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III
Power



Quarantine, sanitisation, colonialism and the construction of the 'contagious Arab' in the Mediterranean, 1830s–1900

John Chircop

Introduction

This chapter seeks to investigate quarantines – their set-up and sanitisation procedures – much as others have discussed other medical/hygienist institutions, in terms of their links with contemporary structures of power, mainly in connection with Western European colonial expansion in the southern and eastern littoral of the Mediterranean during the nineteenth century. As the growing volume of literature on the comparative history of colonial medicine demonstrates, Western biomedicine and sanitation were employed as 'tools of Empire' – to use Daniel Headrick's phrase¹ – as instruments to 'civilize' and control the 'indigenous body'.² Thus, it is increasingly being argued that the export of Western medicine and hygienist ventures – scientific discourse, practices – and hence the establishment of quarantine systems on the lazaretto model, was intimately embedded in and went hand in hand with informal colonial penetration and direct imperial acquisitions³ of non-European lands, in the process corroborating Western European assertions of cultural–scientific superiority over 'native peoples'.⁴

Attentive to new insights emerging from recent literature, and engaging with the theoretical debates, this chapter focuses on the transfer of Western medical/hygienist theories and the related sanitary instruments and practices – in this case the quarantine lazaretto system – to various city ports in North Africa and the eastern Mediterranean during the nineteenth century. It consequently seeks to make evident the

extent to which the conveyance of this Western sanitary technology and set of practices – presented to the local populations as beneficial instruments of modernity – facilitated colonial incursions in the political economies of these countries, most of which – apart from Morocco – were under Ottoman rule. In order to explore such issues, I shall focus on the several sanitary councils (also known as quarantine boards) created in the main regional ports. Although a thoroughly researched study still needs to be undertaken, this chapter uses the literature available to explore these sanitary councils as spaces of negotiation facilitating the transfer of contemporary epidemiological and medical knowledge – and the role they played in the construction of lazaretto establishments.

These sanitary councils have not received much scholarly attention in the historical literature, yet they were the earliest permanent sites of discussion on international sanitation – made up of resident European consuls, doctors and sanitary advisors in conversation with native physicians, public health and local state functionaries – and they preceded the first 1851 ISC by several years. By contrast, the history of the eleven ISCs until 1903 – also the subject of this chapter – has been dealt with by quite a number of scholars. Most studies shed light on the influence which these ISCs had on the shaping of interstate public health diplomacy⁵ and how it came to exacerbate the ‘South–North health divide.’⁶ Other established scholarly works, such as Peter Baldwin’s study of contagion and the state in Europe, make use of the ISC records to illustrate the strategies adopted by the modern European states to prevent the spread of epidemics as well as to investigate the intricate social and political consequences that these left on the evolution of their public health infrastructures.⁷ For the purpose of this chapter, this historical literature helps to provide the wider contexts in which each ISC was convened, assisting in our understanding of the complex interests involved in the European countries’ design and operation of the network of lazarettos in the Mediterranean and beyond.

By the time that the first ISC was convened, Western European trade, political hegemony and colonial projects were being bolstered by technological advances in transport and communication technology. Inducing an unprecedented acceleration in movement, they simultaneously spurred the rapid diffusion of epidemics by accelerating the transmission of disease from one regional corner to another and between

continents, as happened with cholera in 1831–32. By exploring this wider context, and particularly indicating the various geo-strategic and colonial interests of the European powers in the Mediterranean region and how these were reflected in the proceedings of the ISCs, we can approach the operations of the lazarettos from a different perspective. This allows us to put at the centre of analysis the experiences of 'Arab' peoples themselves – often the focus of hygienist strategies including the lazarettos. By investigating the institutional architecture of these quarantine-lazarettos,⁸ this study seeks to show their double role as preventive public health institutions but also, and more intriguingly, as devices for social control and colonisation. Focusing on specific quarantine practices – especially the disinfection of the body – which came to be rigorously conducted in these lazarettos, will make more visible the ways and the extent to which 'Muslim-Arabs', as local residents or/and as *hajjis* (pilgrims), were restrained, disinfected and put under surveillance: procedures which were also employed to reconstruct and publicly legitimise in contemporary discourse the stereotype⁹ of the 'Muslim-Arab' as 'threatening 'contagious bodies' – these being essential features of the colonising process then underway.

Contraction of time and space: situating the International Sanitary Conferences

The first ISC was convened in Paris in 1851, at a time of rapid innovation in transport and communication technology – steamships, railways and the laying of the cable telegraph – which brought about an unprecedented shrinking of time and space. Intensification of speed was harnessed and used¹⁰ by the European industrial powers, starting with Britain and France, to assist their colonial penetration of North Africa and the eastern Ottoman domains, which would eventually lead to their formal imperial acquisition.¹¹ This ushered in an era marked by velocity in human mobility, travel and exchange, by greater geographical interconnectivity¹² through which the various zones of the Mediterranean came to be incorporated in the emerging world economy.¹³

The complementary transition made from sail to steamships radically shortened travel time; for instance, the journey from Marseilles to Constantinople was reduced from six weeks to six days.¹⁴ European steamships came to override traditional shipping routes, multiplying

their interport linkages, criss-crossing from the west to the east of the region and beyond.¹⁵ Actually, by 1846, British and French steamships had already forged direct and faster connections with the Black Sea and the Caspian Sea.¹⁶ Subsequently, the opening of the Suez Canal in 1869 radically cut travel time further and condensed the spatial expanses between Europe, the East and India. The voyages from London to Bombay around the Cape of Good Hope, which covered 10,667 nautical miles, and to Hong Kong which travelled a distance of 13,180 nautical miles, were now being made across the Mediterranean and via the Suez Canal, cutting the nautical mileage to 6,274 and 9,799 miles respectively.¹⁷ This continued to raise the volume of shipping and intensify the magnitude of human movement in all its forms:¹⁸ from mass migration, particularly from southern Europe to the Maghreb and the Levant, to the rapid deployment of colonial troops to all corners of the region, to the numbers of Muslim pilgrims – markedly from British India – on their journey to Mecca.¹⁹

The increased speed of transport not only intensified human mobility and physical contact, it also accelerated the recurrence and transmission of contagious diseases within the region and from one continent to another.²⁰ Devastating epidemics – not least the plague – had of course been experienced before the nineteenth century,²¹ but the speed and ferocity by which plague and, after 1831, cholera were now spreading caught European states unprepared, unable to effectively deal with and prevent them crossing their national frontiers. In the case of cholera, its spread was helped by the growth and speed of technologically-driven commerce, travel and colonial expansion, and the emergence of the ideology and practice of 'free trade'. Up until then, cholera had spread from India into Asia during the 1820s – coming to be known as the first cholera pandemic – but in 1831–32 the disease dispersed²² in tentacle fashion, via the major travel routes on land, waterways and seas, passing through Russia and thence penetrating Europe, reaching Paris and London in 1832. Leaving a high mortality rate in its trail,²³ this epidemic raised alarm in the European states, creating a general sense of anxiety in their populations.

With the intention of discussing sanitary arrangements and of harmonising quarantine practices in the Mediterranean, the French Government in 1834 tried to convene an international conference, but without success.²⁴ Subsequently, cholera erupted time and again in

epidemic waves, savaging Europe in 1848–49 (and then in 1854 and in the mid 1860s), following which the French Government, fretful about the vulnerability of its extensive national borders on the Mediterranean Sea to such diseases – made worse by its direct colonial contacts with Algeria – once again took the initiative to organise an International Sanitary Conference which this time was successfully convened in 1851.²⁵ Austria-Hungary, Great Britain, Spain, Portugal, Russia as well as Greece, Sardinia and Tuscany, the Papal states, the Kingdom of the Two Sicilies and the Ottoman Porte, besides France, sent delegates to Paris – from 23 July 1851 to 19 January 1852²⁶ – for the first international sanitary gathering, which put as its main objective the creation of an interstate mechanism to fight the increasingly rapid transmission of infectious disease²⁷ before it reached the European borders. European delegates sought to achieve this goal without giving away any of their shipping and commercial advantages or impeding their governments' expansionary designs in the Mediterranean.

However, for these envoys, both diplomats and doctors, the ultimate task of this conference was rendered difficult by the fact that in 1851, as J. Sheldon Watts argues, 'the old-style understanding of cholera was rendered obsolete',²⁸ as contagionism was being challenged by new miasmal–environmentalist theories, as discussed below. This meant that even though European representatives presented themselves as delegates of the most 'scientifically advanced' and 'civilised' countries, they could not but utter ambiguities, if not acknowledge outright ignorance, regarding the real causes and nature of cholera. In practical terms, they were unsure of how to effectively prevent any outbreaks or abate the accelerated spread of such trans-border pandemics. Moreover, as time passed, deepening conflicts among European nations made negotiations in the ISCs even more convoluted. As from the third ISC of 1866 in Constantinople, which was summoned against mounting rivalry between the European powers for control of the Mediterranean and particularly the Ottoman territories,²⁹ it became increasingly difficult for delegates to find common positions on various trans-border sanitary issues. The ensuing ISCs saw the European delegations expressing their different quarantine–sanitary views more firmly. The southern Europeans, who usually shared a pro-quarantine position, came under attack from the British representatives for both failing to thwart the spread of epidemics by their restrictive measures, and creating

difficulties for commerce and travel.³⁰ Many of these incompatible positions reflected changing European geo-political concerns in the region, which need to be made clear.

Geo-politics of quarantine: the Mediterranean turned
'passageway' – laboratory

What comes out clearly from the proceedings of most of the ISCs³¹ was that the Mediterranean came to be represented as a fluid carrier of contagious disease, and that this representation was framed in part by another representation of it as a geo-strategic corridor (see Figure 8.1).³² This means that a Western geo-political view emerged which encapsulated and reproduced deeply entrenched conceptions of the eastern and North African – mostly Ottoman-ruled – lands as disease-ridden and unhygienic, which were a dangerous source of contagious disease that threatened the rest of the Mediterranean and Europe.³³ Certainly the common representation of Egypt as a plague-nurturing terrain³⁴ and as a principal gateway of cholera from India fell within this Eurocentric view. Supported by an expanding volume of scientific knowledge gathered by European consuls, doctors and hygienists resident in the regional city ports, this geo-strategic perspective came to infuse the diplomatic sanitary discourse of the post-1866 ISCs and especially that of 1885 in Rome.³⁵ The last was convened as a result of the shocking death rate and social havoc caused by the 1883–87 cholera pandemic, which claimed some 20,000 lives in Spain alone in 1885, and sought to reach an agreement to strengthen the quarantine system by standardising regulations and practices of all lazarettos along the shores of the Mediterranean, the Suez Canal and the Red Sea, in direct communication with the Orient.

Coming around three years after the British acquisition of Egypt, the Rome conference, which was called by two of Britain's rival colonial powers – France and Germany – was marked by a concerted attack against the former for 'not taking seriously' its international obligations to tighten the quarantine system on the route from India to the Suez Canal and Egypt.³⁶ Such harsh criticism and antagonistic proceedings were these which, although delivered in the latest medico-hygienist parlance, were partly, indeed substantially, prompted by their aggressive rivalry over the Suez Canal area. In any case, similar geo-strategically

motivated controversies between British envoys and other European delegates, especially the French, did direct the attention of the ISC onto the Suez Canal as a shortcut which was accelerating the diffusion of 'Asiatic Cholera' into Europe (Figure 8.1). Hence the twenty-eight delegates attending the 1885 sanitary conference in Rome decided to appoint an independent sanitary board to regulate and oversee the quarantine procedures operated on all maritime vessels passing through the Suez Canal.³⁷ A similar sanitary board had been proposed by the French in the 1866 conference, but the British had opposed it. Now that they came to control Egypt, the British approved of such an initiative.

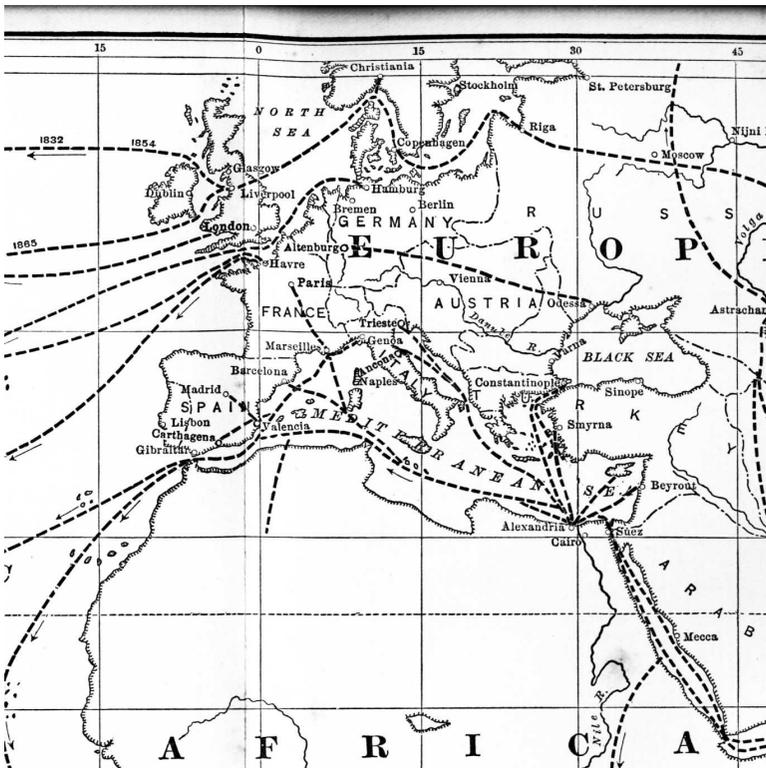


Figure 8.1 Chart of the Mediterranean as a main 'corridor' for the diffusion of cholera.

As a result, this zone came to be described as 'high risk' due to its direct links with the 'Orient', especially with the Hejaz and India that came to be marked red in the geo-epidemiological configuration of the world.³⁸

The differences of opinion and positions taken on issues of quarantine among the European delegates at the ISCs were in various shades and measures articulated in two major medical theories – the microbial–contagionist and the miasmatic–environmentalist – which tended to divide the European medical body at the time.³⁹ On the one hand, the old contagionist medical school held the idea that cholera, like plague, and yellow fever were transmitted through physical contact with already infected human beings, animals and contaminated objects. In this view, the only instrument known to obstruct the spread of such contagious disease was quarantine – the physical segregation or spatial isolation of travellers, the fumigation of their clothes, personal belongings and merchandise – in maritime lazarettos and/or *cordon sanitaires* located on transit routes and access points on land.⁴⁰

Contagionism as a medical philosophy was largely shared by the delegates of the southern European countries⁴¹ – the Italian states, Greece and Spain, as well as Portugal. These, except for the latter, were all Mediterranean riparian states with extensive shipping interests and dense commercial networking with the Ottoman domains.⁴² Experiencing rising vulnerability to rapidly transmitted disease, especially cholera, they favoured the maintenance of their quarantine institutions – in various degrees – as either inevitable or as a 'necessary evil'. Most of them pushed for the standardisation of quarantine regulations while trying to balance this with the least possible encumbrance on their shipping and travel activities. At a domestic level, the governments also feared that outbreaks of epidemics could instigate outbursts of popular rebellion,⁴³ and were therefore determined to maintain quarantine to keep disease out of their borders, to serve as a means of social control and to maintain public order. Quarantine stations and procedures also marked the crossing of a country's national frontiers and therefore helped to promote a collective feeling of national security. Hence it was feared that any act which could be perceived as intended to demolish lazarettos or quarantine stations could trigger social panic from sectors of the population and fuel political opposition.⁴⁴ This despite the fact that on numerous occasions it was quarantine itself – especially the cordoning of whole neighbourhoods or communities – which often

created resentment and exacerbated social discontent in different countries,

All in all, the need to strengthen and regulate the increasing number of quarantine stations along the Mediterranean littoral with a uniform code of practice seemed to be the most pragmatic solution at hand for the governments in the region.⁴⁵ In truth many public health officials in Mediterranean Europe were not eager to experiment with sanitary measures that excluded the lazaretto institution, which, to their minds, was the only instrument that was proven to provide a realistic degree of protection against the infiltration of contagious disease through their national borders. These positions by and large usually conformed to those taken by the French delegations at the ISCs. Being a leading European power with an extensive Mediterranean coast and with huge trade, political and colonial interests in the region, France took an 'exemplary' pragmatic stand which held on to quarantine as a 'necessary evil', seeking to regulate and standardise its quarantine regulations and practices without hindering free-trade circulation. This even though some of the delegates themselves became increasingly sceptical of its worth in preventing epidemics.⁴⁶

Elaborating on this solidly pragmatic platform, most of the European delegates attending the sanitary conferences granted that the lazaretto system, if regulated by them and extended to cover the southern and eastern rims of the Mediterranean, could develop a prophylactic barrier against the diffusion of plague, cholera and other contagious diseases before any of these reached the European borders. Quarantine continued to be operated even by the British in their Mediterranean domains where these were long-established practices. Being the most vociferous exponents of anti-quarantine policies internationally, the British were in a slow and piecemeal fashion relaxing, and by mid century rarely implementing, quarantine on their national territory.⁴⁷ On the other hand, by continuing to operate and actually consolidating the long-standing lazarettos in its network of colonial ports – which were known to be the strictest in the region⁴⁸ – Britain assured that its commercial ships were not denied pratique from other Mediterranean ports. Home-bound shipping from the East and North Africa underwent strict quarantine in one of its ports – usually either Malta or Gibraltar⁴⁹ or Corfu in the Ionian islands (up until 1864) – from where vessels carrying the British flag obtained a clean bill of health which enabled them to

proceed directly to any regional/European port ‘unhindered’.⁵⁰ In this way, the British sought to abide by their quarantine obligations – so deeply entrenched in Mediterranean shipping and port practices – while still adhering to an anticontagionist sanitary policy,⁵¹ and without obstructing their international trade, shipping activities and travel. This pragmatism was lambasted as thoroughly inconsistent by uncompromising adherents of the miasmatic anticontagionist medical school, such as the editor of *The Boston Medical and Surgical Journal* who did not mince words to present Britain’s quarantine practices in its Mediterranean ports as ‘hyprocritical’:

England is as deeply in the mire as the Papal and Neapolitan governments, in regard to Malta and the Ionian Islands. How the minister of foreign affairs could play the hypocrite, without blushing to confusion, in sanctioning the movement of the General Board of Health, by sending a representative to Paris, is quite unaccountable.⁵²

On the other hand, miasmatic environmentalism as a medical theory attributed the transmission of cholera and other contagious diseases to atmospheric pollution – foul air and climate – as well as contaminated water, decaying matter and putrescence which directly infected the body.⁵³ Propped up by accumulating scientific evidence, this miasmatic medical theory rejected quarantine measures as unwarranted and instead promoted regulated sanitation, cleanliness of the environment and personal hygiene.⁵⁴ Such anticontagionist philosophy was in harmony with Britain’s ‘free-trade’ and ‘open-sea’ ideology. It was in Britain – more than in any other country – that the merchants’ lobby, arguing that trade was bearing the brunt of quarantine restrictions, appealed to their government to abandon or at least radically prune such quarantine measures.⁵⁵ Antiquarantinism gained extensive influence in Britain due to the ties forged between prevailing trade, shipping and financial interests and the state’s geo-strategic–imperial ventures around the globe.

In addition, because the aerial–miasmatic theory was environmentally based and hence solidly terrestrial, it came to be embroiled with the expansionary projects of the powerful colonial lobby. Identifying cholera and plague, together with diseases such as ‘sleeping sickness’ and schistosomiasis, as ‘tropical diseases’ and locating them in the ‘hot climates’ of extra-European lands, miasmatic theory was employed to

assist colonial intervention in these territories as part of a self-proclaimed civilising mission imposed on indigenous people.⁵⁶ A case in point was the already mentioned contemporary association of plague with Egypt's climatic–environmental conditions – most emphatically with those 'endemicallly' found in the Nile Valley⁵⁷ – which in miasmatic terminology constituted the ideal ground for the eruption of contagious disease.⁵⁸ Keeping this contagion under control purportedly required the specialised assistance of Western sanitation and medical knowledge. From this miasmatic–environmentalist perspective, the principal cause of the outbreak and diffusion of cholera came to be linked with contaminated water in 'backward lands', as argued by the highly influential *British Medical Journal* in August 1893: 'the pollution of the wells at Mecca is the chief agent in the dissemination of cholera [...] water alone is the medium through which the pestilence spreads.'⁵⁹

This quote exemplifies the political orientation which by the 1890s was taken by the miasmatic–environmentalists and which implicated them with British – and indeed European – imperial intervention in various parts of the globe.⁶⁰ Deeply influencing British medical thinking and public health practice, the aerial–miasmatic theory of epidemics was carried by the physicians and sanitarians who were despatched in the 'tropical colonies', that is, on the frontline of colonial expansion, and in our case in the East and North African territories.⁶¹ In 1854–55, this medical philosophy had been given credit by John Snow's (1813–58) findings that cholera was – as later echoed in the above quotation – transmitted by drinking contaminated water.⁶² Snow's discovery had been positively received by delegates attending the second ISC of 1859 which appointed an international board of physicians tasked with using data from these findings to investigate the link between atmospheric and environmental factors and the incubation and transmission of contagious disease in North Africa and the East. However, by 1884 Robert Koch (1843–1910) came out with a bacteriological explanation of cholera by identifying the cholera *comma bacillus*,⁶³ and came to emphasise the importance of quarantine in abating the proliferation of such epidemics. Koch's participation in the Rome conference spurred a rigorous scientifically informed discussion on the aetiology and transmission of cholera and the possible ways of preventing its diffusion, even though many medical specialists remained convinced that the *vibrio cholerae bacillus* was not the *cause* but the *product* of the disease. Yet

again, Robert Koch's theory of the cholera microorganism was followed by another explanation provided by the German medic and hygienist Max von Pettenkofer (1818–1901), who argued that cholera could only be contagious under specific environmental conditions. Disagreeing with Koch's thesis that the *comma bacillus* was the only factor producing the disease,⁶⁴ Pettenkofer demonstrated that cholera showed contagious and miasmatic features. He proposed personal hygiene, home cleanliness and sanitary education to combat its diffusion.

In the imperialist climate generated during the last quarter of the nineteenth century, scientific–medical findings were appropriated by the colonial lobbies, which applied them to the idea of the civilising mission to provide the cultural, civil and moral justification for European intervention in non-European lands, most of which were under Ottoman control. Medical theories came to be more specifically employed in the colonial construction of the 'Arab Muslims' as potential carriers of contagion and their countries as 'disease-ridden' which required immediate sanitisation. In this colonising, Eurocentric discourse, the controversies initiated by the medical discoveries – which have historically proved essential for improvement in biomedicine⁶⁵ – were glossed over, while attention was directed onto the alleged 'contagious threat' coming from the Muslim *Hajj*.

The Mediterranean: Europe's imperial medical archive and 'prophylactic'

The urge to collect epidemiological information – through new medical specialisations such as medical topography – 'from source', and its processing and archiving in the metropolis (as in Paris and London), gained impetus following the first cholera epidemic in Europe. Physicians and sanitarians, many of whom were usually sent by their government or medical institutions to conduct research work on the spot, ended up advising local regimes and being involved in the design and implementation of public sanitary institutions. A number of these foreign resident doctors and sanitary advisors, merchants and consuls, conjointly with native physicians and state functionaries, were appointed by local authorities to sit on new sanitary councils – or boards of quarantine – created in the various ports of Turkey, Egypt, the Ottoman regencies and Morocco. As such these sanitary councils served as sites

of negotiation between these European agents and their local counterparts, while charged with the construction and sharing of the management of lazarettos and other public health institutions in their resident city ports. It stands to reason that, therefore, these sanitary councils came to mirror the competing trade, political and colonial interests of each of their European members' nations, as much as echoing the varying claims made by native medics and public health officials.

On a sanitary level, these boards gave rise to dialogue – which nevertheless became ever more one-sided and dominated by Europeans – between the indigenous medical–sanitary traditions and the increasingly influential European medical theories and sanitary practices. On one occasion, Lord Ponsonby, acting as British ambassador to Constantinople, opposing the stricter quarantine regulations recently imposed, and drawing from miasmatic–environmental theories of epidemics, argued that quarantine was of no avail against the spread of contagious diseases. The ambassador further expressed his worries that despite the official assurances given by the Ottoman Capitulations, the new sanitary regulations empowered Turkish health officials to search the private homes of British subjects. In a letter to the Ottoman authorities in January 1839, Ponsonby declared himself strongly 'averse to these measures.'⁶⁶ Epidemics, he contended, could only be combated effectively 'by introducing cleanliness and ventilation in Constantinople', and not by restrictive quarantine. In a similar vein, anticontagionist miasmatic theories were frequently voiced by trade and shipping representatives within – and from outside – the sanitary councils, in support of appeals to abolish or at least reduce quarantine restrictions to the lowest possible. Frequently, merchants, supported by their consular representatives, many of whom were in business partnerships themselves,⁶⁷ came to be involved in the nationalistic agendas of their own governments. This complicated negotiations and hindered the taking of decisions and the carrying out of specific quarantine measures, regulations and procedures in their respective ports.

The first of such sanitary boards was set up in 1828 by Muhammad Ali (1805–48), the de facto ruler of an 'independent' Egypt – which came to occupy the Ottoman provinces of Syria and Cilicia (1831–40) – who was much influenced by Western European and especially French sanitary practices.⁶⁸ The 'quarantine board' set up in Alexandria was commissioned to establish a quarantine station to supervise its

operations and to issue bills of health.⁶⁹ Also referred to as *Commission Consulaire de Santé* (Consular Commission for Health), this board included 'foreign' European doctors, sanitary technicians and consular representatives who rubbed shoulders with their Egyptian counterparts, giving it an international character. Apart from the one at Alexandria, other quarantine stations came to be built along the coast of Egyptian-ruled lands: one in Damietta, another one in Rosetta in 1831,⁷⁰ and four years later in Beirut to filter maritime traffic passing from Syrian ports.⁷¹ In 1837, another sanitary board was founded with the task of creating a lazaretto to quarantine ships passing through the Bosphorus.

By this time, the Ottoman Porte itself had taken the initiative to construct its own quarantine stations and thus extend the regional chain of lazarettos along the eastern rim of the Mediterranean and beyond the Bosphorus. Actually, in 1836 the *Meclis-i Kebir-i Umur u Sihhiye* (Superior Council of Health) was founded at Constantinople, made up of eight Ottoman representatives and nine 'foreign' (European) physicians living in the city together with five representatives of foreign embassies.⁷² As well as being handed the task of setting up a lazaretto, this Council was in charge of formulating 'modern' public health regulations and supervising their implementation in that city port. Presented as part of the *Tanzimat*⁷³ – the process of modernisation through the reorganisation of the Ottoman State – initiated by Sultan Mahmud II, supported by the Ottoman ruling elites, the new Superior Council of Health led to the building of quarantine establishments and infection hospitals in Turkey itself and in its neighbouring domains. By 1840, the Porte was able to pass a series of so-called quarantine 'organic regulations', which were compiled by the Council, to regulate all lazarettos under its control,⁷⁴ starting with that in Constantinople and including two stations located on the sea passages into Anatolia and Rumelia.

Concurrently with the setting up of sanitary boards and lazarettos in Turkey and its eastern possessions, other quarantine stations were being established in the North African ports, starting with that of Tunis in 1835.⁷⁵ Five years later, in 1840, the Sultan of Morocco formed a Sanitary Council which was to advise on the preventive measures to be applied against the importation of epidemics, including the need to construct a lazaretto which, together with the one in British-Gibraltar, would greatly assist the policing and filtering of the traffic flow through

the western entry of the Mediterranean. Although varying in their lazaretto procedures and regulations, with some of the establishments considered operationally volatile, by the 1850s the principle of quarantining ships to prevent the spread of contagious diseases along the main routes came to be accepted by most Arab-Muslim governments in the Mediterranean.

During the fifteen years or so preceding the first ISC in 1851, these sanitary councils not only operated as negotiation sites of an international character, and as advisors and designers of quarantine establishments to the local administrations, but also served as information gathering centres. A large volume of the knowledge – of an epidemiological and sanitary nature – collected by these sanitary councils was to be tabled in the ISCs, in support of the many European delegates' proposals to standardise international quarantine regulations.⁷⁶ Most of this qualitative and quantitative data – packaged as scientific evidence – was despatched to, and processed in, European medical archives by consuls and physicians sitting on the several quarantine boards, as well as by explorers, colonial scientists and travelling scholars. These gathered all sorts of medical-sanitary knowledge, tabulated statistics, drew reports,⁷⁷ chartered disease-prone or 'ideal' breeding grounds of specific contagious disease and mapped regional-global epidemic routes. One eminent medical scientist was Robert Koch, who in 1883 went on an expedition in Egypt to investigate the aetiology of plague, sending back reports on a country which, as already noted, was considered a principal breeding ground of 'tropical disease'.⁷⁸ All in all, the scientific-medical investigations which researchers, physicians, medical topographers and others conducted in these territories were framed within, and reproduced, their own European medical and public health theories. Ostensibly objective and ideologically neutral, these theories of epidemics were frequently swathed in racial and ethnic presumptions of Western 'civilised superiority' over the non-European natives – in this case 'the Arabs'. This, of course, illustrates the extent to which European medical science was infused by the 'imperial spirit of the era'.⁷⁹ Having been collated and methodically organised in European medical archives, this knowledge was, as Thomas Richards argues, 'enlisted into the service of the Empire', and together with other emerging fields of expertise – like biology and geography – came 'to function as an extension of the imperial project'.⁸⁰

Along with their gathering and despatching of information, as well as their direct involvement in the setting-up and administration of lazarettos, European consuls, traders and physicians came to take over a rising share of responsibilities over the domestic public health, which had previously lain in native and Ottoman hands. This in turn significantly boosted their influence on sectors of the local ruling elites and the state authorities. By supervising and administering quarantine procedures, they gained increasing control of entries and exits of these countries' coastal borders. Such transfer of decision-making power from local to 'foreign' hands reflected and sustained the ongoing informal colonial penetration,⁸¹ which would eventually lead to the subjugation of these countries to Western European supremacy.⁸² What happened in Tunisia can be taken as a case in point. Protesting against the restrictions imposed by the local authorities on vessels entering port to stop cholera, but which also disrupted British and European commercial activities,⁸³ resident foreign consuls and merchants solicited to be involved in any other decisions regarding quarantine arrangements in the regency. Consequently, a number of them were called by the Bey to form a new sanitary council in charge of formulating quarantine regulations.⁸⁴ This, of course, provided them with greater power leverage.⁸⁵ Decisions taken in the Tunis sanitary council and on the other sanitary boards in North Africa would in the long term have deep politico-economic effects – which were similar to the impact left by the Ottoman Capitulations – facilitating colonial infiltration and hastening the collapse of the Ottoman Empire.⁸⁶

Actually, the regulations and codes of procedure adopted by the sanitary councils for local lazarettos, which were then elaborated and standardised by the ISCs and applied to the quarantine stations,⁸⁷ privileged trade vessels flying European flags and their merchandise over those from Egypt and the Ottoman ports.⁸⁸ The hierarchical classification of persons, merchandise and ships adopted in these lazarettos – indicating the intensity of disinfection and the required duration of quarantine according to their specific degree of 'contagiousness' – was determined by their declared 'origins.'⁸⁹ By and large, inward ships originating from 'Arab' ports and carrying indigenous products were marked as 'highly infective' and had to pass through stricter and lengthier quarantine procedures. Such classification encoded an essentialist bipolarity in which European 'white bodies' as well as their merchandise and

vessels were unambiguously associated with outright cleanliness, while 'Muslim'/'Arab'/'Ottoman' bodies, products and ships were considered in various degrees as contagious. A standard scheme of classification was – through the work of the sanitary councils and the ISCs – transferred and structured in the regulations and operations of North African and Levantine lazarettos. Taking the Beirut lazaretto as example, a three-tier classification was adopted here: 'healthy European'; 'suspect Egyptian, Syrian and Greek'; and 'contaminated Ottoman'.⁹⁰ In the southern European lazarettos – such as British-controlled Gibraltar, Malta and Corfu⁹¹ – quarantine procedures were carried out according to a scale of 'contagiousness' (or 'contamination') which listed ships, products and persons from Egypt and Ottoman ports as 'highly susceptible epidemic carriers', having to endure the strictest segregation and the most meticulous disinfection procedures in 'normal circumstances'.⁹² This contrasted with the 'lighter treatment' and shorter quarantine duration awaiting British and other northwestern European crews, travellers, their vessels and their merchandise, especially those arriving directly from European ports.

Constructing the 'threatening' 'contagious' Arab

The setting up of lazarettos and quarantine systems in Ottoman and other city ports around the Mediterranean was presented as an act of European 'enlightenment' or of colonial 'benevolence', and considered by the native elites as instruments of 'modernisation' for their countries. As with the sanitary councils, the quarantine lazarettos functioned also as sites for European-'native' talks, negotiation and collaboration. In due course, however, they came to assert Western self-proclaimed scientific-medical superiority over the Arab populations who, it was claimed, if left to their natural inclinations would spend their 'barbaric existence' in foul, disease-ridden conditions.⁹³ Such contemptuous, inherently racist, attitudes and discourse against 'native Arabs' were expressed, visualised and circulated by the popular press and other genres of literature in Europe, and seeped into political and diplomatic parlance. Hence the condescending treatment of Arabs and Muslims in general, and of the Ottoman Porte in particular, as observed in the proceedings of the ISCs. A *British Medical Journal* article published a couple of months before the start of the 1894 ISC

held in Paris illustrates such self-proclaimed European supremacy in no uncertain terms:

The problem, indeed, is full of complexity [...] It must not be forgotten, however, that in this Meccan business the Porte is the central figure, and that whatever any conference may decide will be of but small avail so long as the sultan remains passive. For any real progress we must look to the self-interest of the Mohammedans themselves.⁹⁴

A narrative went that 'Arabs' – often disparagingly referred to as 'Mohammedians', as in the above quote – were so incompetent that they were unable to progress in the field of hygiene and sanitisation which, it was believed, contrasted with their cultural traditions, customs and way of life. 'Arabs' were stereotyped as lazy, dirty,⁹⁵ disease-carrying, disordered bodies, and as such comprised an enduring negative and 'threatening' image in colonial ideology and the European collective imagination.⁹⁶ Often modelled on the imagined figure of the *fellahin* as prototype, Arabs were depicted as slow moving, leading unproductive lives, overwhelmed by an enervating climate, and thus unadaptable to the accelerated rhythm of an ordered life,⁹⁷ considered to be a principal feature of 'modernity' characterising Western civilisation. In the different genres of European literature produced at the time, Arab countries and their predominantly Muslim populations were imagined, as Edward Said puts it, as a 'decrepit carcass awaiting his [European] restorative efforts'. The Oriental Arab had, according to this narrative, fallen 'into a savage state', with a 'civilization, religion and manners [...] so low, barbaric, and antithetical as to merit reconquest'.⁹⁸

This portrayal of the Arabs as unhygienic and disease-carrying bodies was superimposed on, and meshed with, the politically constructed representation of the Turkish Empire and the Porte itself as the 'Sick Man of Europe'.⁹⁹ This well-known label has historically been attributed to Tsar Nicholas I just before the outbreak of the Crimean War in 1853, when referring to the inability of the Sublime Porte to hold together its vast domains. 'We have a sick man on our hands, a man who is seriously sick,'¹⁰⁰ the Tsar was reported to have stated by G.H. Seymour, British ambassador at St Petersburg, in his correspondence to Lord Russell.¹⁰¹ The image quickly percolated into political-diplomatic discourse during the course of the long debate on the Eastern Question. Recurring waves of so called 'Oriental', 'Asiatic' and 'Arabic' pestilential

epidemics of cholera and plague – which devastated continental Europe, Britain and America during this same period – seemed to affirm these negative conceptions of the Arabs and of the Sublime Porte. For the remaining crises-laden period of the Eastern Question, that ran from the Crimean War to the First World War, the image of the 'Sick Man' characterised as infective, decrepit, terminally ill, continued to be used to represent the weak political state of the Sublime Porte and its crumbling empire in European literature and journals.¹⁰² This portrayal intermeshed with the personification of cholera and plague as essentially 'Arab', which in turn reproduced the perception of the 'Arab-Muslim[s]' as threatening bodies (both in terms of contagious disease and political instability) that needed to be restrained and kept out of the European borders.

In real terms, in as much as the Porte was visualised as politically moribund – a 'very sick man' – it was kept on 'life support' by the Concert of Europe¹⁰³ (the alliance between the European Powers between 1814–1914), while the task of protecting the European borders from epidemics emanating from this 'insalubrious' body was given to the ISCs. With the Turkish state perceived as being unable to hold together its vast domains, and hopelessly incapable of implementing political and sanitary 'reforms', it lay with the 'enlightened' Europeans – as part of their self-proclaimed civilising mission – to intervene with their hygienist instruments, to do so. As *The British Medical Journal* put it:

Since Turkey refuses to put her house in order, it is clearly the duty of the civilized world to take such steps as may be necessary to compel her to do so [...] From every point of view the Turkish authorities are to blame; and it is almost incredible that Europe should allow a state of things to exist which is manifestly fraught with peril to the commonweal.¹⁰⁴

The use of hygienist interventionism – based on modern scientific sanitary–medical knowledge and technology – to drive the wider project of civilising the allegedly 'backward' Arabs,¹⁰⁵ gained impetus in the 1870s, with the creation of medical specialisms such as 'tropical medicine' – which dealt with diseases such as malaria, schistosomiasis and plague – in the chief European medical institutions. These were being utilised, as Roy Porter put it, in 'the spirit of the era of imperialism [by the great

powers] battling to settle the “Less Civilized” parts of the globe.’¹⁰⁶ Such hygienist strategies were shaped by a Eurocentric bipolar vista – which posed the ‘civilised Western Europeans’ against the ‘uncivilised Arabs’ – that seeped into mainstream political discourse and articulated much of the proceedings of the ISCs from 1851 to 1894. With the opening of the Suez Canal in 1869, the principle destination of worship for Muslims – Mecca – was brought much closer in travel time to Europe. As much as it emerged as a highly strategic ‘open nerve’ in the European powers’ – especially the British – global lines of communication,¹⁰⁷ the Suez Canal also came to be marked as a main passageway accelerating the diffusion of cholera into Europe. This prompted the European states to set up an interborder sanitary mechanism for the vigilance and filtering of traffic passing through the Canal and into the Mediterranean body of seas. Most sanitarians agreed that this objective could only be achieved by consolidating and standardising all quarantine stations into a prophylactic network covering the Mediterranean littoral, the Red Sea and beyond. Driven by this hygienist objective, from the late 1860s lazaretto establishments took on a sharper biopolitical *modus operandi*: physically restraining, segregating, clinically observing and disinfecting ‘Arab Muslims’ and other ‘alien’ bodies perceived as potentially contagious and ‘threatening’, before these could ‘infect’ the traffic flows on the major travel routes and lifelines of communication across the Mediterranean into Europe.

Quarantine measures on ‘Arab-Muslim’ bodies on the move were actually intensified following the outbreak of an epidemic during the *Hajj* of 1865.¹⁰⁸ This prompted European doctors, hygienists and politicians to point specifically to the Hejaz as a major incubation ground – a ‘*cholera nidus*’ – and conveyor of this contagious disease into Europe.¹⁰⁹ In truth, this cholera epidemic came – as it did earlier – to be transmitted from India to Mecca, killing 30,000 solely at the Hejaz; it then savagely spread into Anatolia from where it penetrated Europe taking a heavy toll of 200,000 persons in the major cities that it hit. From then onwards, in the sanitary discourse and practice which came to dominate public health institutions around Europe, particularly in France, Muslim pilgrims came to be labelled as liable vectors of pestilential diseases. The French Government, alarmed by the growing numbers of pilgrims returning from Mecca to North Africa,¹¹⁰ with whom there was uninterrupted intercourse – especially through Algeria

under their colonial administration – took the initiative to call a third ISC in 1866.¹¹¹

Mirroring the strong political–hygienist intentions behind its convening, this third ISC was organised in Constantinople, the seat of the Ottoman Porte that ruled over and was accountable for the Hejaz. While India was indicated straightaway as the 'home of cholera', with the Indian Government being advised to impose strict quarantine on pilgrims, the focus of attention shifted to the *Hajj*, the Hejaz and Mecca itself as European delegates pressed for a plan to regulate the clustering of pilgrims there and to sanitise this territory.¹¹² One main proponent of this hygienist strategy was the French delegate Dr Sulpice-Antoine Fauvel (1813–84), who bid the Ottoman Porte to dispatch a sanitary commission to the Hejaz to thoroughly investigate the real state of public health and of the pilgrims amassing there.¹¹³ Demanding that the Porte take tangible action in 'its own domains' reflected the disparaging treatment the latter was receiving from most of the European delegates. These shared the belief that Turkey was incapable of taking seriously its international responsibilities of surveillance and sanitisation of the Hejaz, in addition to overseeing and disciplining the pilgrimages.

The identification of 'contagiousness' with Muslim pilgrims overcrowding Mecca¹¹⁴ was further sustained by the repeated epidemic outbreaks reported in this area and which led to the convening of other ISCs. Hence, for instance, the 1872 cholera that erupted in the Hejaz and rapidly diffused into Egypt, where it took some 60,000 lives in three months before spreading further into Europe and reaching America, raised alarm in most governments and led to the calling of the fourth ISC in Vienna in July 1874. This conference was marked by 'scientifically informed' talks between envoys to find the most practical course to incisively intervene to filter all traffic – mainly, though not only, through lazarettos – passing from the Suez Canal zone and the Hejaz.¹¹⁵ Nevertheless, it took until 1893 – with the eighth ISC in Dresden – for delegates to reach an agreement to secure a regulated standardisation of procedures in all lazaretto stations around the Mediterranean and on the major routes to Mecca. Subsequently, the Ottoman authorities, overseen by European hygienists, were obliged to rigorously enforce specific quarantine practices – including disinfection procedures on pilgrims – and execute social discipline in the Hejaz and all ports of embarkation en route to and from Mecca. Strict hygienist measures

on individual Muslim bodies at these ports were further intensified by the eleventh ISC held in Paris in 1903, which was convened a year after another cholera epidemic had erupted during the *Hajj*.¹¹⁶ This conference appointed a sanitary commission made up of foremost hygienists to supervise the carrying out of sanitary procedures and other preventive measures on location as well as distribute medicine in a concerted way:

to regulate the pilgrim traffic in the Red Sea and Persian Gulf, with the view of preventing the importation of cholera to Mecca, and its dissemination thence along the track of the returning *hajjis*.¹¹⁷

One enduring effect left by this series of ISCs was the marking of the chief trajectories of the Muslim pilgrimage to Mecca as ‘infective routes’ of cholera into Europe and, by association, of the Arab-Muslims as vectors of such epidemics. This corroborated the deeply rooted stereotyped image of the ‘Muslim-Arab’ pilgrim which, as argued above, had been in circulation through Orientalist literature¹¹⁸ – mainly in travellers’ accounts, but also in works on medical topography and other ‘scientific’ narratives – which depicted the Hejaz as ‘barren and retarded’.¹¹⁹ Echoing this growing aversion towards Muslims in Europe was the French hygienist Adrien Proust (1834–1903), when in 1873 he wrote that Europeans were ‘every year, at the mercy of the pilgrimage to Mecca.’¹²⁰ By this he was conveying the state of mind of most other European sanitarians, doctors and diplomats who held Mecca and the *Hajj* accountable for the breeding and transmission of the scourge of cholera in Europe. The article published in the authoritative *The British Medical Journal* on the 26 August 1893 is typical of this widely spread feeling in Europe:

As long as the Hedjaz remains a closed book to the hygienic world, so long shall we be in danger [...] It is intolerable in the nineteenth century that fanaticism should be allowed to close the doors to all humanising influences throughout a vast territory [...] Is it not time that life in Paris and London were protected against the Old Coprophagan, the dirt-eating Death that abides at Mecca? Self-preservation is the first law of Nature. The Hadji must permit the setting of his house in order, or the Haj must not go on.¹²¹

By this time, the prophylactic chain of lazarettos stretching along the northern and southern Mediterranean coasts and the Suez Canal

had been extended to the Red Sea and Persian Gulf to cover the length of the main passageways to Mecca. By 1885, two quarantine stations were set up in Jeddah and Yambo, while others had already been built on Perim Island in 1866 and on Kamaran Island in 1881. In this Kamaran establishment, for example, all disembarking Muslim pilgrims were treated 'as infected' and passed through a meticulous disinfection of their bodies, with their clothes and all other personal belongings being systematically 'fumigated'.¹²² These painstaking and lengthy sanitary procedures became increasingly burdensome to, and negatively perceived by, the Muslim pilgrims and other travellers. All strict hygienist measures practised at the ports of departure for Mecca – particularly those decided upon at the 1894 Paris ISC – stretched the quarantine period for 'pilgrimage boats' from five to ten days, and thus led to substantial delays in the *Hajj*, creating wide-ranging disgruntlement.

In addition, the policing of the principal pilgrimage routes to Mecca¹²³ was tightened by procedures which responded to the general perceptions and fears of the 'Muslim-Arabs'.¹²⁴ In the chief ports of embarkation, the latter were to pass through a filtering process which selected those who could proceed on their pilgrimage according to their socio-economic status. This was based on the logic that wealthy pilgrims would be better equipped to travel in 'hygienic conditions' and to thus avoid contracting and transmitting disease. Still, selectivity according to one's wealth or social status went against Islamic teaching, which advocated opportunities for every 'able bodied Muslim', poor or wealthy, to accomplish the *Hajj* once in a lifetime.¹²⁵ The option thus left for the poor, who did not possess the officially demanded means to travel rapidly to the Ka'ba in Mecca and back, was the traditional and much slower journey on land and across the desert. In a way this long voyage served as an incubation period for any contagious disease to appear, with pilgrims who contracted cholera or plague usually falling ill and/or dying before their arrival. Then again, in all the quarantine stations, Muslim pilgrims had to undergo rigorous disinfection, including undressing 'in open space' – a practice which was felt to be debasing, particularly when it involved Muslim women.¹²⁶ Such routine sanitary procedures came to vindicate the fixed European identification of all 'Muslims'/'Arabs' as menacing bodies, needing to be socially disciplined, disinfected and subdued into 'modernity'.

Conclusion

By the second half of the nineteenth century, quarantine came to be deeply implicated with European colonial expansion in the Mediterranean basin. The numerous lazarettos which were established on the North African and the Eastern coasts of the region were designed by Europeans, and then operated on the Western sanitary quarantine model, with the guidelines, regulations and procedures set by the International Sanitary Conferences and expedited by European consuls, physicians and sanitary officials/hygienists on the spot. Many of these European agents had also served on – and actually patronised – the handful of boards of health (or quarantine boards) earlier established in some of these same ports and consequently came to act as advisors and administrators of the lazarettos which they had assisted to set up.

The ensuing network of lazarettos accompanied, and actually gave impetus to, the creeping economic penetration and ascending political hegemony of the European powers which gradually started to give way, in various degrees, to formal colonial rule – a process which hastened the disintegration of an already weak Ottoman Empire. Against such a complicated geo-political scenario, intensified by hostile intra-European imperial rivalry, the lazarettos, acclaimed as vital public health institutions, came to function as powerful instruments which vetted the bulk of the shipping traffic and led to the consolidation of new imperial steamship and communication routes. Concurrently, lazarettos served as nodal colonial sites, abetting the European powers' imperial expansion in multiple ways and means, including the use of elaborate institutional procedures and reconfiguring of a discourse (using modern medical–sanitary phraseology) and practices which endorsed the colonial subjection of 'native' Arabs as an 'inferior race'.

Most lazarettos located on the southern and eastern coasts of the Middle Sea and – following the opening of the Suez Canal in 1869 – on the major maritime routes to the Orient/India, fell directly under European surveillance and control. These came increasingly to be regulated and driven to operate on prefixed sanitary regulations and standardised practices issued and imposed by the series of international conventions and sanitary commissions ensuing from the ISCs. This chapter argues that with the construction of such a network of lazarettos, spread along the major seaways crossing the Mediterranean to India and the 'Orient', the European powers were assured of a frontline prophylactic barrier

against the diffusion of contagious disease – especially cholera – into Europe. Narrowing down analysis on the actual quarantine procedures used in these lazarettos it has been shown how, through these fixed regulations and a selective code of practice, maritime quarantine favoured and facilitated European shipping, trade and travel, as much as it hindered 'Arab', 'Ottoman' mercantile ships, travellers and crews arriving from North African and Levantine ports. Standing quarantine rules compelled non-European vessels and travellers to undergo stricter and much lengthier detention, isolation and hygienist procedures. This proved to be a thoroughly discriminatory treatment which further intensified the unequal trade relations in the region in as much as it consolidated the European states' rising control over international maritime traffic and commerce.

This chapter has also explored the use of Western medical theories – articulated in pro- anti- or middle-of-the-way quarantinist positions – examining how these came to be entangled in the colonial discourse of the civilising mission, which nourished a racist sense of supremacy over purportedly 'inferior' Arabs. New and older medical/hygienist theories came to validate lazaretto practices based on a fixed hierarchy of classification which labelled as 'highly contagious' (or 'highly susceptible to epidemic disease') Arab and Ottoman vessels, merchandise, but most importantly persons. In practice this meant that these people had to undergo highly restrictive, heavily protracted and rigorous hygienist measures including the much-detested ritual of undressing and disinfection/fumigation. As such the lazaretto exercised strong biopolitical restrictions on Arab bodies, not only deterring their movement but elaborating, and continuously reproducing, the stereotyped image of the 'dirty' and 'contagious' Muslim-Arab – especially those on the annual *Hajj* to Mecca – as a 'threat' to public health, social order and Western civilisation.

Notes

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 - 5 Norman Howard Jones, *The Scientific Background of the International Sanitary Conferences, 1851–1839*, Geneva, WHO, 1975; Mark Harrison, ‘Disease, diplomacy and international commerce: the origins of international sanitary regulations in the nineteenth century’, *Journal of Global History* 1, 2006, 197–217.
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 - 7 Peter Baldwin, *Contagion and the State in Europe, 1830–1930*, Cambridge, Cambridge University Press, 2005.
 - 8 In Foucaultian terms, lazarettos can be seen as ‘enclosed functional sites’ (Michel Foucault, *Discipline and Punish: The Birth of the Prison*, Middlesex, Penguin, 1991, 143–144).
 - 9 For the deeply rooted negative stereotyping of the ‘Arab’ and the ‘Turk’ in the European imagination, see Ann Thompson, *Barbary and Enlightenment. European Attitudes towards the Maghreb in the 18th Century*, Leiden, E.J. Brill, 1987.
 - 10 Headrick, *The Tools of Empire*.
 - 11 France had already occupied Algeria in 1830 and in 1881 Tunisia. Britain gained Cyprus in 1878 and Egypt in 1882 – apart from its control of Gibraltar (from 1705), Malta as from 1800, and the Ionian Islands from 1814 to 1864.
 - 12 Huber, ‘The unification of the globe by disease?’, 453–476.
 - 13 On the integration of the various ports of the Mediterranean in the world economic system, see R. Kasaba, C. Keyder and F. Tabak,

- 'Eastern Mediterranean port cities and their bourgeoisies: merchants, political projects and nation states', *F. Braudel Review* X, 1, 1986, 121–135.
- 14 Yrjö Kaukiainen, 'Shrinking the world: improvements in the speed of information transmission, c. 1820–1870', *European Review of Economic History* 5, 2001, 17–18, 26–29.
 - 15 See David Haworth and Stephen Haworth, *The Story of the P & O. The Peninsular and Oriental Steam Navigation Company*, London, Weidenfeld & Nicolson, 1986, 32–36.
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 - 17 *The Peninsular & Oriental Pocket Book*, London, 1879.
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 - 22 Mishra, *Pilgrimage, Politics and Pestilence*.
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 - 27 Jones, *The Scientific Background*, p. 10.
 - 28 J. Sheldon Watts, 'From rapid change to stasis: official responses to cholera in British-ruled India and Egypt: 1860 to c.1921', *Journal of World History* 12, 2, 2001, 452–463.
 - 29 M.E. Chamberlain, *The Scramble for Africa*, New York, Longman, 1995, 3–16.
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- 35 Mariko Ogawa, ‘Uneasy bedfellows: science and politics in the refutation of Koch’s bacterial theory of cholera’, *Bulletin of History of Medicine* 74, 2000, 697–698.
- 36 Maglen, ‘Politics of quarantine in the 19th century’, 2873.
- 37 Baldwin, *Contagion and the State in Europe*, 206, 229–231.
- 38 See Mishra, *Pilgrimage, Politics and Pestilence*, *passim*.
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- 46 See speech by François Melier, French delegate at the 1851 Conference, 27 September 1851 in *Procès-Verbaux de la Conférence Sanitaire, 1852 – Séance du 31 Octobre 1851*.
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- 53 Research in miasmatic–aerial aetiology produced a large volume of medical literature – mainly as 'medical topography' – with quite a proportion of it dealing with 'tropical diseases' in the colonies.
- 54 James C. Riley, *Rising Life Expectancy: A Global History*, New York and Cambridge, Cambridge University Press, 2001.
- 55 Baldwin, *Contagion and the State in Europe*, 201, 203–207.
- 56 See Philip D. Curtin, *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century*, Cambridge, Cambridge University Press, 1989.
- 57 Roy Porter, 'Medical Science', R. Porter (ed.), *The Cambridge History of Medicine*, Cambridge, Cambridge University Press, 2006, 136–175.
- 58 *Report on Quarantine London, 1848*, 8–9; Kuhnke, *Lives at Risk*, 65–67.
- 59 *The British Medical Journal*, 26 August 1893.
- 60 See Bush, *Imperialism and Postcolonialism*, 206; Comaroff, *Ethnography and the Historical Imagination*, 216–217.
- 61 In these territories where 'the periodical return of epidemic disease appears to afford further corroboration of the connection between this class of diseases and particular atmospheric conditions' (*Report on Quarantine and the whole class of epidemic disease*, London, HMSO, 1849, 8–9).
- 62 Cf. [Snow John], *Snow On Cholera being a reprint of two papers*, London, Milford Oxford University Press, 1936.

- 63 It must be noted that the *cholera bacillus* was already identified by Filippo Pacini in 1854, but was not accepted in the dominant medical climate of the time (William Coleman, 'Koch's comma bacillus: the first year', *Bulletin of the History of Medicine* 61, 1987, 315–342; also Cosmacini, *Le Spade di Democle*, 118.)
- 64 Roy Porter, *The Greatest Benefit to Mankind. Medical History from Antiquity to the Present*, London, Fontana Press, 1999, 436–437.
- 65 Baldwin, *Contagion and the State in Europe*, 231–233.
- 66 Philip Manel, *Constantinople. City of the World's Desire, 1453–1925*, London, Penguin Books, 1997, 256; Daniel Panzac, *La Peste dans l'empire Ottoman 1700–1850*, Louvain, Peeters, 1985, 476, 482.
- 67 As in the case of Tunisia: Nancy E. Gallagher, *Medicine and Power in Tunisia 1780–1900*, Cambridge, Cambridge University Press, 2002. See also D.C.M. Platt, *The Cinderella Service: British Consuls since 1825*, Connecticut, Archon Books, 1971.
- 68 See Panagiotis Krokidas and Athanasios Gekas, 'Public health in Crete under the rule of Mehmed Ali in the 1830s', *Egypt monde Arabe* 4, 2007, 35–54.
- 69 Panzac, *La Peste dans l'empire Ottoman*, 413–423.
- 70 Cf. Kuhnke, *Lives at Risk*, 2.
- 71 The Sanitary Board in Beirut was founded in 1834 and included the French, Greek, Danish, Spanish and Austrian consuls. It was followed by the establishment of a lazaretto in the same port where all Syria-bound ships were to stop for quarantine. Toufoul Abou-Hodeib, 'Quarantine and trade: the case of Beirut, 1831–1840', *International Journal of Maritime History* XIX, 2, 2007, 223, 230.
- 72 This Council was made up of 'local members': the president, the interpreter, two Muslim officials and four physicians trained in European universities. The foreign representatives came from Austria, Belgium, France, England, Greece, Russia, Sardinia and Italy.
- 73 On the Tanzimat as a modernising process initiated 'from within', see Dietrich Jung with Wolfgang Piccoli, *Turkey at The Crossroads. Ottoman Legacies and a Greater Middle East*, London, Zed Books, 2001, 38–40.
- 74 'Per l'Impero è in vigor il regolamento organico 24 maggio 1840, compilato dal Consiglio di Sanità, per le provenienze di mare tanto a Constantinopoli che per gli altri scali dell' impero stesso', Brussolini, 1881, 57–58.
- 75 Nancy E. Gallagher, 'Contagion and quarantine in Tunis and Cairo, 1800–1870', *Maghreb Review* 7, 1982, 108–111.
- 76 *Procès-Verbaux de la Conférence Sanitaire – 1851, passim*.
- 77 For instance: *Report on Quarantine*, London, 1849, 6–9 on Egypt.

- 78 Coleman, 'Koch's comma bacillus: the first year', 314–341; Kuhnke, *Lives at Risk*, 65–67.
- 79 Bush, *Imperialism and Postcolonialism*, 149, 163.
- 80 Thomas Richards, *The Imperial Archive. Knowledge and the Fantasy of Empire*, London and New York, Verso, 1993, 6.
- 81 P.J. Cain and G. Hopkins, *British Imperialism. Innovation and Expansion*, London and New York, Longman, 1993, 7–9, 235–238; Jurgen Osterhammel, *Colonialism. A Theoretical View*, Princeton, Markus Wiener Publishers, 1999, 18–20.
- 82 A.L. Macfie, *The Eastern Question 1774–1923*, London and New York, Longman, 46–47.
- 83 Gallagher, *Medicine and Power in Tunisia*, 40.
- 84 *Ibid.*, 42.
- 85 For an analysis of the mounting European influence on the Tunisian ruling elites, see F. Robert Hunt, 'The comparative history of Tunisia and Egypt in the nineteenth century: a re-examination', *Arab Historical Review for Ottoman Studies* 7/8, 1993, 59–70.
- 86 L.S. Stavrianos, *Global Rift. The Third World Comes of Age*, New York, Quill, 1981, 129–131.
- 87 On the classification of persons, goods and ships according to specific scales of 'contagiousness' or 'infectiveness', see No.1 *Au Procès-Verbaux de la Séance du 21 Octobre 1851*, Annex No.1.
- 88 Bussolini, *Delle Istituzioni di Sanita Marittima*, 269–70.
- 89 Annex no. 1., *Proces-Verbaux de la séance du Octobre 1851*.
- 90 Abou-Hodeib, 'Quarantine and trade', 233, 236.
- 91 [Dr De Valcourt – letter to editor], *The British Medical Journal*, 26 August 1893.
- 92 John Davy, *Notes and Observations on the Ionian Islands and Malta; With Some Remarks on Constantinople*, vol.1, London, Smith Elder, 1842, 341; Chircop, 'The British Imperial Network in the Mediterranean', 148–150.
- 93 Bush, *Imperialism and Postcolonialism*, 162–163.
- 94 'A further International Sanitary Conference', *The British Medical Journal*, 27 January 1894.
- 95 According to Forbes: 'the Arabs among whom a garment is never changed or washed, until it drops in pieces from their bodies'. Frederick Forbes, *Thesis on the nature and history of Plague as observed in the North Eastern Provinces of India*, London, W.H. Allen & Co., MDCCCXL, 46.
- 96 Alatas Syed Hussein, *The Myth of the Lazy Native. A Study of the image of the Malays, Filipinos and Javanese from the 16th to the 20th Century and its Function in the Ideology of Colonial Capitalism*, London, Frank Cass, 1977.

- 97 See Patrice Bourdelais, *Les epidemies terrassées: une histoire de pays riches*, Paris, Le Martiniere, 2003, 122.
- 98 Edward Said, *Orientalism. Western Conceptions of the Orient*, Middlesex, Penguin, 1995, 171–172.
- 99 M.E. Chamberlain, *Pax Britannica? British Foreign Policy 1789–1914*, London and New York, Longman, 1995, 90, 138–140.
- 100 This was later taken on and elaborated by European historians to become an established term in the historiography of the Ottoman Empire until very recently (Salto Rasha, ‘The Not So Sick Man of Europe’, *Al-Abram weekly – books supplement*, 15/25 August 2004, <http://weekly.ahram.org> (accessed 18 August 2017)).
- 101 Lawrence Guymer, *Curing the Sick Man. Sir Henry Butwer and the Ottoman Empire, 1858–1865*, Netherlands, Republic of Letters, 2011.
- 102 Andrew Wheatecraft, *The Ottomans. Dissolving Images*, London, Penguin, 1995, 205.
- 103 Paul W. Shroeder, ‘International Politics, Peace, and War, 1815–1914’ in T.C.W. Blanning (ed.), *The Nineteenth Century. Europe 1789–1914*, Oxford, Oxford University Press, 2000, 158–209.
- 104 ‘Mecca and the cholera’, *British Medical Journal*, 26 August 1893.
- 105 Comaroff, *Ethnography and the Historical Imagination*, 215–217.
- 106 Porter, ‘Medical science’, 163.
- 107 James Morris refers to the Suez Canal as ‘an exposed nerve in the anatomy of the [British] Empire’ (James Morris, *Pax Britannica. The Climax of an Empire*, London, Faber and Faber, 1975, 58). See also C.B. Fawcett. ‘The Life Line of the British Empire’, in W.H. Weigart and V. Stefansson (eds), *New Compass of the World. A Symposium of Political Geography*, London, H.G. Harrap, 1949, 238–248.
- 108 It has been consecutively estimated that during the period 1807–73, between 30,000 and 160,000 pilgrims visited Mecca each year, with the number rising more and more owing to rapid transport from the Mediterranean to the Mecca and from the latter to India. This pilgrimage and the crowded ritual gathering were marked as main conduits of epidemics to Europe and worldwide, with some twenty epidemics believed to have originated in the Hejaz during the period 1831–1900.
- 109 More importantly, this seemed to be confirmed ‘scientifically’ with the discovery of a variant of the *comma bacillus* (identified in 1883 by Robert Koch), which was named El Tor – taking the name of a locality in the Sinai, where this variant was found among Egyptian Muslim pilgrims coming from Mecca (Cosmacini, *Le Spade di Democle*, 118). A lazaretto was actually built on El Tor.
- 110 Shelton Watts, ‘From rapid change to stasis’, 344–345. See also F.E. Peters, *The Hajj: The Muslim Pilgrimage to Mecca and the Holy Places*, Princeton, Princeton University Press, 1994, 301–302.

- 111 This 1866 ICS was attended by representatives – both diplomats and physicians – of eighteen states. Salih Efendi and Dr Bartoletti represented the Ottoman State. Others represented Austria, Belgium, Denmark, Egypt, England, France, Greece, Iran, Italy, the Netherlands, Portugal, Prussia, Russia, Spain, Sweden and Norway and the Vatican.
- 112 Mark Harrison, 'Quarantine, pilgrimage, and colonial trade', *The Indian Economic and Social History Review* 29, 1992, 117–44.
- 113 Ibid. On the preventive measures to be adopted at the Hejaz, see Firmin Duguet, *Le pèlerinage de la Mecque au point de vue religieux social et sanitaire. Pier le Docteur Duguet, Médecin Général, Inspecteur général du Conseil Sanitaire, maritime et quarantenaire d'Égypte. Avec une préface de Justin Godard*, Paris, Editions Reider, 1932.
- 114 Peters, *The Hajj*, 301–303.
- 115 *Procès-verbaux de la Conférence sanitaire internationale Ouverte à Vienne le 1 Juillet 1874*, Vienna, Impr. Royale, 1874.
- 116 With delegations from Austria-Hungary, Britain, Belgium, France, Denmark, Greece, Germany, Italy, the Netherlands, Persia, Russia, Spain, Sweden and Norway, Turkey and the USA.
- 117 'A further International Sanitary Conference', *The British Medical Journal*.
- 118 Thompson, *Barbary and Enlightenment*, *passim*.
- 119 Said, *Orientalism*, 235.
- 120 A. Proust, *Essai sur l'hygiène internationale: ses applications contre la peste, la fièvre jaune et le choléra asiatique*, Paris, Masson, 1873; *La défense de l'Europe contre la peste: et la conférence de Venise de 1897*, Paris, Masson, 1892.
- 121 *The British Medical Journal*, 26 August 1893.
- 122 Baldwin, *Contagion and the State in Europe*, 231.
- 123 For a later discussion on the rigour of quarantine procedures and environmental hygiene as well as the possible use of inoculation, see Duguet, *Le pèlerinage de la Mecque*, *passim*.
- 124 David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, Berkeley, University of California Press, 1993, 186–189.
- 125 Azim Nanji, *Dictionary of Islam*, London, Penguin, 2008, 61.
- 126 Huber, 'The unification of the globe by disease?', 469. But even previously, in 1838, in the newly established lazarettos such as that of Beirut, travellers were examined 'by a European doctor who inspected their mouths with a stick and scanned their bare bodies for signs of plague' (Charles G. Addison, *Damascus and Palmyra: A Journey to the East with a Sketch of the State and Prospects of Syria under Brahmin Pasha*, London, Carey & Hart, 1838, 98).