

Colonial co-operation and regional construction: Anglo-French medical and sanitary relations in South East Asia

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Abstract

Beyond the traditional imperialist rivalry often discussed, there were also some examples of regional collaboration between western powers and colonies in South East Asia. The sanitary and medical inter-colonial co-operation between French Indo-China and British possessions in South Asia is one of them. And while the current events of the atypical pneumopathy (SARS) and the bird flu have reimposed this question on the international scene, it seems important to relate the premises of a more solid regional organisation like the scientific collaboration which expanded between the 1870's and 1920's under French and British patronage.

The contribution of the colonisation to regional construction in South East Asia can be evaluated with the description of the foundations (reasons, technical means and actors) and the forms taken by this sanitary and medical inter-colonial collaboration.

A necessary and structured collaboration

Common goals and preoccupations

The existence of common goals led in South East Asia to real inter-colonial collaboration between two colonial powers which were supposed to be rivals. Like everywhere, the colonisers had to consolidate their authority through the administration and the economic exploitation of their Asiatic possessions and protectorates. But the local conditions were specific. The distance from the home country, the existence of ancient local civilisations and political structures, the natural constraints, were objective conditions that French and British had to be aware of.

At the beginning of the conquest of Cochinchina, the French expeditionary corps was confronted with difficult weather conditions and exposed to endemic diseases (malaria, jungle fever), which also stopped the British conquest in the Malay Peninsula and in some regions of South Burma. Beyond exploration and pacification, the colonial power was based on the settlement of numerous

colonisers: civil administrators, military planters, traders and of course European women capable of setting up the basis of a real colonial society. This European presence, symbol and mark of an efficient colonial domination, could only be built in viable sanitary conditions. Many efforts had been undertaken in this direction so that the colonisers could come and settle in Singapore, as in Saigon, near the Irrawaddy or the Mekong without risking their lives.

Therefore, the European population had to be protected, but not only them. The Natives and other immigrants (Chinese or Indians in particular) had to be preserved too. A numerous and robust workforce was essential to the development of the colonies. It also represented a potential market for European goods and an important income thanks to the direct taxes and the consumption of highly-taxed local products, like rice alcohol or opium.¹

Nevertheless, health and public hygiene represented an economic, political and social challenge in the colonies. In this context, it was essential to struggle against tropical diseases, regional epidemics or epiphytes: a real obsession in Middle-Asia.

As the safety and the development of international trade were important, the Westerners also aimed at preserving the settlement of the colonisers and the native workforce; at the same time they wanted to bring human progress in order to justify their imperialist conquest. The colonial literature generally supports the idea that it was a real “*civilizing mission*”; the coloniser had the “duty” to bring the “*help of Western science*” to the Natives in order to ensure their education and their material and moral development.²

Yet, in South East Asia, some human or animal diseases were endemic, that is to say permanent. Specific measures taking into account the local conditions were needed. For example, fighting the cattle plague, which prevailed in Laos couldn't be solved by only a partial sacrifice of the cattle. Even a massive slaughter of the Annamite livestock could not put an end to the disease because the Burmese, Siamese and Annamite borders were not tight. And such a plague could not be fought by these specific methods only. New seats of diseases were always reappearing. Most of endemic diseases in Indochina, like malaria or leprosy had regional dimensions. These diseases had to be treated as such, that is to say in a totally holistic and not in a strictly local way. Under these conditions, only scientific research could bring fast and useful results to all.

In case some diseases could not be eradicated, the goal was to limit the risks of contamination of the most harmful diseases for colonial development. The porosity of the borders and the various local exchanges made waves of contamination frequent, following the shipping trade or the traditional caravan routes. Plague and cholera could easily spread through the whole peninsula. One understands that an official and close collaboration had to be organised between the different possessions and countries to estimate the threats, to send information quickly, to take preventive and adequate measures and,

¹ Descours-Gatin Chantal, *Quand l'opium finançait la colonisation, histoire de la ferme de l'opium en Indochine*, Paris, l'Harmattan, 1992. The study of Le Failler Philippe, *Le mouvement anti-opium et l'Indochine*, 1906–40, thèse de doctorat, Université de Provence, 1993, shows the ambiguity of the question of opium.

² Chevallier Auguste, *L'organisation de l'agriculture coloniale en Indochine et dans la métropole*, GGI, Saigon, Ardin et fils, 1918, p. 6.

sometimes, to avoid the spread of false rumours leading to measures which could hinder local trade.

We have seen that the arguments for a medical and sanitary collaboration were encouraged by imperialist general goals and by more specific Asiatic preoccupations.

Actors and means

The French and British possessions were not isolated from each other and their proximity contributed to the frequency of their relations. But, from the “packet” to the telephone, technical progress made possible and explains the development of scientific co-operation between the colonies. Thanks to this progress, information could be transmitted more efficiently and people got around more easily.

The local maritime lines were numerous and agreements on postal traffic³ or for the transport of troops and the repatriation of patients⁴ were made in order to ensure more frequent links and to create a tighter local network. As for telegraph links or underwater cables, even if they essentially belonged to the British, they already formed an operating network⁵. The specific use of wireless telegraphy⁶ and telephone at the beginning of the 1920's was still unusual and expensive. It was only used in “emergencies”.

The technical possibilities of these various means of communication for regional co-operation were determining conditions, but they cannot be dissociated from the actors who used them. The existence of human resources which were organized in private or active institutional networks laid the foundations of inter-colonial co-operation.

Foremost, we must insist on the central role of the consuls in the colonies. The networks of the French and British consuls in South East Asia constituted the most efficient forces of inter-colonial co-operation. Thanks to their roles and positions even in the neighbouring colonies⁷, the French Consuls in the Straits Settlements, in Burma or in India and the British Consulate in French Indo-China were essential mediators. They represented an “inter-face” between the numerous demands for information on the sanitary state or for the prophylactic measures which could be undertaken by the colonial authorities or by French or British private organisations. Thanks to their experience and the constitution of a network of local advisors, the consuls answered these various demands by gathering and transmitting information and publications available on the spot, or they investigated by themselves. They also acted as logistic support and as go-betweens for the local authorities

³ For example the Postal agreement between the Straits Settlements and the government of Cochin-China in December 1874. CAOM, Indochine, GGI, 11843. Many others followed.

⁴ Mae, CCC, Singapour, Vol. 3, 1856/66: letter from the French Consul of Singapore to the Foreign Affairs Minister, April 19th 1863.

⁵ Because the French did not have any national company, they had to join the Eastern Extension Telegraph Company in 1871. CAOM, Indochine, GGI, 7253.

⁶ Mancini Jean-Maric, *De la TSF à la radiodiffusion, Influences et enjeux sur une colonie française d'Asie: Indochine, 1920-39*, Mémoire de DEA, Université de Provence, 1993.

⁷ See the map of the French and English consular networks in South-East Asia in annex.

in order to initiate and to ensure the course of scientific partnership and of research missions.

Like other individuals or people appointed by the State, they embodied this inter-colonial collaboration through human relations. When personalities worked towards substantial cooperation, it was because they understood the futility of isolated actions and felt encouraged by a higher will and common interest which could also be found in the scientific institutes established in this area at the time.

Thus, some scientific institutes whose influence exceeded the colonial borders were also privileged instruments of research and regional co-operation.

The first “exotic” Pasteur institute was created in Saigon in 1889 to bring, “(...) *the benefits of vaccination against the smallpox and the rage to our large colony in Indo-China and to the peoples of the Far-East (...) and soon the bitten people of Java and Siam, Singapore, Tongking and even Japan rushed to the capital of Cochin-China.*”⁸ The success of this institute was regional and international. Scientific research about tropical and epizootic diseases, social hygiene and foodstuffs was made in Indochina. But their work and repercussions exceeded the limits of the French possessions and the Pasteur institutes of Indochina aroused the curiosity of the British possessions. They even gave them specific financial support. And in 1896, for example, the Colonial Secretary of Singapore, Sir Swettenham, sent a laudatory letter to the Government of Cochin-China with 500 piasters writing that the institute of Saigon was so famous that it attracted patients (most fortunate) of the neighbouring British colonies.⁹

At the end of our period, another sign testifies the regional fame of this institute. In 1923 the Consul of France in Singapore, André Danjou develops a project to organize “*a local representation in Malaysia for the products of the Pasteur institute.*”¹⁰ This initiative, which seems to conclude years of international collaboration, was supported by Doctor Noël Bernard, director of the Pasteur institute in Saigon and by Doctor Conrad, Head of the Health Department of the Straits Settlements, who is in charge of the local promotion of the project corresponded directly with Dr Bernard. Collaboration is not only public, but it also implicates private companies: Dr Conrad “*managed to make a local firm pay for the overheads, the sending of notes, advertising, etc.*” The project was in an advanced state and Dr Conrad was even thinking of “*the extension of the business to Java*”. This project was not completed, but it reveals the importance and the ambition that this scientific collaboration had generated.

Within these Pasteur institutes, eminent personalities highly contributed to reinforce these inter-colonial relations thanks to their research and their personal approach. We can mention here the emblematic life of Dr Yersin,

⁸ Morin H., Jacotot H., Genevray J., *Les instituts Pasteur d'Indochine en 1934*, Archives de L'institut Pasteur, 1934, p. 5.

⁹ CAOM, Indochine, GGI, 23878, letter from the Colonial Secretary to the GGI, on June, 11th 1896. Once again in 1899 the Straits Government thanked the Pasteur Institute in Saigon for having sent serum and offered them 500 piasters. CAOM, Indochine, GGI 53962.

¹⁰ CAOM, Indochine, GGI 32922, letter from the French Consul of Singapore to Doctor Bernard, August 14th 1923.

bacteriologist at the Pasteur institute in Paris. In 1894 Dr Yersin is in charge of a mission to study the plague whose ravages in China threatened Southern Asia. He chose to go to Hong-Kong to be able to work under better conditions in a British hospital. There he discovered the bacillus of the plague. Back in France, he developed a serum able to prevent and cure this disease. This discovery resulted, in a way, from a first Anglo-French collaboration. It continued in 1896 when Yersin was once again requested by the colonial authorities of India, which were confronted with a terrible epidemic of plague in Bombay¹¹. He delivered the serum and asked Dr Simond to start its local manufacturing with the help of the British.¹²

On the British side, we have to mention the role of the medical institute of Kuala Lumpur. As early as 1901, the Residence of the Federated Malay States published an explicit note on this subject. Officially transmitted to the General Governor of Indo-China, this note announced the opening of an establishment in the capital, which was dedicated to medical research and open to researchers from all over the world¹³. This letter specifies the different departments in this institute and insists on the newness of the equipment: "*The Medical Department is fully equipped for special and general pathological work, for the scientific study of clinical medicine, experimental physiology and bacteriology. A modern mortuary with refrigerator chamber is a feature. (...) A Chemistry Department is in order to for both organic and inorganic research. There is in addition a well-equipped Photographic Department, facilities for biological research and good working library.*" The Consul of France in Singapore who visited this laboratory by himself admits, that "*it gives unexpected advantages and facilities to doctors and explorers*". Moreover, the institute can accommodate scientific missions as well as medical students for longer stays. A co-operation could not start in better conditions.

Finally, we can mention the example of an international organisation with a regional purpose: *the Far Eastern Association for Tropical Medicine*. Resulting from an American initiative, it was founded in Manila in 1904, under the name of *Philippine Island Medical Association*. Little by little, this association attracted representatives from Asian states and possessions (Siam, China, Indo-China, Hong-Kong, Malay States and Ceylon¹⁴). In 1909, choosing a broader name, *the Far Eastern Association for Tropical Medicine* claimed its ambition. Its goal was to contribute to progress in medical science in the Far East, to encourage scientific co-operation and to homogenise the different practices. The essence of its action was based on congresses where the different aspects of research and experimentation were reviewed.

¹¹ Mollaret Henri, Brossolet Jacqueline, *Yersin un pasteurien en Indochine*, Belin, 1993, p.190-91.

¹² CAOM, Indochine, GGI, 20579, Letter from the GGI to the Director of the Health Department in Saigon, on October 1st 1898.

¹³ CAOM, Indochine, GGI, 54000, Official note to the General Resident of the Federated Malay States, on July 10th 1901, transmitted by the French Consul of Singapore to the GGI on February 20th 1902. According to Monnais-Rousselot Laurence, *Médecine coloniale, pratiques de santé et société en Indochine française (1860-1939)*, thèse de doctorat, Université de Paris VII, 1997: This Research Institute had to act as a counterbalance regarding the Pasteur Institute of Saigon (p. 877).

¹⁴ Gaide L., *Congrès scientifique et sanitaire en Extrême-Orient (1908-1930)*, Hanoi, IDEO, 1930, p. 7.

Common scientific and imperialist preoccupations brought European colonisers together. This interest also lay in the importance of the technical and human means used to develop the European co-operation at the local level. Thanks to improved means of communication, private or institutional actors organised networks. Little by little, they formed the vectors of an inter-colonial collaboration whose nature and importance will be analysed now.

A multiform collaboration

Exchanges of information

In order to prevent epidemics, which could affect their possessions, information was regularly conveyed on this subject in the different colonial services. As for French Indo-China, the Maritime Medical Police Force delivered the bills of health to the ships, they organised field hospitals (lazarets) and services to disinfect ships in case of epidemics. Furthermore, the Veterinary Service of Indo-China was in charge of epizootic diseases (rage, cattle plague, foot-and-mouth disease, for example) whose conclusions were regularly published¹⁵. This service also organised vaccination campaigns and slaughtering when necessary. On the British side, the same services existed in India and in the Straits Settlements. Therefore, epidemiological reports were transmitted to the colonies and to the neighbouring countries and vice versa.¹⁶

The regulations adopted by the colonial authorities in Singapore were proposed as a model for Indo-China. In 1900, the Consul of France in Singapore suggested to the General Governor of Indo-China to publish weekly “*rules of quarantine*” like the local newspaper of the Government of the Straits. He wrote: “*I am often asked if the ships coming from such or such a port are exempted from duties, subjected to quarantine or to sanitary inspection when they arrived in Indo-China. Sometimes I cannot answer precisely. You will understand, Mr General Governor the advantages, for trade and navigation, of this practice adopted in the Straits which could be useful for the colonies of the Republic.*”¹⁷

Yet, the respect of medical safety could also cause harmful problems for trade (delays, impossibility to enter or to leave a port). It was always necessary to cope with these two requirements. Maintaining strict control but not an absolute prohibition to enter the colonies from possibly infected places was generally done, but this rule was not always easy to adhere to.

For example, in 1899, the sanitary authorities in Singapore had taken measures of isolation against ships coming from Saigon. Yet, after investigation, the consul of France of this city realised that this decision was taken only because a newspaper, *The Mekong*, published information about a choleric

¹⁵ *Indochine, situation générale de la colonie pendant l'année 1912*, Hanoi, Imprimerie d'Extrême-orient, 1913.

¹⁶ ANVH, RST, 76224, French Consuls in the Far East (1897–1905). CAOM, Indochine, GGI, 42520.

¹⁷ CAOM, Indochine, GGI, 53978, letter from the French Consul of Singapore to the GGI, on July 19th 1900.

epidemic in Cochin-China. The story was rather unreliable, and two days later the General Governor of Indo-China formally denied this piece of information by cablegram. But, the Colonial Secretary of the Straits Settlements did not reply and the measures were maintained. These measures were limited to the deck of Asian people and to a medical inspection at their arrival. Therefore, the Consul of France in Singapore suggested to the General Governor of Indo-China to co-operate “*and not to take Asian passengers on the deck*” in order to reduce the risks of quarantine. The problem was not there, but rather at the level of the press, which had nourished Anglo-French tensions and influenced the decision of the Governor of the Straits. According to the French Consul, this measure was not correct because, “*(...) Sir Alexander Sweetenham made his decision only because of an article in a newspaper without trying to get information from the British consul in Saigon. It is more than thoughtlessness, it is irresponsibility (...) his hidden goal was to consider Indo-China as plague-stricken (...) I have just written another letter of protest against this dishonest behaviour that I will bring to the attention of the Ministry of Foreign Affairs.*”¹⁸

This case of quarantine raised a question of principle. The Consul was indignant when he said to a civil servant of the Straits: “*you create a dangerous precedent. If you do not take into account what the Council of Health of Indo-china says, I will not listen to what the Council of Health in Singapore says. And I will put in quarantine what comes from Singapore when I feel like it.*”¹⁹

Economic competition started again. Unlike the co-operation at work regarding health, measures of commercial retaliation could be taken through announcements of quarantine. This example is rather isolated, but it permits us to relativize the importance of this collaboration. Essentially however, regional agreements prevailed. In general, all the ships had to show a license when they entered a harbour, a sort of visa which specified its sanitary status: “*(...) In case of no bill of health, the visit of the ship, the delivery of sanitary passports to European and Asian people as well as the medical inspection of Natives without papers could be required*”²⁰. But when the bill of health was clear, the “*free practice*” was given and the ship was subjected to no restriction. These sanitary rules became less strict thanks to the advancement of research. In 1907, an Indo-Chinese decree suggested that in case of plague the observation had to be reduced “*from 12 days to 5 days for all European and Asian travellers who accept the preventive vaccination by an injection of anti-plague serum.*”²¹

Beyond the mere warning, a particular attention is given to therapeutic measures. Their nature, their application and of course their efficiency were tested and evaluated. One observed what was done elsewhere to take the best of it. French and British possessions in Asia were often places of experimentation of innovating prophylactic and curative measures. For example, in 1873, the

¹⁸ CAOM, Indochine, GGI, 53938, letter from the French Consul of Singapore to the GGI, on December 16, 1899.

¹⁹ MAE, CCC, Singapour, Vol. 8, letter from the French Consul of Singapore to the MAE, on December 22, 1899.

²⁰ *Indochine, situation générale de la colonie pendant l'année 1912*, Hanoi, Imprimerie d'Extrême-orient, 1913.

²¹ CAOM, Indochine, GGI, 6752, letter from General Director of the Health Department of Indo-China to the GGI on June 1, 1907.

Consul of France in Singapore sent a note to the Governor of Cochin-China about the epidemic of cholera, which prevailed in the district. Dead people were numerous and the Government of the Straits took measures to stop the disease. The Consul described the measures precisely: "*Cleaning all the streams (...) with quicklime, putting dry ground in the latrines, whitewashing the houses inside and outside, setting fire around the houses in the morning and in the evening, putting heaps of coconuts barks with tar at the corner of all the streets and in all the districts. Every house where a case of cholera takes place must be disinfected with carbolic acid.*"²² All these ingredients could easily be found in any hospital or police station of the city. There is a general mobilisation and the French Consul in Singapore notices that: "*The Colonial Secretary, the Chief doctor of the Colony and several notables keep taking care of patients.*" (Similarly to the Chinese Prime Minister during the SARS epidemic on all TVs of the world). The French Consul in Singapore specified the exact and surprising dosage of the medicines given to the patients: "*(...) hypodermic ammonia injections, mustard plaster, stimulants: Cognac, Champagne and finally pills whose composition will be found in annex n°1.*" The efficiency of the governmental action and measures were proven by facts. One month later, the French Consul in Singapore announced that the cholera had been eradicated in Singapore.²³

Many medical works were also exchanged. For example, in 1902, the Governor of the Straits Settlements sent to the General Governor of Indo-China two copies of the official report about the cattle-plague of Dr Braddon, doctor of the Government in Negri Sembilan.²⁴

To complete these exchanges of information, research missions were sent to neighbouring colonies and continued the scientific collaboration in practice.

Regional research missions

French missions were financed by France or by Indo-China and given to civil servants or colonisers who had experience of the regional conditions²⁵. On the other hand, we did not find any examples of medical British missions in the countries of French Indo-China so far. We must specify that these inter-colonial missions had a broader scientific nature and different goals (covering geography, botany, ethnology, etc); political and economic intentions were never very far from the scientific objectives.

The study of leprosy and the organisation of leper-houses in the British possessions was the subject of several French missions, but the mission of Dr Jeanselme who went to British Burma and Malaya to study this disease, is the most relevant example.

²² CAOM, Indochine, GGI, 14226, letter from the French Consul of Singapore to the Governor of the Cochin-China, on August 8th 1873.

²³ CAOM, Indochine, GGI, 14191, letter from the French Consul of Singapore to the Governor of the Cochin-China, on September 19th 1873.

²⁴ CAOM, Indochine, GGI, 53956, letter from the French Consul of Singapore to the GGI, on June 10th 1902.

²⁵ We can mention the example of Henri Brenier, Director of the Agriculture and Trade Department of Indo-China.

In 1899, Jeanselme sent his mission report to the General Governor of Indo-China²⁶. He drew very positive conclusions from this trip and encouraged the Government to take British methods as a starting point. Jeanselme also pointed out the free delivery of medicines to the Natives and the quality of hospital infrastructures: “*In Burma, every town has got its own hospital led by a local doctor.*” Because of the lack of European doctors in Asia, the British required local doctors who studied in the Anglo-Indian universities of Madras, Bombay or Calcutta. Jeanselme understood the scientific benefits of this practice, but he also insisted on the political benefits of such a solution, since, according to him, in case of rebellion, this local elite “*would side with the British.*” However the future was to show, above all, the contrary.

Beyond these general considerations and the British official regulations (“Lepers Act”), Dr Jeanselme’s report revealed his work on the ground. He spent a whole week in a leper-house in Mandalay “*to understand how a British leper-house worked.*”²⁷ There, he could listen to patients, study the plans of the hospital as well as the construction and the ventilation of the buildings, etc. Then, he did the same thing in Rangoon and Penang whose leper house seemed to be a model hospital. According to him, the welcoming of patients explained how numerous they were. “*They are sure to find good food, water for their ablutions and care.*”²⁸ They came to these leper-houses on their own free will, whereas an imprisonment could only lead to pitiful results. He advised to do the same in Indo-China where the building of two leper-houses at least would be necessary.²⁹

Thus, from a scientific expedition, Jeanselme drew both medical and political conclusions. Even if there was no direct collaboration, Jeanselme observed what was done in the neighbouring colonies in order to compare and to recommend the best experiences to Indo-China. According to Laurence Monnais-Rousselot, Dr Jeanselme’s mission pointed out: “*Three new orientations, which will now prevail in every scientific expedition. Firstly, these medical investigations are led in the whole Far East with a particular attention for Yunnan, Burma, Siam and Singapore. Then, the incursions in British territories also aim at spying their sanitary organisation. And above all, Jeanselme’s reports, as well as his successors’ ones, are conveyed by the General Governor, even when they are not expressly for him.*”³⁰ These practices influenced decisions. This was shown by the application of the Anglo-Indian model of local doctors in Indo-China.³¹

The exchange of sanitary and medical information was done thanks to a extensive correspondence and missions of research. But the results were summed up above all during regional medical congresses.

²⁶ CAOM, Indochine, GGI, 22123, letter from Doctor Jeanselme to the GGI, on October 5, 1899.

²⁷ *Ibid.* p. 5.

²⁸ *Ibid.* p. 12.

²⁹ He proposed the building of leper-houses near Poulo-Condore and in Halong Bay. However it was only in 1903 that a leper-house was created in Conchin-China on the Islands of Culao-Rong facing Mytho.

³⁰ Monnais-Rousselot Laurence, *Médecine coloniale ...*, p. 794.

³¹ *Ibid.* p. 194.

The organisation of regional congresses

The first congress organised under the patronage of the *Far Eastern Association for Tropical Medicine* took place in Hong-Kong in 1910. In 1913, a congress was held in Saigon and dealt with various topics like dysentery, typhoid fever, malaria, leprosy and some other local diseases. Then, after a colloquium in Batavia, the members of the FEATM met in Singapore in 1923 to talk about beriberi.³²

The main diseases, which concerned this part of the world, were the topics of individual papers. The official members were medical researchers who held high positions in the Health Departments of their colonies. Can we deduce practical application from these congresses on the ground?

According to Laurence Monnais-Rousselot, it is difficult to know but “*We can suppose at least that the Indo-Chinese authorities took part to the meetings.*”³³ She does not mention any example of application regarding anti-malaria campaign,³⁴ but Dr Gaide gives at least one example. After the Singapore congress, a local committee was organised to study beriberi. The General Government of Indo-China appointed a delegate of Indo-China to represent the colony and also named “*a commission which will aim at studying beriberi and its relations on the consumption and exportation of rice and at writing a report for the next congress*”³⁵ which was to be organised two years later in Japan.

This example shows that these congresses did not only aim at ratifying new discoveries. They also intended to sum up different research and to set up action plans all over Asia.

Conclusion

In the medical and sanitary field, a real and multiform collaboration was set up in South East Asia in the last part of the 19th century and the first decades of the 20th. The political partition and the differences due to concurrent colonial fields did not prevent the development of a scientific collaboration justified by the same regional interests.

Philanthropic goals, but also economic and political motives, encouraged such a partnership between French Indo-China, which had structures and famous researchers, and British possessions which could take advantage of a former and positive experience.

³² Gaide L., *Congrès scientifique et sanitaire en Extrême-Orient (1908–1930)*, Hanoi, IDEO, 1930.

³³ Monnais-Rousselot Laurence, *Médecine coloniale...*, p. 879.

³⁴ Monnais-Rousselot Laurence, *Médecine coloniale...*, note 187, p. 879: “*Coming back from Singapore, N. Bernard explains to Calmette the interest of his participation to the congress of 1923 and to the trip in the Malay States. Very impressed by the organisation of the anti-malaria struggle, as soon as he came back, he says he had asked the governor of Cochin-China to set up the same program and had asked credits for this purpose.*” Coorespondance Bernard, letter to Calmette. September, 27 1909. Archives of the Pasteur institute of Paris.

³⁵ Gaide L., *Congrès scientifiques et sanitaires en Extrême-Orient (1908–1930)*, Hanoi, IDEO, 1930, p. 30.

However, this collaboration was limited. Most of it were exchanges and crosschecks of information, which rarely led to programs of joint research and experimentation. Therefore, the repercussions on the population were different according to the cases, the regions and the means.

Some successes were obvious at the local level and symbolised the movement of internationalisation of science. We must point out the discovery of anti-plague serums or the improvement of prophylactic measures against diseases like malaria or cholera.

Considering this the notion of a colonial contribution to a regional development in South East Asia seems to be real. And, if today, this regional integration is still problematic and incomplete, the existence of medical institutes created during the colonial period (like the Pasteur Institutes of Vietnam) or the enforcement of preventive measures in case of dangerous epidemics (like SARS) shows the important legacy of inter-colonial collaboration in South East Asia.

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