms of their Zionist ideals. These accounts reveal that treating Arabs with trachoma served as a sphere where doctors could “go native” or make Arabs “modern,” highlighting the benefits of Zionism by bestowing humanitarian assistance to the East. Eye doctors in private practice understood Arabs not as subjects obliged to assimilate, as they had Yemenite Jews, but as a potential patient base in an over-saturated medical market. I look at how these narratives complicate

and conserve the colonial fiction of Arab indebtedness to Zionist welfare, even as the Hadassah anti-trachoma campaign deliberately excluded them.

After the State of Israel was founded in 1948, trachoma had become a “problem of global health,” apparent in the new UN health organizations created to tackle diseases, and the concurrent international research program that was determined to at last isolate trachoma’s elusive agent. Both agendas were possible with the spate of new technologies that proffered as a result of World War II, including antibiotics, chemical and cytological tests, and laboratory equipment. Israel’s ability to enter this conversation, and its continued concern in trachoma was the result of the mass migration of North African Jews in the 1950s. This was manifest in two distinct ways. Within Israel’s borders, the mass immigration from North African and Middle Eastern countries “recreated the trachoma problem” (even as the mass departure of Palestinian refugees removed much of the burden), and spurred new forms of panic, fear, and stigmatization of the disease. I trace the debates surrounding the form and continuation of the Hadassah anti-trachoma campaign to counter the narrative that trachoma was “eradicated” by 1948. The burgeoning ophthalmology department of the Hadassah Hebrew University Hospital combined small-scale prophylactic activities with a robust Trachoma Research Unit, whose activities included isolating the trachoma agent and trying to develop a trachoma vaccine. Rather than merely patients, Mizrahi and Arab residents of the Jerusalem corridor became research subjects. The unique legacy of ocular expertise enabled Israeli ophthalmologists to gain international repute in medical research in the postwar scientific landscape.

Although the anti-trachoma campaign in Israel had dwindled from its peak in the Mandate period, the American Jewish Joint Distribution Committee’s (JDC) “Mass Trachoma Project” was in full swing in the mellah of Casablanca in 1953, spreading to Marrakesh, Taroudant, and Tunis in 1954. The JDC was the largest Jewish philanthropic

organization in the world, and had turned its attention to North Africa after the crisis of Holocaust refugees in Europe had petered down. Trachoma was tagged, along with tuberculosis and ringworm, as diseases that could overwhelm Israel's already tenuous health services, and therefore appropriate for medical selection (although this restriction was enforced inconsistently across countries, and was eliminated after 1953). The Mass Trachoma Project could then be construed as another example of collaboration between the JDC and the Jewish Agency in service of Zionist immigration.

However, focusing solely on immigration obscures a different global context in which JDC operated: that of development in the decolonizing Third World. JDC personnel were steeped in this mental universe that championed modernization as a quintessential American mission, and development assistance as an indispensable part of defining America's place in the Cold War world. The Mass Trachoma Project was emblematic of the disease control campaigns that characterized international health in the postwar period, and championed the World Health Organization's terms of "mass campaign"—even though two blocks of an urban neighborhood was not exactly mass—and sought to "eradicate" the disease. Indeed, JDC efforts were concurrent with World Health Organization (WHO) anti-trachoma campaigns in Morocco, and mimicked its practices while adapting them to suit particular Jewish needs. Early 1950s North Africa was postwar, but not postcolonial; and the French Protectorate battled with the JDC and the WHO to claim it knew its natives best. The Mass Trachoma Project underlines that the future of Moroccan Jewry was uncertain, and that the JDC was invested in maintaining Jewish life in situ, and presenting itself as an international organization on a par with the WHO and Santé that participated in health development. Using material from the World Health Organization archives, the JDC archives, and medical publications, I claim that a historical investigation of Jewish anti-trachoma efforts in Morocco foregrounds often overlooked actors of postwar colonial medicine, and

demonstrates how international Jewish philanthropic organizations took part in shaping global health priorities.

I lastly survey Israel's extensive eye aid programs to sub-Saharan Africa within the 1960s postcolonial world when development became enshrined as an international norm. Trachoma, at this point, was no longer a Jewish problem. However, it could serve to heal a thorny "diplomatic problem." The Ministry of Foreign Affairs had realized Israel's socio-political isolation when it was not invited to the 1955 Bandung Conference of Asian and African states. To counter Arab diplomatic objectives in the international arena, Israel sought to develop ties to decolonized African states as an extension of their "periphery doctrine." At the political height of the Third World, Israel could use its triumph over trachoma to both indicate its alliance with developing countries, and prove its achievement of modernity. I will explicate the medical and scientific practices of the eye aid program, and how it both replicated and sought to distinguish itself from perceived colonial practices. Addressing Israel's self-fashioning in this highly visible and competitive arena of international exchange, I examine Israel's claims to be a bridgehead between East and West, and its short-lived affiliation with the Global South through ocular aid. Africa became an extra-territorial site of pioneering for eye doctors that provided a new reservoir of clinical and research experiences, creating a means to professionalization that was no longer available within its own borders. By carrying the examination of eye care into its first two decades rather than ending in 1948 with the creation of the state, we can see how Israel further created a range of representations of itself that were not clearly European, but that teetered between West and non-West, colonial and post-colonial, developing and developed.

A Final Thought

"Would it not be strange then, if we, the people of the Book and of science, who desire to create in Palestine a center for culture of the highest kind, not only for the East but for the world, should fail to do something in the way of solving scientific problems? One of these

problems is the etiology and therapy of trachoma. For decades this question has been occupying men of science, and its solution ought to be found here in Palestine."²³

-Dr. Haim Yassky, Ophthalmologist and Executive Director of the Hadassah Medical Organization (1931-1948), 1921

*"Somebody has said that you could look at Israel in two ways: an effort to answer Jewish questions or as an effort to answer world questions...the fight against trachoma...reflects the dual light of life here—to cure our own sickness and to show other countries, especially Eastern ones, what can be done."*²⁴

-Dr. Isaac Michaelson, Head of the Hadassah Hospital Ophthalmology Department (1954-1974), 1951

A generation apart, Haim Yassky and Isaac Michaelson figure as major physicians in the story that follows. The similarity of their sentiments is striking. Despite sweeping changes in political context and medical conditions, trachoma represented two coexisting and competing forces that collectively shaped Israel's development: a desire to prove its worth on the world stage and to the Middle East. Keeping these attitudes in mind has helped me discover how trachoma remained salient even when it was no longer a national endemic concern. Trachoma was constructed as a disease of social importance especially relevant to the "local" environment, which could mean Palestine, the Middle East and North Africa, or the entire developing world. This expertise had cache in scientific journals, international conferences, and to the World Health Organization. It would be the impulse to pursue these two audiences that thrust trachoma through multiple waves of relevance and interest to Jews in the Middle East. The specificities of Jewish concerns fit into and have in part shaped the history of trachoma in the twentieth century.

²³ Haim Yassky, "The Institute for the Investigation of Trachoma and the Campaign Against Trachoma," n.d., J113/414, HMO Papers, CZA.

²⁴ Isaac Michaelson, "The Fight Against Trachoma in Israel," n.d., ISA/RG 57/G/180/12.

CHAPTER 1

The Blinding Scourge of the East

Introduction

The Trachoma Conference, the first Hebrew medical conference of Jewish physicians in Palestine, ended with a farewell party in the Old City of Jerusalem at the Amdursky Hotel on April 2, 1914. The editors of the published proceedings recalled that “the mood was jubilant, and even awe-inspiring...glasses were raised to the success of the war against trachoma, and to the blooming of Hebrew science...at a late hour, the friends parted with hearts full of hope and mutual regards that they would participate in the second trachoma conference.”¹ Almost half of all Jewish physicians in Palestine—twenty-four out of fifty—came to Jerusalem for the three-day affair, both ophthalmologists and generalists, as well as school teachers interested in learning more about the eye disease that pervaded their classrooms.

The Nathan and Lina Strauss Jewish Health Bureau hosted the conference, one of Jerusalem’s budding new medical research institutes charged with investigating the “two scourges of Palestine,” malaria and trachoma.² Endemic and visible, these diseases defined Palestine’s medical landscape for Zionist settlers and visitors. As one touring American rabbi put it, “Who hasn’t heard that Palestine is a land of malaria and trachoma? I suspect there are many people who have heard very little else.”³ While malaria was a familiar threat to administrators throughout the colonial world, trachoma was equated as the disease par excellence of the Orient, both in the geographic and cultural sense. Practically every country

¹ *Proceedings of the First Trachoma Conference: The First of Hebrew Physicians in Palestine* (Jerusalem: Nathan Straus Jewish Health Bureau, 1915) 124.

² Albert Montefiore Hyamson, *Palestine: The Rebirth of an Ancient People* (A. A. Knopf, 1917) 220.

³ Joseph Silverman, “Pen Pictures of the New Palestine Impressions of an American Tourist,” *Chicago Sentinel* (November 13, 1924) 9.

contended with trachoma, yet physicians considered the incidence rate so appalling in Egypt and Palestine that one had to see it to believe it: “Inhabitants of Egypt and Palestine suffer from eye diseases to an extent that can hardly be realized unless one has lived in the East.”⁴

The most important accomplishment of the Jerusalem Trachoma Conference, and its intended aspiration, was to create a plan for a public health anti-trachoma campaign that would span the entire Yishuv (the Jewish community in Palestine). This was difficult to do when no one knew what trachoma was exactly. Physicians in Palestine and throughout the world mulled over nearly every facet of the disease: the causes of trachoma and its transmission, diagnostic markers, and even the name itself.⁵ While Alphonse Laveran identified the causative agent of malaria in 1880, and Ronald Ross demonstrated that the anopheles mosquito was its vector seven years later, physicians researching trachoma had no such luck. It was not for a lack of trying. Ludwig Halberstaeder and Stanislaus von Prowazek, two curious assistants instructed to research gonorrhoea in Java in 1907, instead inoculated orangutans with trachoma scrapings. They discovered small bodies within infected cells they christened “chlamydozoa” that they believed caused trachoma.⁶ However, these inclusion bodies were also found in other diseases, creating doubt whether they were the real trachoma agent. Without a smoking gun, all modes of infection remained possible.

Even when the agent remained elusive, there was a strong consensus that poverty, unhygienic practices, and ignorance facilitated trachoma.⁷ Descriptions of trachoma never

⁴ Theodore Harrison Butler, “The Clinical Features, Bacteriology, and Treatment of Acute Ophthalmia in the East, with an Analysis of 5,700 Cases,” *Royal London Ophthalmic Hospital Reports and Journal of Ophthalmic Medicine and Surgery* 17 (1907): 115.

⁵ See Julius Boldt, *Trachoma* (Hodder and Stoughton, 1904); Ernst Fuchs, *The Causes and the Prevention of Blindness* (Baillière, Tindall and Cox, 1885); Robert Henry Elliot, *Tropical Ophthalmology* (Hodder & Stoughton, 1920); A. F. MacCallan, *Trachoma and Its Complications in Egypt* (Cambridge University Press, 1913); Sir Stewart Duke-Elder, *A Century of International Ophthalmology, 1857-1957* (Kimpton, 1958).

⁶ Phillips Thygeson, MD : *External Eye Disease and the Proctor Foundation : an Interview* (Foundation of the American Academy of Ophthalmology ; Regional Oral History Office, University of California at Berkeley, 1988) 52.

⁷ Boldt, *Trachoma*, 23.

failed to underline this link. Dr. Nahum Shimkin, an ophthalmologist in Haifa, wrote that “As far as the sanitary conditions of the Arab population in the villages are concerned, it is only necessary to see their mud huts without adequate light or ventilation, to see the whole family lying on the dirty floor or sleeping on unwashed and unclean bedding, to see the children dirty and uncared for, with pus discharging from their eyes, beset by multitudes of flies” to realize how easy the spread of trachoma was.⁸ Physicians indicated inadequate housing, overcrowding, scarce water supplies, infrequent washing, flies, and common use of towels, handkerchiefs, and cosmetics were all to blame. The frequency of trachoma was so tightly bound to living conditions that its prevalence “serves as a very reliable index to the social, economic and cultural status of the district affected.”⁹

Although trachoma was a fluid entity and global phenomenon, physicians in Palestine conceived of and conducted the one of the longest anti-trachoma campaigns in the twentieth century.¹⁰ Why and how did this group of Jewish ophthalmologists, mostly European immigrants at the beginning of their careers, frame trachoma as an urgent medical, cultural, and scientific problem? I will trace the story of Jewish ocular expertise and incidence through Egypt, Germany, and Palestine in order to delineate trachoma’s significance on the cusp of World War I.

Trachoma first gained widespread global recognition when it struck French and British armies invading Egypt at the turn of the nineteenth century.¹¹ Military officials, physicians, and travelers shocked at the ubiquity of eye disease came to see Egypt as “its

⁸ Nahum Shimkin, “Trachoma in Palestine: Its Epidemiology and a Review of Measures for Dealing With It,” *The British Journal of Ophthalmology* 10:5 (1926): 266.

⁹ Aaron Brav, “Trachoma as a Sociologic Index,” *American Medicine* 20 (1914): 41.

¹⁰ An anti-trachoma public health campaign in Mandate Palestine and Israel lasted from 1918-1960. Egypt and Russia also had long standing anti-trachoma campaigns throughout the twentieth century.

¹¹ Mary C. Karasch, “Ophthalmia (Conjunctivitis and Trachoma),” in *The Cambridge World History of Human Disease*, ed. K. F. Kiple (New York: Cambridge University Press, 1993) 903.

cradle and historic birthplace.”¹² German Jewish ophthalmologists pioneered writing the history of their branch, and helped to cement the notion that the origins of trachoma were located in Egypt and that ophthalmology was an Arabic science. Their historical conclusions added weight to the numerous physician and traveller firsthand accounts of rampant eye diseases in Egypt and its neighbor Palestine, which had the distinction of being second worst site for the disease in the world.¹³ A few students of Dr. Julius Hirschberg, the premier ophthalmologist-orientalist, took up his love of history and were active Zionists.¹⁴ This academic genealogy attuned Jewish eye doctors to trachoma as a disease of the East before they ever got there, and even encouraged young Zionist medical students to specialize in ophthalmology in order to fulfill Palestine’s special need.

Since trachoma originated in the Middle East, it was also embedded as a disease of primitive Arab culture, making it exigent as a Zionist health priority. After all, there were almost as many “cataractous, cross-eyed, sore-eyed Jews” as there were Arabs.¹⁵ An integral aspect of Zionist ideology was its “powerful mission civilisatrice to awaken the Middle East from its narcotized Levantine torpor, to shatter the fossilized soil of the Holy Land with European tools and technology.”¹⁶ Yanking Jews out of their “Levantine torpor” and placing them firmly within the enlightened camp was necessary in order for them to be modern. Treating trachoma was not only a matter of disease eradication, but of cultural demarcation.

¹² John McCullen MD, “Trachoma: A Disease of Equal Importance to Ophthalmologist and Public Health Officer and What the Government Is Doing to Eradicate and Prevent Its Further Spread,” *Journal of Ophthalmology and Otolaryngology* 11:2 (1917): 35.

¹³ Ernst Fuchs, *Text-book of Ophthalmology* (New York: D. Appleton, 1892) 177.

¹⁴ These include Dr. Harry Friedenwald and Dr. Aryeh Feigenbaum. Other Jewish ophthalmologist-historians included Philadelphians Dr. Benjamin Lee Gordon and Dr. Aaron Brav.

¹⁵ Flavel Benjamin Tiffany, *Around the World by an Oculist* (New York: Franklin Hudson Publishers, 1917) 107.

¹⁶ Derek J. Penslar, “Zionism, Colonialism and Postcolonialism,” *Journal of Israeli History* 20:2–3 (2001): 86.

As Haim Yassky, a Yishuv ophthalmologist and Hadassah administrator wrote, “there is no other cultured country that has the number of trachoma patients as large as we do.”¹⁷

However, ophthalmologists were not only interested in mass treatment, but in the highest levels of scientific research and inquiry. Successful ocular research projects and institutes would bring international recognition, strengthening the value of Zionist science and justifying national aspirations.¹⁸ The development of ocular expertise in Palestine would not only solve a Jewish problem, but would also highlight the benefits of Zionism by serving as humanitarian assistance for the rest of the East. Theodor Herzl envisioned this distinct contribution in his 1903 novel, *Altneuland*, when describing a Jerusalem eye clinic: “large numbers of people, gentlemen, have had their eyesight saved or restored there. You can imagine what a benefaction that clinic is for the Orient... The blessings bestowed by our medical institutions have won us more friends in Palestine and the neighboring countries than all our industrial and technical progress.”¹⁹

None of this progress could be made without money. American philanthropists made trachoma a priority perhaps to the same extent as physicians did. While ophthalmologists constructed trachoma as indigenous to the Arab East, American immigration officials pinned it as an Eastern European Jewish characteristic. The United States Public Health Service (USPHS) in 1897 designated trachoma a “dangerous, contagious disease” and concluded that a diagnosis demanded immediate return to the port of origin. Trachoma was the reason 87% of migrants were rejected from America on health grounds between 1897-1903, stigmatizing Eastern European Jews, as well as Greek, Syrian, and Italian immigrants.²⁰ Dr. Aaron Brav, a

¹⁷ Letter from Haim Yassky to Henrietta Szold, 3/30/25, Box J113/411, Hadassah Collection, Central Zionist Archives (CZA), Jerusalem.

¹⁸ Sandy Sufian, “Colonial Malariology, Medical Borders, and Sharing Scientific Knowledge in Mandatory Palestine,” *Science in Context* 19:3 (2006): 381.

¹⁹ Theodor Herzl, *Altneuland = Old-new Land: Novel* (Haifa: Haifa Pub. Co. 1964) 62.

²⁰ Krista Maglen, “Importing Trachoma: The Introduction into Britain of American Ideas of an ‘Immigrant Disease’, 1892–1906,” *Immigrants & Minorities* 23, no. 1 (2005): 80.

Jewish ophthalmologist in Philadelphia, thought the USPHS went too far in demonizing trachoma, and termed their sentiments “trachomaphobia...This is a peculiar nervous affection, affecting some members of our profession who go into hysterical convulsions every time they see a few granules on the lids of a foreigner.”²¹ It would not be farfetched to speculate that apprehension about trachoma stateside in part fueled the initial stream of funding American philanthropists Nathan Strauss and Henrietta Szold unleashed for anti-trachoma activities in Palestine. Indeed, Szold sent two American nurses to tackle trachoma in a Jerusalem eye clinic on Hadassah’s inaugural mission in 1913.²²

Through interweaving narrative threads about the history of ophthalmology, the construction of trachoma as a “blinding scourge of the Orient,” and Zionist efforts to create national scientific expertise, we can understand why and how trachoma fascinated. Physicians, scientists, travelers, patients and politicians formulated eye health as integral to the cultural modernization of Palestine, as well as to its national scientific development. This chapter will therefore both discuss how trachoma became formulated as a disease of the East, and how that conception was transformed into a scientific practice and thought. Trachoma was in concert an idea and an idiosyncratic illness, and it is impossible to disentangle the discourses of trachoma from the epidemiology of the disease itself.

How Ophthalmia Became Egyptian: Trachoma at the Turn of the Century

Who had trachoma? Dr. Julius Boldt, a German ophthalmologist, proclaimed in his book *Trachoma* (1904) that the eye disease “extends more or less over the whole world”: it “had made terrible ravages in almost every country in Europe...and throughout Asia trachoma is found to be no respecter of race, the Aryan, Semitic, and Mongolian suffering

²¹ Aaron Brav, “Are We in Danger of Trachoma?,” *New York Medical Journal* 93, no. 9 (March 4, 1911): 112.

²² Shifra Shvarts and Shehory-Rubin, Zipora, *Hadassah for the Health of the People* (Hebrew). (Jerusalem: Hasifria Hazionit, 2003) 41.

with equal and terrible frequency.”²³ However, some countries were more afflicted than others. It was “practically universal” in Egypt, Morocco, Tunisia, Algeria, Palestine, Arabia, Persia and Iraq, “very common” in Italy, Greece, Poland, Finland, Russia, China, Japan, and Mexico, and yet “rare” in Canada, Denmark and Sweden.²⁴ Physicians proffered theories to explain why.

In the age of tropical disease that placed a premium on place, physicians debated how geographical and climactic factors might play a role in trachoma incidence. The Oriental environment was found culpable of near-universal trachoma, including the “dazzling light from a cloudless sky, the tremendous heat, the hot south wind or sandstorm (chamsin), the dust from the desert, and the suppression of perspiration owing to the cool nights and the dew.”²⁵ Shimkin explained that winds carried dust and sand that penetrated the eyes, and that heat triggered people to wipe the sweat from their face and eyes with dirty hands, further exacerbating the trauma.²⁶ On the other hand, as one professor noted, “we find it prevailing enormously in moist and foggy Ireland.”²⁷ French ophthalmologist Dr. Paul Chibret determined that trachoma infrequently occurred above 200 meters, explaining why alpine Switzerland was unaffected. However, it did not explain why the mountainous Caucasus, at over 2,000 meters, was rife.²⁸ Although there was no hard and fast geographic rule that could determine trachoma prevalence, the environment persisted as a contributing causal factor.

²³ Treacher-Collins, Introduction to *Trachoma*, xii.

²⁴ A. F. MacCallan, “The Epidemiology of Trachoma,” *The British Journal of Ophthalmology* 15, no. 7 (1931): 369.

²⁵ Boldt, *Trachoma*, 127.

²⁶ Shimkin, “Trachoma in Palestine,” 267.

²⁷ Fuchs, *The Causes and Prevention of Blindness*, 156.

²⁸ Boldt, *Trachoma*, 120.

Other ophthalmologists determined “the trachoma problem is one of race, not place.”²⁹ Dr. Swan Burnett of Washington, DC, argued that African-Americans were practically immune to trachoma, only seeing six possible cases in fifteen years among 10,000 “Negro” eyes.³⁰ Major Yarr of Moorfields Hospital in London, classified racial disposition into three categories: susceptible, relatively immune, and completely immune. Susceptible races included Japanese, Chinese, Jews, Poles, Italians and Irish, the relatively immune were West Africans and African-Americans, and the completely immune were indigenous Canadian tribes. Chibret claimed the French and Celts were most immune of the white races, while the Jews were most vulnerable.³¹ Others refuted Jewish predisposition, claiming that it “shrinks into insignificance when we consider that the well-to-do Jew is as free from the disease as his Christian neighbor.”³² Racial receptivity to trachoma was not generally accepted by the beginning of the twentieth century, but some groups continued to be stigmatized by it.

This was especially true in the case of Jewish immigrants to the United States. Many scholars of immigration have investigated trachoma as the “signature disease of medical exclusion” and “a powerful symbol of the threats of immigrant disease, dependency, and economic ruin” in Ellis Island, Angel Island, and Great Britain.³³ American policy-makers

²⁹ M. T. Yarr, “Trachoma and Race,” *British Medical Journal* 1, no. 2001 (1899): 1086.

³⁰ Swan Moses Burnett, “Racial Influence in the Etiology of Trachoma,” *Medical News* (November 22, 1890): 543.

³¹ Boldt, *Trachoma*, 132.

³² Collins, Introduction to *Trachoma*, xii.

³³ Anne-Emanuelle Birn, “Six Seconds Per Eyelid: The Medical Inspection of Immigrants at Ellis Island, 1892-1914,” *Dynamis*, 17 (1997): 281-316; Alan M. Kraut, *Silent Travelers: Germs, Genes, and the Immigrant Menace* (New York: Basic Books, 1994), pp. 50-77; Elizabeth Yew, “Medical Inspection of Immigrants at Ellis Island, 1891-1924,” *Bull. N.Y. Acad. Med.*, 56 (1980): 488-51; Howard Markel, “‘The Eyes Have It’: Trachoma, the Perception of Disease, the United States Public Health Service, and the American Jewish Immigration Experience, 1897-1924,” *Bulletin of the History of Medicine* 74:3 (2000): 525-560; Krista Maglen, “Importing Trachoma: The Introduction into Britain of American Ideas of an ‘Immigrant Disease’, 1892-1906,” *Immigrants & Minorities* 23:1 (2005): 80-99; Kenneth E. Collins, *Be Well!: Jewish Health and Welfare in Glasgow, 1860-1914* (Tuckwell Press, Ltd., 2001).

and the United States Public Health Service (USPHS) espoused a strong current of nativist thought that employed trachoma to scientifically explain why immigrants were inferior, using medical rather than racial grounds for exclusion. Eastern European Jewish American immigrant aid societies, the Yiddish press, the Yiddish theater, social agencies, and Jewish ophthalmologists directed their efforts to reform immigration policies and discussed how to handle trachoma's social stigma. The overwhelming majority of trachomatous patients in the United States were not even immigrants, but Native Americans in the Southwest and poor rural whites living in what was known as the "trachoma belt," extending through Virginia, Kentucky, Tennessee, Missouri, Arkansas, Alabama and Oklahoma. Nonetheless, the reputation remained. Jews in Palestine were well aware that a trachoma diagnosis would deny them entry into America.³⁴ Dr. Aaron Masie voiced an unspoken concern and placated his colleagues at the Jerusalem Trachoma Conference: "Maybe in your hearts you fear that our work to eradicate trachoma will lead to increased emigration from the Land of Israel to America. Our confidence is strong that trachoma is not the only link that ties us to the Land."³⁵

Although race was ultimately excluded as a determinant of trachoma, cultural practices were not. British ophthalmologist Dr. Collins implicated Islamic religious rituals, including overcrowded pilgrimages and reused ablution water.³⁶ The common practice of beautifying eyelashes with kohl (antimony; black sulfide), smeared with a common marwid (stick) for the whole family was thought to be an important vehicle of contagion.³⁷ Professor Snellen of Utrecht surmised Jews in Amsterdam had high rates of trachoma because of

³⁴ Harry Friedenwald, "The Ophthalmias of Palestine," *Transactions of the American Ophthalmological Society* 14:1 (1915): 283.

³⁵ *First Trachoma Conference*, 121.

³⁶ Treacher-Collins, Introduction to *Trachoma*, xxxix.

³⁷ MacCallan, *Trachoma and Its Complications in Egypt*, 61.

female ceremonial bathing in the mikveh, where submerged eyes bred contact.³⁸ Dr. T. Harrison Butler, a physician working in the Order of St. John Ophthalmic Hospital in Jerusalem, was one of many to implicate fatalism: “One often sees a child with several flies settled in and around its eyes, and the fellaheen mothers are far too apathetic to brush them away.”³⁹ By the early 1900s, there was almost complete agreement that “bad hygienic and social conditions, poverty, and still more want of cleanly habits, wretched houses, indolence, and ignorance” caused trachoma more than anything else.⁴⁰

Diagnosing trachoma, like determining its causes, was also complicated. Physicians classified trachoma into acute or chronic types (a distinction that would ultimately disappear), and devised three or four stages with accompanying symptoms that could aid the diagnosis. Dr. Arthur Ferguson MacCallan, a British ophthalmologist in Egypt, devised a four-stage classification—with four sub-stages—in 1908 that would become the global standard for sixty years.⁴¹ Physicians in Palestine, however, preferred to use Julius Hirschberg's “mild, medium, and severe” classifications, indicating that there was no consensus.⁴² In addition, since there were many eye infections that caused inflammation of the conjunctiva, it was difficult to distinguish between them in a clinical examination. A host of bacterial agents caused acute conjunctivitis, including Koch-Weeks, Morax-Axenfeld, pneumococcus, and gonococcus, which were often coupled with trachoma. These overlapping symptoms and

³⁸ Fuchs 237.

³⁹ Theodore Harrison Butler, “Some Aspects of Ophthalmology in Palestine,” *The Ophthalmoscope* 14 (1916): 69.

⁴⁰ Boldt, *Trachoma*, 127.

⁴¹ Hugh Taylor, *Trachoma : a Blinding Scourge from the Bronze Age to the Twenty-first Century* (Melbourne: Centre for Eye Research Australia, 2008) 41.

⁴² Nahum Shimkin, “Letter to the Editor,” *British Journal of Ophthalmology* 10 (1926): 511–512.

infections were often subsumed under the term “Egyptian ophthalmia” throughout the nineteenth century.⁴³

How did a global disease become Egyptian, and more broadly, Oriental? First, Egypt is where ophthalmia first gained military and political importance.⁴⁴ Egyptian ophthalmia afflicted the French and British armies when they invaded Egypt at the turn of the eighteenth century. It garnered the name “military ophthalmia,” as epidemics affected European armies en masse throughout the Napoleonic Wars. Although it was originally believed to only infect soldiers, their return home soon proved otherwise. The explosive appearance of Egyptian ophthalmia among soldiers and civilians forced European physicians to reconsider the role and importance of eye diseases, which until this period were treated by general surgeons. Egyptian ophthalmia was “so unexpected, so widespread, so incomprehensible and so horrid that every medical practitioner had to know something about it.”⁴⁵ The first eye hospitals were established in Europe, including Moorfields in London, to handle the flood of cases. Hermann von Helmholtz’s invention of the ophthalmoscope in 1850, an instrument that could to examine the retina and other parts of the eye in great detail, helped to establish ophthalmology as a specialty in its own right. That is not to say that trachoma did not exist in Europe before the Napoleonic wars. However, since it was mainly a disease of the rural, agricultural poor, “as long as they could recognize the difference between a horse and a cow at close range, the eyes were not considered in any way defective.”⁴⁶ Egypt was ordained the

⁴³ R. M. Feibel, “John Vetch and the Egyptian Ophthalmia,” *Survey Ophthalmol* 28:2 (1983): 128.

⁴⁴ Aaron Brav, “Are We in Danger of Trachoma?,” *New York Medical Journal* 93:9 (March 4, 1911): 108.

⁴⁵ Taylor, *Trachoma*, 18.

⁴⁶ Brav, “Are We in Danger of Trachoma?,” 108.

source of trachoma, even though some doctors realized that distinction was somewhat arbitrary.⁴⁷

Napoleon Bonaparte's 40,000 troops invaded Egypt in the summer of 1798. Although soldiers faced many new diseases, ophthalmia hit the hardest. By September, "few soldiers had escaped ophthalmia," and had "eyes completely blinded by the swelling of the lids."⁴⁸ The disease appeared in such severe form that it disabled the soldiers from actual service. The French physicians and military surgeons firmly believed that ophthalmia was related to environmental and climatological factors, including the intense sunlight, dry desert air, damp, cool evening air in the delta regions, and the hot winds blowing from the south.⁴⁹ During the Battle of Alexandria (1801) and the Anglo-Egyptian War (1805-7), there was a rapid spread of ophthalmia among British troops as well. Dr. John Vetch, an assistant surgeon in the British Army treated 3,000 eye patients between 1807-1812. His published account, *An Account of the Ophthalmia which appeared in England since the Return of the British Army from Egypt*, described his experiences treating one battalion between August 1805 and August 1806, in which 606 of 700 soldiers developed ophthalmia, 50 became blind in both eyes and a further 40 blind in one eye.⁵⁰ Vetch's book, one of the most detailed from the period, included observations of the granulations under the upper lid, and his recommended treatment was bloodletting for purulent and silver nitrate for chronic cases. In contrast to the French, Vetch believed trachoma was infectious. He enforced strict hygienic measures that

⁴⁷ Treacher-Collins, Introduction to *Trachoma*, ix. "Had Napoleon's ambition led him to sit on the throne of Jamshyd instead of that of the Pharaohs, there can be little doubt that the affection would have been introduced to Europe as the Persian malady."

⁴⁸ Max Meyerhof, "A Short History of Ophthalmia During the Egyptian Campaigns of 1798-1807," *The British Journal of Ophthalmology* 16:3 (1932): 129.

⁴⁹ Taylor, *Trachoma*, 9.

⁵⁰ John Vetch, *An Account of the Ophthalmia Which Has Appeared in England Since the Return of the British Army from Egypt* (London: Longman, 1807).

reduced transmission. In particular, he warned of the danger of the common use of towels and hand basins by soldiers and the need to isolate infected soldiers.

Napoleon's forces were interested not only in military occupation, but in cultural and scientific conquest as well. The Institut d'Égypte, comprised of chemists, biologists, physicians, archeologists, linguists, and historians, accompanied Napoleon to "institute new areas of specialization; to establish new disciplines; to divide, deploy, schematize, tabulate, index, and record everything in sight (and out of sight); to make out of every observable detail a generalization and out of every generalization an immutable law about the Oriental nature, temperament, mentality, custom, or type; and, above all, to transmute living reality into the stuff of texts."⁵¹ This intensive scientific research culminated in the twenty-volume *Description de l'Égypte*. The medical corps conducted exhaustive surveys that became part of this tour de force, including surveys on ophthalmia. Dr. René-Nicolas Dufriche Desgenettes, a French military surgeon, characterized the disease and the resulting blindness as embedded in the landscape: "The most common affliction of all, affecting a third of the population [at Cairo], is some form of disease of the eye; no other town contains so many sightless."⁵² These activities established the triangular relationship between military activity, medicine and imperialism, expanding the role of the imperial physician to look beyond the immediate demands of their patients and to appraise local populations, flora, fauna, and topography.⁵³ Through Napoleon's efforts, Egypt turned into "the live province, the laboratory, the theater of effective Western knowledge about the Orient."⁵⁴ This process allowed Egypt to be

⁵¹ Edward Said, *Orientalism* (Vintage Books, 1979) 86.

⁵² Thomas G. Russell and Terence M. Russell, "Medicine in Egypt at the Time of Napoleon Bonaparte," *British Medical Journal* 327:7429 (2003): 1461.

⁵³ Patricia ME Lorcin, "Imperialism, Colonial Identity, and Race in Algeria, 1830-1870: The Role of the French Medical Corps," *Isis* 90:4 (1999): 658.

⁵⁴ Said, *Orientalism*, 43.

crowned, to put it into modern French, the “land of the blind.” What laboratory could be more attractive to eye doctors?

Shock at the Sight

Familiar with the spate of epidemic ophthalmia infections during the Napoleonic Wars, ophthalmologists who wanted to cut their teeth on Egyptian ophthalmia travelled to the source to investigate clinical conditions. One of the first European ophthalmologists to permanently settle in Egypt in 1869 was Dr. Jacob Tachau, a pupil of Albrecht von Graefe, who practiced first in Cairo and later in Alexandria.⁵⁵ Although not an eye specialist, Dr. Robert Koch, the German bacteriologist of tuberculosis and anthrax fame, went to Egypt in 1883 in order to study the cholera epidemic, and as a side project isolated bacteria swabbed from the eyelids of fifty Egyptian children. Titled the Koch-Weeks bacillus, it was a very contagious and seasonal (April-November) cause of acute conjunctivitis. Victor Morax, the Parisian grandfather of ophthalmic bacteriology, made an official visit to Egypt in 1901, and determined that “acute” trachoma was due to superimposed infections with the gonococcus, the Koch-Weeks bacillus and the pneumococcus.⁵⁶ Arthur Ferguson MacCallan, the “grand old man of trachoma,” was a clinician in Egypt from 1902-1923. He established a network of ophthalmic hospitals, mobile eye clinics, primary school programs, and the Giza Memorial Ophthalmic Laboratory.⁵⁷

These research and tourist visits allowed ophthalmologists to be eyewitnesses to overwhelming ocular abnormalities, repeating and justifying the shock of Oriental eyes in countless books and articles. This is the second reason why ophthalmia became Oriental. Julius Hirschberg, an ophthalmologist and historian, painted a frightening scene: “We are

⁵⁵ Claudius F. Mayer, “Arabism, Egypt, and Max Meyerhof,” *Bulletin of the History of Medicine* 19 (1946): 378.

⁵⁶ Arnold Knapp, “Victor Morax 1866-1935,” *Archives of Ophthalmology* 14:4 (1935): 641.

⁵⁷ Phillips Thygeson, *MD*, 181.

confronted at every step of the journey from Alexandria to the borders of Nubia with the wretched state of the people's eyes. At every station where the train stops between Alexandria and Cairo, we see red and photophobic eyes; one-eyed people, who sometimes wear a glass bead as a charm hanging from the fez over the blind and shrunken globe; the considerable number of totally blind people..."⁵⁸ Joseph Krimsky, the chief oculist in the American Zionist Medical Unit visiting Palestine in 1918, was overwhelmed by trachoma incidence in rural Arab villages: "The filth is indescribable and the flies are uncountable. I have gone through these villages and have examined their people by the hundred and the thousands. The normal eye is a rarity..."⁵⁹ This trope was repeated ad nauseam: Franz Ignaz Pruner, German ophthalmologist and anthropologist wrote, "very few natives in the Delta have normal eyes," while Morax noted that it was "impossible to invert the lids of native Egyptians without finding trachoma."⁶⁰

These impressions were wrapped up in observations about Oriental cultural and social practices. Throughout the nineteenth century there was anxiety about the nature of vision, with the advent of new visual technologies and the modern "scopic" regime. Scholars have argued that modernity's project was most effectively achieved through privileging sight over other senses.⁶¹ Therefore, those who could not see were deprived of the ability of participating fully in the modern world. The perceived Oriental apathy about sight—not swatting flies from one's face or going to the doctor—was antithetical to the idea of vision as

⁵⁸ Boldt, *Trachoma*, 70.

⁵⁹ Joseph Krimsky, "Trachoma in Palestine," *Long Island Medical Journal* 14, no. 4 (1920): 171.

⁶⁰ Boldt, *Trachoma*, 69.

⁶¹ See Martin Jay, *Downcast Eyes: The Denigration of Vision in Twentieth-Century French Thought*. (Berkeley: University of California Press, 1993); Jonathan Crary, *Techniques of the Observer: On Vision and Modernity in the Nineteenth Century* (MIT Press, 1992); David Michael Levin, *Modernity and the Hegemony of Vision* (University of California Press, 1993); Deborah Poole, *Vision, Race, and Modernity: A Visual Economy of the Andean Image World* (Princeton University Press, 1997); Michael Schillmeier, *Rethinking Disability: Bodies, Senses, and Things* (Routledge, 2010); Chris Jenks, *Visual Culture* (Psychology Press, 1995).

progress. For example, Ernest Fuchs, the clinical director at the Second Vienna Eye Hospital and author of the *Text-book of Ophthalmology* (1889), the proclaimed “bible” and primary textbook of the field, published an account of his 1891 trip to Egypt. Like Hirschberg, the sheer number of those afflicted was staggering to him. However, Fuchs did not blame poverty alone: “Even Arabs living amid better conditions often permit their children purposely to run about in rags and wallow in dirt, that they may escape the ‘look of evil’ [evil eye].” That is, Oriental superstition was a factor. Fuchs also noted that Arabs were unacceptably apathetic about the state of their eyes, especially by allowing flies to come close to their faces. I will quote in full because the image recounted is so vivid:

“A few small children are playing before the hut or in the fields; approaching the youngsters, one fancies, and often believes, that they have painted black rings round their eyes; but on coming close one sees that the black rings are dense circles of flies seated along the edges of the lids and at the inner angle of the eye. They seek for food in the secretion, without encountering any disturbance, for the children do not disperse the pests, knowing that others with insatiate appetite would at once take their places.”⁶²

Although Dr. Fuchs was “well prepared beforehand by books of travel” for this spectacle, seeing it with his own eyes “astounded” him.⁶³

The Orientalist Oculist in Nablus

Not all orientalist-oculists were necessarily Europeans shocked at the sight of the blind eyes of the East. Moïse Aaron Schalit was raised in Ottoman Palestine, and decided to become an ophthalmologist after recovering from trachoma himself, publishing his memoirs, *Travelled Roads: Memoirs of a Doctor who Lived in the Land of Israel*, in 1954.⁶⁴ When Schalit was seven years old in 1881, his family immigrated from Ukraine to Rishon Li-Zion.

⁶² Fuchs, Ernst. “Egyptian Ophthalmia.” *Medical Age* 12 (1894): 266.

⁶³ *ibid.*

⁶⁴ Moïshe Aaron Schalit, *Travelled Roads; Memoirs of a Doctor Who Lived in the Land of Israel* (New York: Abelard-Schuman, 1954).

Although he endured silver nitrate treatment in Jerusalem and a surgical operation after becoming afflicted with trachoma, his doctor insisted “that I leave the country as soon as possible for a cooler climate, otherwise my sight would be endangered.”⁶⁵ Although Schalit wondered if he was turning his back on his country by leaving for Geneva, he determined, “What use could I be to Eretz Israel with half-cured eyes? I might even become a burden on my people!”⁶⁶

Schalit travelled to the East not in search of exotic clinical or research opportunities, but simply to make a living. After finishing medical school and ophthalmology post-graduate work in Europe, he returned to the Rishon Li-Zion agricultural colony in 1901. However, the village doctor, perhaps not wanting any competition, dissuaded him from setting up a practice, claiming it was too small of a population to support a specialist. Schalit considered emigration, “but I was determined not to leave Palestine if I could find any opportunity there to practice my profession.”⁶⁷ He took an opening for a physician in Nablus to “help combat the scourge of trachoma,” and his family did not object to his surprise.⁶⁸ Schalit took advantage of the journey, and travelled through Hebron, Jenin, and Jerusalem on his way to Nablus, spending Passover with the Samaritans. His letter of introduction from family physician Hillel Yaffe had preceded him, and when he arrived, he had an apartment, “discarded my toupee and donned a fez,” and started to meet patients.⁶⁹ Schalit seems to have deftly navigated the cultural and economic situation: He attended to the harems of the wealthy, but was also seen as a benefactor of the poor because of he held free Friday consultations. He was especially enamored with the Samaritan community, and “had an

⁶⁵ *ibid.* 167.

⁶⁶ *ibid.* 167.

⁶⁷ *ibid.* 304.

⁶⁸ *ibid.* 299.

⁶⁹ *ibid.* 331.

unrivalled opportunity to study them.”⁷⁰ He wrote extensively about Samaritan history and practices. Doing business with and learning about Arabs was an integral part of Schalit’s experience as a physician. He surmised that, “No doctor could have wished for a better patient than the average Arab” because of what he termed their fatalistic attitude and ability to accept unsuccessful treatment.⁷¹

Whatever orientalist expertise he garnered, however, was also his undoing. Schalit was the personal physician of a rich Arab soap-manufacturer and political autocrat, who had four wives and 22 children. On one occasion, Schalit spent ten days at his house to attend to an illness, but was not adequately paid. In response, Schalit decided to sue him in the Islamic court to prevent the defendant from defaulting in the case of victory. When Schalit did win the case, he requested that the money be awarded to the judge’s mosque. As one can imagine, this victory in court also signified the end of his career in Nablus, having made enemies with a powerful benefactor. In retrospect, Schalit was actually thankful for the whole episode, because “had he behaved honorably toward me I might have remained, plodding away at my practice in the little township of Nablus.”⁷² Schalit came back to Rishon Li-Zion “almost penniless.”⁷³ He felt disappointed that he could not maintain a practice, neither among the Arabs nor among his fellow colonists: “We had all been brought up to put service for the development of our Homeland above everything. Yet the obstacles to a successful medical career in Palestine were insurmountable. The colonists showed no concerns; and my frustrating experiences in Nablus indicated little prospects of a career outside the colonies.”⁷⁴ He ultimately decided to immigrate to Australia, though he worried he might fail there, too:

⁷⁰ *ibid.* 340.

⁷¹ *ibid.* 342.

⁷² *ibid.* 357.

⁷³ *ibid.* 358.

⁷⁴ *ibid.* 359.

“Would I be compelled to go into the bush and work for the Australian aboriginal, just as I had been forced to leave my parents’ home in Rishon to serve the Arab in Nablus?”⁷⁵

Working in Nablus had been a last resort for Schalit to fulfill his desire to serve Palestine, either its Jewish or Arab residents. The fact that he wrote a memoir reveals that despite his failure to remain, he viewed his venture into Nablus as an important part of the Zionist narrative. A review of the book in *Jewish Social Studies*, written in 1955, disagreed: “Not being an active participant in the labors and disappointments of the early days of Jewish colonization of Palestine, his historical illusions are brief and convey little information even to readers who aren’t familiar with those painful and glorious days.”⁷⁶ Schalit’s experience of Palestine was not of the typical agricultural pioneering, but of an Orientalist adventure that dovetailed with the wave of ophthalmologists who also travelled to the East for ocular experiences. However, Schalit himself was of the Orient, got its diseases, and suffered the professional consequences of limited economic opportunities. He lived in Australia for the rest of his life.

Julius Hirschberg and the Ophthalmologist-Orientalist

The travel of ophthalmologists to Egypt and Palestine went hand in hand with the historical positioning of ophthalmology as an Arabic science. Julius Hirschberg, with two leading German Jewish orientalists Julius Lippert and Eugen Mittwoch, travelled to Egypt in 1889 in order to collect and transcribe Arabic manuscripts on eye diseases.⁷⁷ Some examples of the Arabic ocular texts that Hirschberg translated included the Ebers Papyrus, the oldest medical book from 1550 BC; *The Memorial of Oculists*, a classical Arabic textbook on

⁷⁵ *ibid.* 360.

⁷⁶ *Travelled Roads; Memoirs of a Doctor Who Lived in the Land of Israel* by M.A. Schalit, Review by Israel Wäscher, *Jewish Social Studies*, Vol. 17, No. 4 (Oct., 1955), 353.

⁷⁷ Claudius F. Mayer, “Arabism, Egypt, and Max Meyerhof,” *Bulletin of the History of Medicine* 19 (1946): 375.

ophthalmology by Ali ibn Isa (d. 1010 AD), a Christian from Baghdad; and most famously, the ophthalmological section from Persian physician Ibn Sina's (980-1037) *The Canon of Medicine*, which was the predominant textbook in European medical schools until the seventeenth century.⁷⁸ The richness of the archival sources solidified his conclusions: "In the five hundred years from 800 to 1300 of our era there were not less than sixty renowned men of the Arabian world, known to us as oculists or practitioners especially interested in our branch... meanwhile in medieval Europe before the twelfth century none is known as an oculist and in this century only two."⁷⁹

The third reason—after Napoleon's Egyptian campaign and the preponderance of travel narratives—why Egypt was universally known as the "chief seat of the disease" was because Julius Hirschberg and his student Dr. Max Meyerhof constructed ophthalmology as an Arabic science through their historical research. Trachoma then could have an ancient as well as a modern Egyptian pedigree, a narrative that has been incredibly resilient. It is striking that almost every scientific paper on trachoma, up until the present, proclaims that trachoma has "raged since time immemorial" or "has afflicted mankind since recorded history," and then conjures that the Ebers Papyrus "indicates that both acute conjunctivitis and trachoma were rife in the country at the time of its inscription."⁸⁰ Hirschberg and his disciples have evaded academic scrutiny – both in the case of German Jewish Orientalism, because they did not study Islam per se; and in the history of medicine, as their prominence

⁷⁸ A. F. MacCallan, "The Birth of Ophthalmology and Its Development in Early Arabic Literature," *The British Journal of Ophthalmology* 11, no. 2 (1927): 66.

⁷⁹ Julius Hirschberg, "Arabian Ophthalmology," *Journal of the American Medical Association* 45, no. 16 (1905): 1127.

⁸⁰ MacCallan, "Birth of Ophthalmology," 63. See also Julius Schachter and E. Russell Alexander, "Chlamydial Infections," in *Bacterial Infections of Humans* (Springer, 2009), 221–247; Anne-Marie Moulin et al., *Lutte contre le trachome en Afrique subsaharienne* (IRD Editions, 2006); Beatriz Mufioz and S. H. West, "Trachoma: The Forgotten Cause of Blindness," *Epidemiol. Rev* 19, no. 2 (1997): 205–217; Victor H. Hu et al., "Epidemiology and Control of Trachoma: Systematic Review," *Tropical Medicine & International Health* 15, no. 6 (2010): 673–691; Jacques Meyer May, *The Ecology of Human Disease* (MD Publications, 1958).

plummeted in Germany during Nazi rule. Trachoma was constructed as a “blinding scourge of the East” both through historical research and firsthand observations.

Julius Hirschberg (1843-1925) led the most eminent clinical and pedagogical private practice in Berlin from 1869-1907 and trained a cohort of Jewish ophthalmologists to engage in historical activities.⁸¹ Oculists in this intellectual purview founded medical journals, conducted archival research, wrote articles on history of ophthalmology and medicine, learned ancient languages, and amassed large libraries of rare medical books.⁸² Medical history as a sub-discipline of medicine was cultivated in Germany in the nineteenth century to promote the pragmatic ideal of *Bildung*, and was intensified in the 1890s as an antidote to what was considered “excessive reductionism, specialization, commercialism, and cultural disintegration in medicine.”⁸³ The practice of medical history adhered to the “gentleman-physician” ideal well versed in the classic liberal arts.

Hirschberg embodied this archetype. The field of ophthalmology had a tight genealogy in Europe, where students clamored to study under disciples of a small number of nineteenth century masters, including Germans Hermann von Helmholtz and Albrecht von Graefe. Hirschberg was one of von Graefe’s last assistants, and founded his Berlin clinic in 1869. He displayed classic German diligence, and inspired comments such as “frugal with his time,” “a demanding chief,” “stern and serious,” “hardly ever laughed.”⁸⁴ His pride in his titles was evident. Dr. Oscar Fehr, his last assistant, recalled “to be called ‘Doctor’ or ‘Sanitätsrat’ made him furious. He insisted upon being addressed as ‘Geheimer Medizinalrat’

⁸¹ Harry Friedenwald, “Julius Hirschberg,” *Archives of Ophthalmology* 54: 418–421.

⁸² For example Dr. Alexander Jokl, Dr. Harry Friedenwald, and Dr. Aryeh Feigenbaum.

⁸³ Frank Huisman and John Harley Warner, *Locating Medical History: The Stories and Their Meanings* (Johns Hopkins University Press, 2006) 14.

⁸⁴ Alexander Jokl, “Julius Hirschberg.” *American Journal of Ophthalmology* 48 (1959): 329.

even by simple people who hardly knew what this meant.”⁸⁵ In 1877, he founded and was editor for forty years of the *Centralblatt für praktische Augenheilkunde*, a prestigious ophthalmological journal. His scientific publications spanned all aspects of ophthalmology, and every visiting ophthalmologist in Berlin would stop by the “mecca of 36 Karlstrasse.”⁸⁶ He travelled the world, documenting his medical and personal experiences in such works as *Parisian Eye Clinics* (1876), *English Eye Clinics* (1877), *Tunis* (1885), *Egypt; Historical Studies* (1890), *Journeys to America* (1888 and 1905), and *Around the World* (1894).⁸⁷

His magnum opus, however, to the field of ophthalmology was his *History of Ophthalmology (Geschichte der Augenheilkunde)*, published between 1899 and 1918 in 11 volumes, which numbered 4,720 pages.⁸⁸ Dr. Harry Friedenwald, one of his students and an ardent American Zionist, was the not the only to claim that this “is the most comprehensive medical historical work that has ever been published, not of ophthalmology alone, but in the whole field of medical history.”⁸⁹ Hirschberg knew English, French, Italian, Arabic, Greek, and Latin (and half a dozen other languages) and conducted extensive archival research and exhausted primary materials to compose volumes on: ancient ophthalmology in Egypt, Assyria, India, Tibet, Palestine, Babylon, China, Japan, Greece, and Rome; Arab and European ophthalmology in the Middle Ages; the development of modern ophthalmology in Germany, France, England, Italy, Russia, and the United States in the nineteenth century; as well as detailed evaluations of the significant reforms precipitated by Hermann von Helmholtz’ ophthalmoscope, Franciscus Donders’ work on refraction, and Albrecht von

⁸⁵ *ibid* 335.

⁸⁶ Friedenwald, “Julius Hirschberg,” 420.

⁸⁷ Charles Snyder, “Julius Hirschberg, the Neglected Historian of Ophthalmology.,” *Am J Ophthalmol.* 91 (1981): 664–676.

⁸⁸ Julius Hirschberg, *The History of Ophthalmology* [1899-1918] trans. F. C. Blodi, 11 vols. (Bonn, 1982-6).

⁸⁹ Friedenwald, “Julius Hirschberg, 419.

Graefe's clinical methods; and finally the latest practices in Germany and the German-speaking nations up to the beginning of World War I.

In writing this vast, polyglot, encyclopedic history, Hirschberg came to a conclusion hitherto unknown: that ophthalmology as a specialty and branch of medicine was founded by Arabs. In his address to the Section on Ophthalmology of the American Medical Association in Portland, OR in 1905, he concluded: "During this total darkness in the medieval Europe they lighted [sic] and fed the lamps of our science—from the Guadalquivir [Andalusia] to the Nile and to the river Oxus [central Asia]...they were the only masters of medieval Europe in our branch. So we must state that the name of the Arabs, which is written with indelible characters on the firmament, never will be effaced from the memorial stones of ophthalmologic art and science."⁹⁰ Locating the history of "Western science" in the East was not necessarily unique, but the fact that it was coupled with extensive clinical work and travel to the East strengthened the association between eyes and the Orient.⁹¹

Hirschberg's devotion to historical practice spawned a distinguished cohort of second-generation Jewish ophthalmologist-historians, including Max Meyerhof, who "succeeded Julius Hirschberg as the premier medical orientalist of Europe."⁹² Meyerhof graduated with a medical degree in Strasbourg in 1897, and specialized in ophthalmology in clinics in Berlin and Bromberg. A visit in 1900 to Egypt with his uncle Dr. Otto Meyerhof, who would win the Nobel Prize in chemistry in 1922, convinced Max "that Egypt was indeed the classical land of blindness, a country where a young doctor eager to advance the science of ophthalmology by original research would find a fertile field."⁹³ He immigrated to Cairo

⁹⁰ Hirschberg, "Arabian Ophthalmology," 1128.

⁹¹ Marwa Elshakry, "When Science Became Western: Historiographical Reflections," *Isis* 101:1 (2010): 98–109.

⁹² "Max Meyerhof," *British Journal of Ophthalmology* 30 (1946): 499.

⁹³ *ibid.* 381.

in 1903, and became a founding member of Egyptian Ophthalmological Society. He opened a private practice, and saw a total of 30,000 patients until 1914, when he left Egypt for Germany until after the war. On his return, he reopened a practice with his friend H. Peretz, a French Jewish oculist, on Emad-ed-Din Street.

However, he spent most of his time searching for lost or unedited Arabic manuscripts in the libraries of the Khedive and al-Azhar mosque, acquiring a vast amount of materials and a network of Orientalist colleagues. In 1926 he found the Syriac and Arabic translations of certain treatises of Galen, which had been lost in the original Greek and in the Latin version. Two years later, on its centennial celebration, the Egyptian University published his main work, a critical edition of Hunain ibn-Ishaq's (809-877 C.E.) *The Book of the Ten Treatises on the Eye*, the earliest existing textbook on the eye and its diseases. In the late 1930s, with the rise of Nazism, Meyerhof turned his attention to the history of Jewish physicians in medieval Islamic lands, including Maimonides. Although he conducted countless trachoma studies by clinical, bacteriological, and statistical methods, he was unable to fulfill his main ambition of finding the causative agent of trachoma.⁹⁴ Meyerhof published 78 original articles in ophthalmology, 47 in the history of ophthalmology, and over 100 in the history of science and medicine.⁹⁵ In addition, he also published a book, *Le Monde Islamique* (1926), on the history of Islam, Mohammed and the Quran, faith and law, and the current state of the Islamic world.⁹⁶ The links between ocular and orientalist expertise were apparent.

Oriental eyes boggled and flabbergasted visitors to Palestine, in addition to Egypt. In fact, the countries were often paired together in this regard, as Rabbi Stephen Wise did after his trip before the First World War: "We were saddened by one thing, the enormous measure

⁹⁴ *ibid.* 393.

⁹⁵ Joseph Schacht, "Max Meyerhof," *Osiris* (1950): 7–32.

⁹⁶ Max Meyerhof, *Le Monde Islamique* (Paris: F. Rieder, 1926).

of blindness in the Near East...I think I do not exaggerate when I say that I came upon more persons blind in the course of a week in Cairo and Alexandria than in America in fifty years...In Jerusalem I came across the same thing.”⁹⁷ A publication of Keren ha-Yesod claimed that in Palestine “no two Arabs have more than three eyes between them.”⁹⁸ When Bella Tamir, a young immigrant who arrived to Palestine in 1912 walked through the Old City of Jerusalem, she exclaimed, “I was flabbergasted and frightened of the sight of negligence and desperate sadness. What especially caught my attention were the abstract characters of miserable people wrapped in despicable rags, with their rheumy bleary eyes, half-closed due to partial or complete blindness.”⁹⁹ She became an eye nurse in response. She was not the only one to specialize in eye care as a result of Palestine’s reputation. Zionist activists and physicians’ aversion to this image—of the odd-eyed Oriental—triggered them to magnify trachoma as a locus of scientific advancement and medical attention. This abhorrence stemmed from its construction as a disease of the Orient and cultural backwardness. Krimsky even argued that Zionism’s ideals of creating “a healthy material and spiritual culture is impossible under conditions in a land where so large a percentage of the inhabitants are trachomatous.”¹⁰⁰ Whether the organ of the eye was diseased or not came to stand in for the cultural, social, and physical condition of the entire body.

Trachoma in Palestine: Turning a Scourge into a Science

In 1914, American Dr. Harry Friedenwald (1864-1950) travelled to Palestine for two months to treat trachoma cases in Jewish agricultural settlements, Jerusalem, Tiberias, Safed, and Haifa. One of Hirschberg’s protégés, he trained at Johns Hopkins University, worked as a

⁹⁷ Stephen Wise, “Blindness Waning in Palestine,” *New York Times*, December 17, 1922.

⁹⁸ *The Keren ha-Yesod Book. Colonisation Problems of the Eretz-Israel (Palestine) Foundation Fund.* (L. Parsons, 1921).

⁹⁹ Tamir, Bella. “The War Against Trachoma in the Beginning.” *Nurses in Israel* 126 (1984): 35–37.

¹⁰⁰ Joseph Krimsky, *Pilgrimage & Service* (Arno Press, 1977), 35.

professor at the College of Physicians and Surgeons in Baltimore and the University of Maryland Medical School, and was a medical historian of ophthalmology and Jews and medicine. He amassed the largest collection of *medica Judaica*, including the earliest extant Hebrew medical manuscript, which was donated to the Hebrew University in Jerusalem after his death.¹⁰¹ His father Aaron and son Jonas were also ophthalmologists and active Zionists. His trachoma survey was a result of his collaboration with Henrietta Szold, a close childhood friend from Baltimore, to establish the foundations of Hadassah's public health work. Unlike Fuch's account to Egypt, which reads as a travel narrative, Friedenwald's article is full of graphs and statistics, informing the reader of how many children and adults had Trachoma I, II, III, IV in whatever school or settlement. He was hopeful that "with improvement in social and economic conditions, with hygienic reforms, with better knowledge and understanding on the part of the population of the effectiveness of prophylactic and curative treatment, we may look for great reduction in the frequency of trachoma in Palestine."¹⁰²

How was this to be accomplished? The idea of trachoma as a mark of Oriental backwardness was not separate from the contest of trachoma as a scientific and medical enigma. The search for the trachoma agent propelled interest in a disease that was otherwise onerous to treat, repetitive for the practitioner and painful for the patient. When twenty-four ophthalmologists and physicians convened the First Trachoma Conference in Jerusalem in 1914, they were not tasked with only solving a problem of culture, but also of generating scientific principles and designing medical practices. There was no way for physicians to understand the big picture without aggregating practices, people, and trachoma incidence. To do so, physicians built a professional scientific infrastructure around trachoma that included a dedicated department in the Nathan Strauss Jewish Health Station, a national survey, and a

¹⁰¹ Harry Friedenwald, *The Jews and Medicine* (Johns Hopkins Press, 1944).

¹⁰² Harry Friedenwald, "The Ophthalmias of Palestine," *Transactions of the American Ophthalmological Society* 14, no. 1 (1915): 302.

conference all occurring in 1913 and 1914. In the process, they delineated Jews and Arabs, Yemenites and Persians, Georgians and Germans, cultured and uncultured, infected and cured, in order to make sense of their data. Physicians attempted to standardize ideas about a disease concept that was hardly static to create a public health campaign. They realized how unstable these categories were but ultimately conceded that a systematic, scientific campaign required irrefutable ground rules, even when those obscured scientific uncertainties.

There was a foundation of ocular institutions and experts, Jewish and otherwise, working in Ottoman Palestine before the great conference of 1914. Within traditional Zionist historiography, 1882 is often cited as the beginning of “modern” Palestine with the start of the First Aliyah. Less acknowledged is that it also marks the year that the British Order of St. John was granted an Ottoman firman to establish the first eye hospital in Jerusalem. The Order of St. John, which dates back to the times of the Crusades, had wanted to establish a presence in Jerusalem and sought a firman from the Sultan in order to establish a hospital. It was granted after a few years of negotiations. The chosen site, on which a large house was obtained by purchase, was situated east of the Bethlehem Road, bounded from the east by the Valley of Hinnom, not far from the Jaffa gate (today it houses the Har-Zion Hotel on 17 Hebron Road). Sir Edmund Lechmere, the secretary of the Order, received a few letters that hinted an ophthalmic establishment would be most appropriate. Mrs. Burton, author of *The Inner Life of Syria, Palestine and the Holy Land*, wrote to Mr. Lechmere that, “Nowhere are there such beautiful eyes, and nowhere so eaten up with dirt and disease, without hope or remedy, as in [Greater] Syria. A good English oculist would be God’s own blessing out there: the whole country would swarm to him.”¹⁰³

¹⁰³ William Kirkpatrick and Riland Bedford, *The Order of the Hospital of St. John of Jerusalem* (FE Robinson, 1902), 153.

Although the hospital began operating in 1883, the official inauguration was in November 1886. Sir Edmund Lechmere and Lady Lechmere were the honorary guests at the ceremony, along with other distinguished visitors such as the Governor of Jerusalem, the Greek Orthodox Patriarch, the Armenian Patriarch, and the Jewish Chief Rabbi.¹⁰⁴ In the Jerusalem Municipal Archives, there remains a certificate of gratitude signed by the Raphael Meir Panasil Haham Bashi, exclaiming that “we know full well all the kindness thou purposest doing to the in-dwellers of Jerusalem in opening for an Eye Hospital...without any reference to creed or form of faith.”¹⁰⁵ Dr. J.C. Waddell, the first medical officer of the hospital, reported that six months after opening, there had been 1,952 surgeries and 6,138 others had received outpatient services. Dr. J.H. Ogilvie succeeded him in 1886, and reported after three and a half years that 10,000 patients had been treated and that the consultations had numbered nearly 58,000.¹⁰⁶ A report in the *Lancet* described that “that the doors of the hospital are not only besieged, often before daylight, by great numbers of the poorer residents in Jerusalem itself, but also by the fellaheen from all parts of the Holy Land, many of whom make long journeys for the sake of a single consultation.”¹⁰⁷ Arabs were not as apathetic as ophthalmologists had made them out to be.

In 1903, there were no dedicated Jewish eye clinics. Individuals that needed eye care could go to St. John’s Ophthalmic Hospital, or be treated by nurses or medics in one of the general hospitals like Misgav Ladach, Rothschild, and Sha’arei Tzedek. Dr. Aaron Masie provided more specialized care at Bikur Holim.¹⁰⁸ There was also a market for indigenous

¹⁰⁴ Yaron Perry and Efraim Lev, *Modern Medicine in the Holy Land: Pioneering British Medical Services in Late Ottoman Palestine* (I. B. Tauris, 2007).

¹⁰⁵ Jerusalem Municipal Archives, “St. John Eye Hospital,” Box 2680.

¹⁰⁶ Bedford, *The Order of St. John*, 55.

¹⁰⁷ “British Ophthalmic Hospital in Jerusalem,” *Lancet* (May 9, 1903): 1316.

¹⁰⁸ Nissim Levy and Yael Levy, *Physicians of Eretz Yisrael, 1799-1948* (Zichron Yaakov: Itay Bahur, 2012).

care. Rabbi Eliyahu Porush, the hospital rabbi of Sha'arei Tzedek, recounted in his memoir, "Before there was an eye doctor in Jerusalem, a man by the name of Yehoshua Yonah also served as such, dispensing eye drops known as Yehoshua Yonah's Water (eyedrops). In cases of the eye disease, trachoma, 'blue material' [copper sulfate] was sold having been imported from Egypt by Rav Yehoshua Zeiger Macher (watchmaker) who worked on ships."¹⁰⁹ Other indigenous remedies included black tea compresses, an egg white and acetic copper mixture, cauterization (burning the eyelid with a heated instrument), and eye drops from breast milk.¹¹⁰

The first Jewish eye doctor in Jerusalem was Dr. Moshe Erlanger (1880-1963) from Switzerland. He was one of ten children in a religious family, and remained observant until his death. Since he had a beloved tutor whose father lived in Jerusalem and was blind, he decided that he would become an eye doctor. He finished high school in Lausanne, studied medicine in Zurich, and specialized in ophthalmology in Berlin. After he finished his specialization in 1908, he developed contact with Le'maan Zion in Frankfurt, who sent him to staff their eye clinic in Jerusalem. They had established a clinic to counter St. John's Ophthalmic Hospital's popularity, even though the hospital did not engage in missionary activities.¹¹¹

We can glean that from Erlanger's letters back to his parents that his services were just as desired as those of the Order of St. John. On Sunday, Tuesday, and Thursday the patients began waiting in line at 4:00 a.m. in front of the walled gate of the hospital before they entered through at 6:00 a.m. Erlanger dispensed about 80 numbers per day, and if the

¹⁰⁹ Eliyahu Porush, *Early Memories: Recollections Concerning the Settlement of Jerusalem The Old City and Its Environs During the Last Century*, (Salomon Press, 1963) 14.

¹¹⁰ Aref Abu-Rabia, "Indigenous Practices Among Palestinians for Healing Eye Diseases and Inflammations," *Dynamis* 25 (2005): 383-401.

¹¹¹ "Eye Doctor in Jerusalem," *Etmol* 12:2 (March 1977), 11.

poor patients pressured him, he would distribute about 20 more cards for appointments. He worked from 6:30 a.m. until 2:00-3:00 p.m. in the afternoon, sometimes treating over 100 patients without pay. He gave very few prescriptions, and instead treated most patients on the spot with drops, lotions, and different medicines. They were often treated with drops of silver nitrate, zinc sulfate, or other antiseptic or astringent chemicals. He would also massage the conjunctiva with a caustic solution. The pharmacist, who had a European degree, occupied the same room and prepared the medicines according to Erlanger's his instructions. On Wednesday and Friday, he accepted patients who were willing to pay for the treatment, which cost $\frac{1}{4}$ magedi or 2 bishlik. Those days the workload was lighter. He would also accept private patients after lunch around 4:00 p.m., as well as difficult cases or those that required surgery. He did not stay very long in Jerusalem; after two and a half years, he returned to Switzerland, as his parents wanted their bachelor son home.¹¹²

Dr. Albert (Abraham) Ticho came to Jerusalem in 1912 to take over Dr. Erlanger's post. He was born in Moravia and educated in Vienna, immigrating to Palestine with his wife, artist Anna Ticho. He collaborated with Hadassah to supervise the organization's first two American nurses in Palestine in administering eye treatments. Henrietta Szold had founded Hadassah in 1912 in New York City as the Women's Zionist Organization. In 1909, she made her first trip to Palestine and was struck by the difficult socio-economic and health conditions in Jerusalem and throughout the country. At Szold's suggestion, Hadassah decided to initiate anti-trachoma activities, and in 1913, Rose Kaplan and Rachel Landy arrived to aid Ticho.¹¹³ Together they examined 4,000 students in over twenty Jerusalem schools. Ticho went on to create a celebrated private practice in the Aga Rashid Nashashibi house on the

¹¹² *ibid.*

¹¹³ Shifra Shvarts and Shehory-Rubin, Zipora, *Hadassah for the Health of the People* (Hebrew). (Jerusalem: Hasifria Hazionit, 2003) 41.

border between East and West Jerusalem. It was said there was hardly anyone who had not either heard his name or was his patient.¹¹⁴

Aryeh Feigenbaum arrived to Jerusalem one year later to head the eye department of the Nathan Strauss Jewish Health Bureau in Jerusalem, and became one of the most respected and renowned ophthalmologists in mandatory Palestine and Israel. He founded several eye clinics, and expanded systematic eye treatments for school children. He was born in Lvov, and studied medicine in Kiel, Munich, and Vienna. He was one of Hirschberg's last assistants in Berlin, and excelled at humanities scholarship. He was a prolific author on the history of ophthalmology, was one of the founders of Palestine's first medical journal, *Ha'refuah* (1920), founded a Middle Eastern ophthalmic journal, *Folia Ophthalmologica Orientalia* (1932), and wrote the first medical text book in Hebrew, *Ha'ayin* [The Eye] (1927). After his first appointment as the chief of the trachoma department at the Straus Health Station in Jerusalem, he became the chief of the ophthalmology department of the Rothschild-Hadassah Hospital in 1922. He was appointed Professor of Ophthalmology of Hebrew University-Hadassah Hospital in 1939. Feigenbaum was the President of the Palestine Historical Medical Society, first dean of the faculty of the Hebrew University School of Medicine, and a member of the WHO Expert Committee on Trachoma.¹¹⁵

Although Ticho and Feigenbaum were equally celebrated ophthalmologists, they took two very different professional trajectories. While Feigenbaum entered medical academia and took the helm of public health work through managing the anti-trachoma campaign, Ticho remained in private practice, forgoing research to treat Jews and Arabs alike, a quality that remained mythic: "His clinic was perhaps the most real [sic] meeting place in Palestine of East and West, Jew and Arab, secular and religious, rich and poor, and

¹¹⁴ Ephraim Sinai, *With the Entire Eye: The World of a Physician* [Hebrew], (Tel Aviv: Tzrikover, 1984), 81.

¹¹⁵ Orit Navot, "The Campaign Against Trachoma: the Beginnings of Public Health in Eretz Israel," *Cathedra*, 94, (1999), 102.

often prince and beggar.”¹¹⁶ In 1914, however, they held two things in common: both engaged in anti-trachoma work in Jerusalem’s schools, and concerned with creating an anti-trachoma campaign.

Part of their goal was to interest physicians throughout the Yishuv in participating, both in treating students and in compiling “uniform statistics,” as they had started to do. Trachoma was the first disease in Palestine to be considered statistically and these statistics were grouped in myriad ways. Statistics was mostly associated with progress due to its capability of describing comprehensive social reforms toward modernity, and in part devised how people were conceived and thought of. The ability to track trachoma’s incidence went hand in hand with the creation of trachoma as a deviant and abnormal—rather than an universal—characteristic, now precisely ascribed to people of particular ethnic and racial categories. Statistics also made people and practices legible to medical authorities that could then prescribe counsel. Jewish physicians in Palestine turned trachoma from a general, inescapable fact into a scientific object that could be counted, categorized, and controlled.

Jewish physicians were not the first to count trachoma in Palestine. Dr. Theodor Germann, sent by the Russian Palestine society to check children of Christian Orthodox schools, conducted the first formal study between September 10 and December 21, 1896. He examined 2,010 children in Syria and 1,096 in Palestine. In the cities of Palestine he found 38% had trachoma, while in the villages 64% had trachoma. His observations reflected the prevailing trachoma theories of the time: He regarded the absence of rain, the hot and blinding sun, the chalky dust, uncleanliness, the scarcity of water, and poverty as the chief reasons of the prevalence of ophthalmia. He noted that the local population considered the fine, thorn-like hairs covering the fruit of the cactus, the juice of the fig, and flies as causes

¹¹⁶ “The Intellectual Salon of Old Jerusalem,” *Keshet* (1989), Collection of articles on the Ticho family, The Ticho Museum Library, Jerusalem.

for inflammation of the eyes and the spread of the disease. Germann did not deny these theories; he in fact believed that flies may transfer trachoma through sticky fingers. Flies, he thought, caused trachoma when filthy hands were used to drive them away. The fez, he continued, does not protect the eyes from the sun and is the reason why Arabs often touch their face. In general, he found the local population “like all Orientals, lazy, sluggish and fatalist” and that “the whole appalling filthiness of the local residents, coupled with laziness and indolence, favored the spread of the infection...even when help is within reach, how often it is not sought!”¹¹⁷ However, he was convinced that the ophthalmic conditions could improve, for the examination of the eyes of the 103 school children in the large German colony of Haifa did not reveal a single case of trachoma. Jewish physicians at the 1914 conference marveled at this statistic, using it both as an ideal to aspire to and a testament to the superiority of German culture.

Thomas Harrison Butler, who for four years was the assistant surgeon at the St. John Ophthalmic Hospital in Jerusalem, and whose sense of humor “had a certain Churchillian quality,” published research on the frequency of bacteriological eye infections.¹¹⁸ He ascertained that, as in Egypt, acute and chronic bacterial infections were caused by Morax-Axenfeld, Koch-Weeks, Pneumococcus, Gonococcus, or a combination. Since these epidemics were seasonal in nature, and varied in their virulence in different years, Butler also tried to determine the correspondence between ophthalmia and mean temperature-curves in various graphs. He determined rainfall or humidity did not afford any explanation. He did not know why Palestine was particularly subject to such high rates of ophthalmia: “All the

¹¹⁷ Theodor Germann, “Augenaerztliche Beobachtungen in Syrien und Palastina; speciell uber das Trachom in diesen Landern,” *Centralbl. f. Augenheilkunde* (1896): 388.

¹¹⁸ “Thomas Harrison Butler,” *British Journal of Ophthalmology* 29:4 (1945): 217.

conditions of the Near East—the dust, the dirt, the heat, the flies, and the general lack of sanitation—are to be found elsewhere unaccompanied by either trachoma or ophthalmia.”¹¹⁹

Although Germann and Butler took these stabs at quantifying eye disease in Palestine, Dr. Dov Meir Krinkin was the first Jewish physician to undertake a systematic, statistical survey to ascertain the incidence of the disease in the Yishuv. Krinkin was born in 1867 in Druya, Belarus, trained in Berlin and Russia, and immigrated to Palestine in 1911. He settled in Tel Aviv, and was a founder of the Hebrew Medical Association, and the Israeli Ophthalmologist Union.¹²⁰ Under the auspices of the Nathan Strauss Jewish Health Bureau, he sent surveys to fifty schools in Palestine that questioned their practices on treating and relating to children with trachoma. In 1913, Krinkin published a pamphlet of his findings, “Trachoma in the Jewish Schools of Palestine and the Means of Combatting It.”¹²¹

Krinkin undertook a survey for two reasons: to understand how widespread trachoma work was in Jewish schools in Palestine, and the principles on which schools were handling students with trachoma. The purpose of the study was to formulate uniform principles through which schools could handle students with trachoma, both in their acceptance to school, and during the school year. The survey questioned if students were checked for trachoma before school; if they were accepted or not; who did the examination; how the school protected healthy students; and what happened to them in terms of treatment outside and inside of school, among others. Krinkin also requested hard numbers: how many students were in the school, how many had trachoma, and the percentage of those infected. Not all schools could be so precise. One kindergarten in Jaffa did not provide these numbers, but

¹¹⁹ Butler, “Acute Ophthalmia in the East,” 124.

¹²⁰ Arie Feigenbaum, “Dov Meir Krinkin,” *Harefuah* 5 (1931): 221.

¹²¹ Dov Meir Krinkin, *Trachoma in the Jewish Schools of Palestine and the Means of Combatting It* (Jewish Health Bureau, 1913).

instead wrote under the percentage column, “A lot.”¹²² It became clear that practices widely varied in Palestine due to distinct cultural, economic and social attitudes towards trachoma. Krinkin’s self-reflection on his own scientific methodologies and his desire to institute order on a diverse landscape portray the medical, scientific, and cultural anxieties about trachoma that would surface in the conference organized the next year.

Krinkin sent a total of 90 questionnaires to the known 50-60 schools in cities and moshavot, as well as to physicians and local councils. Their geographical reach—including schools in Beirut and Gaza—indicate that the fluidity of the Ottoman Yishuv’s borders. Not every school answered, and those that did, did not necessarily answer every question. He first laid out how each school responded to his questions. The Gymnasia Herziliya in Tel Aviv, for example—the first modern high school in Palestine—had a dedicated school doctor who checked all the students before the start of the school year. Unlike in other schools, students with chronic trachoma were barred from school until they received a note from the doctor attesting that it was cured completely or that it was no longer infectious. The Gymnasia had rejected about 30 kids in the previous seven years who had trachoma. If trachoma precluded a student from school, their parents were responsible for treatment if they lived in Jaffa, and if students lived in the dormitories, the Gymnasia would find treatment. Krinkin noted that the principal of the school, Dr. Bograshov, did not answer the survey question that asked if healthy students were infected for the first time with trachoma at the school.¹²³

On the opposite end of the spectrum, the answer from Gaza revealed school hygiene to be non-existent. According to the teacher, Mr. Zeldes, who answered the survey, the only doctor in Gaza was an English missionary. He treated everyone in the city who went to him, including Jewish students when asked. He did not check the students in the beginning of the school year, there was no treatment in the school, and there was no effort to prevent

¹²² Krinkin, *Trachoma*, 3.

trachomatous children from infecting healthy students. There were 27 students, and almost all of them had eye disease, but Mr. Zeldes did not know which ones because the doctor did not report the name of the diagnosis. The teacher requested that Krinkin send him a popular book about eye disease, so that he could offer the children the required care.¹²⁴

The Talmud Torah and the “Kol Yisrael Haverim” school in Haifa similarly accepted all students without eye checks or administering treatment. The Tachkemoni School and “Kol Yisrael Haverim” in Jerusalem did not even fill out the survey. Religious institutions were well known to be less interested in instituting healthcare measures in schools, deemed modern and intrusive. A lack of resources could also contribute to this situation: no physicians lived in Be’er Yaakov or Gadera so no examinations were done. A doctor from Rishon Li-Zion visited in Be’er Yaacov and determined eleven out of twelve students had trachoma.

In Rishon Le-Zion and Hadera, cultural norms prohibited students from being barred from school because of trachoma. The doctor in Rishon wrote that “life of the moshava is similar to life of one family, and it is not possible to separate out the sick and to distinguish them from the healthy.”¹²⁵ In Hadera, a doctor only found one child with trachoma, and the teacher sent him everyday to the pharmacy to be treated. The teacher explained though “even if trachoma was more widespread, it would not be worth it to exclude them from school because the moshava is small...and the children always play together in the yard.”¹²⁶

Some schools already had sophisticated mechanisms for treating trachomatous students and had developed classroom practices. The “Hevrat Ezra Gan” in Haifa, for

¹²³ *ibid.* 4.

¹²⁴ *ibid.* 6.

¹²⁵ *ibid.* 6.

¹²⁶ *ibid.* 8.

example, only excluded students from school if they had purulent trachoma (pus from the eyes), which they deemed infectious. The students would be treated for free if the parents agreed, but not all did. A doctor treated students in other, non-infectious stages of the disease within the school itself. To prevent infection among children, students with trachoma sat on separate benches at the front of the classroom, and each had their own towel with their name sewn on. In Kfar Tavor, we can imagine how lonely the one child with purulent trachoma who sat on a bench by himself must have been. In Zichron Yaakov, trachoma was divided into three stages: the first stage was no clinical signs of trachoma and almost cured. The second stage was chronic trachoma without pus. Students with second stage trachoma sat on separate benches and the doctor supervised their treatment. The third stage was purulent trachoma. Those students were not accepted to school until they had reached the second stage. Every year the school did not accept six to eight students for a month or two because of trachoma, and these were treated at the pharmacy.

Krinkin took note of these widely varying practices, and that disparity in treatment was not only a result of a lack of resources, but to understandings of the disease, hygiene, and health. Some schools checked students in the beginning of year, some did not, some did part of the time; the doctor almost always was the examiner, but sometimes it was a medic, or both; and there were different criteria of when to exclude and accept a student into school, contingent on disparate understanding of when trachoma was considered “cured.” Some schools had their own treatment rooms, while others made the student go to the local clinic or pharmacy for treatment.

Krinkin realized he had to take the data he collected with a grain of salt. A smattering of doctors, teachers, and medics filled out his questionnaire. Since a trachoma diagnosis was made by a clinical picture and not bacteriological analysis, cases of trachoma may perhaps have actually been conjunctivitis or spring catarrh (inflammation of the cornea and

conjunctiva). He cited a school in the Galilee where two doctors checked students to prove his point: one found trachoma in nearly all, and the other only half.¹²⁷ He concluded that “numbers equal in their value and good for scientific statistics can only be accepted if they are collected by one person,” because multiple people have different points of view of the same diagnostic material. Although Krinkin concluded that his statistics were not “scientific,” he realized that it still brought to light much needed information.¹²⁸ The absence of a streamlined procedure for Hebrew schools to deal with trachoma was proof for Krinkin “how important it was to set one norm that all schools can act by.”¹²⁹

What would this norm be? Krinkin determined that excluding students may be sound for medical reasons, but not at all for our “public-cultural demands.” Excluding students “was a sin the public would not stand for, and it was forbidden from the point of view of general human and national culture.”¹³⁰ He looked to the Prussian anti-trachoma campaign of 1897 for guidance, in which Professor Axenfeld determined that only students with purulent trachoma would be prohibited to attend school, and it was mandatory for those with all other types with trachoma to attend and sit on separate benches. According to this maxim, the Gymnasia Herziliya, perhaps with best intentions, stigmatized students with non-purulent trachoma unnecessarily. Krinkin concluded that most cases of trachoma did not even start in the school, and on the contrary, school had a positive influence of being the place where students were treated and where the doctrine of cleanliness was taught. Krinkin wrote it was important to look to “cultured countries” to see how trachoma was dealt with, and followed Axenfeld’s lead.¹³¹

¹²⁷ *ibid.* 14.

¹²⁸ *ibid.* 14.

¹²⁹ *ibid.* 15.

¹³⁰ *ibid.* 19.

¹³¹ *ibid.* 20.

The principles Krinkin espoused, then, teetered between the interests of the Yishuv and those of individuals. He supported the exclusion of students with purulent trachoma, but not those with scarred or chronic trachoma. The school doctor would ideally treat the infected students, but he also acknowledged that he could not take away the right of the parents to send their child to a private doctor of their choice. Hygienic practices had to be implemented and taught: students with trachoma needed to sit on special benches in the front row, have individual towels, and not to touch their eyes with their fingers. They should use sinks with running water, rather than a still washbasin. There should be medical aphorisms about hygiene tacked on to the school walls and for the children to take home to their parents. Finally, to oversee the process, one specialist doctor needed to visit every settlement of the Yishuv, because “not every doctor has the same opinion, not in his diagnosis, nor in his relationship to trachoma in the schools.”¹³² Krinkin figured that if one specialist checked students in consultation with local physicians, then slowly the practices would stabilize, and they would be able to “present scientific statistics that would illuminate the current situation, and we would succeed in the war against trachoma.”¹³³ Krinkin’s survey revealed not only that patients, teachers, and parents related to trachoma in myriad ways, but also that physicians held themselves to shifting standards.

The Trachoma Conference: Discussing and Defining a Campaign

The small-scale studies in Palestine on trachoma before 1914 did not reflect “modern” science or medicine, according to Krinkin and the rest of his cohort. In order to hasten a transition, Dr. Eliyahu Auerbach, the first eye doctor in Haifa, recommended calling a conference in 1913 for physicians in order to compile their collective years of experience and jointly combat “this terrible plague.” The conference was hosted by the Trachoma

¹³² *ibid.* 26.

¹³³ *ibid.* 28.

Department of the Nathan Straus Health Center in Jerusalem. Bruenn, Feigenbaum, Ticho, and Shimoni-Mekler organized the conference and the program. The conference lasted three days from March 31-April 2, 1914, and the participants felt a “special satisfaction that they gave a push to an important and beneficial enterprise...and their hearts became closer in joint scientific work.”¹³⁴ Auerbach was unable to participate. The conference revealed the range of opinions present among the participants, but also signaled a commitment to understanding and combatting trachoma in a uniform manner throughout the Yishuv. In fact, the suggestions of each paper were either accepted or rejected by a vote, in order to determine the fixed principles of an anti-trachoma campaign. Feigenbaum was one of the authorities of conference, presenting four original papers, as well as conducting a demonstration of surgery on a trachomatous patient jointly with Ticho, his esteemed peer. These men were the conference’s authoritative ocular experts and local Jerusalem hosts.

This anti-trachoma campaign was not the first. Wilhelm Bruenn, who headed the Malarial Unit of the Nathan Straus Health Unit, surveyed past efforts, particularly those of Prussia and Egypt. The Prussian anti-trachoma campaign, which had been run in 1896-1897 by Hirschberg, was familiar to most participants with German training. It ran from 1898-1905, and trained over 700 general physicians to treat trachoma within schools.¹³⁵ The anti-trachoma campaign in Egypt started in 1904, and did not have schools as its locus of intervention. Instead, Arthur Ferguson MacCallan, a British ophthalmologist, ran eight eye hospitals and numerous mobile eye clinics throughout Egypt. Lord Cromer, the British Consul-General in Egypt convinced industrialist Sir Ernest Cassel (who had been interested in the Aswan Dam) to donate £41,000 to start these ophthalmic activities because over 90%

¹³⁴ Introduction, *Trachoma Conference*, i.

¹³⁵ Wilhelm Bruenn, “The Organization of the Anti-Trachoma Campaign,” in *Trachoma Conference*, 84.

of the population had trachoma.¹³⁶ Breunn argued that they should integrate methods from both campaigns into the Yishuv. The campaign, Breunn reasoned, should focus both on treatment and prevention. He ascertained that long lasting treatment might be hard for people to accept when the disease was not terribly painful. Therefore, it had to be free and school was the most appropriate place to treat children. To promote prevention, there would need to be improvements in water distribution, infant health, housing conditions, and public health education on hygiene.

Bruenn also thought they needed to include Arabs and Christians in whatever way they could into their activities. School physicians would work in Arab and Christian schools in cities, while clinics would be open to all. The Egyptian model of mobile clinics would need to be copied for anti-trachoma work in Arab villages, he wrote. Not only did Jews have a “moral obligation” to treat Arabs, he also surmised “we gain allies for all sides.”¹³⁷ Although this was one of the agreed principles of the campaign—that trachoma treatment would be given to all without regard to religion or nationality—political and financial pressures of the Mandate period precluded Arabs as a target of the campaign. Instead, they continued to be welcome in the private practices of Ticho and his cohort, or in mobile clinics of the British Mandate Health Department.

Physicians were just as interested in the scientific and bacteriological questions associated with trachoma, as they were in clinical practices crucial to a campaign. Dr. Arieh Goldberg, who worked at the Jewish Health Bureau, gave a thorough bacteriological review of trachoma, including early studies to isolate the agent and fulfill Koch’s postulates. Although he acknowledged that the investigations “did not go well,” he did determine that the disease was infectious because it was a disease that spread in the family, it had been successfully spread from one person to another (on purpose), and its epidemic appearance, as

¹³⁶ *ibid.* 84.

evidenced in the Napoleonic Wars.¹³⁸ However, some physicians disagreed with him on this point: A Dr. David claimed that they could not retroactively identify the disease that ravaged Napoleon's troops as trachoma because there were no bacteriological tests. Feigenbaum concurred that it was understood that Egyptian ophthalmia was not just trachoma but an amalgamation of infectious eye diseases. Ticho insisted that Napoleon's troops were struck with both trachoma and gonococcal conjunctivitis, as trachoma on its own could not cause such swift blindness. Dr. Goldberg dismissed these concerns, claiming he recalled Napoleon's troops only as an example.¹³⁹ Jewish ophthalmologists understood that not all cases of eye disease were necessarily trachoma, and sought to enhance their understanding of bacterial causes of acute conjunctivitis. These nuances often fell by the wayside in the course of actual fieldwork due to the complications of diagnosis.

As Krinkin had previewed in his survey, the collection and compilation of statistics was an important point of contention in the conference. Practices differed on what information should be collected and who should collect it. Feigenbaum, who had checked 2,124 people in Jerusalem, decided to record: place of examination, age, suspected cases of trachoma, cured cases of trachoma, the stage of trachoma (which he categorized into mild, medium, and severe), and the total number of blind in one or both eyes. Although he did not record ethnicity, that information was almost always revealed by the name of the school, such as "Talmud Torah of the Persians," or "The Arab School of Sheikh Muhammad."¹⁴⁰ Feigenbaum argued that a comprehensive statistical survey would answer questions about the many ethnic groups, religions, and ways of life in Palestine. His original statistics, he

¹³⁷ *ibid.* 86.

¹³⁸ Arie Goldberg, "Experimental Trachoma Research," in *Trachoma Conference*, 2.

¹³⁹ *ibid.* 9.

¹⁴⁰ Arie Feigenbaum, "A Statistical Survey on Trachoma and Other Infectious Eye Diseases in Palestine," in *Trachoma Conference*, 30.

thought, were inadequate: “We need exact statistics from every place so that we can sort out the important conditions from an epidemiological point of view like conditions of his apartment, neighborhood, number of people in his house, etc.”¹⁴¹ Like Krinkin, he knew physicians often differed in their methods. To correct that imbalance, he devised a Jewish Health Bureau eye health card. This individualized card required the examinee’s name, his ethnicity, age, parents’ professions, the place of his house and neighborhood, the number of people and rooms in the house, place of birth, how long he had been in Palestine, if he had been infected previously, the number of infected in his family and house, and a space for other comments. Curing an eye disease, then, required probing a patient’s personal life to an unheard of degree. The stage and status of trachoma was on the other side of the card in Latin, and the physician could circle the patient’s symptoms according to characteristics already printed. Feigenbaum explained that the “correct statistics of trachoma in Eretz Israel” will be based on these cards, which he intended to distribute to every eye doctor in Israel.¹⁴²

Another point debated and cemented as integral to trachoma incidence was the level of one’s culture (*tarbut*). This was sometimes integrated with ethnic essentialism or with economic status. Feigenbaum cited statistics that Yemenites had high rates of trachoma (over forty percent), yet he noticed a difference between the rates of Yemenites living in rural settlements and those living in Jerusalem (where Yemenites had less trachoma than other ethnicities). He went on to explain that trachomatous Yemenites in Jerusalem were born in Palestine rather than Yemen, indicating how important the first years of life were in contracting the disease.¹⁴³ This conclusion seemed to prioritize environment as a causal factor. However, in the same paper, Feigenbaum categorized trachoma as a “family

¹⁴¹ *ibid.* 32.

¹⁴² Arie Feigenbaum, “A Suggestion for Uniform Diagnosis and Statistics,” in *Trachoma Conference*, 82.

¹⁴³ Feigenbaum, “Statistical Survey,” 32.

disease...In poor families that crowd in apartments that are not spacious enough, that do not pay enough attention to demands of hygiene and do not especially worry about cleanliness, the disease finds a fertile nest there.”¹⁴⁴ This seems to blame the family for their apathy. Regardless, the concept of culture and ethnicity were signifiers to track in trachoma statistics and were considered a cause of trachoma; Feigenbaum clearly stated that “Trachoma is caused by two reasons: The main one is the agent that is still unknown, and the second is the low level of culture, with all of its effects (bad hygienic conditions, terrible housing, uncleanliness, etc.).”¹⁴⁵

Krinkin examined the idea of trachoma according to culture and nationality more thoroughly. Krinkin decided to remove the patients from his statistics whose nationality he did not have a large sampling of: Greeks, Armenians, “Ottomans”, Syrians, Russians, Czechs, Bukharans, Moroccans and Georgians. Now with a sampling of 1,655 rather than 1,728 patients, he concluded that 36.2% of Jews had trachoma, 63% of Arabs, and no Germans (Templars).¹⁴⁶ He tried to elucidate why Germans were immune even though they had various social standings, immigrated at different times, and had much contact with Arabs. Although he said this might indicate a racial disposition, he added that the fact that many Germans living on the Volga River had trachoma ruled that out. Instead, it was the German diligence, culture, and especially cleanliness that protected them from trachoma. In his paper, Krinkin went on to group his patients in many ways to explain trachoma rates: time spent in Palestine – less than 5 or 10 years, more than 10 years, born in Palestine, came already sick; urban or village dwellers; gender; age; stage of disease, and occupation. All of these factors were stacked against their nationality (*le’um*) – Ashkenazim born in Palestine,

¹⁴⁴ *ibid.* 33.

¹⁴⁵ J. David, “Flies as the Main Causative Agent of Trachoma,” in *Trachoma Conference*, 64.

¹⁴⁶ Dov Krinkin, “Trachoma in the Land of Israel According to Private Practice,” in *Trachoma Conference*, 38.

immigrant Ashkenazim, Sephardim, Yemenites, Jews in general, Arabs, and Germans.

Krinkin noted that the burden of trachoma was not spread equally and that the level of culture was the main factor of this discrepancy.¹⁴⁷

Not all physicians agreed with Krinkin's interpretation of his statistics, neither his sampling nor in his understanding that European culture curbed trachoma. Krinkin himself acknowledged his statistics had shortcomings because he was in private practice. Patients only went to a private doctor if they could afford it or if they were in pain; therefore, Krinkin's wrote that his statistics did not reflect the rates of trachoma in Jaffa, where he worked, but only of the people who sought out his care. Hospitals and clinics that treated patients for free had a more accurate account of the population. Shimoni-Mekler and Feigenbaum both concurred that his statistics had limited value. Feigenbaum asserted that Yemenites only go to a private practitioner in serious cases, while Ashkenazim ask for the doctor's advice even with the slightest ache.¹⁴⁸ Masie questioned Krinkin's assertion that Ashkenazim were more hygienic. He noted that when there was a meningitis outbreak in Jerusalem, Sephardim were unaffected, which proved that Ashkenazim could also be negligent.¹⁴⁹ Shimoni-Mekler, though, "was happy in his heart" that Germans were not afflicted; it proved to him that Palestine's climate and swamps did not cause trachoma, but that culture which could be improved and gave him hope that Jews could also be free of trachoma.¹⁵⁰

Dr. Jacob David, the doctor of Yavniel in the Lower Galilee, did not get very far in convincing others of his opinions. Both of his papers were not well received. His first paper

¹⁴⁷ *ibid.* 39.

¹⁴⁸ *ibid.* 56.

¹⁴⁹ *ibid.* 55.

¹⁵⁰ *ibid.* 54.

argued that flies were the main agent for spreading trachoma, and ascertained that an anti-trachoma campaign must include eradication of flies.¹⁵¹ Arabs had higher rates of trachoma than Jews because they did not protect their babies' faces from those buzzing vectors. This idea was thoroughly rejected, as most chimed that it was culture and poverty—not flies—that were the main “agents” of trachoma. He had also developed a “preventive” eye drop comprised of zinc sulfate, adrenaline solution, and distilled water, which he administered to all the healthy children of the moshavot under his supervision.¹⁵² He claimed that these children did not develop trachoma or other eye infections, and that his method should be used universally. Although some doctors thought David's eye drops showed promise, others thought that patients would regard these eye drops as a talisman that would decrease physicians' inroads in encouraging hygienic practices. In short, even if the drops did work, they could justify laziness. Others simply did not trust David's small sample.¹⁵³

Although creating a unified campaign was one of the most important goals of the conference, physicians were not shy to point out all the difficulties involved in coercing standardization. Ticho thought it would be impossible to force all schools to participate, as some religious schools resisted medical encroachments. Krinkin thought imposing a standardized treatment was damaging to doctor morale, who needed to “trust his inner conscience” when treating a patient. Despite these setbacks, the physicians did vote whether to implement their colleague's suggestions in anticipation of an intensive campaign. They decided that every school needed a school physician who would receive education in eye diseases and trachoma. The school physician would decide if any student needed to be excluded from school, but in principle all students were accepted. The Nathan Strauss Jewish

¹⁵¹ J. David, “Flies as the Main Causative Agent of Trachoma,” in *Trachoma Conference*, 59.

¹⁵² J. David, “The Systematic Prevention of Trachoma and Infectious Eye Diseases in General,” in *Trachoma Conference*, 112.

¹⁵³ *ibid.* 115.

Health Bureau would provide physicians with moral, scientific, and material support in the anti-trachoma campaign, and publish public health materials “in large lettering and easy language.” Statistics would be collected using Feigenbaum’s form. They agreed the next trachoma conference should be held in Jaffa in 1916.¹⁵⁴

Conclusion

Feigenbaum and Shimoni-Mekler may have already speculated in 1915, the point of publication, that there was not going to be the much hoped for second conference. World War I had erupted, Jerusalem was in disarray, and physicians had been drafted. Despite these hardships, both editors claimed they did not feel themselves exempt from the responsibility to publish the conference proceedings, as they recognized it served as a crucial foundation for future activities.¹⁵⁵ Even with the disruption of war, they were right. Shortly following its end, the nascent Hadassah Medical Organization started a different type of war: a public health anti-trachoma campaign in the Yishuv, building on many of the same principles and methods discussed in 1914.

Trachoma was not only prevalent in Palestine, it was also one of its defining features. This had as much to do with the visual landscape, which seemed to be crowded with blind and impaired eyes, as it had to do with trachoma’s novelty, etiology, and history. Trachoma was constructed as Ottoman Palestine manifest, betraying apathetic poverty, hygienic carelessness, and cultural darkness. The disease’s understood deep roots in the Orient, specifically Egypt, further affixed this picture. The twenty-four ophthalmologists from around the country who gathered in 1914 for the three-day Trachoma Conference were involved in a global scientific-medical debate and in local public health. They discussed the possibility for a multi-faceted approach to trachoma management, which included as many

¹⁵⁴ “Suggestions and Decisions,” in *Trachoma Conference*, 115-117.

¹⁵⁵ “Introduction,” in *Trachoma Conference*, i.

cultural as medical interventions. The ophthalmologists were not only discussing how to treat a disease, but were defining their subjects and engaged in a mass statistical enterprise.

CHAPTER 2

The Traveling Oculist: The Geography of Trachoma in British Mandate Palestine

Introduction

It would have been relatively easy to miss the map, which was tightly folded into four in between the pages of the Hadassah Medical Organization's twentieth anniversary report, "Twenty Years of Medical Service, 1918-1938."¹ Illustrative symbols like a hospital bed or a square clinic pinpoint where a wide variety of Hadassah Medical Organization (HMO) institutions throughout the Yishuv operated, including hospitals, dispensaries, and health welfare centers. However, the icon of the eye is the most numerous, indicating all of the locations where the anti-trachoma campaign was active. The result is a map of Palestine with a pack of floating eyes staring at the viewer.

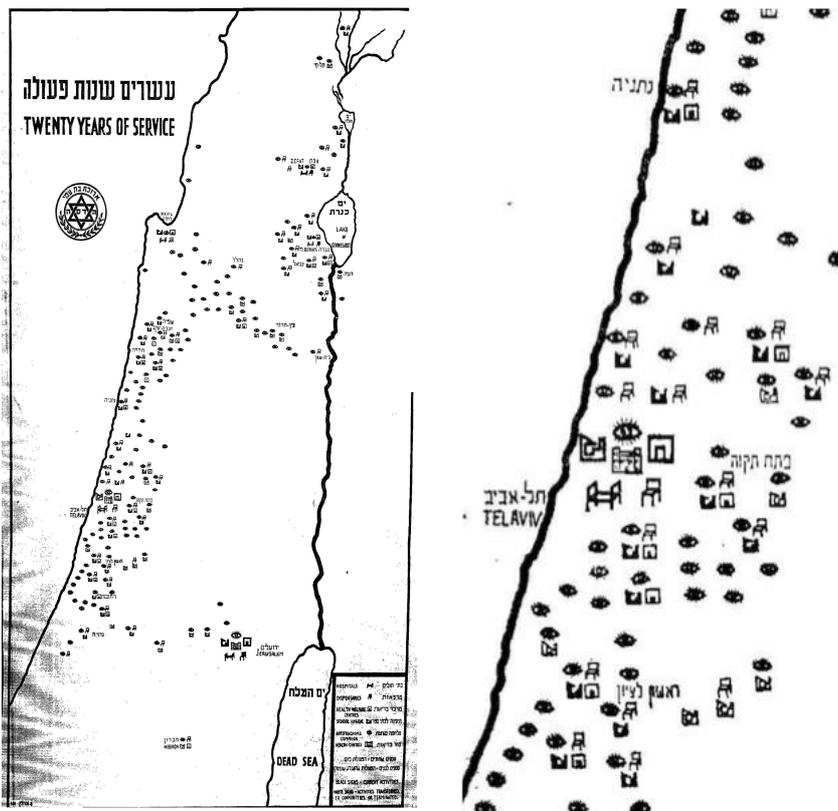


Figure 3: "Twenty Years of Service, 1938" Section Magnified

¹ Hadassah: *Twenty Years of Medical Service to Palestine, 1918-1938*, (Jerusalem: Achvah Co-op Printing Press, 1939).

The map makes clear that the anti-trachoma campaign was the most far-reaching geographic Hadassah health project, and that in most settlements eye care was the sole Hadassah service offered. How did the anti-trachoma campaign command such a large geographic scope? Hadassah depended on the regular journeys of the “traveling oculist” (רופא נודד), a one-man band to travel to over sixty settlements multiple times a year. He or she travelled by horse, donkey, train or foot to every rural Jewish settlement to conduct periodic trachoma checks in school children, distribute individual eye health cards, educate local nurses in administering daily treatment, and perform surgery.² The traveling oculist gathered and calculated statistics on trachoma incidence to be sent back to Hadassah’s central office in Jerusalem, and in so doing, drew into being the very concept of a national population, with its political potential and demands. Continuing a process started with the 1914 Trachoma Conference, the anti-trachoma campaign was a key way in which the Jewish population could be managed and rendered intelligible to Jewish governmental bodies taking shape in British Mandate Palestine.

The symbol of the eye, however, to represent all that the traveling oculist accomplished is somewhat misleading. Although the icon represented the breadth and success of the “war against trachoma,” it obscures that traveling oculists were also institutional representatives deeply embedded in a project to produce knowledge on—and thereby create—the modern nation, which included collecting statistical and demographical information, cultural ethnography, and hygiene instruction. The routes of the traveling oculists coincided with the boundaries of the Yishuv, representing how spaces of public health dovetailed with lines of national identity and governance. Neatly expunged from view is that indigenous Arabs accessed a separate health infrastructure through the British Mandate

² Nahum Shimkin, “On the Problem of Trachoma among the Jews in Palestine,” *Harefuah* 22, no. 4 (February 15, 1942): 58.

Government's Department of Health (GDH), and therefore, excluded from Hadassah's nation-building project. While the map shows how borders were created, it belies all the ways in which eye doctors could also transgress geographic, national and ethnic boundaries. Jewish ophthalmologists in private practice, who existed outside of national departments or organizations, could easily serve Arab patients, and indeed, sought them out. While trachoma was conceptualized as a disease of hygiene to both Hadassah and the GDH—to be confronted by scientific practices and statistics through public health campaigns—this perception did not override trachoma as a “scourge of the East,” an idea that had been solidified in the previous century.

This chapter evaluates not only the medical practices and the daily activities of the traveling oculist and the private practitioner, but consider how trachoma served as a multivalent site to express Zionist interpretations of the indigenous population. When and where was the ideology of hygiene deployed to treat eyes? How did ophthalmologists construct their Jewish and Arab patients through socio-medical practices and discourses? How did the mobility of physicians facilitate social scientific and medical knowledge production in systematic and informal ways? These questions challenge the triumphalist story of medical progress by teasing out how social intervention was an integral part of forming scientific expertise on trachoma, and how that expertise shaped, evaluated and critiqued cultural practices. The map depicts variations in how ocular hygiene became a medically legitimated form of cultural intervention, and how orientalized pathology was performed and interpreted in heterogeneous ways across political and ethnic geography. The history of how trachoma was conceptualized over a variegated terrain reveals that disciplining national institutions were coterminous with medical practices that breached borders between Arab and Jewish populations.

The epidemiology of trachoma itself was crucial to why services to tackle it were most widespread, and how eye doctors could transcend their function as mere medical interlocutors: the restoration of sight and healthy eyes had to be accompanied by the population's acceptance of modern health practices, including washing one's hands and face. Trachoma became the primary locus of Hadassah's Department of School Hygiene because it encompassed the tension both between hygiene as a set of practices, and as an ideology of modernization and culture.³ Since trachoma was considered an indelible feature of the apathetic, backwards Arab, its absence in the Jewish population would denote its transformation into Western and modern subjects that could become part of the Jewish national collective. Hadassah therefore poured its financial resources into trachoma treatment both to promote the conventions of hygiene and for cultural demarcation between Jews and Arabs. That is the reason eyes were the most common dot on the map: the modernity of the body was most acutely manifest in the health of the eye.

From an epidemiological standpoint, the Hadassah anti-trachoma campaign was a resounding success: incidence rates dropped from around 40% in 1918 to less than 2% by the mid-1940s in the Jewish community. However, trachoma remained an urgent public health risk amongst Yemenite Jews in rural settlements, even as overall rates declined.⁴ Trachoma treatment was proffered to Yemenites as a means of earning a place within Yishuv civil society, but they continued to be excluded from socio-economic advancement and could not resolve the hygienic chasm demanded of them. Traveling oculists explained this failure through reinforcing trachoma as a marker of oriental cultural deficiencies, while also recognizing that Yemenites could not escape the agricultural economy that had prescribed

³ For a complete discussion on the role of hygiene in Mandatory Palestine, see, Dafna Hirsch, *"We Are Here to Bring the West": Hygiene Education and Culture Building in the Jewish Society of Mandate Palestine* (Israel: The Ben Gurion Research Institute, 2014).

⁴ Natan Dobryzinski, "The Anti-Trachoma Campaign in Palestine in the Past and in the Future," Sept 1944, J113/2542, HMO Papers, CZA.

their poverty. These discourses fluidly existed in tandem. In stark contrast, trachoma incidence in the rural settlements of European immigrants was always relegated to the presence of Arab workers, highlighting that the distinction between East and West existed not necessarily on the level of diagnosis, but in how it was interpreted.⁵

Southern Palestine, whose residents were indigenous Arab, was cut completely from the map. The GDH, in conjuncture with the St. John Ophthalmic Hospital in Jerusalem, operated a robust network of eye services, including traveling ophthalmic hospitals, trachoma treatment in schools, and central clinics, even if these services did not reach the same proportion of the population as they did in the Jewish sector.⁶ However, the lines between North and South did not only delineate between Jewish and Arab populations, but also of ocular epidemiology. Southern Palestine contended with severe summer bacterial eye infections that produced more severe cases of trachoma, as well as a higher incidence of blindness.⁷ By calling attention to the similarities and differences between Hadassah's campaign and that of the GDH, I explore how Hadassah differentiated Jews from Arab "natives" through improved ocular health (even if faced with a less damaging problem), and therefore exempt from "colonial" standards and in demand of higher rights and services.

Even though Arabs were excluded from Hadassah's anti-trachoma campaign, that does not imply that they were never served by Jewish eye doctors. The chapter examines two first-person narratives to analyze how eye doctors conceived of operating a private practice for Palestinian Arab patients in terms of their Zionist ideals. These are Dr. Ephraim Sinai's memoir, *With the Entire Eye: The World of a Physician* (1984), which in part documents his

⁵ See Dafna Hirsch, "'We Are Here to Bring the West, Not Only to Ourselves': Zionist Occidentalism and the Discourse of Hygiene in Mandate Palestine," *International Journal of Middle East Studies* 41, no. 4 (November 2009): 577–94.

⁶ See Government of Palestine Department of Health, *Annual Report* for years 1922 through 1940.

⁷ John Strathearn, The problem of blindness in Palestine, *Folia Ophthalmologica Orientalia* 1 (1933) 127.

journey to Gaza to set up an eye clinic, and an unpublished essay by Jenny Cramer, the clinic manager and wife of the Nahariya ophthalmologist, Dr. Max Cramer, titled “Our Arab Practice” (1961).⁸ Eye doctors in private practice understood Arabs not as subjects of reform, as they had Yemenite Jews, but as a possible economic market. The memoirs reveal that their authors thought that their access to the Arab population, and the ethnographic knowledge gained, was unique and worth writing about at length, echoing a nineteenth-century sentiment: “The medical profession afforded the best passport to a traveller in the East and gave him access to the inhabitations and even to the harems of a people whose prejudices debarred other Europeans from that intercourse with them which is essential to a knowledge of their modes and customs.”⁹ I look at how these narratives complicate and conserve the colonial fiction of Arab indebtedness to Zionist welfare, as well as reveal conflicting visions of Zionist conceptions of and relationship to the native population.¹⁰ Including the stories of private practitioners—whose papers are elusive in the archive—illustrates how individuals transgressed cultural and geographic boundaries at certain points, even if they associated with national institutions at others.¹¹

Both Hadassah oculists and private physicians partook in the act of traveling, which was an integral part of fulfilling the Zionist task of “knowing the land” (*yediat ha’aretz*), and in so doing could create certain conceptions of the nation. The Hadassah anti-trachoma campaign was a “medical mobilization of civic potential” in the creation of a modern,

⁸ Ephraim Sinai, *With the Entire Eye: The World of a Physician* [Hebrew], (Tel Aviv: Tzrikover, 1984); Jenny Cramer, “Our Arab Practice,” K13/167, CZA.

⁹ R.R Madden, “Travels in Turkey, Egypt, Nubia And Palestine in 1824, 1825, 1826 And 1827,” 2 vols (London: Henry Colburn, 1829), vol. I, p. i in Sobhi M. Bekawi, *English Travel Literature Dealing with Palestine from 1800-1850* (Cairo: Associated Institution for the Study and Presentation of Arab Cultural Values, 1978), 89.

¹⁰ Gil Eyal, *The Disenchantment of the Orient: Expertise in Arab Affairs and the Israeli State*, (Stanford, CA: Stanford University Press, 2006), 10.

hygienic, Western Yishuv.¹² The traveling oculist knit together disparate and unconnected settlements into a national framework that could be studied, controlled, and manipulated, bringing scientific norms from the city into the country. Although the intent of the anti-trachoma campaign was to create a regime of public health triggered by the scientific impulse to record and quantify, the result was often met with the complex reality of lived experience. A national anti-trachoma campaign was in fact the sum product of numerous local circumstances, interactions, and personnel, that created kaleidoscopic manifestations of disease management, welded together to create an image of institutional strength. The private doctor, on the other hand, produced a different image of nation, one that implied that cultural separatism was not an inevitable part of Zionist settlement. Knowledge of the orient was crucial to both actors, either as a means to affect transformation or to appreciate the authentic native. Eye care defined a number of boundaries—geographic, cultural, infrastructural—in the name of nation building, leading the anti-trachoma campaign to acquire a different character after the State of Israel was founded in 1948. This was not only due to trachoma’s rapidly declining incidence, but also because alternate governmental lines had been drawn, creating different institutions to serve newly formed citizens.

The “War Against Trachoma”: A Colonial Campaign?

Healthcare in Mandate Palestine was part of a colonial moment, and in many key ways Hadassah’s anti-trachoma campaign was situated within the broader context of colonial medical practices.¹³ The very notion of having a “war against trachoma” was a result of the

¹¹ On the value of social biography see Gershon Shafir and Mark LeVine, “Introduction: Social Biographies in Making Sense of History,” in Gershon Shafir and Mark LeVine eds., *Struggle and Survival in Palestine/Israel*, Berkeley: UC Press, 2012) 1-20.

¹² Warwick Anderson, *Colonial Pathologies*, 4.

¹³ See, for example, Richard Keller, *Colonial madness: psychiatry in French North Africa* (Chicago: University of Chicago Press 2007); David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993); Randall Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1990); Megan Vaughn, *Curing Their Ills: Colonial Power and African Illness*

effect of World War I, which influenced how diseases were tackled in great, military-style campaigns, often though ignoring the overall socio-economic conditions that caused them. Instead, the focus was on eradication of the pathogen or its vector. Officials sometimes viewed their public health programs as a kind of moral justification for colonialism, even though their implementation was often a matter of political economy: whether the disease affected Europeans, prevented the colonized from working, or when health could enable colonized peoples to buy more products from the metropole. These public health programs offered “technical” fixes, often backed by much scientific research and institutes, implemented through a team of top-heavy with physicians rather than through popular participation in tandem with other social welfare activities.¹⁴ Recent histories of colonial medicine discuss the tension between the idea of civilization and notions of difference that were deeply embedded in culture and biology.¹⁵

Yet, a consideration of trachoma within Palestine, where it affected over half of the population in the beginning of the mandate, reveals that it was not a typical colonial disease, not in its etiology nor in the organizations tasked to tackle it. Trachoma was a non-fatal disease that affected poor, rural communities, and therefore not of prime importance to colonial interests. It did not affect the farmer’s ability to work, and colonists were not likely to catch it. While the Hadassah “war against trachoma” sought to assimilate an internal “other”—Yemenite Jews—by tackling a disease of the East, the British were shocked into action by the 1931 Census that pinned Palestine with the highest rate of blindness in the

(Palo Alto: Stanford University Press, 1992); Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, N.C.: Duke University Press, 1999). For a historiographical review, see, Warwick Anderson, “Postcolonial Histories of Medicine,” in Huisman F. and Warner J. Harley (eds), *Locating Medical History: The Stories and Their Meanings* (Baltimore: Johns Hopkins) 285–306.

¹⁴ John Farley, *Bilharzia: A History of Imperial Tropical Medicine*, (Cambridge: Cambridge University Press, 1991).

¹⁵ Warwick Anderson. *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines*, (Durham: Duke University Press, 2006).

world, an unflattering statistic. The multitude of institutions treating trachoma was in part due to Palestine's unique state structures: it was part of the Ottoman Empire until 1917, when the British military administration established rule and obtained a mandate from the League of Nations in June 1922 to govern. Although the "dual society" model has been contested, there is no question that during the Mandate the Jewish leadership created and funded many of its own services and institutions, while the British operated separate services, like education and healthcare, for the Palestinian Arab population.¹⁶ Therefore, although Hadassah was a non-profit organization, it operated as a proto-state health department, utilizing similar assumptions and practices as an American organization seeking to modernize Palestine. Under Mandate rule, the British were obliged to send reports to the League of Nations on the details of their governance, opening up colonial mechanisms to scrutiny and justification.¹⁷ The provision of health was emblematic of good governance as a whole.

Hadassah was not simply a Zionist organization, but was also modeled on American women's benevolent societies that were prevalent during the Progressive era. Both in the United States and the Yishuv, Hadassah avoided affiliation with political parties—an inappropriate activity for women—and treated both Jews and Arabs to foreground American pluralism.¹⁸ The discourse of medicine, health and science also billed itself as objective and impartial. Hadassah activities, which included child welfare, health, and sanitation, were typical for women's activism at the time and part of the "maternalist" rhetoric. Child health

¹⁶ Lockman argued that the Arab and Jewish communities of the mandate should be treated as having been "constituted and shaped within a complex matrix of economic, political, social, and cultural interactions," rather than as developing independently and autonomously, as depicted in the "dual society" model of conventional historiography. See, Zachary Lockman, *Comrades and Enemies: Arab and Jewish Workers in Palestine 1906–1948* (Berkeley, 1996).

¹⁷ See Susan Pedersen, "The Meaning of the Mandates System: An Argument," *Geschichte und Gesellschaft*, 32 (4): 560–582.

¹⁸ Mira Katzburg-Yungman, "Women and Zionist activity in Erez Israel: the case of Hadassah, 1913-1958," *American Jewish Women and the Zionist Enterprise*, Eds: Shulamit Reinharz and Mark A. Raider. Waltham, Mass: Brandeis University Press, 2005. 163.

was considered crucial as the basis for preventive care and a healthy nation.¹⁹ Part of the Hadassah rhetoric was singling out Mizrahi Jewish children as those especially in need of social welfare services, who needed to be reformed in order to fit into the national collective. The nurses' mission was to inculcate modern and Western ideas about health to Jewish mothers who still held fast to "superstitious and foolish customs," as well as to educate them with "American ideas of scientific motherhood."²⁰ There are two other significant reasons why Hadassah disproportionately worked in the Mizrahi community: they were Jerusalem's equivalent to the American urban poor in which Progressivist policies had been practiced, as well as disenfranchised enough that a women's organization could legitimately claim superiority.²¹ These motivations undoubtedly influenced the financial resources Hadassah put into the anti-trachoma campaign, which outweighed all the other activities in the Department of School Hygiene.²²

In the previous chapter, I outlined why trachoma had become a disease of interest to Jewish physicians—through its imagined understanding as a "scourge of the East" and as an actual endemic disease—and the piecemeal efforts that took place before World War I. The seeds of a coordinated anti-trachoma campaign started in earnest immediately after the war, when the crippling medical situation in Palestine prompted the Hadassah Women's Zionist Organization of America to send the American Zionist Medical Unit (AZMU) with a team of forty-four doctors, nurses, and administrations equipped with four hundred tons of supplies.²³

¹⁹ Shifra Shvarts and Shehory-Rubin, Zipora, *Hadassah for the Health of the People* (Hebrew). (Jerusalem: Hasifria Hazionit, 2003) 42.

²⁰ Erica B. Simmons, "Playgrounds and Penny Lunches in Palestine: American Social Welfare in the Yishuv," *American Jewish History* 92.3 (2006), 270.

²¹ Dafna Hirsch, "'Interpreters of Occident to the Awakening Orient': The Jewish Public Health Nurse in Mandate Palestine," *Comparative Studies in Society and History* 50, no. 01 (January 2008): 233.

²² *Hadassah: Twenty Years of Medical Service to Palestine, 1918-1938*, (Jerusalem: Achvah Co-op Printing Press, 1939) 144*.

²³ American Zionist Medical Unit for Palestine, *Zionist Organization of America*, 1919.

Among the doctors of the mission were Joseph Krinsky and Izak Alcazar, two ophthalmologists commissioned to treat the spread of trachoma. Alcazar established the seeds of a school based anti-trachoma campaign in Jaffa and Jerusalem. He divided the schools into districts of 500 students, each headed by a trained eye nurse, and checked every student once every three months. The nurse recorded each diagnosis and followed up with daily treatment by massaging the eyelid with a cotton applicator moistened with antibacterial solutions, along with eye drops of silver proteinate, silver nitrate, zinc sulphate, and copper sulphate. Alcazar's scheme was a continuation of Ticho and Feigenbaum's work in Jerusalem schools, which had been discussed and lauded in the 1914 Trachoma Conference. In both cities, he estimated he had over seven thousand students under his supervision. Although he returned to Long Beach, CA after the mission, he concluded that, "This is by far the most important work I have done in Palestine. How much greater the results would be if three or four physicians could devote their whole time to this urgent and worthy problem!"²⁴

Anti-trachoma work in urban areas quickly expanded. Hadassah opened general eye clinics in their hospitals in Jerusalem, Jaffa, Haifa, Tiberias, and Safed that all patients could attend for free or minimal payment. Within four years these five Hadassah clinics made 726,050 patient contacts for eye diseases, besides a simultaneous effort to target infected children at home and in school.²⁵ In urban areas, eye doctors checked students four times a year and recorded their eye condition on special eye health cards.²⁶ The contents of the card were frequently debated and in flux. In a 1927 Hadassah ophthalmologist conference, participants discussed if the card should include the child's gender or if he or she had recently

²⁴ Izak Alcazar, "Conditions in Palestine during the War and Medical Relief among the Civil Population and the Refugees," *The Boston Medical and Surgical Journal* 184, no. 4 (1921): 96.

²⁵ Haim Yassky, "Ce Qui est fait par Hadassah Medical Organisation contre le trachome en Palestine," *Revue Internationale du Trachome* (July 1926) 89-106.

²⁶ "Scientific Conference of School Physicians," *Yediot Hadassah* 15-16 (Jan-Feb 1926) 21.

immigrated to the country. Ophthalmologists decided that immigration had a significant impact on trachoma rates, especially in Jerusalem and Tiberias, where new immigrants arrived from Persia and Yemen. These new criterion were in addition to a rubric that marked all of the Jewish ethnic groups, as well as urban, rural, and Bedouin Muslims and Christians. In addition, the group decided that the card needed to contain the diagnosis and therapy, including all the changes in condition during the treatment; every date of treatment in the cases of trachoma on conjunctivitis; results of bacteriological testing; as well as a space for free comments.²⁷ These decisions did not only configure how trachoma was to be measured and counted, but also determined what type of information was needed on a “national” scale.

While numerous photographs of the urban trachoma campaign were preserved for Hadassah promotional purposes, they also illuminate what daily treatment might have looked like. The photograph below was taken in Tiberias in 1926 at a boys’ religious school, evidenced by the pupils’ earlocks and wide yarmulkes.²⁸ The treatment, although routine, seemed to take place in an improvised setup. Rather than in a clinic, the eye treatment was outdoors, subject to disordered conditions: the stone pavement was uneven, the water basin—filled with Lysol to disinfect the nurses’ hands between each pupil?—sat precariously on a chair, and the medicine cabinet was flung open. A group of fourteen boys patiently waited their turn, the concept of a line deeply entrenched. Each one held his eye health card, which the nurse would notate after the examination. They craned their necks to take a peek at the current victim, who appeared to be uneasy (as anyone would who received copper sulfate in their eye), with his head held steady in the nurse’s lap, while his hands squirmed. The nurse patted his eye with a cotton ball, surrounded with an array of bottles and droppers on the tablecloth-covered outdoor table, a meager attempt to maintain decorum or “hygiene.”

²⁷ “Hadassah Ophthalmologists’ Conference,” *Yediot Hadassah* 29-30 (April-May 1927) 22-23.

²⁸ “Orthodox boys in line for eye examination,” 1926, Clinics and Stations: Tiberias, Box 2, RG 18, HMO Papers, CJH.



Figure 4: “Orthodox boys in line for eye examination,” 1926

In the photograph below at a co-ed, apparently secular Jewish school in Tiberias in the same year, very similar conditions existed.²⁹ In this case, they are standing outside a dedicated “Treatment Room,” whose sign is in the upper left hand corner, while the male teacher stood to the side, overseeing the entire process. Although eye treatment was a disciplining measure—and the students do appear ordered—they also seem to be makeshift, with each school nurse managing their task with whatever facilities were available.

²⁹ “Boys and girls together in line for eye examination,” 1926, Clinics and Stations: Tiberias, Box 2, RG 18, HMO Papers, CJH.

1926. H.M.O. Tiberias. Anti-trachoma Service



Figure 5: “Boys and girls together in line for eye examination,” 1926

The Hadassah campaign gained ophthalmic international renown. The methods of the campaign were published in the *Revue Internationale du Trachome*, a scientific publication at the Pasteur Institute in Paris, and garnered much interest among French colonial administrators in North Africa.³⁰ Dr. Judith Kozlova, the director of the Hadassah eye clinic in the Old City of Jerusalem, attended the 1928 International Congress of Tropical Disease in Cairo, and had colleague Dr. M. Tawfiq show her how trachoma treatment was carried out in Egyptian schools. She noted that Egypt and Hadassah in Jerusalem had a similar number of children under their supervision, 8,000, and she exclaimed that, “We can tell from these results that our work that Hadassah is doing is not less than the government of Egypt!”³¹

Despite the obvious difference in budget between the Government of Egypt and the Hadassah

³⁰ Victor Morax, “L’organisation de la lutte contre le trachome en Algerie,” *Revue Internationale du Trachome*, 6:1 (Jan 1931) 6.

³¹ Judith Kozlova, “School Eye Treatment in Egypt and Eretz Yisrael,” *Yediot Hadassah* 43-49 (June-Dec 1928) 17.

Medical Organization, Kozlova returned to Jerusalem happy that that their work “is satisfactory and appropriate for the conditions of the country.”³²

The Traveling Oculist: Creating a National Map and the Obstacles to Universalizing Medical Practice

Despite the well-organized program in Jerusalem and other urban centers, with access to a plethora of medical clinics and personnel, there was limited anti-trachoma efforts in the rural part of the Yishuv. Yassky, as acting director of the Ophthalmology Department of the Hadassah Hospital in Tel Aviv, had visited nearby Yemenite settlements, and was shocked at the incidence of trachoma, claiming that attending to the moshavot (settlements) was its own full-time job. In a report to Hadassah management, Yassky wrote that, “I need to emphasize that it’s Hadassah’s holy obligation to take responsibility for the whole anti-trachoma campaign...All of our work and success in the city has no value if the moshavot remain in such a terrible state...we will capture the trust and love of the rural Yishuv. We will educate the Yishuv to take care of their eyes and this education is half the battle in the campaign against one of the most serious obstacles to developing the Yishuv.”³³ In response, Yassky was assigned the task of investigating trachoma in the Judean settlements in 1924, and devised a program to bring ocular care to settlements in Judea, Samaria, the Jordan Valley, and the Upper and Lower Galilee.

Yassky, however, did not follow the *modus operandi* of mobile eye care, which had been to send traveling hospitals to rural districts for months at a stretch. The first mobile eye clinics had been organized in Russia by Professor Bellarminoff beginning in 1893, who had sent seven “flying columns” of two to three eye specialists and one to two nurses to different parts of Russia for a two-month period.³⁴ Arthur Ferguson MacCallan, the Ophthalmic

³² *ibid.*

³³ Yassky to HMO, n.d., J113/7874, HMO Papers, CZA.

³⁴ Vladimir Filatov, *My Path in Science*, (Moscow: Foreign Languages Publishing House, 1957) 135.

Surgeon and Inspector of Egypt, organized and administered traveling ophthalmic hospitals based on Bellarminoff's method. The first encampment, consisting of ten or twelve large tents, was pitched in the neighborhood of Menuf on the Egyptian Delta in January 1904.³⁵ Each camping ground was occupied for four to six months, before it moved to the next district. Although mobile hospitals were followed by the construction of some permanent eye clinics in both Russia and Egypt, in most towns when the hospital packed up, so did available eye treatment.

Perhaps Yassky intuited the limitations of hauling a clinic around Palestine, or he may have simply made do with Hadassah's budget limitations when he decided to send a more portable object around: himself.³⁶ Mobile hospitals were completely voluntary, but the task of what became known as the "traveling oculist" was to infiltrate each community, checking not only all school children, but also adults, conduct surgeries, and converse with local medical personnel, parents, and teachers about eye health.³⁷ Historians Kapil Raj, Alida Metcalf, among others, have focused attention on "go-betweens" whose activities in the colonial world contributed to the process of circulating ideas; to the venues or zones of contact where scientific practices and knowledge were negotiated; and to the networks of exchange that facilitated circulation. This scholarship has been "peculiarly concerned with the mobile lives led by such agents and with the relation between their strikingly improvised activities and the robust institutions that they helped produce."³⁸ However, this work has focused primarily on the early modern world, and has imposed uniform and smooth processes on what was a

³⁵ A.F. MacCallan, "Four Years Work with the Ophthalmic Hospitals in Egypt," *The British Medical Journal* (Oct 19, 1907) 1072.

³⁶ Yassky would shift from ophthalmology to administration, becoming first the director of the Jerusalem branch of the Hadassah Medical Organization, and in 1931 its executive director. His death in 1948 during the siege of the medical convoy on Mount Scopus was made famous.

³⁷ Yassky to Bluestone, 13 Jan 1927, J113/414, HMO Papers, CZA.

³⁸ Simon, Schaffer, *The Brokered World: Go-betweens and Global Intelligence, 1770-1820*, (Sagamore Beach, Mass: Science History Publications, 2009) xi.

complex and multidirectional network.³⁹ Traveling oculists operated as “go-between” as they traversed the country mediating between the medical administration, rural healthcare personnel, and rural residents, and providing Hadassah with scientific data that helped to shape the direction of Yishuv healthcare.

There was a tension between the apparent freedom of the traveling oculist, and the scientific knowledge he or she was tasked to produce. Hadassah central management was at first wary of setting loose a lone employee without direct supervision. The process of streamlining information between physicians and administrators in creating a bureaucracy was not straightforward, and constantly negotiated. There were streams of reports from each traveling oculist that filtered back to the central office that not only reported the percentage of trachoma-infected residents, but also the quality of local medical personnel, the state of health clinics, and the socio-economic level of each settlement.⁴⁰ This makes it unsurprising that Yassky, who had the opportunity to get a bird’s eye view of public health in the entire Yishuv, went on to become the Executive Director of the Hadassah Medical Organization in 1931. After Yassky had moved on to Hadassah administration, Hadassah continued to employ one or two traveling oculists at a time to provide care for the sixty outlying settlements and moshavim of the Yishuv. These included Dr. Ephraim Sinai (1927-1929), Dr. Bella Mirenburg (1930-1935), Dr. Nathan Dobrzynski (1940s), Dr. Schaja Derbaum (1920s and 1950s), and Dr. Tamar Rozenet (1950s).⁴¹ The process of creating knowledge about the nation was then quite individuated, with each physician traveling and writing in their own style and disposition. Travel was not only a means, but also a mode of scientific work in

³⁹ See Warwick Anderson, “Making Global Health History: The Postcolonial Worldliness of Biomedicine,” *Social History of Medicine* (2014) 5-7.

⁴⁰ The HMO Papers in the CZA contain the traveling oculist papers of Yassky, Mirenburg, Sinai, and Dobryzinski.

⁴¹ Haim Yassky, “Report: Anti-Trachoma Work in Palestine: What Has Been Done and What Remains to be Done, 1926,” J113/101, HMO Papers, CZA.

which the outside world could become the laboratory. The scientific knowledge the traveling oculist produced included maps, statistics, medical reports, and ethnographic insights.⁴²

The act of mapping out the anti-trachoma campaign through traveling was an integral part not only to public health, but also in creating the national topography. Sinai, for example, wrote with gusto on the many beautiful walks and views he encountered when traveling from settlement to settlement. Especially important to Sinai was traversing the train route through the Jezreel Valley, which he termed a “meaningful experience [through] the heart of the Hebrew nation of Israel, and not of Mandatory Palestine.”⁴³ Physician mobility not only facilitated medical knowledge production, but was also a way for physicians to become pioneers and fulfill the Zionist ideal of “knowing the land” (*yediat ha’aretz*). Unlike the scientists who constructed malarial maps, these physicians did not only learn and create a geography, but interacted with people from literally every Yishuv settlement: traveling oculists treated patients, entered their homes, coordinated with rural local physicians and nurses, and educated with public health lectures.⁴⁴ The practice of medicine necessitated physical contact, and this contact enabled traveling oculists to be part physician, part ethnographer, and part pioneer. This form of pioneering (*halutziut*) is perhaps best expressed in a eulogy to Yassky in 1948, written by Hadassah’s national medical committee’s chairwoman:

“It was virgin territory. He became a circuit rider on a mission of health. He set up and regularly visited rural control centers, riding on horseback or on a donkey, sometimes traveling for hours on foot, for there was no network of buses to the outlying settlements. This was the happiest, perhaps most carefree period of his life. He learned to know every village of the country he loved; his eye lit up with every new tree planted. He saw

⁴² See Sandra Sufian, *Healing the Land and the Nation: Malaria and the Zionist Project in Palestine, 1920-1947* (Chicago: University of Chicago Press, 2007) 217.

⁴³ Sinai 129.

⁴⁴ Sufian 217.

the fresh fruits of his painstaking effort. The blight of trachoma was beginning to recede beyond his fondest expectations.”⁴⁵



The Hadassah central management was at first unsure of how to keep tabs on Yassky, and interrogated his reports in detail. For example, the manager berated Yassky for sending one report in Russian, as he “did not need to know any language besides the three official ones,” and demanded that he send his reports in Hebrew going forward.⁴⁶ The manager was also not pleased with the speed of Yassky’s correspondence, claiming three weeks was too long for a reply. Although Yassky had informed him that in all the settlements in Judea there were 194 students with trachoma and that he conducted 22 surgeries, the manager exclaimed that he did not know how many treatments were done, the reason for each treatment, or how many students were checked in total: “What was the point of the numbers if not for statistics?”⁴⁷ He could also not believe 22 surgeries was enough for a month’s worth of work. To tighten his supervision, the manager requested daily, in addition to monthly, reports.

This level of oversight insulted Yassky, which he complained was demanded of no one else.⁴⁸ The manager replied that it was not out of distrust, but since Yassky was the only one who “moves from place to place, from branch to branch, it’s difficult for us to follow all of his activities in each place.”⁴⁹ Although they were short lived, Yassky did send daily reports of his hour-to-hour activities, which highlight not only how long the examinations lasted, but also the number of hours spent traveling in day, which amounted to as much as

⁴⁵ Etta Rosensohn, “He Died in the Driver’s Seat,” Apr 1948, Box 17, Folder “Press Releases,” RG 15, HMO Papers, CJH.

⁴⁶ HMO to Yassky, 13 Aug 1924, J113/410, HMO Papers, CZA.

⁴⁷ *ibid.*

⁴⁸ Yassky to HMO, 25 Aug 1924, J113/410, HMO Papers, CZA.

⁴⁹ HMO to Yassky, 27 Aug 1924, J113/410, HMO Papers, CZA.

five.⁵⁰ Despite the sentimentality of traveling throughout the Yishuv, the realities of the road were one of traveling oculists' most sticking complications and complaints. Sinai traveled by train, bus, donkey-drawn carriage, and even walked.⁵¹ Traveling oculists voiced the difficulty of traversing the country without a car all the way through the fifties. These logistical difficulties were a product of the mobility inherent in such a nationalizing public health program. To complete an entire circuit of the country, Yassky outlined that he needed at least four weeks for the settlements in the center, and three to four weeks for the settlements in the north.⁵² In response to another frustrated manager interrogating the reports of her two months of work, Mirenburg wrote that, "it's impossible to write about everything."⁵³ There were limitations of the report to capture the traveling oculist's activities, even if that was what they were supposed to represent.

The campaign relied upon the cooperation of the local doctor, medic, and nurses to continue treatment in between the traveling oculist's visits. Nurses were considered the primary agents through which physicians could relay the norms of hygienic practice. As Dafna Hirsch argued, nurses were primarily from Eastern European backgrounds who "having been transformed from 'Eastern women' into 'pioneers of Western civilization'...had to act as mediators, interacting with the lowest sections of the population, and entering the feminine territory of the home, from which physicians preferred to stay away."⁵⁴ Yassky was adamant that local nurses and medics in the Yemenite community had to possess special personal qualities to establish a relationship of "respect and unity...to be full of idealistic feelings that will establish a special moral quality to the work, and bring him

⁵⁰ Yassky, "Daily Report," 22 Aug 1924, J113/410, HMO Papers, CZA.

⁵¹ Sinai 117.

⁵² Yassky to Bluestone, 13 Jan 1927, J113/414, HMO Papers, CZA.

⁵³ Mirenburg to HMO, 19 Apr 1937, J113/767, HMO Papers, CZA.

⁵⁴ Hirsch, "'Interpreters of Occident'," 249-250.

the strong will to raise the poor conditions of the Yemenites.”⁵⁵ Not all nurses were up to his expectations and in numerous reports he pointed out that the nurse present in certain settlements “could not be more wrong” for the position.⁵⁶ In addition to the daily treatments of copper sulfate, as part of the anti-trachoma campaign, the nurse also “had to visit Yemenites in their houses and constantly influence them to change their way of life to fit the elements of hygiene.”⁵⁷

Through these trips, Sinai befriended individual nurses, and respected their commitment; they often lived in the communities they worked in and took care of the “brunt work” of the anti-trachoma campaign. In Sha’arayim, Sinai referred to the nurse as a “white angel” who from morning until night wandered the alleys to treat children, while in Mahane Yehuda, the nurses would eagerly wait for him to help deal with their large caseload.⁵⁸ While Sinai was a mediator between the Hadassah administration and trachomatous patients, he relied on local nurses to facilitate his work. The role of the nurse was so crucial, that Yassky surmised that “experience has shown that the most important feature of the anti-trachoma work is daily treatment.”⁵⁹

However, this cooperation was not necessarily forthcoming. Many of the schools complained that the traveling oculist did not give them proper notice on their arrival, and then improperly interrupted the class in the middle of a lesson.⁶⁰ Local physicians also actively resisted the incursion of outsiders, and did not necessarily see the value of a visit of an eye

⁵⁵ Yassky to HMO, 21 Oct 1924, J113/7874, HMO Papers, CZA.

⁵⁶ *ibid.*

⁵⁷ Yassky, “The Plan to Conduct the Anti-Trachoma Campaign in the Yemenite Settlements,” n.d., J113/410, HMO Papers, CZA.

⁵⁸ Sinai 120.

⁵⁹ Yassky, “Anti-Trachoma Work in Palestine: What Has Been Done and What Remains to be Done,” n.d., J113/101, HMO Papers, CZA.

⁶⁰ Mirenburg to Hadassah, 26 June 1934, J113/766, HMO Papers, CZA.

specialist. Mirenburg informed the Hadassah Central Office that the local physician of Beer Tuvia had not notified the school of her visit. When she returned to his office to provide him with the pupils' eye cards, Mirenburg was shocked that he exclaimed that there "was nothing she could teach him," and that she was not wanted nor invited to the settlement. Mirenburg mused he was irked because she was a woman.⁶¹

Other reports seem to suggest local apathy about treating eyes. In some clinics, the eye cards were not filled out correctly, or worse, even lost.⁶² Yassky explained that the work was very monotonous, and it was the job of the traveling oculist to interest the doctor of the moshava in eye care. In fact, Yassky complained that the relationship of most country doctors towards the anti-trachoma campaign "was not serious," and that they understood little about trachoma and other eye diseases.⁶³ He noticed some medical workers either ignored giving treatment, or gave it haphazardly, in an effort to look productive.⁶⁴ He tried, sometimes successfully, to convince local doctors to be enthusiastic and to take responsibility for the campaign. Although Hadassah headquarters prioritized trachoma, it was not necessarily universally thought of as important. Yassky recommended that Hadassah require all doctors sent to rural settlements to undergo a course in eye diseases.⁶⁵

Some rural settlements, however, lacked any local personnel to carry out the daily eye regimen. Chaotic conditions that did not necessarily live up to Hadassah's own medical aspirations stymied the traveling oculist's scientific impulse to number and categorize trachoma in precise statistics. In the Yemenite moshav of Elyashiv, for example, Mirenburg

⁶¹ *ibid.*

⁶² Mirenburg, "Report Nov 1934-Jan 1935," n.d., J113/766, HMO Papers, CZA.

⁶³ Yassky to HMO, 4 Aug 1924, J113/7874, HMO Papers, CZA.

⁶⁴ Yassky, "Report #1," 1926, J113/7523, HMO Papers, CZA.

⁶⁵ "Resolutions of the Commission of Hadassah Ophthalmologists appointed to pass upon the Memorandum submitted by Dr. Yaski," 1926, Box 58a/2, HMO Papers, CJH.

exasperated that there was no one to whom to give the results of her student examination—which indicated 39% of whom had trachoma—and that she had wasted her efforts traveling to a settlement that “was far from the whole world.”⁶⁶ Although Elyashiv had maintained a health clinic in the past, Kupat Holim shut it down when moshav members neglected to pay their yearly health insurance. This scenario was repeated in Nahliel, a Yemenite settlement, where Mirenburg complained that she arrived to a shuttered clinic and absent doctor. Appalled that the children walked around with pus in their eyes, and that “materials were strewn on the floor” of the clinic, she cried, “Where is the war against trachoma?!”⁶⁷

Traveling oculists could act as general Hadassah clinic inspectors, relaying criticism that could otherwise have gone unnoticed by the central office. Although healthcare was a means to assert Jewish modernity, Hadassah’s own clinics could fail to achieve the Western standards of hygiene they were supposed to exemplify. In one of Sinai’s traveling oculist reports, he reported general disorder, uncleanliness, and a disregard to basic hygienic principles in a settlement clinic.⁶⁸ He recommended that Hadassah issue new rules for personnel to follow, including the daily mopping of the floors, cleaning the furniture (dust was bad for the eyes), swatting of flies, and cleaning the entranceway. Sinai thought some clinics were so poorly kept that it was unpleasant to work there, in addition to the fact that it made a poor impression of the institution. During the summer, where there was high incidence of infectious eye disease, patients left their trash outside the clinic while they waited to be seen, and he demanded the installation of trashcans. Sinai considered the table where the medicine was kept the most important part of the clinic, and demanded that the eye drops needed to be closed well, with the dropper in the antiseptic bottle, rather than lying

⁶⁶ Mirenburg, “Report Dec 1936-Feb 1937,” n.d., J113/767, HMO Papers, CZA.

⁶⁷ Mirenburg to HMO, 13 Jan 1935, J113/767, HMO Papers, CZA.

⁶⁸ Sinai to HMO, 10 Aug 1928, J113/416, HMO Papers, CZA.

around on paper Yassky also noted that in one clinic the medicines were full of dust, eye drops were left open, and medical tools were missing. He thought it was better to stop the treatment than to continue in such disarray.⁶⁹

Justifying the role of the traveling oculist in the Hadassah anti-trachoma campaign became difficult once trachoma was no longer a national health concern. Starting in the mid-1940s, a conscious reorganization of the campaign was discussed. By that point, the rate of infection dropped to 2% overall within the Yishuv.⁷⁰ Dobrzynski, a traveling oculist, advocated for a great reduction in the scope of the campaign: instead of visiting every rural area, some of which had been free of trachoma for some time, he recommended focusing exclusively on “Oriental” schools.⁷¹ Trachoma is “now in certain pockets, just as gold is found in certain pockets. In our communities, those pockets are the oriental communities. This is a danger to the Jewish community as a whole.”⁷² In addition he advocated for the discontinuation of the use of the traveling oculist and instead to set up a district anti-trachoma physician, who could collect data, and then report to a country wide anti-trachoma supervisor.⁷³ The switch to centralized clinics, rather than relying on traveling oculists also reflected the changing role of the physician. A physician no longer had the versatile tasks of investigating patients’ homes, meeting local nurses, transmitting ethnographic knowledge to the Hadassah administration, and literally seeking out the patient. Instead, the patient was now responsible for the decision to find medical care, and the physician’s expertise became limited to their biomedical know-how, to the diagnosis and prognosis.

⁶⁹ Yassky, “Report #2: Northern Settlements,” J113/7523, HMO Papers, CZA.

⁷⁰ Natan Dobrzynski, “The Anti-Trachoma Campaign in Palestine in the Past and in the Future,” HMO Papers, CZA.

⁷¹ *ibid.*

⁷² *ibid.*

⁷³ *ibid.*

Dr. Moshe Sherman, the administrator for the Physician's Union, also agreed in that organization's newsletter that the traveling oculist was an outdated model. Now that the number of physicians had grown, "We can cancel the program with a clear conscience, and can organize a new program at the hands of the local doctor."⁷⁴ Although Dobryzinski vehemently disagreed with Sherman's assessment—explicitly mentioning the lack of physicians in Yemenite communities—it became increasingly clear that the traveling oculist completing a national circuit was no longer considered desirable. Disposing of the traveling oculist and shrinking the anti-trachoma campaign was a way to claim success of the westernization of Palestine. The fact that trachoma still persisted in Mizrahi communities—although in lesser numbers—was a not only considered a medical threat, but a cultural threat to the whole Yishuv. Explicitly directing the campaign only at these communities further reinforced the distinction of trachoma as an oriental disease.

After the founding of the State of Israel in 1948, Middle Eastern Jewish immigration and the state's new responsibility for the Arab population did prompt the anti-trachoma campaign to re-launch under very different circumstances. Rather than a smooth transition, the campaign suffered difficulties of transportation, budget, and management. Hadassah no longer managed the campaign due to budgetary restrictions. Kupat Holim, the Army, and the new Ministry of Health all became involved in some fashion, but a lack of coordination, communication, money, and medications created "chaos" in the field.⁷⁵ Perhaps most prominently, the Ministry of Health decided to create a pilot program in Haifa at the end of 1950.⁷⁶ The plan of the experiment was to detect all existing cases of trachoma in the schools

⁷⁴ Moshe Sherman, "The Traveling Oculist," *Miktav L'haver* [Newsletter of the Central Committee of the Hebrew Physician's Union in Eretz Yisrael]. 4 April 1941, J113/2542, HMO Papers, CZA.

⁷⁵ Israel Feitelberg, "Survey on Trachoma for Kupat Holim, Jerusalem Region," 1 May 1952, ISA/RG 57/G/180/12.

⁷⁶ "Israel," *Journal of the American Medical Association* 152, no. 5 (May 30, 1953): 471.

situated in the numerous Arab and Jewish settlements, to treat them, and, in cases of reinfection after cure, to detect and treat family members. Rather than disappearing as physicians had predicted, the figure of the traveling oculist was still very much alive and relevant. With the tremendous increase in population, travel as a means and mode of science had become an impossible headache, not as for Sinai, a way to “learn the land.”

Nowhere is this clearer than in the reports of Dr. Tamar (Rosenthal) Rozenet, who had recently been hired to be a traveling oculist for this pilot campaign. Rozenet was born in 1896, studied medicine in Napoli, and immigrated to Palestine in 1925. She had started working as an ophthalmologist in the Musrara neighborhood in Jerusalem, and moved on to Tiberias and Hadera before settling in Haifa.⁷⁷ What really irked Rozenet, and would eventually lead to her resignation, was transportation. No private transport was provided to her, and she complained that this made the campaign inefficient. Not only did she have to stick to a bus schedule with set times, but in the villages and settlements themselves, schools were far apart, and that once she had to walk two hours in the mud, which ruined her shoes.⁷⁸ When Rozenet arrived to Arab villages in the summer, when school was out, she had to find the teacher, mukhtar or even farmers in the middle of the field to track down children to check.⁷⁹ She complained that she often lost time because she didn't know whether schools would be open or not. If she was given a driver, it was often in a big truck that sunk in the mud of unpaved roads.⁸⁰

A photograph of her waiting for the bus exemplified her plight. She looked dignified, perhaps as a physician should, but her circumstances were anything but. Rozenet is centered

⁷⁷ Nissim Levy, *Physicians of the Holy Land, 1799-1948* (Israel: Itay Bahur Publishing, 2012) 389.

⁷⁸ Tamar Rozenet, “Report Dec 1950-Jan 1951,” n.d., ISA/RG 57/6/180/12.

⁷⁹ Tamar Rozenet, “Report on Eye Checks of Students in Acre and Haifa Region June 1950,” n.d., ISA/RG 57/6/180/12.

⁸⁰ Tamar Rozenet, “Report Dec 1950-Jan 1951,” n.d., ISA/RG 57/6/180/12.

in the photograph, standing on the side of a paved road, next to a lonely, rickety bus stop. The panorama reveals both a long barren field behind her, with a few electric poles dotting the landscape, as well as a curved road, empty of any vehicle or passerby. Rozenet herself is wearing a lovely white dress, and a large sun hat, which she is tilting to one side with her hand. Under her other arm is a large black physician's bag. Rozenet's bag would have contained a combination of sulfa drugs, copper sulfate topical ointments, and perhaps even some aureomycin, a new antibiotic that Israel was testing for trachoma treatment. However, although Rozenet looks determined, she did not treat any patients that day. The caption indicates that she was waiting to go from one transit camp to another, and on this occasion, as on many others, the bus did not arrive on time and the appointment with the children could not be met.⁸¹



Figure 6: "Tamar Rozenet," undated, Israel State Archives

Isaac Michaelson, the head of the Haifa campaign, reiterated that the following factors were needed to stamp out trachoma: Ophthalmologists, nurses and dressers, drugs, and

⁸¹ Isaac Michaelson, "The Fight Against Trachoma in Israel," n.d., ISA/RG 57/6/180/12.

transport.⁸² But, Michaelson concluded that the campaign was a failure due to a lack of transport. He tried to raise money aboard for an ophthalmic ambulance, a Ford Bulldog to be exact, but he was unsuccessful.⁸³ In a fundraising bid, he explained the importance of trachoma this way: “Trachoma is not a medical problem, but an administrative one...it has been said that four jeeps could solve the problem of trachoma in Israel.”⁸⁴ This is a completely different conception from the Mandate period of what the problem of trachoma represented, and how it could be solved. Rather than requiring a cultural transformation, political will and a few antibiotics would do the trick.

Transforming Oriental Habits through Ocular Hygiene: Yemenites and the Rural Economy of Healthcare

The traveling oculist laid bare the disparities in health facilities and health conditions in the Yishuv, and in so doing, brought the rural Yemenite community sharply into relief. Much of the traveling oculist reports pointed to their distress, and how (or whether) they could reduce their trachoma incidence. In the name of the “conquest of labor” principle, the Palestine Office of the World Zionist Organization sent Shmuel Yavnieli on a mission to Yemen to promote immigration in order to replace Palestinian agricultural laborers in the Jewish-owned plantation colonies.⁸⁵ However, the Yemenite immigrants failed to replace the Arab worker, as they refused to accept Arab wages. Instead of a solution to an old question, a new socio-economic problem was created. The Zionists did not adequately plan for their housing, and built shoddy settlements far from the existing moshavot, including Sha’arayim, Mahane Yehuda, Nachliel, and Nachalat Yehuda.⁸⁶ The establishment did not want Yemenites to do

⁸² Michaelson to Sheba, 5 Jun 1952, ISA/RG 57/6/180/12.

⁸³ Michaelson to Department of Social Medicine, Ministry of Health, 5 Aug 1951, ISA/RG 57/6/180/12.

⁸⁴ I. C. Michaelson, “Ophthalmology,” *Quarterly Review of the Harefuah* 13–14, no. 1–2 (June 1952): 42.

⁸⁵ Gershon Shafir, Land, *Labor and the Origins of the Israeli Palestinian Conflict: 1881-1914*, (New York: Cambridge University, 1989) 91-123.

⁸⁶ Shafir 105.

semi-skilled or skilled labor that would put them in competition with Ashkenazim.

Ashkenazim framed themselves as “idealistic workers” who could blaze the trail and set moral standards for the community, and framed Yemenites as “natural workers,” who could add manpower to the Ashkenazi efforts. While both groups of Jewish workers failed to displace the more efficient Palestinian laborers, the Ashkenazim, having been allotted land by the Jewish National Fund, went on to establish kibbutzim and moshavim, and become the pioneering founding fathers of the country. The Yemenites, no less pioneering in actual fact, were left to fend for themselves, and were excluded from both the collective settlements and Zionist mythology.⁸⁷

While the urban residents received the benefits of improved infrastructure and health access over the course of the British Mandate, dramatically decreasing trachoma incidence, traveling oculists’ reports highlighted that Yemenites continued to suffer in high rates. This was evident even to the GDH, which claimed that “the disease is almost confined to the Yemenite Jews.”⁸⁸ The prevalence and persistence of the disease in Yemenite communities meant that traveling oculists constructed the Yemenite as a medical and cultural liability through scientific publications, reports, and correspondence. Yemenites became classified as a special category of medical and social intervention, and physicians relied on oriental essentialism in their assessments, even as they tried to incorporate Yemenites within the Jewish collective through hygiene education. This dichotomy revealed the tension within the medical project as a whole: the Hadassah anti-trachoma campaign both served to integrate Yemenite Jews into the Jewish national body by providing prophylactic and curative care, while simultaneously reinforcing their inferiority and cultural difference. Since physicians were incapable of changing the labor economy that had relegated Yemenites to the bottom

⁸⁷ Shafir 110.

⁸⁸ “Note on Government Ophthalmic Service with special reference to Vaad Leumi’s request for special grant for a parallel service,” n.d., ISA/RG 10/M/1623/4562.

rung, the burden was placed on individuals to reform habits even when environmental conditions proved these prohibitive.

During the first half of the twentieth century, hygiene did not simply encompass cleanliness, but a whole range of practices and discourses on the correct way to live based on scientific knowledge.⁸⁹ Hadassah, as an American woman's Zionist organization based on Progressivist ideals, prioritized hygiene education and preventive medicine as integral to modernization. The traveling oculist was responsible not only for eye treatment, but to give public health lectures, instruct in hygienic practices, and investigate home conditions.⁹⁰ In addition to the individual eye health card, there was also a family eye health card that prompted the oculist to note the number of rooms in a house with windows or floors, the number of beds and how many people slept per bed, if there was a bathroom, the uncleanness of the yard, the house's water source, and if inhabitants washed their face every morning and evening.⁹¹ They would hand out pamphlets to encourage inhabitants to wash their hands, cut their fingernails, allow light and air into the room, and to give sick family members their own towel, washbasin, and bedding.⁹² As Yassky explained: "This campaign is waged not only on eye treatment in schools and clinics, but mainly to supervise and treat family hygiene. In order to get satisfactory results, we need to connect the work of the ophthalmologist with that of an area's general hygiene. That is what the traveling oculist does

⁸⁹ See Charles E. Rosenberg, Library Company of Philadelphia, and College of Physicians of Philadelphia, *Right Living: An Anglo-American Tradition of Self-Help Medicine and Hygiene* (JHU Press, 2003); Warwick Anderson, "Immunization and Hygiene in the Colonial Philippines," *Journal of the History of Medicine and Allied Sciences* 62, no. 1 (January 1, 2007): 1–20; Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health*, Checked out (New York: Palgrave Macmillan, 2004); Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (University of California Press, 2004).

⁹⁰ Yassky to HMO, 22 June 1924, J113/7874, HMO Papers, CZA.

⁹¹ "Hadassah Family Folder," n.d., Box 687/15, Arieh Feigenbaum Papers, Jerusalem Municipal Archives (JMA).

⁹² Arieh Feigenbaum, *The Eye: Its Anatomy, Maintaining its Health, and Its Treatment* (Jerusalem: Hadassah Women Zionist Organization of America Press, 1927) 138.

in that he is not only a professional in eye diseases, but also receives a special course in public hygiene.”⁹³

However, the constant hygienic rebuke of Yemenites coexisted with a romanticizing and sympathetic orientalist view of Yemenites “as symbols of an authentic, original Judaism.”⁹⁴ Even if physicians appropriated the discourse of Yemenites as “natural workers,” they did not agree that they therefore “needed less pay, less immigrant or socialist worker benefits, less attention paid to the quality of their housing.”⁹⁵ Physicians brought attention to the Yemenites’ plight, demanding their equal access to healthcare and that their conditions be changed, even if they found Yemenite culture also culpable. Krimsky, the AZMU ophthalmologist, expressed this in 1918 when he first saw Yemenites in Hedera: “Here I found about seventy Yemenites, living under the most wretched conditions, of filth, poverty and overcrowding... They are paid exceedingly small wages and nearly all of them suffer from malaria and trachoma in aggravated form... I was grieved to find that the colonists here, as elsewhere, are totally indifferent to the unfortunate plight of their wretched brethren.”⁹⁶ The anti-trachoma campaign in the Yemenite settlements highlighted the multiple tensions inherent in explaining the persistence of trachoma: between oriental authenticity as a positive trait or negative factor, and whether prescribing eye ointments, hygienic habits or a reformed political economy was the solution. However, “both the romanticization and the modernization narratives share the discursive production of the Mizrahi family as a site of deviance from an implicit cultural normativity.”⁹⁷ Ashkenazim in

⁹³ Yassky to Sternfeld, 13 Aug 1934, J113/766, HMO Papers, CZA.

⁹⁴ Hannan Hever, “The Kinneret,” *Journal of Modern Jewish Studies* 6, no. 2 (July 1, 2007): 141.

⁹⁵ Aziza Khazzoom, “The Great Chain of Orientalism: Jewish Identity, Stigma Management, and Ethnic Exclusion in Israel,” *American Sociological Review* 68, no. 4 (August 1, 2003): 488.

⁹⁶ Joseph Krimsky, *Pilgrimage & Service* (New York: Arno Press, 1977) 119.

⁹⁷ Ella Shohat, “Rupture and Return: Zionist Discourse and the Study of Arab Jews,” *Social Text* 75:21 (2003) 66.

rural settlements inflicted with trachoma were never framed in need of cultural reform, whose incidence instead was blamed on living in proximity to Arab workers.⁹⁸

The reports of the traveling oculists repeatedly singled out Yemenite communities as a stronghold for trachoma, poverty, and depressed living conditions. In 1928, Sinai wrote that despite years work in Yemenite neighborhoods, “it’s like we’re starting from the beginning.”⁹⁹ He elucidated that the main reasons for this situation was the horrible hygienic conditions in both families and in the schools: “In every place that you turn your eyes, there is dirt, overcrowding, and a lack of water...everyone who comes sees the sadness.”¹⁰⁰ Sinai also claimed that Yemenites relied heavily on amulets and folk healers, and continued the “cure” of putting kohl on the eyes, even if he claimed that further the spread trachoma. He noted most of the doctors and medics became apathetic at the seemingly permanent problem.¹⁰¹ That is clear in Mirenburg’s case, when she decried that trachoma rates in the Yemenite settlements of Shivat Zion and Mahane Yehuda were not improving after seven years, despite the fact that she had even tried modifying treatments. She was exasperated: she did not know how to improve the situation, and she thought these settlements in the country were the only ones like this. She concluded: “there must be a special reason for this.”¹⁰² This note exemplified her frustration with the fact that her medical expertise did not seem to be causing the desired prognosis. Instead, Yemenite cultural difference seemed to be a source of biological resistance.

⁹⁸ See, for example, Haim Yassky, *What is there to know about Eye Health?*, (Jerusalem: HMO Press, 1927) 15.

⁹⁹ Sinai, “Trachoma Situation in Schools and Kindergartens in Moshavot,” *Yediot Hadassah* 38-42 (Jan-May 1928) 34.

¹⁰⁰ *ibid.*

¹⁰¹ *ibid.*

¹⁰² Mirenburg to HMO, 4 Mar 1934, J113/766, HMO Papers, CZA.

Mordechai Brachyahu, the director of the Department of School Hygiene, corroborated the traveling oculists' reports and was quite sure that the solution required a radical intervention. After a visit to the Yemenite settlements of Sha'arayim and Rehovot, he was disgusted that Yemenite houses only consisted of a dark, overcrowded room for a family of six. Nutrition was inadequate, and parents "reject medical treatment."¹⁰³ Rather than public health education, which he assumed would be for naught, he demanded that nurses' needed to enter the houses each day "to ask if anyone was sick, to open the blinds herself, the windows, to take the bedding outside to air."¹⁰⁴ However, he ultimately decided that "there's no other way to save the diligent Yemenites from degeneration than to establish a 24 hour nursery...because Yemenite mothers don't know how to take care of their children, that is a sad fact."¹⁰⁵ The "Sisyphean" task of teaching Yemenites hygiene meant to Brachyahu that they did not even deserve custody over their own children.¹⁰⁶

Despite Brachyahu's opinion, trachoma was indeed a primary venue in which to inculcate modern hygiene in the Yishuv. Although distinguished by specialist knowledge and techniques, eye care became one of the largest fields through which Hadassah pursued public health and general hygiene because of trachoma's constructed etiology. As Nahum Shimkin, the Hadassah physician in Haifa, stated, "The treatment in schools is important not only from the point of view of the treatment per se...but from the fact that he learns early in life the importance of the hygiene of his eyes and carries into the home the principles instilled into him...The school is thus not only a center of education in its narrower sense, but a means of

¹⁰³ Brachyahu to HMO, 19 Jan 1925, J113/7874, HMO Papers, CZA.

¹⁰⁴ *ibid.*

¹⁰⁵ *ibid.*

¹⁰⁶ Mordechai Brachyahu, *Avodat hahigiena bevatei hasefer* [Hygiene work in schools](Jerusalem, 1929), 29.

disseminating the doctrine of hygiene and health throughout the land.”¹⁰⁷ The restoration of sight and healthy eyes, therefore, had to be accompanied by the population’s acceptance of modern health practices and cultural transformation, if not through social or economic reform. If trachoma was a disease of hygiene, then behaviors between people and their environments needed to be governed, and eye health rested on the the individual’s responsibility to become modern.

In 1925, Hadassah and the GDH co-sponsored a “health week,” a free, country-wide event for all inhabitants of Palestine to relay “intensive propaganda” on public health efforts.¹⁰⁸ One of that year’s themes was ocular hygiene, which produced a number of written materials meant to instruct the public on taking care of one’s eye health. Hadassah published a pamphlet entitled, “And Guard Your Eyes,” echoing the biblical Hebrew phrasing of the Ten Commandments to convey authority.¹⁰⁹ The format of the pamphlet, in fact, replicated a list of the “commandments” of ocular hygiene, though the author could only narrow them down to twelve. The first commandment placed responsibility squarely on the individual to take charge: “Have you paid attention, how many those with sick eyes are around you? Did you know, most are sick because of laziness and lack of knowledge in the ways of hygiene and health?”¹¹⁰ It then instructed the public to follow such “laws” as washing their hands, cleaning their houses and yards, and avoid touching infected persons. Translating hygienic practices into religious terms was an attempt to appeal to the values and language of the communities they were meant to serve. The pamphlet intended to impart biomedical precepts to supplant “idolatrous” folk remedies and superstitions that “your neighbors tell you to do.

¹⁰⁷ Nahum Shimkin, “Trachoma in Palestine: Its Epidemiology and a Review of Measures for Dealing With It,” *The British Journal of Ophthalmology* 10:5 (1926): 274.

¹⁰⁸ Sufian 246.

¹⁰⁹ Arie Feigenbaum, *The Eye: Its Epidemiology, Guarding its Health and Treating It*, 138.

¹¹⁰ *ibid.*

These people do not know anything about medicine because they did not study it and instead of helping, they can only cause harm to your health.”¹¹¹ It particularly chastised the use of kohl as an eye cosmetic, which was common in Middle Eastern Jewish communities.

However, the pamphlet also appealed to the sense of belief in magic that it supposed its readers would have, repeating twice that one could have trachoma without feeling any symptoms, and therefore should go to the eye doctor at every opportunity.¹¹² Rather than creating a new biomedical paradigm based on science and rationality, the eye doctor was to displace the folk healer. Kozlova, the ophthalmologist in charge of the Hadassah ophthalmic clinic in the Old City of Jerusalem, lamented that Moroccans and Yemenites “still believed in amulets and folk remedies of the medical magicians,” yet acknowledged that ocular hygiene propaganda had also made inroads in changing the relationship between families to the “new national institutions.”¹¹³ Even if residents were more apt to attend the clinic, Kozlova pointed out that “you can’t guard against eye disease without washing bedding, towels, dishes, etc. The main reason is the low material and social status of the inhabitants,” which appears to be an essentialist characteristic.¹¹⁴

The promotion of general hygiene, as well as systematic school surveillance, had great effects in reducing the rates of trachoma among Jews from 40.7% in 1918 to 10.6% in 1926.¹¹⁵ Despite this success, a telling 1926 report, “Anti-Trachoma Work in Palestine: What Has Been Done and What Remains to be Done,” written by Yassky described what he

¹¹¹ *ibid.*

¹¹² *ibid.*

¹¹³ Judith Kozlova, “Activities of the Eye Clinic in the Old City of Jerusalem,” *Yediot Hadassah* 33-34 (Aug-Sept 1927) 13.

¹¹⁴ *ibid.*

¹¹⁵ Natan Dobryzinski, “The Anti-Trachoma Campaign in Palestine in the Past and in the Future,” HMO Papers, CZA.

thought were the shortcomings of the school based approach.¹¹⁶ At the outset of the Mandate, Yassky noted that, “Palestine is no better off than other Near Eastern countries from the point of view of trachoma, large numbers both of Jews and Arabs being infected.”¹¹⁷ Although the campaign had made headways in urban areas, Yassky lamented that conducting the anti-trachoma campaign through the Department of School Hygiene was not as effective in the rural outlying communities. In describing why the rates of trachoma were higher in rural settlements, he brought up four points: “the Arab workers living in the colonies, most of whom had trachoma; bad sanitary conditions in most of the old colonies; insufficient water supply; and low cultural level of the population.”¹¹⁸ Despite their awareness of the problem, ophthalmologists could not provide “a good water supply for the whole population.”¹¹⁹ Mirenburg noted that, “we don’t do anything to improve their [Yemenites’] general condition... I don’t have the strength to give suggestions, according to my thinking it’s impossible to change the situation with easy fixes or bad reports...it truly requires strong governmental measures.”¹²⁰ In light of these limitations, Yassky most forcefully suggested the only way to prevent the “dead stop” in the trachoma campaign was to “penetrate into the family and into the home.”¹²¹ Yassky determined that treatment required house-to-house eye examinations to reach the entire population and obligatory lessons in the hygiene of the eye.

These ideas were corroborated at the 1928 Second Conference for the Department of School Hygiene, where physicians debated the extent of their progress and how the campaign

¹¹⁶ Haim Yassky, “Report: Anti-Trachoma Work in Palestine: What Has Been Done and What Remains to be Done,” n.d., J113/101, HMO Papers, CZA.

¹¹⁷ *ibid.*

¹¹⁸ *ibid.*

¹¹⁹ *ibid.*

¹²⁰ Mirenburg to HMO, 2 June 1935, J113/766, HMO Papers, CZA.

¹²¹ Haim Yassky, “Report: Anti-Trachoma Work in Palestine: What Has Been Done and What Remains to be Done,” HMO Papers.

should evolve and move forward. Both Kozlova and Sinai agreed that “the family is the nest of trachoma.”¹²² The suggestion of reforming the family was in tandem with Hadassah’s general outlook that the Mizrahi family was a necessary object of change, not only because Ashkenazi pioneer culture prioritized peer relations over the family, but also because it was considered an isolated unit that perpetuated unhygienic habits.¹²³ Visiting the home was a medically sound way to treat trachoma, since infection usually occurred under age five, and treatment in school was ineffective if a child could be reinfected by a toddler sibling.¹²⁴ Yassky treated the illness with the most up-to-date methods that he knew, but this expert treatment also had deeper implications within the Zionist framework: the behavior of the disease itself was the conduit through which physicians could suggest cultural reformations in scientific language.

Instead of solely implicating cultural essentialism, the traveling oculists were also deeply troubled by the Yemenites’ socio-economic situation, and pointed to the absence of adequate and free healthcare facilities in the settlements. Sinai was well aware of the Yemenites’ harsh conditions in Shivat Zion, considering he lived in Rishon Li-Zion, the neighboring moshava, and took note that while there was no trachoma where he lived, the seventy Yemenite families next door were very afflicted.¹²⁵ Sinai published an article in *Ha’refuah*, the Hebrew medical journal, entitled, “The Question of Trachoma among the Yemenites,” in which he admitted that he did not actually think the principle of trachoma was

¹²² Judith Kozlova, “Sources of Infection for Trachoma in Jerusalem,” *Yediot Hadassah* 38-42 (Jan-May 1928) 27.

¹²³ Marcella Simoni, *A Healthy Nation: Zionist Health Policies in British Palestine (1930-1939)* (Italy: Libreria Editrice Cafoscarina, 2010) 175.

¹²⁴ Bella Mirenburg, “The Anti-trachoma Campaign in Jewish Schools of Jerusalem,” *American Journal of Ophthalmology* 31:10 (Oct 1948) 1290.

¹²⁵ Sinai 119.

different in the Yemenites, but that there were specific epidemiological factors to consider.¹²⁶ He concluded that Yemenites did not have trachoma in Yemen, but became severely infected only once they moved to Palestine, indicating it was not an essentialist fact, and common to many immigrant populations. He concluded that the difficult conditions in the Aden way station and during the trip from Yemen to Palestine, coupled with the poor living conditions in Palestine “were a heavy burden” not of the Yemenites’ own making.¹²⁷

These concerns were used interchangeably with cultural judgments, indicating that they could not necessarily be disentangled. This tension was brought to the fore in a ten page report Yassky was commissioned to write specifically about the Yemenites, titled “The Plan to Conduct the Anti-Trachoma Campaign in the Yemenite Settlements.”¹²⁸ Yassky firstly exalted the diligence of the Yemenite community in settling the land and in being excellent agricultural workers. He lauded their economic role within the Yishuv, one in which he thought they were well suited, and blamed the colonists for giving them poor wages and inadequate housing that caused poor sanitary conditions. Yassky pleaded that, “Of all the Jewish elements that come to the country, this public exemplifies nationalist pride, dauntless spirit, great patience, and adaptation to work, and we need to pay them special attention.”¹²⁹

However, he also took the opportunity to harshly denounce Yemenite maternity practices, the lack of infant care, and the alarming mortality rate. Yemenites, he claimed, only go to the doctor when it is too late and in emergencies, and if they do, prefer the “terrible treatment of soot mixed with smeared kohl” prescribed by the folk healer.¹³⁰ While he noted

¹²⁶ Ephraim Sinai, “The Question of Trachoma among the Yemenites,” *Harefuah* 6:1 (1932) 12.

¹²⁷ *ibid.* 24.

¹²⁸ Haim Yassky, “The Plan to Conduct the Anti-Trachoma Campaign in the Yemenite Settlements,” 1925, J113/766, HMO Papers, CZA.

¹²⁹ *ibid.*

¹³⁰ *ibid.*

that these sanitary conditions caused trachoma, he exclaimed that the “number of trachomatous is so big that you cannot imagine it in a civilized community.”¹³¹ Yassky believed change needed to come on the level of cultural practices, but he seemed to have an implicit faith in the transformative power of Western education and treatment, writing that “this small ethnic group [*edah*] has an intelligent and talented nature, and understands and values the importance of the help given it.”¹³² Yassky equally blamed Hadassah for not providing sufficient medical care (as the local private practices were prohibitively expensive), social and cultural practices, and poor wages for the Yemenites’ frightening medical circumstances. The Yemenites warranted a separate report and medical strategy than the rest of the Yishuv for both their orientalist essentialism and for their economic exceptionalism.

The orientalist appraisal of Yemenite trachoma incidence was not always a rebuke, but could be expressed as a romanticization of their religious convictions. Sinai argued that his own experiences in rural Yemenite clinics did not only provide “systematic appraisal on the state of the eyes, but perhaps more importantly, gave the wide opportunity to come in contact with the Yemenite community, to study and to see their ways of life, to recognize their perspectives on illnesses generally, and eye disease in particular, and to understand their folk treatments and beliefs.”¹³³ In his medical paper on trachoma, he noted that the men studied Torah and were observant, that they knew Hebrew, but spoke a Hebrew-Arabic dialect amongst themselves, and that they had ingrained superstitions that were difficult for outsiders to understand.¹³⁴ Children over three studied in the *kuttav* “hunched over holy

¹³¹ *ibid.*

¹³² *ibid.*

¹³³ Ephraim Sinai, “The Question of Trachoma among the Yemenites,” 12.

¹³⁴ Sinai 119.

books,” and when the *hacham* would bring the children to the clinic, they would obediently wait for their turn without any resistance to the painful treatment.¹³⁵ As an eye doctor, Sinai had an opportunity to develop expertise on Yemenite social practices through observation, and could see himself as an “Orientalist expert.” The act of traveling to most of the Yishuv settlements enabled him to make regional general judgments about the ethnic character of trachoma that otherwise would not have been possible.

This “Orientalist expertise,” however, involved a deliberate refusal to admit that Hadassah’s own financial policies with Yemenite settlements could impede their general medical care. Hadassah contract negotiations with the Shivat Zion council illuminate that the economics of sustaining a Hadassah medical clinic in Yemenite settlements was incompatible with the success of the anti-trachoma campaign. To pay for clinic upkeep and general medical care, each Yemenite family had to contribute a yearly health tax to the Shivat Zion council so it could fulfill its annual contract with Hadassah.¹³⁶ The council had a difficult time collecting payments, and the state of their clinic reflected this financial situation: Bertha Landsman, who visited the clinic in Shivat Zion, claimed that, “I find this clinic room is absolutely in the most deplorable condition. The furniture consists of dirty boxes and is most inadequate. It is not becoming for a Medical Organization such as Hadassah to acknowledge a clinic equipped and conducted as this clinic is.”¹³⁷

However, the traveling oculist treated patients free of charge as part of a public health campaign. The Shivat Zion council repeatedly wrote to the Hadassah central office that free eye care was detrimental to their collection of the yearly health tax to support the general

¹³⁵ *ibid.*

¹³⁶ Shivat Zion Council to HMO, 9 June 1928, J113/765, HMO Papers, CZA.

¹³⁷ Landsman to HMO, 21 Oct 1928, J113/765, HMO Papers, CZA.

medical clinic.¹³⁸ They claimed that eye care was considered so valuable that families would be willing to pay for it, and when given gratuitously, it decreased the incentive amongst some families to contribute their financial share.¹³⁹ The Shivat Zion council members were strong negotiators in determining their medical care, and clearly tried to improve their community's relationship with Hadassah despite their financial debts. Rather than ignorant or apathetic, the council tried to prove that the leadership understood modern values of health and hygiene, and were "trying to teach our own that health is something that's worth a few prutot, not less than bread or water."¹⁴⁰

The Hadassah physicians claimed an anti-trachoma campaign that would require payment would be unsuccessful: "if we're not flexible with the payment, then trachoma will spread to healthy children and our work will be for naught."¹⁴¹ An unfortunate catch-22 emerged: The Shivat Zion council wanted eye care to be a paid-for service in order to increase compliance of clinic payments to Hadassah, but Hadassah wanted eye care to be free in order to reach every student. Hadassah did not grant the Shivat Zion council any slack in its yearly contribution, and eventually Shivat Zion agreed to pay in installments after Hadassah sued them for payment.¹⁴² This story reveals that Yemenites were hardly apathetic about their eye care, and deftly tried to negotiate their health payments in light of their social circumstances and health values. The public health campaign was complicated by the economics of health care in rural settlements, which was not considered a complimentary right.

¹³⁸ Levontin to HMO, 8 Apr 1920, J113/765, HMO Papers, CZA.

¹³⁹ Shivat Zion Council to HMO, 24 June 1931, J113/765, HMO Papers, CZA.

¹⁴⁰ *ibid.*

¹⁴¹ Sinai to HMO, 22 Feb 1930, J113/765, HMO Papers, CZA.

¹⁴² Shivat Zion Council to HMO, 13 Nov 1932, J113/765, HMO Papers, CZA.

Ashkenazi pioneers, living in rural settlements, were conceptualized completely differently and were not held culpable for trachoma incidence. In Ashkenazi settlements, Sinai attributed trachoma cases to the fact that Arab workers lived in the moshavim with their families “like animals.”¹⁴³ He wrote that in Yesod Ha’mala, in the Huleh Valley, the number of Arab workers even exceeded the number of Jewish residents, without mentioning the influx of seasonal Arab laborers. Sinai expounded that Arab workers living in moshavim in the Galilee and Sharon were a potent source of spreading trachoma and malaria, and as long as moshavim depended on Arab labor, there would not be a chance for its eradication.¹⁴⁴ Sinai argued that to solve this problem required expelling Arabs outside of the settlements, which he thought he could accomplish “with good will and little resources.”¹⁴⁵ The discrepancy of the discourse of trachoma between Ashkenazi and Yemenite settlements highlights that the distinction between East and West existed not necessarily on the level of practice, but of interpretation.¹⁴⁶ In contrast, the warden of the St. John Ophthalmic Hospital in Jerusalem, Sir John Strathearn, thought the encounter with Jewish colonists improved the Arabs’ lot, rather than serving as a source of dangerous contagion for the Jews:

“As one travels northwards...means of communication increase and contact with a higher type of civilization becomes closer. I was especially struck with in the Zeita group of villages (Tul Karm sub-district); many of their young men are employed in the Jewish agricultural colonies; however much they grumbled at the lowness of their daily wage, or bemoaned their servitude on the land that used to belong to their village, there was no denying the beneficial effect of this contact...the improved bearing, brighter mentality, less evasive and more straightforward reply to questions, lack of servility amounting at times to rudeness...was indisputable. Their houses, women-folk and children suggested the same improvement.”¹⁴⁷

¹⁴³ Sinai to HMO, 15 Aug 1928, J113/416, HMO Papers, CZA.

¹⁴⁴ Sinai 136.

¹⁴⁵ Sinai, “Trachoma Situation in Schools and Kindergartens in Moshavot,” *Yediot Hadassah* 38-42 (Jan-May 1928) 33.

¹⁴⁶ Hirsch, ““We Are Here to Bring the West, Not Only to Ourselves,”” 591.

¹⁴⁷ John Strathearn, “The problem of blindness in Palestine,” *Folia Ophthalmologica Orientalia* 1 (1933) 286.

Arabs were deliberately excluded from Hadassah's anti-trachoma campaign, even if at times ophthalmologists made medical justifications to warrant their inclusion. Yassky believed that Hadassah should spend resources against trachoma in the Arab population to prevent its spread to Jewish communities, but he could not drum up support for this position. In a letter to Henrietta Szold, Yassky argued that, "It is possible to say that our government [the British Mandate] does almost nothing against the spread of trachoma in Arab villages and they are the big source of infection...there is one rational way: that is to arrange an anti-trachoma campaign in Arab villages."¹⁴⁸ He claimed he could find funding from the Anti-Trachoma League, newly established by the Pasteur Institute in Paris, for this endeavor. This was on the heels of an unsuccessful lobby to the British Mandate government to make anti-trachoma treatment mandatory in Palestine.¹⁴⁹

To jumpstart his efforts, Yassky began treating students at the Arab school in Sedgera. However, the GDH claimed Yassky had no authority in the Arab schools, and compelled him to stop.¹⁵⁰ Szold concluded that "the campaign would not be carried to them, in their quarters and centers," but that "Arab patients would not be denied admission and treatment, if and when they applied...but they would not be sought out."¹⁵¹ The GDH may have forbid Hadassah encroachment on their rule, yet Szold and Hadassah Director Bluestone were not enthusiastic about spending funds in this direction either.¹⁵² This inconsistency highlights that medical services were an important aspect of establishing lines of national governance, rather than necessarily implementing the most sound strategies at curing disease.

¹⁴⁸ Yassky to Szold, 30 Mar 1925, J113/411, HMO Papers, CZA.

¹⁴⁹ Yassky, "Memorandum A," n.d., Box 58a/2, HMO Papers, CJH.

¹⁵⁰ Yassky, "Report #17: Moshavot of the Galilee," 15 Jan 1925, J113/7274, HMO Papers, CZA.

¹⁵¹ Szold to Bluestone, 20 Jan 1926, J113/414, HMO Papers, CZA.

¹⁵² Mordechai Brechayahu, "Letter to Hadassah Administration, 20 Apr 1925," CZA J113/411.

The borders of government shifted after 1948, when the State of Israel was responsible for both Jewish and Arab health. Providing healthcare to the Arab population, just as it was to the British government, was a way to claim general governance and to earn goodwill. However, it tended to suffer from the same setbacks as it did to new Jewish immigrants. When the Ministry of Health fired a nurse that was treating students in Arab schools in 1949 due to budgetary concerns, the Military governor wrote that she needed to be rehired because then they will complain that, “not only will the medical service not get better, it would have gotten worse compared to the British Mandate.”¹⁵³ In 1950, an article in the Arabic daily, *al-Yom*, reported that there were trachoma cases in Wadi Ara, and that the population requested that the Ministry of Health provide an ophthalmologist.¹⁵⁴ In 1952, the principal of a school in Daliyat al-Carmel wrote to the Ministry of Health that the local physician refused to visit their school, leaving his students without any eye care.¹⁵⁵ A state physician in Nazareth, aware that neglecting Arab health could have social and political consequences, wrote that, “The time has come to change the face of things in the direction of effective, true, serious work, and not to leave them crawling like they were during the Mandate in so primitive a state.”¹⁵⁶

“Hideous Annual Crop of Blind Eyes”: Southern Palestine as Outside the Map

The Hadassah anti-trachoma map clearly highlighted where their activities did not take place: the West Bank and the Southern Districts, which were almost completely populated by the indigenous population. Although the GDH health budget was limited, combatting eye diseases was a major priority both in schools and in clinics. In fact, Sir John

¹⁵³ Military Governor (Eastern Galilee) to Malchi, 22 Apr 1949, ISA/RG 57/G/156/16.

¹⁵⁴ “Trachoma,” 30 Aug 1950, *al-Yom*, ISA/RG 57/6/180/12.

¹⁵⁵ Duri to Moskowitz, 6 Mar 1952, ISA/RG 57/G/156/16.

¹⁵⁶ Sever to Taushtein, 1 Apr 1952, ISA/RG 57/G/156/16.

Strathearn, the Chief Warden of the St. John Ophthalmic Hospital in Jerusalem, conceived of trachoma and eye infections similarly as a “social” problem, and that even with the extension of medical services, “the living conditions of the villages would still continue to produce this hideous annual crop of blind eyes.”¹⁵⁷ Therefore, Strathearn’s methods of eye treatment did not only include drops and ointments, but the instillation of village latrines, improved housing, and the training of select village girls in “cleanliness, the duties of a housewife and the elements of hygiene.”¹⁵⁸ The GDH’s largest concern, however, was not the endemic trachoma, but the epidemic summer eye infections that made “blindness in one or in both eyes...higher in certain sub-districts of the Southern District than any known part of the world.”¹⁵⁹ Since Jews did not suffer from these summer infections to the same extent, Hadassah claimed in multiple graphs and reports that its work was more successful than British efforts.¹⁶⁰ Despite the GDH’s mobile ophthalmic units and regional clinics, the rate of decrease in eye disease did not rival Hadassah’s, not least due to the differences in regional epidemiology.

During the first years of British rule, the GDH maintained a traveling ophthalmic unit during the summer season in the southern coastal belt and in Nablus, Ramleh and Hebron; in addition to instituting trachoma treatment as part of the School Medical Service. This was not unlike Hadassah’s Department of School Hygiene, yet the proportion of school attendance was markedly lower, and relied more heavily on teachers’ participation.¹⁶¹ Considered “the most important complaint of the school children in Palestine,” the GDH compelled teachers

¹⁵⁷ John Strathearn, “The problem of blindness in Palestine,” 286.

¹⁵⁸ Heron to Chief Secretary Jerusalem, 16 July 1935, ISA/RG 10/M/1623/4571.

¹⁵⁹ Heron to Chief Secretary Jerusalem, 15 Nov 1932, ISA/RG 10/M/1623/4564.

¹⁶⁰ See, for example, Bella Mirenburg, “The Anti-trachoma Campaign in Jewish Schools of Jerusalem,” *American Journal of Ophthalmology*, 31:10 (1948): 1289.

¹⁶¹ Government of Palestine, *Department of Health Annual Report* (1922), 46; 56.

to treat trachoma through daily eye drops in village schools, while medical officers or nurses checked children where possible in urban areas.¹⁶² The GDH honored teachers “who were found to have carried out treatment most efficiently and to have obtained the best results,” with a letter of thanks from His Excellency the High Commissioner.¹⁶³ The British government determined at the inception of its control that the extent and reach of ophthalmic treatment “established a more intimate contact between the Government and the people than is possible in most other branches of Government work.”¹⁶⁴ However, in 1923, the traveling ophthalmic clinics ceased operations due to budget constraints, as well as the expense of maintaining elaborate equipment and staff of the mobile clinic that were only used during the summer months.¹⁶⁵

In order to save funds, the GDH officially disbanded its Ophthalmic Unit in 1924 to partner with the St. John Ophthalmic Hospital in Jerusalem. Stationary ophthalmic clinics were established in Gaza, Ramleh, Nablus, Beersheba and Acre, and continued to examine approximately 11,000 students a year for trachoma until 1930, not a significant increase from 1922, even when attendance at government schools had increased by 30%.¹⁶⁶ These modest efforts were rattled out of complacency when the 1931 census revealed that Palestine had the highest rate of blindness in the world, surpassing even Egypt as the “land of the blind.”¹⁶⁷ This result hurtled eye care to the top of the colonial health priority list: “The general conclusion to be drawn is that, of the infirmities having a direct effect on the social and economic life of the people as a whole, blindness, whether partial or total, is incomparably

¹⁶² Government of Palestine, *Department of Health Annual Report* (1924), 33.

¹⁶³ Government of Palestine, *Department of Health Annual Report* (1923) 46.

¹⁶⁴ Government of Palestine, *Department of Health Annual Report* (1922), 56.

¹⁶⁵ John Strathearn, “The problem of blindness in Palestine,” 284.

¹⁶⁶ Government of Palestine, *Department of Health Annual Report* (1930), 62.

¹⁶⁷ E Mills, *Census of Palestine*, (Alexandria, 1931), Vol.1, 247.

the greatest adverse factor, and demands a concentration of attention towards prevention and cure of eye diseases at the expense of, if need be, of the attention given to the other infirmities of social importance in Palestine at the present time.”¹⁶⁸ In response to this verdict, the GDH expanded ophthalmic services by reinstating the mobile ophthalmic unit, as well as establishing additional stationary urban and subsidiary village clinics staffed by tamurgis (male eye nurses).¹⁶⁹

Appalled by the results of the 1931 Census, Strathearn decided to conduct himself ophthalmic examinations in a dozen random villages, chosen by the Superintendent of the Census, to determine if the census results were indeed accurate, and to collect data on the correlations between rates of blindness and socio-economic conditions.¹⁷⁰ He visited every house in the village, noting its “type, windows, ventilation, cleanliness,” and examined each resident.¹⁷¹ Although his sample was slightly less than the census, he determined that the census results were an underestimate, and confirmed that the “incidence of blindness in the southern area is twice that in the northern area” which “by far the greatest proportion...arises from conjunctivitis.”¹⁷² Since “practically every villager had trachoma,” he declared it was not considered in and of itself a cause of blindness, but greatly exacerbated the effects of conjunctivitis.¹⁷³

Acute conjunctivitis is a virulent inflammation of the mucous membrane lining the inner sides of the eyelids and forming a thin translucent membrane over the front of the

¹⁶⁸ *ibid* 228.

¹⁶⁹ Sami M Shihab, *The Government Ophthalmic Service in Palestine, XVth Concilium Ophthalmologicum* (Egypt, 1937) 35.

¹⁷⁰ E Mills, *Census of Palestine*, 224.

¹⁷¹ John Strathearn, “The problem of blindness in Palestine,” 126.

¹⁷² *ibid.* 127.

¹⁷³ *ibid.* 135.

eyeball. It is a highly contagious bacterial infection, but the actual organism varies; some are more destructive than others, but all can swiftly cause permanent vision loss. In severe cases, the cornea becomes ulcerated, spreading the inflammation inwards and destroying the eyeball until it shrinks (shrunken globe). If the ulcer heals, it may leave a dense scar in its place which can diminish vision.¹⁷⁴ Its prevalence in Southern Palestine was thought to be associated with the lack of rain: “Eye disease is associated with heat, dust and glare, and that good rainfall which ensures constant green vegetation, acting as a screen against dust in dry weather, is an effective combatant against the affliction.”¹⁷⁵ However, the “insanitary circumstances of the villages” were thought to aggravate the process.¹⁷⁶ Emphasizing the culpability of individual and collective habits absolved the British government from investing in major social reforms. Although the extensive poverty and environmental factors were given their due, it was thought that “the people themselves, however, present the most serious difficulties. They tend to become apathetic: they expect miracles from eye-drops and, since no miracle happens, they neglect the troublesome routine which curative treatment...requires.”¹⁷⁷ Therefore, Strathearn’s most pressing solution to cure epidemics required the circulation of self-disciplining hygienic practices, rather than the increase of governmental services.

Strathearn lobbied the GDH to “open a school to teach the rudiments of the art of living” to “village girls” based in Jerusalem.¹⁷⁸ The proposal demanded the recruitment of prospects at the marriageable age of 15 or 16, to be taught “elementary hygiene, the rudiments of home nursing and first aid (with special emphasis on what not to do)” in a

¹⁷⁴ AF MacCallan, *Trachoma and Its Complications in Egypt*, 11-22.

¹⁷⁵ E. Mills, *Census of Palestine*, 242.

¹⁷⁶ *ibid.* 243.

¹⁷⁷ *ibid.* 246.

¹⁷⁸ John Strathearn, “The problem of blindness in Palestine,” 288.

boarding house staffed by voluntary Arab women who had graduated from British or American institutions, with “no attempt to teach them reading or writing.”¹⁷⁹ She would impart her knowledge from a “model house” built in the center of the village from local materials, properly ventilated with “necessary conveniences.”¹⁸⁰ The new exemplar of hygiene teaching in a modern house was an exhibit that the villagers would be tasked to replicate.¹⁸¹ Colonel George Heron, the executive director of the GDH, recommended that Strathearn’s “proposal be given a very serious trial,” because he agreed that hygiene education would be of a more “permanent value and would be cumulative in its effects in the general, and ophthalmic, hygiene in villages.”¹⁸² He thought, however, that the school should be based in Hebron, rather than Jerusalem, where village conditions could be more easily copied. Although the Chief Commissioner of Palestine allocated the necessary funding for increased ophthalmic clinics and the mobile unit, he requested that the Order of St. John expend its funds on the proposed school.¹⁸³

In 1933, the Order decided to allocate £300 to the village scheme, less than half of the budget Strathearn originally proposed.¹⁸⁴ It appears that Heron, and perhaps Starthearn as well, were in contact with British authorities in India who operated a similar “scheme of elementary district nursing” whose “results so far achieved are definitely encouraging.”¹⁸⁵ Rather than just a network of colonial rule, it was also a family business: Blanche Seaman, who wrote to Heron on the success of the village scheme in India and its applicability in

¹⁷⁹ John Strathearn, “The problem of blindness in Palestine,” 289.

¹⁸⁰ John Strathearn, “The problem of blindness in Palestine,” 290.

¹⁸¹ See the “world as exhibition” analysis in Timothy Mitchell, *Colonising Egypt* (Berkeley: University of California Press, 1988).

¹⁸² Heron to Chief Secretary Jerusalem, 8 Dec 1932, ISA/RG 10/M/1623/4564.

¹⁸³ Chief Secretary Jerusalem to Strathearn, 23 Dec 1932, ISA/RG 10/M/1623/4564.

¹⁸⁴ Strathearn to Chief Secretary Jerusalem, 8 Mar 1933, ISA/RG 10/M/1623/4571.

Palestine, was encouraged that “the village near Jerusalem started on last year—Kolonia—seems to have had real benefit from the work done, even though there was only my aged mother to supervise it, not knowing the language or much about bad eyes.”¹⁸⁶ Although Strathearn claimed that, “the school is already a success and offers great possibilities for the good of the country,” the Order was not prepared to maintain the school indefinitely and the GDH refused to subsidize it.¹⁸⁷ There are archival gaps on the operation of the school, and indeed, how long it lasted. Heron seemed to have backtracked on his initial enthusiasm, claiming that it would be impossible to entice girls to leave their villages at marriageable age. Although the hygiene education would be valuable, Heron thought that its utility was limited, since “all these girls will marry and not have time or inclination to treat other than their own children.”¹⁸⁸ Therefore, it improves “social than medical conditions,” if the training is not on mass scale.¹⁸⁹ Rather than planting so-called agents of hygiene in the villages, Heron attempted to secure more funding for Infant Welfare and Mothercraft centers, staffed by British nurses, which he deemed more effective.¹⁹⁰ Although Strathearn was willing to privately fundraise for the school, Heron ultimately did not believe in the civic potential of hygiene to transform Palestinians into modern subjects, and shelved this tactic in place of more traditional forms of medical intervention.

Private Practice: The Hakim as Pioneer

¹⁸⁵ Banerjee to Secretary, Village Uplift Board, Central Provinces, Nagpur, 10 Apr 1934, ISA/RG 10/M/1623/4571.

¹⁸⁶ Seaman to Heron, 9 June 1934, ISA/RG 10/M/1623/4571.

¹⁸⁷ Wauchope to Perowne, 19 July 1935, ISA/RG 10/M/1623/4571.

¹⁸⁸ Heron to Chief Secretary Jerusalem, 16 July 1935, ISA/RG 10/M/1623/4571.

¹⁸⁹ *ibid.*

¹⁹⁰ *ibid.*

Trachoma and the treatment of eye disease created a wide milieu of relationships between European Jews, Middle Eastern Jews and indigenous Palestinian Arabs that transcended the Hadassah and GDH public health campaigns. These interactions took place through private practice in cities, rural settlements, and Arab towns, illustrating how European Jewish physicians crisscrossed the lines of governance health organizations had reinforced. This was primarily an economic decision. A Hadassah report proclaimed that “unfortunately the situation in Palestine from the point of view of the medical profession is tragic” in terms of employment.¹⁹¹ Although the same report contended that the “Arab population offers only a very limited field for the exercise of the profession of medicine,” eye doctors had much better possibilities of success.¹⁹² This was both because of the widespread prevalence of trachoma and infectious eye diseases, and because ophthalmology required specialized expertise.

In the Hadassah anti-trachoma campaign, physicians attempted to strip markers of the “orient” from their patients (even if the accomplishment of that task was forever deferred), but eye doctors in private practice lauded their success in attracting Arab patients and in becoming enough of “Orientalist experts” to write about their new-found knowledge at length. I use two ophthalmologists’ memoirs to offer alternative visions of Zionism’s relationship to the indigenous population, supporting the idea that cultural separatism was not an inevitable part of Zionist settlement. These accounts are reminiscent of ophthalmologists’ tales of their sojourns in Egypt or Ottoman Palestine, who treated going to the “East” as much as an orientalist as an ocular endeavor. The so-called rational and scientific Hadassah anti-trachoma campaign did not therefore displace this older, independent, and ethnographic style of medical practice.

¹⁹¹ Hadassah Medical Organization Third Report, September 1920-December 1921 (Jerusalem, 1922) 73.

¹⁹² *ibid.*

In this later period, however, both narratives conceptualize philanthropic aid to indigenous natives as a valid form of Zionist pioneering (*halutzit*). Ephraim Sinai traveled to Gaza, seeking Arabs not as subjects of reform, but as an economic necessity to keep afloat an over-saturated medical market. Going to Gaza and learning about Arab customs, he reasoned, would be his own form of pioneering when it was not financially feasible to treat Jews. Max Cramer, who had hoped to cast away his ophthalmological career in order to be an agricultural pioneer in Nahariya, soon realized that he had Arab neighbors in the apparent “land without a people,” and accepted that he must make his living by treating them in the face of floundering farming pursuits. His wife, Jenny, as the clinic manager, wrote of her attempts to run a German clinic—with attendant modes of hygiene and order—for a population that she thought often disregarded those rules. While Sinai “went native” in Gaza, the Cramers attempted to “civilize” the Arabs through introducing Western conventions, even if unsuccessfully. Rather than pegged as bourgeois professionals, these physicians could apply the distinct rugged ethic developed for agriculture to medical treatment for the native population: “These excellent pioneers are thrown on their own resources, and they are deprived of the aids given by modern medicine to diagnosis and therapeutics in civilized countries.”¹⁹³ These memoirs are unique texts because they shed light on how ophthalmologists perceived their own role within the Yishuv as physicians who could maintain extended contact with the Arab population. Healthcare in Mandate Palestine was institutionally separated between Jews and Arabs, but the work of private physicians often transgressed this boundary in a country not only of multiple diseases, but also of unemployment and economic hardship.

Although I will focus on the section on his practice in Gaza, Sinai’s memoir, *With the Entire Eye: The World of a Physician*, captures the entire “world” in which an

¹⁹³ Hans Mühsam, “The Hygienic Institute in Palestine,” in *Zionist Work in Palestine*, ed. Israel Cohen (London:

ophthalmologist in Mandate Palestine could be a “go-between” figure between multiple authorities and residents.¹⁹⁴ His career ran the gamut of Yishuv medical history: his medical education in Tartu, Estonia and Berlin, his first medical post in Palestine as the only Jewish physician in Gaza in 1924, his work as an assistant in Ticho’s Jerusalem eye clinic, and his travels throughout Palestine as a Hadassah traveling oculist. Sinai decided to specialize in ophthalmology in Berlin because he considered infectious eye diseases the most critical in Palestine. Upon his arrival in Jaffa in 1924, he shadowed a physician on a moshav near Gadera “in order to understand the fellahin and their accepted medical practices.”¹⁹⁵ Sinai understood orientalist knowledge as an integral part of medical practice. To this end, he described in detail how Arabs would arrive to the doctor’s clinic in the morning with their camels and donkeys, their style of dress, jewelry, and their “special smell of dirt and sweat, mixed with the smell of a heated taboun.”¹⁹⁶ Sinai considered developing expertise on Arab customs, bodies, and society to be critical to a successful career in Palestine, as his predecessor had done.

Finding medical employment in the urban centers was difficult, as Palestine had a large number of European physician immigrants.¹⁹⁷ Sinai set out to network in order to assess his options, and he met with both Feigenbaum and Ticho in Jerusalem. At Sinai’s insinuation that he might start practicing ophthalmology in Jerusalem, Ticho sternly replied that patients only wanted to see him and were used only to him.¹⁹⁸ When Sinai decided to leave the saturated Jerusalem market to visit Shimkin in Haifa, he noticed most of Shimkin’s patients

Zionist Central Office, 1911) 70.

¹⁹⁴ Ephraim Sinai, *With the Entire Eye: The World of a Physician* [Hebrew], (Tel Aviv: Tzrikover, 1984).

¹⁹⁵ Sinai 84.

¹⁹⁶ *ibid.*

¹⁹⁷ Hadassah Medical Organization Third Report, September 1920-December 1921 (Jerusalem, 1922) 73.

¹⁹⁸ Sinai 90.

were Arab. Like Ticho, Shimkin was warm until he heard Sinai was considering setting up shop in town: “Haifa? There’s no one in Haifa except me.”¹⁹⁹ Although private practice had appeared to be Sinai’s most viable option, each urban area had a respected and established ophthalmologist who commanded the key Arab patient constituency and shut out outside competition.

Sinai investigated the possibility of becoming the sole Jewish physician in an Arab city, when he learned that a few other Jewish physicians were also living in Arab towns, including in Lod, Ramleh, Akko, and Jericho. When he heard that Dr. Yizraeli in Gaza was looking for a replacement, Sinai decided to travel there and had good reason to think that this endeavor would be successful. On the train ride to Gaza, Sinai had already decided to accept the assignment, as he felt he had no other choice: “My fate would be, it seems, to live with the Arabs.”²⁰⁰ Sinai framed this post as a type of *halutziut*, or pioneering, that was commensurate with the Zionist mission of “settling the land.” This type of pioneering was “to live in Gaza, to recognize the Arabs from up close, to learn their language and their customs.”²⁰¹ This sentiment strongly demonstrated how integral orientalist knowledge was not only for medical practice, but for Sinai’s vision of Palestine “as a metaphor for metamorphosis.”²⁰² Although Sinai was clearly apprehensive about moving to Gaza, he perceived the opportunity as one aligned with his Zionist values.

Sinai sealed the financial matters with Yizraeli, bought his pharmacy and medicines, as well as took over the lease of his clinic. Although Sinai was worried that he did not have a lot of experience with general medicine, Yizraeli reassured him that most cases were eye

¹⁹⁹ Sinai 93.

²⁰⁰ Sinai 94.

²⁰¹ Sinai 99.

²⁰² Eyal 60.

diseases, and that the other diseases were typical of Palestine: typhus, dysentery, and pediatric disease. He also “inherited” Yizraeli’s thirteen-year-old assistant, Rashid, who helped him around the house and clinic. As was the custom, he hired a local for three shillings to publicize his services, shouting in Arabic in the Gazan streets: “A new physician from Germany! An expert in eye diseases, surgery, and children!”²⁰³ Sinai considered his relationships with Arabs to be sound, and enjoyed greetings and invitations for coffee with his neighbors. He tried to learn and speak Arabic (his tutor was compensated with vaccinations against syphilis), and engaged in political debates in which most pointed their fingers to blame the British for any hardship.²⁰⁴

Although Sinai believed he had made headway in acclimating to Arab society, his hope for a successful ophthalmic practice was quickly lost. Most of his patients were poor workers, fellahin or Bedouins with incurable blindness, and those who could see, albeit poorly, did not feel a need to see a doctor. Therefore, the lifeblood of an ophthalmologist—cataracts, glaucoma, and corrective vision—he almost did not see at all.²⁰⁵ The Gazan effendiya and merchant classes, who had these ailments, preferred to travel to Jerusalem to Ticho’s clinic or to the St. John Ophthalmic Hospital. Sinai also experienced problems with payment, which was four shillings a visit: some would give counterfeit money, and others would ask to pay later and never did. Sinai’s pioneering spirit waned, and he did not “see a point in remaining a doctor of Arabs all of his life.”²⁰⁶ What appeared to be an economic opportunity was in fact a fiscal failure.

²⁰³ Sinai 97.

²⁰⁴ Sinai 99.

²⁰⁵ Sinai 101.

²⁰⁶ *ibid.*

The collapse of his eye clinic seems counterintuitive, especially when one considers that the percentage of trachoma in the Arab population was 70%, and it was even more prevalent in the south than in the north of Palestine. This experience complicates the image of trachoma as the “scourge” of the Middle East, and reveals in the context of limited medical services, Gazans had developed alternate methods of dealing with eye disease. Although Sinai had been told that Arabs prefer going to Jewish doctors, they had other options, including indigenous cures, British eye clinics, the St. John Ophthalmic Hospital in Jerusalem, or ignoring it altogether. The epidemiology of trachoma did not lend itself to quick treatment: it was a slow and progressive disease that often did not hurt until it was in the advanced stages. Joseph Krinsky, a visiting American physician in Palestine, explained that Arabs “may, and in most instances do, go on for months disregarding symptoms which to more civilized and sensitive eyes would be painful and annoying.”²⁰⁷ Various reasons—economic, cultural, and medical—led to the dissolution of Sinai’s practice in Gaza. Unlike Ticho and Shimkin, Sinai was unable to make a professional name within the Arab community for whatever reason, and became employed by the Hadassah Medical Organization when he decided to stop persevering in that direction.



A twenty-page booklet is the only item in a single file at the Central Zionist Archives, handwritten in German by Jenny Cramer, the wife of Max Cramer, titled “Our Arab Clinic.”²⁰⁸ I suspect Jenny herself donated it. Jenny was the office manager and assistant of her husband’s practice, recording patients’ file cards and registering reception, and caring for the day-to-day life of the practice. Rather than a doctor traveling in search of a market, Cramer attracted Arabs to his practice. The tone of Jenny’s narrative is quite nostalgic, and

²⁰⁷ Joseph Krinsky, “Trachoma in Palestine,” *Long Island Medical Journal* 14:4 (April 1920) 174.

²⁰⁸ Jenny Cramer, “Our Arab Practice,” K13/167, CZA.

implies that their practice—which was so different than what they envisioned life in Palestine would be like—actually brought great meaning to their lives at a time when agricultural endeavors in Nahariya struggled financially. Although Max and Jenny had been ignorant to the fact that they even had Arab neighbors, they learned some Arabic and they tried to run the most “modern” clinic they could, given the circumstances. The clinic was not only a way to earn money—the Cramers refused to run a charity operation—but was an opportunity to bestow modern values to the Arab population, a promise of Zionism’s virtues.

Jenny and Max quickly realized when they went to Palestine in 1933 on a scouting trip that all of the cities had a surplus of physicians, and Max was not interested in competing for patients. Instead, they opted to be pioneers, and settled in the agricultural settlement of Nahariya. Max brought his ophthalmological equipment from Germany just in case, and would occasionally treat a member of the moshav. Jenny wrote that one day an Arab neighbor who maintained friendly relations with moshav members came to Max to be treated for an eye disease. She assumed that it must have been from him that the Arab population learned that her husband was an eye doctor.²⁰⁹

On the whole, Jenny wrote that the moshav had no connection to the Arab population, and that the 1936 Arab Revolt reinforced this distinction. After the revolt subsided in 1938, however, Arab patients appeared almost daily and asked to see Max, the “hakim” (physician). While Max enjoyed seeing the occasional patient, he was soon inundated with an onslaught of visitors to the point where the work was no longer enjoyable. Max could not communicate with the patients, knowing no Arabic, and he did not understand people’s names or where they came from. Jenny confesses that their ignorance was such that they did not know at the time that the patients came from villages that were quite close.²¹⁰

²⁰⁹ *ibid.*

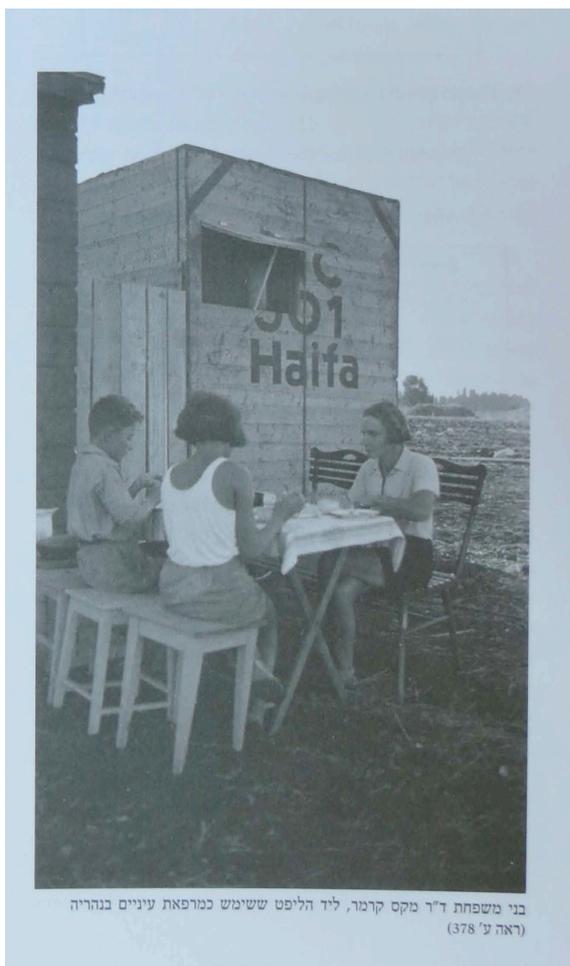


Figure 7: Jenny Cramer, next to the trailer that Max used as his eye clinic in Nahariya



Figure 8: Jenny Cramer, 1961

Rather than catering the conventions of their practice to attract Arab patients, Max was quite miserable by the schism between their cultural conceptions of medicine:

“Alas, he said, a clinic like this does not give pleasure. I can hardly communicate with the people. They see the doctor as a magician. If the first treatment is not immediately successful, they don’t come back, even though it would be necessary to treat them several times. If they feel relief right after the first treatment, they believe I am a miracle worker and bring me their old, hopelessly ill people, half blind people, entirely blind people, and expect me to perform miracles. It is very depressing to disappoint these hopes every day.”²¹¹

Two ENT physician colleagues joined his practice in order to lift his spirits, and assumingly to reap the same financial benefit. Together they would often treat sixty patients in one

²¹⁰ *ibid.*

²¹¹ *ibid.*

morning. Jenny painted a very busy scene: while two patients sat waiting for ointments or injections, a third was at the eye chart, a fourth in the dark room waiting to be checked with the ophthalmoscope, and a fifth lying on the operating table awaiting outpatient surgery. Many times, she wrote, ten people would come from one village, almost all with neglected trachoma.

Jenny was adamant about maintaining “order” in the clinic. Rather than letting patients wait under the fig tree where they could rush in to Max’s examining room, they had to wait outside the gate. She maintained file cards of each patient, recording their diagnoses and if they had paid (refusing to give a prescription or to see the patient again if they had not). To complete this task, Jenny wrote that she learned a bit of Arabic, including “Where are you from? Which village? And your name?”²¹² Jenny felt that she had begun to understand the diversity of the Arab community, and took special note of people’s clothing, including the wearing practices of the keffiyeh, and the differences in female veils and dresses between Druze, Christians, and Bedouins. This emphasis on order sometimes clashed with Arab customs, though Jenny would not bend to them. She recalled that an effendi had arrived by private car and expected to cut the line, and the fellahin readily acquiesced. Max, however, insisted on waiting by turn, offending the effendi who never returned.

Jenny also tried to enforce hygienic measures, though it seemed with a bit of good humor. Patients would come with their families, and bring baskets of food including, pita, onions, tomatoes, pepper, olives, grapes, oranges, white cheese and hard-boiled eggs. Jenny worried about the flies buzzing around the baskets, and was armed with “Flit,” an insecticide that she that she confessed the flies were immune to. While Max would attempt to create a sterile environment for his patient, providing clean pillow covers and fresh gauze, he was often thwarted when “suddenly the mother, a Bedouin or fellah, would interfere and wipe

²¹² *ibid.*

away the child's pus with the dirty seam of her skirt."²¹³ The Cramers attempted to maintain "hygiene," but it seemed that no one else noticed their standards: the Health Department never visited, she wrote, though she assumed they must have known about the clinic since Arabs came from as far away as Lebanon, Transjordan, and Gaza.

In the spring of 1948, Jenny and Max saw lines of cars heading towards Lebanon. After the war, the Cramers did not reopen the clinic, not least because the majority of the Arab population they had served had left. Max began working at a new eye clinic Kupat Holim had opened in Nahariya. Jenny concluded her essay by stating: "Now all of this dates back many years, my husband has been dead for seven years. I simply sit at night, telling myself about bygone times. Nothing has remained of the work in the clinic but the memories of a full, active life."²¹⁴ Jenny illuminated the day-to-day life of a rural eye clinic from 1935-1948, demonstrating how the couple improvised their activities and responded to and interpreted the culture of the patients they treated. Rather than a story of economic failure, it seems to be one of success, fulfillment and sentimentality. Although Max had been at first disheartened by Arab patients, after years of managed "disorder," he determined that, "We are helping people. A primitive clinic like this is exactly what they need and where they feel comfortable. Otherwise they would not be coming here in droves."²¹⁵ It must have been very stimulating for Max and Jenny to use the skills they had brought from Germany to run a clinic, however hectic and primitive they considered it, as an "Arab practice"—bringing progress to the Arab population—reconciled bourgeois medical practice with the Zionist pioneering. The exclusion of Arab patients from the Hadassah campaign had made them visible to another group of eye doctors. Both the Hadassah public health campaign and

²¹³ *ibid.*

²¹⁴ *ibid.*

²¹⁵ *ibid.*

private practice represented alternate modes of Zionism's conceptions of the Orient.

Conclusion

Arieh Feigenbaum devoted twenty pages in his ophthalmic textbook, *Ha'ayin* (1927), to trachoma and its epidemiology, treatment, and prevalence in Palestine. He classified trachoma as a “folks’ disease in those countries that are based on a low cultural level; a poor man’s disease, the indigent forming the majority of sufferers; a children’s disease, as the infection occurs in early childhood; and lastly, for obvious reasons, a family disease.”²¹⁶ These classifications highlight that the epidemiology of trachoma was integral to its conception as a target of biomedical and social solutions. The traveling oculist was to produce both medical statistics on the disease, and to cultivate cultural expertise in order to proscribe hygienic reforms. Mirenburg reinforced this conception in her published paper in the *American Journal of Ophthalmology*: “The physicians engaged in anti-trachoma work know that they are social workers and that their success depends in the same measure on the treatment of the individual case as on the degree to which they are able to reach the population by instruction. Of course, much depends on the social standard and adaptability of the various population groups and it is not surprising that results are not uniform in all communities.”²¹⁷ Mirenburg’s attitudes towards her patients were representative of how Jewish physicians oscillated between orientalist essentialism and a tacit belief that hygienic education could be transformative. It was critical that trachoma rates decrease in the Yemenite communities, because “there is no other cultured country that has the number of trachoma patients as large as we do.”²¹⁸ The “war against trachoma” served to create a visual and medical distinction between Jews and Arabs in a time of nationalist development.

²¹⁶ Arieh Feigenbaum, *The Eye: Its Anatomy, Maintaining its Health, and Its Treatment*, 56.

²¹⁷ Mirenburg 1290.

²¹⁸ Yassky to Szold, 30 March 1925, J113/411, HMO Papers, CZA.

The GDH also conceived of trachoma as a disease of hygiene and poverty in the Arab population, and instituted their own brand of hygienic reforms through a “village girls school.” With the lack of investment in infrastructure and socio-economic improvements, however, acute conjunctivitis and trachoma continued to have a large effect on rates of blindness. Both Hadassah and GDH conducted mass disease campaigns, supported by reams of physician reports and statistics that illustrate how trachoma was supposed to be calculated and controlled. However, these campaigns continued alongside a much older form of private practice. Cramer and Sinai’s memoirs reveal that treating eye disease among indigenous Arabs could also be conceived of as Zionist acts of pioneering. Knowledge of the orient was important for both Hadassah traveling oculists and private practitioners, either to inculcate hygienic norms to Yemenite patients, or to build a profitable private practice. Sinai had been part of both endeavors at different stages of his career.

Mobility was central to the creation of these varied relationships. The sources that make up this story—including the reports of traveling oculists and the memoirs—are all rooted in traveling experiences that were translated into genres of scientific and ethnographic literature. The act of traveling allowed for the independent, improvised, and informalized practices that were characteristic of eye care. The Hadassah proto-state disciplining practices of collecting detailed scientific data and patient information was subject to transportation and communication setbacks. Although a mass campaign supported by science and statistics was the preferred method of combatting trachoma, the accompanying westernizing and colonizing discourses were not all encompassing.

The founding of the State of Israel in 1948 changed the country’s trachoma incidence in two crucial ways: the concurrent exodus of the Arab population, and the mass immigration of Jewish immigrants from the Middle East and North Africa. Between 1948-1952, among the 720,000 new immigrants that had arrived to Israel, about 10.5% had trachoma. About

80% of Yemenite immigrants and 25% of North African immigrants were infected.²¹⁹ In total, there was an estimated 78,642 cases.²²⁰ Mirenburg, a former traveling oculist and employee of the Hadassah Hospital Ophthalmology Department, warned that their hard work would have to start from scratch and resume with its former force. She had checked families who had arrived from Morocco and Algeria in the Baka neighborhood of Jerusalem, some in which every member had active trachoma.²²¹ Dr. Israel Feitelberg, Mirenburg's co-worker, surveyed trachoma in Jerusalem and similarly deduced that "now, whole tribes are affected, including: Yemenites, North Africans, Kurds, from the old to the young."²²² Making efforts even more difficult was the transience of the population itself, which often moved between transit camps and settlements before the time consuming treatment was completed. Trachoma had become conceptualized as a disease of oriental "immigration," rather than a "native" disease of Palestine, as the majority of the "natives" had fled. Through immigration, Feigenbaum argued that, "the element of backwardness, so obvious in former Palestine, was not completely eliminated in this new Israel."²²³

However, trachoma had also become a different disease entity. Sulfa drugs and antibiotics in the late forties and early fifties had transformed trachoma treatment. Rather than a chronic disease requiring daily treatment for at least half a year, antibiotics could cure trachoma in a matter of two months. The "blinding scourge," with systematic treatment, did not lead to as many complications as it once had, and reduced the incidence of other eye

²¹⁹ Avi Picard, "Immigration, Health and Social Control: Medical Aspects of the Policy Governing Aliyah from Morocco and Tunisia, 1951–54," *The Journal of Israeli History* 22, no. 2 (2003): 35.

²²⁰ A. Sternberg, "Social and Health Aspects of the Mass Immigration 1948-1952," *Harefuah* 44:7 (1 Apr 1953) 153.

²²¹ Mirenburg to HMO, 16 Jan 1950, J113/2542, HMO Papers, CZA.

²²² Israel Feitelberg, "Survey on Trachoma for Kupat Holim, Jerusalem Region," 1 May 1952, ISA/RG 57/G/180/12.

²²³ Aryeh Feigenbaum, "Causes of Blindness in Israel," *The Sight-Saving Review* 21, no. 1 (Spring 1951): 17.

infections. Although trachoma still interested Israeli health authorities, it had sharply declined as a priority and was underfunded in the eyes of ophthalmologists. Efforts to eradicate trachoma by recreating the intensity and geographic scope of Hadassah's "war against trachoma," never succeeded, due to lack of funds, interested personnel, and because improvement in housing, education, and sanitation lowered trachoma incidence without eye doctor involvement.

Historian Rhona Seidelman has written the first detailed history about the Ringworm and Trachoma Institute in the Sha'ar ha-Aliyah immigration-processing center in the 1950s. She argues that "conceptually...trachoma was always marginalized: its introduction into the institute was an afterthought, it was overlooked by the journalists in the 1955 tour, and in archival documentation on the institute it is sidelined in contrast to ringworm."²²⁴ This accurately reflects the declining interest in trachoma both as a disease entity and as a cultural marker. The traveling oculist continued to operate on a more regional basis, but was an underpaid part-time government employee instead of a respected figure of public health. Various permutations of dedicated anti-trachoma work lasted into the 1960s, much to the Ministry of Health's chagrin: a director wrote that, "Trachoma treatment needs to turn into treatment that is paid for in Kupat Holim clinics throughout the country. We can't continue to treat trachoma forever as a special disease with Ministry of Health funds."²²⁵ Rather than investigating 1950s trachoma only in the context of immigrant health in transit camps, we can understand the ways in which trachoma and ocular diseases were understood to be important through taking a more global view that reveals how it became a site of medical intervention in North Africa itself.

²²⁴ Rhona Seidelman, Ilan Troen and Shifra Shvarts "'Healing' the bodies and souls of immigrant children: The Ringworm and Trachoma Institute, Sha'ar ha-Aliyah, 1952-1960," *Journal of Israeli History* 29:2 (2011) 204.

²²⁵ Yafeh to Mani, 28 June 1960, ISA/RG 57/G/5085/1.

CHAPTER 3

The Moroccan Mass Trachoma Project: Jews, Development and Global Health

Introduction

In the winter of 1953, the international Jewish philanthropic organizations, the American Jewish Joint Distribution Committee (JDC) and Oeuvres de Secours aux Enfants (OSE), conducted the Mass Trachoma Project in one square block of Casablanca's mellah (Jewish quarter). One ophthalmologist, one nurse, and a social worker renovated a vacant cafe bar at 74 Rue de Four—across the street from the synagogue in the heart of their pilot project—into the JDC-OSE eye clinic equipped with leftover tables and chairs, a file cabinet, and boxes of aureomycin antibiotic ointment. Electric light and running water were at hand in the doctor's examining room, while sewing machines sat in a corner where nurses would stitch their own uniforms. The clinic would soon serve half of the 1600 residents in need of treatment on two adjoining streets.¹

The year of 1953 is a transitional one in which to examine a disease campaign in Jewish North Africa. While it was the postwar period, awash in new norms and institutions, it was not yet the postcolonial moment in Morocco, where the French Protectorate would remain in power until 1956. Although Israel's founding in 1948 hastened immigration from throughout the Middle East, aliyah figures had dropped off considerably from Morocco between 1951-1953, as the political and economic situation improved for Jewish residents. The literature on mass disease campaigns has sidestepped a campaign like the Mass Trachoma Project—conducted by a Jewish NGO—instead focusing on state efforts within the context of full-blown Cold War politics. Trachoma was neither malaria nor smallpox, the two

¹ "Narrative Report for the Mass Treatment for Trachoma," 25 Feb 1953, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

diseases whose stories have most often been retold within a blatant US-Soviet rivalry.²

Understandings of its treatment and etiology, therefore, do not fit so neatly within the rubric of diseases the World Health Organization decided to tackle that could easily win hearts and minds through technological innovations.

Paying heed to this particular project and moment opens up the possibility of inserting Jews into a narrative of colonial and decolonizing medicine, and in so doing, creating new genealogies of global health. A confluence of factors made trachoma in North Africa a Jewish concern, which led to successful formal requests to UNICEF and the World Health Organization to organize anti-trachoma campaigns in Morocco. When we take Jews as an analytical category into consideration, we can evaluate how the simultaneous WHO and JDC anti-trachoma campaigns were in conversation, both in terms of medical practices and political contest with the French Protectorate Department of Health. Jews were central to constructing trachoma in North Africa as a global concern in the postwar period, and placing the spotlight on the Mass Trachoma Project proves that “the history of world health cannot be understood as anything but merged formations of colonial, national, and ‘world’ politics, played out on specific local ground.”³

The postwar campaigns against infectious diseases are usually glossed over in a line or two in existing work on Jewish North Africa, revealing the fact that they existed, without much else.⁴ Trachoma was tagged, along with tuberculosis and ringworm, as diseases that

² Randall M. Packard and Peter J. Brown, “Rethinking Health, Development, and Malaria: Historicizing a Cultural Model in International Health,” *Medical Anthropology* 17, no. 3 (May 1, 1997): 181–94; Erez Manela, “A Pox on Your Narrative: Writing Disease Control into Cold War History,” *Diplomatic History* 34, no. 2 (April 1, 2010): 299–323.

³ Alison Bashford, *Medicine at the border. Disease, globalization and security, 1850 to the present* (New York: Palgrave Macmillan; 2006) 4.

⁴ Yaron Tsur, *A Torn Community: Moroccan Jewry and Nationalism, 1943-54 [Hebrew]* (Tel Aviv: University of Tel Aviv, 2001); Michael M. Laskier, *North African Jewry in the Twentieth Century: The Jews of Morocco, Tunisia, and Algeria* (NYU Press, 1994); Michael M. Laskier, *The Alliance Israélite Universelle and the Jewish Communities of Morocco, 1862-1962* (Albany: State University of New York Press, 1983).

could overwhelm Israel's already tenuous health services, and therefore appropriate for medical selection.⁵ Prospective emigrants with the telltale signs of inturned eyelashes or cloudy corneas were not allowed to immigrate, and could stall their whole family's move by at least three months.⁶ Disease control measures could fashion more suitable immigrants to Israel, who could bypass these medical restrictions. The Mass Trachoma Project is then most often construed as another example of collaboration between the JDC and the Jewish Agency in service of Zionist immigration.

However, focusing solely on immigration obscures a different global context in which JDC operated: that of development in the decolonizing Third World. In the postwar era, the Western nation-states championed projects of technical assistance based on "knowledge acquired in rapidly changing industrialized societies...made available to those communities that are less advanced and less well equipped."⁷ The role of the United Nations and international non-governmental organizations have increasingly been considered within the development enterprise.⁸ JDC personnel were steeped in this mental universe that championed modernization as a quintessential American mission, and development assistance as an indispensable part of defining America's place in the world.⁹ The Mass

⁵ See Nadav Davidovitch and Shifra Shvarts, "Health and Hegemony: Preventive Medicine, Immigrants and the Israeli Melting Pot," *Israel Studies* 9, no. 2 (2004): 150–79; Avi Picard, "Immigration, Health and Social Control: Medical Aspects of the Policy Governing Aliyah from Morocco and Tunisia, 1951–54," *The Journal of Israeli History* 22, no. 2 (2003): 32–60; Michael M. Laskier, *North African Jewry in the Twentieth Century: The Jews of Morocco, Tunisia, and Algeria* (NY: NYU Press, 1994).

⁶ Picard 52.

⁷ Sunil Amrith and Glenda Sluga, "New Histories of the United Nations," *Journal of World History* 19, no. 3 (2008): 261.

⁸ See, for example, Akira Iriye, *Global Community: The Role of International Organizations in the Making of the Contemporary World* (Berkeley, CA, 2002); Amy L. S. Staples, *The Birth of Development: How the World Bank, Food And Agriculture Organization, And World Health Organization Have Changed the World 1945–1965* (Kent, Ohio, 2006); Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge, MA, 2008).

⁹ David Ekbladh, *The Great American Mission: Modernization and the Construction of an American World Order: Modernization and the Construction of an American World Order* (Princeton University Press, 2011) 5.

Trachoma Project fits into a “new global history of modernization” that not only denaturalizes the state and heavy industry, and but also focuses on a single project in which to pinpoint the perspectives of multiple principal actors and traces the effects of changing practices.¹⁰

The JDC since its founding in 1914 had been engaged in humanitarian relief and resettlement of Jewish refugees in Europe, as well as reconstruction aid after both World Wars. In addition, the JDC engaged in what Derek Penslar termed, “Jewish social policy,” which was “social engineering, an attempt to create a blueprint for a new type of Jew, both in the diaspora and in Palestine...the makers of Jewish social policy strove for rationality, planning and centralization.”¹¹ However, the practices of this technical expertise are rarely discussed. Development was also about ordering society and measuring progress against the yardstick of technology, and was a way for the JDC to claim “a symbiotic relationship between the political interests of the Jews, and of a certain Great Power,” in this case, the United States.¹² Although Penslar argues that after World War II, Jewish social policy was no longer concerned with the “malformed Jewish occupational profile that must be changed through ‘productivization,’” that reading disregards JDC’s work in North Africa, which was very much about tending to a underdeveloped population.¹³ The stop-gap measures which had preoccupied the JDC after WWI—immigration assistance, relief efforts, and reconstruction activities—could be transformed from rehabilitation to development in North Africa. William Bein, the Morocco Country Director, conceived of aid to Morocco as distinct from past European efforts: “Morocco is probably the only country where we are carrying on

¹⁰ David C. Engerman and Corinna R. Unger, “Introduction: Towards a Global History of Modernization,” *Diplomatic History* 33, no. 3 (2009): 380-383.

¹¹ Derek J. Penslar, *Israel in History: Jewish State in Comparative Perspective* (New York: Oxford University Press, 2007) 142.

¹² *ibid.* 136.

¹³ *ibid.* 148-149.

a program of aid to the local population. I was thinking a good deal about this, because we have no refugee problem there; we have no displaced persons... We are working for and on behalf of the local population.”¹⁴

If we regard the practices of the Mass Trachoma Project to be just as important as its purpose, then we cannot simply evaluate JDC-OSE medical aid within the rubric of Jewish social engineering or a Zionist teleology, but within the history of global health. At the same time JDC employees were mapping the mellah block in anticipation of their scheme, the World Health Organization and UNICEF workers were trekking in jeeps through the foothills of the south Atlas Mountains, providing mass anti-trachoma treatment to whole villages at a time.¹⁵ How did JDC’s anti-trachoma efforts fit into a global conversation about medical aid, and how did the global ambitions of the JDC affect, alter, undermine, and strengthen the Zionist imperative of curing Jews of trachoma in the mellah?

The Mass Trachoma Project was emblematic of the disease control campaigns that characterized international health in the postwar period, implemented through new technical interventions, in this case, antibiotics.¹⁶ The JDC was sure to follow the treatment recommendations of the First Report of the WHO Expert Committee on Trachoma. However, this “magic bullet” approach to medicine was in constant tension with “social medicine,” which highlighted the importance of social and economic conditions to the practice of public

¹⁴ “Excerpt from Verbatim Record of Mr. Bein’s Report to the Executive Committee Meeting,” 4/11/1951, 45/54 #45, Records of the New York office of the American Jewish Joint Distribution Committee JDC Archives. For critical assessments of development, see Arturo Escobar, *Encountering Development: The Making and Unmaking of the Third World* (Princeton: Princeton University Press, 1995); Gilbert Rist, *The History of Development: From Western Origins to Global Faith*, 3rd ed. (New York: Zed Books, 2010); or more recently Andreas Eckert, Stephan Malinowski, and Corinna Unger, eds., Special Issue on “Modernizing Missions: Approaches to ‘Developing’ the Non-Western World after 1945,” *J. Mod. Eur. Hist.*, 2010, 8.

¹⁵ “Trachoma Control: A Review of WHO-Aided Campaigns,” *Chronicle of the World Health Organization* 10 (1956): 231–38.

¹⁶ Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65* (Palgrave Macmillan, 2006), 3.

health.¹⁷ Although the ideals of social medicine were enshrined in the WHO's constitution—"Health is not only the absence of infirmity or disease but also a state of...mental and social well-being"—in practice, the WHO on the whole refrained from reforming public health infrastructure in favor of disease eradication programs with the diffuse expectation that economic growth would follow.¹⁸

However, trachoma presented a unique set of difficulties, to both the JDC and the WHO. The recommended treatment for trachoma was the topical application of the antibiotic, aureomycin, inside the rim of the lower eyelid four times a day for sixty days.¹⁹ This required at least some cooperation on the part of the local population, unlike, say, the BCG vaccination for tuberculosis that was a one-time shot to the arm. Trachoma was also understood to "present different epidemiological and clinical aspects in various geographical areas," requiring more local research and pilot projects than malaria, where no attention to local conditions was taken into account.²⁰ The JDC and the WHO both understood trachoma to be inseparable from socio-economic conditions, yet neither was in a position of governance—as the French Protectorate was—to actually do anything about it. Instead, they attempted to change individual social practices through health education, each through different strategies. Trachoma is an ideal case in which to examine how the boundaries of what was considered "medical" were negotiated in this period, and the varying ways in which the JDC and the WHO-UNICEF conducted a medical campaign against a professed social

¹⁷ Amrith 18.

¹⁸ Kelley Lee, *The World Health Organization* (London/New York: Routledge, 2009), 79; Socrates Litsios, *The Tomorrow of Malaria* (Wellington: Pacific Press, 1996); Randall M. Packard, "Malaria Dreams: Postwar Visions of Health and Development in the Third World," *Med. Anthropol.*, 1997, 17, 279–96.

¹⁹ World Health Organization, "Expert Committee on Trachoma: First Report [of a Meeting Held in Geneva from 3 to 8 March 1952]," 1952.

²⁰ "Report on Activities on Trachoma and associated ophthalmias to the UNICEF/WHO Joint Committee on Health Policy." 15 Apr 1954, JC7/UNICEF-WHO/2, UN Archives. See also, Randall M. Packard, "Malaria Dreams: Postwar Visions of Health and Development in the Third World," *Medical Anthropology* 17, no. 3 (May 1, 1997): 290.

disease. Moroccan Jews were not only conceived of potential immigrants, but also as potential subjects of development: “Meantime Moroccan Jewry itself has been growing up. It is more self-aware. It’s eager to improve itself. It has begun to grasp the need for developing mind and body, not only to be more useful in Israel, but simply for the sake of developing.”²¹

The JDC’s anti-trachoma campaign was not simply about disease eradication, but was invested in forming a modern Jewish population that was bereft of trachoma’s sign of backwardness. The JDC-OSE therefore created an innovative scheme of health education run by nurses and social workers in order to treat a disease that they predicted would elude antibiotics alone.²² While promoting new international norms, the JDC purveyors of development ideology modified WHO practices in order to make it more successful in a particular Jewish situation. WHO physicians argued for the necessity of health education, but their efforts could not match the intensity of the JDC’s program. This was in part due to scale, as they attempted to cover all of Southern Morocco, as well as school programs in urban areas. Despite varying engagement with social medical practices, it is important to note that they were both “vertical” disease campaigns aimed at treating a single disease, and both treatments, ultimately, were centered around smearing antibiotic on the eye.

Many historians of French North Africa have investigated how practices and discourses of medicine sustained the systems of social differentiation that lay at the heart of colonial power.²³ However, Jews have rarely factored into their analytic frameworks that pit French physicians and officials against Muslim natives. Scholars of North African Jewish

²¹ Hal Lehrman, “Morocco’s Jews Enter the 20th Century: An Adventure in Redemption,” *Commentary* (Aug 1954) 118-126.

²² “Narrative Report for the Mass Treatment for Trachoma,” 25 Feb 1953, JDC Archives.

²³ See, for example: Richard C. Keller, *Colonial Madness: Psychiatry in French North Africa* (University of Chicago Press, 2008); Ellen J. Amster, *Medicine and the Saints: Science, Islam, and the Colonial Encounter in Morocco, 1877-1956* (University of Texas Press, 2013); Hannah-Louise Clark, “Civilization and Syphilization: A Doctor and His Disease in Colonial Morocco,” *Bulletin of the History of Medicine* 87, no. 1 (2013): 86–114; Nancy Elizabeth Gallagher, *Medicine and Power in Tunisia, 1780-1900* (Cambridge University Press, 2002).

history have largely eschewed understanding their subjects within the historiographies of colonial and postcolonial medicine and science, even as work has decidedly reassessed the modernization paradigm, and has critically reexamined their political and cultural experiences during the modern period.²⁴ It is also precisely this period, between World War II and independence, where there is a hole in the Moroccan historiography that exclusively focuses on themes of nationalism and monarchy, which this story dodges.²⁵

Instead, I seek to add to the burgeoning literature that addresses the relationship between Jews and colonialism by superimposing the lens of medicine and science, raising perhaps more questions than answers about the wavering ideological discourses of medicine, philanthropy and development on one hand, and between Zionist, colonial and global governance on the other. Jewish health was not just a Zionist project, but was happening in Morocco by an American organization, revealing that the Jewish body was a crucial site of differentiation in decolonizing Morocco.²⁶

Trachoma as Disease and Idea

“If you can think in your mind of Victor Hugo’s ‘Les Miserables,’ and add a little dash of Dante’s ‘Inferno,’ and then think of everything that is filthy and dirty and revolting, work up the worst picture and that will be better than Casablanca’s mellah,” Morris Laub professed in his address at the American Jewish Joint Distribution Committee (JDC) Country

²⁴ See, for example: Joshua Schreier, *Arabs of the Jewish Faith: The Civilizing Mission in Colonial Algeria* (New Brunswick, 2010); Aomar Boum, *Memories of Absence: How Muslims Remember Jews in Morocco* (Stanford University Press, 2013), Daniel J. Schroeter, “The Shifting Boundaries of Moroccan Jewish Identities,” *Jewish Social Studies* 15, no. 1 (2008): 145–64; Emily Gottreich, *The Mellah of Marrakesh: Jewish and Muslim Space in Morocco’s Red City* (Indiana University Press, 2007); Sarah Abrevaya Stein, *Saharan Jews and the Fate of French Algeria* (University of Chicago Press, 2014).

²⁵ Susan Gilson Miller, “Filling a historical parenthesis: an introduction to ‘Morocco from World War II to Independence’,” *The Journal of North African Studies*, 19:4 (2014): 461-474.

²⁶ This is in addition the motley array of legal status options in North Africa, which have received much consideration. See Sarah Abrevaya Stein, *Saharan Jews and the Fate of French Algeria* (University of Chicago Press, 2014).

Directors' Conference on October 12, 1949.²⁷ After seeing the mellah for the first time, Hubert Lyautey, the first French Resident General of Morocco, apparently said that it had to be razed to the ground.²⁸ At 40,000 residents, the Casablanca mellah was the largest Jewish urban quarter in Morocco, and the object of JDC's horrid fascination. JDC directors, in no uncertain terms tried often to describe what they deemed the indescribable: "Arab attitudes, historical tradition, and local environment... have joined to compound a Jewish poverty, misery, and wretchedness which must be seen and felt and smelled to be believed."²⁹ They saw "burrows dug deep, lumps of clay with apertures instead of doors and windows, without furniture and with no order at all"; smelled "piles of refuse and garbage" and gasped that, "germs bearing all sorts of horrible diseases revel here undisturbed."³⁰

These images, that were trumpeted both in external and internal publications, reveal that the Casablanca mellah was constructed as a place of oriental backwards since time immemorial, leaving their inhabitants as "creatures from not merely a different longitude but another era—remote, barbarous, and unredeemable."³¹ However, the Casablanca mellah's population growth was very much a result of modern socio-economic phenomenon. When Lyautey arrived in Casablanca, the mellah only had 5,000 residents. The French Protectorate's distinct urban policy decided to leave the "old quarters" untouched out of romantic notions of the orient, while constructing a modern city in its outskirts, resulting in

²⁷ Morris Laub, "Address," 12 Oct 1949, 45/54 #45, JDC Archives.

²⁸ "Country Report Morocco," 31 Aug 1954. Folder ADM.34, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

²⁹ "AJC Report Morocco," Mar 1954, 45/54 #45, JDC Archives.

³⁰ Rozin, Orit. *The Rise of the Individual in 1950s Israel: A Challenge to Collectivism* (Brandeis University Press, 2011) 177.

³¹ Hal Lehrman, "Morocco's Jews Enter the 20th Century: Leaves from a Traveler's Notebook—II," *Commentary* (Sept 1954) 233-239.

the medina and mellah to burst at the seams.³² Overcrowding was not only due to the lack of housing development, but also to the mass migration from Morocco's rural south spurred by famines and droughts during World War II.³³ By the time the JDC arrived, Casablanca was reeling from an influx of impoverished migrants, which helped to create the medical devastation that JDC personnel witnessed.

The interest in the welfare North African Jews, who numbered 500,000—with half them in Morocco—came to the fore in the aftermath of World War II, as the “greatest reserves” of Jews after the Holocaust. The JDC was one of the primary organizations providing emergency relief and emigration aid to war survivors.³⁴ With the inability to access Jews in Eastern Europe behind the Iron Curtain, or independent Muslim states, like Egypt and Iraq, the French imperial presence allowed Jewish NGOs to establish local footholds in North Africa that could more effectively connect local concerns to global politics. North African Jews therefore became an important pool of potential emigrants to Israel. To this end, JDC had declared the health of North African Jews “one of the largest and most important problems facing world Jewry.”³⁵

The JDC first encountered the socio-medical needs of the mellah in 1948. Although their entry into Morocco relief started as early as 1940 during World War II to assist European refugees, it was not amplified until 1947, when the JDC opened a French North African department in its Paris Headquarters. Initial funds were piecemeal and went to

³² Susan Gilson Miller, *A History of Modern Morocco* (Cambridge University Press, 2013) 93-94.

³³ Andre Chouraqui, *Between East and West: A History of the Jews in North Africa* (New York: Jewish Publication Society, 1968) 265.

³⁴ Moses A. Leavitt, *The JDC Story: Highlights of JDC Activities, 1914-1952* (American Jewish Joint Distribution Committee, 1953).

³⁵ “Addendum to Doc. 7 on New Areas of Need” n.d., Folder NA.41, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

resettle Jewish victims of violence in Oudjda and Djrada.³⁶ By the end of 1948, Dr. Jacob Landes went on a medical mission to Morocco in order to evaluate the social situation and confirmed that Morocco “represented a bottomless pit as far as welfare activities were concerned.”³⁷ Although JDC activities included maternity care, childcare, and nutrition, Dr. Schmidt, the medical director of AJDC concluded that, “the first problem of magnitude seemed to us to be trachoma.”³⁸

The infectious eye disease trachoma was conjured again and again to reiterate the destitution of Casablanca’s mellah and of North African Jewry writ large, imparting utter helplessness with its seeming totality. Any JDC report on the social conditions of Morocco contained a variant of the following: “The sight of hundreds and thousands of blind beggars, victims of trachoma, roaming the streets or sitting in front of synagogues and mosques is heartrending.”³⁹ The frequency of trachoma was thought to represent the “degree of civilization...the technical and cultural development of a country...in short, the standard of life.”⁴⁰ The prevalence of trachoma was a litmus test for backwardness, one with a long historical precedent.⁴¹

In addition, the trope of the “blinding scourge of the Orient” reverberated as much in North Africa as it did in Palestine. It was frequently used in travel or medical literature as a trope to denote Arab apathy and primitiveness. The presence of trachoma was used to

³⁶ “Report: North Africa: Hunger, Disease, Oppression,” 7 Feb 1949, Folder NA.41, JDC Archives.

³⁷ “AJC Report Morocco,” March 1954, JDC Archives.

³⁸ “Meeting of the Medical Advisory Committee of the AJDC,” 5 Oct 1954, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

³⁹ William Bein, “Introduction to JDC Activities in Morocco,” 1 Mar 1954, Folder MO.88, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

⁴⁰ Roger Nataf, “General Considerations on Trachoma From the Standpoint of Migrations,” n.d., Folder MO.26, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

⁴¹ See Julius Boldt, *Trachoma* (Hodder and Stoughton, 1904); Arthur A. Siniscal, “The Trachoma Story,” *Public Health Reports* 70, no. 5 (1955): 497-507; Phillips Thygeson and R. Nataf, “Etiologic Problems in Trachoma,” *Rev. Int. Trach* 35 (1958): 177-227.

perpetuate essentialist and Orientalist conceptions of North African Jews, which had deep repercussions in the way they were perceived in Israel.⁴² Some JDC physicians reiterated this paternalistic rhetoric; one ophthalmologist in Tripoli, for example, concluded that trachoma affected those who “live in promiscuity with the natives... The character of the population affected, mostly apathetic and tolerant of the disease, make the prophylaxis very difficult... the work of a medical-sanitary organization is very obstructed by various moral and material factors.”⁴³ Historian Maud Mandel has argued that international Jewish organizations played a role in constructing North African Jews as a single unit that were in danger from Arab nationalists.⁴⁴ The medical status of North African Jews—afflicted with trachoma, tuberculosis, and tinea—also contributed to the construction of an unified subject that was not only in dire need of a political savior, but also one of social welfare. Rather than individual subjectivities, biomedicine created a group identity with a distinct collective psychology and body.⁴⁵

JDC’s fundraising abilities were hampered from misgivings about the Moroccan Jews’ possibility to westernize. Journalist Hal Lerhman expounded that American Jews were “dubious... [when] they were first exhorted to open their purses wider for the salvation of their North African ‘brethren’... the appeal for funds to help such ‘Jews’ sounded like an artful dodge of the professional money-raisers who needed to stay in business with new

⁴² See Rhona D. Seidelman, S. Ilan Troen, and Shifra Shvarts, “‘Healing’ the Bodies and Souls of Immigrant Children: The Ringworm and Trachoma Institute, Sha’ar ha-Aliyah, 1952–1960,” *The Journal of Israeli History* 29, no. 2 (2010): 191–211; Nadav Davidovitch and Shifra Shvarts, “Health and Hegemony: Preventive Medicine, Immigrants and the Israeli Melting Pot,” *Israel Studies* 9, no. 2 (2004): 150–79; Avi Picard, “Immigration, Health and Social Control: Medical Aspects of the Policy Governing Aliyah from Morocco and Tunisia, 1951–54,” *The Journal of Israeli History* 22, no. 2 (2003): 32–60.

⁴³ “Medical-Sanitary Activity of the AJDC-OSE in Tripolitania,” 26 Feb 1952, Folder 42, Records of the New York office of the American Jewish Joint Distribution Committee, JDC Archives.

⁴⁴ Maud S. Mandel, *Muslims and Jews in France: History of a Conflict* (Princeton N.J.: Princeton University Press, 2014) 35-58.

⁴⁵ See Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Palo Alto: Stanford University Press, 1991).

slogans and fresh clients after Hitler's departure."⁴⁶ Historian Avi Picard argued that the JDC dramatized the horror of the North African situation in order to increase fundraising, but that it had the opposite effect by alienating Americans from relating to North Africans as fellow Jews.⁴⁷ Moroccan Jewish immigration to Israel was then seen as a threat, rather than a godsend. United Jewish Appeals fundraiser Myrtle Karp admitted that "To see the children with the eyes all infected with trachoma...all we could think of was that they would make a Mellah of any place they lived in Israel. It was a terrible thought."⁴⁸

However, concurrently, the JDC had an interest in proving that trachoma proliferated not because of the "character" of the population, but because of the environment of the mellah and the larger Arab milieu. William Bein boisterously exclaimed that as soon as Jews left the mellah they are "living like flowers in the sunshine."⁴⁹ This was crucial if they were to be considered as a large reservoir of potential immigrants to Israel. One JDC official was aware that reports of the conditions in North Africa "have raised the vague feeling that the Jews who live there are, somehow, 'pariahs', or disease-ridden untouchables; that they are Jews who are 'different'. That is a misconception that ought to be wiped out. These Jews are 'different' only because their environment is different."⁵⁰ He went on to explain that trachoma is not something to be "dreaded," but could be readily cured by fairly simple and inexpensive health measures.⁵¹ With the advent of sulfa drugs and antibiotics in the postwar

⁴⁶ Hal Lehrman, "Morocco's Jews Enter the 20th Century: Leaves from a Traveler's Notebook—II," *Commentary* (Sept 1954) 233-239.

⁴⁷ Avi Picard, "Funding Aliyah: American Jewry and North African Jews, 1952-1956," in *The Social Scientific Study of Jewry: Sources, Approaches, Debates*, ed. Uzi Rebhun (Oxford: Oxford University Press, 2014), 231-49.

⁴⁸ Interview with Myrtle Karp, 15 March 1976, Avraham Harman Institute of Contemporary Jewry, Oral History Division (OHD) (Jerusalem), file no. 128-26.

⁴⁹ "Minutes of Conference of AJDC Country Directors," October 1953. Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

⁵⁰ "AJC Report Morocco," March 1954, JDC Archives.

⁵¹ *ibid.*

period, trachoma could be transformed from an ever present, chronic disease to one that was relatively easy to treat.

The discourses around trachoma and Moroccan Jews wavered between pessimistic racial essentialism and the belief that western medicine could create a new subject, revealing that boundary between civilized and uncivilized was unstable and could be negotiated. Medical aid, then, was not simply about curing a disease, but was a social project to shape subjects of a waning empire to be fit for future citizenship, wherever that may be. Trachoma was also considered a disease of childhood, and the JDC was particularly interested in reforming Moroccan youth for their political future.⁵² Bein argued that health was “essentially interlocked with the social and political position of the Moroccan Jew...it is essential, therefore, to find a legal and political program that will go hand in hand with the welfare program.”⁵³ The JDC conceived of Israel as the most obvious—if not only—answer in that regard. Certainly, Dr. Moshe Prywes, the head of medical services of Union-OSE, wrote in his memoir that the only reason the JDC opened thirty new OSE clinics throughout North Africa was to streamline their exit to Israel, though he was able to cajole Moroccan physicians to participate who did not think that aliyah was inevitable: ““What is the harm if you and I make a new start in improving the health of Morocco’s poorer class of Jewish children?””⁵⁴

The mass effort to cure trachoma escalated because those infected were at least temporarily barred from immigrating to Israel. This tension—between trachoma as a mark of backwardness and as a disease that could be cured relatively quickly—made trachoma a controversial criteria for medical selection. Those with all stages of trachoma, infectious and

⁵² “Report: North Africa: Hunger, Disease, Oppression,” 7 Feb 1949, JDC Archives.

⁵³ “AJC Report Morocco,” March 1954, JDC Archives.

⁵⁴ Moshe Prywes and Haim Chertok, *Prisoner of Hope*, (Brandeis University, 1996) 201.

inactive, were not allowed to enter Israel from North Africa from 1949-1951.⁵⁵ They could become eligible, but had to be treated in transit camps for at least three months, either in Casablanca or in Marseille, before entering Israel. Approximately 78,642 immigrants diagnosed with trachoma who entered Israel between 1948-1952 (mainly from Yemen where the emergency situation precluded medical selection), more than twice the amount of cases than the next frequent disease, malaria.⁵⁶ This reinforced the fear that Israel would become the dumping ground of world Jewry's diseased, and prompted the government to "protect itself against a social disease which not only weakens the individual but the entire nation."⁵⁷

The Law of Return, which limited immigration to Israel for those "likely to endanger public health," was broadly interpreted. Ben-Gurion claimed that the Law of Return banned all trachoma patients, while Berl Locker, the chairman of the Jewish Agency executive, argued that it only barred those in the infectious stage of trachoma.⁵⁸ What happened on the ground seems to have partly been the choice of Israeli government or Jewish Agency officials, some of who were more likely to be lenient.⁵⁹ The Jewish Agency representatives lobbied to reduce the trachoma restrictions, which they felt unnecessarily slowed down the immigration process, with limited success until 1953.⁶⁰ Although the Israeli government was particularly interested in JDC's activities because they "insured the desired standard of health

⁵⁵ "General Directions for Medical Control of Immigrants," January 1949. Folder P.I.59, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

⁵⁶ "Program of the Conference on Medical and Health Problems in Areas of AJDC Activity," 28 June 1954, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

⁵⁷ Nataf, "General Considerations on Trachoma From the Standpoint of Migrations," JDC Archives.

⁵⁸ Picard, "Immigration, Health and Social Control: Medical Aspects of the Policy Governing Aliyah from Morocco and Tunisia, 1951-54," 37.

⁵⁹ *ibid.* 43.

⁶⁰ AJDC Tunis to Health Department, 11 Mar 1952, Folder TU.43, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

for the prospective immigrant,” the JDC was not willing to be forced into the role of a mere agent.⁶¹

In fact, the JDC’s role in the aliyah process had been unsettled. From 1949-1951, the JDC operated the transit camps in France jointly with the Jewish Agency, and supported them financially. In 1951, they relinquished control of the camps completely to the Jewish Agency. In addition, the JDC had ceased to be the primary funder of Cadima, the Moroccan Aliyah organization.⁶² Although I do not have evidence of a direct correlation, it seems plausible that this may have been because of JDC’s failed management of the Hashed Camp during the “Magic Carpet” immigration in Yemen. Esther Meir-Glitzstein argues that the JDC oversight of the Yemenite immigration was a downright disaster, which led to needless deaths, in part because it was solely responsible for a complicated operation.⁶³ This tension becomes clear in the meeting between the Jewish Agency and the JDC when discussing how transfer would actually work on the ground. Mr. Ofek, a Jewish Agency official, asked if there was any way health care could be prioritized for the potential emigrant. Dr. Alexander Gonik, the medical director for the JDC, replied negatively, since the “JDC program in Morocco was primarily concerned with curing the local population.”⁶⁴ Ofek then explains that if the JDC increased trachoma and ringworm treatment, that it “would also be in the interests of JDC as it would mean that more people would have emigrated.” Katzki demurs, claiming that the expansion of the JDC medical program in North Africa exceeds the limits of the particular meeting. Stripped of a mission completely dedicated to aliyah, the JDC could

⁶¹ “Program of the Conference on Medical and Health Problems in Areas of AJDC Activity,” 28 June 1954, JDC Archives.

⁶² Michael M. Laskier, *North African Jewry in the Twentieth Century: The Jews of Morocco, Tunisia, and Algeria* (New York: New York University Press, 1994), 113.

⁶³ Esther Meir-Glitzstein, *The “Magic Carpet” Exodus of Yemenite Jewry: An Israeli Formative Myth* (Chicago: Sussex Academic Press, 2014).

⁶⁴ “Minutes of Meeting of AJDC Representative with Jewish Agency Officials,” 1 Mar 1951, Folder P.I.218, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

reframe its medical activities in terms of “helping Jews help themselves live in the place they want to live,” rather than simply in terms of promoting immigration.⁶⁵

Between 1949-1953, immigration to Morocco proceeded unevenly. In addition to the effects of medical selection, Moroccans were also less likely to want to leave because of social and economic advances, and were discouraged from reports of poor treatment in Israel.⁶⁶ Immigration to Israel only started to pick up again as a viable solution after the Petitjean pogroms in August 1954. Therefore, 1953 reflects a unique and volatile moment, where a JDC worker in Morocco, Egon Fink, could honestly ask, “But now, who knows? Aliyah remains a solid possibility for the future, but it can’t any longer be regarded as inevitable.”⁶⁷

The intense Jewish interest in trachoma in North Africa—both for reasons of aliyah and socio-economic status in Morocco—led Jewish leaders to transcend the vertical alliance with the state and to seek direction from the newly created UN organizations in their efforts. Andre Chouraqui, the vice president of the UNICEF Advisory Committee of Non-Governmental Organizations (and Secretary General of Alliance Israelite Universelle), was the first to propose to UNICEF to start an anti-trachoma campaign in North Africa.⁶⁸ Although I have been unable to locate the UN document—if indeed it was ever published—a number of secondary sources confirm that the Consultative Council of Jewish Organizations brought the problem of trachoma to UN attention during the first meeting of the UNICEF-

⁶⁵ Esther Meir-Glitzstein, *The “Magic Carpet” Exodus of Yemenite Jewry: An Israeli Formative Myth* (Chicago: Sussex Academic Press, 2014) 52.

⁶⁶ Tsur, *A Torn Community*, 106–108, 140–144, 275–287, 310, 345; Michael M. Laskier, “Jewish Emigration from Morocco to Israel: Government Policies and the Position of International Jewish Organizations, 1949-56,” *Middle Eastern Studies* 25, no. 3 (July 1989): 324–331.

⁶⁷ Hal Lehrman, “Morocco’s Jews Enter the 20th Century: An Adventure in Redemption,” *Commentary* (Aug 1954) 118-126.

⁶⁸ Weill, Eugene. “Aide-Memoire,” July 30, 1949. AM Présidence 002a. AIU Archives; Chouraqui, André. Letter to René Cassin, January 24, 1950. AM Présidence 003a. AIU Archives. Thanks go to Nathan Kurz for locating these sources.

NGO advisory committee meeting in July 1949 in Geneva.⁶⁹ Chouraqui was told that the proposal had to come from the French government, and the CCJO engaged in negotiations with the French government in order to solicit such a request.⁷⁰ It was eventually forthcoming; the President of the International Children's Center in Paris helped put together a French proposal to the UNICEF executive board. It became the first, and one of the most well known examples of a NGO recommendation being turned into a UNICEF project.⁷¹ The Jewish interest in combating trachoma, then, was not only crucial to the formation of a prominent global health campaign, but also in creating and adapting what the standards of that campaign would be. Jewish organizations' initiative sparked a WHO and UNICEF interest in trachoma in North Africa, even though this origin became camouflaged in official campaign reports.

The Social Worker in the Streets: The Practices of the Mass Trachoma Project

Trachoma became the subject of a robust and global scientific attempt in the 1950s to not only isolate the agent, but to also test the efficacy of various antibiotics.⁷² The physicians of OSE-Maroc contributed to this literature, and published their findings based on their treatment of schoolchildren in the Pasteur Institute-based journal, the *Revue Internationale du Trachome*, even if the JDC medical director concluded that the "results obtained were neither world-shaking nor original."⁷³ An innovative mass trachoma campaign, however, could bring international recognition to the voluntary organization if successful.

⁶⁹ Alba Isabel Zizzamia, *NGO/UNICEF Cooperation: a Historical Perspective* (United Nations Children's Fund, 1987) 18; *American Jewish Year Book, 1951* (New York: American Jewish Committee, 1951) 448-449.

⁷⁰ *American Jewish Year Book, 1951* (New York: American Jewish Committee, 1951) 449.

⁷¹ Zizzamia 60.

⁷² See, for example: Phillips Thygeson, "The Present Status of Laboratory Research in Trachoma," *Bulletin of the World Health Organization* 19, no. 1 (1958): 129-152; Matthieu J. Freyche, "Antibiotics and Sulfonamides in the Treatment of Trachoma," *Bulletin of the World Health Organization* 2, no. 4 (1950): 523-544.

⁷³ Letter from AJDC Casablanca to Health Department, 19 Dec 1950, Folder MO.109, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

Alexander Gonik, the medical director for JDC, wrote a proposal for the “Mass Trachoma Project” in November 1952.⁷⁴ Although OSE Clinics had ophthalmic dispensaries and had been treating eye patients since 1949, the mass project proposal argued that past work “has not been done in a systematic manner and with a sound epidemiological approach.”⁷⁵ There had been no standardization on treatment or diagnosis of trachoma, and in some cases “only one member of the family was treated,” leaving the opportunity for reinfection more than likely. Producing numeric data reflected science as an universal language, and as a technology of distance that could communicate ideas beyond the local community.⁷⁶ However, without a specific agent or cure, the problem of what exactly trachoma was was still ongoing.⁷⁷ There was a tension between the scientific imperative to standardize ideas about trachoma, and the growing understanding that the epidemiology of trachoma had regional variation, including its age of onset, mode of transmission, and clinical course.⁷⁸

The Mass Trachoma Project stood to correct these shortcomings in two ways: it would introduce standardized procedures for diagnosis and treatment in order to tabulate and evaluate the results in a scientific manner; and second, rather than depend on patients to come to the clinic, the campaign would conduct treatment in “their homes, schools, working places, or treatment center in their sector.”⁷⁹ The WHO recommended treatment for trachoma was the topical application of the antibiotic, aureomycin, inside the rim of the lower eyelid four

⁷⁴ “Mass Treatment of Trachoma,” Nov 1952, Folder MO.109, , Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

⁷⁵ *ibid.*

⁷⁶ Theodore M. Porter, *Trust in Numbers: The Pursuit of Objectivity in Science and Public Life* (Princeton University Press, 1996) ix.

⁷⁷ Arthur A. Siniscal, “The Trachoma Story,” *Public Health Reports* 70, no. 5 (1955): 497-507.

⁷⁸ World Health Organization, “Expert Committee on Trachoma: First Report [of a Meeting Held in Geneva from 3 to 8 March 1952],” 1952.

times a day for sixty days.⁸⁰ There seemingly was no other way to accomplish this treatment than for the patient to receive it at home.

The JDC hoped to gain experience from their focus of one square block in order to scale the project to larger areas, as well as to collect data that would evaluate the effect of their method of treatment. Even more so, they wanted to evaluate the “epidemiological effects of mass treatment” by tracking the rate of newly infected cases.⁸¹ These goals were indeed identical to what WHO-UNICEF wanted to achieve in their pilot projects in southern Morocco.⁸² The JDC even got swept away in the language of lofty WHO campaigns, claiming that “one of the important objectives in our health program in Morocco is the control of trachoma, and its *ultimate complete eradication*” (emphasis mine).⁸³ The Mass Trachoma Project was also hardly “mass” on the same scale as WHO activities. Gonik expressly based his proposal on the First Report of the WHO Expert Committee on Trachoma, but transformed the report’s vague suggestions into concrete practices.

The First WHO Expert Committee Report on Trachoma stated that the basic control of trachoma should include the following: “Casefinding and treatment of patients; rational health education of the people, adapted to their particular conditions; and destruction of possible vector agents, and other environmental sanitation measures.”⁸⁴ The pilot project became just as much an experiment in statistics collection and social services as it was a disease campaign. The “casefinding” of patients produced a vast data set that did not

⁷⁹ *ibid.*

⁸⁰ *ibid.*

⁸¹ “Mass Treatment of Trachoma,” November 1952, JDC Archives.

⁸² “Morocco - Trachoma and Associated Eye Diseases,” 27 Mar 1952, E/ICEF/1952/R.0313, UNICEF Archives.

⁸³ “Mass Treatment of Trachoma,” November 1952, JDC Archives.

⁸⁴ World Health Organization, “Expert Committee on Trachoma: First Report [of a Meeting Held in Geneva from 3 to 8 March 1952],” 1952.

comment simply on trachoma, but was a complete demographic survey. Gonik advocated for the use of new technologies, including punch cards, in order to tabulate complex statistics about trachoma incidence within families and over time.⁸⁵

The Mass Trachoma Project was the first JDC medical project to incorporate social services within its planning, offering what they hoped to be “rational health education.” In 1952, OSE medical workers expressed interest in incorporating social services into their medical service, as they had begun to question the “effectiveness of their work.”⁸⁶ They requested a professional social worker to “foresee which people could best profit from help and in what direction to work with them.”⁸⁷ The function of the social worker within OSE health services was to “give the doctor a social picture of the patient’s background and family, which will help the doctor better to understand the patient...[and] must help the patient to understand better how to follow the doctor’s instructions.”⁸⁸ The Mass Trachoma Project was co-organized by a social worker, and the nurse-aides received social training to learn how to interact with mellah residents. Health education was not a standardized enterprise, but was translated by each nurse one by one to each family, in their homes, in order to obtain maximum compliance. This was a vastly different conception of health education from the WHO, which relied on posters and films to translate their message with no recourse to check comprehension.

The JDC concluded that environmental sanitation measures were beyond the scope of a voluntary organization. Fly control, which had been considered a cause of trachoma insofar as much as they flew from pus-filled eye to eye spreading the infection, was admittedly a

⁸⁵ AJDC Casablanca to AJDC Paris-Budget Department, 21 Apr 1953, Folder MO.109, JDC Archives.

⁸⁶ “Analysis of the Social Services Department of OSE Casablanca,” October 1953, Folder MO.56, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

⁸⁷ *ibid.*

⁸⁸ *ibid.*

short-term solution as flies grew resistant to insecticide.⁸⁹ It was, however, a strategy taken seriously by the WHO, which in general was more likely to veer towards technical solutions rather than those that relied on cultural competence.⁹⁰

Although Gonik helped to prepare the outlines for the Mass Trachoma Project and took a deep interest in its success, three women ran it on the ground. Dr. Maria Kony, an ophthalmologist for OSE-Morocco had arrived to Casablanca in 1950 from the Ophthalmic Clinic in Vienna, and was in charge of the treatment aspect of the project.⁹¹ Sylvia Hurwitz was the OSE Public Nurse responsible for teaching the nurse-aides basic nursing techniques and public health principles, and to supervise the treatment in the home and clinic.⁹² Hurwitz was a graduate of Simmons College (MA), and served as a nurse in the US Army during World War II, before joining the JDC in North Africa.⁹³ Carla Aghib was hired by Janet Siebold, the head of social services of OSE-Casablanca, to supervise the “social” aspects of the program: Aghib received her social work degree from UC Berkeley, had complete a medical survey as part of her thesis, and had a “healthy degree of self-confidence.”⁹⁴

The definition of “social services” was very much American inflected. The social service curriculum was devised by the staff of the Paul Baerwald School of Social Work, which opened in France in 1949 based on American techniques, with extension courses

⁸⁹ J. Reinhardt et al., “Studies on the Epidemiology and Control of Seasonal Conjunctivitis and Trachoma in Southern Morocco,” *Bulletin of the World Health Organization* 39, no. 4 (1968): 497.

⁹⁰ Sunil Amrith, “Development and Disease: The United Nations and Public Health, c. 1945-55,” in M. Daunton and F. Trentmann, *Worlds of Political Economy: Knowledge and power in the nineteenth and twentieth centuries* (London: Palgrave, 2004).

⁹¹ Letter from OSE Maroc to Union OSE, 5 Apr 1951, Folder 45/54 #67, Records of the New York office of the American Jewish Joint Distribution Committee, JDC Archives.

⁹² “Report Mass Trachoma Treatment Project,” August 1953, MO.110, JDC Archives.

⁹³ Sylvia Beatrice Meyer’s Obituary. N.p., n.d. Web. 26 Feb. 2015.
<<http://www.legacy.com/obituaries/blueridgenow/obituary.aspx?pid=164914389>>.

⁹⁴ Janet Siebold, “Report from Casablanca” 13 Dec 1952, MO.109, JDC Archives.

offered in Casablanca beginning in 1951.⁹⁵ While European social services emphasized administration of “systems of social insurance, pensions, and trade union systems of mutual aid,” the JDC (an American organization itself), deemed American developments much more suitable in treating the “Jewish emergency” in Europe, North Africa, and Israel: “They were devising and perfecting techniques for making the services offered to individuals and families effective and efficient, either through the way in which the services themselves were being offered or in the way the citizenry of the community was brought together for the support and coordination of the servicing agencies.”⁹⁶ The JDC’s use of American theories of social work were first used to reshape French Jewish communal life according to American frameworks, a process that Mandel termed “cultural imperialism.”⁹⁷ This critique is complicated when these techniques are leveled in Morocco, and would prove to be of much agitation to the French authorities. Rather than simply reiterating paternalism, the JDC and the French Santé were in direct competition in asserting development strategies, even if the JDC thought French imperialism was necessary for the Jewish future in Morocco. This fit well into the development rhetoric at the time, where a journalist could claim, “At least as precious as the financial help have been the standards that American know-how has set, the new projects and vistas it has suggested to the Moroccan Jews.”⁹⁸

The corner of Rue du Four and Impasse ez Zaouche in the Casablanca Mellah was picked for the pilot project because the social organization Ezra was already working in the area, and the team concluded the population might be more receptive to medical intervention.

⁹⁵ “JDC Paul Baerwald School Faculty to Bring American Social Service Techniques to Morocco and Tunisia,” 23 Aug 1951, NY AR194554 / 4 / 2 / 2 / 5.

⁹⁶ “Paul Baerwald School of Social Work,” 6 Mar 1950, Folder 1771, Records of the New York office of the American Jewish Joint Distribution Committee, JDC Archives.

⁹⁷ Maud S. Mandel, “Philanthropy or Cultural Imperialism? The Impact of American Jewish Aid in Post-Holocaust France,” *Jewish Social Studies* 9, no. 1 (2002): 53–94.

⁹⁸ Hal Lehrman, “Morocco’s Jews Enter the 20th Century: An Adventure in Redemption,” *Commentary* (Aug 1954) 118-126.

Although the community had promised JDC-OSE a room from which to conduct their activities, none was forthcoming. Aghib and Hurwitz chanced upon a vacant kosher restaurant that they were able to rent from the previous occupant and covert into an anti-trachoma clinic. They removed the bar and stove, and brought in medical supplies and file cabinets, and repurposed the chairs and tables. They repaired the electrical installation, and installed a door.⁹⁹

The foot soldiers of the campaign were a group of 22 hired nurse-aides, who would conduct the community census, and go door-to-door delivering the required treatment multiple times a day. In her recruiting of nurse-aides, Siebold claimed that the nurses not only had to be competent from a medical point of view, but should have the ability to speak Judeo-Arabic and write French simultaneously, the ability to “make human contacts” and conduct simple and effective interviews.¹⁰⁰ They were employed as part-time workers on a three-month contract, with a possibility of longer employment. Once hired, they learned the mechanics of trachoma treatment under the supervision of Kony at the Ozar Hatorah School where students were already treated with aureomycin ointment.¹⁰¹

In order to train them for the census taking, Aghib and Hurwitz led discussions on “all the feelings they will encounter, reasons for them, and some practical ways of meeting them,” and gave them the opportunity to discuss, individually and in a group, all of the “concrete difficulties” they encountered. The main focus of the nurse-aides’ training was to help them “develop confidence in people in order to get them to want to come for treatment and to continue it, and to recognize social problems which should be referred to social agencies.”¹⁰²

⁹⁹ “Report Mass Trachoma Treatment Project,” August 1953, JDC Archives.

¹⁰⁰ “Employment of a Social Worker for the Trachoma Program,” 20 Jan 1953, MO.110, JDC Archives.

¹⁰¹ “Report Mass Trachoma Treatment Project,” August 1953, JDC Archives.

¹⁰² “Excerpt Weekly Report of Janet Siebold,” 22 Dec 1952, MO.109, JDC Archives.

To illustrate proper interviewing techniques, students demonstrated on each other before the class, which led to group discussions and critiques. Aghib claimed this strategy helped the group get to know each other better, as well as to help them “overcome their initial fear of speaking before strangers.”¹⁰³

The initial census was, in fact, incorporated into the curriculum. On January 25, Aghib picked the five “ablest girls” to each conduct three family interviews in order to have a “representative sample of the acceptance by the population of the census taking.”¹⁰⁴ Each was directly supervised by a trained social worker, and briefed by Aghib. The aides would note the age and sex of each family member, as well as occupation. Upon review, Siebold noted that there was a “tendency for aides to become involved in lengthy discussions which had no bearing on the work at hand,” but they concluded the population accepted the census taking very well, and some even “offered mint tea, sweets and Pepsi-Cola.”¹⁰⁵ Afterwards, these nurse-aides would then supervise the other nurse-aides on their census visits, which was a deliberate teaching technique. Aghib noted that some aides appeared to “have better insight into the situation than others.”¹⁰⁶

The census, with every nurse aide participating, took one week to complete. They tabulated 2,691 people in 529 families. Each aide spent considerable time “explaining and describing the purpose of the project” and made it a rule to answer every question with a “complete and detailed answer.” They did encounter some resistance to this invasive activity, with a few families declining to give the requested information. With information about the majority of Jewish residents—and 91 Muslims—on those two streets, Kony then had to

¹⁰³ “Narrative Report of the Program for the Mass Treatment of Trachoma,” 25 Feb 1953, MO.110, JDC Archives.

¹⁰⁴ “Report Mass Trachoma Treatment Project,” August 1953, JDC Archives.

¹⁰⁵ “Narrative Report of the Program for the Mass Treatment of Trachoma,” 25 Feb 1953, MO.110, JDC Archives.

¹⁰⁶ *ibid.*

complete the medical examinations to determine who had trachoma. The aides were assigned to set number of families and accompanied them to the trachoma center for Kony to examine them.¹⁰⁷ Seventy-five percent of the population was diagnosed trachoma, with forty-seven percent requiring treatment.¹⁰⁸



Figure 9: Jewish mother and child at the OSE trachoma center, c. 1954

The nurses sewed their own outfits, and were given leather bags in which to keep soap, alcohol, cotton napkins, and tubes of aureomycin. The OSE-Maroc Trachoma Center

¹⁰⁷ *ibid.*

was open everyday from 7am-9pm, weekends included. The nurses worked in seven-hour shifts, six days a week, with an average caseload of 170 patients. Although treatment of aureomycin four times a day was the accepted WHO treatment, it soon became obvious that this was not feasible. They aimed at twice a day, with most of the treatment given at home during the morning and evening, reaching about 1200 people daily. Although reaching the working population was eventually considered impractical, because of the travel time and distances, those who worked in the mellah did receive treatment at work, as seen below.¹⁰⁹



Figure 10: Jewish store owner is being treated for trachoma in his store, c. 1950s

In order to carry out the scientific mission of the trachoma campaign, the JDC compiled information that seemed to befit a government rather than a voluntary organization.

¹⁰⁸ "Report Mass Trachoma Treatment Project," August 1953, JDC Archives.

¹⁰⁹ *ibid.*

For example, there had not been a map of the one block they were to study. Aghib did a survey of the area, and counted 128 houses on two streets, and drew a numerical diagram.¹¹⁰ The nurse-aides noted the housing conditions of the community in order to learn “the extent of overcrowding and of the amenities available for the inhabitants, such as piped water, latrines, etc.”¹¹¹ The individual and family record cards also amassed “a great deal of varied and useful information--of value not only to ourselves but to governmental and other authorities.”¹¹² The individual record card was four pages of heavy cardboard paper divided into three parts: social and diagnostic information, treatment, and control examinations, which were filed according to family and address. The nurse-aides also devised a family record card, with the names of each family member, whether they had trachoma, and their treatment schedule. This was affixed to the wall of each resident’s house in order to control the attendance of the patients, as well as to provide an incentive for the patients to follow their own treatment.¹¹³

Accurate statistics were considered vital, and the JDC medical department in Paris hired experts who recommended punch cards. Gonik was quite keen to use the punch card system for sorting and tabulation of such a large amount of data. Rather than use an IBM machine, Gonik had consulted a few firms in Paris that “prepare and sell punch cards which are, when completed, hand sorted by means of something which can best be described as a knitting needle.”¹¹⁴ This technology, however, was quite cumbersome to those whose task it was to copy the information from the record onto the punch card. Aghib noted the work

¹¹⁰ “Narrative Report of the Program for the Mass Treatment of Trachoma,” 25 Feb 1953, MO.110, JDC Archives.

¹¹¹ *ibid.*

¹¹² AJDC Paris to AJDC Casablanca, 3 May 1953, Folder ORG.193, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

¹¹³ “Report Mass Trachoma Treatment Project,” August 1953, JDC Archives.

¹¹⁴ AJDC Casablanca to AJDC Paris-Budget Department, 21 Apr 1953, Folder MO.109, JDC Archives.

required “accuracy and full attention,” and therefore not more than 6-8 cards could be completed in one hour.¹¹⁵ Gonik explained that the punch cards will “aid us in formulating different types of statistics.”¹¹⁶ Special staff was hired for the sole purpose of calculating daily statistics and to transfer medical information from the nurse-aides’ daily sheets to the medical records.

Although the results of the campaign were encouraging, they were hardly conclusive. After two months treatment, reexamination showed a cure in about 30% of the population, marked improvement in 40% and no change in 30% of the cases.¹¹⁷ Despite the extraordinary measures to reach the population, there was an understanding that, “the social conditions were such that the medical treatment given had little possibility to bring a real change to this population. The poor housing and the lack of hygienic conditions, seemed to be overwhelming factors that could not be overcome... although the main purpose was to treat trachoma it was not possible to remain silent in front of a distressing situation.”¹¹⁸ The population would often ask the nurse-aides for help on social issues not related to trachoma. Aghib referred the case of the Bouhdana family, on 32 Rue du Four, to OSE social services. Zorra Bouhdana wanted to place her 18-year-old daughter, Anita, in an mental institution, as she needed to be under “constant surveillance.” Aghib wrote that Anita was judged by her family to be irresponsible for her actions, as she became pregnant with an unknown young man. She subsequently had an abortion, and suffered from a resulting infection. Anita had no education and had no work experience because of her “limited intelligence.” Aghib concluded that she thought “a social worker could help this family better understand Anita's

¹¹⁵ “Report for the Period June 16-June 30, 1953,” 3 July 1953, MO.110, JDC Archives.

¹¹⁶ “Report of March 31 to April 12, 1953,” 14 Apr 1953, MO.110, JDC Archives.

¹¹⁷ “Report Mass Trachoma Treatment Project,” August 1953, JDC Archives.

¹¹⁸ *ibid.*

situation, and if necessary, help to find effective placement for the girl.”¹¹⁹ Trachoma treatment, then, was never simply about trachoma treatment.

The Santé, or the French Protectorate Health Ministry of Morocco, was particularly interested in the work of the Mass Trachoma Project. Health officials first wanted to make sure that the campaign did not arise the antagonism of the Arab population.¹²⁰ Dr. Georges Sicault, the executive director of the Santé, made it clear to JDC-OSE that the Mass Trachoma Project would be under the direction and supervision of the Santé, and that the supervisor would be the French director of hygiene services.¹²¹ Both Aghib and Hurwitz wrote a letter to Gonik to complain about the fact that they were excluded from deliberations between JDC-OSE and the Santé about the project since they were the ones to “bear the brunt” of the responsibilities of making it a success.¹²² In addition, the Santé sent a male nurse, Mr. Vives, to work for the campaign, ostensibly as an inside spy. Aghib and Hurwitz did not enjoy the intrusion of Vives, “who has shown little interest and initiative in his work, and has behaved rather indiscreetly with the nurse-aides” with one getting fired as a result.¹²³

In addition to wanting frequent contact and supervision of the Mass Trachoma Project, the Santé was also openly antagonistic. For example, they did not grant the JDC-OSE permission to distribute pamphlets or prepare health education posters about the campaign in the mellah.¹²⁴ Although Sicault implied that the Santé would contribute financially to the campaign, he never followed through.¹²⁵ In addition, he was peeved that the campaign was

¹¹⁹ “Composition de Famille,” 2 Apr 1953, JDC Archives.

¹²⁰ “Compte-Rendu de la visite à la Direction de la Santé à Rabat,” 27 Oct 1952, MO.109, JDC Archives.

¹²¹ “Report Mass Trachoma Treatment Project,” August 1953, JDC Archives.

¹²² Carla Aghib and Sylvia Hurwitz to Alexander Gonik, 23 Feb 1953, MO.109, JDC Archives.

¹²³ “Weekly Report of March 16 to March 22 1953,” 24 Mar 1953, MO.110, JDC Archives.

¹²⁴ “Report Mass Trachoma Treatment Project,” August 1953, JDC Archives.

¹²⁵ “Memorandum Re: Mass Trachoma Project, Morocco,” 20 Nov 1953, MO.109, JDC Archives.

backed by an American organization, and implemented American social service principles. In a meeting with OSE administrators, Sicault “mentioned that OSE is completely JDC dominated and directed and that certain activities are looked upon with great suspicion by the authorities, most particularly the trachoma projects, certain of whose aspects are considered ‘anti-French’ ...the feeling prevails in official medical circles that JDC wishes to show through the Trachoma Project that ‘We, the Americans, know better.’”¹²⁶

These tensions reveal the anxieties of governance during the age of decolonization. The French Protectorate welcomed technical and financial aid from the WHO-UNICEF and the JDC, but demanded oversight and were eager to claim their successes as the government’s own. The Mass Trachoma Project flaunted its American conception of social services, and therefore, was executed in a way that was not in line with French preferences. The postwar idea that disease eradication was within the realm of possibility turned health into a central responsibility of government and a right of the modern subject, leaving the French to scramble to provide services that had long been neglected. The JDC and the WHO superseded the state, but were obliged to operate within the colonial system.

The Summer without Conjunctivitis: The WHO-UNICEF Anti-Trachoma Campaign

The history of WHO mass disease campaigns in the 1950s tend to fit squarely with the Cold War narrative that highlight US-Soviet competition to win the hearts and minds of the Third World. The failed malaria eradication campaign, which has received the most scholarly attention, was one of the World Health Organization’s first projects because it was constructed as a problem of social and economic development (rather than solely of public health), and was also perceived as an opportunity to eradicate communism.¹²⁷ Between 1949-

¹²⁶ “Memorandum Strictly Confidential,” 10 Dec 1953, ORG.193, JDC Archives.

¹²⁷ Socrates Litsios, “Malaria Control, the Cold War, and the Postwar Reorganization of International Assistance,” *Medical Anthropology* 17, no. 3 (May 1, 1997): 255–78; Randall M. Packard and Peter J. Brown, “Rethinking Health, Development, and Malaria: Historicizing a Cultural Model in International Health,” *Medical Anthropology* 17, no. 3 (May 1, 1997): 181–94; Randall M. Packard, “Malaria Dreams: Postwar

1956, the WHO closely aligned with American interests and foreign policy, as the Soviet Union and Eastern Bloc withdrew their support from the organization (although it reversed course in 1957). Rather than focus on perpetual enmity, historian Manela explains how the US and the Soviet Union could collaborate on the successful Smallpox Eradication Campaign: “Russians and Americans could agree on what a ‘developed’ society looked like in terms of its medical and scientific practices, if not its social arrangements, and they could collaborate in the application of their shared ‘modern’ knowledge and technical expertise in the pursuit of such development in the global south.”¹²⁸ Although his approach to the US-Soviet relationship differs, Manela’s focus is still the Cold War, and his primary interest is to intervene in Cold War historiography through explicating how international organizations and non-state actors circumvented official foreign policy.

The WHO-UNICEF anti-trachoma campaign does not fit so easily into a Cold War paradigm. Morocco was of great interest to American policy because of its strategic geographic position, but the Americans faced a diplomatic dilemma: how to be both tactful towards France, their ally, while at the same time forge relationships with North African nationalists and promote self-determination, even if in theory.¹²⁹ American diplomats did not take France to task over its insistence on empire until the light was almost snuffed out. In any case, they agreed that communism was more of a threat to Algeria than to Morocco or Tunisia, and the Soviets were more interested in placating France as long as the French

Visions of Health and Development in the Third World,” *Medical Anthropology* 17, no. 3 (May 1, 1997): 279–96; Marcos Cueto, *Cold War, Deadly Fevers* (Baltimore: Johns Hopkins University Press, 2007).

¹²⁸ Erez Manela, “A Pox on Your Narrative: Writing Disease Control into Cold War History,” *Diplomatic History* 34, no. 2 (April 1, 2010): 299–323.

¹²⁹ Hadhri, Mohieddine. “U.S. Foreign Policy Toward North Africa During the Cold War: From Eisenhower to Kennedy (1953–1963).” *The Journal of the Middle East and Africa* 5, no. 2 (May 4, 2014): 95–110; Thomas, Martin. “Defending a Lost Cause? France and the United States Vision of Imperial Rule in French North Africa, 1945–1956.” *Diplomatic History* 26, no. 2 (April 1, 2002): 215–47.

Communist Party (PCF) held political sway, instead of advocating for North African independence.¹³⁰

Rather than contextualize anti-trachoma activities in Morocco through a Cold War battleground—as a monolithic view of WHO campaigns might—I argue that the anti-trachoma campaign was part of the French postwar effort to retain control of Morocco through top-down planning, inspired by the new global faith in social engineering and development norms. WHO and French physicians thought curing trachoma could create economic growth, using economic development as a justification for public health. The trachoma campaign was a good financial deal: the cost of the drugs was “moderate,” and the community gains “a considerable economic value of the restoration to health of the workers...In Tunisia, for example, a country of 3.5 million inhabitants, 25 million working days per year are lost through trachoma and other eye diseases.”¹³¹ The French used the WHO-UNICEF as a new source of funding to continue its civilizing mission, now labeled as “development,” in order to create the appearance of a modernizing—if not modern—populace and a new 20/20 seeing workforce.

Although Dr. Mattheiu Jean Freyche, the Secretary of the Expert Advisory Panel on Trachoma (WHO), contended that trachoma affected 15% of the world’s population and that WHO “could not be indifferent to the health and social aspects of trachoma,” the UNICEF-WHO Joint Committee on Health Policy had been wary from the start to conduct an anti-trachoma campaign for a number of reasons.¹³² First, the recommended course of action required the cooperation of the patient over a long period of time. The first UNICEF

¹³⁰ Thomas 223.

¹³¹ World Health Organization, “Expert Committee on Trachoma: First Report [of a Meeting Held in Geneva from 3 to 8 March 1952],” 1952.

¹³² Mattheiu Jean-Freyche (1951), “Some Gaps in the Present Knowledge of the Epidemiology of Trachoma,” (unpublished working document WHO/Trachoma/6).

campaigns, such as the BCG vaccine campaign against tuberculosis, required a one-time vaccine, which could allow the triumph of technics over cultural expertise. However, a UNICEF historian noted that, “a tube of ointment was not an injection. People had to want to use it enough to spend time, effort, and sometimes their own money to buy it. That meant they had to make a judgment about its value against other priorities in their lives.”¹³³ In addition, the Committee claimed “it is useless to attempt to combat trachoma alone...only temporary results in the alleviation of suffering could be expected unless very long-term work was undertaken covering both education of the public and improvement of environmental conditions.”¹³⁴ This was a tacit recognition that trachoma did not make an ideal case study for a mass campaign, either from the practical or promotional point of view.

Regardless, in 1952, UNICEF appropriated \$100,000 to anti-trachoma work in Morocco to be directed by Dr. John Reinhardt, an ophthalmologist for the WHO, and named trachoma “the foremost public health program in Morocco.”¹³⁵ The French Government requested supplies and transport from UNICEF for the campaign for at least two years, while the Government would spend \$271,000 on personnel, treatment and medical supplies.¹³⁶ A limited part of the country was chosen for the campaign in the foothills of the south Atlas Range in Southern Morocco, in the Dades, Dedra and Draa valleys. Three experimental areas were designated: Skoura in 1952, Ouarzazate in 1953, and Goulmima in 1954.¹³⁷ The government proposed the mass disease campaign as follows: to firstly set up mobile teams to operate in highly endemic areas, to detect the number of trachoma and bacterial eye

¹³³ Maggie Black, *The Children and the Nations* (Peregrine Smith Books, 1987) 106.

¹³⁴ “JCHP Report - April 1952,” 11 Apr 1952, Folder E/ICEF/1952/192, UNICEF Archives.

¹³⁵ “Morocco - Trachoma and Associated Eye Diseases,” 27 Mar 1952, Folder E/ICEF/1952/R.0313, UNICEF Archives.

¹³⁶ *ibid.*

¹³⁷ J. Reinhardt et al., “Studies on the Epidemiology and Control of Seasonal Conjunctivitis and Trachoma in Southern Morocco,” *Bulletin of the World Health Organization* 39, no. 4 (1968): 500.

infections in the area, which they estimated to be between 120,000-150,000, as well as to give free, sustained antibiotic treatment. While they envisioned that a number of patients would be gathered at the local clinics, they also decided to give away the aureomycin ointment directly to the patients or to school teachers who could then treat themselves and their students.¹³⁸

Rather than directly treat trachoma, the WHO-UNICEF decided to wage an “oblique attack against the complicating factor,” seasonal conjunctivitis, caused by the Koch-Weeks or gonococcus bacteria.¹³⁹ The epidemic season ran from June to November, and for three days each month, a mobile team put in each resident’s eye—with infection or not—aureomycin ointment. Residents would assemble in groups of 600-1,200 people. Within one month, therefore, the entire population would be treated. During the summer of 1953, 17 teams of 87 people treated approximately 114,000 people. Each treatment team consisted of a male nurse, a secretary, and a driver, who registered the whole population into a “conjunctivitis registry” according to family.¹⁴⁰ The campaign workers were much like one anonymous UN worker who wrote that he had decided to go into public health after serving in the Army Medical Corps in Africa: “My credentials consist of a simple nursing diploma and, more important, what I have learned while riding mules, bicycles, camels, and in jeeps to put into practical effect the plans laid down by successive medical officers who have come to this region of the world.”¹⁴¹ Each month, the teams would treat 8 communities, or about 8,000-10,000 people.

¹³⁸ “Morocco - Trachoma and Associated Eye Diseases,” 27 Mar 1952, Folder E/ICEF/1952/R.0313, UNICEF Archives.

¹³⁹ “Trachoma Control: A Review of WHO-Aided Campaigns,” *Chronicle of the World Health Organization* 10 (1956): 232.

¹⁴⁰ “Morocco - Trachoma and Associated Eye Diseases,” 27 Mar 1952, Folder E/ICEF/1952/R.0313, UNICEF Archives.

¹⁴¹ My Favorite Eye Man, *British Journal of Ophthalmology* (1966) 50: 553-555.

Transport, which consumed one third of the campaign budget, proved to be extremely challenging. Fourteen Renault jeeps traversed the desert in the middle of the summer, and a number of those initial vehicles had to be replaced. Residents were expected to gather at the camp for treatment at 7:00 a.m. and 5:00 p.m. daily, while the teams' struggled to travel between communities: the temperature ranged from 104-122° Fahrenheit in the middle of the day, causing "engine trouble with vehicles and heavy wear on the tires."¹⁴² The results of the campaign were effective, however, in substantially reducing the cases of acute conjunctivitis and reducing corneal complications. The administrators claimed that this success "won the enthusiastic cooperation" of the residents who called that season the "summer without conjunctivitis," or in Arabic, "*saif balash ramad*."¹⁴³ These campaigns, however, needed to continue at least for three summers, administrators argued, in order to have a lasting effect on trachoma incidence. Chronic cases served as a breeding reservoir for next summer's epidemics.¹⁴⁴

By the third summer, the WHO-UNICEF campaign decided that "supervised self-treatment," distributing the ointment to families who "are now acquainted with its' beneficial effects and who know how to administer it" was the next step. They were confident "that to avoid the undoubted inconvenience of assembling for treatment, the inhabitants will...treat themselves regularly." Although aureomycin was supposed to be on sale in local pharmacies for a reduced price, in the South there were not enough pharmacies to make sales accessible. Ointment was sold in tabac shops, but often failed to be regularly stocked. Instead, a black

¹⁴² *ibid.*

¹⁴³ "Recommendation by the Executive Director for an Apportionment to Morocco for the Extension of the Campaign Against Trachoma and Associated Eye Diseases," 19 Feb 1954, Folder E/ICEF/L.571, UNICEF Archives.

¹⁴⁴ *ibid.*

market developed for the ointment, in which it could be sold for a profit.¹⁴⁵ In addition, although WHO-UNICEF workers may have taught residents how to apply the ointment, “in practice, clumsy fingers might squeeze too much from the tube at a time and quickly exhaust its contents; or the top might be lost, or the goat eat it and the ointment dry up.”¹⁴⁶ The results of self-application can be ascertained from a 1968 study published in the Bulletin of the World Health Organization, concluding that “the over-all prevalence of trachoma was unaffected by the mass-treatment campaign” from more than ten years prior.¹⁴⁷

The JDC-OSE lobbied for the WHO-UNICEF campaign to affect as many Jews as possible, and even tried to obtain some of the funds set aside for the project for their own campaign. Dr. Mosberg, the director of OSE-Morocco, had hoped that he could convince Georges Sicault to pick villages in the South that had a Jewish population for WHO-UNICEF anti-trachoma work.¹⁴⁸ Although Jews were not heavily concentrated in the areas where the UNICEF teams worked, there were some. It was reported that some OSE nurses were attached to UNICEF teams, and assigned to exclusive work in the mellahs.¹⁴⁹ Reinhardts noted the trachoma incidence was severe in the Jewish population: “the Jewish children and the Jewish population were usually found to be suffering from a more severe and florid form of trachoma than the Berber population. The prevalence was 100% in both ethnic groups.”¹⁵⁰ Esther Bubley, a well-known Jewish American photographer, was sent to Morocco to document the UNICEF campaign, and captured a photo specifically of Jews in line waiting

¹⁴⁵ John Reinhardts (1958), Report on the Actual Status and Evaluation of the Communicable Eye Disease Control Project in Morocco (unpublished working document WHO/EUR/Morocco/1).

¹⁴⁶ Black 106.

¹⁴⁷ K Kupka, B Nizetic, and J Reinhardts, “Sampling Studies on the Epidemiology and Control of Trachoma in Southern Morocco,” *Bulletin of the World Health Organization* 39, no. 4 (1968): 547.

¹⁴⁸ OSE-Maroc to Alexander Gonik, 17 Nov 1953, MO.109, JDC Archives.

¹⁴⁹ “Minutes of Conference of AJDC Country Directors,” October 1953, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

for treatment. Gonik met with WHO officials in Geneva, and had agreed to send them a report of their final conclusions, indicating that Jewish practices could have an effect on WHO standards.¹⁵¹



Figure 11: Moroccan Jews awaiting eye treatment by UNICEF doctors, treatment of trachoma, 1953

At the same time as the rural anti-conjunctivitis campaigns, anti-trachoma campaigns were carried out in urban schools, first in Marrakesh, where over 90% of the population was considered infected with trachoma. Reinhardts gave a nod to the JDC-OSE anti-trachoma measures, and noted what an effect their campaign had on the Jewish community “with its well organized system of social and medical assistance.”¹⁵² The practices of the Mass Trachoma Project had by then been replicated in Marrakesh, and Reinhardts lauded that “treatment was given by specially instructed social workers during house to house visits.”¹⁵³

Health education was considered integral to WHO-UNICEF efforts, which included lectures, posters, and “a basic education film on treatment of the eyes by instillation [that]

¹⁵⁰ J. Reinhardts, “Collective Antibiotic Treatment of Trachoma,” 681.

¹⁵¹ Health Department to H. Efenbein, 17 Mar 1953, MO.109, JDC.

¹⁵² J. Reinhardts, “Collective Antibiotic Treatment of Trachoma,” 679.

¹⁵³ *ibid.*

excited much interest.”¹⁵⁴ However, the WHO-UNICEF team hoped the treatment would speak for itself, and that its magic would convince the population of the benefits of its use when comprehension failed: Reinhardt asserted that the “the simplicity of the scheme is the best propaganda for trachoma treatment itself,” and that “the rapid effect of the antibiotic ointment in giving quick symptomatic relief was the best propaganda for the campaign.”¹⁵⁵ The team struggled with the actual communication of health messages, and seemed to be at a loss on how to explain contagion, prevention and hygiene.¹⁵⁶ The tone of the suggestions was always tentative, and almost resigned to the fact that they would never be understood.¹⁵⁷ Although the WHO and UNICEF had grand aspirations to eradicate trachoma, the language and ideology of paternalism did not disappear: Reinhardt blamed “the slow progress in the knowledge of health and sanitary problems and the lack of initiative in the population to change the very low standards of general conditions of life,” on the campaign’s shortcomings.¹⁵⁸

Decolonizing Health and the Anxieties of a WHO Geography

The French Protectorate and the JDC both tried to maintain their legitimacy on the world stage by mooring their own medical goals onto the anchor of the World Health Organization. Each reformulated their own political needs within the context of global health, masking their own colonial or organizational imperatives in order to take advantage of this new source of funding. In the process of sanctioning these relationships, however, their

¹⁵⁴ “Recommendation by the Executive Director for an Apportionment to Morocco for the Extension of the Campaign Against Trachoma and Associated Eye Diseases,” 19 Feb 1954, Folder E/ICEF/L.571, UNICEF Archives.

¹⁵⁵ J. Reinhardt, “Collective Antibiotic Treatment of Trachoma,” 699; Reinhardt, “Report on the Actual Status and Evaluation of the Communicable Eye Disease Control Project in Morocco,” 1958, WHO/EUR/Morocco/1, WHO Archives.

¹⁵⁶ Reinhardt, “Report on the Actual Status and Evaluation of the Communicable Eye Disease Control Project in Morocco,” 1958, WHO/EUR/Morocco/1, WHO Archives.

¹⁵⁷ *ibid.*

ulterior motives bubbled to the surface and frustrated their attempts to affiliate with the WHO. France was keen to have Morocco and Tunisia join the WHO European region, and succeeded despite objections from African and Eastern Mediterranean region member states.¹⁵⁹ The JDC, on the other hand, was unsuccessful in joining the WHO as consultative member until 1963, when it devised an ingenious solution in which to satisfy WHO requirements.

In the Second WHO World Health Assembly in 1951, France attempted to gain admission for Morocco and Tunisia to the European region, despite strong protest that neither country could possibly be conceived as part of Europe. Dr. Hashem (Egypt), claimed that North Africa “formed, from a geographical or any other point of view, part of Africa and not of Europe.”¹⁶⁰ M. Maspétiol (France) countered that North Africa’s “choice of the European Region was entirely reasonable, and indeed inevitable.”¹⁶¹ Maspétiol continued to engage in geographic gymnastics to claim that the “Western Mediterranean” was distinct unit, and in any case, Egypt was part of the Eastern Mediterranean rather than the African region. Hashem argued back that, “the status of protectorate did not deprive a territory of its international personality, and consequently of responsibility for its own membership in any international organization, especially those of a technical nature.”¹⁶² France was in the position of having to explain and justify the legal definition of a protectorate to the

¹⁵⁸ *ibid.*

¹⁵⁹ For a detailed discussion, see, Jessica Pearson-Patel, “Remapeando as fronteiras da saúde imperial: a Organização Mundial de Saúde e os debates internacionais sobre a regionalização do Norte de África francês, 1945-1956,” in *Os passados do presente: Internacionalismo, imperialismo e a construção do mundo contemporâneo*, eds. Miguel Bandeira Jerónimo e José Pedro Monteiro (Coimbra: Almedina, 2015).

¹⁶⁰ “Committee on Administration, Finance and Legal Matters: provisional minutes of the ninth meeting, Palais des Nations, Geneva, Saturday, 19 May 1951 at 10:30 a.m.,” A4/AFL/Min/9, <http://www.who.int/iris/handle/10665/101686#sthash.GjkQ7wIV.dpuf>

¹⁶¹ *ibid.*

¹⁶² “Committee on Administration, Finance and Legal Matters: provisional minutes of the tenth meeting, Palais des Nations, Geneva, Monday, 21 May 1951 at 10 a.m.,” A4/AFL/Min/10 <http://apps.who.int/iris/handle/10665/101687#sthash.T9mPptqJ.dpuf>

international community, when it was difficult to understand themselves what it meant in the decolonizing world.

Sicault claimed it was not “political nor sentimental” reasons for the request, but for health reasons alone.¹⁶³ He detailed that the group of diseases to be found in Morocco—including trachoma—were the same as in Europe, particularly in Spain and Italy. Other justifications included that 80% of Morocco’s commerce was with Europe, and that the Saharan desert precluded Morocco from being a part of Africa. This must have sounded like a farce to anyone, but particularly to Dr. Logba (Liberia), who put it plainly: “I personally fail to see the relationship between Europe and Northern Africa—leaving out politics and speaking strictly from a medical and public health point of view. I fail to see any connection whatsoever.”¹⁶⁴ After tabling the motion to vote numerous times, it seems that representatives simply were tired of deliberating the subject and approved France’s request for Morocco to join the European region.¹⁶⁵ Although France was able to maintain the conception of imperial autonomy in this instance, it was summarily challenged in the heavy opposition to their proposal to place Tunisia and Morocco in the European region.

The JDC was not as successful in obtaining consultative status with the World Health Organization, and had to create a whole new entity in 1963 to be finally admitted. In June 1948, the JDC was one of the first organizations to congratulate the WHO on the creation of the World Health Assembly as the “highest international authority on public health,” and looked forward to learning how international voluntary organizations could gain consultative

¹⁶³ “Committee on Administration, Finance and Legal Matters: provisional minutes of the sixth meeting, Palais des Nations, Geneva, Wednesday, 14 May 1952 at 2:30 p.m.,” A5/AFL/Min/6
<http://apps.who.int/iris/handle/10665/102166#sthash.6ambLvoj.dpuf>

¹⁶⁴ “Tenth plenary meeting, Palais des Nations, Geneva, Wednesday, 21 May 1952 at 4 p.m.: provisional verbatim record,” A5/VR/10
<http://apps.who.int/iris/handle/10665/102245#sthash.gqNLomp1.dpuf>

¹⁶⁵ *ibid.*

status at the WHO.¹⁶⁶ In its first application to receive recognized status in 1950, two issues arose: since it was based in New York, it was not considered an international organization, and it was sectarian in nature.¹⁶⁷ Although the executive director ultimately determined that sectarian organizations could gain consultative status, they continued to exclude the JDC because despite its international functioning, its organizational structure remained American.

In order to rectify this limitation, the JDC contemplated settling up an “international JDC” that would adhere to each of the WHO’s criterion, with headquarters in Geneva. It came to be known as the “International Council on Jewish Social and Welfare Services (INTERCO)” comprised of the JDC, the Central British Fund for Jewish Relief and Rehabilitation, the Jewish Colonization Association, the United HIAS Service, the Standing Conference on European Jewish Community Services, and the World ORT Union.¹⁶⁸ However, their application was unanimously rejected, because it was unclear how INTERCO’s activities were in the WHO’s direct field of interest.¹⁶⁹ Although in 1953, this would not have been contested considering JDC’s extensive medical work in North Africa, ten years later it had become less clear. INTERCO was ultimately able to round up enough delegate votes, and with an addendum to their application, became a consultative member in 1963.

Conclusion

¹⁶⁶ “Messages of Welcome,” First World Health Assembly, 10 Jul 1948, A/55, <http://www.who.int/iris/handle/10665/97756#sthash.YAFsYsXb.dpuf>

¹⁶⁷ “Health Department to Mr. Beckelman, Re: Who File #99B20” 15 Feb 1954, G 45-54/2/3/7/ORG.470, JDC Archives.

¹⁶⁸ Jerome J. Jacobson to Mr. Charles H. Jordan, 12 Sept 1960, NY AR195564/2/1/1062, JDC Archives.

¹⁶⁹ “Information on non-governmental organizations applying for official relations with WHO: International Council on Jewish Social and Welfare Services,” 1963, EB33/NGO/1 <<http://apps.who.int/iris/handle/10665/137028#sthash.tPXfPrgH.dpuf>>

In 1954, the JDC hosted a four-day conference for fifty attendees in the UNESCO House in Paris on the “Medical and Health Problems in Areas of AJDC Activity.”¹⁷⁰ Invited speakers included international physicians and researchers, including world renowned Giambattista Bietti, an Italian ophthalmologist, who gave a detailed, scientific talk on the epidemiology of trachoma. His presence at the conference indicated JDC’s commitment to scientific professionalism and prestige. The next day, Alan C. Stevenson, who was the chair of the Department of Social and Preventative Medicine at Queen’s University, Belfast, gave a talk on the “Organization of Health and Social Services in the Community.” Stevenson attempted to expand the notion of disease control, arguing that the “medical” is as much a socio-cultural endeavor as it is a scientific one: “There is no disease which is an entirely medical problem. We were hearing about trachoma yesterday and we had a most interesting and comprehensive outline of etiology and the pathology, epidemiology and control measures and so on, but trachoma could be eradicated from a community without a doctor ever seeing that community because trachoma is a social and economic disease.”¹⁷¹ Stevenson continued to respectfully deride the work of the World Health Organization, who he feared focused too much on “big, dramatic attacks on specific diseases” without paying attention to instituting “parallel social improvements,” which without the diseases would “come back, and in a remarkably short time, be as bad as ever.”¹⁷²

The fact that this discussion occurred at the conference clues us into JDC’s participation in a major debate on the practice of mass disease campaigns in the postwar period. The rare aligning of interests between the JDC and the WHO occurred because both

¹⁷⁰ “Proceedings of the Conference on Medical and Health Problems in Areas of AJDC Activity,” 28 June 1952, Folder 438A, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

¹⁷¹ *ibid.*

¹⁷² *ibid.*

organizations had were interested in the health of the decolonizing world. The JDC was interested in mitigating Jewish poverty and disease in Morocco due to the Jewish population's sheer size in the aftermath of the Holocaust, and looked to the WHO to advance its health campaign. Rather than merely replicate WHO practices, the JDC relied on the field of social work to overcome difficulties in communication and comprehension to treat trachoma, a disease that both organizations admittedly felt was not well suited for a disease campaign. However, as international organizations, neither the JDC nor the WHO could assume the role of the state to change the conditions of the poor. In 1958, Gonik concluded that, "by reason of its chronicity, association with low standards of hygiene and sanitation which still prevail in many homes, and the lack of a specific cure, it may not be possible to reduce the morbidity of trachoma."¹⁷³

The JDC was able to join the new international medical sphere by taking part in medical aid, even if ostensibly the impetus for an anti-trachoma campaign was to smooth immigration to Israel. The JDC operated within a Cold War and development global framing that provided the template for a disease campaign, yet Morocco was not a typical site for Cold War politicking, nor the JDC a classic partner in decolonizing health. Its goals were not only to reduce trachoma incidence, but to fashion Jews free of "backwards" infectious diseases, whether they intended to stay in Morocco or immigrate to Israel. The interest in trachoma suited both of JDC's goals to prepare potential emigrants to Israel and to maintain Jewish life in situ. A historical investigation of Jewish anti-trachoma efforts in Morocco foregrounds often overlooked actors of postwar colonial medicine, and demonstrates how international Jewish philanthropic organizations took part in shaping global health

¹⁷³ "A Brief Review of the Anti-Trachoma Programme OSE-Maroc," November 1963, Folder 428B, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

priorities.¹⁷⁴ While the JDC reaped the benefits of WHO's pronouncements on trachoma control and adapted them to their interests, the WHO-UNICEF also watched the JDC project "with a great deal of interest," and ultimately the Third Report of the WHO Expert Committee on Trachoma included JDC's innovations.¹⁷⁵ North Africa in the 1950s appears to be the only time and place where Jewish organizations and the WHO worked side by side in medical development; soon thereafter, emigration made the Jewish population insignificant in the Third World. The Mass Trachoma Project in Casablanca opens up new questions that help to reimagine how focusing on "Jewish health" in North Africa can reconceptualize notions of international and global health in the 1950s.

¹⁷⁴ See Alison Bashford, "Global Biopolitics and the History of World Health," *History of the Human Sciences* 19, no. 1 (2006): 67–88; Warwick Anderson, "Making Global Health History: The Postcolonial Worldliness of Biomedicine," *Social History of Medicine*, 2014, 1-13; Iris Borowy, "Shifting Between Biomedical and Social Medicine: International Health Organizations in the 20th Century," *History Compass* 12, no. 6 (2014): 517–30; John Farley, *To Cast Out Disease: A History of the International Health Division of the Rockefeller Foundation, 1913–1951* (New York, 2004); Anne-Emanuelle Birn, *Marriage of Convenience: Rockefeller International Health and Revolutionary Mexico* (Rochester, NY, 2006); Marcos Cueto, *Cold War, Deadly Fevers: Malaria Eradication in Mexico, 1955–1975* (Baltimore, 2007); Randall Packard, *The Making of a Tropical Disease: A Short History of Malaria* (Baltimore, 2008).

¹⁷⁵ "Thirty-ninth Annual Meeting of the American Jewish Joint Distribution Committee Plenary Session," December 10, 1953, Folder 2212, Records of the Geneva Office of the American Jewish Joint Distribution Committee, JDC Archives.

CHAPTER 4

Eyeing Africa: Disease as Diplomacy

Introduction

Mrs. Florence Perlman, a national board member of the Hadassah Women's Zionist Organization of America and the national chairman of the Hadassah Medical Organization, took a two-month tour of Africa in 1962, visiting 21 cities in 13 countries. In her report, "My Recent Trip to Africa," she wrote that the "highlight" of her trip was her first-hand observation of the work of the Hadassah ophthalmologists in Monrovia, Liberia, who had opened and operated a 22-bed eye hospital. With every bed filled, and 150 "natives" waiting in line for eye examinations she concluded, "Hadassah is helping to light up the darkness of a continent which is turning its face to the sun."¹ Dr. Hanan Zauberman, who served for one year in this Liberian eye clinic, and was subsequently the chair of the Hadassah University Hospital Ophthalmology Department from 1973 to 1998, summarized the success of his department's aid program: between 1959 and 1984, over thirty Israeli ophthalmologists examined approximately 500,000 outpatients and conducted 20,000 major eye surgeries in an estimated total population of 45 million people.² He wrote, "The impact of this work has been incalculable in terms of both professional and human experience, and has enriched each of us who has worked in Africa."³

This ophthalmic aid program in Liberia, which was funded by Israel's Ministry of Foreign Affairs division of International Cooperation (Mashav), soon expanded to Tanzania

¹ Florence Perlman, "My Recent Trip to Africa," 5 September 1962, Box 133/14, RG2, The Hadassah Medical Organization (HMO) Papers in the Hadassah Archives, Center for Jewish History (CJH), New York.

² Hanan Zauberman, "Israeli Ophthalmologists in Africa," 1984, Box 171/5, RG2, HMO Papers.

³ *ibid.*

(1962), Ethiopia (1962), Malawi (1965), Kenya, (1965), and Rwanda (1966).⁴ This international medical program was part of a larger Israeli strategy of offering technical expertise to developing countries.⁵ Although Mashav funded the eye aid program, it did not come up with the idea nor even determine how it was run. That honor went to Dr. Isaac Chesar Michaelson, the chair of the Ophthalmology Department at the Hadassah University Hospital in Jerusalem from 1953 to 1973. Michaelson, a Scottish emigre and world-renowned scholar, was able to take advantage of Mashav's purse-strings to pursue his own vision for ophthalmic education in Israel, requiring his residents to serve in Africa for two years as part of their training, and provided funds for research abroad.⁶ He also trained African physicians to specialize in ophthalmology at the Hadassah Hospital, creating a cadre of native experts to run the clinics after the Israelis would return home. Many of Michaelson's students became chairs of ophthalmology departments in hospitals throughout Israel, marking that shared experience as a rite of passage and practically mandatory to jumpstart an academic medical career.⁷ Michaelson leveraged his department's African connections to spearhead the world's first international conference on "public health ophthalmology," featuring participants from both Western and developing countries, and cementing Hadassah's locus as a center for ophthalmic innovation.⁸ Although the tension between Mashav's diplomatic objectives and

⁴ Isaac C. Michaelson, "A Programme for Medical Help to Developing Countries," *World Hospitals* 4 (1968): 59–62.

⁵ Susan Gitelson, "Israel's African Setback in Perspective," *Israel in the Third World* eds. Michael Curtis and Susan Gitelson (New Brunswick, N.J., 1976) 183.

⁶ Isaac Michaelson to Hannah Goldberg, 11 October 1963, Box 103M, RG2, HMO Papers.

⁷ Shmuel Penchas, "Hadassah in Africa and Asia: Jubilee Address," 1987 May, Box 171/5, RG2, HMO Papers.

⁸ Isaac Michaelson and Elaine Berman, *Causes and Prevention of Blindness: Proceedings of the Jerusalem Seminar on the Prevention of Blindness 25-27 August 1971, Jerusalem* (London: Academic Press) 1972.

Michaelson's own professional and medical aims could come to a head in the field, Michaelson's dedication to the program ensured that it continued largely unencumbered.⁹

Eye aid became the largest and longest focus of Israel's international medical aid. Why? I argue that Michaelson was able to formulate eye health as encapsulating the tensions of an incipient Israeli political identity, that was at once advocating to be part of the non-aligned bloc of postcolonial nations, as well as proving itself as a scientific, progressive state by becoming a donor country. Since eye diseases had longstanding cultural associations with ignorance, Israel's dispatch of over thirty ophthalmologists to Africa over fourteen years enabled the state to associate with Africa as an equal. However, since Israel had already overcome a "primitive" disease, it was a few rungs higher in the ladder of development and could identify with the Western world that was likewise involved in development projects. Michaelson articulated ocular aid, then, as one such province that demonstrated that "Israel's medical profession itself is a synthesis of East and West" (as one contemporary of the program put it), combining its developing status with a progressive hospital department.¹⁰ Eye aid was not simply circumstantial, but fit a longstanding leitmotif that correlated eye care with the medical needs of Israel's geographic position in the Middle East. Michaelson capitalized on this historic expertise when political circumstances turned sub-Saharan Africa into Israel's new "East," to which Israel needed to prove her worth in order to secure her place both within the Arab and the postcolonial world.

While Michaelson harnessed this persuasive rhetoric to describe the project's practices, as well as the source of its expertise, the implementation of the eye aid program did

⁹ Practically every secondary source on Mashav aid in the 1960s cites ophthalmology as a successful example of technical aid. See, for example, Jehudi J. Karanek, *Israeli Technical Assistance to Developing Countries* (Geneva, 1969) p. 72; Mordechai Elihau Kreinin, *Israel and Africa, A Study in Technical Cooperation* (New York, 1964) p. 150; Leopold Laufer, *Israel and the Developing Countries: New Approaches to Cooperation* (New York: Twentieth Century Fund, 1967) p. 148-150.

¹⁰ "Undergraduate Programme for Students from African and Asian Countries at the Hebrew University-Hadassah Medical School in Jerusalem, Israel," n.d., Box 133/14, RG2, HMO Papers.

not necessarily live up to these ideals. Even with his insistence, for example, that the eye aid program was distinct from missionary and “colonial” medicine—reifying Israel’s non-colonial intentions—the project indeed replicated neocolonial elements through imagining African space as a training ground to gain expertise and outpost for research. Michaelson’s role model was his fellow Scot, Sir David Livingstone, the celebrated nineteenth-century physician explorer to Africa, and Hadassah administrators frequently employed colonial imagery to describe their entree into “darkest Africa.”¹¹ Although eye aid was said to be the pinnacle of an “integrated” project, with the training of African physicians concurrent to Israeli ophthalmologists setting up an eye clinic, the project was not integrated into the host country’s health services.¹² Therefore, the fate of the eye clinic was at the hands of the sole African ophthalmologist, who might turn to private practice or opportunities abroad instead of staffing the public clinic Israelis had hoped he would take over.

The strong symbolism that eye diseases had in Israel with being modern, and therefore a particularly appropriate form of aid, did not always resonate in African countries. In fact, it was widely understood, both by Israeli diplomats and African leaders, that primary care was a far more pressing medical need than ophthalmology.¹³ In some cases, Israel had to foot the bill of the ophthalmologists’ salary abroad (rather than the receiving country) when Michaelson failed to persuade the appropriate minister to allocate the necessary funds. However, since the Foreign Ministry had difficulty recruiting other physicians for reasons of salary and job security, ophthalmologists remained Israel’s number one doctor sent to Africa.

Trachoma was constructed, in the eyes of the program’s funders, as a device to solve a diplomatic problem, rather than a medical one. Although “Africa” was constructed as an

¹¹ Kalman Mann to Florence Perlman, 5 June 1960, Box 133/14, RG2, HMO Papers.

¹² Laufer 150.

¹³ Minutes of the Mashav Meeting, 20 June 1962, RG 130, Ministry of Foreign Affairs 473/11, Israel State Archives, Jerusalem.

united space, the eye aid program only went where Mashav had political interest: North Africa was closed to Michaelson, despite its high incidence of eye disease, and West and East African countries were of most strategic interest to the Foreign Ministry. How many Liberians or Tanzanians were seen, treated or cured did not concern Mashav. The obsessive tracking of trachoma statistics when Jewish populations in Palestine were concerned did not transfer to the sub-Saharan landscape. In fact, Mashav ignored trachoma incidence in the Falasha Jews in Ethiopia in order to not upset the Emperor Haile Sallasié, highlighting how even Jewish trachoma was subjugated to political maneuvering. The symbolism of an eye clinic, an ophthalmologist, or a mobile unit served the diplomatic mission in and of itself by bringing Israeli ocular expertise to countries where there was often not a single eye doctor. The success of the program, therefore, was measured not in terms of improved eye health—of which Israeli aid could only be a drop in the bucket—but of diplomatic achievement. Hadassah's role to “light up the darkness” in Africa was ostensibly about eyesight and modernization, but instead concerned African countries envisioning Israel as a natural ally.

However, it was not exclusively a project of state politics. Michaelson wielded trachoma's “diplomatic mission” to advance the professionalization of his department and of Israeli science. The development of ophthalmic research through the ingathering of data and people from African countries advanced Israel's credentials in an era in which scientific research could be used to substantiate nations' international standing. Participation in global health initiatives and the production of scientific research was an avenue through which Hadassah could gain global repute, on a par with American and European centers. The Hadassah University Hospital imagined itself, due to its proximity to Africa and Asia, as a kind of advanced international trading hub for Third World peoples and diseases. The Hadassah Medical School developed special undergraduate and graduate degree programs for African students in English, and several graduates led medical departments and ministries of

health in over a dozen of their native countries.¹⁴ The transnational circulation of physicians, patients, students, diseases, and body parts were crucial to clinical and political formations that established the legitimacy of the Hadassah Ophthalmology Department on a global scale, and in turn, bolstered the position of Israel as a scientific state.

The Geopolitics of Israel in Africa

The Israeli eye aid program launched in the 1960s and was part of an international “development decade,” when technocratic optimism about rational methods of socio-economic progress in the Third World was at its height. President Kennedy spearheaded foreign economic and technical aid programs throughout postcolonial states as part of the Cold War contest to “preserve freedom.”¹⁵ Development, however, was not simply an American export, nor was it only focused on heavy industry. Recent scholarship has emphasized development as a global phenomenon that was disputed between and within blocs, looking beyond the United States-Soviet rivalry for variations on ideology and intention.¹⁶ It also served as a way for colonial powers, such as Britain and France, to maintain their presence and influence by another name. The anti-colonial movement in North Africa that had garnered worldwide attention in the 1950s acquiesced to the thirty new sub-Saharan African and Asian states that gained independence between 1957-1966 as the new focal points of development.

¹⁴ Shmuel Penchas, “Hadassah in Africa and Asia: Jubilee Address,” CJH.

¹⁵ Robert Goldwin, *Why Foreign Aid? Two Messages from President Kennedy* (Chicago: Rand McNally 1963): 5.

¹⁶ David C. Engerman and Corinna R. Unger, “Introduction: Towards a Global History of Modernization,” *Diplomatic History* 33, no. 3 (2009): 375–85. This has included work on Western European programs that analyze the shift from colonial administration to postcolonial aid. See, for example, Andreas Eckert, Stephan Malinowski, and Corinna Unger, eds., Special Issue on “Modernizing Missions: Approaches to ‘Developing’ the Non-Western World after 1945,” *Journal of Modern European History*, Vol. 8, 2010.

In Israel's case, too, foreign aid was "usually political, often ideological, sometimes psychological, but never disinterested."¹⁷ The Ministry of Foreign Affairs had realized Israel's socio-political isolation when it was the only Middle Eastern country not invited to the 1955 Bandung Conference of Asian and African states, due to strong Arab opposition.¹⁸ The Bandung Conference was the first called for postcolonial nations of the UN in Asia or Africa to meet, solidifying its position of nonalignment, and creating "the feeling of political possibility presented through this first occasion of 'Third World' solidarity... It represented a coalition of new nations that possessed the autonomy to enact a novel world order committed to human rights, self-determination, and world peace."¹⁹ When Israel was not invited out of fear of Arab boycott of the conference—despite its colonial past, geographic position in Asia and nonaligned status—the Israeli Foreign Ministry was shattered: "There we were defending ourselves against Arab provocations when suddenly from behind us reared the accusing finger of half of mankind."²⁰ When an anti-Israel resolution passed at Bandung, it amplified the government's motivation to counter Arab diplomatic objectives in the international arena through developing ties to decolonized African states. Three main goals of Israeli diplomacy during its first decade were to gain regional recognition, international recognition, and strategic ties with a superpower state.²¹ Development was a means to fulfill the first two, and through so doing, finally secure the third. Israel's inability to secure ally status with either the

¹⁷ D.V. Segre, "The Philosophy and Practice of Israel's International Cooperation," *Israel in the Third World*, eds. Michael Curtis and Susan Gitelson (New Brunswick N.J.: Transaction Books, 1976) 3.

¹⁸ Ran Kochan, "Israel in Third World Forums," *Israel in the Third World*, eds. Michael Curtis and Susan Gitelson (New Brunswick N.J.: Transaction Books, 1976) 250-254.

¹⁹ Christopher J. Lee, *Making a World after Empire: The Bandung Moment and Its Political Afterlives* (Athens, OH, 2010), 16.

²⁰ Samuel Decalo, *Israel and Africa: the politics of co-operation—a study of foreign policy and technical assistance*, University of Pennsylvania, 1967 (Doctoral Dissertation).

²¹ Uri Bialer, "Top Hat, Tuxedo and Cannons: Israeli Foreign Policy from 1948 to 1956 as a Field of Study," *Israel Studies* 7, no. 1 (2002): 1–80.

USSR or the United States had led France to become its main arms supplier, finding a common enemy in Egypt.²²

What was critically important about the potential friendship with the Third World was that the sheer number of new countries created could grant Israel global support at the United Nations.²³ As a country born out of a UN vote, Israel realized that member countries could have a say in issues critical to Israel's welfare.²⁴ While Israel's efforts focused initially in the mid-fifties in West Africa to isolate North African influence, efforts later moved to East Africa as part of the Israeli periphery doctrine and security concerns.²⁵ The countries that received eye aid reflect this strategy. Israel differentiated its aid from Western powers by focusing on the transfer of expertise rather than capital, and by positioning itself as a postcolonial developing country in order to structure its assistance in terms of solidarity, rather than superiority, with African states. To that end, Israel sent 4,341 experts to serve in developing countries, while 15,258 trainees from Africa, Asia and Latin America received instruction in Israel in (order of program size) agriculture, education, and medicine.²⁶ The Ministry of Foreign Affairs cited several reasons why Israel's experience mirrored those of Africa, which included geographic similarity, having the shared experience of a "bitter struggle for national self-determination," and enduring historic persecution.²⁷

Affinity was a difficult argument to make, however, in terms of economic index. In 1960, Israel's per capita gross national product was approximately \$540, almost double than

²² Avi Shlaim, "Israel, the Great Powers, and the Middle East Crisis of 1958," *The Journal of Imperial and Commonwealth History* 27, no. 2 (1999): 179.

²³ Gitelson 182.

²⁴ Laufer 20.

²⁵ Zach Levey, "Israel's Entry to Africa, 1956–61," *Diplomacy and Statecraft* 12, no. 3 (2001): 90.

²⁶ Arye Oded, "Africa in Israeli Foreign Policy—Expectations and Disenchantment: Historical and Diplomatic Aspects," *Israel Studies* 15, no. 3 (Fall 2010): 131.

²⁷ Michael Brecher, "Israel and 'Afro-Asia,'" *International Journal*, 16, no. 2 (1961): 107.

the next highest in the Third World, Malaysia, and ten times that of Ethiopia.²⁸ In the medical field, the comparison was even starker. While Israel had the highest ratio of doctors in the world (1:400), Africa had the lowest.²⁹ Israel then appeared to occupy an unique place in the “development” scale: the country’s “‘in-between’ status represents the ‘next step’ on the development ladder—far ahead of their [developing countries’] present status but not so far as to be appear beyond reach. This no doubt is one of the reasons for the symbolic significance that Israel seems to have attained in the emerging world.”³⁰ This was useful rhetoric for a country unsure of where it would fall in the new postcolonial world order. Since Israel fell on the “next step,” however, it could assert supremacy while maintaining an image of being parallel.

This political positioning—between developing and developed—was important in order to break the Arab world’s boycott and efforts to turn Israel into a pariah state. Israel could create a map devoid of the Arab states when it solidified its role as “in-between” on the development scale between the West and sub-Saharan Africa. When heralding that its “approach to a problem which confronts Africa” should be replicated, Israel could focus on its success in modernization, while tuning out Arab political enmity. This strategy minimized the voices of the Arab bloc that could blind the Third World from seeing Israel clearly as Afro-Asian, as it did at Bandung. The intended effect of leaping over the “wall of hatred and boycott” to help African countries was to force the Arab world to capitulate to the new alliance, with one foreign minister claiming: “I hope, that after ten years of joint efforts with

²⁸ Michael Brecher, *The New States of Asia: A Political Analysis* (New York: Oxford University Press, 1963) 124.

²⁹ Laufer 80.

³⁰ Laufer 14.

African and Asian states, Israeli experts will build bridges with African countries that today belong in the enemy camp.”³¹

This political moment of Israel’s engagement with the Third World has been largely overlooked. In the previous chapter, I argued that Jewish organizations had been removed from the conversation on technical expertise in the developing world, partly because the time and place it captured—1953 Morocco—represented a crossroads of ideology, migration, and governance. Israel’s extensive aid programs in Africa in the 1960s, similarly, have been excised from the literature on development, because “neither East nor West, developed nor undeveloped, capitalist nor socialist, Third World nor First World,” social scientists had swallowed Israel’s claim of exceptionality, and demurred from categorizing the Israeli case. Some scholarship on Israeli-African relations and development aid did proliferate during the 1960s and 1970s—mainly from the actors involved—when it was a current events issue. This literature tended to praise the efficacy and uniqueness of Israeli aid, alongside muted critique of its implementation.³² Of particular interest was Leopold Laufer’s, *Israel and the Developing Countries: New Approaches to Cooperation*, which was commissioned by the Twentieth Century Fund to investigate Israel as a case study of the best practices of technical aid between developing countries.³³ The book took for granted that Israeli aid represented a unique scheme of development that was distinct from American, European, and Soviet

³¹ Michael Brecher, “Israel and ‘Afro-Asia’,” 131; Harry S. Truman Institute for the Advancement of Peace, *International Cooperation-Problems and Trends: A General Symposium on the Problems of Mashav* (Rehovot: The Center for Settlement Research, 1969) 4.

³² See Samuel Decalo, *Israel and Africa: Forty Years, 1956-1996* (Gainesville: University of Florida Press, 1998); Susan A. Gitelson, “Israel’s African Setback Perspective,” in *Israel in the Third World*, ed. Michael Curtis and Susan A. Gitelson (New Brunswick, N.J.: Transaction Books, 1976); Mordechai E. Kreinin, *Israel and Africa: A Study in Technical Cooperation* (New York: Praeger, 1964); Leopold Laufer, *Israel and the Developing Countries: New Approaches to Cooperation* (New York: Twentieth Century Fund, 1967).

³³ The Twentieth Century Fund is a non-profit foundation that “seeks to throw light upon emerging issues of our times.”

contributions, and characterized Israeli aid as the “largest and most varied program” of what is now known as South-South aid.³⁴

Scholarly work in political science considered the diplomatic break of Israeli-African relations in 1973, and the possibilities of rapprochement in the 1980s.³⁵ After a thirty-year lull, Israeli scholars using declassified archival material or postcolonial theory have recently published exciting work on diplomatic relations, the geopolitics of development, and Africa within the Israeli cultural imagination.³⁶ However, this period of Israeli history has been woefully understudied. This is part because of current political paradigms that take for granted Israel’s allegiance with the United States, dating back to the 1970s and 1980s when Israel consciously tied itself more closely to the West politically, economically, and culturally.³⁷ The flashpoints of the Israeli-Arab conflict tended to obscure the Israel-African “honeymoon” as a worthy site of investigation. And finally, Israel’s relationship with South Africa during apartheid, and the conflation of Israel as an apartheid state, shadowed Israel’s other relationship with Black Africa.

It is important to note that Israel’s ties with Africa were not only a matter of diplomacy, interests, strategy, economics, and politics, but also concerned the country’s own identity; the same argument one historian notes about American aid to Africa could be applied to Israel: “Development, therefore, was always a political matter—not merely a technical one—and one infused not only with ideas about American interests, but also

³⁴ See Renu Modi, ed., *South-South Cooperation: Africa on the Centre Stage* (New York: Palgrave Macmillan, 2011).

³⁵ Olusola Ojo, *Africa and Israel: Relations in Perspective* (Boulder, Colo.: Westview Press, 1988); Joel Peters, *Israel and Africa: The Problematic Friendship* (London: British Academic Press, 1992).

³⁶ See Zach Levey, *Israel in Africa 1956-1976* (Martinus Nijhoff Publishers, 2012); Haim Yacobi, “The Moral Geopolitics of Exported Spatial Development: Revisiting Israeli Involvement in Africa,” *Geopolitics* 15, no. 3 (2010): 441–61; Eitan Bar-Yosef, *Vila ba-jungel: africa ba-tarbut ha-israelit* [A Villa in the Jungle: Africa in Israeli Culture] (Van-Leer Institute and Hakibbutz Hameuchad Press, 2013).

³⁷ Benjamin Neuberger, *Israel’s Relations with the Third World (1948-2008)*, (Tel Aviv: The S. Daniel Abraham Center for International and Regional Studies, Tel Aviv University 2009) 7.

culturally specific meanings of American identity.”³⁸ Eitan Bar Yosef, a literary scholar and cultural theorist, has successfully argued that Africa remained a sphere in Hebrew culture in which to ascribe national, racial, and territorial fantasies. Rather than only “whitening” Israelis, however, service to Africa also “blackened” them by reiterating the rhetoric that Israel was part of the Afro-Asian alliance.³⁹ While the culture of the Mandate period has been described as one that “marked and transgressed” the line between Jew and Arab, this fluidity was thought to have hardened by the creation of the state.⁴⁰ By carrying the examination of eye care into its first two decades rather than ending in 1948, we can see how the eye aid project represented Israel and Israelis as Western and non-Western, colonial and post-colonial, developing and developed. This chapter explores the nature of these dualities, and how overlapping representations of Israel and eye disease were manifest in the diplomatic and medical sphere.

To Serve, to Teach, to Leave: Ocular Development

Isaac Michaelson was born in Scotland in 1903 and trained in at the Royal College of Physicians and Surgeons, Glasgow and Edinburgh. He decided to specialize in ophthalmology in his early twenties because of Palestine’s reputation for eye diseases (he “had always had a special interest in Zionism”).⁴¹ After serving as a major in the British Army Medical Corps in Egypt and Palestine during World War II, he worked as an ophthalmic surgeon and consultant for the Israel Defense Forces during the 1948 War and formally immigrated. He settled first in Haifa, establishing the clinical and research facilities of the Ophthalmology Department of the Rambam Government Hospital, before accepting a

³⁸ Larry Grubbs, *Secular Missionaries: Americans and African Development in the 1960s* (Amherst: University of Massachusetts Press, 2010) 5.

³⁹ Dr. Ayala Levin’s insight.

⁴⁰ Gil Eyal, *The Disenchantment of the Orient: Expertise in Arab Affairs and the Israeli State*, (Stanford, 2006).

⁴¹ “Ophthalmologist from Israel,” Sept 1960, Box 133/14, RG2, HMO Papers, CJH.

position as the chair of the department at the Hebrew University-Hadassah Medical School. His international reputation as a clinician and scholar were well known and solidified after co-authoring, *Textbook of the Fundus of the Eye*, with A.J. Ballantyne (his Scottish mentor), and was awarded the 1960 Israel Prize in Medical Sciences for his achievements.⁴²

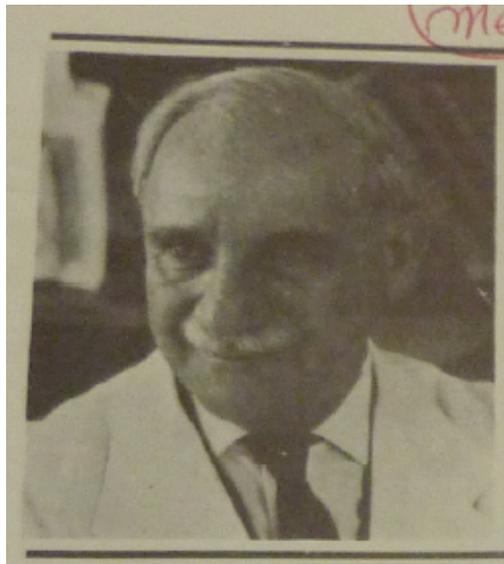


Figure 12: Isaac C. Michaelson

Although trachoma prevalence had fueled the rise of ophthalmology in Mandate Palestine, by the mid to late fifties it was no longer a major public health threat in Israel. Its disappearance from Europe and the United States meant that trachoma had lost its place as a global disease, and instead became a disease of the developing world, one which was often neglected in the face of more pressing (and fatal) priorities.⁴³ Although trachoma was still a clinical concern among immigrants from North Africa, the Middle East, and the Arab population, campaign efforts continued reluctantly and woefully underfunded.⁴⁴ The declining incidence and urgency of ophthalmic disease had put the Hadassah Hospital

⁴² *ibid.*

⁴³ G. H. Werner, B. Latte, and A. Contini, "Trachoma," *Scientific American* 210 (January 1964): 79–86.

⁴⁴ I. C. Michaelson, "Ophthalmology," *Quarterly Review of the Harefuah* 13–14, no. 1–2 (June 1952): 40–43.

Department of Ophthalmology in danger of losing its prominence and focus.⁴⁵ The renowned chair of the department, Feigenbaum, had held the position from 1922 to 1953, and the transition to Michaelson's leadership had not been a pleasant one.⁴⁶ In addition, Michaelson claimed that the department suffered from "long periods of understaffing," and the "difficulty of persuading new graduates to take up ophthalmology" during political and institutional transformations post-statehood.⁴⁷

To counter this slump, Michaelson attempted to turn Hadassah's previous experience with trachoma into a research expertise of what he called "social ophthalmology," inspired by public health. In 1956, Michaelson raised the idea of obtaining a mobile ambulance to quicken anti-trachoma efforts in the Jerusalem corridor, a string of villages in the outskirts of Jerusalem that primarily housed recent immigrants.⁴⁸ He sent Batya Maythar and Israel Feitelberg, two longtime staff members of the department, to do small-scale trachoma treatments in that area, but found their efforts severely restricted by the lack of transport. While they examined and checked students for trachoma, they also collected samples in order to conduct virological research. Michaelson claimed that "the research aspect [of trachoma] is of a greater concern to us" than the clinical, and noted that there had been a 500% increase of laboratory hours in the department, partly dedicated to isolate the trachoma agent; study trachoma antibodies; and to conduct a controlled investigation of therapies.⁴⁹

⁴⁵ Rates were quite low in Israel at this point, and trachoma was not considered as important as fatal diseases, like malaria, to funding organizations.

⁴⁶ Aryeh Feigenbaum to Joseph Hirsch, 15 November 1949, Box 103A, RG2, HMO Papers. In Feigenbaum's personal correspondence, it was referred to "L'affaire Michaelson." Personality and professional conflicts.

⁴⁷ Isaac Michaelson to Jaacov, 7 March 1960, J113/7456, HMO Papers, Central Zionist Archives (CZA), Jerusalem.

⁴⁸ Minutes from the conversation between Michaelson and Navratzki, 23 July 1956, J113/7453, HMO Papers, CZA.

⁴⁹ Michaelson to Karpas, 29 Nov 1956, J113/7453, HMO Papers, CZA.

In 1959, Michaelson finally obtained a \$7,500 grant from the American National Council to Combat Blindness to set up a mobile eye clinic that could operate three days a week, speeding up Maythar's and Feitelberg's efforts.⁵⁰ Hadassah added IL 10,000 to Michaelson's funds to employ both a fulltime virologist and mobile clinic driver.⁵¹ The American leadership of the Hadassah Medical Organization emphasized that research, rather than treatment, was the chief impetus of the mobile clinic. When told that the mobile unit would meander primarily in the Jerusalem corridor, but occasionally to Nazareth or Arab villages in the North where trachoma was rampant, Rebecca Tulin, the chairwoman of the Hadassah Medical Organization Committee, wrote back: "We want to be certain that no expansion of preventive services in trachoma should take place in the areas mentioned. We know too well that when a service is given, very often, the population expects that service to continue and we look upon this project only from a purely research angle."⁵² This further exemplifies how unfashionable trachoma treatment had become, as well as how unwilling Hadassah was to expend resources on the Arab population. The women at Hadassah were able to get the splashy press they had sought from scientific research. While on fieldwork, Maythar swapped a trachoma sample from a five month-old child, and eventually isolated the trachoma agent. The Hadassah team of virologists became the third research unit in the world to succeed in this task.⁵³

From the very beginning of his tenure as chair, Michaelson formulated the ophthalmology department's role as having a "special direction" in order to "orientate itself

⁵⁰ Mayers to Michaelson, 2 July 1958, J113/7454, HMO Papers, CZA.

⁵¹ Tulin to Mann, 11 July 1958, J113/7452, HMO Papers, CZA.

⁵² Tulin to Mann, 23 Sept 1958, J113/7454, HMO Papers, CZA.

⁵³ Arthur Soper, "Those that Walked in Darkness: The Work of the Hadassah Ophthalmological Department," n.d., J113/7455, HMO Papers, CZA.

to the responsibilities of an immigrant country and to its geographical position.”⁵⁴

Michaelson considered “trachoma research a must for this department, not only because of the needs local to our country, but in fulfillment of our function in social and medical matters in this part of the world.”⁵⁵ In service to that vision, he visited the Gaza Strip in order to initiate an anti-trachoma program, but his plans were thwarted by the political climate.⁵⁶ He acutely felt that ophthalmic research and clinical activities in Israel represented an opportunity not only to serve immigrants from the Middle East and North African countries, but to also showcase Israeli medical leadership to the nascent postcolonial world. With striking foresight, he noted in 1957 that “the political position does not encourage intervisits [sic] between the staff of this Department and similar departments in Africa and Asia. That time may come and in the meantime we try to measure up ourselves against this possibility.”⁵⁷ Therefore, when the opportunity arose for Michaelson to send his residents to Africa, he seized it. The exchange fulfilled one of his longstanding desires for the department, rather than a change of course.

1959 was not only the year the mobile eye clinic was inaugurated, but also when a crop of bright students arrived at the department.⁵⁸ The influx of young trainees coincided with a fortuitous invitation that ensured that their practice of “social ophthalmology” would extend far beyond the Jerusalem corridor.



There are various versions of how Michaelson started the ocular aid program. In one story, Liberia asked the WHO for an expert to survey eye diseases in their country, and the

⁵⁴ Isaac Michaelson, “Draft Article,” n.d., J113/7453, HMO Papers, CZA.

⁵⁵ Isaac Michaelson, “Trachoma Research in Israel,” 21 Mar 1958, J113/7454, HMO Papers, CZA.

⁵⁶ Isaac Michaelson, “Draft Article,” n.d., J113/7453.

⁵⁷ *ibid.*

⁵⁸ Michaelson to Jaaquov, 7 Mar 1960, J113/7456, HMO Papers, CZA.

WHO turned to Israel because of Michaelson's reputation.⁵⁹ Shmuel Penchas, the Director of the Hadassah Medical Organization, colorfully recounted that the cooperation started when President William Tubman of Liberia needed a new pair of glasses. Rather than wait three weeks for spectacles to arrive from London, he decided to turn to Israel for assistance.⁶⁰ The most plausible is that Liberia asked the Israeli Ministry of Foreign Affairs directly.⁶¹ The paper trail conveyed that the Liberian Ambassador to Israel, Ernst Yancy, called Walter Eytan, the Director General of Israel Foreign Ministry, and told him that his country needed two eye doctors urgently.⁶² The request had come "straight from the Liberian president," and perhaps he wanted a cheaper option than the Americans who would only set up an eye clinic at the cost of \$300,000.⁶³ The Israeli bureaucrats were happy to have an official request, as Yancy had previously privately invited physicians to take up certain posts in Liberia, creating a market for Israeli private practice that did not suit Mashav's political interests.⁶⁴ The multitude of versions indicate how often it was told and retold as a success story in speeches and reports.

The Israeli Ministry of Foreign Affairs, under Prime Minister Golda Meir, approached Michaelson to travel to Liberia to examine President Tubman and his family. President Tubman then invited Michaelson to survey eye conditions in Liberia, as there were no ophthalmologists in the country. Bringing along Shoshana Barshai, the chief nurse in the Hadassah operating theater, they took a whirlwind eight-day tour of Liberia by chartered

⁵⁹ Florence Perlman, "My Recent Trip to Africa," HMO Papers.

⁶⁰ Shmuel Penchas, "Hadassah in Africa and Asia: Jubilee Address," HMO Papers.

⁶¹ "Eye Specialist Submits Report to President," *The Liberian Age*, 31 August 1959, Box 103M, RG2, HMO Papers, CJH.

⁶² Walter Eytan to Hanan Aynor, 6 July 1959, ISA/RG 130/MFA/2030/9.

⁶³ Olusolam Ojo, *Africa and Israel: Relations in Perspective*, (Boulder: Westview Press, 1988) 10.

⁶⁴ A. Ben Horin to Hanan Aynor, 29 May 1959, ISA/RG 130/MFA/1930/12.

plane, visiting Monrovia, Cape Palmas, Bassa and Sinoe. Michaelson examined the eyes of 200 patients, advised on surgeries, and consulted with the President, his Medical Advisory Council, and the Liberian Public Health Authorities. His suggestions included opening an eye hospital with 20 beds and an operating theater in the capital Monrovia alongside a general hospital, to be initially operated by Israeli ophthalmologists.⁶⁵

In his “Report on Ophthalmological Services Required in Liberia,” Michaelson articulated for the first time his own motto of development which the department continued to use for the next twenty years: “To serve, to teach, to leave.”⁶⁶ His vision of ocular aid focused on a seven-year plan, consisting of three stages. In the first stage, which would last about nine months, two qualified Liberian nurses would come to the Hadassah University Hospital for specialized eye training; equipment was to be ordered from abroad; and a building would be found to adapt to an eye hospital, with an outpatient clinic. During the second stage, which was to last for four years, two teams of Israeli eye surgeons and optometrists were to service the new department each for two years, together with the Liberian nurses who would return from Jerusalem. During the second stage, two Liberian doctors would come to Jerusalem to begin specialized training and prepare the way for the third and final stage, in which Liberian and Israeli eye doctors would work together in Monrovia. Michaelson predicted that this final stage would last two years, at the end of which time there would be no need for outside help with regard to all ophthalmic services.⁶⁷ The most notable emphasis was placed on the fact that the Israelis would “leave,” distinguishing them from colonial career physicians. Yancy, the Liberian Ambassador in Israel, “was most appreciative of the fact that it was Hadassah’s intention to ‘pull out’ of Liberia once the new

⁶⁵ Isaac Michaelson, “Report on Ophthalmological Service Required in Liberia,” 9 Sept 1959, Box 103M, HMO Papers, CJH.

⁶⁶ *ibid.*

⁶⁷ *ibid.*

Eye Hospital could be run by local physicians and nurses, and he saw in this attitude on the part of Israel and Hadassah a wonderful type of technical assistance.”⁶⁸ This basic framework guided how eye aid was carried out in all other African countries that requested it from Israel.⁶⁹

This project was often highlighted as a model of why Israeli aid was attractive. Michaelson fended off fears of Communist or colonial infiltration through providing medical education for Africans and devising an exit plan from the start. These characteristics were showcased in what Mashav termed the “integrated project,” the stalwart of Israeli development philosophy, which combined service with the training of local personnel.⁷⁰ The Monrovia eye clinic was often cited in newspaper and scholarly articles “as a highly successful ‘integrated’ project,” and Michaelson’s maxim of “To serve, to teach, to leave” became the rallying cry of all of Mashav’s programs.⁷¹ The Israeli eye doctor was differentiated from Belgian, French, or British physicians who had spent their professional lives in African countries, and continued to remain as private practitioners or aid workers. With his residents streamlined to serve in Africa, Michaelson sidestepped the bureaucracy that was present in larger countries.⁷² Barely two months after Yancy’s initial request, Michaelson had landed in Liberia on his scouting mission. One scholar summarized the program’s praise this way: “Israel’s work with African countries on treatment of blindness and related problems is an example of cooperation at its best. It demonstrates the usefulness

⁶⁸ Mann to Perlman, 5 June 1960, Box 133/14, RG 2, HMO Papers, CJH.

⁶⁹ Isaac Michaelson, “Ophthalmology in Developing Countries,” *American Journal of Ophthalmology*, 59 (1965) 412.

⁷⁰ Zvi Yehuda Hershlag, *Israel-Africa Cooperation: Final Report* (Tel Aviv: Tel Aviv University, Research Project on Israel-Africa Cooperation, 1973); Nora Levin, “Israel and the Developing World: New Concepts in Technical Assistance,” *Bulletin of the Atomic Scientists* (November 1972) 38.

⁷¹ Laufer 30.

⁷² “Israel’s Amazing Foreign Aid Programme,” Nov 1961, Box 133/14, RG 2, HMO Papers, CJH.

and potential of a limited, specialized program in which one country transmits to another particular knowledge and skills, and in turn, benefits from the effort.”⁷³

The program’s success story was Moses Chirambo from Malawi who came to Hadassah to specialize in ophthalmology in 1970. He was thought to have “exemplified” Michaelson’s tradition of service when he opened the Southern Africa Development Corporation School of Ophthalmology in Lilongwe in 1980, training ophthalmic medical assistants from all Southern African countries with funding from Sight Savers International, and opened four eye hospitals in each region of Malawi.⁷⁴ In 2008, he was appointed as the country’s Minister of Health, but passed away in 2010.⁷⁵ Although he achieved a political position forty years after it would have been expedient for Israel, it is worth noting that Malawi was one of four African countries that did not sever ties with Israel in 1973.

The creation of an ophthalmic exchange program was a very material way to demonstrate Israel’s in-between developing status, and that “what Hadassah did in Palestine 42 years ago can be duplicated in Africa today.”⁷⁶ A Hebrew University report linked eye aid to Africa on Israel’s own struggles with endemic eye diseases during the Mandate period.⁷⁷ This trope was emphasized at the graduation of the first two Liberian nurses from the six-month postgraduate course in the Hadassah Ophthalmology Department who were set to return to Monrovia. In the graduation speech, Kalman Mann, the Director of the Hadassah Medical Organization, affirmed that Hadassah also started with two nurses in 1913—

⁷³ Laufer 130.

⁷⁴ Hanan Zauberman, “Israeli Ophthalmologists in Africa,” HMO Papers.

⁷⁵ “Remembering Moses Chirambo, Malawi Ophthalmologist & Minister of Health.” International Council of Ophthalmology, 15 Aug. 2010. Web. 07 July 2015.

⁷⁶ Kalman Mann, “Hadassah Aid to Ethiopia and Liberia,” 7 December 1960, Box 133/14, RG 2, HMO Papers, CJH.

⁷⁷ *Hebrew University Cooperation with Developing Countries* (Draft), (Jerusalem: The Authority for Research and Development, The Hebrew University of Jerusalem), Harry S. Truman Institute for the Advancement of Peace, 1970.

Americans Rose Kaplan and Rachel Landy—who were sent to treat trachoma at a Jerusalem clinic with Albert (Abraham) Ticho.⁷⁸ Correlating the two Liberian and American ophthalmic nurses illuminated how eye health could be considered the grounds not only of medical development, but also of political similarities between Israel and Africa.

The Hadassah Medical Organization itself did not donate any financial contributions to the African program, but reaped the benefits of its positive press. The rationale for avoiding funds was because “donors giving large amounts of money for work in Israel may be distressed if we were siphoning off a portion for other countries.”⁷⁹ As an American organization, Hadassah administrators could construe African aid as an extension of their work of modernizing Palestine, a trickling down of American expertise, rather than the exportation of a specific Israeli know-how, like the Nahal brigades or moshav settlements. Steeped in Kennedy’s mindset, the Hadassah ladies viewed its aid to Africa as promoting American, not just Zionist, values abroad.⁸⁰

Perlman, the American national chairwoman of the Hadassah Medical Organization, did just this when she expounding on the distinctions between Hadassah and colonial physicians. During her trip to Africa, she made a point to visit Dr. Albert Schweitzer’s hospital in Lamberene, Gabon, perhaps the most famous medical missionary of the twentieth century. Although Perlman thought Schweitzer at first made a great contribution to bringing worldwide attention to African health, she was “really horrified at the carelessness in sanitary precautions,” and criticized Schweitzer’s belief that “they [Africans] are not ready for modern medicine and would go back to the witch doctors” if it weren’t for his village.⁸¹ The

⁷⁸ Kalman Mann, “Hadassah Aid to Ethiopia and Liberia,” HMO Papers.

⁷⁹ Schacht to Lieberman, 10 Dec 1963, Box 133/14, RG 2, HMO Papers, CJH.

⁸⁰ *In the American Tradition: The Hadassah Story*. Dir. Sidney Milstein. Aegis Productions, 1963. Videocassette.

⁸¹ Florence Perlman, “My Recent Trip to Africa,” HMO Papers.

Israeli eye clinic in Liberia convinced her that “Africans are ready to accept modern hospital facilities,” indicating that Israelis truly brought technological innovations to Africa, while European physicians were stuck in a colonial mindset.⁸²

Eliyahu Neumann, who Perlman had met on her trip, and his wife Miriam, an optometrist, were the first team to open and operate the 22-bed eye hospital and optometry clinic in Monrovia, along with Hanan Zauberman who came in September 1960. They examined 12,000 patients and perform 1,000 surgeries over two years.⁸³ Unlike other African countries, Liberia did not have endemic trachoma, and most surgical cases were due to cataracts or glaucoma. Patients came from all over the country, including foreign countries such as the Ivory Coast and Sierra Leone. The two doctors did not, however, confine their activities to the capital. Zauberman conducted a regular monthly clinic in the government hospital in Cape Palmas, a major town, and both conducted mobile eye clinics in the rural interior.⁸⁴ President Tubman officially honored Neumann, and Perlman acknowledged that he seemed “a little regretful to give up the independence and administrative responsibility which he has experienced here.”⁸⁵

It was not an accident that Israel’s first program was in Liberia. Under US influence, Liberia voted for a Jewish state in Palestine in 1947, and President Tubman believed in affinities between the Back to Africa movement and Zionism, both settler societies that returned to their native homeland.⁸⁶ The eye clinic was arguably the most notable technical

⁸² *ibid.*

⁸³ Gideon Tadmor, “‘Lighten mine eyes’: prevention of blindness, cure of blindness, training of the blind: a joint venture between Israel and developing countries in Africa and the Middle East,” *Shalom, Alumni Bulletin of Israel-Trained Students* (Jerusalem, 1963) 11.

⁸⁴ Tadmor 12.

⁸⁵ Florence Perlman, “My Recent Trip to Africa,” HMO Papers.

⁸⁶ Yekutiel Gershoni, “Liberia and Israel: The Evolution of a Relationship,” *Liberian Studies Journal*, 14:1 (1989) 35.

project in Liberia. The request for two eye doctors had come from President Tubman, and Israel ascribed great political importance to fulfilling his wish.⁸⁷ There may have been another reason, a more personal one, as to why Tubman wanted eye specialists in particular: he had eye problems of his own. The chickenpox virus inflamed the irises of both of Tubman's eyes in 1962, and he was diagnosed with glaucoma at the same time. In 1967, Zolu D. Traub, the ophthalmologist Michaelson had trained at Hadassah, urged Michaelson and Zauberman to rush to Monrovia to perform emergency cataract surgery on Tubman, briefing in a telegram: "Please bring with you Zeiss ophthalmoscope and one hand lamp."⁸⁸ Rather than be operated on abroad, Tubman felt that he "should set an example and avail himself of the same facilities his people used," and underwent a successful surgery in the eye clinic the Israelis had developed.⁸⁹

President Tubman's trust of Israeli physicians—to the extent that he put himself under the knife—revealed the status Israeli physicians and healthcare had achieved in Liberia. Medical aid constituted 40% of Israeli technical expertise to Liberia, a higher percentage than in any other country.⁹⁰ Dr. Michael Davies, a Professor at the Hebrew University-Hadassah Hospital, had acted as the acting Health Minister of the country when Dr. Edward Barclay, the Liberian Health minister went to the United States for a one-year fellowship, as he trusted the Israelis more than the Americans.⁹¹ As Head of the Liberian Health Services, Davies had presidential authority to make whatever changes he deemed necessary to the administration of health services.⁹² Dr. Beller, a doctor who had visited Liberia, wrote of eye care that, "Dr.

⁸⁷ Haim Aynor to S. Syman, 22 July 1959, ISA/RG 130/MFA/1930/11.

⁸⁸ Zolu Traub to Isaac Michaelson, 11 May 1967, ISA/RG 130/MFA/2877/15.

⁸⁹ Hanan Zauberman, "Israeli Ophthalmologists in Africa," HMO Papers.

⁹⁰ "Israeli Aid in the Medical and Sanitary Fields," Sept 1968, ISA/RG 130/MFA/2915/20.

⁹¹ A. Remez to H. Yavor, 31 August 1960, ISA/RG 130/MFA/1930/12.

⁹² Michael Davies to Foreign Ministry, 1 Dec 1961, ISA/RG 130/MFA/1930/12.

Neuman has a central role in the medical life here... and that was confirmed by the Health Minister and other government officials.”⁹³

In fact, Tubman thought so highly of Israeli medical services, that the Israeli government could not keep up with his requests, to the Israeli ambassador’s chagrin. He wrote anxious letters back to Mashav headquarters, complaining that Liberia will get physicians from America if Israel could not fill the requests, and that “our enemies will rejoice in our failures.”⁹⁴ Although Davies’ had the “full trust of the President,” his attempts to reform what he called the nepotistic and untrained Ministry of Health ruffled too many feathers after he decided to fire 80 health workers (with the President’s permission).⁹⁵ He concluded that other ministers only wanted the development that could be bought with money—hotels, ports, and roads—while spurning changes in education and health services. Davies advised Mashav to stick to sending specialists who could earn Israel a “good name,” as any project to change the administrative structure of a government ministry was “destined to fail.”⁹⁶ If there was a tension between development practices and political goodwill, the latter took precedence.

Although eye aid was an “integrated project,” it was not integrated into the host country’s own health services, and as Davies’ experience suggests, it would have been an uphill battle to do so. The maintenance of the program, which appeared so neat in Michaelson’s motto, could in fact easily fall apart. In Liberia, Zolu Traub was sent in 1962 to train at Hadassah for two years to specialize in ophthalmology. He returned to Monrovia to practice at the eye clinic, overlapping with Israeli Moshe Lazar who served in Liberia from 1964 to 1966. The transfer of services did not, however, proceed as expected. Michaelson on

⁹³ A. Beller to H. Yahil, 20 June 1960, ISA/RG 130/MFA/1930/12.

⁹⁴ Cohen to Remez, 22 Feb 1961, ISA/RG 130/MFA/1930/12.

⁹⁵ Cohen to Remez, 1 Mar 1961, ISA/RG 130/MFA/1930/12.

⁹⁶ Davies to Ministry of Foreign Affairs, 1 Dec 1961, ISA/RG 130/MFA/1930/12.

a 1965 visit to the clinic was “slightly disappointed” in Traub because he was “starting to act like the rest of the Liberian physicians,” prioritizing private practice over the clinic.⁹⁷ In 1966, the Israeli Ambassador to Liberia claimed that Traub “doesn’t do anything to further the profession. He goes his way, but that doesn’t have to bother us.”⁹⁸ The Hadassah Ophthalmology Department continued to send residents to Monrovia up until the early 1970s (well over the seven years the transfer of expertise was supposed to take). In 1971, Michaelson wrote that the “unreliability of Traub is clear and goodwill is going...I think it is possible that Traub wants us out so he could bring in an American group...this may automatically bring him a fellowship the United States.”⁹⁹ Michaelson pressured the Liberian government to send a second doctor to specialize in ophthalmology in Hadassah, but he did not succeed. In fact, after Traub retired, President Doe contacted Hadassah to renew cooperation in ophthalmology and send another ophthalmologist in 1984. The department obliged.¹⁰⁰

“Parcel of Human Eyes”: African Ocular Research as Extra-Territorial Pioneering

The development of large-scale ocular aid programs in Africa was not, however, only about giving. The presence of Hadassah physicians in Africa provided excellent opportunities for research and acquiring clinical experience. Mrs. Perlman related as much, when she wrote that Eliyahu Neumann, the first director of the Monrovia clinic, claimed that he had done as much surgery in Africa in two years, as he would have had the opportunity to do in fifteen in Israel. In addition, Neumann spent two days a week conducting research on river blindness at the Liberian Institute of the American Foundation for Tropical Diseases, resulting in eight

⁹⁷ Astar to Liba, 6 July 1965, ISA/RG 130/MFA/1930/14.

⁹⁸ Astar to Bein, 27 Nov 1967, ISA/RG 130/MFA/2877/15.

⁹⁹ Michaelson to Rodan, 24 Dec 1971, ISA/RG 130/MFA/4837/4.

¹⁰⁰ Hanan Zauberman, “Israeli Ophthalmologists in Africa,” HMO Papers.

publications.¹⁰¹ Michaelson's plan "did not envisage, what has since become clear, the great scope for ophthalmic research in African countries, especially when combined with the laboratory facilities of a 'parent' department."¹⁰² Neumann could return to Jerusalem a skillful surgeon and a seasoned scholar. From 1959-1973, Israeli physicians conducted sixty studies on African eye diseases.¹⁰³ This research was subsidized by grants made by the Fund for Ocular Research in Africa, which was effectively run by Michaelson but funded by Mashav. Michaelson was able to convince Mashav that a special research grant allowed for the recruitment of more doctors; enriched the service of eye doctors in Africa; and produced publications in international journals that publicized Mashav's work.¹⁰⁴ Ocular aid was then not only an exportation of uniquely acquired expertise, but also an importation of new knowledge to examine and international prestige to advance.

This "colonial distance" that enabled physicians to face a host of clinical and life experiences, also allowed them to experiment and create new knowledges that would not have been possible in the center. Hadassah ophthalmologists serving in Africa published not only on tropical ocular diseases, but also on ocular diseases that seemed to present themselves differently among different racial groups. The Hadassah ophthalmic teams in Africa confirmed that retinal detachment was much less frequent among Africans than among Caucasians. Combined research between Jerusalem and clinical statistical studies in Tanzania and Liberia included: "investigation of the chemistry of the outer layer of the retina with particular regard to any difference that may exist between African and Caucasian eyes; [and] an examination of the physical separability of the retinal layer in African and Caucasian

¹⁰¹ Florence Perlman, "My Recent Trip to Africa," HMO Papers.

¹⁰² Isaac Michaelson, "Ophthalmology in Developing Countries," *American Journal of Ophthalmology*, 59 (1965) 412.

¹⁰³ Arye Oded, "Fifty Years of Mashav Activity," *Jewish Political Studies Review*, 21:3/4, (Fall 2009) 101.

¹⁰⁴ Isaac Michaelson to Ministry of Foreign Affairs, 30 Mar 1970, ISA/RG 130/MFA/4386/16.

eyes.”¹⁰⁵ Ophthalmology could now not only mark cultural and economic disparities, but also biological variance. The development of racial typologies of the eye had many implications, including, perhaps, that Israelis were just as invested in creating difference between Israeli and African bodies, as they were in promoting state similarities. Although Michaelson had taken great care in creating a postcolonial program, it nonetheless replicated some colonial elements.

Michaelson himself was a product of the British Empire, and looked up to British heroes of imperialism. Michaelson’s wife, Ora, recounted in her memoir that her husband had always been interested in medical aid to Africa, “perhaps, guessing, that the reason was that as a child he grew up in Edinburgh on Livingstone Street, named after Dr. Livingstone who discovered a large part of Africa.”¹⁰⁶ David Livingstone was a nineteenth-century Scottish medical missionary who distinguished himself as an explorer and author. Hanan Zauberman, Michaelson’s student and successor as chair, had also heard this story and wrote that during their strolls through Jerusalem, Michaelson would describe how growing up on Livingstone Street inspired his way of thinking about establishing links between Jewish and African people. Zauberman even witnessed him fulfill this small dream: “I recall that in 1963 when he came to supervise our work and organize research, we travelled to Tabora, where Dr. Livingstone’s main residence had been. When Prof. Michaelson visited the Livingstone memorial, he engaged in a bit of monologue that went, ‘Dr. Livingstone, I presume?’”¹⁰⁷

While Livingstone’s death galvanized the scramble for Africa, he is remembered as treating Africans as equals, and “his reputation on the continent is better than that of

¹⁰⁵ “Department of Ophthalmology,” Hadassah Medical Organization Annual Report 1964-1965, Jerusalem, Israel.

¹⁰⁶ Ora Michaelson, *Memoirs of Isaac and Ora Michaelson* (Jerusalem, 1982).

¹⁰⁷ Hanan Zauberman, “Israeli Ophthalmologists in Africa,” HMO Papers.

any European explorer, missionary, or politician.”¹⁰⁸ Livingston was then a particularly fitting and ambiguous role model for Michaelson’s own medical assistance, who objected to forthright racism, but who also functioned in a world where the contours of power had already been shaped. Michaelson maintained a belief in colonial benevolence, claiming that “although it is a moot question whether the colonial powers did all they might have, it must be admitted that countries under colonial rule had better medical services than those which did not.”¹⁰⁹ While Michaelson attempted to fashion a program that expunged any colonial overtones—in line with the technical aid projects of the day—even Israeli development tooted a theme on the civilizing mission.

These riffs on colonialism were evident in an Israeli governmental film about the eye aid program. Eager to create a film about his African efforts, Michaelson dashed off identical letters to Israeli ambassadors in Rwanda, Malawi and Tanzania, asking for their support for the making of a documentary about the eye clinics in their countries. He sketched possible film outlines, including the one that got made which echoed the missionary plot line of bringing “light to the blind”: “Blind patient in village—trip to hospital—admission—stay in hospital—operation—recovery—return of vision—return to village.”¹¹⁰ With financial backing from Hadassah and Mashav, Wim Van Leer, the founder of the Jerusalem Cinematheque, directed the film in Rwanda titled (with an eye towards Michaelson’s proclivities), “Dr. Loewenstein, I Presume?”¹¹¹ In the opening segments of the film, the narrator reports:

“It was under the white man in the Victorian era under the pressures of domestic bliss, that he began to explore the Africa

¹⁰⁸ Nancy J. Jacobs, *African History through Sources: Volume 1, Colonial Contexts and Everyday Experiences, c. 1850–1946* (Cambridge University Press, 2014) 53-55.

¹⁰⁹ Isaac Michaelson, “Israel’s Best Ambassadors,” Sept 1967, Box 133/14, RG 2, HMO Papers, CJH.

¹¹⁰ Michaelson to Harel, 31 March 1967, ISA/RG 130/MFA/2877/35/.

¹¹¹ *Dr. Loewenstein, I Presume?*. Dir. Wim Van Leer. 1968. Film reel. Israel State Film Archives.

continent, thereby bringing the blessings of civilization to his black brothers. Some like Dr. Livingstone lost their way, bringing to prosperity the memorable phrase, 'Dr. Livingstone, I presume?' Later, much later, the white man departed by order, returned by request for a new vision. The State of Israel never saw those colonial days, yet now over 3000 Israeli specialists have taken part in Africa's rebirth. And now there is a new phrase: 'Dr. Loewenstein, I presume?'"¹¹²

Dr. Loewenstein was not actually the name of any ophthalmologist in Israel, but signified a typical German Jewish name that paired well with Livingstone. The imagery seems to mock the end of colonialism, showing a cartoon of a large black hand ordering a ship to leave to illustrate decolonization. The ship immediately turned face back to Africa, with the black hand shaking a white hand on board to signal the age of development. Israelis, it implied, can bring the blessings of civilization to Africa as well as any Brit, and can take part in this new neocolonial contest. The colonial imagery takes on new meanings in the final scene of the film, which alluded to the Israeli victory of the 1967 War.

"And is not Hadassah rising from the Judean Hills his brother keeper? Brotherhood knows nothing of creed or color. Israel spread her wings to go forward to the dark corners of the earth, wherever man is in need, armed with skill and determination and fortified by a new unity symbolized by a new Jerusalem. The word will go forth to a fearful world where an immense task remains to be done."¹¹³

Shots of the Dome of the Rock and a soundtrack of the "Jerusalem of Gold" accompanied those words, indicating that Israel's messianic capture of new territories at home were aligned with her task in Africa.

Botched trachoma vaccine trials in Malawi also indicated the colonial undertones of Michaelson's project. Trachoma, as previously mentioned, turned into a major laboratory focus that fit in with Michaelson's larger vision of "social ophthalmology." The emphasis on preventive medicine led researchers worldwide to study the possibility

¹¹² *ibid.*

¹¹³ *ibid.*

of a trachoma vaccine, including laboratories at the Harvard School of Public Health, the US Navy in Taiwan, and the Lister Institute for Preventive Medicine in London.¹¹⁴ Hans Bernkopf of the Virology Department and Batya Maythar of the Ophthalmology Department collaborated in developing a trachoma vaccine, using the reservoir of Jerusalem corridor patients as their research subjects. However, they could not develop a solution with “sufficient antibodies to protect the eye because the contact of body fluids with the eye is so very small.”¹¹⁵ The Hadassah Women’s Organization of America was extremely excited about this project, putting pressure on Hadassah researchers to publish and make statements to the press.¹¹⁶ Mrs. Mildred Weisenfeld, the executive director of the National Council to Combat Blindness, said progress at Hadassah on the trachoma vaccine was “truly the most exciting news that I have heard in a long time...I will be anxious to hear, too, when this is an established fact.”¹¹⁷

Michaelson actively arranged to conduct trachoma vaccine trials in Malawi, notifying Mashav to prepare service passports for Maythar and Bernkopf, while he secured airfare funding from the Hadassah medical school research endowment. However, the Hadassah research was not the only one having trouble receiving positive results; most vaccine trials were inconclusive, and even resulted in more severe forms of the disease.¹¹⁸ Michaelson decided and relayed in his personal report to President Banda of Malawi not to go ahead with vaccination trials, claiming that “I am not yet satisfied that the vaccine has been so developed

¹¹⁴ Hugh Taylor, *Trachoma: a Blinding Scourge from the Bronze Age to the Twenty-first Century* (Melbourne: Centre for Eye Research Australia, 2008) 168.

¹¹⁵ Kalman J. Mann, “HMO Medical Center Seminar Address,” 7 March 1961, Box 133/14, RG 2, HMO Papers, CJH.

¹¹⁶ Charles Segal to Kalman Mann, 6 May 1963, Box 143/5, RG 2, HMO Papers, CJH.

¹¹⁷ Mildred Weisenfeld to J. Karpas, 8 June 1959, J113/7455, HMO Papers, CZA.

¹¹⁸ Satasuk Joy Bhosai, “Trachoma: an update on prevention, diagnosis, and treatment,” *Current Opinion Ophthalmology* 23:4 (2012) 290.

that it prevents trachoma to a sufficient degree as to justify the expense and trouble of its use.”¹¹⁹ President Banda responded in kind, “I agree with what you say about a trachoma vaccine, and indeed I am reluctant that my people should be experimented upon in this respect.”¹²⁰ The cold comment implied that Israel should not consider itself welcome to Malawians as mass research subjects.

Rather than replace the model of the colonial physician, as Michaelson envisioned, Mashav hoped Israelis would simply usurp their position. Israeli physicians both competed and collaborated with colonial physicians who had now found themselves working in a decolonized world. Dr. Peery, working in a the new Haile Selassie Hospital in Massawa, Eritrea (part of Ethiopia from 1952-1991), opened with Mashav funds, wrote a detailed report to the Israeli consul-general in Addis Ababa about the negative attitudes of Italians towards them: “Before we came, they had a complete monopoly of medical practice in the country, which, apart from the economic position, gave them quite a lot of influence, and they were exploiting it.”¹²¹ The Israeli surgeon was a direct rival. The Eritrean Director of Medical Services apparently had been nice enough “as long as we were in Asmara doing practically nothing,” but refused help once the hospital opened because “he was always working hand in glove with the Italian medical personnel,” and only furthered their interests.¹²² Because the fact that the hospital had to overcome suspicion on the part of the Muslim population, limited manpower and supplies, Peery was not sure if the hospital could succeed in its “desired propaganda effect...if we are to achieve it, we must be so much better than the others that the layman should see and appreciate it, and that’s not easy.”¹²³ Another physician, writing in

¹¹⁹ Isaac Michaelson to President Banda, 19 Oct 1965, ISA/RG 130/MFA/1930/3.

¹²⁰ President Banda to Isaac Michaelson, 5 Jan 1966, ISA/RG 130/MFA/2877/34.

¹²¹ Peery to Consul General of Israel in Ethiopia, 16 June 1961, ISA/RG 130/MFA/1922/14.

¹²² *ibid.*

¹²³ *ibid.*

1965, blamed Mashav's limited resources for not taking enough advantage of the postcolonial moment to cement their power, claiming, "I am not exaggerating when I say we could have bought our world here if at the time when the Italians in Eritrea left in 1964 if we would've sent 20-30 doctors quickly," but Kupat Holim held up the appointments and the moment had passed.¹²⁴ Medicine was another avenue towards political power, and the Mashav wanted Israelis to imitate the Italians, rather than create a new paradigm.

Israeli physicians also collaborated with European physicians and missionaries. In the film, "Dr. Loewenstein, I Presume," the narrator introduces the viewers to Father Bourdieu, who before serving as a missionary in Rwanda for thirty years had been a lens grinder in his native Belgium. When the work of the Israeli ophthalmologists created a demand for eyeglasses, Father Bourdieu returned to his craft, "grateful to those, who like Dr. Sacks [the Israeli ophthalmologist], are looking after the corpore sano end."¹²⁵ At the same time, the film subtly mocks the work of the missionaries, claiming that their education led Africans to Karl Marx rather than to Saint Mark.

Although the ocular experts were supposed to return home—as in Michaelson's "To serve, to teach, to leave" motto—scientific research was not intended to be time-bound. Towards the end of the eye documentary, Michaelson appears in the hills of Ein Karem with his colleagues, and claimed that after Israeli eye doctors returned to Jerusalem, "Research in African eye diseases, that will go on, and that will be the link between the bush and Hadassah."¹²⁶ Mashav bureaucrats were also interested in leaving a lasting presence in Liberia. Moshe Lazar, an Israeli eye doctor who served in Liberia from 1964-1966, recommended that Mashav donate an ambulance to act as a mobile clinic in rural regions, and

¹²⁴ A. Matan, "Report on my Work in Ethiopia as a Regional Physician," 21 July 1965, ISA/RG 130/MFA/1922/13.

¹²⁵ *Dr. Loewenstein, I Presume?*. Dir. Wim Van Leer. 1968. Film reel. Israel State Film Archives.

¹²⁶ *ibid.*

that could transport patients to the eye clinic in Monrovia for surgery. The ambulance could then act as the “Israeli representative” once the Israelis had left the country.¹²⁷ With much fanfare, Mashav was able to buy a Commer Land Rover ambulance to operate as a mobile eye clinic for IL 15,000 and shipped it to Liberia as a gift for President Tubman’s seventieth birthday. It had been highly appreciated by the President and was considered the nicest present he received.¹²⁸

Ocular aid took place not only within Africa but also involved bringing people and specimens into Israel. Kalman Mann, the Director-General of the Hadassah Medical Organization, gave an HMO Medical Center Seminar address at the Hotel Commodore in New York City on March 7, 1961.¹²⁹ He began by relating this story: while he was sitting in his office in Jerusalem, he received a phone call from the Chief Rabbi of South Africa, Rabbi Louis Rabinowitz, who wanted to deliver something to him in person. After traveling throughout the Far East, Rabbi Rabinowitz had been asked to carry a package from the Ophthalmic Hospital in Bangkok: “The parcel I am carrying is not really befitting a Rabbi, but I was assured at Bangkok that it was a great humanitarian thing – a parcel of human eyes.” This specimen of eyes had rare pathologies that were sent to Michaelson to be studied. Mann “was not surprised that Bangkok University sent the parcel across the Indian Ocean and across the Himalayan Mountains to little Israel to make a study of the eyes in that queer little parcel...human beings and human parcels have been coming to this department for a long time.”¹³⁰

¹²⁷ Lazar to Israeli Consulate in Ethiopia, 4 Jan 1964, ISA/RG 130/MFA/1930/14.

¹²⁸ Foreign Ministry to Liberian Ambassador, 15 November 1965, ISA/RG 130/MFA/1930/4.

¹²⁹ Dr. Kalman J. Mann, “HMO Medical Center Seminar Address,” HMO Papers.

¹³⁰ *ibid.*

A pair of Thai eyes, as Mann noted, was not the only package he received. Neumann, serving in the Liberian eye clinic in Monrovia, sent him a 20 mm corkscrew-shaped worm pulled from the eye of a nine-year-old boy. Neumann had not identified the worm in any textbook, and wanted it examined to determine the therapy and type of disease. Mann also told the story of a three-year-old girl from Iran who came to Israel after failed attempts in Germany and France to remove a cancerous tumor in her eye. In Israel, she was treated with cobalt, and an electro-retinocoagulator (pre-laser technology) was used to burn the tumor away; a year later, Mann claimed, “the eye is perfect; the sight is perfect; the vision is perfect.”¹³¹ Why were these “human beings and human parcels” regarded as valuable to Hadassah? Research on Third World eyes and diseases constituted the continued relevance and prestige of the Hadassah Hospital Ophthalmology Department. As local endemic pathologies minimized, the Ophthalmology Department needed to establish its reputation through scientific research by literally importing diseased eyes of the global periphery. This reputation was transformed into international respect.

Israeli ocular research in Africa, coupled with trachoma expertise at home, formed the basis and justification for Michaelson’s conference, “Causes and Prevention of Blindness: The Jerusalem Seminar on the Prevention of Blindness,” under the auspices of the Israel Academy of Sciences and Humanities, and co-sponsored by the Hadassah Medical Organization and the Israel Ophthalmological Society in 1971.¹³² This was the first large-scale seminar on public health ophthalmology in the world, with 450 delegates from 41 countries participating, including many distinguished clinicians. One participant claimed, “Here we have the real giants of ophthalmology,” and another wrote that he met the “King-

¹³¹ *ibid.*

¹³² Isaac Michaelson and Elaine Berman, *Causes and Prevention of Blindness: Proceedings of the Jerusalem Seminar on the Prevention of Blindness 25-27 August 1971, Jerusalem* (London: Academic Press) 1972.

Pins' of ophthalmology from every end of the globe" in Jerusalem.¹³³ Ophthalmologists, scientists, public health administrators, and representatives of international organizations (including the WHO, the Royal Commonwealth Society of the Blind, and the International Association for the Prevention of Blindness) participated in sessions on eye diseases in both developing and developed countries, the meaning and implementation of public health ophthalmology, and ocular research agendas.

In his welcome address, Michaelson reinforced his country's unique qualifications, stating that, "It seemed natural to hold this seminar in Jerusalem because half of Israel's population has come from developing countries while the other half originates from developed countries. Israel's experience in helping developing countries with their eye problems was another reason for convening the seminar in this country."¹³⁴ During the conference, Israel's eye aid program was highlighted as model for organizations and nations to follow, as it was the only one of its kind whose goal was to provide eye services in a developing country with the training of ophthalmologists and nurses. As the host of the conference, Michaelson won universal praise and respect not only for himself, but for Israeli capabilities: Alfred Edward Maumenee Jr., the director of the Wilmer Eye Institute at Johns Hopkins Hospital from 1955 to 1979 and the foremost corneal transplant and cataract surgeon in the world, wrote to Michaelson after the conference: "Words fail me when I attempt to tell you what a superb job you did in putting on the Congress last week...It will go down as a monument to your many capabilities...I was truly impressed with Israel."¹³⁵

¹³³ Philip Gillon, "World Prevention of Blindness Committee formed at Jerusalem International Seminar," 31 Oct 1971, ISA/RG 130/MFA/4794/29.

¹³⁴ Isaac Michaelson and Elaine Berman eds., *Causes and Prevention of Blindness: Proceedings of the Jerusalem Seminar on the Prevention of Blindness 25-27 August 1971, Jerusalem, 1972.*

¹³⁵ Maumenee to Michaelson, 1 September 1971, ISA/RG 130/MFA/4794/29.

Michaelson had less of a success convincing the World Health Organization that Israel served as the perfect site between developing and developed. While the WHO did send a representative to the conference who gave a paper on its blindness prevention activities, it refused Michaelson's requests to co-sponsor because "political difficulties would not allow for universal participation, including those countries where trachoma has highest rates."¹³⁶ Michaelson's formulation left out the Arab East from his global visions to prevent blindness, and therefore, the WHO was not so easily swayed that Israel's expertise was at all unique. In his attempts to convince Professor Barrie R. Jones of Moorfields' Eye Hospital in London to attend the conference, a distinguished trachoma expert who had conducted extended field studies in Tunisia, Iran, and Iraq, Michaelson wrote that, "political difficulties should not prevent medical progress. We feel the medical truth regarding the prevention of blindness *is in us*, and we can't be silent on the matter"¹³⁷ [emphasis mine]. This ultimately did not coax Jones to attend, who cited competing obligations.¹³⁸

Diplomats and Development: Politics of Healthcare

The benefits of ocular aid from Michaelson's standpoint were undeniable: his department had grown in "scope, experience, and reputation" since 1959.¹³⁹ However, not all diplomatic personnel serving in Africa evaluated eye aid as politically expedient. Ambassador Gideon (Geda) Shohat of Malawi was one of Michaelson's most outspoken critics within the pages of Mashav correspondence. He was the son of famed Manya and Israel Shohat, founders of the Sedjera collective in the Galilee in 1907 and leaders of the guard association "Hashomer." Although biographies of Manya Shohat abound, Geda is

¹³⁶ Tarizzo to Candau, 20 Jan 1970, 6/440/2, World Health Organization (WHO) Archives, Geneva.

¹³⁷ Michaelson to Jones, 31 Dec 1970, 6/440/2, WHO Archives.

¹³⁸ Jones to Tarizzo, 25 Jan 1971, 6/440/2, WHO Archives.

¹³⁹ Laufer 128-129.

seldom eluded to.¹⁴⁰ Shohat was a pilot in the British Royal Air Force (RAF) during World War II and later became one of the founding pilots of the Israeli Air Force, rising to the rank of Colonel. Shohat did not discredit the humanitarian value of eye aid, but he was skeptical of its prominence within Israeli medical aid perched from his home post of Blantyre. This became especially clear when Michaelson tried to send a second ophthalmologist to Malawi in 1965, Saul Merin, to work with Michael Freund. According to Michaelson's scheme, to build basic eye services required physicians working in pairs.

However, a second eye doctor was not allotted for in the aid contract between Malawi and Israel, and Malawi was unwilling to allocate resources for a second eye doctor's salary.¹⁴¹ If the position was insisted upon, the IL 50,000 salary would be the responsibility of Mashav. Shohat was certain that a second ophthalmologist was not necessary: "It seems to be me that we need to avoid suggesting to them that we'll pay the full salary of an expert, unless it seems like a top priority. The measure of a 'top priority' is first of all how badly they want it, in what capacity it's important to them. It's clear that our goal is not just to push help, but first to consider the 'political profit' that we earn from it, and that's based to what degree the issue 'hurts' them."¹⁴² When pressed with the fact that one eye doctor alone could not make an important contribution, Shohat retaliated in his signature sarcastic style: " 'Important' to whom? To humanity? To the name of God? To the people of Malawi, maybe yes, and if the Malawian Health Ministry is not ready to allocate a placement for this, it seems that it's not important enough to them. Dr. Freund himself wrote that 'consciousness of this issue is lacking in the Health Ministry.' Do we need to raise the consciousness?"¹⁴³

¹⁴⁰ Except for the fact that he committed suicide in 1966. Gershon Shafir, "Revolutionary Pioneer: Manya Shohat and her Commune," in *Struggle and Survival in Palestine/Israel* (Berkeley: UC Press, 2013) 70.

¹⁴¹ Primor to Shohat, 27 May 1965, ISA/RG 130/MFA/1930/7.

¹⁴² Shohat to Foreign Ministry, 10 March 1964, ISA/RG 130/MFA/1930/6.

¹⁴³ Shohat to Mashav, 21 June 1965, ISA/RG 130/MFA/1930/7.

This argument took place within the context of an inability to recruit general doctors to serve in Malawi. For example, at the Lilongwe Hospital there were three Israeli surgeons serving that Mashav could not find replacements for once their terms of service had finished. Rather than worrying about a second eye doctor, Shohat though Mashav should be worrying about filling the roles of a surgeon and general doctor for a 500 bed hospital that had been bereft of both. Shohat was incredulous that recruiting general physicians was such a difficult endeavor and found the recruitment strategies suspect: “If you take the issue seriously, don’t send letters, but a good ‘salesman’ to hospitals to engage in real recruitment!”¹⁴⁴

In countries that lacked widespread medical services, eye aid could be seen as too specialized a focus, a point of view reiterated by both governmental and medical personnel, both of whom agreed that what developing countries needed most was the expert general physician who could work independently. However, the type of doctor “with wide experience in all areas of medicine—internal, pediatrics, surgery, obstetrics—doesn’t exist in Israel, not in the immigrants nor in the Jerusalemites.”¹⁴⁵ The history of health services in Israel had created curative clinical physicians working in clinics, or specialized doctors in hospitals.¹⁴⁶ Michaelson stated that, “there are few candidates for this activity, because there is little or no room in Israel for the medical all-rounder.”¹⁴⁷ The fields of preventive or family medicine were not valued or prevalent, in part to Israeli medical training which was not as broad as in the British system. This is one case in point that Israel’s developing status did not necessarily translate into exportable expertise.

¹⁴⁴ Shohat to Mashav, 29 June 1965, ISA/RG 130/MFA/1930/7.

¹⁴⁵ Cohen to Davies, 12 Feb 1961, ISA/RG 130/MFA/1930/12.

¹⁴⁶ Mashav Meeting Minutes, 20 June 1962, ISA/RG 130/MFA/473/11.

¹⁴⁷ Michaelson to Remez, 21 June 1962, ISA/RG 130/MFA/473/11.

Except in one field. In a meeting on medical aid with representatives from Hadassah, Mashav, and the Ministry of Health, Prof. Berman of the Hebrew University-Hadassah Hospital did not mince his words: “It’s impossible to say that we ourselves succeeded in fields in which we penetrated abroad. Most of the activities we ourselves have not dealt with—except trachoma.”¹⁴⁸ He went on to state that medical school students were not trained to work in Africa and Asia, did not know how to be generalists, and did not know anything about tropical diseases. He thought improved training was necessary for physicians before they went abroad, both in the medical circumstances and in African society and culture.

There was a tension in the direction of medical aid between what officials perceived Africans’ needs to be and what Israel could actually provide. Israeli officials recognized that they would not be able to solve African health problems, which they estimated required 10,000 physicians.¹⁴⁹ Dr. Cohen, the Director of Health Services, bluntly told one physician, “I want to tell you what I tell everyone that goes to Africa: we can’t solve the health problems of other countries.”¹⁵⁰ Michaelson tried to boost the viability of specialist aid to Mashav Director Aaron Remez, by claiming public health was “tied up with social, political, and psychological factors which limit cooperation from outside the involved country.”¹⁵¹ Specialist services, however, could make a pointed impact. He thought only excellent trained people could be sent, with their job assured on their return, and that a teaching program for local personnel should be combined with service. Department heads instead of hospital directors or the Ministry of Health could do the most to encourage service. He had in effect outlined his own eye program, which at that point was operating in Liberia, Ethiopia and

¹⁴⁸ Mashav Meeting Minutes, 20 June 1962, ISA/RG 130/MFA/473/11.

¹⁴⁹ *ibid.*

¹⁵⁰ Cohen to Davies, 12 Feb 1961, ISA/RG 130/MFA/1930/12.

¹⁵¹ Michaelson to Remez, 21 June 1962, ISA/RG 130/MFA/473/11.

Tanzania. The fact that ophthalmology was rooted in dealing with a local “tropical” disease lent legitimacy to Michaelson’s program, even though it was agreed eye disease was not Africa’s most pressing medical problem.

The inability to recruit physicians to serve in Africa, despite the saturation at home, was a sticking point for Mashav personnel. A 1964 report on Mashav activities complained that despite having the highest ratio of doctors in the world, Kupat Holim and hospitals did not support their physicians serving abroad in developing countries. The report continued that, “It’s hard to believe that Israel, with her 5,000 physicians, is not able to recruit 80-100 doctors for service (today we have 40-50 doctors).”¹⁵²

The question of salary was an important one that required constant negotiation. Officials understood that it would be difficult to recruit physicians to work in Africa without “significant financial advantages.”¹⁵³ Zohar, a member of Mashav administration, suggested that physicians should be able to bring home a car, or the monetary equivalent of a car, without taxes. He stated that “physicians were not less pioneering than the general population,” but without financial gain, it would be impossible to fulfill the scheme.¹⁵⁴ Michaelson was regularly able to negotiate a salary of up to \$8,000 per year for his trainees in Africa. This was significant, because it was 2-3 times what a trainee in Israel could make.¹⁵⁵

Michaelson himself tried to convince Shohat that two ophthalmologists were not a luxury, but absolutely necessary to perform surgery, outpatient procedures, train medical assistants, engage in preventive measures, and operate mobile clinics outside Blantyre. In

¹⁵² Gideon Tadmor, *Report on International Cooperation* (Jerusalem: Israel Government, 1965) 10.

¹⁵³ Zohar, “Suggestions on Ways to Give Medical Aid to Developing Countries,” n.d., ISA/RG 130/MFA/473/11.

¹⁵⁴ *ibid.*

¹⁵⁵ Schiff to Ben Yaakov, 24 July 1963, ISA/RG 130/MFA/1930/11.

order to give Freund “the opportunity of doing real and not colonial medicine,” two doctors were necessary from the “basic medical point of view and therefore finally from the political point of view.”¹⁵⁶ The distinction between “real” and “colonial” medicine suggested that Michaelson understood this rhetoric might have some sway with Shohat, even if practice his residents could not create systemic change in medical health services. Michaelson had no qualms telling Shohat that, “You are completely wrong in your certainty that treatment of the young is dependent on the request, the willingness to pay, and the gratitude.”¹⁵⁷ Because the two doctors would treat not only the masses, but the “highest official of the land,” integrated treatment would lead to both appreciation of the aid and the financial allocation for it.

David Golan, the head of Mashav, also wrote to Shohat that he agreed that the political outcome was the most important aspect of technical aid, but he reminded him that some projects were not necessarily requested by the country, but were coerced until the recipients recognized their value.¹⁵⁸ Golan trusted Michaelson’s professional judgment that the doctors could have impressive results in eradicating eye diseases and blindness in Malawi, which he thought could have an enormous political effect. Ophthalmology was one of the fields that could garner public attention, even if it was not considered high priority for the receiving country. The ratio of eye doctors in Africa was 1:4,000,000 and most of the countries Israel served did not even have a single eye specialist.¹⁵⁹ The act of “bringing light to the blind,” in the case of corneal grafting or cataract surgery, could be popular press for the immediate medical effect and for that metaphor’s historical resonance.

¹⁵⁶ Michaelson to Shohat, 12 July 1965, ISA/RG 130/MFA/1930/7.

¹⁵⁷ Michaelson to Shohat, 29 July 1965, ISA/RG 130/MFA/1930/7.

¹⁵⁸ Golan to Shohat, 14 July 1965, ISA/RG 130/MFA/1930/7.

¹⁵⁹ John Wilson, “Keynote Address,” in *Causes and Prevention of Blindness: Proceedings of the Jerusalem Seminar on the Prevention of Blindness 25-27 August 1971, Jerusalem, 1972.*

Shohat's letters, however, continued to outpour: "I have learned from experience that aid given without a request is not appreciated and, on the contrary, the Government concerned always believes that there is an ulterior motive behind such aid."¹⁶⁰ Although Shohat believed there could be a political benefit, he did not believe the cost of IL 100,000 was worth taxpayers' money. Shohat was well aware that Michaelson's insistence on two doctors was also self-serving, in terms of broadening the ophthalmologists' training, research opportunities, and ability to boast of a one-of-a-kind ocular project, which he would do at his 1971 conference. Anticipating the type of medical innovation Michaelson would tout, Shohat wrote that, "We don't care about 'corrective' or 'preventive,' and to add we don't care about Malawi or Africa, we care about Israel, and our considerations are based on what's good for Israel. If at some international conference on ophthalmology someone can say that in Malawi they did preventive and corrective eye care, great! But here in Malawi, this benefit is superfluous at best! It's a waste of money and shouldn't go on for another year!"¹⁶¹ It should be noted that a second physician was sent. Although Shohat's letters had weight at the Jerusalem headquarters, Michaelson's program was almost universally admired by Mashav, and technocrats understood that it was also very personally meaningful to him and did not want to disappoint. They also did not have much choice: "Professor Michaelson is today the only one that sends doctors under Mashav—all the other activities are not worth talking about—there is almost no other physician that goes."¹⁶²

Perhaps predictably, Shohat even argued that trachoma was a medical lame duck. He noted that Feitelberg, who had done a two-week survey of trachoma in Malawi, found the disease only in the southern parts of the country, an area that also had high rates of more

¹⁶⁰ Shohat to Tuval, 15 June 1965, ISA/RG 130/MFA/1930/7.

¹⁶¹ Shohat to Haviv, 7 Mar 1966, ISA/RG 130/MFA/2877/34.

¹⁶² Shatil to Israeli Consulate in Ethiopia, 15 Dec 1964, ISA/RG 130/MFA/1922/12.

pressing diseases like bilharzia, malaria, tuberculosis and leprosy. Around the capital of Blantyre, he found trachoma rates of less than 1%. In a letter to Mashav, Shohat even cited that a scientific article, “Medical Impressions of Nyasaland,” from the English journal *Medicine and Science in Israel* did not once mention trachoma as common infectious disease.¹⁶³

Despite disagreement about whether trachoma was a worthwhile medical issue to pursue, Feitelberg reported an enthusiastic reception. In his final report, Feitelberg claimed that villagers eagerly awaited his arrival. While he checked 6000 people for trachoma, entire villages among them, he publicized that he was a “gift from Israel to help them.”¹⁶⁴ He also organized a three-day course on eye disease for medical workers from around the country. Feitelberg explained that they “gathered for the first time to learn together, to exchange ideas, and to feel for the first time that someone thinks about them, is interested in them, teaches them, and that ‘someone’ comes from Israel.”¹⁶⁵ Feitelberg also had private meetings with Dr. Park, the Minister of Health, and President Banda, indicating his political access. Feitelberg concluded that “I am convinced of the help we give to developing countries, health is the most important, and even if most of the patients don’t know who or what gives him help, the elite and the leadership understand very well the importance of our work and knows how to value it.”¹⁶⁶

It is clear from this report Feitelberg knew he had a diplomatic role to play, and tried to broadcast Israel’s good name. Diplomats believed “healthcare is the only sphere our enemies in and outside of Africa cannot slander effectively...because this is an unquestioned

¹⁶³ Shohat to Mashav, 16 Aug 1965, ISA/RG 130/MFA/1930/7.

¹⁶⁴ Feitelberg to Mashav, 1 Nov 1965, ISA/RG 130/MFA/1930/3.

¹⁶⁵ *ibid.*

¹⁶⁶ *ibid.*

humanitarian field.”¹⁶⁷ Ambassador Aaron Ofri in Kampala wrote a clear memo of what ambassadors expected from Israeli physicians working with Mashav titled, “My Position on the Question of Medical Aid to Africa.”¹⁶⁸ Ofri demanded that physicians were required to have a relationship with the local embassy, and needed to view his medical and national mission as one: “When a native says, ‘a white doctor from Israel,’ the doctor represents the State of Israel, and not just the medical profession.”¹⁶⁹ The physician needed to be experienced, in order to compete with doctors from other countries, and to maintain high positions in the serving hospital. He insinuated that local elites knew novice physicians came to Africa to gain “experience on the backs of the locals,” which was not preferred. To fulfill his political mission, a physician’s house “needs to be open not only to his friends the whites, but also to black doctors even if they are junior in the profession, as there are good chances that they will be important in health services or politics.”¹⁷⁰ The diplomat was also interested in medical work that would garner publicity, and that the public would find interesting. To that end, he preferred the service of a social surgeon at a central hospital, who could talk at cocktail parties, rather than scientists who were performing studies that could be less easily communicated. To fulfill this goal, the ambassador wanted physicians to remain in the capital, where they could be social elites, rather than serve in rural areas, where the “hasbara value would fade away.”¹⁷¹ With the dearth of physicians in Africa, those in service would not only treat the general population, but also political and social leaders. The ambassador claimed the “Hippocratic Oath does not prevent the physician from taking the order to take

¹⁶⁷ Zohar, “Suggestions on Ways to Give Medical Aid to Developing Countries,” n.d., ISA/RG 130/MFA/473/11.

¹⁶⁸ Ofri to Harel, 3 July 1970, ISA/RG 130/MFA/4426/12.

¹⁶⁹ *ibid.*

¹⁷⁰ *ibid.*

¹⁷¹ *ibid.*

care of a member of the ruling family” that would be politically expedient to Israel. A small number of Michaelson’s recruits, then, were judged by diplomats to be ineffective because of their personalities.¹⁷²

The political driven mission of Mashav, and therefore of the physician, limited medical care to what might be considered its most natural beneficiaries: the Ethiopian Falasha or Beta Israel Jews. Ethiopia was Israel’s most important security interest in East Africa, not only because of its strategic location on the Red Sea, but also because it served to contain Nasser’s sphere of influence.¹⁷³ Mashav was willing to subsidize a lone physician, Dan Harel, to set up a mobile clinic for the Falashas in the Gondar region, whose salary was supplemented with funds from a hodgepodge of organizations, including the World Jewish Congress (WJC), the British-OSE, and the Central British Fund.¹⁷⁴ However, the Emperor Haile Sellasie refused to consider any special assistance to the Falashas that would distinguish them from other Ethiopians, and would not hear of immigration to Israel.¹⁷⁵ The local governor of Gondar considered the WJC a political rather than a humanitarian organization, and held up Harel’s clinic for several months until an audience with the Emperor assured him that Harel treated all in the mixed villages.¹⁷⁶ Over fifty percent of Harel’s patients came to his clinic for eye diseases, and trachoma rates in Ethiopia hovered between 64-90%.¹⁷⁷ Norman Bentwich, the former attorney general of Mandate Palestine, founded the Standing Conference of the Welfare of Ethiopian Jews in 1961, and wrote

¹⁷² Harari to Harel, 29 June 1970, ISA/RG 130/MFA/4426/12.

¹⁷³ Levey, *Israel in Africa 1956-1976*, 47.

¹⁷⁴ Bentwich to Israeli Ambassador in Ethiopia, n.d., ISA/RG 130/MFA/1921/1.

¹⁷⁵ Haggai Erlich, *Alliance and Alienation: Ethiopia and Israel in the Days of Haile Selassie* (Red Sea Press, 2013) 80.

¹⁷⁶ Israeli Embassy to Ben Yaakov, 24 April 1963, ISA/RG 130/MFA/1921/1.

¹⁷⁷ Dan Harel, “Twelve Months Working with the Falashas,” 3 May 1964, ISA/RG 130/MFA/1921/1.

desperate letters to Hadassah and the Israel Foreign Ministry to continue funding Falasha medical services.¹⁷⁸ In 1966, Mashav ultimately decided to end its contributions, “emphasizing that this issue belongs to Jewish philanthropic organizations and digresses (financially and topically) from the activities of Mashav’s framework whose goal is to grow cooperation between Israel and other countries.”¹⁷⁹

The medical aid Mashav was organizing for the rest of the Ethiopian population, paradoxically, was an anti-trachoma campaign. Feitelberg, who had been previously involved in trachoma research at Hadassah, was shipped to Ethiopia “with many ideas and big plans” for a mass project, but was ultimately made to understand by the Ethiopian Ministry of Health that his goal was to lecture to the Medical Officers and nurses in Health Centers on how to recognize and treat communicable eye diseases.¹⁸⁰ A *Ma’ariv* article detailing his activities described him as a true pioneer, who had travelled throughout the whole country in “a jeep, the back of mules, and even in boats” and encountered “hyenas, venomous snakes, and crocodiles,” in the name of treating eye diseases.¹⁸¹ Since Feitelberg at the time was working for Kupat Holim, which did not support physicians going abroad, his term in Ethiopia was not renewed after one year.¹⁸² After attending Michaelson’s conference in 1971, the first Ethiopian ophthalmologist Paulos Quana’a, who had been trained in Beirut, became very excited about the possibility of collaborating with Israelis in renewing an anti-trachoma campaign.¹⁸³ Mashav, however, was no longer interested in funding this endeavor: it was too large of a project with too big of a budget that had no political influence. Perhaps, a

¹⁷⁸ Bentwich to Mann, 1 Aug 1968, Box 160/1, RG 2, HMO Papers, CJH.

¹⁷⁹ Naim to Amir, 9 June 1966, ISA/RG 130/MFA/472/15.

¹⁸⁰ Israel Feitelberg, “The Fight Against Trachoma in Ethiopia,” *Ethiopian Medical Journal*, 2(1964), 229.

¹⁸¹ “Israelis in Ethiopia Fight Against Trachoma,” *Ma’ariv*, n.d., ISA/RG 130/MFA/1922/12.

¹⁸² Mashav to Israeli Embassy in Ethiopia, 23 Dec 1964, ISA/RG 130/MFA/1922/12.

¹⁸³ Harel to Mashav, 15 Oct 1971, ISA/RG 130/MFA/4401/6.

technocrat wrote, Quana'a could turn to a country like Sweden or the WHO that could afford it.¹⁸⁴

Conclusion

In 1968, the Senior Medical Superintendent of the Queen Elizabeth's Hospital in Blantyre, Malawi, gave a speech of thanks to the Israeli Ambassador for a £150 check to purchase ophthalmic surgical equipment for a new eye operating room. He noted "as far as ophthalmic services in Malawi are concerned, this has become the monopoly of Israel."¹⁸⁵ □ Michaelson had successfully conceptualized and exported Israeli ophthalmology as a sphere of concentrated expertise—a product of its geographic position in the Middle East—that was distinguished from European and American capabilities. Africa became an extra-territorial site of Zionist pioneering for eye doctors that provided a new reservoir of patients and experiences, creating a threshold of professionalism that was no longer available within its own borders. However, "Africa" was not an unified space: the countries available to Michaelson's program were determined by Mashav considerations, and regional differentiation in personnel and political circumstance mottled his ambitions and approaches. The eye aid program became Mashav's largest medical program abroad because Michaelson spun eye treatment as a Zionist innovation not less than the kibbutz or the Nahal Brigades.

Through Israel's self-fashioning in the highly visible and competitive arena of international exchange, the state was able to achieve a short-lived affiliation with the Global South through positioning itself as a bridgehead between East and West. Ophthalmic research and medical aid was one strategy employed to bolster Israel's standing in the international

¹⁸⁴ Trigur to Harel, 27 Dec 1971, ISA/RG 130/MFA/4401/6.

¹⁸⁵ "Speech of Thanks made by the Senior Medical Superintendent on the Occasion of receiving from the Ambassador of Israel a Check for £150 to be used in the Ophthalmic Theater," undated, ISA/RG 130/MFA/2934/17.

arena, and was considered “one of Mashav’s most successful undertakings.”¹⁸⁶ However, it was not exclusively a project of state politics. Michaelson wielded trachoma’s “diplomatic mission” to advance the professionalization of his department and of Israeli science.

Although Michaelson attempted to delineate a postcolonial medical development program that was distinct from its European colonial predecessors, the eye aid program did pay heed to some extent to a colonial model. These aid programs, and the mobility of people and ideas they facilitated, enabled ophthalmologists to establish Israel as an internationally recognized research center.

The much-heralded technical assistance that Israel provided contributed immensely to its enhanced standing in Africa of the 1960s. Israel’s image in Africa was “disproportionate to its actual size, strength, and global sway.”¹⁸⁷ In fact, Israel had at times the second largest diplomatic presence in sub-Saharan Africa, with thirty-two diplomatic missions by the mid-1960s.¹⁸⁸ Ophthalmic expertise remained significant in the postcolonial period because it was Israel’s exclusive brand of medical aid, and it was able to continue marking distinctions between peoples and cultures, even as the categories and vocabulary changed from the British Mandate era.

¹⁸⁶ Shimon Avimor and Hanan Aynor, eds., *Thirty Years of Israel’s International Technical Assistance and Cooperation* (Jerusalem: The Harry S. Truman Institute for the Advancement of Peace, 1989) E12.

¹⁸⁷ Benjamin Neuberger, *Israel’s Relations with the Third World (1948-2008)*, (Tel Aviv, 2009) 28.

¹⁸⁸ *ibid.*

Conclusion

In 1927, Haim Yassky wrote in his pamphlet on ocular hygiene, *What is there to Know about Eye Health?*, that “Our medical obligation is not only to cure the ailments of the organ, but to help create the conditions where there is no room for disease.”¹ This perfectly encapsulates the tension between medical and cultural expertise—as well as between technical and social interventions—that have shadowed how trachoma was conceptualized throughout the past one hundred years. Physicians, institutions, scientists, and citizens in Palestine and Israel interpreted trachoma as a disease of the Orient, hygiene, development and diplomacy, and subsequently generated different strategies to handle trachoma both as empirical reality and as imagined understanding.

During the Ottoman period, trachoma was not yet a distinct entity, consisting of symptoms and effects overlapping with a host of other infectious diseases, broadly identified as ophthalmia or conjunctivitis. Although trachoma and its understood ocular manifestations were present around the globe, the French and British invasions of Egypt and the subsequent deforming of their armies helped to solidify trachoma as a scourge of the East. A cadre of ophthalmologists travelled to North Africa, Egypt and Palestine to study trachoma’s clinical symptoms and historical origins, turning “ocular orientalism” into required medical expertise for anyone interested in trachoma. European Jewish ophthalmologists were active participants in this enterprise, in part spurred by German Jewish orientalism, the advent of history of medicine as a scholarly discipline, and Zionism. Trachoma was not something that could be treated, but was instead an essentialist, omnipresent fact of life in the East. This was a geographic, cultural and social stigma, a cornerstone disease of “tropical ophthalmology,” as well as of the backwards, primitive, and poor.

¹ Haim Yassky, *What is There to Know About Eye Health?* [Hebrew]. (Jerusalem: Hadassah, 1927) 3.

As bacterial and scientific research transformed trachoma at the turn of the twentieth century into a separate biological fact, trachoma was no longer simply an object of ethnography, but could be considered managed through an intensive statistical enterprise. Jewish physicians in Mandate Palestine began utilizing the science of hygiene to describe the population's shortcomings, as well as a legitimate method of treatment alongside topical copper sulfate. Through treating patients, tabulating trachoma incidence, and inspecting homes across the Yishuv, the lone traveling oculist was engaged in creating borders of health and of nation. These were not as rigid as they might appear, as Jewish ophthalmologists continued to engage in private practice, venturing to earn professional prestige and financial gain among indigenous Arab patients. Both forms of public health were thought to require attendant orientalist expertise, revealing that trachoma treatment could not be an impersonal intervention.

The physical acts of medical care on the ground—by the Hadassah anti-trachoma campaign, the British Mandate Government of Department of Health's mobile eye clinics, mission hospitals, and private doctors—did indeed have epidemiological repercussions. Trachoma was no longer endemic, despite the threat that it would renew with the mass immigration from Middle Eastern and North African countries. However, this was not only due to systematic eye treatment. Ophthalmologists at the Hadassah Hospital wrote in 1960 that improvement in housing and social conditions, as well as in general education, were the leading causes of decreasing trachoma rates.² With the eye disease no longer ubiquitous, and now more readily cured with sulfa drugs and antibiotics, it had lost its medical and cultural prominence within the State of Israel's borders.

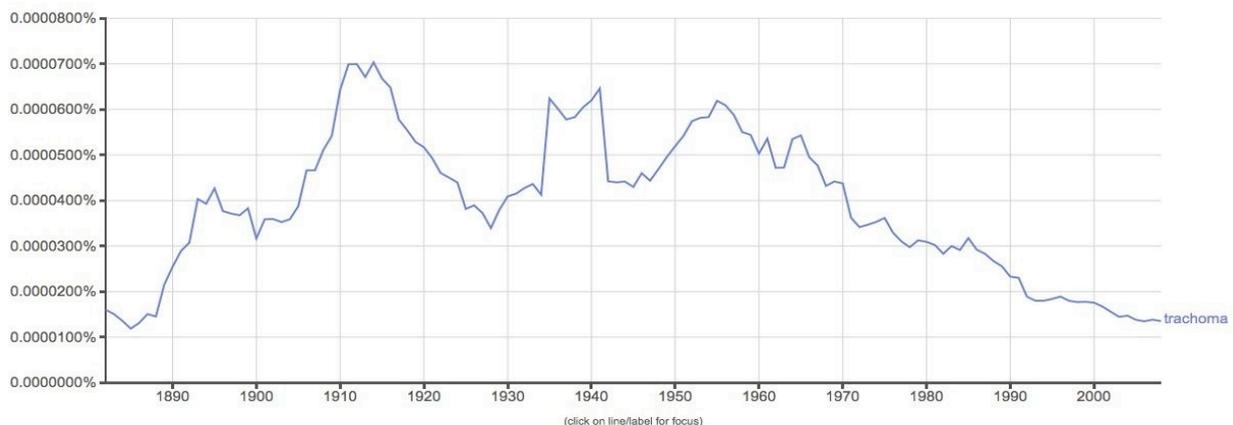
² B. Maythar and I. Feitelberg, "Progressive Solution of the Problem of Trachoma in Israel," *Ha'refuah* 59, no. 6 (September 15, 1960).

However, the aftermath of the Holocaust and the creation of the State turned world Jewry's attention to North African communities, a new trachomatous Jewish population. International organizations, particularly the JDC and OSE, took part in using the rich discourse of trachoma to both inscribe Moroccan Jews as indelibly backwards, as well as to write a new narrative of global health and development that was heralded by the World Health Organization. The JDC enacted its own pilot project to balance the tension between the technical and the social in the mellah of Casablanca, relying foremost on antibiotics, but utilizing a team of social workers to educate and convince residents to participate in a disciplined campaign. The inability of a NGO, or indeed the WHO, to refashion the socio-economic environment that had made trachoma flourish was disheartening in a period of great faith in the seemingly limitless power of science and technology. Set in the postwar mood of decolonization, trachoma treatment was not simply to prepare Moroccan Jews for aliyah, but to "develop" them to be possible future citizens in situ. Trachoma remained a mark of the East, but also became an index of development, with its implied economic and political world order.

By the end of the 1950s, trachoma was no longer a Jewish problem. There was no sizable Jewish community left in the Third World, and trachoma had been sharply reduced in Israel. However, when a research group in China isolated the trachoma agent, *chlamydia trachomatis*, for the first time in 1957, it gained new ground as topic of scientific inquiry. Isaac Michaelson capitalized on Hadassah's historic expertise by forming a trachoma research group at the Hadassah Hospital in Jerusalem, which became the third team in the world to replicate China's achievement. When geopolitical circumstances led the State of Israel to open up funds for technical aid projects in select sub-Saharan countries, Michaelson jumped on the opportunity to train his own ophthalmology students and to widen his research agenda. Rather than erase Palestine's own struggle with eye disease, Michaelson emphasized

his country's primitive past in order to reproduce the Ministry of Foreign Affairs' rhetoric that Israel was a postcolonial country that belonged in the non-alignment bloc. Both the State and Michaelson understood that Israeli medical aid to Africa could only be a "drop in the bucket," but goodwill proved to be superior to incidence rates in the quest to cure a disease of diplomacy.

This Jewish history of trachoma both dovetails and diverges from its global trajectory as a disease of interest, or more often, disinterest. A look at Google Books NGram viewer illustrates the steady decline of publications on trachoma from 1954, which as of 2007, reached the same nadir as it had been in 1882. Trachoma attracted scholarly interest during three peaks: when it was a disease of immigration exclusion, particularly at Ellis Island from 1903-1914; the advent of sulfa drugs in 1935; and the push to isolate the trachoma agent in the mid-1950s. While Jewish history is particularly intertwined with that first peak, indeed



helped to create it, trachoma remained a global Jewish concern through the 1950s, and not just at points of novel therapeutics. That is because it was not simply a biomedical phenomenon, but a cultural and social one that had symbolic import just as great as its effects of ocular disability. Even against the backdrop of declining global concern with infectious eye diseases (and the later rise of the "big three": malaria, tuberculosis, and HIV/AIDS), Michaelson tried to create a movement of public health ophthalmology in the 1960s and 70s. However, because trachoma was unresponsive to technics alone, it was not a fit candidate for

either vertical WHO “eradication” campaigns, nor a profitable market for pharmaceutical companies. When Israeli geopolitics no longer required African assistance, trachoma slid into obscurity—everywhere—even as it remained the world’s leading cause of preventable blindness with 500 million people infected.³

How is trachoma conceptualized today? In the mid-1990s, pilot projects in Morocco and Egypt led to a new WHO-sponsored method of treating trachoma, the SAFE strategy, involving four components: Surgery (a simple procedure to reverse trichiasis, the inversion of the eyelids); Antibiotics (azithromycin, with only one dose necessary); Face washing (personal hygiene); and Environmental cleanliness (use of latrines and general hygiene to reduce flies).⁴ This is a new permutation of the connection between the technical and social, zeroing in on specific hygienic behaviors for individual bodies to perform. A resolution of the World Health Assembly in 1997 established the Global Alliance for the Elimination of Blinding Trachoma by the year 2020 (GET 2020), providing more support to surgery and antibiotics than the latter two reforms. In 1998, the Edna McConnell Clark Foundation partnered with Pfizer to create the International Trachoma Initiative to implement the SAFE strategy, and in particular, the “A” part through the donation of Zithromax (also used for lung, skin and other chlamydial infections). In 2003, the WHO classified trachoma as one of seventeen “neglected tropical diseases” that all affected those in poverty and deemed appropriate to tackle as a group. Trachoma now affects approximately 21 million people worldwide, and researchers are optimistic that the goal of GET 2020 can be achieved.⁵ The

³ Chandler R. Dawson, Barrie R. Jones, and M. L. Tarizzo, *Guide to Trachoma Control in Programmes for the Prevention of Blindness* (World Health Organization, 1981) 7.

⁴ Levine, Ruth. 2007. “Case 10: Controlling Trachoma in Morocco” (PDF). In *Case studies in global health: Millions saved*. Sudbury, MA: Jones and Bartlett.
<http://files.givewell.org/files/DWDA%202009/Interventions/Millions%20Saved-Case%2010-Trachoma%20in%20Morocco.pdf>

⁵ Danny Haddad, Teshome Gebre, and Hillary Rono, “Elimination of Blinding Trachoma by 2020: A Call for Rapid Scale-up and Strengthening Programmes,” *International Health* 6, no. 3 (2014): 156.

language of confidence is striking, considering researchers themselves note that “elimination of trachoma requires improvement in education and hygiene practices, improved accessibility to water, and economic development of endemic regions.”⁶ As a disease of big pharma, the SAFE strategy has managed to divert attention away from structural inequalities to noncompliant bodies, and that “fundamentally social forces and processes come to be embodied as biological events.”⁷ Perhaps, then, trachoma is the same as ever.

⁶ Pashtoon M Kasi et al., “Blinding Trachoma: A Disease of Poverty,” *PLoS Med* 1, no. 2 (November 30, 2004): 108.

⁷ Paul Farmer, *Infections and Inequalities: The Modern Plagues* (University of California Press, 2001) 14.

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Archives and Archival Collections

AIU = Alliance Israélite Universelle Archives, Paris

BML = Hadassah Berman Medical Library, Jerusalem

CAHU = Central Archives of the Hebrew University, Jerusalem

CJH = Center for Jewish History, New York

CZA = Central Zionist Archives, Jerusalem

IFA = Israel Film Archive, Jerusalem Cinematheque

ISA = Israel State Archives

JDC = American Jewish Joint Distribution Committee Archives, Jerusalem

JDC = American Jewish Joint Distribution Committee Archives, New York

JMA = Jerusalem Municipality Archives

NLI = National Library of Israel

NYPL = New York Public Library, New York

OHD = Oral History Division of the Hebrew University Institute of Contemporary Jewry, Jerusalem

SJFA = Steven Spielberg Jewish Film Archive, Jerusalem

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