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PERSPECTIVE

SYPHILIS IN COLONIAL MOROCCO THE CASE OF BOUSBIR

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ABSTRACT
Syphilis is a venereal disease. Morocco has witnessed syphilis since the fifteenth century and the treatment of this disease remained archaic until the Protectorate was established.
With the establishment of the colonial system in Morocco, the phenomenon of prostitution spread. Protectorate authorities designated a particular place in Casablanca for such activity that developed: Bousbir district. The authorities' efforts failed to regulate and organize such activity because of the development of clandestine prostitution in relation to urban growth and the increase of employed, poor and downgraded urban population, especially among women who practice prostitution, and due to lack of a real social policy of the Protectorate concerning the policy of land-use planning or control that were a priority.

KEY WORDS: Bousbir, Morocco, venereal diseases, syphilis, protectorate.

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INTRODUCTION
Syphilis is a venereal disease. It appeared since at least five centuries ago in Europe. Syphilis deeply marked the minds of contemporary people because of its rapid evolution and destruction.
At the same time, Morocco witnessed syphilis. The treatment of this disease remained archaic until the advent of the Protectorate, which established a real policy of treating this particular disease, and venereal diseases in general.
With the establishment of the colonial system in Morocco, the phenomenon of prostitution spread. Protectorate authorities designated a particular place in Casablanca for such activity which developed: Bousbir district.

Our work will address the following:
Firstly, combating venereal diseases while focusing on syphilis.
Secondly, treating syphilis during the colonial period in Bousbir.

THE HISTORY OF BOUSBIR AND PROSTITUTION IN COLONIAL MOROCCO
In 1914 (1), Protectorate authorities decided, in Casablanca as in other cities in Morocco, to group the prostitutes into the alleyways of the old medina for the fear of a syphilis infection. The red-light district of Casablanca followed the example set in Algiers since 1830, where evil can be limited and its spread can be controlled by sex workers (2).
The authorities built houses on land owned by Prosper Ferrieu who, despite himself, gave his name to the district. Distorted by the people, Prosper became Bousbir (1). In this enclosed area, the French wanted to monitor the prostitutes' health with regular medical visits. With time, the district was part of a city center being one of the big urban dreams of Marshal Lyautey. It was decided in 1923 to move the district to a less central location (1). It was then moved out of sight, to Derb Soltane. Entirely surrounded by walls, it had only one entrance, located on the east side and guarded by both the military and the police.

The district was, at the time, considered as a model of organization and ending of the problem of prostitution, because we had reduced the problem in a simple operation of a woman subject to several consequences where medical consequences and mostly syphilis required routine medical check-ups that were supposed to protect the "healthy society" from its "unhealthy" members (3). According to Christelle Taraud, prostitution was also a symbol of colonial rule. Colonists organize red-light districts, that marginalize women, and it is in fact a real State racism (3). The system made prostitution invisible in the city's public spaces, because Bousbir was isolated and visibility was still shocking (3).

SYPHILIS CASE

History and the Protectorate

The beginning of syphilis in Europe according to historical sources was in the late fifteenth century in Spain where syphilis was introduced by Christopher Columbus' men upon their return from the New World (4). The first time syphilis was mentioned in Morocco dates back to the early sixteenth century with Leo Africanus and its spread by the expellees from Spain (5). Syphilis was, for a long time, treated with the traditional means of the time until the establishment of the French Protectorate in 1912, which set up a program to fight contagious diseases including syphilis (6). Pierre Parent explained the whole medical policy which included syphilis: "I wish to see native hospitals, for both men and women .... I wish patients to be followed up, particularly regarding this scourge called syphilis" (7). The anti-syphilis fight was one of the first battles conducted in Morocco with strong treatment means of the time that were: the arsenic derivatives (8). The screening and treatment of the population were massive (9). Doctors Lacapere and Leredde created, in 1916 in Morocco, the first two anti-syphilitic clinics in Fez and Casablanca with the use of Arsenobenzol in syphilis treatment (10). Lacapère estimated the prevalence of syphilis in Morocco from 75 to 90% of the population, with the main risk factor which was poor hygiene: "In Morocco, syphilis is much more widespread than in France and the risks of contamination are still much bigger" with the frequency of canker in Moroccan cities compared to the countryside.

Syphilis and society.

Moroccans considered syphilis a normal or usual condition that was not to be ashamed of since some of the symptoms were not painful. For the majority of French doctors of the Protectorate, faced with the scourge of syphilis, the fight against venereal diseases became the key aspect of sex education for Moroccans. But, being prisoners of the colonialist perspective using medicine to serve colonialism, these doctors saw the high frequency of syphilis as a symptom of degeneration of the "Moroccan race", alongside the major communicable diseases. Coercive and humiliating actions of sanitary control, disinfection or vaccination lead, in many cases on micro-resistance, to the phenomenon of forced medicalization. The regulation of prostitution was undertaken by providing brothels or specialized districts, enabling medical control of prostitutes. Clinics specialized in venereology, ophthalmology and tuberculosis received mostly female clientele (11). It should also be noted that the development of the Moroccan society, and especially Casablanca, under the Protectorate, with all its aspects, and the economic crisis that Morocco witnessed, widely influenced prostitution and venereal diseases as a result. Lacapère suggested that the Arab "syphilization" was closely linked to cultural habits (12).

One of the most striking examples of the interaction of Moroccan society with syphilis was the term "Nowar" in Moroccan dialect, which referred to syphilis (12). Moroccans distinguished the different phases of syphilis with a particular lexicon. Moroccans used the term "changher" to designate primary syphilis chancre. Secondary syphilis and tertiary syphilis were called Nowar (flowers), and sometimes "mrd el-Kebir" (the great disease) or "mrd al-fssad " (adultery disease) (12).

The fight against syphilis in Bousbir clinic

The clinic of Bousbir was responsible for the prophylaxis and the treatment provided by a full-time doctor and nurses. The doctor of the clinic treated only specific venereal diseases, "Genital examination of the women who live in the red-light district takes place twice a week, after an identity check by the police" (1) .

The doctor performs medical checks and ensures proper adherence to treatment of patients with a venereal disease, with a well-detailed medical record: "a medical record that includes, among other information, the diagnosis of the patient's condition, lab results and treatment history" (1) .

The patient prostitute is hospitalized for free to the clinic, and can only be discharged after full recovery (1). The clinic also had a surveillance and prophylaxis cabin at the entrance of the district with a Moroccan nurse manager, where every client after every visit to the district tries to disinfect, "a Moroccan nurse and a former soldier are always available ... With an activity record" (1).

However, according to Christelle Taraud: "The repressive legislation serves only one thing: the frantic economic exploitation of women. This system has never helped rehabilitate or heal women. The ultimate scandal is health tax: it charges the women for this degrading visit." There were two reasons which could compel prostitutes to accept the medical visit, despite having to pay: on the one hand, the severe punishment they would bear if evidence of contagiousness could be found, and on the other hand, being certain that no vexatious measure of the police would impede the free practice of their profession (1).

PATIENT MANAGEMENT IN BOUSBIR

The management of venereal diseases in Bousbir was within the framework of cooperation between physicians of the clinic of Bousbir and doctors of the hygiene service, "the doctors in charge of the clinic provide, in collaboration with doctors of hygiene service, health monitoring and treatment of prostitutes..." (1). This monitoring was well-regulated, "... but it is a modernized regulation, requiring particularly prostitutes to take hygiene measures, to undergo frequent medical visits and maintenance treatments that prevent them from the disease..." (1).

If we believe the colonial historical sources, the results would be significant: "in the cities, we no longer see these horrible mutilations we see frequently, it has been only a few years." However, consultations in Bousbir were not for free; prostitutes pay for their consultations, which was sometimes a barrier to attend medical consultations for some.

CONCLUSION

Bousbir disappeared in 1953 (13), mainly because of the activism by the two abolitionist doctors Jean Mathieu and

P-H Maury, authors of the study "The Monitored Moroccan Prostitution of Casablanca, The Red-light District", which highlighted the horrible living conditions of the prostitutes of Bousbir and the “condensation camp" atmosphere of the district. In addition, the French Government failed in its commitment to regulate and organize prostitution because of the development of clandestine prostitution in relation to urban growth and the increase of employed, poor and downgraded urban population, especially among women who practice prostitution, and due to lack of a real social policy of the Protectorate concerning the policy of land-use planning or control that were a priority (1).

AUTHORS’ CONTRIBUTIONS

The participation of each author corresponds to the criteria of authorship and contributorship emphasized in the Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly work in Medical Journals of the International Committee of Medical Journal Editors. Indeed, all the authors have actively participated in the redaction, the revision of the manuscript and provided approval for this final revised version.

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COMPETING INTERESTS

The authors declare no competing interests.

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