# 15: Tangerian Ghosts and Riffian Realities: The Limits of Colonial Public Health in Spanish Morocco (1906–1921)[135]

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## Introduction

In May 1930, the internationally-renowned Italian parasitologist, Gustavo Pittaluga, (who had settled in Spain) and one of his disciples, Francisco Ruiz Morote, visited the Spanish Protectorate in Morocco after attending the International Conference on Malaria held in Algiers. They were accompanied by Captain Dr. Joaquín Sanz Astolfi, Director of the Laboratory of Clinical Analysis of the Tettouan Military Hospital, who had also travelled with them to Algiers as representative of the Protectorate's Health Services (Sanz Astolfi 1931–1932). During their short trip, Pittaluga and Morote got a glimpse of the Protectorate's health organisation and institutions, its sanitary conditions as well as the plans and outcomes of the first anti-malarial campaign launched the previous year. After the visit, they published a paper in Pittaluga's journal, *Medicina de los Países Cálidos*, which also appeared in *África*, the journal of the Spanish Army in Morocco.

In that paper, Pittaluga claimed that Spanish health initiatives in Morocco had been

> guided in an excessively military sense, abandoning some of the main scientific and public health orientations which must be the base, never to be forgotten, of every doctor's actions […] (Pittaluga & Ruiz Morote 1930).

But he added "that all prevention has vanished on contact with a cosy, full-of-promises reality" (Pittaluga & Ruiz Morote 1930). Morote confirmed this impression when he wrote that

> remembering the visit is enough to eagerly wish that the work developed there would become better known in the metropolis and to know to what extent public health work has contributed and is contributing to improving the population health status and to easing Protectorate's duties.

Out of all initiatives, for Morote

> the most impressive ones are those concerning rural dispensaries [strictly called "dispensaries for natives"]. They are advanced posts of civilization, now

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enjoying the peace they contributed to sow in such an efficient way (Pittaluga & Ruiz Morote 1930).

In fact, by the time of Pittaluga and Morote's travel, there existed a network of 58 "dispensaries for natives" in Spanish Morocco, ten of them in the towns and 48 in the countryside, spread throughout the Protectorate's territory. They were run by Spanish doctors and Spanish and Moroccan auxiliary personnel. They generally had exploratory, analytical and surgical equipment and small infirmaries, and they were provided periodically with drugs, vaccines and, when necessary, with disinfection devices. These dispensaries had begun to offer outpatient, clinical and surgical care and were used as the basis for the launching of the first health campaigns against malaria, typhoid fever or syphilis (Delgado 1930). The network of dispensaries may be taken as a symbol of the deployment of a health system in Spanish Morocco. Its presence was represented throughout the 20,000 $km^2$ of territory, and its coverage of a population that overall was estimated at between 600,000 and one million inhabitants.

But things had been quite different in the years prior to the Rif War (1921–1927) and, obviously, in the course of it. Despite a tradition of medical activities in Morocco since the last quarter of the 19th century, Spain was unable to establish more than four urban and sixteen countryside dispensaries in its Protectorate zone before 1921. In this first period of existence, activities of dispensaries for natives were hindered by personnel and equipment problems, by the lack of proper facilities and funding, and by the lack of administrative co-ordination between the ministries of State and War and between Tettouan and Melilla. Spain also acted under pressure of measures taken by France in its much larger Moroccan Protectorate, exhibited in either its inability to match developments there, or in the constant menace of French interference in the Spanish zone (Martínez Antonio et al. 2003; Molero Mesa et al. 2002; Molero Mesa 2003).

However, as this paper attempts to show, another major obstacle for the creation of dispensaries for natives during this period was the relative persistence of Morocco's public health structures and agency. Since the 19th century, Moroccan public health action had been expressed in different forms, ranging from government participation in modern state-wide organs, such as the Sanitary Council of Tangiers, to popular rejection of foreign intervention. Most historiography on the French and Spanish Protectorates in Morocco has tended to ignore or underestimate the development of the Moroccan state prior to and after 1912, though as it will be seen, Moroccan agency proved resilient and influenced public health developments in the Spanish and French Protectorates for many years after they were formally established.

When this agency is systematically taken into account, the question of the colonial character of the Spanish (and French) Morocco's health system arises. Many historians have argued that the Protectorate regime was only a façade for direct colonial action (Hoisington 1995; Rivet 1996; Gershovich 2000; Pennell 2000; Villanova 2004). However, the impact of events taking place in Morocco was too strongly felt in metropolitan Spain (and France) to consider them as

"merely" colonial. Conversely, Spain (and France) had to display too much direct intervention to control Moroccan authorities and territory to describe their activities as "mere" colonization. In the case of Spain, it seems especially clear that differences were not of such a degree as to explain its relationship with Morocco in colonialist terms. Their interaction resembled more a conflict between countries of similar (weak) power: similarity led to war, not to colonization, and to expropriation or seizure of local authority, not to its intervention. An attempt will be made to clarify this crucial issue, although present conclusions cannot be but tentative, as they are based almost exclusively on Spanish and French sources. The main hypotheses may nevertheless be taken into consideration while the process of gathering data from Moroccan archives is carried out. Specific public health developments concerning the Jewish community are not addressed in this paper, an absence which should also be corrected in future works.

## Caring for the Ports and the Army
## Public Health and the State in 19th Century Morocco

### *Did Moroccan Public Health Exist?*

In order to understand the weight of the Moroccan "factor" in the creation of dispensaries for natives in Spanish Morocco, it is first necessary to examine the trajectory of Morocco's public health during the 19th century. In broad terms, the period 1822–1894 was an epoch of relative stability for the country, especially the last twenty years (Laroui 1993). Such stability, however, far from being static, was a fruit of a constant, tension-filled compromise between the numerous forces which operated on the Moroccan stage. Internally, the Sultan and the *Makhzan* (Moroccan government) interacted with local actors (*caïds* = governors, *zawias* = religious brotherhoods), social groups (*ulamas* = religious experts, commercial bourgeoisie, urban artisans) and certain territories (Rif, High Atlas, Saharan oasis) in order to reach some degree of cohesion for Moroccan society. Externally, the autonomy and sovereignty of Morocco evolved through relationships with several European and Western states as well as other Arab-Islamic countries (mainly the Ottoman Empire and Egypt) and with nearby colonies (French Algeria and Senegal), foreign enclaves (Spanish strongholds in the north and factories on the Saharan coast) and British Gibraltar. The international status quo on the so-called Moroccan question (parallel to other *questions d'Orient* such as the "Ottoman question" and the "Chinese question") was maintained to some extent throughout the century.

Out of this dynamic and troublesome balance, a number of administrative, economic, military, institutional, legislative, cultural or political transformations materialised. However, they are usually interpreted as the outcomes of "informal" or direct imperialism exerted on the country, whose only chance was to resist and delay them as much as possible. But in accordance with authors such as Abdallah Laroui or Wielfried Rollman, it could be said that the role played by Moroccan authorities in those transformations seems more active than mere resistance. In the field of public health the following questions must be asked: what was Moroccan

in Morocco's public health, if anything? And what were the effects of such "Moroccanness" in the health system, if any? Based upon this author's PhD research (Martínez Antonio 2005a) it will be first argued that "Moroccanness" or Moroccan agency consisted of two coupled mechanisms of multiple *diversification* and personal/oligarchic *authoritarianism*. On the one hand, attempts were made to keep unstoppable European intervention in matters of medicine and public health at bay by fostering participation of as many foreign countries as possible so that competition between them arose, along with a complication of administrative procedures. On the other hand, increasing internal fragmentation of Morocco's health system was somewhat slowed down by an authoritarian concentration of competencies in the hands of the Sultan and the Makhzan. In this way, sanitary measures could be taken and imposed without negotiation with social, local or territorial actors, while administrative procedures were eased. In sum, Moroccan weakness did not lead to dependence and anarchy in public health but rather to a kind of fragile autonomy.

This particular Moroccan agency led, in the second place, to a predominance of the *maritime* and *military* components of the health system. In my opinion, health systems in the 19th century were generally composed of four branches (navy, army, maritime and land-based public health) or, in other words, they were configured along a double civil-military and internal-external axis (Martinez Antonio 2005). Maritime and army public health were prominent in Morocco because in both spheres a balance could be kept between international and Moroccan sanitary interests and also between the extension of the health system to a wider population and territory and the tendency of some localities to different degrees of self-management. Such balances were not possible in navy and land public health, which suffered from a high degree of foreign dependence and internal heterogeneity. In some way, the first two branches tried to compensate the lacks of the latter, often assuming part of their competencies and tasks, though this did not mean that they succeeded in achieving their own goals. However, it seems certain that the most complex and comprehensive structures of Moroccan public health were those caring for the ports and the Army.

This analysis can provide perspective on colonialist (and post-colonialist) accounts which have pictured the Moroccan authorities and people as having no interest in public health issues or merely resisting and conditioning imposed European initiatives in different ways. Colonialist accounts have promoted an unfair view of Morocco as a "medieval" country regarding health and medicine, reduced to a fossilised mosaic of classical Arabic medical institutions and practitioners, Muslim charity, folk healers and "superstitious" practices. All of these existed, of course, but so too did other more comprehensive and newly-created public health structures, whose existence was, at least in part, sought and enabled by the efforts of Moroccan authorities. On the other hand, it is also necessary to keep a distance from nationalist (and Islamist) historiographies which construct Moroccan medicine as free from European influence and homogeneously based on the Arab tradition or which regard foreign influence just as an imposition. In general, it is

more useful to consider the differences between the history of public health in Morocco and in European countries as differences of degree and not of kind. On these conceptual grounds, a basic picture of the higher structures and most relevant institutions of 19th century Moroccan public health are presented in the next two paragraphs.

*The Reigns of Moulay Abderrahman (1822–1859) and Sidi Mohammed IV (1859–1873)*

An improved system of maritime public health began to be set up in Morocco during the reign of Sultan Moulay Abderrahman. The so-called International or Maritime Sanitary Council of Morocco, based in the port city of Tangier (also called the Council of Tangier), obtained a formal delegation of power from the Sultan (*firman*) in 1840 to "be responsible for the maintenance of public health on the Empire's littoral, to elaborate all regulations and take all measures to carry out this purpose" (Raynaud 1900; El-Bezzaz 1982–1983). Though its precedents went back as far as 1792, the Sanitary Council of Tangier was essentially contemporary to others created in the main ports of the Arab-Islamic Mediterranean countries, such as Tunis (1835), Istanbul (1838–1839), Alexandria (1843) and Tripoli (Gallagher 1983; Panzac 1986; Schepin & Yermakov 1991; Moulin 1995; Mizrahi 2003). In the following years, the Council improved its internal organisation through a permanent commission and a secretary. In addition, delegations were established in the other "imperial ports" (Tettouan, Larache, Rabat, Casablanca, Mazagan, Safi and Mogador) from 1846 on. Medical personnel was gradually attached to the Council, and revenues were raised by charging fees to ships for sanitary inspection. Finally, a provisional quarantine station was established on the isle of Mogador in 1865, so that pilgrims returning from Mecca could be isolated if cholera was suspected.

It has usually been argued that the Council of Tangier was in fact a foreign institution, given that its members were the foreign diplomatic representatives in the city and its main budget was provided by foreign governments. Thus, its measures would have been dependent on the plans for foreign "penetration" in Morocco, the "civilisation" of the country, the promotion of European commercial exchanges and the protection of European communities in the port cities (Raynaud 1900; El-Bezzaz 1982–1983). But this picture, though partly accurate, is nonetheless too reductionistic. To begin with, the Sultan had only "delegated" power in maritime health affairs to the Council, a precaution which would long be regretted by European representatives. For example, when it came to sensitive matters such as the control of maritime pilgrimage to Mecca, the Sultan often imposed his decisions upon the Council's recommendations, because he still held executive power. Morocco also received foreign representation comprised of up to fourteen countries (Great Britain, France, Spain, Russia, Norway, Sweden, Portugal, Denmark, the Netherlands, Belgium, Austria-Hungary, the United States, Italy and Germany) that were obligated to making equal economic contributions and to rotate among the posts periodically. Agreement was naturally difficult and the threat of one country's imperialist interests being predominant was neutralised

to a certain extent. Furthermore, in regard to pilgrimages to Mecca, the Sultan had appointed consuls (*wakils*) in Gibraltar, Tunis, Alexandria and Cairo, which probably allowed the Tangier Council to keep regular contact with its counterparts of those cities, as did the Council of Tunis (El-Bezzaz 1985; Gallagher 1983). Undoubtedly, cooperation with other Arab-Islamic countries was the most effective way of avoiding European inherence.

On the other hand, a degree of direct control over the Council was exerted by Moroccan authorities through the *naib*, the Sultan's official representative in Tangier since 1848, who acted as a *de facto* Minister of Foreign Affairs (Rollman 1983; Pennell 2000). All the Council's resolutions had to be submitted to his office, the *Dar al-Niaba*, and then sent to the Sultan for approval. This resulted in increased centralisation and co-ordination of maritime sanitary affairs throughout the country. Besides, slow and long official procedures could reduce the actual efficiency of European proposals when necessary. Finally, the *naib* could influence measures proposed by the Council so that they were not only of benefit to foreign residents and European commerce, but also to the fast-growing native population of port cities and to the new Moroccan commercial bourgeoisie. In the port cities, the *caids* and *pachás* were charged with controlling the Council's delegates and their approval was necessary for any measure taken in case of epidemics.

The relative development of maritime public health in Morocco was used as a basis for proposing changes in land public health. In Tangier, the Council tried to extend its measures from the port to the city itself and also to support initiatives taken by civil doctors of the growing European community. It became common in this period for European settlers to propose sanitary reforms in case of epidemics of cholera or other diseases and to seek the support of the European consuls in the Council. A similar process occurred in the port cities (Raynaud 1902). However, the *firman* of 1840 had not allowed the extension of activities of the Council towards urban public health. The risk was higher for Moroccan authorities in this field because the number of foreign countries would have been reduced and control over local authorities would have been more difficult to achieve. The same happened for European countries because they would have been obliged to increase their expenses, competence between them would have increased and popular rejection of their influence would have been more serious. Therefore, no confluence of interests took place. On the one hand, Europeans attempted modest initiatives; on the other, traditional Moroccan institutions persisted. In Tangier and in the other ports, there existed urban assemblies composed of local authorities (*caïd*, *pachá*), merchants, *ulama*, doctors (*tobba*) and the market inspector (*muhtasib*) which had traditionally been in charge of proposing anti-epidemic measures. For example, in Tettouan during the plague epidemic of 1799–1800, "eminent city notables, including the *ulama*, decided that it was necessary to close the city gates so that it would be preserved from any contagion" (El-Bezzaz 1985). The assemblies still kept some of their power during this period and were

also responsible for the good conditions of streets, buildings, slaughterhouses, the water supply and food sold in markets. In Tangier, for example, the *muhtasib*

> for cleaning the streets and squares, raised a little tax on the slaughtered cattle and directed a brigade of ten workers who swept the streets and gathered the litter, which they put on a limited number of donkeys to be taken to the orchards surrounding the city (Laredo 1994).

Parallel to the Council of Tangier, the sultans Moulay Abdehrraman and Sidi Mohammed IV also started the transformation of military public health as part of their general reform of the Army (*nizam al-askr*) which followed Moroccan defeats against France (1844) and Spain (1860) (Rollman 1983). In this matter they followed the path established by the Ottoman Empire and Egypt (also by Tunis and by the army of the Algerian resistant, *Abd al-Qadir*). In the Ottoman Empire Sultan Mahmud II had created schools of military medicine and surgery in 1827 and 1828 respectively, which were unified in the Imperial School of Medicine (*Mekteb-i Sahâne-i Tibbiye*) in 1839, directed by the Austrian Dr. Bernard (Lewis 1984; Ishanoglu 1992; Panzac 1995). In Egypt Pasha Mehmet Ali had founded the School of Military Medicine at the Hospital Abu Zabal in Cairo in 1826–1827, directed by the French doctor Antoine Barthèlemy Clot, also known as Clot Bey (Panzac 1989).

Moroccan developments seem to have been much more modest than those in the Ottoman Empire and Egypt in this period, although further research is still needed on the subject. However, it is quite certain that Morocco contacted both countries in order to limit European influence in its military public health, as was the case for the maritime branch. Driss Mossaoui has shown that some Moroccan students were sent to study in the schools of Cairo and Istanbul during this period (Mossaoui 1995). They should have been attached to the new military regiments (*'askar*), which increased from their original number of 900 to more than 3,000 men in 1870. Moulay Abderrahman requested of Mehmet Ali that scientific and military works be translated into Arabic from European languages (mainly French), and a number of them could have been medical books, perhaps the same that Clot Bey had sent to Tunisian authorities in 1854 (Gallagher 1983). European influence in the Moroccan army medicine already existed in this period, though it was split between different countries. Since the end of the 18th century, it had been usual for Spanish military doctors, as well as naval surgeons from Gibraltar, to travel to Morocco at the request of the Sultan (Justel 1991). In 1861, a big supply of drugs that was probably addressed to the Army was acquired from France (Amster 2003). An important question which has not been systematically posed is the role of "renegades" (converts to Islam), especially of Spanish origin, as practitioners in the Moroccan army.

For most of this period, there was no formal Ministry of War. The *katib al-jish* (chief of the *jish* or *guich* regiments) remained the highest military officer, although in 1845 Moulay Abderrahman relied on his son, the future Sultan Mohammed VI, for directly supervising and fostering the modernisation of the army. It was in the first years of his reign that Sidi Mohammed created the post of

*wazir al-harb* or Minister of War (Rollman 1983). Greater military centralisation was then achieved, and it went along with a more permanent organisation of the army throughout the country, because *askaris* were distributed in the Sultan's guard and in garrisons in the main cities. These developments should have affected sanitary and medical structures as well, in the sense of a greater control by central authorities, although there is a lack of specific data about this issue. In addition, it seems plausible that Moroccan military doctors did not enjoy much executive power compared with their military chiefs, as this was also true in most European armies. This consultative character limited the extent of European interventions in military public health, as was the case with the Sanitary Council of Tangier. Finally, the army tried to be used as basis for extending reforms to land public health. A clear example is that the army was usually charged with implementing "sanitary cordons" around cities or areas in case of epidemics (Raynaud 1902). However, results were quite modest.

*The Reigns of Moulay Hassan I (1873–1894) and Moulay Abd el-Aziz (1894–1906)*

During the reigns of Moulay Hassan I and Moulay Abd el-Aziz, maritime and military public health continued to be predominant in Morocco and their development was achieved by similar mechanisms as in previous decades. However, Morocco's "sanitary autonomy" in the international context and "sanitary cohesion" inside the country became more and more precarious from the 1880s onward. By then, Western health systems were swiftly moving to a new basis. The former system of quarantines, sanitary cordons, sanitation and disinfection had been mainly consultative in character. It had concentrated its activity on temporary epidemic outbreaks and had relied on contagionist or miasmatic interpretations of disease. This system started to give way to one of *inspection*, which was based on a permanent health administration, where the increasing executive power of doctors was displayed through new institutions such as laboratories and supported by the new scientific doctrines of bacteriology and experimental hygiene (Rosen 1958; Porter 1994, 1999). Moroccan authorities were interested in these new developments, but were also aware that they enabled a greater degree of European intervention in the country's public health which risked eroding the cohesion of traditional public health structures and the support of practitioners and people alike.

In maritime public health, for example, European doctors played an increasing role in the Sanitary Council of Tangier. "Medical advisors" had begun to be appointed regularly from the 1860s onward, mainly in Tangier, and the consuls relied more and more on their technical expertise. For example, they assumed the sanitary inspection of the port of Tangier and elaborated the Council's quarantine regulation, approved in 1878. In the beginning these doctors were private practitioners working for the European communities but, for example, from 1885 onward, Spain officially attached doctors to its Moroccan consulates (Felipe Ovilo, Enrique Rebolledo, Severo Cenarro and Antonio Jordán among others). European doctors were also appointed to the Mogador lazaret so that they directly

supervised the quarantine of Mecca pilgrims. The Spanish doctors Cenarro and Rebolledo assumed this task in the 1890s, although still under strict control of the Moroccan authorities. In 1900, under the increasing menace of a plague outbreak similar to the one that had affected Porto in 1899, the French doctor based in Algiers, Louis Raynaud, was recruited by the Sultan for that mission. Once he had reorganised the lazaret in 1901, he appointed another Algiers health officer, Dr. Gagé, and a Council medical advisor to supervise the quarantine under his instructions (Raynaud 1902).

It was following doctors' suggestions that the European consuls systematically pressed the Moroccan government to have the Mogador lazaret organised on a more permanent and scientific basis. They also counted on the force of agreements reached at the International Sanitary Conferences of Dresden (1894) and Venice (1897). For example, the second article of the Venice Sanitary Convention stated:

> It will be recommended to the competent authorities in Morocco to implement, in the country's ports, measures in harmony with those stated in the general [international] sanitary regulations, in order to prevent the invasion and diffusion of plague.

The distant placement in Mogador and the inadequacy of its building and equipment never fully satisfied Europeans. Dr. Enrique Rebolledo was the first to make a report suggesting the need for creating a new lazaret. Soon after his arrival, Dr. Louis Raynaud sent a new report to the Council and to Moroccan authorities proposing the establishment of a *lazaret definitif* in Tangier, the ten-mile distant Punta Malabata being regarded as an ideal setting (Raynaud 1902). It was not until 1909 that an international commission was appointed to study the exact location and characteristics of the future lazaret, although it was probably never built (Laredo 1994).

The creation of a modern lazaret was a main concern of the Tangier Sanitary Council, but new public health developments spoke less for this kind of institution than for a permanent health administration in the port cities. By means of such administration the hygienic conditions of streets and buildings, slaughterhouses, sewage systems, water systems or garbage removal could be controlled in order to improve the general urban health status, thereby strengthening the city's defences in case of epidemics. In this sense, the Council succeeded in supporting the creation of the Hygiene and Sanitary Commission in Tangier in 1892 (with a brief predecessor in 1884) based upon a formal delegation from the Sultan to the Council of the responsibility "for assuming the cleansing of the city of Tangier, the street paving and the repairing and building of sewage collectors" (Marco 1913). Although this measure could not be extended to other port cities, the new commission and the lazaret project served as arguments for European consuls to propose a reorganisation of the Council in 1899 so that it truly acted as a permanent maritime health "service", that is, was given real executive powers.

In general all these new transformations in maritime public health ran strongly against Moroccan interests because they tended to shift executive power in health

affairs into the hands of foreign technical experts which the country could not provide itself (or, at least, not in sufficient numbers). However, Moroccan authorities strived to keep their agency in sanitary affairs. For example, the centralising role of the *naib* was assumed by the new Ministry of Foreign Affairs because "daily contact with the consuls had allowed him [the *naib*] to take on more and more power" and to pursue his own particular interests (Pennell 2000). On the other hand, Moulay Hassan re-confirmed the 1840 "delegation" to the Council by means of a new *dahir* (official decree) in 1879, thus keeping his personal authority in sanitary affairs. Dr. Raynaud complained that the *dahir* kept on restricting the Council's jurisdiction, allowing it only "to admit or reject the ships arriving from the ports of the Empire, to put them in quarantine and fix its duration according to the regulations of sanitary affairs". Thus, the Council's action remained "exclusively limited to the sea and not to land" (Raynaud 1902).

Impotence caused despair and, sometimes, rage in European representatives. An 1899 memorandum of the Sanitary Council complained about the "almost insurmountable obstacles, which render its aims and its deliberations useless". The memorandum continued:

> The *Makhzan* will not modernise itself, the Moroccan statesman in power is not sensitive to the best intentioned and most disinterested advice. The axiom which has been confirmed up to now, that 'the Sanitary Council is but an organ of the Sultan', who has the power to sanction or reject any agreed resolution, not only avoids consequently any fertile activity, but casts a doubt over its own right of existence.

Moroccan authorities also managed to slow down the creation of the Hygiene Commission of Tangier and later to exert significant control over it. Until 1903, the Commission remained mainly a private initiative of local European doctors. Only then, an organic regulation was approved and European consuls participated for the first time in its sessions (Marco 1913). The 1879 *dahir* made it difficult for the Commission to count on the Council's support, while the persistence of local functionaries, such as the *muhtasib,* did much to discourage its work. In the words of their members themselves, the first attempt to create it in 1884 failed because

> [...] the *muhtasib* and his personnel first, the administrator of Sultan's properties and the different market members, the *nadir* or administrator of the Mosque's properties, the select Israelite board, the governor and his Khalifa, all in one word conspired against the existence of the Commission [...] (Marco 1913).

Finally, institutions most representative of the new "hygienist" model of European public health, such as disinfection stations or bacteriological/analytical laboratories, had to wait longer to be created. Only after the Protectorate regime was established in 1912 could the French Pasteur Institute and a Spanish Laboratory start their activities in Tangier.

Nevertheless, in spite of Moroccan efforts, the number of foreign countries with actual weight in maritime public health affairs shrank to France, Great Britain,

Spain and perhaps Germany. The connection of Dr. Raynaud and Dr. Gagé with French Algeria revealed that French expansionism in the Maghreb was severely threatening Morocco. For Spain, doctors Felipe Ovilo and Enrique Rebolledo achieved significant influence due to their role as medical advisors of the Council, and the same could be said of Severo Cenarro, strongly committed to the Hygiene Commission until his death in 1898. Great Britain reinforced its involvement, always relying on its commercial and naval power and on the links with Gibraltar, while Germany's influence was mainly felt at the turn of the century. This fact, combined with the loss of contacts with other Arab-Islamic countries, revealed a stronger and more incisive European influence on Moroccan maritime public health.

On the other hand, Hassan I continued the process of transformation of the Moroccan army begun by his father and his grandfather. Military public health was not an exception. A medical student, Abd al-Salam al-'Alami, was sent to the School of Military Medicine *Qasr al-Aini* in Cairo to become a military doctor, as others had been before him (Mossaoui & Roux Dessarps 1992; Amster 2003). However, initiatives under the influence of European countries became predominant in this period over collaboration with other Arab-Islamic countries. In 1886, an School of Military Medicine was created at Tangier under the direction of the Spanish Army doctor Felipe Ovilo Canales, that functioned until 1899 (Martínez Antonio 2005c). At least twelve Moroccan students are recorded as having started a two-year course focused on anatomy and therapeutics and complemented by practical clinical and surgical assistance under surveillance of Drs. Ovilo and Cenarro in the attached dispensary that was founded the same year. Some of them did not complete their studies for several reasons, but others such as Mustapha Essandi, Hamed Romani and Mohammed Dukaly, whom Ovilo soon began to treat as "disciples", prolonged their training. They even travelled to Spain in 1888 to pass university exams and to become acquainted with Madrid's main research and clinical centres.

Ovilo's pupils soon participated in *harkas* (minor armed expeditions) sent by the Sultan to punish northern *qabilas*, as Si Ahmed Temsamami did in Boccoia in 1896. According to Ellen Amster, he

> was designated by the *Makhzan* military doctor attached to the expedition of Moulay Abdesselam el Mrani, of Ben el Bagdadi and of Mahboub, where he fulfilled his role using European methods (Amster 2003).

Felipe Ovilo himself was appointed chief of the health services of the *harka* sent against the *qabila* of Anghera in 1892. A project to establish a military hospital in Tangier was also foreseen in connection with the school, the Spanish Dispensary being the first step in its realisation. But "the first Muslim Hospital to be created in Morocco for centuries" was not finally created. However, the Spanish Dispensary, as well as the English Mission Hospital and the French Hospital in Tangier, assisted Moroccan troops on several occasions and served then as part-time military hospitals.

France also became strongly involved in Moroccan military public health and managed to achieve a privileged position among other European countries. Dr. Fernand Linarès, a member of the French Military Mission in Morocco (sent in 1877 under the direction of Jules Erckman), entered the personal service of the Sultan in Fez from 1882 onward and accompanied him on different occasions, for example, in the *mhalla* to Tafilalet in 1893. Linarès became a key agent for French policy in Morocco during his long stay in the country (1877–1902). His influence upon the Sultan and the *Makhzan* was strongly felt, and it was most probably at his suggestion that the new Sultan Moulay Abd el-Aziz, *de facto* his Grand Vizir and regent Ba Ahmed (1894–1901), decided to take Arab graduates from the School of Medicine of Algiers for the army service (Amster 2003). Through Linarès, France became the main foreign influence in Moroccan military public health. His role was much more decisive than that of other European doctors formally attached to the court, such as Dr. Adolfo Ladrón de Guevara (1889–1892 and 1894–1897), who could never achieve significant influence (Rollman 1983). Finally, a number of the military officers periodically sent to Gibraltar by Hassan I were trained as "medics" for service in the *askar* regiments (Rollman 1983). Purchase of medical equipment or products as well as the sending of students to military schools of medicine in Europe or America have not yet been confirmed, but should not be discarded as possibilities, given that other countries were still involved in different ways in Moroccan military reforms during this period (Pennell 2000).

Moroccan authorities managed to keep a degree of control over these initiatives which tended to take military public health out of their hands. For example, centralisation of military affairs was reinforced by Hassan I through the strengthening of the Ministry of War (*wazir al-harb*). The Sultan also succeeded in keeping European military doctors far from him and the central *Makhzan* for some periods. Adolfo Ladrón de Guevara was usually confined to the area of Tettouan and Tangier, as were the other members of the tiny Spanish Military Mission in Morocco. Felipe Ovilo, due to his work at the School of Medicine, remained most of the time in Tangier, even if he met Hassan I there in 1889 and participated in Spanish embassies to Rabat in 1887 and to Marrakech in 1894. Dr. Linarès was already in Morocco in 1877, but it was only from 1882 onward that he could settle in Fez as the Sultan's personal physician. Besides, he could not accompany the Sultan in all his *mhallas,* as he did, for example, in 1893. European military doctors were also assigned to different branches of the Moroccan Army, so that their influence was diversified. Finally, the School of Tangier was only officially recognised when the Sultan visited Tangier in 1889. It was the Moroccan government which paid the students a grant and gave them an "annual suit", thus keeping them under its control, although more important in this regard was that these school-educated military doctors were themselves Moroccan. Control of this institution was so significant that, in 1899 the Spanish Minister in Tangier complained that

> the *Makhzan* and the Moors in general think that its creation and tolerance [of the school] are signs of excessive benevolence towards Spain, which they tend to correct from time to time with a systematic opposition and intransigence [...]. Thus, instead of diffusing Spanish influence in the Empire, this Legation is obliged to spend what it has in periodic begging and supplications to the *Makhzan* so that the students are given the modest grant and the annual suit that were fixed by the deceased Sultan.

The last quarter of the 19th century thus saw the situation of Moroccan public health worsen. In comparison with the middle decades of the century, there were no dramatic events as the wars with France and Spain but new developments in international public health pushed Morocco's health system to its limits. Exchanges with other Arab-Islamic countries virtually ceased; the number of European countries with decisive influence shrank; central authority moved to the very person of the Sultan; and local resistance grew stronger. Instead of allowing controllable changes, the Moroccan tactic gradually shifted to avoiding any change at all, as almost all helped undermine its interests. This policy of "obstruction" was stigmatised by foreign representatives although it continued to be a form of Moroccan agency to their profound despair.

## Between *Makzhan* and *Siba*. Provincial and Local Public Health in Northern Morocco at the End of the 19th Century

Thus far a brief sketch has been drawn of the central (or state) level of the public health framework as it was configured in Morocco during the 19th century. An attempt has been made to show how Moroccan agency acted at this level by fostering diversification of the inevitable Western influence and authoritarian concentration of power in the hands of the Sultan and his central *Makhzan*. It has also been shown how this agency resulted in the preferential transformation of the maritime and military branches of Morocco's health system, in contrast to much weaker public health changes in naval and land public health. However, if the creation of dispensaries in Spanish Morocco is to be understood, lower levels of Moroccan public health must be also analysed. The north of the country has been chosen for this examination because it will increase the focus on the future Spanish "zone of influence", actually the main interest of this study. However, this analysis could be applied to Morocco as a whole. Instead of the whole 19th century, just the final decades will be studied.

To speak of public health levels means that in the usually alleged breach between *bilad al-Makzhzan* (government controlled areas) and *bilad al-Siba* (autonomous areas only recognising the Sultan as spiritual leader) or between the cities and the countryside in Morocco, there existed in fact an articulated chain of administrative, institutional or political organisms and authorities – no matter how thin it might have been. Even if this chain did not reach a significant part of Morocco's population and territory, it showed the existence of a Moroccan public health system broader than most descriptions account for. This study shows that

there were four levels – the Sultan-central Makhzan, provincial, local, and the *siba* – the latter being in fact the limit of reach and showing particular characteristics. This general framework proved to be resilient, having an undeniable impact on the French and Spanish Protectorates when they began to be established in 1912. At all four levels, diversification and authoritarianism, as well as predominance of military and maritime public health prolonged themselves, though this kind of "fractality" was expressed in particular developments at every level.

*The "Provincial" Level: Tangier*

In northern Morocco, a number of loosely defined provinces, whose centres were cities such as Tangier, Fez, Oujda or Ouazzane, were defined in the second half of the 19th century. In Tangier, provincial power crystallised around the *naib*. This post was transformed from a *de facto* minister of Foreign Affairs into a functionary subordinated to the actual minister established by Hassan I in 1879 because he pursued his own interests more than those of the Sultan (Pennell 2000). However, this change was not so clear, as nothing was in the city of the Strait, and the *naib* actually stood at an intermediate position between the *wazirs* (ministers) of the central *Makhzan* and local officers such as the *caid* (military governor) and the *pachá* (civil governor). The post had been "provincialized" because it could no longer have a state-wide influence but it became (and was tolerated as) the "hand" of the Sultan for everything occurring between Tangier and Melilla (Zaim 1988). It is not strange that the post became a virtual monopoly of two important families of Andalusian descent of Northern Morocco, first through Mohammed Bargach of Salé (1860–1886) and later through Mohammed Torres of Tettouan (1886–1908).

In the same period, and not by chance, the position of foreign consuls in Tangier in relation to their metropolitan governments' activities in Morocco changed as well. For many decades the main foreign actors in Morocco, the Tangier consuls began to lose their primacy by the last quarter of the 19th century. European governments managed to directly reach the Sultan, either by more and more frequent embassies, or by permanent missions settled in port cities or in any of the imperial capitals – Fez, Marrakesh, Meknes and Rabat. Those new representatives assumed the main role in the policy of "peaceful penetration" and "civilisation" displayed in the Moroccan administration. The cases of Harry MacLean or Fernand Linarès are most representative of this shift (Des Cilleuls 1959; Pennell 2000). Tangier's consuls became increasingly "provincialized" and their activities were more and more confined to the north of the country.

This provincialization of the *naib* and the foreign representatives was also reflected in public health. In the case of maritime public health, the Sanitary Council of Tangier remained a state-wide organism but new developments were increasingly achieved through direct contacts of European representatives with the Sultan and central *Makhzan*. For example, the 1892 "delegation" of Hassan I that allowed the creation of the Hygiene Commission was a result of the embassy of the French Consul, Count of Auvigni, to the court (Marco 1913). The Council could but acknowledge the "sterility of its efforts to veil for Europe's public health" because it worked "as an organ of the Sultan and needs the sovereign

sanction to make agreements effective." The appointment of Dr. Raynaud in 1900 was probably made directly by the Sultan after a suggestion from Dr. Linarès.

The project of the quarantine station in Tangier reflected very clearly the ambiguity of the Council as a vehicle of state and provincial interests at the same time, an ambiguity that may have influenced its final failure. On the one hand, the new location was favourable for Tangerian notables (the *naib* – first and foremost) and the merchants of Tettouan and Larache who worried about the sanitary dangers associated with their growing commerce with Spain or France. Spanish commerce with Morocco focused also in practice on the northern area of the country as reflected in the establishment of regular sea connections by the *Compañía Transatlántica* in 1887, whereby Tangier occupied the central position (geographic and economic) in the traffic between Cádiz, Málaga and Barcelona in Spain and Rabat, Mazagan and Mogador in Morocco (Rodrigo 2002). The Spanish population in Tangier rose to 6,000, by far the largest European community in the city, and Spaniards were also predominant in Tettouan. The Spanish Legation in Tangier had accordingly a growing interest in protecting the southern shores of the Iberian peninsular and Spanish citizens in those cities rather than Morocco's littoral as a whole. On the other hand, Tangier was also a more adequate location than Mogador for controlling maritime health in rapidly developing ports such as Casablanca and Rabat, where Makhzan and French interests were predominant. Finally, the Sultan and Great Britain were interested in maintaining the Council as a guarantee against any dismemberment of Moroccan public health and as a guarantee of persisting influence due to the proximity of Gibraltar.

In military public health, the School of Military Medicine is most representative of the increasing provincial detour of Tangerian actors. During his visit to Tangier in 1889, Hassan I issued a *dahir* by which he compromised by recruiting students for the school from throughout Morocco, but, in practice, future doctors continued to be mostly, if not exclusively, Tangerians. Dr. Felipe Ovilo confirmed this in 1891:

> On occasion of the great Muslim feast of *Aid Seguer*, the pupils of this School of Medicine, supported by His Shariffian Majesty, marched for the first time grouped and uniformed, taking their place in the military ranks that accompanied the Governor of Tangier. This fact has had the strongest effect on the authorities and the Moorish people, *even more as they are sons of this city*, who by order of His Shariffian Majesty have been chosen as the future doctors of the Moroccan Army (Lourido Díaz 1996).

It was also very significant that on the occasion of Hassan I's audience with Dr. Felipe Ovilo in 1889 in Tangier, the Sultan was accompanied by his Ministry of Foreign Affairs, Si Fedul Garnitt, and not by the *naib*, Mohammed Torres, who had been directly involved in the creation of the medical school through his contacts with Spanish representatives. In a way, the Sultan was trying to reaffirm his control over the initiative and that of his minister. Nevertheless, he failed and Torres's interests prevailed. Pupils were recruited from good families of the city (Temsamami, Dukkali) and were nominated or at least approved by him, as he

was in the position of "dispensing favours" to local notables, therefore reinforcing both his position and theirs.

Another relevant sign of provincialization was that the school's doctors were sent mostly, if not exclusively, to serve in military expeditions taking place on the northern fringe of the country. These became very frequent and included, for example, those against the Anghera in 1892, the Ibuqquyen in 1889, 1896 and 1898, and the Guelaia in 1880 and 1893–1894 (Pennell 2000). Most of these were not *mhallas* commanded by the Sultan, but smaller *harkas* led by Sultan's relatives, such as Prince Moulay Arafa or Prince Moulay Bu Beker and accompanied by secondary *Makhzan* authorities, local *caïds* and military chiefs. In the case of Anghera, the *harka* was completely organized from Tangier. In the other cases, there was usually co-operation between Tangier, which sent troops by sea to disembark in Melilla and move to the hinterland, and Tadla, Oujda or even Fez, which sent troops by land. To sum it up, Tangerian military doctors acted regionally in a defined area of the country, while, in contrast, Algerian doctors recruited by Ba Ahmed at the suggestion of Fernand Linarès probably acted in a wider territory.

Similarly, the Spanish Legation and, in general, all Spanish representatives in Tangier pressed for the school to be created in this city and not in Ceuta, where the Spanish government had been thinking of establishing several institutions in the 1880s. The failure of the Spanish Military Mission in Morocco, which had its base in Ceuta and Tettouan, may also be explained by the lack of support from Spanish representatives in Tangier. In this way, these Tangier residents retained their power even if they could no longer act on a general Moroccan level and limited themselves to contacts with the *naib* and local notables. Provincialization resulted in Spain finding it increasingly hard to reach the Sultan and have a significant impact on Morocco's general public health.

In summary, the provincial level of Moroccan public health essentially reproduced the characteristics of the state level, though through different actors. The *naib* and the consuls became subordinated to the Makhzan and foreign embassies or missions, though they retained a degree of autonomy. Some periodical efforts were made to control this situation but, in general, autonomy posed no serious threat because regional actors did not intend to question higher authorities, and these, in turn, let them act with relative freedom for their interests. The project of the quarantine station in Tangier and especially the creation of the School of Medicine in this city reflected the increasing provincial detour of Tangerian initiatives.

*The Local Level: Anghera and Guelaia*

If most analyses tend to subsume the provincial level into the central Moroccan government, the local level is usually reduced to the *siba*. It is true that in the second half of the 19th century, it became increasingly difficult for the Sultan and for Tangier authorities to keep *qabilas* such as Anghera and Guelaia under control. For the first time, local leaders managed to concentrate power in whole *qabilas* (or in most of their fractions) and managed to act on their own, often

creating problems to the Sultan and *Makhzan*. The difference with the provincial level was that local autonomy posed a much more serious danger. Whether they set up irregular forces to defend their territory from European expansionism, organised seasonal migration to nearby European enclaves and colonies, or engaged in smuggling, local leaders threatened the Sultan's authority and legitimacy. Nonetheless, what they actually intended was to assume functions of defence and organisation that they considered the Sultan was unable to render in their areas. This fact connected them, though weakly, with the rest of Moroccan structures.

In addition, Moroccan central and regional authorities managed to neutralize local autonomy to a certain extent by using authoritarian measures supported by strong use of force, either military or diplomatic. For example, it has already been mentioned that *harkas* were periodically sent from the 1880s on to control the above mentioned *qabilas*. As a result, more or less strong garrisons under the command of *caids* were established in the vicinity of Ceuta (Anghera) and in Silwan (close to Melilla) (Pennell 2000). Their missions included preventing armed incidents with Spanish enclaves, preventing *qabilians* from settling and cultivating neutral land around Ceuta and Melilla, regulating commercial exchanges through customs, and controlling migration to European enclaves and colonies. In the course of time, garrisons tended to become disorganised and new local leaders turned again to concentrate power. However, when armed incidents re-appeared or denunciations of smuggling were made by European countries, new expeditions were sent which either re-established the garrisons and dissuaded the *qabilians* or repressed them. On the other hand, the Sultan managed to keep on acting as the exclusive representative of Moroccan interests, preventing local leaders from participating in international negotiations such as the Spanish-Moroccan Treaty of 1894 which followed the armed clashes between the Guelaia and the Spanish military units in Melilla.

Changes in the northern *qabilas* were paralleled by those in nearby European enclaves and colonies, which also became increasingly autonomous from the metropolitan governments and their higher representatives in Morocco. In the case of the Spanish enclaves, for example, the military authorities in Ceuta and Melilla became officially or *de facto* separated from the Commandant Generalships of Andalusia and Granada in the last quarter of the 19$^{th}$ century. There was little coordination with the Spanish representatives in Tangier, a lack of communication that resulted in local military authorities developing an increasing mentality of expansion which did not fit well with the Spanish *status quo* policy towards Morocco. In addition, smuggling of products (guns included) accounted for a significant percentage of the enclaves' otherwise restricted economy and the creation of military units composed of *qabilians* (*Compañía de Moros Tiradores del Rif* in Melilla in 1859, which was transformed into the *Milicia Voluntaria de Ceuta* in 1895) was fostered (Arqués & Gibert 1992). The armed conflict near Melilla in 1893–1894 was triggered by the construction of a new post in the *campo* that had been ordered by the Military Governor, General Margallo, who was killed by Riffians in the course of combat. Similar developments were taking

place in the French Algerian region of South Oranais, where, for example, military officers often decided on their own new operations or advances into the Moroccan-Algerian border zone.

In other words, European enclaves and colonies tried to pursue expansionist objectives that they thought their governments were not implementing as they should. Increasing autonomy posed a more serious threat for metropolitan governments than the autonomy of the Tangier consuls. In the case of Spain, the enclaves' aggressive initiatives could potentially cause the failure of the politics of *status quo* and "peaceful penetration" by forcing Morocco first to limit Spanish activities and second to grant new privileges to other European representatives after the inevitable protests. Thus, Spain tried to reinforce coordination of the enclaves with its general policy in Morocco by developing their military administration and institutions, by establishing duty-free ports or by creating customs. These measures could not prevent periodic armed incidents or smuggling but at least reduced them. As it is seen, both Morocco and Spain tried to keep local actors under control, even if Moroccan measures were more drastic than those in the Spanish enclaves.

All these events were also reflected in public health. At the local level, foreign intervention was clearer. For example, Eastern Riffian seasonal migration to agricultural complexes in French Algeria intensified in the second half of the 19th century. There were two main itineraries: by sea, through the port of Melilla towards the ports of Oran and Nemours or by land, through the frontier adjoining Oran province. Migration involved thousands of Riffians every summer, with the consequent danger of spreading epidemics. That is why, for example, French Algerian health authorities began to take measures concerning migrants, such as compulsory smallpox vaccination and disinfection of ships and personal effects, which enhanced the development of their maritime public health services. On the other hand, increasing regulation of commerce between the Spanish enclaves and Oran province, on one side, and the nearby *qabilas*, on the other, led to the establishment of customs by the Europeans, as in Melilla from 1867 on (Zaim 1988). Commerce regulation improved sanitary control because, for example, the marketplace was located outside the town, in the *campo*, preventing *qabilians* from reaching the city and Spaniards from travelling to the countryside. Other measures for *qabilians,* such as smallpox vaccination, may also have been used.

Military public health followed a similar path. This period saw an increase of Spanish garrisons and also of the units of Riffians under Spanish command (*Milicia Voluntaria de Ceuta*). Accordingly, from the middle of the 1880s, the Spanish government had decided to improve the military hospitals in the area so that they had better facilities and equipment, more personnel and larger capacity. The hospitals of Ceuta and Melilla increased in size to 200 beds, while in the Peñón de Alhucemas, Peñón de Vélez and Chafarinas Islands, there were 50 places (Larra 1900). But these institutions also had the purpose of "attraction" for nearby *qabilas*. According to the military doctor Ángel de Larra Cerezo, more than one thousand Riffians had been assisted in those hospitals between 1885 and

1900, a number that included not only civilians but also, for example, "100 Riffians" who had fought against Melilla troops in 1893–1894 (Larra 1900). In fact, assistance to Riffian combatants, either involved in clashes against Spaniards or inside their *qabilas*, seemed to be very frequent, because Larra confirmed that in the military hospitals "the Moors cured of serious wounds and operated on are very numerous" (Larra 1900). Smallpox vaccination may also have been done on Riffians. Besides, Spanish Army doctors travelled from time to time to the "Moorish camp" to carry out surgical operations or provide clinical care to local notables, though "the risk for their lives" limited this measure to isolated cases. Similar developments, though surely on a larger scale, may have taken place in the region bordering on French Algeria.

For Morocco, these facts implied a severe threat to its control over local public health. Though some degree of control could be achieved, the local agency of the *qabilas* could not be completely channelled. In maritime public health, the fact that migrants followed different routes reveals the attempt to avoid *Makhzan* control, as well as dependency exclusively on one European enclave or colony and therefore a form of diversification. The same could be said for commerce. Local leaders of *qabilas* sought to acquire some control over the flux of migrants and products, so that they could benefit most from them and reinforce their authority. Clandestine migration and smuggling also provided a means of thwarting the effectiveness of Spanish and French sanitary measures, as well as *Makhzan* control. In this context, official *harkas* sent to Anghera and Guelaia systematically tried to ensure legal commerce of these *qabilas* with nearby enclaves. Fighting against smuggling was an indirect means of achieving more "sanitary security", and it is not strange that the Sanitary Council of Tangier considered it a priority for avoiding the risk of epidemics. Morocco also interacted with competence between the Spanish enclaves and French Algeria in the area.

In military public health, *qabilas*' agency was again not absent and was reflected first in travels to both Spanish and French military hospitals in order to avoid dependency on one or the other. Smuggling of drugs and medical material with foreign enclaves should not be discarded. Local leaders could also severely hinder sanitary measures by launching hostilities which prevented people or combatants from travelling to the enclaves. Moroccan central and regional authorities tried to ensure control through the military doctors sent to these areas as part of the *harkas*. These were mainly the doctors trained in the School of Tangier, although, as mentioned earlier, Felipe Ovilo himself participated in the expedition to Anghera in 1892. It is possible that these doctors offered their services to the Riffians and Jbalians immediately after the fighting, but we do not know if any of them remained in the garrisons for a more prolonged time. Algerian doctors recruited through French influence could also have a role in the region, thus allowing Morocco not to depend exclusively on one country.

*The bilad al-siba: Ibuqquyen*

Beyond the local level, the analysis of Moroccan public health becomes even more complex. In the Tangier province, *qabilas* such as Ibuqquyen, Ait Warya-

ghar, Beni Arus, Ait Said or Ajmás, in fact, up to two thirds of the future Spanish Protectorate, were only linked to the system described here too loosely to properly become a part of it. Structurally, this happened mainly because these *qabilas* did not manage to act collectively externally and establish a single authority internally. This fact prevented them from having a *collective* link within the chain of Moroccan power and to interact *collectively* with European countries, representatives, colonies or enclaves. It is a matter here of a "microscopic" dimension of society – fractions, sub-fractions, clans – which have usually been analysed with the help of anthropological concepts by a long list of anthropologists of Moroccan society, such as Robert Montagne, Ernst Gellner, David M. Hart, David Seddon or Henry Munson Jr.

However, this shift from historical to anthropological analysis should not be overemphasized. If applying the term "public health" at this level may seem excessive, there existed nonetheless health structures to meet the care needs of groups of people – even if their complexity was very small. Apparently, events seemed to be confined within *qabilas*, conveying a sense of isolation and fragmentation. But it could be said that transformations taking place at this level were a simplified version of those occurring in Anghera and Guelaia and, therefore, parallel to the general changes in the rest of Moroccan public health. This meant nonetheless a higher degree of autonomy in the face of Moroccan and European central, provincial and local authorities, that was very close to virtual independence. This was reflected in the very slow pace of maritime and military developments in comparison with traditional importance of "naval" and civil interests.

In the last decade of the 19th century, the *qabila* of Ibuqquyen, located in the central Rif, provided a most representative example of developments found in the area. Ibuqquyen armed activities still seemed to focus mainly on the coastline and the sea. The particular balance of European naval power in the Eastern Mediterranean and the almost non-existence of the Moroccoan Navy allowed local fishermen to engage in gun smuggling with the Spanish enclaves of Peñón de Vélez and Peñón de Alhucemas and, more important, directly with foreign ships sailing near the coast. Smuggling was so widespread that by 1889 more than 50,000 guns a year were being sold on the whole Rif coast (Pennell 2000). It was this combination of guns and sea skills which led to "piratical" actions, that is, modest naval activities (in the sense of a military navy). In Ibuqquyen, small boats (*carabos*) manned with a bunch of armed *qabilians* or simply armed men hidden on the coast were able to create a sustained series of incidents with foreign ships from the 1880s on, with their cargo being confiscated, their crews, ransomed or the ships sunk. It is probable that some of these incidents were triggered by Europeans not respecting smuggling deals (exchange of foodstuff, skins or wax for guns and products) and showed that *qabilians* were able to ensure their position to a certain extent in front of abuses. Smuggling and other naval activities allowed the *rais* (chief or boss) Mesaud ibn Amar, aka "Sibara" (a corrupted form of

Civera, the name of a famous Spanish Admiral) and his associate Abdelkrim ben el-Hayy Ali Luh to become very powerful men in Ibuqquyen (Pennell 2001).

On the other hand, the concentration of power in Ibuqquyen took place mainly around religious or civil leaders, such as *cheikhs*, not around military *caudillos*. The roots of this fact rested in the persistence of traditional social structures of Riffians in a context of weak articulation of civil administration in Morocco and lack of civil influence by European countries. If the internal authority of the Sultan and the *Makzhan* relied on and was mainly exerted through the army, the importance of religious and civil leaders in the central Rif could only reflect its limits or, to put it in positive terms, Riffian ability of affirming its identity and traditions. The fact that local *qadis* (Islamic judges), such as the father of Abdelkrim in Ait Waryaghar, were confirmed in their posts by the Sultans and were asked to support them through the *bay'a* (an oath of allegiance paid by all Moroccan authorities and groups to every new Sultan), does not contradict the fact that their authority was derived mainly from the dynamics of local society and not from the central power.

Accordingly, health care in Ibuqquyen had mainly a naval and civil orientation. On the one hand, the relative weight of "piratical" activities and smuggling, plus alternative routes of seasonal migration, kept them quite out of reach of the French Algerian and Tangier maritime health services. It could happen that drugs or basic medical material were obtained in deals with the Spanish enclaves and foreign ships or by pillage, although it has not been possible to confirm this fact. On the other hand, traditional practitioners of various sorts and scattered *djemas* (mosques), *dar dmanas* (houses of religious brotherhoods or *tariqas*) and *shurfa* (saints) shrines continued to provide for the needs of most local inhabitants. As long as significant irregular forces were difficult to organize, military health care remained secondary in importance.

The autonomy of action of Ibuqquyen towards Moroccan authorities was matched by similar developments in the Spanish enclaves of the area towards peninsular authorities. The Legation of Tangier supported the *harkas* sent to punish *qabilians* by allowing Moroccan troops to disembark in Melilla or its surroundings and then move to the central Rif. However, it was also the *peñones* of Alhucemas and Vélez that needed control, because they acted almost independently given their insignificance. Though formally in a state of hostility towards coastal *qabilas*, both *peñones* were in practice supplied with foodstuffs by them and, in turn, allowed the smuggling of Riffians with foreign and Spanish ships (and engaged in it) (Villalobos 2004). In this way, they fostered Ibuqquyen autonomy as much as their own, thus hindering *Makhzan* and Spanish general interests at the same time.

In public health, military hospitals located in Vélez and Alhucemas had a predominantly civil function. The military garrisons in both enclaves were so reduced (one Infantry company in theory) that state functionaries (teacher, telegrapher, lighthouse keeper, customs officer), their families and the families of the Army officers, plus a tiny Jewish community, accounted for most of the work of the

army doctors. The Spanish military hospitals of Alhucemas Vélez also carried out a task of "attraction" similar to that in Ceuta and Melilla but with the difference that benefits were mainly for civilians and not for Riffian irregular combatants. Up until 1909, Lieutenant Dr. Manuel Bastos Ansart observed that the coastal *qabilas* "used to bring us for assistance all ill people who were not cured by the potions and magic of their saints" (Bastos 1969).

Both the *Makhzan* and the Spanish authorities tried to put an end to this situation. In the first case, the maximum degree of control was achieved after the 1898 *harka*. The brutality of this expedition reflected the degree of force Moroccan authorities had to display in order to exert some control on the area. It was also characteristic of the strongly authoritarian character of the Ba Ahmed regency in his efforts to keep the country united. The first objectives of the *harka* were to supress naval activities and disorganise civil society because those were the key mechanisms for Ibuqquyen autonomy. The two Moroccan gunboats supporting the expedition, the *Hassani* and the *Turki*, confiscated two *carabos* used by local people. On the other hand, *Makhzan* troops executed four local *cheikhs*, burnt fields, destroyed houses, imposed heavy fines and took almost 400 prisoners to Fez (Pennell 2000). In the second place, the brutal use of force was intended to integrate incipient military and maritime structures under Makhzan authority. For example, Ibuqquyen had managed to organise a force of 500 armed men to oppose the *harka* (Hart 1976) while its "commerce" free from taxes such as those imposed in the imperial ports had disliked the Makhzan since the 1840s (Pennell 2000). Besides, the Ait Waryaghar had been engaged in a "seven years war" during the 1890s, in which fractions of nearby *qabilas* (Temsamam, Ait Ammart, Ait Tuzin and also Ibuqquyen) had also been involved.

Military and maritime structures had made slow developments in previous years as an extension of naval and civil power, but now the goal was to promote them under Makhzan control because that would allow connection with the rest of Morocco and subordination to central and provincial authorities. The *harka* imposed Makhzan military authority in the area by repressing Ibuqquyen forces and integrating combatants from Ait Waryaghar and other *qabilas*. On the basis of military force, a reform of civil structures was made through the appointment of new *amils* or *imgharen* (local governors of fractions). After the punishment, the *harka* remained camped in the fraction of Izimmuren and its presence discouraged naval activities, compelling *qabilians* to commerce through the customs stations of Melilla or Ceuta and to increase seasonal migration to French Algeria and Tangier. Through both exceptional methods, the Ibuqquyen (and the central Rif in general) seemed to join the general frame of the Moroccan state, but this did not last long. The *harka* retreated one year later to Tafersit in the Eastern Rif and in 1904 to Taza and Fez. This quick fading of *Makhzan* authority enabled local autonomy once again, this time led by the Ait Waryaghar, who had traditionally had "their backs turned on the sea" (Hart 1976). Military and maritime structures had advanced but were now beyond control of the Sultan and the *naib*.

In public health, the army doctors who travelled with the *harka*, Mahboub and Si Ahmed Temsamami, embodied the extension of the activities of the School of Tangier to the central Rif. In Ellen Amster's words, Temsamami used "European methods" in a task which comprised assistance to official troops and local contingents. As the *harka* itself, the presence of military doctors probably did not last long. On the other hand, repression in Ibuqquyen provoked part of the local population to migrate temporarily or definitively to Tangier, French Algeria and even to continental Europe, thus being subjected to health measures of the respective maritime authorities. After the retreat of the *harka*, a number of local inhabitants resumed their naval activities and escaped again the control of maritime health.

In the case of Spain, the strategy consisted of linking the *peñones* with Melilla under a single military command, especially during and after the incidents of 1893–1894, and of reinforcing the Spanish military institutions and garrisons in Vélez and Alhucemas. On this basis, smuggling diminished and the business of civilians and Jews with the army increased. In public health, the army doctors had to focus more on officers and soldiers. However, the almost incredibly tiny size of both enclaves and the impossibility of extending activities to coastal *qabilas* prevented major changes. Assistance to Spanish and Riffian civilians continued to be a relevant part of the doctors' work.

If there is one thing that should be remembered from this brief presentation of the different levels of Moroccan public health is that there existed an articulated transition between central institutions and the areas beyond their reach. The provincial and local levels of the Moroccan state and public health actually existed and should not be relegated into the extremes of *makhzan* and *siba* as is usually done. Despite autonomous tendencies, these intermediate levels were connected to the general frame of Moroccan public health through more or less authoritarian procedures. Similarly, despite strong European influence, Moroccan authorities managed to keep a degree of initiative in public health affairs at all levels. As a result, diversification and authoritarian concentration, and the predominance of military and maritime public health were reproduced as general characteristics of the Moroccan health system. Only at the level of *siba* were these characteristics reversed, and only there, did a breach with the rest of the country occur. A more complex picture arises from this perspective, which helps better explain the future difficulties of Spain and France in reorganising public health in their Protectorates.

## Tangerian Ghosts and Riffian Realities
## The Limits of Colonial Public Health in Spanish Morocco

After the signing of the Act of Algeciras (1906), the doors were finally open for Spain and France to intervene more directly in Moroccan public health in their respective zones of influence. The Protectorate treaties between France and Morocco (March 12, 1912) and France and Spain (November 27, 1912) were a new step in this direction. As a theoretical result of these agreements, the unified Moroccan public health regime should have given way to separate health systems

in each zone. The challenge for French and Spanish authorities was not to create structures out of nothing, but rather to reform pre-existing levels in each zone. Europeans would now lead the process and have the executive power, thus finally ending Moroccan initiatives. Territories and population that had been out of reach would become integrated. A more balanced development of public health would also be encouraged, so that all four branches – maritime, military, naval, land – had similar weight. Direction of public health affairs would be more technical, based upon the expertise of doctors and upon scientific institutions such as laboratories. In theory, the Protectorate regime would allow more Moroccan participation in the health system than a colonial regime, but ultimately Moroccan institutions and personnel would be subordinated to French and Spanish authorities.

In practice, neither Algeciras nor the Protectorate treaties ended Moroccan agency. Abdallah Laroui has affirmed, against colonialist narratives, that the initiatives of the Moroccan state lasted until 1912: only from then on did "initiatives" give way to "reactions" (Laroui 1993). This study argues, however, that though most fragile and more tenuous than ever, Moroccan initiatives continued to exert a persistent influence in the newly established French and Spanish Protectorates until the late 1920s. (In fact, one could wonder if initiatives ever disappeared, as the nationalist movement gained momentum already in the early 1930s.) In Spanish Morocco's public health, perhaps the clearest proof of this was that the maritime and military branches kept on being pre-eminent in the newly established health system. This had to do with the fact that the new system continued to be influenced by the Sanitary Council of Tangier (which was still functioning), while a significant part of the territory and population managed to stay out of reach. The so-called "Tangier question" and "Rif question" – which I have termed the Tangerian ghosts and Riffian realities – were the paradigmatic examples of the difficulties created for Spain by the continuity of Moroccan agency and institutions during this period. Only by an increasing use of force, diplomatic and military, and by an increasing authoritarian concentration of power could Spain slowly begin to solve both "questions" and to establish a health system in its zone. But in this way, it moved away from the very Protectorate regime it sought and was obliged to deploy.

### *"Tangerian Ghosts"*

### *The Persistence of the Sanitary Council of Tangier*

*From Consular Doctors to Urban Dispensaries (1906–1912).* The Algeciras Conference marked the beginning of a new phase in the "Morocco question" and paved the way for the future establishment of Protectorate regimes. In their tacitly acknowledged "zones of influence," France and Spain compromised to support the authority of the Sultan and the *Makhzan* in order that the necessary modernisation of the army, finances, industry, commerce and health system could be achieved. In practice, this meant an unprecedented degree of intervention of those two countries in Moroccan institutions. However, as Abdallah Laroui has shown, the Act of Algeciras was the "last victory" of the Sultan against foreign powers,

which would serve as a basis for future moves towards independence in the 1940s and 1950s (Laroui 1993).

One of the main reasons for this was that Tangier remained outside both zones of influence. The city stood at the same time as the last site of Moroccan authority and as the last site where multiple foreign influences could be overtly exerted. Some of the old international and *Makhzan* institutions remained, while other new "international" organisms were planned or created. It was countries such as Great Britain and Germany who were especially interested in supporting the autonomy of the city and in still recognising some authority to the Sultan. That was a means for them to maintain some intervention in Moroccan affairs and to prevent France and Spain from exerting exclusive control in their zones of influence. The so-called "Tangier question" would prove influential in all spheres, including public health.

Health issues were not among those regulated by the Act of Algeciras, which limited itself to the following agreements: 1) Creation of a police force in Tangier and other ports; 2) Fight against smuggling; 3) Creation of a Moroccan State Bank; 4) New taxes and improvement of the financial system; 5) Reform of the customs; and 6) Public works and public services. However, this very absence implied that an institution so important and with such a long trajectory as the Sanitary Council of Tangier remained untouched. In fact, the Council was once mentioned in the text, in the fourth chapter, article 61, regarding the question of a new tax on urban properties which should be used for public works in the main cities:

> A Tanger, cette quotité sera versée au Conseil Sanitaire Internationale, qui en réglera l'emploi jusqu'á la création d'une organisation municipale.

Nothing was said about the Council's authority in public health, which dated back to the times of Sultan Moulay Abdehrraman. Nor was anything said about its possible replacement by other equivalent institutions in the French and Spanish zones. So the Council was subtly acknowledged, and its functions were neither denied nor reshaped. Far from disappearing or being dismantled, it started to become a kind of "ghost", as did the zone of Tangier as a whole, its structures and its old regulations of 1840 and 1879 inevitably interfering with the maritime health institutions France and Spain planned to create in their respective zones of influence.

In fact, the impact of the "Tangier question" for Spain (and France) was multiple. On the one hand, the persistence of the Council meant that Spain could not concentrate its efforts exclusively in its zone of influence. Spanish representatives had to be kept in Tangier and in ports of the French zone as part of the old system which had not disappeared. In addition, other European countries could keep influencing maritime public health in both zones. On the other hand, the Tangier Legation kept an important role as co-ordinator of Spanish delegates in the ports of the Spanish zone. Its power would interfere with a future maritime health authority based in Spanish Morocco. Third, the traditional weight of the Larache delegation could transform it in the centre of maritime health in the

Spanish zone, but this would probably allow too much Moroccan participation because Spanish presence and influence in this city were weak in comparison, for example, with Tettouan. Finally, urban public health, of which dispensaries for natives were to become a most representative component, was also disrupted because the Council had not received authorisation from the Sultan to create health institutions in the cities – except for Tangier itself. In this context, it is not strange that the control of maritime public health became of extreme importance for the development of a health system in Spanish Morocco – at least in the Western zone.

These "shortcomings" of Algeciras' resolutions implied that maritime public health in the Spanish zone did not change much in the years 1906–1912 from former decades. Curiously, the most immediate and almost exclusive effect of Algeciras was the creation of dispensaries for natives in the Atlantic coast cities. They were set up on the basis of the "consular doctors" who had been working in Moroccan ports since the 1880s. One of them, Captain Dr. Francisco García Belenguer, who worked in Larache, was the first to suggest in June 1906 that a dispensary should be built in that city. It was necessary to extend medical services to a wider population of "poor Moors and Israelites" so that Spanish influence was consolidated and the work of the French doctor recently sent to the city, neutralised. (France would keep a dispensary in Larache and a doctor in Tettouan for many years). Following this proposal, the doctor of the Spanish Legation in Tangier, Major Dr. Francisco Triviño Valdivia presented to the Ministry of State a project for creating dispensaries in the Spanish zone four months later (*Proyecto de instrucciones para la organización y funcionamiento de los dispensarios médicos de España en Marruecos*). Two years later, the new doctor in Larache, Captain Dr. Carlos Vilaplana González, wrote a new tract entitled *Bases para los dispensarios de Marruecos. Dispensario de Larache*, another attempt at defining the characteristics of the dispensaries.

The centrality of Larache was not only expressed by its leading role in proposing the creation of dispensaries. In 1911, Spain launched a military operation to secure that city and Ksar el-Kebir in the face of French moves near the unofficial borders of the Spanish zone of influence. After this operation and many delays and bureaucratic proceedings, three urban dispensaries were created in the Atlantic region. The first was started in Larache in 1908, under the direction of Carlos Vilaplana González (1908–1911) and afterwards Ángel Jack Ocampo (1911–1919); the second, in Asilah in 1911 with Francisco Moreno Sáenz (1911–1921); and the third in Ksar el-Kebir in 1912, with Ramiro Torreira Martínez (1912–1913) and Manuel Ocaña López (1914–1921). They had nonetheless a provisional character, lacking proper equipment, auxiliary personnel and even buildings of their own in some cases during the first years. The directors of dispensaries were dependent on the Spanish consuls in those cities and subsequently on the Spanish Legation in Tangier. All administrative paperwork, medical registers and sanitary initiatives had to be submitted to Tangier for knowledge of

and eventual approval by the Legation and by the Ministry of State in Madrid. The role of the Tangier Legation would persist in the following years.

In fact, the creation of dispensaries was not so paradoxical because obtaining control of the Council delegations was much more difficult than making a slight extension of the work of consular doctors. However, the very provisionality of dispensaries showed that such control was necessary for obtaining financial resources and improving their facilities and equipment. This was not the only problem. As it was said before, Spanish initiatives were not restricted to its zone of influence. That is why, for example, Dr. Francisco García Belenguer was sent to Fez in 1908, where he stayed at Moulay Abd el-Hafid's (1908–1912) personal service until the Protectorate treaties were signed. His main task was to try and influence the Sultan and the *Makhzan* and to send reports to the Tangier Legation, informing about their activities. But it was too late for him to exert an influence similar to that of Fernand Linarès at the end of the 19th century. Spain also kept consular doctors in Casablanca and Mogador. At least in the first of those cities a dispensary was established which was connected to the Tangier Legation. The military doctors who served in Casablanca were Antonio Moncada y Álvarez (until 1910), Carlos Amor y Rico (1911–1917) and Vicente Vidal Frenero (1921–1931), while those in Mogador were José Blanco Larruscaín (until 1911), Práxedes Llisterri y Ferrer (1912–1913) and Gabino Gil y Sáinz (1914–1915). Resources and personnel were used to keep Spanish influence in the whole of Morocco until the 1920s with the subsequent dispersion of meagre resources.

*The Strategy of the Juntas Locales (1913–1915).* The French and Spanish Protectorates were finally established in March and November of 1912, respectively, but Tangier and its surroundings confirmed their autonomy from both. The city was assigned a vaguely international character, which would take almost fifteen years to be legally defined. This fact deepened the impact of the "Tangier question" on the Spanish Protectorate's maritime public health. On the one hand, it confirmed the persistence of the Sanitary Council, whose existence and jurisdiction were once again taken for granted. Spain should then keep its activities in Tangier and other ports of Morocco. On the other hand, Spain could not use the Legation of Tangier to lead public health in its zone of influence. Tangerian ascendancy in the Northern region would have provided a powerful legitimacy, an administrative basis and a unity of action for Spanish health activities in its new Protectorate. Instead, a new centre had to be "invented" that would not enjoy Tangier's pedigree and would suffer from interferences of the Legation. Tettouan was officially chosen as new centre but Larache possessed similar, if not more favourable, conditions for the task. The Council's delegation in Larache had been traditionally more important and, as has been shown, the first dispensaries for natives had been established in Larache and nearby cities. Finally, the problems of creating urban health institutions and extending their reach into the countryside would remain.

In these unfavourable circumstances, Spain began to define its Protectorate health system. The French-Spanish Treaty of November 1912 lacked any refe-

rence to public health matters, and it was necessary to wait for a provisional Protectorate regulation approved by Royal Orders issued in February and April 1913. According to these regulations "public health and hygiene" affairs were assigned to the Delegation of Native Services (later, Native Affairs), one of the three offices of the Spanish *Alta Comisaría* (High Commission) in Tettouan. In addition, *Juntas locales de Higiene* (Local Hygiene Boards), were to be established in the main cities. Apart from the regulations, a new urban dispensary was created in Tettouan just after the occupation of the city in February 1913 under direction of the military doctor Leopoldo Martínez Olmedo (1913–1919). Finally, Dr. García Belenguer was appointed as "intimate consultant" of the new Khalifa (higher Moroccan representative for the Spanish zone), Moulay el-Mehdi. He was supposed to carry out the same tasks as under the Sultan Moulay Abd el-Hafid in previous years.

These initial measures could not hide the persistent debility when faced with the Sanitary Council of Tangier, which was explicitly reflected in the specific orders given to the Delegation of Native Services in the 1913 provisional regulations. According to them, the main task of this organ in health affairs was to strive for the "confluence of the Spanish public health action (dispensaries of Larache, Ksar el-Kebir, Asilah, Tettouan, Nador and Zoco el Had [the latter being two countryside dispensaries run by the Army in the Melilla region] with the delegations of the Sanitary Council of Tangier, and its expansion in due terms". Debility was quickly given a more proper name. On the occasion of a plague outbreak in the Atlantic region in September 1913, a sanitary commission was sent from Spain by the Ministry of State, headed by the Spanish Maritime Health Inspector himself, Manuel Martín Salazar. Some months before, the ministry had already proposed that Martín Salazar should present a design for organising the health services of the Protectorate (following a plague outbreak in the Canary Islands). The *Proyecto de Organización de los servicios sanitarios de la zona de influence española en Marruecos* was finished in May and published in November and became the first detailed legal text on public health for Spanish Morocco.

Among other things, the plan proposed the creation of the Hygiene Institute in Larache, whose director would become the Protectorate's Health Inspector. Subordinated to him, medical officers in Larache, Tettouan, Ksar el-Kebir and Asilah would be in charge of the maritime health stations in the ports as well as the urban dispensaries. They would also serve as members of the local boards of those cities in order to take general hygienic measures. Larache's Institute would also serve as basis for the creation of a Spanish School of Tropical Pathology in Africa. However, the plan failed because Martín Salazar ignored the implications of the Sanitary Council of Tangier. During his stay in Morocco, he finally realised that neither Spain nor France could adequately organise their Protectorates' public health

> because they lack the indispensable *sanitary autonomy*, due to the existence of an International Treaty that assigns such a delicate matter in the Moroccan Empire to different national representatives, badly suited for this kind of

> services, prone to disagreements based on interests beyond public hygiene and besides often sterilised by the technical incompetence of officials charged with a task which is essentially unknown to them.

Thus, *sanitary autonomy* was still the real challenge for Spain, even though the Protectorate had been already established, and maritime public health was the key to this autonomy because the more control exercised in this field, the more the development of urban and countryside health services would be possible. As a result of the commission, two provisional "sanitary parks" were established in the ports of Larache and Asilah, but its work ran parallel to that of the Council delegations and they depended directly on the Spanish Maritime Health Inspection. This measure was clearly insufficient and Martín Salazar asked the Ministry of State to reach an agreement with France in order to obtain sanitary autonomy and also to press for a reform of the Sanitary Council bureau so that Spain could increase its influence in it. More realistically, Martín Salazar also proposed a local strategy to start bringing sanitary power into Spanish hands. He stated that

> as long as the Sanitary Council of Tangier does not acknowledge our sanitary autonomy in the ports of our domain, it could be demanded from the Consular Corps of the different cities that the right to intervene in the sanitary examination of ships would be delegated to this Spanish doctor [the dispensary doctor].

In fact, that right was not "demanded" but taken by force. Spanish authorities decided to use the newly created *Juntas de Servicios Locales* (Local Boards) as bases for the use of diplomatic force against the Protectorate legal frame. The first *Juntas* had been established in Tettouan, Larache, Ksar el-Kebir and Asilah by a *dahir* of June 10, 1913 (Cordero Torres 1943). Despite their initial financial and legal problems, they provided the institutional space for Spanish consuls to act apart from other European representatives and from Moroccan authorities. In the absence of specific Local Health Boards, they assumed public health competencies, placing urban dispensaries under their control. More important, they tried and pre-empt maritime health competencies from the Council delegations. It was a way either to avoid interference from the Council of Tangier, or to increase the role of the Delegation of Native Services of Tettouan in front of the Tangier Legation and Larache.

This process took a particular form in each of the three main ports of the Spanish zone. The first move was made in the least important, Asilah, during the second half of 1913. The Spanish Consul, who acted then as Council delegate, appointed the dispensary doctor, Francisco Moreno Sáenz, as his successor. This was a challenge to the Council, as it was this organ that still had the power to appoint its delegates. This action provoked official protests of the government of Austria-Hungary to the Spanish Ambassador in Vienna in May 1914. The argument was that, although the Council had not been created as a result of an international convention, it was "an institution acknowledged by many international

treaties", among them in the "article 176 of the International Sanitary Convention of Paris, signed by Spain, and the article 61 of the International Act of Algeciras".

Spain tried to act more carefully on the next occasion to avoid such diplomatic incidents. This time, the objective was Larache, the main port of Spanish Morocco. On January 1, 1914, the Spanish Consul José Buigas Dalmau was to start his term as Council delegate for the next six months. A doctor from Martín Salazar's commission, Benigno García Castrillo, was still in the city in charge of the provisional "sanitary park" that had been installed in the port, and the Council health official was a Spaniard named Ildefonso Hernández. Buigas first tried to "obtain" the post of delegate from the Belgian consul in December following secret instructions from the Ministry of State, but the consul refused to act without previous authorisation by the Council. Then, on January 1, Buigas received his post and immediately ordered Dr. Castrillo to assume the sanitary inspection of ships, while Hernández would become his "substitute". Buigas planned to keep this situation beyond June 30, as he expected no protests during the following term of the French consul, because "France seeks for its zone the same independence we seek for ours". These legal subterfuges proved effective: France did not protest, Dr. Castrillo inspected the ships, equipment and facilities were improved and the money raised through ship inspection was not sent to Tangier.

Despite all precautions, the economic importance of the port of Larache made protests from other countries all the more expected. This time it was Great Britain that complained to the Spanish government. On January 1, 1915, the British consul in Larache began his term as delegate, and the same day the British consul in Tangier became president of the Sanitary Council. Besides, Great Britain had not yet officially acknowledged the Spanish Protectorate. To respond to British protests, the Ministry of State asked for a copy of the 1840 Council regulations to the Tangier Legation, and some time later sent a note to the British Ambassador in Madrid with a wide array of arguments defending the Spanish position. For example, the Council was not the result of an international agreement; Spain had been charged with implementing a public health administration in the name of the *Makhzan*; and a sanitary station had been set up in Larache that provided a preventive service that had not existed before. In addition, the 1861 Treaty of Commerce with Morocco, still in force, also allowed Spanish consuls to issue sanitary certificates for boats on the Rif coast. Finally, the international conventions stated that consuls were not prepared to render adequate health service, which should be assigned to trained personnel as Spain had done in Larache.

The First World War, which had already started, also provided a powerful argument. It was necessary to maintain the *de facto* situation in Larache and Asilah in order to ensure the "neutrality" of the ports of Spanish Morocco, because a British or French consul "could raise problems with ships of belligerent countries". Sanitary inspection by Spain would be more "objective" because "a foreign consul may be a self-interested party in the present European conflict". So, the Ministry of State could affirm that "the war was the cause of Mr. Buigas keeping the delegation post". Finally, in October 1915, the consul in Larache sent

a copy to the Ministry of State of the sanitary certificate made by the French consul of Kenitra for an English ship. If sanitary inspection in Kenitra was done by the French consul and not by the Council delegate, the Spanish initiative in Larache seemed not so unjustified. Strictly, both problems were not equivalent because the port of Kenitra had had no Council delegate prior to the Protectorate. However, the fact that France made moves to control maritime public health in its zone supported Spanish demands for its own.

The problem did not disappear and was brought to the fore every time a new foreign diplomat began his term as president of the Sanitary Council. In November 1915, it was the Russian diplomatic agent in Tangier who, as Council president, again demanded a solution for the delegation of Larache. He proposed that the Spanish consul could "incidentally and given the present circumstances keep the post of delegate as long as he sent the money raised by ship inspection since mid-1914 to Tangier". The Ministry of State and the Tangier Legation were eager to accept this proposal but only if it was taken as "definitive and not provisional", that is, the Spanish consul in Larache "would always be the Sanitary Council delegate" and the doctor of the *Junta* would be responsible for ship inspection. No agreement was reached and the situation remained as before.

In the view of the Ministry of State, it was only a matter of time before a similar problem arose in the third main port of the Spanish zone, Tettouan. Despite being the Protectorate's official capital, in Tettouan's port, Martil, maritime public health still remained in the hands of the Council delegate. On January 1, 1916 the French delegate was to surrender the post to the German consul for the next six months. But as these two countries were at war, the French consul suggested to the *Alto Comisario* (High Commissioner), General Francisco Gómez Jordana, that the Spanish consul became the delegate. Gómez Jordana sent the proposal to the Ministry of State, which accepted the idea. However, at the last moment, France decided to propose the consul of the Netherlands as the new Council delegate, with the subsequent deception and protests of Spanish Protectorate authorities.

This fact just confirmed Tettouan's secondary role in relation to Larache between 1913 and 1915. The lack of centralised control on maritime public health was reflected in new plague outbreaks. In addition, Tettouan could not stop the activities of the Spanish Legation in Tangier, which carried much of the weight of the strategy of the *Juntas*. Besides, Spanish activities continued in other parts of Morocco. Just after the Protectorate was established, a Spanish Laboratory of Bacteriology had begun its work in Tangier almost simultaneously and in direct competition with the French Pasteur Institute headed by Dr. Paul Remlinger (Moulin 1997). The military doctors Celestino Moreno Ochoa (1913–1917) and Francisco Mora Caldés (1917–1921) were its first directors. Consular doctors continued to be appointed to the Spanish Legation and often served in the Spanish Hospital that had been in operation since 1888. In this period, the military doctors Federico Baeza and Francisco Triviño were replaced by Enrique Pedraza de Vivanco (1914–1918) and Emilio Crespo y García de Tejada (1915–1917). On the other hand, Spanish doctors in Casablanca and Mogador continued their task in

both cities during these years, though with uncertain purpose, while the southern zone of the Spanish Protectorate (Cape Juby/Tarfaya) still awaited effective occupation.

Despite all problems, the pre-emption of maritime health competencies by the *Juntas* provided the "umbrella" for the start of the later so-called *Sanidad Majzén* (*Makhzan* public health), that is, the health services created and controlled by Spanish authorities but addressed to the Moroccan civil population in the name of the Khalifa, in other words, the Protectorate health system as such, directed from Tettouan and addressed to Moroccans. The *Juntas* were able to acquire financial resources from ship inspection and from the Ministry of State (since 1915). The posts of Officers of Local Health Services or Local Boards Health Officers, that is, a kind of municipal health inspectors, were created the same year. The "sanitary parks" of Larache and Asilah were officially integrated in the *Juntas* and the first statistics of ship inspection were collected and sent to the High Commission. Urban dispensaries were officially recognised as "*Makhzan* dispensaries" by a *dahir* of January 1, 1915. The number of people ("Moors", "Israelites" and Spaniards or Europeans) treated in these centres grew significantly. But more important, public health measures could be planned on a regular basis and a wider scale. For example, in October 1915, the High Commission ordered the Officer of Local Health Services in Larache to design a form to collect statistical data "for a better knowledge of the salubrity of this city", which was subsequently extended to the other main towns. Morbidity and mortality data were then ranked according to a standard nosology, and included information on nationality and religion. As a result, monthly statistics started to be submitted to the High Commission and published in the *Boletín Oficial de la Zona de Protectorado de España en Marruecos (BOZPEM)*, providing a first picture of the Protectorate's epidemiology.

Preventive measures such as smallpox vaccination increased. For example, just a few weeks after Tettouan was occupied and its dispensary created, the Spanish consul in the city asked the Ministry of State to send 800 doses of smallpox vaccine "so that the doctor attached to the Consulate may vaccinate for free those natives who ask for it". It was clearly a propagandistic measure, although it was justified due to the "appearance" of some cases of smallpox and the "necessity of diffusing among the native population the use of vaccination". In Larache the consul Buigas asked in June 1914 that a "depot of sera and vaccines" be installed in the city, and that smallpox vaccine be sent. The petition was written, not by chance, just a few days before the consul started the procedure to try seize the Council delegation post and was justified using the same arguments as in Tettouan. Apart from these opportunistic occasions, vaccination was done regularly as public health structures stabilised. For example, a "vaccination service" was organised in the dispensary of Larache from June 1915. Its announcement stated:

> In the dispensary of Larache, vaccination will be offered for free to all indigents of every nationality, from 10 to 12 in the morning and 2 to 4 in the after-

noon. Apart from smallpox vaccine, anti-typhoid vaccine and anti-diphtheria serum will be provided to the poor, also for free.

Dispensaries also offered the poor population drugs for free, which were supplied by the Military Hygiene Institute in Madrid. Finally, projects for new water conducts and sewage collection began to be planned and discussed by the *Juntas* of the main cities.

*The Creation of the Health Inspection and the "Denunciation" of the Council of Tangier (1916–1918).* The 1915 budget of the Ministry of State for Morocco included for the first time a sum for a "doctor, General Health Inspector". Administrative documents confirm that both Spanish peninsular and Protectorate authorities planned the appointment of a Protectorate Health Inspector during the second half of that year. In contrast with former projects for Larache, the new post was presumably be given to the director of the Tettouan's civil infirmary, which had been created for the assistance of the Spanish population of the city already in 1914. In November 1915, a public call was issued by Manuel Martín Salazar and some time later Dr. Eduardo Lomo Godoy, director of the civil infirmary of Tettouan, was appointed to the post. The selection committee included Jorge Francisco Tello, head of the Epidemiology Section of the "Alfonso XIII" Hygiene Institute of Madrid who had accompanied Martín Salazar in the 1913 commission; the Spanish Representative in the *Office International d'Hygiene Publique* of Paris, Dr. Ángel Pulido, former Spanish General Health Inspector, 1901–1902; Dr. Víctor Llorente, a specialist in sera and vaccines who owned an important laboratory in Madrid; and the Professor of Parasitology and Tropical Pathology of Madrid, Gustavo Pittaluga (Rico Avello 1969). Such an imposing group of hygienists was surely intended to give the candidate the full support of the Spanish public health establishment.

This fact reflected the increased legitimacy and power that Tettouan had gained as the public health centre of Spanish Morocco. In fact, the promotion of Tettouan was a main objective of the High Commissioner Francisco Gómez Jordana during his term from July 1915 until December 1918. Soon after his appointment, the first official regulation for the Spanish Protectorate was approved on January 24, 1916. In public health, this regulation confirmed the creation of a General Health Inspection inside the Delegation of Native Affairs, whose main function was to act as consultative board for the High Commission in "public health and hygiene affairs". Periodical visits were also to be made to the health services by the inspector in order to suggest possible reforms, while a general report had to be submitted to the High Commission at least every two years. Dependent on the Health Inspection, the directors of civil hospitals and infirmaries would become "delegates for the services of health intervention".

However, the 1916 regulations had quite a limited effect in creating a technical public health authority with actual executive power. The inspection and its delegations remained a consultative body, so final decisions were in the hands of the Delegate of Native Affairs and the local consuls-interveners. Dependence on

metropolitan public health was still high. To that date, the civil hospitals and infirmaries built or planned were still intended exclusively for Spanish citizens, leaving dispensaries as the sole *Makzhan* services. This last fact is very important because the Ministry of State would give more and more support to institutions exclusively directed to Spaniards, instead of promoting Protectorate centres. The risk began of grow of negating Spain's international compromises towards Morocco which would develop in the years to come.

In these circumstances, new acts of force for acquiring maritime health competencies were necessary to further strengthen the Health Inspection and Tettouan's central role. The international context would prove decisive for this process. Shortly after the 1916 regulations were approved, French authorities in Morocco decided to "denounce" the 1840 *firman* by which the Sanitary Council of Tangier had been established. The state of war was crucial in this action against legal agreements, which was probably intended to stop German interference in Morocco, so strongly felt prior to and during the war period. The decision was conveyed to the foreign representatives in Tangier through the delegate of the Sultan in that city. The *Residence Generale* (French High Commission in Morocco) had decided to take full control of its zone's maritime public health, which was to be governed through a new legal regulation to be approved after the "denunciation" had gone into effect.

Immediately, the Spanish Legation in Tangier contacted the Ministry of State and expressed its dissatisfaction that France had not informed Spanish authorities "so that both governments would have simultaneously acted in both zones". However, it was not too late to co-ordinate Spanish initiatives with those of French authorities. The "denunciation" of the 1840 *firman* was a very convenient move for Spanish Morocco's interest in achieving its "sanitary independence". Thus, the Legation began planning a parallel "denunciation" to be published on the same date as the French statement which would put an end to the Council's interference in the Spanish zone. Soon afterwards, a regulation "reorganising maritime health police" would be approved which would serve as the basis for "the future sanitary regulations". The Legation felt confident of this manoeuvre, as no diplomatic protest, especially from Great Britain, had followed the French decision.

The plan was put into action through a Khalifian *dahir* published in the BOZPEM on March 13, 1916 – the same day as the French Sultanian *dahir* – which was to go into effect on March 19. The law established that the *pachás* of the port cities would assume the responsibilities of the Council's delegates in maritime public health, "though they could, nonetheless, delegate this function in benefit of the service". A royal decree from the High Commission March 29, 1916 put into effect this new delegation of authority from the *pachás* to the Spanish Consul-Interveners. In sum, jurisdiction in sanitary matters had been removed from the Council and returned to the *Makhzan* (reversing the events of 1840), which, in turn, had re-delegated the power in this field to the French and Spanish Protectorate authorities.

However, the effect of these measures was not as decisive as it was planned. This was largely due to Great Britain's will to continue its support of the Council. Just a month after the French and Spanish *dahirs* were published, the British ambassador in Madrid, Sir Arthur Hardinge, addressed the Minister of State, the Count of Romanones, to convey the opinion of the British government that the suppression of the Council would cause serious inconvenience due to the absence of a central organ that could co-ordinate quarantine policy and the application of sanitary regulations in the Spanish and French zones and Tangier. To avoid this, Hardinge proposed the creation of a new "Sanitary Council of Morocco" on the basis of articles 27 and 102 of the planned Tangier Statute, which was then being negotiated between France, Great Britain and Spain.

Hardinge reiterated his proposal to the new Minister of State, Amalio Gimeno, in August. Some days later, the French ambassador in Spain transmitted the complete agreement of its government with the British plan. Caught by surprise, the Minister of State requested a report from the chief of the Tangier Legation, F. Serrat, who was also surprised because, in his opinion, there was nothing in article 27 to support the French-British proposal, and he had no knowledge of the existence of an article 102. He nonetheless found a clear explanation for the "paradoxical fact" of "re-creating a Sanitary Council or restoring the existing with its former powers": it would mean again accepting foreign intervention "after having paid with sacrifices for the independence of our action in Morocco". For Great Britain, it was a way to retain its intervention in Moroccan public health, while the benefit for France would be that the new Council would favour its never-abandoned ambition of controlling the whole of Morocco at the expense of the Spanish zone. Serrat thought that Spain should reject this proposal and defend its decisions against the two countries. If a co-ordinated action on quarantine or any other issue was considered necessary, "it would suffice to follow the corresponding international regulations adopted in the different Sanitary Conventions". Besides, it would be more important for Spain to co-ordinate maritime public health in the ports of Spanish Morocco "with regulations in force in the *península* and Spanish African enclaves" than with the rest of Moroccan ports.

As a result of these diplomatic manoeuvres, maritime public health was still unable to achieve sufficient autonomy in Spanish Morocco. The provisional "sanitary parks" installed in Larache and Asilah after the end of 1913 had not become "sanitary stations", although such projects were planned since 1915. Consequently, the *Sanidad Majzén* directed from Tettouan kept its modest development. Interference from the Tangier Legation continued. For example, the Spanish bacteriological laboratory in that city increased its activities in Spanish Morocco. In 1915 its services included diagnosis and assistance in rabies cases from Tettouan, Larache, Ksar el-Kebir and Asilah. In 1917, the laboratory asked the Institute of Military Hygiene to send antityphoid, anti-paratyphoid, anti-dysenteric and haemolytic sera, as well as smallpox vaccine, all for diagnostic purposes. Competition with the laboratory of Tangier still came mainly from Larache, not from Tettouan. As was mentioned above, in 1914 the Spanish consul Buigas had

asked for a "deposit of sera and vaccines" from the Alfonso XIII Hygiene Institute to be established in the city and "periodically renewed". This initiative did not succeed, but in 1916 the Commander General of Larache asked the Tangier Laboratory to send "anti-rabies marrows" for local treatment of the rising number of patients in the area. The director, Dr. Francisco Mora Caldés, refused partly on technical grounds and partly because he thought its laboratory was prepared to "treat all individuals coming from our zone of influence, either military or civilians, who need as the sole requisite their presence in this city during the time of the treatment". It seems clear that the laboratory wanted to keep its prerogatives at the expense of Larache.

*The Authoritarianism of the High Commissioner (1918–1921).* Two years had to pass for Tettouan to finally become the centre of Spanish Morocco public health. The defeat of Germany in World War I increased freedom of movement for France and Spain in Morocco, putting an end to more than a decade of German intervention after Algeciras. On September 24, 1918, a *dahir* was published with the heading *Dahir organizando el servicio sanitario de la Zona*. This *dahir* stated "that the power attached to the *Makhzan* in sanitary affairs would be permanently delegated to the Delegate of Native Affairs of the High Commission of Spain in Morocco". The "denunciation" of 1916 had failed because it had returned the jurisdiction of the Council to the hands of the *Makhzan*, but it had not made a distinction between the Sultanian (French) and the Khalifian (Spanish) *Makhzan*. This open flank had been used by the British and French authorities to exert claims for intervention in maritime health affairs in Spanish Morocco, as has been seen. The new *dahir* closed this door by making the Delegate of Native Affairs and not the *Khalifa* or its *Makhzan* the direct recipient of responsibility for maritime health issues in the Spanish zone. Thus, further interference was prevented, but it was at the cost of a new act of force on the Protectorate legal frame. Now it was plainly clear that Spain did not "protect" Moroccan authorities but directly assumed their competencies. It was all the more natural that, as a result of this decision, Dr. García Belenguer ended his mission as "intimate consultant" near the *Khalifa*.

The *dahir* created a Central Board of Health (*Junta Central de Sanidad*) composed of ten members and located in Tettouan. Its president was the Delegate of Native Affairs. The other members included a functionary of the General Secretary of the High Commission, who was to represent the interests of civil authorities; a member of the Military Cabinet of the High Commission, who would represent the Army; the "doctor who acts as consultant of the Delegation of Native Affairs", that is, the Health Inspector; the Chief of Military Public Health in Tettouan; a doctor, a pharmacist and a veterinary appointed by the High Commission; an architect from the Delegation of Public Works (*Fomento*); and a secretary without a vote from the staff of the Delegation of Native Affairs. Subordinate to this central board, specific Local Health Boards (*Juntas locales de Sanidad*) were created inside the *Juntas Locales* of Tettouan, Larache, Ksar el-

Kebir and Asilah. Each of these boards contained 12 members: the *pachá*, who was the president; the local consul-intervener, who was the vice-president; a representative of the Army; the director of the civil hospital in Tettouan and Larache and of the civil infirmary in Ksar el-Kebir and Asilah; a military doctor; the chief of the municipal health services; a pharmacist and a veterinary appointed by the Delegation of Native Affairs with approval of the High Commissioner; three proprietors (one Spanish, one Muslim, one Jew) appointed in the same way; and a secretary from the local intervention office.

On the other hand, the *dahir* made reference to new institutions, the so-called "mixed infirmaries". In fact, the civil budget for Spanish Morocco published on the January 1, 1918 had included sums for the personnel and expenses of two "infirmaries for natives" (exclusively for Moroccans) in Tettouan and Larache and two "mixed infirmaries" (for Spaniards and Moroccans) in Asilah and Ksar el-Kebir. Such infirmaries had already started operation between 1917 and 1918, and their personnel included, in the first case, two Spanish doctors, two Spanish auxiliaries, two Moroccan nurses (one male, one female), a Moroccan cook and a Moroccan porter; and in the second case, a Spanish doctor, two Spanish auxiliaries, two Spanish nurses (one male, one female), a Spanish cook and a Moroccan porter. The infirmaries were considered a necessary complement to the dispensaries for natives, because they offered surgical services and a place for convalescence. This service could not be provided by dispensaries and, provisionally, had been assigned to military hospitals, as will be shown later.

Despite all, the situation had not changed so much. If the Health Inspector was modestly referred to as the "doctor who acts as consultant of the Delegation of Native Affairs", it was because he lacked executive power as well as the administrative, institutional, financial and technical means to plan and implement a public health policy. The Health Boards were to act "only as consultative bodies, from which the Delegate and its local representatives [the local consuls-interveners] would seek advice when an epidemic of bubonic plague or any of similar danger appears". In 1921 Spanish Morocco still lacked proper sanitary stations in its ports, an Institute of Hygiene and a central depot for medical material. No health campaigns against syphilis, malaria, typhus or tuberculosis had been launched. The budget for civil public health (for Spaniards and Moroccans) had risen to a modest six per cent of the total for the Protectorate (781,000 out of 13,699,322 pesetas) when the infirmaries were planned in 1915, but in 1918 it was reduced to a meagre 2.5 per cent of the global expenses (229,000 out of 11,956,822 pesetas), almost one third of which was for the personnel's wages. Some of these expenses were for Spanish-only or part-Spanish institutions (two civil hospitals, two civil infirmaries, two mixed infirmaries). Two "sanitary parks", four modest urban dispensaries and four small infirmaries, two of them "mixed", were clearly insufficient for *Makhzan* public health to ensure adequate assistance for Spanish Morocco's urban population, even though this group comprised only a 10–15 per cent of the zone's total.

The space allotted to the *Sanidad Majzén* was, then, small and clearly insufficient, a side-effect of persistent "Tangerian ghosts" that refused to disappear. Impotence led to further authoritarianism in front of the Khalifian Makhzan, which was regarded as the only way of acquiring control over health matters. Thus, in the 1918 *dahir*, the High Commissioner himself was given strong control over health affairs, even over the Delegate of Native Affairs. His formal approval was required before agreements of the Central Health Board were executed and also for the appointment of three out of nine voting members in the central board and five out of eleven in the local boards. This authoritarian manoeuvre was representative of the period when General Dámaso Berenguer served as High Commissioner (1919–1922). Berenguer managed to concentrate civil and military power in Spanish Morocco in the face of interference from the *peninsula*, from the Tangier Legation and from Moroccan representatives (Cordero Torres 1943). He did so in quite a "personal" way, as all initiatives were taken by him, and he appointed men in his confidence to key posts (Nerín 2005). In this way, the position of Tettouan was clearly strengthened in relation to Larache and Tangier, and it would be more so after the strong military campaign that took place from 1919 to 1921, which resulted in the complete or partial submission of the *qabilas* of Anghera, Wad Ras, Beni Hosmar, Beni Hassan, Beni Messauar, Jbel Hebib, Beni Said, Beni Gorfet, Beni Ider, Beni Arus and the holy city of Chefchauen in Ajmás. Most of the new territories under Spain's control were to be administered from Tettouan, while Chefchauen was not organised as a regional centre.

However, authoritarianism hindered even more the technical authority of the Health Inspector. It was usually the High Commissioner himself or his General Secretary who addressed the Ministry of State or the Ministry of War to deal with public health affairs. Thus, it is not strange that the Health Inspection was temporarily suppressed in the new Protectorate regulations issued on July 12, 1924. Concentration of power in the hands of the High Commissioner had other "collateral" consequences. The growing autonomy of Tettouan towards Spanish peninsular institutions meant that the Protectorate's health system would have to finance itself with the specific Protectorate budget, with less and less money being received as direct contributions from the Ministries of State and War. If the Spanish General Health Inspection and the Public Health Section of the Ministry of War could no longer intervene as much in Protectorate affairs, then their expenditures to the protectorate would be cut. Instead, both ministries focused more and more on purely Spanish interests.

For example, since 1918 the Military Hygiene Institute of Madrid refused to continue providing free drugs and vaccines to the dispensaries and to the Tangier Laboratory, thus limiting its services to military hospitals and infirmaries. In 1921 the Ministry of War decided to carry out a general reorganisation of its services and personnel in Spanish Morocco. Reorganisation meant reducing costs and relocating staff and institutions to better fit strictly military needs that were determined by the difficult campaigns underway in the Tettouan and Melilla regions. Military doctors serving in Tangier and in some Moroccan cities of the French

zone, as well as in the south zone of the Protectorate were an easy target. There were three consular doctors in Tangier, Francisco García Belenguer (1918–1921), Luis Sampedro Díez (1919–1921) and Carlos Amor y Rico (1918–1921) – the latter replaced that very year by Ignacio Fernández de Castro – plus the director of the Spanish Laboratory and a military veterinarian, Tomás García Cuenca. In addition there was the Casablanca dispensary and a consular doctor in Rabat, Carlos Amor y Rico (1921–1931), who had been appointed that year. Finally, the military doctor Salvador Sanz Perea worked for the Delegation of the High Commission in Cape Juby since the occupation of this area in 1916. The budgets for all these doctors were terminated. Besides, the countryside dispensary of Laucién, near Tettouan, was moved to Chefchauen in 1921, so that medical assistance was provided to the forces which had recently occupied the city.

On the other hand, the Ministry of State focused more and more on health services directed to Spanish citizens only. Thus, the Ministry kept on financing the civil hospitals and infirmaries established in Tettouan and Larache but made no attempt to increase its contribution to mixed infirmaries and infirmaries for natives, nor to urban dispensaries. The number of these centres did not grow from 1918 on and plans for transforming infirmaries for natives into hospitals, as well as for creating a new mixed infirmary in Chefchauen were not brought to fruition. The Ministry also refused any further effort to establish definitive maritime health stations in the ports. Yet, it assumed responsibility for the wages of the doctors and veterinarians serving in Tangier, Casablanca, Mogador and Cape Juby, so that Spanish presence in the whole of Morocco was not abandoned. In short, the growing autonomy of Spanish Morocco's health system and the financial shortages in the peninsula resulted in both ministries concentrating as much as possible on their particular (Spanish) interests in Morocco, limiting support given to institutions directed to Moroccans. It could not have been a worse moment, because Spain was occupying more and more territory, which called for a wider health organisation.

As a brief resume, maritime public health continued to be as important in Spanish Morocco as it had been before for Moroccan authorities. This fact revealed the persistence of external influences, namely the Sanitary Council of Tangier, which made it difficult to develop the *Sanidad Majzén*, which was reduced to two "sanitary parks" and a small number of urban dispensaries and infirmaries. Efforts of Spanish authorities to reverse this situation led to a growing authoritarianism towards the Mazkhzan and the Health Inspection alike and to diplomatic acts of force contrary to international agreements. Finally, the High Commission had to maximise its resources due to the decreasing or stagnating financial contribution from the Ministries of State and War, with the result of no more centres being created between 1918 and 1921 and preferential attention for Spanish citizens. In short, Spanish Morocco "sanitary autonomy" was only achieved by progressively moving away from the Protectorate's legal frame. This was not so paradoxical as it may seem: it just revealed that the degree of effort

needed to establish a health system in Morocco, was much more than a "typical" colony or even a Protectorate would have called for.

## *"Riffian Realities"*
## *The Opposition to Spanish Presence in the Rif*

The network of dispensaries for natives set up in Spanish Morocco comprised not only those in the cities, but also the ones created in the countryside. These dispensaries had to face equally strong problems as their urban counterparts during the period 1906–1921, although the challenges were of a different kind. They were the result of persistent armed opposition of some *qabilas* to Spanish military activities in the name of the Sultan and ultimately of a rejection of the Sultan's authority. The result was that military public health was soon regarded as crucial for using the new health system to control maritime jurisdictions. If interference from the Sanitary Council of Tangier was especially felt in the Atlantic region of Spanish Morocco, local armed opposition would become especially prominent in the Melilla region – though not exclusively.

*Military Reform and the Fight against Smuggling. The "Rif Question"*. The Act of Algeciras had agreed to the creation of a "police force" in the eight main ports (or "imperial ports") of Morocco (Tangier, Tettouan, Larache, Rabat, Casablanca, Mogador, Safi and Agadir). This "Shariffian Police" would remain under the formal authority of the Sultan, and would be composed of Moroccan soldiers and European officers and sub-officers and it would be coordinated from Tangier by a Swiss chief. In Tettouan and Larache, the officers would be Spanish, in Tangier and Casablanca, they would be Spanish and French, and in the rest of the ports, they would be French. The new force would comprise between 2,000 and 2,500 men, many of whom would come from former *askar* units serving in those cities, which had been trained by foreign instructors in previous decades. It was a new step in the reform of the Moroccan army, though at the cost of a higher degree of intervention by European countries.

However, Moroccan initiative had been preserved to a certain extent. A military "Tangier question" had been created, which would cause serious trouble for Spanish military activities in Western Morocco, including public health. On the one hand, the formal persistence of Morocco's military structures implied a dispersion of efforts for Spain, as it was obliged to contribute to "Police forces" in Tangier and other ports which would probably be outside its zone of influence. Army officers were sent to their assigned ports and, in 1907, some Spanish army units accompanied French troops when they occupied Casablanca. On the other hand, the Legation of Tangier kept its role of co-ordination of army officers and personnel appointed to the Spanish consulates, even if the foreseen autonomy of Tangier would separate it from the Spanish zone of influence. This fact would hinder the autonomy of Ceuta military authorities or of the new military command Spain planned to set up in its zone. Third, the traditional weight of Larache (and of the Atlantic zone, in general) remained. Such a development could determine a central role of this city in the future military command of Spanish Morocco,

although this implied less control by Spanish authorities than the equivalent influence of Ceuta would ensure in Tettouan. Finally, the measures agreed in Algeciras concerned only military structures and this prevented Spain (and France) from deploying civil initiatives towards the population of the cities or the countryside. In short, developments in the Western region of the Spanish zone of influence continued to be strongly conditioned by the formal persistence of the Sultan's military sovereignty.

In principle, the reform of the Moroccan army agreed to in Algeciras did not reach the Eastern part of the Spanish zone, in general Eastern Morocco. It seems, however, that a unit of "Shariffian Police" was also created in Melilla, an exceptional case given that the rest of units were located in Moroccan towns. Besides, the military Governor of Melilla acted as a de facto consul in relationships with the Makhzan, as had been done for decades. A special "delegate of the Sultan" was projected in the failed Spanish-Moroccan Treaty of 1910 and, in fact, a Moroccan official named el-Bachir acted as such during the military campaign of 1911 to try and dissuade Riffians of attacking Spanish troops (Mesa et al. 2001). However, these measures were essentially taken as a result of more or less official agreements between Spain and Morocco and, therefore, were outside the new international legal frame. Instead, Algeciras had formulated a specific objective for the Rif and Eastern Morocco: the fight against gun smuggling. One of the six sections of the legal text was exclusively devoted to that issue, which comprised a wide array of dispositions, measures and punishments. Special attention was given to maritime smuggling, probably due to its importance since the end of the 19$^{th}$ century. According to the Act, "l'application du Règlement sur la contrebande des armes dans le Riff et, en général, dans les régions frontières des possessions Espagnoles, restera l'affaire exclusive de l'Espagne et du Maroc". The same was said for the regions close to French Algeria, where French and Moroccan authorities would have the exclusive responsibility of preventing the gun traffic.

It could be said that this distinction between military measures in the West and the East of Morocco showed the increasing debility of the country in the face of foreign intervention. In a way, Morocco was not only being divided in two main zones of influence, Spanish in the extreme North and French in the centre, but in each of them a longitudinal separation was being drawn. However, this measure also threatened to make difficult the creation of a unified military authority in Spanish Morocco and French Morocco, given the consequent separation and diversity of methods between Spanish and French authorities in Tangier, on the one hand, and in Melilla and the South Oranais, on the other. In spite of it all, the use of the term "gun smuggling" was an attempt to keep to some extent a link between the situation and institutions in both longitudinal extremes of the country. For Morocco, it was the way of preserving its military sovereignty, as the fight against the gun traffic could be considered a measure complementing army reforms, and the authority of the Sultan was not questioned. For Spain and France, it was the way of avoiding a lack of coordination of efforts in Morocco and also of ensuring that their action reached the whole territory of their zones of influence.

In the end, all actors involved in Algeciras and all measures agreed to the act attempted to deny the fact that some groups and territories in Morocco were in a process of self-determination towards the Sultan and had the ability to oppose serious armed resistance to him or to any of his "protectors". In Eastern Morocco, the acquiescence of the Sultan to foreign interference was regarded as demonstrating the demise of his functions. Besides, the exclusion of Tangier from the two zones of influence helped finally undermine the legitimacy and reach that Moroccan regional authorities had managed to display with great difficulties in previous decades. The autonomy of Tangier, that "last victory" of the Sultan in Algeciras, would be inseparable from his "first defeat", the move to independence of some areas of the country. The "Tangier question" would be inseparable of the "Rif question". However, Algeciras also attempted denying the particularities of Spanish (and French) presence in Eastern Morocco. As it is been shown, Melilla had the ability to launch its own initiatives, different from those favored by Spanish authorities in Ceuta and Tangier. Besides, as this city would probably be outside the Spanish zone of influence, it felt even less obliged to subordinate its actions to the new military centres that had been projected in Western Morocco. The "Rif question" had a Spanish side, much the same as the "Tangier question".

In these circumstances, and despite the "smuggling" rhetoric, the situation in the Eastern part of the Spanish zone of influence tended to define itself increasingly in its own terms. The link with the Atlantic region was weak. On the Moroccan side, the Sultan's military authority had virtually vanished in the area. Since 1904, the false pretender to the throne and supposed *Mahdi* (a millennial figure frequent in movements of resistance in North Africa) el-Roghi Bu Hamara had ousted the Makhzan garrison in Silwan and installed himself as actual authority in Guelaia (Pennell 2000). It was said before that the *harka* sent against the Ibuqquyen in 1898 had quickly abandoned the central Rif, leaving that area beyond the reach of Makhzan forces. However, given that Moroccan military integrity had been confirmed in Algeciras, el-Roghi lacked any official recognition despite his actual power in the Eastern Rif. If he could not promote himself as a valid representative of the Sultan in front of Spanish authorities, as long as the Sultan did not grant him a specific status inside Morocco, the only solution was to move away from his authority. In the case of the central Rif, social fragmentation avoided any collective leadership, but anyway, existing leaders neither had the authorisation to act in the name of the Sultan, nor wanted to obtain it.

On the Spanish side, Melilla, the Chafarinas Islands and the *peñones* of Vélez and Alhucemas had "smuggling" as one of their relevant occupations, another sign of their traditional marginalisation from Spanish action in Morocco. Guns coming from Gibraltar and from French Algerian and Andalusian ports were transmitted by the enclaves to *qabilians,* or at least they allowed the traffic. But beyond that, "smuggling" was just another aspect of the close relationship of Melilla and the enclaves with their surroundings. In some repects, it was difficult to say that they were strictly "Spanish". As it was shown before, the enclave was regularly used by Makzhan *harkas* in their way from Tangier to the central Rif

during the last quarter of the 19th century. A unit of "Shariffian Police" had been created there. The *campo* was a zone of transition where Riffians entered to sell their products in the market and buy other merchandise. The port of Melilla was increasingly used for seasonal migration of Riffians to French Algeria. It was in this city that the first military unit composed of Riffian soldiers (the *Compañía de Moros Tiradores del Rif*) had been created in 1859 (Arqués & Gibert 1992). *Qabilians* travelled to the *peñones* to supply them with foodstuffs and buy products. Besides, Spanish official institutions were almost absent. Melilla, and even more Chafarinas, Vélez and Alhucemas, were not proper "cities", as they lacked town councilsor other municipal services. While in Ceuta a Commandant Generalship existed since the last quarter of the 19th century, a Governorship was the only military command in Melilla, which also comprised Chafarinas and the *peñones*. As a consequence of this situation, a tendency persisted in Melilla to act apart from Spanish authorities in Tangier and Ceuta, which would prove difficult to suppress.

The interference of Algeciras smuggling regulations would not only be the cause of a division between Tettouan and Melilla, but also of a very complicated articulation of Spanish military action in the Rif. In some way, the problems were parallel to those created by the autonomy of Tangier in the Atlantic region. On the one hand, Spain had to spend some of its modest resources in reinforcing the Spanish character of Melilla and the other enclaves. A part of the human and material means invested by the army in those places was therefore directed to themselves and not to activities in Morocco. It could be said that the enclaves were being somewhat "re-occupied" even if they were formally Spanish possessions. On the other hand, if a new military administration was finally established by Spain in Moroccan territory, it would suffer interference from Melilla and the other enclaves. Their traditional military structures, which had dealt with the Makhzan and the Riffians until then, would persist, though they would now be separated from the zone of influence. Third, the traditional weight of Silwan in the region made that town a candidate for becoming the centre of the new military administration, but the cost would be a higher degree of local participation than Melilla was willing to accept. Finally, military activities could not be a pretext for initiatives towards civilians, as there had been no agreement on the issue in Algeciras.

*From Military Hospitals to Countryside Dispensaries (1906–1912).* All these events were reflected in military public health. If maritime health was the key for Spanish action in Morocco in the Atlantic region, its military counterpart would have the leading role in the Rif. However, the Algeciras regulations prevented major changes in the period 1906–1912. Substantial efforts were devoted, in the first place, to existing military hospitals in Melilla, the Chafarinas Islands and the peñones of Vélez and Alhucemas. For example, following the first military operations, the Ministry of War decided to raise the category of the hospital of Melilla (known as *Hospital Central*), which became "first class" in March 1908. It

was consequently given more personnel and equipment to be able to cope with the rising needs of new troops and foreseen operations. During the 1909 and 1911 campaigns, Melilla counted on two groups of military hospitals and several infirmaries, though most centres were provisional (army barracks, schools, theatres, churches). The Central Office of Military Public Health of the military Governorship of Melilla was transformed by an inspection inside the new Captain Generalship created the 1st of June, 1910. Evacuation of wounded and ill was done to the military hospitals of Chafarinas and Málaga. A deposit of medical material, a laboratory and a radiological cabinet were provisionally installed (Lapresa 1910). Despite all this, infrastructures and personnel were clearly insufficient for assisting a garrison where the numbers had risen to more than 20,000 men (Mesa et al. 2001).

The concentration of efforts on the military institutions of the Spanish enclaves left few resources for actions aimed at Riffians. Besides, they continued to be managed from the enclaves themselves to a great extent, even if the enclaves would probably be outside the future Spanish Morocco. Military hospitals in Melilla, Chafarinas and the *peñones* carried on with their task of "attraction" as they had been doing since the last quarter of the 19th century and even increased it. For example, Vélez and Alhucemas demanded more facilities and means in order to extend Spanish influence in the coastal *qabilas*. In 1910 or 1911, the military doctor appointed to Alhucemas, Manuel Bastos Ansart, argued in a report addressed to the Section of Military Public Health of the Ministry of War that the assistance of natives was in fact the main task of the hospital, as the garrison was very small. Thus, he asked for new clinical and surgical equipment, which was immediately sent from Spain (Bastos 1969). It seems that the new material was installed in a part of the military hospital, because a separate and permanent dispensary for natives was demanded in 1914. However, assistance could be provided for a growing number of Riffians.

A new health institution for Riffians was created in Melilla. Just after the Algeciras Act was signed, the Spanish Ministry of Public Works launched a plan to build a series of civilian infrastructures in Ceuta, Melilla and the Chafarinas Islands which would foster Spanish influence in its Moroccan zone. In Melilla, the trust of the Marquis of Comillas, one of the biggest Spanish capitalists, won the contract to build the port, as well as "a market with *fondak* [hostel] and cattle lodges, an store for grain and merchandise and an infirmary for natives" (Rodrigo 2002). Such an infirmary or hospital, the later-called *Hospital indígena*, began to be built in 1907 and was finished in 1909. Although it enjoyed civil status, its personnel consisted of military doctors and auxiliaries. It did not take long for it to be fully integrated in military public health. Its task was to assist Riffian soldiers, even though, during the campaigns, it served also as military infirmary for Spanish troops.

But the most important development in the enclaves was the creation of a Native Affairs administration of the army in Melilla. This was a consequence of the first direct operations of the Spanish army in Moroccan territory, launched in

January 1908. The justification of the military Governor General José Marina for these operations was the defeat of a *mhalla* sent by Sultan Moulay Abd el-Aziz against el-Roghi, which implied Morocco's inability of ensuring its compromise of direct control in the area. Spain would then assume the responsibility of preventing "gun smuggling" carried out by el-Roghi in Restinga (a site some 20 km from Melilla) and, in general, of ensuring the Sultan's authority in the Eastern Rif. A small fraction of Moroccan territory was occupied, where two military posts were established at Restinga and Cabo de Agua (in front of the Chafarinas Islands). The garrisons included a military doctor who, apart from assisting Spanish troops, started to offer his services to *qabilians*. As they lacked specific facilities and remained directly attached to Melilla's military health organisation, their task was a slightly more permanent version of previous (and scarce) travels of military hospitals doctors to assist local notables (Larra 1900).

The direct presence of Spanish troops outside Melilla altered the fragile balance of the area. El-Roghi tried to strengthen his position by expanding into the central Rif, but he was defeated. In December 1908, he was ousted from his headquarters in Silwan by the Guelaians and replaced by two new local leaders, Mohammed Amezzian and Chadly, his former lieutenant (Villalobos 2004). Following some incidents with Spanish workers in the mines of Ait Bu-Ifrur in the summer of 1909, the Spanish Army engaged in fighting against Amezzian and Chadly's *harkas* which resulted in the "Desastre del Barranco del Lobo" (July 27, 1909), where more than 150 Spanish officers and soldiers were killed and 900 wounded. More troops had to be sent from Spain (a fact that had already caused serious revolts in Barcelona and other cities in July), and, with their support, the 1909 campaign finally ended with the complete or partial occupation of the *qabilas* of Beni Sicar, Mazuza, Ait Bu Ifrur, Kebdana, Ulad-Settut and Ait Bu-Yahi. Later on, in 1911, new operations were initiated which resulted in the death of Amezzian. The Kert campaign ended in 1912 with the new boundaries for the occupied territory reaching the right bank of the River Kert and the inclusion of two more *qabilas*, Ait Sidel and Ait Bu-Gafar, under Spanish rule.

Just before the 1909 campaign, an Office for Native Affairs was created inside the military command of Melilla, with a subordinated information office in Cabo de Agua. The task of this office was to gather all kinds of information about the occupied territory and the nearby *qabilas* to ensure both control and future advances. It was the direct precedent of the so-called *Oficinas de intervención* or *Intervenciones militares* (the equivalent of the *Services de renseignement de l'Armée* in French Morocco). In close physical and administrative connection with these offices, the first units of the so-called *Policía indígena* (Native Police) were established just after the campaign in the *qabilas* of Guelaia and Kebdana. The Native Police consisted of Spanish officers and Riffian soldiers and combined the control of public order with the support to Spanish army units. Finally, Melilla authorities were "allowed to attach to the offices anyone who, as garrison doctors, may be necessary for the assistance of the Moors". This statement was the origin

of dispensaries for natives in the Eastern Rif area, which acted as the third element of the military Native Affairs administration set up in the Melilla region.

At the end of 1909, the first countryside dispensary was established in Zoco el-Had of the *qabila* of Beni Sicar under the direction of Lieutenant Dr. Sebastián Lazo García (1909–1914), later followed by Ángel Sánchez Sánchez (1914–1916), Alberto Conradí Rodríguez (1916–1918), Francisco Camacho Cánovas (1919–1920), Manuel Peris Torres (1921–1922) and Tomás de Fez Sánchez (1923–1924). It was still provisional by nature, a small wooden barrack with modest equipment, some drugs and ointments and no vaccines or sera. In July 1910, a part of the military infirmary built in the village of Nador (Mazuza) also started to serve as a provisional dispensary under the direction of Lieutenant Dr. José Valdés Lambea (1910–1915) and later of Nemesio Díaz Mena (1916–1918) and Octavio Gómez Salas (1919–1921). After these first steps, a project was drafted the same year for establishing four permanent dispensaries in Zoco el-Had, Nador, Atlaten (Ait Sidel) and Zoco el-Arbaa of Arkeman (Kebdana). A Royal Order of March 6, 1911 finally approved their creation and specific status, which was different in principle from military infirmaries and garrison service. Approval was also given some time later for another centre in Zoco el Tlatza of Ain Ben Rahal, close to Silwan (Ait Bu Ifrur). However, only those of Zoco el-Had and Nador were actually built before the Protectorate Treaty. In Atlaten and Zoco el-Arbaa, as in Restinga, Cabo de Agua and other posts, military doctors continued their work as before.

By then, dispensaries had become part of a more complex organisation of *intervención militar*, headed by the newly created Sub-inspection of Native Troops and Affairs of the Captain Generalship of Melilla (5th January, 1912), which already counted on several information offices, units of Native Police and groups of *Fuerzas Regulares Indígenas* (new colonial units created on the 30th June, 1911), as well as on the aforementioned dispensaries and doctors. It should be borne in mind that, despite the term "countryside", dispensaries were mainly directed to the assistance of Riffian soldiers of the two newly created corps (especially of the Native Police, because the groups of *Regulares* had their own attached doctors). Maybe for this reason they were assigned a different name in Spanish (*consultorios*) than the urban dispensaries of the Atlantic cities (*dispensarios*), a name already in use in Spanish military public health. In principle, Spain could not extend the service towards the local population because its action in the Rif had a purely military justification. However, dispensaries assisted civilians from the first moment, as the mission of "attraction" or "civilisation" was regarded as crucial. But it is also true that in the first years, many of them were the families and relatives of Riffian soldiers. This was not new for the Spanish army, given that in the *peninsula* the families and relatives of officers were assisted for free in military hospitals and had access to free drugs in military pharmacies (Martínez Antonio 2005a). If it is also considered that countryside dispensaries assisted Spanish soldiers, it is clear that the task of these centres, despite its importance, was too

huge to be achieved satisfactorily (Riffian soldiers + Riffian civilians + Spanish soldiers).

Apparently, the Native Affairs administration of the army had a colonial flavour similar to the famous "oil stain" strategy deployed by General Lyautey from the South Oranais (Hoisington 1995). However, it was not strictly colonial because it depended on the direct military expansion of the Spanish regular army. It is true that, due to Algeciras compromises, military actions in the Eastern Rif had to be justified in terms of "police operations" and "restoration" of the Sultan's authority. That is why the army presence had to be organised on the basis of military posts and systematic disarmament of the population could not be achieved. In principle, attacks were only launched in "response" to aggression and advances after a *qabila* had asked for "protection". Despite everything, the 1909 and Kert campaigns mobilised thousands of men and caused hundreds of casualties on both sides. Those campaigns were mainly carried out by the mobilisation of peninsular contingents, despite the creation of the first units of Native Police and *Regulares*. The Spanish army had crossed the limits of Melilla and established a permanent presence in some *qabilas*. In short, only through the direct use of military force, through the "seizure" or "expropriation" of Morocco's military sovereignty, could the first *intervenciones militares* be created. Collaboration of minor local leaders was then achieved through them, and Riffians began to be enrolled in the Native Police and *Regulares* or to participate in irregular *harkas* in support of Spanish units. In public health, the first dispensaries started their work, but they depended more on the Inspection of Military Public Health of the Captain Generalship than on the Sub-inspection of Native Troops and Affairs, which lacked a specific health section. Dispensary doctors lacked any specific status within the Army Medical Corps and they were often appointed to army units when necessary. Many of their patients were Spanish soldiers and, of course, the officers of *intervención*. The whole "colonial" system depended, then, on the Spanish regular army.

This was not exceptional. Spain was just following the example of France, whose advances from French Algeria progressed so quickly that they risked provoking the loss of the Eastern part of the Spanish zone of influence in Morocco. Since 1903, General Lyautey had relentlessly moved into Moroccan territory from the South Oranais. In 1907, the city of Oujda was occupied by French Algerian troops and, soon afterwards, the *qabila* of Beni Snassen was brought under control. The French had contacted el-Roghi for mining concessions and even sent a force against him which crossed the river Muluya but was defeated. In public health, Lyautey had begun to use military doctors to provide assistance to the colonial forces and local population, a crucial feature of his "oil stain" strategy. In 1910, the *Service de Santé des confines Algero-Marocaines* was created, which threatened to extend its influence to the left bank of the river Muluya (Cilleuls 1959). In practice, the South Oranais and Melilla were involved in similar problems and similar strategies and competed in the same area.

On the other hand, as it was said before, the Native Affairs administration of the army was directed from Melilla and was integrated in its military structures, though the enclave itself would probably remain outside the Spanish zone of influence. A new military centre in Moroccan territory would then suffer interference from Melilla and would also have to compete with Silwan, the traditional Makhzan military post in the area. Silwan enjoyed traditional legitimacy in Eastern Morocco and it is not strange that el-Roghi established his headquarters there. However, if Silwan became the Spanish military centre in the Rif, that would mean allowing more Riffian participation than Melilla was eager to accept. A first example of this was provided soon after Algeciras. In 1906, the *Sindicato Español de Minas del Rif* (SEMR) – a company where the Marquis of Comillas and another powerful businessman and politician, the Count of Romanones, participated – was given permission by el-Roghi to exploit iron ore in Uixan in the *qabila* of Ait Bu-Ifrur. A Spanish civil doctor, Víctor Ruiz Albéniz, was hired by the company to care for Moroccan and Spanish workers, but he was also unofficially charged by Melilla military authorities to act as an agent near the pretender. Ruiz Albéniz managed to become el-Roghi's "personal doctor" and, as such, he lived "under his protection" for ten months in Moroccan territory (Ruiz Albéniz 1922). It is not unlikely that he was also charged with the assistance of el-Roghi's *harka*, the most powerful in the area. As this irregular unit protected Spanish interests, it acted as a de facto colonial force in which Ruiz Albéniz could have worked as a kind of medical chief. However, the wish for more control of Melilla and the fear of international and Moroccan protests (el-Roghi lacked any official status) meant that Spain did not support el-Roghi's expedition to the *qabila* Ait Waryaghar in September 1908, which ended in an astounding defeat. Ruiz Albéniz complained that he had not been allowed to "go through Restinga and cure the [soldiers of el-Roghi] wounded gathered in the *alcazaba* [el Roghi's headquarters in *Silwan*]" (Ruiz Albéniz 1922). The retreat of el-Roghi from Guelaia put an end to this moves.

Spanish troops occupied Silwan in September 1909. A strong military garrison was established and a military infirmary was created. But there was no collaboration with Riffian leaders and, therefore, the new Spanish Silwan had no legitimacy among the local population. El-Roghi had been supported by Guelaians because he had assumed their interests. When Spain could not count on them, they were strong enough to oppose the Spanish army through the new leaders Amezzian and Chadly and through popular resistance. For complex reasons, namely the debility of Spain in regard to international agreements and its lack of control on Melilla, collaboration with Riffians was discarded, but "Riffian realities" refused to be denied and would cause serious problems in the following years. In this context, the town of Nador could only have little authority as embryonic centre of the newly occupied territories. The triangular relationship Tangier-Tettouan-Larache in the Atlantic zone had a close parallel in the Eastern Rif: Melilla-Nador-Silwan. Nador had previously had little or no importance in the Eastern Rif and in fact the town was almost made out of nothing, a kind of

colonial village if the presence of the army had not been so explicit. Trapped between the Native Affairs administration of Melilla and the regular army in Silwan and advanced posts, its theoretical role as regional centre during this period – and for many years – would be more virtual than real. In addition, Nador was theoretically dependant on Spanish authorities in the West, another fact which would deprive it of legitimacy when faced with Riffians and also with the Spanish army in the Melilla region.

To end this section, it should be added that this pseudo-colonial system also made possible the beginning of civil institutions. The first so-called *Juntas de Arbitrios* were created in the villages of Nador and Cabo de Agua in 1912. The *Juntas de Arbitrios* followed the model of the ones already existing in Melilla, Chafarinas and the *peñones*. They were a kind of municipal council of a lesser category than those of the peninsular municipalities and Ceuta, though they also depended on the Ministry of Interior (Cordero Torres 1943). As stated before, Melilla was not a proper "city" and therefore lacked a town council and a public health board, nothing strange in an enclave that had acted for centuries as a mere garrison-prison and lacked a significant number of civilians until after the Spanish-Moroccan War of 1859–1860. In fact, the *Junta* of Melilla was controlled by the army and presided over by a general, so it tended to confuse itself with the military administration. Its public health activities were extremely modest. A so-called sub-delegate of medicine worked at its service, but civilians were assisted either in the military *Hospital Central* or by private practitioners. If the *Junta* proposed any sanitary measures, it was the army which was usually most affected by them and which would put them to work.

The modest civil public health suffered problems parallel to those of the army. First, most of the scarce civil resources invested in the area aimed mostly at creating institutions in Melilla and the enclaves which had not existed previously. The main interest was to improve the situation of the Spaniards themselves, more than to act on behalf of the Riffians. Second, the *Junta* of Melilla kept on controlling measures towards civilians in the Rif, although the enclave would remain outside the Spanish zone of influence. For example, the *Hospital Central* continued to assist Riffians as it had done before. As early as 1910 two separate ten-bed wards for "*moros y moras*" (male and female Moors) were created. The hospital personnel included two Moroccan male nurses, who acted at the same time as interpreters, and a Moroccan cook, who prepared food according to medical instructions but adapted it "to the taste of natives". On the other hand, the creation of the new *Juntas* of Nador and Cabo de Agua made it difficult to establish *intervenciones civiles* (the equivalent of the *controleurs civiles* in French Morocco) in those villages. Their connection with Melilla hindered the central role of Nador in the area. As a result, their activities were mainly directed towards Spanish settlers. For example, in 1910, the director of the military infirmary of Nador asked Melilla if civilians could be assisted in that centre. He received a positive answer regarding Spaniards but nothing was said about Riffians. In 1911 the chief of the army health service of the "territory of Nador" informed Melilla authorities again

about the need for "regulating health assistance for [Spanish] civilians and moors" in the area. In his opinion, the village of Nador had to be provided with health services "in similar conditions as the *plazas menores* [Vélez and Alhucemas] and the rest of villages in Spain", because its population was rapidly expanding. The answer was that Spanish civilians could receive "first aid" in the military infirmary and be sent to the *Hospital Central* of Melilla in case of severe illness. Besides, a military doctor would visit patients at home, receiving for that work a supplement from the *fondo de arbitrios* (a precedent of the *Junta de arbitrios*). There were no regulations, however, concerning the Riffians.

The third problem was that public health action on civil Riffians should have relied on local leaders and institutions and allowed them a degree of participation. Again, el-Roghi could have been a crucial actor but collaboration was not possible in the end. As a result, private initiatives were launched in the area which, at the same time, aroused widespread rejection by Riffians, and menaced the development of a civil colonial public health centred in Nador. Those initiatives were represented by the CEMR. After the campaigns of 1909 and 1911, the company consolidated its mining activities in Uixán. Ruiz Albéniz had to care for the growing number of workers, many of them Riffians or Moroccans in general. The company had its own health care facilities, which were mainly intended for mild problems. In case of serious trauma or illness, patients were sent to Melilla. In addition, other complementary initiatives were taken. Dr. Ruiz Albéniz reported that in 1908 he promoted the creation of a "bread oven" which produced more than 500 kilograms of wheat bread a day, not only for workers but for "everyone who passed through Beni Bu Ifrur". He claimed that "in the whole *qabila*, the daily flapjack made of barley, nutritional basis of the native family, was abandoned" (Ruiz Albéniz 1922).

The conclusion of this section is that only under the "umbrella" of direct action of the Spanish regular army could a "colonial" military public health be sketched in the Eastern Rif during this period, of which countryside dispensaries were the most representative institutions. Local armed opposition made military public health the key of Spanish action in the area, much as maritime public health was in the Atlantic region. Then, the situation had not changed so much from former decades when Moroccan authority still prevailed. The direct use of military force in the name of the Sultan was the subterfuge to act on Moroccan territory but, at the same time, moved Spain away from a true "colonial" action which should have relied on local leaders and institutions to a greater extent. Besides, the connection with Spanish authorities in Western Morocco was problematic and, in fact, two different processes had started in each extreme of the Spanish zone of influence. The "Rif question" stood behind all this.

*The Modest Growth of the Network of Dispensaries (1913–1915).* The establishment of the Protectorate brought about some punctual changes that did not substantially alter the framework of Spanish action in the Rif. As stated before, in the provisional regulations of February and April 1913 the Delegate for Native

Services in Tettouan had been given responsibility for "hygiene and public health" affairs. The consuls in the cities would be his local representatives, except for the Melilla region, where the absence of diplomatic personnel made the Commandant General a *de facto* consul. On the other hand, a post of "Inspector of the Information and Native Affairs Offices" was also created inside the High Commission, which was supposed to centralise the work of the Sub-inspection of Native Troops and Affairs of Melilla and of the newly created Negotiates of Natives Affairs of Ceuta and Larache (transformed into Sections in 1913 and Sub-inspections in 1914). In principle, these measures would mean that the Delegate and the Inspector would co-ordinate existing countryside dispensaries in the Melilla region and those which were to be newly created throughout the zone in the following years. In practice, their power and resources were quite virtual and the connection with Tettouan remained very weak. In the Eastern Rif, existing dispensaries continued to be essentially directed from what was now called the Commandant Generalship of Melilla.

However weak it was, the connection helped Nador acquire some importance as the regional centre of public health in the Rif. The dispensaries of Nador and Zoco el-Had (but especially the former) increased their activity, which consisted mainly of small surgical interventions, smallpox vaccination, drug dispensing, the use of Elmerich ointment for scabies and 606 salvarsan injections for syphilis. There were also some beds for isolating patients with infectious diseases or for convalescence. The buildings were improved, auxiliaries were attached and houses for the doctors were built. During 1913, Zoco el-Had was already providing around 300 treatments per month, and Nador, almost 1,000. In addition, doctors often travelled to the nearby *duars* (small settlements scattered throughout the country) to assist patients and vaccinate people in an effort to extend "attraction". In November 1913 Dr. Valdés Lambea asked for and received laboratory equipment "to begin with the study of Riffian pathology" in Nador. This included a microscope, a centrifugator and a complete set of laboratory reactives, glassware and instruments. With the new equipment, he expected that

> the study of regional pathology could be based on solid grounds and the diagnosis will be more precise and scientific, the treatments and the task we have been assigned will be closer to the work a doctor can conduct from modern dispensaries (Valdés 1914).

In a way, Valdés was trying to act as head of Spanish military doctors in the area, though he was not officially acknowledged as such and lacked any administrative basis. Apart from obtaining the laboratory, he published a short Arabic-Riffian-Spanish vocabulary for doctors' use and, in 1914, the first annual report of his activities in the Nador dispensary. He also assumed the assistance of the Native Police unit called *Tabor de Alhucemas*, the former unit of "Shariffian Police" of Melilla which had been established in Nador. The other permanent dispensary, Zoco el-Had, was the second in importance, and its director, Dr. Lazo García, published his first annual report in 1913 in the Spanish medical journal *Los progresos de la clínica* with the title "La medicina militar española en el Rif", as

well as a leaflet published by the Military Hygiene Institute of Madrid (Lazo 1913). In the following years, Lazo and Valdés published a number of articles in other Spanish medical journals, such as the *Revista de Sanidad Militar*, *España médica* and *Revista Clínica de Madrid*. Their articles mainly consisted either of descriptions of rare clinical forms of diseases or of general information gathered about frequent diseases, without much scientific discussion or laboratory data.

In their annual reports, Valdés and Lazo gave preferential attention to the work oriented towards civil Riffians. However, the bulk of patients continued to be the soldiers of the Native Police and Regulares, their families and relatives. As Dr. Lazo acknowledged, his first group smallpox vaccination was made on the 120 soldiers of Zoco el Had's Native Police unit, "beginning, to be exemplary, with the Spanish officers" (Lazo 1913). In any case, the assistance of Riffian soldiers could be considered as the "military side" of the "civilising" role assigned to dispensaries in the newly established Protectorate, even if the Native Police and Regulares were not formally under the authority of the Khalifa. But it was more difficult to justify the use of dispensaries by the Spanish regular army. When reading the Army personal records of Valdés, Lazo and other dispensaries's doctors, it becomes clear how often they had to assist Spanish troops in the area and participate in military operations, with the subsequent neglect of their functions towards Riffians. Despite its persistence, this parallel work was seldom mentioned in their annual reports and caused problems. For example, the Ministry of State paid a supplement to doctors, constructed the buildings and provided a fixed amount for maintenance expenses (medical supplies). This compromise was confirmed after countryside dispensaries were labelled as "Makzhan dispensaries" in 1915, as were those in the cities. However, the ministry became reluctant to continue its support to countryside dispensaries as they served mainly military purposes. Besides, the ministry could not participate in the management of those centres or direct their activities because there were no consuls-interveners in the Rif, as there were in the Atlantic port cities. Finally, the ministry would have preferred giving preference to civil Riffians instead of Riffians soldiers.

Despite these problems, new dispensaries were established in the Eastern Rif in the period 1913–1916. In May 1914, the Commandant Generalship of Melilla proposed to the High Commissioner that the two permanent dispensaries which had been planned for Atlaten and Zoco el Arbaa of Arkeman in 1911 should be built instead in Monte Arruit (Ait Bu-Yahi) and Tauriat Hamed (Ait Sidel). The reason was that in those years the occupied territory had widened, and it was now more convenient for the dispensaries to be located on the borders with unoccupied *qabilas*. In the budget of the Ministry of State for 1914 and 1915, credits were assigned for the building of those two dispensaries, as well as for three other permanent centres in Zaio (Ulad Settut), Yazanen (Ait Bu-Gafar) and again in Zoco el-Arbaa of Arkeman (Kebdana). All those five dispensaries maintained, however, a provisional character as part of the military infirmaries installed in those posts or in nearby places. For example, the facilities in Yazanen consisted of a wooden barrack attached to the military infirmary located inside the perimeter of

the garrison camp. In Monte Arruit and Tauriat Hamed, assistance of Riffians was the responsibility of either the garrison doctors, or of doctors from the military infirmaries at Atlaten and Silwan. Silwan military doctors were also in charge of assistance in Zaio. In Yazanen, service was provided by the doctor of its own infirmary, first Octavio Palazón Yebra (1914–1915), later followed by Asterio de Pablo Gutiérrez (1916) and Luis Muruzábal Sagües (1917). The same happened in Zoco el-Arbaa, with Roberto Solans Labedán (1914), Mariano Graíño Noriega (1915–1916) and Domingo García Doctor (1917). A permanent installation of these five dispensaries had to wait until 1917–1918, and then some of them changed their location.

In the end, the extension of the network of countryside dispensaries continued to depend on the direct presence of the Army, a result of new operations, now not only launched in the Rif, but also in the regions of Tettouan and Larache. The difference from former years was their greater extent and scope. The rhetoric of "police operations" in the name of the Sultan and of "preventing smuggling" was set aside to a certain degree when the Protectorate was established, and Spain was able to act more freely in its zone. Thus, the years 1913–1916 saw an almost uninterrupted series of small moves aimed at the enlargement of the territory under Spanish control. However, the fact that military operations by 1916 had only resulted in the control of 600 $km^2$ in Melilla and in the presence of the Spanish Army in less than one fifth of the small Protectorate's territory shows the extent of Riffian and Jbalian armed opposition. In Melilla, General Gómez Jordana was in command during this period before leaving for the High Commission in Tettouan.

Jordana fostered the development of dispensaries for natives in collaboration with Tettouan but kept on relying on the army as the main basis of the system. Military public health in the enclaves continued to be improved. For example, a permanent laboratory was finally established in Melilla. Its origins went back to a provisional centre installed by the Military Hygiene Institute of Madrid during the "1909 campaign". When the combats was over, Melilla's authorities proposed that the material be kept in the enclave so that a proper laboratory could be established. Time passed until a provisional centre was attached to the first group of military hospitals in Melilla in 1911, during the "Kert campaign". Although analytical-bacteriological laboratories had been created in the eight peninsular Commandant Generalships after 1909, the Melilla laboratory had to wait until December 1913 to be organised on a permanent basis. Its first director was Major Dr. Antonio Redondo Flores (1911–1919?), later followed by Ángel Morales Fernández (1919–192?). Other personnel included a "chief of services", Captain Dr. Paulino F. Martos, five auxiliaries – instructed soldiers from the Military Health Corps Brigade of Melilla – and four assistants (Calatraveño 1916).

On the other hand, the enclaves continued to interfere on assistance of Riffians carried out from countryside dispensaries and on the central role of Nador in the area. In Melilla, the *Hospital Central* continued its task as well as the infirmary for natives, which, in Lazo's opinion, had been actually transformed into a real *Hospital militar indígena* for it provided assistance exclusively to Moroccan

soldiers of the Native Police and *Regulares* (Lazo 1913). However, the problem of who should pay for civilians' expenses began to appear, and military authorities and the *Junta de arbitrios* of Melilla often complained to the High Commissioner and the Ministry of State about the slow construction of civil centres. Through the Sub-inspection of Native Troops and Affairs and the new Sub-inspection of Military Public Health, Melilla kept its central role over Nador. In Vélez and Alhucemas, it seems probable that a specific locale for assisting Riffians was obtained from the government when the Protectorate was established. In Vélez, for example, a provisional barrack was set up in March 1914 on the lowest part of the rock "so that female Moors and children come in greater numbers without having to overcome their shame of going up to the garrison". In its first year of existence (March 1914 – February 1915) more than 800 patients were assisted, 23 of them requiring surgical intervention. Severe cases were sent to the military hospitals of Tettouan or Melilla. In general, the bulk of patients travelled to Vélez and Alhucemas from September to November, that is, the months when malaria was more intense. For example, 351 patients were treated in Vélez in September and October 1915 alone, 243 of whom were diagnosed with that disease. Serious malaria outbreaks were recorded in the area in 1914 and 1916. Among the military doctors working in Alhucemas in this period were Manuel Bastos Ansart (1911) and Antonio Muñoz (1915).

Finally, the army increased the number of military infirmaries and doctors in military posts, thus taking resources away from dispensaries and infirmaries for natives and overlapping with their role towards Riffians. In the Melilla region, there existed eight military infirmaries (Nador, Silwan, Cabo de Agua, Atlaten, Yazanen, Restinga, Zoco el Arbaa of Arkemam and Avanzamiento) and a good number of scattered military posts, in some cases with their own doctor. The direct presence of the army implied the complete lack of participation of Riffians and resulted in persisting opposition against Spanish doctors, even those of dispensaries. For example, the latter had to be systematically escorted by the Native Police when travelling to the *duars* due to the risk of being attacked by *qabilians*. Most patients continued to visit one or more traditional practitioners before going to the dispensary. Women seldom appeared, except for unmarried girls and older women. Doctors tried to combat this reluctance by publicizing success stories from clinical or surgical cases with spectacular symptoms, but good survival rates, in order to convince and "attract" people. For example, Valdés began to receive more frequent visits in Nador after he performed an amputation on a Riffian whose hand had been blown up by dynamite and after he removed a tumour from the back of another man (Valdés 1913).

The growth of military public health in the Melilla region, either direct or in the form of dispensaries for natives, allowed the increase of actions towards civil Riffians. The task of military hospitals in the enclaves has been already commented, as well as the "attraction" strategy of countryside dispensaries. Regarding the latter, the provisional regulations of 1913 had stated that the Delegate had to seek for the "confluence" of all dispensaries with the structures of the Sanitary

Council of Tangier. This allowed a certain participation of the Ministry of State in the area and a certain connection with Tettouan for the development of civil public health for Riffians. But results were modest. For example, the post of civil nurse was created in the Nador dispensary in 1914, due to the number of civilians assisted there. Antonio Burgos Berlanga was appointed to the post. The laboratory installed in Nador was partly financed by the Ministry of State given that its object was in principle the study of "Riffian pathology" in general, and, therefore, civilians could also benefit from their services.

In contrast, public health for civil Spaniards continued its development, fostered by the growing number of Spanish settlers in Melilla and towns such as Nador, Cabo de Agua, Monte Arruit and others. The *Junta de arbitrios* of Melilla substantially increased its budget and a new one was created in 1916 in the village of Zaio, which raised to three the total number existing in the Eastern Rif. But the connection with the Western urban *Juntas* under the central direction of the Delegation of Native Affairs was very weak and, in practice, they remained dependent on the *Junta de arbitrios* of Melilla. Their focus on Spaniards resulted in few or no initiatives towards Riffians and their Spanish character prevented their use by the Ministry of State or the High Commission as basis for civilian public health. To worsen things, the *Juntas* began using dispensaries for assistance of Spaniards, thus interfering with their task towards Riffians. For example, 308 of the 794 patients (39 per cent) assisted in Nador in a trimester of 1916 were Spanish settlers, while in Monte Arruit they comprised 60 of 137 (43 per cent). Finally, in advanced areas private companies continued to be important health care providers. In the iron mines of Ait Bu Ifrur, Dr. Ruiz Albéniz continued with his task until 1923, when he turned over the post to Dr. Lope García de Obeso. The number of miners working for the now called *Compañía Española de Minas del Rif* (CEMR) rose to some two thousand during this period. Many of the workers were Spaniards, but the rest came from all over the Rif and beyond. Local rejection to this initiative was probably even more intense than in the case of the dispensaries.

*The Paradoxical Definition of Nador as Regional Centre (1916–1918).* The Protectorate regulations of January 1916 confirmed the creation of the Health Inspection inside the Delegation of Native Affairs. In principle, this was a new step towards integration of countryside and urban dispensaries under a single technical organisation centralised in Tettouan. As it was said before, this measure was the result of a greater freedom of movement of Spain in Morocco due to World War I. Precisely, Spain had been able to increase diplomatic force against Morocco through the "denunciation" of the Sanitary Council of Tangier. Freedom of movement also allowed Spanish authorities to challenge Moroccan military sovereignty and have direct interaction with local leaders who lacked official or international status. But contacts could only be pacific and collaborative in this period because France pressured Spain not to undertake direct military operations while their own were prevented by the war.

The result was a modest reinforcement of Tettouan as military centre of Spanish Morocco, including public health. Although the Inspection of Troops and Native Affairs Offices of the High Commission ceased to exist in the new regulations, the newly created Sub-inspection of Native Affairs and Troops of Tettouan occupied its place in some way. Collaboration of General Gómez Jordana with the Jbalian leader Ahmed el-Raisuni led to the creation of dispensaries in Laucién (Beni Ider) and Ain Yir in September 1917, which served mainly to assist Spanish troops and Raisuni's *harka* in their joint operations against Anghera. The Sub-inspection of Tettouan was responsible for those dispensaries and was also in charge of assisting the first official Makhzan troops, the so-called *Mejalas Xerifianas or Mehalas Jalifianas* (created in 1913), though they were still reduced to little more than a personal guard of the Khalifa in Tettouan. Given that the chief of the Sub-inspection was the High Commissioner himself, it began to assume a central role in native affairs in some way.

Though essentially important, these changes were in the end more formal than effective for the Melilla region. In the first case, the reach of the Health Inspection was limited by the impossibility of appointing delegates in the Rif, due to the absence of civil hospitals, infirmaries or dispensaries in the area. In the second case, the Sub-inspection of Native Affairs and Troops of Melilla kept its position ahead of Tettouan. This weak connection with Tettouan implied that the role of Nador as a regional centre continued to be secondary. Collaboration with local leaders fostered by the new Commandant General of Melilla, General Aizpuru was far less relevant than in the Western zone and did not help Nador either. In fact, military operations were brought to a halt between 1916 and 1918, and no new countryside dispensaries could be created. The only change was that some of them were moved to more convenient places before the operations ended or just after. For example, it was proposed that the two dispensaries in Monte Arruit and Tauriat Hamed be re-located near the new borders with the non-occupied territory. In the end it was only the latter that was transferred, first to the post of Ras Tikermin (Mtalza) in May 1916 and afterwards to the post of Yarf el-Baax (Mtalza) at the end of that year or the beginning of 1917.

The annual report published in 1918 by Lieutenant Dr. Policarpo Carrasco about his work in the dispensary of Yarf el-Baax that appeared as a journal article in the *Revista de Sanidad Militar* provides an example of the work done in the countryside during this period (Carrasco 1918). In the last seven months of 1917, Dr. Carrasco assisted 1,152 patients, mainly from the *qabilas* of Guelaia, Mtalza and Ait Said. He prescribed sulphate and quinine chloride for malaria, Ehmerich ointment for scabies, opium derivates for pain, atropine for heart disorders or analgesics for headaches. He applied antiseptics to leg ulcers and recommended specific diets for different gastrointestinal disorders. He also conducted surgery on a native policeman to remove a bullet that was lodged in his abdomen. There was regular contact with the *Hospital indígena* and the Laboratory of Melilla. On the one hand, severe cases of illness, trauma and gun wounds were treated in Melilla after first being sent to the military infirmary in Kandussi. On the other hand,

Major Dr. Redondo Flores visited the area on several occasions to inspect the location and sanitary conditions of the military camps and proposed hygienic measures and works on the river beds to decrease the high incidence of malaria among the troops. Following his suggestions, Dr. Carrasco himself proceeded to treat wastewater dumps with petrol and ordered the periodic ventilation of tents.

Yet, traditional problems persisted. For example, the high price of quinine limited its systematic use, a treatment that mainly was used only "for the natives of the 10th unit of Native Police and for some civilian Moors". The most severe cases of trauma and wounds were in practice due to armed incidents (including bomb explosions) between *qabilians* and the native policemen. It is not strange that Carrasco made some remarks about the "great limitations" of his work and the influence of the "very peculiar characteristics of our relationships with the natives of non-submissive territory [namely, the *qabila* of Ait Said] on the number of patients assisted in the dispensary and on nearby military posts". The dispensary provided assistance, not only to Riffian soldiers of the Native Police and *Regulares* but also to a "considerable" number of Spanish troops, though statistics were not published because "this task is not a part of its official mission" (Carrasco 1918). In short, assistance to Riffian civilians must have been still quite reduced.

Traditional interventions also persisted in Nador. For example, the military laboratory of Melilla became more sophisticated. In 1916, it comprised six departments: 1) clinical analysis; 2) hygienic analysis; 3) bacteriology and parasitology; 4) normal and pathological histology; 5) sera and vaccines; and 6) general services. It acted as the depot for vaccines and sera sent by the Military Hygiene Institute of Madrid for Spanish troops and countryside dispensaries. Thus, it could proceed to deploy periodical vaccination campaigns against smallpox and typhoid fever, mainly on Spanish recruits. Other functions included the periodical inspection of military centres and camps and research on malarial *foci*, plague outbreaks and other diseases. Dr. Redondo expected that the laboratory would become an "Institute of Colonial Hygiene" in charge of the technical direction of the Protectorate's sanitary policy, from which the existing laboratories in Ceuta, Larache and Tangier would depend (Calatraveño 1916). However, the "great expectations" of Dr. Redondo were far from reality. The human and material resources of the laboratory were insufficient, and diseases such as malaria and syphilis remained extensive (Molero Mesa 2003). Competition between Melilla, Tangier and Larache resulted in a general lack of co-ordination. On the other hand, military hospitals of the enclaves continued their task of "attraction". In September 1916, the dispensaries of Vélez and Alhucemas received authorisation from Melilla to provide free medicines to "manifestly poor natives", as did countryside dispensaries. The number of patients assisted increased due to a new malaria outbreak in 1918. Finally, the network of military infirmaries and posts was not very much altered due to inactivity, except for the creation of a new infirmary in Kandussi.

However, a crucial process started which would become more important in the following years. If the higher definition of Tettouan as centre of Makhzan military

public health and of Nador as regional office was not relevant in absolute terms during this period, it began to be so in relative terms. The reason was paradoxical: the Ministries of War, State and Interior started to freeze their direct contribution to Spanish activities in Morocco. If Protectorate organisms were to enjoy more autonomy with the new regulation, then they would have to count only on their own financial, material and human resources without calling for direct support from those ministries. This meant, on the one hand, the impossibility of expanding the modest network of dispensaries and infirmaries for natives. By contrast, it meant also that they were assuming assistance to Riffians with less interference from Spanish institutions in Tangier and the Spanish enclaves.

In the case of the Ministy of War, the Military Public Health Section began to think if it should keep on providing free drugs for countryside dispensaries or if, on the contrary, they should be financed by the Ministry of State. Besides, the Military Hygiene Institute, which sent vaccines and sera to the laboratories in Melilla, Larache and Ceuta, complained about the burden it posed for the adequate operation of military laboratories in Spain. These questions were important because the army contribution for the assistance of Riffian soldiers and civilians must have been high in absolute and sometimes in relative terms. In 1915, for example, the health budget accounted for 4.3 per cent of the total budget of the Ministry of War destined for "Action in Morocco" (4.7 million out of a total of 108 million pesetas). In 1917 this percentage essentially remained at 4.2 per cent (4.2 million out of a total of 100 million pesetas). It has been impossible to know how much money was assigned exclusively for Riffians and how much for the Melilla region, because the budget for "Action in Morocco" was not detailed. But given that the army paid for wages of the dispensaries' doctors, for vaccines, drugs and equipment of those centres, for hospital care of Riffian soldiers and their families and relatives in Melilla, and for "attraction" from the enclaves, it seems clear that cuts in the budget should have been crucial. The army started to concentrate on Spanish troops and to abandon its traditional role of "attraction" from Spanish enclaves.

On the other hand, the Ministry of State kept its contribution to the *Sanidad Majzén* at a standstill. In fact, its financial support for the Melilla region decreased from 43,880 pesetas for seven dispensaries in 1915 to 31,950 pesetas for nine dispensaries in 1918–1921. The civil nurse in the dispensary of Nador had to leave his post in the summer of 1916 because the ministry stopped paying his wages. Finally, the *Junta de arbitrios* of Melilla asked for assistance to Riffians in the *Hospital Central* to be charged to the Protectorate's budget. The *Junta de arbitrios* reported that the expenses for hospitalisation in Melilla were equal to the whole budget of the *Sanidad Majzén* (about 68,000 pesetas) and were compromising measures directed towards the Spanish population. Both ministries focused more and more on Spaniards, either in the civil hospitals and infirmaries of the Western region, or in the activities of the *Juntas de arbitrios* in the Eastern Rif.

*Military Expansionism and the Authoritarianism of General Silvestre (1918–1921)*. The Protectorate health regulations issued in 1918 deepened previous developments. Those regulations organised the consultative branch of the Health Inspection through the creation of the Central Health Board and the Local Health Boards. This measure extended the theoretical reach of Tettouan towards countryside dispensaries in the Melilla region. Despite the lack of consuls-interveners in the area and of civil hospitals or infirmaries, it was the head officers of the units of Native Police who were supposed to act as general representatives of the Delegate of Native Affairs for public health affairs. However, the relative connection achieved between urban and rural, civilian and military dispensaries, the relative extension of the *Sanidad Majzén* to the Eastern Rif in this period, owed more to the growing authoritarianism of the High Commissioner. As has been said previously, the regulations of 1918 allowed the High Commissioner to personally control the appointment of many members of the consultative boards, depriving the Health Inspector and even the Delegate of Native Affairs of much of their power.

In addition, a number of military regulations issued between 1918 and 1921 gave the High Commissioner greater control of the Native Affairs administration of the army. For example, on December 11, 1918, the Commandant Generalship of Larache became subordinated to that of Ceuta-Tettouan. This affected all departments, including the Sub-inspection of Troops and Native Affairs. A second decree, issued January 25, 1919, appointed General Berenguer as chief inspector of the Army, not only in the Protectorate but also in Ceuta and Melilla, with the honours of "Crown Minister". Among his new personal powers, he became head of a new Direction of Offices and Centres of Information and Police. Everything concerning the "recruitment, organisation and posts" of the Native Affairs administration of the army was decided by him directly, although he could delegate his authority to the General Commandants (Cordero Torres 1943; Villanova 2004). In July 1920, a royal order of the Ministry of War confirmed that countryside dispensaries were dependant on the Sub-inspections of Native Troops and Affairs and not on the Military Public Health sections of the Commandant Generalships, thus supporting the control of the High Commissioner.

As a result of his personal concentration of civil and military power, General Berenguer began to manage public health affairs by himself or through his secretary. He was in direct touch with the Ministries of State and War for these issues, leaving no technical autonomy to the Health Inspector. In the Eastern Rif, he managed to appoint a Consul-Intervener for Nador in 1919, who established the first *Junta local de intervención* in the area. This fact resulted in some important civil public health projects being planned for Nador, which attempted to finally make this town the regional centre of *Sanidad Majzén* in the area associated with Tettouan. First, a "service for analysis of food and drink" was demanded in July 1919, because the existing laboratory in Melilla was limiting its service to the city. The Consul-Intervener argued that some peninsular food factories selling their products in the area had been affected by trichinosis or lacked proper

sanitary conditions, with subsequent danger for human health. In his opinion, it was a fact that "beverages elaborated with industrial alcohols and oils (so much employed by the *qabilas*) made not only from olives, and drinks sweetened with saccharine" were being widely sold in the area. Thus, it was necessary to establish this service to control the hygienic quality of products. In fact, the consul proposed that a service to control the *cantinas* in the "European villages" be created under direction of the new *Junta comarcal* of Nador (former *Junta de arbitrios*) and another one for "native consumers and cantinas established outside the perimeter of military camps, which sell articles to the non-military public", under the direction of the Consulate-Intervention.

Second, the High Commissioner proposed to the Ministry of State the creation of a mixed infirmary in Nador in the spring of 1921, so that clinical and surgical care could be provided for all Eastern Rif patients. General Fernández Silvestre offered installation of a barrack of 45 x 10 m. in the town, but the proposal was rejected due to poor hygienic conditions. The Delegation of Public Works of the High Commission was charged with planning a project that would meet all the technical requirements and that would be financed by the civil construction section of the Protectorate budget. Its status would be the same as that of the mixed infirmaries built in Asilah and Ksar el-Kebir, and to the one being planned simultaneously for Chefchauen. Third, after February 1921, the Military Hygiene Institute of Madrid refused to send more sera and vaccines to the laboratory of Melilla for use in the countryside dispensaries. This fact moved the Commandant General Fernández Silvestre to request that the High Commissioner created a "depot of sera and vaccines" in the Eastern Rif, so that these products could be supplied to all countryside dispensaries in the area and vaccination campaigns could be launched. The High Commissioner agreed with the proposal and contacted the Ministry of State to decide where it should be located, though, in his opinion, "it seems natural that it was the dispensary of Nador, whose town is regarded as capital or head of that region".

In the end, none of these projects materialised before the Rif War. If they had succeeded, Nador would have been able to effectively lead and co-ordinate the network of countryside dispensaries in the area. But this network expanded, nonetheless, with the creation of two more centres in 1918–1921. One of them was located in Kaddur (Ait Sidel), whose director was Francisco Irañeta y Urriza (1919–1920) and later Severiano Bustamante y Fernández de Luco (1921). The other was located in Reyén/Hassi Berkan (Ait Bu Yahi), directed by Roberto Solans Labedán (1918–1919), Manuel Peris Torres (1920) and Elías Nager Martínez (1921). Besides, the five provisional dispensaries previously existing in the area were made permanent. In Monte Arruit, the directors were Benito Roldán Sevilla (1918–1919) and José Espina Rull (1920–1921); in Zaio, Francisco Rodríguez González (1918), Elías Nager Martínez (1919–1920) and Eugenio Martín Alonso (1921); in Zoco el-Arbaa of Arkeman, Domingo García Doctor (1918–1920) and Ramón Jiménez Muñoz (1921); in Sammar (previously, Yazanen), Luis Muruzábal Sagüés (1918), José Malva López (1919–1920) and

Damián Navarro García (1921–1922); and in Ras Tikermin/Yarf el-Baax, Policarpo Carrasco (1918), Juan García y Gutiérrez (1919–1920) and José Ventosa y Pasoda (1921). The last statistics collected of countryside dispensaries were those of 1919. In the first trimester of that year, Kaddur had made 334 treatments, Sammar, 294, Hassi Berkan, 360, Zoco el-Arbaa, 453 and Monte Arruit, 488.

Apart from the authoritarianism of the High Commissioner, the higher definition of the *Sanidad Majzén* in the Eastern Rif with Nador as its centre was favoured by less interference from Melilla and the other enclaves, whose task of "attraction" was substantially reduced. For example, the *Junta de arbitrios* of Melilla and military authorities refused to pay for assistance of Riffians on the *Hospital Central* and focused its resources on the growing Spanish population and the permanent garrisons. In the case of Vélez and Alhucemas, "attraction" had never achieved great success. For example, in Vélez, less than 1,000 patients were assisted in 1915, an insignificant number given that the central Rif and Ghomara, despite the lack of urban centres, were densely populated areas within which almost half of the population of Spanish Morocco was concentrated. It was not surprise, because Native Police and *Regulares* were always the main original impulse for dispensaries, but physical separation from the coast prevented their creation in the *peñones*. In fact, neither doctors, nor officers were ever allowed to travel or visit the *qabilas*. In contrast, dispensaries increased their work towards Spanish settlers, even if their number was inevitably small. In both enclaves, there existed *Juntas de arbitrios* which benefited from dispensaries intended in principle for Riffians. Finally, from 1918 on, periodical in-communication reduced even more their work of "attraction". A severe outbreak of malaria in the central Rif in September 1918 was not followed by an increase of the work of dispensaries as in the outbreaks of 1914 and 1916. Instead, it was decided to forbid the travel of patients to the dispensaries on the grounds of the "sanitary menace" they posed for the Spaniards. "In-communication" became a way of pressuring the Riffians, especially when hunger struck the area in 1919–1921, but it also revealed the tendency of both enclaves to concentrate on their own interests.

Direct interference from the ministries of State and War was also reduced, even if this had as many positive aspects as negative ones. The first ministry distrusted the experiences of past years, when its contribution to dispensaries had been distorted by the preferential assistance provided to Riffian and Spanish soldiers. When General Berenguer asked State to request laboratory products from the Alfonso XIII Hygiene Institute of Madrid for the future depot of Nador, the ministry declined the proposal on the grounds that expenses in Melilla and its region should be assumed by the Ministry of War or by the Ministry of Interior. The creation of the mixed infirmary and the laboratory of analysis were not supported on similar grounds, though another factor was also the general reduction of the Ministry's expenses in Morocco and its subsequent concentration on its particular "Spanish" interests.

On the other hand, the Ministry of War focused more and more in the interests of the regular army. The defeat of Germany in World War I resulted in Spain

being able to re-start more intense operations in its zone without the risk of being disturbed so much by complaints of Moroccan authorities or other foreign countries. The period 1918–1921 saw the extension of controlled territory as it more than doubled, reaching a peak of about 50 per cent of the total of Spanish Morocco. In Melilla, the campaign gained momentum under command of General Fernández Silvestre, who in less than one year (May 1920–March 1921) doubled the territory under Spanish control. The area rose to some 4,000 $km^2$ and included new *qabilas* such as Mtalza, Ait Said, Ait Ulishek, Tafersit and fractions of Ait Tuzin and Temsamam. The rapid advance of the Army required more resources, but the Spanish government sought to put a stop to the astronomical military budget (more than 40 per cent of total state expenses) and to the use of Spanish troops abroad (in consonance with European developments after WWI). Thus, the Ministry of War reduced its contributions to Protectorate public health, suppressed its activities in Tangier, French Morocco and Cape Juby and proceeded to a general re-organisation of the Army health service in Spanish Morocco which took place in 1920–1921. In the first case, the supply of drugs, vaccines and sera or medical equipment to countryside dispensaries was reduced, especially to Nador, which was increasing its civil activities by the decision of Tettouan.

In short, a unified, centralised public health system was about to extend itself to both extremes of Spanish Morocco after fifteen years of efforts. The authoritarianism of the High Commission and the decreasing direct role of the Ministries of War and State resulted in more administrative, institutional or political autonomy for the *Sanidad Majzén* and in a relative degree of connection between the Atlantic region and the Eastern Rif. This was achieved at the cost of less technical autonomy for the Health Inspector when facing the High Commissioner and doctors when facing consuls-interveners and military chiefs. However, the Protectorate health system seemed to be reaching its limits, even if half of Spanish Morocco was still outside its control. The *Sanidad Majzén* suffered from severe deficiencies in the Eastern Rif which provoked discontent in *qabilians*, either civilians or soldiers.

For example, in the "pacified" zone dispensaries which were at last in a position of increasing their action towards civil Riffians, had to act in unfavourable conditions. On the one hand, they could count on less money from the Ministry of State and less material from the Ministry of War. The possibility of suppressing some centres and the replacement of military doctors by civilians were even considered, given that the army needed more personnel on the vanguard. On the other hand, more effort was required to "attract" civilians to the dispensary than had been necessary for native troops. For example, dispensary doctors were given horses to be able to visit the *duars* and assist *qabilians* at home, probably because "spontaneous" visits were not so frequent. Finally, Spanish settlers began to use the dispensaries. The *Juntas* of towns outside Melilla had developed, especially the one in Nador, which became a *Junta comarcal* (county board). Doctors were hired to assist the Spanish poor and civil cemeteries were built in some of them. However, they lacked health facilities and therefore, in towns such as Nador and Monte

Arruit, a growing number of Spaniards was assisted in the dispensaries for natives, with the subsequent harm for the Riffians' interests. Finally, the delay of the projects of laboratory, infirmary and vaccine depot in Nador contributed to the discrediting of the Tettouan initiatives, which had never been viewed with enthusiasm in the Rif.

Assistance to Riffian soldiers also worsened. The growing number of Native Police units (those which had been newly created and those which had been moved to the front) and the two groups of *Regulares* were widely used for the new operations because the government had reduced the Spanish regular forces by one third. Native troops not only suffered from higher casualties in operations, but they were also badly assisted because of the lack of specific health facilities in the newly occupied territories. A project for creating dispensaries for natives in Dar Drius, Sidi Hossain, Zoco el-Telata and the *qabila* of Temsamam was considered in 1920 which could have helped solve this problem while starting the "attraction" policy in those *qabilas*. However, the project was finally postponed due to the lack of resources and personnel. The doctors in the dispensaries had been given horses for following Native Police units in their operations, but their multiple tasks made this measure clearly insufficient. Given the situation, Riffian soldiers could not be very content with Tettouan's decisions. In sum, the absolute number of Riffian civilians and soldiers receiving health care in the Eastern Rif had increased in the period 1918–1921 but, in relation to the total territory and population now under Spanish control, the percentage had decreased and, besides, the services provided became more precarious. This fact surely contributed to the increasing discontent in the occupied *qabilas* with a Protectorate system whose deployment was becoming so problematic.

In this situation, the impulse for consolidation of the *Sanidad Majzén* depended on new military advances which finally reached the central Rif, the ultimate objective of the Spanish army in Melilla for almost fifteen years. The modest success of Nador and of the network of countryside dispensaries in the Eastern Rif had been a result of military operations of the regular army. Only the new and rapid advances of 1918–1921 and the displacement of the bulk of the army and native forces deeper into Riffian territory had allowed the creation of a "pacified" zone around Melilla, leaving enough space for the *Sanidad Majzén* to appear. However, the cut of expenses prevented a real growth of the army health service and caused, instead, a redistribution of centres and personnel towards the front line. The military infirmaries of Restinga, Zoco el-Arbaa, Atlaten, Yazanen and Monte Arruit were suppressed while new ones were created in Kaddur and Dar Drius, plus two hospitals in Dar Drius and one in Annual. The infirmaries of Kandussi, Silwan and Cabo de Agua were kept. Dar Drius had become the new advanced centre of the army health service in the Rif instead of Silwan.

Concentration of forces and resources on the front was an attempt to achieve the decisive goal but showed the difficulties of Spain and the extent of local opposition. It was more difficult than ever to speak of a "police operation" as preparatives ressembled those for war. It seemed clear that the central Rif would have to

be conquered and defeated, even if that would imply a complete move away from Protectorate obligations, even from the usual procedures of the Melilla region. Important *harkas* of significant size begun to be organised by initiative of the Ait Waryaghar and some attacks were launched against Vélez and Alhucemas. For example, during the malaria outbreak in 1918, Spanish authorities in Vélez informed Melilla that

> On the occasion of the closure of this enclave due to the epidemic, a great effervescence dominates the nearby *campo*, to the point of menace of fire if they [qabilians] are not allowed to travel to the enclave. I have been told by some chiefs with whom I have got in touch that the most intransigent are the Beni Urriaguel, which are trying to gather *qabilas* to attack the enclave. [...] if the way is not left open for them, they will make war. I have received a proposal from the *qabilas* of Bocoya, Beni Iteft and Beni-Bu-Frah that if they are allowed to pass, they would stand guard to prevent the Beni Ammart from coming, as they are the only ones affected by the epidemic [...].

While waiting for combat, the Spanish profited from hunger in the Rif to obtain submission from local chiefs, even if this meant clearly abandoning its mission of "protection" (Madariaga 1999). In fact, the rapid advances of General Silvestre were based on this strategy, which suited well with the lack of means of the Spanish army. On the other hand, the supposed mineral riches of the central Rif moved some Spanish capitalists to try and obtain direct concessions for exploitation from the Riffians instead of through the French Sultan and the Spanish Khalifa. In this way, benefits would be higher and the subsequent monopoly would not be endangered by foreign intervention or Protectorate regulation. While Spanish military officers or even the dispensary doctors were not allowed to enter into the central Rif, a representative of a Spanish mining company, Antonio Got, travelled periodically to Ait Waryaghar in 1921 and contacted Riffian representatives to negotiate permission for exploitation (Ruiz Albéniz 1922). Mining activities would probably be accompanied by private health initiatives such as those displayed by the CEMR.

In short, brutalisation and abuses of different sorts were progressively seen as the only effective means of extending Spanish control into the heart of the Rif. If the increasing use of force had been essential for the development of public health in the Eastern *qabilas*, the only way of overcoming resistance in the central Rif was a greater degree of force. No room would be available for participation of central Riffians, less that there was once for el-Roghi and Guelaians. That was the authoritarian move made by General Silvestre, a personal detour that moved Spanish action in Eastern Morocco further away from the theoretical protectorate it had agreed to. It should be said, however, that this move was not exclusive of Melilla aurhorities because General Berenguer had been engaged in open war with el-Raisuni in Jbala since 1918. The difference was that the lack of means in Melilla and the embryonic situation of Protectorate structures in the area made brutal and abusive measures more clear.

Yet, these procedures were characteristic of Spanish Morocco as a whole, even if it was the decisions of General Silvestre that finally failed and the opposition of the central Rif under the leadership of Abd el-Krim that finally succeeded. Here, the expulsion of the Spaniards and the rejection of the Sultan were progressively seen as the only solution for ensuring respect for identity and autonomy of action. The only way for central Riffians to create a health system was to establish it themselves. This required a concentrarion of power over traditional social structures in the area in order to oblige people to fight as well as a complete rejection of "colonial" or "protectorate" collaboration with Spaniards and even of Moroccan sovereignty. That was the authoritarian move made by Abd el-Krim, and his success in 1921 was the final proof that "Riffian realities" could not be denied.

## Conclusion
## The Limits of Colonial Public Health in Spanish Morocco

After the events of Annual in July 1921 and the fall of the whole structure of Spanish action in the Melilla region, the Riffians and Ghomarians under the command of Abd el-Krim prolonged their triumphal march until they controlled about 80 per cent of Spanish Morocco by mid-1925 and a part of the French Protectorate in the vicinity of Taza and Fez. The "Republic of the Rif" was proclaimed and a Riffian government was established which carried out a series of administrative, religious, military and economic reforms to ensure its independence and the success of operations against the Spanish and French armies. Public health was included among these reforms. Medical material was obtained from the defeated Spanish Army, including a fully-equipped military hospital in Chefchauen, hastily abandoned as the army withdrew from the city in 1925. A number of Moroccan doctors as well as some foreigners, such as Dr. Walter Hutyens, worked for the Riffians, especially providing health care for the troops. As part of a campaign for international recognition, Abd el-Krim asked the International Committee of the Red Cross for medical aid and sought help from Muslim charities and civil associations in Great Britain and other parts of the world. He also attempted to be admitted to the League of Nations. His final defeat in March 1926 by the combined effort of France and Spain and the end of the Rif War in the following year put an end to the brief trajectory of an independent and modest "Riffian public health".

The end of the Rif War was paralleled by the signing of an agreement among the European powers about Tangier. A regulation was approved which gave the city and its surroundings the status of an "International Zone", to be governed by a complicated set of institutions in which French, British and Spanish representatives played different roles. The separation of Tangier from the French and Spanish Protectorates was finally confirmed. In public health matters, the most important consequence was the end of the Sanitary Council of Tangier, which was replaced by a Commission of Hygiene and Public Works whose actions were restricted to the international zone. Interference in sanitary questions from Tangier

was then reduced to a minimum, though probably not completely stopped. France and Spain could finally organise health services on their own in their respective Protectorates, although they kept their presence in the city on the Strait through different clinical and research institutions. The agreement concerning Tangier also brought about a better separation of both Protectorates which led to a reduction of, if not an end to, French public health activities in Spanish Morocco and vice-versa.

Perhaps the victory over Riffians and the agreement concerning Tangier did not put an end to Moroccan and Riffian initiatives against foreign domination, but that is another story. However, both events marked the end of a phase in Morocco's history, including the history of its public health. The present article has tried to clarify some important issues regarding this historical phase, first in Morocco as a whole during the 19th century, later in the Spanish zone of influence between 1906 and 1921. Perhaps the most important and general conclusion is that, contrary to what has been usually stated, Moroccan authorities worried about public health and had the ability to actively influence its development to a significant extent. The general mechanisms of authoritarianism and diversification and the primacy of the maritime and military branches of the health system reflected Moroccan agency and placed the country's public health in an intermediate position between that of a "typical" European country and that of a "typical" colony. As a result of those efforts, public health structures continued to influence the Spanish and French zones of influence after Algeciras and the protectorate treaties.

In this sense, the current analysis has allowed a definition of the Moroccan case on its own "intermediate" or "transitional" terms without relying, on the one hand, on colonialist schemes or on nationalist premises. The colonialist view has tended to deprive Morocco of much of its historical agency by magnifying European domination either to confirm or to deny its effects. Post-colonialist accounts often fail to grasp Moroccan initiatives because these were stronger, more autonomous and more organised than a mere resistance to or a distortion of European decisions. The lack of post-colonial studies for Morocco and for the Maghreb at large is probably not only a result of their academic "marginality", as Edmund Burke III puts it (Burke III 2000), but of the inadequacy of those schemes for the Moroccan case (although the author has criticised colonialism and nationalism as "essentialising narratives" that should be abandoned). Regarding nationalism, it has exaggerated the degree of autonomy and cohesion of Morocco over the influence of European countries reagarding traditional Arabic institutions or the specificities of certain regions and communities (Riffians, Berbers of the Atlas, Saharaouis, black population, Jewish communities). On this basis, the present analysis could also be useful for a better understanding of the history of public health in the Mediterranean countries in general, which were generally affected by processes of foreign influence and internal fragmentation. The Mediterranean of the 19th and first half of the 20th centuries would be better conceived as a zone where differences in public health between the North and the South, the East and the West,

the European and the Arab-Islamic countries, were more matter of degree than of kind.

Of course, differences existed and Moroccan agency was insufficient to finally ensure its "sanitary independence". However, it was the relative development achieved by Morocco's health system after the 19th century which explains why France and especially Spain had serious difficulties in establishing a new health system in their zones of influence. For Spain, these difficulties were paradigmatically expressed in the "questions" of Tangier and the Rif, which led to a never-ending series of incidents essentially reflecting its impotence to proceed within the framework of the legal regulations of Algeciras and the Treaty of the Protectorate. "Tangerian ghosts" and "Riffian realities" became a nightmare for Spanish action in Morocco well after 1912.

In the end, the health system in Spanish Morocco in the period 1906–1921 failed to be established on Protectorate/colonial grounds, despite its formal appearance. A protectorate public health seemed to exist through the creation of a General Health Inspection into the Delegation of Native Affairs of the High Commission and its consultative branch composed of a Central Health Board and Local Health Boards in which Moroccan authorities were represented. The so-called *Sanidad Majzén* comprised port services, urban and countryside dispensaries, mixed infirmaries and infirmaries for natives, all exclusively financed by the Protectorate's budget from 1918 on. Moroccan auxiliary personnel were employed in different institutions. This system managed to reach the Melilla region where, for many years, public health was essentially framed within a specific Native Affairs Administration of the army with a kind of colonial "flavour". Here, Moroccans enrolled as soldiers of the Native Police and *Regulares* were assisted in countryside dispensaries, as well as their families and relatives.

However, appearances were deceiving. The higher responsibility for public health was not merely an intervention imposed by Spanish authorities but was directly assumed by the Delegate of Native Affairs and the High Commissioner from 1918 on to avoid constant interference from Tangier and from the dangers of French expansionism. This was an act of diplomatic force that had started with the strategy of the local boards and was accelerated by the German defeat in World War I. So the *Sanidad Majzén* was not based on "protection" but on "seizure". On the other hand, the increase of military operations in the Protectorate from 1918 on led to mounting confrontation with local opposition in what seemed more a war than colonisation. Both tendencies were confirmed after 1921 with the almost simultaneous closure of the Tangier and Rif questions. The Tangier Statute was then negotiated directly by Great Britain, France, Spain and Italy without the participation of the Sultan of Morocco or its delegate. The Rif War became a "European style" campaign (Gershovich 2000) with tens of thousands of deaths on each side, with the first aero-naval joint operations in history and merciless gas-bombings. Despite Gustavo Pittaluga's and Francisco Ruiz Morote's opinions, dispensaries for natives had not succeeded in their tasks of "civilisation"

and "pacification", but rather could only be established throughout Spanish Morocco as a result of harsh combat and diplomatic force.

Therefore, the degree of diplomatic and military force used against Morocco and the Rif makes the terms "protectorate" and "colony" inadequate. The Spanish zone was rather an occupied or conquered area, with an authoritarian administration. Conversely, the tremendous effort required to finally achieve "pacification" had serious consequences for Spain, namely the establishment of the dictatorship of General Miguel Primo de Rivera (1923–1930), which had important effects in the field of public health. This impact at home is just another proof of why Spanish action in Morocco can hardly be defined as "colonisation".

## References


Amster E.J. (2003) *Medicine and sainthood: Islamic science, French colonialism and the politics of healing in Morocco, 1877–1935*. Ann Arbor, MI: UMI Dissertation Services.

Amster E.J. (2004) "The many deaths of Dr. Emile Mauchamp: Medicine, Technology and Popular Politics in pre-Protectorate Morocco, 1877–1912" *International Journal of Middle East Studies,* 36:409–428.

Arqués E. & Gibert N. (1992) *Los Mogataces. Los primeros soldados moros de España en África*. Málaga-Ceuta: (Ed.) Algazara – Instituto de Estudios Ceutíes. Reedición.

Bastos Ansart M. (1969) *De las guerras coloniales a la guerra civil. Memorias de un cirujano*. Barcelona: Espasa-Calpe.

Burke III E. (2000) "Theorizing the Histories of Colonialism and Nationalism in the Arab Maghrib" In: Ahmida A. (ed.) *Beyond Colonialism and Nationalism in the Maghrib: History, Culture and Politics*. Pp. 17–34. New York: Palgrave.

Calatraveño Dr. (1916) "El laboratorio de análisis de Sanidad militar de Melilla" *Hygia,* [s.n.]: 69–75.

Carrasco P. (1918) "Labor realizada en el consultorio indígena de Yarf-el-Bas durante el año 1917" *Revista de Sanidad militar,* 8:393–398, 456–462, 489–499, 519–523.

Castejon Bolea R. (2001) *Moral sexual y enfermedad: La medicina española frente al peligro antivenéreo (1868–1936)*. Granada: Universidad de Granada-Instituto Alicantino de Cultura "Juan Gil-Albert".

Cilleuls J. des (1959) "La participation des Médecins des groupes sanitaires mobiles a l'Assistance Médicale Indigène et à la conquête du Maroc" *Histoire Médicale,* 9:5–39.

Cordero Torres J.M. (1943) *Organización del Protectorado español en Marruecos*. 2 vols., Madrid: Editora Nacional.

Delgado E. (1930) *La sanidad en Marruecos. Información somera de cuanto ha hecho España en materia sanitaria*. Ceuta: Alta Comisaría de España en Marruecos.

El Bezzaz M.A. (1982–83) "La chronique scandaleuse du pelerinage marocain a la La Mecque au XIXème siecle" *Hesperis-Tamuda,* 20–21:319–331.

El Bezzaz M.A. (1984) "Les debuts de la reglementation sanitaire du pelerinage marocain a La Mecque (1831–1866)" *Hesperis-Tamuda,* 22:67–77.

El Bezzaz M.A. (1985) "La peste de 1798–1800 au Maroc" *Hesperis-Tamuda,* 23:57–81.

Gallagher N.E. (1983) *Medicine and Power in Tunisia, 1780–1900*. Cambridge: Cambridge University Press.

Gershovich M. (2000) *French Military Rule in Morocco. Colonialism and its Consequences*. London-Portland: Frank Cass.

Hart D.M. (1976) *The Aith Waryaghar of the Moroccan Rif: An Ethnography and History*. Tucson: University of Arizona Press.

Hoisington Jr W. (1995) *Lyautey and the French Protectorate in Morocco*. New York: St. Martin's Press.

Ishanoglu U.E. (1992) "Ottomans and European Science" In: Petitjean P., Jami C. & Moulin A.M. (eds.) *Science and Empires*. Dordrecht-Boston-London: Kluwer Academic Publishing.

Justel Calabozo B. (1991) *El Médico Coll en la corte del sultán de Marruecos: año 1800*. Cádiz: Servicio de Publicaciones de la Universidad de Cádiz/Instituto de Cooperación con el Mundo Árabe.

Lapresa J. (1910) "Apuntes históricos de la campaña sanitaria de Melilla en el año de 1909" Unpublished manuscript.

Laredo I. (1994) *Memorias de un viejo tangerino*. S.l.: La Porte [Facsímil. Madrid: C. Bermejo, 1935].

Laroui A. (1993) *Esquisses historiques sur le Maroc d'aujourdui*. S.l.: Centre Culturel Arabe.

Larra Cerezo Á. de (1900) *Les Services sanitaires d'Espagne en Afrique*. Madrid: Imprimerie du Depot de la Guerre.

Lazo García S. (1913) "La medicina militar española en el Rif" *Los Progresos de la Clínica,* 1:193–248.

Lewis B. (1984) *Comment l'Islam a découvert l'Europe*. Paris: Gallimard.

Lourido Díaz R. (1996) "Las instituciones médico-sanitarias creadas por iniciativa del P. Lerchundi" *Archivo Iberoamericano,* 56:223–224.

Madariaga M.R. de (1999) *España y el Rif. Crónica de una historia casi olvidada*. Melilla: UNED.

Marco C. (1913) *La Comisión de Higiene y de Limpieza de Tánger. Historia de sus poderes, sus reglamentos, sus concesiones y otros datos de interés local*. Tánger: Imprenta de "El Porvenir".

Martín Corrales E. (2002) "El nacionalismo catalán y la expansión colonial española en Marruecos: De la guerra de África a la entrada en vigor del Protectorado (1860–1912)" In: Martín Corrales E. (ed.) *Marruecos y el colonialismo español (1859–1912). De la guerra de África a la "penetración pacífica"*. Pp. 167–215. Barcelona: Bellaterra.

Martínez Antonio F.J. (2005a) *El proceso de sanitarización en los Imperios español y marroquí durante las décadas centrales del siglo XIX*. Doctoral thesis. Barcelona: Universitat Autónoma de Barcelona.

Martínez Antonio F.J. (2005b) "La sanidad en Marruecos a mediados del siglo XIX" *Medicina e Historia,* 4ª época, Nº 2.

Martínez Antonio F.J. (2005c) "Higienismo, regeneracionismo, africanismo. El doctor Felipe Ovilo Canales y la Escuela de Medicina y el Dispensario de Tánger (1886–1899)" *Revista digital del FIMAM*. [www.fimam.org]

Martínez Antonio F.J., Jiménez Lucena I. & Molero Mesa J. (2003) "La política sanitaria del protectorado de España en Marruecos: El Informe Delgado (1927)" In: AA.VV. *Actes de la VII Trobada d'Historia de la Ciència i de la Tècnica (Barcelona, 14–17 novembre 2002*. Pp. 661-670. Barcelona: Societat Catalana d'Història de la Ciència i de la Tècnica,

Mesa J.L. et al. (2001) *Las campañas de Marruecos, 1909–1927*. Madrid, Almena.

Mizrahi J.-D. (2003) "Politique sanitaire et impérialisme à l'heure de la révolution pastorienne: le Conseil Sanitaire de Constantinople (1838–1923)" In: Kançal S., Mizrahi J.-D. & Saul S. (eds.) *Méditerranée, Moyen-Orient: deux siècles de relations internationales. Recherches en hommage à Jacques Thobie*. Paris: L'Harmattan.

Molero Mesa J. (1990) "Francisco Moliner y Nicolás (1851–1915) y el inicio de la lucha antituberculosa en España" *Asclepio* XLII, 1: 253-280.

Molero Mesa J. (2003) "Militares, "moros" y mosquitos: El paludismo en el Protectorado español en Marruecos" In: Roderíguez Ocaña E. et al. *La acción médico-social contra el paludismo en la España metropolitana y colonial del siglo XX*. Pp. 323–380. Madrid: CSIC.

Molero Mesa J., Jiménez Lucena I. & Martínez Antonio F.J. (2002) "Salud, enfermedad y colonización en el Protectorado español en Marruecos" In: Rodríguez Mediano F. & de Felipe H. (eds.) *El Protectorado español en Marruecos. Gestión colonial e identidades*. Pp. 181–216. Madrid: CSIC.

Moulin A.M. (1997) "Les instituts Pasteur de la Méditerranée arabe: une religion scientifique en pays d'Islam" In: Longuenesse E. (ed.) *Santé, médecine et societé dans le monde arabe*. Pp. 129–164. Paris: L'Harmattan.

Moussaoui D. & Roux-Dessarps M. (eds.) (1995) *Histoire de la Médecine au Maroc et dans les Pays Arabes et Musulmans*. Casablanca: Imp. Najah El Jadida.

Nerín G. (2005) *La guerra que vino de África*. Barcelona: Crítica.

Panzac D. (1986) *Quarantines et lazarets. L'Europe et la peste d'Orient*. Edisud: Aix-en-Provence.

Panzac D. (1989) "Médecine révolutionnaire et révolution de la médecine dans l'Égypte de Muhammad Ali: le Dr. Clot Bey" *Revue du Monde Musulman et de la Méditerranée,* 52–53:94–110.

Panzac D. (1995) "Vingt ans au service de la médecine turque. Le Dr. Fauvel a Istanbul (1847–1867)" In: Longuenesse E. (ed.) *Santé, médecine et societé dans le monde arabe*. Pp. 165–181. Paris: L'Harmattan.

Pennell C.R. (2000) *Morocco since 1830. A history*. London: Hurst and Co.

Pennell C.R. (2001) *La Guerra del Rif. Abdelkrim El-Jattabi y su Estado rifeño*. Melilla: UNED.

Pittaluga G. & Ruiz Morote F. (1930) "Una memoria interesante. Los doctores Pittaluga y Morote en Marruecos" *África,* 6:265–268.

Porter D. (ed.) (1994) *The History of Public Health and the Modern State*. Amsterdam: Clio Medica/Rodopi Ed.

Porter D. (1999) *Health, Civilization, and the State. A History of Public Health from Ancient to Modern Times*. London: Routledge.

Raynaud L. (1902) *Etude sur l'Hygiene et la Médecine au Maroc suivie d'une notice sur la Climatologie des principales villes de l'Empire*. Alger: Imp. S. Leon.

Rico-Avello C. (1969) *Historia de la Sanidad española (1900–1925)*. Madrid: E. Giménez.

Rivet D. (1996) *Lyautey et l'institution du Protectorat français au Maroc*. 3 vols. Paris: L'Harmattan.

Rodrigo y Alharilla M. (2002) "Una avanzadilla española en África: el grupo empresarial Comillas" In: Martín Corrales E. (ed.) *Marruecos y el colonialismo español (1859–1912). De la guerra de África a la "penetración pacífica"*. Pp. 133–166. Barcelona: Bellaterra.

Rodríguez Ocaña E. (2005) *Salud pública en España. Ciencia, profesión y política, siglos XVIII-XX*. Granada: Universidad de Granada.

Rodríguez Ocaña E et al. (2003) *La acción médico-social contra el paludismo en la España metropolitana y colonial del siglo XX*. Madrid: CSIC.

Rollman W.J. (1983) *The "New Order" in a pre-colonial muslim-society: Military reform in Morocco, 1844–1904*. 2 vols. PhD Thesis. Ann Arbor: University of Michigan.

Rosen G. (1958) *A History of Public Health*. New York: MD Publications.

Ruiz Albéniz V. (1922) *Ecce Homo. Prueba documental y aportes inéditos sobre las causas del derrumbamiento y consecuencias de él*. Madrid: Sucesores de Rivadeneyra.

Sanz Astolfi J. (1931–1932) "Resumen de las comunicaciones presentadas e impresiones recogidas en el II Congreso Internacional de Paludismo, celebrado en Argel del 19 al 21 de Mayo de 1930" *Revista de Sanidad Militar,* 21:329–332, 359–366; 22:13–22, 36–40.

Schepin O.P. & Yermakov W.V. (1991) *International Quarantine*. Madison: International Universities Press Inc.

Sims A.C.P. (1972) "The English Hospital, Tangier, 1883–1908" *Medical History,* 16:285–290.

Valdés Lambea J. (1914) *El dispensario indígena de Nador. 1ª memoria anual. Labor realizada y contribución al estudio de la Patología del Rif. Estadística*. Melilla: Tipografía de La Gaceta.

Villalobos F. (2004) *El sueño colonial. Las guerras de España en Marruecos*. Barcelona: Ariel.

Villanova J.L. (2004) *El Protectorado de España en Marruecos. Organización política y territorial*. Barcelona: Bellaterra.

Zaim F. (1988) "Le Maroc Méditerranéen au XIXe siècle ou la frontière intérieure" *Revue du Monde Musulman et de la Méditerranée*, 48–49:61–95.

## Archives and libraries

Archivo General de la Administración. Fondo África. Alcalá de Henares (Madrid)

Servicio Histórico Militar. Fondo África. Madrid.

Archivo Histórico Militar. Sección Sanidad Militar. Segovia.

Archivo y Biblioteca del Protectorado español en Marruecos. Tettouan.

Biblioteca Nacional de España. Fondo García Figueras. Madrid.

Biblioteca de la Academia General Militar. Zaragoza.

Bibliothèque Nationale de France. Paris.

Bibliothèque Interuniversitaire de Médecine. Paris.