Contested bodies: Medicine, public health and mass immigration to Israel

Nadav Davidovitch, Rhona Seidelman and Shifra Shvarts

ABSTRACT

The State of Israel was established in May 1948. By its eighth Independence Day, the small country, with a population of only 600,000 Jews, faced the formidable task of absorbing over 1,000,000 new immigrants. Some of these immigrants were Holocaust survivors in poor health, and many others came from Yemen, North Africa, Iraq and India, where they had suffered chronic malnutrition and extremely high mortality rates. Despite arduous economic conditions and the lack of infrastructure in health, education and housing, and despite the poor health status of many immigrants, all epidemics were contained. Confident in the justice and necessity of their science, the approaches of health care workers to the immigrants' bodies were acts that were often foreign and traumatic to the immigrants, who came from different cultures and medical traditions. The aim of this article to explore how the Israeli health care system of the 1950s approached the immigrants' bodies and how these medical policies and practices were perceived by the immigrants and shaped their identities and attitude toward the State. We examine this topic through the examples of medical selection of immigrants, vaccination policy, ringworm irradiation, and isolation and treatment of immigrants at the Shaar Ha'aliya (Gate of Immigration) *camp.*

Introduction

The mass immigration to Israel in the 1950s, the first years of the State's gestation following its establishment in 1948,[1] was a period dense with drama. It is a multifaceted

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1 The years of the mass immigration are generally accepted to have been 1948-1956, for after 1956 there was a significant decline in the number of immigrants. The first three years are generally given much

story: an ingathering of peoples from dozens of countries, taking place on the backdrop of war. It is a story of refugees, new immigrants, "landed" immigrants, native-born Israeli Jews and their encounter.

For the immigrants, it was a story of separation from homes, distance from the familiar, uprooting, relocation and the hope of growing new attachments and roots.[2] For some, it was an inspired act, infused with messianic significance, a return to the Holy Land; for others, it was an act of nationalism, entailing identification with, and desire to be a part of, political Zionism; for still others, it was the last resort after being left with no nationality and no other potential asylum. All were coping with the need to adjust their hopes and expectations to the harsh reality of foreignness and reconstruction.

For Jews already living in Israel,[3] there was excitement surrounding the realization and construction of a sovereign Jewish State. But this excitement was mixed with a fear of how the immigrants, in their foreignness, would change the ideal State which the earlier pioneers had hopes of creating. Thus, official State policy during the 1950s was that of a "melting pot" (Lissak, 1999; Zameret, 1997): through education, medicine, language, religious practice and culture, the immigrants would be transformed from Diaspora Jews into Israelis. Yet, as in other immigration countries, this was not a simple top-to-bottom indoctrination: newcomers and veterans alike struggled daily in their interactions, which were accompanied by an intricate process of negotiation and resistance.

As part of the melting pot philosophy and policy, medicine and public health went beyond the curative and preventative spheres into the social. The migrants' bodies were approached as entities to be cleaned and acculturated (Davidovitch and Shvarts, 2004). Confident in the justice and necessity of their science, the approaches of health care workers to the immigrants' bodies were acts that were often foreign and traumatic to the immigrants, who came from different cultures and medical traditions. It is the aim of this paper to explore how the Israeli health care system of the 1950s approached the immigrants' bodies. We will examine this through the examples of immigration regulation, vaccination, ringworm irradiation and quarantine/isolation. All of these case studies will be located within the context of body politics, nation-building and immigration. Our research aspires to show that these topics should be viewed in a

attention, as it was in that period that the Jewish population of Israel, which had numbered around 650,000, absorbed approximately 700,000 immigrants. For exact numbers on the mass immigration, see Hacohen (1994) and Lissak (1999).

2 For a classic work on the immigration experience, see Handlin (1973).

3 Definition of the terms "native" or "immigrant" is a challenge when used in the context of Israel, particularly in this period. Dalia Ofer (1996) addresses the subjectivity of this concept, whereby people who had arrived in 1946-1947 were considered "veterans," whereas those who came after 1948 were "immigrants."

context that is broader than mere preventive medicine. The practice of vaccinating children or irradiating them for ringworm took place within a larger conflict over perceptions of health, illness and care for children, as well as the State's intrusion into the private sphere. Indeed, the practices of vaccination or ringworm irradiation were, in the final analysis, a struggle over "the body of the child," which was played out through the injection of vaccines into the bodies of the young and through irradiating scalps against a fungal disease.

It appears that, in the end, most of the immigrants accepted the establishment's various forms of medical intervention. Thus, we do not intend to claim that, in the 1950s, there was wide-scale or organized resistance to public health measures among immigrants. But from reading primary and secondary source material relating to the years of the mass immigration following the establishment of the State of Israel, one can reconstruct many cases of opposition that cannot be ignored. Medical selection, vaccination and mass ringworm treatment–and particularly those of children, who were the primary target of the public health programs–constitute some of the points of opposition from which one can learn about health care and State power. One can see how that power came into play with the immigrants and their bodies and, finally, how the immigrants responded to that State power.[4]

Context: Nation-building and the immigrant body

With the end of the British Mandatory government, the newly independent State of Israel worked to establish and crystallize government institutions and implement democratic rule. It endeavored to gain recognition on the global stage while fighting a war with its neighbors.[5] On an internal level, the new State was in the process of understanding and formulating its own concept of citizenship. Several of the issues with which it was grappling were: Should the State be open to all Jews, even those who did not conform to the Zionist paradigm? What place did non-Europeans have in a concept founded on European values and a European mind-set? What place could religion have within a framework of avowed secularism? Could cultural differences be a part of a model of conformity?

These were not new questions for Zionist society, yet with the founding of the State of Israel, the context changed, both on the formal institutional level and on the symbolic

4 A similar analysis of micro-resistance, related to the settlement policy of the newcomers in the 1950s, can be found in Kemp (2002).

5 For the political, social, economic and military dimensions involved in Israel's establishment, see Troen and Lucas (1995).

and practical levels of citizenship formation. Of further significance is that this period of nation-building and self-definition took place amidst reverberations of the Holocaust. The understanding of the Holocaust, so soon after the end of the war, was in the first stages of transforming and traumatizing the Jewish collective consciousness and identity, through such public events as the debate over reparations from Germany and the "Kastner trial."[6] Particular to Israel's problem of coping with the Holocaust was the issue of how to reconcile Zionist ideology with the reality of the immigrant Holocaust survivors.

In Zionist thought, life in the Diaspora had caused Jews to undergo a process of physical and psychical degeneration (Tzahor, 1998:132). The return of the Jewish people to the Land of Israel was to be curative both for Jews and the land itself by affording Jews the opportunity to be industrious and active in physical labor (Avineri, 1981:154). In Herzl's utopian novel *Altneuland*, one of the canonical Zionist texts, Zionists in the Land of Israel are transformed from the sickly, frivolous and ignoble characters that they were in the Diaspora to strong, well-built visions of health (Davidovitch and Seidelman, 2004). Indeed, the self-image the new Israelis perpetuated was of health and robust strength with a conviction of having left illness and weakness behind them in the Diaspora.[7] Thus, the arrival of the physically ill and emotionally weary Jews essentially put the Zionists in a position where they had to confront their own demons.[8] For arriving on their shores in the thousands were flesh-and-blood reminders of the reality from which they had been trying to distance themselves: the "weak" and "diminished" Diaspora Jew as an indissoluble part of the "strong" and "healthy" Israeli.

The arrival of Holocaust survivors–who were suffering from various physical and mental ailments and who came to Israel in large numbers after the establishment of the State–led to tension. Those survivors coming from Displaced Persons (DPs) camps in Europe suffered from various chronic diseases ranging from tuberculosis to mental illness. Their arrival sparked a debate on the idea of unlimited migration, a policy that would put demands on the new country's already strained resources. General suspicion of the survivors, as expressed by many in Israeli society, did not help simplify the absorption process. The change in the demography of the migration to Israel, from

6 The trial of Malkiel Gruenwald, which has come to be known as the "Kastner trial," was held in Jerusalem in 1954. Gruenwald was sued for libel after having publicly accused Israel (Rudolf) Kastner, a Hungarian Holocaust survivor and Mapai party member, of having collaborated with the Nazis. The proceedings of the trial turned on Kastner, with the judge famously declaring that he "had sold his soul to the devil" (Weitz, 1995, 1996).

7 Meira Weiss (2002) offers an analysis of the construction of the perceived ideal Israeli body–healthy, powerful, Jewish Ashkenazi and male–that is largely in defiance of the perception of the Diaspora Jew.

8 For a leading study on the immigration and absorption process of Holocaust survivors, see Yablonka (1999). On the politics of Holocaust memory, including of its survivors, see Zertal (2005).

mainly European to Arab countries, added to these already extant tensions, as can be seen in the veteran Israelis' perception and reception of the immigrants from North African and Asian countries (Lissak, 2003; Tsur, 1997:73). The many studies undertaken on this issue reveal themes of xenophobia, classism, racism and disgust. Considerable archival material has been gathered to support the thesis that the Ashkenazi establishment feared that North African Jews in general, but particularly those of Moroccan extraction, would threaten the quality of the population and culture with "Levantinization" (Malka, 1998; Picard, 2003; Shvarts et. al., 2005).

Of the many studies on this topic, one of the most thought-provoking is Orit Rozin's discussion of the Ashkenazi description of Mizrahi ("Oriental") immigrants in terms of physical disgust. Her research highlights the central role that perceptions of health had in framing the disdain held towards the immigrants (see also Photo 1):

> It was already in Yemen that the potential immigrants were described as having no knowledge of personal hygiene. North African immigrants were also described as being unfamiliar with basic hygiene. The idea that immigrants from Islamic countries didn't maintain any hygienic practices, didn't know how to use the

Hadassah brings medical care to the Ma'abarot (Hazel Greenwald, 1952, courtesy of Hadassah, The Women's Zionist Organization of America, Inc.).

> bathroom and were unable to keep their bodies and household utensils clean, was very common amongst the native-born Israeli Jews. As a result the absorption workers (mostly women), volunteers and female soldiers invested great efforts in changing the new immigrants' habits while they were staying in immigrant camps and *maabarot* [temporary housing settlements]. The health services were to impart the immigrants with knowledge of hygienic practices once they moved into permanent housing (Rozin, 2002:199).

Rozin's theory is substantiated by Meira Weiss' (2001) work on the missing Yemenite children.[9] Accordingly, these discussions emphasize how the perception of the immigrants' otherness largely stemmed from perceptions of health, ill-health, filth and the ideal or "chosen" body. These perceptions had an important influence on the process that was taking place in Israeli society, whereby new ideals of citizenship were being forged. This process involved the formation and destruction of borders between the "normal," "healthy" and "civilized" body, on the one hand, and the "pathological," "ill" or "primitive" body, on the other. Furthermore, all this was taking place on the backdrop of movement–the movement of immigrants, health care workers, real diseases and ideas. Thus, as will be described in this paper through specific case studies, images and practices from the medical and health domains, informed boundaries of inclusion and exclusion in Israeli citizenship.

Context: Medical science, Zionist ideology and immigration

The medical practices of the Israeli health care system during the mass immigration were predominantly those of Western medical science. However, these Western medical traditions took on a unique twist in Israel, where all aspects of life were infused with Zionist ideology. Indeed science, technology, medicine and public health played central roles in Zionist thought; they were fields of knowledge that would create the ideal Zionist State, whereby the Diaspora Jew would be transformed into the healthy, strong Zionist, connected to and healed by the Land of Israel. These programs drew on the

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9 Reference is to Yemenite children who disappeared from immigration and transit camps over the period 1948-1954. Several families of the missing children accused the State and State personnel of kidnapping their children. Yair Sheleg (2001) wrote in *Haaretz:*

> The Cohen-Kedmi National Commission of Inquiry into the disappearance of the Yemenite children has unequivocally rejected claims of "an all-inclusive establishment plot" to take children away from Yemenite immigrants and hand them over to childless families for adoption... The commission deemed it possible that...children were handed over for adoption following decisions made by "individual" local social workers–but not as part of an official Israeli establishment policy.

wellsprings of American and European influences, but also arose, at least in part, from the Zionist establishment's conception of creating a "new man" (Peled, 2002).

Health care services in the *Yishuv*[10] had their roots in European and American concepts of medicine and public health, as well as Jewish traditions of *bikur holim* and *linat tzedek*.[11] Jewish doctors, born and trained in Europe, were brought over by philanthropists Moses Montefiore and Baron Edmond de Rothschild in the mid-nineteenth century. These physicians took the place previously held by traditional healers. Later, in what is known as the Fifth Aliya, numerous German physicians settled in the *Yishuv* in Palestine, thus significantly contributing to the continued presence of European-trained health care workers. The American approach gained a strong foothold primarily through the works of Hadassah, the philanthropic Women's Zionist Organization of America. Hadassah first began its work in medicine and public health in Palestine in the early twentieth century.[12]

Studies have shown that Zionist appropriation of medicine and public health was not only on the theoretical level; it was also carried out in practical terms during both the British Mandatory period and the establishment of the Jewish State. Parenting manuals were distributed amongst mothers to instruct them on how best to raise healthy Zionist children (Stoller-Liss, 2003). During the British Mandatory period, Hadassah regularly held public Health Week sessions, which exposed the community to the benefits of physical activity, personal and public hygiene, and nutrition. Indeed, one cannot understand the roots of immigration policy during the mass immigration of the 1950s without taking into consideration the strong public health traditions that existed in Zionist ideology. These traditions, imported from Europe and the United States, were adapted to the local context of Palestine and were already in practice prior to the establishment of the Jewish State.

Recognizing the significant role European and American thought had in shaping Israeli health care and its approach to immigrant health, it is necessary to address the role of eugenics. Although in the public mind, eugenics (a Greek term meaning "well born" or "good breeding") is associated primarily with Nazi atrocities, its influence on both the science and politics of the first half of the twentieth century was great.[13] Indeed,

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10 *Yishuv*, literally "settlement" or "community," is the term used to refer to the Jewish community in Palestine prior to the establishment of the State of Israel.

11 *Bikur holim* is the charitable act of visiting the ill; *linat tzedek* is a tradition of night-time watch over the ill to ensure that they are not alone. On how these traditions were incorporated in Jewish health care in Palestine, see Shvarts (2002).

12 For the history of the first Jewish doctors and hospitals in Jerusalem, see Shvarts (2001/2). For the history of Hadassah involvement in Israeli health care, see Shvarts and Brown (1998:28-46).

13 On eugenics, see Kevles (1985). For a recent analysis of eugenics in the U.S. and its influences after WWII, see Stern (2005).

the many studies conducted on the importance eugenics commanded in the medical world in the United States and Europe at the onset of the twentieth century have shown the significant impact it made on immigration policies. The eugenic outlook became intertwined with colonialist practices that presented the white/European body as the "right" model (Warwick, 2003). Although eugenics as a scientific concept lost its appeal after WWII, its ideological influence did not suddenly disappear. This influence can be traced to immigration, mental health and other public health practices that exist to this very day, even if they are not directly referred to as eugenics. The Zionist ideology, with its European foundations and aspirations to forge a "New Jew," fit in well with this approach (Efron, 1993; Falk, 1998). Public health policy toward immigrants in Israel was founded on a similar view of public health practices as a vehicle for shaping a person who would be healthy in body and soul. (For a typical scene of health education for mothers at a "Drop of Milk" station in a transit camp at Rosh Ha'Ayin, see Photo 1.) This was deemed an important goal not only on the level of the individual, but also on the level of the nation as a whole. Immigrants who were the target of health education programs were often described as "passive raw material" that could be molded by authorities. Yet, the immigrants possessed their own perspectives on health and illness that were not always in keeping with those of the absorbing society. While good intentions on the part of the health care system indeed brought about a significant improvement in health indices, such as infant and maternal mortality, infectious disease incidence, and mortality, they also came at a complex social cost.

Regulation and selection

The issue of medical selection during the 1950s was not a cut-and-dry scenario of necessity/philosophy leading from policy to implementation. It was an issue that challenged the fundamental ethos of the Jewish State, right from the start of sovereign rule, by raising the question of entitlement to the Jewish State and sentiments of discrimination, questions that persist to this day. Within Zionist thought, unregulated *aliya*–open-door acceptance of all Jews to the Land of Israel–is a powerful philosophy. This concept of the Right of Return, the right of every Jew to claim and be a part of the Land of Israel, is challenged by the central political Zionist tenet of building an ideal society.

Each of the five major waves of *aliya* that preceded the establishment of the State had been both limited in scope and strongly ideological. While the Zionist movement has always been made up of various branches (e.g., Religious Zionists, Cultural Zionists, Labor Zionists), a common thread between these various ideological approaches was the drive to establish and build an ideal society. Indeed, at the core of Herzl's vision, as depicted in his utopian novel *Altneuland* (a manifesto thinly cloaked in dramatic

narrative) stands the creation of an ideal "new society."[14] Notwithstanding the ideal of unfettered *aliya*, creation of an ideal society necessitates regulation to ensure that inclusion is limited to those subscribing to these philosophies and capable of implementing them.

British Mandate authorities established three categories through which Jews could qualify for immigration permits to Palestine: Category A was reserved for "capitalists," who were few in number; Category C applied to laborers; and Category D referred to dependents of the other two categories, and thus was conditional on the family wage-earner's capacity to support them. While there was no quota on Category A applicants, Categories C and D applicants were capped. Mandate authorities gave the authority for relegating these certificates to the Jewish Agency. Control over Category C applicants allowed the Jewish Agency to control the core component in Jewish immigration to the Land of Israel.[15] With this authority, the Jewish Agency implemented a selection policy based on medical fitness. Given the fact that they were allowed few people, they needed to ensure that those coming could handle the work required and that their limited number of certificates would not be wasted on someone physically incapable of contributing to the State.

When the State moved from British to sovereign Jewish rule, the issue of medical selection took on a different meaning. At this point it no longer concerned limitations to the Jewish community imposed by a foreign ruler; it now took on the significance of Jews prohibiting the entry of other Jews into the Land of Israel. As in most nation-states, immigrants to Israel were not allowed to freely come as they chose. The Law of Return, the principal document framing the nature of immigration regulation in Israel passed unanimously in the Knesset in 1950, included among its stipulations that an individual could be prevented from immigrating "if the Minister of Interior was convinced that the applicant...was liable to endanger the public health or the security of the State" (Shachar, 1993:126).

Although medical selection was a central issue of debate amongst policy makers in the 1950s, it largely remained on the theoretical level; the number of people denied entry for medical reasons was minimal. In cases where illness was detected, the carrier was treated abroad or, if that was not possible, isolated in Israel until the illness was properly treated. As historian Amy Fairchild has shown, exclusionary and inclusive practices have a long history in immigrant-receiving nations, whether in terms of the population, the work force, or the culture. In many cases the inclusion of immigrants

14 This humanistic, egalitarian welfare state is represented in Herzl's utopia by the motto "Liberalism, Tolerance, Love of Mankind!" (Herzl, 1960:109).

15 For a detailed discussion on the medical selection debate during the British Mandate in Palestine, see Davidovitch and Shvarts (2005).

prevailed, despite the rhetoric of exclusion and disciplinary practices, as exemplified in medical examination practices (Fairchild, 2003).

The significance of the issue perhaps lies primarily in the debate itself, for the philosophy of medical selection underscores the traditionally held perception of immigrants as carriers, not only of infectious diseases but also of dangerous political ideas that could destabilize social order. The line between the biological and the social in contemporary discussions of immigration was easily crossed. Throughout the course of the twentieth century, questions of health and immigration gained an increasingly firm hold on the process of receiving immigrants from various countries, questions often fuelled by fear of the foreigner and the "other." In more than one case, medicine served as a means of preventing the entrance of certain immigrants, but in the final analysis, those immigrants who were not permitted to enter the country for medical reasons were few in number. In fact, medicine served more as an assimilation tool for immigrants into local society, and as a litmus test of the apprehensions of the absorbing society, than as a means of obstruction. This is not to say that public health considerations were not relevant or justified, but history shows that, in general, fear of disease can spread rapidly, leading to alienation of the victims and social tensions (Kraut, 1995; Markel, 1997).

Vaccinations

Immigrant camps established abroad constituted the first sites for engaging in public health work, including vaccinations. According to letters and reports sent by physicians in the camps, problems arose from a shortage of vaccines and the distance between the camps and medical supply facilities, as well as the suitable transportation of the vaccines. All of these difficulties delayed full implementation of the vaccination program as planned by the Israeli Immigrant Medical Services. In addition, staff had to deal with cases of side effects from vaccinations, particularly local skin infections.[16]

Although vaccinations were given to all Israelis, newcomers and veterans alike, archival material indicates that emphasis was put on achieving a high level of coverage among immigrants. The immigrants were supposed to be vaccinated during their sojourn in *machanot ma'avar* (processing camps) prior to embarking for Israel, but there were cases where vaccinations were carried out on the ships going to Israel. However, often

16 See, for instance, "Memorandum on a visit to Aden, June 18-September 16, 1949," September 20, 1949, Ministry of Health, Labor and Pioneer Archive, Levon Institute, IV, 104-181, portfolio #17.

vaccinations were administered only in Israel, either because of a loss of records or a failure to vaccinate immigrants abroad because of vaccine shortages.[17]

One of the important vaccines administered was against smallpox. During this period, there was not one specific technique for vaccination against smallpox that enjoyed unanimous consent. Various means of introducing the vaccine were used, such as a single prick, a series of pricks and peeling off a small piece of skin to inject the vaccine. These methods sometimes caused infection or created a large and ugly scar.[18] In all cases, the sign that the vaccine had "taken" was the appearance of a scab a week after administration. There was no technique for measuring the level of antibodies, nor was there any other procedure for determining whether the level of immunity was high enough to protect subjects against the outbreak of disease. Consequently, children who had received vaccines had to be brought by their mothers to have the scar examined. Testimonies indicate that the scarring process was considered ugly, particularly in the case of girls.[19] Bandaging the area was forbidden, and mothers were instructed not to wash their children for three days after vaccination. The vaccination area then had to be kept dry for a week. At the end of the seven-day period the child was examined to see if the vaccine had taken or not. If not, the child had to be re-vaccinated (Kleinberg, 1950). In the years 1949, 1950 and 1953, following word of an outbreak of smallpox in neighboring countries, mass vaccination campaigns were announced in the papers, on the radio, and by street posters urging individuals to be vaccinated.[20]

The scarring produced by smallpox vaccinations should be understood not merely as a necessary nuisance. Symbolically, it served as a state-imposed mark on its citizens–most of them newly arrived immigrants and children. Alternative methods of scarification, such as the possibility of vaccinating girls under the knee, should the mother demand this for cosmetic reasons, ought to also be considered as part of a

17 See correspondence from Dr. Y. Shapira to Dr. Fritz Yekutiel, "*Harkavat abaabuot le-olim chadashim*" (Smallpox Vaccination for New Immigrants), January 1, 1956, Israel State Archives, 2/13/G/B5084.

18 Essentially smallpox vaccination techniques have not changed since that period. This issue reemerged recently when the Israeli Ministry of Health decided to vaccinate against smallpox the "first responders" in case of a bioterrorist attack.

19 Interview with B.S., a doctor who practiced at the time and worked in immigrant camps in the 1950s. The physician said that at times they vaccinated girls under the nipple for cosmetic reasons, to hide the scar. No sign of this "method" could be found in contemporary medical textbooks, but the medical literature of the period mentioned the possibility of vaccinating girls under the knee, should the mother demand this for cosmetic reasons. The authors usually do not recommend these methods due to the pain and sensitivity involved. See Lyght (1950:680-681).

20 See, for instance, correspondence classified "secret–very urgent" from Dr. Fritz Yekutiel, "*Peulot mini'a neged aba'abuot shchorot*" (Preventive Measures Against Smallpox), January 21, 1953, Israel State Archives, B5084/13/G.

negotiation process on how citizens' bodies should be marked as potentially healthy bodies. From an additional important perspective, these vaccinations can be seen as yet another ritual in the trying route to citizenship.

Another vaccine was that against typhoid fever, an infectious disease causing diarrhea. Vaccination against typhoid, for both tourists and immigrants, was already common under the British Mandate. It did not, however, enjoy the same obligatory statutory status of smallpox vaccination and did not target the entire population; rather, it was primarily given to new immigrants and soldiers.[21] Furthermore, the utility of the typhoid vaccine was subject to controversy. Many physicians argued that vaccination could not replace good hygienic practices, such as washing hands and fruit–practices that were inculcated in various hygiene projects. It was felt that vaccination essentially undermined such campaigns. This was in contrast to smallpox, a contagious disease that was considered unrelated to personal hygiene.

Despite the debate over its utility, vaccination of immigrants against typhoid was viewed as important and remained a component in the health care program up until the mid-1950s.[22] Complete immunity required a series of three vaccinations, and the follow-up of this procedure was difficult to administer in the conditions that prevailed in Israel in the 1950s. Additionally, vaccinations could not be fully given outside Israel and completing the series on time once the people had already arrived was problematic. Reports by epidemiologists reveal that coverage averaged 55%, a number that was considered low and could not provide full protection for the population against an outbreak of typhoid, making the vaccination program all the more controversial.[23]

Thus, study of the typhoid vaccination programs raises questions of invasive and painful procedures that were costly, difficult to administer effectively and of questionable efficacy. For smallpox, however, there was greater consensus within the health care system. Nevertheless, the procedure was difficult and prolonged for the recipients.

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21 For information on the degree of public response to calls for vaccination against typhoid, see *"Horaot chisun chova neged typhoid: Kshaim be-peilut tavruah be-rachavei ha-aretz"* (Instructions for Compulsory Vaccination against Typhoid: Difficulties in Sanitation Activities Throughout the Country), *Haaretz* (April 9, 1952): "...Last year's attempt to reach the public to vaccinate via propaganda failed in essence. Last year only 200 people received the required vaccination, at least 2/3 of them schoolchildren and adolescents, that is, the response among adults was almost nil." The article underscored that the primary danger was tied to "mass immigration and our economic straits."

22 On the controversy over typhoid vaccination vs. hygiene, see editorial in *Hygiene and Health*, 1940, 1:8-9.

23 In 1954, the Epidemiology Department of the Ministry of Health recommended that only school-age children receive the vaccination. See correspondence from Dr. Fritz Yekutiel to the Director General, Ministry of Health, Israel State Archives, 4520-2/5/4/G. In 1957, typhoid vaccinations were removed from the vaccination program in schools.

While vaccination controversies certainly had their internal medical logic, they need to be situated within the broader context of creating and contesting borders of citizenship. Several studies on anti-vaccination movements in England and the U.S. situated the debate within the context of democracy and citizenship. How, for example, should the state intervene in the lives of its citizens? How can it inculcate practices that it deems to be for the greater public good? Indeed, how can a government claim custodianship over the bodies of its citizens in the first place? While one does not find a coherent mass movement of anti-vaccinationists during this period of mass immigration to Israel, the interaction between immigrants and public health officials during the vaccination campaigns played an important role in the broader process of creating Israeli citizens.

Mass ringworm irradiation

Ringworm of the scalp is a fungal disease caused by various Tinea species, affecting mainly children and young adults. The disease has been known for centuries and has been usually related to other "loathsome" diseases, such as trachoma, parasitic infections and venereal disease. These repellent diseases could have serious consequences for their carriers: "loathsome" diseases were classified in Category A, which denied entrance to the U.S. during mass immigration at the turn of the twentieth century (Kleinberg, 1950). They were also included by physicians, nurses, educators and other public health personnel in the hygienic programs developed mainly in Europe and the North America.

Between 1949 and 1960, thousands of immigrants to Israel, many from North African countries, were irradiated against ringworm of the scalp.[24] At the time this was a recognized mainstream medical treatment. Yet the scale and scope of this mass public health program makes the Israeli case unique.

According to the official narrative, this was a success story: ringworm and other infectious disease rates declined relatively rapidly (Grushka, 1959). But the consequences were severe. Several decades after receiving the X-ray treatment, the immigrants who had been irradiated developed complications ranging from ugly scars to life-threatening meningioma and thyroid cancers.[25] In 1994, the State enacted a

24 The exact number of irradiated children is unknown. It is clear that previous estimations (based mainly on epidemiological investigations of Prof. Baruch Modan, a public health physician and epidemiologist), which put the numbers close to 20,000, were too conservative. Part of the reason for the discrepancy is that many children were irradiated abroad.

25 Baruch Modan was the main whistle-blower regarding the consequences of the mass ringworm irradiations. Over the years, he published several articles on the subject that were substantial in the enactment of the compensation law (Modan et al., 1974, 1977; Ron et al., 1989; see also Modan and Peri, 2002).

compensation law that established a bureaucratic apparatus of committees to evaluate the damages and claims.

From the turn of the twentieth century, with the discovery of the X-ray and its growing use in medical diagnosis and treatment, various medical authors were already praising the use of scalp irradiation to combat and treat ringworm. Although the consequences of X-ray irradiation–mainly development of various malignancies–were gradually discovered, ringworm irradiation was still considered throughout the world to be a mainstream "scientific" treatment until the late 1950s.

Yet, when discussing ringworm irradiation, one must reconstruct the very mundane practicalities of this treatment. The X-ray irradiation was actually the "easy" part of the treatment. The therapy included cutting the person's hair to a length of 0.5 cm to allow for several consecutive irradiation treatments of the scalp. A temporary sterile cap was put on for eighteen to twenty-one days. Subsequently, hot wax was put on the head and immediately removed once the wax had hardened, leading to complete epilation of the hair. In fact, most of the irradiated children generally recall this painful part of the treatment. The irradiation itself, with its long-term consequences, is a fainter memory. Some of the children (most of the treated patients were young) were recalled for a second and even third course of treatment because of relapses.

Ringworm irradiation in Israel did not actually start in the 1950s. In the mid- 1920s, the Hadassah Medical Organization introduced an X-ray machine, of which they made extensive use in their public health campaign in the *Yishuv*, a campaign which included ringworm treatment. Ringworm irradiations were conducted in a highly efficient manner during the pre-State era, yet after the establishment of the State of Israel, the scale changed dramatically. The objective of the temporary processing camps in the immigrants' countries of origin was, among other things, to carry out medical classification and treatment including that for ringworm. Yet, although immigrants were gathered in these camps prior to their arrival in Israel, medical checkups or full treatment were often not possible. The immigrants themselves did not view medical examinations in a positive light. Some Holocaust survivors sought to avoid medical examinations which triggered memories of medical "selections" in the concentration camps. Many immigrants tried to escape medical examinations through various methods, even sending others to be examined in their stead out of fear that their immigration would be delayed should some medical problem be discovered (Davidovitch and Shvarts, 2004).

These gaps in medical screening and categorization resulted in adoption of a policy by which additional medical inspection and classification were carried out in the *Shaar Ha'aliya* (Gate of Immigration) processing camp upon arrival in Israel. Even after leaving the camp, children who had been diagnosed with ringworm were sent to *Shaar Ha'aliya* (and later on to other centers in Tel Aviv and Nazareth) to receive the full treatment. These children were taken from their parents, their heads were shaved, and they received treatment which lasted anywhere from several days to weeks, at which time they were returned to their families. Even after returning to their parents, their

treatment continued: they were kept in isolation and forced to wear a hat, suffering both physically and emotionally as a result.

Isolation and treatment: The *Shaar Ha'aliya* camp

One can see in *Shaar Ha'aliya* camp a physical manifestation of the melting pot policy. Literally, the "Gate of Immigration," it signifies a passageway, a threshold for the immigrant's transformation into an *oleh* (immigrant). Physically, it was the first home to thousands of new immigrants in Israel. Bureaucratically, it was a place where the immigrants were first officially inscribed as Israelis: militarily, socially and medically. Symbolically, it was the starting point for shedding the body of the Diaspora Jew and becoming Israeli.

Located off the shore of Haifa in what had previously been British army barracks, *Shaar Ha'aliya* was the largest immigration camp of the mass immigration: over 300,000 of the approximately 700,000 immigrants in this period passed through its gates (Weisberger, 1986). Dr. Giora Josephtal, head of the Jewish Agency's Immigration Department, had encouraged the government to establish large quarters to make the processing of immigrants more efficient. *Shaar Ha'aliya* was thus opened in 1949 with the aim of providing a contained environment to ensure that, prior to absorption into the society, immigrants would undergo final medical examinations and be registered for military and social purposes (Weisberger, 1986:70). To prevent people from leaving before processing was completed, the camp was surrounded by barbed wire and overseen by a police force. This was done despite concerns that it would resemble a concentration camp (Weisberger, 1986:71).

The initial plans for *Shaar Ha'aliya* to process 5,000 people and discharge them before the next 5,000 arrived three days later, quickly fell through. Very soon after its implementation in 1949, a huge backlog of thousands of people overflowed the camp quarters. The environment was cramped, uncomfortable and unsanitary. A shortage of health care staff, both physicians and nurses, meant that those who worked there were under extreme pressure (Weisberger, 1986:70). Often there was no common language between the immigrant ethnic groups and the camp personnel, and few ways of bridging the huge chasms that lay between them.

The role of the health care services in *Shaar Ha'aliya* was to examine and vaccinate the immigrants and, where deemed necessary, to treat and isolate them. Within several days, every immigrant underwent a physical, including examination by a dermatologist (with emphasis on diagnosis of venereal diseases, leprosy and ringworm) and an ophthalmologist (with emphasis on diagnosis of trachoma and other contagious eye ailments). Those immigrants found to be ill were isolated on the premises or taken to Rambam Hospital in Haifa (Sternberg, 1973:123).

Yehuda Weisberger describes the atmosphere of mistrust amongst the parents whose children were taken by the medical personnel for examination or treatment:

> We were strangers in their eyes, and they did not believe us. Their past experience had taught them to not even trust Jews...the fear in their eyes was clear. When we were finally given a child or a sick baby, we were witnesses to many difficult scenes. The parents were overcome with despair, as though they were parting with their children forever (1986:88; authors' translation).

There were various stages in how *Shaar Ha'aliya* functioned: from 1949 to 1950, when State policy was to absorb newcomers in immigrant camps, it served as the largest immigrant processing camp, a place where people lived and received all social services from the State. While the intention had been that people stay in *Shaar Ha'aliya* for only a few days, there were cases of families living there for months on end. Due to the high cost of maintaining State support for immigrant camps, and the concern that immigrants would thus have no incentive to live independently, absorption policy was changed in 1950 to that of *maabarot*: temporary housing settlements near large, established municipal centers. The concept of the *maabarot* was that the State would provide only housing for the immigrants, while they would be independent with regard to food, work and so forth. Despite this change in policy, it was not until around 1953 that the population of *Shaar Ha'aliya* was significantly reduced (Weisberger, 1986:107). From 1952 to 1956, immigrants were no longer housed in the camp; rather, it served as the largest center for ringworm irradiation. But in all these stages, what remained constant was that it was an isolated environment, physically setting the immigrants apart from others. Its primary function was to heal the immigrants in a space separate from non-immigrant Israeli society.

Negotiation and resistance

These case studies we have presented of regulation, vaccination, ringworm irradiation and isolation have dealt primarily with the cut-and-dry "official story," as recorded in various reports of the Ministry of Health (see, e.g., Grushka, 1959). Yet, a deeper examination, based on additional documentation and written and oral testimony, reveals a far more complex reality. A harsh picture emerges from the accounts given by various doctors and nurses who visited the immigrant camps. Sanitary conditions were dismal; piles of trash and open sewage were common (Hacohen, 1994:264-266). Poor sanitation and other negative conditions were reflected in the statistics: high infant mortality levels spiraled, peaking at 157 deaths per thousand live births among residents of the *maabarot*. All of these statistics generated harsh criticism.[26]

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26 On the state of infants in the transit camps, see Sternberg (1973:38-68); see also "Controversy over infant mortality in Israel." *Public Health*, September-October 1958:16-19; as well as correspondence

Public health officials encountered grave difficulties in their implementation of preventive medicine policies, including vaccination. Although vaccinations were supposed to be documented in the immigrants' registration cards and in the clinic logs, in practice records were not always accurate and sometimes documents were lost, leading to needless re-vaccination. Dr. Chaim Sheba, Deputy General of the Ministry of Health in 1951, underscored the severity of the situation when, in a meeting with the Coordination Institute on July 11, 1951, he raised the suggestion that food ration stamps be given to immigrants on condition that they substantiate that they had been vaccinated (Israel State Archives, 4250-2/6/4/G).

In the first conference of General Sick Fund pediatricians held in Netanya, a resolution was passed that called upon the Ministry of Education to demand that every child entering kindergarten present a document certifying the youngster had received a diphtheria shot.[27] These solutions, which made preventive medicine (whether through vaccination or medication) a pre-condition for receiving another "service," were considered legitimate by many doctors.

The same attitude is reflected in the impressions of a nurse that worked in the *maabarot* in the 1950s. She speaks of the "impossibility" of explaining to the immigrants what was going on and why:

> The vaccinations were not known to the majority of immigrants and their objection to vaccination was strident at times and a source of great frustration to the nurse. One could compare the attempt to explain and convince the immigrants of the need for vaccination to an attempt to explain to an infant the meaning of treatment with DDT or vaccination against smallpox (Rosental Munk, 1979:232).

This motif–that there was no sense in explaining the meaning of various medical procedures to immigrants due to their mental and spiritual "limitations"–is repeated time and again by medical staff of the period. The logic behind this perception was that

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from Dr. Towstein to Dr. Lotan, on the health status of infants in the transit camps, July 16, 1952, Israel State Archives, 188/7/G/4265. For another document that describes conditions in the *maabarot* from the perspective of doctors who served there, see Dr. Emanuel Margalit and Dr. Betzalel Pinchas, "*Hirhurim al ha-sherut ha-refui ba-maabarot*" (Reflections on Medical Service in the *Maabarot*), n.d., Israel State Archives, 4265/188/7/G.

27 According to an article in *Haaretz* ("First conference of Sick Fund pediatricians," April 9, 1950):

> The sum total of problems in medical assistance and preventive [medicine] which exacerbated with the closing down of the immigrants camps and transfer of the inhabitants to *maabarot* and immigrant neighborhoods throughout the country was discussed at the first conference of Sick Fund pediatricians that opened on Friday at the retreat facility in Netanya. Participants and lecturers did not limit themselves to a professional-medical discussion but dealt with the problems of the immigrant child from a social standpoint, *for social problems become medical problems as well* (emphasis added).

the medical personnel could make decisions on health issues in light of the preferential knowledge they held. And yet, this knowledge was strongly anchored in a perception of "what is a healthy body" vs. "what is a sick body" and how the immigrants' bodies should be transformed and integrated into the body politic of the new State. The "wardenship" over the bodies of inhabitants of Israel in the 1950s – one of the peak points of nation-building–fits into what anthropologist Meira Weiss labels "the culture of the Chosen Body," the very culture that sought to create an Israeli collective identity (Weiss, 2001). But these perceptions were not always consistent with the perceptions of the body, health and illness held by those being absorbed, a fact that caused tension and clashes.

In response to official public health policy, immigrants developed their own public health perceptions. This did not necessarily imply automatic rejection or resistance. Most of the time immigrants complied with and accepted public health measures in the belief that these practices would improve their health or would even help them achieve quicker assimilation into Israeli society.

Yet, from time to time, various public health practices provoked strong resistance. Mass vaccination, treatment for ringworm and other preventive medicine measures could trigger opposition and dissent. Usually these events were not remarkable. They took place in a gray and harsh daily regime or routine that is difficult for us to reconstruct. This "micro-resistance," which surfaced mostly on the local level, pointed to the interaction and conflicts between public health personnel and the immigrants. The newcomers had their opportunities, although limited and sometimes problematic, to maneuver and negotiate with the establishment. Of course, not all immigrants reacted in the same manner and they cannot be regarded as a monolithic entity. Similarly, the agents operating in the public health realm, many of whom were immigrants themselves, came from various professions and traditions–physicians, nurses, social workers, and so on. Yet, a common feature of the negotiation process between immigrants and health workers concerned practices that involved the body.

Conclusion: Contested bodies

This context makes it easier to understand the testimony of Phyllis Palgi, the first anthropologist to work with the Ministry of Health in 1953. Palgi related how, in a visit she conducted with public health nurses in one of the then-new settlements comprising immigrants from the Atlas Mountains of Morocco, the immigrants threw stones at the nurses who had come to vaccinate their children. Common rumor held that the nurses had come to put "tainted blood" in the bodies of their children (Palgi, 1993).

Rumors of inoculating contaminated blood and abuse of "medical power" against weak populations were not limited to the province of health issues in the 1950s in Israel. Various anthropological studies demonstrate that the spread of similar rumors

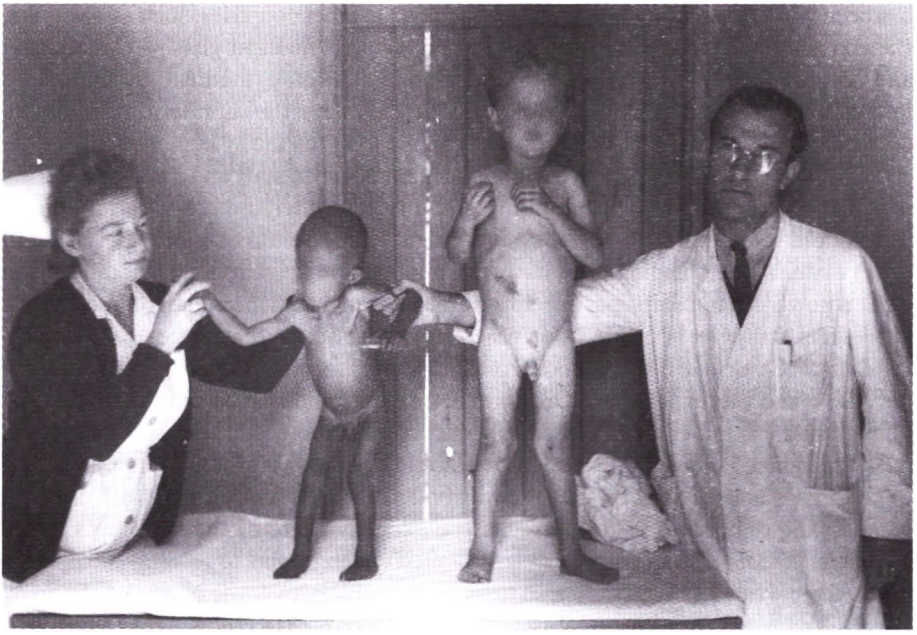
has been witnessed among immigrant populations in other countries, such as Australia, Canada and the United States–a phenomenon labeled "medical gossip" (Manderson and Allotey, 2003). According to Manderson and Allotey, medical gossip among immigrant groups serves a number of objectives. While in the short term such rumors create conflict with the local health system, in the long run the system internalizes the criticism and attempts to improve communication between staff and immigrants. This is achieved through various cultural facilitators who interact both with immigrant populations and with the medical system. Thus, such tension can ultimately lead to better mutual understanding. It is, however, important to keep in mind that the tension reflects power relationships and attempts by the State to model the bodies of immigrants. Often this struggle is carried out *vis-à-vis* control over the bodies of children.

Control of the State over the bodies of children was manifested in a more significant, pervasive and fateful manner. One should bear in mind that, during the period of immigrant encampments of "tent cities"–the period that preceded the *maabarot*, with their "enhanced housing" of wooden shacks and tin huts–all infants were transferred to children's houses shortly after their arrival. This area was virtually off limits to parents, and the babies were left under the exclusive care of the children's house personnel. Through strict enforcement of limited visiting rights to feeding and nursing times, there was what Weiss referred to as State "mastery over the bodies of children" (2001:98). From the outset, therefore, the children symbolized at once very different things to their parents than they did to the medical teams. There were cases where parents went to the children's house, only to be told that their infant had been transferred to a hospital, based on the evaluation of the medical staff–a decision taken without consulting the parents. To travel to a hospital from these tent encampments or from a *maabara* was an extremely complex operation under conditions prevailing in the 1950s. Nevertheless, doctors and nurses have testified that there were cases where parents attempted to visit their child in hospital only to be told that their child had died. Without entering the controversy of the State inquiry over the disappearance of a certain number of Yemenite children during this period,[28] there is no question that these children and the authority over their bodies that the medical system exercised constituted a defining issue in the clash between immigrants and the State (see Photo 2).[29]

The new immigrants viewed the children–who constituted a core axis in Zionist perceptions of the rebirth of the Hebrew nation in its homeland–very differently. It is

28 The third report on the missing Yemenite children was published in 2002. One of the core issues was the subject of the infant houses and transfer of sick infants to hospitals.

29 The health system was not the only one tied to this "struggle." Other hegemonic systems, such as the educational system, the army and other social institutions, constituted additional challenges in the "remolding" of the immigrants' identity.



Juxtaposition of a malnourished, "sick" Yemenite child and a "healthy" Ashkenazi-looking child (Governmental Press Archives, c1950).

easy to imagine that the high incidence of illness and death only amplified parents' sense of need to protect their children in every way possible. The medical establishment was often perceived as an assistive and beneficial agency, but reciprocal relations were very complex and, contrary to the perception amongst the absorbing society, the immigrants did not play a solely passive role. Thus, for instance, simplistic descriptions found in many historiographic accounts of the period which explain how children were transferred for care–such as "at the beginning the parents were opposed to concentration of the sick children in separate camps, but in short order they were agreeable to such a move" (Hacohen, 1994:282)[30]–do not fully address the complexity of the subject, omitting the immigrants as active protagonists.

An important point for historical understanding of the relationship between the State, public health personnel and the population is the fact that, for a long time, public

30 Alchananai gives a similar "explanation" in an article that describes the medical care of immigrants: "One can cite with satisfaction that women from Yemen who at the beginning didn't want to give their children to the infant house, began to fathom the great blessing of these institutions and now they give their children to the infant house willingly and happily" (1950:8).

health measures, such as the administration of vaccinations, was an important component in Western colonial systems. Westerners brought with them various vaccinations which they wanted to administer to local populations, both out of benevolence and because it was a matter of self-interest to eliminate endemic diseases within their colonies. Despite such good intentions, these efforts caused local populations to identify public health policies with repressive and foreign regimes.

Much has been written about the tie between Zionism and colonialism. In the Israeli context, the importation, intellectually and physically, of Western medicine in the midst of an accelerated progress of immigration from a large number of countries presents a unique case for scholars of health and immigration.

To understand the resistance to public health, one must take into account the tension existing between the freedom of the individual and the limits of State power. At the turn of the twentieth century, various radical political groups in the United States and Europe were opposed to vaccination and other public health measures in two areas: as part of general opposition to State intervention in the private lives of its citizens, and as part of opposition to any kind of invasive medical procedure on a person's body. Thus, resistance was part of a larger context connected to questions about the limits of State power in domains that belong to the private sphere: family life, education, religion and health.[31]

It is important to remember that immigrant populations were one of the key groups on which public health personnel in various countries focused. Arrival in a new country–a process that included medical examination in most cases–provided an opportunity to carry out mass vaccination of immigrant populations. The perception that immigrants as a group were less healthy than the local population served as the justification for an inflexible policy with regard to preventive medicine, including, among other steps, the adoption of mass treatments of various kinds.

As the historian David Arnold claims, the State views its ability to supervise and control the body politic through disciplining the individual's body (Arnold, 1993). Public health personnel, as part of a broader system of regulations that govern hygiene, health and the care of infants, constitute one example of the ways in which countries supervise the bodies of their citizens. The use of State authority and power is all the more amplified when it is applied to weaker or marginalized elements in the population. Yet, this process is one of struggle, negotiation and resistance; a process that determined the borders of citizenship while defining the relationships between the State and various components of its society. In the case of "Oriental" Jews immigrating to Israel, the health domain served as an important field for playing out conflicts and negotiations

31 On the democratic potential of health-related debates and the political aspects of these struggles, see Johnston (2004).

over how "normal" and "proper" bodies should be developed and absorbed in the new society. These contested immigrant bodies varied: from Holocaust survivors arriving from Displaced Persons (DPs) camps in Europe to "Oriental" Jews coming from Arab countries. The discourses and practices of the field of health, together with those of other fields (such as education, military or settlement policies), are best understood through the ongoing relationship between the State and its new citizens.

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