Isolating the Subject: Cholera, Control and Sanitary Discourse in the Istanbul International Sanitary Conference of 1866

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Handan Kılınç

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The thesis of Handan Kılınç

is approved by:

Prof. Dr. Edhem Eldem (Advisor)…….

Prof. Dr. Nuran Yıldırım ……

Doç.Dr. Nadir Özbek .....

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Abstract

This study aims at studying the process of Istanbul International Sanitary Conference of 1866, politic structure of the conference and the condition of the Ottoman Empire through this process. The third international sanitary conference, which was gathered in Istanbul, only dealt with cholera disease. The main goal of the Istanbul International Sanitary Conference was to prevent the spread of cholera epidemic from Hejaz to Europe. The conference approved that the origin of cholera was India and the disease was transported by Indian pilgrims to Hejaz in hajj period and then western pilgrims spread it from Hejaz to Europe. In this case, European delegates focused on the sanitary condition of the Ottoman Empire. For this reason, the conference decided that restrictive sanitary measures and quarantine methods should be performed by the Ottoman Empire in Hejaz. Consequently, in the Istanbul International Sanitary Conference, European delegations used modern sanitary knowledge and measures as a political tool in order to give priority to benefits of Europe and to control some districts like Hejaz and Egypt. Thus, the sanitary measures approved by the conference were based on isolation, exclusion in order to segregate "diseased Eastern populations" from the West.

Özet

Bu çalışmanın amacı, 1865 kolera salgını sonrası toplanan 1866 İstanbul Uluslararası Sağlık Konferansı sürecini incelemek ve bu süreç boyunca gerçekleşen bazı tartışmaları, uygulanan sağlık politikalarını ve Osmanlı İmparatorluğu'nun durumunu aydınlatmak, aynı zamanda sürece farklı bir açıdan bakmaktır. 19. yüzyılın ikinci yarısından itibaren düzenlenmeye başlanan uluslararası sağlık konferanslarının temel amacı yüzyıl boyunca etkili olan salgın hastalıkların Avrupa'ya ulaşmasını engellemekti. Bu amaçla 1866 yılında İstanbul'da toplanan III. İstanbul Uluslararası Sağlık Konferansı sadece kolera hastalığı ve salgınları ile ilgilendi. Konferansta koleranın kaynağı Hindistan olarak belirlenirken, hastalığın Hintli hacılar vasıtasıyla hac döneminde Hicaz'a taşındığı, oradan da batıya giden hacılarla Avrupa'ya yayıldığına karar verildi. Konferansta, hacılar ve Hac dönemi üzerinde yoğun tartışmalar yapılırken, Avrupalı delegeler bölge üzerinde sert ve kısıtlayıcı tedbirler alınması için Osmanlı İmparatorluğu'na baskı uyguladılar. Bu nedenle, Osmanlı Devleti'nin Hicaz'da sağlık önlemleri alması ve karantina yöntemlerini uygulaması kararlaştırıldı. Neticede İstanbul Uluslararası Sağlık konferansı, kolera salgınları karşısında Avrupa devletlerinin menfaatlerini ön plana çıkaran ve Hicaz, Mısır gibi bölgeleri kontrol etmeyi amaçlayan politik bir araca dönüşmüştür. Bu konferans "hastalıklı doğu nüfusunu" Batı Avrupa'dan uzak tutmak için sert karantina önlemlerini uygulamayı kabul ederken, "doğu ve batı"yı iki farklı dünya olarak kabul etmiş ve sağlık söylemi üzerinden yeniden tarif etmiştir.

Contents

Introduction

The subject of this study is the analysis of Ottoman sanitary policy through the International Sanitary Conference held in Istanbul in 1866. My main aim in writing this work is not limited to an account of the conference, but aims also at studying its social and political implications. In short, the aim of this study is to demonstrate the existence of connections between sanitation and control and between cholera epidemics and international policy, with a view to clarify the political dimension and intentions of the Istanbul Sanitary Conference.

During my research, I have come across mostly neglected ground, so I am aware of the fact that I have left some subjects and aspects of the conference uncovered. On the other hand, it is practically impossible to mention all matters, sessions and debates in the conference, or to give a detailed account of the conference and sanitary policies of the Ottoman Empire. Eventually, this study will attempt to understand the social and political arguments during the process of the conference in order to explain the importance of cholera epidemics in international relations.

Epidemic diseases, particularly cholera, caused the death of many in the Muslim world and in the West throughout the nineteenth century. Medical efforts in the Muslim and western worlds were slow in finding an effective cure to this particular disease. Lack of knowledge about the nature of cholera and of its remedy increased its destructive impact on populations.

Cholera, as a mysterious disaster, influenced national and international affairs.[1] During the 1865 Hajj (Muslim pilgrimage) period, cholera broke out among pilgrims, and then spread to a large part of the world. European countries collaborated to keep away cholera epidemics and secure their boundaries from the disease. In the wake of the 1865 cholera epidemic, the Istanbul Sanitary Conference was organized to prevent future occurrences, to protect Europe from the disease and to isolate and exclude pilgrims. Throughout the conference, the representatives of European countries tried to coerce the Ottoman Empire to put barriers between their boundaries and the Hedjaz.

In the Ottoman Empire, the shift from classical Islamic to Western medicine played a considerable part in the modernization period. Regarding epidemic diseases and their prevention, the Empire adopted new sanitary policies and institutions based on western experience and institutions. In the nineteenth century, the international sanitary conferences and the restrictive measures on public health to be implemented against cholera epidemics were significant matters in the understanding of political relations between the Ottoman Empire and European powers. At that time, international sanitary policy was based on the isolation and exclusion of infected populations or individuals in order to control cholera epidemics.[2]

As historical issues, the Istanbul International Sanitary Conference and public health in the Ottoman Empire are largely uncharted territories. However, some students working on the history of colonial medicine and epidemic diseases in British India shortly deal with the conference with reference to some of the issues treated in their works.[3] One such study is

[1] Nancy Elizabeth Gallagher, *Medicine and Power in Tunisia, 1780-1900*, (Cambridge University Press, 1983), pp. 2-6.
[2] C. Strange and A. Bashford (ed.), *Isolation: Places and Practices of Exclusion*, (Routledge, 2003); J.S. Kahn, *Modernity and Exclusion*, (London; Sage, 2001).
[3] David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, (University of California Press, 1993); Gyan Prakash, *Another Reason: Science and The Imagination of British India*, (Princeton; Princeton Universty Press, 1999), pp. 137.

Public Health in British India[4] by Mark Harrison. Harrison gives an important place to the conference and to the pilgrimage problem in Mecca in his study,[5] and approaches the issue from the perspective of colonial medicine and cholera epidemics in British India in the nineteenth century. In *Lives at Risk*, La Verne Kuhnke mentions the conference within the context of the history of public health in nineteenth-century Egypt.[6]

In my study, I have structured the topic of the Istanbul International Sanitary Conference in three chapters.

The first chapter is intended to be an introduction. It attempts to give general information about cholera epidemics, disease theory, public health and medical institutions in the Ottoman Empire, as well as the Istanbul Sanitary Conference. The main aim is to draw a picture explaining the general conditions before the Conference was held.

The second chapter is devoted to the analysis of the process of the Sanitary Conference. It focuses particularly on some important discussions concerning the proposal prepared and submitted by the French government. These discussions reveal some of the basic objectives and different aspects of the conference.

The third chapter attempts to make a closer analysis of the conference in order to clarify its social and political background. The conference, which produced political discourses and instruments intended to control the quarantine system, the pilgrims and the cholera epidemics within the boundaries of the Ottoman Empire, is analyzed in order to reach a better understanding of the political issues in its process and performances.

In this study, arguments are based on official documents registered at the time of the conference. As mentioned above, the first and second chapters aim to give information about

[4] Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914*, (Cambridge University Press, 1994).
[5] *Ibid.*, pp. 117-138.
[6] La Verne Kuhnke, *Lives at the Risk: Public Health in Nineteenth-Century Egypt*, (University of California Press, 1990), pp. 101-102.

the 1865 cholera epidemic, sanitary policies formed to combat it and also important discussions, statements and established decisions observed throughout sessions of the conference. In the third chapter, arguments are presented to draw attention to the political background of the conference. The Istanbul International Sanitary Conference like others formalized problematic sanitary precautions that added to segregation, isolation and exclusion. In the conference, statements and demands of European delegates that determined outcomes of the conference attempted to mark Eastern countries as diseased and dangerous and thus constructed a divided portrait of the world with the infected Orient on the one hand and the healthy West on the other. Therefore, European delegates acted as "isolators" aiming to apply restrictive measures in order to isolate infected subjects of the Orient within the closed confines of quarantine zones. The conference defended their sanitation policies, which were to be practiced to protect humanity and especially healthy populations of the West from possible cholera epidemics. Throughout the conference, the Ottoman Empire was forced by almost all delegates of the conference to put barriers between East and West. Therefore, the Empire set up quarantine systems on Hejaz and changed its position from isolated subject to isolator against pilgrimages. As a result, the conference tended to use sanitation and hygiene as major supports to create its political tools and to control the East politically and economically through sanitary regulations.

Chapter I

Cholera Disease in the Nineteenth Century

Cholera as an epidemic disaster is one of the most important events that can define the nineteenth century. It spread throughout a vast area of the world, from Asia to Europe and the United States, and killed its victims with shocking speed throughout the century. Until 1817, it had only been seen in Bengal, where there had been sporadic outbreaks among the rural population. In that particular year, the disease moved outside Bengal. Thus, in the following years, cholera outbreaks emerged as a new kind of disease in different areas of the world.[7]

After 1817, this dreadful killer disease started spreading from India to Asia and Europe. Until the end of the nineteenth century, the medical profession had unclear and controversial views about the origin of cholera and its ways of contamination. Nevertheless, according to the general opinion in Europe, cholera was an Asiatic disease and tended to spread from Asia to Europe. In this case, the origin of cholera epidemics and the reason for deaths in Europe were perceived as the result of a diseased East sending cholera and other epidemic diseases to contaminate and invade the European continent. However, even though cholera did originate

[7] Mark Harrison, *op. cit.*, pp. 99.

from the East, it spread through the European continent rapidly because of predominantly unhealthy living conditions.

Europeans showed both great fear of and interest in this disease that affected their lives and imaginations. In Europe, the disease was viewed as a disease of the poor, who were already perceived as a threat to the health of the wealthy. Unhealthy living conditions of the poor populations facilitated the spread of cholera into the districts and houses of the poor from which it moved on to the better-off areas in the cities.

During the Industrial Revolution, industrial movements created new towns and cities, which, being close to factories, developed in an unhealthy and disorderly way. The laboring class had to live in the slums, as only the middle class lived in the suburbs since they were the ones who were able to afford transportation costs as they traveled every day into town to go to work. The laboring class had to compress into overcrowded places of the inner city districts. In this case, overcrowded living conditions became a significant problem and facilitated the spreading of epidemic diseases amongst the laboring class, immigrants and poor populations. During this period, infective diseases such as cholera, tuberculosis and scarlet fever were major threats to public health. Towns quickly enlarged in unhealthy conditions as the rural poor and the immigrants overcrowded cities. The rapid population growth led to the unplanned development of towns and cities. Small towns grew into huge cities as a result of the Industrial Revolution. These conditions led to the growing use of rooms shared by two or more families, which made living conditions unbearable with open sewers, cramped alleys, fetid smells, and damp and squalid living quarters. Some houses were called back-to-back houses as there were no backyards; toilets had to be shared between neighbors and were practically never cleaned. People had to get their water from the river dirtied by sewage and

carrying all the dirt from the town. As a result, governments in Europe had to produce and manage policies and apply public health measures to maintain the health of their populations.[8]

These unhealthy living conditions certainly played a great role in the spreading of diseases. Diseases were rife at that time, with outbreaks of cholera, typhoid and typhus, which led to a life expectancy that rarely exceeded 40. In the nineteenth century, these diseases spread very rapidly. Polluted drinking water caused cholera epidemics as well as dysentery and typhoid, which swept throughout Europe through the years 1830-33, 1847-48 and 1865.[9]

Cholera affected such a vast part of the world in the nineteenth century that it was called the cholera century. On the other hand, medical information about cholera was insufficient to determine the nature of the disease. Thus, its unknown character produced lengthy discussions among medical circles with respect to possible preventive measures.

During the nineteenth century in Europe, there were different explanations for the causes of the disease, which directly affected the measures taken to prevent epidemics from spreading. The theory of contagion was based on an ancient belief that disease was spread through direct contact among people. Girolamo Fracastoro provided the certain account of this theory in his well-known study *On Contagion*, published in 1546. Fracastoro claimed that living disease seeds possibly caused the contagiousness of diseases, since these contaminated seeds spread disease to other individuals through direct contact. For this reason, he defended the quarantine system and suggested quarantine, sequestration and fumigation to prevent the

[8] Anne Hardy, *The epidemic streets: infectious disease and the rise of preventive medicine*, 1856-1900, (Clarendon Press, 1993).

[9] Dorothy Porter, *Health, Civilization and the State: A history of public health from ancient to modern times*, (London and New York; Routledge, 1999), pp. 79-91.

disease from spreading. This theory persevered and remained unchanged until the middle of the nineteenth century.[10]

Another theory on the causes of the disease was derived from the Hippocratic idea according to which foul and contaminated air was responsible for propagating diseases. The miasmatic theory indicated that foul smells originating from swamps and rotten organic matter and toxic elements could pollute the environment, poison the atmosphere and cause disease for susceptible individuals.[11] The obvious aspect of the miasmatic theory was that it opposed quarantine systems. The miasmatic theory claimed that environmental improvement should be used as an effective method to prevent disease instead of the quarantine system.[12]

By the early nineteenth century, diseases that went beyond barriers of quarantine stations and spread even in healthy communities undermined the theory of contagion and quarantine measures. The miasmatic theory was therefore used to defend the cancellation of quarantine measures on shipping, towns and individuals. During the nineteenth century cholera epidemics, serious debates on quarantine methods and methods of eliminating environmental pollution emerged in European countries. In England, the miasmatic theory maintained its validity among many medical professionals and also amongst the public. Edward Chadwick restricted the practice of quarantine and formalized public health policies and institutions for sanitary improvement. The miasmatic theory, in explaining causes of diseases, was the essential doctrine of Edwin Chadwick's and other sanitarians' projects. Chadwick's comment to the parliamentary commission in 1846 was that all smell is disease, and this view determined most of the environmental sanitary reforms of the mid-nineteenth century. He

[10] Dorothy Porter, *Ibid.*, pp. 81-82; Kuhnke, *op. cit.*, p. 1
[11] Kuhnke, *op. cit.*, p. 3.
[12] Porter, *op. cit.*, p. 82.

strongly recommended that clean streets, well-ventilated housing, and effective sewage systems were most important in protecting the health of populations.[13]

During the 1831-1832 cholera epidemics, and despite riots in Russia, Prussia and New York quarantine measures were applied, but cholera spread through Western countries in spite of all attempts to isolate the infected grounds and districts. During the 1848 cholera epidemic, the use of quarantine was reduced due to the effect of anti-contagionist views. The two main disease theories defined as contagionist and anti-contagionist were significant in determining preventive measures until the middle of the nineteenth century.[14]

The water-born transmission of cholera was demonstrated by studies of English doctors John Sutherland and John Snow in the mid-nineteenth century. John Sutherland (1808–1891) was the appointed inspector to the General Board of Health of England in 1848. According to Sutherland's report prepared for the Board, contaminated water was the most important source of transmission of cholera. The report modified views about cholera. Sutherland used registers on the cholera outbreak experienced in Hope Street, Salford, and formed statistical evidence to exhibit connections between contaminated water and cholera. During the outbreak, cholera incidents were observed only in houses where people provided drinking water from the contaminated pump. He also informed that water in contaminated pumps involved cholera seeds. Sutherland therefore defined water as a most significant vehicle for transmission of cholera epidemics.[15]

John Snow (1813–1858) explained his cholera theory in a pamphlet published in August 1849. He used clinical observations of the cholera cases to prove the first part of his theory, connected to the pathology of cholera. He observed cholera patients and stated that the

[13] Stephanie J Snow, "Commentary: Sutherland, Snow and Water: the Transmission of Cholera in the Nineteenth Century", *International Journal of Epidemiology* (2002), 31, p. 909
[14] Porter, *op. cit.*, pp. 82-83.
[15] Stephanie J Snow, op. cit., pp. 909 and George Davey Smith, "Commentary: Behind the Broad Street Pump: Aetiology, Epidemiology and Prevention of Cholera in Mid-19th Century Britain", *International Journal of Epidemiology* (2002), 31, pp. 920-932.

cholera poison involved in contaminated water penetrated into the human body through the alimentary canal and then multiplied itself in the stomach and bowels. Snow advanced his arguments that choleric faeces in permeating into water sources and through sewers into rivers contaminated the public water supply. He suggested that preventive measures should be based on personal hygiene and that living and working conditions should be improved in order to limit the potential for faecal-oral transmission. He published the second edition of *On the Mode of Communication of Cholera* in 1855. He presented new observations related to cholera cases to extend his theory.[16]

In 1875, Louis Pasteur developed the germ theory which asserted that microorganisms cause certain diseases in the human body. With the studies of Pasteur, the germ theory replaced the miasma theory. In 1883, Robert Koch definitively identified the cholera bacillus.

As mentioned above, disease theory and western medical knowledge about cholera reached clear scientific evidence only at the end of the nineteenth century. Western medicine, which developed rapidly during the nineteenth century, occupied a central place in Western scientific thought and had a deep impact on the indigenous medicines of different cultures. In other words, throughout the nineteenth century, western medical knowledge influenced eastern countries and colonized areas and gradually took the place of their indigenous medicines.[17] Thus, medical knowledge and sanitary policies soon turned into governmental tools to control populations through medical treatment, vaccination, sanitary regulation, diseases and patient registration and isolation.

At this point, it can be said that the Ottoman Empire took into consideration western medicine as an alternative to its classical medical structure and institutions. Clearly, the

[16] Snow, *op. cit.*, p. 909-910.
[17] Nancy Elizabeth Gallagher, *op.cit.,* pp. 83-92.

nineteenth century was a modernization period for the Ottoman Empire, which took western medicine as a model for its reforms.

In the nineteenth century, in the Ottoman Empire, disease theory and the level of medical knowledge and institutions were mostly connected to two separate sources, western and classical medicine. The Ottoman Empire had a long history of medical practice that was based especially on classical Islamic medicine. In the Empire, the passage from classical Ottoman to western medicine constituted a significant aspect of the modernization process.

The concept of disease within Ottoman medicine did not show a uniform character in the nineteenth century. Classical Islamic and western medicine were still the most significant sources of knowledge.[18] Classical Islamic medicine was a hybrid structure originating from the Greek and Medieval Arabic medical traditions.[19] It is known that the concept of disease according to Islamic medicine was based on the miasmatic theory. This theory, which was put forward by Hippocrates and then developed and taken up by Galen and Ibn Sina (Avicenna) was the basic theory in classical Islamic medicine. According to Ibn Sina, different factors caused diseases. These could be internal problems of the body and external or environmental factors that were based on changes in the position of stars and planets, the influence of longitude and latitude, geography, climatic changes and events, the effects of atmospheric events and temperature changes within different seasons, the condition and quality of air, the position of the house one lives in, the effects of rest, activity and sleep, psychological factors, the effect of diet, the role of water, the effects of retention and elimination, the effects of baths

[18] Nukhet Varlık Akarsu, *The Study of Plague Treatise*, unpublished MA thesis of Bogazici University, (2000), pp. 5.
[19] A.I. Sabra, "The Appropriation and Subsequent Naturalization of Greek Science in Medieval Islam: A Preliminary Statement", *History of Science*, XXV, (1987), pp. 223-243.

etc..[20] Among these factors, earthquakes were accepted as an important signal in understanding the imminence of epidemic diseases such as cholera.[21]

Throughout the nineteenth century in the Ottoman Empire, classical Islamic medicine maintained its validity through printed books and the practice of medical treatment. Yet, at the same time, the Empire began to transfer western medical knowledge to establish modern medical institutions. As a result, two different medical traditions, one indigenous and the other western, came to be used simultaneously in the Empire.

One important reason for the reformation of the medical structure attempted by the Ottoman Empire was the cholera epidemics that struck the country during the nineteenth century. During the reign of Mahmud II, the administration had to take measures against the first cholera epidemic that struck the Empire in 1831.[22] It was on this occasion that Mustafa Behcet Effendi[23] wrote a pamphlet called *Kolera Risalesi*, in which he aimed to give information about the symptoms of cholera and to inform the Ottoman public about the disease. This pamphlet was delivered to military and civil officials.[24] It is important to note that the first quarantine application was implemented to prevent that particular cholera epidemic. At the same time, the quarantine practices of the Empire accelerated the westernization process of the Ottoman medical system.

Ismail Effendi, Imperial Chief physician, wrote another pamphlet about cholera in 1847. In his pamphlet, he shared the idea that cholera was a contagious disease, although he did not believe that it could be passed from human to human. Thus, he stated that diseased humans were not a source of cholera contamination for healthy humans. It was clear that in his work,

[20] Ibn Sina, *Kanun fi't-Tıbb*, transl. Esin Kahya, Ankara, Atatürk Kültür Merkezi Yayınları, 1995, pp. 113-152.
[21] Akarsu, *op. cit.*, p. 15.
[22] Nuran Yildirim, "Tanzimat'tan Cumhuriyet'e Koruyucu Sağlık Uygulamaları", *Tanzimat'tan Cumhuriyet'e Türkiye Ansiklopedisi*, vol. 5 (Istanbul: İletişim Yayınları, 1985), p. 1326.
[23] Mustafa Behcet Efendi (1774-1834) served as Chief Physician three times between 1803-1807, 1816-1821 and 1823-1834. He participated in the effort to establish a School of Medicine. At the same time, he played a leading role in the foundation of a quarantine administration in the Ottoman Empire.
[24] Feridun Nafiz Uzluk, "Kolera Risalesi", *Türk Tıp Tarihi Arkivi*, vol. 4, 1935, pp. 145-156.

he did not establish a clear definition of the causes of the disease, since germ theory was not known at his time.[25]

During the cholera epidemic of 1865, some personal efforts were made against the disease in Istanbul. Vincent Peche, one of the pharmacists of the palace, used his anti-choleric mixture to cure cholera patients.[26] In a similar way, Cyrus Hamlin, an educator at Robert College, composed two special formulae, which were used on many cholera patients. One of his formulae was composed of laudanum, spirit of camphor, tincture of rhubarb and the other of laudanum, tincture of capsicum, tincture of ginger and cardamom.[27]

It is significant to note that medical knowledge and the number of medical professionals who contributed to the struggle against the disaster of cholera were quite limited and certainly insufficient to prevent the disease. At that point in time, the Ottoman Empire focused on modern medical institutions instead of classical structures to solve health problems, and it had started to invite western medical professionals to establish medical schools and hospitals based on European examples.

The Westernization of Medical Institutions in the Ottoman Empire

In the nineteenth century Ottoman Empire, after the foundation of the new army, *Asakir-i Mansure-i Muhammediye,* health problems began to appear among soldiers. Mahmud II gave importance to sanitary conditions in the army and wanted to meet the requirement of medical staff within the army. However, deficiency of well-educated physicians and medical training

[25] Hekimbaşı Ismail, *Kolera Risalesi*, Istanbul Mekteb-i Tıbbiye-i Adliye-i Şahane litografya destgahı, 1263(1847).
[26] Suzan Bozkurt, Nuran Yıldırım, Yeşim Işıl Ülman, Bülent Özaltay, "1865 Kolera Salgınında Mabeyn-i Hümayun Eczacısı Vincent Peche ile Robert Kolej'den Cyrus Hamlin'in Kullandıkları Antikolerik Terkipler", *Osmanlı Bilimi Araştırmaları*, ed. Feza Günergün, vol. III, no:2 (2002), p. 56.
[27] Cyrus Hamlin, *Among The Turks*, Robert Carter and Brothers, (New York, 1878) pp. 308-309

was a significant problem in the Ottoman Empire. In this case, Mahmud II made some reforms on medical training in order to improve sanitary conditions in the army. On March 14th, 1827, the Imperial School of Medicine (*Tıbhane-i Âmire*) was founded by Mahmud II upon the urging of Mustafa Behcet Efendi, who was a determining character in modernising the Ottoman sanitary foundations. He, as the chief physician of the palace, was aware of the significance of modern medical education and sanitary measures against epidemic diseases that threatened the health of soldiers. On December 23rd, 1826, he presented an official statement to Sultan Mahmud II in order to explain the necessity of modern medical education and of opening the Imperial School of Medicine. He indicated that "among the Victorious Soldiers of Muhammad (*Asakir-i Mansure-i Muhammediye*) and other military units, the wounded and the sick should be treated and cured thanks to medical methods, both in times of war and of peace." Thanks to his efforts, modern medical education in the Empire started with the foundation of the Imperial School of Medicine (*Tıbhane-i Amire*).[28]

The Imperial School of Medicine was reorganized under the name of *Mekteb-i Tıbbiye-i Adliye-i Şahane* in 1839. Charles Ambroise Bernard, an Austrian physician, was invited from Vienna and was appointed director of the school in order to contribute to the modernization of medicine.[29]

Mahmud II gave a speech at the opening ceremony of the Imperial School of Medicine, which constitutes a fine example of the spirit of his sanitary reforms.[30] As mentioned in this

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[28] Ayten Altıntaş, " Osmanlılarda Tıp Eğitimi (Tıphane-i Âmire Dönemi*)", in Osmanlı Devleti'nde Sağlık Hizmetleri Sempozyumu*, Bilal Ak and Adnan Ataç, ed., (Ankara, 2000), pp. 90-96, also for related sources see Nuran Yıldırım, "Tıphane-i Âmire", in *Istanbul Ansiklopedisi*, vol. 7, (Istanbul: Kültür Bakanlığı ve Tarih Vakfı, 1994); Bedi N. Şehsuvaroğlu , "Türk Istanbul'da Tıp Öğretimi", *in Türk Istanbul'da Tıp Öğretiminin 500. Yıldönümü*, (Istanbul; Istanbul Üniversitesi Istanbul Tıp Fakültesi Yayınları, 1971).

[29] Yeşim Işıl Ulman, *Journal de Constantinople'a Göre Mekteb-i Tıbbiye-i Adliye-i Şâhâne'nin Galatasaray Dönemi*, Istanbul Universitesi Sağlık Bilimleri Enstitüsü, Deontoloji ve Tıp Tarihi Anabilim Dalı,unpublished MA thesis, (Istanbul, 1994), pp. 5, 36-39.

speech, the language of education at the Imperial School of Medicine was French. The language of medical education, the need for academic instructors and medical books were major problems in student training perspectives. Until the founding of the Civilian Medical School, medical training continued in French.

It should be mentioned that in the establishment of a new medical school and in the modernization of medicine, Mahmud II's primary concern was the army. The main reason for the establishment of the Imperial School of Medicine was to provide health services to the new army. It can be said that the establishment of a new medical school played an important role in the sanitary organization of the army as well as in westernization movements.

In 1867, the first civilian medical school (*Mekteb-i Tıbbıye-i Mülkiye-i Şahane*) was opened during the reign of Sultan Abdülaziz. The efforts of Salih Effendi, head of *Mekteb-i Tıbbiye-i Adliye-i Şahane,* were significant in establishing civilian medical schools. He presented a report and a reminder to the Sultan in order to declare the necessity of a civilian medical school. In addition, lessons in this school were given in Turkish. The main reason for

[30] "I have given precedence to this school because it will be dedicated to a sacred duty—the preservation of human health.... The instruction in medicine will be in French. You may ask why this should be in a foreign language. Let me explain the difficulties, which enforce this now.... It is true that many books were written among us [Muslims] on medical sciences and that the Europeans even learned many things by translating these books into their own languages. The books were written in Arabic however, and, as they ceased to be objects of interest and care in the Muslim schools for many years and as the number of men who knew them decreased, they became obsolete. To go back to these works now and plunge into their study in order to translate the science of medicine into our own language, Turkish, would be a painstaking job actually requiring many years. Having appropriated these works into their own languages, the Europeans have been busy improving upon them for more than a hundred years. In addition, they have facilitated the methods of teaching these subjects greatly and have added their new discoveries. Therefore, the Arabic works seem to me somewhat defective in comparison with these European works on medicine. Even if we claim that these defects can be overcome by borrowing from the new works, still they can not be translated into Turkish quickly because it takes at least ten years to master the Arabic language in addition to five or six years for the study of medicine. And what we need is well-trained doctors for our troops and for our people, on the one hand, and to have the medical sciences incorporated into our own language and our own medical literature codified, on the other. Therefore, my purpose in having you study the French language is not to teach you French as such but that you may learn medicine-and in order to incorporate that science step by step into our own language. Medicine will be taught in Turkish in our land only when this has been done." (Niyazi Berkes, *The Development of Secularism in Turkey*, McGill University Press, Montreal, 1964, pp. 100-110).

establishing a civil medical school in Istanbul was to produce enough doctors to respond to the growing needs of the civilian population.[31]

Before the nineteenth century, medical doctors generally also performed the tasks of pharmacists in the Ottoman Empire. In 1839-1840, a specific course on pharmacology was opened at the Imperial School of Medicine. During this period, Antoine Calleja was appointed to give the first true chemistry and pharmacology lessons and professional methods in the Imperial School of Medicine.[32] The curriculum of the Civilian Medical School, opened in 1867, also included a course in pharmacology.

The turning point of the nineteenth century in medicine was the establishment of the germ theory by Louis Pasteur in 1875, which radically changed medical and sanitary theory and practice in most of the world. In the 1880s, bacteriology and virology were also introduced in the Ottoman Empire. During the reign of Abdülhamid II, a commission of doctors was sent to the Pasteur Institute in France where they worked on microbiology, parasitology and zoology. After the commission returned to Istanbul, one of its members, Zoeros Pasha, was appointed as director of the laboratory that was opened in at the Medical School. It was called *Dersaadet Da'ul-kelb ve Bakteriyoloji Ameliyathanesi* (The Istanbul Rabies and Bacteriology Laboratory).[33]

Official Health Foundations and Public Health

In the Ottoman Empire, charitable health institutions were the basic structure for the Ottoman population's health. Sultans provided permanent income to religious charitable

[31]Ayten Altıntaş, "Mülkî Tıbbiye'nin Kuruluşu", *Tarih ve Toplum*, vol. 31, no: 184, (Nisan, 1999), pp. 216-222 and also Ekrem Kadri Unat and Mustafa Samastı, *Mekteb-i Tıbbiye-i Mülkiye 1867-1909*, (Istanbul; Istanbul Universitesi Cerrahpaşa Tıp Fakültesi Yayınları, 1990).

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[32] Yeşim Işıl Ulman, " Muallim Antoine Calleja ve Eczanesi ", in *Eczacılık Tarihi Araştırmaları*, Afife Mat ed., (Istanbul, 2003), pp. 196-197.

[33] Ekrem Kadri Unat, *Osmanlı İmparatorluğunda Bakteriyoloji ve Viroloji*, İstanbul Üniversitesi Cerrahpaşa Tıp Fakültesi Yayınları, (İstanbul, 1970).

foundations that financed medical and social service complexes. At the same time, charity was important in supplying needs for the poor population in the Empire. Until the nineteenth century, the medical practice of the Empire did not attain an effective health care strategy for the public, nor did it reach it anywhere else in the world. In the Ottoman Empire, physicians' missions were generally supposed to fulfill procedures and to prescribe remedies. In addition, physicians helped their patients with diet and nutrition, which were perhaps the most significant part of treatment in the hospitals. Actually, the Ottoman public applied very common solutions like home remedies to receive treatments. In the Empire, regulation of markets, bazaars and shops was the major affair for public health. For this reason, the Empire attempted to organize and control these selling centers in order to supply sanitation and health. However, the Empire did not organize many medical and sanitary relationships until the middle of the nineteenth century. In addition, medical knowledge and medical practice remained in their classical structure prior to nineteenth century improvements.[34]

At the middle of the nineteenth century, the Imperial capital witnessed many European visitors following the commercial treaty of 1838 between England and the Ottoman Empire. This treaty paved the way for the growth of foreign trade and the emergence of a successful merchant class of resident foreigners. Besides, during the Crimean War in the years of 1854-1856 a vast number of British and French soldiers came to the Imperial capital in order to fight on the Ottoman side against Russia. After the war, some foreign soldiers did not leave Istanbul and they stayed in the capital to maintain their commercial affairs and relations. They also transferred their experience of the recent European applications on urban planning and organization. From this time, these European residents attempted to state their demands concerning improvements of municipal service in the Imperial capital. The foundation of

[34] Rhoads Murphey, "Ottoman Medicine and Transculturalism from the Sixteenth through the Eighteenth Century", *Bulletin of the History of Medicine 66*, (1992), pp. 379, 387-388

Sehremaneti, which was founded as the first public service of the Ottoman Empire in 1855, can be seen as a response to the demands of foreigners in the district of *Galata*. The tasks of the *Sehremaneti* contained some older duties of the *muhtasib* to organize and inspect goods, guilds and merchants, prices, sanitation of the markets, and the condition of streets and bazaars[35]. In addition, because of the Crimean War, the Ottoman Empire was officially accepted by Europe as a member of the Council of Europe at the Treaty of Paris in 1856. This membership of the Council of Europe indicates a westernization process that includes municipal reforms organized in the hands of highly westernized council.

In the year of 1859, a municipal council was established to propose some activities and projects to the *Sehremaneti* in the European district of Istanbul. The council included European and non-Muslim Ottoman members. The council and particularly its foreign members had influence on local managements and organizations in the capital. The council concentrated on some issues involving street lighting, a ban on ambulatory peddlers, and the creation of central fish and vegetable markets. The council also suggested detailed rules, reforms and procedures to control commercial goods and marketplaces. In the capital, bakeries, butcher shops, pharmacies, wine shops and public baths could regulate their activities in providing sanitary conditions and commercial order. Especially detailed rules that were determined in order to inspect food sellers and candy manufacturers defined the legal composition and purity standards for these products. On the other hand, the council did not achieve enough results to implement and enforce its reforms because of inadequacy of material sources.[36]

On May 13th, 1852, the Regulation of Pharmaceutics (*Nizamname-i Eczacıyan Der Memalik-i Osmaniye*) was legalized by the Ottoman government in order to control

[35] Steven Rosenthal, "Foreigners and Municipal Reform in Istanbul: 1855-1865", *International Journal of Middle East Studies 11*(1980), pp. 228-230, 237.
[36] Rosenthal, *op. cit*., pp. 237-240.

pharmacies and to prevent unqualified persons who threatened public health. In 1861, *Nizamnamei Eczacıyan* was reorganized and published under the name of Regulation Related to the Performance of Civilian Pharmacists (*Beledi Ispenciyarlık Sanatının Icrasına Dair Nizamname*) which aimed at regulating pharmaceutical practices in the Ottoman Empire. [37] In the same year, Regulations Related to Civilian Medical Sciences in the Imperial Ottoman Domain (*Memalik-i Mahrusa-i Şahanede Tababet-i Belediye Icrasına Dair*) was published to organize practices of doctors who had to hold a diploma from the Imperial School of Medicine or a known European Medical Academy or to be certified by the Office of Public Health in the Imperial School of Medicine.[38]

Another issue concerning public health was epidemic diseases and precautions which were connected to the quarantine methods in the Ottoman Empire. In 1831, the first serious quarantine regulations began in the Empire. Mustafa Behcet Effendi as an imperial head physician organized some restrictive measures against cholera epidemics. In the reign of Mahmud II, the use of quarantine was started by his efforts. Ships arriving from the Black Sea underwent quarantine in *Istinye*, and ships arriving from the Islamic countries underwent the same procedure in *Büyükliman*. The first quarantine applications could not be maintained by the Ottoman government for a long time.[39]

In the East, quarantine councils had started to be established by the Ottoman Empire, Egypt and Iran since the 1830s.[40] The Quarantine Council (*Meclis-i Tahaffuz/ Karantina Meclisi*) was established by Mahmud II in 1838. The first president of the council was Abdullah Molla.

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[37] Nuran Yıldırım, " Nizamname-i Eczacıyan der Memalik-i Osmaniye- Osmanlı Devleti'nde Eczacılar Nizamnamesi -1852", *in IV. Türk Eczacılık Tarihi Toplantısı Bildirileri*, Emre Dölen ed., (Istanbul, Marmara Universitesi Yayınları, 2000), pp. 46-62.

[38]"Memalik-i Mahrusa-i Şahanede Tababet-i Belediye Icrasına Dair Nizamname (Osmanlı İmparatorluğu'nda Sivil Hekimlerin Tababet İcrasına Dair Nizamname)7 Rebiülahir 1278 (2 Ekim 1861)", Osman Nuri, *Mecelle-i Umur-i Belediye*, vol.IV, Dersaadet 1331, s. 7-9.

[39]Ahmet Mithat Efendi, "Devlet-i Aliyye-i Osmâniye'de Karantina Yani Usûl-i Tahaffuzun Târihçesi", Abdullah Köşe transl., *Osmanlı Bilimi Araştırmaları*, vol.V, no: 1, (Istanbul Universitesi Yayınları, 2003), pp. 90-91, Bedi N. Şehsuvaroğlu, *Türkiye Karantina Tarihine Giriş*, Istanbul Universitesi Tıp Fakültesi Mecmuası, (Istanbul, 1957), pp. 603-619. and also see Ahmed Lütfi, *Lütfi Tarhi*, Istanbul 1302, pp.126.

[40] Bedi N. Şehsuvaroğlu, op. cit., pp. 319.

From 1846 to 1889, Bartolletti Effendi remained as a president of the council. This council was the first organization related to public health established in the Ottoman Empire. However, the Quarantine Council gave primary importance to ports and did not have a large effect on the general population. For this reason, it must be considered a civil health organization, but not a public health organization.[41]

In 1840, the council became an international structure with European members. Germany, England, Austria, Spain, France, Sweden, Norway, Russia, Holland, Belgium, Italy, Greece, America and Iran sent their delegates, who were elected as representatives of foreign embassies in the Empire to participate in the council which proposed to protect the Empire against epidemic diseases coming from outside. The main reason for this decision of the Empire was to reduce the continual objections of the European Countries about the practice of quarantine in the Empire and to facilitate matters related to them.[42] Thus, together with the Ottoman members, the European doctors and the delegates of European countries were included in the council.

At the beginning, the delegates of European countries had temporary participation in the Quarantine Council, but afterwards their membership turned into permanent positions. The European delegates behaved to the contrary of the expectations of the Ottoman Empire that had aimed to facilitate the practice of quarantine with their membership.

Finding material resources for the expenses of quarantine regulations became an important problem in the Ottoman Empire. Through the application of quarantine, the Empire tried to decrease its economic burden by applying quarantine taxation to foreign ships. The Empire decided to organize quarantine taxation according to the rules of the Paris Sanitary

[41] Nuran Yildirim, *op.cit*., pp. 1320.
[42] Bedi N. Şehsuvaroğlu, op. cit., pp. 320- 21, and Ahmet Mithat Efendi, op. cit., pp. 98-99.

Conference.[43] Thus, the rules of Ottoman quarantine taxation became valid in 1856. However, the European countries opposed this new practice of quarantine taxation. Because of this opposition from European countries, the Empire could not take these taxes from the foreign ships. The quarantine taxation (*Karantina Rusumat Tarifesi*) was scarcely put into application in the Ottoman Empire in 1872.[44]

The Cholera Epidemic of 1865 in The Ottoman Empire

Cholera is an acute, diarrhoeal illness caused by infection of the intestine with the bacterium *Vibrio cholerae*. The infection is often mild or without symptoms, but sometimes it can be severe. Infected persons have severe disease characterized by profuse watery diarrhoea, vomiting, and leg cramps. In these persons, rapid loss of body fluids leads to dehydration and shock. Without treatment, death can occur within hours. A person may get cholera by drinking water or eating food contaminated with the cholera bacterium. In an epidemic, the source of the contamination is usually the faeces of an infected person. The disease can spread rapidly in areas with inadequate treatment of sewage and drinking water.

Cholera originated in India in 1768, it was seen in Assam, Bengal, and the Ganges river valley. It spread rapidly throughout the world. The first cholera pandemic, lasting from 1817 to 1823, surfaced in Calcutta and spread rapidly through India and Asia, yet failed to affect Europe. However, it struck Europe with four severe pandemics. In 1827, cholera spread to Russia in 1829 and China in 1831 and then to European countries, England, the Ottoman

[43] Emine Melek Atabek, *1851'de Paris'te toplanan I. Milletlerarası Sağlık Konferansı ve Tükler*, Istanbul Üniversitesi Cerrahpaşa Tıp Fakültesi Yayınları, Istanbul, 1974, pp. 88- 89.
[44] Ahmet Mithat Efendi, op. cit., pp. 119.

Empire and West Africa.[45] It is estimated that twenty-five million people died during this first pandemic. The other cholera pandemics were seen in the years 1840-1862, 1863-1875 and 1883-1894.

The caravan routes conveyed the disease as the earlier international routes of cholera were from India to Persia from where it spread to Russia and the Arab Lands. This disease was carried by passengers of steamships from Egypt to Europe and also to the Americas. The domination of the British Empire and the East- Indian Company in internal and global commerce and connections with India caused cholera to come from India and spread on an international scale. Thus, maritime trade of the British Empire with India facilitated the spread of the disease from port to port through infected goods, which were recycled clothing or foodstuffs. In addition, the rapidity of travel by ships and railways from India to different areas enabled infected individuals to propagate the disease.[46]

Muslim pilgrims came from all over the world to Hejaz at the time of the religious ceremony, Hajj. For this reason, the Hejaz seemed like a center from which cholera was distributed all over the world, especially to Europe. The pilgrims preferred the caravan routes to reach Mecca until the advent of the steam ship. In the year of 1858, steam travel began, and with this important event travel time between ports was reduced. Steam ships and railways contributed to trade, travel and also spreading cholera all around the world. Throughout the nineteenth century, cholera was a serious threat for the Ottoman Empire that had to take measures to prevent the spread of this disease among pilgrims at the time of Hajj in the Hejaz. However, the connection between the pilgrims and cholera was not recognized

[45] Conference Sanitaire Internationale, *Rapport: Sur Les Questions Du Programme, Mai, 1866*, (Constantinople ; Imprimerie Du Levant Herald, 1866), pp. 4-6.
[46] Amir A. Afkhami, " Disease and Water Supply: The Case of Cholera in 19th Century Iran", *Bulletin series*, Yale School of Forestry and Environmental Studies, Middle Eastern Natural Environments, no 103, (1998), pp. 207.

until 1865. The Ottoman ports, especially Egypt were menaced by the various cholera epidemics which broke out between 1831 and 1902.[47]

The cholera pandemic of 1826 first reached the Eastern Mediterranean coasts. It spread to other populated areas like Alexandria, Cyprus and Syria in 1831. Cholera disaster first appeared in Istanbul in the same year. Louis Mongeri[48] registered that at least 3,000 cases of death were noted during the epidemic of 1831. In 1832, cholera largely invaded the Ottoman Empire. It is an important to point out that this epidemic influenced the Empire's decisions in taking measures against cholera disasters.

Cholera invaded India and China in the 1840s and severely devastated Iran in 1846. This epidemic spread to Mecca and Medina and caused the death of 5,000 pilgrims. Cholera was carried by pilgrims to Istanbul and Egypt in 1847. 4,275 out of 9,237 people infected died from the disease in Istanbul in that year[49]. The imperial capital was struck by another cholera epidemic in the 1850s.

Another critical cholera epidemic affected the Ottoman Empire in 1865. This cholera epidemic was the well-documented contagious disease of the Ottoman Empire in the nineteenth century. The cholera epidemic of 1865 dramatically progressed from the Hejaz to Egypt and from there to Europe. The reason for this epidemic in Egypt was infected steamships, which transported pilgrims from Hejaz to Suez. The ships, the captains of which declared incomplete information about the health of their passengers, were given pratique, a clean bill of health , by officials in Suez in order to continue their voyage. Nevertheless,

[47] La Verne Kuhnke, *op. cit*., pp. 49, 65-67.
[48] Louis Mongeri was an Italian physician living and working in the Istanbul. He wrote articles in the Medical Gazette and a book which mentioned his observations and experiences about cholera epidemics of the capital in 1865. In his writings, he explained that how cholera spread, how the inhabitants reacted to the disease, and how the government worked to combat it. His writings are the best document of 1865 cholera epidemic in the nineteenth century Ottoman Empire.
[49] Nuran Yıldırım, *op.cit*., pp. 1326.

during the voyage deaths from cholera had occurred among passengers in the ships[50]. News about the disease reached the imperial capital from Egypt. However, officials there supposed that the deaths related to plague and for that reason no one in the capital took the cases seriously. Telegrams from Alexandria reached the capital indicating cholera, but too late to take measures. At the same time, cholera had newly reached Izmir, where people believed that the air must be poisoned. People began to leave the city in panic[51].

On 28th June 1865, *Moukbir-i Surur* came from Alexandria to transport an Ottoman pasha with other passengers to the imperial capital. At the same time, this official ship carried cholera to the capital[52]. The ship had completed five days of its voyage. For this reason, according to quarantine rules, the ship had been left earlier from quarantine with a pratique. The quarantine officials did not apply quarantine procedures, since there was no suspicion or reason to isolate the passengers of the ship within quarantine stations. Thus, port officials allowed the passengers to disembark. During the night, twelve passengers who showed some symptoms of cholera, such as diarrhea, arrived in the port. Diseased people were sent to the naval hospital which was near the military dockyard. It is important to note that the first cholera cases appeared among workers of this dockyard. After suspected death cases, officials in the Board of Health started an investigation to find the cause of death. As a result of the investigation, they understood that there had been some cases linked to diarrhea on board while the ship was on route, and then two men had died and were buried at sea. After investigation, the ship was disinfected at the fumigation station at Büyükliman. On the other hand, cholera spread among dockyard workers at the port and then they carried the disease

[50] Gulden Sarıyıldız, "XIX. Yüzyılda Osmanlı Imparatorluğu'nda Kolera Salgını", *in Tarih Boyunca Doğal Afetler ve Deprem Semineri*, İstanbul Univesitesi Edebiyat Fakültesi, Tarih Araştırma Merkezi, II. Baskı, İstanbul, 2002, pp. 314.
[51] Louis Mongeri, *Etudes sur l'epidemie de cholera qui a regne a Costantinople en 1865, suivres d'un appendice sur la nature du cholera et des deviors medicines sanitaires*, Constantinople Imprimerie, M. de Castro, 1866, pp. 12.
[52] *Ibid*., pp. 13.

into their living quarters which were the *Kasımpaşa* district[53]. Thus, the epidemic called great cholera began in the capital in 1865.

According to Mongeri, after 12 or 15 days, death cases firstly emerged in *Kasımpaşa* where Armenian and Kurdish workers lived in the crowded and unhealthy *hans*. Cholera was not seen in any other district of Istanbul at this period. It is likely in this situation that those very poor laborers of *Kasımpaşa* rarely went away from the district. Mongeri considered that an infected worker coming from *Kasımpasa* visited a coffee house in *Yeniköy*, where the Greeks and Jews frequently gathered, and then the cholera from this infected worker spread to the Greeks and Jews and then from them to their families on the 13th July. On July 14th, a police officer reported some sick men in the barracks. The cholera cases emerged among Muslim, Greek and Armenian residents in the *Yeniköy* district at the night of the 15th. Inhabitants of the district attempted to escape from cholera, thus they transported their infection to other parts of the cities. [54]. Cyrus Hamlin mentions this epidemic of Istanbul in his book Among the Turks:

"Its most terrible ravages were in the onset of 1865. During the last days of August of that year, business ceased and the great capital attended to nothing but burial of the dead. By the actual account of an English friend, more bodies were carried out of one gate than the whole number of deaths reported by government; the latter hoping to diminish the panic by the false report."[55]

He shortly explains the conditions of Muslim and Jew inhabitants during this time in another part of his book[56]:

[53] Conference Sanitaire Internationale, *Rapport: Sur Les Questions Du Programme,* pp. 22-23.
[54] *Ibid,* pp. 19.
[55] Cyrus Hamlin, *op. cit.*, pp. 304.
[56] *Ibid*, pp. 313

"As in the plague, so in the cholera the Moslems and Jews were the greatest sufferers; the latter for their filth, the former for their fatalism. Filth and fatalism are grand aids-de-camp of the enemy."

Mongeri states that *Fuad Paşa* organized a convention together with the officials of the Board of Health and the Imperial School of Medicine in order to reduce of effects of the epidemic and take some measures. At the outcome of this meeting, a commission at the head of the *Sadrazam* was established to protect the health of the Ottoman public against existing cholera epidemics. The tasks of the commission supplied a sufficient number of doctors to manage the medical service in Istanbul. The commission consulted with the Chief of Military Sanitation to determine measures, which should be quickly taken. At the different central districts of Istanbul, dispensaries and posts of aid were found, which were organized to facilitate the health service of the administration which distributed required materials to temporary hospitals. Medical staff were divided into three groups who were inspectors, resident doctors and medical aids.[57]

At the same time, a new health commission was established under the administration of Mehmet Paşa, Minister of the Police, alongside the principle doctor of that ministry acting as his assistant. Doctors Mongeri, Naranzi, Galenzi, Paravioale Bey, Salih Bey, Stepan Bey and Zographies became the general members of the commission.

During the 1865 cholera epidemic, medical officials reported all cases of cholera; those reports involved lists which related names, ages and dwelling places of victims. They also notified all cases considered to be threats for public health.

Mongeri noted that the officials did not complete their plans in practice during epidemics, since different complications appeared in organizing and realizing plans. In some cases, individuals often behaved contrary to the fixed rules of public hygiene and sanitation. On the

[57] Louis Mongeri, *op. cit.,* pp. 21-22

other hand, the number of doctors, pharmacies and hospitals was not sufficient to provide for the requirements of the public. In Istanbul, pharmacies were appointed by the government to distribute remedies to infected people free of charge. However, many pharmacies were closed because of the insufficiency of personnel and medicinal supplies. As a solution to provide for the needs of hospitals, the Board of Health sent out mobile medical units. Four large hospitals in the capital and a small hospital with a capacity of 20 to 30 beds were established in each village on the Bosphorus.[58]

The health commission received reports from appointed doctors who were Pisti, Litzika, Zoeros, Stampa, Metaxa, Oksa, Ferro, Triandaphilides, Bolonaki, Fleury and de Castro. The first reports, which were presented to the health commission on July 19th, explained that the first Cholera cases were seen along the Bosphorus in Kasımpaşa or Yeniköy, after a short time cholera spread to other districts of Istanbul. [59]

Dr Litzika reported that 24 death cases were determined in Yeniköy between the 17th and the 19th of July. The people suffered not only from cholera, but also from the threat of starvation. He requested that food and necessary materials should be sent to temporary hospitals.

On 17th July, Dr. Bolonki reported that death or illness had not been seen in Tatavla, but two cases were appeared on 19th July. Dr. Zoeros noted in his report that one case was seen in Beşiktaş on 19th July. Mongeri informed that the estimated result for cholera cases and the number of infected individuals had increased to 9,000 by 19th July[60].

By 21st July, cholera cases appeared on the both sides of the Bosphorus. Cholera entered and invaded nearly every village of the Bosphorus in almost the same way. It emerged and spread rapidly among the houses of residents on the waterfront and then it continued to be

[58] *Ibid*, pp. 23.
[59] *Ibid*, pp. 23.
[60] *Ibid,* pp. 24-25.

diffused along valleys and ravines. Under the attacks of cholera, there was not any safe area left in the city.

In his book, Mongeri added that according to the official approach accepted in the Ottoman Empire, cholera was not a contaminating disease from person to person and for this reason, the application of quarantine on people, commercial goods and transport vessels was only a waste of time. In the capital, some doctors confronted this approach of the Empire. They indicated an important event that the wrong decisions of the Ottoman officials concerning Moukbiri-Surur in Büyükliman had caused the cholera epidemic and allowed the infected sailors to escape the required isolation and quarantine rules. Mongeri noted that the officials of the capital refused to cordon the city off, effecting large-scale quarantine. Approximately 40,000 to 50,000 individuals became infected from cholera within a week.[61]

During the epidemic, *Mehmet Pasha,* the minister of police*,* took some sanitary measures in the city. He closed down slaughterhouses which were working inside the capital. He organized fumigation teams to disinfect coffins and conveyed corpses and remains ,which had been interred a long time before, from the ancient cemeteries of the old city to new cemeteries in order to provide hygienic conditions into the capital. He persuaded many reluctant large homeowners who temporarily converted their residences into infirmaries to serve patients.[62]

According to some points of view, the other disaster called the fire of Hocapaşa played an important role in putting an end to this epidemic. After the fire, the rate of cholera deaths reduced and the disease almost disappeared for one week in Istanbul.[63]

[61] *Ibid*, pp. 34-38.
[62] *Ibid*, pp.55-56
[63] Nuran Yıldırım, Kolera Salgınları, in *İstanbul Ansiklopedisi*, vol.V, pp. 46.

The Istanbul International Sanitary Conference of 1866

The beginning of international health governance is located in the series of international sanitary conferences that took place between 1851 and 1903. These international sanitary conferences arranged to control cross-border transmission of infectious diseases, especially cholera and yellow fever. In the following years of 1817, cholera started to spread outside Bengal. The two cholera epidemics that invaded Europe between 1830 and 1847 were promoted by the increased circulation of goods and people between East and West which accompanied developments in international commerce following the invention steamships and railroads. European countries organized the international sanitary conferences as a responsive mechanism for the economic and political problems originated from cholera epidemics.[64]

The first sanitary conference, which was followed by diplomatic and medical representatives of twelve governments was convened in Paris in 1851. The conference focused particularly on political, commercial interests and also regulating in a uniform way the quarantine and lazarettos in the Mediterranean. In the conference, delegates decided to exclude the discussions on scientific and etiological approaches. Commerce, trade, economic competition and regulation of quarantine systems were primary concerns of the conference.[65] Throughout the first international sanitary conference, and also the others, the Middle East was seen as an area responsible for contaminating Europe with cholera epidemics.

The second international sanitary conference was convened in 1859 in Paris. Economic and political conflicts among participant countries became clear in this conference, where a

[64] Kelly Loughlin and Virginia Berridge, Global Health Governance: Historical Dimensions of Global Governance, *Discussion Paper 2*, Centre on Global Change & Health London School of Hygiene & Tropical Medicine (University of London, March 2002), pp. 6-7.

[65] Emine Melek Atabek, *op. cit.,* pp. 32-33.

uniform regulation of quarantine systems was discussed. Quarantine measures and closing the ports caused obstruction to the maritime economies of the European countries. The conferences of 1851 and 1859 were organized to discuss threats of epidemic diseases and quarantine regulations. However, at the end of the conferences, the decisions did not attain any legal status to determine international sanitary rules and apply coercive measures or penalties.

As mentioned above, in the year 1865 cholera spread from Hejaz to Egypt and then to Europe. Railroads and maritime links between the Middle East and Europe facilitated the propagation of the disease. In this period, the railway line of the Alexandria-Cairo-Suez link, which connected steamship transportation in the Mediterranean and the Red Sea had reduced traveling time in the Middle East. The rail-sea road was frequently used by pilgrims who preferred this road instead of the difficulties of the caravan treks. In 1865, a cholera outbreak had appeared in India, from which it propagated among pilgrims in the period of Hajj. It was an auspicious year, Hajj al Jum'a, for pilgrims who reached a greater number than before. As a result of the rail-marine transportation, cholera rapidly spread from Hejaz to the West. [66]

The emergence of the cholera epidemics in the European continent activated France, which called related governments in convening an international sanitary conference against cholera epidemics in 1866. The third international sanitary conference was held under French initiative in Istanbul.

The first session of the conference was held on February 13th. Ali Pasha, Minister of Ottoman Foreign Affairs, opened it. The countries represented at the sessions of the Conference, and the names of the delegates sent by them, were as follows:

Austria, represented by M. Vetsera and Dr. Sotto

[66] Amir Arsalan Afkhami," Defending the Guarded Domain: Epidemics and the Emergence of an International Sanitary Policy in Iran", *Comparative Studies of South Asia, Africa and the Middle East*, vol. XIX, no. 1 (1999), pp. 124.

Belgium, represented by Noidans

Denmark, represented by Dumreicher

Spain, represented by Don Antonio Maria Sagovia and Dr. Monlau

Papal States, represented by Brunoni, Dr. Ignace Sparado

France, represented by Lallemand and Dr. Fauvel

Great Britain, represented by William Stuart, Dr. E. D. Dickson, Dr. E. Goodeve

Greece, represented by Kallergi, Dr. G.A. Maccas

Italy, represented by Alexandre Vernoni, Prof. Frederic Bosi, Dr. Salvatori

Holland, represented by Keun and Dr. Millingen

Iran, represented by Mirza Malcom Khan, Dr. Sawas Effendi

Portugal, represented by Edouard Pinto de Soveral and Dr. B. A. Gomes

Prussia, represented by Baron Testa and Dr. Muhlig

Russia, represented by Dr. Pelikan, Dr. Lenz, Dr. Bykow

Sweden and Norway, represented by Oluf Stenersen, Dr. Hubsch

Ottoman Empire, represented by Salih Effendi, Dr. Bartoletti

Egypt, represented by Dr. Salem Bey

At the Conference, the program was prepared, and its works were divided into four parts[67]:

1- Origin and development of cholera

2- Mode of its propagation

3- Measures of preservation

4- Form in which the resolutions adopted by the Conference were to be embodied.

In the process of the conference, the commissions appointed by the Conference had studied the above-mentioned subjects and presented their reports to delegates, who discussed those

[67] FO 881/1475, Turkey: Report. Work performed by Sanitary Conference at Constantinople. Cholera, October 3, pp. 1

reports. The commissions appointed for the study of the two first-mentioned groups were composed of all the medical delegates, with three diplomatic members. On the other hand, the commissions for the remaining groups were constituted indiscriminately of diplomatic and medical delegates. The commissions at the Conference presented six reports[68]:

1- On the origin and propagation of cholera

2- A historical sketch of the epidemic of 1865

3- On measures of hygiene

4- On measures of restriction

5- On measures especially applicable to the East

6- On the form to be given to the resolutions of the Conference

The Istanbul international sanitary conference completed its works with 44 sessions on the 26th of September. During the sessions, the conference basically focused on some important points related to the origin and the spread of cholera, the means of preventing its diffusion. Therein, discussions about the etiological and nosological nature of cholera were held to determine the nature of the disease. However, the etiological information concerned with the disease was not sufficient to define its nature at that time. For this reason, the inquiries of the related commission on this question did not reach a clear conclusion to stop discussions among delegates. On the other hand, despite insufficient information about the nature of the disease, the conference accepted cholera as a contagious disease officially.

The main concern of the Conference was the subject of the third commission which worked on protective precautions. The defensive measures were taken in the Orient to prevent recurrent invasions of cholera in Europe. It is obvious that the basic aim of the Conference was to protect the West against the threats of cholera, which spread from the East. For this reason, the European delegates saw the Middle East countries, especially The Ottoman

[68] *Ibid*, pp. 1

Empire and Iran, as a barrier to keep and to control the cholera epidemics. According to the decisions, the cholera epidemics originated from the Ganges delta in India, not from Hejaz, but the period of Hajj was the risky time to spread the disease into Europe.

Throughout the Istanbul International Sanitary Conference of 1866, the Ottoman Empire confronted difficult and comprehensive debates and demands of the European nations on the quarantine measures, strict health policies on Hajj and pilgrims. European delegates, especially France, demanded strict measures to be taken by the Ottoman Empire in Hejaz. For this reason, the Ottoman Empire carried significant political and economic responsibilities connected with international sanitary policies and cholera epidemics. However, it cannot be stated that the Empire established its public health policy and practices within its boundaries as a result of this process; it did not realize a satisfactory public health policy and organization.

Chapter II

The Process of The Istanbul International Sanitary Conference

Cholera had appeared among Muslim pilgrims several times at the Hajj periods before 1865, but this time it struck more severely and suddenly than previous times. That year, the feast of Qurban Bayram, the Muslim festival of sacrifices, coincided with a Friday, Hajj al-Jum'a, which was a special case considered by Muslims as being seven times more blessed than the feast on an ordinary Friday. For this reason, a greater number of pilgrims visited Hejaz. At that period, cholera was in Mecca and Medina and mortality rates reached high levels amongst Pilgrims. They transported the disease outside Hejaz. It is important to notice that from 1858 on, pilgrims started to use steamship transportation to come from Hejaz to Egypt and then the Alexandria-Cairo-Suez railway line connected to the steamship transport to the Mediterranean instead of regular caravan road.[69]

After the Hajj of 1865, steamships transported pilgrims from Hejaz to Suez in which port physicians inspected health conditions on board to report suspected cases of cholera, and then if no cholera cases were found they permitted the steamships to enter at Suez without

[69]FO, 195/864, Conference Sanitaire Internationale, *Rapport: Sur Les Questions Du Programme, mai, 1866*, pp. 19.

obstacles. On the other hand, at Suez, they did not register any death cases of passengers, which were declared by the steamship captains as a result of ordinary diseases, but showed to be cholera cases later on. It is obvious that the declarations of steamships about the death cases were not true. Thus, the steamships carried pilgrims to Suez and from there they headed towards Alexandria by railway. After the increase of death cases from cholera in Alexandria, foreigners began to leave Egypt and head to other ports of the Mediterranean-Beirut, Cyprus, Malta, Smyrna, Istanbul, Trieste, Ancona, Marseilles, Valencia- and they carried the disease to these ports.[70] As mentioned and explained earlier, Moukbir-i Surur transferred the disease from Egypt to Istanbul.

The cholera epidemic of 1865 severely damaged the West as well as Eastern countries. Following the cholera epidemic of 1865, the international attention focused on Hajj periods and Muslim pilgrim traffic. European powers had the same opinion about one point: the disease spread from East to Europe because of pilgrims, so they had to control sanitary conditions and movement of pilgrims to impede the entrance of the disease in Europe. Thus, with the initiative of France, who called for an emergency meeting, they moved against the new dashes of cholera. They decided to organize an international sanitary conference to coordinate necessary measures in order to protect Europe from cholera epidemics. It was not a surprise that the European powers offered the mission of organizing the third international sanitary conference to the Ottoman Empire. Actually, Europe described the Empire as a critical cholera source due to the Hejaz district. Obviously, they expected the Conference to focus on pilgrims, who should have been controlled by the Ottoman Empire to keep possible cholera epidemics within boundaries of Hejaz at the hajj period of 1866. Thus, before the conference, European powers determined scope and goals of the conference. However, The

[70] La Verne Kuhnke, *op. cit*., pp. 65-66.

Ottoman Empire accepted to organize an international sanitary conference that gathered in Istanbul on February 13th of 1866.

At that time, Ali Pasha, Minister of the Ottoman Foreign Affairs, opened the first meeting of the conference at *Galata Sarai*, to which the diplomatic and medical delegates of Austria, Belgium, Spain, France, Great Britain, Greece, Italy, Iran, Russia, Prussia, Portugal, Sweden, Norway, the Ottoman Empire and Egypt participated. After the short speech of Ali Pasha, M. Lallemand suggested Salih Efendi, who had been elected, as a chairman[71].

In the first meeting, the conference took some decisions about the works to be done, which included the tasks of the chairman and the voting methods. Afterwards, a committee was formed to prepare a working program for the conference.

The French delegation did not spare a minute in declaring its precaution plan ever since the first meeting. The urgent proposition made by French delegates aimed at regulating the return of pilgrims from Mecca, in the event of a cholera break out in Hejaz during the pilgrimage period of that year. Lallemand said that before the conference was held, the French government had considered making a working program for it, but the government had given up preparing any program which could be formed by the conference. Instead of that, it decided that French delegates had to prepare an urgent proposition in the name of their government to be presented to the conference.

Following this short speech of Lallemand, another French delegate Dr. A. Fauvel, read the urgent proposition made by France, which caused serious conflicts and debates among delegates especially during the first month of the conference. It contained the urgent measures about the cholera case that could appear among pilgrims gathered in Mecca. The

[71] A. Fauvel, *Le Cholera*: *Expose des Travaux de la Conference Sanitaire Internationale de Constantinople,* (Paris, 1868), pp. 93-97.

proposition that determined the route of the conference should be taken into account for its general aim to be understood.

Dr. Fauvel said, in his speech:

"Gentlemen,

Among many questions which must occupy the conference, there is one which distinguishes between all by an urgent particular character and which, because of that, must have priority over others.

We want to speak about measures to be taken for the case where the cholera would appear this year among the Pilgrims brought together in Mecca

We like to hope that this possibility will not be carried out; but finally nothing guarantees it to us, and it is our duty to answer with dignity to the confidence placed in us by our respective Governments, to secure ourselves against this danger.

See, indeed, Gentlemen, what a sad thing it would be if, while we seriously discuss on the origin and the means of preventing the importation of cholera, this disease made a new irruption by following the pilgrims.

It is thus a measurement of precaution for the nearest danger which we come to subject urgently to your deliberations.

Let us not forget that the pilgrims are yet on the way for the holy places and that the time of their return is not distant.

However, let us pass to the question itself. Let us take it such as it is presented to us this year, in other words at the time the pilgrimage is in process of achievement, and where the pilgrims are about to carry out their return.

Let us suppose now that cholera exists among them: what would the danger consist of? and what would have to be done to prevent it ?

The danger would consist, as you know, in the probability of the importation of the disease into Egypt by the pilgrims returning by sea, piled up on steamers and thrown by thousands, in a very-short time, on the Egyptian littoral.

Such is the new danger which gravity is revealed to all of us by the events of last year. The danger was quite less formerly when the pilgrims followed caravans or had other maritime vehicles, only weak boats which, skirting the dimensions, spent a very-long time to achieve the voyage.

As of the importation by pilgrims returning on ground, it has little to fear. The experiment, indeed, proved that a long walk by stages in the desert was, against cholera, the best of quarantine applied to a multitude.

Last year the caravans, who left Mecca endangered with cholera, arrived to Damascus and Suez completely purged of the disease. For eighteen years that I have been working on this question, nothing that I know of has come to contradict this harmlessness.

Thus, it is only with the return by sea that there is danger, against which it is important to be protected.

What could be done for that?

Would we impose a quarantine to the pilgrims on their arrival to Suez or in any other port of Egypt? Yes, if they had been a few hundreds of travelers under ordinary conditions; and still when we discuss the question of the lazarettos applicable to cholera, we will see how much this question is full of difficulties. But the will to dominate serious measures of quarantine to the arrival of thousands of pilgrims, bearing cholera and unloading almost at the same time on the Egyptian ground, would be an unreasonable claim. According to us, such quarantine would be a misleading show and not the guarantee we are in title to reach from the Conference.

Would we try, to decrease the multitude of newcomers to Egypt, to regulate in a suitable way the loading in Jeddah, to make a choice, to fix the number of embarked, etc...?

But this sort of precaution would require, to be put in execution, a considerable armed force to the wearing of loading. You represent this multitude under the threat of cholera, struck with terror and wanting to flee at any price, and judge if measures of order which all is about, would not bring bloody collisions infallibly.

Last year, the ships in departure were in some extent taken by the storming runaways. We can affirm that it would be the same this year in similar circumstances; and if the attack of the ships was prevented by a maritime force, you can easily imagine what would have occurred on ground to the number of the individuals to arrive. It thus should not count, according to us, on this kind of measurement, for this year at least. We add that in any case, it would be only one mean of decreasing the danger and by no means of removing it.

We thought that it would still be possible, in the event of cholera, to deposit the pilgrims embarked on a point at the intermediate littoral between Hejaz and Egypt, at Tor for example at the foot of the Sinai mount, and to dominate them to a suitable quarantine. This idea will undoubtedly have to be taken into account for the future, although it is not without serious disadvantages; but you will recognize without sorrow which measure does not improve in a few days such an establishment and which one, for this year, would be impracticable.

Thus, what remains to be done? What remains, according to us, is putting through practicing the simplest measure, promptest, easiest to carry out and sourest, which offers less disadvantages under all the reports: it would consist, in the event of cholera among the pilgrims, in stopping temporarily, in other words throughout any maritime communication, the epidemic between the Arabic ports and Egyptian littoral, while opening to the pilgrims, for their return to Egypt, an overland route they can follow by caravan. In other words, the pilgrims would be forced to quarantine, either on the spot for those who would prefer to await in Hejaz for the end of the epidemic, or in the desert for those in greater number who would follow the caravan."[72]

[72] FO, 195/864, *International Choléra Conférence*, 1866: Annexe au procès-verbal no 1, pp. 1-3

In his speech, Fauvel continued to mention how these measures were to be put into practice. According to the proposition, the Ottoman government should carry out the following operations:

1- The Ottoman Sanitary Commission, which would be sent to Hejaz, would give a report to inform about the pilgrims' health conditions.

2- Several battleships would attend there to close maritime traffic.

3- At the soil of Egypt, observing centers would be constituted to impede ships which landed their passengers illegally[73].

Finally, he said that this proposition completely left to the Ottoman Empire all of its authority and dispensed them from direct intervention by the sanitary police with the pilgrimage, so delicate and so filled with dangers. The only inconvenience of their proposition would be, if necessary, having to bother for a moment with traffic, which target was transport by sea of the pilgrims. However, this inconvenience did not seem to be serious for them when they looked at the general condition. [74]

Actually, the French government's proposition, which was supported by the majority of the delegates, summarizes the main concern and goal of the conference. Fauvel as a spokesman for all of Europe, not only France, clearly demanded that the Ottoman Empire had to take all necessary precautions strictly, even if this bothered pilgrims, keeping Asiatic cholera into its boundaries away from Europe. Obviously, the French government, who perceived this proposition as a starting point for the conference to determine the general agenda, attempted to obstruct oppositions and reduce speculations about its proposition throughout the conference.

[73] Ibid, pp.4
[74] Ibid, pp.5

It is important that the discussions on this proposition delayed the commencement of the real work of the conference until 8 March; at the sixth meeting on 3 March, the conference reached a clear decision about this urgent proposition. It is a fact that the general rules of the French proposition were approved by the conference, which modified and arranged the urgent proposition. Through those meetings, a clear condition appeared that almost all the European delegates supported the urgent proposition, on the other hand, other delegates, who were coerced with the responsibilities of a possible cholera case among pilgrims during that year, tried to reduce its difficulties. These opponent delegates were from the Ottoman Empire, Iran, Russia and Britannia. Although these delegates refused the French proposition and suggested different projects, the French proposition was accepted by the majority of the delegates[75].

Discussions on the French Proposition

As mentioned above, at the first meeting, the conference put a commission in charge of presenting a report at the second meeting. The members of this commission were Vetsera, Dr. Fauvel, F. Bosi, Dr Sawas Effendi, Dr. Lenz, W. Stuart and Dr. Bartoletti. It is not surprising that this commission encountered many discussions among its members during the working period and consequently it did not arrange any reports for the second meeting.

On 22 February, the conference was convened at Galata- Sarai for the second time. According to the recordings of this session, William Stuart, the chairman of the commission, explained that any agreement on some quite important points related to the urgent proposition had been obtained through three sessions of the commission. Bartoletti as a member of it had been nominated to make a report as a result of this commission, but he had not completed his

[75] FO, 195/864, *Séance du 1 March 1866*, no 5, pp. 45

work. For this reason, an additional time was required to make a sufficient report which the conference had to give this time to the commission and also to Bartoletti after serious objections.

The additional time demanded by the commission caused intensive objections from the delegates who criticized the commission, which would waste the time of the conference with its request on additional time and they required starting general discussions about the French proposition immediately. They emphasized that the time of the conference was rather limited and that they had to have taken efficient measures by the end of the Hajj period. Because of this reason, it had to move quickly and effectively.

At this point, Stuart gave his note to the conference to explain his opinions regarding the situation of the commission and the urgent proposition. In his note, he said:

"...

I cannot tell whether the other members of the conference were treated more attentively; but the British members were informed about the French proposition not earlier than the first session while Mr. Fauvel was reading.

We came together there merely a few weeks after the beginning of the Hajj period, for this reason we did not anticipate that we would be invited to put an urgent measure plan to be voted in the conference. We did not have satisfactory time and consciousness to deal with the real results of the condition, which was stated by the invitation of the French Emperor's government to our government. This invitation says clearly, ' the aim of the conference will be to explore what cholera resulted from, to research its structure and progress, to determine its main starting place, shortly to produce solutions for removing the disease from the origin and taking control of it.' As the invitation itself indicated, an outcome appeared to be related to it; the final purpose of our works is the measures which will be taken against cholera and our subject, which must be dealt with by us in the first place, is the causes and structure of the disease.

....

But how will the situation be if we begin with the end? Wouldn't it be a wrong way, but what if we begin from the end? It will be said to us, undoubtedly, that these urgent measures are only temporary, which nouns do not engage for the later measures. However, is it not necessary that we must have clear and definite proofs about the reasons of cholera and the effectiveness of measures, even if these measures are practiced temporarily?

....

My mission as a member of diplomatic commission is to confront every kind of measure which will be able to hamper trade. If the necessity of the condition is not clearly proved to

me, and if the approval of my government is not taken, I will not share the decision of the conference about the urgent measures."[76]

Stuart finally added that they were being invited to accept the French proposition without a discussion. However, there was another proposition which would be presented by the Ottoman delegate. In this condition, he demanded for the conference to give additional time to the Ottoman delegate and to the commission.

The problem is that almost all conference delegates were ready to approve the proposition and they directly coerced on the others, who were the Ottoman Empire, Great Britain, Iran and Russia, for accepting it quickly. On the other hand, as clearly defined by the British delegates, the British government was hesitating to decide on such a plan. Through the conference, the British delegates displayed an undecided position in general and they chose to use noncommittal vote for some decisions. Dr. Fauvel implicitly criticized this attitude of theirs as an indirect reaction against the urgent proposition. According to him, the meaning of the indirect resistance was to show more reaction to this proposition for and to make it fail by postponing it. The authors of this resistance exposed themselves neither positively nor negatively, thus they impeded to make a definitive decision with regard to the proposition, which was urgent and important. He added that the Ottoman delegate, who would prepare to present an opposed proposal, prevented the works of the conference.[77] The other delegates mentioned their discontent about the postponement request of the commission and agreed with Fauvel's opinions.

The French delegates, who were being supported by the majority of the conference, frequently focused on the return date of the pilgrims from Hajj to state the crucial nature of the condition. It is obvious that from the beginning the conference made definite that if there

[76] FO, 195/864, *Séance du 22 février 1866*, no 2, pp. 5-6.

[77] *Ibid*, pp. 8

was a cholera threat, this threat was linked to the pilgrims transporting the disease from the Orient to the West. In this case, this threat should have been prevented by the conference firstly.

Meanwhile, Bartoletti rejected the claims about an opposed proposal to be made by him, but he as the Ottoman delegate would present a correction project, which involved the approach of the Ottoman government to the French proposal. Furthermore, Salih Effendi made an additional explanation that the basic principle of the Ottoman delegates was to prevent the spread of cholera if it broke out among pilgrims before they left Hejaz. However, the Ottoman Empire would be personally charged of performing the urgent measures mentioned in the French proposition. In this condition, it was not denied that the conference had to take into consideration all propositions of the Bab-ı Ali government which conveyed with the way of its delegates. On the other hand, the Ottoman delegates had not stated any declarations whether they would reject the measures determined by the conference and also whether they would prepare an inharmonious proposal with France. Nevertheless, they merely stated that they had not been clarified by the conference adequately. Thus, it could be understood that the Ottoman delegates had learned the urgent proposition of the French for the first time at the Conference, not before, so they had not expected such a condition. In this case, they needed sufficient time to comprehend and to investigate the proposal for the question marks. At the end of his speech, he said that if the Ottoman delegates were forced to accept the proposition, they would not demonstrate an active role during the works of the conference.[78] Therefore, Salih Effendi with this statement summarized the request of the commission and especially Bartoletti, and explained the position of the Empire against the situation.

[78] *Ibid*, pp. 10-11

Following the speech of Salih Effendi, Fauvel responded to him that there was no mistake made by the French government for they had prepared an urgent and necessary proposition to prevent a possible cholera threat, while the Ottoman delegates were caught unprepared against such mostly serious problems.

These debates indicated that the two different and opposite sides were formed as the supporters of the French proposition and the opponents against it from the beginning of the meetings. It is an illustrative example of this situation that Lenz declared that four powers, the Ottoman Empire, Iran, Russia and Britain who more closely related to the pilgrim question, were asking for the delay. The conference had to pay attention to this demand. On this declaration of the Russian delegate, Fauvel once again protested that the return of the pilgrims was not only the concern of these powers, but also the concern of all nations. He added that Lenz was preoccupying himself with the destiny of the pilgrims, but he was neglecting the interest of other people.

Another important point was the level of medical knowledge about the nature of cholera, which was not clarified as scientific by the conference, which assumed cholera was a contagious disease to facilitate its works and to approve the proposition. Fauvel said that the related commission by the doctor members decided that cholera was a contagious disease, and also when the conference accepted the proposition, at the same time, it would accept cholera as a contagious disease.[79] No doubt, the French proposition was based on contagious theory. On the other hand, especially the British delegates opposed to the certainty of contagionist views over how cholera was spread. They did not believe that cholera was directly communicable from person to person. Dr. Goodeve, as most British doctors at this time, defended the assumption that cholera appeared only in definite places where people lived in unhealthy conditions, thus quality of environmental circumstances determined whether the

[79] *Ibid,* pp. 15

disease would spread or not. In this case, the British government and its medical profession had rejected quarantine system for a long time[80]. Nevertheless, with exception of the British delegates, the conference agreed unanimously that cholera was communicated with the discharges of infected persons mingling with water.

As the result of these debates, the conference was postponed lastly to the third session on 26 February. Therefore, the conference resumed discussions on the urgent proposition and the report of commission at that time. In this session, Bartoletti read the report of the commission and also presented the opposing or changed proposal by the Ottoman government. As a conclusion, the delegates did not reach any agreement among themselves. In the commission, while Vetsera, Fauvel and Bosi were using their votes positively regarding the proposition, Sawas Effendi, Lenz and Bartoletti voted against it and Stuart stayed as noncommittal. [81]

This report of the commission exhibited the general objections, which indicated drawbacks and risks linked to France's precaution plan. Through the fourth meeting, contrary views against the French plan were gathered around some points, which were expressed similarly in the first two meetings of the conference. This report treated the contrary views definitely. The first contradiction, as Stuart mentioned in the preceding session, was about the nature of cholera that was accepted as a contagious disease by some commission members without any discussion nor approval in the conference. It is interesting that in reply to the first contradiction, these members stated that the conference adopted the contagionist approach to cholera in the meeting, that it was not true that such a decision is not seen in its proceedings, but the commission took the decision on this approach with five votes except Britain.[82]

[80] Mark Harrison, *op. cit.*, pp. 118.
[81] FO, 195/864, *Séance du 26 du 26 Fevrier 1866* ; no 3, pp. 3
[82] FO, 195/864, *Séance du 26 du 26 Fevrier 1866* ; 1th annexe au proces-verbal no 3, pp. 1-2

As known, the French plan was based on the idea that in the event of cholera among the pilgrims, any maritime communication between the Arabic ports and the Egyptian littoral would be closed with a temporary prohibition and desert road followed by caravans would be opened to them for their return to Egypt. In other words, it was due to the measures that the pilgrims had to stay in Hejaz or they had to return on desert routes with big caravans.

In the report, Bartoletti read that all the members of the commission had primary concerns about the possible threats that cholera epidemics could show among the pilgrims that year. It agreed with the seriousness of the present condition and the necessity of an effective barricade. However, at this point, the proposition of France had been criticized because of the application ways and strict measures, not for being unimportant or unnecessary. Actually, some members owing to the restrictive feature of the measures did not favor it. They protested the proposition anxiously due to possible risks. As in the case of pilgrims who were waiting for the epidemic around Mecca to finish, they could face difficulties originated from starvation and drought resulting from the lack of satisfactory sources to supply their needs. At the same time, the other groups, who would want to leave from there without waiting, had to travel with caravans, but this was not easy. The caravan voyage had lost its former popularity even among Arabians since the beginning of steamship transportation. Especially Jeddah could be under the threat of pilgrims flowing to the city in terror of starvation and epidemic disease in order to escape with ships and plunder for finding food.[83] It was a reality that poor pilgrims whose number was increasing every year were to face many difficulties due to poverty.

Afterwards, Bartoletti suggested the correction plan of the Ottoman Empire which attempted to modify the difficult and restrictive conditions of the French proposition. In the Ottoman plan, orderly transportation of pilgrims via steamships, instead of an absolute

[83] *Ibid*, pp. 2

maritime prohibition, was proposed. According to this, they would be separated into groups and only got on the ships officially determined by the government to transport them from Hejaz to the different quarantine points of the Egyptian land, which would be at the shore of the Red sea. For example, Sinai Peninsula and Al Quseir, and there they would be put in quarantine firmly. Consequently, they would wait at the quarantine points until the ending of quarantine period. After this time, they would leave from there. In that case, if pilgrims wanted to return through the caravan road they would be free to make their own decision.[84]

Russia and Iran showed their reflexes against the condition in the session and also Iran presented its propositions, which were not approved by other delegates in the conference. After Bartoletti, Dr Sawas effendi verbalized his recommendation in the name of his country. Iran delegates recommended that the proposal of a maritime ban at Jeddah port should be adopted identically, and the Yambo port should be opened for pilgrims instead. Therefore, they had to follow the desert way with caravans to reach Medina and then Yambo'al Bahr, in which steamships would carry them to Egypt. Thus, he suggested only one way for them instead of an absolute ban. However if cholera appeared among pilgrims, as the Ottoman delegate declared earlier, they would be put in quarantine.

This third meeting was a scene where the Ottoman and Iran delegations tried to especially demonstrate objections and resistance to modify the urgent proposition, but their efforts had an adequate power for realizing this aim. By that time, Salih Effendi lastly added some different points to Bartoletti's proposal to make a new convincing and favorable plan for the supporters of the urgent proposition. He mentioned that new doctors would participate in the Hejaz Sanitary Commission, thus effective measures would be practiced by them. Salih Effendi asked a question considering Indian pilgrims, who were to be held like the others in Hejaz in the case of cholera epidemic, where one port at the south of Jeddah would be open

[84] *Ibid*, pp. 3

for them. He asked about "the need of keeping them held in Jeddah?" According to him, they would be sent with British steamships immediately to their country, because a proper port might not be found at the south of Jeddah.

Following these recommendations, Fauvel was given the priority to speak about developing the French proposition, but he chose to wait for possible new plans against him and gave his priority to Dr. Pelikan. Some delegates considered that this behavior of his was against the parliamentary method.

Pelikan, Russian delegate, did not agree with the French delegation about the ways of infection by cholera, he had reached different results in his investigations. He explained that according to statistic documents, the cholera epidemic, which still had been seen in some parts of India, while arriving in Europe had not followed the same path two years successively. Actually, the 1865 epidemic had left many seeds of cholera in Europe, these seeds, which would be more dangerous than transporting the disease by pilgrims to the continent as they would blossom in spring. In such case, the French proposition could obtain a consideration only at the framework of its ostensible urgency.

Mirza Malkam Khan presented an additional note to the proposal of Sawas Effendi. He suggested Omar port together with Yambo. He stated that the pilgrim's convoy should not be formed from the beginning, thus not leaving them to starvation and drought in the desert, a behavior that would fit better to the name of humanity. As Malkam Khan explains,

> *"The acceptance of the recommendation would raise storms of hatred in the Muslim world and create the most serious difficulties for oriental governments. The ideas, customs, doctrines and logic of Asia were so different from those of Europe that the mere idea that Muslim Sovereigns had come to an understanding with European powers to regulate the progression of the pilgrims would be sufficient to change the relations completely of those Sovereigns with their subjects and would expose them to the attacks of fanaticism all the more violent because in recent times everything had been done to restrain it.*
>
> *The European Powers could obtain everything from the people of Asia on condition that they knew how to keep appearances and to give to their demands a form that would*

make them acceptable, and it was for that reason that the ports of Yambo and Omar should be left open."[85]

Generally, these counter-propositions were based on certain protests, which were linked to water, food and transportation problems.

The third meeting on discussing whole recommendations was postponed to 27 February. In the fourth meeting, mentioned propositions determined the agenda of the conference. There had been two different proposals of the Ottoman Empire and Iran against the French for last séance. Shared way of these proposals was to impede an absolute maritime ban between Hejaz and Egypt. Actually, the main anxiety of these powers faced a huge reflection of Muslims, because of that, shortly, as Malcom Khan said, they knew "how to save appearances".

As known, in the third session, Fauvel had not replied to claims and criticisms coming from the Ottoman Empire, Iran, Russia, and Britannia. In that period, he verbalized approaches of the French delegation to answer counter points of view. In his speech, he dealt with whole counter points of view and criticisms one by one, so he summarized a general situation. Actually, both sides knew each other's ideas. All contradictions and defenses had been stated by opposite sides as reciprocal through the meetings of the commission. After works of the commission had not brought to any clear result, opposite sides started to clarify their approaches and projects convincing the delegates of the conference to accepting their opinions. However, it is clear that the French project had more supporters within the Conference. Moreover, the French delegation was aware of this, therefore, Fauvel spoke in oppressive and disdainful words.

[85] *Ibid,* pp. 7

In the fourth session, Fauvel gave his longer lecture which claimed that their proposal had more sufficient features than others, which involved all threats and inconveniences in their sense and they would prove their rightfulness to the conference and demonstrate the lightness of other proposals. [86]

Indeed, he asserted that the conference had actually recognized the French proposal by vote and approved its urgent structure and significance at the first session; therein these debates and criticisms were too unnecessary.

Seriously, he attacked opposite opinions which were considered exaggerated and giving importance only to appearance. Firstly, he replied shortly to the scientific claims of Pelikan that cholera had appeared in Mecca many years successively in the same way. There were epidemics of years 1847, 1848 and 1846.

In order to show the ineffectiveness of any objection, he occasionally asked "how inconvenient would it be, that year, if cholera was not spread among pilgrims, to take a precaution which would not be a burden if not implemented?" Thereafter, he began to declare some statements, which were details that caused bother, about pilgrims who had been surging on holy lands and they would have completed their sacred visits by means of the feast of Qurban Bayram. After this time, they would return to their homelands by sea or land. An important group who would follow maritime road to Egypt and Syria to reach their homelands was concerned by the conference. Especially, Indian, African, all Muslims who preferred maritime road for transportation would board on ships from Egypt. It was a critical point to note that cholera might have spread into Europe because of these pilgrims. Fauvel verbalized once again that the French proposal, which was about a maritime ban between the Arabian ports and the Egyptian littoral in the event of an outbreak among Mecca pilgrims, was the

[86] FO, 195/864, *Séance du 27 février 1866*, pp. 4-5

most effective solution among several projects in order to prevent possible cholera threats to be transported by pilgrims.

With respect to this, he put forward his explanations and replies to refuse the Ottoman claims. Some of these were based on poverty and conditions of poor pilgrims. According to the Ottoman delegation, even the poorest pilgrims would need at least two camels. That was a mistake, in any case these poor people would be helped by charitable Muslims who supported them financially.

Mainly, four privileged zones to be related to the Hajj subject were Jeddah, Yanbo'l Bahr, Mecca and Medina. Fauvel gave short information about these cities in order to demonstrate that they had richness and resources abundant enough to supply needs of inhabitants and also visitors. They would not confront with any difficulties and chaos during a possible embargo. He mentioned different examples that involved some details and convincing knowledge about abundant water, grain sources and thus he drew such a scheme in front of the conference, getting alarmed about the results of a maritime ban on Hejaz was unnecessary, because this area had satisfactory power to endure a temporary embargo. In addition, according to him, there would not be any transportation problems for pilgrims who would prefer to follow landline by caravan to go to their grounds, because camels and caravans were the wealth of that area.

Obviously, there was only one precaution proposed by France, which should be approved before starting the conference's works and particularly the return of the pilgrims. This precaution targeted to put a barricade between the Middle East, which became a passageway for cholera, and Europe. In this case, France and other European supporters did not give any opportunity for objections of responsible nations, which resisted against this limiting demand of Europe. Fauvel clarified the situation so that together with the breaking out of cholera in Hejaz, primarily the pilgrims would be informed about existing particular circumstances,

means of sea transportation and shipping companies were kept temporarily closed until the end of the epidemic. After this ban, some people would try to escape from there, but some would stay around Mecca and would wait until it finished. It could not be said that they would not flow to the port of Jeddah, if they knew that they would definitely not find any way of sea transportation.

Another assertion of the Ottoman delegates was that there was no suitable port for Indian pilgrims in Jeddah, but he declared that there was one eligible port at the south of Jeddah, he wanted to give the good news that this well known port was El Qunfudhah.

Lastly Fauvel gathered criticisms against the Ottoman's proposals around three points;

1- Measures that would have been taken at the stage of setting out were to increase the number of doctors in the Hejaz Commission and also to get the support of local authorities in order to have present armed forces to control the boarding of ships. The deficiency of control on ships quietly caused tragic outcomes like collisions and fights among agitated crowds of pilgrims. Thus, a terrible clash would be inevitable.

2- Measures that would have to be taken during the voyage were that eight steamships had to be used in order to transport pilgrims from Hedjaz to quarantine zones. He was not sure about this proposal, were there really eight steamships? On the other hand, such a number of ships would not be adequate to transport all pilgrims, who would rapidly grow impatient during that period. It was clear that crowds would flow into Jeddah to board on steamships. It was interesting that the Ottoman delegates had criticized their proposal on similar distress; they had claimed that pilgrims would rush to Jeddah as a reflex to the maritime ban.

3- Measures were directed for founding quarantines in arrival points but the Ottoman delegates had not explained where to establish them. In addition, they had proposed that the Ottoman government would supply all financial needs and requirements of medical staff and

pharmacists for quarantine zones. There were important practical problems with this project. It was obvious that the ships would carry passengers, in that case how would their provisions be carried? Famine, starvation would have appeared in these quarantine areas. At the same time, troops should be constituted to control these areas; it was a dilemma that in the course of time these troops would be a dangerous source of spreading cholera.

Thus, Fauvel worked to declare the failing points of the Ottoman plan, not having the required time and the necessary preparation for transporting pilgrims from Hejaz to Egypt, founding quarantine stations in Hejaz and Egypt and supplying needs for pilgrims in quarantines.

At the end of the speech, he depicted the deficiency of Iran proposals, but he did not want to deal with the suggestion of Malcom Khan, who said that the Hajj trip could have been cancelled as a consequence of that situation, and he left this to the judgments of Muslim governments. At the same time, he added that Malcom Khan had warned about Asian mentality structure, but he perceived that there was not a necessity for mentioning this. Meanwhile, he mentioned the second suggestion of Iran from Sawas Effendi noting the impossibility of implying the plan, because how would pilgrims be forced to go at first place to Medina instead of Yambo' al Bahr? According to his judgment, the delegation of Iran was concerned with one thing and that is keeping up appearances. In this case, the consequence of measures suggested by Iran would be raising difficulties and problems in that area and Europe. According to Fauvel, Iran meant, " We'll be allowing cholera to destroy pilgrims and Europeans, but we'll be keeping appearances on the other hand". However, this kind of principle might be carried out to the East, so his delegation refused all obstructive and non-functional proposals.

After he made his speech, other delegates, particularly Kalergi, Muhlig and Sotto, confirmed his words and even Muhlig said that the conference got sufficient information

about the French and opposed proposals. He thought that all of the other speeches would be unnecessary. The conference understood that proposals were unimportant except the French one in such a condition, clearly the French proposition was accepted by it. Following him, Bartoletti protested this approach "It is a demand to accept the French proposal without discussing, but there are discussion and objection rights for all delegates which should be protected by the conference."[87]

Consequently, these debates were delayed to subsequent sessions where the basic rules of the French proposition were admitted by the conference despite eight rejection votes.[88] In the sixth session on 3 March, some changes related to details were made on measures proposed by France and fundamental dispositions that were almost the same as the French proposal that was declared by the conference. [89]

As an outcome of that, after the here-above mentioned debates, the conference really began to focus on its labors, which were divided into four parts that were origins and developments of cholera, its mode of propagation, measures of preservation and resolutions adopted by the conference[90].

Meanwhile, after two months passed with the commission, which had been appointed to research preliminary group questions, the conference continued to meet on its works. In fact, it waited till the end of the Hajj period and the return of pilgrims to learn about their health conditions from 8 March until 28 May. Before the French proposal was adopted by the conference, the Ottoman Government on statement of the Istanbul Sanitary Council for the hajj period of 1866 at Hejaz had appointed The Ottoman Sanitary Commission.[91] The task of this Council that had been formed with Christian and Muslim physicians was to improve

[87] *Ibid*., pp. 23
[88] FO, 195/864, *Séance du 1 mars 1866*, pp 45
[89] FO, 195/864, *Séance du 3 mars 1866*, pp. 17-18.
[90] FO , 195/864, *Séance du* 8 mars 1866, Rapport, pp. 1-6
[91] *İMVL ,* No. 549/24655, 4 Za 1282

health conditions of pilgrims and to supply all hygienic measures. This Council carried out its mission at Hejaz. Consequently, no cholera cases appeared in Hejaz, from where the Ottoman Sanitary Commission sent its reports giving information about the condition to the conference during May and June of 1866.

Moreover, before the return of pilgrims from Hejaz, the conference made some changes on the urgent proposal due to political reasons, because the Ottoman Empire could face some conflicts and complications created by Muslims. According to those changes, before entering Egypt, pilgrims would be taken under quarantine at El-Wesch, a port at the north of Medina, instead of blocking all exits from Hejaz. Thus, the Western pilgrims, due to their return, would perform a fifteen days' quarantine at El-Wesch if cholera breaks out in Hejaz during their stay, and the land caravans would, in such circumstances, have been inspected before entering Egypt or Syria, and, if necessary, would also perform quarantine.

At this point, another problem appeared: what would happen if cholera broke out in Egypt? As mentioned earlier, the approved French plan had directed that in the event of cholera among the pilgrims, any maritime traffic and communication between the Arabic ports and Egyptian littoral should have to be stopped temporarily, in other words any maritime communication of Hejaz will have been prevented except overland route followed by the caravans. However, this plan had changed because of the possibility of a political conflict rising from pilgrims. On the other hand, the conference wanted to take quarantine measures at the Egyptian ports against the probability of cholera threats, which had not appeared among pilgrims at Hejaz. It discussed this subject, while some delegates demanded quarantine to prevent the entrance of cholera from Egypt to Europe, others, who thought that quarantine would damage international trade between Europe, Egypt and Asia, severely rejected this demand because of commercial reasons. It is known that, in that time, Egypt had a more important position for Mediterranean trade. As a result of discussions, the conference could

not reach any clear decision about this subject; in other words, it could not venture international commerce against the majority of delegate rejections[92]. Besides, no cholera case had been seen in Egypt at the time[93].

The preliminary group questions of the Program: Origins and propagation of Cholera

The Sanitary Conference appointed one commission, which was separated into six subcommittees to facilitate their labors, to research over the origins and developments of cholera and its mode of propagation. The commission was composed of three of the diplomatic and all of the medical delegates, comprising altogether twenty-four out of thirty-six members of the conference. Shortly, the task of the first committee consisting of chairmen Segovia, Goodeve, Van-Geuns and Pelikan, was to search for answers about the origin of cholera. The task of the second committee consisting of chairmen Lallemend, Muhlig, Hubsch and Pelikan, was to investigate on importation and transmissibility of the disease. The task of the third committee consisting of chairmen Sotto, Maccan, Monlau, Noidans and Sawas, was to work on infecting conditions .The task of the fourth committee consisting of chairmen Gomez, Lenz, Fauvel and Salem, was to determine the effect of crowds, which were at quarantine areas, troops, fairs, hajj visits, ports, on its spreading. The task of the fifth committee consisting of chairmen Millinges, Bossi, and Dickson, was to constitute a doctrine dedicated to protection. The task of the sixth committee consisting of chairmen Goodeve, Bartoletti, Bykow and Salvatori, was to present a general opinion about the development and spreading through 1865[94].

[92] A. Fauvel, *op. cit*., pp. 60-63.
[93] *Ibid*, pp. 65.
[94] *Ibid*, pp. 126

During two months, the commission had realized nineteen meetings to prepare a general report, which was presented on May the 28th. The conference debated some approaches of this report and reached a conclusion about it.

The official formulation about the origin of cholera declared by the Conference indicated that its origin was not Europe native where it had no spontaneous origins. On the other hand, the cholera epidemics that had appeared in different periods of the nineteenth century had devastated the world and had always been originated from India. At the same time, it had been easy to go back to the source. However, it was not easy to explain historical reasons about how it had appeared in India, but it was known that cholera had existed there permanently, or in an endemic form. Before 1817, cholera as an endemic had been seen in India, but in the year of 1817, cholera entered a new stage and took an epidemic form. From then on, it went beyond the boarders of India and spread outside. Cholera first appeared in Europe in 1830. According to the approach of the conference, there were two different types of the disease; cholera nosiras that was seen only in Europe and was a less dangerous form, and Asiatic cholera, which was a dangerous type of the disease, originated from India.

The idea pronounced by some delegates that cholera originated in the soil of the Ganges, because of the Hindus leaving their corpses on its banks, was a favorite one at the conference, but Edward Goodeve, a British delegate, rejected it and notified that same conditions could had been seen in other rivers of India, not only Ganges, and cholera epidemics had not been determined in these rivers. According to him, the continuance of cholera permanently present in some grounds of British India was not related to any peculiarity of the soil. The Existence of epidemic diseases in British India was directly a result of unfavorable environmental conditions. In this case, the continuous transmission of cholera was derived from unhealthy living conditions created by Indian people, under the effect of convenient climatic circumstances. In addition, the belief that was built on the argument that the East Indian

Company did not efficiently provide hydraulic facilities made by their predecessors was also neglected.

In the sessions, some discussions intensively arose on one subject: whether Asiatic cholera was permanent in some regions that were Indo-Chine, China, Island group of India, Afghanistan, Pakistan, Iran and East and South shores of the Arab Peninsula. Sawas Effendi did not accept the statement that cholera was present in an endemic form in Iran. On the other hand, the conference did not reach any clear agreement or result regarding this subject. However, it was declared that cholera had definitely not been originated from Europe, the Ottoman Empire, North Africa or both sides of America where cholera did not have a native source or origin. In this case, Asiatic cholera did not appear spontaneously in these regions as it definitely originated outside of Europe.

The conference pronounced that cholera was a transmissible disease contaminating from human to human, and it diffused through the persistent contact between infected and healthy individuals. It might have been transmitted by patients who were at the stage of developed cholera, and also by people suffering from choleric diarrhea, who were able to move about, and who were apparently healthy for some days during the progressing of the disease. These last, by their unquestioned and unsuspected moving, were the most dangerous to the communities among whom they socialized [95].

Another way of infection was the discharges from stomach and bowels, which might poison natural sources, especially air or water, and thus spread the disease among a vast number of people without the need for actual intercourse. Cholera might be communicated by exposures of people to the atmosphere of buildings, places or vessels which had been occupied by infected individuals, and to the emanations from clothes, bedding or other articles which had been in contact with infected individuals, or which had become soiled by their

[95] FO, 78/2006, pp. 1 and also FO, 78/2008, pp. 18

discharges. Infected articles or places should be closed and excluded from free air, since they might transfer their dangerous and contained poison for a long time. The cholera poison might contaminate clothes, houses, and ships which under some definitive circumstances in a dormant state might contain the disease for a long time. Thus, these, as infected cholera vehicles, might spread its poison among healthy populations throughout different areas. Nevertheless, the conference did not determine a clear judgment on goods, because although infected manufacturing goods or merchandises and animals indicated a suspected position as related to contamination by the disease, any proof about infection derived from these was not obtained.[96]

The period of incubation from the time of reception of the poison to its manifestation in some form or other was considered by the conference as a short time. The conference considered that the incubation in the acute form was generally rapid, and that it seldom or never extended beyond a few days from the moment of infection. There were some different opinions concerning the duration of choleric diarrhea, and as for the time that it might continue to be infectious. The great majority of the Conference considered that the separations of such cases for a term of ten days from the sources of infection would be sufficient to decide whether they would pass cholera or not.

Some delegates continued thinking that this diarrhea period might extend beyond a fortnight. However, without denying the possible occurrence of such exceptional cases, the majority of the Conference were not convinced that the evidence adduced in their support was satisfactory, and that for practical purposes it would not be justified to apply measures based on such questionable examples.[97]

[96] FO, 78/2006, pp. 1
[97] FO, 78/2008,pp.18

The conference reckoned that the main reason of the transmissibility of the disease was human intercourse, at the same time it also approved that unhealthy local conditions intensified cholera epidemics. In the conference, unhealthy localities where populations lived in overcrowded houses and a dirty environment poisoned with decomposing organic wastes and were exposed to foul air and contaminated water were determined as central places for diffusion of the disease. The conference therefore did not suppose that transmissibility through contact between individuals was a unique condition for the contamination by the disease, however it was the major and clean cause for the spread of the disease. In this case, it focused on transmissibility of the disease and isolated precautions in order to segregate from healthy populations unhealthy ones instead of improvement of unfavorable environmental factors and living conditions.

As a result, the conference decided that cholera was the product of India, that human intercourse was the main reason of its migration from infected grounds to other areas. It was transferred by the means of its vehicles and its rapidity was connected with its movements. In addition, bad sanitary conditions intensified its development

The third group questions of the conference: Measures of Prevention

The third group questions that caused some intensive discussions among the delegates conquered the most important and longest section of the conference [98]. The commission charged by the conference to determine content, order of agenda and classification of third group questions presented in its report on 28th of May, it separated measures of prevention into three basic parts to solve this problem. These were measures of hygiene, measures of

[98] A. Fauvel, *op. cit*., pp. 41-72.

disinfections and measures of restriction. But some delegates brought forward different proposals against that. Fauvel especially, with the support of many delegates, suggested a confront-proposal related to classification. However, the conference approved the commission's work.

Nearly all of the conference agreed on the necessity of taking hygienic and disinfectant measures, but they did not approve restrictive measures, because some of the delegates did not agree over the contamination of the disease. According to some assumptions of Iran and Russia, the disease could have been transferred by atmosphere and soil; in this case, measures of quarantine were ineffective to prevent it. On the other hand, supporters of the quarantine system rejected this assumption and mentioned the experiences of Italy and Greece in order to give well-known and convincing examples of the importance of that system. Italy and Greece had totally avoided the disease which was raging around them in 1865. Italy had entirely cut itself out of communication with infected places. Greece had caused all arrivals from infected localities to perform severe quarantines at four islands- Delos, Salamis, Kiathos and Vido- and had not communicated with infected places.

A negative assumption coming from the opposed side was that the results of isolation in the cases of Italy and Greece were hardly criticized in comparison to what occurred in other places that were said to be invaded in spite of restrictive measures. However, as a response to this opinion, the quarantines had been enforced at Marseilles and some other ports of the Mediterranean were ineffective, either for their incompleteness or because they were established too late, that was, after direct communication with infected ports had taken place.

Restrictive measures were intended to separate infected people or things from healthy ones. They comprised isolation upon first cases of cholera which happened in one place, and which might even have been applied to exclude infected localities or small towns from communication with their neighbors. According to the conference, during the application of

quarantine, isolation was necessary to control movements of people. On the other hand, this measure would seldom be practicable in Europe. Another restrictive measure was the interruption of all communications with an infected port or district, throughout the epidemic duration. This was considered a measure only applicable to exceptional cases. The last restriction was quarantine.

As for quarantine which was applied on vehicles and people transferred by sea, the conference considered that a ten day period was sufficient, that this period would be satisfactory to supply requirements of every case without exacting more from commerce than the public safety demanded.

Some delegates proposed a longer period of observation, especially for difficult conditions encountering the investigation of the existence of choleric diarrhea among crews and passengers of ships, but this suggestion was not accepted by conference because it gave uncertainty to the length of the period of quarantine. Thus, the conference adopted its system of restriction to control the conditions of vessels coming from an infected port.

Quarantine that would be practiced to ships had been divided into two categories: Quarantine of observation and strict quarantine. The former was applied to vessels which were in a healthy state and which were free from overcrowding. The later method of quarantine was applied to vessels which had cholera and choleric diarrhea and which were overcrowded with passengers, especially with pilgrims, emigrants or troops.

The conference decided that quarantine, which was applied to arrivals by land, could be useful to control pilgrims, emigrants and troops. Its duration would be of ten days[99]. The progress of cholera westward should be controlled by restrictive precautions for land as well as sea. The precautions concerning land would be applied on the frontiers of the Punjab, Iran, central Asia, and the borders of Russia. Those concerning the sea were practiced to the usual

[99] FO, 78/2008,pp. 19-20

cholera routes through the Persian Gulf and Red Sea. The ordinary rules of the quarantine system were supposed satisfactory for the shores of the Persian Gulf, however a more detailed plan was prepared for the Red Sea. All ships, especially coming from India, entering the Red Sea would have been inspected at Perim, an island near to Yemen at the southern entrance of the Red Sea. If necessary, they would have be taken under quarantine at Al-Tor, a city in Sinai Peninsula, and ships that transported pilgrims would be detained under quarantine at stations near Strait of Babel Mandeb, the large strait at the entrance of the Red Sea. Furthermore, these ships should have been controlled according to the Native Passenger Act of 1858, which was reorganized and then adopted by the conference. The Western Pilgrims on their return would be taken under quarantine for fifteen days at El-Wesch, a port at the north of Medina.

A bill of health delivered by the Local Sanitary Board was necessary for all ships. In addition, the conference declared that when the first cholera case appeared, this case should be noted on the bill of health until the last case of cholera and that after fifteen days vessels should be allowed to elapse into free practice. Moreover, the bill of health should not be changed for a new one, until vessels reached their ultimate destination. The bill of health should be printed in two languages, one of which should be French. It would be prepared according to the sample presented by the Paris Sanitary Conference. At the same time, the conference demanded that the Ottoman Empire would enact a penal code to prevent false declarations made by captain of ships at the Ottoman ports.

It was a requirement that Lazarettos should be established into all quarantine stations to isolate infected people and to disinfect goods. The conference indicated that they would have to be placed into isolated areas like an island, so that they would not become a dangerous source of spreading the disease to public areas.

The conference had organized restrictive measures for stopping the progress of cholera in general. On the other hand, it stated that the application of measures particularly prepared to stop its development in Hejaz and India was the great important condition for the preservation of Europe and the control of its progress towards Europe. The conference indicated that checking the development of cholera and taking measures concerning hygiene, controlling regulation of Indian pilgrims, which should have be applied by the British Government in India were the most effective. Besides, it implied that the British Government should enforce on the Indian Government in order to undertake researches about the origin, endemicity, epidemicity of cholera, which might become a source for discovering a way of exterminating the disease. On the other hand, at Mecca, measures against the disease would have to be adopted, similar to the operations applied by the British Government at the India.[100]

As to the above-mentioned outlines, the conference expressed measures to be applied against cholera. These measures were to be carried out under the control of the International Sanitary Board. Thus, cholera and its progress along the pilgrim-trains, as well as in the ordinary communications in the Red Sea could be controlled systematically.[101]

The Closure of the Sanitary Conference

The Istanbul International Sanitary Conference completed its works at the end of the forty-fourth meeting on September the 26th, 1866.

[100] FO, 78/2008,pp.20
[101] *Ibid.*, pp. 20-21

At this last meeting, the conference formed the resolutions in a report which involved all decisions taken during the sessions[102]. These decisions, mentioned above generally, were the results of the reports presented by commissions to the conference.

It is obvious that the conference could not clearly come to a decision on some questions because of commercial benefits, political reasons or unsatisfactory scientific knowledge about cholera. In these conditions, the conference caused some significant contradictions and duality with related decisions and loss of effectiveness on the international arena.

[102] A. Fauvel, *op.cit*., pp. 630-664.

Chapter III

The International Sanitary Policy of the Conference: Disease, Crisis and Control

"Thus, the 11th International Sanitary Conference in 53 years had as its essential purpose the protection of Europe against the importation of exotic diseases…"

- Norman Howard-Jones -

"….bacteria and viruses travel almost as fast as money. With globalization, a single microbial sea washes all of humankind…"

- Gro Harlem Brundtland -

Throughout the nineteenth century, some infectious diseases like tuberculosis, smallpox, yellow fever and cholera played an important role in international affairs. Before the nineteenth century, different epidemics with destructive power, such as plague, had affected the lives of people; spreading rapidly from one continent to another as a result of the

introduction of modern transportation vessels. Cholera, which had been an endemic disease in Bengal before it turned into epidemic structure, spread towards Asia and Europe from India by the means of steamships and railroads [103]. Thus, cholera, which had a harmful power on Europe in the age of industrialization, which as early as other epidemic diseases, affected connected fields including international commerce, policy, public health, control of international boundaries and colonialism.

Europe's hegemony and authority via different tools of power and science penetrated other areas of the world, not only colonizing grounds but also undeveloped countries, all through the modernization process of the nineteenth century. Thus, European medical knowledge like other scientific fields controlled the rest of the world via modern institutions. In the same century, European countries used medical knowledge and institutions in order to protect themselves from epidemic diseases originating from the East and also to reorganize Eastern countries according to their modernization ideals and continental benefits. Moreover, Asia was generally seen to be an unhealthy, diseased and dangerous ground for Europe due to epidemics[104]. In these conditions, they executed coercive politics on the Middle East and also other parts of Asia to control epidemic diseases and international sanitary policy and to prevent the entrance of 'Asian diseases' to Europe.

Obviously, international sanitary policy was a result of a hegemonic thought of Europe that organized international sanitary conferences in the time of huge epidemic disasters. It is a reality that European countries needed to protect themselves (especially their trades and material and production goods) and to keep the population healthy against these disasters for industry's sake. The sanitary conferences were held on that mean. They merely focused on

[103] David Arnold, *The New Cambridge History of India: Science, Technology and Medicine in Colonial India*, (Cambridge University Press, 2000), pp.92-128.
[104] Richard J. Evans, " *Epidemics and Revolutions: cholera in nineteenth century Europe*", in Epidemics and Ideas: Essays on historical perception of pestilence, edited by Terence Ranger and Paul Slack, (Cambridge University Press, 1994), pp. 154

their sanitary and commercial benefits, which were at the center of the conferences' agenda. In other words, despite that the conference was organized internationally, Europe was only interested in their benefits, not protection of Eastern countries. They coerced the Ottoman Empire to take measures and to prevent the entrance of epidemic diseases to the continent, and they dealt with hygienic conditions and protection of Eastern countries in a narrow frame, unlike their interest in hygienic measures related to their own benefits. It was not a surprise that these conferences resulted in a Euro-centric structure and therefore the East was not able to obtain a position as the subject.

From the middle of the nineteenth century to the twentieth century, many sanitary conferences were arranged in different major European cities. The means of sanitation that showed a limited range of usage generally indicated restrictive measures like quarantine[105]. Such conferences displayed an uncalled concern in politics whereas the original medical concern was insufficiently covered and was neglected on the behalf of politics. In other words, the political aspect of the conferences weighed heavier compared to the main medical goals and paid more to the policy than to the remedy.

As mentioned earlier, the fact that the Istanbul Sanitary conference demonstrated that cholera originated from India or another Asian country was not an important point for many European powers, despite the fact that the conference stated the origin of the disease to be India[106]. Actually, it was significant that the disease was coming from the East. For this reason, cholera and the East were put on the same scale. Shortly, European members of the conference tended to determine two separate sides as diseased Orient and healthy West. In this context, the Ottoman Empire tried to separate from Orient and its diseased image in order to affiliate healthy West. It is important to understand the position of the Empire in front of

[105] Alison Bashford, "*Migration, borders and public heath: Histories of the future?*", Wellcome History 26 (Summer, 2004), pp. 2
[106] A. Fauvel, *op. cit*., pp. 630.

the West. The Empire wanted its own identified position, which was rebuilt through a modernization process, according to western standard. Thus, it produced Ottoman orientalism within its political discourse.[107] The Ottoman Empire, which tried to acquit itself continuously, performed significant sanitary projects to modify its negative-believed images in Europe. Since the 1830s the Empire carried out sanitary regulations, thus at strategic ports new quarantine stations and also lazarettos were established, needs of medical personal were supplied for quarantines and hospitals and especially health conditions in Hejaz were improved by the Empire.

Throughout the nineteenth century, the Ottoman Empire, which attempted reforms according to European standards, took part into a modernization process. Particularly during the reign of Mahmut II, and then the Tanzimat period, modernization of medical institutions started in the Empire. At that time, the Empire invited European physicians who had to found modern medical institutions like medical schools, hospitals and quarantine systems, which began to replace indigenous medical institutions. After foreign physicians took some critical positions within medical institutions, European domination began to appear. The Municipal Council and Quarantine Council bared pressures from Europe.

Since 1840, foreign members have been able to participate in the meetings of the Quarantine Council. They mostly orientated Council decisions. There is another noticeable point that some European members of this Ottoman sanitary council represented their countries at the international sanitary conference. Examples might be given that Fauvel, Monlau, Segovia, Bartoletti, Sawas Efendi and Dickson took part in the Quarantine Council as diplomatic and medical members, and at the same time, they joined the sanitary conference. Furthermore, these members got experiences and special information about medical, political and economical conditions of the Ottoman Empire, thus they used their

[107] Ussama Makdisi, " Ottoman Orientalism", *The American Historical Review*, volume 107, and no: 3, (June 2002), pp. 769- 772.

information to pressure on the Empire at the conference. It is true to say that those sanitary instituions served strictly controlling the Empire rather than improving its sanitary situation.

Before the Istanbul Sanitary Conference was held, the Empire sent a commission to take measures for possible health complications in Hejaz[108]. The commission completed its works and then it prepared reports related to sanitary arrangements to inform the conference and the Ottoman government. According to the reports of the commission, first of all, whole cisterns and also sewers had been cleaned in Mecca. At the same time, garbage had been regularly collected from streets. Inspectors had checked food sold at bazaars and shops. Mobile hospitals and medical personnel had served patients. Requirements of poor pilgrims were satisfied. New laundries and slaughterhouses were established to obtain hygienic places. Fountains and sources of water had been divided into parts for different usages, thus water for drinking and personal cleaning was supplied from separate fountains. In Mina, 45 distinct wells for animal remains and 500 wells to be used as toilets were dug. Ships and pilgrims were strictly controlled at the ports and no cholera cases were encountered [109].

Quarantine measures and other sanitary regulations applied at different ports and in Hejaz turned out to be a serious burden for the Ottoman Empire economically and politically. It is a historical fact that the Ottomans gave more importance to the Hejaz district as it was a holy place for the whole Muslim world. Throughout centuries, it financed the district, as improving health conditions and supplying feedings for pilgrims and security was a prestigious domain. At the same time, the protection of the balance of the relations between the Ottoman Empire and local administrations of Hejaz was an important issue. Furthermore, the Ottomans did not attain powerful sovereignty in order to control the local administration

[108] BOA, *IMM* no: 1286 and also *A.MKT.MHM* no: 349/ 99 – (16.L.1282) and *IMVL* no: 549/24655, 4.Za.1282
[109]BOA, *A.MKT.MHM* 365/81, 15.C. 1283 and also FO, 195/864, *Séance du 28 Mai 1866*, pp 5-6.

of Hejaz[110], and so the Ottoman Empire faced many difficulties during the Hajj period of 1866. The sovereignty problem on the district obstructed the Ottoman Empire, which did not easily practice measures of quarantine and other sanitary precautions in Hejaz. On the other hand, in the nineteenth century, the Empire showed some strategic changes in its policies related to Hejaz. In that century, particularly during the process of the sanitary conference, the Empire exhibited colonialist tendencies in sanitary applications and policies performed in Hejaz. It is interesting that the Empire reorganized its sovereignty in Hejaz according to colonialist rules. Indeed, it transferred 'civilization" to the land through sanitary and hygienic regulations. In this case, the Empire attempted to demonstrate its policies as being a sovereign as a colonialist on the disordered and unhealthy district as the British Empire in India.

Although the conference declared the origin of cholera as India, the Empire frequently used some of the statements in their different official documents in order to specify "the pure condition of Hejaz" and to separate Hejaz from diseased India:" It was understood that cholera is originated from India", "cholera spread from India to Hejaz" or " It was understood that cholera came from India to Mecca and Medina"[111]. This statement was repeated in documents to purify the Empire from suspicions regarding being diseased and to clarify that the origin of cholera concerned neither the Ottoman Empire nor Hejaz, but only India. While the Empire drew attention to the Indian origin of the disease, it produced its own orient. The Empire attempted to acquit its own position under the gaze of the West, and to show that the Empire was an integral part of the West and a segregate ground from diseased Orient. Actually, although European powers demanded important sanitary regulations from the

[110] Suraiya Faroqhi, *Pilgrims and Sultans: the Hajj under the Ottomans*, 1517-1683 (London; New York; Tauris; New York ;St. Martin's, 1994), pp. 200-210.
[111] BOA, *A.MKT.MHM* 365/81 - 15.C. 1283, İ.HR 223/12999-1 - 29.B.1283, *IMVL* 562/25242 - 08.L.1283, *A.MKT.MHM* 375/31 - 21.L.1283.

Empire, they did not display a desirous image of wanting to incorporate the Empire into the western powers.

It is a clear result to consider that the Ottoman Empire had to take into consideration not only reactions from European powers but also signals from Hejaz, thus the Empire remained at a narrow ground between the Muslim world and the West to solve sanitary and hygiene problems. The most important risk expected by the Ottomans was to encounter a furious reaction coming from Muslims. Because of that, it did not wish to approve the first proposal of the French government that included coercive measures applied by military force, a restrictive quarantine system and observation. However, later this proposal was modified by the conference to reduce possible reactions from pilgrims against the Ottoman Empire. Therefore, pilgrims were not pleased at the compulsory quarantine practices, especially applied by the Egyptian government at El Wesch, because they encountered unsatisfactory conditions and long quarantine periods[112]. On the other hand, pilgrims did not show any significant reactions or disorder against officials. The performance of the Empire was to provide a balance between West and Muslim world. Actually, at the end of the sanitary and hygienic measures that were carried out to improve sanitary conditions of Hejaz, the Empire targeted to acquit its own position in front of the West rather than the Muslim world. In this context, it carried civilization and modernization into its territories, which were away from imperial capital.

The Ottoman Empire dwelled in difficulties establishing new quarantines and improving sanitary foundations of Hejaz because of the lack of financial sources. It did not easily finance the quarantine system, which was an economic burden for it[113]. As mentioned earlier, the Ottomans attempted to increase the rate of taxation, which would have been taken from

[112] FO, 195/864, *Séance du 28 Mai 1866*, pp 6-7.
[113] Gülden Sarıyıldız, *Hicaz Karantina Teşkilatı (1865-1914)*, Türk Tarih Kurumu Basımevi, (Ankara, 1996), pp. 29-32 and also FO 195/864, the report of Quarantina Council within proceeding of seance 10 on 31 May of 1866, pp. 27-33.

ships at quarantine, thus it would have solved financial problems related to the expenditures of quarantines. Briefly, the Ottomans aimed at establishing a balance between revenues and expenditures for quarantines. On the other hand, it did not find a permanent solution for the economical burden of quarantine stations. For this reason, after epidemics, quarantine stations were being closed because of financial problems[114].

It is important to note that following the Crimean War (1854-1856) the Ottoman Empire, which faced economic crises permanently, depended on financial supports taken from an outside which tried to dominate the Empire indirectly. During the nineteenth century, the Empire struggled many economic and political problems internal as well as external. At this point, sanitary problems and cholera epidemics caused some crises for the Empire, which had to satisfy demands coming from European powers. As mentioned above, European powers attempted to control sanitary regulations, quarantine stations of the Ottoman Empire as well as important ports, commercial roads and areas. They penetrated within all kinds of international or national sanitary organizations with way of medicalization.

Another example is the Paris Sanitary Conference for the clarification of the condition of the Ottoman Empire across the West. In that conference, eleven European members and the Ottoman Empire, which was the one member from the East, convened at Paris, in 1851. It negotiated the sanitary convention and regulations of quarantines practiced at the ports of the Mediterranean. At the conference, quarantine regulations for cholera led to many discussions regardless of their use. Members of Austria, Britain and Russia considered that the quarantine was an insufficient measure to prevent from cholera, but at the end of the discussions, the conference decided that the quarantine should have been practiced for plague and yellow fever as well as cholera[115].

[114] FO 195/864, *the report of Quarantina Council*, pp. 27-28.
[115] Emine Melek Atabek, op. cit., pp. 49-65.

Bartelotti Effendi who represented the Ottoman Empire gave general information about the quarantine system in the Empire[116]. He added that Indian pilgrims had contaminated other pilgrims with cholera during the Haj period. The East was seen in the conference as a dangerous area, because diseases spread from there to Europe. Some European members of the Conference declared their suspicion about sanitary foundation and institutions of the East that implied the Ottoman Empire. These members said that Europe did not accept the bill of health approved by the Ottoman Empire and did not permit free transition of ships coming from the Ottoman ports. The conference debated guarantees given by the Ottoman Empire, which had to persuade Europe about the sufficiency of measures taken in quarantine stations.

On those debates Dr. Bô said, " *are sanitary institutions imperfect only at the Middle East? Have we gathered in here to improve sanitary institutions of our countries? If so, why are we showing suspicion for the Ottoman Empire?*"[117]

As an answer, Dr. Rossenberg spoke, "… *nobody suspects the quarantine system of Italy, even if it becomes the weakest of other quarantine systems, but the condition of the East was so different.*"[118]

As a result of the debates, the conference approved that European ports would accept Eastern ships after eight days of voyage, on condition that the ship carried a doctor on board and had a bill of health.

The first sanitary conference demonstrated that European countries thought that important epidemic diseases had originated from the East for a long time. Generally, the East referred to the Ottoman Empire, because diseases passed from ports of the Empire to Europe. Moreover, this conference demanded some regulations from the Empire in order to

[116] *Ibid,* pp. 38-45
[117] *Ibid*, pp. 63
[118] *Ibid*, pp. 65

consolidate the position of foreign delegates into the Istanbul Quarantine Council[119]. It was obvious that European powers attempted to obtain important positions in sanitary institutions of the Ottoman Empire to control quarantine stations, ports, thus they would have indirectly dominated both commercial and sanitary conditions of the Empire.

During the Istanbul Sanitary Conference, the majority of European members had forced decisions of the conference to establish an international organization for sanitary control at the entrance of the Red Sea. Thus, the conference with majority of votes approved that Sanitary control organizations at the entrance of the Red Sea should carry an international character. According to judgments, sanitary works and regulations, which would have been managed by the Ottoman and Egyptian governments, would be possible with the aid of assistances and controls of Europe[120]. The Ottoman delegates did not declare any rejection about these sentences from the conference. However, they refused the proposal about international quarantine stations, which would have been kept under control by directions of a combined council[121]. On the other hand, the European members of the Istanbul Quarantine Council that had an international structure were effective and medical observers were inspecting on quarantines of the Red Sea as well as other quarantines of the Ottoman Empire. Moreover, European doctors, rather than Muslims, had been working at the quarantine stations and lazarettos of the Ottoman Empire for a long time.[122]

Additionally, the British delegation rejected international control of the Red Sea and quarantine stations, therefore, they mentioned within their report,

> *"As a general rule we could not admit the practicability of foreign interference in the local administration of any state, whether in sanitary matters or otherwise; and whether this applied to our own possessions, or to those of the Ottoman Government.*

[119] *Ibid*, pp. 68-70.
[120] A. Fauvel, *op. cit*., pp. 647-648.
[121] *Ibid*, pp. 657.
[122] Gülden Sarıyıldız, *op. cit*., pp.16.

We, therefore, could not join in the vote of the Conference for international institutions in the Red Sea."[123]

The British delegation, generally standing as the opposing side, rejected some sentences of the conference, if those were to be harmful to their commercial or political benefits. On the other side, although the Ottoman delegates refused some oppressive judgments, they accepted resolutions of the conference generally. Consequently, the Ottoman Empire tried to proceed in harmony with general tendencies of the conference throughout the process. Furthermore, it evidently struggled to organize the required works to improve sanitary situation of Hejaz from 1865 to 1868[124].

Clearly, the conference resolutions included some important risks and controversial sentences for the British Empire. The British delegation clarified these problems in its reports. According to the report written on the outcomes of the conference:

" From the foregoing statement it will be apparent to your Lordship that a large share of the measures proposed by the conference are directed towards India, and the cholera routes between India and Europe. The responsibility which attaches to India as being the source of the disease, and its connections with Europe have been prominently brought forward by the Conference.

Impressed with events of 1865, it has directed special attention to the Red Sea channel, and above all to the Mahometan pilgrims. We propose to consider in what manner the danger, if any, has increased of late years.

The ordinary traffic between India and Suez is not likely to be more dangerous now than it has been for the last twenty years, during which steam communication has been in constant operation. The pilgrim traffic between India and the Hejaz continues to be carried out in nearly the same manner as heretofore; steam-transport being very little employed by it. In 1865 only four steamers were freighted for this purpose: they carried 894 passengers out of the 20,000 Eastern pilgrims said to have visited Mecca, and they had no cholera deaths amongst their crews or passengers. If any new source of apprehension, therefore, has risen, it must lie in the application of steam-transport between the Hejaz and Suez, and which is now largely employed for the conveyance of pilgrims. The crowding of these boats and the short duration of their passage has

[123] FO, 78/2008(document I), pp. 6.

[124] BOA, *A.MKT.MHM* no : 336/74-10-S-1282; *IMVL* no : 549/24655 - 4-Za-1282; *I.DH* no : 548/38183 - 25-Z-1282*; A.MKT.MHM* no : 357/ 3 - 19.M.1283 ; *A.MKT.MHM* no : 365/81 - 15.C. 1283 ; *A.MKT.MHM* no : 369/18 - 21.B.1283 ; *I.HR* no : 223/12999-1 - 29.B.1283 ; *A.MKT.MHM* no : 762/73 ; *A.MKT.MHM* no : 762/81 - 29.N.1283 ; *IMVL* no : 562/25242 - 08.L.1283; *I.MMS* no : 34/ 1287 – 16.L.1283 ; *A.MKT.MHM* no : 375/31 - 21.L.1283 ; *I.MMS* no : 35/1448 ; *A.MKT.MHM* no : 390/46 5.Ca.1284 ; *I.DH* no :563/39226 - 28.M.1284 ; *I.DH* no : 575/ 40044 13.M.1285.

certainly increased the risks of an importation of disease into Egypt, whenever it occurs in the Hejaz during the season of the pilgrimage."[125]

During sessions and their reports, the British delegations indicated that Hejaz was a risky area for the spreading of the disease to Egypt and then Europe. In this case, strict measures should have been focused on the Hejaz district rather than India.

Following the statement, the delegation carried on declaring its observations:

" The Conference has fixed to ten days the term of quarantine for maritime arrivals from an infected port. If this rule is adopted throughout Europe, it will greatly embarrass and delay our communications with the neighboring continent; nor would it be of much use when applied to one Continental State while its communications by land with other States remained free; still, if such checks could be tolerated, they would increase the chances of keeping out the malady, and people moving in masses, such as emigrants, might be submitted to this restriction without much inconvenience. But if quarantine cannot be carried out between England and the Continent, still it might be advantageously enforced in the communications between England and the Mediterranean, and between England and America."[126]

At the end of the Conference, application areas of restrictive quarantine systems were specified as a limited ground between Europe and India, nevertheless practice of a strict quarantine system between European ports was considered by European members of the conference to be useless and harmful for continental relations. In other words, the quarantine measures, which should not have been used for the European continent, were definitely necessary to prevent from outsider ships coming from epidemic ports of the Middle East and India. Fauvel in his book clearly asks, " Who could propose such measures to impede on European relations seriously?"[127]

According to conference decisions, health passports and disinfection certificates were used to inspect and regulate vessels. These documents were a method for registering movements,

[125] FO, 78/2008(document I), pp. 5
[126] *Ibid*, pp. 6
[127] A. Fauvel, *op.cit*., pp. 41-42.

restricting, and identifying people. Thus, these sanitary documents served to govern commercial vessels and people or individuals.

General policy of the conference was to keep possible cholera epidemics within boundaries of Hejaz far from Egyptian ports and Europe. Moreover, it implied that British Empire and local Indian governments could have taken necessary hygienic and restrictive precautions against the disease[128]. Actually, restrictive precautions, isolation and observation were coercively based on the Hejaz district and pilgrimage rather than India. In addition, the conference stated contradicting judgments about quarantine measures. It is known that the contagious approach of the disease occurred dominatingly at the conference, thus, quarantine measures were accepted inevitably to prevent the disease. On the other hand, the conference declared that quarantine measures taken by the Ottoman government in Hejaz could not be sufficient, of course, to supply the security of Europe[129].

Isolation and Exclusion as a Sanitary Policy

Isolation, a coercive method to separate diseased or risky populations from healthy ones and to insulate within geopolitical boundaries against epidemic diseases, was used as an old precaution. In the nineteenth century, medical authorities and governments consolidated their coercive sanitary methods to classify people to be undesirable or dangerous and to segregate them from healthy and productive population. Governments involved in the modernization project realized that problematic populations were categorized within some specific concepts

[128] *Ibid*, pp. 645-653.
[129] *Ibid*, pp. 649.

like mad, infectious, deviant, unfit, and were confined into isolated places and were controlled by treatment, care and observation.[130]

Public health, as a modern policy connected with quarantine methods, isolated hospitals and zones, medical police and sanitary cordons of the nineteenth century, were used to govern population. In the political and cultural history of Europe, restriction on foredoom of some people was justified as being protection of majority and humanity. For this reason, restriction and isolation applied by state sanitary policies were normalized by problematic applications based on rights and obligations to improve and manage undesirable populations, who were guilty because of their diseases and unhealthy conditions.[131]

Sanitary organizations regarding isolation and exclusion aimed at managing and defining problematic populations in order to separate clean from unclean and to draw a line between healthy and unhealthy. Western techniques on rationale exclusion and isolation were transferred by different political powers, which used these techniques as hybrid practices of exclusion and isolation for punishment and cure of their own populations.

Isolation and exclusion were closely connected with international sanitary policies that were created through conferences of the nineteenth century. International sanitary policies were based on modern medical, hygienic and disinfected methods, quarantines, isolated hospitals, sanitary cordons and sanitary commissions for isolation and exclusion of risky societies. International sanitary conferences were organized by Western powers to control epidemic diseases like cholera, typhus, plague, and yellow fewer and to govern and define undesirable population, that is to say Eastern populations.

Similarly, the Istanbul International Sanitary Conference formulated its reasons and credible explanations to rationalize isolation and exclusion to be practiced through the

[130] Carolyn Strange and Alison Bashford , *op. cit*., pp. 1
[131] Ibid, pp. 4.

quarantine system. European members of the conference supported and approved quarantine measures to isolate and exclude problem populations, who were pilgrims, for the good of humanity. Interestingly, Humanity concepts changed place from their ordinary meaning to special and territorial usage. Problem populations were pilgrims (as potentially infected or infected), and on the other side, humanity was used to refer to Europe only. In the conference, isolation and exclusion was expounded and rationalized with humanitarian principles. Constantly, European members demanded exclusion and isolation and put barricades between infected areas of the East and Europe[132]. Therefore, infected or potentially infected pilgrims should be segregated from humanity, actually Europe, by means of protective and preventive measures. Obviously, the conference normalized punishment for potentially infected and dangerous pilgrims. Quarantine measures were a punishment for them.

Quarantine measures arranged by the conference included disciplinary rules, techniques of surveillance and segregation in order to isolate cholera victims into boundaries of quarantine zones. Strict quarantine as a punishment method functioned to be an open-prison. Therefore, quarantine as a classical sanitary institution meant isolation, discipline and punishment rather than treatment. According to judgments of the conference, quarantines should be established into naturally isolated and excluded undesirable zones like islands and wastelands and places remote from settled populations. Physical and geographical isolation in undesirable zones involves punishment methods. Keeping potentially infected people in naturally isolated zones was presented by the conference as hygiene and sanitation measures.

Compulsory quarantine revealed another distinction between outsider and insider or between isolator and isolated. In the proceedings of the conference, those positions, outsider and insider, can be shown definitely. Cholera has an origin and a territory, so it is called

[132] FO, 195/864, *Séance du 27 Fevrier 1866*, no:4, pp. 19

Asiatic. European members of the conference drew boundaries to determine outside and inside: Europe to be inside and Asia to be outside, and at the same time, European to be insider and isolator, Asian to be outsider and isolated. Normally, European members attempted to segregate themselves with barricades from the outsider Asian population and Asiatic cholera.

The Istanbul Sanitary Conference targeted restrictive methods to prevent cholera epidemics. In this case, the conference did not deal with treatment and sanitation methods to improve health conditions of pilgrims and other problem populations efficiently due to limited and unsatisfactory medical knowledge. Thus, it applied isolation as a sanitation and hygiene method. Consequently, although this conference was organized in order to solve the cholera problem with sanitation methods, it accepted political and partial judgments and restrictive measures. According to the general position of the conference, sanitation means protection for Europe.

The process of the conferences determined East and West to be two segregated sides. Segregations and determinations of the sanitary conferences characterized the imagination of East and West according to Western thought. East was defined as being unclean, dangerous, diseased, infected, undesirable, and risky for the healthy, hygienic, desirable, clean, safe West. The conference consolidated images of the East being linked to the cholera disease.

The Istanbul Sanitary Conference, called Cholera conference, created such imagination throughout its sessions. The Ottoman Empire, Iran and India were taken under pressure by European powers because of their Muslim populations, who were looked at as guilty of the contamination of cholera epidemics in Europe. During the time of the conference, from February the 13th to September the 26th, the Ottoman Empire was under surveillance of European powers that coerced isolation and exclusion methods on the Ottoman subjects, especially pilgrims in Hejaz. It is a dilemma that the Ottoman Empire was isolated and

excluded from Europe to be protected from cholera epidemics; yet on the other hand, it isolated Ottoman subjects into its boundaries by quarantine systems to prevent the spreading of cholera to Europe. Thus, the Ottoman Empire occurred to be not only isolated, but also an isolator. In addition, the Empire as a colonialist power performed quarantine rules on isolating Muslim subjects according to orientalism created by the Western thought. Through the conference, the Empire acknowledged general Western thought concerning East or Orient, so it attempted to exhibit a modern Ottoman portrayal to gain trust from the West.

Cholera as the most destructive epidemic disaster of the nineteenth century shaped images of the East in the Western mind. In other words, images and definitions of cholera were mixed with comments about the East. Throughout the nineteenth century, cholera, which was a highly political disease, had a capacity of showing huge distinctions between the poor and the rich, between the host society and immigrant communities, between the East and the West[133]. In the same way, through the process of the Istanbul Sanitary Conference, cholera drew a dividing line between Europe and the East, especially the Ottoman lands.

It was a traditional manner for all cultures to apply metaphors about diseases, which were generally identified by military metaphors like attacks, invasion, devastation, conquest etc. Western and Eastern nations produced images and metaphors relating to cholera in their mentality. The inscrutable disease that was characterized by suddenness of its attack did not follow a logical line of progression. It demonstrated the greatest irregularity and caprice for medical professions and victims, because it might suddenly disappear and then mysteriously reappear long or short time later in the same place. Therefore, cholera obtained a variety of diverse cultural and political identifications and interpretations, many of which characterized disease with disorder[134].

[133] David Arnold, *op.cit.*, pp.159
[134] Ibid, pp.161.

Europe encountered the severity of the disease at the height of a self-confident era of economic growth, material progress, scientific achievement and expanding European dominion over the world. It is of most importance to point that the disease that came from the "uncivilized" East challenged common assumptions of European political and scientific superiority. The disease demonstrated vulnerability of most civilized people against its ravages. The disease made an impression on the European mentality, which reacted to the East the same way it did to cholera. European governments and medical professions, who remained ineffective in understanding causes and treatment of the disease, showed a particular interest in associations between cholera epidemics and Eastern territories. Cholera associated with oriental backgrounds caused a European political and coercive understanding, which isolated and excluded Eastern populations from the West[135].

In the nineteenth century, European literature and culture were celebrating the age of beautiful death regarding tuberculosis, which made an impress on the western disease perception. Tuberculosis was identified with beauty and delicacy. According to this perception of the disease, it added beautifying and dramatic influence on the deaths of its victims[136]. On the other hand, cholera did not have such images in literature and historical writings.

Metaphorically, cholera, because of its mysterious structure, was thought like a cool killer to take the souls of its victims. It had images associated with dirt, unhealthy crowds, evil, and poverty. It undermined bourgeois comfort and optimism in major towns and cities of the nineteenth century Europe due to miserable poor populations. Cholera epidemics penetrated into poor districts and affected the poor more than the rich. According to the European middle class thoughts about the disease and body health, the poor should blame only themselves for being responsible for their illnesses and misery. Drunkards, layabouts,

[135] Richard J. Evans, *op. cit*., pp. 154
[136] Susan Sontag, *Illness as Metaphor and Aids and its Metaphors*, Picador (2001), pp. 40-43.

vagabonds, undeserving poor were responsible for the spreading of the disease to other areas of cities[137]. Discourse on cholera exhibited a dichotomy between civilized and uncivilized, rich and poor, West and East. At the latest point, the Western gathered all images of cholera in the Eastern concept: uncivilized, unhealthy and poor.

During the sessions of the Istanbul sanitary conference, images of cholera became clear by speeches of delegates. As an example, Fauvel explained that cholera was a brutal and uncompromising enemy, so it might be prevented with constant sanitary policies. Medicine and doctors were helpless against cholera because of insufficient medical knowledge, therefore escaping from cholera was not possible if it once seized[138].

The cholera disease was separated into two different forms: Asiatic and European. First of all, this differentiation indicated territorial exclusion between Asia and Europe medically. Asiatic cholera that was defined as a dangerous epidemic form belonged to Asia, but European cholera as an unimportant form appeared only in Europe[139].

As a result, the Istanbul International Sanitary Conference mirrored orientalist western thought, modernization performance of the Ottoman Empire and segregation created by Western mind between East and West.

[137] Richard J. Evans, *op. cit.*, pp. 154-155.
[138] FO, 195/864, *Séance du 27 Fevrier 1866*, no:4, pp. 19
[139]FO, 195/864, *Rapport sur les questions du programme*, (mai, 1866), pp. 4-6.

Conclusion

In the nineteenth century, cholera and sanitation as political tools acquired a major place in international relations. Due to the incapacity of medical authorities of dealing with cholera, cholera epidemics invaded vast portions of the world and affected the lives of populations in the East and the West. In that century, health measures imposed by governments took the shape of restrictive precautions. The quarantine system was used to manage potentially infected and undesirable populations and to isolate them from healthy and clean territories. In the conference, isolation and exclusion were approved to be applied for the sake of humanity: a word that only referred to and only meant Europe. Thus, quarantine measures were normalized to isolate and exclude infected pilgrims, to keep them away from Europe.

The Istanbul International Sanitary Conference was based on Orientalist western thought. It reproduced the Orient according to western ideals in order to classify oriental or eastern Muslim subjects as dangerous, infected and undesirable. European representatives at the conference determined the progress of the conference and its judgments. According to these judgments, the East, particularly the Hejaz and India, were marked as infected grounds, which should be isolated from the West. It is a clear portrayal created by European representatives that there were two separate sides to the world: "diseased East and pure West". The creation of two distinct worlds was normalized by the conference, especially by the European members present there; the conference thus conceptualized the "diseased East" and acknowledged its claims about the disease and the East as a general rule. Segregating and classifying policies in the conference were based on sanitary and hygienic discourses shaped

by the modernization project of the West. Therefore, Oriental Muslim subjects would have to be blocked in quarantine zones according to the understanding of humanity by modern Europe without any discussion of western judgments by the East.

In the nineteenth century, Western powers transferred their views on modernization, as well as its tools and institutions in order to penetrate "underdeveloped" localities everywhere in the world. They colonized vast areas in order to bring "civilization" to these underdeveloped regions. Through the civilizing mission of the West, the Orient was identified within the Western discourse as a colonial image and a symbol of backwardness. Following the development of railways and steamships, growing commercial relations and the interests of European powers in some Eastern localities caused the transmission of some infectious diseases to Europe. For this reason, the civilized West created a new image of the Orient based on disease, risk and filth. It is important to note that cholera was divided into two different types, Asiatic and European. Asiatic cholera had a more dangerous and fatal character than its European equivalent. Images of Asiatic cholera were the same as the portrayal of the Orient. On the other hand, for centuries many severe epidemics of different diseases had been appearing throughout the West as well as the East. However, modern Europe exhibited a clear attitude about its sanitary condition as if such cases of epidemic disease had never been seen on the continent. In this case, the western discourse claimed that epidemic diseases could only appear in, and originate from, Eastern countries, and they did could not be rooted in the European continent.

The conference mirrored the attitude of the West toward eastern Muslim subjects. The representation of Western thought was based on the idea that the East involved only backwardness and uncivilized experiences. According to European delegates at the conference, the protection of the European continent against Asiatic cholera as its basic aim was possible only by applying restrictive precautions, so that obstacles should be set up

between East and West. The Ottoman Empire conformed to this western vision and applied restrictive sanitary measures on Muslim pilgrimages by transferring civilized hygienic regulations, much like a colonizer in the Arab lands. For this reason, Ottoman Orientalism appeared in the Hejaz and was based on medicalization and hygiene.

In the nineteenth century, Ottoman Orientalism showed its effect in reforms and modern institutions. The Ottoman Empire attempted to control different subjects considered as problematic populations such as nomad tribes, populations from different nations and pilgrims that threatened the Empire from several perspectives. For this reason, the Empire tried to reorganize these populations according to its benefits and govern them in order to reduce their risk. It started to use modern methods and institutions that involved medical, hygienic, militarist and educational structures as part of its reform and modernization attempts. In that century, through civilizing missions, the Empire constituted modern institutions to manage its subjects, especially problematic populations, and thus carried out modern sanitary rules as well as other methods in the Hejaz. At this point, the Empire represented itself mostly as a colonizing power facing the Muslims, rather than as a Muslim power. In that century, while the Empire left its pre-modern imperial structure behind, it acknowledged Europe as an advanced model for the reorganization and redefinition of mentalities as well as institutions. The Empire together with its reforms transferred Orientalist images and ideas created in the Western world during through modernization process. Ottoman Orientalism, applied to the Empire's Muslim subjects, especially in the Arab lands, contained images similar to the Western mind which were based on the backwardness of the East. In this case, the Ottoman elite attempted to dissociate themselves from this uncivilized and pre-modern Muslim world.

During the conference, the Ottoman Empire frequently tried to acquit its own self-image about its sanitary condition in front of European representatives; however, it did not reach a complete success in order to dissociate itself from "diseased orient".

Consequently, the Istanbul International Sanitary Conference depended on Western mentality. A sanitary organization and health measures were imposed to prevent the spreading of possible cholera epidemics to the European continent and to control undesirable populations within isolated zones. Isolation and exclusion were adopted in the conference as sanitary methods and also as a punishment for infected Muslim subjects. Within the concept of two separate worlds, the oriental or eastern Muslim subjects were viewed as a sort of negative image of Europe. The conference created its own justifications, which were based on the threat of a possible cholera epidemic and the importance of sanitation and hygiene in order to blame the East and to govern the eastern Muslim populations as isolated subjects.

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