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EXPRESSING ENTITLEMENT IN COLONIAL ALGERIA: VILLAGERS, MEDICAL DOCTORS, AND THE STATE IN THE EARLY 20TH CENTURY

Abstract
This article expands our understanding of state–society interactions in rural Algeria under French colonial rule, focusing specifically on villages in the eastern department of Constantine. I analyze previously unstudied administrative records, newspapers, petitions, and complaints to show how sanitary regulations and medical expertise came to shape relationships among villagers, local elites, and the colonial state from the early 20th century. Villagers responded to state-led medicalization by seeking the protection of medical doctors, not only from disease but also from the state itself. In particular, they sought to avoid heavy-handed treatment by qaʾids and local elites who applied disease control measures without appropriate medical knowledge. Furthermore, close examination of petitions sent during World War I suggests that hardships experienced by rural communities during the war accentuated nascent feelings of entitlement across demographic, ethnic, and religious communal boundaries toward state medical treatment.

Keywords: colonialism; medicine; peasants; social history; World War I

In early March 1917, three women and a child in the tiny *madshīr* (hamlet) of Runda in the Aurès (Awras) Mountains of Algeria died from "a great disease." The news spread along official channels, first reaching the elders of the village of al-Akhdhara, who told the shaykh of *duwwār* Ghassira, who informed the agha of the Bani bu Sliman (Bani Abu Sulayman) that Runda petitioned for "a doctor to come to the sick."[1] The agha commanded the shaykh to isolate sufferers and forbade other villagers from visiting them. He then wrote to a local representative of French authority, the administrator of the *commune mixte* of Belezma based in Corneille (present-day Merouana/Mirwana), asking for a doctor to attend to the villagers.[2] "The characteristics of this illness are that it begins with fever and then red pimples break out on the sick person," reported the agha. "Three or four days afterwards, he becomes deaf, until he dies." The agha continued, "truly they do not know what this disease is, whether it is the black pustule [*al-ḥabb al-sūdāʾ*] or measles [*bū zagāgh*]."[3]

The "great disease" was only the most recent misfortune to afflict the villagers in Runda. Four months prior, small-scale acts of resistance to compulsory conscription

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in neighboring *communes mixtes* and in Belezma itself had developed into widespread insurrection.[4] French troops descended on the Aurès region—a contingent of 6,142 soldiers and 106 officers in November 1916, increasing to 13,892 soldiers and 217 officers in January 1917 as the resistance showed no sign of abating—and engaged in a range of repressive tactics to quell resistance and enforce conscription.[5] Soldiers seized livestock and grain, destroyed silos, took hostages from the families of men refusing conscription, and burned villages; the air force bombarded the presumed mountain hideouts of deserters and resisters.[6] Predictably, epidemic disease followed in the wake of hunger and misery. In the month prior to the outbreak of disease in Runda, ninety-three of the hostages taken in the *communes mixtes* of Aïn Touta (ʿAyn al-Tuta), Batna, Belezma, and Corneille died from typhus.[7] The "great disease" in Runda may itself have been typhus, the symptoms of which were known to include fever, rashes, and altered mental states.[8] By appealing to local authority figures for a doctor to treat a terrifying affliction, villagers and elders sought the protection of the state. They did so even as soldiers were taking their men, beasts, and grain, and civil agents of the state were rounding up and isolating vulnerable members of their community.

How was it that villagers in the remote mountain hamlet of Runda came to seek the aid of a doctor? Why did they view the provision of a doctor as the authorities' responsibility? In contrast to scholarship on medicine and the state in sub-Saharan Africa and Egypt, much of the work on the history of medicine in Algeria has had little to say about how ordinary people responded to state medicine.[9] The reasons for this are partly methodological, and partly due to the perception that state medicine was solely a vehicle for colonial ideology and settlement, meaning that there was not much of it in rural Algeria.[10] Yet, as I will demonstrate, the petition from Runda was not an isolated incident but part of a broader trend of communities and individuals in rural Algeria expecting and asking for medical attention from colonial authorities—even if they knew from experience that they might not receive it.

This article draws upon official correspondence, ethnographic literature, and popular petitions in Arabic, French, and Judeo-Arabic originating in eastern Algeria to explicate the role that doctors and their expertise played in relationships among villagers, local elites, and the colonial state from the early 20th century.[11] These source materials have not yet received the attention of professional historians, and neither have the origins and early history of French public health legislation and medical infrastructures established in this period. I show that while inhabitants of major rural centers were more likely than villagers in the *duwwār* to encounter state medical services such as doctor's consultations, vaccination, and drug distribution, all villagers lived in the shadow of sanitary policing. They responded to the expansion of the state and its medical rhetoric with "medicalization from below," by seeking the protection of doctors, not only from disease but also from the state itself.[12] Top-down measures served as a locus of self-articulation for villagers of all different religious and legal categories, who began to speak back to the state and make demands that served their collective interests.

This study builds on a generation of scholarship on social and political relations in Algeria under colonialism that has challenged the "dichotomized representation of two societies, 'dominant' and 'subject.'"[13] Such a representation followed naturally from colonial legal and discursive categories established by the French state during the 19th century, which imposed French subjecthood on Algeria's Muslim population and

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Saharan Jews, and extended French citizenship to European settlers and the remaining indigenous Jewish population. It has continued to be reinforced by national ideology, even as scholars have insisted on presenting Muslim, Jewish, and European populations as internally differentiated by class and ethnic origin.[14] My research introduces further complexity and dynamism into our understanding of social relations and the exercise of power in Algeria, in two ways.

First, it takes a regional and local history approach, excavating sources that shed light on ordinary villagers in eastern Algeria (see Fig. 1 for a map identifying all referenced place names). In particular, evidence from Châteaudun-du-Rhumel (Shalghum al-ʿAid) and La Meskiana (Miskiyyana) during World War I shows that villagers across the dividing lines of religion and legal status experienced entitlement to medical services similarly, and sometimes even took collective action that bridged these boundaries. The latter point bears out Gilbert Meynier's conjecture that the adversities of the war may have resulted in solidarity or a "modus vivendi" between settlers and fellahin (peasants).[15] It also suggests that the colony or state is not the appropriate unit of analysis for understanding how communities and individuals within them came to feel entitlement towards medical services, since entitlement was formed by specific local experiences, including but not limited to the degree of contact with the French administrative apparatus.[16]

Second, and relatedly, the article makes sources in local languages central to its method of research and analysis. These materials range from the *akhbār* (reports) of qa'ids to collective and individual *shikāyāt* (complaints) and petitions.[17] The attempts of subaltern populations to engage state authorities have constituted an important site of analysis for scholars of the Ottoman Empire and its successor states.[18] Historians of Algeria who reference such documentation have all but neglected petitions which the regional archives of Constantine hold in abundance and which can also be obtained off-catalogue at the Archives nationales d'Outre-mer in Aix-en-Provence.[19] These sources should not be viewed as "purer," more "authentic" reflections of the Algerian experience but rather as so many transparencies, which reveal a background image only when layered with their French translations, commentaries, and responses. As I show, examination of the discrepancies between petitions and their translations yields revealing insights into the different ways that Muslim, Jewish, and settler populations engaged with the state and asserted their entitlement to medical attention.

MEDICAL POLICING IN ALGERIA

A recurring motif in official rhetoric in Algeria from the 19th century until decolonization is medicine serving as a tool of European settlement and the consolidation of colonial rule.[20] However, in reality, comparatively few European physicians were willing to practice medicine in rural zones. Those who did often described themselves colloquially as the *toubib du bled* (*ṭabīb al-bilād*), with the pejorative meaning of "backcountry doctor." Many of these held posts as *médecins de colonisation* (doctors of colonization) in *circonscriptions médicales* (medical circumscriptions). The *Service médical de colonisation* of which they were a part was established in 1853 to support and ensure the survival of fledgling European settlements. Each *médecin de colonisation* attempted to cultivate a private practice but also received a stipend from state coffers for performing a statutory

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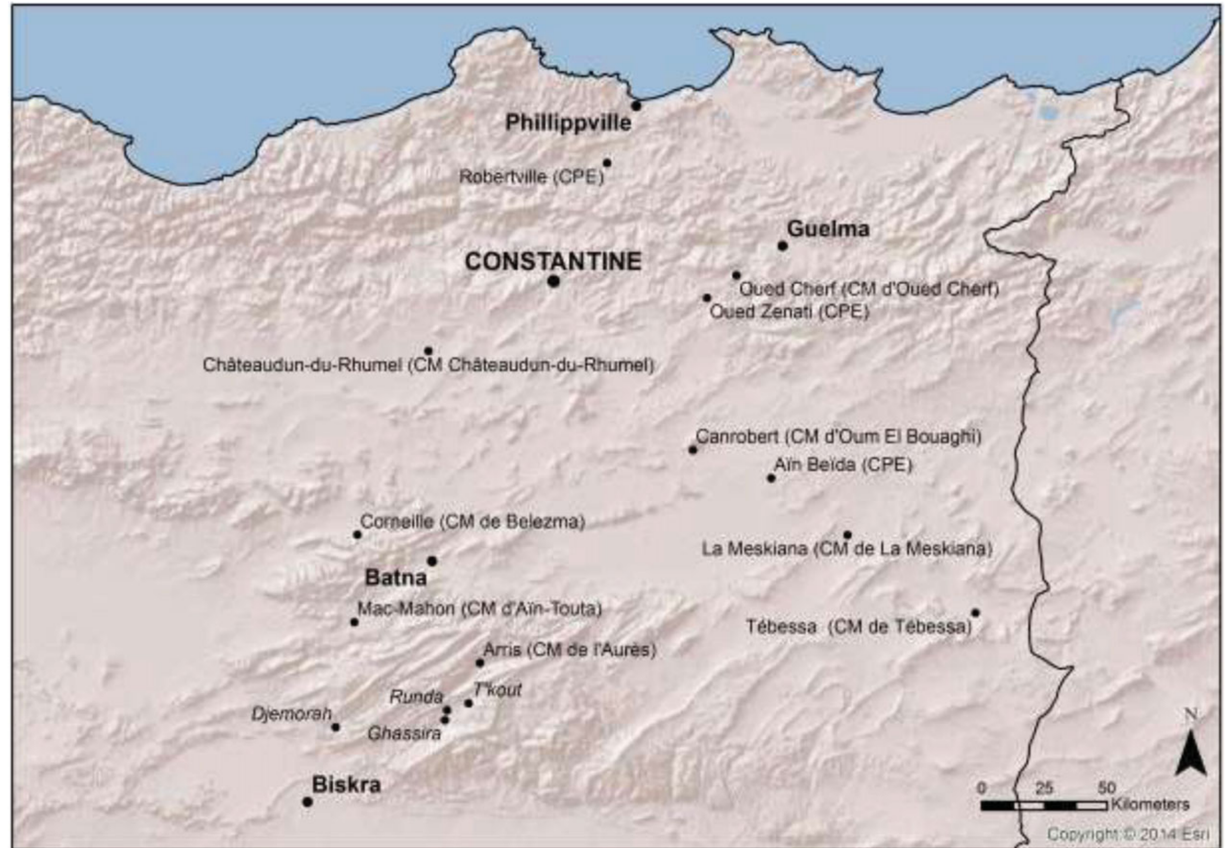

FIGURE 1. (Color online) Villages and administrative centers in eastern Algeria.

number of free public consultations; a monthly inspection of schoolchildren and sex workers; food and water quality inspections; and various administrative functions.[21] Given that the *circonscriptions médicales* served by *médecins de colonisation* covered vast territories in which the only connection between centers, farms, and *duwwār* might be unpaved mule tracks, this was a daunting career prospect.

The lack of interest from European physicians created limited employment opportunities in rural regions for autochthonous Jewish and Muslim medics, otherwise disregarded within their profession on the grounds of religion. For example, a decade prior to the outbreak of World War I, an official training program was established to provide *médecins de colonisation* with an *auxiliaire médical indigène* (medical auxiliary) in order to increase medical outreach to Muslim villagers in the *duwwār*. Medical auxiliaries were recruited exclusively among Muslim youths aged between nineteen and twenty-four who possessed the *Certificat d'études primaires* and could demonstrate competency in French composition, arithmetic, general knowledge of hygiene, and Arabic translation. They received truncated medical training, were paid a fraction of the salary of the *médecin de colonisation*, and—so it was thought—would accept difficult rural postings without complaint.[22]

The creation of secondary personnel was part of the colonial authorities in Algeria having to adapt to new social legislation introduced in France. A key piece of legislation was the *loi du 30 novembre 1892 sur l'exercice de la médecine,* which revised the licensing laws for doctors, health officers, and midwives, and required certified professionals to declare cases of infectious diseases to public authorities. Another was the *loi du 15 juillet 1893 sur l'assistance médicale gratuite*, which pledged free home visits or hospitalization to indigent citizens and charged licensed medical professionals and communal authorities with responsibility for medical policing and public declaration of infectious disease. A final piece of legislation, the *loi du 15 février 1902 rélative à la protection de la Santé publique*, expanded the professional responsibilities of doctors to include compulsory declaration and disinfection of thirteen diseases—exanthematic typhus among them. The 1902 law also established mechanisms for policing health at the local level by requiring each mayor, in consultation with the municipal council, to draw up a statement of sanitary regulations (*règlement sanitaire*) for his commune.[23]

These laws did not apply mechanically to France's three Algerian departments, in particular because they entailed fiscal liabilities that members of the *Délégations financières algériennes*, the assembly with voting powers over the colonial budget, were unwilling to meet.[24] Thus, the 1893 law brought medical assistance to indigent European settlers but not to Algeria's Muslims. It was only in 1904 that the notion of an *Assistance médicale des indigènes* was proposed for Muslims in rural areas.[25] Subsequently, so-called "native" infirmaries were introduced in some *centres de colonisation* (centers of colonization) but these did not become an extensive network: in 1906, there were twelve infirmaries where a European *médecin de colonisation* provided consultations and a Muslim *auxiliaire médical* provided full-time staffing; this number increased to twenty by 1907, thirty by 1908, and sixty-two by 1914 (see Fig. 2 for map). These installations were intended to reduce communal expenses by keeping indigent Muslims out of public hospitals.[26] They were also touted as bringing French medicine to rural areas. In some cases, local administrators attempted to imitate Islamic discursive practice by using the Arabic language and religious references—often with imperfect results—to

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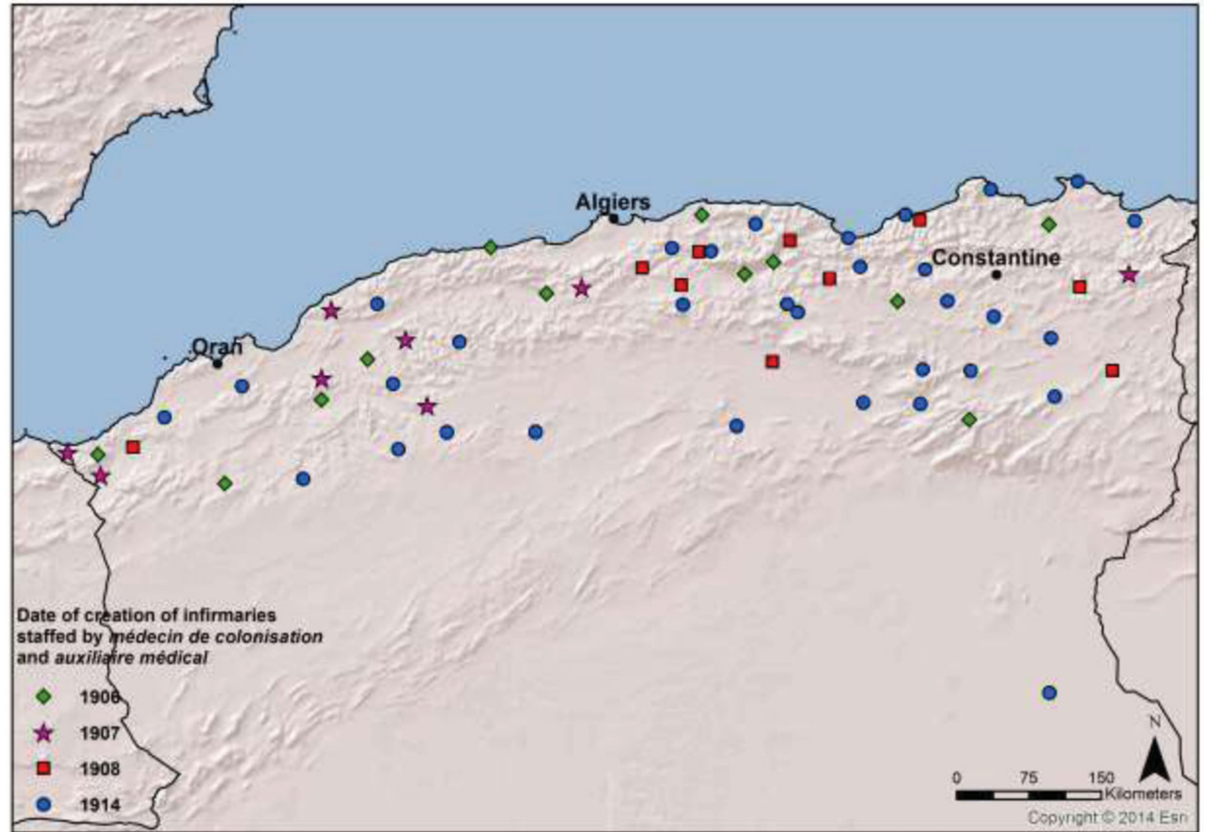

FIGURE 2. (Color online) Location and date of creation of infirmaries staffed by *médecins de colonisation* and *auxiliaires médicaux.*

promote notions of hygiene and state medical services. "Come to the French doctor," urged the administrator of Oum el-Bouaghi (Umm al-Buwaqi) in a pamphlet rendered in awkward Arabic, "he will treat you extremely and freely."[27] However, these services were concentrated in *centres de colonisation*, not in the *duwwār* where the vast majority of Algerian Muslims lived; and because of the parsimony of communal budgets (and the attitude of some doctors), free consultations were offered to only a tiny fraction of those who needed them.

Similarly, the law on the protection of public health was not applied automatically in Algeria, for it was deemed necessary first to adapt it to the perceived environmental, pathological, and social conditions of the colony. The legal instrument underwent scrutiny by numerous government bodies, shuttling back and forth between the *Conseil d'état* in Paris and the *Conseil de gouvernement* in Algiers, the *Académie de médecine,* and the *Conseil supérieur d'hygiène* (a new national organism established to oversee the 1902 law).[28] Eventually Governor General Charles Jonnart agreed to the terms of the *décret du 5 août 1908, relatif à l'application à l'Algérie de la loi sur la protection de la santé publique*, to take effect on 5 August 1909.

In some respects, the Algerian decree resembled its metropolitan precursor: it required each commune to declare and publish sanitary regulations, and reproduced the same numbered system of diseases requiring compulsory declaration and disinfection.[29] In other respects, the document contained variations specific to rural Arab and Muslim bodies, reflecting the guiding belief among officials and physicians that this population was a "reservoir" of poverty, fatalism, and infection.[30] For example, the putative relationship between variolization, "native" smallpox, and European victims gave rise to racialized smallpox vaccination legislation for the *communes mixtes*.[31]

Other differences were more subtle, but no less significant for villagers in the *duwwār*. Sanitary regulations were to be distributed in bilingual format, both French and Arabic. The regional archives in Constantine hold several boxes of these booklets, the contents of which were also spelled out on six-foot high bills suitable for affixing to a wall at the administrator's *burj* (fort, office). A number of clauses in the regulations enhanced the power of state agents and increased the intrusiveness of the law substantially in regard to Muslims' business interests. Owners of *fanādiq* (hotels) and *maqāh/cafés maures* (coffeehouses, "Moorish coffeehouses"), establishments which typically provided overnight accommodation for migrant laborers and travelers, as well as managers of *ḥammams/bain maures* (public baths, "Moorish baths") were deemed responsible legally for declaring cases of illness among their lodgers and clients.[32] These duties did not apply to owners of comparable establishments for Europeans. The regulations also placed communities and their sick under draconian rules of behavior. In the event that one of thirteen legally declarable diseases was detected in a *commune mixte*, regulations stipulated the immediate removal of the sick person to a purpose-built or makeshift public isolation hut located no fewer than 150 meters from other habitations. According to printed directives, the hut was to offer separate rooms for men and women. Entrance to the hut was to be limited to the sick and those persons responsible for their nursing or treatment. Regulations demanded frequent disinfection of linens, clothing, personal items, and other objects used during the care of the sick. The decision to burn a victim's clothing, as well as his *gourbi* (*qūrbī*, hut or shack), wooden branches, straw, and other effects, was left to the doctor.[33] In some communes, the Arabic version tempered

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the severity of these measures by promising compensation (*muʿāwaḍa*) in cash or in kind to individuals whose belongings had been destroyed.[34] According to one set of Arabic-language regulations, compensation would apply in "special circumstances" (*fī aḥyān khuṣūṣiyya*), but no form of reparations is mentioned anywhere in the French version—and nor is there indication in the archives to suggest that such monies were ever paid.[35]

The most fundamental distinction between regulations in France and in Algeria's major towns and colonial settlements on the one hand, and those affecting Muslim villagers in the *duwwār* on the other, had to do with application and enforcement. In communes and *communes de plein exercice*, mayoral officials concerned with re-election could choose to ignore unwelcome sanitary legislation rather than enforce it.[36] Doctors' syndicates vigorously defended private, market-based care against institutionalization.[37] Individuals with resources to obtain a second medical opinion were able to evade isolation and other sanitary measures. To consider but one example, the police commissioner of Tiaret (Tiyarat) in western Algeria complained that he was unable to force the hospitalization of a Mrs. Vigiano because after she had been certified as having typhus her husband produced a second medical certificate testifying that she was not ill with the disease. Although it was clear that the sick woman could not be satisfactorily isolated and cared for amidst her family in their small two-roomed dwelling, the police commissioner was unable to prevail: "As you know, discord has long reigned among the doctors of Tiaret, and today's case that I am telling you about is one that has happened before. It seems that doctors don't always give much consideration to the general interest and public health."[38] In contrast, in Algeria's *communes mixtes*, administrators were appointed, not elected, and a cadre of doctors was already partly institutionalized within the *Service médical de colonisation*. Above all, villagers in the *duwwār* had limited or no regular access to a medical doctor, and no option of a second medical opinion.

Since licensed medical professionals were too thin on the ground to police populations and their diseases reliably, responsibility for enforcing sanitary regulations fell upon the indigenous leadership, particularly the qaʾids who represented French authority in the *duwwār*. Under communal sanitary regulations, qaʾids and other local leaders who identified unusual levels of morbidity or mortality in their areas (*shiddat al-wafāʾ*), or a case of declarable disease or suspicious death, were required to notify the administrator immediately via a *khabr* (pl. *akhbār*, report).[39] Each household in which disease was detected required its own *khabr*, which narrated the name, age, *duwwār* of residence, parentage, and age of each victim, and the presumed illness or cause of death.[40] Records after World War I show that routine, timely reporting of morbidity and mortality was expected of qaʾids and earned them favorable comments in their annual review and a pay bonus.[41] In contrast, qaʾids' failure to report disease or a suspicious death could lead to an investigation or even dismissal.[42] Sanitary policing provided a language and operational framework for administrators to evaluate the efficiency and trustworthiness of "native" leadership in the *communes mixtes*; indeed, the evidence of *akhbār* suggests that medical policing became a mechanism through which indigenous leaders sought to build relationships with colonial officials and gain their trust.[43]

The result of the close connection between sanitary policing and administrative performance reviews was qaʾids' enthusiastic enforcement of sanitary regulations. As if measures such as the isolation of sick or recovering persons and the destruction of

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shelter and clothing were not distressing enough for individuals and their families, the manner in which regulations were applied could have far-reaching consequences for entire communities, as indicated by a petition, in this instance from western Algeria. In January 1929, Kaddour ould Benaissa Smaïne (Qaddur Awlad bin ʿIsa Ismaʿil) and Tahar ould Abed Belkhamessa (Tahar Awlad ʿAbid bin al-Khamisa) wrote in French to the administrator of Tiaret, appealing for an isolation order to be lifted:

> The civil doctor and native rural policeman of *douar* Guertoufa [Qartufa] came the two of them to the *douar* and came into our two tents only they found one native Boubeker ould abdel Kader [Abu Bakr Awlad ʿAbd al-Qadir] ill . . . Seven or eight days after the departure of the doctor and the policeman he died—since then no death. Following the order given by the qaid saying that by the order of M. Administrator that Smaïn Kaddour ould Benaïssa and Belkhamessa Tahar ould Abed are forbidden to go to the centre of Guertoufa and to the markets of Tiaret . . . At present there are 31 people in two Arab tents who are dying of hunger . . . They are not working and they cannot go to the markets to sell their animals to live because of the order of the qaid . . . We just want you to follow up our request or to make a doctor come to [see] if there are sick people.[44]

Sanitary legislation in colonial Algeria, as in metropolitan France, was driven by concerns about acute epidemic disease. However, as this section has shown, local regulations and the manner of their enforcement presumed that epidemic disease originated with Arab and Muslim villagers and businesses in the *communes mixtes*. Qaʾids' efforts to sequester the inhabitants of the *duwwār* were intended to protect residents of *centres de colonisation* and urban settings from injury. At their most extreme, sanitary measures ordered by administrators took the form of a sanitary cordon around villages enforced by soldiers.[45] Villagers in the *duwwār* could not evade quarantine and isolation rules in the way that poor Europeans in *centres de colonisation* could. The expert diagnosis of the state doctor was their only counterweight to heavy-handed treatment by local leadership and colonial officials.

MEDICAL PLURALISM IN THE AURÈS

The suffering villagers of Runda, with whom this article began, provide a further concrete example of how these regulations were applied. The elders in the village of al-Akhdhara called for a doctor after learning of the frightening deaths of three women and a child. Before the agha of the Bani bu Sliman had communicated the request to the administrator in Belezma, the former had already commanded the shaykh to isolate sufferers and to forbid villagers from visiting them. The agha's orders conformed to municipal sanitary regulations but were an inversion of local practices of disease management.

Colonial state archives distort the nature of predecessors and alternatives to French medicine by mentioning these only in the punitive context of "illegal" medical practice. However, in this particular instance, contemporary ethnographic materials gathered in the vicinity of Runda can supplement the silence of the colonial archive. Oxford postgraduate student in anthropology Melville Hilton-Simpson and his wife Helen traveled to Algeria in 1913–14 and again immediately following World War I to conduct research for a thesis on medicine and surgery among the Berbers of the Aurès.[46] French officials who met the Hilton-Simpsons informed them that "the practice of surgery by persons who do not possess the necessary French qualification

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[was] prohibited by law," but this was not correct, strictly speaking.[47] An imperial decree of 12 July 1851 had first extended French medical licensing laws to Algeria but explicitly exempted from prosecution "natives, Muslims or Jews, who practice medicine, surgery and midwifery on behalf of their coreligionists."[48] Subsequent decrees in 1896, 1927, and 1935 restricted medicine to licensed practitioners (and, in the case of the *loi du 16 août 1940 sur l'exercice de la médecine*, banned Jews and persons "born of a foreign father" from the medical profession, Algerian Muslims included). However, the 1851 decree remained on the law books and senior officials discreetly encouraged administrators to ignore the implications of the 1896 decree for "native" healers. It was recognized that eradicating various and essential medical, surgical, and birthing practices performed by nonlicensed healers was both impossible and impractical, given the sheer numbers of indigenous Algerians and the tiny number of licensed practitioners.[49] This did not prevent French officials locally from acting as if there was a *de facto* prohibition. A French medical officer who spoke with the Hilton-Simpsons predicted that healers would be wary of their inquiries, and that they would "never see either a surgeon or an instrument although . . . operations were frequently performed in the area."[50]

In fact, Melville and Helen Hilton-Simpson's efforts generated more than 200 slips of paper with notes on surgical and medical practices, photographs, surgical instruments, and even bone fragments that they gathered in the vicinity of Biskra and Batna. Melville Hilton-Simpson noted that they were assigned Arab and Shawi assistants to accompany them on their travels, and that a number of these were related to local healers and surgeons, which facilitated his research. He also claimed that "the general practitioners of the Aurès" were more willing to talk openly to an Englishman, in contrast to the usual attitude of "extreme secrecy" they showed towards (presumably French) outsiders.[51] The couple therefore had access to at least some of the therapeutic and preventive resources that escaped the sight of French officials but may have been available to the villagers of Runda.

According to the surgeons and healers with whom Hilton-Simpson conversed, cholera and other epidemic diseases were "combated by withdrawing the population of the stricken village to the shelter of the high-lying pine forests which are considered impregnable by the armies of 'jenoun,' or demons, which are believed to cause the outbreak."[52] Thus, sanitary regulations whereby the healthy stayed put and the sick were expelled and isolated contradicted local practice whereby the healthy *and* sick fled their village to evade malevolent spirits.[53] Hilton-Simpson noted the use of Qur'anic texts, "worn, or, written on paper . . . burnt for fumigating patient[s]" for the treatment of fever. He also recorded encountering a layman in a desert oasis who "advised fumigation in the smoke of burning date-stones as a remedy for fever," and a "sorceress" who proposed fumigation in "hoopoe's feathers, black sheep's wool, and oleander leaves." The combination of smoke and holy scripture was intended to irritate and expel jinn. This contrasted with official regulations that were not conducted under the auspices of Islam, and which required burning and disinfecting personal objects rather than fumigating the individual person. Two measures considered to be effective against the jinn that caused fever were charms made of the head of a viper and, more prosaically, quinine.[54] This antipyretic, used principally to treat malaria, had been introduced to Muslim physicians over the course of the 19th century.[55] Hilton-Simpson found that it had become widely

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appreciated and obtainable "in tablet form in the large towns," but was difficult to obtain in rural areas.[56]

Had the villagers of Runda attempted evasive measures and remedies such as these before the women and child died? We lack positive proof that they did. It is understandable that the elders of al-Akhdhara would remain silent on this issue given the prejudice shown towards indigenous healers. However, the report transmitted verbally by the elders to the shaykh, and in writing to the agha and the administrator, provides a clue that someone had examined the sick carefully, perhaps in order to explore therapeutic options. After all, the elders were able to report in concise detail the natural history of the infection, and *at least four days* had elapsed between the first signs of sickness and their informing the authorities of the presence of a "great disease."

In the literature on colonial medicine, the manner in which the villagers selected among different therapeutic options might be termed "medical pluralism." A 1978 study by anthropologist John Janzen proposed "medical pluralism" and "lay therapy management" as analytic tools for comprehending how people navigate "differently designed and conceived medical systems."[57] Rather than assuming the primacy of the doctor–patient relationship, Jansen's innovation during his research among the BaKongo was to observe the different individuals involved in medical experience—patients, kinship groups, and various experts—and the symbolic meaning and practical consequences of different types of therapy. Historians of Africa (and of other contexts) have found "medical pluralism" to be the default under colonialism.[58] Historian Megan Vaughan showed the limitations of colonial biopower to form African subjectivities; colonial states such as the British dependencies in East and Central Africa from the 1890s to the 1950s were not modern states and so lacked sufficient information and coercive capacity to impose biopower. As Vaughan explained, "In Africa at least, colonial medics were simply too thin on the ground and their instruments too blunt to be viewed either as agents of oppression or as liberators from disease, and studies of African demography confirm this view."[59] In Vaughan's assessment, a "clash" of medicines or the victory of biomedicine would have required far greater organization on the part of the state medical apparatus.

The evidence provided by the Hilton-Simpsons and the model of medical pluralism are helpful insofar as they suggest why villagers in Runda might not have notified French authorities immediately of the "great disease." However, they miss the role that the doctor's expertise played outside of the field of therapeutics, in that of colonial law and administration. In Algeria, the "blunt instrument" and "agents of oppression" in question were not so much medicine and colonial medics as they were sanitary regulations and heavy-handed local elites and administrators. The elders of al-Akhdhara did not formulate a request for a doctor only because family and neighbors had reached the limits of local medical knowledge, or care by family and friends was unable to provide relief. They also called for a doctor to come to their aid because the shaykh and his assistants did not care for the sick appropriately as they policed them and shut them away.

What is more, the sufferers, kinship groups, and elders who navigated multiple medicines in the Aurès were operating under multiple technologies of rule and domination. The government was conscripting young men while collectively punishing the inhabitants of the region for resistance to the measure. From another archival find, it appears that ninety villagers in T'kout (Takut)—barely six kilometers from Runda—

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resorted to the expedient of writing to the prefect of Constantine "in total peace" to secure the safety of their tribe and restore their livelihoods (*maʿāsh*). Their lengthy *shikāya* denounced certain tribes for rising up against the government and conscription, insisting that they had presented their children on the appointed day and had tried to persuade the "corrupt" (the men resisting conscription) to change their ways.[60] In a similar way, by requesting a doctor the villagers in Runda opened up a channel for peaceful communication with the government in the midst of violence and distrust. In retrospect, it seems an almost poignant expression of villagers' faith that the authorities might have something to offer other than repression.

MEDICALIZATION FROM ABOVE

Unfortunately for the villagers of Runda, the administrator in Batna was unable to provide access to a licensed physician. A medical officer stationed some ninety kilometers away, Schmitko (first name unknown), refused to leave his post in Batna to attend to the villagers in Runda on the basis that he was waiting for orders to join the Armée d'Orient on campaign.[61] There were no other licensed physicians to be found in the entire Aurès. In fact, the region had never known regular state medical services of any kind. Dorothée Chellier, the first European female doctor to practice in Algeria, had carried out an official government medical mission to the women of the region from 1895 to 1899, and a Catholic religious society, the Pères Blancs, established a hospital for Muslims at Arris in 1895, but the post of *médecin de colonisation* for the Aurès had been filled only intermittently.[62]

It was not only the Aurès that lacked a licensed medical professional in 1917. An estimated 10,490 doctors served the French army during World War I, and career army medics comprised barely 15 percent of this contingent, a mere 1,495 doctors and 126 pharmacists.[63] This meant that staffing levels in the Service de santé des armées were met by the demedicalization of France and Algeria. Within weeks of Germany's declaration of war on 3 August 1914, the colony saw the hasty and ill-planned deployment of physicians to serve in medical units on the front, in North African military hospitals, or in the reserves, and later as intendants in Algerian prisoner of war camps. Twenty-three out of ninety-six Muslim *auxiliaires médicaux* left their posts in Algeria to serve as conscripts or volunteers in theaters of conflict and campaigns in France, Egypt, Greece, and the Hijaz.[64] The ranks of *médecins de colonisation* were specifically targeted for medical mobilization. In 1915 the subprefect of Mostaganem (Mustaghanam) suggested that so many doctors were called up that, for a time, the communes of the interior of Oran were stripped of their licensed physicians.[65] In spite of a 21 April 1916 circular that ordered special treatment and demobilization for Algeria's *médecins de colonisation*, by 1917 only fifty-three out of 100 in service in Algeria before the war remained at their posts.[66]

The department of Constantine had been considered severely undermedicalized even before the war, both by metropolitan standards and in comparison to Algeria's other French departments. It had the highest proportion of *médecins de colonisation* of the three departments, and the lowest number of private practitioners, pharmacists, and midwives, because most *centres de colonisation* in the department were too poor to support their livelihoods. A total of 106 private and communal physicians and *médecins*

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de colonisation worked in the department during peacetime, supplying an area the size of Portugal—this compared with at least 190 and 111 in the departments of Algiers and Oran respectively.[67] By the winter of 1914, only forty-two of these 106 doctors remained in service along with twenty-five Muslim *auxiliaires médicaux*.[68] Nine of the forty-two remaining physicians were *médecins de colonisation* who provided free services: two had been exempted from military service because of age, two were injured or disabled, two were discharged, and one was in the army reserves. This meant that the effects of medical mobilization were felt disproportionately in areas that lost their *médecin de colonisation*, who was typically the only licensed medical practitioner in these locales.

In view of the scarcity of *médecins de colonisation*, *auxiliaires médicaux*, and infirmaries, the vast majority of the rural population was without regular access to state medical services during peacetime. Did the removal of these doctors during wartime make any difference? Were there noticeable effects on levels of morbidity or mortality at the macrolevel? Was the absence of doctors remarked upon at the microlevel, where communities must have been relying on alternative therapies and healers for relief anyway? We find preliminary answers to these questions in official correspondence, for when doctors were mobilized, infirmaries and medical rounds had to be suspended. Mayors and administrators dispatched letters and urgent telegraphs to the authorities in Algiers concerning the sanitary situation in their communes. In these communications, four problems stand out as common concerns: disease levels, budgets, the malfunctioning of regulatory systems, and the waste of medical personnel.

Local authorities expressed concern about specific categories of disease and social groups. Infectious diseases such as measles and scarlet fever, and seasonal fevers, were cause for alarm. Some health problems were uncommon but caused disproportionate levels of social anxiety. For instance, when a European woman gave birth to a stillborn infant in the *commune mixte* of Sedrata (Sidrata), the lack of medical attention was blamed; the news was relayed by urgent telegram to the governor general.[69] The management of malaria in particular was disrupted during the war, not only because the mobilization of *médecins de colonisation* put an end to the distribution of free quinine sulfate tablets, but also because shortages disrupted supply. Without quinine prophylaxis, levels of absenteeism among agricultural labor increased. These problems were no doubt sensationalized by local officials in order to attract attention from prefects, but there does seem to have been a statistical basis for alarm: for instance, the mayor of Oued Zenati (Wadi al-Zinati) drew on his commune's sanitary records to point to abnormal mortality levels compared with the previous year.[70]

Disease and death were not the sum total of the problem from the perspective of local authorities, however. Without a medical doctor on hand to diagnose and treat epidemic diseases, those suffering their effects might press for admittance to a hospital. Authority figures were apprehensive about the fiscal implications of this behavior on the communal budget. According to the Mayor of Robertville (present-day Majaz al-Shish), near Philippeville (Skikda),

> Our free consultations and dispensary service, with which we had achieved remarkable results in terms of the number of natives treated and the economy, not only the costs of hospitalization, are suspended. There are many native and even European poor in my commune, and so I am assailed every day by the sick demanding either the doctor or a ticket for entry to the hospital. Unable to

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satisfy their legitimate request for the doctor and unwilling to hand out hospital admission except in serious cases, which one needs an understanding of science to recognize, the sick who have the means go off to the town to consult a doctor, who at their request simply admits them for [hospital] treatment, causing my communal budget to bear extremely high costs.[71]

In the mayor's view, the difficulty in Robertville arose not from disease itself, but from the lack of scientific expertise available locally—expertise that enabled the commune to make a triage of the sick during peacetime. Sufferers with means were able to use private physicians to manipulate the system. From the language of the mayor's request, we can see that he dramatized his concerns to achieve the return of the *médecin de colonisation* ("remarkable results," "assailed . . . by the sick," and "extremely high costs"). Nonetheless, his response and others like it suggest that, whatever their medical effects, the *médecin de colonisation, auxiliaire médical*, and *infirmerie* were proving effective in reducing demands on communal budgets during peacetime.

Medical mobilization also meant that there were not enough doctors to register births and deaths, or to conduct autopsies and provide evidence for criminal courts. Some *auxiliaires médicaux* received authorization from the local judiciary to carry out autopsies and sign death certificates, and documents they produced were used as evidence in criminal and civil cases, until the authorities in Algiers demanded an end to the practice.[72] Significantly, it was not the judiciary that objected to the expedient, but an official in the security services who learned that a Muslim medical assistant had prepared forensic evidence against a European in a criminal prosecution; this caused the governor general to intervene.[73] In addition to the impact on judicial proceedings, the cessation or interruption of medical services also stood in the way of processing medical exams for workers cudgeled into "volunteering" en masse for factory work in France, especially as these men did not turn up for examination on fixed days.[74] For instance, the administrator of La Meskiana despaired when the *médecin de colonisation* for the commune left his post—the third to do so in as many years. Not only had this departure caused the infirmary to close and consultations and medical checks in the *duwwār* to cease, explained the administrator, but also, "the recruitment of workers volunteering for engagements [*venant spontanément s'engager*] in the factories of France is impossible without a doctor in place."[75] A shortage of physicians threatened to paralyze the judiciary and the smooth functioning of a French war machine that depended on a constant flow of migrant labor. These documents make clear that the importance of the doctor to colonial governance extended beyond sanitary and medical matters; the doctor played a vital role in ensuring the functioning of the legal, fiscal, and economic regime under colonialism.

Some official communications insisted upon a rights-based understanding of medical care in order to strengthen their argument; with the doctor mobilized, "it [was] impossible for the population of Gounod to receive the medical assistance to which it has the right," wrote the administrator of the *commune mixte* of Oued Cherf (Wadi al-Sharf) to the subprefect of Guelma (Qalima), in reference to both settler and Muslim inhabitants.[76] It is possible that officials were encouraged to apply pressure by mobilized doctors themselves in cases where these had been displaced within Algeria to military hospitals. Having been the target of many requests, the prefect of Constantine wrote to the governor general that "certain mobilized doctors have told me that they have barely an hour of

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work per day."[77] Jewish physician André Attal (ʿAttal) from the city of Constantine was among those who wrote to the prefect to complain about this situation. Attal had been mobilized and posted to Biskra, where he considered himself underemployed inspecting prisoners of war for disease. Meanwhile, he asserted, "the number of doctors [in the city of Constantine] is insufficient, and the native population in particular—Arab and Jewish—is almost deprived of medical care since the departure of the doctors who routinely visited them." Attal asked the prefect of Constantine to intercede with the Inspecteur général du service de santé de l'armée de l'Afrique du Nord, in order to arrange his release from the post. The request included an unsubtle rebuke: "I would like to believe that the military authority would not wish to show any less solicitude to [the native population] than it does to German prisoners."[78] As the above vignettes show, authority figures made a strong case for the importance of public health and medical services as scientific instruments of the state and the trans-Mediterranean economy, but also insisted that state medical services served an important public function.

MEDICALIZATION FROM BELOW

Consultations by the *médecin de colonisation* and *auxiliaire médical* were a recent development, and an extremely limited one at that. Nonetheless, it is apparent that some rural populations had developed expectations of the state regarding the provision of medical doctors. This point is demonstrated by a petition formulated in August 1915 and signed by 161 residents of the *commune mixte* of Châteaudun-du-Rhumel, a rich cereal-growing region some fifty-five kilometers to the southwest of the city of Constantine. The petition demanded the immediate return of a *médecin de colonisation*, ideally doctor Jean Nicolaï who had served villagers until his mobilization. Within eleven days of the petition reaching the attention of the prefectural authorities, Nicolaï was released from military service and returned to his appreciative community.[79]

The instigator behind the Châteaudun-du-Rhumel petition was Paul Francheschi, the son of a notable local landowner of Corsican extraction. Francheschi's petition began by asserting the importance of Châteaudun. It echoed official discourse in its concern with facts and figures: the *commune mixte* was one of the largest and most populous in Algeria, comprising a population of 35,000 dispersed across four *centres de colonisation*, as well as many large farms connected only by simple tracks.[80] Logistical issues were an obstacle to the provision of "immediate and frequent healthcare" during peacetime, but the situation had been notably aggravated by the mobilization of Nicolaï. The return of a doctor was essential, because it was "important to ensure the sanitary service of such a large population, deprived of any medical help, at the time of farm work during the season of high temperatures, and later when plowing during the rainy season."[81] The connection between this agenda and Francheschi's private interests is clear, as he required able-bodied labor in his own fields.

However, it was not merely the European landowning class that supported the petition. Indeed, two of the first signatures sought by Francheschi were those of ʿAli bu Ahmad (ʿAli Abu Ahmad) and Mohamed Hadboum (Muhammad Hadbum) (occupations unknown). Many of the signatures are illegible, but crossreferencing with the birth and death registers for the *commune mixte* yields some data about individual identities.[82] For instance, there was considerable support for the petition from the sizeable Algerian

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Jewish population of the *commune mixte*. Businessmen Moise Amar, Mordechai Attal, and David Aouzerats, the beltmaker Jatron Atlan, and clerk Rahman Guedj signed in French; other Châteaudun Jews used Arabic, such as Musa bin Yusuf and Amram al-Harbi al-Rahman; David ben Zaken signed in Judeo-Arabic script. Twenty-five Algerian Muslim men added their signatures, the majority in Arabic script. Finally, the Europeans of Corsican, Maltese, Italian, Alsatian, and French origin who signed came from diverse occupational backgrounds. Some were men whose wives had lost children at birth or in early infancy, such as the road-mender Alfred Moutin, his brother-in-law the cultivator Noël Balibouze, and the nightwatchman Paul Deschamps. Nine wives and widows also signed. Even without background details for every signatory, the onomastic evidence alone makes clear that the doctor and the infirmary had generated feelings of entitlement across religious, class, and gender lines.

A second petition originated in the *commune mixte* of La Meskiana in July 1917 (see Fig. 3). Official figures from the turn of the century recorded an estimated population of 57,802 seminomadic "natives" and 1,919 Europeans spread over 448,480 hectares.[83] It took administrative orders at least two days to reach the administrator of La Meskiana from the prefecture of Constantine, which was situated 220 kilometers away.[84] The *duwwār* sixty or seventy kilometers distance from the infirmary in La Meskiana were barely accessible by mule tracks.[85] Whereas the previous petition united the European, Muslim, and Jewish inhabitants of Châteaudun-du-Rhumel, the Muslim landowners, tradesmen, and their servants who signed the *shikāya* from La Meskiana did so independently of Europeans and Jews. Seventy-three individuals signed the *shikāya*, which was written in a mixture of classical Arabic and Arabic dialect. It was probably drawn up by Salah bin [illegible] bin Gharbal al-Jarbi, whose signature resembles the handwriting of the text closely. The petition drew a considerable portion of its support—nine of its total seventy-three signatures—from men belonging to families from the Tunisian island of Djerba (Jarba).

Praise be to God!
Your Grace, Sir, Administrator of the District of Miskiyyana, peace upon you, from your servants presenting their petition to your exalted eminence, God's blessings.

We the inhabitants of the village of Miskiyyana ask you kindly that there be a doctor in the circumscription as there was in the past. Illness has befallen our area and the place is known for its diseases during the hot season and the quinine is not sufficient. It is well known, your Grace, that diseases are different and every disease requires its own remedy. The doctor treats each disease according to the patient.
Second, it is clear your Grace that ʿAyn al-Baidaʾ and Tibissa are a known distance away. The sick person grows weak on his walk to the doctor and does harm to himself. Thus we appeal to and crave from your eminence that you designate [a doctor] according to our demand.[86]

The general message of the *shikāya* evoked a central element of the Châteaudun petition—that medical assistance was essential during the hot season—and added that it was detrimental for the sick to travel far for treatment. The *shikāya* was also reminiscent of the report from the mayor of Robertville. While the mayor had complained that only the doctor had the ability to recognize diseases and to decide upon the appropriate course of action, the Meskianis declared that "the doctor treats each disease according to the patient" (*wa-l-ṭabīb yuʿālij kull marīẓ* [sic] *ḥasab marḍihi*). In these carefully crafted

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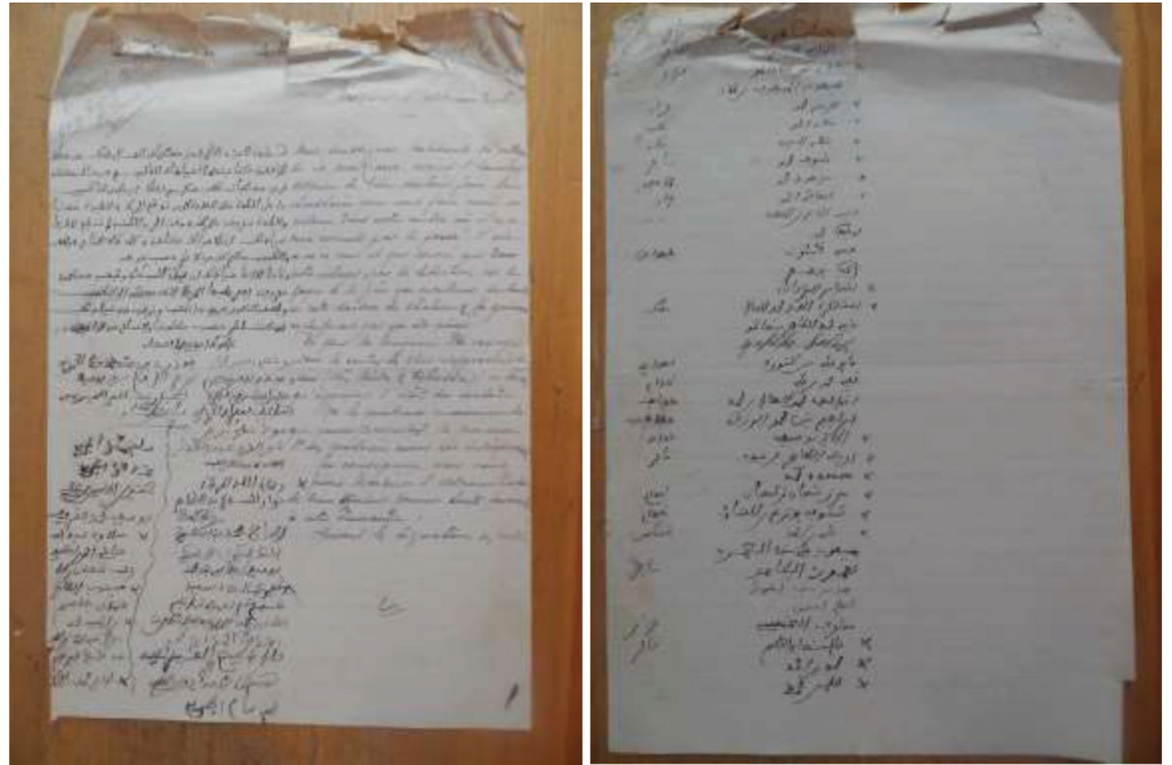

FIGURE 3. (Color online) S*hikāya* from the Muslim villagers of La Meskiana, 29 July 1917. Image reproduced with permission from Archives nationales d'outre-mer (ANOM, France) ALG CONST B3/452.

phrases, the petitioners of La Meskiana recognized the *médecin de colonisation* as a gatekeeper to resources such as quinine and an expert of the state. Where the *shikāya* differed from the Châteaudun document and official requests was in its tone: only the Meskianis framed their request as a plea from servants to a gracious and exalted master.

A nameless translator at the prefecture in Constantine phrased the appeal very differently:

> We, the undersigned, inhabitants of the village of La Meskiana, have the honor to request to kindly arrange to appoint a doctor to our center where he will practice as in the past. It is not unknown to you that our village, because of its position, is a hotbed of fever *par excellence*, especially in the hot season, and quinine is not enough by itself.
> In addition, the length of travel to the centers closest to us (Aïn Beida [ʿAyn al-Baydaʾ] and Tébessa [Tibissa]) worsens the condition of the patient. In view of the numerous drawbacks that may result, the presence of a physician is indispensable.
> Accordingly, we beg you Mr. Administrator to kindly respond favorably to our request.[87]

The essential message of the petition was carried over, but the translation displayed marked differences in format and register. The *shikāya* scribe had demonstrated some familiarity with bureaucratic norms, to the extent that he placed a date at the head and wrote only on the left-hand side of the page, leaving the right-hand side blank for a translation. Nonetheless, the *shikāya* opened with *al-ḥamd li-llāh,* an element not typically included in administrative correspondence in the French language, and invoked God's blessings on the prefect. The translator's text conformed the petition to the conventions of secular, bureaucratic French, eliminating the religious formulas and employing impersonal phrases.[88]

Significantly, the translator also purified the servile language of the original petition. The original choice of terminology (namely, *khuddām,* servants) expressed the subordination and acquiescence to state authority of Muslim subjects. The translation elevated the petitioners of La Meskiana from the status of *khuddām* to the less subservient, more neutral position of "we, the undersigned." It also erased evidence of villagers' concern for health and their enthusiasm for state medicine and expertise.

Additional background provided by a series of correspondence between the prefect, the administrator, and the inhabitants of La Meskiana reveals just how deep the inhabitants' enthusiasm for the expertise of the doctor ran. The petitioners' phrase "in the past" gave time-honored status to a medical post that was barely a decade old. An infirmary had been opened in La Meskiana in December 1908 under the direction of *médecin de colonisation* Marc Savin-Vaillant and *auxiliaire médical* Ammar ben Ahmed Selmi (ʿAmmar bin Ahmad Salmi). Savin-Vaillant wrote to a government commission in 1911 to say that the infirmary was functioning well with excellent results. Selmi assisted him ably by writing up patient notes, dispensing drugs, applying bandages, acting as anesthetist and performing vaccinations. But after a few attempts, Savin-Vaillant gave up taking Selmi on house calls, since Meskianis refused to expose their female kin to his sight. Husbands and fathers were willing to let a *rūmī* (European, or Christian) doctor physically examine their womenfolk, for Savin-Vaillant was an unbeliever and so existed outside the pale of their community, but they would not contravene strict local practices of female seclusion for his Muslim assistant. The orthodox Muslim population of La Meskiana accepted the French doctor and his Muslim assistant on their own terms.[89]

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Following the mobilization of Savin-Vaillant in the first weeks of the war, Schmitko—the same person who refused to attend to the villagers of Runda in March 1917—was found as a replacement.[90] The new *médecin de colonisation* rapidly fell out with the administrator and the entire local population.[91] While drawing a government salary, Schmitko refused to interrupt his "meals or rest" to see patients, would not leave his home when it was "too hot to go out," declined to hospitalize the chronically ill on the grounds that it was "useless from a medical point of view," and refused to treat sick children whose parents were behind with their bills.[92] He also seems to have extorted domestic labor from patients in return for hospitalization or treatment.[93]

Europeans in the *commune mixte* did not organize a collective complaint, but instead sent individual petitions to the authorities. A widow, Mrs. Tomati, made a heartfelt appeal in broken French to the prefect of Constantine on behalf of herself and her ten children:

> I don't have a fixed month[ly income]. And he gets his indemnities every month. And he doesn't have children, but I have ten still living. He gave me until September 2 [to pay]. I have sick children. I don't know if I can manage [to bring in the harvest] and leave my family on their own. I think he must receive the *collisation* [sic] allowance.[94]

Schmitko had refused to treat two of widow Tomati's daughters, Emilie and Cyprienne, on the basis that she had not paid for medical treatment received by an eleventh child Louis, who had died from his illness. As a result, widow Tomati had had to carry Emilie on her back the forty kilometers from La Meskiana to Aïn Beida to seek a cure: the same difficult trek of which the Muslim Meskianis complained. Widow Tomati may have been only semiliterate, but she recognized that Schmitko held a rank of responsibility to the colonization ("collisation") of the area, and was aware of the state's undertaking towards its citizens. Schmitko received a salary from the central government, which, widow Tomati believed, obliged him to treat all villagers—regardless of whether they were entitled to free care and medicine.

La Meskiana was "known for its fevers," but there was no pharmacist and the greengrocer of the village could only occasionally furnish supplies of quinine. Muslim and European villagers unable to carry their sick to Aïn Beïda or worried about the cost of doctor's fees sought alternative healing in the vicinity. The war had disrupted the smallpox vaccination sessions once conducted by Savin-Vaillant and Selmi, which meant that families concerned about the disease took alternative precautions: the administrator arrested a woman he claimed to have found "going to variolate her neighbors" and locked her in the courtyard of his office (she was released after a warning). One of the many Tomati children refused treatment by Schmitko almost died after her desperate mother obtained an illegal vaccination for her from an unknown source. Another inhabitant of the district, Meziane Tebessi (Miziyani Tibissi), complained to the administrator after he suffered a serious case of poisoning as a result of taking a remedy sold by a druggist in Aïn Beïda. All of these incidents were attributed to Schmitko's neglect.[95] After nearly a year of medical negligence, intriguing, and petitioning, Schmitko was given his marching orders and dispatched to the Aurès, from whence he ignored the people of Runda.[96] It was at this point that the Jarbis of La Meskiana organized a petition to the prefect. As in the case of Châteaudun-du-Rhumel, the prefect responded with alacrity, by dispatching the Jewish physician Haïm Achour (Hayyam ʿAshur) to the post.

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Schmitko's appalling reputation does not seem to have damaged the institution of *médecin de colonisation* in the eyes of petitioners, since they were willing to take a chance on his replacement. But why were they willing to take this chance? Perhaps it was because men from Djerba were prominent in the grocery trade in Aïn Beïda and the *commune mixte*. In all likelihood the Jarbis in the petition belonged to the network of Ibadi artisans and traders that stretched from Djerba to the Mzab valley.[97] These traders, along with the other signatories, were concerned to defend their business interests. Indeed, the scribe helpfully annotated the list of signatures appended to the *shikāya* with each man's occupation: the signatories included seven traders, five butchers, two coffeehouse owners, a bath attendant, a night watchman, a barber, a landowner, and four servants. The traders, coffeehouse owners, and bath attendant would be the first to be affected by disease control policies if an epidemic was announced. As we have seen, in the event of an outbreak of disease, establishments such as coffeehouses and bathhouses were closed down by the municipality and a sanitary cordon might be raised around entire villages, preventing transportation of trade goods and movement of buyers and sellers. Although many in the colonial chain of command were authorized to impose sanitary regulations, only a medical doctor could provide access to free drugs such as quinine and determine when disease outbreaks were no longer a threat requiring quarantine.

CONCLUSIONS

Popular petitions and *shikāyāt* from the archives of the *communes mixtes* have been uncharted and untapped sources for historians of Algeria. This article has demonstrated that such documents in their original languages, as well as a wealth of administrative records located in Algerian and French archives, are not only precious sources for writing local histories of colonialism, adding new detail to our understanding of the lived experience of French colonial occupation and rule. They can also contribute to broadening existing narratives of political and social relations in Algeria. Popular petitions and official communications reveal a mutually intelligible vocabulary of need for medical attention, expert judgment, and drug supplies between state and rural society. They suggest that historians should place state sanitary structures and medicine at the heart of their understanding of the dynamics of power in the *communes mixtes* from the early 20th century onward.

These dynamics become clearly visible during World War I. The medical service in the department of Constantine disposed of a mere 106 doctors, and so Muslim and settler villagers alike depended on alternative healers and therapies, resources that government officials defined as "illegal" but were mostly powerless to prevent. Yet the mobilization of state-appointed doctors resulted in complaints and petitions from officials and villagers alike, who insisted on the importance of a doctor to the survival of their communities. In part, this was because sanitary regulations introduced barely a decade earlier had established a new area of life in which agents of the state intruded. The regulations included forced quarantine and isolation measures, the burning of *gourbi*s, and other measures that were injurious to communal livelihoods as well as distressing to individuals and their families. The doctor might appear at the vanguard of these unwelcome intrusions in people's lives and livelihoods, but at least his presence offered

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some small guarantee of mitigating more unpleasant interference from local leadership and administrators.

Historians have long been aware that Algerian Muslims developed new forms of political consciousness as a result of soldiering and laboring during World War I.[98] It may be that the hardships caused by sanitary regulations, along with the contemporary experiences of state-imposed conscription and military repression, contributed to state medicine's becoming more deeply graven onto popular consciousness than the quantity and quality of these services would otherwise suggest. That is, villagers' demands for a doctor were a product not only of anxieties about disease, but also of solidarities and sacrifices borne of wartime. Villagers acted across a broad range of geographic and demographic constituencies on the basis of the belief that the government was responsible for providing a doctor during disease outbreaks. They asked for the doctor and medical services because this was the idiom through which they knew how to engage the state. Officials responded to their petitions with alacrity—no doubt concerned to forestall further civil unrest and epidemics—by ordering doctors to attend to distressed populations.

Although villager-subjects and villager-citizens may have evinced entitlement in their petitions for a doctor, as this article has made clear, they did not all speak in one voice. The Muslim businessmen of La Meskiana showed careful attention to official discourse, turning it back on the government in their declaration that "diseases are different and every disease requires its own remedy." The Meskianis expressed an attitude of entitlement towards the doctor based on specific local precedent that stretched back only nine years—a stance that seems quite remarkable given that medical services were limited and intermittent during this period and, according to local opinion, even inhumane under the tenure of Dr. Schmitko. This was experience-based entitlement, but it was voiced as an appeal for mercy and goodwill from servants vulnerable to the arbitrary will of an administrative overlord. Meanwhile, French authority and the rhetoric and infrastructures of state medicine were more remote concepts in the hamlet of Runda. Here villagers spoke to power collectively through the medium of the social institutions (the "elders") and local elites who had real, physical control over their lives rather than voicing their concerns directly to distant officials by means of paper, scribe, and individual signatures.

In contrast, in the petition from Châteaudun-du-Rhumel, the scion of a settler landowning family argued point-by-point for the return of the doctor in terms of rights-based entitlement. The text demanded the sanitary services that were due to a large population and necessary for the viability of local agriculture. A settler in La Meskiana, Mrs. Tomati, took this sense of prerogative even further. The widow made a moral claim on the administrator, the prefect, and the *médecin de colonisation* in particular. To her, the doctor was a figurehead of "collisation" and thus he should be held responsible by the authorities for ensuring the wellbeing of its infant settlers.[99] European petitioners spoke in a rights-based language of entitlement.

Despite shared content between these requests, the disparate form of their composition seems to indicate how rural villagers were destined to experience entitlement in asymmetrical ways under colonialism. Or does it? These petitions suggest that the experience of entitlement was not always a function of an individual's legal status under colonialism, but was also formed by specific experiences within local socioeconomic environments. This is evinced by the fact that Muslims and Jews joined forces with the

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settlers of Châteaudun-du-Rhûmel, and expressed themselves as rights-bearing individuals, "We, the undersigned." It is also suggested by the act of erasure performed by the nameless translator at the Prefecture in Constantine, who reframed the *shikāya* from La Meskiana and so transformed beseeching servants into villagers conversant with the language of bureaucracy. The translator and the Châteaudun petitions attempted to navigate the space between the positions of "subject" and the full-fledged "citizen," and so confound historical frameworks that posit "two societies, dominant and 'subject.'"[100]

Petitioners traversed multiple linguistic registers, but translators and functionaries rendered their words into the language of actionable bureaucracy. As a result, villagers' determination to engage the state on its terms may not have been visible to French administrators who relied on redacted French translations. Similarly, historians of Algeria have tended to underestimate the agency of rural Muslims, and the complex ways in which they related to the colonial state. In performing close readings of *shikāyāt* and exploring the discrepancies between these texts and their translations, this article has elucidated the ways in which people who found themselves the victims of state oppression roundly asserted their entitlement in the face of it.

NOTES

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[1]*Duwwār* (Fr. *douar*), literally meaning "circles," was an administrative term used to delimit a group of "native" dwellings or encampments. The *duwwār* discussed in this article were attached to *communes mixtes* (CM), a form of administrative unit in existence from 1858 to 1956 (although different territories were incorporated into *communes mixtes* at different times, and boundaries shifted over time). Each *commune mixte* comprised a *centre de colonisation*, inhabited by a "mixed" population of Europeans, Jews, and Muslims, and a number of outlying *duwwār,* the entirety under the sole charge of an administrator appointed in Algiers. Another administrative entity referred to in this article is the *commune de plein exercice* (CPE). These units were comparable in size and organization to French *communes*, and were governed by an elected mayor and municipal councils. On the *commune mixte*, see Christine Mussard, "La commune mixte: l'espace d'une rencontre," in *Histoire de l'Algérie à la période coloniale, 1830–1962,* ed. Abderrahmane Bouchène, Jean-Pierre Peyroulou, Ouanassa Siari Tengour, and Sylvie Thénault (Paris: Découverte, 2012).

[2]Technically the agha should have written to the administrator of the *Commune mixte* of the Aurès, into which *duwwār* Ghassira had been incorporated in 1912.

[3]Archives nationales d'Outre-Mer, Aix-en-Provence, France (hereafter ANOM) CONST B/3/241, letter Agha Bani bu Sliman to Administrator CM Belezma, 19 March 1917. *Al-ḥabb al-sūdā'* (the black pustule) conventionally referred to variety of smallpox. In certain regions of the Aurès, the term *bū zagāgh* denoted measles. I am grateful to Professor Larbi Abid for this information.

[4]Compulsory conscription for Algerian Muslim male subjects was introduced in 1912, but the contingent was only selectively levied until decrees of 7 and 14 September 1916 authorized full conscription in 1917. See Gilbert Meynier, "Les Algériens et la guerre de 1914–1918," in *Histoire de l'Algérie à la période coloniale,*

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229–34. A detailed account of insurrections against conscription is given in Gilbert Meynier**,** *L'Algérie révélée,* 2nd ed. (Paris: Editions Bouchène, 2015), 559–86. See also Charles-Robert Ageron, "Les troubles insurrectionnels du sud Constantinois Novembre 1916–Janvier 1917," in *Genèse de l'Algérie algérienne*, ed. Charles-Robert Ageron (Paris: Éditions Bouchène, 2005), 89–106.

[5]Figures are taken from Ouanassa Siari Tengour, "La révolte de 1916 dans l'Aurès," *Histoire de l'Algérie à la période coloniale*, 255–60, reference on 257. The repression officially ran from November 1916 to autumn 1917, but patrols of black troops were used to "pacify" rural unrest years after the armistice. See ANOM ALG CONST B3/452 CM Fedj M'Zala, "Surveillance politique des indigenes," 31 May 1920.

[6]On the severity of the official response, see Tengour, "La révolte de 1916 dans l'Aurès," 255–60.

[7]A further thirty of the hostages died from dysentery; twenty-five from smallpox; ten from influenza; and five from pneumonia. ANOM ALG CONST B3/214, "Indigènes en prévention de Commission disciplinaire décédés du typhus" and "CM de Belezma. Année 1917. Mois de février. Déclarations des maladies épidémiques transmises à l'Inspecteur d'Hygiène."

[8]The letter from the agha of the Bani Bu Sliman was archived alongside tabulated typhus deaths from the prison, which suggests that record keepers associated the mysterious deaths in Runda with the epidemic of typhus in the prison, even if villagers did not possess this information.

[9]Examples of work that take a subaltern perspective on colonial medicine in sub-Saharan Africa include *inter alia*, Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, N.C.: Duke University Press, 1999); Luise White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley, Calif.: University of California Press, 2000); and Julie Livingston, *Debility and the Moral Imagination in Botswana* (Bloomington, Ind.: Indiana University Press, 2005). For the case of Egypt, see Khaled Fahmy, "Dissecting the Modern Egyptian State," *International Journal of Middle East Studies* 47 (2015): 559–62; and Liat Kozma, *Policing Egyptian Women: Sex, Law and Medicine in Khedival Egypt* (Syracuse, N.Y.: Syracuse University Press, 2011).

[10]Previous work on medicine in rural Algeria has concentrated on 19th-century developments. See, for example, Yvonne Turin, *Affrontements culturels dans l'Algérie coloniale: écoles, médecines, religion, 1830–1880* (Paris: F. Maspero, 1971); William Gallois, "Local Responses to French Medical Imperialism in Late Nineteenth-Century Algeria," *Social History of Medicine* 20 (2007): 315–31; and Bertrand Taithe, "Entre deux mondes: médecins indigènes et médecine indigène en Algérie, 1860–1905," in *La santé des populations civiles et militaires: Nouvelles approches et nouvelles sources hospitalières, XVIIe–XVIIIe siècles,* ed. Élisabeth Belmas and Serenella Nonnis-Vigilante (Villeneuve d'Ascq, France: Presses Univ. Septentrion, 2010), 99–112. Insofar as these studies rely exclusively on French archives and the records of religious societies, and do not use Arabic-language sources, the complexity of individuals' motivations and responses are not fully considered. The potential of using archives located in Algeria and nongovernment sources such as oral histories is exemplified by Jennifer Johnson, *The Battle for Algeria: Sovereignty, Health Care, and Humanitarianism* (Philadelphia, Pa.: University of Pennsylvania Press, 2016).

[11]The sources examined in this article span the period from c. 1900 to the late 1930s.

[12]I owe this term to Beth Linker, *War's Waste: Rehabilitation in World War 1 America* (Chicago: University of Chicago Press, 2011), 126. A more common use of the term "medicalization," particularly among sociologists, refers to the process by which social or personal problems are reframed as medical issues requiring therapeutic management. Like Linker, I use "medicalization from above/below" to mean the demand for medical care and its institutions.

[13]I owe this phrase to Fanny Colonna, "Une véritable Histoire sociale de l'Algérie coloniale rendrait-elle possible une approche plus réaliste du present?," *Réflexions et perspectives* 1 (2012): 485–97, reference on 486.

[14]Works that insist on internal divisions among the categories "Muslim," "settler," and "Jew" include Michael Brett, "The Colonial Period in the Maghrib and Its Aftermath: The Present State of Historical Writing," *Journal of African History* 17 (1976): 291–305; David Prochaska, *Making Algeria French: Colonialism in Bône, 1870–1920* (Cambridge: Cambridge University Press, 1990); and Sarah Abrevaya Stein, *Saharan Jews and the Fate of French Algeria* (Chicago: University of Chicago Press, 2014).

[15]Meynier, *L'Algérie révélée*, 519.

[16]Scholars who have engaged in rethinking social history under colonialism, including the problem of sources and scales of analysis, are Joëlle Bahloul, *The Architecture of Memory: A Jewish–Muslim Household in Colonial Algeria, 1937–1962* (Cambridge: Editions de la Maison des Sciences de l'Homme and Cambridge

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University Press, 1996 [1992]); Fanny Colonna, for example, *Le meunier, les moines et le bandit: des vies quotidiennes dans les Aurès (Algérie) du XXe siècle: récits* (Paris: Actes Sud, 2010); and James McDougall and Robert P. Parks, "Locating Social Analysis in the Maghrib," *Journal of North African Studies* 18.5 (2013): 631–38. The nature and extent of political and social contacts across religious and racial boundaries was problematized by Emmanuel Blanchard and Sylvie Thenault, "Quel 'monde du contact'? Pour une histoire sociale de l'Algérie pendant la période coloniale," *Le Mouvement social* 236 (2011): 3–7.

[17]The records of *communes mixtes* are filled with petitions and letters composed in both classical Arabic and the Arabic of everyday speech. Comparison of materials from the arrondissement of Bougie (present-day Bijaya) and the *communes mixtes* of Aïn Témouchent (ʿAyn Timushant) and Tiaret (Tiyarat) suggests that qaʾids in the Berberophone region of Kabylia prepared reports and correspondence in Arabic until the 1930s and 1940s, while those in predominantly Arabophone regions of western Algeria used Arabic until at least the 1950s.

[18]See, for example, Nora Lafi, "La gouvernance ottomane des équilibres locaux: le rôle du bureau central des pétitions à Istanbul et l'usage de ses archives," in *Les archives, la société et les Sciences humaine: Actes du colloque international tenu à Tunis de 22 au 24 février 2010*, ed. Kmar Bendana-Kchir, Hassan El-Annabi, Habib Belaid, Hédi Jallab, and Mabrouk Jebahi (Tunis: Cahier de CERES, 2010), 261–74. Work that examines state–society relations by paying close attention to the form and content of popular petitions include John Chalcraft, "The Coal-Heavers of Port Saʿid: State-Making and Worker Protest, 1869–1914," *International Labour and Working Class History* 60 (2001): 110–24; Chalcraft , *The Striking Cabbies of Cairo and Other Stories: Crafts and Guilds in Egypt, 1863–1914* (Albany, N.Y.: SUNY Press, 2004); Chalcraft, "Engaging the State: Peasants and Petitions in Egypt on the Eve of Colonial Rule," *International Journal of Middle East Studies* 37 (2005): 303–25; and Fruma Zachs and Yuval Ben-Bassat, "Women's Visibility in Petitions from Greater Syria during the Late Ottoman Period," *International Journal of Middle East Studies* 47 (2015): 765–81.

[19]Petitions by Algerian notables and high-profile figures such as Hamdan bin ʿUthman Khuja have drawn the attention of scholars. See, e.g., Charles-Robert Ageron, *Les Algériens musulmans et la France, 1871–1919,* vol. 2 (Algiers: Éditions Bouchène, 2005 [1968]); and James McDougall, "A World No Longer Shared: Losing the *droit de cité* in Nineteenth-Century Algiers," *Journal of the Economic and Social History of the Orient*, forthcoming. Joshua Schreier, *Arabs of the Jewish Faith: The Civilizing Mission in Colonial Algeria* (Rutgers, N.J.: Rutgers University Press, 2010) contains extended analysis of petitions from urban Jews, and Stein, *Saharan Jews* those of Mzabi Jews.

[20]See Hannah-Louise Clark, "Doctoring the *Bled*: Medical Auxiliaries and the Administration of Rural Life, 1904–1954" (PhD diss., Princeton University, 2014), introduction.

[21]This section draws extensively on Clark, "Doctoring the *Bled*," which discusses the varied backgrounds and career trajectories of *médecins de colonisation.* The figure of the *médecin de colonisation* is examined in detail in Charlotte Chopin, "Embodying 'the New White Race': Colonial Doctors and Settler Society in Algeria, 1878–1911," *Social History of Medicine* 29 (2016): 1–20.

[22]Medical auxiliary training comprised two years of study and one year of apprenticeship. In contrast, university studies in medicine, which were open only to holders of the baccalauréat, required four years of study and completion of a doctoral thesis. Auxiliary recruitment and training is discussed in Clark, "Doctoring the *Bled*."

[23]On the origins of these laws, see S. Antoniotti, V. Pellisier, M. C. Siméoni, and C. Manuel, "Déclaration obligatoire des maladies infectieuses. Des maladies «pestilentielles» aux maladies «émergentes»," *Santé publique* 14 (2002): 165–78. For the full text of the law, see "La loi de santé publique de 1902," *Le Tribunes de la santé* 4.25 (2009): 129, accessed 29 March 2016, http://www.cairn.info/revue-les-tribunes-de-la-sante-2009-4-page-129.htm. Articles 5 and 7 of the 1902 law stipulate obligatory declaration and disinfection.

[24]The *Délégations financières algériennes* were founded in 1898 to devolve some degree of autonomy to the three *départements* of Algeria. The assembly comprised three groups of speakers, whose debates were conducted in isolation from one another, representing the interests of rural settlers (*délégation des colons*, with twenty-four members), urban settlers (*délégation des non-colons*, with twenty-four members), and the autochthonous population (with only twenty-one members—fifteen in the *Section arabe* and six in the *Section kabyle*). A purely consultative body at its inception, in 1901 the *délégations* were granted voting rights to determine the colonial budget, a right which became effective from 1902. The inbuilt distortions within the system of representation ensured that the agenda and interests of settlers and large landowners always prevailed. A detailed account of the institution is provided in Jacques Bouveresse, *Un parlement colonial? Les*

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délégations financières algériennes (1898–1945), 2 vols. (Mont Saint-Aignan: Publications des Universités de Rouen et du Havre, 2008 and 2010).

[25]*Assistance médicale des indigènes. Circulaire du Gouverneur général aux Préfets (5 Décembre 1904). Infirmeries indigènes—Consultations gratuites—Ophtalmies—Vaccinations—Aménagement des sources thermo-minérales—Hygiène* (Algiers: Imprimerie Victor Heinz, 1904).

[26]Infirmaries were given limited funding from the central colonial budget, and were mostly supported by municipal receipts and private donations. This was consistent with the manner in which medical assistance was financed in France. See Matthew Ramsey, "Public Health in France," in *The History of Public Health and the Modern State*, ed. Dorothy Porter (Atlanta, Ga.: Editions Rodopi, 1994), 45–118.

[27]Henri Dubouloz, *Premiers soins à donner aux malades et conseils pratiques d'hygiène / Jamaʿa Maʿrufa Hafz al-Sihha wa-Hiyya Faransawiyya* (Constantine: Imprimerie Adolphe Braham, 1897).

[28]"Aventures d'un Règlement Sanitaire," *al-Akhbar*, 20 February 1910.

[29]Edmond Bruch, "Étude sur l'application à l'Algérie de la loi sur la protection de la Santé publique du 15 février 1902," *Archives de Thérapeutique et d'Hygiène coloniales* (1908): 256–64, 289–300.

[30]In fact, structural inequalities under colonialism and conditions of existence created by the colonial labor market (including poverty, hunger, poor housing, and overcrowding) not only fostered disease but also encouraged the transmission of diseases such as tuberculosis from Europeans to Algerian Muslims. See, for example, Matthieu Fintz, "Épidémiologie de l'invasion et constitution de l'identité biosociale des *fellahin* dans l'Algérie coloniale (1910–1962). La lutte contre le paludisme au regard des recherches sur la production des savoirs," in *Chantiers et defis de la recherche sur le Maghreb contemporain*, ed. Pierre Robert Baduel (Paris: IRMC–Karthala, 2008), 117–33; and Clifford Rosenberg, *Infection, Inequality, and the Colonial State: The Spread of TB From France to Algeria and Back, 1830–Present* (work in progress).

[31]Hannah-Louise Clark, "Administering Vaccination in Interwar Algeria: *Auxiliaires médicaux*, Smallpox, and the Colonial State in the *Communes mixtes*," *French Politics, Culture & Society* 34.2 (forthcoming).

[32]Archives régionales de Constantine, Constantine, Algeria (hereafter ARC), Règlements sanitaires communaux 1910–11 and CM règlement sanitaires E à A 1910–20. See *Commune Mixte d'Aïn-el-Ksar. Hygiène publique. Règlement sanitaire municipal* (Batna, Algeria: Imprimerie administrative et commercial Beun, 1910).

[33]See, for example, "Commune Mixte El-Mila. Règlement sanitaire," 346–47; "Commune Mixte d'Aïn-el-Ksar. Hygiène publique. Règlement sanitaire municipal," 13; and "Règlement sanitaire de la Commune Mixte de Fedj-M'Zala," 7–9.

[34]Boet, "al-Qanun al-Hawz fi Hafz al-Sihha" for al-Hamma, 16 January 1910. Cf. Cortade, "Règlement sanitaire de la Commune mixte de Fedj M'zala," 9 October 1910.

[35]Reparations were offered when sick livestock had to be slaughtered; see discussion of animals with glanders in ANOM ALG AINTE I/9.

[36]Lion Murard and Patrick Zylberman, *L'Hygiène dans la République: la santé publique en France, ou, l'utopie contrarié: 1870–1918* (Paris: Fayard, 1996); Patrick Zylberman and Lion Murard, "Experts et notables. Les bureaux municipaux d'hygiène en France (1879–1914)," *Gèneses* 10.10 (1993): 53–73.

[37]Martha Lee Hildreth, *Doctors, Bureaucrats, and Public Health in France, 1888–1902* (New York: Garland, 1987).

[38]ANOM CM Tiaret (uncatalogued), letter Commissaire de Police to Mayor of Tiaret, 28 July 1921.

[39]ARC Archives communales 685, "Commune de Mila, Règlement sanitaire, Règlement Rural," 25 January 1911, 346.

[40]Each *khabr* was typically handwritten on a sheet of lined or blank paper folded vertically in half: the left side reserved for the qa'id's handwriting, the right side for a French translation carried out by a secretary. The more sophisticated of these documents were prepared on official communal letterhead (on which a vertical line was traced by black ink or perforations) and signed with an official seal. But many *akhbār* were written hastily on reused paper scraps. *Akhbār* found in ANOM ALG AINTE and Tiaret (uncatalogued) and in ARC 56 Akbou cluster in the 1920s and 1930s. The lack of counterparts in the post–World War II era may be a consequence of the vagaries of archivization, but is plausibly the result of the introduction of the telephone and its generalization in these decades.

[41]Archives nationales d'Algérie, Birkhadem, Algiers, Algeria (henceforth ANA) DZ/AN/17E/1395, "Rapport de Tournée, Inspecteur Général des Services d'Hygiène de l'Algérie," 5 November 1921. See also ANOM CM Tiaret 34/Santé Publique (uncatalogued), circular "Typhus. Mesures de defense et de protection."

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[42]One such investigation features in ARC Archives Communales 631, letter Administrator CM Takitount to Préfet de Constantine, "La Typhus au Douar Maouia," 25 July 1936. Another appears in ANOM ALG AINTE I/9, Circular, "Surveillance à exercer sur les populations indigènes," 5 March 1931. A dismissal is mentioned in ANOM ALG AINTE I/9, letter Administrator CM Aïn el Arba to Préfet d'Oran, 6 December 1926.

[43]See, for example, CM Tiaret (uncatalogued), ARC 56 Akbou and Archives Communales 631, letter 21 March 1937, qaʾid of *duwwār* Oukaour to Administrator CM Akbou.

[44]ANOM CM Tiaret (uncatalogued) Archives I/21, Santé publique, letter 31 January 1929.

[45]ANOM ALG AINTE/I/9, see correspondence regarding Oued Sebbah, November and December 1926. The prefect of Oran ordered 150 armed sentries to camp around *duwwār* al-ʿAyisha for more than a week to prevent the movement of villagers, in response to a panicked letter from the administrator of CM Aïn Temouchent speculating that the village was infected by plague. The file contains no evidence, medical or other, that supports the administrator's claim.

[46]Hilton-Simpson was not a medic but had formed an interest in medical practice among the Shawi Berbers after reading a paper in the journal *L'anthropologie* that discussed Shawi practices of skull trepanation. Henri Malbot and René Verneau, "Les Chaouias et la trépanation du crâne dans l'Aurès. Les trépaneurs et la trépanation," *L'Anthropologie* 8 (1897): 174–204.

[47]Pitt Rivers Museum Manuscript Collections, University of Oxford (henceforth PRMMC), Hilton-Simpson Papers (H-SP), item A: thesis, "Medicine among the Berbers of the Aurès," 5.

[48]ANA Territoires du Sud (henceforth TDS) 0531.

[49]ANA DZ/AN/17E/2026, Governor General Jules Cambon, cited in Secrétaire générale délégué pour le Préfet d'Alger to sous-préfets, "Recueil des Actes Administratifs. No 113. 1er Bureau. Police des Professions Médicales – Indigènes musulmans," 9 September 1897.

[50]PRMMC H-SP, item A, 5.

[51]Ibid., 5, 7–8.

[52]Ibid., 11.

[53]The villagers may also have been aware of a number of hadith that offered advice on correct behavior in the face of epidemics (*al-wabāʾ*) and plague (*al-ṭaʿūn*), such as those from the highly respected collections of al-Bukhari and Muslim ibn al-Hajjaj. These were discussed in a text by Muhammad bin Mustafa ibn al-Khuja Kamal, *Tanwir al-Adhhan fi al-Haththʿala al-Taharraz wa-Hafz al-Abdan* (Algiers: Imprimerie Fontana Frères, 1896), which circulated widely in Algeria at the turn of the 20th century.

[54]PRMMC H-SP, item G, working slip number 72.

[55]Jane Murphy, "Natural History and Materia Medica in Eighteenth-Century North Africa" (paper presented at the conference "The Historical Career of Mike Mahoney," Princeton University, 15–16 May 2009).

[56]PRMMC H-SP, item A, 12–13.

[57]John Janzen, *The Quest for Therapy: Medical Pluralism in Lower Zaire* (Berkeley, Calif.: University of California Press, 1978), xviii.

[58]Medical pluralism presents an interesting parallel with legal forum shopping. See, for example, Jessica M. Marglin, *Across Legal Lines: Jews and Muslims in Modern Morocco* (New Haven, Conn.: Yale University Press, forthcoming).

[59]See Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, Calif.: Stanford University Press, 1991); and Vaughan "Healing and Curing: Issues in the Social History and Anthropology of Medicine in Africa," *Social History of Medicine* 7 (1994): 283–95, reference on 288.

[60]ANOM CONST B/2/214, undated petition, *duwwār* Zillatou.

[61]ANOM ALG CONST B3/214, letter Administrator CM Aurès to Sous-Préfet Batna, 16 March 1917.

[62]Dorothée Chellier, *Voyage dans l'Aurès: notes d'un médecin envoyé en mission chez les femmes arabes* (Tizi Ouzou: Imprimerie J. Chellier, 1895); Chellier, *Notes de voyage et rapport a M. le gouverneur général d'une mission médicale chez les indigènes de l'algérie 1896* (Montélimar: Bourbon, 1897).

[63]Figures drawn from Christine Debue-Barazer and Sébastien Perrolat, "1914–18: guerre, chirurgie, image. Le Service de Santé et ses répresentations dans la société militaire," *Sociétés & Représentations* 25 (2008): 233–53.

[64]Military service records for a number of *auxiliaires médicaux* were found in the Service des archives de la wilaya d'Alger, Algeria (henceforth SAWA), 3V61.

[65]ANA TDS 0531, letter Sous-Préfet Mostaganem to Préfet d'Alger, 21 April 1915.

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[66]See ANOM B3/430, Médecin inspecteur général Calmette, "Concours des médecins militaires au service médical des populations civiles," 21 April 1916. Figures of *médecins de colonisation* are given in Meynier, *L'Algérie révelée*, 509.

[67]ANA CK 079, *Statistique du personnel médical et pharmaceutique de France et d'Algérie, année 1906*; ANOM ALG/CONST B3/430 Novembre–Décembre 1914, "Liste nominative des Médecins, Chirurgiens, Officiers de Santé, Pharmaciens, Sages-Femmes, Dentistes et Vétérinaires exerçant dans le département de Constantine au 1er janvier 1914," 10 February 1914.

[68]ANOM ALG/CONST B3/430 1914/Novembre–Décembre 1914.

[69]ANOM ALG CONST B3/452, telegram Préfet de Constantine to Governor General, 25 January 1915.

[70]Ibid., letter Maire de la commune de pleine exercice d'Oued-Zenati to Préfet de Constantine, 28 December 1914.

[71]ANOM ALG/CONST B3/430, letter Maire Robertville to Sous-préfet Philippeville, 9 September 1915.

[72]ANA TDS 0531, telegram Procureur général Mostaganem to Justice de la paix Trézel, August 1914. See also letter, Sous-préfet Mostaganem to Préfet d'Oran, 21 April 1915; and letter Procureur Général près de la Cour d'Appel d'Alger to Governor General, 25 May 1915.

[73]Ibid., letter Sous-préfet Mostaganem to Préfet d'Oran, 21 April 1915.

[74]ANOM ALG CONST B3/430, letter Administrator CM Oued-Marsa to Préfet de Constantine, 5 August 1916.

[75]ANOM ALG CONST B3/452, letter Administrator CM La Meskiana to Préfet de Constantine, 17 August 1917.

[76]Ibid., letter Administrator CM Oued-Cherf to Sous-préfet Guelma, 6 March 1917.

[77]Ibid., telegraph Préfet de Constantine to Governor General, 25 January 1915.

[78]ANOM ALG/CONST B3/430 1915/2e sem, letter Dr. Attal to Préfet de Constantine, 23 March 1915.

[79]Ibid., letter no. 935M, Médecin Principal 1e classe Bouchereau to Préfet de Constantine, 7 September 1915.

[80]See André Nouschi, *Enquête sur le niveau de vie des populations rurales constantinois de la conquete jusqu'en 1919* (Paris: Presses Universitaires des France, 1961), chaps. 4–9 for a detailed description of the commune.

[81]ANOM ALG/CONST B3/430, petition, no date.

[82]Information on European and Jewish inhabitants of Châteaudun-du-Rhumel was consulted at ANOM, via IREL (instruments de recherché en ligne) *état civil* records, accessed 29 March 2016, http://anom.archivesnationales.culture.gouv.fr/caomec2/recherche.php?territoire=ALGERIE. It has not yet been possible to consult the *état civil* for the Muslim population of Châteaudun-du-Rhumel, which is held in the ANA.

[83]Henri Soulié and Lucien Raynaud, "De la nécessité d'organiser en Algérie un corps d'infirmiers ou aides-médecins indigènes," *Compte-rendu du Congrès colonial français*, 29 May–5 June 1901, Section de Médecine et d'Hygiène coloniales, 245–50, figures on 245.

[84]Didier Guignard, *L'Abus du pouvoir dans l'Algérie coloniale* (Paris: Presses Universitaires de Paris Ouest, 2010), 74.

[85]Description taken from Henri Soulié, "L'Assistance publique chez les Indigènes musulmans de l'Algérie," *Bulletin médical de l'Algérie* 14.10 (1903): 384–85.

[86]ANOM ALG CONST B3/452, *shikāya*, inhabitants of La Meskiana, 29 July 1917.

[87]Ibid., French translation.

[88]Colette Establet's study of qa'ids in the *cercle* of Tébessa (Tibissa) described how this region was drawn into the French administrative net between 1851 and 1915. Establet identified a bureaucratic formalism emerging in the correspondence of the Bureaux arabes, which she argued reflected qa'ids' transformation from charismatic and traditional power figures into bureaucratic brokers of the French state. Colette Establet, *Être Caïd dans l'Algérie Coloniale* (Paris: Centre Nationale de la Recherche Scientifique, 1991), 227–52.

[89]ANA TDS 0531 Questionnaire, Marc Savin-Vaillant, La Meskiana, 3 May 1911.

[90]ANOM ALG/CONST B3/430 Novembre–Décembre 1914, "Liste nominative des médecins communaux du département de Constantine; Liste des autres médecins se trouvant dans les Communes du département et non appelés sous les drapeaux; infirmeries indigènes," October 1914 (no date).

[91]ANOM ALG/CONST B3/452, letter Administrator CM La Meskiana to Préfet de Constantine, 5 December 1916 and reference to complaint made on 27 November 1916. New charges were addressed to the Préfet

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on 5 December 1916 in response to a complaint made by Schmitko against the administrator. Schmitko's original letter has not come to light and so it is not possible to see his defense.

[92]Ibid., letter Administrator CM de La Meskiana to Préfet de Constantine, 5 December 1916.

[93]Ibid., letter Mrs. Tomati to Préfet de Constantine, 25 August 1916.

[94]Ibid.

[95]Ibid., letter Administrator CM La Meskiana to Préfet de Constantine, 5 December 1916.

[96]ANOM ALG/CONST B3/452, letter Administrator CM Arris to Sous-préfet Batna, 16 March 1917.

[97]George Coppolani, "Ain-Beida—La Source Blanche—Souvenirs d'en face," *ʿAin al-Baydaʾ Tarikh*, accessed 29 March 2016, http://ainbeidahistoire.blogspot.co.uk/p/blog-page_6.html.

[98]On the political consequences of wartime services, see Rabah Aissaoui, "Exile and the Politics of Return and Liberation: Algerian Colonial Workers and Anti-Colonialism in France during the Inter-War Period," *French History* 25 (2011): 214–31; Meynier, *L'Algérie Révelée*; Meynier, "Les Algériens et la guerre de 1914-1919"; and André Nouschi, *L'Algérie amère 1914–1994* (Paris: Éditions de la Maison des Sciences de l'homme, 1995), chap. 3.

[99]For activities carried out by the burj in the *cercle* of Tébessa from 1872 to 1890, see Establet, *Être Caïd dans l'Algérie Coloniale,* 177–90.

[100]Similarly, it is possible to find evidence in the archives of distressed Europeans who stepped into an ambiguous position beneath that of citizen deliberately—for example, by marrying a Muslim.

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