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Nurses from Here – Epidemics from There. The Encounter between Nurses from Eretz Israel and Holocaust Survivors Abroad, in an Effort to Eradicate Epidemics and Morbidity 1945–1948

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Abstract

Throughout history, wars and epidemics have been interrelated, as are *immigration* and *health problems*. At the end of the Second World War (WWII), Jewish survivors of the Holocaust wandered across European countries hoping to find living relatives. Many of them were gathered in temporary displaced persons camps operated by the Allied forces and humanitarian organizations. The survivors were in poor health, exhausted physically, emotionally, and morally, and suffered from a variety of contagious diseases. The purpose of this article is to shed light on the roles, experiences, and contributions of the nurses "from here" – Eretz Israel – who volunteered as emissaries to care for their Jewish brothers and sisters wherever needed.

Our study followed the nurses through three different immigration camps between 1945 and 1948. First, in the displaced persons camps (DP camps) for Holocaust survivors in Germany ("over there"). Next, in the detention camps in Cyprus, where the British held refugees caught trying to enter Eretz Israel without the correct immigration papers ("over there"). Lastly, a short glimpse into the complex reality the nurses faced within the absorption camps for new immigrants in Israel ("back here"). The nurses' ingenuity and resourcefulness made up for the lack of means and infrastructure in eradicating epidemics and caring for the immigrants. In the light of the current trends of mass immigration and global pandemics, the discussion focuses on potential lessons that can be learned from the unique Israeli experience of integrating immigrants and overcoming epidemics.

Keywords: Nursing History, Immigration, Epidemics, Israel, Eretz Israel, Holocaust Survivors

1 Introduction

1.1 Background and Rationale

Throughout history, *wars* and *epidemics* have been interrelated, as are *immigration* and *health problems*. Israel is a relatively young state, established in 1948, which already has a long, unique and impressive record in absorbing mass waves of immigration, and overcoming a variety of imported and endemic epidemics. In fact, the essence of the Zionist movement was to fulfill the old dream of the ingathering of exiles and the return of the children of Israel to their homeland.[1]

At the end of the Second World War (1945), Jewish survivors of the Holocaust wandered across European countries hoping to find living relatives. Many of them (around 250,000) were concentrated in temporary displaced persons camps (DP camps) and other residential arrangements in the American and British Occupation Zones in Austria and Italy, and particularly in Germany. The camps were operated by the Allied

[1] Jeremiah, 31:16.

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forces and humanitarian organizations.[2] The survivors were in poor health, exhausted physically, emotionally, and morally after years of hunger, torture and forced labor in concentration camps, or ghettos, or from constantly hiding and fleeing from Nazi persecution.

In addition to the poor hygienic conditions, the survivors suffered from a variety of contagious diseases (TB, typhoid, scabies etc.), extreme malnutrition, and post-traumatic stress disorders.[3] They were not welcome in their previous neighborhoods, nor did they have homes to return to. Furthermore, they were not allowed to start a new life in a different country. They could not go to Israel, as Palestine/Eretz Israel[4] at that time was still under the British Mandate and operated a closed-border policy. The United States also operated an immigration restriction policy.

The survivors were imprisoned again in an impossible dead-end situation. They pleaded for help in despair: "We were saved, but have not become liberated as of yet."[5] The pre-statehood Jewish community in Israel (the *Yishuv*) felt they had a duty to rescue, cure and rehabilitate their fellow surviving brothers and sisters, but actually had very little to offer apart from good will gestures, as they themselves were under British restrictions. Nevertheless, between 1945 and 1948, the Yishuv sent about 400 emissaries *(Shelichim)*, men and women, to prepare the survivors for their future life in Israel while also providing humanitarian help.[6]

The purpose of this article is to shed light on the roles, experiences and contributions of the nurses who volunteered to leave their families for a period of about two years to care for their Jewish brothers and sisters wherever needed. We describe the nurses' experiences in eradicating epidemics within the camps and helping the Holocaust survivors at three different sites on their long and draining voyage to Israel: first, right after the war in the DP camps in Germany; then, after being caught as illegal immigrants, back in the detained immigration camps in Cyprus, and finally – after Israel's independence – shedding some light on the condition of immigrants' health within the newcomers' absorption camps in Israel. We will discuss the dilemmas and the long-term effects that the treatment of epidemics had on the immigrants, the care providers, and the nursing profession, and offer some insights and suggestions for dealing with the current interaction of global pandemics and mass migration of refugees.

1.2 Methods

Documenting the historiography of nursing practice in general presents methodological difficulties, especially when it is practiced in unstructured, dynamic circumstances, as in the topic under study. First and foremost, it is generally agreed that nurses are better doers than writers; secondly, because of the transient nature of the camps the

2 Rosenberg-Friedman 2007, pp. 121–155.
3 Schein 2010, pp. 10–11.
4 Israel was called Eretz Israel (or Palestine) during the British Mandate of 1917–1948.
5 The pleas of the imprisoned survivors in the camps: "Allow us to reach to the last corner of hope – Israel". In: "Davar" newspaper, September 3, 1945.
6 Schaary 1981, pp. 28–35.

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documentation of the events is incomplete, not kept in one place, unorganized and difficult to access. Thirdly, little has been previously written about the role of the Eretz Israel nurses in helping the Holocaust survivors, so we focused our studies on exploring, documenting, and publishing their unique contribution to nursing and to the history of the country. Fourthly, most of the existing literature sources are in Hebrew and not accessible to an international audience. This paper is therefore the first exposure of the original testimony of nurses dealing with the extreme reality of immigrants, epidemics and distress, providing lessons which are also relevant to the present global situation.

In searching for relevant information, we relied on a variety of sources, including our own previous extensive historical research.[7] The additional relevant materials included official texts, letters, official reports, protocols, press cuttings, and journals. The study is also reliant on written memoirs and oral history interviews. The use of oral testimonies is vital in providing support for issues described in other sources and for shedding light on subjects not documented in writing.[8]

2 The Nurses in Service of the Holocaust Survivors within the DP Camps

Before 1912, there was not even one registered nurse in Eretz Israel. It was Hadassah, a voluntary organization of Jewish American women, which established the first nursing school in Jerusalem in 1918 and developed progressive public health services. Toward the end of 1943, the Jewish community in Eretz Israel (the *Yishuv*) started to understand the shocking magnitude of the Holocaust in Europe. During the graduation ceremony at the Hadassah Nursing School, Ms. Kantor, the director, referred to the sacred mission that nurses would face after the war:

> Do not forget how much work we'll have when our brothers and sisters, the remains of the victims and saints, will begin their arrival in masses. A lot of the responsibility for their absorption will be placed on our shoulders.[9]

In a nursing journal, Ms. Mohliver anticipated the complexity of the forthcoming challenge. She wrote:

> The expected absorption of our brothers will be bloody – they are refugees of sword and starvation, injured in their bodies and souls. For such immigration, we nurses need to prepare and train ourselves to bring remedy to the souls and bodies of these tortured brothers.[10]

7 Weiss 2022; Golander/Brick 2008.
8 Rosenberg-Friedman 2008.
9 Speech by Ms Kantor at the Hadassah graduation ceremony, December 21, 1944, The Central Zionist Archives, 5/II165.
10 Ms Sara Mohliver, The Building of Eeretz Israel. In: The Nurse, December 22, 1943, The Central Zionist Archives, J117/282.

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Shortly after the war ended in Europe (1945), several humanitarian organizations volunteered to help the Allied military forces, which evidently did not have a clear policy as to what to do with the growing numbers of refugees, or how to handle the disastrous sanitation and personal hygiene, the overcrowded housing, the need to feed, manage, and care for these "walking dead people".[11]

Among these organizations were the United Nations Relief and Rehabilitation Administration (UNRRA), and several Jewish bodies were involved in the American Jewish Joint Distribution (JDC) and the "Welfare Platoon" *(Ploogot Hasaahad*) formed in 1944 by the Jewish Agency.[12] The first Eretz Israeli nurses who volunteered to treat the Holocaust survivors in the DP camps belonged to the two latter organizations. They were well experienced in public health thinking and techniques. They dealt with comprehensive urgent problems, performed health screenings, improved the survivors' living conditions, treated typical common diseases (TB, ringworm, scabies, etc.), and improved the survivors' health and welfare.[13] We will elaborate on three significant nurse figures representing two different aid organizations.

2.1 Nurses as Emissaries of Care: Ms. Rebecca Lyons

Ms. Rebecca Lyons, later better known as Prof. Beccy (Rebecca) Bergman, was nominated to be the Chief Nurse for the American JDC in the American Zone of Germany (1946–1948). The JDC, commonly called the Joint, was established in the United States in 1914 by a small group of wealthy Jewish philanthropists, and later became the largest and most effective Jewish relief organization, capable of managing several projects simultaneously around the globe. The JDC's ideology is to respond to distress and the emerging needs of Jewish people wherever needed. Its motto – "rescue, relief, and reconstruction" – was expressed in various ways: establishing soup kitchens during WWI, distributing food packages and helping refugees escape from Nazi regimes during WWII. The Joint's strategy has always been to cooperate with and help local communities, with the agreement of the relevant governments. The Joint financed infrastructure and the operation of services inside and outside the DP camps, and provided food, medication, transportation, professional services, and training as needed.[14]

Prof. Rebecca Bergman (1919–2015) was chosen for the position in Germany due to her previous experiences of caring for refugees in the British detainee camp in Atlit, where illegal immigrants who arrived by ship were held. In 1944, Prof. Bergman joined the Middle East Relief and Refugee Administration (MERRA), a British aid organization which set up temporary tent cities in the Sinai Desert in Egypt to care for 40,000 Yugoslavian and Greek war refugees, mainly children, women, and the elderly. The combination of the desert heat, a lack of sanitation, and overcrowding led to outbreaks of disease and epidemics. Prof. Bergman successfully stopped the spread of measles by transforming an abandoned aircraft hangar into a children's hospital for isolation.

11 Keynan 1996, p. 11.
12 Yahil 2016, pp. 30–31.
13 Rosenberg-Friedman 2007.
14 Golander/Brick 2008, pp. 1–12.

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Without speaking their languages, she demonstrated to the sick children's relatives how to treat them effectively.[15]

Prof. Bergman demonstrated the same creativity, sensitivity, and flexible thinking in the Atlit detainee camp that she had exhibited in finding efficient and versatile solutions for endless deficiencies and complications in Germany when she was barely 27 years old. Within the chaotic atmosphere that prevailed in Germany after the war, she succeeded in creating "something out of nothing". Prof. Bergman and her driver searched for and found essential valuable medical equipment in deserted warehouses, and converted empty buildings into equipped medical and dental clinics. She cooperated with local Jewish communities to trace and take in orphan children and the sick and infirm. She translated pamphlets and essential information into Yiddish and encouraged the survivors to take advantage of the new network of medical and relief services that had been opened for them. In order to overcome the manpower shortage and the survivors' idleness and apathy, she organized a short training course for nurses' assistants and recruited physicians and nurses from among the survivors. During the two years she spent in Germany, she set up and assembled a range of essential health services that treated thousands of survivors and prepared them for their arrival in Israel.

Prof. Bergman shared her experiences and published her letters concerning her work with the Holocaust survivors in Israeli journals.[16] In her memoirs she specifically mentioned accompanying a group of tuberculosis survivors on a trip from Munich to the sanatorium in Davos, Switzerland. Another memorable experience was the month she spent with the people of the Exodus after they were shipped back to Germany. She was impressed by their strength and determination and treasured the Exodus membership card of honor she was awarded by their leader.[17] She also documented tough memories, the emotional distress, the voices of joy and/or devastation when the survivors found out what had happened to their loved ones during the war. "There was so much tragedy that it almost became the norm."[18]

In 1948, she left her post in Germany to take on another challenging assignment in Israel. When the War of Independence broke out, she was drafted and assigned to open and head a frontline military hospital in Jerusalem. Later on, she became the chief nurse of Malben-Joint, a philanthropic organization that cared for elderly, disabled and infirm newcomers across Israel. She initiated and led the academization of nursing education and chaired the first nursing department at Tel Aviv University. Prof. Bergman became an international leader and carried out official roles as the second Vice-President of the International Council of Nurses (ICN) and as a World Health Organization (WHO) consultant for developing countries. She was presented with many prestigious prizes and awards. Prof. Bergman is the first and only nurse to be

15 Bergman 2000, pp. 5–6; Golander 2009.
16 Lyons 1946, pp. 12-14.
17 Bergman 2000, p. 11.
18 Bergman 2000, p. 8.

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awarded the nation's highest honor, the Israel Prize, for her life-long contribution to society and the nation.

As mentioned above, the pre-state administration in Eretz Israel, the Jewish Agency, responded willingly to the survivors' plea for help and organized the Welfare Platoon. Between 1945 and 1948, a total of about 400 emissaries, men and women, volunteered to serve for a minimum period of one year in the DP camps, most of them in the American Occupation Zone in Germany. The camps were under the authority of the Allied forces, while UNRRA provided the everyday necessities and the relief services for the survivors.

After seven months of bureaucratic barriers, it was finally agreed that the Welfare Platoon's emissaries would function independently but within the framework of UNRRA and would wear UNRRA uniforms. The emissaries' official role was to prepare the survivors for their future lives in Eretz Israel, while also providing humanitarian aid. In practice, each emissary carried out his/her assignment differently according to their understanding, abilities, and circumstances.

Of the 132 identified emissaries reported by Keynan (1996), about half were women, equally divided between mothers and those without children. A breakdown by profession showed that they were mostly educators and people with experience in childcare. Very few came from the health care system. These included four nurses, one psychologist, one physician and six social workers.[19] We were able to trace three out of the four nurses, all of whom came from *kibbutzim* (communal settlements in Israel, typically agricultural).

The first known nurse to be sent for the missions in Austria and Germany was Rebecca Linkovski. However, we chose to report the work of Zvia Lahar and Tzila Rosen, as their experiences were better documented, supported by memoirs, letters, oral interviews, and some personal acquaintances. Their narratives reflected the major concerns and challenges they faced in caring for Holocaust survivors and the emotional burden they experienced.

2.2 Mrs. Tzila Rosen

Tzila Rosen (1903–1972) was born in Bukovina, Romania, came to Israel as a young pioneer in 1926, and was one of the founders of Kibbutz Sarid. She was trained in childcare and development and later completed her professional education in nursing. She specialized in pediatric nursing. The kibbutz ideology was the influencing spirit in those days and children's welfare and socialization was of the utmost importance.

According to the kibbutz doctrines of those days, the collective interest of the group and the nation took precedence over individual preferences. Therefore, to free up the parents for their communal chores, and to provide the children with the best possible care and socialization, the kibbutz children were raised together with their age group in communal children's homes within the kibbutz. Every afternoon, after work, the

[19] Keynan 1996, p. 132.

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children spent several hours of quality time with their parents, but most of their daily care was provided by a trained childcare worker (nanny). She cared for them, watched them when they were sick, and monitored their vaccinations.

Tzila headed the health and development activities of all the children's homes in her kibbutz, guided the childcare workers and cooperated with other health agencies on behalf of the children. Because of her expertise, she was called in to participate in relevant national assignments: She cared for the "Children of Tehran" – a special group of about 700 children, mostly orphans who escaped from Poland during the war and who were finally brought to Israel through Tehran in 1943 with the help of the British army. These children were cared for in the Atlit detainee camp and Tzila was called to head the nursery and children's homes of this fragile group.[20]

In 1947, when she was 44 years old, and already a mother of three children, she joined the Welfare Platoon and was sent to Germany to open mother and child clinics in coordination with UNRRA in the DP camps. In her ongoing reports and letters, she reported special actions and events, together with her impressions from her mission. Her writings reflect the fragile complexity of the mission and the encounter between the two different world views.[21] She describes, with deep sympathy, the significance that children had for the lives of the survivors. Many of them had lost their babies during the war and were eager to rebuild new families and a new life for themselves. She pointed out the very high birth rate in the camps, as well as the difficulties that arose in raising these precious children within those circumstances. At the same time, she was critical of the behavior of the mothers. In her diary she wrote (May 2, 1947):

> Today 12 mothers visited the mother and child clinic. The main problems are their bad practices that need to be uprooted, mainly concerning nutrition: All children are breastfed without any regulated schedule. The mothers keep the babies by their breast during the whole night. They continue breast feeding even beyond the age of 1½ years. Artificial food is given against all the accepted wisdom of modern medicine. Vegetables and fruits are rarely given to the kids. People are suspicious and don't trust the things they're "given." There's so much that needs explaining to these mothers. They need tutoring even in basic and general things about nutrition, how to hold the baby, personal hygiene [...].

She also added: "Today we finally received a baby's weighing scale. It is a huge progress."[22]

Toward the end of her assignment, she proudly wrote to her friend in the kibbutz (March 14, 1948) from the city of Kassel:

> So far, I've set up six mother and child clinics [...]. I've mentored nurses both at work and through lectures [...]. We employ German doctors and this is itself an issue [...]. We have many cases of rickets, the most difficult

[20] A Mother and a Nurse 1973, p. 44.
[21] A Mother and a Nurse 1973, p. 44.
[22] A Mother and a Nurse 1973, pp. 45–46.

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> cases are among the children of Romanian Jews, who have wandered for many months from place to place. Among the older kids there are a lot of rotten teeth, lice, itching and skin problems [...]. Among the survivors in Germany, we have about 8,000 disabled people, invalids and people with chronic disabilities. They will not be accepted as emigrants in any other country. We will be obliged to bring them to Eretz Israel, but first they must be cured here and taught a vocation according to their capabilities [...].[23]

Upon her return to Israel, Tzila Rosen continued to hold leadership positions and initiated new national projects. She founded the national Health Committee for the kibbutzim, whose goal was to formulate a unified health policy for the kibbutzim and serve as a platform for information exchange and mutual learning. In 1949, she founded the Nursing School of the Kibbutz Movement.[24]

2.3 Mrs. Zvia Lahar-Hershkovits

Another emissary nurse who played a crucial role was Zvia Lahar-Hershkovits (1915–2011). Zvia was born in Bialystok (Russia/Poland) and emigrated to Eretz Israel with her family at the age of 8 (1923). She later joined the Jewish defense organization (*Haganah*) which was a paramilitary organization (1920–1948). Zvia had a long and impressive record of participating in various operations and was wounded in one of them. She joined the Kibbutz Giv'at Brenner and graduated from the Hadassah Nursing School. After the death of her husband, a soldier in the Jewish Brigade within the British forces, she volunteered to serve in the DP camps. In the light of her previous achievements, she was assigned to head a DP camp in Germany (1945–1948).

A collection of her letters was published in a book entitled "Buds of Hope" (2002). In her letters she described the complexity of the survivors' lives. The longer they stayed in the camps, the more ambivalent they became towards the emissaries from Eretz Israel. On her arrival in the DP camps, it seems that both sides held high expectations: "They (the survivors) waited for us to bring the gospel of *aliyah* (emigrating to Eretz Israel),"[25] while she herself wrote that she was thrilled with the honor and the responsibility of serving the survivors as a manager of the camp. However, the reality she faced was gloomy and disappointing. On September 2, 1947 she wrote from Ulm, Germany:

> The food supply was cut in half, it is extremely cold, the black market is booming. They exchange everything bought or stolen. It is hard to blame the survivors. These people are hungry. They are cold in their body and soul. Our promises have not been fulfilled. There are no permits (to enter Eretz Israel). There is no work. The only thing they can do is to trade with each other [...].[26]

[23] A Mother and a Nurse 1973, p. 44.
[24] A Mother and a Nurse 1973, pp. 31–32.
[25] Lahar-Hershkovits 2002, p. 20.
[26] Keynan 1996, p. 154.

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Zvia was also especially concerned with the Romanian Jews' situation:

> The pressure from the Romanian Jews is seriously mounting. They came with nothing on them. They suffer from many acute and chronic illnesses, pulmonary and intestinal diseases. Their transport to Germany was a disaster [...] endless walking, no one to lead them. Someone threw the people on the trucks, including the babies [...] they were driven around almost aimlessly [...] they changed their route with every rumor about Russia closing its borders.[27]

Zvia played an important role in the "escape operation" (*Habricha*), the organization of illegal emigration to Israel, mainly by sea. On her return to Israel, she continued to serve in meaningful leadership positions within the national Health Committee for the kibbutzim and the Israeli Nurses' Union.[28]

3 The Nurses in the British Detention Camps in Cyprus

The detention camps in Atlit (in Eretz Israel), Mauritius, and Cyprus were transit camps which were opened by the British Mandate authorities to imprison the 85,000 immigrants who attempted to enter Eretz Israel without permits. For political and diplomatic reasons, the British authorities had limited the number of immigration certificates for Jewish applicants to Eretz Israel during 1920–1948. The situation worsened still further when the sixth updated version of the White Paper (1939) restricted the number of permits to only 15,000 a year for five years. As the persecution of Jews dramatically intensified in German-occupied Europe during the Nazi era, the urgency driving the immigration became more acute.

This limited supply of legal permits was nowhere near enough to meet the rising demand, especially after the war. Several Zionist organizations worked together to facilitate the immigration of refugees even without permits. During the post-war era (1945–1948), the collectively organized Habricha escape efforts succeeded in shipping 70,000 Holocaust survivors from different ports in Europe to Eretz Israel on 66 ships. Altogether, by the time the state was established, about 120,000 emigrants had entered the country this way. Over half of the shipments were stopped by the British patrols. Most of the intercepted immigrants were sent to detention camps, first in Atlit, and Mauritius (1940–1945) and, when these became overcrowded in 1946, they were shipped to Cyprus (1946–1949).[29]

Weiss (2002) studied the nursing care in these detention camps. The study describes the organization and the practice of nursing in each camp, and compares the camps in Mauritius, Cyprus, and Aden (British camp for Yemeni Jews).[30] As most of the European immigrants were deported to Cyprus, we will present a short description of the

[27] Lahar-Hershkovits personal letter from Munich, November 30, 1947, Ghetto Fighters' House Archive, RM 23306.
[28] Lahar-Hershkovits 2002, p. 79.
[29] Naor 1991, pp. 110–118; Bogner 1991, pp. 13–15, 36–40.
[30] Weiss 2002.

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health challenges faced by the team of nurses from Eretz Israel who served in the Cyprus camps.

Overall, about 52,000 deportees were sent to Cyprus on 39 ships. Most of the deportees were born in Poland and Romania, some came from Bulgaria and North Africa. They were settled in temporary camps that had previously been used by the British army. The "summer camp" mainly consisted of a group of tents surrounded by barbed wire. The "winter camps" had tin cabins and were therefore considered to afford somewhat improved living conditions. The British army provided the essential supply of water, food, basic daily needs and medical care. However, the provisions were insufficient, and the conditions were harsh and not suitable for a civilian population. One can only imagine the depth of the survivors' despair and frustration when their dreams of a new life in their new homeland were shattered, and they were forced to adjust again to life in a detention camp.

3.1 The Medical Condition and Treatment of the Detainees

Most of the Cyprus deportees were young and relatively healthy, as they had previously been medically screened for the voyage. Yet, right from the beginning, 15 cases of open tuberculosis were detected and a similar number of old tuberculosis. There were also cases of typhoid fever, and diarrhea was common, as were scabies and pediculosis. Most of the health problems stemmed from the poor conditions in the camps: no running water, few toilets, overcrowding, and poor nutrition.[31]

Following an official visit by the medical delegations of the JDC and the Yishuv, management of the medical service in the camps was transferred to the JDC. Gradually and systematically, the JDC financed and directed its effort towards improving the poor living conditions, expanding the health services, and enriching the psycho-social wellbeing of the deportees. The delegates from Eretz Israel played a significant part in these operations. They set up children's homes and youth camps, taught them Hebrew and music, provided vocational training, and exposed them to Judaism and the modern Israeli culture and spirit.

3.2 Nurses and Nursing within the Detention Camps

The very first medical delegation sent to the camps included two nurses from Hadassah Hospital: Ms. Ahuva Goldfarb and Ms. Gotha Gostinski. The initial idea was that they would not replace the British team, but rather focus on medical examinations and screening of the refugees, in a manner similar to that operating in the DP camps. But in the light of the devastating conditions, the neglect, and the high incidence of wounds and abscesses, they changed their original plan completely.[32] They adapted barracks into clinics, and tents into small hospitals (patients' rooms). They rearranged the medical supplies and equipment, allocated suitable places for the nursery and the kitchen, as well as for the health staff's housing. They trained nurses from among the

[31] Schaary 1981, p. 138.
[32] Weiss 2002, p. 216.

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deportees to work in the hospital. The need for proper nutritional food was identified as an urgent concern as it was insufficient and unappetizing. On the recommendation of the Hadassah hospital staff, the JDC began providing food supplements.[33]

The nurses played a comprehensive and pivotal role in the refugees' lives in sickness and in health (2,200 babies were born on the island). They felt pride in their contribution to the assistance provided to the detainees, and sympathized with their hardships. In their letters, they described the unbearable conditions on the island.

Ms. Ahuva Goldfarb was a public health nurse. She had previous professional experience with refugees in the Atlit camp. She served two terms in Cyprus and later volunteered to work in the temporary refugee camp in Aden. She described the depressing visual and spiritual atmosphere that prevailed in Cyprus upon their arrival.

> Wooden cabins without a floor. There is not a single tree to be seen. Everything is colored gray and brown. Masses of people are wandering aimlessly around the camp, doing nothing. They wear worn shirts, and short pants supported by rope belts. They walked barefoot, and a state of degenerate indifference overcame all.[34]

Another senior nurse sent to Cyprus was Ms. Ida Wissotzky. She received her diploma in nursing from Warsaw. Almost everyone in her family perished in the Holocaust. She saw the mission to Cyprus as a fulfillment of a dream, the first front line of Zionism. She was especially sensitive to the resilience of the orphaned children.[35] She summarized her thoughts and experiences from Cyprus in a newspaper article in January 1979:

> Almost every one of them had spent six years in a German concentration camp and/or a British camp, and did not know that somewhere there is a life in which death and terror are not found [...]. These children who were born in the ghettos or European refugee camps had never seen a field, a tree, a life [...].[36]

In general, aside from several expert and influential nurses, most of the nurses who served in Cyprus were young and new to nursing or childcare. They went straight from the protective environment of the school in Eretz Israel to the demanding constraints of the camp. They faced young people the same age as themselves – but with long and tragic life experiences. They argued that even though they had been thoroughly prepared for their work, no one could foresee the reality that they would have to face in the camps.[37] Almost immediately upon their arrival, they had to act resourcefully, improvise, and find creative solutions. The set of difficulties which piled up in front of the nurses was almost discouraging in its severity. Yet they continued to pursue their

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33 Weiss 2002, p. 217.
34 Nurses Tell 1968, p. 49.
35 An article by Ida Wissotzky "Winter – Cyprus 1947", published in: Al Hamishmar newspaper, Hotam supplement 1979, quoted in: Henigman 1983, pp. 16–17.
36 Henigman 1983, p. 21.
37 Weiss 2002, p. 324.

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mission even under these almost impossible conditions. Something of what they faced can be learned from nurses' memoirs published in a booklet of Hadassah graduates. One of the nurses wrote:

> From August to November of 1946, I worked in Cyprus. Behind a barbed wire fence, I saw poor human skeletons wandering around with dissatisfied faces from inaction. Many of them are bereaved parents and orphaned children who have not yet experienced the meaning of a family. The weather is bad. It is humid, hot and stuffy in the summer, and cold and very wet in the winter. There is no electricity, nor flashlights. The people are living in tents, several families share one tent. Drinking water is rationed, five liters per person.

She added that they opened a “humble” nursery in an old building. Washing the diapers in the salty sea water caused severe irritations for “these feeble babies”. They asked for an extra amount of sugar water, which the nurses kept in special locked boilers. The food was limited and dull. The nurses supplemented the families with egg powder, soaps and combs. She concluded that even in such tough circumstances the refugees made special efforts to restore normalcy as much as possible.[38]

In conclusion, the major health problems presented by the deportees resulted from poor sanitation and hygiene. Wounds, skin rashes, widespread furunculosis, and burns were all treated by dressings and medication. Scabies and pediculosis resulted from the combination of poor living conditions and the difficulty of washing clothes and blankets. Spraying with DDT was an essential and common treatment in the camps. Tuberculosis patients were quarantined in the island’s hospital. Heart disease, diabetes, and digestive problems were related to nutritional deficiencies, and were also treated through various diets and vitamins. The young neophyte nurses implemented principles of public health nursing, preventive medicine, community and emergency nursing in their practice.

3.3 Back to the Homeland to Face New Challenges

On their return to Israel, many of the nurses from Cyprus followed the newcomers and worked at the absorption camps in Israel. Others returned to their previous workplaces. The former chief nurses of the Cyprus camps, who had been carefully screened and chosen for their demanding position in the detention camps, grew to assume top leadership positions following their mission in the camps. Several refugees, who were care assistants on the island, continued their professional training in one of Israel’s schools of nursing. As for the refugees, with the final evacuation of the camps in February 1949, the detention chapter of their lives finally ended, but the next chapter saw them enduring the absorption camps in Israel.

[38] Nurses Tell 1968, pp. 50–51.

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4 Epilogue – Nursing in the Absorption Camps in Israel

With the termination of thirty years of the British Mandate, and the declaration of the State of Israel (May 14, 1948), the new state had to face two formidable tasks simultaneously: fighting the War of Independence while absorbing masses of new immigrants. During the second half of 1948, in the midst of difficult battles, Israel absorbed 102,000 new immigrants, a sixth of its entire Jewish population, in 20 improvised absorption camps.[39]

At the end of the War of Independence (July 20, 1949), the young state addressed the urgent task of assuring free Jewish immigration. Within three and a half years the population of Israel doubled: 650,000 people absorbed nearly 700,000 new immigrants from dozens of places in the diaspora – a rate of absorption unprecedented in the world.[40]

The ingathering of the Holocaust survivors and the evacuation of the DP camps was a promissory note that had to be redeemed. To a great extent, the distress and danger to which Jews were subjected in their native countries dictated the order of priority followed when selecting waves of immigration ("immigration of distress" vs "immigration of rescue"). Challenges included addressing the unique personal and cultural characteristics of the immigrants. The majority of the first newcomers were very poor, in ill health, with high morbidity rates due largely to infectious diseases. A large proportion of the children and older persons, especially from Yemen, suffered from extreme malnutrition and dehydration. The percentage of disabled people, those with mental illness and chronic illness, was relatively high. About 10% of the immigrants suffered from a disease which necessitated immediate hospitalization. In addition, in 1949 a polio epidemic broke out throughout the country and lasted for a decade.[41]

Furthermore, during the early years of immigration, Israel did not have sufficient manpower, resources or hospital beds to treat and isolate patients with contagious diseases. The immigrants' health issues became a focus of political and social debates. The division was between those who called for a reduction in the rate of immigration from countries with high morbidity, and those who demanded first the improvement of their health in one of the transit camps located in France, Italy and Germany. Those camps were operated by the JDC and other relief organizations. In contrast, others sided with those who wanted to bring in as many immigrants as possible, for fear that the window of opportunity would close.

The full account of how Israel managed to eradicate the epidemics and absorb the newcomers from diverse cultural backgrounds into the "Israeli melting pot" is beyond the scope of this paper. Nonetheless, there is an important lesson to learn from Israel's multicultural experience.[42]

39 Sicron 1986, pp. 32–52.
40 Golander/Brick 2008, pp. 4–5.
41 Stoler-Liss/Shvarts/Shani 2016, pp. 11–12.
42 Stoler-Liss/Shvarts/Shani 2016, p. 14 (Ben Gurion diary, citation no. 13).

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Providing proper care to these selected groups presented a huge challenge for several reasons: First, their illnesses demanded special expertise, which the Israeli doctors and nurses did not possess. Second, in contrast with other refugee groups, there were some from developing countries who lacked their own health personnel to lead them and mediate their needs to the establishment and provide support. Third, language differences, communication barriers and women's literacy seriously affected health education and social interactions. Fourth, vast cultural differences and modern health illiteracy posed barriers to treatment. Fifth, the idea of providing health care in the absorption camps using the total care model ("efficient kibbutz model" as in Cyprus), was foreign to the immigrants and often undesired.[43] The nurses played a pivotal role in overcoming these barriers. They were committed, creative and skillful soldiers in the battle to eradicate epidemics and improve the immigrants' health.

Most of the nurses who worked in the camps were young and inexperienced and either volunteered or were sent by their health agencies. During their interviews, they described the creative solutions they used to facilitate communication and enlist the immigrants' cooperation (using gestures and demonstrations, compiling a dictionary of useful terms in different languages, using an intermediary, etc.). They had painful memories of their experiences of holding a dying baby in their arms, and not being able to help. Another nurse remembered the screams of a sick child while she gave him the painful known treatment for ringworm. Living in the absorption camps, they shared the same difficult living conditions, and were often infected with the same contagious diseases. Despite their difficulties, they took enormous satisfaction and pride in their mission. In fact, following our interviews, several of the nurses are writing their memoirs.[44]

5 Discussion and Implications

What can be learned, in retrospect, from this unique Israeli experience of integrating immigrants and overcoming epidemics during the early years of the post-WWII era? Furthermore, what is the relevance of these experiences to the current trends of immigration and pandemics? And finally, how is nursing related to these two interrelated phenomena?

Our study followed the practice of nurses "from here" (Eretz Israel) through three different immigration camps during the short period between 1945 and 1948. First, in the DP camps for Holocaust survivors in Germany ("over there"). Next, in the detention camps in Cyprus, where the British held refugees who attempted to enter Eretz Israel without the correct papers ("over there"). Lastly, a note about challenges faced by both the health care providers and the new immigrants within the absorption camps in Israel, ("back here"). We argue that – in spite of the immense differences between the camps, the diversity of the residents' characteristics and the health needs that the

[43] Stoler-Liss/Shvarts/Shani 2016, pp. 150 (citation no. 2, 3); HaCohen 1994, p. 200.
[44] Personal interview: Malka Grebler, 2019, 2022 (Pardes Hana), Yael Gilad, 2019, 2022 (Hod Hasaron).

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nurses faced – there are many similarities between the essential approaches and strategies they followed.

5.1 Nurses' Contributions

Nursing has a social mandate and a proven historical record of eradicating epidemics and achieving remarkable outcomes by applying a preventive medicine philosophy and health promotion techniques.[45] Styles (1982) believes in the critical importance of the *sense of social significance*, both for the personal development of nurses and for the profession.[46]

In that spirit, the nurses from Eretz Israel demonstrated the utmost confidence in the nation's task of ingathering its fellow brothers and sisters from exile and establishing a homeland in Israel. They volunteered to be sent on extremely demanding missions abroad and/or at home, while paying a high personal price. Often their health was affected, their personal safety endangered, and their own families' needs were neglected. They were totally committed to accomplishing their assignments. Referring to nurses and physicians,[47] two major interrelated goals were identified in their "battle for the nation's health":

1. To participate in the national effort of helping the immigrants become Israelis. In accordance with the "melting pot" dogma and the public health principles, the care providers encouraged the immigrants to adopt Israeli patterns of behavior and thinking. The intent was not cultural extinction but a desire to build a nation and a healthy young new generation (the social mandate).

2. To save lives, prevent the spread of epidemics, lower infant mortality etc. (the curing mandate).

In retrospect, the nurses helped to successfully achieve both the social mandate and the health mandate. Indeed, toward the end of Israel's first decade, most of the serious health problems that endangered the country were treated and resolved. Tuberculosis, malaria, polio, and syphilis almost completely disappeared. Polio vaccinations (Salk and Sabin) eradicated the polio virus. The incidence of ringworm, trachoma and gonorrhea dropped drastically with the development of new antifungal ointments and antibiotics. The rate of infant mortality decreased due to mother and child clinics, which were successful in assimilating health education techniques, increasing the hospital birth rate, and providing nutritional and health services in schools.[48]

5.2 Strengths and Pitfalls

There is a general lesson that can be learned from analyzing both the strengths and the weaknesses of the accumulated Israeli experiences of integrating immigrants and

45 Crowan Novak 1988, pp. 80–87.
46 Styles 1982, p. 123.
47 Stoler-Liss/Shvarts/Shani 2016, p. 265.
48 Stoler-Liss/Shvarts/Shani 2016, p. 291.

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fighting epidemics. We will refer to the organization of care services, the perspectives of the recipients of care, and the development of the nursing profession.

Considering the harsh conditions, in which the health personnel had to react swiftly to complex situations, their ability to find creative solutions, improvise, and get organized quickly were critical for achieving their goals. However, although these intuitive successful techniques could be effective and appropriate in resolving sporadic and local problems, they were not sufficient as a general plan to rely on. In effect, successful solutions and insights which were formulated in one camp were not necessarily passed on to another camp, nor were the recommendations translated into a deliberate policy of action.

Another characteristic of the camps' organization of services was the multiplicity of voluntary and philanthropic organizations that took part in the provision of a wide range of essential health and welfare services. The advantages of multiple organizations cooperating and complementing each other are obvious, yet this situation could also lead to deficiencies, duplications, and the absence of a leading plan of action. In fact, one could argue that an over-reliance on philanthropic organizations to provide full-scale services is undesirable as it could lead to reducing the state's responsibility.

The very fact that an entire country is enthusiastic about absorbing and assimilating masses of immigrants in its territory is a rare phenomenon in itself. Nurses and other health providers devoted considerable effort and thought to finding the best possible means to cure the immigrants and help them become independent and productive citizens. Given the lack of infrastructure resources and the harsh living conditions within the different camps, the centralized model of providing care, which was common and somewhat similar to the one practiced in the kibbutzim, seemed to be the best model for medical and financial effectiveness. Babies were treated and cared for in nurseries, tuberculosis patients were sent to temporary sanitariums, and children with ringworm to designated care centers. Care was basically regimented and centralized.

During those stormy days, little attention was given to the care recipients' traditions, feelings, or preferences. Mistakes were certainly made – but mainly from a lack of knowledge and with good intentions. It was only years later that some of the immigrants' voices of frustration were heard and documented, describing what they perceived as paternalism and poor cultural considerations.[49]

Nurses, both as individuals and as a profession, made a significant and unique contribution to the achievement of overcoming epidemics and absorbing the newcomers. Undoubtedly, the days of great immigration increased the recognition and prestige of the nursing profession, especially in the light of the shortage of physicians. The number of nurses increased dramatically through the recruitment of immigrant nurses and by opening new programs and nursing schools to train licensed practical nurses and registered nurses.

[49] Sternberg 1973, pp. 161–164; Alfi 2018.

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The increase in the supply of nurses came at the expense of the profession's composition. In 1949 the majority of nurses (71%) were Registered Nurses (RNs), but by 1963 only 41% were RNs, compared with 59% Licensed Practical Nurses (LPNs).[50] The nurses' place in public health improved, but the academization of nursing weakened.[51] This goal of academizing nursing, which was raised as early as 1922, was finally achieved in 1968, when Prof. Rebecca Bergman opened the first department of nursing at Tel Aviv University. It took that long to be implemented "because there was always something more pressing on the agenda".[52]

5.3 Migration, Pandemics and Global Implications

The links between epidemics and mass immigration are not only of historic interest, but have currently become a global burning issue.[53] In fact, since 2005, and especially in the last decade, the number of refugees and economic migrants in the world has jumped by 100% to reach 80 million people globally, according to UNHCR[54] or 40 million according to Eyal.[55] A great deal of the increase relates to refugees who have escaped war zones, yet the majority are undocumented migrant workers who arrive from developing countries to seek a better life in modern welfare states.

With globalization, transferable diseases can easily develop into epidemics and pandemics. Immigrants, especially asylum seekers, are often particularly vulnerable to contagious infections, both as spreaders and as victims, due to pre- and post-migration risk factors.[56] Pre-migration factors include torture and refugee trauma, which may result in mental and physical illness. The refugees often come from conflict areas, with inadequate access to health services. Post-migration factors include detention, length of asylum procedure, language barriers, and a lack of knowledge about the new health care system. Prevalent physical problems include tuberculosis, HIV/AIDS, hepatitis A and B, parasitic diseases, and non-specific body pains. Mental health problems include depression and post-traumatic stress disorder (PTSD).[57]

Migrants are especially at risk in the current COVID-19 pandemic. Many live in densely packed quarters and rely on low-income jobs where it is impossible to implement social distancing. They may have limited access to personal protective equipment and healthcare and have higher rates of conditions that contribute to COVID-19 complications.[58] In light of the pre-migration difficulties and the many barriers to vaccination rooted in their unique status, it is crucial to solve this problem globally. Teerawattananon and his group report on their experience in vaccinating undocumented mi-

50 "Nursing in Israel." Ministry of Health: Report of 1963.
51 Weiss/Boretz-Peles 2014; Miller 1996, p. 12.
52 Zwanger 1995, p. 13. And also The Council for Higher Education, 11 March 1985, pp. 39–42.
53 Teerawattananon et al. 2021.
54 United Nations High Commissioner for Refugees (UNHCR) 2020.
55 Eyal 2018, pp. 193–195.
56 Norredam/Mygind/Krasnik 2005, pp. 285–286.
57 Norredam/Mygind/Krasnik 2005, p. 285.
58 International Organization for Migration (IOM) 2019.

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grants in Singapore and Thailand. They call for a collective effort for a global vaccination alliance, as well as for each country to be accountable for vaccinating those living within its borders, including undocumented migrants.

> […] this is a challenging task. However, all nations must work together to protect the vulnerable and extend healthcare to everyone, for "no one is safe, until everyone is safe".[59]

Shallish (2020) actually proposed a conceptual-practice model for coping with outbreaks of infectious diseases in waves of immigration like those that the world is currently facing. Her model is based on lessons learned from her historical research on the eradication of tuberculosis in Israel.[60] The model refers mainly to the immigrant as a potential spreader of infectious diseases. The "four arms model" (meaning helping hands) is an organizational outline which consists of four consecutive and complementary stages/directions that governments are advised to follow:

1. Preliminary actions to *prevent* the outbreak of the disease, which should be taken *before* entering the country (i.e. medical screening, isolation and treatment).

2. Taking essential *preventive* measures immediately on arrival and *before* immigrants are *assimilated* into the general population. This includes maintenance of strict hygiene conditions, social distancing, digital registration and data sets, medical treatment and vaccination, culturally sensitive health education and instruction, and centralized management of care.

3. Recruiting and training of suitable personnel, knowledgeable about and responsive to the immigrants' specific needs and culture.

4. Actions to *assimilate* immigrants in the general population. This final stage translates into providing counseling and support services to avoid the segregation of migrants and facilitate their genuine integration into society.

The encounter between mass immigration and epidemics is not just a medical problem, but rather a complex combination of political, social, economic, cultural and health phenomena, with significant potential implications that can be either positive or harmful. Nurses are in a unique position to make a difference to the health of immigrants and the wellbeing of society. In fact, there is a growing need to develop refugee health nursing as a specialty. Desmyth and her friends, employed by various Australian agencies for refugee health programs and services, refer specifically in their editorial article to refugees, but their descriptions also fit other categories of immigrants.[61] The authors believe that the key roles of this specialty are providing primary care that is culturally responsive, promoting health literacy and empowerment, and advocacy for these patients within healthcare systems. They state that such a specialty

[59] Teerawattananon et al. 2021.
[60] Shallish 2020, pp. 190–199.
[61] Desmyth et al. 2021.

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demands a vast extent of specific knowledge, understanding and skills, including immunization, oral health, nutrition, infectious diseases and parasitology, family planning and mental health.

Looking back on the practice of the young and dedicated nurses who cared for the Jewish immigrants in the different types of camps – the obvious conclusion is that they did in fact perform the actions proposed by the model.[62] They intuitively fulfilled most of the desired key roles expected of an advanced nursing specialist.[63] Their heroic practice should be unveiled, their story should be told, and their contributions should be cherished in the history of nursing and the Israeli nation.

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[62] Shallish 2020, pp. 190–199.
[63] Desmyth et al. 2021.

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