Muted Voices: Immigrant Women’s Experiences of Medical Encounters during Mass Immigration to Israel in the 1950s

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Abstract

The unmediated voice of the women is hardly ever heard in the social science literature on mass migration, leaving the discussion in the hands of politicians, media publicists, and ethnic activists. This article seeks to rectify this deficiency by analyzing women’s perspectives on the health-related issues during mass immigration of the early years of the State. The study is based on 25 in-depth interviews with women who immigrated to Israel from The Middle East and Europe during the 1950s. Along with the embodied narrative that the immigrants adopted in the course of their absorption, we also present categories that reflected the immigrants’ own perceptions of their bodies, identities, and the process of health-related change they underwent. In conclusion we analyze women’s encounters with the Israeli medical system using the gendered perspective.

Introduction

The saga of the encounter between new immigrants of the 1950s with Israel’s medical system has not been told until now. In recent years, medical treatment of immigrants in the 1950s has emerged in the public discourse in such contexts as compensation of adults who were irradiated for ringworm as children (and suffered damage to their health), and the appointment of a state investigatory committee that reexamined the disappearance of Yemenite children. Moreover, the discourse in the political arena and in the arts has only exposed the lack of serious scholarship on medical history

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1 The research was conducted under a National Science Foundation grant 121704.
2 Tinea capitis.
3 This phenomenon is prominent in the TV documentary series Ruach Kadim (Desert Winds) and the documentary film Yaldei HaGazezet (The Ringworm Children).
during the period of mass immigration that followed establishment of the State of Israel. In contrast with other issues tied to treatment of immigrants, such as education (Zameret, 1993; Zameret 1997), cultural oppression (Kimmerling, 1999), economics (Swirsky and Bernstein, 1993) or housing (Hacohen, 1994), the question of medical treatment was only addressed briefly or parenthetically (Kachenski, 1986; Hacohen, 1994; Shvarts, 2000). The initial studies that examined health absorption in the course of mass immigration in the 1950s focused primarily on the perspective of institutions (Shvarts, 2000) or health personnel (Rozin, 2002; Stoler-Liss and Shvarts, 2004; Stoler-Liss and Shvarts, 2009).

Moreover, the Israeli research literature covered the absorption processes of new immigrants mainly from the macro-social perspective (Lissak, 1999), using cultural or ideological (Shokeid and Deshen, 1999; Kemp, 2002), institutional (Hacohen, 1994), economic (Fairchild, 2003) or clinical-epidemiological approach (Shlomowitz, 1997). Even in the studies carried out at the micro-level and based on immigrant narratives, these are typically presented psychologically as examples of successful coping, as a basis for future literary work or as the roots of ethnic folklore (Mirsky, 2005; Schely-Newman, 1996; Santa Ana, 1999).

As a result, the unmediated voice of the immigrants is hardly ever heard in the social science literature on mass migration, leaving this discussion in the hands of politicians, mass media publicists, and ethnic activists. In the rare instances where the voice of immigrants has been heard, these were only men, while voices of the immigrant women have been largely missing (Dahan-Kalev, 2002). The absence of the female narrative and a desire to repair and balance male-dominated ‘his-tory’ with ‘her-story’ in order to create a fuller, richer and more accurate picture of reality is not new; it began some four decades ago in the work of feminist historians (Kelly-Gadol, 1976; Malman, 1993; Scott, 1986). Joan Kelly-Gadol argued that women’s absence not only presents an incomplete historical truth, but also constructs historical periods and their evaluation solely from a male perspective. Re-inclusion of the feminine narrative can show that periods that were perceived and presented (from a male perspective) as dark and stagnant were in fact better for women (such as the Middle Ages, at least for women of status), while periods traditionally presented as high and innovative, such as the Renaissance, were actually worse for women (Kelly-Gadol, 1976). In the course of the 1990s, feminist scholars (for example Canning, 1999) noted the importance of the body in feminist research. The body, according to this approach, is analyzed not only as a metaphorical or allegorical social entity, but rather as a concrete physical site that is socially, culturally and politically fashioned, and that differs from place to place and from time to time. According to this view, cultural and social histories are inscribed on the body and this is done in different ways, organized on the basis of gender, social class and ethnicity. The concept of inscription, in contrast with discourse analysis, does not annul the existence of genuine corporal bodies, because they are not solely the product of discourse. (Canning, 1999).

The theoretical framework used in this research is standpoint theory, which focuses on differences in perspective and identity. According to this theory, the inherent differences between men and women in capitalist and patriarchal systems create differences in the status of men and women. The male position is dominant, and it trivializes women’s standpoint as that of the weak. But weakness has its own strengths: the power dynamics require the weak to understand the dominant perspective (while the strong are not required nor do they bother to understand the weak). This gives the weak group a richer and more complete perspective, even a
more objective one. The individual in society belongs to a number of groups and a number of perspectives (particularly along the gender, social class and race axes); as a result, the weaker the outlook of the individual, the more comprehensive, complex and significant the individual’s socio-historical description will be. Hence, the role of documentation of women’s experiences among different ethnicities and social classes, in all the complexity of the perspective they harbor – for example the experiences of poor Black women or Mizrachi women (Krolokke and Scott Sorensen, 2006; Dahan-Kalev, 2002). The strength of standpoint theory is also the source of its primary weakness: Its scholarly products are fragmented, insular and limited, making it difficult to formulate any conclusions that go beyond individual experience; these conclusions are often arbitrary, hinging solely on the researcher’s subjective assessment of significance and meaning. This is the case in the work of Ron (2009) that describes (extensively and for the first time) the subjective outlook of Mizrachi women from a development town, including their immigration experiences. Her work, however, lacks any analysis of their absorption from a health standpoint, although a number of respondents raised episodes relevant to this topic, on their own initiative.4

This article seeks to rectify this deficiency in the research literature – the absence of immigrants in general and women in particular, and women’s perspectives on the health-related issues during mass immigration to Israel between the years 1949-1956. The study is based on 25 in-depth interviews with women who immigrated to Israel in the 1950s, carried out in 2005-2006.5 The women interviewed had immigrated to Israel between the years 1948-1954 as young adults6 (two-thirds of the informants) or as girls7 (one third of the informants) and at the time of the interviews were aged 70 to 85. Half of them were immigrants from Central and Western Europe and half immigrants from Asia and North Africa. All the names appearing below are fictitious to maintain confidentiality of the participants. All the interviews were carried out using the unstructured in-depth format (Sabar Ben-Yahoshua, 1990). This type of interview was chosen because the period of mass immigration was an emotionally-loaded and highly politicized period that has remained ‘hot’ on the public agenda until this day. Nevertheless, a ‘framework of questions’ was formulated for the interviewers’ use in order to ensure that all the important topics were covered. Thematic analysis of the interviews was carried out (Sh’kedi, 2003).

4 This is particularly marked when Ron frames the narrative about ringworm treatment that one of the interviewees related to as “resistance” to the interview process. Ron brought the story in her work only in order to please the interviewee, and did not analyze its significance for the woman (Ron, 2009: 71-73).
5 The interviews with immigrants cited in this paper were part of a more comprehensive study that included 250 interviewees who immigrated in the 1950s. A random sample of 25 interviews with women living in different parts of Israel was chosen for this analysis, representing a variety of origins, ages and social classes. The interviews took place primarily in the homes of the informants and were audio-tapped; each interview lasted between 1.5 to 3 hours. The interviews were transcribed as soon as possible after the taping session. The following research assistants carried out these interviews: Valeria Borstein, Alexandra Rusetzky, Rona Seidelman, Idan Gil, Yaalah Tamari, Keren Dayan and No’it Arafì.
6 The oldest of the young adults was born in 1917, and the youngest was born in 1932 (she immigrated married with an infant). The young adults immigrated as young mothers, or after losing a baby or a spouse.
7 The oldest of the girls was born in 1934 and the youngest in 1942. Most women who were in their late teens and yearly twenties came to Israel unmarried and without children. Five Yemenite girls were married by the time of immigration.
In another work by the authors (Stoler-Liss and Shvarts, 2009) the absorption process in the 1950s has been described, from the perspective of Israeli health system, as that of disembodiment (in the sense of detachment) of the immigrant’s body from his/her identity. This enabled the transformation the immigrant’s body into a ‘neutral’ or ‘normal’ body – that is ‘one of us’, or, in other words enabled the embodiment of the new identity.\(^8\) It was also claimed that the process of ‘disembodiment’ allowed examining the immigrant’s body or self outside the frame of ethnic identity. Constitutive and categorizing agents of the absorbing society view the immigrant body as a temporary identity, an entity that can be molded and redefined. The ‘immigrant body’ appears with the immigrant’s arrival in Israel but ceases to exist from the moment the immigrant is declared ‘absorbed’ or no longer in need of institutional absorption systems. This process of disembodiment can partly explain the roots of some attitudes and perspectives that immigrant interviewees expressed more than 50 years later.

Ron’s recent research (2009) documents the outcome of this process – the almost complete embodiment of the hegemonic-Zionist ‘we’ by the female immigrants. Ron’s interviewees (we are addressing only those who parallel the first-generation women immigrants in our study) perceive their arrival in Israel and the period surrounding this event as a pioneering endeavor, similar to that of members of the Second and Third Aliyah. The women describe their active contribution to the State and the Zionist enterprise; some adopt the terminology of ‘pioneers,’ thus challenging the Zionist narrative that presents immigrants of the 1950s as passive. The embodiment process is not complete and carries a certain degree of criticism and variance, as well as areas with alternative meaning and even resistance to the dominant script. (Ron, 2009)

In the interviews conducted with 1950s immigrants in this research, the hegemonic characteristics of ‘Israeliness’ (Kimmerling, 1999) adopted by the immigrants have also emerged in a very clear fashion. Mythic presentations of the period of mass immigration and its difficulties, presenting this as part of the Zionist narrative of progress, pioneering endeavor, and building of a new society are repeated in almost all the interviews. Yet, along with the embodied narrative that the immigrants adopted in the course of their absorption, there were also categories that reflected the immigrants’ views of their bodies, identities and the process of health-related change they underwent. These perceptions are the focus of the present work, which first presents the interviewees’ perceptions of their bodies and then describes the categories relevant for gender analysis.

**Body and immigration**

**The healthy body**

Most interviewees perceived themselves at the time of their immigration as young healthy women, and this finding cuts across countries of origin, age groups and socioeconomic strata. Perceptions that one had enjoyed good health typified most of the interviewees, both the girls and young women who immigrated being pregnant or as mothers. Even Holocaust survivors, who had endured terrible privation including malnutrition, infestation and exposure that definitely jeopardized their health (whether

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\(^8\) Embodiment is defined by Canning (1999) as the process of constructing the body by adoption of social practices in a social space. Embodiment implies that the changes are so deep, that they completely alter the body’s identity.
they came directly or through British internment camps in Cyprus) claimed that their health was good at the time they immigrated. Thus, Tirtza said: “No one was sick at all, we didn’t hear about anyone who was sick.” Only a small number of respondents spoke of serious illness or suspected health problems in the course of their immigration. For example, Khava was liberated from the Bergen-Belsen concentration camp and sent to Sweden to recuperate, where it was suspected she had tuberculosis. Sara, who came with a group of undocumented immigrants from Iran via Istanbul, noted her baby had come down with measles on the journey. Shlomit described her health status in Casablanca as ‘very good’ except for having ringworm.

Perception of good health among the immigrants appears in the interviews not only in response to direct interviewer queries about their health status, but also when the participants were asked about medical examinations and treatments prior to arrival in Israel. A third of the interviewees did not remember at all that they had undergone examination and treatment, or remembered that they had definitely not undergone them – in contrast with ‘others’ who had. There were two main reasons given by informants as to why they were not examined in their country of origin – young age and good health, or affiliation with a particular ‘selected’ group. All those who said they had not been checked, viewed the absence of medical checkups as a status-booster to their self-image, setting them apart from the mainstream of mass immigration.

Yehudit, who came from Yemen, belonged to the latter group of those who remember undergoing medical checkups and receiving medical examination and treatment on their way to Israel. These interviewees described in depth the checkups and treatments they had undergone before immigrating. In addition to a medical checkup by a general physician, they cited eye examinations, vaccinations and disinfection with DDT.

At Hashid we also met the people from the [Jewish] Agency. There they did checkups on us, did inoculations, spraying [sic. dusting] with DDT. They did everything to us. (Lavana)

Yeah, sure. They sprayed us with DDT and they brought a doctor who examined us from head to toe prior to migration, and also when we immigrated they sprayed us [again] with DDT. But to tell you the truth – it was OK as far as we were concerned because we wanted to come to Israel so badly that it didn’t matter what happened. We accepted it with understanding. (Ada)

Here as well the respondents underscored that they themselves were healthy. Lavana regarded the treatments and checkups as stemming from this being the first encounter with Jewish Agency officials in charge of their absorption, and also as reflecting harsh conditions in the desert, i.e. the hardships the immigrants had encountered on their way to the transit camp in Hashid. Ada is an example of the adoption of the hegemonic Zionist outlook, while she views the difficulties of the checkups and treatment as marginal in comparison with the ultimate Zionist objective – to make Aliyah.

The immigrants’ perception of the immigrant body as healthy is directly opposite to the views harbored by the medical personnel absorbing the immigrants. The system viewed the immigrants as ill, and their immigration as an opportunity for physical cure, education and cultural change (Stoler-Liss and Shvarts, 2004; Stoler-Liss, 2006;
Stoler-Liss and Shvarts, 2009). The healthy self-perceptions of the immigrants challenge the dominant Zionist perception that the immigrants were ‘supposed’ to internalize in the course of their absorption.

**The active body**

The discourse employed by the interviewees concerning their immigration and health issues was expressed in the active, not passive, tense. The interviewees often use the active tense and present the entire resettlement process – except for the first stage just after arrival – as an active dialogue. In describing the initial stage of their immigration they often used the passive tense: ‘[they] took us’, ‘[they] received us’; ‘[they] sent us’, ‘[they] transferred us’. Likewise, the medical checkups and treatment they underwent soon after arrival were described thus: ‘[they] gave us checkups’, ‘[they] gave us DDT’, ‘[they] brought a doctor’, ‘[they] didn’t let us go to Israel’. The situation changes in passages relating to the period after the initial resettlement. Recollections of the absorption stage are marked by the respondents’ usage of active verbs, e.g. “My child was in infant’s house in camp C, and I was in camp A. I used to walk in the snow, the pouring rain’ to breastfeed him, and then walked back.” (Yehudit)

The passage from passive to active state is clear in the quote from Tirtza, who came as a young girl from Romania:

> Later we were transferred to Pardes-Chana immigrant camp. We were living in tin shacks. There I started to work in agriculture. If we needed medical care we would turn to someone and they would send us to a clinic or hospital. (Tirtza)

Again, in contrast with health personnel’s unequivocal characterization of the immigrants as passive (Stoler-Liss and Shvarts, 2004), interviews with the immigrants themselves exhibit a graduated change in perception: Passiveness at the initial stages of immigration is followed during the absorption process – as a profound expression of this process – by a gradual passage to the active-verb narrative. As in the case of the healthy body, the perceptions of the active body are also part of the immigrants’ adoption of the dominant worldview in the course of the negation and re-embodiment process they underwent. These immigrant women did not see themselves as objects of the Zionist enterprise that moved them, absorbed them and manipulated their passive body. Rather, they are active participants in the absorption process which they themselves initiated, conducted, worked at and invested in – not passive entities that received care or were absorbed. The adoption of the hegemonic discourse is critical: the women immigrants *include themselves* among those engaged in the absorption process, and as such, they challenge the dominant discourse which sees them as objects of care, cure and transformation.

**The examined body**

Some of the women encountered attempts at medical selection, or what they thought was medical selection, in the transit camps and at the intake camps in Israel. In fact, the selection described by the interviewees in the current study was very feeble and in practice was toothless. One should keep in mind that all the respondents had immigrated to Israel during the mass immigration of the 1950s, and their very presence in the country attests to the fact that they have passed any screening attempts. When immigrants were prohibited from going to Israel due to suspected
health problems, or when they feared that their immigration would be delayed if a particular disease or disability was discovered, they devised solutions that enabled them to immigrate anyway, either by obtaining a doctor’s approval elsewhere or by hiding the most prominent disease symptoms.

Yes, they said that anyone who is sick, limp or something they will not sign-in. So I said [to my self] come on, they won’t notice my hand” (Miriam, whose hand has been injured in Libya, hid the problem when she entered Israel.)

In contrast with the scope and nature of medical examinations in the transit camps abroad, almost all the immigrants were checked upon entering the country. The interviewees who underwent entry checkups differed in their retrospective attitude towards the treatments they had experienced. The larger group among those who underwent entry checkups and treatments did not recall them as a traumatic or harsh experience. They typically described the checks for lice, inoculations and disinfection with DDT as expected and normal. Like the checkups and treatments abroad, these were seldom perceived as an expression of a special flaw or having been ‘singled out’ for a more intense treatment than other immigrants. On the contrary, the only ‘differentiating factor’ the respondents saw was their being young and healthy, and hence of a special status.

They didn’t give us examinations, maybe only DDT and that’s all. Not vaccinations or anything. We were healthy. Young. (Osnat)

They gave us DDT at the Haifa port. But we didn’t receive vaccinations and not anything else….. (Esther)

Miriam, an immigrant from Libya with a disability in the use of her arm, explained in the interview that the objective of the hospital checkups was to direct the immigrants to places of settlement suitable to them, or in her words, “to know where I am going.” Tirtza, a young girl from Romania, justified the checkups, the way doctors treated her, and the willingness of the immigrants to allow such examinations:

They took you and they examined you. Vaccinations, lice, and DDT but it was all right - we accepted this as the way it had to be. The attitude of the doctors examining [us] was all right. They tried to translate languages for us, but it was all right. (Tirtza)

In contrast to these mild, even positive, recollections of medical examinations upon entering the country, a portion of the respondents described their treatment in very harsh terms. Some explicitly linked the treatment to their powerlessness as new immigrants who did not know Hebrew and who did not understand what was being done to them:

When we got here, that is to Camp A, they immediately put us in the showers and [they] gave us a spraying because we were full of lice [the interviewee laughed]. We didn’t know Hebrew and what they were doing to us. We let them [do it]. (Bracha)

This group used harsh metaphors (“like sheep to the slaughter”) to describe the medical encounters upon arrival in the country, and particularly mass disinfection with DDT. Some of the respondents even began to curse at this juncture of the interview.
The reception was unforgettable. Indescribable. In Libya they sewed me a special pretty dress for the trip to Israel...I got stuff [dumped] on my head...They put on something that looked like plaster – in the eyes, in the hair, on the new dress... I’ll never forgive them for this. [If] they thought we had lice ... they had to check first, not treat us like sheep to the slaughter.” (Tzipora)

The examined body treated with DDT – the immigrant’s live body subjected to medical treatments in the transit camp and when entering Israel - is present in the memories of the immigrants alongside the cultural constructs adopted as part of the negation and embodiment. Thus, parallel to the healthy body and the active body lays the antithesis – the examined body and the passive and diseased body. Parallel to the adopted imagery borrowed from the dominant culture, and the alterations the immigrant women added in the course of embodying them, the treatments were engraved on the body or at least inscribed in the memories of the immigrants. It points to adoption (whether agreeably or in anger) of the dominant perception of the immigrant’s body as diseased and in need of treatment. The perceptions of the body presented by the informants, at times contrary to one another, demonstrate the traumatic nature of the negation and embodiment process, as well as the unique, contextualized and unstable concepts of identity.

Gender and immigration

In general, the interviewees described the story of their absorption in Israel as a positive and successful narrative of integration, education, starting a family, giving birth and raising children, as well as long work days. In these successful life stories, the ties between the private journey, family life, and the Zionist immigration and absorption enterprise are being framed by the negation and embodiment processes.

Marriage

Leah got married in Bulgaria after the Second World War to a man she met in the HaChalutz movement; Rachel got married in Bergen-Belsen camp in the course of the war; Dina was wed in Tripoli in an arranged marriage to one of her father’s laborers; and Chava was married in Hungary to an older established gentleman whom her brothers chose. A portion of the respondents, particularly those who reported having chosen their spouses, described their married life as happy and marked by togetherness, even equality among the partners. Others, including those wed in unions arranged by family members, spoke of crises, separation and relationships marked by inequality.

My youngest brother, seven years younger...when I came back to Hungary [after WWII] he waited for me there. He wanted me to marry an older man who had everything. I had nothing. I didn’t want it... eventually I married him. He is the father of my son. In Israel I divorced him...I was left with empty hands again. Later I went with another man but he was a drunk.” (Chava)

Embodiment of the ethos of gender equality was raised particularly in the descriptions of child marriages, especially in the interviews with women from Yemen.

I was married as a little girl and I didn’t work [Question: At what age did you get married?] At a very, very young age - twelve. [Q: After you
began to menstruate, you were married off?] I didn’t even... [have a period].” (Chana)

They immediately married me off to a man who was thirty, and I was a young 15 year-old girl who didn’t know anything about what to do with a man.” (Bracha)

The women described their marriages as children as mistakes, or as unavoidable events reflecting the condition of the Jews in Yemen. Thus, one interviewee related how she had been married as a child after been orphaned, because there was the apprehension that without the protection of marriage she would be kidnapped by their non-Jewish neighbors. Other women’s stories were similar, and they stressed that this practice was not normative or widespread among Yemenite immigrants; rather, it was a solution to specific stressful situations within a family. The interviewees presented such child marriages as the root of troubles that they faced later in life.

**Childbirth**

The interviewees, who came from a host of different countries and cultures, reported different birthing customs that were normative there. A large number of these women – from African and Asian countries, as well as Europe – described home deliveries as a common practice, generally with the assistance of a traditional midwife. Another smaller portion of the respondents, primarily urban women from European backgrounds, told of hospital deliveries in their country of origin. On the eve of mass immigration more than 90 percent of the deliveries in Israel were carried out in hospitals (Stoler-Liss, 2006: 67). When the immigrants arrived in Israel, hospital deliveries were presented to them as the norm, and as part of gender relations in Israel. The immigrants who delivered in Israel, for the most part, recalled the experience of a hospital delivery in a positive manner.

*She [the daughter] was born in Hadassah [Hospital]. I was with other women in the room. I gave birth in the hospital. It was a Jewish hospital, no? Conditions there weren’t so great but it was Jewish...* (Sara)

At the same time, there were several interviews where respondents who expressed dissatisfaction with treatment in the hospital. A few even said that after their first hospital delivery, they chose to give birth to the rest of their children at home.

*That hospital had just been opened, and I think I was the first expectant mother there... and the conditions there were so bad it was off the charts. No food, no room, one bed high like this and one bed just off the floor...What’s all this sub-standard stuff in a new hospital with new white walls yet!! It wasn’t good at all, and I got a very high fever and fainted and fell. They gave me a slew of stitches, and I had an infection and felt lousy. On Saturday my husband came and took me home in a taxi.”* (Tikva)

Another issue that was raised regarding hospital deliveries was modesty and lack of privacy for birthing women. It was a key reason given by doctors and nurses at the time to the preference for home deliveries by some immigrants in the early 1950s (Stoler-Liss and Shvarts, 2004). In this study, women recalled their embarrassment and feelings of discomfit in the hospital milieu that over time was eased along with adoption of the Israelis norms and familiarity with hospital culture.
I was embarrassed the first time when they elevated your legs and cut you [referring to the birthing position and episiotomies]. [We] weren’t used to this. Afterwards I saw everyone did this, and the main thing [was] that they saved me. (Khana)

The geographic isolation of some immigrant settlements, lack of familiarity with hospitals and modesty/privacy issues resulted in home deliveries being common among immigrant women for a limited period (1949-1954). This phenomenon ended in 1954 when a Mother’s Insurance Law was legislated that created direct financial incentives for hospital births (Stoler-Liss and Shvarts, 2004). The informants who reported home deliveries usually did not mention the Law as influencing their decision but the isolation of their places of residence. Others mentioned an unpleasant prior experience in a hospital delivery or cited “lack of need” for hospitals to engage in obstetrics. Most of those who mentioned home deliveries were immigrants from Yemen.

There’s the midwife. During the pregnancy there’s no treatment. Nothing. A regular delivery Thank God everything was OK. I gave birth in a prefab in Norris with a midwife.” (khana, Norris Work Village)

I got pregnant after a year, and I gave birth at home. (Question: Who delivered you?) ‘Fat Yehudit’. She was an Ashkenazi Jewe, Yehudit the Midwife would deliver all of us. She would come to the home and it was OK, not like in the hospital where they would open the legs up in the air….at home you deliver joyfully. (Bracha)

The infant house

While the immigrants embodied to a great extent the hegemonic Israeli perspective on marriage and childbirth, their attitudes towards the so-called infant house reflect cleavages in the isolation and embodiment processes. The infant houses that operated in immigrant camps in the years of mass immigration were designed to provide better living conditions (heating, hygiene and less crowded quarters) than those of adult residents of the camps, child care by professional caregivers and guidance for mothers. The infant houses, in contrast to the similar arrangements on the kibbutz, were not welcomed by the interviewees as ‘liberating women from the burden of infant-raising’. The infant houses were closed in immigrant camps throughout the country in the early 50s, but continued to operate in special camps for Yemenites at Ein Shemer and Rosh HaAin. Interviews revealed that the immigrant women did not receive explanations as to the rationale behind the infant house system and its objectives, and consequently viewed the order to ‘hand-over their children’ to infant houses as an arbitrary directive that reflected their alleged inability to care for their own children. Therefore, they recalled that they took pains to watch over their children all day long in the infant house, or at least to come nurse them at frequent intervals. From the immigrant’s standpoint, they fulfilled their motherly roles according to the dominant perspective in the best way possible, even when their children were taken to distant infant houses.

9 Norris mentioned by Khana was a work camp for immigrants from Yemen on the Gilboa that like all the working villages was built on a hilltop without providing access for vehicles. See: Kamon, 2001.
10 The caretakers were in part employees of the Ministry of Health or the Ministry of Labor who had been trained in special infant care courses, and part were volunteers who were members of women’s organizations from nearby settlements, and so forth. In May 1950, there were 58 children’s houses, extending to all immigrant camps with a population of 100,000 (Hacohen, 1994).
I was with the child all day in the infant house. From the minute we arrived, they took the children to the infant house, and we would take turns watching over the babies every night, and I requested to watch over them all day so I could sit near my child all the time...We couldn’t take them – only in the infant house [were we allowed to be with our babies]. They kept them there like this.” (Yehudit)

Apparently, the interviewees were not pleased with the infant house system. They were hurt and felt that such an ‘expropriation’ of their children was an expression of lack of reliance on their mothering skills. This is a clear zone of these women’s disagreement with the hegemonic messages on motherhood and childrearing.

Tipat Halav (Mother and Child Clinics)
At the Tipat Halav (‘Milk Drop’) clinics, mothers received guidance in infant care and their offspring were weighed and received vaccinations. In the early 1950s, the clinics’ work also included home visits – a practice that had two objectives: providing direct supervision of nurses over the living conditions of the infants, and convincing mothers to come to the clinics so their children’s development could be monitored. In contrast with their attitudes towards the children’s houses, all the interviewees had a very positive attitude towards Mother & Child Clinics. Many respondents recalled the clinic’s staff as the ones who helped them in daily difficulties they encountered in their first years after arrival. In particular, they cited cases where their children were fed at clinics. Other interviewees recalled receipt of products such as powdered milk or diapers.

They helped...gave out better powdered milk, [they] explained how to care [for the infant], what to do. They did a good job, gave me guidance sometimes what to do in all sorts of situations. (Tirtza)

As soon as the infant was born, a nurse from Tipat Halav came to the house. She checked how the baby was, if everything was OK. She showed how to change a diaper, how to feed, so that the mother wouldn’t suffocate the infant. She also checked how the mother was doing, the heat [temperature] in the room, the heat [temperature] of the water when bathing the baby. (Tzipora)

At the same time there were descriptions of resistance to the work of Tipat Halav, mostly mild, even latent. This kind of resistance was characterized by lack of cooperation – open or concealed - with the clinic’s activity or certain instructions that went against the mothers’ own understanding. The primary form of resistance was not to go to the clinic and to ignore ‘appointments’ set-up by the nurses.

I didn’t take the baby to Tipat Halav until nurse Shoshana came [to my house] and said to me ‘Where are you?! You gave birth three months ago and need vaccinations. Where are you?!’ They explained things to me and I took the child for vaccinations and she [Shoshana] said ‘How did you care for her on your own [without the nurse’s guidance] and she has grown so fast and healthy’. And she didn’t need a doctor nor Tipat Halav...So the nurse explained to me that once every ten days one needed to come and weigh [the baby] and so I did. (Tikva)

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Another form of resistance was to ‘play along’ with the nurses guidance (and then do as they pleased).

They didn’t explain anything to me but I knew everything myself. I would take him a few times, kacha for checkups at Tipat Halav [‘as if for checkups’ - for appearance sake]. I’d feed him and the nurse would ask ‘What are you giving your child to eat?’ and I’d tell her ‘Just what you told me.’ She would say ‘Great!’ . [When] I made him cereal the child was gaining weight fast, and so she understood why the child was so healthy and fat like it should be. Today I teach my granddaughter ‘Don’t listen to Tipat Halav, do what you want’. (Bracha)

So, in the case of Tipat Halav, most informants exhibited enthusiastic agreement with the hegemonic outlook, and cases of resistance were mild and even marginal in nature.

Hospitalization and the ‘kidnapped Yemenite children’ controversy

The issue of hospitalization of babies and toddlers was frequently raised spontaneously in interviews after participants were asked about medical services they received after immigration. The interviewees spoke at length about the prolonged separation from their hospitalized children, and in many cases the respondents expressed fears of losing them.

He [the infant] was sick and they took him to Bait Galim in Haifa...It’s a hospital [referring to Rambam Hospital]. I was really depressed that they took him and didn’t allow me to visit him....and he was hospitalized there for a month and a half and I didn’t see him....Afterwards they really did bring the child [back] ” (Yehudit)

As in descriptions of the infants’ houses, some respondents stressed the effort required in order not to be separated from their hospitalized infant. These women described long periods at the bedside of their sick children, or at least daily visits to the infants’ room – or standing outside the window. They described long trips by vehicle or on foot, and linked the efforts they invested in visiting their children with their eventual release. Parallel to stories about hospitalizations that had a ‘happy ending,’ there were interviews that described the disappearance of children during hospitalization. Most interviewees who complained about their lost children were immigrants from Yemen. Those who thought their child had been ‘lost’ or ‘kidnapped’ were very young mothers – sometimes child-brides for whom the infant was their first child. A portion of the interviewees clearly linked the disappearance of the baby to their own relative weakness, and described clearly, how ‘stronger’ people succeeded in locating the children who had disappeared.

I was at the hospital in Jaffa and I was only 18 years-old – damn this place and their memory! After three days they would return the infants to all the mothers, and my mother and I were also waiting -- and I didn’t know how to speak Hebrew, so I said to the nurses [in Arabic] ‘Idi walidi’, that is – ‘Bring me my child.’ And the nurse says “You’re only a child yourself, and you already want children?!’ I remember her words when she said: “We don’t know [why], but your child has died.” (Bracha)
The issue of the alleged deaths or disappearance of the newborns is perhaps the deepest trauma preventing the adoption of the dominant narrative by the immigrant women. The descriptions are harsh, unforgiving and the women blame the health personnel for the loss of the babies. In general, the interviewees have adopted the rhetoric on women and gender that was part of the dominant culture. But within this adoption there were areas where the immigrants’ interpretation clashes with that of the absorbing society. The absorbing caregivers viewed the immigrant women in general, and Mizrahi immigrants in particular, as unfit mothers whose babies would be better off if cared for by the institutions such as infant houses, and who should be ‘educated’ in motherhood through institutions like Tipat Halav. The immigrants themselves have a self-image of good and dedicated mothers according to the gendered value system they adopted in Israel. Therefore, serious events such as the loss of children in the course of institutional care were viewed by them as double tragedy entailing the loss of the children and the challenge to their moral reputation – the ‘failure’ of no longer being good Israeli mothers.

Conclusion: Women’s “health absorption” in the 1950s

This study is the first attempt to focus on the immigrant women themselves and to document their health-related perspectives and experiences during mass immigration of the 1950s. The dominant self-perception of most interviewees is that they had immigrated as young and healthy women whose contact with the health system was minimal. Using body and gender categories, the various manners in which new immigrant women were absorbed in the health realm have been elucidated. Through body analysis, we explored the paths by which these women either embodied or resisted the official imagery of immigrants, their proper absorption and matters of health and sickness. The research revealed the way the immigrant women perceived themselves and their bodies as young, healthy and strong – a view diametrically opposite to the way the absorbing system construed them, relating to the immigrant woman’s body as weak, deficient and in need of treatment. In contrast with the dominant view of the new immigrant women (especially those from the Moslem countries) as weak and passive figures within a restrictive patriarchal system, most interviewees have adopted the more equal gender rhetoric of the dominant Israeli culture. Those views were not, in any sense, feminist, but opposed explicit manifestations of patriarchy like child marriages. Furthermore, the women immigrants viewed themselves as independent actors rather than passive recipients of state-provided services.

The participants’ self-perception as a special group, separate from and superior to ‘other immigrants’, is an interesting mirroring effect of the 1950s medical teams and their self-image vis-à-vis the immigrants in their care (Stoler-Liss, 2006). By forging clear differences between themselves and Others, the informants reflect the power of adoption/embodiment of a dominant culture – an on-going process of self-assertion and exclusion of the Other. This process is indicative of acceptance of the cultural values championed by the Israeli medical staff and viewed as a sign of absorption’s success, at least in the health realm, according to the ‘melting pot’ principles prevailing at the time. Along with this success, our research also exposes the cleavages and gaps in the embodiment process and sheds light on its variety and richness in the gradual forging of the collective Israeli identity.

References


