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Colonial Administration in British Africa during the Influenza Epidemic of 1918-19

Sandra M. Tomkins

Résumé
Il s’agit ici de l’épidémie d’influenza dont ont été victimes les colonies britanniques en Afrique entre 1918 et 1919. Le but de cette étude est de vérifier l’argument selon lequel les sciences médicales européennes ont dans une certaine mesure légitimé le Nouvel Impérialisme. Dans la métropole même, la réaction de l’Office Colonial devant le désastre qui se déroulait dans ses territoires a été tardive et inefficace. En Afrique, les administrateurs locaux ont réagi de manière plus pragmatique; pourtant, la médecine européenne s’est révélée impuissante, incapable de combattre l’influenza, et les efforts déployés pour soulager l’état de détresse générale étaient limités par de maigres ressources. Il est ironique de penser que c’est leur fierté dans leur approche scientifique et rationnelle qui est en fait responsable de pratiques profondément contraires à l’esprit scientifique elles-mêmes accompagnées de critiques dirigées contre les Africains jugés superstitieux et obscurantistes pour avoir rejeté l’aide européenne. Ainsi, en défi de multiples preuves du contraire, l’épisode a été interprété comme étant la victoire du rationalisme occidental et le signe du besoin constant de l’Afrique d’être conseillée et guidée par l’Europe.

Introduction
A flourishing debate among historians of imperialism in Africa concerns the role of science and technology in European expansion and administration (see, for example, Headrick 1979, 1981, 1988; Kubicek 1967, 1990; Alam 1978; Bailes 1980). Until quite recently, historians shared the contemporary view that medicine was a straightforward element of colonial administration and its legacy (see MacLeod and Lewis 1988; Arnold 1988). With the growth of “scientific medicine,” and specifically the germ theory of disease, Western medical science was viewed as unquestionably beneficial and progressive. Indeed, it was perceived as perhaps the only indisputably legitimiz-

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ing facet of European imperialism (Arnold 1988, 3, 16). Recent scholarship has challenged this schema. Far from being a neutral and value-free tool, medicine is now recognized as a cultural artifact carrying its own assumptions and prejudices. Instead of their former emphasis on medicine's assumed neutrality, historians now argue it was instrumental in maintaining European authority. As a unique area of cultural contact, medicine is now identified as a potentially rich source of insights regarding the principles and practice of imperialism (see especially Arnold 1988).

It has also become commonplace to acknowledge that the real achievements of modern medicine were relatively slight in the late nineteenth and early twentieth centuries. Despite some significant advances such as diphtheria antitoxin, factors such as environmental health and nutrition, and not direct medical intervention, are seen to underlie the general improvement in public health in Europe. With scarcer resources and fewer staff, the impact of modern medicine was even less striking overseas despite some spectacular exceptions such as the eradication of yellow fever in Cuba and Panama. Nonetheless, the status of the medical profession was rising markedly in this period. Notwithstanding the lack of demonstrable cures, the achievements of medical science were sufficient in two ways to bolster this prestige. First, physicians wielded a powerful explanatory model of disease, couched in scientific language, and apparatus that rapidly distanced them from the lay public and acted as a potent tool of professionalization. Second, the methodology of medical science at this time was more important than its results. Many had confidence and optimism that medical research held the key to the challenge of disease, but also believed it would naturally take time and patience to unlock the mysteries (Shortt 1983, 51-68).

These changes significantly elevated the status of medical practice within European and North American society. Their influence in overseas possessions, where the "lay public" were subjugated indigenous populations, was even more noticeable. Medicine thus became an integral element in the establishment and maintenance of European status and authority. Previously, colonial medicine had been relatively pluralistic, its practitioners even assuming that local inhabitants might know best about prevalent disease patterns and treatments. With the advent of the germ theory, however, came the "growing conviction of the unique rationality and superior efficacy of western medicine" (Arnold 1988, 12, 17-18). Scientific medicine was deemed to be culturally neutral – a cholera bacillus was the same anywhere – therefore universally employable as an inherently progressive tool of empire. By contrast, indigenous practices were viewed as superstitious, fatalistic, and a hindrance to European progress.

The perception of a fundamental dichotomy between "temperate" and "tropical" medicine served only to strengthen this trend. The tropics were
seen as an entirely separate entity, characterized by exotic diseases, and Europeans' survival in this hostile environment was seen as a measure of their success and superiority (Arnold 1988, 7-8; Ernst 1988). This dualistic view also enabled imperialists to maintain their faith in the ascendancy of Western medicine despite its marginal impact on colonial ill-health. On the one hand, "tropical diseases" were new to European medical science, but they would inevitably come under its sway, given time and patience. Advances in yellow fever and malarial prophylaxis were promising indicators of such progress. On the other hand, diseases such as cholera and smallpox, which had been vanquished in the temperate world, persisted in the tropics. Although European science had been credited with the elimination of such diseases in Europe, their persistence elsewhere was viewed as evidence of indigenous inadequacy and backwardness. Medical science thus became central to the self-styled civilizing mission of the New Imperialism.

Epidemics were particularly important in this ideology of colonial medicine. According to Roy MacLeod,

> When they threatened the status quo, epidemics also created conditions favourable to the consolidation of imperial or government rule. . . . Empires which based their claims of occupation and settlement in part on the moral superiority of European civilization, and saw an obligation to secure the safety of their subjects, found their credibility as purveyors of European culture and rational government intricately tied to their power to control the spread of disease (MacLeod and Lewis 1988, 10-11).

The influenza pandemic of 1918-19, second only to the fourteenth century Black Death in both relative and absolute mortality, was unquestionably the greatest challenge to Western imperialism from this quarter. Truly pandemic, it swept the globe in a matter of months, and its most peculiar and disturbing feature was the overwhelming preponderance of young adult mortality. Influenza was completely impervious to the methods and practices of European - or any other - medicine. Its extreme infectivity, short incubation period, and the imperfect nature of vaccines hamper efforts to prevent or contain outbreaks even today, while efforts in 1918-19 were further limited, since the virus had not yet been identified. Then as now, no cure existed. Medical science could only counsel bed rest, symptomatic treatment, and then hope for the best.

The sheer scale of the pandemic makes it historically important. In both Western societies and former European colonies, it has now gradually begun to receive the attention it merits (Phillips 1987, 1990; Ohadike 1981; Patterson 1983; Phimister 1973; Ranger 1988; Patterson and Pyle 1983; 1991; see also Tomkins 1992a). In its implicit challenge to the perceived superiority of
Western medical science, the epidemic raises a number of questions in imperial history. This is not to suggest, however, that the epidemic of 1918-19 presented an inevitable blow to European imperialism. It was, after all, comprehensible within the ethic of medical science outlined above. Colonial administrators could, therefore, have admitted their inability to cope without undermining their fundamental faith that European medicine would, eventually and inevitably, find the answer. If they had done so, the episode would be of only intrinsic interest. But, at least in the British dependencies, administrators did not respond in this way; rather, they insisted vehemently that they could, and demonstrably were, managing the crisis effectively. In the context of escalating mortality rates and complete social and economic dislocation, these repeated and emphatic claims reveal the complexities and inconsistencies of the imperial mentality in the face of the epidemic.

Obviously, the epidemic experience in Britain's African colonies was shaped by a variety of factors, and the response to it involved the participation of Europeans and Africans in many different capacities. An examination of colonial officialdom during the epidemic overlooks the evident contributions of other Europeans, most notably medical missionaries, and above all, of Africans themselves. Nevertheless, a focus on colonial officialdom is justified for three reasons. First, the responses of other groups merit their own studies. A comprehensive consideration of the epidemic response in even a single colony or region would exceed an article-length study. Terence Ranger's work on African responses to the epidemic in Southern Rhodesia suggests the richness of such possibilities. Second, the experiences of Britain's diverse African possessions during the epidemic offer a broad perspective on several pertinent questions in imperial history. These include the relationship of domestic and imperial policy, the role of scientific expertise in the formulation of colonial policy, and the role of medical science in the maintenance of European authority. Finally, the disease appeared to originate in British West Africa. As a result, questions of both its origins and imperial administrators' responsibilities were particularly acute and controversial.

This article therefore focusses on British policy making and perceptions of African responses to the epidemic, rather than on African responses per se, relying chiefly on Colonial Office records. It does not, of course, include South Africa, which was not under Colonial Office authority and has also been extensively examined by Howard Phillips (Phillips 1987, 1990). Since influenza could neither be prevented nor cured, objective successes or failures, in terms of lives saved, will not be identified. Instead, the actions of colonial administrators, as they illustrate underlying assumptions and
attitudes, will be surveyed. Next, the progress of the epidemic through British Africa will be traced. Finally, after a consideration of practical responses to the epidemic, British perceptions of the episode will be discussed.

Despite its early knowledge of the outbreak and much-vaunted access to scientific expertise, the Colonial Office failed even to warn its dependencies of the approach of the disease, offering only impractical advice on prevention long after the fact. Although the "men on the spot" in Africa responded more promptly and pragmatically, and with remarkable uniformity given the rudimentary nature of colonial administration and the severity of the epidemic, their efforts were singularly unsuccessful. Moreover, in their eagerness to employ "scientific" European remedies vis-à-vis local "superstition," British administrators often indulged in highly unscientific practices. Even though medical science was claimed the victor over African obscurantism during this influenza epidemic, the only true victor was the virus itself. Hence, a blinkered and prejudiced ideal of European medical superiority, when put into practice, belied its "scientific" basis.

The Colonial Office

In order to establish the context within which local administrators worked, an understanding of the Colonial Office's role is essential. Medical affairs in each colony were overseen by a Medical Department, headed by the Chief Medical Officer and staffed by District Medical Officers, who were responsible to the Governor and Executive Council. The Colonial Office undertook general policy initiatives, which were then implemented by each colony's executive machinery. Although the Colonial Office was the ultimate policy arbiter, implementation varied considerably according to the individual circumstances of the various colonies.

In the early twentieth century, the Colonial Office closely followed improvements in scientific and medical knowledge, largely as a result of recent advances regarding yellow fever and malaria (Harrison 1978). The Department reacted promptly to these developments with a keen sense of their potential application to colonial affairs. The Colonial Office helped to found the London School of Tropical Medicine, and a medical advisory committee for tropical Africa was formed. Malarial prophylaxis was undertaken, chiefly in West Africa (and primarily for the benefit of European populations). In these respects, the Medical Department was sensitive to colonial applications of scientific developments, making prompt use of this expertise (Kubicek 1967).

The Colonial Office's response to the influenza pandemic of 1918-19, a mere few years later, was, by contrast, passive in the extreme. The earliest appearance of virulent influenza occurred in the British West African colony
of Sierra Leone in August 1918, and the Department received numerous reports regarding its rapid diffusion and the ensuing social disruption and high mortality rates. Nonetheless, no action was taken; other colonies were not even warned about its spread. Only in November 1918, when influenza was rampant in Britain itself, did the Colonial Office express concern over the disease's progress through the colonies and issue a circular notice of warning and advice. By the time the notice reached most colonies, however, the virulent phase of the epidemic had subsided.

This lacklustre response was closely linked to the fact that the Colonial Office's recent interest in scientific and medical matters did not extend beyond tropical diseases. The African medical advisory committee was specifically concerned with tropical medicine, and otherwise expert advice, when necessary, was solicited from other government departments. In November 1918 the Colonial Office thus appealed to the Local Government Board, the chief public health agency in Britain, for advice and information. Given that the Board was bitterly criticized for its inadequate response to the epidemic in Britain itself, however, it proved a weak reed of authority for Colonial Office policy.

Indeed, the British Local Government Board's response to the epidemic was unique in emphasizing the possibility of prevention. With remarkable uniformity, other policy makers in the United States, Canada, Australia, New Zealand, and South Africa recognized the futility of influenza prevention and overwhelmingly directed their efforts to the relief of epidemic-related distress through the provision of nursing assistance, home helps, soup kitchens, and dispensaries. In Britain, however, medical professionals and public health administrators alike clung rigidly to the premise of preventive measures against an epidemic that rapidly proved to be unstoppable. Ironically, therefore, Britain, which had by far the most sophisticated public health machinery among those societies where the epidemic has been chronicled, mounted the least effective response (Tomkins 1992b). (The reasons behind this policy response are, however, beyond the scope of this study.)

Thus, when Colonial Office officials appealed to the Local Government Board for information, they received the recommendation that preventive measures be taken against an unpreventable disease. The Local Government Board's pamphlet on influenza prevention, included in the colonial circular of 5 November 1918, emphasized *inter alia* that children should be excluded from cinemas for the duration of the epidemic. This preventionist stance of the Colonial Office does not necessarily imply, however, that colonial administrators followed its lead. By the time the memorandum arrived, most colonies were already emerging from the worst weeks of the epidemic and had, by necessity, dealt with it according to local initiatives.
Fig. 1: Primary influenza diffusion pathways in sub-Saharan Africa during the 1918-19 epidemic.
Fig. 2: Waves of influenza diffusion in sub-Saharan Africa during the latter half of 1918.

Source: Patterson and Pyle 1983.
The Course of the Epidemic

One of the world's first outbreaks of virulent influenza occurred in British West Africa. As Alfred Crosby (1989) has observed, it appeared virtually simultaneously in late August in New England, Brest (France), and Sierra Leone. From Sierra Leone, it spread throughout Africa along major transportation and communications arteries (Figures 1 and 2). Mortality figures are unreliable, especially outside of urban areas, but the epidemic was undoubtedly severe. Freetown lost four percent of its population in three weeks. Not less than 1.5 per cent of the population of Lagos died, and the toll in the provinces of Nigeria was thought to be even greater, with about 200,000 deaths in the northern provinces and 260,000 in the south (about three percent of the population). Deaths in the Gold Coast totalled at least four percent of the population, and the Gambia, by far the smallest colony, sustained about 10,000 deaths. The West African colonies were a scene of abject misery and social dislocation. These losses could “not fail to have an appreciable effect on the productive capacity of the country during the next few years.”

Indeed, most observers asserted their inability to describe the extent of the disaster. The Medical Officer in Accra reported that:

... within ten days, the town presented a changed appearance, places of business were closed and the market was more or less deserted. The streets were silent and empty, trade was at a standstill, and the greatest depression prevailed.

Given the novel nature of the disease in Sierra Leone, its origins became a point of great contention. Many identified its appearance with the arrival of HMS Mantua in Freetown on 15 August, which had had many mild cases of influenza aboard. Within two weeks, the city was virtually paralyzed. Some observers believed that the disease had arrived in all its virulence with the Mantua. Others suggested that, while the ship unquestionably brought the mild influenza which had prevailed in Europe during the summer, its virulence increased in Freetown, and, in fact, the Mantua took the deadly virus back to Britain. Colonial administrators argued that even though no action had been taken until two weeks after the appearance of virulent influenza, the epidemic could not have been curtailed in any case, except by “intolerable restrictions” which could not have guaranteed success.

Local inhabitants were nonetheless angered by the arrival of the epidemic. In Freetown, particularly during the early stages of the epidemic, when it appeared that Sierra Leone was uniquely hard-hit and the government seemed singularly culpable, the indigenous populations of the West African colonies supported a number of newspapers that were unanimous in their criticism. These newspapers blamed the government's “apparent neglect if not shortsightedness” for the “wholesale deaths” in the colony, because it had allowed so serious a disease to enter with so little concern
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(Colonial and Provincial Reporter 14 September 1918, 21 September 1918; Sierra Leone Weekly News 7 September 1918). The spread of the disease to other colonies only partly deflated such accusations.

In response to the dispute over the Mantua, the Colonial Office instituted an enquiry by the Advisory Medical and Sanitary Committee for Tropical Africa in London, focussing on the failure of the governor to act, after he had been made aware of influenza aboard the ship on 15 August. He did not summon the medical staff until 27 August and, although warnings were then issued promptly to Nigeria and the Gold Coast, coastal steamers had already carried the disease elsewhere. In short, sanitary measures in Sierra Leone were found to be "more or less in abeyance." However, the matter was not pursued, and the enquiry never submitted a report or set of recommendations, no doubt largely because of the rapid growth of the epidemic. In any case, the committee was skeptical of quarantine as a practical measure.

In retrospect, the unprecedented virulence of influenza in 1918 absolves both levels of administration of responsibility for foreseeing or forestalling the outbreak. However, the Colonial Office's complete failure to act following the events in Sierra Leone was far more serious. It had received a stream of reports regarding the devastation in Sierra Leone, and it also possessed a cable communications network for the speedy transmission of information. Even as influenza spread throughout West Africa, the Colonial Office failed to warn its other African possessions and more far-flung colonies. While skepticism regarding the utility of quarantine was probably justified, forewarning of the epidemic would have allowed preparations to be made in advance. In this case, European technology and medical science could have offered potential benefits to colonial populations, but these opportunities went unrealized.

Local administrators proved more sensitive to the threat than did the metropolitan authority. Sierra Leone, for instance, warned its neighbours of the epidemic. The Gold Coast followed this example, by notifying Nigeria of the approach of the epidemic, and Nigeria itself stressed that:

... concerted action on the part of all colonies is necessary ... for mutual advantage to notify each other at the earliest instance and allow preventive measures to be taken ... not to give necessary information "a day after the fair."  

In addition, both Nigeria and the Gold Coast instituted maritime quarantines and made the disease notifiable, without any real hope of success, but in the expectation that early detection of the disease would allow their relief efforts to be employed with maximum efficiency.  

Although the epidemic became no less deadly as it spread throughout Africa, reports and rumours of events in West Africa served to forewarn other areas to some extent. The epidemic reached Southern Africa in late
September-October 1918, beginning in the ports and then spreading inland to the High Commission territories. As elsewhere, reliable statistics are not available, but some estimates suggest that seven percent of all black mine-workers in Southern Rhodesia died, as did over five percent of the population of Bechuanaland (Roberts 1986, 622). By the time the epidemic reached East Africa, its ravages were sufficiently well known that British administrators anticipated it with resignation and even stoicism. The East Africa Protectorate expected it would appear "like everywhere else," and again, death tolls were estimated at up to five percent of entire populations.

Local Responses
The epidemic exceeded the experiences and resources of colonial Medical Departments. Although in the past they had had some success in forestalling epidemics of plague and smallpox by maritime quarantine, these methods were unlikely to be successful against influenza, which spread explosively and was less readily identifiable. At the same time, colonial medical administration suffered from chronic underfunding and staffing shortages. Recruits to the colonial medical service were generally recent medical graduates. With the advances in tropical medicine of the late nineteenth century, postgraduate training increasingly became a prerequisite for medical service. Colonial medicine was not, however, a popular calling, especially in notoriously unhealthy West Africa, and frequent delays were encountered in filling posts. Officials expressed concern at the difficulty of attracting suitably qualified men, particularly to the hinterlands, and frequently the resident commissioner, who had no particular medical expertise, was forced to handle district health administration for long periods of time (Jeffries 1956).

The limited available funds were allocated to the enforcement of maritime inspection and quarantine, urban sanitation, and the preservation of "European" life and health. By 1918, even fewer resources were being assigned to colonial medical administration, owing to the demands of European warfare.

In spite of these limitations, colonial administrators in British Africa generally responded promptly and vigorously to the epidemic. Sierra Leone was, of course, the first colony to act. In Freetown, the Acting Senior Sanitary Officer, John Allan, established temporary dispensaries for the distribution of medicines. Handbills of advice were distributed, appeared in the local press, and were sent to large employers. Sanitary inspectors made house-to-house visitations to detect the disease and provide consultation, and an Auxiliary Hospital was opened (although local inhabitants proved reluctant to enter it). Volunteers were recruited from the European community to participate in the relief effort.

This response in Sierra Leone established a pattern, which was repeated throughout British Africa with remarkable uniformity. Its most striking
feature was that, in contrast to practice in Britain itself and to the advice of the Colonial Office, the authorities focussed their energies on coping with the effects of the epidemic. This was true even in colonies forewarned by Sierra Leone’s experience, which might have hoped to keep the disease at bay. Officials employed preventive measures (chiefly ship inspection and quarantine) only in order to, at best, slow the entry of the disease and then trace its course. On the whole, they directed their efforts more towards relieving distress through the provision of medicines, hospital accommodation, foodstuffs, and health visits.

The Gold Coast and the Gambia mounted similar campaigns. Of all the West African colonies, Nigeria organized the most thorough measures, partly because warnings from Sierra Leone and the Gambia had enabled administrators to plan in advance. Once established in Lagos, the epidemic caused widespread panic among local Nigerians, who began to flee in great numbers to the interior of the colony. Administrators focussed on reassuring the indigenous population and convincing them of the need to remain in Lagos where qualified medical aid was available. Simple leaflets of advice, in English and Yoruba, were distributed, and house-to-house visitation was undertaken with the help of European volunteers. However, the territory covered was inevitably a small fraction of the whole, and the rapid spread of the disease soon frustrated these endeavours.

Most Southern African colonies were well apprised of the disease’s ravages in West Africa, and prevention was equally soon dismissed as a policy option. Influenza was regarded as unpreventable, except by extreme measures, which would not only be “prohibitive to the commerce of the country,” but would also require an enormous staff. In Swaziland, the Resident Commissioner instructed his District Officers to inform locals, through their Chiefs, that the disease would soon be upon them and that medicines would be available at certain centres. A total of £3,500 was spent on stocks of medicines (quinine, aspirin, salts, and disinfectants), temporary hospitals were organized, and Europeans were called upon to perform nursing and other work. Basutoland was likewise prepared, and both Resident Commissioners recorded that they could not speak too highly of the selfless efforts of the European volunteers. Bechuanaland was also readied for the epidemic in advance, and the distribution of simple drugs and advice was emphasized there.

In contrast to these careful plans, the epidemic was unexpected in Southern Rhodesia, where official and press reports conveyed a portrait of complete social and economic dislocation. The network of available information was seemingly haphazard in the absence of early initiatives from London. The authorities were criticized somewhat for failing to anticipate the epidemic and prepare accordingly, as the response of large numbers of native
inhabitants to the epidemic was to flee from the European centres (Bulawayo Chronicle 15 November 1918; Rhodesia Herald 21 November 1918). As a result, the first priority of the British authorities was to reassure the indigenous population and impress on them the need to remain where they would benefit from European medical attention. As elsewhere, the most comprehensive efforts were undertaken in the centres of European population and focussed on the provision of medicines, emergency hospitals, soup kitchens, and house-to-house visitation. Relief measures were also undertaken on the mine compounds, and volunteers distributed medicines and advice to the native reserves (Bulawayo Chronicle 18 October 1918).

The East African colonies were fully aware of the approaching epidemic, and again administrators uniformly rejected preventive measures. Zamzibar and Nyasaland mounted the most comprehensive efforts. Both established stringent quarantine measures, again without expectation of success but in the hope of delaying the disease and tracing its earliest appearance, while preparing to cope with its effects. Measures were directed at relieving distress, principally through the circulation of pamphlets of advice and the distribution of medicines (East African Standard 9 November 1918: 17). Zanzibar's particular circumstances, as an island with a relatively small population, account for both its sensitivity to the threat of sea-borne epidemics and its ability to muster a general relief effort, including the establishment of dispensaries and soup kitchens, with some measure of success. Nyasaland's prompt and thorough response was probably due to its close proximity to, and keen awareness of events in, South Africa (Nyasaland Times 31 October 1918; 7 November 1918; 14 November 1918).

Despite variations in climate, terrain, institutional organization, and patterns of settlement within British Africa, colonial administrators' responses to the epidemic were remarkably similar. Naturally, their emphases were diverse, and the dynamics of the relief effort differed from the trading colonies of West Africa to the settler colonies of the east and south. One notable variation was the contribution made by European women in the latter. In general, however, epidemic policy in each colony was directed towards the relief of distress. Not only were these policies initiated independently and spontaneously in each colony, but they were directly contradictory to official Colonial Office advice. The fact that colonial administrators were more progressive than their metropolitan counterparts in recognizing the limitations of preventive measures against influenza is all the more remarkable, since colonial societies, with their more limited transportation links, might be expected to have been more amenable to preventive action.

Nonetheless, these measures were effectively useless because of the nature of the disease and the scarcity of resources. Especially outside the European centres, the relief effort could reach only a small fraction of the
local population. Moreover, even had there been sufficient staff and resources to mount a comprehensive campaign, European science was powerless to combat the disease per se. The most possible was the relief of epidemic-related distress, with little reduction in the death toll. It remains to consider how this reality affected European attitudes and the role of scientific prestige in the maintenance of British authority.

The Mythology of the Epidemic

Colonial administrators constructed a veritable mythology of the epidemic experience, based on the image of the European community selflessly united to minister to its stricken subjects. European volunteers did work long hours, often at much personal risk of infection, in makeshift hospitals and in the visitation of local communities. In Sierra Leone, the Principal Medical Officer was generous in his praise of their exertions, recording that the organizer “deserves the greatest credit for prompt and tactful action, and grasped the situation from the outset in a masterly manner.” The Resident Commissioner of Basutoland could “not speak too highly of the self sacrificing efforts of volunteers,” while administrators in Southern Rhodesia felt that the epidemic effort was “a magnificent example of the gradually increasing consideration which is being shown by Europeans to the aboriginal native” (Rhodesia Herald 29 November 1918). The governor and the Medical Officer of Nyasaland were both fulsome in their praise, particularly of the “truly benevolent service rendered by European women . . . who so nobly came to the assistance of the sick.”

The enlightenment and benevolence displayed by the European community were contrasted sharply with the qualities of superstition and ignorance manifested by indigenous groups. An observer in Nyasaland commented on the “superstitious ideas the onset of a sudden disease like this has on the minds of the ignorant” (East African Standard 23 November 1918: 24). This perceived lapse into superstition included much antagonism towards the British, who were often blamed for the presence of the disease. As a result, local inhabitants often fled from urban centres, not realizing that they were merely speeding the spread of the disease. In the eyes of colonial administrators, such behaviour hampered the relief effort and further endangered African lives by rejecting European medicine and aid. Furthermore, African living conditions contributed to high mortality rates, and when house-to-house visitation was attempted, its efficacy was undermined by deception and concealment of cases. Many accounts considered that...

...it is of very little use to distribute quinine or similar medicine amongst these so called low class natives, as they seem not to appreciate it, but believe that the medicines supplied by Europeans do more harm than good.
Such responses were most pronounced in West Africa and Southern Rhodesia [Bulawayo Chronicle 15 November 1918; Rhodesia Herald 21 November 1918].

British officials and volunteers persevered in the face of this perceived intransigence, often believing that their own benevolence would improve race relations in the wake of the epidemic. According to them, it

... called out the best in everyone. It brought together in the cause of humanity the two races, all classes, and those of diverse opinions, and all the universal presence of suffering and of death has done something – has, I believe done a great deal – in most places to soften acerbities [sic] and to bring about a mutual appreciation [Rhodesia Herald 29 November 1918].

The Chief Native Commissioner in Southern Rhodesia asserted: “the feelings thus aroused should do much to strengthen the relationship between European employer and native employee.” The apparent contradiction between this view, and his own accounts of hostility and resentment towards Europeans, was reconciled in the feeling that “though the natives did not like to take our medicine, the fact that the white men had been sent to try and assist them was greatly appreciated.”

The British position contained several inherent contradictions, the most important of which was that much-vaunted “European” science and methods produced no tangible results. Although partly the result of inadequate resources, this contradiction was chiefly due to the absence of any effective treatment or cure in the arsenal of European medicine. The British sense of superiority was based on knowledge and techniques that were no more successful than those of the much-maligned Africans. In fact, British statistics compiled in 1919, and confirmed in a study by Ian Phimister, revealed that the African death rate in the European areas of the Southern African territories was nearly three times that on the reserves. This disparity was probably due to overcrowding.

This misplaced sense of the prestige of European measures was nowhere more evident than in the distribution of drugs. What was meant by “drugs” was rarely elucidated, but in the absence of substantial supplies of aspirin and quinine (which, in any case, offered only symptomatic relief), the term probably referred to vague concoctions of coloured water. The East Africa Protectorate’s Medical Officer observed that “drugs are of little value” in treating influenza, yet stressed the distribution of “drugs” in his relief effort. It appears that this emphasis on “drugs” was more of a placebo for the administration’s need to supply effective, “European” remedies to their subjects, than for the local peoples themselves. Thus, faith in “scientific” remedies ironically resulted in some very unscientific practices. The same
may be true in the other African colonies, where the “drugs” that formed a central part of the relief effort were rarely identified.

The sense of confidence with which colonial administrators faced the epidemic also dulled their understanding of its novelty and extent. Contemporary estimates placed Indian mortality at seven million; in comparison with this figure, African administrators congratulated themselves on limiting the ravages of the disease in their territories to “only” four to five percent of the population. This self-satisfaction betrayed a triple irony. First, the relative toll in Africa was at least as high as the Indian figure, the latter merely reflecting India’s huge population. Second, an epidemic mortality rate of five percent of an entire population in a matter of weeks was, in se, a staggering toll, unprecedented in European experience since the Black Death. Yet colonial administrators prided themselves on their achievement. Third, the self-styled purveyors of European science and medicine proved unable to grasp the significance, or even the dimensions, of the single greatest medical crisis of modern times.

This self-confidence in European methods and practices also led colonial administrators and observers to criticize any and all indigenous responses to the epidemic. In some areas, including Southern Rhodesia, the flight of Africans from European centres, ascribed to their reversion to superstition in the face of the crisis, was identified as both a cause of high mortality, and a hindrance to the European relief effort. Yet, in neighbouring Bechuanaland, their tendency to gather together met with exactly the same criticisms. The Resident Commissioner observed that

The tendency of the Bechuana to congregate in huge villages, which has its origins in causes no longer in existence, has always been criticized by Government officials and others, but, owing to the inborn conservatism of these people, hitherto without result. This visitation, however, has afforded a painful object lesson which, it is hoped, will not be without its effect on Chiefs and people, and it will be my care to see that they at any rate understand it.

These contradictions, and the fact that existing public health machinery and scientific knowledge were helpless, were rarely acknowledged by colonial administrators, who continued to regard the epidemic effort as a great success. There was much genuine (if paternalistic) emphasis on the need to protect and aid African communities, and European medical staff and volunteers did work under great strain and self-sacrifice. However, this “success” was measured not in terms of lives saved or distress alleviated, but by the devotion and selflessness of those who participated. British officials and volunteers derived great satisfaction from the fact that, in simplest terms, they had done their best. They felt that they had thereby displayed their superior
moral character, while indigenous populations, lapsing into superstition and ignorance, had confirmed their ongoing need for European guidance.

These contradictions were not lost on African observers. While this article does not purport to explore African responses comprehensively, the active lay press served as an interesting source of opinion to which colonial policy makers were sensitive. Indeed, as the governor of Sierra Leone remarked, the lavish praise of the relief effort "requires some supplementing" in view of "the very abusive press campaign against the Government and its alleged carelessness and indifference." This response was most pronounced in West Africa, because of the novel nature of the disease and the flourishing local press. Furthermore, as T.S. Gale has argued, the advances in tropical medicine of the late nineteenth century resulted in a growing emphasis on the preservation of European life in British West Africa and the concurrent neglect of African towns. This policy caused much disillusionment with British rule, especially among European-trained African doctors who, excluded from the West African Medical Service, came to be at the forefront of critical local opinion. Thus, the wellspring of discontent in West Africa was particularly sensitive to health issues (Gale 1970).

African observers, for their part, found much to criticize in the British relief efforts. The attempt to prevent the spread of the disease in Lagos included the isolation of suspected cases, in what were alleged to be appalling conditions. The flight of many Nigerians and their mistrust of European medicine were based not on ignorance, but instead on the knowledge of... the reckless disregard for human Native life displayed by the authorities... people are hustled out to practically certain death in a building where... those sent are obliged to lie on bare cement floor. It is not a wise thing to depend on Force as the most essential weapon for stamping out an epidemic. The cooperation of the people is vital and cannot be ensured with the present methods, which make people run away not from fear of disease, but fear of officials and their ways (Lagos Standard 2 October 1918).

In the face of a crisis in which European science and methods were not simply inadequate, but positively harmful, the aspersions cast on the "native character" for failing to cooperate were deeply resented (Colonial and Provincial Reporter 11 January 1919). Furthermore, the local press angrily rejected British accusations of "yellow journalism" and alarmist coverage of the epidemic. The fault lay, rather, in the government's own lack of initiative in an unprecedented crisis (Gold Coast Independent 21 September 1918). In particular, its failure to restrain private enterprise during the epidemic, especially widespread profiteering in medicine and food (Lagos Standard 9-16 October 1918; Sierra Leone Guardian and Foreign Mails
11 October 1918], was roundly criticized. The epidemic also revealed to West Africans that they

. . . are good enough to pay their house tax and to be deprived of their belongings and houses by public sale for non-payment thereof, but they are . . . to be ignored as to medical treatment and preventive measures during the dreadful crisis (Colonial and Provincial Reporter 28 September 1918; 2 November 1918; Sierra Leone Weekly News 21 September 1918).

Tensions between colonial commercial enterprises and epidemic relief were most explicit in Southern Rhodesia. Mining representatives criticized the government’s handling of the epidemic; however, their charges of incompetence reflected a desire to get the mines working again, for the mineworkers “are the bread earners of the country. If their labour is allowed to drift away, and it cannot be held in idleness, bankruptcy will be the country’s fate.” While mining representatives did seek care for the sick, their greater priority was to facilitate the speedy return of healthy and convalescent workers to the mines. This policy was identified as a major factor in the high rate of relapse, with many such cases resulting in death.42

To these criticisms of their motives and methods, British administrators reiterated their satisfaction at the selfless devotion of officials and volunteers who had done their best to cope in difficult circumstances. These sentiments were not lost on the local press, which observed that

. . . if their humanity and philanthropy in attending a class of natives which have on other occasions been contemptuously and disdainfully called ‘dirty niggers’ is sincere and genuine, it is to be admired; we trust that the daily opportunities afforded them to display such humanity will be taken advantage of (Colonial and Provincial Reporter, 26 October 1918; see also Sierra Leone Weekly News 21 September 1918).

Far from feeling that they had been the beneficiaries of a benevolent administration, African leaders wondered “why was there such a remarkable coldness amounting to indifference in our rulers with respect to ourselves?” (Sierra Leone Weekly News 21 September 1918; see also Colonial and Provincial Reporter 2 November 1918). Granted even that the British community had made a great effort with scarce resources, this was not an excuse or palliative for the fundamental problem: the scarcity of resources in the first place. The exclusion of European-trained African doctors from the West African Medical Service seemed to exemplify the lack of real priority given to health issues. The Gold Coast Leader stressed that it was not entirely the fault of the current administration, but of a colonial system.
which would neutralise the efforts of the most enlightened Administration. Apart from the Influenza now raging, these considerations would be sufficiently weighty. With death on every hand even a Crown Colony Government can have no excuse for going to sleep over an urgent public need and an equally urgent public demand (Gold Coast Leader 19 October 1918, 3; see also Colonial and Provincial Reporter 21 September 1918; Sierra Leone Weekly News, 7 September 1918, 14 September 1918). Years of neglect and exploitation could not be compensated by a single act of kindness, especially one which cast aspersions on the "native character," when the efforts of the British themselves were helpless against the onslaught of influenza.

British participants and observers remained immune to the real implications of the epidemic, even as their attitudes revealed inherent contradictions. If British administrators, with the benefit of European science, were, in fact, able to deal with the epidemic, then their culpability lay in a response that was too little and too late. These claims to efficacy were, however, groundless, and were sustained only by making a scapegoat of the "native character." Thus, the British criticized indigenous peoples on the one hand for fleeing, on the other for congregating, and condemned the "superstitions" rejection of drugs, which they themselves knew to be useless. To the local press, on the other hand, the response to the epidemic was a revelation and confirmation of the failures of British colonial administration. Colonial authorities, meanwhile, preferred to picture the episode in terms of their individual acts of heroism.

Conclusion
The failure of British colonial administration to make a more fundamental and enduring response to a disease that killed millions of its subjects within a matter of weeks is the epidemic's most striking revelation. Gale has argued that although the trend towards the provision of medical services for Africans began in the First World War and culminated in the 1920s, the influenza epidemic had no discernible effects on public health policy (Gale 1970, 389). While it is true that British administrators explicitly denied the policy implications of the epidemic, the African response revealed much dissatisfaction over medical affairs. Leaders in the port cities felt:

The epidemic ought therefore to be made a distinct point of departure in the history of our country. It has been made ten times plainer... that our welfare lies in our standing up and doing things for ourselves (Sierra Leone Weekly News 21 September 1918).

This study is not concerned with indigenous reactions per se, but it suggests that much valuable research remains to be done on the impact of the
epidemic on African social and political history. South Africa has also not been included in this study, chiefly because it was an independent administrative entity. It is worth noting, however, that it constituted an exception to the policy record in the Colonial Office jurisdictions. As Howard Phillips has chronicled, the epidemic prompted significant public health reforms at both national and local levels in the Dominion. It is likely that similar efforts were undertaken at the municipal level in British Africa, especially in the larger urban areas of the southern African settler colonies. Research on this level of administration would also constitute a valuable addition to the influenza literature.

In contrast to the passivity of the Colonial Office, the colonial governments in Africa did at least respond promptly and pragmatically to the outbreak, but their efforts were quickly overwhelmed and the spirit of energy and initiative in medical policy did not outlast the epidemic. This failure stemmed from an unwillingness to acknowledge the implications of the epidemic for European convictions regarding the superiority of medical science. Indeed, their very pride in their scientific and rational approach prevented British administrators in Africa from recognizing, or responding effectively, to the world’s worst epidemic since the Black Death. This faith in science led to some highly unscientific practices and to the concomitant criticism of Africans for rejecting European measures, which were rife with inconsistencies and sometimes positively harmful.

This conviction regarding the virtues of Western medical science ultimately united health professionals and administrators at home and abroad. In both cases, the lay public was repeatedly admonished not to worry and to trust medical science. In Africa, where the “lay public” was indigenous, these assertions took on overtones of the superiority not only of the Europeans’ science, but also of their moral character. The revelations of the “native character” during the epidemic served both to explain the limited success of European efforts and to reaffirm Africa’s ongoing need for European guidance. In this way, colonial administrators interpreted the epidemic as a confirmation of the right and necessity of British rule, despite all evidence to the contrary. The short-lived nature of the epidemic and concurrent preoccupations with issues of war and peace allowed administrators at home and abroad to emerge with this faith intact, and even with unfounded pride in their achievements.

Notes
1. Of course, Europeans were far from impervious to tropical diseases even after the development of quinine prophylaxis, and a corollary of this belief was the rapid institutionalization and/or invaliding home of sick Europeans.
2. While these successes are now often seen as modest and isolated achievements – not
least because the new techniques were generally employed only to the benefit of European health and interests - they were perceived at the time as a powerful indicator of the potential of Western science.


7. CO 98/30, Gold Coast Annual Medical Report [1918], 7-8; see also CO 879/118/1061/61, Report on Influenza in Sierra Leone, 21 October 1918, 181; CO 657/8/1920/1, Sierra Leone Annual Medical Report [1918], 79; CO 879/118/1061/71, Report on Influenza in the Gambia, 235.

8. CO 270/47, Sierra Leone Annual Sanitary Report (1918), 54-5.

9. The pages of many colonial newspapers are either not numbered, or the quality of microfilm makes it very difficult to decipher the numbers. Many page numbers are therefore not listed, but as most of these papers are only four to six pages long, the material is easily located.

10. CO 879/118/1061/67, Minutes of the Advisory Medical and Sanitary Committee for Tropical Africa (hereafter MAMSCTA), 3 December 1918, 223; CO 879/118/1061/113, MAMSCTA, 1 April 1919, 285; CO 879/118/1061/122, MAMSCTA, 6 May 1919, 300.

11. CO 657/8/1920/1, Nigeria Annual Medical Report [1918], 87.


13. Basutoland, Bechuanaland, and Swaziland comprised the South Africa High Commission territories, and the High Commissioner also had certain powers over native policies in Northern and Southern Rhodesia, which were administered by the British South Africa Company. The High Commissionership was vested in the Governor-General of South Africa. In the latter capacity, the Governor-General played a constitutional role in the self-governing Union; in the former, he was the supreme authority in the British possessions, responsible only to the Colonial Secretary. Resident Commissioners in each territory reported to him.


17. CO 89/14, Gambia Legislative Council Minutes, 2 December 1918; CO 879/118/1061/71, Report on Influenza in the Gambia, 234-36; CO 98/30, Gold Coast Annual Medical Report [1918], 27.


20. Resident Commissioner D. Honey to High Commissioner, 15 February 1919, CO 417/625/18933, Swaziland Original Correspondence, 1919; Resident Commissioner

22. CO 525/82/45872, Nyasaland Original Correspondence, 9 April 1919; CO 688/3, Zanzibar Annual Medical Report [1918], 92; CO 685/3, Uganda Annual Medical Report [1919], 63-4; CO 713/3/59424, Somaliland Register of Correspondence, 9 December 1918; CO 544/10, East Africa Annual Medical Report [1918], 209-10, 233; CO 544/6, Minutes of the Legislative Council of the East Africa Protectorate, 1918, 7.


27. Duff to Colonial Office, 27 February 1919, CO 525/82/45872, Nyasaland Original Correspondence; CO 626/6, Minutes of the Nyasaland Legislative Council, 15-16 July 1918, 2-3.


35. CO 544/10, East Africa Protectorate Annual Medical Report [1918], 233.

36. Recent scholarship suggests that it may have been as much as three times this figure; see Mills [1986].

37. This refers to the entire population, not simply to those who contracted influenza. CO 417/625/18933, Report on Influenza in Swaziland, 5; MacGregor to High Commissioner, 23 October 1918, CO 417/606/4205/18/19, Report on Influenza in Bechuanaland.

38. This is not necessarily true, as figures for both areas are incomplete and unsatisfactory. The point is, rather, that this was the logical conclusion of the figures that were available to African administrators, and in which they took such pride.
39. Of course, chronic diseases have always taken a greater toll of lives than more spectacular epidemic visitations. As a single disease episode, the influenza epidemic certainly deserves this notoriety.

40. MacGregor to High Commissioner, 23 October 1918, CO 417/606/4205/18/19, Report on Influenza in Bechuanaland.


42. See press clippings in CO 417/606/4187/18/19, Report on Influenza in Southern Rhodesia.

43. See also CO 98/31, Minutes of the Gold Coast Legislative Council, 29 October 1918.

Bibliography


