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Prevention and stigma: the sanitary control of Muslim pilgrims from the Balkans, 1830–1914

Christian Promitzer

Introduction

The fight against plague and cholera allegedly or actually communicated by Muslim pilgrims from India and Southeast Asia while on the *Hajj* (pilgrimage to Mecca) has been the object of sustained research in the field of medical history. A recent contribution, Stefan Winkle's book *Cultural History of Epidemics*, explains how intensified maritime traffic over the course of the nineteenth century made the region of the Hejaz on the Western coast of the Arabian Peninsula a hotspot for the outward diffusion of cholera. This region – which is now part of Saudi Arabia – belonged to the Ottoman Empire until the end of the First World War and comprised the central sites of Muslim pilgrimage: Mecca and Medina. In parallel, when cholera was identified as a water-borne disease, the holy Zamzam well in Mecca was considered a major source of contagion as thousands of pilgrims immersed their burial gowns in the open water, drank from it and filled small bottles to take it back to their relatives, friends and the sick in their native lands.¹

In his authoritative work on the influence of contagious diseases on the public health policies of the major European powers, Peter Baldwin identifies the fourth cholera pandemic as the decisive moment when attention was focused on the Ottoman Empire and Muslim pilgrims as possible vectors for the spread of the disease. Baldwin pointed out that in 1865 pilgrims from Java and Bengal communicated cholera to fellow Muslims from other countries on their arrival to Mecca. From

Hejaz the epidemic spread via Suez to Egypt, and from the port of Alexandria throughout the Mediterranean. Within weeks, the whole of Europe was infected. An ISC – the third after those held in Paris in 1851 and 1859 – was convened in Constantinople the following year. During this international conference, the representatives of the main European powers asked the Ottoman Porte and Egypt to implement severe measures of control and quarantine upon the Muslim pilgrims coming from and going through their territories.²

The first time that cholera made its way from India and modern-day Iraq to Mecca had been in 1831, during the second pandemic, killing around 3,000 pilgrims.³ In 1846, cholera, again from the Indian sub-continent, reached Mecca for the second time, claiming nearly 15,000 victims, the majority of whom were pilgrims.⁴ However, in marked contrast to the subsequent pandemic of 1865, the geographic reach of the epidemics of 1831 and 1846 passing through Mecca was limited to the Near East and Northern Africa. To be sure, on those occasions the European continent was not left unaffected, but the disease would actually arrive via Russia. This means that from the European point of view, until 1865, Mecca was only a secondary route in the transmission and spread of cholera.

In 1883, the *Hajj* found itself again in the midst of the international struggle against cholera. In that year, pilgrims returning from Mecca triggered a severe epidemic outbreak in Egypt that would cost the lives of more than 50,000 people. The European public became highly concerned, since this was the first outbreak in the region after the opening of the Suez Canal in 1869. Some contemporaries accused British ships carrying the Egyptian pilgrims of having brought the disease on board on their return from India. In any case, the hospitals of Alexandria saw the activities of various national teams of medical doctors sent from Europe that wanted to detect the causal germ of cholera. As is well known, the German bacteriologist Robert Koch would seize the prize.⁵ From that moment until the First World War, Egypt and the Ottoman Empire would be subject to stronger surveillance by the 'European Concert' with respect to their actual commitment to exert various forms of sanitary control and quarantine measures upon Muslim pilgrims based upon the new scientific findings provided by bacteriology.⁶

In my opinion, the fact that most of the existing historiography on the relation between the Muslim pilgrimage and cholera concentrates

on Western Europe, the Middle East and British India is responsible for a most interesting part of the story remaining completely ignored. I am referring to the question of Balkan Muslims, and also in part to the role of the Habsburg Empire (Austria-Hungary), in the control of the *Hajj* from 1867. With regard to the question of Muslims in the Balkans, which – apart from those in the Caucasus – were and still are the only autochthonous Muslim population in Europe, it is surprising that no relevant study has yet been conducted on their *hajjis*. As late as the Congress of Berlin of 1878 that put an end to the Russo-Turkish War, estimates pointed to more than 4 million Muslims living in the European provinces of the Ottoman Empire, which meant circa 35% of the total Balkan population. After the war, ‘Turkey-in-Europe’, i.e. the Ottoman possessions in the Balkans, would be reduced to Albania, Kosovo, Macedonia and Thrace. As a result, in 1878, half a million Slav Muslims living in Bosnia-Herzegovina would fall under Austro-Hungarian administration and later, in 1908, came to be integrated into the Dual Monarchy. The autonomous principality of Bulgaria (which in 1908 became an independent monarchy) was also home to a considerable number of Muslims of Slavic, Turkic and Roma descent. Finally, small Muslim minorities lived in the independent states of Montenegro and Romania.⁷

With regard to the role played by Austria-Hungary, it is evident that it was already losing its status as a Great Power in a process accelerated by the military defeat against Prussia in 1866 in the struggle for preponderance in the German Bund. In spite of this, the Habsburg Monarchy remained – in competition with Russia – a potent actor in southeastern Europe that still managed to exert some significant influence in the affairs of the Ottoman Empire. Taking into account this double background, this chapter will begin by addressing the general circumstances surrounding the annual displacement of Muslim pilgrims from the Balkans to Mecca from 1878 until the Balkan Wars of 1912–13. This will be followed by an examination of the methods of disinfection and quarantine that Balkan *hajjis* had to undergo on their return home. Focus will be on the cases of Bosnia-Herzegovina and Bulgaria, taking into account the fact that the latter country had to deal not only with its own Muslim pilgrims but with Serbian and Bosnian *hajjis* passing through its territory (preferring the use of the railway to navigation).

Muslim pilgrims from the Balkans and the establishment of Ottoman quarantines (1830–78)

Throughout the nineteenth century, male Muslims from the Balkans participated in the pilgrimages to the holy places of Islam on the Arabian Peninsula. Since the mid 1830s travellers from the Eastern Balkans – Bulgaria – could use steamships that were routinely plying the lower course of the Danube and the Black Sea in order to get to Constantinople. From this port, they could connect to international travel routes. With regard to pilgrims from the Central Balkans – Kosovo, Macedonia and Western Thrace – they would embark at the port of Salonika for Alexandria. Their fellow pilgrims from the Western Balkans – namely those from Bosnia-Herzegovina, Montenegro and Albania – relied on the vessels provided by the ‘Austrian Loyd’ steamship company. The latter would leave from the ports of the Eastern Adriatic coast – with Trieste as the main point of departure – and arrive either in Beirut or in Alexandria, from where the difficult land route had to be taken on camel caravans. This information, the only such available on the transport of Balkan *hajjis*, has been taken from an 1868 article on the global itineraries of Muslim pilgrims written by the Austrian doctor Jacob Eduard Polak (1820–91). Polak, who in the 1850s became court physician to the ruler of Persia Naser-al-Din Shah, wrote this work – whose main subject was the role of pilgrims in the spread of cholera – in his capacity as Austrian delegate to the third ISC held in Constantinople.⁸ By contrast, Ottoman sanitary records, including those preserved in the archives, as well as the unpublished records of foreign consular offices in the Balkans, remain largely unexamined by historians.

Since the late 1830s, the Ottoman Empire had established sanitary offices in all of its districts. Maritime and terrestrial quarantines were enforced in the event of plague and cholera outbreaks. Actually, an epidemic of plague, which struck both Constantinople and the European part of the empire in 1836 and the following years, was the *raison d’être* for this innovation, putting an end to the traditional religious opposition to such public health measures. Despite this, the Muslim population – like that of European countries one or two centuries before – had to undergo what Martin Dinges has called ‘a learning process’ before accepting that the imposition of quarantine was meant to protect them from epidemic diseases.⁹ Still, 500 Muslim women protested against the introduction

of quarantine in the Bulgarian port of Varna in 1840 and threatened the life of the newly installed director of the local sanitary office.¹⁰ It is worth noting that with the imposition of quarantines, the plague retreated from the European part of the Ottoman Empire for good. Apart from internal repercussions, the implementation of quarantines in the Ottoman Empire was also of international significance. Thus, a high Ottoman official duly presided over the Supreme International Sanitary Board in Constantinople, but most of the members of this body were diplomatic representatives of the European great powers and medical doctors from these same countries.¹¹ This reflected how Western medicine had infiltrated the vast field of healthcare in the Ottoman Empire, while the recently founded Imperial Medical School still needed some time to produce native doctors of relevance.¹²

The geo-epidemiological meaning of quarantines in the Ottoman Empire seems evident: due to the intensification of international trade the European powers had a vital interest in reducing maritime quarantine in their own ports and for their ships abroad and for this they needed the Ottomans to develop a reliable sanitary administration. These were the same reasons why pruned – ‘contingent’ or otherwise attenuated – variants of contagionism or even the outright anticontagionist miasma theory, particularly in Britain, became popular over a timespan which the renowned medical historian Erwin Ackerknecht assessed between 1821 and 1867.¹³ But this was also the period when quarantines – for the adherents of traditional contagionism the ideal instrument to prevent plague and cholera – were introduced in the Ottoman Empire. With regard to plague and cholera, the Ottoman Empire was considered a major threat to the Christian part of Europe, and for reasons of self-defence the concepts of attenuated contagionism and miasma theory had to end at the ports and borders of the Western European powers. European observers consequently held the view that quarantines in the Ottoman Empire – a country they perceived as lagging well behind the standards of Western civilisation and hygiene – would be of great use because of their protective character for the emerging capitalist economies of the European continent.¹⁴ Therefore, the anti-miasmatic turn ascribed to the 1866 ISC in Constantinople, when the delegates of the European Great Powers reconsidered quarantines, was not perceived as such by the representatives of the Ottoman Empire. For them, it rather meant that the pressures imposed on them

since the 1830s were only being intensified. At that juncture they realised that the issue of Muslim pilgrims was no longer an internal affair but also an international matter and that the West – at least in part – asked for its share in controlling the itineraries of the *hajjis* in the Red Sea and Egypt, which was formally subject to the Ottoman sultan, but in practice increasingly under French and British influence.¹⁵

In this emerging scenario of imperialism and epidemic threat, the scarce and casual information on the autochthonous Muslims in the Balkans throughout the entire period is puzzling – though analogous to other peripheral Islamic localities such as Morocco, as Francisco Javier Martínez has shown in Chapter 3. Balkan Muslims played a negligible role in the proceedings of the International Sanitary Conferences, although this group, of all possible vectors of cholera, was the one positioned geographically closest to the heart of the Danube monarchy, and thereby of Europe. The alleged responsibility of Muslim pilgrims for the spread of cholera to the Mediterranean and Western Europe, brought forward by the European delegates at the Constantinople Conference, did not take those pilgrims into consideration. In other words: a new international sanitary policy which increased pressure on the Ottoman Empire by associating the threat of cholera with a religious ritual – the Muslim pilgrimage to Mecca – was put in place in 1866, and a culprit – the *hajjis* – was found, but, curiously enough, at the same time, this scheme was not applied to the local framework of the Ottoman Balkans, the closest Ottoman possessions to Europe. The fact that this negligence was not followed by any harmful effects over the subsequent years, reveals, at least in part, that the new sanitary policy did not only rest on scientific, but also on ideological, pillars, the latter undoubtedly targeting the unhygienic consequences attributed to Muslim religious practices and these in turn being used as a justification for keeping the *hajjis* under surveillance.

In any case, the *hajjis* travelling from the Balkans did not play an essential role in Western policies of prevention up to the late 1870s. Neither did they in Ottoman public health. The network of Ottoman sanitary offices, responsible for quarantines and control of maritime traffic, actually left large spaces uncovered. The few medical doctors in the Ottoman Empire were concentrated in the larger cities or were field surgeons serving in the army who did not visit the villages where the bulk of the Balkan Muslim population lived. Both the rural town and

village Muslim populations in the region relied on folk healers, the so-called *hekimins*. Only the elites of Balkan Muslim society (mostly the governors of the provinces) had modern physicians at their personal service. These additional factors further explain the scarcity of information on the medical control of Muslim pilgrims from the Balkans. In the end, medical control of pilgrims, no matter what part of the Arab-Islamic world they came from, seemed to be limited to the Hejaz itself and to a handful of large Egyptian and Ottoman ports.

However, both the political situation in southeast Europe and the international sanitary policies addressing Muslim pilgrims would change by the end of the 1870s. With regard to the former, armed insurrections of the Christian population of the Balkans against Ottoman rule, a local war of the vassal states Serbia and Montenegro against the sultan and, finally, the Russo-Ottoman War of 1877–78 resulted in a tremendous defeat for the Ottoman Empire which drastically reduced its European provinces. In June 1878, the new political and territorial reordering of the Balkans was sanctioned by the European great powers at the Congress of Berlin stipulating the independence of Romania, Serbia and Montenegro from the Ottoman Empire, heralding the foundation of an autonomous Bulgarian principality, and the transfer of the administration of the province of Bosnia-Herzegovina from the Ottoman Empire to Austria-Hungary (Figure 6.1). Consequently, the local Muslim populations were bereft of their religious and secular ruler, which for centuries had protected and encouraged their existence in the European provinces of the Ottoman Empire. Change was particularly felt in the case of Bosnia-Herzegovina and Bulgaria, both home to considerable Muslim populations. In Bosnia, the new imperial Austro-Hungarian administration sought to patronise its Muslim subjects and to minimise the influence of the Ottoman Empire, with the sultan still formally the head of this province. In autonomous Bulgaria, which nevertheless remained an Ottoman vassal state, a more robust policy vis-à-vis Muslims was pursued instead.

Meanwhile, throughout this time and the following decades, international sanitary policies were evolving. After the 1866 conference in Constantinople, and in particular following the cholera epidemic of 1881–82 in Arabia and Hejaz, Muslim pilgrims passing the Egyptian port of Alexandria, the Suez Canal and/or the Red Sea would increasingly come under international sanitary control. The quarantine

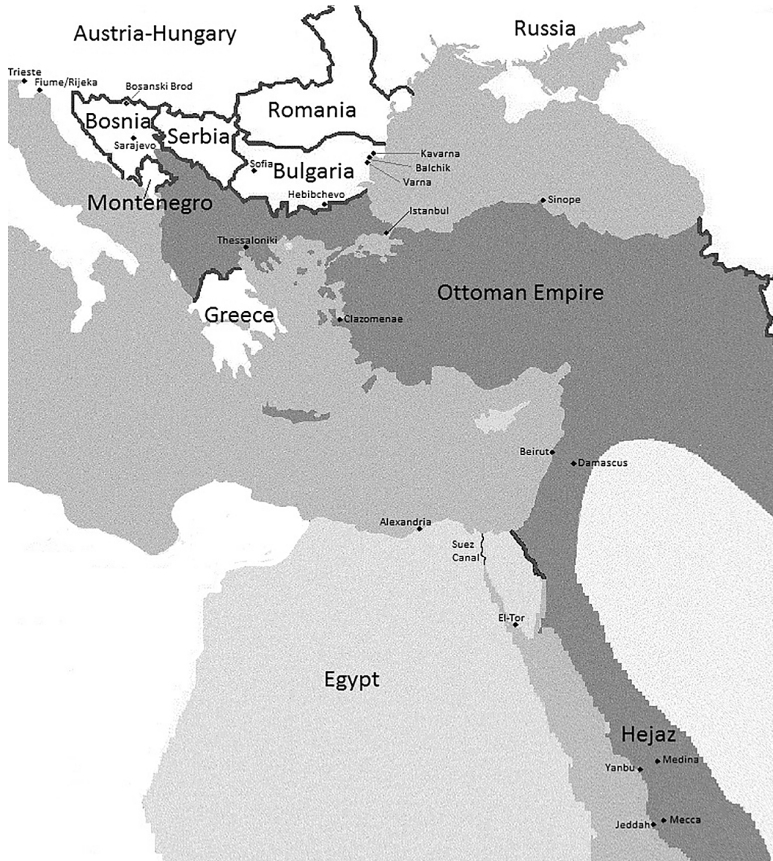


Figure 6.1 The Balkans and the Near East at the turn of the twentieth century.

stations of El Tor and Alexandria became the most important check-points for Ottoman and North African pilgrims. After a renewed outbreak of cholera in the Hejaz in 1890, European governments perceived the *hajjis* as an ever-greater threat to their countries. At the ISCs of Venice in 1892, Dresden in 1893, Paris in 1894 and Venice again in 1897, the ‘Concert of Europe’ agreed on a package of anti-epidemic measures (medical inspection, disinfection, quarantine, treatment of

the diseased and deceased) to be applied to the *hajjis*.¹⁶ The European powers dispatched permanent sanitary delegates to the Red Sea port of Jeddah, on the Hejaz coast, which was the principal gateway for pilgrims. On their return trip, the usual treatment for Ottoman and North African pilgrims in 1902 foresaw fifteen days of quarantine in El Tor under supervision of the Egyptian sanitary authorities, and thereafter five additional days of quarantine under Ottoman supervision – either in Beirut, in Lebanese Tripoli or in Clazomenae on the western coast of Anatolia. Those who did not return by sea, but joined the Holy Caravan on its way back through the Syrian Desert, had to undergo quarantine before passing the gates of Damascus.¹⁷ But this was not the entire story. Returning Balkan pilgrims could expect further sanitary treatment in Bulgaria, Serbia and Bosnia itself, depending on where they came from and which itineraries they chose – whether travelling by train through the Balkan states or by ship to Trieste or Fiume/Rijeka for the Bosnian pilgrims or by ship to the Black Sea port of Varna for the Bulgarian *hajjis*. We will now proceed to examine in some detail the local measures applied to Muslim pilgrims departing from or returning to Bosnia-Herzegovina and Bulgaria.

The control of the Muslim pilgrimage from Bosnia-Herzegovina since 1878

Thanks to a short but remarkable article written by two Bosnian authors, Sreten Bošković and Ajša Smailbegović, we have precise information about the Muslim pilgrims from Bosnia during the period under study.¹⁸ Their annual number was officially between 50 and 130 persons who, by and large, opted for the railway overland route to Constantinople with only a small fraction taking the ships of the Austrian Lloyd at Trieste or Fiume. The Austro-Hungarian authorities were rather concerned about the possibility of Arab agitators coming to Bosnia for encouraging participation in the *Hajj*, or returning Bosnian *hajjis* importing plague or cholera. Over the course of the fifth cholera pandemic, which hit the Arabian Peninsula and Mecca in 1881–82, the Bosnian local government resolved that Bosnian Muslims should only leave for the *Hajj* with special passports and only in groups. Beginning in 1890, the local government designated a formal leader (*Reis-ul Hudžadž*) for every pilgrim party. This leader would be an authoritative person with good

knowledge of the religious rituals, able to supervise the health of the pilgrims and, on their return, to report on the health risks that they had encountered. In the same year, the Austro-Hungarian authorities signed an agreement with the Austrian Lloyd regarding the transport of Bosnian *hajjis* to the Hejaz.¹⁹

Bošković and Smailbegović have calculated that the average death rate among Bosnian *hajjis* in the last two decades of the nineteenth century ranged between 30 and 40%. They point out, however, that cholera was not the only cause of death while travelling. Many pilgrims were middle-aged or older and suffered from previous chronic or geriatric diseases and simply succumbed during the troublesome passage on ships and the aforementioned inhospitable caravans through the Arabian desert. Dysentery (the so-called *hajjis'* diarrhoea) and heat stroke also claimed their share. Naturally, such diseases made the older pilgrims more susceptible to attacks of cholera.²⁰ In 1890, out of 104 Bosnian *hajjis* only 63 would return to their home country. That time it was definitely the cholera epidemic in the Hejaz region which was responsible for the loss of life. Egyptian (i.e. British) medical authorities were on high alert. On their return, aboard an Austrian Lloyd vessel, the *hajjis* had to stop at the quarantine camp on the Sinai Peninsula in El Tor. They were medically inspected, their luggage was disinfected and they had to stay in quarantine for twenty days. On their way through the Suez Canal their ship was not allowed to come ashore at any Egyptian port. Because some of the *hajjis* were from Anatolia, the ship disembarked in Smyrna. There – on order of the International Sanitary Board of Constantinople – the Bosnian *hajjis* again had to undergo medical inspection and their luggage was disinfected once more. From Smyrna the ship took its passage to the Austrian port of Trieste. In the Hospital of St Bartholomew the *hajjis* were again, for the third time, put under quarantine – this time the procedure would last seven days. Over this entire trip starting from the Arabian port of Jeddah, about twenty-eight pilgrims died.²¹

The following year, cholera was again rampant in the Hejaz. This time the Bosnian Government sent a doctor to escort the pilgrims on their return from Jeddah. Unfortunately, Dr Julije Macanec succumbed to typhus upon his arrival there, so the Bosnian authorities had to dispatch another physician, Justin Karlinski, the district doctor from Konjic, a town located 50 km southwest of Sarajevo. In total, there were thirty-six

fatalities among the Bosnian *hajjis* in 1891, which accounted for a mortality rate of 35.3%.²² From that moment, the Bosnian Government would always dispatch a medical doctor with the departing *hajjis*. In 1892, the mortality rate sank to 'only' 9.5%, but it jolted up to 49% the following year, when a new wave of cholera reached the Hejaz region. In 1894, the death rate again decreased to 13.2%, and in 1895 – due to a new invasion in the Hejaz – it again reached 35.5%. In 1896, a massive cholera epidemic that was raging in Egypt led the Bosnian Government and the international sanitary authorities to dissuade prospective pilgrims from the journey. Among the few people who nonetheless went on the *Hajj* (seventy-four men) the mortality rate was relatively low (16.2%); the reason for this being that the Hejaz region was not affected by the Egyptian outbreak.²³

To make matters worse, 1897 saw the third pandemic of bubonic plague spreading out from India – where it had arrived from its original 1893 foci in China. Fears arose that the plague would be communicated to Europe via the returning *hajjis*. Consequently, the ISC held that year in Venice passed several regulations which foresaw intensified anti-epidemic measures at the quarantine stations of El Tor, Beirut and Clazomenae. Like France and Russia did with their colonial and state Muslim populations respectively, the Bosnian Government forbade its citizens to go on the *Hajj*. This resolution was also supported by the local Muslim authorities but, as a matter of fact, several hundred males who realised that it was impossible to obtain the special '*Hajj* passports', went to other countries and took Ottoman passports before travelling on to Mecca. More than 500 people evaded control in this manner. The Bosnian Government threatened them with prohibiting their return home and burning their personal belongings should plague be discovered. However, the Austro-Hungarian authorities finally complied with the wish of the pilgrims and sent a doctor to join the travellers who had left the country without formal organisation. Since there were cases of plague in the Hejaz, these pilgrims had to undergo twenty-one days of quarantine in Constantinople upon their return and suffer several hardships by the national sanitary authorities of Bulgaria and Serbia when they took the overland route home. Despite such dangerous circumstances, the mortality rate was only about 7%.²⁴

In 1898 and 1899, the epidemiological situation in the Hejaz region was still considered to be dangerous. In compliance with international

regulations, the Bosnian Government forbade the *Hajj* once again, but eventually had to give in, and even organised group travels with a leader and medical doctor.²⁵ During the spring of 1898, many pilgrims had again made their way to the Hejaz outside of the officially organised travel group, forcing the Bosnian authorities to warn the neighbouring provinces of the Habsburg Empire – Croatia and Dalmatia – not to allow the passage of returning Muslim pilgrims through their territories so long as they were not in possession of official documents issued by the Bosnian provincial government. In the event of infection, they had to undergo a quarantine of seven days with their luggage and clothing being disinfected.²⁶ The same harsh measures were repeated in 1899.²⁷ In 1900, the situation in Hejaz improved, such that the official restriction of the *Hajj* could be suspended. The mortality rate among Bosnian *hajjis* sank to about 2%.²⁸ The following year sanitary facilities and protective measures along the Bosnian border underwent a revision owing to the large number of returning *hajjis*. In the town of Bosanski Brod, located on the northern frontier, where the *hajjis* who had taken the overland route from Constantinople arrived, a new quarantine station was erected. In addition to a medical inspection and the disinfection of the pilgrims and their luggage, the head physician also carried out bacteriological tests. After their return home, the pilgrims were kept under observation for at least ten days. The only other option for *hajjis* re-entering the territory legally (and in possession of a special permit) from Ottoman territory was through the Montenegro–Bosnia border crossing of Metaljka, but here too they had to undergo the same treatment as in Bosanski Brod.²⁹ Additionally, Arabian agitators for the *Hajj* were placed under severe sanitary control, as were those *hajjis* who had not travelled with the official tour groups.³⁰

The regulation of 1901 was still in force in 1910. However, after the opening of the Hejaz railway from Medina to Damascus in 1908, many pilgrims chose to return in small groups or even individually by train instead of joining the common group of the *Reis-ul Hudžadž* and contending with the quarantine of El Tor. Austro-Hungarian experts on the region – geographers and diplomats – considered the Hejaz railway a possible sanitary threat, since pilgrims who used it could easily evade Ottoman quarantines.³¹ In the interim, Russia had joined India as a second permanent centre of cholera, a significant circumstance since

the recently completed Trans-Caspian railway could transport pilgrims from Central Asia and China to the Black Sea within five to six days. Already, in 1908, pilgrims from the Caucasus had introduced cholera to the holy sites of Islam, and two years later Russian steamboats transported diseased pilgrims who had caught the epidemic in Sinope (on the Anatolian shore of the Black Sea).³² In the aftermath, Bosnian sanitary authorities instructed the border guards of the province to make sure that all returning *hajjis* produced a certificate that they had undergone sanitary treatment in Bosanski Brod, in default of which they were not permitted entry and had to be immediately sent to the quarantine station of this town.³³ This was only the final wall of protection. At the twelfth ISC of Paris in early 1912 the Austro-Hungarian delegate – who had been medical chief of the provincial government of Bosnia-Herzegovina since 1901 – praised the efforts to put either the passengers of pilgrim ships arriving from the north (i.e. from Russia) under quarantine in El Tor or to erect a separate new quarantine station for them along the northern coast of the Red Sea, as the Ottoman sanitary authorities had promised to do.³⁴ In actuality, the Balkan Wars and the ensuing outbreak of the First World War ultimately prevented any such plans from being implemented.

Bulgaria and the issue of Muslim pilgrims

The Muslim population remaining in Bulgaria – those who had not taken flight during the Russo-Turkish War of 1877–78 or subsequently immigrated to the Ottoman Empire – consisted predominantly of Turks. They were met with reserve, and in Bulgarian eyes they bore the stigma of being part of the increasingly odious Ottoman legacy. With regard to the *Hajj*, apart from these native Muslim Turks, the Bulgarian authorities also had to deal with Bosnian Muslims who took the transit route from Constantinople to Bosnia on the transversal Balkan railway completed by the early 1880s – which later became famous as part of the so-called ‘Orient Express’. We should add that until 1908 Bulgaria remained a tributary state of the Ottoman Empire and that as a consequence the system of quarantines operated according to Ottoman regulations. Hence, the Supreme International Sanitary Board of Constantinople could theoretically outline the quarantine policies of the Bulgarian principality. Nevertheless, this prerogative left ample room

for its Bulgarian interpreters, leading to permanent conflicts between the sanitary institutions of the Ottoman Empire and Bulgaria. The first incident occurred in late March 1882 when the Bulgarian authorities of the port of Varna detected several cases of cholera among the disembarked pilgrims who were returning from the *Hajj*. They ordered that a military cordon encompass the lazaretto of Varna, but the International Sanitary Board of Constantinople denied the occurrence of cholera, while further contradictory news about the incident was received. In order to assess the state of affairs, the representatives of the European powers dispatched a medical commission to Varna.³⁵ By early May it was an official fact that twelve pilgrims on board the steamer *Aurora* which had arrived from Constantinople had been struck by cholera, five of them subsequently succumbing to the disease. The chief physician of Sofia, the Bulgarian capital, who had also declared that the epidemic was Asian cholera, ordered the luggage of pilgrims (which allegedly spread loathsome odours) to be burnt. The authorities prohibited Muslims who returned from the Hejaz from entering Bulgaria by land. All pilgrims arriving by sea had to undergo a fortnight of quarantine in the lazaretto of Varna as well as in those of the nearby ports of Balchik and Kavarna.³⁶

This initial episode would have longlasting and severe consequences for the further treatment of Muslim pilgrims in Bulgaria. From here on the Bulgarian sanitary authorities would resort on several occasions to intensive radical disinfection measures and, with respect to pilgrims entering the country by land, to excessive use of terrestrial quarantines. The latter measure would receive public criticism during the eighth ISC of 1893 in Dresden, which formalised the system of medical inspection that Peter Baldwin has called neoquarantinist. According to this system, the achievements of bacteriology would allow replacement of quarantine measures with regular medical inspection of suspect persons at their homes.³⁷ However, such a procedure was not perceived as adequate by 'Oriental' countries, where quarantine measures against Muslim pilgrims had been intensified. Baldwin argues on good grounds that:

the attempt to loosen quarantinist measures in the West, to shift from old-fashioned precautions to the revision system and more generally to neoquarantinism, depended in large part on Europe's ability to impose more drastic regulations on the Orient than it was – increasingly – willing to tolerate at home.³⁸

There was no Bulgarian delegate present at the Dresden conference, but the ample use of terrestrial quarantines by Bulgaria was for the first time criticised by the Romanian delegate in that meeting. His objection was not made out of sympathy with the fate of Muslim pilgrims, however, but rather owed to demands for freer traffic and navigation along the Danube, which were being hampered by Bulgarian quarantines.³⁹ The Serbian delegate paid lip service to the general condemnation of terrestrial quarantines. He reminded the conference delegates that both Turkey and Bulgaria maintained an excessive system of quarantines. Therefore, as long as its two nearest neighbours did not change their strategy, Serbia felt likewise compelled to retain terrestrial quarantines.⁴⁰ This conduct may have arisen from the fact that the Muslim pilgrims from Bosnia had to cross Serbia on their way back home.

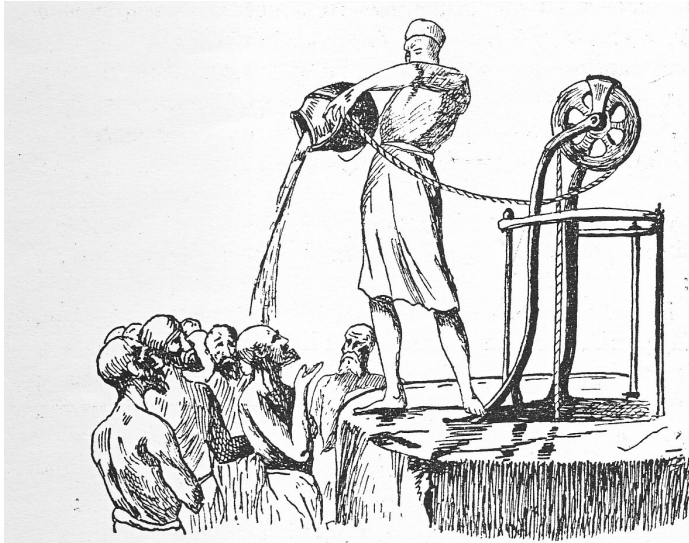
One year later, the Austro-Hungarian delegate at the first ISC in Paris mentioned the hardships of the Bosnian pilgrims on their return through the Balkans. In 1893, with cholera raging in the Hejaz region, they had become victims of harsh treatment from the Bulgarian and Serbian authorities. Quarantines in these two countries – certainly not the first ones endured by the *hajjis* on their long way back home – lasted about five and three days respectively. Although not lengthy, the fact that accommodation of the pilgrims during these interludes was not provided for, together with disinfection measures allegedly involving the dousing of travellers in acrid phenol, made the experience quite trying.⁴¹ With that denunciation Austria-Hungary wanted to trigger Bulgaria's and Serbia's compliance with Western countries in a shared refusal of quarantinist measures in their territories, since Muslim pilgrims were previously subjected to them in El Tor, Alexandria, Beirut and Smyrna. In the Austro-Hungarian conception of geo-epidemiology, Serbia and Bulgaria were therefore expected to comply with the West and to renounce harsh preventive measures which fettered them to 'the Orient', because in terms of hygienic standards they were considered as states which had already passed the test of being part of 'the Occident'. Ironically, it was the Austrian rejection of Muslims as reminders of a painful and despised Ottoman past that induced those two countries to continue with old-fashioned quarantinism.

The official Bulgarian point of view would be finally presented at the tenth ISC in Venice in 1897, when the issue of plague entered the agenda. For the first time a Bulgarian delegate, the medical doctor

Marin Rusev (1864–1935), one of the most avid promoters of public health in that country, was appointed. Rusev made clear that his position with respect to the maintenance of terrestrial quarantines by his country was not up for negotiation, and this applied particularly to Muslim pilgrims for whom the revision system – medical inspection of suspect persons at their places of residence – was impracticable:

We have 800,000 Muslims among us, many of whom will make the pilgrimage each year. Pilgrims from Bulgaria, like those of European Turkey, usually arrive at Jeddah, the port of Mecca, and in this port and on their way to Mecca they meet pilgrims from Bombay, i.e. from the contaminated regions. In this way, they can bring us the plague, as they did more than once with regard to other diseases, such as cholera. And I must add that in our country the Muslims live in villages far from the doctors who could monitor their health after their return from Mecca.⁴²

Rusev declared that his government would continue to follow the suggestions of the Supreme International Sanitary Board of the Ottoman Empire with respect to sanitary measures to be taken in view of the pilgrimage, as long as the conference did not decide otherwise. But he also left no doubt that the Bulgarian Government would prefer a total ban or at least a restriction of the pilgrimage to Mecca.⁴³ He explained his strong support for the ample use of quarantines together with the mandatory and rigorous application of disinfection through the fact that Bulgaria had remained free of cholera in 1892–93, while the surrounding countries had become infected.⁴⁴ The Venice conference nonetheless passed a convention with regard to land borders, railway traffic and travellers which once more condemned the use of terrestrial quarantines. Rusev succeeded, however, in having an ambiguous clause incorporated which allowed the backdoor use of quarantines.⁴⁵ Consequently, when Bosnian Muslims returned from that year's *Hajj*, they were subjected to a severe quarantine of twenty-four hours and a disinfection of their luggage at Hebibchevo (today Lyubemets), on the Bulgarian border with the Ottoman Empire. On their way through Serbia, they were sent back to the Serbo–Bulgarian border crossing at Tsaribrod (today Dimitrovgrad) where they had to undergo another twenty-four hour quarantine before their transit through Serbia was allowed. And finally, as already mentioned, at the border crossing of Bosanski Brod they had to pass a final medical inspection with their luggage being disinfected once again (Figures 6.2 and 6.3).⁴⁶



Фиг. VI.

Земземовски поливания отъ „Земземовския кладенецъ“ при мусулманский пелеринажъ.

Figure 6.2 Muslim pilgrims experiencing the pouring of water from the Zamzam well.

In February 1903, Marin Rusev became head of the Bulgarian public health administration during a fluid and unstable period created by the presence of cholera and plague in the Red Sea region. As was already the case during the tenth ISC of 1897, Rusev remained categorical about quarantine and only one month after his promotion he tightened the regulations for the *hajjis*:

- 1) Mohammedans who depart for pilgrimage, on their return to Bulgaria, are allowed to enter only through [the ports of] Burgas, Varna, and [the terrestrial border crossing of] Hebibchevo; all other checkpoints are closed for them; 2) Mohammedan *hajjis* are only allowed to re-enter after strong medical examination and disinfection of their luggage and all their belongings, including [holy] water from the Zamzam Well [in Mecca]; for this end they are put under quarantine as long as is necessary to execute examination and disinfection; 3) Trains from Turkey carrying



Figure 6.3 A typical Muslim pilgrim from Bulgaria with usual luggage.

Mohammedan *hajjis* have to stop at the quarantine of Hebibchevo in order to drop the *hajjis* and their luggage; 4) Bosnian *hajjis* are only allowed when in transit, that is, they are not allowed to leave the train or to communicate in any way with the local population of the railway stations from which the train passes on its way through Bulgaria.⁴⁷

And what is more, these measures were retained even after the plague in Egypt was officially brought under control, at least for the time being.⁴⁸ Consequently, during the eleventh ISC held some months later in Paris, the Ottoman Empire, Bulgaria and Greece were criticised by the Austro-Hungarian delegate for forming part of that block of countries – now already in a clear minority – which still upheld the principle of quarantine thereby obstructing ‘commercial transactions in the East.’⁴⁹ During the following years, the Bulgarian sanitary authorities somewhat eased their hitherto restrictive policy. In 1909, the Bulgarian ‘Provisional Instructions for the Coastal Sanitary Service in Times of Cholera Risk’ were enacted, taking a step toward the acceptance of the

1903 Paris ISC in questions such as the ample use of disinfection, though they still clung to the observation period of classical quarantine. Among the native *hajjis*, those who had not passed the quarantine in El Tor because they had used the Hejaz railway were treated with the utmost caution and had to undergo quarantine.⁵⁰

Conclusions

This chapter has tried to show that the issue of Muslim pilgrims from the Balkans as possible vectors of cholera (and also of plague) came into the foreground only after the Congress of Berlin in 1878. Hitherto, it had not played any particular role in the general debates about how to protect Europe against 'Oriental' epidemics. This is surprising, because with the opening of the lower course of the Danube for international trade after the Crimean War, the protective character of the sanitary cordon at the Habsburg Military Frontier with the Ottoman Empire had been lost, and it was consequently abolished.⁵¹ Only after Austria-Hungary began to administer the Ottoman province of Bosnia-Herzegovina in 1878 did the issue of medical control of Bosnian *hajjis* enter the agenda. Over the ensuing years, the newly founded principality of Bulgaria began to focus on its own *hajjis* as well as on Bosnian Muslim pilgrims crossing the country on their return home. At the time, Bulgaria was the only other region in the Balkans no longer under direct Ottoman control which nevertheless had a considerable Muslim population, if we leave aside the then small Muslim minorities of Montenegro (within its pre-1913 borders) and of the Romanian Dobruja. Serbia was in this period largely homogeneous from an ethnic-national point of view, a situation that would change after it took hold of the regions of Kosovo, Sandžak and Macedonia – with their considerable Muslim populations – after the Balkan Wars of 1912–13.

The treatment of Muslim pilgrims by the multi-ethnic and 'universal' Dual Monarchy and the 'parochial' Bulgarian nation-state seems to be different at first glance, though in practice it was very similar. The Austro-Hungarian authorities dealt with the Muslim pilgrims in an apparently benevolent way. They desired to win over a population which to a great extent still adhered to the social and political conventions of the pre-1878 order. This 'benevolence' had a patronising overtone, however. Epidemic control was introduced by organising pilgrimages

under a leader and on a group basis. Control was further exerted by a medical doctor who accompanied the group on its return and by rigid measures of medical inspection, disinfection and quarantine, if advisable, on the return of the *hajjis*. As already said, it is still questionable whether these measures were experienced by all of the Bosnian *hajjis*, since there were always many who preferred to travel on their own. At the International Sanitary Conferences, Austria-Hungary advocated neoquarantinism and condemned the Bulgarian and Serbian adherence to old quarantinism, but at home – in the Bosnian quarantine facilities – it behaved not so differently from those countries. The ideological background underpinning this conduct shown by the Dual Monarchy – regardless of the reasonableness of the applied anti-epidemic measures – was one embedded in a sense of superiority of a Central European civilisation against the allegedly backward and fanatic Muslim population of Bosnia and Herzegovina. The reasons for Bulgaria's prolonged preservation of old quarantinism, enriched by the application of rigid disinfection are, in turn, manifold and not absolutely consistent. They were in part linked to Bulgarian dependence on Ottoman strategies with respect to the sanitary supervision of travellers and commodities, partly of a geo-epidemiological nature and finally attributable to an anti-Muslim attitude which was inscribed – as is the case of Serbian nationalism – in the Bulgarian national code (*Nationscode* in German). Bulgarian nationalism needed the local Muslims as a negative discursive figure which reminded of the perpetually reiterated oppression of the Bulgarian nation during the Ottoman period.⁵² The Bulgarian case is only another example of how public health is always prone to serve an exclusive national cause.

It would be useful to discuss whether the case of the Balkan *hajjis* forms a variant of 'medical Orientalism', i.e. a specific attitude of containment of the Muslim world by the use of Western medicine. In this chapter, we have sought to demonstrate how practical measures reflected doctrinal changes with respect to the nature of cholera – namely the connection between contagionism and quarantines, miasma theory and the rejection of quarantines, bacteriology and neoquarantinism. The essence of 'medical Orientalism' was unequal power relations which are expressed in the fact that the old and rigid system of quarantine in the Orient was the precondition for the mild variant of neoquarantinism in Europe and therewith facilitated the prosperity of

capitalist trade. But still, these theoretical combinations, put to practice, allowed for a degree of flexibility, this 'space' being subsequently used, for example, by the Austro-Hungarian authorities in an ambiguous way which could be described as 'nesting Orientalism'⁵³ in order to combine official neoquarantinism with tacit quarantinism at home. The Bulgarian case was much less complex, as authorities did not try to hide their intentions to subject native and Bosnian Muslim pilgrims to various hardships. But both examples show that the containment of Muslim pilgrims was not purely a sanitary/medical matter, but was also influenced by processes of cultural and political stigmatisation. In any case, the suspension of maritime traffic caused by the First World War in the Eastern Mediterranean, and the deep geo-political changes brought about by the conflict, relocated the nexus between the Muslim pilgrimage from the Balkans and the dissemination, not only of plague and cholera, but also of other epidemic diseases like typhus and smallpox, in a new context which falls outside the scope of this chapter.

Notes

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