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Influenza Pandemic (Africa)

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This article provides the first continent-wide overview of the catastrophic, worldwide “Spanish” influenza pandemic in Africa. It focuses on the virus’ arrival, the countermeasures that vainly tried to stem it, its lethal and paralyzing impact on town and country, and the immediate and longer-term consequences that flowed from its ravages. The article also addresses the questions of why the pandemic was so severe south of the Sahara and how it was linked to World War I.

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Introduction

Even though the devastating “Spanish” influenza pandemic of 1918-1919 killed nearly 2 percent of Africa’s population within six months, there has been very limited investigation of this catastrophe, especially in Franco- and Lusophone Africa. This article provides the first continent-wide overview of the disaster, though it concentrates on the worst-hit sub-Saharan region. It traces the pandemic’s

arrival and spread, the unsuccessful attempts to check it, the enormous disruption of everyday life that it caused, the demographic havoc it wrought, and the effects of all of these on Africans at the time and for at least one generation thereafter. In doing this, the following five sections also consider two even larger questions – the pandemic’s relationship to World War I and why it was so severe in sub-Saharan Africa.

Origin, Arrival and Spread

Of all six continents, Africa – and particularly sub-Saharan Africa – suffered the highest average mortality rate in the pandemic.^[1] On the causative H1N1 influenza virus, its possible evolution and the highly infectious and life-threatening character of the pandemic it drove, see the entry in this online encyclopedia for “[The ‘Spanish’ Influenza of 1918-1919](#)”. That entry refers to the pandemic’s three distinct but related waves, an infectious but relatively mild first wave in March-July 1918, the deadly second wave in August-December 1918, and a serious but more moderate third wave in 1919.

In the case of Africa, only [North Africa](#) and, belatedly, a corner of southeast Africa, appear to have experienced the first wave. This means that, unlike the Americas, Europe and Asia (all of which were swept by the first wave), most of sub-Saharan Africa’s initial exposure to the pandemic was to the lethal second wave. The corollary of this was that the bulk of its population, unlike most other inhabitants of the world, had no opportunity to contract first-wave “Spanish” flu and thereby develop a degree of immunity to its far deadlier successor a few months later. They were therefore hit by the full, unmitigated force of the pandemic’s second wave – and it showed.

The only Africans to escape this onslaught, at least partially, were those living in the two regions of Africa touched by the first wave, viz. North Africa (the Maghrib and [Egypt](#)) and southeastern Africa (especially [South Africa’s](#) Natal Province and adjoining territories). The impact of the lethal second wave in these regions was markedly lighter than elsewhere on the continent, presumably because of their inhabitants’ prior, immunizing exposure to the first wave. Certainly some contemporaries believed this to be the case and explained the difference as arising from where in Africa the epidemic had commenced. For example, in one district in Southern Rhodesia, locals distinguished between a less severe strain of the disease emanating from Natal and a more severe form coming from Cape Town. Their gendered worldview led them to label the former the “female” version and the latter the “male”.^[2] Alas, for the majority of Africans, it was the “male” form of the “Spanish” flu that they first encountered.

Between mid-August and late September 1918, the virulent second wave entered sub-Saharan Africa through three of its war-swollen seaports, Freetown, Cape Town and Mombasa. In each case, war-related factors played a significant role. To Freetown, the virus came from [England](#) aboard a Royal Navy warship on which it had begun to rage during the voyage south. By the time this vessel docked in Freetown on 14 August 1918, 124 of its crew had been laid low. Nonetheless, it was not

placed under strict quarantine, probably because the civilian authorities there were reluctant to disrupt naval operations. Colliers were therefore permitted on board to load coal, while medical staff from other warships came over to help out in its sickbay. The result was that, within days, the port's colliers and dock labourers were going down with "Spanish" flu like ninepins, as were sailors aboard the other warships. From them it quickly spread to Freetown's general population, 70 percent of whom were stricken within a fortnight. Describing a situation that was to become common throughout Africa in the coming weeks, the governor reported, "The disease spread with devastating rapidity, disorganizing everything. Everybody was attacked almost at once."^[3]

The infection of Cape Town and its interior stemmed directly from Freetown. Two troopships transporting South African Native Labour Corps troops home from Europe had stopped in Freetown to coal at the height of the outbreak. No sooner did they leave the port than cases of "Spanish" flu began to appear on board. This prompted the health authorities in Cape Town to hospitalize those who were still sick when the ships tied up there in September 1918 and to confine the remaining soldiers to a military camp for two days, under less-than-rigid quarantine. When none showed symptoms of influenza, they were formally demobilized and allowed to embark on trains for their homes all over the country. The next day, cases of "Spanish" influenza appeared among the staff of the military camp and the transport unit that had conveyed the troops there, among the hospital staff, and among stevedores and fishermen working in the harbour.

Whether the ship from India that is reported to have brought the "Spanish" flu to the third African point of entry, Mombasa, late in September 1918 had a military connection too is unclear. However, what is known is that the disease was soon prevalent among the Kenyan [Carrier Corps](#) who fanned out from the port across Kenya on being demobilized. As they travelled upcountry, so did the gathering epidemic, sweeping through the countryside via rail, road and river. A similar pattern of infection is evident from the Tanganyikan coast inland, and from there into Nyasaland. A [King's African Rifles](#) Regiment marching along this route to be demobilized "strewn the road with dead and dying", an official on the spot reported grimly.^[4]

Thus did the influenza virus spread, to a greater or lesser extent, throughout sub-Saharan Africa in the last quarter of 1918. From these three ports – which had become veritable nodes of infection for the continent – the pandemic spread along the coast and far inland, engulfing community after community.

Prime vectors on land were newly demobilized soldiers and carriers/porters, families fleeing infected towns for their lives, and railway personnel and migrant workers desperate to escape from mine compounds and barracks where death was rampant. In Kimberley, for example, thousands of diamond miners "made up their minds to leave, and if De Beers [the mineowners] did not agree [they insisted] they would break out, even if fired upon", reported a panicky labour agent,^[5] while an official in Northern Rhodesia recalled "the pell-mell flight from many labour centres [there] and the natural reluctance to return to what were regarded as centres of infection".^[6]

Within three months of its arrival by sea, therefore, the H1N1 influenza virus was causing death and mayhem even deep in the interior of west, central, southern and eastern Africa thanks to the ubiquity of flu-infected men on the move. As one historian recognized, it was as if “the colonial transportation network had been planned in preparation for the pandemic”,^[7] allowing the latter to ravage the continent far and wide, from Dakar to Mombasa and from the Cape to the Congo.

Paralysis and Disruption

Paralysis, or at very least acute disruption of all routine activities, followed in the wake of the pandemic as it struck down person after person, family after family. In many towns and villages shops, banks and businesses struggled to remain open for want of staff; public transport, schooling, church services and court proceedings were curtailed; mines, factories and workshops suspended operations; even the provision of basic services like sanitary removal, mail delivery and policing faltered. Cape Town’s main streets “are almost deserted in the middle of the day”, noted an awed journalist. “Business has become quite a secondary consideration, and sight seeing and amusements have lost all attractions... . Cape Town is like a city of mourning...and nothing is talked of or thought about other than Influenza.”^[8] In Accra a doctor described similar scenes – “the suspension of public business, the paralysis of trade, indeed the almost entire cessation of all activities save those connected with the care of the sick and the disposal of the dead.”^[9] Addis Ababa “looked like a dead city”, remembered a longtime resident,^[10] a shutdown which extended even to the government. “Abyssinian Govt. utterly disorganised as a result of influenza epidemic”, a British diplomat telegraphed home.^[11] According to the Italian minister, it was “no longer possible to regard Abyssinian Government as a serious organization with which the Powers can satisfactorily treat.”^[12]

In rural areas tilling, planting and harvesting came to a halt and cows were left un milked because whole households lay sick or dying in their homes. “[F]or two weeks a great solemn hush has prevailed”, wrote a rural resident of South Africa about his surroundings. “[N]o one to be seen, no one to be heard; no life on the farms, no work in the lands. Lord influenza and his followers have...the countryside in their grip.”^[13] For exactly the same reason, as an agricultural officer in rural Sierra Leone explained, there were “very few fit persons to scare away birds which consequently took their tithe of the crop”.^[14] A small settlement in northern Gold Coast resembled “a deserted village, one sees no one”, observed a passing official.^[15]

Nor was this temporary paralysis of the agricultural cycle without medium-term consequences, for in east and southeast Africa it coincided with planting time. Because fit labour was now in even shorter supply, less seed was sown, producing a much diminished harvest in 1919 and, consequently, famine or near-famine conditions. The deaths from starvation which resulted, as well as the increased flow of migrant labourers to towns, desperate for income to buy food for their hungry families, were two of the many less obvious knock-on effects of the pandemic. Another was the

introduction of quick-growing varieties of maize and beans in a bid to prevent a second famine, while, for a similar reason, in southern Nigeria peasants switched to planting cassava rather than yams as their staple crop as the former required less labour to cultivate and could be sown and harvested all year round. The speed with which cassava appeared in 1919-1920 in fields previously devoted to yams “may be regarded as a pointer to the magnitude of the food crisis that accompanied the influenza pandemic”, concluded a historian.^[16]

Countermeasures

Medical and administrative authorities were overwhelmed by the withering force of the pandemic. As there was no medical antidote to influenza or its complications at the time, the best that doctors could prescribe was either palliative or supportive of natural recovery and good nursing. As usual, in the absence of a sure biomedical cure, quack remedies proliferated to meet the anguished popular demand for an antidote.

For their part, where they had sufficient resources, governments acted in accordance with the advice of their experts in such matters, their medical officers. They distributed leaflets containing hints on prevention and treatment of “Spanish” flu, opened emergency hospitals, supplied hastily-concocted vaccines and special “flu mixtures” to the public, organized home visits to provide food and succour to the sick and despatched to the worst-hit areas those army doctors and nurses who could be spared. In a very few cases, where the situation was extremely dire (for instance in Kimberley, Windhoek and Port Louis), they divided towns into fixed medical districts and allocated one doctor to each to treat all the sick there, irrespective of who their usual doctor was. However, in most places no such targeted relief was available – especially in rural areas where most Africans lived – and families and individuals were left to fend for themselves if their surrounding community was itself too stricken to assist.

In this inauspicious situation most resorted to traditional herbal or folk remedies, practices and deterrents (like wearing amulets, sprinkling *muti* – traditional medicine – on approach roads, or hanging charms on doors). However, these usually proved as ineffective as biomedical treatment that, anyway, was still viewed with suspicion by many Africans because of its association with the apparatus of colonialism. In Southern Rhodesia, for example, many locals “ran away and hid” when “they heard anyone was near administering medicine”,^[17] while in rural South Africa an Anglican bishop and his team of relief workers found “the people simply w[oul]d not have us. One stood outside his hut and insisted his child was better: another woman took our medicine but said we had come to poison them.”^[18]

The Toll

In these grim circumstances deaths soared – Southern Rhodesia’s medical director described how

“people were numbed and staggered with the immensity of the disaster”^[19] – prompting fears across the continent that entire populations might be destroyed. In rural Gold Coast, for example, villagers wondered “if this is the end of the world”,^[20] while a black South African believed that the disease “threatens the existence of the entire race”.^[21] In Cape Town, a prominent financier was shaken by the reply of a senior government health officer to his question as to whether the city’s population was going to be wiped out. He was told by the doctor, “For the first time in my life I’m panicky, and I believe we are.”^[22]

Indeed, in towns like Kimberley, Addis Ababa, Port Louis, Windhoek, Ilorin, Sekondi, Bloemfontein and Bathurst (all of which lost over 4 percent of their populations to “Spanish” flu) such a cataclysmic outcome must have seemed possible. With deaths topping 300 per day in Kimberley at the height of the epidemic, a contemporary calculated that, at that rate, in sixteen months no one would be left alive in the city.^[23]

Although the statistics for “Spanish” flu mortality in Africa by whole countries are very inexact, the worst hit states appear to have been those where three features came together: first exposure to the pandemic only in its most virulent, second-wave form; being part of an extensive transport network by sea or by land; being regularly traversed by large numbers of people on the move, such as soldiers, sailors and migrant workers. That all three features coincided most fully in countries like South Africa, Kenya, Cameroon, Gold Coast, Gambia, Tanganyika and Nyasaland, and that these appear to have sustained the highest flu mortality (more than 5 percent of their populations) is unlikely to be coincidental. Nor is it likely to be coincidental that flu mortality in North Africa (where the toxic trio of features was not simultaneously present) probably did not rise above 1 percent of the population.^[24]

Significant differences in mortality across the continent notwithstanding, it is estimated that, *in toto*, the pandemic carried off some 2.4 million Africans (about 1.8 percent of the continent’s population); of these, 2.2 million were in sub-Saharan Africa, where the mortality rate may have reached 2.3 percent overall.^[25] Since, as elsewhere in the world, the bulk of those who died were young adults between eighteen and forty, the effect on societies was disastrous in terms of loss of labour, reproductive capacity, parents, breadwinners and family structures. For the continent, it was a sudden demographic, social and economic catastrophe without precedent.

Consequences

Most immediately, this loss of lives meant the creation, virtually at a stroke, of ten to twelve million orphans in Africa. In most cases these flu orphans were incorporated into extended families, but in settler colonies like South Africa and Southern Rhodesia, white orphans were put up for adoption or placed in orphanages, the number of which grew rapidly in 1919-1920 to meet this specific need. Those who fell through both the familial and institutional nets were left to care for themselves as

street children or lone wolves. Whatever their post-pandemic status, however, it would be unusual if many of the flu orphans were left unaffected emotionally and psychologically by the sudden death of one or both parents. As one ninety-year-old man who had lost his mother when he was ten admitted wistfully in 1998, “I have missed her ever since”.^[26]

Being so wholly and incomprehensibly surrounded by death affected many adults spiritually too. Some saw this as a sign of divine or ancestral wrath for sins of commission or omission – “The Lord has a controversy with us and His hand is stretched out for vengeance”, declared one Freetown newspaper^[27] – and made haste to mend their ways by improving their religious conduct or honouring their ancestors more fully.

For others, the decimation caused by the pandemic showed that their existing religion was not proof against evil, thus prompting a flurry of conversions to Christianity or Islam by traditional believers or of reversions from Christianity and Islam back to traditional beliefs. Rejoicing at the stream of would-be converts to Christianity, missionaries in several parts of the continent spoke insensitively about “the compensating blessings accompanying the ravages of the recent influenza epidemic seen in the awakened interest among the heathen, and a desire for the Word of God.”^[28]

Those Christians whose faith was not undermined by the pandemic but whose opinion of its clergy was, on account of their unsatisfying theology and practices in the face of the dire crisis, sought an alternative in the creation of their own African-initiated churches. As a result, between 1918 and 1921 over fifty such churches blossomed around the continent, displaying some individual features but all having independence from mainline denominations in common. In Nigeria “Aladura” praying churches dominated. In the Belgian Congo, the new congregations followed the model of the messianic church founded by Simon Kimbangu (1887-1951) who, in the midst of the epidemic there, had heard what he took to be Christ’s voice commanding him “to bear witness before your brethren and to convert them” as they had been unfaithful and therefore chastised through the flu.^[29] In Nyasaland, the failure of colonial medicine, missionaries and government to counter the pandemic helped revive the Watch Tower Movement, which perceived in this failure proof that European rule would soon collapse; in southern Africa, on the other hand, it was the millenarian visions of prophets like Nontetha Nkwenkwe (1875-1935), George Khambule (1884-1949) and Eliyasi Vilakathi amidst the pandemic that launched the Zionist churches.

To those who sought an explanation for so many deaths in traditional African religion, the epidemic was not of divine but of human origin. To them, evil stemmed from the actions of malevolent witches or wizards seeking to destroy them and their families. Accordingly, in the aftermath of the “Spanish” flu in southern, central and eastern Africa, professional witch-finders were in high demand to smell out those responsible. That they did so on a large scale and that action then followed by vengeful families to punish these malevolent individuals by killing or attacking them is borne out by the surge in such cases before the courts in 1919-1920.

Others did not require the services of witch-finders to explain what to them was quite obvious, viz.

that the epidemic was somehow related to World War I, either by design or by accident. Indigenous names like “war air”, *chipindupindu* (Yao for “disease from seeking to make a profit in wartime”) and *kaapitohanga* (Herero for “disease which passes through like a bullet”) all attest to this,^[30] as does the explicit explanation that the pandemic was caused by “the blood of so many people who were killed in the White man’s war together with the smoke from the guns...stirred by the wind. The air was fouled... .”^[31]

To yet others, such an explanation ignored what was even more apparent to them, that white colonists were behind the disease out of sheer hatred and malice towards Africans. It was, declared one, a “White Man’s Flu”,^[32] another insisting that “this disease was a device of the Europeans to finish off the Native races of South Africa”.^[33] Clearly the colonial presence in Africa was an object of deep popular suspicion to many.

To the biomedically-advised colonial governments themselves, the reason for the pandemic’s severity in Africa was to be found in the natural not the supernatural world, in germs and the insanitary environments in which they flourished. Therefore, their primary response lay in public health and sanitary reforms. In almost every territory the pandemic was followed by energetic but short-term clean-ups of towns and villages. As a Freetown newspaper preached, “prayers without proper sanitation avaieth naught... .”^[34] Far less common – only South Africa, Kenya and Mauritius went this far – was the comprehensive reform of the rudimentary public health systems that had failed so dismally in 1918, the construction of new hospitals and more salubrious housing and the creation of early-warning measures using radio and telegraph to alert health authorities to the presence of infectious diseases aboard incoming ships.

However, to these preventive measures, most towns in settler territories like South Africa, Southern Rhodesia and Kenya added more extensive residential segregation, in the belief that physical distance between the races would safeguard the physical health of whites against “diseased” blacks. As the prime minister of South Africa, Jan Smuts (1870-1950), explained in 1923 in a debate on the new Natives (Urban Areas) Bill, which nationally laid down the principle of residential segregation for Africans in towns, “If the principles of that Bill...were fairly applied in South Africa, we should remove what was to-day a grievance and a menace to health and decent living in this country.”^[35]

Conclusion

In sum, the “Spanish” influenza pandemic of 1918-19 left an indelible mark on the demographic, social, economic, medical, cultural, psychological, religious and spiritual character of sub-Saharan Africa for at least one generation. In territories as far apart as Nigeria, Kenya, South-West Africa and South Africa, its dire memory remained stamped on the names given to age-sets and individuals born in 1918 and 1919, and even to those years themselves.^[36] Indeed, for the rest of the 20th century, it became a popular means of dating other events as happening before or after “the flu”. In

the sombre recollection of one old man in Malawi in 1973, 1918 was the year when “God was angry”.^[37]

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Notes

1. ↑ Johnson, Niall / Mueller, Juergen: Updating the Accounts. Global Mortality of the 1918-1920 ‘Spanish’ Influenza Pandemic, in: *Bulletin of the History of Medicine* 76/1 (2002), pp. 110-14, tables 1-5. Note, however, that by confining the unit of analysis to continents, a number of islands where the mortality skyrocketed (e.g. Western Samoa, Fiji, Nauru and Tonga) have been excluded.
2. ↑ Mueller, Juergen: What’s in a Name? Spanish Influenza in Africa and What Local Names Say about the Perception of this Pandemic, unpublished paper for the conference “The Spanish Flu after 80 Years”, Cape Town 1998, p. 11.
3. ↑ Cited in Gewalt, Jan-Bart: Spanish Influenza in Africa. Some Comments regarding Source Material and Future Research, unpublished working paper 77/2007, African Studies Centre, Leiden 2007, p. 20.
4. ↑ Cited in Page, Melvin E.: *The Chiwaya War. Malawians and the First World War*, Boulder 2000, p. 166.
5. ↑ Cited in Phillips, Howard: “Black October”. The Impact of the Spanish Influenza Epidemic of 1918 on South Africa, Pretoria 1990, pp. 51f.
6. ↑ Cited in Yoshikuni, Tsuneo: Strike-Action and Self-Help Associations. Zimbabwean Worker Protest and Culture after World War I, in: *Journal of Southern African Studies* 15/3 (1989), p. 442.
7. ↑ Patterson, K. David / Pyle, Gerald F.: The Diffusion of Influenza in sub-Saharan Africa during the 1918-1919 Pandemic, in: *Social Science and Medicine* 17/17 (1983), p. 1302.
8. ↑ Cited in Phillips, *Black October* 1990, p. 21.
9. ↑ Cited in Patterson, K. David: The Influenza Epidemic of 1918 in the Gold Coast. in: *Journal of African History* 24/4 (1983), p. 488.
10. ↑ Cited in Pankhurst, Richard: *An Introduction to the Medical History of Ethiopia*, Trenton 1990, p. 60.
11. ↑ Pankhurst, *An Introduction* 1990, p. 59.
12. ↑ Pankhurst, *An Introduction* 1990, p. 59.
13. ↑ Cited in Phillips, *Black October* 1990, pp. 81f.
14. ↑ Cited in Cole, Festus: “Man-Hu”. The Influenza Epidemic in Sierra Leone, 1918, unpublished seminar paper, African History Seminar, SOAS, University of London 1992, p. 13.
15. ↑ Cited in Gewalt, *Spanish Influenza* 2007, p. 13.

16. † Ohadike, Don C.: The Influenza Pandemic of 1918-19 and the Spread of Cassava Cultivation on the Lower Niger. A Case Study in Historical Linkages, in: *Journal of African History* 22/3 (1981), p. 388.
17. † Cited in Ranger, Terence O.: The Influenza Pandemic in Southern Rhodesia. A Crisis of Comprehension, in: Arnold, David (ed.): *Imperial Medicine and Indigenous Societies*, Manchester 1988, p. 177.
18. † Cited in Phillips, *Black October* 1990, p. 85.
19. † Cited in Phimister, Ian R.: The Spanish Influenza Pandemic of 1918 and its Impact on the Southern Rhodesian Mining Industry, in: *Central African Journal of Medicine* 19/7 (1973), p. 144.
20. † Cited in Gewalt, *Spanish Influenza* 2007, p. 13.
21. † Cited in Phillips, *Black October* 1990, p. 82.
22. † Cited in Collier, Richard: *The Plague of the Spanish Lady. The Influenza Pandemic of 1918-1919*, London 1974, p. 56.
23. † Phillips, *Black October* 1990, p. 47.
24. † Johnson / Mueller, *Updating the Accounts* 2002, p. 110 , table 1.
25. † Johnson / Mueller, *Updating the Accounts* 2002, p. 110 , table 1.
26. † Interview with anonymous caller on SABC radio programme, "Talk at Will", 18 September 1998.
27. † Cited in Cole, *Man-Hu* 1992, p. 15.
28. † Cited in Phillips, *Black October* 1990, pp. 91f.
29. † Cited in Sundkler, Bengt / Street, Christopher: *A History of the Church in Africa*, Cambridge 2000, p. 781.
30. † Cited in Page, *The Chiwaya War* 2000, pp. 171f; Gewalt, *Spanish Influenza* 2007, p. 17.
31. † Cited in Musambachime, Mwelwa C.: *Consequences of the Influenza Pandemic of 1918 on Zambia and Malawi*, unpublished paper for the conference, "The Spanish Flu after 80 Years", Cape Town 1998, p. 6.
32. † Cited in Mueller, *What's in a Name?* 1998, p. 5.
33. † Cited in Phillips, *Black October* 1990, p. 85.
34. † Cited in Cole, *Man-Hu* 1992, p. 15.
35. † Cited in Phillips, *Black October* 1990, pp. 227f.
36. † Mueller, *What's in a Name?* 1998, pp. 8f; Gewalt, *Spanish Influenza* 2007, p. 17; Phillips, *Black October* 1990, p. 236.
37. † Cited in Page, *The Chiwaya War* 2000, p. 176.

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