A stage for policy making: health promotion and the making of public health problems in Jerusalem from the Ottomans to the Mandate (1908-1925)

by Philippe Bourmaud

Department of History, Université Lyon III

Two men were standing on a rather crammed exhibition stand, welcoming the visitors among cholera outfit boxes, boards running slogans such as "Stamp out sickness and pest – Encourage health", and charts and diagrams regarding smallpox and other diseases[1]. The picture was shot by Paul Carley, a malaria expert working for the International Health Board of the Rockefeller Foundation, during the Health Week organized in Palestine from the 17th to the 22nd of November 1924. The (Zionist) Hadassah Medical Organization had initiated the program, with the support of the British mandatory government, with a successful health exhibition in Jerusalem as a highlight of the week[2].

Throughout the 19th century, Western medicine had come to rely increasingly on a heavy amount of statistics to define disease, etiological factors and therapeutic efficacy[3]. Yet putting data about cholera and smallpox on a stand named "Epidemic and Vital Statistics" in a popular exhibition showed something new: the staging of statistics as proof and a pedagogical tool for public consumption. This reflected an early twentieth century belief in the objectivity of public problems such as social problems or, as was the case here, public health problems. Yet in order to reach a large public, public problems have to be built into something other than an objective statement of facts: narratives of collective vulnerability, social threats and a demand for policy response. Indeed, instead of reflecting epidemiological concerns, making out public health problems was becoming an essential part of efforts towards health promotion in the late Ottoman Empire, involving actors with an ax to grind. The goal of bringing up a healthier Ottoman population brought together actors with quite different worldviews, such as Ottoman administrative reformers who had long sought to engineer the transformation of the population, and intellectuals of the *Nahda*, the Arab cultural renaissance, who advocated modern education to elicit civic mobilization and social improvements. With the opening of public debate and the intensification of public mobilization after the reestablishment of the constitution in 1908, the list of actors committed to the issue only grew longer, including Jewish and Arab political contenders for the future of Palestine.

By then, Jerusalem was not at the heart of Palestine's public health problems, but it provided a stage on which they could be shown and solutions could be presented to the general public, in Palestine and beyond. The city captured global popular imagination through its associations with biblical narratives of miraculous cures, it offered a particularly high concentration of sanitary and medical institutions, a growing administration to organize health promotion, experts and social reformers, as well as venues for them to express their views to the public in the blooming press. With the British occupation in 1917 and the establishment of the mandates system, the staging effect was reinforced, due to the examination of mandatory government by the League of Nations and the desire of the British power to make it clear to the world that it was abiding by the two obligations on which the Palestine mandate rested: facilitating the establishment of a Jewish national home in Palestine, and respecting the rights of the non-Jewish, i.e. Arab, population of the country. The Health Week illustrated this: though conceived by a Zionist organization, it was engineered into a bi-communal event by the mandatory power, since the issue of health transcended community boundaries.

Or did it? Health has become over time a contentious issue in the Palestinian-Israeli conflict, with experts on both sides trading arguments and counter-arguments regarding the sanitary effects of inequalities and security measures on the Palestinian population, the priorities of Israeli policies, or the marginal character of cooperation in the field of healthcare. Tensions in the field of health already existed during the mandatory period, especially after the arrival of about 800 German Jewish physicians between 1933 and 1935, and the political attempts by Arab physicians to organize their profession along community lines in reaction to these new competitors. Yet the nature of the health sector in mandatory Palestine was already a dual one by then, between a growing, Zionist-led Jewish healthcare system, and a much more modest healthcare provision for Arabs, between the limited options of government and voluntary institutions. This article argues that right from the beginning of British rule, tensions emerged

about health priorities that would eventually fall along community lines. Formulating public health problems and claiming expertise on them were ways of shaping the health sector and created a dual system, in spite of such visible moments of cooperation as the Health Week of 1924. In a system which, from Ottoman to British rule, left limited means for centralized healthcare, the study of specialized, missionary or general periodicals such as the newspapers *Filastin* (founded 1911) and *Mir'at al-sharq* (founded 1919) as well as documents from the Rockefeller Foundation pertaining to its collaboration with the Hadassah Medical Organization show different political patterns in the construction of public health problems before 1914 and after the Great War.

A showroom for sanitary reform in the Middle East

Between Ottoman health reforms and foreign charities, the making of a sanitary hub

By 1908, Jerusalem had become one of the urban centers concentrating the greatest number of health institutions in the Ottoman Empire. The foundation of such institutions was a common feature of the main Ottoman cities from the Tanzimat era onwards. Yet in Jerusalem, the development of hospitals and dispensaries predated the main impetus to develop the health sector, Empire-wide, and followed logics of its own.

In spite of a spate of medical and educational foundations breaking away from traditional Ottoman medicine since the beginning of the 19th century, it was after the Crimean war that health reforms accelerated. Comparisons between the results of Ottoman, British and French military medicine[4] and cooperation between physicians boosted the demands for new rules of practice and the territorial development of the Ottoman healthcare system. One of the main institutional tools to territorialize reforms and give access to modern healthcare

was the municipality. The Jerusalem municipality, founded in the 1860s, was one among half a dozen prototypical cities whose reformed municipal administration was to expand public services, including health.

In Jerusalem, however, the development of sanitary institutions did not follow a pattern of development of public health services, but it grew out of charities and philanthropic activity, until these morphed into elements of outright foreign influence and Zionist social engineering. Starting in 1842, the founding of hospitals and dispensaries, later on laboratories, multiplied until World War I. This was a self-accelerating process, based not on consideration of public access to services, but of clientèle. European protector states provided healthcare, at first as a tool to further missionary activity and national influence. Yet over time, communities started to consider charity healthcare as a right, all the more as they could play, at their own micro level, on the geopolitical rivalries between protector states, and threaten to move into another religious clientèle if service was not forthcoming[5]. These institutions were also places where state-of-the-art medical equipment would be displayed, and model medical services set up in order to attract new patients. Earlier *bimaristans* and, in the last decades of the 19th century, a municipal hospital showed that the Ottoman state was part of the game, but the logic of territorial expansion of state services was overwhelmed by the inflationary tendencies of national clientèles. Zionists, who around 1905 started to build more systematic expertise on health in Palestine[6], were not so much driven by inter-community competition than by their own perceived needs for sanitation and medicine, and a desire to move away from philanthropy. By 1914, Lebanese-born journalist and novelist Jurji Zaydan could note that Palestine offered the largest scope of sanitary services, and Jerusalem, the greatest concentration of health institutions in the Levant[7]. At just about the same time, physicians started to cut a political figure in the city.

Occupying the media stage to assert the medical profession

The visibility of physicians, eager to bring health to a prominent position within public discourse, was not just the effect of the multiplication of health institutions: schools also multiplied, and yet teachers were far from enjoying the status of physicians in late Ottoman Palestine. Following Ottoman reforms, there were also professional motivations for physicians to occupy the media arena. The Tanzimat and Hamidian period saw, all at once, a series of codes regulating the practice of the medical professions, the growth in the number of practitioners, physicians, pharmacists or midwives, trained in modern medical schools. And yet, even though the process became intensified under sultan Abdül Hamid II, trained practitioners were few and far between, and did not always command the trust of their patients. While trained practitioners claimed a monopoly on up-to-date medicine, they had to compete on the ground with many practitioners without a degree.

Discourse on medical practice became polarized, first and foremost between trained and non-trained practitioners, but also between physicians on the one hand and other health professions, such as pharmacists and midwives, accused of acting as physicians, on the other. Professional legitimacy was a constant component of educational discourse on health, which aimed not only at informing the population about sanitary dangers, but at monopolizing public discourse on health by asserting the medical knowledge of modern physicians, as opposed to the not-so-up-to-date knowledge of traditional practitioners.

An established discursive field: sanitary advice

Indeed, pieces on health soon became a recurrent feature in the Ottoman press, whether under the reformist influence of the Tanzimat or among the intellectual circles of the Arab *Nahda*. Newspapers and journals opened their columns to physicians and let them give the readership increasingly specialized health

advice. The *genre* was also becoming increasingly accessible to the population of the Empire: starting in 1858, the *Gazette Medicale d'Orient*, written in French, targeted a readership that could hardly extend beyond the circles of francophone physicians and the European population of Pera[8]. Yet by 1860-1861, Ahmad Faris al-Shidyaq peppered his journal, *Al-Jawā'ib*, with health-related pieces, and by 1875, an Arabic-language scientific journal called *Al-Ṭabīb* (the physician), published by circles close to the Syrian Protestant College of Beirut (later the American University of Beirut), devoted a large share of its articles to health. Of course, even those vernacular publications raise the question of who could read which kind of written text, and in what context. Newspapers were reported to be read out loud in the cafés. But more than this, what interest did readers and overhearers give to health-related articles?

Though there was a literacy bias in these types of publications, barring a very large part of the Ottoman population from accessing them, "health advice" pieces generally showed similar contents. The topic, a disease or a behavior, was presented in some of its dramatic effects. Up-to-date knowledge of etiological factors was then usually detailed. Epidemiological data were then introduced, often enough to incriminate social and cultural practices. Prevention measures, mostly individual, completed the piece. A discursive field emerged out of the accumulation of those articles, inasmuch as they were often answering one another, and they were also implicitly answering the views of unorthodox or non-trained practitioners.

Another cause for conflicts in the realm of health expertise derived from distrust towards medical powers, following dramatic sanitary decisions. The memory of the 1902-1903 cholera epidemics remained vivid in Palestine prior to World War I. The disease had first reached the regions East of the Jordan, where workers were building the Hijaz Railway, but local administration had hushed its presence and denied its advance towards Jerusalem and the rest of Palestine, until the massive death toll made it impossible to hide its presence any longer. In

reaction, post-1908, physicians would often intervene in the public debate to criticize the administration, and in particular to doubt its anti-epidemic measures. With the opening of an Ottoman public space after the reestablishment of the constitution, critical discourses on health developed.

Publicizing "objective" public health problems

Objective issues?

The 1908 Young Turk revolution and the ensuing wave of critical debate on state, municipal and other public affairs catalyzed civic demands at a particular time in the history of social sciences. Social enquiry was being boosted by the development of social statistics: Ottoman intellectuals read Durkheim[9]. The SPC trained its students, among whom there always were a few Jerusalemites, in methodologies of research inspired by the "social problem" approach and the type of large investigation characteristic of the progressive era in the United States. Graduates of the latter institution and its rival, the Université Saint-Joseph kept by the Jesuits in Beirut, each one in its style and with its social project, encouraged their students to speak up, and indeed, a number of them became public intellectuals during the Second constitutional era, all the more as the circles of intellectual debate multiplied, in Jerusalem and elsewhere[10].

At the same time, enquiry procedures, judicial or academic, were being reformed[11] and popularized through novels[12] – in much the same fashion as the advent of the detective story coincided with the coming of age of criminology in Europe[13]. Formulating the problem, revealing the culprit, making out the motives, all these intellectual goals were part and parcel of the belief that problems could be made objective and publicized in order to reform society. The rapid growth and demographic transformations of Jerusalem, turning into an

immigrant city in the decades prior to the war, made it a focus of interest from that perspective.

A stage for global solidarity and charity abuse

Among the public problems that surfaced during that period, public health problems occupied a significant place, and could become a windfall for moral entrepreneurs. It was not that Jerusalem was the unhealthiest locale in the region. Indeed, when systematic sanitary enquiries were initiated during the Mandate, many other places in Palestine presented higher rates of prevalence for malaria, tuberculosis, or trachoma. Yet given the concentration of medical manpower in the city, health conditions were given special prominence, in the hope of kick-starting political responses[14]. In the aftermath of the catastrophic public handling of the 1902-1903 cholera epidemic, revealing public health problems became a way of criticizing political powers. In Jerusalem, however, there was a longer history of making a case for local public health problems in order to solicit donors far and wide, which elicited doubts regarding the reality of the problems. In late 1913, Paul Ritsche, a professor of music at the school of the German Borromean sisters in Jerusalem, launched an appeal in the German Catholic press, mentioning the high numbers of blind people in the city and denouncing the lack of public action and foreign charitable organizations to take care of them. The appeal asked donors to provide the financial means for a German catholic institution for the blind, which it claimed was about to open. The call received a blunt refutation by Belgian priest Adolf Dunkel in the German-language missionary quarterly *Das Heilige Land*, who criticized Ritsche for ignoring a number of existing facilities for the blind, from the British Saint John Eye hospital to the *Hospice* of the French Filles de la Charité, and for wrongly claiming church support[15]. Jerusalem's conditions tended to be formulated as global problems, with interested actors playing on the lack of information and gullibility of distant donors to make cases that would not hold water when presented to a local audience. But given the weight of foreign

investments in the city, there was no clear separation between the global construction of public health problems and local policy responses.

Federating academic efforts

Making public health conditions objective was a legitimate procedure in epidemiological research. And yet, even when this was done in an academic setting, the result was to highlight the social construction of the data and to serve agendas outside of the academic sphere. In 1911, on the occasion of the medical conference of the Syrian Protestant College, Taufik Canan, valedictorian of the 1905 promotion of the college's medical department published in *Al-Kulliyeh*, the journal of the alumni, an academic article revealing the epidemic character of cerebro-spinal meningitis in Jerusalem. The piece consisted of a presentation of statistical data and clinical cases and made the case for serotherapy whenever the disease was suspected. It insisted on clinical considerations: Jerusalem physicians had long confused the disease with particular forms of such common pathologies in the city as malaria and tuberculosis, until the German physician of the Shaare Tzedek hospital, Dr. Moritz Wallach, suspected cerebro-spinal meningitis on a more pronounced symptomatic case, and submitted it to a bacteriological test. Since then, over the three years 1909, 1910 and 1911, it was possible to establish the epidemic character of the disease in all seasons except summer. Given the limited diffusion of *Al-Kulliyeh*, the piece was hardly designed to stir public debate[16].

What it did was to show the benefit of cross-institutional cooperation in researching and prioritizing public health problems. Making out the meningitis epidemic was complicated by the competitive pattern of relations between medical institutions and between practitioners in Jerusalem. Limited communication between hospitals, which were the main source of available epidemiological information, made it difficult to reach a level of statistical significance. In the case of cerebro-spinal meningitis, 185 cases were established

over three years, based on small cross-institutional networks, at the intersection of which stood Dr. Canaan[17]. A first network was composed of German physicians, across denominational differences: on top of the Köln-born Jewish Dr. Wallach, it included Dr. Grussendorf, head physician of the German Lutheran hospital of the Kaiserwerth deaconesses of Jerusalem, and his assistant, Dr. Canaan. The latter practitioner had close relations with Wallach, whom he had temporarily replaced during 1910. A second connection linked Canaan and his colleague and former fellow student at SPC, Dr. Albert Abou-Chédid, a Jewish physician of Algerian origin working at the Ottoman municipal hospital of the city[18]. Not only did national rivalries and denominational tensions usually prevent such cooperation, but the diversity of training among Jerusalem's foreign or foreign-trained physicians was also a hindrance to scientific communication. In the case of meningitis, national and academic links enabled a relative uniformity of observation and treatment: the four men used the same testing technique through lumbar puncture, and adhered mostly to the same treatment with a Berlin-produced serum[19]. In the years following the article, attempts at organizing medical observations into a common framework of epidemiological research and public policy planning started to materialize and reinforced the role of Jerusalem as a hub of health in the Ottoman Empire.

An attempt at defining and hierarchizing public health problems: the International Sanitary Administration of Jerusalem (1912-1914)

The years leading to World War I saw the institutionalization and the professionalization of public health research in Jerusalem. The decisive event was the arrival, in 1912, of the German malaria commission headed by Dr. Panwiss and Professor Peter Mühlens in the city, on an enquiry mission that would further take him to Aleppo and Istanbul. Mühlens was a specialist in tropical medicine and malaria at the Institut für Schiffs- und Tropikenkrankheiten in Hamburg, one of the academic strongholds of German colonialism. In Jerusalem, Mühlens gave a series of conferences on malaria that attracted an audience of

physicians of various nationalities and religious faiths. Thus Mühlens, whose intent betrayed the protocolonial interests of Germany in the Ottoman Empire, brought together specialists of public health with diverging political views, Jews and Arabs, British, Swedes and Italians. This did not mean that the priorities of the institutions reflected evenly the interests of all concerned[20].

To the best of my knowledge, fairly little is known about the short-lived International Health Administration of Jerusalem. The institution, which was located outside of the walls of the Old City between Notre-Dame de France and Damascus Gate, was neither in charge of localized sanitary control in the way of the Sanitary Councils of Constantinople and Alexandria, since Jerusalem was not a node of international circulation[21] ; nor a much more ambitious international organization in the fashion of the Paris-based Office International d'Hygiène Publique[22]. The list of its priorities and objectives reveals changing functions, away from the strict perspective of foreign institutions and Zionist colonization organizations, towards a wider definition of public health issues. By April 1913, malaria, a disease that first and foremost killed immigrants, and was much less lethal for autochthonous populations after the first few years of life, was still the main priority of the Administration. Among its goals were also to establish a Bacteriological Institute, an idea nurtured by American Zionist philanthropist Nathan Straus. Other directions of research gave importance to the priorities of European bacteriological institutions, such as rabies, rather than to the public health concerns that were being discussed in the press[23]. Yet by October, *Das Heilige Lande* was able to report the widening of the scope of research to include a program on tuberculosis, by then a growing urban concern across the communities, in Jerusalem and in other locales of Palestine such as Nablus[24]. This balance between the sanitary interests of the (mostly Jewish) immigration and the concerns of the local population was, in spite of the expansion of health services, harder to find after the Great War.

The mandatory order: competing efforts to shape health priorities

Health in the political economy of the mandate

In the aftermath of World War I, health promotion gained importance in the political economy of the new territory of Palestine. First, the British armies that occupied the Levant between the spring of 1917 and the end of October 1918 were confronted with the precarious sanitary situation and the epidemics at the end of Ottoman rule: on top of typhus and later, the so-called Spanish influenza, the troops were heavily affected by malaria in epidemic proportions. As the disease targeted in priority newcomers in the country, it soon became as much a priority for the new authorities as it had been for Zionist organizations prior to the war[25]. Short for cash, and as a demonstration of the new order that prevailed in Palestine after the Balfour declaration, the occupation authorities allowed through 1918 the American Zionist sanitary and educational organization Hadassah to send emergency medical help through the agency of an American Zionist Medical Unit (AZMU) [26], later to become the Hadassah Medical Organization (HMO). Gradually, the British authorities also permitted pre-war voluntary medical institutions to bring back their staff and start their work anew. They also financed emergency public sanitary and medical institutions, expanding the public sector in health until, by 1922-1923, post-war epidemiological normalization gave them confidence enough to impose major cuts. Health was largely delegated to non-public actors operating with the benediction of the colonial state.

Two features characterized the political economy of the mandate-in-waiting. One was the role of private organizations doing public tasks: those were not only missionary or Zionist organizations, but also international philanthropic societies. Among these, the Joint Distribution Committee (JDC), an American Jewish relief organization, and the Rockefeller Foundation occupied a prominent

place. The Rockefeller Foundation had adopted a policy of picking one local actor to further its agendas. Already prior to the war, it was working in Greater Syria with the SPC; by the end of the war, its main partner in Palestine had become Hadassah. Yet as the situation stabilized, both the JDC and the Rockefeller Foundation started to reconsider the partnership, in order to devote more financial means to the Department of Health of the Government of Palestine, the colonial ministry of health, and thus, to contribute more directly to state-building[27]. This reflected a transition from emergency help to development policy, but HMO authorities opposed the move: if the JDC moved its subventions from a Zionist organization to public institutions that were meant to cater for the needs of all, was it still furthering Zionist aims?

The other dominant feature was the exposition of health policies in Palestine to international public opinion. With the adoption of the principle of the examination of mandatory policies by the League of Nations, health was to be given visibility: the League drafted a questionnaire which was meant to guide the writing of the annual reports of mandatory governments. The questions included health concerns, requesting data on the main pathologies, on venereal diseases in particular[28], and on vital statistics. The mandates system was reinforcing the theatrical dimension of health policies that had been emerging prior to the war.

The political economy of mandatory health policies was characterized by an early division of labor between the colonial government, which was in charge of the Arab population or delegated healthcare responsibilities for it to voluntary, mainly missionary institutions, and the Zionist organizations, essentially the HMO, which was to address the needs of the Jewish population. This division of labor was in fact not so clear, and liable to shifts as budget priorities changed. This was a source of conflict between the British Department of Health and the HMO, supported by local Zionist politicians. In July 1922, Rockefeller University academic and JDC representative Alfred E. Cohn travelled to Palestine to get in touch with the main officials of the Department of Health and the HMO, in order

to assess possibilities for refocusing the work of the latter organization, and suggest ways of redirecting JDC subventions between the two, as well as assessing the sanitary needs of the Jewish community in Palestine[29]. During a meeting with Palestinian Zionist leaders Arthur Ruppin and Menachem Ussishkin, the latter considered that the hands of the government of Palestine were tied by their obligations to provide equally for Jews and Arabs. As a result, they claimed that a strict division of work should characterize the allocation of resources, with the Department of Health ensuring sanitation in Arab majority locales, and by the Zionist Executive and the HMO, with financial support from the Keren HaYesod and the JDC, in Jewish majority locales[30]. In that configuration, Jewish subventions should go solely to Jewish organizations, rather than to public institutions as the JDC was now contemplating.

In the mandatory configuration of health policies, the main actors were fewer, but divided by sharper political oppositions than prior to the war. As polarization between Jews and Arabs grew, the pre-World War I segmentation of healthcare between ethno-religious community became less significant, all the more as Arab and Jewish nationalisms, boosted by the war, developed discourses on the need for health institutions to foster national solidarity. Most foreign powers, except Britain, were now irrelevant, and so were their interventions in the health sectors, now deprived of their earlier potential for political influence. Indeed, Palestinian physicians now argued that they should be submitted to a logic of service rather than to remain charities, and in order for this to happen, should be examined by the health authorities as any other health institutions in Palestine. During the summer of 1920, an editor for the Jerusalem-based newspaper *Mir'āt al-Šarq*, possibly its editor-in-chief, Pennsylvania University trained physician Niqula Shehadeh, published on the front page an "Open letter to the Department of Health", where he denounced the quality of medical services in the many foreign hospitals of Jerusalem. Under the protection of the capitulations prior to 1914, these institutions had provided healthcare of dubious quality, based on the notion that they were offering benevolent help to the population. If a real

healthcare service was to emerge in Palestine, argued the author, foreign medical institutions should be included in government oversight, and be submitted to the same exigency of quality of service as any other[31]. Even though the Department of Health remained wary of acting against voluntary institutions that gave healthcare at rock bottom price, the criteria of public health policy were evolving towards a needs-based approach, which reflected the way public health problems were increasingly understood[32].

Policy makers under the public eye

The mandate made it more necessary than before the war to publicize public health problems and the adequacy of policy responses. The procedures of the mandates system, through the examination of the annual reports of the mandatory governments by the League, incited mandatory powers to look for efficacy in health policy : in Ruanda-Urundi, the Belgian mandatory power targeted yaws as a disease liable to produce effective cure at limited cost[33]. Yet Palestine was the show window of the mandates and modern colonization during the Interwar period, which increased the attention paid by public health officials to public opinion. In July 1922, Cohn noted how keenly aware his interlocutors, in particular colonel Heron, the director of the Department of Health, and Rubinow, the head of the HMO in Palestine, were of the international attention given to their results[34].

Advertising one's efforts towards public health, as evidenced by Cohn's interviews, was a driving concern within the Department of Health and the HMO. Conversely, losing financial support was supposed to carry a negative judgment on the supported institutions, which were very touchy regarding bad publicity. After JDC official Bernard Flexner advocated transferring the work of HMO in public health to the Department of Health, Rubinow reacted angrily and mobilized in April 1922 judge Louis Brandeis to oppose the move, arguing that the JDC in effect slapped the HMO in the face, to favor the Department of Health

whose director he branded as an anti-Semite and a man eager to push himself under the limelight[35]. Publicity concerns also motivated Ruppin and Ussishkin's opposition to the transfer of responsibility, as they argued that it was doubtful that the government of Palestine, which was tied by its obligation to provide equally for Jews and Arabs, would give publicity to the support of the Zionist organization if the JDC decided to fund it[36].

One of the ways to make one's own publicity was to reveal public health problems and make public warning. One of the bones of contention between the HMO and the Department of Health was the work of the head of the Jerusalem bacteriological laboratory of the HMO, Israel Kligler. The man, the main Zionist expert on malaria during the Interwar period, had become insufferable to Heron on account of his revealing epidemics, which cast in return an unfavorable light on the prevention work of the colonial government. During the summer government, Kligler and his aides showed the epidemic prevalence of typhoid fever in Jerusalem, and went on to show the high prevalence of bilharziasis and ankylostomiasis in various parts of Palestine. The 1922 attempt by Flexner to place Kligler and his team under government control by displacing them to a state laboratory in Haifa may have been inspired by Heron, who appeared eager to control publicity on public health problems[37]. The affair also highlighted the struggle for the control of priorities in health policy between Zionist organizations who conceived their priorities from the sole perspective of the Jewish, largely immigrant, community, and the British authorities who had to consider Arab interests as well.

The Health Week: behind cooperation, the asymmetries of policy making

Jerusalem was the place where these debates took place and the stage where public health problems would be given the most publicity. Most of the tensions regarding the spheres of intervention of the government and Zionist actors were formulated behind closed doors, but they shed light on why, once the relations

between the Department of Health and the HMO had stabilized and the political climate had improved, by 1924, both institutions were eager to make a unanimous show about the universal benefits of mandatory public health policy and Zionist sanitary investments. The Health Week was initiated by HMO employees, but the involvement of the Department of Health and the Department of Education helped attract Arab health professionals, school teachers and pupils. It was crucial for the project to be successful, that the main attraction, the health exhibition organized in the former Russian compound in Jerusalem, should attract as many visitors as possible. Assessment of their numbers varied from 6,000[38], to 34,000[39], and up to 51,000 in an official report[40], which hints at an intent to inflate figures.

The organization of the Health Week was all at once very normative and very demonstrative. It played on oppositions between good practices and common practices, for instance through the device of miniature nurseries, one of them a model and the other an unsanitary one. If the contrast was not clear enough, at least two employees, one for Hebrew-speakers and the other for Arabic-speakers were there constantly to provide explanations. In order to bring in as many people as possible, including workers and employees, the exhibition remained open for three nights during the week. Posters of mosquitoes, slogans, and bathroom equipment were also there to inspire public imagination and promote modern hygienic behaviors[41]. This pedagogy of health somehow reproduced Western domestic and public models, as well as the priorities of immigrants. Still, it probably helped make these acceptable to Arab citizens who, by 1920, were infuriated by the authoritarian behavior of Department of Health employees, barging into private houses, much to the ire of Muslim families in particular, and emptying water tanks to prevent malaria, even by mid-summer[42]. The staging of public health policies made them gradually more acceptable.

One uncommon feature of the Health Week exhibition, however, was a reminder of the tensions that had existed since the end of the war regarding public health

priorities. What can be more dull, in an otherwise attractive program, than a stand dedicated to vital statistics, such as morbidity rates and infant mortality rates? Infant mortality, in particular, was becoming a major index of sanitary conditions, and, together with medicalization rates, a tool to appreciate, in the long run, the effectiveness of health policies. Indeed, one of Rubinow's reproaches to Heron was that he was able to boast the efficacy of his services while the infant mortality rates for the Arab population oscillated between 250 and 300‰, while 80% of the rural population did not have proper access to a trained physician[43]. This was certainly disingenuous, given the time required to train physicians (5 to 6 years in most medical school at the time) and the efforts of the Department of Health to train health practitioners without a degree, midwives in particular, to update the standards of rural health. Yet this logic was not proper to Rubinow, but was pregnant throughout the mandate. Speaking about African mandates in June 1925, Swiss academic William Rappard, a member of the Permanent Mandates Commission in charge of examining the results of mandatory governments, took vital statistics as the yardstick of the success of the mandates to improve the life of their population[44]. Actors in the field of health in Palestine were already fully familiar with that reasoning.

Conclusion:

So what does this story tell us about the modern history of Jerusalem? Debates between science and society take place on a stage, and due to its concentration of medical institutions early on, the city offered the wherewithal and the array of potential experts to be such a stage. Between Beirut and Cairo, there were, however, other contenders in the Arab Levant, with larger capacities to produce books, journals and newspapers, and the same kinds of public problems, if not bigger ones to solve. Yet with the mandate, Jerusalem offered two things that could trigger enhanced research: divergences over health policy priorities, and

expertise with transnational and global connections and a sense of the importance of public opinion.

Already prior to 1914, health experts were bringing to light new public health problems, but as a part of their academic work. Although they were linked with different clientèles, it was hard to discern in their recommendations clear policy choices between the interests of specific segments of the population.

This was to change after World War I. While epidemiological studies now extended beyond Jerusalem and engulfed the whole populated areas of Palestine, Jerusalem remained the place where policy decisions were taken and health institutions, public and private, strove to make their case to external funding sources. The capacity to identify public health problems and suggest solutions was one of the criteria that surfaced during that period, but so was the necessity to provide modern services for all. In that context, the Jerusalem medical milieu could exhibit experts whose work on Palestine's health problems led to international careers: Kligler went on to become an important actor within the League of Nations Health Organisation, while Taufik Canaan briefly worked for it as a leprosy expert.

The organization of the Health Week shows that these experts, Jews as well as Arabs, were capable of working on the same projects. Yet in the background, health experts were fighting over their communities' respective contribution to the sanitary transformation of the countries, using such indicators as vital statistics and their trends over time. During the work of the UN commission of enquiry on Palestine which paved the way for the 1947 partition plan, Jewish and Arab experts were still bickering over vital statistics as a factor of political legitimacy. The bone of contention was pretty much the same as back in the 1920s, but as the issue was becoming completely internationalized, the stage of debate moved away and from Jerusalem, to New York.

1 Rockefeller Archive Center, Tarrytown, NY (hereafter: RAC), Rockefeller Foundation records (hereafter: RF), FA003, series 825: Palestine, box 170, folder 3290 [hereafter: FA033, 825/170/3290] : Paul Carley, photograph n° 13271, Health Exhibit held at Jerusalem. Epidemic and Vital Statistics, 30 January 1925.

2 Erica B. Simmons, *Hadassah and the Zionist Project*, Lanham, MD, Rowman & Littlefield, 2006, p. 69-70.

3 James H. Cassedy, *American Medicine and Statistical Thinking, 1800-1860*, Bloomington, IL, iUniverse, 1999.

4 Claire Fredj, "Compter les morts de Crimée: un tournant sur l'identité professionnelle des médecins de l'armée française (1865-1882)", *Histoire, Économie et Société*, 2010/3, p. 95-108.

5 *Norbert Schwake, Die Entwicklung des Krankenhauswesens der Stadt Jerusalem vom Begin des 19. bis zum Beginn des 20. Jahrhunderts*, 2 Vol., Herzogenrath, Verlag Murken-Altrogge, 1983.

6 Aaron Sandler, "Medizinische Bibliographie für Syrien, Palästina und Cypern". *Zeitschrift. des deutschen Palästinavereins*, 1905, XXVIII, p. 131—146.

7 Jurjī Zaydān, "Filasṭīn" [La Palestine], in *Mu'allafāt Jurjī Zaydān al-kāmilah* [The complete works of Jurjī Zaydān], 21 vol., Beirut, Dār al-Jīl, 1982, vol. 19, p. 542-543.

8 Claire Fredj, "Quelle langue pour quelles élites ? L'usage du français dans le monde médical ottoman (1839-1914)", in Güneş Işiskel et Emmanuel Szurek (dir.), Turcs et Français. Une histoire culturelle 1860-1960, Rennes, PUR, 2014, p. 73-98.

9 Uriel Heyd, *Foundations of Turkish Nationalism: The Life and Teachings of Ziya Gökalp*, Westport, CT, Hyperion Press 1979.

10 Leyla Dakhli, *Une Génération d'intellectuels arabes: Syrie et Liban, 1908-1940*, coll. "Terres d'islam", Paris, Karthala – IISMM, 2009 ; Michelle U. Campos, *Ottoman Brothers: Muslims, Christians and Jews in Early Twentieth Century Palestine*, Stanford, Stanford University Press, 2011.

11 Noémi Lévy-Aksu, "Savoirs et savoir-faire dans la police ottomane", in Vincent Milliot (ed.), *Ëtre policier. Métiers de police en Europe (XVIIIe-XXe siècles)*, Rennes, Presses Universitaires de Rennes, 2008.

12 M. Şükrü Hanioğlu, *A Brief History of the Ottoman Empire*, 2010, p. 98-99.

13 Luc Boltanski, *Enigmes et Complots: une enquête à propos d'enquêtes*, Paris, NRF – Gallimard, 2012.

14 See for instance: Ilyās Ṣawābīnī, "*Al-Sill fi'l-Quds wa-asbāb intišārihi fihā"* [Tuberculosis in Jerusalem and the reasons for its spread], in *Filasṭīn*, n°59, 12/08/1911, p. 2 ; n° 60, 16/08/1911, p. 2 ; and n° 62, 23/08/1911, p. 2.

15 Adolf Dunkel, "Blindenfürsorge in Jerusalem", *Das Heilige Land*, n° 1, 1 January 1914, pp. 35-45.

16 Taufik Canaan, "Cerebro-spinal meningitis in Jerusalem", *Al-Kulliyeh,* vol. 2, n° 6, April 1911, p. 206-215.

17 *Ibid.*

18 See my own piece on Canaan's networks: Philippe Bourmaud, "'A son of the country'. Dr Tawfiq Canaan, modernist physician and Palestinian ethnographer", in Mark LeVine & Gershon Shafir (eds.), *Struggle and Survival in Palestine/Israel*, Berkeley, University of California Press, 2012, p. 104-124.

19 Canaan, *Art. cit.*

20 "Nachrichten aus dem Hl. Lande", *Das Heilige Land*, n° 2, 1 April 1913, p. 120-121.

21 On both sanitary councils, see Sylvia Chiffoleau: *De la Peste d'Orient à l'OMS.*

Genèse de la santé publique internationale, Rennes, Presses Universitaires de Rennes, 2012.

22 Céline Paillette, "Epidémies, santé et ordre mondial. Le rôle des organisations sanitaires internationales, 19031923", *Monde(s). Histoire Espaces Relations*, n° 2, 2012, p. 235-256.

23 "Nachrichten aus dem Hl. Lande", *Das Heilige Land*, n° 2, 1 April 1913, p. 120-121.

24 "Nachrichten aus dem Hl. Lande", *Das Heilige Land*, n° 4, 1 October 1913, p. 240-241.

25 Sandra M. Sufian, *Healing the Land and the Nation: Malaria and the Zionist Project, 1920-1947*, Chicago, The University of Chicago Press, 2007.

26 Jeffrey Gurock, *American Zionism. Mission and Politics: American Jewish History*, London, Routledge, 2014.

27 RAC, RF, FA802, 825, box 18: Rubinow to Seligsberg, Jerusalem, 5 April 1922.

28 Ellen L. Fleischmann, "'Unnatural Vices' or Unnatural Rule? The Case of a Sex Questionnaire and the British Mandate", *Jerusalem Quarterly*, n° 11-12, 2001, p. 14-23.

29 RAC, RF, FA802, 825, box 18: Alfred E. Cohn, "Final report and contract, ca. 1922".

30 RAC, RF, FA802, 825, box 18: "Notes for Dr Cohn", 8 July 1922.

31 "Kitāb maftūḥ ilā dā'irat al-ṣiḥḥah" [Open letter to the Department of Health], *Mir'āt al-Šarq*, n° 47, 18 August 1920, p. 1-2.

32 Marc-Olivier Desplaudes, "Une fiction d'institution: les "besoins de santé de la population"", in Claude Gilbert et Emmanuel Henry (dir.), *Comment se construisent les problèmes de santé publique*, Paris, Éditions La Découverte, 2009, p. 253-270.

33 Anne Cornet, *Politiques de Santé et contrat social au Rwanda, 1920-1940*, Paris, Karthala, 2011.

34 RAC, RF, FA802, 825, box 18: Alfred E. Cohn, "Final report and contract, ca. 1922".

35 RAC, RF, FA802, 825, box 18: Rubinow to Seligsberg, Jerusalem, 5 April 1922 ; Rubinow to Brandeis, Jerusalem, 22 June 1922.

36 RAC, RF, FA802, 825, box 18: "Notes for Dr Cohn", 8 July 1922.

37 RAC, RF, FA802, 825, box 18: Rubinow to Seligsberg, Jerusalem, 5 April 1922.

38 Simmons, *Op. cit.*, p. 70.

39 Sufian, *Op. cit.*, 142

40 RAC, RF, FA115, 825, 2, box 61: Paul S. Carley, "Health Week in Palestine", 1924.

41 *Ibid.*

42 "Kitāb maftūḥ ilā dā'irat al-ṣiḥḥah" [Open letter to the Department of Health], *Mir'āt al-Šarq*, n° 47, 18 August 1920, p. 1-2.

43 RAC, RF, FA802, 825, box 18: Rubinow to Seligsberg, Jerusalem, 5 April 1922.

44 Quoted in: Philippe Bourmaud, "Les faux-semblants d'une politique internationale: la Société des Nations et la lutte contre l'alcoolisme dans les mandats (1919-1930)", in Philippe Bourmaud (dir.), "Re-reading mandate history through a health policy lens", *Bulletin Canadien d'histoire de la médecine*, vol. 30, n° 2, 2013, p. 69-90.