

An Embryonic Border: Racial Discourses and Compulsory Vaccination for Indian Immigrants at Ports in Colonial Burma, 1870-1937

Une frontière embryonnaire : discours raciaux et vaccination obligatoire des immigrants indiens dans les ports de la Birmanie coloniale, 1870-1937

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An embryonic border

Racial discourses and compulsory vaccination for Indian immigrants at ports in colonial Burma, 1870-1937¹

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This paper examines how an administrative border emerged between historically and culturally different and geographically separate regions which nevertheless had been integrated into one state under the colonial power. As a result of three Anglo-Burmese wars in the 19th century, Burma was colonized by the British. During the course of its colonization, the country formally became a province of India. Hence no border had existed between Burma and the rest of India until 1937 when the former was separated from the latter. This connection with India brought Burma unrestricted labour supply from India which was necessary for the growth of the economy. But at the same time, such a vast flow of people included undesirable elements like criminals, beggars and people sick of infectious diseases which caused social problems in Burma. While the government of Burma attempted to deter or exclude those undesirable elements in order to maintain social order, these attempts were frustrated by several factors. In spite of these circumstances, the local government started taking more decisive policy for examinations of immigrants after the middle of the 1910s. No border existed yet, but port cities, especially Rangoon, gradually assumed function of checking people who came from “outside” into “inside”. I would like to call this phenomenon, tentatively, the emergence of an embryonic border. As a part of this phenomenon, this paper describes a history of sanitary regulations for Indian immigrant labourers in colonial Burma, by focusing on a case

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of implementation of compulsory vaccination at ports. And it points out that those regulations were formed on the basis of racial discourses for Indian labourers.

THE PLURAL SOCIETY IN LOWER BURMA AND INDIAN URBAN LABOURERS

Since the second half of the 19th century, the British had transformed Burma into the biggest granary both in India and in the whole British Empire. In this process Rangoon became important economically as the shipping port for rice and administratively as the capital of the province of Burma. The development of the delta region into a rice producing area had created a huge labour demand in Lower Burma. At the beginning the British authority actively promoted migration of cultivators from India to Burma for the development of waste and unproductive lands. This suited not only the object of the local government of Burma but also the one of the central government of India, because it might relieve the congestion of the most densely populated districts in India where a serious famine tended to occur. But, in spite of the intention of the governments, waste lands in the delta regions were mostly cultivated by immigrants from Upper Burma (Baxter 1941: 45, Chakravarti 1971: 8-9).

On the other hand, the volume of Indian immigrants itself steadily increased (see figure 1 and 2). Competition between shipping companies resulted in a decrease in passengers' fares, and the prospects for employment in port cities were so attractive that these Indian immigrants no longer needed government assistance for transport to Burma. This reduced the necessity of active encouragement policy of the local government so that the policy was abandoned by the end of the 19th century. A huge flow of impoverished people from congested areas to the newly developing province was still convenient to the central government of India. Since then the government of India basically had not interfered with this migration issue (Chakravarti 1971: 9).

Most Indians who immigrated to Burma were people of lower castes from the Madras and Bengal Presidencies. According to the census records in the last decades of the 19th century, over 60 percent of Indian population in Burma were born in Madras Presidency. Most of them were Telugu or Tamil speakers. 25-30 percent of Indian population in Burma in the same period was from Bengal Presidency. Among Indians from Bengal, Chittagonians constituted around 40 percent (Adas 1974: 89-99).

Many of these Indian immigrants were sojourners who sought temporary jobs in the urban labour market, for example, as mill-workers or stevedores. They were not like settlers for rural agricultural development as intended by the government at the beginning. Some of them worked as agricultural labourers in rural areas, but it was only during busy harvest seasons. Most of immigrants came to Burma alone leaving their family in the home country. They usually worked in Burma for a few years and then went back home, and if they got a chance, they could come back to Burma again to earn money for another few years (Ito 1981: 35-39).

Because many of them sought employment in the port-cities, Indian population in Burma was concentrated in urban areas. Especially in Rangoon, the capital and the largest port-city in colonial Burma, Indians became a majority since the 1890s (figure 3). Indian population in this city was so visible as to give visitors an impression that Rangoon was more an Indian than a Burmese city (for instance, see Kelly 1905: 6).

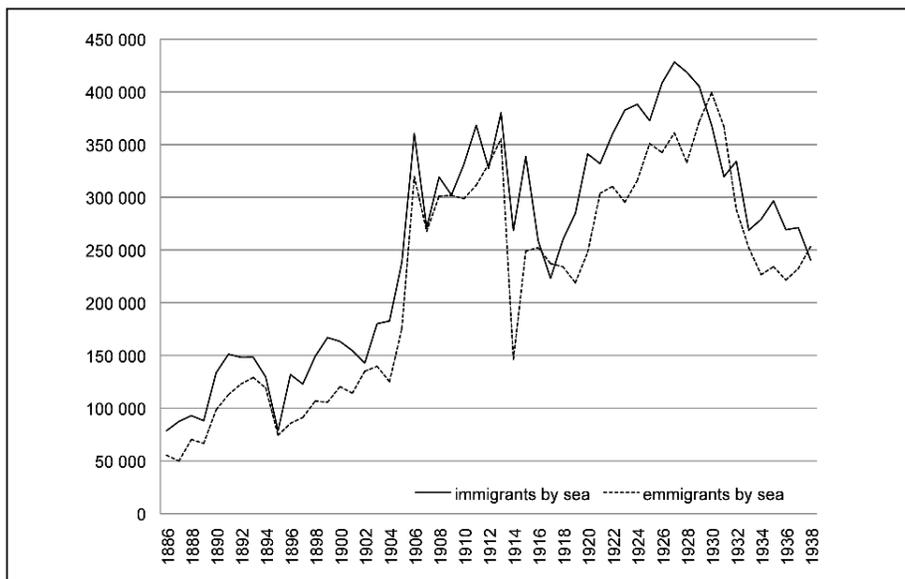
Figure 1: Indian Population in Burma, 1881-1931

	Burma			Arakan Division			Burma excluding Arakan		
	Total Population	Indian Population	%	Total Population	Indian Population	%	Total Population	Indian Population	%
1881	3,736,771	243,123	6.5	587,518	113,557	19.3	3,149,253	129,566	4.1
1891	8,098,014	420,830	5.2	671,899	137,922	20.5	7,426,115	282,908	3.8
1901	10,490,624	568,263	5.4	762,102	173,884	22.8	9,728,522	394,379	4.1
1911	12,115,217	743,288	6.1	839,896	197,990	23.6	11,275,321	545,298	4.8
1921	13,212,192	887,077	6.7	909,246	206,990	22.8	12,302,946	680,087	5.5
1931	14,667,146	1,017,825	6.9	1,008,535	217,801	21.6	13,658,611	800,024	5.9

Sources: Baxter (1941: 4-9); Chakravarti (1971: 15-19).

Notes: Most of Indians in Arakan were permanent population on the border region, and had nothing in common with other Indian immigrants in Burma.

Figure 2: Immigrants into and emigrants from Burma by Sea, 1886-1938



Sources: RAB 1886-1932; Baxter (1941: 121, appendix 6a).

Notes: Total of returns from following ports:

- 1886-87 Rangoon only
- 1888-89 Rangoon + Akyab
- 1890-99 Rangoon + Akyab + Moulmein
- 1900-38 Rangoon + Akyab + Moulmein + Bassein + Tavoy + Mergui.

This relative concentration of Indian population in urban areas led to the genesis of a plural society.² Broadly speaking, this society was characterized by the dichotomic division of labour, that is, Indian immigrant labourers in the urban industry (processing and transportation) and Burmese cultivators in rural paddy fields (production). This paper focuses on the former part of the whole society.

However, reality was much more complicated than such a simple dichotomy. All the more Rangoon society was diverse and cosmopolitan (cf. figure 3). There were all sorts of people: British administrators, Gujarati merchants, Cantonese carpenters etc. It should be noted that even in cities there still remained considerable Burmese residents. And people categorized as Indian labourers included various religious and ethno-linguistic groups. To an extent each group was engaged in a specific occupation. For example, Tamils and Oriyas were employed for landing coal from boats, Chittagonians rowed small boats called *sampan*, Hindustanis worked as durwans or peons. Numerically most outstanding among Indian groups were Telugu speakers. They worked as coolies in rice mills, saw mills and wharfs (RCLI 1931 Part I: 1-2; Beninson 1928: 5-6). There was another divide of labour along ethnic/racial lines within the urban context. Nevertheless it is safe to say that the most prominent character of Rangoon society was the overwhelming number of single male immigrant labourers from India and their high mobility.

Figure 3: Population in Rangoon by ethnic group, 1872-1931

	1872	%	1881	%	1891	%	1901	%	1911	%	1921	%	1931	%
Burmese	66,337	67	66,676	50	73,288	41	81,680	35	90,793	31	106,242	31	127,540	32
Indian	24,879	25	57,536	43	90,037	50	131,431	56	169,719	58	189,334	55	212,929	53
Indo-Burman	-	-	-	-	442	0	464	0	3,699	1	8,691	3	12,560	3
Chinese	3,181	3	3,752	3	8,053	4	11,018	5	16,055	5	23,819	7	30,626	8
European	2,419	2	3,366	3	4,284	2	4,238	2	6,068	2	3,947	1	4,426	1
Eurasian	1,438	1	2,706	2	3,711	2	4,674	2	5,831	2	8,343	2	9,977	3
Others	491	0	416	0	509	0	1,376	1	1,151	0	1,586	0	2,357	1
Total	98,745	100	134,176	100	180,324	100	234,881	100	293,316	100	341,962	100	400,415	100

Sources: Census 1872-1931.

Notes: These figures were calculated from several census tables by the author. The categories do not necessarily represent racial classification of contemporary census-takers.

“THE FOCI OF THE EPIDEMIC”: SANITARY DISCOURSES ON INDIAN LABOURERS

By the end of the 19th century, the economy of Burma became dependent on the above mentioned social structure, within which Indian immigrant labourers contributed much to its progress. But their existence entailed some social problems. Above all insanitary conditions in coolie barracks (in other words tenement houses or lodging houses) alerted the British authority. After arriving in a Burmese port city, Indian immigrant workers were housed in small rooms of coolie barracks. There existed serious overcrowding and insanitary living conditions.

This problem was most obvious in Rangoon. As early as 1871, the Civil Surgeon of Rangoon described the condition in these coolie barracks as follows: “on visiting of some of them late in the evening I found that so crowded were they that there was scarcely space enough to pass through without treading on some person”.³ Since the 1880s the municipal authority made rules affecting these buildings to ease such a condition, but few of them worked efficiently (Pearn 1939: 258-259). As time passed and Indian immigrants increased, this overcrowding problem became more and more serious. Central quarters in the city, where these buildings concentrated, showed higher population density compared with other quarters. In 1930 it was reported that: “It is not unusual to find a tenement room 12½' × 40' occupied by as many as 40 or 50 people”.⁴

Serious overcrowding without enough light and ventilation were considered to cause filthy and insanitary conditions. Medical officials were to blame these buildings as “the foci of the epidemic” (Pearn 1939: 258, RSABB 1873: 45). This criticism seemed to be caused not only by the actual observation of coolie barracks but also by racial prejudices of British administrators in this period. They attributed the insanitary conditions in coolie barracks, to an extent, to Indian race, culture and habits. The clearest expression of such thought was a sentence in the census report for 1911 which explained the cause of overcrowding problem in Rangoon.

The problem is very largely not one of the space but of racial habits. The immigrant cooly from Southern India is accustomed to live in overcrowded barracks whatever may be the area of dwelling space available. (Census 1911: 21.)

Probably this kind of prejudice that Indians had an insanitary habit had been formed in India by the middle of the 19th century. In the tropical medicine at the time, the close connection was imagined between climate, environment, culture and constitution of inhabitants. Indians' vulnerability to disease was explained by their physical weakness which was a consequent of Indian climate and social institution (Harrison 1999: 110; Arnold 1993: 36-43). British administrators brought such perceptions into Burma and reconfirmed them through observation of the real problem mentioned above.

When such notions were brought into Burma, British administrators contrasted the image of Indians with that of Burmese.⁵ In their perception, while Indians had insanitary habits and tended to be sick as a race, Burmese were regarded as comparatively robust and healthy. For instance, in the resolution on the sanitary administration in British Burma for 1874, it was noted under the section “Favorable conditions of climate, &c., as compared with other provinces in British India” that:

The Chief Commissioner⁶ would observe that, while distrusting the statistics submitted by the Sanitary Commissioner, he does not wish it to be understood that British Burma is not one of the healthiest provinces of the East. The conditions which occasion so much sickness and mortality in India have no counterpart here. In India, the dwellings of the poorer classes are close, ill-ventilated, confined mud buildings; in Burma, they are raised from the ground, and the plank walling and bamboo and grass floors allow free ingress and egress of air. There is no lack of space or overcrowding, and cattle are not, as a rule, kept under the same roof as their owners. Observation alone sufficiently establishes the fact that no place in India can show such swarms of plumps, healthy-looking children, or such vivacious, manly inhabitants as Burma. (RSABB 1874: 4.)

This statement emphasized difference in the style of living between India and Burma, which was probably considered as a result of climate. Moreover it seemed to explain that such difference in climate and the style of living mattered in making the constitution and the health condition of inhabitants. Burmese were not considered as healthy as Europeans, but once compared with Indians they were perceived positively (RSABB 1871: 30). This contrast of images for Burmese and Indians survived well into the 20th century.⁷

Other characteristics of the discourse for Indian immigrant labourers were concerning infectious diseases. British administrators thought that Indian immigrants constantly imported dangerous infectious diseases into Burma. And there were perception that the disease so introduced spread immediately among Indian immigrants in an overcrowded coolie barrack, and then, because of fluidity of labourers, the disease became epidemic in the wider area which affected rural Burmese population. There was this logic behind the perception that coolie barracks were “the foci of the epidemic”. We can find this kind of discourse in accounts on various infectious diseases in colonial sanitary reports.⁸ But it was most clearly expressed in the discussion for preventing smallpox by the compulsory vaccination at ports which the latter part of this paper examines.

LEGALIZING VACCINATION FOR INDIAN LABOURERS

General vaccination policy in India and Burma

Smallpox was one of the most dangerous infectious diseases. Its mortality was high. Nearly one-third of infected people died. Even if an infected person could survive fortunately, pockmarks disfigured his face and sometimes he was to suffer from blindness. To control this disease, European colonialists introduced and propagated vaccination in the colonies.⁹

By the middle of the 19th century, British colonizers in India implemented sanitary administration to protect their own health by separating European communities from Indian societies. Sanitary conditions of Indian people were neglected at large. But during the course of the 19th century, colonizers realized that their own health could be protected only when they could improve sanitary conditions of a huge local population surrounding them. While priority continued to be put on the European health, the government strengthened intervention with indigenous societies, especially concerning infectious diseases. David Arnold depicted this change of sanitary policy of the colonial government as from “colonial enclavism” to “public health”

(Arnold 1993: 61-115). Vaccination against smallpox was the pioneer and exemplar of public health policy in India (*ibid.*: 156). Moreover, because many of colonial administrators had absolute confidence in the superiority of vaccination as a proven Western technology, they expected that vaccination programme demonstrated the benevolence of their rule towards the colonized population¹⁰.

In 1880 the government of India promulgated the first Vaccination Act.¹¹ Its intention was to propagate vaccination and substitute it for inoculation. Technically, inoculation meant operations that induced resistance by means of matter containing the human smallpox virus (*variola*), while vaccination used a range of animal poxes containing the *vaccinia* virus. Because prevalence of inoculation was considered as the danger to public health and the obstacle to promotion of vaccination, the act of 1880 prohibited inoculation and prescribed the compulsory vaccination for children. This act was applied to Burma, then a province of India, and became the basic line of the vaccination policy in the province. This act was confined to those municipalities and cantonments that actively wanted vaccination. But the government of Burma gradually enlarged the scope of this act, both in area within which this act was applied and in definition of inoculation, through the subsequent local legislations (see figure 4).¹²

Figure 4: Vaccination Enactments in Burma

1880	The Vaccination Act [an act of Indian Legislature]
1900	The Burma Vaccination Law Amendment Act
1908	The Burma Prohibition of Inoculation and Licensing of Vaccinators Act
1909	The Burma Vaccination Law Amendment Act
1916	The Burma Prohibition of Inoculation and Licensing of Vaccinators Amendment Act
1928	The Burma Vaccination Law Amendment (Amendment) Act

Source: (Burma 1934).

Compulsory vaccination at ports

In addition to inoculation, there was another target of vaccination legislations in Burma. That was Indian immigrants. It should be noted that the Vaccination Act of 1880 prescribed compulsory vaccination only for children; under fourteen years old in case of boys and eight years old in case of girls (Burma 1934: 56). Compulsory vaccination for children would be effective for increasing immunity of a stable community in a certain territory. But in Rangoon it was far from enough.¹³ There was a habitual influx of a large number of “unprotected” Indian immigrants. The word “unprotected” meant that they did not acquire immunity to smallpox either by vaccination or by infection. Most of these immigrants were male adults and beyond the scope of the Vaccination Act of 1880.

Under these circumstances, local medical officers in Rangoon were accustomed to vaccinate Indian labourers by stretching interpretation of the act. This practice

was problematized in August of 1896 when one Indian servant died following such compulsory vaccination. After this incident, vaccination for Indian labourers was blamed as illegal and finally banned by the Municipal authority in spite of medical officers' opposition. As a result, the number of vaccination in Rangoon decreased and the danger of smallpox epidemics arose.¹⁴ In addition to this, in September of the same year, a serious plague epidemic occurred in Bombay. So the government of Burma also became alert to importation of infectious diseases.¹⁵ The issue of vaccination for Indian immigrants was considered in the government of Burma with the newly established Legislative Council.¹⁶

In this process, H.L. Eales, the President of the Rangoon Municipality, the very person who banned the compulsory vaccination for immigrants, repeatedly petitioned the government for the exceptional legislation which legally enforced adult vaccination in the city. In the letter to the government, dated 23 March 1899, he emphasized the danger caused by the "Hindoos", probably labouring classes from Madras presidency, and proposed the necessary measure:

Municipal Committee has been alive to the danger that Rangoon has been subject to for years from the presence in its midst, and the continued importation, of a large unprotected class of Hindoos that is very subject to small-pox, and the members of which from their habits and mode of life cannot help but foster and disseminate this fell disease throughout Rangoon. Their love of crowding together in their habitations and their practice of hiding cases of small-pox, added to their unprotected state, make their presence in Rangoon the greatest factor in the propagation of small-pox. I quite agree with the Municipal Health Officer and the Municipal Committee that nothing short of the compulsory vaccination of all unprotected coolies before being allowed to enter Rangoon will be of material effect in ridding Rangoon of recurring epidemics of small-pox.¹⁷

Given the mobility of immigrant labourers, it was safer to vaccinate them before entering the city. But the Lieutenant-Governor Frederic Fryer had already judged that the wholesale vaccination of all unprotected immigrants at Rangoon port was not practicable. This conclusion was arrived at in consequence of the opinion, which was expressed by the Rangoon Chamber of Commerce, that such a measure would injuriously affect the trade of the province by restricting the importation of labour.¹⁸ As a result of a long discussion, in 1900, the Burma Vaccination Act Amendment Act was promulgated. It enabled the compulsory vaccination of inmates of coolie barracks, but the most important provision enforcing vaccination to immigrants at ports had been withdrawn before the enactment (RAB 1898: 28, 1899: 91).

The government of Burma, as an alternative measure, inquired the government of Madras whether it could pass the local act to enforce vaccination to unprotected emigrants before embarkation for Burma at Madras ports.¹⁹ The response from Madras was that "the matter must be left in the first instance to the Government of Burma".²⁰ The government of Burma had to take the responsibility alone for solving this problem.

In 1905 and 1906, the severe epidemic of smallpox occurred in Rangoon and spread into other districts in Lower Burma.²¹ The government of Burma realized the necessity of stricter and more effective measures to prevent smallpox. In order to solicit the sanction of the Governor-General of India to the new bill, the clichéd phrases on the danger of Indian labourers were repeated.²² This time the Chamber of Commerce

raised no objection, because the plague regulations which had been enforced in the port of Rangoon since 1897 had little affected the number of immigrants.²³

Finally in 1909 the Vaccination Act was amended again. Section 9 of this act for the first time prescribed compulsory vaccination for unprotected immigrants at ports. Under this section, the Port Health Officer of Rangoon was given the power to “require any person who has travelled on board the vessel for the purpose of coming to Burma to work as a labourer to be inspected and if on inspection he is found to be unprotected to be vaccinated”.²⁴ This provision was intended for “every person who when so requested fails to show by documentary or other evidence that he is not a labourer”.²⁵ This definition of “labourer” was wide enough to include immigrant beggars who were sometimes accused as disseminators of infectious diseases.²⁶ Though this long-awaited provision equipped the Health Department with a strong measure, because of the cost and the practical difficulty, the application of the section was discontinued soon. And it was only temporarily applied during the prevalence of a smallpox epidemic in eastern parts of India (Burma 1918a: ii).

The vaccination committee in 1917

In February 1916, the government of Burma authorized the application of section 9 because an epidemic of smallpox took place in Madras. Though the application was authorized for a temporary period only, owing to the continued detection of infected passengers, the government had no opportunity to withdraw the application. During this period, the measures taken by the Health Department raised some complaints among passengers from India. Then in August 1917, the government appointed a committee to consider the propriety of the measures (Burma 1918a: ii, 1).

The members of the committee were consisted of 6 persons; the Commissioner of Pegu Division, the President of the Rangoon Municipal Committee, the Director of Pasteur Institute, the Chairman of the Burma Chamber of Commerce, and the representatives of Indian and Burmese communities.²⁷ The committee collected the related statistics and took evidence of witnesses. After the investigation, all members except one reached a consensus.²⁸ They pointed out the following facts in their report. First, compared with other Indian provinces, Burma was unique in the point that the whole of the movement of the population took place through one port, Rangoon.²⁹ Second, practically the whole immigrants and emigrants were Indians, and the indigenous population in Burma stayed at home. Third, all but a small proportion of these immigrants were unprotected and belonged to the laboring class whose habits were such as to make them peculiarly liable to small-pox infection. Fourth, the resident population of Rangoon was fairly well protected by vaccination and it followed therefore that the material that kept the infection in existence was provided by unprotected immigrants (Burma 1918a: 1-11).

Then the committee concluded that the danger to the health of Rangoon, and incidentally to Burma, from the annual influx of unprotected Indian immigrants was a real one, and that although the arrangements at the wharf were far from ideal and ought to be improved, yet the inconvenience that they involve was small by comparison with the great dangers to health and life which the withdrawal of this precaution would entail (*id.*). The government accordingly confirmed that the application of section 9 of the 1909 Act was a necessary precaution to safeguard Burma from smallpox

infection (Burma 1918a: iv). Thereafter the measure of the compulsory vaccination for immigrants at Rangoon port was regularized on a permanent basis.

Of course section 9 of the 1909 Act was legislated for easing the scourge of smallpox. But it worked in a different way as well. Close examination of almost all passengers under this provision could detect other infectious diseases at the port.³⁰ In the 1910s, the plague regulations had already been relaxed and medical inspection on visiting vessels under Indian Ports Act of 1908 was far from sufficient to check the importation of infectious diseases. The Sanitary Commissioner of Burma wrote in 1918 that Port Health Officer's powers under the Indian Ports Act permitted only of a general observation of the passengers and crew while crowded together on board, and did not extend to medical or clinical examination of individual persons. And he continued

This [Indian Ports] Act is therefore of little use for the protection of the Port and Province from the introduction of dangerous infections, [...]. It is therefore fortunate that we possess a further line of defence in the powers conferred on the Port Health Staff for the inspection of passengers as to their state of vaccination under the Vaccination Act of 1909.³¹

In the middle of the 1910s, by authorizing section 9 of the 1909 Act permanently, the government of Burma established the system medically screening Indian immigrants in two ways; detection of infected diseases by inspection and compulsory vaccination for unprotected persons.

The next section of this paper deals with various discourses of the agents who took part in the discussion in the 1917 committee, and traces the historical process which they took afterwards.

CONTESTED DISCOURSES: RACE, CLASS, AND THE COLONIAL STATE

Race

As it has been mentioned above, the legislating process for compulsory vaccination always accompanied racial discourses on Indian labourers which ascribed the occurrence of an epidemic to their insanitary habits or weak constitution. The majority of the committee in 1917 also demonstrated their wariness about Indian labourers in the last paragraph of their report. There, while admitting that the advantages of the intercourse between Burma and the Indian labourer were mutual, they contemptuously claimed that:

[...] the advantages connected with the presence of the Indian labourer have been by no means unattained by serious evils. In intelligence and education he is inferior to the indigenous inhabitant of the Province and his standard of comfort and civilization is very much lower. His habits are dirty and his presence in any numbers in a village renders it difficult or impossible to enforce the simple but effective sanitary rules whose efficiency in the prevention of disease has been proved by experience and which are imposed by the authority of Burmese public opinion. From his usefulness therefore must be deducted the fact that the Indian labourer is a centre and focus of disease wherever he has established himself. (Burma 1918a: 11.)

The majority of the committee emphasized the dangers caused by the existence of Indian labourers and recommended the government to take precautions against them.

But there was the limitation when the government sought to take such a measure. They advised the government as follows:

[...] it is the duty of the Government of Burma, while doing nothing to lessen the benefits accruing from the presence of the Indian labourer, to enforce every safeguard against the dangers to the health and welfare of the permanent population of the Province involved by his residence among them. (Burma 1918a: 11.)

This remark seemed to represent the position of the government of Burma properly. Here certainly the committee put importance on the public health policy targeted at Indian labourers, but it is worth noting that they took for granted that such a policy could be carried on as far as it did not damage economic interests. Under this limitation, the discourse emphasizing the dangers of Indian labourers worked to legitimate the medical inspection at the port.

Among six members of the committee, only one member who opposed the conclusion of the majority was P. J. Mehta. This person was a leader of Indian community in Burma, who had established a Burma branch of the Indian National Congress in 1908 (Chakravarti 1971: 99; Mahajani 1960: 34). Keen to promote the welfare of laboring classes, he was also one of the founders of the Social Service League in Rangoon.³² The government appointed him as a member of the vaccination committee accepting the nomination by the league (Burma 1918a: iv). When the majority of the committee reached a consensus, he totally dissented from the committee's findings³³ and presented the minute of dissent.³⁴ What resented him most was the racial prejudice against Indian people among colonial officials. He rejected the official view that regarded the public health problem as racial or cultural, and maintained that it was nothing but a socio-economic problem within the city of Rangoon.

The men that come to Rangoon from the Telugu districts of the Madras Presidency for work on the docks, mills, factories, etc., are tall, well-built and very often pictures of health. [...] the fault is neither in their constitution, nor in their habits, nor in the village that gave them birth. The fault is of the people, who employ them on scanty wages, and provide them with small, dirty and insanitary dwellings. (*Ibid.*: 96.)

This remark contrarily suggested that the government evaded its responsibility by deploying racial discourses. Once the serious overcrowding in coolie barracks was explained culturally, for example by Indians' "love of crowding together",³⁵ the government was released from the painful task to take fundamental solutions for the problem. Indeed the government could not take such solutions. Constructing sanitary accommodations for labourers by public funds entailed prohibitive costs (Burma 1921: 52). Restricting the quantity of immigrants was out of the question because it must "lessen the benefits accruing from the presence of the Indian labourer" as the majority of the committee pointed out (Burma 1918a: 11).

Moreover, Mehta went further to suspect the hidden intention behind the racial discourses, and warned that "There are forces in Burma making for hatred and contempt of Indians. They must be dispelled and not encouraged. It is a dangerous policy to set up one race against another" (Burma 1918a: 150). He ended his minute of dissent with the conclusion that "the proposed vaccination cannot prevent smallpox epidemics in Burma. It can only aggravate racial bitterness" (*ibid.*: 152).

It was not clear whether the government had such an intention or not. But it was certain that the government utilized various discourses in accordance with objects that it sought to achieve. In the early 1920s when the government launched the redevelopment project of Rangoon, the government designated the quarters of poor Burmese residents as “slums”, and drove them out in order to reclaim the sites, while leaving coolie barracks intact as “necessary evils”. In this time, Burmese nationalists actively deployed the racial discourse on insanitary habits of Indian labourers in a vernacular newspaper and maintained that it was Indians not Burmese who should be dispelled from the city.³⁶ As a result, these discourses were to work for aggravating antagonism between Burmese and Indians as Mehta anxiously predicted.

Class

Under section 9 of the 1909 Act, it was “any person who has travelled on board the vessel for the purpose of coming to Burma to work as a labourer” who was subject to medical inspection at ports, and “every person who when so requested fails to show by documentary or other evidence that he is not a labourer” was deemed as a such person (*ibid.*: 5). This provision had a certain extent of ambiguity, so evoked a considerable grievance among passengers when the section was authorized. One witness for the 1917 committee said:

One most important thing to be observed here is that our Port Health Officer never takes trouble to find out coolies from the respectable deck passengers and examines everyone and gives order to vaccinate almost all deck passengers and thus very often the vaccinated respectable people are vaccinated again and again.³⁷

This person, an Indian trader, felt bitter about that the Health Officer did not distinguish him from coolie classes. According to F.A. Foy, the Port Health Officer of Rangoon, the real objectors to medical and vaccination inspections were a relatively few deck passengers of a class above that of coolie, such as Indian clerks, small merchants (*ibid.*: 15). Voices of laboring classes were muted in the official records. While there was a political leader, like P. J. Mehta, who attempted to protect interests of the lowest class, the lower middle class became to articulate their own good.³⁸

In relation to these complains from the Indian middle class, the majority’s report criticized the existing provision as neither logical nor scientific (*ibid.*: 5). This opinion was probably led by C.R. Pearce, the Director of the Pasteur Institute, who was the medical representative in the committee. From the standpoint of medical science, it seemed proper to inspect every passenger regardless of his class. Based on the understanding that “The law as it stands is a good sample of a type of class-legislation, vicious in principle, and now happily rapidly becoming obsolete”, the committee recommended to the government an amendment in the law abolishing the class distinction and rendering all passengers arriving in Rangoon liable to inspection and to vaccination if found unprotected (*ibid.*: 10).

In this regard, however, the government took priority of the administrative practicality over the medical principle. It pointed out that the committee’s use of the terms “logical” and “scientific” was highly artificial, and stated that “The true criterion to apply to the Act is whether it substantially achieves the object for which it has been devised” (*ibid.*: iv). The government accordingly decided not to move in the direction

of amending the law, while showing some consideration to the Indian middle class. To exempt the middle class from the medical inspection at the port, the government directed that the measures should be modified in order to bring them into stricter conformity with the existing law (*ibid.*: v).

But, ten years later, the government bent it to the medical principle to legislate for the more radical measure. In consequence of another serious smallpox epidemic in Rangoon in 1925, the bill to amend the 1909 Act was proposed in the Legislative Council in 1927. It was intended to abolish the class distinction in section 9 of the previous act as the 1917 committee recommended.³⁹ Moreover, the new bill, by adding the new section 12A to the 1909 Act, would give the Rangoon municipality the power to make rules for enforcing revaccination to anyone who attained the age of twelve years (Burma 1934: 1109-1110). The rules were to give the health authorities in Rangoon the discretion which enable them to vaccinate anyone arbitrarily regardless of whether he had been vaccinated or not.⁴⁰ This bill was enacted in the next year, despite of the opposition of a member of the Legislative Council from the Indian constituency in Rangoon that it was “a wild and sweeping measure including every class of Indian” (BLCP 1927, Vol. X: 37-38). Thereafter the number of vaccination at the port radically increased (see figure 5). Medical screening of Indian immigrants was thus strengthened again, and all immigrants became subject to medical inspection and vaccination. Now the class distinction within Indians was completely overshadowed by the distinction of “outside” from “inside” in the administrative discourse.

CONCLUSION

In consequence of the fact that Burma was colonized as a province of India, a huge number of immigrant labourers flowed into Rangoon which established its position as the economic and administrative centre of the province by the end of the 19th century. Overcrowding and insanitary conditions in coolie barracks in Rangoon alerted British administrators and developed both the perception and the discourse that Indians as a race had insanitary habits and imported epidemic diseases into and disseminated them in Burma. Based on this perception, the government of Burma attempted to maintain public health in the province by constructing the system for checking immigrants' health condition at the port of Rangoon.

In spite of many limitations caused by the colonial settings peculiar to Burma, the system for sanitary regulations at the port had been realized by the late 1910s. This suggested that while the British officials in Burma had to behave not to damage the interests of the central government of India and the Chamber of Commerce which represented the British Empire, they also had to seek to achieve the governance in the province, especially in Rangoon. Here the racial discourses which stigmatized Indians as disseminators of dangerous diseases worked to legitimate such a policy for local needs which might be contrary to imperial interests, though it was clear by the middle of the 1910s that the compulsory vaccination did not hamper the economic progress of the province.

Another opponent to the sanitary regulations at the port was the Indian middle class. They claimed that they should be exempted from medical inspection at the port, and the measure should be applied only to the laboring classes. Though the

government of Burma accepted their opposition once in 1918, it widened the scope of the measure to all immigrants by sea from outside Burma by the late 1920s. Seeking the more effective measure to prevent immigrants from bringing dangerous diseases into Burma, the government abandoned class distinction by having recourse to medical science.

During the course of the period of this study, Burma was still a part of India, but a border with the function of institutionally separating Indians from Burmese gradually emerged at Rangoon where cosmopolitanism seemed to flourish and no border seemed to exist. This was a part of the process in which Burma as an administrative entity was transforming itself from a province in India to a state separate from India, which also seemed to have affinity with Burmese imagination of a nation as well, although under the colonial limitations both the border and the state were still embryonic ones.

Figure 5: The number of vaccination at ports in Burma, 1917-1932

Year	“Immigrants to Burma (a)”	“Persons who were vaccinated at ports (b)”	$b/a \times 100$ (%)
1917	237 184	11 330	4,78
1918	259 922	6 055	2,33
1919	284 779	6 455	2,27
1920	341 180	14 718	4,31
1921	331 992	18 366	5,53
1922	360 038	n.a.	n.a.
1923	382 724	27 155	7,10
1924	388 205	30 202	7,78
1925	372 733	41 169	11,05
1926	408 464	49 763	12,18
1927	428 343	44 937	10,49
1928	418 698	186 966	44,65
1929	405 393	216 854	53,49
1930	368 590	194 534	52,78
1931	309 426	165 990	53,64
1932	300 368	173 025	57,60

Sources: (RAB 1917-1932).

Notes: Figures in column (a) are returns from ports same as figure 2. Figures in column (b) are returns from Rangoon port only from 1917 to 1929, and from ports of Rangoon and Akyab from 1930 to 1932.

Notes

1. This paper is originally based on my B.A. thesis submitted to the University of Tokyo (Osada 2004) and has been developed by the archival research in Yangon and London.
2. This phrase was used by Furnivall firstly. His definition of a plural society is following: "There is a plural society, with different sections of the community living side by side, but separately, within the same political unit. Even in the economic sphere there is a division of labour along racial lines" (Furnivall 1956: 304-305). Adas criticized Furnivall's model as a static "equilibrium model" and developed it into "conflict model" in order to enable historical analysis. By this model, he argued that a symbiotic relationship between different races which emerged in Lower Burma by the 1890s was gradually shaken because of the closing of the agricultural frontier after 1908, and finally serious communal conflicts arose under the economic crisis in the 1930s (Adas 1974: 104). This paper based on Adas' understanding.
3. The Civil Surgeon's Report, Rangoon, appended to *RSABB for 1871* (RSABB 1871: 15).
4. (RCLI 1931 Part I: 6-7) . This problem was discussed frequently in the late 1920s and the early 1930s (see Burma 1927: 67-87; Rao 1930: 82-109; Andrew 1933: 166-181).
5. A contrasted image of Burma with India can be seen in other spheres as well. For example, British appraised high status of Burmese women in comparison with suppressed Indian women (Ikeya 2005).
6. Ashley Eden (Chief Commissioner of Burma, 1871-1875). He spent about 20 years in Bengal before his appointment in Burma (Stephen 1888: 354-355).
7. For example, in reply to enquiries of the Royal Commission on Labour in India in 1930, G. G. Jolly, Director of Public Health, Burma, wrote that: "Generally speaking, it is my opinion that the physique of the Indian immigrant cooly is on the average definitely inferior to that of the Burman labour" (RCLI 1931 Part I: 20).
8. See (Ritchell 2006: 174-175). In 1899, a President of the Rangoon Municipality wrote that "Generally, [...] epidemic, whether of small-pox or cholera, do originate amongst Hindoos". A letter, No. 1656-1224, from H. L. Eales, President, Rangoon Municipality, to the Secretary to the Government of Burma, dated the 23rd March 1899, in Government of Burma Home Proceedings, March 1899 (IOR/P/5560, the shelf mark in the British Library, the same shall apply hereinafter).
9. To write this sub-section, I owed much to the following studies; (Arnold 1993; Bhattacharya *et al.* 2005; Naono 2009).
10. (Bhattacharya *et al.* 2005: 3; Naono 2009: 3-5). But these recent studies on vaccination history in this region reveals that vaccination in these colonies was not efficient as previously believed. By focusing on the technological developments for producing and transporting lymph, they argued how colonial officials struggled to gain effective lymph under the tropical climates.
11. On the vaccination act of 1880 and its legislating process in India, see (Burma 1934: 53-60; Arnold 1993: 150-156).
12. In addition to extension of the 1880 Act itself, local acts of 1908 and 1916 enlarged the scope of the 1880 Act along these lines (Osada 2004: 15-19; Naono 2009: 116-139, 176-178).
13. The Vaccination Act of 1880 was extended to Rangoon Municipality in 1884 (Naono 2009: 176).
14. (RAB 1896: 231; 1897: 96). Using contemporary English newspaper articles, Naono describes this incident as confrontation between medical authorities and municipal authorities (Naono 2009: 175, 179-180). But she seems to put too much stress on the political explanation. I think this incident was concerning a provision of the law, because the President of Rangoon Municipality soon became an active promoter to legalize compulsory vaccination for Indian labourers as will be seen in the next paragraph.
15. Medical inspection of all visiting vessels and selective quarantine was imposed on the Burmese ports (Burma 1901: 22-32; Harrison 1992: 137-139).

16. In 1897 the Chief Commissioner was promoted to be the Lieutenant Governor, and the government of Burma was given the Legislative Council. Since then the government of Burma has legislated their own vaccination acts.
17. A letter, No. 1656-1224, from H. L. Eales, President, Rangoon Municipality, to the Secretary to the Government of Burma, dated the 23rd March 1899, in Government of Burma Home Proceedings, March 1899 (IOR/P/5560).
18. Burma Home Department letter No. 599—1Z-13, from the Secretary to the Government of India, Home Department, dated the 17th August 1897, in Government of Burma Home Proceedings, August 1897 (IOR/P/5100).
19. Burma General Department letter No. 169—1Z-4, from the Secretary to the Government of Burma, to the Chief Secretary to the Government of Madras, dated the 11th October 1898, in Government of Burma Home Proceedings, October 1898 (IOR/P/5340).
20. A letter No. 407 (Public), from the G. Stokes, Chief Secretary to the Government of Madras, to the Secretary to the Government of Burma, dated the 7th April 1899, in Government of Burma Home Proceedings, May 1899 (IOR/P/5560).
21. In 1905, 3,975 cases with 1,276 deaths took place only in Rangoon [RAB 1905: 63]. For whole Burma, the number of deaths due to smallpox was 6,161 in 1905 and 8,540 in 1906. Many of them took place in Lower Burma (RAB 1905: 61; 1906: 64). These figures were at odds with Naono's table (Naono 2009: 188). She might mix up figures during these years.
22. "[T]heir habits are such that it spreads rapidly among them and constantly tends to become epidemic. They arrived in Rangoon periodically in great numbers and form a large floating population, crowded together in barracks, lodging-houses and factories in a manner which must be conducive to the spread of any contagious disease. In their unprotected condition they are undoubtedly the principal means of spreading small-pox in an epidemic form throughout the town", Burma Medical Department letter No. 836—2Z-4, from W. F. Rice, Secretary to the Government of Burma, to the Secretary to the Government of India, Home Department (Medical), dated the 26th January 1907, in Government of Burma Medical Proceedings, January 1907 (IOR/P/7501).
23. *Ibid.*
24. This section was reproduced in (Burma 1918a: 5).
25. *Ibid.*
26. The problem of immigrant beggars was discussed in the Legislative Council at least twice in 1904 and 1914 (BG, 11 Apr. 1914, Part III, pp. 56-61)
27. In this order, their names were O. J. Obbard, Gavin Scott, C.R. Pearce, E. O. Anderson, P. J. Mehta, Maung Po Han (Burma 1918a: 1).
28. The one who opposed to the majority was P. J. Mehta, the representative of Indian community. We will see his opinion in the next section.
29. The committee excluded Arakan from consideration (Burma 1918a: 2).
30. Annual reports of the Port Health Officer, Rangoon, contained statistics of detected cases at the port under the Vaccination Law as well as the Indian Ports Act.
31. Sanitary Department letter No. 2136, from C. E. Williams, Sanitary Commissioner of Burma, to the Secretary to the Government of Burma, dated the 14th May 1918, in (RPHOR 1917: no pagination).
32. In May 1917 it was criticized in *Rangoon Gazette*, an English newspaper that a shipping company treated Indian labourers badly when it transported them between India and Burma. Next month, in order to protect interests of deck passengers and to take up works of humanitarian nature, the Social Service League was organized (Burma 1918b: 1).
33. Even Mehta denied efficacy of vaccination. He reinforced his argument by referring both to his own experience as the Superintendent of Vaccination in a native state in India and to the anti-vaccination discourses in contemporary Europe (Burma 1918a: 77-109). His opinion about this was ignored by the government as "extreme views" (Burma 1918a: iv). Here science and

technology was also a terrain of contested discourses. But arguing about that was beyond the scope of this paper. See footnotes 10 and 40 in this paper as well.

34. This minute of dissent was even longer than the majority's report. The former was published as appendix to the latter (Burma 1918a: 73-152).
35. See footnote 17.
36. I am preparing another paper to develop the argument in this paragraph.
37. Statement of L. V. Mehta, a trader (Burma 1918a: 50).
38. At the same time as the Vaccination committee in 1917, another committee was appointed to investigate hardships suffered by deck passengers. In the resolution of the report of the committee, the government also observed that: "It is manifest that a large number of the witnesses have been using the pretext of the inconvenience suffered by the coolies to dwell upon the inconvenience to middle class persons, who do not care to pay for second class accommodation, but dislike being crowded among the coolies who travel as deck passengers. The movement appears to have come from such persons and not from the coolies on whose behalf the representations have been made" (Burma 1918b: i).
39. The bill was enacted as it was proposed in the next year. On the contents of the 1928 Act, see (Burma 1934: 1109-1110).
40. This section reflected the change of the medical theory. Between 1900 and 1910, medical officials in India came to realize that the first vaccination operation did not impart lifelong protection, and that it needed to be boosted by a second operation, or "revaccination" (Bhat-tacharya *et al.* 2005: 155). Medical officials in Burma had also realized the same thing by the 1917 (Burma 1918a: 36).

References

■ ARCHIVAL SOURCES

Asia, Pacific and Africa Collections, British Library, London, UK.
 Government of Burma, Home Proceedings, 1897-1899.
 Government of Burma, Medical Proceedings, 1907.

■ OFFICIAL PUBLICATIONS

Periodicals

- BLCF Proceedings of the Legislative Council of the Governor of Burma 1927
- BG Burma Gazette
- Census Census of India 1872-1931
- RAB Report on the Administration of (Lower) Burma 1886-1932
- RSABB Report on the Sanitary Administration of British Burma 1871-1875
- RPHOR Annual Report of the Port Health Officer, Rangoon 1915-1921

Reports

- BAXTER, James, 1941, *Report on Indian immigration*, Rangoon: Superintendent, Government Printing and Stationery.
- BENNINSON, J. J., 1928, *Report of an Enquiry into the Standard and Cost of Living of the Working Classes in Rangoon*, Rangoon: Superintendent, Govt. Print and Stationery.
- BURMA, 1901, *The Burma Plague Manual containing The Epidemic Diseases Act, 1897, and The Rules, Orders, and Notifications issued thereunder* (First Edition), Rangoon: Superintendent, Government Printing.
- 1918a, *Report on the Committee Appointed to Investigate the Alleged Hardships caused by the Compulsory Vaccination, under the Provision of Section 9 of the Burma Vaccination Law Amendment Act, 1909, of Labourers arriving in Rangoon by Sea*, Rangoon: Office of the Superintendent, Government Printing.

- 1918b, *Report of the Committee Appointed to Enquire into the Allegations of Inconvenience and Hardship Suffered by Deck Passengers Travelling between Burma and India*, Rangoon: Office of the Superintendent, Government Printing.
 - 1921, *Reports of the Suburban Development Committee Rangoon: and the Departmental Committee on Town Planning Burma with Resolution of the Local Government*, Rangoon: Office of the Superintendent, Government Printing.
 - 1927, *Report on the Public Health of Rangoon*, Vol.1, Rangoon: Superintendent, Government Printing and Stationery.
 - 1934, *The Burma Code* (6th edition), Rangoon: Superintendent, Government Printing and Stationery.
- RCLI (Royal Commission on Labour in India), 1931, *Burma* (Evidence Vol. X, consists of Part I Written Evidence and Part II Oral Evidence), Simla: Government of India Press.

■ SECONDARY SOURCES

- ADAS, Michael, 1974, *The Burma Delta: Economic Development and Social Change on an Asian Rice Frontier, 1852-1941*, Madison: University of Wisconsin Press.
- ANDREW, E. J. L., 1933, *Indian Labour in Rangoon*, London: Oxford University Press.
- ARNOLD, David, 1993, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India*, Berkeley: University of California Press.
- BHATTACHARYA, Sanjoy, Mark HARRISON & Michael WORBOYS, 2005, *Fractured States: Smallpox, Public Health and Vaccination Policy in British India, 1800-1947*, New Delhi: Orient Longman.
- CHAKRAVARTI, Nalini Ranjan, 1971, *The Indian Minority in Burma: The Rise and Decline of an Immigrant Community*, London, New York: Oxford University Press.
- FURNIVALL, John Sydenham, 1956, *Colonial Policy and Practice: A Comparative Study of Burma and Netherlands India*, New York: New York University Press.
- HARRISON, Mark, 1992, "Quarantine, pilgrimage, and colonial trade: India 1866-1900", *Indian Economic and Social History Review*, 29: 117-144.
- 1999, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India, 1600-1850*, New Delhi: Oxford University Press.
- IKEYA, Chie, 2005, "The 'Traditional' High Status of Women in Burma", *The Journal of Burma Studies*, 10: 51-81.
- ITO, Toshikatsu, 1981, "Development of the Delta in Lower Burma and Immigration: the 'pull-push' approach to migration from Upper Burma", *Socio-Economic History* (Shakai-Keizai-Shigaku), 47, 4: 33-57 (in Japanese).
- KELLY, Robert Talbot, 1905, *Burma: Painted & Described*, London: Adam and Charles Black.
- MAHAJANI, Usha, 1960, *The Role of Indian Minorities in Burma and Malaya*, Westport, Conn.: Greenwood Press.
- NAONO, Atsuko, 2009, *The State of Vaccination: The Fight Against Smallpox in Colonial Burma*, Hyderabad: Orient Blackswan Private Limited.
- OSADA, Noriyuki, 2004, "Plural society and public health: The vaccination policy in British Burma", B.A. Thesis, University of Tokyo, Tokyo (in Japanese, unpublished).
- PEARN, Bertie Reginald, 1939, *A History of Rangoon*, Rangoon: American Baptist Mission Press.
- RAO, Narayana, 1930, *Contract Labour in Burma*, Madras: Current Thought Press.
- RITCHELL, Judith L., 2006, *Disease and Demography in Colonial Burma*, Copenhagen: NIAS Press.
- STEPHEN, Leslie, 1888, *Dictionary of National Biography*, Vol. 16, London: Smith, Elder.

Abstract: This paper examines how an administrative border emerged between historically and culturally different and geographically separate regions which nevertheless had been integrated into one state under the colonial power. As a result of three Anglo-Burmese wars in the 19th century, Burma was colonized by the British. During the course of its colonization, the country formally became a province of India. Hence no border had existed between Burma and the rest of India until 1937 when the former was separated from the latter. This connection with India brought Burma unrestricted labour supply from India which was necessary for the growth of the economy. But at the same time, such a vast flow of people included undesirable elements like criminals, beggars and people sick of infectious diseases which caused social problems in Burma. While the government of Burma attempted to deter or exclude those undesirable elements in order to maintain social order, these attempts were frustrated by several factors. In spite of these circumstances, the local government started taking more decisive policy for examinations of immigrants after the middle of the 1910s. No border existed yet, but port cities, especially Rangoon, gradually assumed function of checking people who came from “outside” into “inside”. I would like to call this phenomenon, tentatively, the emergence of an embryonic border. As a part of this phenomenon, this paper describes a history of sanitary regulations for Indian immigrant labourers in colonial Burma, by focusing on a case of implementation of compulsory vaccination at ports. And it points out that those regulations were formed on the basis of racial discourses for Indian labourers.

Une frontière embryonnaire: discours raciaux et vaccination obligatoire des immigrants indiens dans les ports de la Birmanie coloniale, 1870-1937

Résumé: Cet article montre comment une frontière administrative est apparue entre deux régions historiquement et culturellement différentes et géographiquement séparées réunies toutefois en un État par un pouvoir colonial. Après trois guerres anglo-birmanes au XIX^e siècle, la Birmanie devint une colonie britannique et pendant cette colonisation le pays devint officiellement une province indienne. De fait aucune frontière ne séparait la Birmanie du reste de l'Inde jusqu'en 1937 quand une séparation fut opérée entre les deux. Ce lien avec l'Inde entraîna un apport non limité de main-d'œuvre depuis l'Inde, nécessaire à la croissance de l'économie. Ce flot de population comprenait des éléments indésirables: criminels, mendiants, personnes atteintes de maladies contagieuses qui étaient sources de problèmes sociaux en Birmanie. Le gouvernement de Birmanie rencontra des difficultés dans ses tentatives de décourager ou d'exclure ces éléments indésirables pour assurer le maintien de l'ordre social. Malgré tout, après le milieu de la décennie 1910, le gouvernement local commença par mettre en place une politique plus déterminée dans l'examen des immigrants. Les frontières restaient inexistantes, mais les villes portuaires, Rangoon tout particulièrement, entreprirent de contrôler les gens se rendant de l'« extérieur » vers l'« intérieur ». Je souhaiterais proposer de baptiser ce phénomène frontière embryonnaire. Dans ce phénomène, cet article développe une histoire des règlements sanitaires pour les travailleurs immigrés indiens dans la Birmanie coloniale, en focalisant sur le cas des vaccinations obligatoires dans les ports, et en soulignant que ces règlements étaient fondés sur des discours raciaux concernant les travailleurs indiens.

Keywords: Burma/Myanmar – Rangoon/Yangon – port-city – border – immigration – Indians – public health – vaccination – imperial medicine – racial discourse.

Mots-clés: Birmanie/Myanmar – Rangoun/Yangon – villes portuaires – frontière – immigration – Indiens – santé publique – vaccination – médecine impériale – discours racial.