Setting a Barricade against the East Wind:
Western Polynesia and the 1918 Influenza Pandemic

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Abstract

This dissertation is a comparative analysis of the experience of several western Polynesian states during the 1918-1920 influenza pandemic, and in particular an inquiry into how the response to the second wave of this pandemic determined the mortality for each island group. Historically, Pacific island states have faced challenges in controlling infectious disease. Distance, isolation, lack of resources, and the turbulent nature of local political authority have limited the ability of these states to mount an effective response to the transmission of introduced infections. The territories of Polynesia attempted a wide range of social measures for control of the 1918-1920 influenza pandemic. Their success or lack thereof depended more upon political and economic variables than indigenous cultural or health factors.

The colonial entities of Fiji, Western Samoa, and Tonga were sequentially infected with the 1918 pandemic strain of influenza by the SS Talune that departed from Auckland in November 1918. Despite being infected by the same strain of the virus, at the same time of year, and the significant number of cultural commonalities between these states, their experience of the influenza was broadly divergent. This work seeks to understand the forces that drove the differential outcomes.

Fiji had warning of the approach of influenza, yet the colonial medical staff discounted the risk and faced strong economic pressure to avoid quarantine measures. Fiji also had the largest and most ethnically diverse population, thus complicating education and outreach efforts, as well as strong recent memory of a devastating measles epidemic that destroyed indigenous confidence in the colonial medical system. Roughly five percent of the population of Fiji died.

Western Samoa had a military garrison with little governing experience as well as a plantation economy that faced significant strain if isolation measures were put into place. Settlement patterns drove rapid spread of the disease and plantation agriculture led to famine across the group during the convalescent period. Western Samoa experienced the world’s highest known death rate from the 1918 outbreak with one quarter of the population succumbing.
Tonga experienced a collapse of the political system in a state where tradition still played a large role. In the absence of the traditional political elite the populace were left to their own devices, and suffered accordingly. Somewhere between four and eight percent of Tongans were killed.

Yet American Samoa, fifty kilometers from Western Samoa, was perhaps the only polity across the globe to experience no mortality from the influenza pandemic. A small, homogenous state under US Navy control, quarantine was successfully implemented and maintained for years, preventing the infection from reaching the island group in its most virulent form. This success was a factor in the maintenance of American Samoa as a colonial bastion while Western Samoa sought independence from New Zealand.

A range of social, political, and economic factors determined outcomes as each of these states were exposed to influenza. The cultural, the political, and the medical are inextricably intertwined and it is these differences between the states, not their broad similarities, which define the experience of epidemic disease.
Preface and Acknowledgements

This work began with my time as a Public Health Nurse in northwestern Alaska. One of the villages I was fortunate enough to be responsible for was Brevig Mission, whose residents were willing to allow Johan Hultin to exhume the bodies of those that had died in the influenza pandemic of 1918-1919. This work led directly to the re-creation of the viral genome of this particular influenza variant and a huge amount of subsequent research. Having been close to such momentous work, I began researching the impact of the 1918-1919 pandemic in the arctic. Unfortunately there were very few written records of the event. While searching for an area with similar issues of isolation and logistics, the Pacific island states were obvious candidates. Many people in Alaska supported and inspired my work, and they all have my thanks.

The University of Otago and the government of New Zealand have been very generous both in financially supporting my research efforts and encouraging me along the way. The Department of History & Art History and the Division of Humanities have been willing to support my research travel and conference attendance, without which my research could not have progressed. The Norton Sound Economic Development Corporation and Norton Sound Health Corporation have provided additional funding, as has the New Zealand Nurses’ Association. To all these groups I offer my most heartfelt thanks.

The greatest guidance and support I have received has come from my two wonderful supervisors. Barbara Brookes and Judy Bennett have been sources of endless information, contacts, and suggestions while gently nudging me to stay on track. Their patience and support have been boundless. I have been truly privileged to learn from the best. Thank you both, and I hope this makes you proud.

My thanks as well to the Hocken Library in Dunedin; the Western Pacific High Commission Archives in Auckland; the National Archives and Turnbull Library in Wellington; and the National Archives of the United States, Great Britain, Australia, Fiji, Samoa, and Tonga. Their employees have met every request with
cheerful assistance. No matter where I have traveled the open enthusiasm that I have been greeted with has amazed me.

Additional assistance has come from many academics across several disciplines. In particular I would like to thank the following: Robert Glass at the American Samoan archives in San Bruno; Sandra Tarte and Ian Campbell for their assistance in Fiji and Vicki Luker for her advice in preparing for that trip; Phyllis Herda and the late Elizabeth Wood-Ellem for their insight into Tonga; Brij Lal, Anne Hattori, and Doug Munro for their broad knowledge of the Pacific as a whole; Gavin Maclean and Geoffrey Rice for their background concerning New Zealand, and Dennis Shanks for a view of the medical side of the pandemic. I am certain I have forgotten some that have helped me along my way. Please forgive any omission.

To my officemates: Tomorrow is a myth, and my boots smell of donkeys.

Marika; thank you for your patience, your support, and your unconditional love throughout this process. I love you with all of my being. Now it is your turn.

This work is dedicated to my parents. They taught me the love of learning, and how to read a newspaper before I could walk properly. They have been unflagging in their encouragement, and have always helped me to chart a course that seemed right. Frequently the path taken was a course far from where their instincts would suggest. Thanks folks, I love you both more than I can say.
# Contents

Abstract iii  
Preface and Acknowledgements v  
Contents vii  
List of Maps ix  
List of Figures x  
List of Abbreviations xii  
Glossary xiii  

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Chapter 1</td>
<td>Influenza 15</td>
</tr>
<tr>
<td>Chapter 2</td>
<td>Fiji 67</td>
</tr>
<tr>
<td>Fiji before the Epidemic</td>
<td>74</td>
</tr>
<tr>
<td>Trade and Economics</td>
<td>86</td>
</tr>
<tr>
<td>Medical History and Infrastructure</td>
<td>90</td>
</tr>
<tr>
<td>The Fijian Epidemic</td>
<td>106</td>
</tr>
<tr>
<td>Outside of Suva</td>
<td>128</td>
</tr>
<tr>
<td>Recovery and Consequences</td>
<td>136</td>
</tr>
</tbody>
</table>
List of Maps

1. Path of the *Talune*, October-November 1918 69
2. Islands of Fiji 75
3. Samoa 154
4. The Samoas 221
5. American Samoa 222
6. Tonga 270
7.
List of Figures

1. USSCo. *Talune* 68
2. Ratu Seru Epenisa Cakobau, date unknown 79
3. Crop rotation, Indian tenant farm, Vunisamaloa, ca. 1920s 82
4. People gathering at the wharf in Suva, 1900. 84
5. First graduating class of the Central Medical School of Fiji, 1888 103
6. Influenza information pamphlet issued by Fijian government, 12/11/18 116
7. Levuka, 1905 136
8. Nukulau Quarantine Station, Fiji 144
9. *Samoan Times*, front page 151
10. Raising the German flag at Mulinu’u, Samoa, 1900 164
11. Copra plantation, German Samoa 166
12. The raising of the British flag in Apia, 30 August, 1914 172
13. Colonel Robert Logan, 30 August, 1914 173
14. *Sydney Daily Telegraph*, article 197
15. *The Samoa Times*, obituary 200
16. A view of the governor’s mansion in Pago Pago from the Goat Island Quarantine Facility 224
17. Proposal for increasing capacity of Quarantine Station on Goat Island, Pago Pago Harbour, 1911 245
18. A copy of Governor Poyer’s order announcing the quarantine against Western Samoa   252
19. Tongan population figures   271
20. King George Tupou II   280
21. Queen Salote Tupou, shortly before her ascension   292
22. The Royal Palace, Nuku’alofa   302
# List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUSN</td>
<td>Australasian United Steam Navigation</td>
</tr>
<tr>
<td>BWPT</td>
<td>British Western Pacific Territories (forerunner of the WPHC)</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
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<tr>
<td>CSR</td>
<td>Colonial Sugar Refining Company</td>
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<tr>
<td>DPHG</td>
<td>Deutsche Handels und Plantagen-Gesellschaft der Sudsee-Inseln zu Hamburg</td>
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<tr>
<td>DMO</td>
<td>District Medical Officer (Fiji)</td>
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<tr>
<td>GBP</td>
<td>Great Britain Pound</td>
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<tr>
<td>LMS</td>
<td>London Missionary Society</td>
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<tr>
<td>OSC</td>
<td>Oceanic Steamship Company</td>
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<tr>
<td>PHO</td>
<td>Port Health Officer</td>
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<tr>
<td>PMO</td>
<td>Principal Medical Officer (Samoa)</td>
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<td>RN</td>
<td>Royal Navy</td>
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<tr>
<td>SEC</td>
<td>Samoan Epidemic Commission</td>
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<tr>
<td>SMO</td>
<td>Senior Medical Officer (Fiji)</td>
</tr>
<tr>
<td>USN</td>
<td>United States Navy</td>
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<tr>
<td>USSCo</td>
<td>Union Steamship Company</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>WPHC</td>
<td>Western Pacific High Commission</td>
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</tbody>
</table>
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fomite</td>
<td>An inanimate object or substance, such as clothing, furniture, or soap, that is capable of transmitting infectious organisms from one individual to another.</td>
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<tr>
<td>Miasma theory</td>
<td>That disease is caused by a miasma, a noxious form of ‘bad air’.</td>
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<tr>
<td>Vector (disease)</td>
<td>Any agent that carries and transmits an infectious pathogen into another living organism</td>
</tr>
</tbody>
</table>
Introduction

On the wharf clusters a crowd of strange figures. How savage these Fijians look! The hair stiff, erect, and spreading in a huge mop above the dark faces: the features flat and negroid: the skin all shades from deep copper to actual black: the expression untamed and wild – all these alarm the timid traveller, and he says he will never go ashore among such savages! For all that we are in Suva, the European capital of Fiji, and a populous and busy town. And the ‘horrible savages’ are merely the peaceable labourers employed by the Union Steam Ship Company for cargo work...

Beatrice Grimshaw, 1907

Ms. Grimshaw wrote this passage for a brochure encouraging tourism to Fiji and Western Polynesia along the route of the Talune, a steamer of the United Steamship Company (USSCo.) based in New Zealand. Visiting Fiji, Samoa, Tonga, and other sites as needed, the regular passenger and cargo runs of the USSCo. linked these islands to the greater world. For the indigenous inhabitants of the islands, and more markedly for those Europeans and Americans who found themselves working, living, or sometimes hiding in these miniscule paradises, the monthly arrival of the steamer was a reminder that the outside world bustled on despite the lazy transit of the tropical sun across archipelagos seemingly unchanging. For the Fijian, the Samoan, the Tongan, the ships brought goods unavailable on the islands, mail from distant relatives, work unloading the vessels, and occasionally transit to other islands or the adventures of the larger world. For expatriates, the ships delivered all of the above as well as newspapers, magazines, luxury items, family members visiting or returning from abroad, and most especially gossip. Though Fiji and Western Samoa hosted telegraph stations, and both these states as well as American Samoa had wireless telegraphy apparatus (radio) news was always at a premium. Such steamers

1 Union Steam Ship Company of New Zealand and Beatrice Grimshaw, Tours to the South Sea Islands, Tonga, Samoa, Fiji. (Dunedin, N.Z.: The Union Steamship Company, 1914).
hauled the cargo that supplied and funded the colonial enterprises in the Pacific islands, but were eagerly awaited for the connections to distant others they facilitated.

As Grimshaw’s quote suggests, their arrival in port was greeted by as many local people as could break away from their daily routines. In the baking heat these vessels would steam into port flanked by outriggers and whaleboats bearing local residents offering wares, seeking news, or simply calling greeting. Once portside business was complete and the ship cleared for landing, passengers would stream off while local labourers and curious others came aboard. Mail would be discharged for sorting and delivery into anxious hands, and stores near the port would proudly display the latest newspapers from Auckland or Sydney. Such arrivals were a monthly holiday; a break from the regular days, regular weather, and regular habits of the torrid zones.

In late 1918 news was sought even more eagerly than was accustomed. The war in Europe, to which a small number of local men as well as significant resources had been dispatched in the name of empire, was drawing to a sanguineous climax. For the boys who survived the battlefields there was still the risk of disease, an influenza which had ravaged Europe, Africa, and the Americas over the preceding several months. Fiji had news updates several days a week in the local paper, while in sleepy Tonga bulletins would arrive with visitors, or upon the steamers themselves. Yet the news was seldom complete, and only the arrival of letters and documents upon the steamers could confirm the constant rumours. Thus, when the Talune left Auckland for the islands on her regular run in late October of that year, she was returning as a welcome visitor. She did carry news in her holds of the war and of illness, but it was her infected passengers and crew that carried the most portentous cargo.
The influenza pandemic of 1918-1920 visited like an apparition, stealing away the young and healthy in an unprecedented manner. Officials could not agree on a source, a set of treatments, or preventive therapies. It struck at a moment of great vulnerability. Men had been uprooted in the name of patriotism and thrown together with others from across the globe on battlefields foreign to them all. Staff and equipment that might have helped protect Suva or Nuku’alofa against the pandemic had been devoured by the great battlefields of Europe. Modern colonial empires controlled much of the globe, bringing ever more distant and sheltered populations into contact with western society and the diseases it harbored. The pharmacopeia available in 1918 consisted of quinine joined with the new wonder drug, aspirin, neither of which demonstrated significant efficacy against the pandemic. The medical community could not agree on a causative agent or a method of transmission. Even the most stalwart of public health professionals and civil servants must have quailed in their private moments. In the distant colonial outposts of the Pacific islands, few understood what approached.

Much has been written about the impact of the 1918, or Spanish, influenza pandemic. It has been offered as a factor in the Versailles negotiations after World War I,\textsuperscript{2} described as the cause for enduring social etiquette changes in Japan, and blamed in part for the eventual failure of New Zealand’s colonial mandate in Western Samoa.\textsuperscript{3} Such political and cultural histories tend to focus on the great powers, and their large populations. In contrast medical studies examine the nature of the virus and the changes that made it so virulent, often without analyzing the social vulnerabilities exploited by these viral adaptations. Few authors attempt to

combine the two, telling the story of a medical event with some political background, or a political tale with medical details.

This is a work of medical history focused upon a particular locality. I have chosen the Pacific, and in particular Anglophone western Polynesia (the Samoas and Tonga) and Fiji, for several reasons. The states under study are small and geographically contained. Relatively distant from other states and separated by the Pacific, communication and refugee flows between the areas under study were difficult in 1918. Given their location, they experienced the same problems as other isolated areas with complex logistics such as small communities in the arctic, indigenous communities in outback Australia, or Amazonian villages. The states in question were all infected in a short period by the same vector, the passengers and crew of the *Talune*, steaming out of Auckland. The island groups had significant social differences, but their basic diet, climate, and many cultural elements were similar enough to be discounted as the source of their radically different outcomes upon contact with the infection.

This is also a history of early twentieth century colonialism in the states under study. Different forms of colonial government developed in each. Fiji was a directly ruled element of the British Empire. Tonga had autonomy in home affairs but Britain controlled foreign affairs through her Protectorate over the kingdom. Western Samoa had been ruled by New Zealand via military occupation since 1914. American Samoa was a United States’ Naval Station with direct rule by the naval commandant. The different expressions of colonialism determined (in cooperation with missionary groups) medical infrastructures and relations with neighboring states, far beyond the straight-forward political ramifications of their organization.
This thesis argues that small, isolated states face unique challenges and opportunities in controlling infectious disease, demonstrated by the experience of Fiji and Western Polynesia. The territories of Fiji and Western Polynesia attempted a wide range of social measures for control of the 1918-1920 influenza pandemic. Their success, or lack thereof, depended upon a range of political, social, cultural, medical, and economic variables rather than any single determining factor.

The 1918 influenza pandemic differed from those that have come since, including the global outbreaks in 1957 and 1969, in its virulence and in the age distribution of those that succumbed. Conservative global estimates place mortality at between 50 and 100 million people. Western Samoa lost nearly half of its fifteen to forty-five year old population in roughly eight weeks. It was the most deadly acute epidemic of the modern age, causing greater human mortality in twenty-five weeks than AIDS/HIV caused in its first documented twenty-five years.

Mortality rates differed greatly among locales. Local rates depended on a great number of variables including transportation networks, previous exposure to infectious disease, population density, and the infrastructure in place to allow movement of surplus supplies to locations hardest hit. The absence of medical staff still deployed in the battle zones of the First World War contributed to high mortality rates across the Pacific.

The islands of Polynesia serve as exceptional examples for study of the 1918 influenza and attempts to control its spread and devastation. These islands were geographically discrete, outside the easy reach of quick transport services in an era before passenger air traffic was common, and (outside of Fiji) had a highly homogenous population. While there were cultural and historical differences present, these existed mainly between states rather than dividing intra-state
populations. In these islands more than any other locale on the globe, the entry, dissemination, and eventual control or abatement of the influenza epidemic can be studied across societies with a minimum of confounding factors. The similarities among the island groups allows for illuminating comparisons with fewer sources of bias. Differences in the style and philosophy of colonial rule on the part of Britain, the United States, and New Zealand determined the presence of infrastructure and how intact local power structures remained. Such elements combined with differing trade patterns, variations in cultural approaches and attitudes toward disease, and a range of other social constructs to function as variables in a study of how societies attempted to cope with pandemic illness.

This thesis seeks to analyze the events in these states upon the appearance of the pandemic in 1918. The states chosen for study each illuminate a different aspect of the 1918 pandemic. The Samoas present the most obvious example of radically different outcomes from the influenza. Western Samoa (now Samoa) and American Samoa were parts of the same culture, fragmented by geopolitical strife between outside powers. While many cultural elements have since diverged, at the time of the 1918 influenza the split was still in the recent past and very few differences existed regarding dietary patterns, traditional governance systems, and local attitude toward disease. Certainly significant genetic variation between the two populations is unlikely given the degree of intermarriage over the centuries before they came under foreign control. Yet Western Samoa had perhaps the world’s highest rate of influenza mortality at roughly twenty-six percent of the population, while American Samoa seems to have escaped without a single death. Similarly Fiji, despite a greater cultural heterogeneity, larger size, and range of climactic zones had a moderate mortality rate of 5.2 percent. Tonga maintained some local sovereignty yet almost all government
functions collapsed in the face of the virus, and the local death rate was most likely higher than that of Fiji.

For a narrative thesis such as is attempted here, the methodology consists of the evaluation of primary and secondary sources, then using these sources to create an interpretation of events. The thesis seeks to defend such an interpretation through the demonstration of support from reputable source material in a logical framework. Therefore a note on sources and their selection is necessary at this point.

In attempting to create a syncretic social and medical history of the pandemic in the four political entities under discussion it has been necessary to limit sources in order to meet thesis requirements, both regarding length and duration of study. The material available for the history of influenza alone is incredibly broad, without including the historiography of each political entity, the region as a whole, social response to epidemics/pandemics, and the colonial and missionary enterprises in the Pacific. Works in each of these fields have been omitted, but the most referenced and most applicable materials in each subject have been utilized.

Regarding influenza primary medical sources from the time were crucial to understand the state of medical opinion surrounding influenza and which responses would be considered standard for medical officers in the states under question. Works such as the Memorandum by the Royal College of Physicians\(^4\) provide context for medical and political decisions regarding influenza, and contemporary works regarding the pandemic have been included where available. These are supplemented by more modern writings ranging from popular histories to epidemiological pieces and evaluations of more recent influenza outbreaks, selected for their breadth, depth, and medical basis. Such current scholarship helps to explain

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\(^4\) Royal College of Physicians, “A Memorandum on Influenza from the Royal College of Physicians in London” (Royal Gazette, April, 1919, Fiji, n.d.).
the course of the pandemic, while the works contemporary to 1918 shed light on the motivation of actors in response to the illness.

Evaluating the specific histories of the four island groups under study here posed a variety of problems. In some areas records were few, and those which had been produced in 1918 had since been lost. Public health agencies in some states actually came into being because of the pandemic, thus offering no official health infrastructure records contemporaneous with the outbreak to consult. Each group of islands had a different political structure with differing affinity for and capability to produce the type of bureaucratic records which would have been most useful for this work. Missionary record keeping varied in scope and quality depending upon denomination and numbers of staff present in each state. Often very good records were maintained for the European population and workers on plantations, while the indigenous population left little lasting written evidence. Colonial officials carried their own biases and agendas, as do all authors, and these must be kept in mind when using official documents. Unfortunately, this work is several decades too far removed from the event to make much use of oral history aside from general impressions, as very few pandemic survivors live today. Where available, personal memoirs have been sought and used including those of missionaries and tourists. Very little fiction has been produced regarding the time and place in question, and what exists uses the pandemic as a context, not a key element, and thus have little role in this work.

Fiji possesses the widest available historiography of the time. The Fijian Archives held a great deal of material, including mission records, as did the Western Pacific High Commission Archives at the University of Auckland. These have been used extensively, and the full records of the Fiji Times and Herald serve to broaden the history to include elements of society either outside of government interest or at
times in opposition to government decisions. Further mission records have been accessed through the Pacific Manuscript Bureau (Pambu), though the Roman Catholic records are mainly in French. General histories of Fiji and works from the Fiji Society gave background to health and social traditions, and I have relied on the secondary works and suggestions of scholars of Fiji (and the other island groups) for further suggestions of primary sources. Where possible official records supported by newspaper reporting have been utilized.

Western Samoa (modern Samoa) holds little archival material from the 1918-1920 era, and the great social dislocation of the time is reflected by the limited first hand accounts available. *The Samoa Times* archive in Apia did provide a significant amount of information, and there was some material at the National Museum. Most records from the time reside in Archives New Zealand and the Turnbull Library in Wellington. To supplement these sources the works of Samoan historians were sought, as well as those of general historians of the Pacific. Historians of the *Mau* such as Michael Field provided a view of the epidemic impact on Samoan society. Where available I have also incorporated the memoirs and reports of relief workers.

Western Samoa appears as an anecdote in nearly every global history of the 1918-1920 pandemic, due to its high death rate, but there are very few explanations offered for the disaster which unfolded. The single most useful source for such an explanation as well as a timeline of events is the report of the Samoan Epidemic Commission (SEC), which has been used widely throughout this study. The lack of alternative materials has caused dependence in this work upon the records of the Colonial Government which offers the largest source of information from the Samoan epidemic.
American Samoa presents a narrow historical record in comparison with Western Samoa or Fiji. The naval administration kept complete records of communications, orders, and periodic reports. Yet the absence of a newspaper and the headquartering of most mission groups active in the Samoas in Apia make for a sparse literature of the time aside from naval records. The fact that American Samoa avoided a disaster, rather than experienced such, also inspired few works of analysis. Most of the information regarding American Samoa and its response to the pandemic comes from naval records and the report of the SEC, leavened where possible with local missionary records and the memoirs of visitors.

Tonga, though suffering greatly from the outbreak, has perhaps the narrowest historiography of the four areas under consideration in 1918. Possessing no newspaper at the time and maintaining a putative independence, and thus having little colonial infrastructure outside the person of the Consul, what records remain are personal or mission documents. The Consul’s reports and correspondence were crucial and accessed in the WPHC Archive as well as the National Archives in London. Notes of the relief missions which reached Tonga have been incorporated. Outside of these documents mission records from Pambu and to a lesser degree on site in Nuku’alofa have been used, along with a small range of documents held at the Tongan Royal Archives. The late Elizabeth Wood-Ellem was crucial in pointing out several personal accounts of the time and suggesting mission sources, and her work on Queen Salote offered telling detail of the Royal experience of the epidemic. Other records apparently have been lost to weather and infrastructure issues in Tonga.

In the end, colonial and mission records have formed much of the basis for this work. Where available personal and newspaper accounts have been offered to supplement and at times oppose the government narrative. The passage of time has eliminated many other sources.
Several works on Polynesian history have also informed the structure of this thesis. *Worlds Apart*, Campbell’s general history of the Pacific Island peoples, has been extremely useful in this regard. Campbell provides a very accessible summary of the pre-colonial and colonial experiences of the region with emphasis upon the impact of missions and other early colonial structures. In particular the overview of the differing colonial regimes in the four states under study is clear. McArthur’s work on Polynesian demographic history, *Island Populations of the Pacific*, has also been invaluable; most significantly to establish population trends at the time of the pandemic and to review the problems with population estimates and census efforts in the colonial states. MacArthur also touches on the presence of previous influenza outbreaks in the islands. Her work is meticulous and the data is well supported. Unfortunately given the relatively lax recordkeeping of the time all numbers given can be best viewed as estimates.

This element of estimation regarding numbers of deaths related to the individual epidemics of each island group under study must be acknowledged. McArthur focuses upon census data as the most reliable population count in these colonies and kingdoms. Yet these numbers, and the numbers reported directly after the epidemics had raged through these islands, are still generally estimates. Whether estimates or not the sources of the raw data from which they are generated are rarely completely revealed, leaving questions as to their veracity. However, as Johnson and Mueller note:

> Recognizing the limitations, it is generally accepted that recorded statistics of influenza morbidity and mortality are likely to be a significant

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understatement. These limitations can include nonregistration, missing records, misdiagnosis, and nonmedical certification…7

Thus if these estimates are incorrect, it is likely they err by being too low.

Yet there are reasons to work with these mortality statistics as offered, knowing their limits. The colonial entities in place had been gathering census numbers in these states (outside of Tonga) for decades and there were mechanisms in place for counting the populations in most areas. Missions kept death records of their parishioners which contributed to the final numbers. Counts from body disposal teams can also be considered strong data. Nonetheless, the numbers of deaths used in this work are not presented as absolutes, but they serve to demonstrate differences in overall impact between societies. Where issues are known, they are addressed in the individual chapters devoted to each polity.

Miles’ work Infectious Diseases: Colonizing the Pacific?8 is not comprehensive, yet it makes a sound argument for the absence of influenza in the islands before European contact and uses demographics to good effect to demonstrate the impact once it became endemic to the region. It also demonstrates the breadth of illnesses present in the states under study, all of which could be compounding factors in influenza mortality. The Fijian measles of 1875 discouraged use of western medical facilities in 1918, for example. The author notes the seeming vulnerability of Pacific Island peoples to respiratory diseases but does not suggest a cause for this.

Several other works have proven valuable as context for the region. A Concise History of New Zealand9 by Mein Smith touched upon issues of New Zealand

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9 Philippa Mein Smith, A Concise History of New Zealand (Melbourne: Cambridge University Press, 2005).
colonialism and Polynesian nationalism that were pertinent to the review of Western Samoa. *The Cambridge History of the Pacific Islanders*¹⁰, edited by Denoon, provided background for the region and multiple authors’ views of Polynesian and broader Pacific culture and development. *The Changing Pacific*¹¹, edited by Gunson, offered the same view for a more modern timeframe.

*Imperial Hygiene*¹² by Bashford argues that public health was a tool of colonialism. In her argument metropolitan governments recognized that colonization involved the risk of exposure and transmission of novel diseases. Public health served in the colonies as a justification for intervention, a tool of governance, and a barrier preventing the exportation of the dangerous ‘other’ to the home country. Accordingly public health cannot be assessed as a success or failure in reference to the colonized peoples, because at heart it was not for their benefit. To agree with her hypothesis is to see public health efforts as colonial methods of control. Her gaze turns specifically to quarantine as a protective barrier against foreign culture more than foreign illness in *Contagion: Historical and Cultural Studies*¹³ published with Hooker in 2001. While illuminating and well reasoned, such an argument would not apply to all the states under study. The actions of the Fijian administration fit her model, while those of Tongan and American Samoan administrations fall well outside Bashford’s construct.

Polynesia and Fiji have not been subject to an in-depth study of states’ reaction to the 1918 pandemic, yet they seem a fertile area of inquiry. I can think of

no other location on the globe where a group of states in a relatively small area shared so many cultural and physical aspects while experiencing such great imposed differences.

The Talune crossed the borders of each of the states under study: Fiji, Western Samoa, American Samoa, and Tonga, just as the influenza swept across the globe. The states in question are small enough to allow for a holistic evaluation of their experience of the 1918 pandemic. They are similar enough to make comparison beneficial. The course of the Talune determined infection in western Polynesia and Fiji in November, 1918. The vessel’s course shall in turn serve as a structure for its narrative.
Chapter 1: Influenza

Flu is probably the most important virus we know about. Certainly, 1918 leaves HIV looking like a bit of a picnic. That’s not to say HIV isn’t serious – but the fact that flu spreads by aerosol means you can’t restrain it. HIV, you can be careful. Polio, you can clean up the water supply. CJD, you can slaughter the cows. But a respiratory virus – no, that’s scary.

Professor John Oxford

In mid-1918 sailors in the United States Navy began presenting with an unknown illness. Symptoms ranged from headaches to profound depression or delirium. Blood gushed from noses, ears, eyes, mouths, and rectums. Body aches similar to dengue, the notorious ‘break-bone’ fever, wracked victims accompanied by coughing violent enough to tear apart the muscles and cartilage of the thorax. Some vomited uncontrollably. Many showed signs of cyanosis (oxygen starvation), with a blue tinge around the lips and extremities. In an unfortunate few the cyanosis was so severe as to make them appear dusky or even violet. These men were judged to be beyond help and set aside to die, allowing for care providers to focus upon those more likely to survive.

Medical researchers and military physicians desperately pored through their lists of differential diagnoses. The symptoms suggested a range of potential pathogens, but the syndrome did not match any precisely. While some researchers continued to insist that the new outbreak stemmed from a previously unknown pathogen, the majority returned to look at a more banal possibility. After other

hypotheses were exhausted, the unlikely became the best guess. Their assumptions proved correct fifteen years later when the virus at the heart of the illness was finally identified. This new plague was merely the most recent visit of a well-known raider. This was influenza.

Human experience with influenza-like diseases stretches to our earliest descriptive literature. In 412 B.C. Hippocrates, in Book IV of *Of the Epidemics*, discussed a respiratory illness which appeared around the winter solstice. Termed by him “the Cough of Perinthos”, this disease led to frequent relapses and deaths from pneumonia. He attributed the illness to the seasonal change of winds. Livy mentions another possible influenza outbreak. In August of 212 B.C. a Roman army besieging Achradina developed a respiratory illness, as did their opponents, to a degree that forced the cessation of hostilities. All those tending the ill became sick themselves, and eventually so many were stricken that the dead were left to rot where they fell.

While not universally accepted as influenza, many researchers identify the earliest recorded pan-European outbreaks of the disease from the 16th century. Outbreaks reportedly from African sources in 1510 and 1562 matched the speed of transmission and general symptoms of influenza. During the 1562 illness Lord Randolph in Edinburgh wrote to Lord Cecil regarding the as then undefined malady:

Maye it please you Honor, immediately upon the Quene’s arrival here, she fell acquainted with a new disease that is common in this towne, called here the newe acquayntance, which passed also through her whole courte, neither sparinge lords, ladies, nor damoysells not so much as either Frenche or English. It ys a plague in their heads that have yt, and a soreness in their stomaches, with a great coughe, that remayneth with some longer, with others shorter tyme, as yt findeth apte bodies for the nature of the disease. The queen

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kept her bed six days. There was no appearance of danger, or manie that die of the disease, excepte some olde folks.\textsuperscript{5}

Influenza in some form has been with humanity for at least half a millennia. The presenting form has not remained static. In any discussion of the illness, it is important to clarify between endemic influenza, the epidemic form, and the pandemic. Endemic influenza is the yearly reoccurrence (normally in the winter months in temperate zones) or constant low-level activity (in the tropics) of the disease in the human population. Epidemic influenza is the occasional surge in cases within a defined area, appearing often in company with a new version of the infection demonstrating new attributes; for example a higher mortality or more significant infectiousness. Pandemic influenza, for the purposes of this thesis, is defined as an unusually geographically extensive and severe infection of influenza compared to recent global experience. While epidemic influenza develops into the pandemic form (pandemic simply being the concurrent epidemic presentation of the disease in a large number of areas) endemic does not normally lead to epidemic forms. Usually a significant change must occur in the endemic form before an epidemic is likely. Mention of influenza in works of history almost always refers to the epidemic/pandemic forms. In this work epidemic will be used to describe local or national outbreaks of influenza while pandemic will be used to identify the global series of epidemics. The endemic form is no more noteworthy than the weather, and just as constant in most human populations.

The first global pandemic of what is believed to be influenza for which we possess records appears in 1580. Starting in Asia the illness appeared in Europe, Africa, and the Americas. Reports describe all of Europe infected within six weeks, with only one in twenty residents not showing signs of infection. Reflecting the

behavior of later pandemics, Britain experienced this infection in two distinct waves and in general urban areas saw higher mortality than rural zones. The 1580 pandemic, having killed more than 9,000 people in Rome, inspired two Italian historians, Domenico and Pietro Buoninsegni, to name the illness based upon the baleful “influence” of the stars that they regarded as its source: influenza. A disease with a description matching that of epidemic influenza struck England in 1658. By the mid eighteenth century this name found wide usage in English medical literature. Other attributions of this baleful “influence” were to a range of heavenly bodies, volcanic eruptions, and earthquakes.

These last two sources of influence were chosen because they explained the emergence of the miasma seen commonly as the source of epidemic influenza. With the sudden appearance of the disease amongst wide swathes of the population contagious spread seemed unlikely, as other diseases known to pass from person to person did not distribute so widely, so quickly. European and American medical traditions in the nineteenth century debated the origins of disease. The work of Snow and Semmelweis in the mid 1800s added credence to the idea of microscopic organisms as disease carriers, but theories of miasma and other alternate methods of disease transmission held their partisans well into the 1900s. Environmental factors or disequilibrium in the body both held many adherents as explanations of most illness. As late as 1894 Charles Creighton, the British physician and eminent epidemiologist, cited the infection of an entire country in weeks, a town in days, and a household seemingly within hours as evidence for the impossibility of a contagious source for influenza. Dr. Thomas Glass of Exeter in 1852 argued that:

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6 Ibid., 26.
Nor does this distemper arise, which is, I think, at present, the more general opinion, from contagion. For in this city, in the year 1729, it was conjectured, that two thousand persons at least were seized with it in one night. But what is more extraordinary, before the Autumn, in the year 1557, it attacked all parts of Spain at once, so that the greatest part of the people in that Kingdom were seized with it almost on the same day.

Instead a miasma, an invisible gas or condition of the air, seemed to explain the simultaneous appearance throughout whole populations. Geologic activity, such as volcanoes and earthquakes, might well release such miasmas from underground.

Dr. Creighton’s peers did not uniformly agree. By the time of the 1889-1890 outbreak the medical community of Europe and North America harbored many vociferous supporters of the germ theory of disease put forward by Robert Koch. Seeking a bacterial source for the affliction, Richard Pfeiffer worked in Germany to isolate a causative agent. He gathered great numbers of a previously unidentified bacterium from throat swabs of influenza patients and felt comfortable with declaring this organism, incorrectly, as the source of the disease. The potential offender became known as Pfeiffer’s Bacillus and played an ambiguous role in the fight against the next pandemic, 28 years later.

This conflict between those embracing the miasma theory and those seeking a contagious source reflected the turmoil in the medical establishment. The late 1800s produced sweeping changes in the practice and style of medicine, starting in Europe and moving out to the Americas and European colonial outposts. The rise of laboratory medicine disproved many commonly held opinions regarding the source and treatment of ill health, and competing schools of thought sought to fill the intellectual void. As early as 1831 Hamburg, Germany hosted weekly debates between adherents of ‘contagionist’ and ‘miasmaist’ medical factions who sought

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10 Ibid., 2.
control of the city’s efforts against cholera. That such debate would occur in Germany is not surprising, given German physicians’ leading role in creation of a new, research and laboratory based style of medicine. The contagionists argued for quarantine and exclusion of disease by prevention, while the miasmaists saw infection as inevitable and sought to ameliorate the suffering of those already afflicted.\textsuperscript{11} The failure of quarantine attempts to exclude infection led many local doctors to doubt the contagionist model. The inability of the medical profession to agree on a single approach for addressing public health complaints helped generate an increasingly general disrepute for the entire field in the public eye.

By 1918 many physicians and researchers knew of viruses, but generally only in the abstract. The difficulty inherent in identifying and reproducing them made for a difficult research environment. Some infectious material was known to be able to pass through filters that would block the smallest identified bacteria. These ‘filterable viruses’ eluded most study, though Martinus Beijerinck identified tobacco mosaic virus in 1899 and successful laboratory growth of vaccinia virus occurred in 1913. Despite these advances, viral study occupied only a tiny niche of medical research at the time.

In fact the miasma theory, or proponents of other environmentally-based theories, seemed to have the dominant position in the debate well after the 1918 pandemic had abated. Respected researchers in 1918 believed that influenza was a wind-borne infection, and that it emerged with a set periodicity rather than in randomly spaced pandemics.\textsuperscript{12} Richter in 1921 blamed the 1918 influenza on anti-

\textsuperscript{12} Greenwood, M, “The Epidemiology of Influenza,” \textit{British Medical Journal} 2, no. 3021 (November 23, 1918): 563.
cyclonic weather conditions, and Magelssen in 1923 attributed vaso-motor insufficiency caused by weather conditions for the pandemic.\textsuperscript{13}

The public held varied theories. Citizens of belligerent countries inevitably blamed the machinations of enemy agents for the introduction of the pandemic. Astrological disturbances, open windows, unclean clothing, and contaminated food also shared the blame.\textsuperscript{14} In the absence of a medical majority opinion, these sources seemed as likely as any.

Contagionists researching the cause of the influenza outbreak in 1918 found it difficult to demonstrate a viral origin. After passing throat washings from infected humans through a filter to eliminate bacteria, monkeys, rabbits, and other animals were inoculated with these fluids. No successful infections were noted. Human studies included the exposure of volunteers to the fluid from deceased victims’ lungs after it had been passed through another bacterial filter. Once again few infections occurred. By 1922 Robert Donaldson of St. George’s Hospital, London, following a surge of research inspired by the 1918 pandemic, would argue that “there is not the slightest shred of evidence that the disease is due to a so-called filter-passing virus.”\textsuperscript{15} Having seemingly ruled out viral transmission, researchers returned to the battle between a bacterial and a miasmic source of infection.

One final element that puzzled researchers emerged from observations of swine. Despite vocal opposition from the pork industry, J. S. Koen, a veterinarian with the U.S. government based in Iowa, suggested that swine herds became infected


\textsuperscript{14} Kirsty E. Duncan, \textit{Hunting the 1918 Flu: One Scientist’s Search for a Killer Virus} (University of Toronto Press, 2003), 15.

\textsuperscript{15} Beveridge, \textit{Influenza}, 3.
with the ‘second wave’ of influenza which devastated so much of humanity in late 1918. He argued in 1919 that:

The similarity of the epidemic among people and the epidemic among pigs was so close, the reports so frequent, that an outbreak in the family would be followed immediately by an outbreak among the hogs, and *vice versa*, as to present a most striking coincidence if not suggesting a close relation between the two conditions. It looked like “flu”, and until proved it was not “flu”. I shall stand by that diagnosis.16

These elements raised troubling questions. What kind of miasma would concurrently affect both humans and swine, and yet no other animals? What type of bacteria? Was the causative organism one that had an intermediary stage in pigs before moving to humans, or perhaps the order was reversed? Would slaughter of pigs stop the disease from spreading, or merely exacerbate the hunger in its wake? Should prevention efforts concentrate on the farmhouse or the stockyard? Resolution of this debate through isolation of the influenza virus did not occur until 1933 (influenza A) and 1940 (influenza B).17

Without knowing how influenza spread, without identifying the cause, prevention in 1918 was difficult. Advocates of a bacterial origin sought a causative organism to use in vaccine manufacture. Pfeiffer’s bacillus in combination with a range of bacterial agents served as the core of these vaccines, which being based on a non-causative organism demonstrated limited or no efficacy. Miasma campaigners sought to determine environmental conditions that might be more dangerous, and ways to physically avoid illness. Yet fighting an invisible, unidentified element of the air offered little hope. While researchers puzzled and fought over origins, the focus of most medical staff shifted to treatment of symptoms.

16 Ibid., 4.
The medical profession had numerous opportunities to practice treatment. Between the 1580 pandemic that gave influenza its name and the 1918 that cemented its place in history, the disease continued its frequent visits to the nations of the world. By 1688 a disease that matched modern influenza raged in Europe and Virginia. Another similar outbreak occurred in 1699. The next two hundred years saw between seven and ten pandemics of influenza sweep across Europe. These outbreaks shared a general pattern of seasonal presentation and geographic spread. They appeared in the fall or winter and slowly spread east to west or south to north, sometimes taking months to travel across Eurasia. Most of these pandemics were first reported in Central Asia or China, though at least two are reported to have emerged from North Africa. By 1918 influenza long held a place in the disease pantheon of those parts of the world closely connected by trade and commerce. Areas outside of such a zone, such as Polynesia, quickly came to recognize it as an adjunct of European presence.

Influenza, as defined in 1918 (and today), is a respiratory ailment whose symptoms include fever, cough, body aches, eye inflammation, headache, sometimes nausea and/or vomiting, and extreme weakness. Symptoms can last up to two weeks, though most people start to feel better after three to five days, and an infected person may take several weeks to fully recover. ‘Flu differs from the common cold by the presence of aches, fever, and depression. Those most likely to succumb to the disease are the aged, the very young, and those with underlying medical conditions. Death from influenza itself is relatively rare, however, with the majority of deaths in both epidemic/pandemic and endemic influenza coming from secondary respiratory infections of the weakened lung, usually leading to fatal pneumonias.

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19 Collier, *The Plague of the Spanish Lady*, 34.
Physicians linked pneumonia and influenza by the turn of the 20th century. Medical schools taught that an elevated fever after the fourth or fifth day of an influenza infection suggested further pulmonary problems to come. The treatments of such pneumonias varied widely, and the dividing line between ‘simple influenza’ and pneumonia reflected more the caution of the physician attending than an established differential diagnosis. Influenza sickened and pneumonia killed, beyond this little was sure.

By early 1918, despite the controversy over causes of both endemic and epidemic/pandemic forms of influenza physicians generally felt comfortable with the disease. As a radically different and much more lethal strain developed, the mild nature of the first wave of 1918 confirmed attitudes that while very infectious, influenza did not pose a major threat. In an era of improving health influenza did not rate close surveillance. Mortality remained low and centered in the aged and the very young, and compared to diseases such as polio the effects were far from dramatic. ‘Flu was a disease a person could count on acquiring throughout the lifespan, and one which they simply suffered through. Even pandemics were hardly crises, especially compared with cholera or smallpox outbreaks. Influenza was a well known, only moderately dangerous, and extremely common companion of humanity.

In most jurisdictions influenza did not even make it on to the ‘notifiable’ list of diseases, those pathogens whose presence was legally mandated to be relayed to medical authorities as soon as they were discovered. These diseases were those generally accepted to be both infectious from person to person and dangerous enough to need an immediate response. The list of notifiable diseases varied over time and by country, and in some cases by port. Australia in 1901 considered the

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20 Beveridge, *Influenza*, 12.
following diseases to be reportable upon ships entering port: cholera, smallpox, yellow fever, and plague.\(^1\) In January, 1918, the State of Utah in the United States held a reasonably standard set of diseases to be notifiable: diphtheria, pertussis (whooping cough), polio, measles, scarlet fever, smallpox, tuberculosis, typhoid, plague, cholera, and yellow fever.\(^2\) Only in Scandinavia was influenza a reportable illness before the 1918 outbreak.\(^3\) As late as mid October 1918, only two cities in the United States (New York and Chicago) and the nations of Australia, Brazil, Honduras, New Zealand, Poland, and South Africa required reporting of influenza cases in response to the second wave of the pandemic.\(^4\) As we shall see, even these countries did not always expand such notification requirements to their colonial possessions.

The lack of ‘notifiable’ status for influenza meant that in most jurisdictions quarantine and other control measures could not be applied as the laws empowering them named notifiable diseases as their target. In New Zealand the health officials in Auckland argued that they had no power to quarantine ships from ports known to be infected with pandemic influenza, despite the presence of ill individuals on board, as the diagnosis was not notifiable and thus not covered under the port regulations.\(^5\) Before mid 1918 for the majority of humans influenza was not seen as an existential threat. The laws and official approach to influenza reflected this.

This fact is worthy of repetition. Influenza was simply not taken seriously by most medical providers. In an era that had seen the development of tetanus toxoid, the widespread use of the smallpox inoculation, and the understanding and partial

\(^1\) Thomas Borthwick, *Quarantine* (Adelaide: Vardon and Pritchard, 1901), 4.
\(^3\) Davies, *Catching Cold*, 44.
\(^4\) Collier, *The Plague of the Spanish Lady*, 156.
\(^5\) Ibid., 95.
control of vectors for malaria and yellow fever, influenza was not worthy of the attention or resources expended on a serious illness. Not only were public health entities at all levels not prepared for an influenza outbreak, they were not looking for one. This was reflected in the lack of legal powers to respond systematically to a pandemic when one developed.

With the approach of the second, lethal wave of influenza to the south Pacific in late 1918 the situation was confused. The disease origin was in dispute, the method of transmission unclear and legal powers to control its spread undefined. Even the name created conflict.

Names are important. The names that endure assign historical events to places and peoples, permanently coloring perceptions. The plethora of names which emerged for the 1918 influenza outbreak reflects the confusion and fear generated by the illness. Perhaps it is natural that in a time of war and the demonization of the ‘other’ so many of the names would identify outsiders as the source. The British called it ‘Flanders Grippe’; the Spanish ‘Naples soldier’. Poles talked of the ‘Bolshevik disease’ while residents of Ceylon muttered of ‘Bombay fever’. Zurich reported cases of ‘La Coquette’ (because her favors were so freely given). Germany saw its final offensive in the west stalled by ‘Blitz Katarrh’ (lightning fever). Hong Kong lost citizens to the ‘too much inside sickness’. Names proliferated as the fear of infection grew.

One name remains with us today. In most of Europe and the Americas the 1918-20 influenza pandemic carries the moniker “Spanish Flu”. The origins of the term, and its attendant “Spanish Lady” to describe the disease in action, are hazy. The most frequently given explanation attributes it to the lack of wartime censorship

\[^{26}\text{Duncan, Hunting the 1918 Flu, 7.}\]
in Spain. The other countries in Europe, embroiled in a seemingly unending war, prevented news of the disease from being printed in the media; arguing for the need to maintain morale. The news out of neutral Spain faced no similar restrictions and carried details of the progress of the pandemic in Iberia, including banner stories regarding the infection of the King. The open media coverage gave the impression that Spain demonstrated infection before the rest of Europe and thus represented the source of the pandemic. Both the Central Powers and the Allies felt little beneficence towards the neutral Spanish government and saw no reason to correct press reports. In fact, best evidence seems to point toward Kansas as the origin of the virus.27

A particularly virulent form of influenza struck Haskell County, Kansas, in January and February 1918.28 Spreading out from this rural, heavily agricultural area along the paths of the great mobilization taking place within the U.S., this new virus reached the military camps by mid March and started its progress towards the Atlantic seaboard, the eventual destination for most of the newly minted soldiers. At this point the virus was not yet as deadly as the eventual pandemic would prove, and other theories exist for the origin of the final lethal product. Some suggest southern China, others a contemporaneous mutation at several sites.29 Regardless of whether the rise of the new variant occurred in Kansas, in Southeast Asia, or somewhere between, the narrative timeline does not support a Spanish origin. The name remains, nonetheless.

Brest, the port of debarkation for American troops in France, reported the first European outbreaks of the new ‘flu in early April. By May it raged through the British Army, travelling with returning troops to Britain in June. The German Army

27 Barry, “The Site of Origin of the 1918 Influenza Pandemic and Its Public Health Implications.”
28 Barry, The Great Influenza, 92.
29 Davies, Catching Cold, 48.
reported infections in May, sufficient to stall the third stage of the last great push on the Western front, an attempt to win the war before U.S. troops could turn the tide. Germany itself suffered in June and the rest of Europe over the next two months. China and India felt the ‘flu in May and June, the large Pacific states in August and September. Some authors, such as Burnet, argued that this demonstrated a separate Asiatic epidemic in early 1918. Later viral study failed to demonstrate a difference between the first-wave types in Europe/North America and those in Asia. Today the first, second, and third waves are seen as a single pandemic. This first wave circumnavigated the globe in six months. While very infectious, it did not cause particularly high mortality. That crisis was yet to come.

Some time in this summer of war and disease, most likely in Western Europe, the influenza of early 1918 changed. A second wave developed and spread out along the networks built to supply the European war effort, engulfing combatants. The wartime conditions in France presented a type of wonderland for viral development. Millions of men from around the world (including a constant infusion of fresh American troops) found themselves thrown together in poor conditions, under great stress, and inadequately fed, housed, and heated. Every community of humans hosts an ever-changing group of infectious diseases, many of which are unique local variants. Most of these men traveled far beyond the norm for their communities and brought their homelands’ viral illnesses with them. In addition, the feeding of the armies drove the gathering of millions of swine behind the front lines, and swine are now known to serve as incubators of human influenza. Finding more appropriate conditions for the evolution of the influenza virus would be difficult indeed.

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30 F. M Burnet, Influenza; a Survey of the Last 50 Years in the Light of Modern Work on the Virus of Epidemic Influenza (Melbourne: Macmillan, 1942), 71.
By late June a British freighter out of Brest docked in Philadelphia with a crew sick from what seemed to be a completely unknown disease; manifesting with extreme cyanosis, copious bleeding, and a frightening mortality. In July the death rate in London skyrocketed, and early August saw cables from diplomats in Switzerland describing an outbreak of what they believed to be the Black Plague.\(^{31}\) The same month saw the docking of a multitude of ships from Europe in U.S. Atlantic ports, some of whose crews were prostrate from the new infection. Soon the ports themselves reported deaths in the dozens, then hundreds, then thousands. October brought the highest death rates for Western Europe; the eastern portion of the Continent buried the greatest number in November.\(^{32}\) From September American troops heading to France faced as likely a death from influenza on the troopship during the journey as from enemy action in the trenches of the front.\(^{33}\)

First reports of the second wave of influenza from outside of Europe and North America came from Sierra Leone, a coaling port in West Africa heavily used by British ships carrying colonial troops and supplies from the Empire. Following the docking of the H.M.S. *Mantua* outbound from Britain in mid-August the port lost nearly its entire workforce to illness. The next few weeks witnessed the deaths of between three and six percent of the African population in the territory.\(^{34}\) By mid-September the disease spread throughout West Africa and penetrated the British colonies in southern Africa from the north. Latin America reported outbreaks in September.\(^{35}\) India felt the second wave in the same month, with at least five million

\(^{32}\) Burnet, *Influenza; a Survey of the Last 50 Years in the Light of Modern Work on the Virus of Epidemic Influenza*, by F. M. Burnet and Ellen Clark, 72.
\(^{33}\) Davies, *Catching Cold*, 62.
\(^{34}\) Barry, *The Great Influenza*, 183.
dead and emergency pyres at railway stations to dispose of the bodies pulled off of trains.\textsuperscript{36} The “Spanish Lady” visited China in October via trade ports.\textsuperscript{37}

Australia and New Zealand both experienced the first wave of influenza in August and September 1918. That these cases of influenza emerged from the first wave is demonstrated by their mortality pattern, killing relatively few and mainly the very old and very young. The relatively mild, and very traditional, presentation of this first wave in the Pacific states contrasted sharply with the terrifying reports concurrently emerging from Europe and the Americas as they suffered the worst of the second wave. Local physicians could thus be justified in complacency, assuming that the first wave represented the worst that they would see and either through luck or some native hardness of constitution, the Pacific states would avoid the seemingly inflated death rates being reported elsewhere. Influenza, after all, never normally presented with such viciousness. Perhaps contemporary physicians thought the press must be playing up the impact in the industrialized nations in order to capture the interest of a war-jaded public. Therefore no justification existed for extreme measures in response.

The pattern changed radically in October when the second wave strain arrived in Auckland. Almost all New Zealand influenza deaths for 1918 occurred after mid-October, and the mortality changed from old and young to focus upon young adults.\textsuperscript{38} October also saw the height of the pandemic in Latin America and the Caribbean.\textsuperscript{39}

\textsuperscript{36} Beveridge, \textit{Influenza}, 31.
\textsuperscript{37} Burnet, \textit{Influenza; a Survey of the Last 50 Years in the Light of Modern Work on the Virus of Epidemic Influenza, by F. M. Burnet and Ellen Clark}, 72.
\textsuperscript{38} Ibid.
\textsuperscript{39} Frost and Sydenstricker, “Epidemic Influenza in Foreign Countries,” 1363.
Australia managed to keep the second wave at bay until January via a rigid quarantine system. Under the leadership of John Howard Lidgett Cumpston the Australian health authorities took the controversial step early enough to avoid the fate of New Zealand. When the second wave did finally break through in January 1919, the influenza proved to be an attenuated version and the severe mortality expected did not materialize (this pattern of delay leading to lowered virulence was repeated in other communities who became infected late in the pandemic). The islands of the south Pacific under Australian rule were protected by these quarantine efforts and generally did not become infected until early 1919. Some island groups, such as Mauritius, held out until mid 1919 or later before infection appeared. A very few, such as American Samoa, never experienced infection at all.

November brought a final bitter irony. For combatants and colonies still not fully involved in the pandemic, the end of the war on November 11, 1918 caused celebrations, public displays, and massive gatherings. Globally, from Canada to French Polynesia, people congregated to celebrate the end of five years of death and privation. Wherever these celebrations occurred, the following weeks witnessed spikes in mortality graphs and agony for families. In many locales the armistice celebrations either facilitated the initial spread of disease or re-energized a waning second wave.

The second wave defied expectations of influenza regarding both season and spread. Infection occurred in the Northern Hemisphere during late summer and early fall, rather than the late autumn and deep winter months of previous outbreaks. Instead of following a steady east to west progression, the disease spread rapidly in all directions from an origin likely in Western Europe. Wherever ships

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40 Crosby, *Epidemic and Peace*, 64.
travelled gathering men and material for the war, and later returning them home, influenza rode along. It spread west to east along the infrastructure of crumbling empires and into the chaos of the Russian Revolution and the end of the imperial era in China. Such unpredictability evoked terror and confusion in medical authorities and government planners.

Following the second wave this virulent form of influenza did not meekly pass away. A third wave struck many of those spared by the second in early 1919. Some argue for a fourth wave in 1920, touching upon Scandinavia and isolated South Atlantic islands.\(^{42}\) The descendants of this virus are present in pigs today, and the 2009 ‘swine ‘flu’ virus demonstrates some genetic descent from the 1918 variant.\(^{43}\)

The second wave of the 1918 influenza pandemic presented a multi-faceted puzzle to governments and medical establishments already engrossed in the calamity of the First World War. The disease was in the wrong season, its cause was misunderstood and debated, transmission was not clear, it occurred in the same year and in some locales concurrently with a much milder first wave, and even the site of origin caused debate. There is little surprise in the fact that the bureaucracies and medical infrastructures across the globe were cautious in their reaction. The difference that drove the terror, however, and for which this influenza variant is accorded its place in the annals of human catastrophe is the nature of the symptoms and the scale of the mortality produced.

As with the endemic influenzas circulating regularly in populations, the majority of those struck by the second and later waves of the 1918 influenza suffered only the standard three to five days of illness. Roughly 80 percent of those under care

\(^{42}\) Johnson and Mueller, “Updating the Accounts,” 107.

were progressing back to normal within a week, though the joint and muscle aches reached levels of severity such to leave victims feeling as if they “had been beaten all over with a club” and malaise often persisted for months.\textsuperscript{44} Pregnant women faced more complications, with studies showing more than a quarter reporting stillbirth/miscarriage or premature labor.\textsuperscript{45}

For an unfortunate minority the second and third waves of the 1918-20 influenza featured a much more violent syndrome. The frequency with which these more virulent symptoms developed seemed linked to the length of cultural exposure to influenza. In those places where the disease had a long-established history, such as Asia, Europe, and North America, from ten to twenty percent of those ill developed the more severe symptoms. In areas with a relatively short history of influenza exposure, such as the arctic and recently established colonies in the Pacific basin, the rate of severe disease may have been several times that.\textsuperscript{46} The young and healthy, so unusually the target of the 1918-20 pandemic, frequently died with horrifying rapidity and abruptness.

A suite of symptoms accompanied these more severe attacks. Many people experienced a lowered level of consciousness, not a coma but bordering on delirium for days or weeks at a time. The passing of time stretched and contracted as if in a fevered dream. Severe pain, occurring almost anywhere in the body, accompanied an overwhelming lassitude and lack of appetite. Fevers as high as 105 F (40.5 C) produced patients with racing pulses and physical tremors sufficient to shake beds. Long term neurological damage from such high body temperatures dogged

\textsuperscript{44} Duncan, \textit{Hunting the 1918 Flu}, 9.
\textsuperscript{46} Barry, \textit{The Great Influenza}, 232.
survivors. The infected describe numbness in extremities, usually temporary but occasionally persistent, leading to the inability to function normally for months after the illness passed. Other victims reported intestinal problems bordering on dysentery and accompanied with severe bleeding. In fact the blood came from anywhere. Frequent, enormous nosebleeds were seen as a positive sign, a suggestion that the fever had broken and the pressure was reducing. At times these nosebleeds occurred with sufficient force to propel blood across neighboring beds. A patient might bleed from their eyes, ears, mouth, rectum, stomach, skin, uterus, and/or lungs. Vomiting and abdominal pain was common. Earaches with pressure leading to eardrum rupture and bleeding feature in physicians’ reports. Other sensory damage such as the failure of the sense of smell or the paralysis of the ocular muscles occurred. Emphysema of the skin, the development of air pockets under the dermis due to leaking lungs, appeared in British hospital reports. Renal failure developed. Tongues swelled, as did spleens and mastoids. Cataracts, sinus infections, hiccoughs, and encephalitis presented without pattern.47

Cyanosis became the hallmark of severe infection. The lungs filled with fluid, a bloody froth which prevented the transfer of oxygen as the inflammatory pulmonary edema worsened.48 When patients moved in bed, serous fluid poured from their mouth and nose. A still conscious victim might cough up a liter of pus from their lungs daily, trying to keep the passages clear. Lungs became so full of fluid and silent to auscultation that doctors were convinced their stethoscopes were broken.49 First the lips and nail-beds of patients darkened, followed by ears, nose, and tongue; finally further extremities such as the fingers and cheeks lost

48 Cox and Subbarao, “Global Epidemiology of Influenza,” 413.
49 Duncan, Hunting the 1918 Flu, 9.
oxygenation. In some cases the trunk actually turned an indigo color. A U.S. Army Doctor from Camp Devens, Massachusetts, described this process:

Two hours after admission they have the Mahogony (sp) spots over the cheek bones, and a few hours later you can begin to see the Cyanosis extending from their ears and spreading all over the face, until it is hard to distinguish the colored men from the white.50

Such severe cyanosis generally indicated terminal cases.

Evidence suggests that the influenza virus did not cause death directly in most cases, but instead weakened the lungs and allowed secondary pneumonias to develop.51 The novel aspect of the 1918-20 second wave was the severity of the damage done and the vulnerability of the resulting patient. Already the leading cause of death globally in 1918, pneumonia mortality during the pandemic climbed in tandem with the number of influenza cases. This link between influenza and pneumonia was well established by 1918, but in that year reached a severity never before or since recorded.

Most influenza deaths in 1918-20 took a week or more, allowing time for secondary lung infections to lead to pneumonia. Less than five percent died in three or fewer days from onset of symptoms.52 This suggests that the cause of most deaths was likely secondary bacterial infections,53 with their longer incubation period, rather than the dramatic viral pneumonias which can develop in under a week.

52 John F Brundage and G Dennis Shanks, “Deaths from Bacterial Pneumonia During 1918-19 Influenza Pandemic,” Emerging Infectious Diseases 14, no. 8 (August 2008): 1194.
Hospitalization might also have contributed to the death rate. In 1918 many of those struck down were moved to huge emergency hospitals, open wards often crowded with the ill. This was more likely to be the case in urban areas, where crowded living conditions seemed to require isolation of the sick individual outside of the home. Bringing in people already weakened by influenza and housing them in open wards facilitated the spread of secondary respiratory infections. While good nursing care demonstrated great efficacy in keeping up survival rates, home isolation with occasional supportive visits might have spared many. “Fresh air” cures advocated by some physicians also helped reduce the spread of these deadly pathogens. While the mortality rate in Boston’s influenza hospitals reached 50 percent, those patients placed outside in the cold, breezy air of Corey Hill survived at significantly higher rates.\(^{54}\)

Those five percent who did die within three days of onset produced terror in the affected populations. Stories are repeated globally of young, healthy people dropping in place as if struck, and dying within hours. This ability to cause aberrant immune-response\(^{55}\), sometimes known as cytokine storm, became a legendary element of the 1918-20 pandemic. Following infection the hale immune systems of young adults would over-react to the presence of the virus, leading to a sequence of inflammatory responses which would eventually flood the lungs with fluid and lead to death. The rapid onset and seemingly ‘out of the blue’ presentation in the healthiest cohort of the population lacked precedent. Physicians at the time argued as to whether they were facing a group of concurrent and synergetic illnesses or one pathogen with multiple, dramatic presentations. Accompanied by rapidly


\(^{55}\) Brundage and Shanks, “Deaths from Bacterial Pneumonia During 1918-19 Influenza Pandemic,” 1198.
developing viral pneumonias and the slower bacterial variants, the 1918 influenza seemed unstoppable.

Kirsty Duncan, medical geographer and influenza researcher with the University of Toronto, recounts the style of such deaths:

Charles Lewis of Cape Town boarded a train for his parents’ home in Sea Point, only three miles away. The conductor signaled the train’s start and immediately dies on the platform. Within minutes, a passenger had fallen dead, and the train stopped to unload the body. And then another traveler collapsed. In total, five people were struck down, and five times the train stopped to unload the dead on the pavement for collection by the municipality. And then, with only a quarter of the distance left to travel to Sea Point, the engineer slumped forward and died. Lewis, thrilled to be alive, gladly walked the rest of the way to his destination.56

Even more than the confusion of the doctors, the governmental limits on news, or the rumors swirling, these daily examples of the extreme potency of this influenza terrified populations, driving people to retreat to their homes where they found themselves without succor when they fell ill.

Differential diagnosis frequently suggested other diseases to attending physicians. The severe joint pain mimicked dengue; the intestinal symptoms typhoid or dysentery. Abdominal pain seemed to point to cholera.57 The appearance of the tongue conjured scarlet fever. The fever reminded tropical physicians of malaria. Sandfly fever, appendicitis, cataracts; this pandemic combined the worst elements of several long-standing nightmares of human disease confusing attempts at control and care. It also spread like fire.

56 Duncan, Hunting the 1918 Flu, 10.
57 Collier, The Plague of the Spanish Lady, 34.
Autopsy did little to clear the matter. Brains were flattened by increased blood pressure; hearts were damaged and flabby; adrenals, kidneys, and testes showed damage; muscles had been torn apart from coughing and convulsions. In some patients even the liver demonstrated sclerotic changes. The lungs excited the most comment. Filled with fluid, crushed by internal pressure, weighing up to six times normal, leaking into the chest cavity; they lost any function. U.S. Army physicians argued that: “The only comparable findings are those of pneumonic plague and those seen following the inhalation of poison gas.”

Gas frequently came to the fore as a possible causative or contributing agent. The long-term debilitating effects of gas weapons, their novelty and notoriety in the war, and the tendency for casualties to face repeated lung infections during their convalescence led to theories blaming gas weapons for the rise of the more deadly second wave. Given the exposure of troops suffering from mild or subclinical first-wave influenza in 1918 to repeated mustard gas attacks some researchers argued that this might have driven the changes necessary to produce the second-wave organism.

Hoping to understand the disease, scientists cultured what they could from lungs of victims. As most of the victims died of bacterial pneumonias it is hardly surprising that pathologists found a range of potentially disease-causing bacteria and searched among them for the causative agent of influenza, hoping to determine a pharmacologic response. The U.S. Navy suggested the following list as potential causative organisms: Pfeiffer’s bacillus; pneumococcus, three types; streptococcus,

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two types.\textsuperscript{50} Without understanding the nature of the infection, this effort provided few results.

Even when physicians accepted that the illness was indeed influenza there remained in some quarters a stubborn refusal to take the outbreak seriously. In the end, it was just influenza. As the second wave struck Arizona in the fall of 1918, the Superintendent of Public Health complained of receiving telegrams such as: “Fifty cases of influenza, all mild, four deaths.”\textsuperscript{61} This inability to accept the danger of influenza reaped a dire harvest.

Some physicians understood the scale of the problem, and the likelihood of a long outbreak. M. Greenwood, a physician and Captain in the British Army, published a piece on the pandemic in November, 1918. Appearing in the \textit{British Medical Journal}, it debunked several theories such as set periodicity and wind-borne status; argued for a recurrence of the disease in 1919 (the third wave); that the infectiousness of the 1918 was no different than that of the 1889 virus, just the fatality rate; and that it needed to be accepted as influenza, despite the variations from the traditionally acknowledged form.\textsuperscript{62} While these points would eventually come to general acceptance, at the time they were but one of many circulating sets of theories regarding the illness.

The physician in 1918 faced a suite of symptoms and a degree of severity outside of the experience of any but a few tropical disease specialists. Whether or not they acknowledged it as influenza meant little in the attempt to control or cure the malady. The cause was unknown. The reason for the range in severity was unknown.

\textsuperscript{61} Crosby, \textit{Epidemic and Peace}, 204.
\textsuperscript{62} Greenwood, M, “The Epidemiology of Influenza,” 563.
The likely length of the pandemic was unknown. Atop all of this came yet another mystery: why the young people?

One exceptional aspect of the 1918-20 in comparison to other influenza pandemics lies in demography. Influenza is generally a disease that kills the elderly and the very young. The 1918-20 pandemic demonstrated a taste for a group usually not bothered greatly by the disease, young adults. Roughly half of those killed were in their twenties and thirties, and if the estimates of 100 million dead are correct that suggests a global death toll in these age brackets of eight to ten percent.\textsuperscript{63} Traditional graphs of mortality from influenza where age of victims is on the horizontal axis are described as ‘U’ graphs, with high levels at either end of the age spectrum and negligible impact in the middle. The 1918-20 influenza instead produced a ‘W’ graph, with a massive spike in the center. This trait served to disable the portion of society normally most capable of caring for others. Young adults who were ill could not take care of children or parents, and in fact often had to rely on these dependents to nurse them through an extended disease and convalescence. Their frequent death meant many households lost their most economically productive members and many orphans fell into the care of the State, or voluntary organizations in the locality.

More than just the young, the 1918-20 pandemic seemed to target the strong. No statistics exist to define the ‘robust’ from the ‘weak’ in terms of mortality, but repeated anecdotal evidence from medical authorities across the globe describe the selective severity of the virus against the seemingly strongest of young people.\textsuperscript{64} Vigorous, healthy rural boys fell in greater numbers in the military camps than their relatively less healthy counterparts from urban areas. No explanation for this trait gains wide acceptance, but it remains one of the defining characteristics of the

\textsuperscript{63} Barry, \textit{The Great Influenza}, 4.
\textsuperscript{64} Crosby, \textit{Epidemic and Peace}, 215.
second-wave 1918 influenza virus. The social dislocation caused by the huge mortality in this age bracket is hard to overstate, and further complicated responses to the pandemic.

Ethnicity and income played dramatic roles in determining mortality rates. The poor suffered more acutely than the rich, in aggregate, due to less nursing care, more fragile infrastructure, and fewer reserves of food or other resources to help those that survived infection to subsist through the extended convalescence. There were exceptions. Residents of leper colonies and the dalits, the untouchable caste in India, both demonstrated lower infection rates presumably due to their minimal contact with the rest of society. While the isolation of those with Hansen’s disease (leprosy) in the colonies was physical, and that of the dalits social, such isolation served both groups and helped lower mortality. Despite such exceptions, for most of the poor the pandemic carried a greater risk of death than for their middle class or wealthy compatriots.

The population of certain countries suffered more than others, for a range of reasons. Social inequality, poor infrastructure, chaotic or minimal government and inadequate resources all contributed to the large number of deaths in places such as India (17 million), China (4-9.5 million), and Russia. Yet none of these factors proved the greatest determinant of mortality.

The greatest risk for death from the 1918 influenza pandemic accrued to recently colonized peoples with relatively short exposures to outside societies. The indigenous peoples living under colonial regimes or in reserves such as the United States’ Indian reservation system, as well as those native peoples in isolated areas

65 Collier, The Plague of the Spanish Lady, 35.
67 Johnson and Mueller, “Updating the Accounts,” 112.
and/or inhospitable climes, suffered appallingly. They shared neither the complete physical isolation of the leper colonies nor the social shunning of the *dalits*. Once introduction of the disease occurred, whether through trade, missionary work, or government agents, it spread furiously through the population. This had been the case in previous pandemics, whether due to a lack of previous exposure or a particular vulnerability, but influenza seemed to strike native peoples especially hard. The U.S. Navy summary of the pandemic in the 1919 Annual Report includes this note: “In brief, Navy reports from Guam, the Philippines, China, Japan, Cuba, Haiti, Santo Domingo, and Nicaragua indicate that influenza among Americans and European was a milder disease than among natives, and that relatively fewer were attacked.”\(^6\) New Caledonia reported an attack rate in the capital, Noumea, of 50 percent for Europeans, and 95 percent for native residents.\(^6\) Estimates of infection amongst American Indians were the same as for whites, 242/1000, but the death rate was four times higher.\(^7\)

Treatments reflected the questions regarding the causative agent and transmission route of influenza and the minimal pharmacopeia available in 1918. Physicians of the contagionist school attempted to treat as they would a bacterial infection. Miasmaists counseled supportive efforts. Without effective regimens for the treatment of influenza and pneumonia palliative care became critical. Nursing care manifested as support of the patient until their body could cope with the disease, secondary infections, and the convalescence proved to be the most important factor in survival rates. Warm food, clean beds, fresh air, and focused personal care saved lives. However the war in Europe siphoned away the most energetic and skilled of medical and nursing staff from many nations, leaving countries woefully

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\(^7\) Ibid., 205.
short of any care providers. Simply put, direct care could save lives but adequate staffing levels were unavailable, even in the most developed of countries.

By 1919 many physicians recognized that general health and supportive care represented their only successes against influenza. The British Royal College of Physicians published a memorandum in the spring of that year suggesting avoidance of crowds, well-ventilated rooms that were airy but not drafty, good food (including war rations), moderate or no alcohol, throat gargles and nasal rinses. While some of the suggestions likely produced little positive response, such as nasal rinses, none of the points proved harmful and most provided some benefit. Good food in particular demonstrated value while being difficult to acquire. 1918 was a year of shortage, of hunger, of blockades. The belligerent nations world-wide experienced caloric shortage (with the notable exception of North America and Oceania), impairing immune systems and slowing recovery. The war stripped countries of food, of medicines, and of skilled providers.

Early in 1919 Dr. T.H. Whitelaw published this summary of his findings from the Edmonton, Alberta pandemic:

The maintaining of bodily health by normal living and the avoidance of panic, worry or fatigue, seemed to be the only practical method of combating the infection. The element of fatigue among doctors and nurses who necessarily had to work long hours, undoubtedly accounted for their tendency to eventually fall victims to the disease, rather than the element of special exposure which their work entailed.

Pharmaceutical interventions tended to be local and experimental. Varied poultices, compresses, and cough syrups developed sworn adherents. One relatively

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71 Royal College of Physicians, “A Memorandum on Influenza from the Royal College of Physicians in London” (Royal Gazette, April, 1919, Fiji).
new drug utilized throughout North America and Europe, aspirin, potentially caused more deaths than it saved. While not an issue in most of the world, in North America, Europe, and their colonies it is possible that many of the cyanotic deaths came from overdoses of aspirin rather than the infection.\(^73\)

Immunization for disease prevention was widely used by 1918. Over the previous century multiple bacterial pathogens, beginning with smallpox, were isolated, cultured, and developed into effective vaccines; successes that made medical providers of the time justifiably proud. Vaccination still stirred controversy, but had become a commonly used tool for disease control, and one generally embraced by the public. Attempting to apply these successes to the influenza pandemic in 1918-20, researchers gathered specimens of bacteria cultured from victims. After isolating and identifying the specimens, medical laboratories released vaccines for general use. These vaccines often assembled a wide range of bacterial pathogens, as the lungs of those severely affected by influenza frequently carried multiple secondary infections any of which could be the elusive causative agent. A large number of vaccines moved into production during the pandemic, with many administered in both military and civilian settings.\(^74\) Unfortunately these vaccines had no effect in slowing the pandemic, which was viral instead of bacterial. The Royal College of Physicians argued in early 1919 that since the causative organism was not known, vaccination against influenza likely held no benefits, though vaccines against secondary infections might hold promise.\(^75\) Anecdotal evidence suggests that the rate of some secondary infections dropped, but given the range of


\(^{74}\) Burnet, Influenza; a Survey of the Last 50 Years in the Light of Modern Work on the Virus of Epidemic Influenza, 102.

\(^{75}\) Royal College of Physicians, “A Memorandum on Influenza from the Royal College of Physicians in London.”
vaccines available and their multi-antigenic nature, confirmation of any beneficial effect becomes impossible. In the words of the Surgeon General of the United States:

Altogether, many thousands of men were vaccinated, with the inevitable result that much conflict of opinion arose from the fact that many individuals vaccinated were not subsequently attacked by influenza. Unless properly controlled, vaccination experiments were without value.\textsuperscript{76}

Vaccinations did serve a purpose in demonstrating activity against the pandemic. At a time when governments faced the inability to act on behalf of terrified populations due to confusion regarding origins and treatments, vaccinations provided concrete proof that officials were concerned about the population’s welfare. Similarly, for a research establishment unable to provide any certainties, vaccination provided an opportunity for action.

Other treatments were more traditional. Home remedies, antiquated medical techniques such as bleeding still embraced by some medical staff, and localized experimental efforts all came into use. In Australia Dr. P Horne Macdonald presented a tract to Parliament detailing how tongue cleansing could not only prevent influenza; it could cure current cases and prevent long-term problems from the disease.\textsuperscript{77}

Patent medicines rushed to fill the gap created by a lack of an effective anti-influenza drug. None of these demonstrated any efficacy, yet at a time when a disease of unknown cause reaped millions of lives, even the faintest hope of an effective countermeasure saw eager acceptance. Because the majority of those who became ill did survive, a range of patent medicines and experimental cures were to be seen as effective, since most people who took them lived. Correlation became


causation. Until virus isolation occurred in 1933 this confusion regarding pharmaceutical interventions remained and efficacy against influenza served as a common sales pitch for a range of products demonstrating questionable efficacy.

The numbers of dead from the 1918-20 influenza are as much in question today as the origin and transmission were in 1918. The most significant recent entry into this debate is Johnson and Mueller’s “Updating the Accounts: Global Mortality of the 1918-1920 "Spanish" Influenza Pandemic”. The authors see gross underestimation of mortality in areas turbulent in 1918-20 such as Russia and India. By their estimation the previous upper limit of fifty million dead is actually the lowest reasonable estimate, while arguments for a figure of one hundred million casualties are sustainable.

Those who survived the most severe forms of the infection faced long and difficult recoveries. Respiratory weakness was common and frequently permanent. Some individuals were unable to return to normal activity for six months or more. It was not uncommon for adults to return home after being ill, and after having lost their spouse, to face a family of children to care for while too weak yet to care for themselves. Inability to work doomed many small businesses and crippled many large firms. The insurance companies of England paid out twice as much in influenza claims in 1918-1919 as they had in five years of war claims. It would be many years before global society would recover demographically and economically to the level of January, 1918.

The scale of the deaths and destruction and the dramatic nature of its progression both individually and across societies make the 1918-1920 influenza pandemic a fertile topic for researchers and historians. The literature is broad, both at

78 Johnson and Mueller, “Updating the Accounts.”
79 Duncan, Hunting the 1918 Flu, 16.
the academic and the popular level. With each new influenza threat that gains traction in the media a new series of dramatically titled texts reach the bookstores. There are a number of historical works that deserve special mention here and that have been useful in my research.

Alfred Crosby’s *Epidemic and Peace*[^80], published originally in 1976 and then repackaged in the early 2000s as *America’s Forgotten Pandemic: The Influenza of 1918* is the classic historical overview of the pandemic. Scholarly and dense, it approaches the event from a narrative angle while assuming the reader has a grasp of the basics of epidemiology. Crosby focuses upon the misunderstanding of the influenza common at the time, especially in reference to its origins and spread. While generally limited to an American stage, with the rest of the world appearing in anecdotal asides, Crosby effectively communicates the confusion of the public health system. In the midst of a seemingly inevitably victorious push against infectious disease, the public health agencies were suddenly confronted by an illness that took an unexpectedly destructive form. The confusion, strain, and hubris of both the medical and political establishments in the face of a deadly pandemic are evident throughout the work. This confusion regarding the nature of influenza on the part of medical and political actors, and its lethal impact, echoes throughout this thesis.

Richard Collier took a more global view of the pandemic in his *Plague of the Spanish Lady*, published in 1996. The failure of the public health systems in many nations, and the inability of political systems already weakened by the First World War to react quickly to an infectious disease crisis, forms the core of his argument. He suggests that without such failures the mortality from the disease might have been much reduced. Colonial Governors come under particular analysis, and are

[^80]: Crosby, *Epidemic and Peace*.
found generally wanting or in his term “second-rate”. The evidence used demonstrate that the lack of understanding in the medical and public health fields, so vividly exemplified in an American setting by Crosby’s works, spanned the globe. Collier moves beyond Crosby’s focus on systemic failure to point out the impact of individual decisions.

Building from both Crosby’s and Collier’s work is The Great Influenza. John Barry’s 2005 popular history of the 1918 pandemic hews closer to Crosby’s work by focusing on the American epidemic and the cast of characters in place to respond. While using the narrative to tell the story of the development of American medicine as a science rather than art, Barry manages to produce the most coherent and expansive view of the global pandemic yet available. He argues strongly that the 1918 strain originated in Haskell County, Kansas. He also discusses the success of public health efforts against the influenza, using this evidence to suggest what might have been done against the disease rather than producing another litany of failures (though there are many of those as well). He argues that the medical system in place in the United States by 1918 was flexible enough to have responded at least somewhat effectively to the influenza had it not been hamstrung by political imperatives during wartime, and simple bureaucratic incompetence. To Barry the 1918 pandemic represents a missed opportunity for the medical systems in place, not simply a failure. His article of 2004 “The site of origin of the 1918 influenza pandemic and its public health implications” served to introduce his arguments regarding the possibility of a Kansas origin (not his own theory but one that he strongly endorses) which are more completely developed in the book of the following year.

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81 Collier, The Plague of the Spanish Lady, 152.
82 Barry, The Great Influenza.
83 Barry, “The Site of Origin of the 1918 Influenza Pandemic and Its Public Health Implications.”
Less significant popular histories abound. Iezzoni’s Influenza 1918\(^84\) focuses upon the human costs without a great deal of analysis. Similarly Kolata’s Flu: The Story of the Great Influenza Pandemic\(^85\) offers often dramatic narrative without depth. There are many others in the same vein.

All of these pieces are meant to have a grand scope. By exposing the reader to the experience of large nations, or the entire globe, they give scale to the tragedy. The use of personal stories makes such tragedy intimate. Yet they are missing the experience of the local. The decisions made in the Governor’s offices and the local public health agency had as much, if not more, to do with the eventual outcome as directives from the capital. Collier’s use of the individual approaches such an analysis, and is a method I use throughout this thesis, but none of these works focus upon decisions at the local level.

The works mentioned above build on first-hand accounts. Governments issued weighty studies soon after the pandemic had passed. The British Ministry of Health issued their report of the pandemic in 1920: Reports on Public Health and Medical Subjects no. 4: Report on the Pandemic of Influenza 1918-1919.\(^86\) At well over 600 pages the work is exhaustive in its description of the known impacts of disease and blunt admission of ignorance regarding causation. The U.S. government published a similar work in Annual Reports of the Department for the Fiscal Year 1919: Report of the Surgeon General.\(^87\) In 1927 Jordan, under the aegis of the American Medical Association, published Epidemic Influenza.\(^88\) At more than 500 pages, it was envisioned as a comprehensive medical history of the global pandemic. Jordan

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\(^{84}\) Iezzoni, Influenza 1918.
\(^{88}\) Jordan, Epidemic Influenza.
addresses the varied theories of cause without expressing a single view and lists successful quarantines at localities across the globe. He also casts doubt on claims of vaccine efficacy from the pandemic and describes the third wave of 1920 and continuing influenza activity through 1923.

Invaluable as source material, such overviews appear aged and confused today. Using assumptions since proved incorrect and data now seen as questionable, they nonetheless offer a window into the responses of the great cities and nations of the world. In such summaries the local travails of small communities hold no place and predictive summaries for future action focus upon the large population centres to the exclusion of more isolated outposts. Polynesia is mentioned, if at all, in a passing summary of the Imperial ramifications of the 1918 influenza. While these facts and figures serve to provide contrast and context, they are history with the broadest possible brush and detail is sorely lacking. My work seeks to uncover the telling detail of the Pacific experience of the ‘flu.

Recent authors have approached influenza from the medical perspective, driven more by the mechanics and epidemiology of the disease than the social implications. Beveridge’s *Influenza: The Last Great Plague* (1978) attempts to tell the history of influenza as a whole, from ancient influenza-like outbreaks through to the Swine ‘Flu scare of 1976. As with many such works it was inspired by the most contemporary influenza event, and the lessons it contains apply most effectively to that event. A solid history of influenza from a medical viewpoint, Beveridge has also produced a cautionary tale against over-reaction to the disease. In his telling quarantine is impossible, and fumigation and masks are accorded little efficacy. He argues that some preparation is possible, but that inevitably most response will be reactive rather than proactive. Yet abatement efforts are simply described as

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89 Beveridge, *Influenza*. 
ineffective, without explanation as to why they were attempted and what the view of their utility was at the time of implementation. This is understandable in the wake of the 1976 Swine ‘Flu fiasco, but does little to expand understanding of the disease or its social impact. While producing a strong survey of medical views and actions against influenza over time, Beveridge gives short shrift to the social, economic, and political context within which such actions occurred.

“The Persistent Legacy of the 1918 Influenza Virus” (2009)⁹⁰ by Morens, Tautenberger, and Fauci is a description of the genetic history of the human influenza virus during and since 1918, and the continuing significance of the 1918 H1N1 variant in human health. Demonstrating why acquisition of an earlier strain of influenza might grant little or no protection against a new variant, the authors explain how quickly the virus can change and reassemble itself into novel forms. Two years earlier Morens and Fauci addressed some of the same issues in “The 1918 Influenza Pandemic: Insights for the 21st Century” (2007)⁹¹ as well as arguing for the presence of multiple viral strains during the 1918 second wave of influenza.⁹² They put forward a pattern of symptoms which they offer as a method of differentiating viral deaths from the 1918 influenza from secondary bacterial infection leading to death in victims weakened by influenza infection. Once again this information is useful in judging the course of the disease and the reactions of actors at the time, but is insufficient to explain the course of events. Such purely medical approaches will be used in this thesis to help describe the course of the individual epidemics within

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⁹⁰ Morens and Fauci, “The 1918 Influenza Pandemic.”
⁹¹ Ibid.
⁹² A view shared by Cox and Subbarao in “Global Epidemiology of Influenza: Past and Present”. Expanding on this point, Brundage and Shanks writing in “Deaths from Bacterial Pneumonia during 1918-19 Influenza Pandemic” suggest that the number of deaths directly from viral action is quite low, perhaps 5%, with the rest due to secondary bacterial action.
their specific combination of social, political, and economic pressures; elements not present in these writings.

The re-creation of the genome of the 1918 variant influenza virus inspired several books and articles. Two are of value in a historical review of the topic as they add details missing from less focused research. Duncan’s work *Hunting the 1918 Flu* speaks to the variety of names given to the 1918 pandemic and the political and social import of each. Davies’ *Catching Cold* is less personal (Duncan was a participant in the failed attempt to extract genetic material in Svalbard) and highlights the controversies that still surround influenza. He quotes researchers supporting his view that influenza might linger in the environment, making a site of origin a moot point. He also suggests that the range of organisms susceptible to influenza might be much larger than the commonly accepted pool and that moose and baboons become demonstrably ill with the virus. A non-fiction author of some renown, Davies demonstrates the range of argument regarding influenza still extant and illustrates how controversy within the scientific community has survived since 1918.

The collection *The Spanish Influenza Pandemic of 1918-19: New Perspectives* (2001), edited by Killingray and Phillips, attempts to bring fresh analysis to many of these arguments. By focusing on non-English speaking areas (Witte on Baden, Rice on Japan, Ramana on Bombay, Iijima on China, Echeverri on Spain, Ellison on Tanzania, and Echenberg on Senegal) and groups with little voice in the media and

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93 Duncan, *Hunting the 1918 Flu*.
94 Davies, *Catching Cold*.
95 A similar set of arguments are put forward by Hope-Simpson as late as 1992 in *The Transmission of Epidemic Influenza* where the author reiterates an argument for influenza latency and weather-related reactivation of the virus which he had made in numerous journal articles over the previous two decades. He suggests that simple infectiousness is not sufficient to explain the spread of influenza over time, a view which still has adherents and was certainly accepted widely in 1918.
academic circles of the time (Herring and Sattenspiel on Arctic peoples, Bristow on nurses in the United States) the new perspectives in the title are upon the impact of the pandemic, not the causes or potential remedial efforts. The collection demonstrates that while cultural factors drove varied responses to the epidemic, some of the decisions made in response to the arrival of the influenza were the same regardless of the culture under study.

Such pieces are valuable for understanding the mechanisms of the virus itself, as well as demonstrating just how contentious some of the arguments around influenza were in 1918 and remain today. The agencies in charge of preparation for and response to infectious disease in the states under study demonstrated the confusion and dissension produced by such gaps in scientific knowledge. The Killingray and Phillips collection served as a strong example of the work I aim to produce, but even with the broad scope of their authors’ subjects the experience of the influenza for people of Polynesia and indeed the Pacific as a whole, aside from Japan, is not addressed.

In recent times several authors have addressed the efficacy of social measures against influenza and other infectious illnesses. Hardy’s *The Epidemic Streets: Infectious Diseases and the Rise of Preventive Medicine, 1856-1900* (1993) charts the development of such interventions over the course of the 1800s and the opposition they faced from political and economic interests. Quarantine in particular came under attack as unnecessary and unsustainable. Her article of the same year “Cholera, Quarantine and the English Preventive System, 1850-1895” recounts the lengths captains and ship-owners would go to avoid quarantine regulations. Hardy

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focuses upon the social impact of the decision to quarantine and the force arrayed against such attempts but does little to address other stakeholders present in these communities. Similar attacks upon quarantine for excessive cost compared to benefit feature in *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910* (2005). Evans’ description of the politics of quarantine in Hamburg and its subsequent military imposition and the social rebellion that followed illustrates just how great an impact such interventions can have on the threatened society. New Zealand’s historical use of quarantine shows the same pattern, according to Hugh Morrison’s dissertation “The Keeper of Paradise: Quarantine as a Measure of Communicable Disease Control in the Late Nineteenth Century New Zealand”99, with political pressure for its use to protect ‘clean’ New Zealand from the dirty ‘other’ but economic pressures eventually putting paid to any efforts at broad quarantine use.100

Two works address the efficacy of such measures specific to influenza. *JAMA* published the Markel et.al. article “Nonpharmaceutical Interventions Implemented by US Cities during the 1918-1919 Influenza Pandemic” in 2007.101 The authors argue that such interventions were not meant to avoid infection entirely, merely to slow the spread of disease in order to distribute the burden of illness over time and lessen the strain on social infrastructure. The two determining factors of the efficacy of interventions were identified as how early in the pandemic interventions were attempted and how long they were used. The earlier, the longer, the more effective

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100 Similar arguments appear in Sehdev’s “The Origin of Quarantine”, Anderson’s *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines*, Borthwick’s *Quarantine*, Dorolle’s “Old Plagues in the Jet Age: International Aspects of Present and Future Control of Communicable Disease, and Aiello et al.’s “Research Findings from Nonpharmaceutical Intervention Studies for Pandemic Influenza and Current Gaps in the Research”.
they seem to have been. H Batesveldt’s edited collection *The 1918-1919 Pandemic of Influenza: The Urban Experience in the Western World* (1993) expands the study to the social interventions utilized in Manchester as well as several American cities. H Batesveldt’s verdict is that by 1918 doctors were not more effective than their predecessors, just less lethal.

While the works devoted to quarantine delve into the social implications of such measures the research specific to influenza merely addresses efficacy. These authors have no interest in why particular interventions functioned or failed, merely to what degree these interventions’ success can be quantified. My thesis seeks to take the discussion of such interventions against influenza and demonstrate the context in which they were applied. Evans’ and Hardy’s analysis of cholera and quarantine are useful models, but they are still focused upon a single intervention against disease. Did Hamburg also apply other methods that worked synergistically with quarantine? By choosing small, isolated states I seek to look at the breadth of interventions and how social pressures impacted them, as well as how they interacted when applied concurrently.

The historical epidemiology of influenza in the years leading up to the 1918 was studied by David Patterson. His 1986 work *Pandemic Influenza 1700-1900* is a trove of theories that seemed reasonable in 1900 yet have since been discarded. Issues such as latent infection and seasonality, miasma, and Pfeiffer’s bacillus are well covered in their historical context, and all of these issues were still very much in contention by mid-1918. Some of these theories still have their advocates, occupying

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a corner of influenza scholarship few aside from Patterson have approached and again demonstrating the persistence of disputes around the disease.

Just as the 1976 Swine ‘Flu inspired Beveridge, the immediate aftermath of the 1918 pandemic saw a broad literature emerge.\(^\text{104}\) Given that the source of infection, method of transmission, and details of illness were not understood for decades after the 1918 pandemic, these works convey the limited understanding of the time. They afford the reader a sense of the medical thought regarding influenza and help inform the analysis of decisions based upon the assumptions of those in authority, be it medical or political. Yet they are medical works, not attempts at social analysis. They are useful elements for such an effort, but alone do little to explain events.\(^\text{105}\)

The 1918 pandemic in Polynesia has very little literature directly devoted to it, instead appearing as asides in the general histories such as those of Collier, Barry, and Crosby. In particular the stark dichotomy of the two Samoas is often described, with Western Samoa having the greatest known mortality from the pandemic of any state, while American Samoa was possibly the only state to completely escape infection. Such material is often offered as evidence of the capriciousness of the disease without analysis of the causes underlying them. Where an explanation is offered it is generally a brief mention of quarantine without discussion of why it was applied in one Samoa and not the other.

\(^\text{104}\) Notable works include Greenwood’s “The Epidemiology of Influenza”, Jefferson and Ferroni’s “The Spanish Influenza Pandemic Seen Through the BMJ’s Eyes: Observations and Unanswered Questions”, and Frost and Sydensticker’s “Epidemic Influenza in Foreign Countries” which demonstrated the global range of infection known by 1919 and the communication networks available at the time.

\(^\text{105}\) Other authors of the era had less sustainable views. Crookshank argues in \textit{Influenza: Essays by Several Authors} argued that Negroses were protected from the flu due to their wide nares (nostrils). Less controversial but still not particularly helpful were the instructions to avoid masks and simply reduce stress as a palliative for Influenza advocated by T. H. Whitelaw in “The Practical Aspects of Quarantine for Influenza.”
I have drawn pieces from works that addressed the social impact of disease in Polynesia. *Island Epidemics* (2000) by Cliff, Haggett, and Smallman-Raynor\(^{106}\) develops a discussion regarding the mobility of labour in the Pacific and the epidemiological consequences of such. The authors posit that the 1918 pandemic in Polynesia was significantly worsened by the need to use Polynesian labour throughout the stops of the Talune as the workers served as prime vectors for transmission of the disease. Sir Charles Hercus offers a listing of diseases present pre and post European contact in his *Disease in Polynesia: Indigenous and Imported* (1962).\(^{107}\) Raeburn Lange’s thesis *A History of Health and Ill-Health in the Cook Islands* (1982)\(^{108}\) also lists the diseases of the time and addresses the nature of sanitation in traditional Polynesian communities. Finally, in *Infectious Diseases: Colonizing the Pacific?* (1997)\(^{109}\) Miles argues for evidence of the presence of occasional significant outbreaks of infectious disease in Polynesian states due to the persistence of traditional isolation practices developed in places such as Tonga and Fiji. Yet the inability of these practices to protect against invading illnesses receives scant examination. None of these works are sufficient in themselves to explain the course of disease events in western Polynesia, all being either specialist tracts or using a much broader scale.

While not directly addressing Polynesia, *Colonial Dis-Ease* (2004)\(^{110}\) allows Hattori to illuminate colonial relationships in colonized states of the Pacific, in particular those under the rule of the U.S. Navy. Though she speaks of Guam, American Samoa was under similar administration and could have easily followed the same fate; repeated infections poorly handled by a public health infrastructure

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\(^{109}\) Miles, *Infectious Diseases: Colonizing the Pacific?*.

more interested in protecting American servicemen from the apparently dangerously infectious indigenous population and teaching that population how to be good (clean) citizens without taking into account the local history, customs, or climate.

New Zealand is considered a part of Polynesia, though with a significantly different political and cultural makeup than the island groups under study. A review of the 1918 epidemic in New Zealand helps to illuminate logistic and climactic issues, though there were few cultural similarities outside of the Maori population. The classic review of the New Zealand epidemic is Rice’s *Black November* (2005). As well as offering a strong narrative history of a small, wealthy country’s experience of the influenza, it touches upon the forces in Wellington which determined New Zealand’s response to the outbreak in the recent colonial acquisition, Western Samoa. Rice lays the fault for the cataclysm there at the feet of both the local administrator and an over-worked, under-informed bureaucracy in New Zealand itself. This work grants an intimate view into public and bureaucratic response to sudden illness in the early 20th century, and the author demonstrates the questionable quality of mortality and morbidity statistics produced during and immediately after the pandemic. This, coupled with the modeling of the dissemination throughout New Zealand, has inspired many elements of my research. The discussion of the *Niagra* as the source of New Zealand’s epidemic is fascinating. The author delves into recent scholarship addressing the potential seeding of populations with the influenza virus, which would then emerge seasonally due to changes in temperature and solar radiation exposure. These opinions still occupy the outer edges of scientific thought regarding influenza, but do not diminish the value of the work overall and serve as a reminder that controversies still exist over issues in question in 1918.

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111 Rice, *Black November*. 
Specific literature for each state under study is scarce. The Presidential Address of the Fiji Society has focused upon disease in Fiji on two occasions: Derrick’s Address of 1955 “1875: Fiji’s Darkest Hour--An Account of the Measles Epidemic of 1875”\textsuperscript{112} that described the carnage visited upon Fiji forty years before the Spanish Influenza and the long-term impact this had on Fijian response to infectious disease and colonial interventions against it and McDonald’s Address of 1959:”Diseases in Fiji”\textsuperscript{113} that further delved into the memories of still living survivors of the 1918 Fijian epidemic to discuss mortality in indigenous health care workers and theories of spread throughout the archipelago. Earlier, the Transactions of the Fiji Society, 1924\textsuperscript{114} featured Father Rougier’s discussion of the history of disease in Fiji. He notes that Fijians were familiar with the idea of respiratory disease being infectious and the need for isolation in such cases. More significantly, he describes the tradition held in Fijian society since the 1875 measles of referring to the colonial hospitals as “houses of death” and their adamant refusal to receive treatment via western medicine. Such views are recounted by a later generation in Spencer’s Disease, Religion and Society in the Fiji Islands (1941).\textsuperscript{115} Spencer also argues forcefully that Fijian views on health cannot be understood without acknowledging their deep roots in religion, since treatment might require a change in behavior or apology every bit as much as medication or surgery. None of these works attempts much analysis of the 1918 outbreak, and all have weaknesses regarding scope and bias, yet they serve as the core of a scant historiography of disease and society specific to Fiji.

\textsuperscript{113} Dr. W. H. McDonald, “Diseases in Fiji; Presidential Address 1959” (Read to Fiji Society, April 13, 1959).
\textsuperscript{114} Father S.M. Rougier, “The Diseases and Medicines of Fiji” (Transactions of the Fiji Society, 1924, April 28, 1924), National Archives of Fiji.
\textsuperscript{115} Dorothy Spencer, Disease, Religion and Society in the Fiji Islands. (New York: J. J. Augustin, 1941), http://openlibrary.org/b/OL17763464M/Disease_religion_and_society_in_the_Fiji_islands.
The history of disease in early post-contact Fiji is addressed by Corney in “The Behaviour of Certain Epidemic Diseases in Natives of Polynesia, with Especial Reference to the Fiji Islands.” (1888). He suggests that quarantine is very appropriate for Fiji, and that far from having an economic interest in minimizing quarantine, plantation owners have an interest in protecting their investment in their staff via such isolation practices. In his experience the traditional village layouts of Fiji are perfect for both sheltering from raids by other communities and facilitating the transfer of infectious disease. Influenza is not a disease amenable to quarantine or social engineering in the author’s view, however, as he believes it to be windborne and thus unavoidable. Given the massive advances in the understanding of infectious illness, the value of this work lies in its reflection of thought regarding disease in the late 1800s.

Addressed as part of a general Samoan history, the epidemic in the eyes of Davidson in Samoa Mo Samoa: Emergence of the Independent State of Western Samoa (1967) becomes a key triggering event for later political change. In his telling, Governor Logan is brave but misguided while the New Zealand colonial bureaucracy in Samoa was simply not up to the task of governing. Such a view is challenged by Ross in New Zealand’s Record in the Pacific Islands in the Twentieth Century (1969) who is sympathetic to Logan. In this interpretation the Administrator did what was possible in an impossible situation. Yet both works focus on Logan even while proclaiming his relative lack of power in the face of catastrophe thus treating the political as the essential element while ignoring medical and broader social factors.

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Building on the work of Davidson, in 1992 Sandra Tomkins published “The Influenza Epidemic of 1918-19 in Western Samoa.” An analysis of one side of the Samoa dichotomy, her review of the actions of the New Zealand colonial administration in Western Samoa is damning. She suggests that there were numerous opportunities for local authorities to prevent infection or more effectively control it once it reached Samoa, but that both local and Wellington-based elites failed in their responsibilities. Citing the findings of the Samoan Epidemic Commission, her discussion of the epidemic in Apia’s domains comes down to a failure in governance, a failure later described as a success by the administrators involved. Similarly, in her “The Failure of Expertise: Public Health Policy in Britain During the 1918-19 Influenza Epidemic” (2002) and “Colonial Administration in British Africa During the Influenza Epidemic of 1918-19” (2004) she extends this argument to the British Empire as a whole, citing the failures of government-funded medical and political bodies to engage effectively in preventative medicine. Despite using the benefits of western medicine as a justification for the colonial system in less developed areas, the colonial structures were unable to bring such promises to fruition when needed.

Samoa Tula’i: Ecclesiastical and Political Face of Samoa’s Independence, 1900-1962 (2004) allows Liuaana to approach the Samoan epidemic from an indigenous viewpoint. This includes the surprise of the Samoan passengers aboard the Talune at the lack of quarantine in Apia, repeated by several witnesses to the Samoan Epidemic Commission, the reported falsehoods of the Captain of the ship, and the severe social

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119 Tomkins, “The Influenza Epidemic of 1918–19 in Western Samoa.”
damage inflicted by the decision to bury bodies in mass graves. The discussion of the resentment of the Samoans due to the epidemic uses sources other than the standard Samoan Epidemic Commission testimony and illustrates the origins and depths of feeling against New Zealand present after the disease had passed.\footnote{Other first-hand accounts of Samoan disease history include F. T. Grey’s “Influenza in Samoa: Value of Vaccines” and James’ “Pathology of Samoa”.


S. M Lambert, A Doctor in Paradise (London: J. M. Dent & sons, ltd, 1942).} The account is not balanced, but is not meant to be. It is the view of the contributors regarding events on the edge of memory, but highly suggestive of social anguish. As such it provides a different perspective than most official histories. Malama Meleisea expands and adds further Samoan perspective in The Making of Modern Samoa.\footnote{Malama Meleisea, The Making of Modern Samoa: Traditional Authority and Colonial Administration in the History of Western Samoa (Suva, Fiji: Institute of Pacific Studies, University of the South Pacific, 1987).}

First hand accounts of Tonga’s epidemic are scanty, but some discussion of the outbreak does appear in Fanua’s Malo Tupou: An Oral History (1997).\footnote{Tupou Posesi Fanua, Lois W. Webster, and Tupou P. Fanua, Malo Tupou: An Oral History, illustrated edition (Auckland, N.Z.: Polynesian Press, 1997), 20.} Like the work of Liuaana regarding the Samoan epidemic, the author works from memories and stories to describe the extent of the illness in Tonga and to argue that the scale of the deaths caused a significant change in burial customs throughout the state. Though not addressing the influenza directly Rev. Collocott’s 1923 article “Sickness, Ghosts, and Medicine in Tonga”\footnote{E. E. V. (Ernest Edgar Vyvyan) Collocott, “Sickness, Ghosts, and Medicine in Tonga,” The Journal of the Polynesian Society 32, no. 127 (1923): 136–142.} does discuss the skill Tongans held in massage, and their willingness to sacrifice to achieve good health. Lambert’s 1942 book A Doctor in Paradise\footnote{S. M Lambert, A Doctor in Paradise (London: J. M. Dent & sons, ltd, 1942).} argues that no single cause led to the vulnerability of Tongans (and Samoans) to the influenza and other diseases, instead there being a synergy between numerous small aspects of their beliefs and customs around illness. More than this fairly uninspired argument, Lambert discusses at length the poor quality of medical staff in the Pacific islands, and suggests that much of the disease in the region could
be attributed to this poor quality of care. Given Lambert’s interest in developing a united Pacific Health Service this argument must be read with restraint. While none of these works is particularly scholarly nor comprehensive, all address aspects of the Tongan experience which have received little attention from historians. My thesis seeks to address this gap.

For disease-specific historical analysis of all the colonized states in Polynesia (as well as Mexico and Australia) Kunitz' Disease and Social Diversity (1996) serves as a solid introduction. His argument, that to comprehend the distribution and impact of disease across cultures requires an understanding of political, social, and cultural forces at work locally, underpins much of this thesis. According to Kunitz, social pressures impacted and helped to determine medical conditions. His example given is that the larger the island in Polynesia the more likely settlers would arrive and establish plantation agriculture, converting the native population into semi-serfs with all the attendant health problems that follow the consequent reduction in social status and autonomy. Within this theoretical structure, the depopulation of the large Polynesian states was an effect of wholesale land and resource dispossession by colonialists, not a cause. Natural history and social history both play roles in the narrative of infections. He also strongly argues for the importance of local historical knowledge when attempting to address infectious disease outbreaks, and the inability to generalize response across different cultures.

Kunitz’s approach, using a wide-ranging analysis of social factors combined with a broad epidemiological knowledge as the basis for understanding disease events in communities and small states, is the model I have chosen to emulate here.

Even so, Kunitz takes a limited view of the Polynesian experience, making it one of a number of case studies of the impact of disease on societies. Little information is present regarding the differences between the various island groups of Polynesia, both on a state and a sub-state level. Discussion of demography as separate from geography is missing, as is mention of the missionary impact. His fundamental premise is well-founded but lacks historical and social analysis specific to this work. Nonetheless, his more holistic approach is well suited for the type of analysis this thesis attempts.

Kunitz’s work, along with that of Tomkins, forms the core structure for my thesis. Tomkins’ focus lies with the failure of colonial structures and as such is a work of political history, missing the medical and epidemiological elements which Kunitz favors in his analysis. My thesis seeks to explain the choices of the political class in part through the context of the nature of the disease they faced, as well as other social pressures. Tomkins’ research has provided a useful example of such political analysis in Polynesia, Kunitz’s an example of the medical/social. This thesis works to combine the approaches of Kunitz and Tomkins in relation to the four locations chosen.

There is only one author of the experience of western Polynesia in the 1918 pandemic that seeks to address multiple sites and factors rather than focusing entirely upon one state or one aspect of the crisis. In 1995 Phyllis Herda published “The 1918 Influenza pandemic in Fiji, Tonga and the Samoas”130 followed five years later by “Disease and the Colonial Narrative: the 1918 Influenza Epidemic in Western

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Herda’s broad knowledge of Polynesia and its colonial history is evident in her discussion of western medicine as a colonial tool and act. Using the 1918 influenza pandemic as an example, she reviews the reluctance of both the political and medical elites in the western Polynesian colonies to act against the disease. Such hesitation is widespread despite these elites use of the potential for protection by western medical techniques as a tool for gaining control over local populations. The fact that the colonial powers defined their success in these islands by their population growth rate led to a paternalistic view of the indigenous populations’ ability to care for themselves, and a willful refusal to incorporate local traditions and customs into responses against the influenza once it had penetrated each colony. The failure lay not in the systems, but in the elite’s view of the colonized.

Herda’s work is the closest to a comparative analysis of the course and impact of the 1918 influenza pandemic in Fiji, the Samoas, and Tonga. Yet her writing focuses on the political, and use of medicine and public health as a tool of colonial control. It is similar to the work of Tomkins, though with a broader reach and a scope including all of the states touched by the Talune. As such, it is the only body of work attempting the comparative discussion of the experience of the influenza across these states. Her findings color this thesis, but the article in question is a survey heavily slanted towards a political history of the event. Once again, the medical elements are lacking, as well as discussion of social factors such as the impact of the varied economic structures of the differing states.

A comparative study bringing together the elements addressed individually by the works mentioned above is necessary to assemble an accurate narrative and

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understand the lessons offered by the experiences of the western Polynesian states. Threads of politics, demography, history, religion, geography, economics, and other aspects of the separate epidemics in each state have been addressed, but never as a whole cloth. Those states visited by the Talune in November, 1918, were not one-dimensional constructs, and their response and history cannot be fully understood by looking at single aspects of their experience. There is a story to be told through incorporating all the elements of culture and medicine into a narrative for each state. There are lessons and insights to be found in the comparison of such stories. These are the goal of this thesis.
Chapter 2: Fiji

Sun drenched islands covered with lush growth and fringed with gorgeous beaches, the Fijian archipelago seemed to define a tropical paradise in 1918. A place of legend to the outside world, full of tales of cannibalism and shipwrecks, Fiji was surprisingly well connected to the trade networks of the time and served as a key outpost of empire. While the ‘developed’ world fought in the second decade of the twentieth century, most of Fiji’s village residents practiced a life not unlike that of their grandparents. Guaranteed in part by a British policy of cultural preservation, change came slowly under the blazing equatorial sun.

As the Union Steamship Company’s (USSCo) Talune approached Fiji in early November 1918, sailing on her standard freight and passenger run, there was a sense of unease. The Talune was a frequent visitor to these shores, making a monthly transit through western Polynesia (map 1); transferring cargo and passengers as she wandered. Yet this time seemed different. The weathered and worn vessel (figure 1), purchased from the Tasmanian Steam Navigation Company in 1891 by the New Zealand-based USSCo followed a course determined by the perishable nature of the fruit she carried back to New Zealand and Australia, and the needs of her passengers aboard. On most visits she was welcomed as a source of news of the outside world, and perhaps a point of contact for those settlers and colonial officers staffing her

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1 Union Steam Ship Company of New Zealand and Grimshaw, Tours to the South Sea Islands, Tonga, Samoa, Fiji.
remote destinations. Yet this trip felt different. The *Talune* had left an Auckland prostrate with influenza of a vicious variety.

(Figure 1: USSCo. *Talune*[^4])

This new threat appeared just as the carnage of the First World War reached its terrible coda. The wireless and newspapers had alternated between hopeful discussions of the end of the long war and horrific descriptions of influenza spreading through the continental states. Fiji’s glorious isolation had slowed or swallowed so many outside influences, but tales were fresh of the 1875 measles and legends of earlier, even deadlier epidemics overrunning the island. Fiji had a broad range of ethnicities in uneasy cohabitation. Infrastructure was limited, and the

population spread out across more than one hundred islands. Local medical traditions provided no solace in the face of foreign diseases, but western medicine was distrusted and avoided. If a new plague did strike, how would Fiji cope?

Certainly not all local elements weighed against an effective Fijian response to a disease threat, for Fiji also hosted a more significant British colonial presence and maintained broader contacts with the outside world than neighboring islands. In a 1916 report to the Government of Australia the Inter-State Commission noted: “The most important group in the Pacific is the Fiji Islands, which are in a far more advanced state of progress both as to the civilization of the natives and as to production and trade than any other part.”

5 The Inter-State Commission, “British and Australian Trade in the South Pacific” (Government of the Commonwealth of Australia, April 8, 1918), 14.
the Trans-Pacific cable dated from 1902, allowing for rapid and reliable transfer of information.⁶ Suva housed the Superintendent of the Pacific Cable Board, responsible for the Pacific portion of the “All Red Line”. This telegraph system linked Australia to Canada and outward to British possessions worldwide.⁷ Fiji sat on three different steamship routes, one each based in Canada, New Zealand, and Australia.⁸ While trade brought risks (the 1918 influenza arrived on one of these regular routes) it also brought information, technology, warnings, and skilled workers. The increased British bureaucratic/colonial presence in Fiji also supported a more significant medical infrastructure than was present in the other colonial territories under study.

Despite such benefits the estimated death rate in Fiji for the influenza epidemic of 1918-1919 hovered around five percent⁹. Why did so many Fijians die in spite of the presence of medical staff and a relatively centralized government? What conditions and assumptions led to the failure to exclude the disease, and what measures did the government employ once the epidemic established itself? With the resources and warnings at hand, why did Fiji’s experience of the influenza not reflect avoidance of disease more closely that Tonga’s four to eight percent mortality?

The influenza epidemic of 1918 struck a Fiji at its most vulnerable. The Colonial government was in the midst of replacing its chief executive (who left in October) and had devoted much of its energies to the Imperial war effort. Local government had been thrown into a chaotic state by the elimination of the Native Affairs Department in 1916. The war drove inflation that left both Fijians and Indo-Fijians with less financial resilience to see them through long convalescent periods. Companies benefitting from increased trade were opposed to any quarantine due to

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⁶ Deryck Scarr, Fiji: A Short History (Brigham Young Univ Inst Polynesian, 1985), 118.
⁷ Collier, The Plague of the Spanish Lady, 259.
⁸ Scarr, Fiji, 118.
potential negative impact on shipping, and the Colonial government was reliant on 
trade revenues to function. Influenza of a mild form was already present on the 
islands in late 1918, leading the medical officers present to be both fatalistic about 
further influenza exposure from foreign vessels and dismissive of the potential 
virulence of the approaching plague. When these officers realized the problem they 
faced, they had a larger and more ethnically and linguistically diverse population to 
reach than any of Fiji’s near neighbors. The Fijians were just forty years from a 
measles epidemic that killed perhaps a quarter to a third of the population and 
destroyed many Fijian’s faith in western medicine, as well as causing massive social 
dislocation. The second wave of the 1918 influenza found a moment of social 
vulnerability in the colony. Fiji’s mortality was a matter of timing.

Fiji is the odd man out in this study. In 1918 Fiji was the centre of British 
influence in Western Polynesia. The largest, the most varied, the wealthiest of any 
state in the area, Fiji was the jewel in the crown of the Western Pacific High 
Commission (WPHC) and the site of its headquarters. While the Fijian tribes in the 
hills were deeply traditional, portions of the coastal population was becoming 
relatively cosmopolitan as the First World War ground to a close. Viti Levu was 
certainly not the Riviera, but the islands were culturally miles away from the 
untouched beaches of ‘Eua in Tonga or Western Samoan Savai‘i. Fiji was the most 
developed, most resource laden, and most important colony in the region, and was 
firmly in British hands.

Fiji’s population in the early 1900s was both larger and more diverse than the 
Samoas or Tonga. In 1918 Fiji hosted the largest proportion of residents from outside 
the Pacific islands of any of the colonial territories under study, with a significant 
minority of the population either originating in or directly descended from workers 
recruited in the Indian subcontinent. The 1911 census of Fiji shows a population of
139,541 persons with 87,096 (62%) being indigenous Fijians, 40,286 (29%) persons of Indian descent, 3707 (3%) Europeans, and the remaining 8,452 (6%) of varied nationality including other Pacific Islanders and those of blended or half caste (mixed-ethnicity parentage) status. The estimated population on the 31st of December, 1917 demonstrated significant growth over this period of British rule. Fijian numbers stood at 91,013, or fifty-five percent of the population; Indo-Fijians at 61,153 or thirty-seven percent, Europeans at 4,824, or three percent, Polynesians at 4,723, or three percent; with the remainder half-castes, Chinese, and others for a total of 165,991. This demonstrates an estimated population growth of nineteen percent in six years, a phenomenal pace. Although indentured workers from the Indian subcontinent ceased to be imported in 1916, it also reflects the impact of these workers settling in the colony, climbing from twenty-nine to thirty-seven percent of the population over six years. The total population of Fiji was much larger than that of Tonga or either Samoan state in 1918 (Western Samoa: 38,302, Tonga: roughly 23,000, American Samoa: roughly 8,000).

Fiji is by far the physically largest of the colonial territories under study; with a land mass of 18,274 square kilometers, versus 2,831 km² for Samoa, 747 km² for Tonga, and 199 km² for American Samoa. Two large islands dominate the group with Viti Levu alone covering more than 10,000 km² (almost three times the rest of Western Polynesia) and Vanua Levu more than 5,000 km². The next largest island in the archipelago is Taveuni at 435 km². The state is a large archipelago of 332 islands

11 Registrar General, Fiji, “Estimated Population on 31st December, 1917,” April 5, 1918, CSO M.P. 2932/18, National Archives of Fiji.
12 Rice, Black November, 200.
13 Kunitz, Disease and Social Diversity, appendix 3–1.
(more than 100 of which were inhabited in 1918) and more than 500 islets, including the more distant islands of Rotuma 400 km to the north and Ceva-i-Ra 450 km to the southwest. The two largest islands are mountainous, with peaks rising as high as 1300 meters and dense jungle along their slopes. Fertile plains ring their coastline where the cultivation and inhabitation are most dense.\textsuperscript{16} The highlands were and are sparsely populated relative to the coasts, with strong cultural differences between the highland tribes and others. The largest towns in 1918, Suva and Levuka, occupy Viti Levu and the nearby island of Ovalau respectively.

Perhaps most significantly for the purposes of this work, as the seat of British power in the region Fiji experienced a radically different set of political conditions than nearby Polynesian colonies. The British presence was entrenched in a way that the Tongan protectorate or the New Zealand occupying forces in Western Samoa had not achieved. Divided into districts under Colonial officers and the local chiefs and leaders they employed, Fiji saw more of the Empire than neighboring groups. In turn, the Empire saw more of value in Fiji. Resources brought trade, trade brought economic interests, and economic interests demand political protection. Unlike Tonga or Western Samoa, Britain was both directly responsible for Fiji as part of the Empire and locally sufficiently well-equipped to act on these responsibilities, or at least that was the assumption.

These variations from other potential case studies make Fiji an essential comparative subject when describing the course of regional responses to the 1918-1920 pandemic. Authorities attempting to control the spread of influenza in Tonga or the Samoas had two populations to which they addressed efforts, organized education, and tailored approaches. These measures targeted the native Polynesians in each of the island groups, but education and instruction of the foreign (generally

\textsuperscript{16} McArthur, \textit{Island Populations of the Pacific}, 1.
European) residents was attempted as well. In contrast, Fiji had at least three main ethnic groups to consider, and the two largest were splintered into many smaller ethnicities. The workers from the subcontinent originated in many different regions and included Hindus, Muslims, and Sikhs. The native Fijians demonstrated divisions based upon traditional chieftainships, but with some Polynesian (Rotuman, Tongan) minorities and strong Tongan influence politically and culturally in the eastern portions of the archipelago. Facing political, linguistic, and cultural complexity, Fiji grappled with a greater challenge in any effort to control the spread of infectious disease.

**Fiji before the Epidemic**

To understand the attempts of Fijian authorities to control the outbreak of epidemic influenza it is helpful to review post-European contact Fijian history and to understand the conditions and structures on the islands in the first days of November 1918. This will inform the discussion to follow. For purposes of this study, the term “Fijians” will be used to represent the ethnic groups already inhabiting Fiji at the time of European contact. “Indo-Fijians” are those workers brought from the Indian subcontinent as well as their families and descendants. “Europeans” are Caucasian individuals from Europe, Australia, New Zealand, and the Americas resident in Fiji.

While Fiji belongs to the geographic unit termed Melanesia, anthropologically the issue is more confused. The indigenous Fijian population physically tends toward Melanesian traits with an admixture of Polynesian groups, yet culturally many Polynesian elements dominate. The Fijian tradition of family descent of chiefly titles is an example; in those Melanesian societies which have such titles they are based more upon merit than descent.
If we accept that Fiji is Melanesian, the archipelago occupies the large, stratified, and complex end of the Melanesian social spectrum. While many small, locally focused chiefly communities existed in near isolation in the highlands of Viti Levu and Vanua Levu, the majority of the population lived in coastal communities of these large islands or on the smaller islands. These groups occupied places in an unstable web of powerful states and less potent tributaries. The relationships and dominance patterns changed frequently and violently, at least during the time of the first European residents. Even with such volatility the years 1800-1875 saw several large, socially intricate chieftaincies dominating much of the archipelago.

(Map 2: Islands of Fiji)

The growth of these proto-kings required resources. Partially in pursuit of such wealth Fiji developed into a hub for a large trading network in the western Pacific. Trade connections existed between the Fiji archipelago and Samoa, Tonga, Niue, Rotuma (politically joined to Fiji in 1881), Tokelau, Tuvalu, Futuna, and ‘Uvea. Kin connections between chiefly families from the trade partners still exist today.  

European contact began in 1643 with Tasman transiting the island group. Cook sighted Vatoa in the Lau group in 1774 but failed to find anyone willing to communicate. In 1789 Bligh also passed the two large islands of the group in the tiny launch he occupied after the Bounty mutiny. Returning in 1782, he charted many of the smaller islands and part of Viti Levu. By the early nineteenth century the sandalwood and whaling trades sparked a brief bout of European commercialism within Fiji, repeated in the 1830s in pursuit of beche-de-mer (sea cucumber). Seeking a different crop amongst the local population, missionaries first arrived in 1835 heralding the permanent presence of Europeans in the islands.

The missionaries formed the core of the initial resident European population in Fiji. The Wesleyan mission in particular spread quickly and by 1840 affiliated ‘mission circuits’ covered most of the current state aside from the highland interior of Viti Levu, eastern Vanua Levu, and some of the Lau and Yasawa islands. Non-missionary settlers increased throughout the 1850s but the interior of Viti Levu saw no European explorers before 1865 and not until the aftermath of the 1874 Cession and the 1875 measles epidemic could Fiji be spoken of as a single political entity.

Some aspects of the Pacific colonial experience defined Fiji just as much as the more indirectly colonized neighbors. A small number of Europeans arrived, helped

19 Howe, Where the Waves Fall.
20 Scarr, Fiji, 9.
21 McArthur, Island Populations of the Pacific, 1.
22 Ibid., 2.
intensify the already present political chaos in order to further their own interests, and then appealed to the colonial powers for protection when local forces turned against them. The fact that Fiji held citizens of several colonial powers concurrently expanding in the Pacific added to the confusion.

Population levels at the time of consistent European contact (roughly 1800 C.E.) are not known with any certainty. Many and varied estimates for the archipelago have been put forward by missionaries and explorers. Wilkes, Commander of the United States Exploring Expedition, suggested 133,500 in 1840. In 1844 missionary John Hunt estimated 300,000. Reverend Walter Lawry in 1850 placed the number at 200,000. Regardless of the true number it is quite likely that Fiji held many more people in 1840 than in 1918 (165,000). The estimates above come from a period more than 50 years after the first recorded extended contacts with Europeans, and reflect the impact of the initial epidemics of European diseases. Given the respiratory epidemic of 1791, dysentery in 1800, and influenza in 1839, MacArthur suggests a decline in population in the 50 years following contact of between one quarter and one half of the population. It is entirely possible that in 1790 Fiji hosted a population of half a million individuals, more than three times the number present on the eve of the influenza of 1918.

The first half of the nineteenth century saw the movement of European religious, economic, and military interests into Fiji. In the early 1820s European traders settled on the small island of Ovalau, off the East coast of Viti Levu, and centered their activities in the village of Levuka. Already a seat of political power for the powerful Bau chiefdom, Levuka slowly grew into the focus of European activity in the archipelago and eventually into a unified Fiji’s first capital. By the 1840 arrival of the United States Exploring Expedition, Fiji hosted Christian missionaries of

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23 Ibid., 5.
several sects as well as the trading interests. Both Polynesian and European mission workers established permanent residence throughout the islands.

Other external players joined the fray as the century waned. Prince Enele Maʻafu of Tonga seized Lau and much of the eastern portion of the archipelago in 1847, cementing a long history of Tongan influence in these areas. Following the accidental burning (and deliberate looting) of the American Consul’s home in Levuka the US government became involved in local politics, demanding significant recompense from the chiefs of the area. No native power in Fiji had the resources to pay such a claim, and some American elements in Fiji used the unpaid claims as a cause to push for incorporation into Washington’s nascent Pacific empire. German (initially from Hamburg before the creation of the Imperial German state) trading interests established themselves at various points in the islands, extending a network which reached into Tonga, Samoa, and both Micronesia and Melanesia.

Ratu Seru Epenisa Cakobau (pronounced thakobau) claimed the chieftaincy of Bau in 1853 and also styled himself Tui Viti (High Chief of Fiji). Converting to Christianity, Ratu Cakobau (figure 2) moved over the next two decades to enforce his claim to the entirety of the archipelago. Despite the defeat of several local rebellions against his ambitions and his avoidance of a conflict with MaʻAfu in the east, the debts and claims against Fiji weighed heavily upon his efforts. With the arrival of the first British Consul, Thomas Pritchard, Ratu Cakobau offered cession of Fiji to Britain in exchange for the payment of outstanding debts. This offer would create a unified Fiji under British control (governed through Ratu Cakobau) and thus eliminate the debt load while ensuring British assistance in defeating Ratu Cakobau’s internal enemies. The actual proposal, made in 1858, offered the British crown direct ownership of not less than 200,000 acres of land in exchange for taking over the debt. After some study, the British government refused the cession, stating that Ratu
Cakobau did not possess the authority to make such an offer. Some authors, such as Phyllis Herda, suggest that in fact Britain was willing to annex Fiji at this time; they were simply waiting for a situation where they could take complete, direct control.

Despite this rebuff Ratu Cakobau continued to dominate Fijian politics. Working with other chiefly title holders in Fiji he created the Confederacy of Fijian

(Figure 2: Ratu Seru Epenisa Cakobau, date unknown)

Despite this rebuff Ratu Cakobau continued to dominate Fijian politics. Working with other chiefly title holders in Fiji he created the Confederacy of Fijian

24 Ibid., 7.
Chiefs in 1865. Under the Confederacy Fiji became a constitutional monarchy in 1871, with European settler support. Ratu Cakobau was named king but power was largely vested in a cabinet and legislature dominated by settlers, mainly colonial Australians.

Within a year the debt situation for the Fijian Government worsened to the point where the viability of the state was in question. Facing intrigue from both the European population and other forces within Fiji, including the Tongan presence in the eastern portion of the country, Ratu Cakobau’s options were limited. At this point resident British officials in Fiji again suggested cession. The British Colonial Office was approached once more, with Ratu Cakobau offering cession in exchange for debt relief.

John Bates Thurston led the negotiations for the Fijian government, acting as Premier of the Cakobau administration. Thurston, a British merchant sailor cast away on Fiji in 1865, became honorary British Consul in 1869 before joining forces with Cakobau. He negotiated with a contingent of settlers and two Commissioners sent from Great Britain, all who arrived already set upon cession. After review the original objections were judged no longer valid and the British agreed to terms. Fiji joined the British Empire on October 10, 1874. After Cession the Fijians kept a numerical majority and most of the land in the colony but government power rested with the British. In most economic sectors Europeans dominated. Deryck Scarr reports Ratu Cakobau’s summation as follows:

Need I say to you, we are under Great Britain because we were indolent, fond of drinking and sleeping. We thought the Tongans were a wise people, and so

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28 Ibid.
they are. They have done what we thought we could do also. They have a government of their own. We could not, because we were not united.29

Sir Arthur Gordon served as the first Governor of British Fiji. Upon his arrival he clearly stated his aims: “My sympathy for the colored races is strong, but my sympathy for my own race is stronger.”30 Gordon actually governed with great concern for the Fijian populace, but he served the British crown as a colonial officer and acted accordingly. Gordon also served as the first High Commissioner of the WPHC, based in Fiji and described more thoroughly later in this chapter.

Fiji did hold a unique place in the British Pacific. Due to the direct cession Fiji had no secondary level of colonial supervision (via Australia or New Zealand), instead being supervised directly from London. The Governor of Fiji, and the High Commissioner of the WPHC, reported directly to the Secretary of State for the Colonies.31 This gave Fiji a surprising amount of flexibility in interpreting policies, priorities and instructions. It also meant that obligations by Australia and New Zealand to share resources were more of a filial nature instead of parental.

Following Cession, the importation of Indian labor into Fiji represented the most significant social change before independence. Gordon’s deliberate policy of banning Fijian labor on the European-owned plantations in order to protect the people and their culture from the fate of the indigenous peoples of the Caribbean islands necessitated the import of outsiders. Positive experiences using Indian labor in other British possessions encouraged colonial administrators to look to South Asia to resolve the labour problem. Between 1879 and 1916 more than 60,000 people from the Indian subcontinent, mostly workers on girmit, or indenture agreements with the

30 Ibid., 5.
plantations, arrived in the islands. While 12,000 of these workers took the opportunity for free passage home after ten years residence, the remainder stayed and joined Fijian society, assimilating to varied extents. These Indo-Fijians received poor wages and generally lived in worse conditions than their Fijian neighbors. In 1890 one fifth of the laborers in the Rewa district received a daily wage lower than their prescribed cost of food on the plantation. They experienced exclusion from most aspects of both European and Fijian society. Yet the number who remained in the islands after their contracts expired suggested either an improved quality of life compared to home or insufficient resources for the journey.

(Figure 3: Crop rotation, Indian tenant farm, Vunisamaloa, ca. 1920s)

32 Scarr, Fiji, 98.
Despite handicaps the Indo-Fijian population established itself and found a niche. Leasing small farms producing sugar and some food crops (figure 3), the survivors of the *girmits* tended to cluster around the sugar mills and commercial centers. This movement into the cash economy, so different from the subsistence agriculture which dominated the Fijian village lifestyle, produced a divergent outcome when epidemic diseases disrupted commercial food distribution.

In 1918 Fiji served as the center of British colonial activities in the Western Pacific. The British Western Pacific Territories (BWPT, and later becoming the WPHC), organized in 1877, included the Cook Islands (from 1893-1900), modern Kiribati (Gilbert Islands), Tuvalu (Ellice Islands), Vanuatu (New Hebrides) where control was shared with France, Niue (Savage Island) from 1900-1901, Nauru (Pleasant Island), Pitcairn Island, Solomon Islands, Tokelau (Union Islands), Tonga (Friendly Islands), and a headquarters in Fiji. The organization of this colonial entity happened fast on the heels of the formal cession of Fiji to Britain in 1875. The chief colonial officer in the BWPT was the High Commissioner, who also served as the Governor of Fiji.\(^3^4\) The presence of the High Commission led to Fijians receiving more direct supervision in their affairs than many other colonized peoples within the BWPT. The British tradition of trusteeship and autonomy under local rulers dominated in the small island possessions.\(^3^5\) The size of Fiji, its cultural diversity, and presence of the relatively large colonial infrastructure needed for the BWPT’s operations led to a more centralized political structure.

Suva became the capital in place of Levuka in 1882. Rupert Brooke described Suva in 1914 as: “a large English town, with two banks, several churches, dental surgeons, a large gaol, auctioneers, bookmakers, two newspapers, and all the other

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Serfing as the economic center and main port of embarkation, most of the outside world passed through the filter of Suva before penetrating the interior of the archipelago (figure 4).

(Figure 4: People Gathering at the Wharf in Suva, 1900)

The Governor’s authority rested upon the Deed of Cession. The Governor /High Commissioner administered Fiji with the assistance and advice of a Legislative Council dominated by representatives of the European community. By 1918 this Council also welcomed two Fijian representatives and one Indo-Fijian. Otherwise, the British attempted to maintain the traditional structure of governance and to rule indirectly through these local elites, exemplified by the annual Great Council of Chiefs, an artifact of Gordon’s administration.

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36 Scarr, Fiji, 78.
To the degree deemed practical, the Gordon Administration accepted the now Colonial Secretary Thurston’s advice and left in place local chiefs. Large chiefdoms became provinces governed by Roko, frequently the traditional hereditary chiefs of the area.\textsuperscript{40} District Officials, Buli, filled the next rank and enacted the instructions of the provincial leaders. Buli generally held traditional rank in the communities they led. Native Stipendary magistrates and village heads served at the village level, once again generally men of traditional rank and status in the particular village. These officials, and other men of rank, would meet the Governor at an annual Great Council of Chiefs, the Bosevakaturaga. The Native Regulations Board, at first with oversight from Ratu Seru Epenisa Cakobau and Secretary Thurston, advised the Governor on Fijian issues.\textsuperscript{41} This structure survived through to 1916 with some changes, but the men of rank still served as the local government structure for the Fijian populace. European representatives governed and served the contract workers, Indo-Fijians, Europeans, and other non-indigenous groups as well as handling colony-wide affairs.

In 1916 the Fijian government acted upon the recommendation of the British Secretary of State for the Colonies and abolished the Native Affairs Department, distributing its work between magistrates and European commissioners. This action was taken over the protests of the Roko, and the impacts reverberated in local government circles for years. Thus, at the time of the influenza pandemic the stability of the local government structure was in question.\textsuperscript{42}

The British Administration in Fiji also found itself in a state of flux in October 1918 with the departure of Western Pacific High Commissioner Sir Ernest ‘Bickham’

\textsuperscript{40} Peter France, The Charter of the Land : Custom and Colonization in Fiji / Peter France (Melbourne :: Oxford University Press, 1969), 107.
\textsuperscript{41} Scarr, The Majesty of Colour, a Life of Sir John Bates Thurston, 23.
\textsuperscript{42} West, Political Advancement in the South Pacific, 21.
Sweet-Escott on October 10th (44 years to the day since the Cession), ending a term of duty begun in July, 1912. Taking his place both as High Commissioner and Governor, Sir Cecil Hunter Rodwell left a fifteen year term as Imperial Secretary to the High Commission in South Africa. While Rodwell proved an efficient administrator, he had no time to learn the subtleties of Fijian politics before the epidemic would strike. Both on a local and a colony-wide level the end of October 1918 found government structures in the midst of significant change.

**Trade and Economics**

Fiji developed a traditional colonial economy, with production and export of raw materials dominating trade. Copra was the most valuable export until the 1900s, with bananas another major trade item. The rise of the Colonial Sugar Refining Company (CSR) vertically integrated the local sugar industry making it much more efficient. By the beginning of the twentieth century the CSR moved into a dominant place in external trade and drove a realignment of the local economy, with sugar towns such as Lautoka and Labasa growing to meet demand for processing and export infrastructure. In 1900 the CSR produced 87.5% of all sugar products in Fiji, exports of which brought in 65% of the colony’s income.

This explosion of sugar agriculture drove greater recruitment of Indian labor, leading to increasingly cramped and unhealthy conditions on plantations. The average mortality for Indian laborers in the fields of CSR matched that of Indians still on the subcontinent and exceeded that of Indian laborers in other British colonies such as Mauritius. Cramped housing also served as an incubator for disease, and

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43 Governor Cecil Rodwell, “Assumption of Duty by Mr. Rodwell as High Commissioner for Western Pacific,” October 10, 1918, Tonga, WPHC M.P. 183/18, University of Auckland, Western Pacific Archive.

44 Scarr, *Fiji*, 96.
many plantations developed their own medical systems to address illness in their labour.

In 1916 sugar exports accounted for 1,209,000 pounds sterling out of total export value of 1,426,000 pounds sterling.\(^{45}\) Imports in 1916 totaled 903,968 pounds value.\(^ {46}\) As a colony Fiji was running a trade surplus of more than 500,000 pounds sterling in 1916, a reminder of the colony’s value to the Empire.

Driven by such lucrative trading relationships Fiji developed an extensive series of links to the outside world. Passenger services included an interisland monthly service from Burns, Philp Co.; a fortnightly Australasian United Steam Navigation (AUSN) service for passengers and bananas from Suva to Sydney in the Levuka; the Union Steamship Company (USSCo) with the Tofua out of Sydney, the Atua from Melbourne, and the Talune and Navua from Auckland, all of which visited on a monthly schedule.\(^ {47}\) The Canadian-American Line steamers Niagara, Makura, and Marama visited monthly on their run from Vancouver to Sydney. The Canadian-Australasian Royal Mail Line offered a Vancouver to Suva monthly steamer. The USSCo lines also served to connect Fiji with Tonga, Samoa, and other nearby islands as needed. The CSR ran their own ship, the SS Fiona, to the refinery in Lautoka, sometimes also utilizing colliers returning to Australia for extra tonnage. Suva and the sugar port of Lautoka served most external trade from the islands. In 1913 (the last year before wartime censorship regarding ship movements came into effect) Fiji saw visits by 148 ships; 138 from British territories and 10 foreign.\(^ {48}\)

Internal trade supported a broader range of vessels and ports. Nadi, Ba, Savusavu, Lau, and Labasa all served the intra-state trade network. There were stops

\(^{45}\) The Inter-State Commission, “British and Australian Trade in the South Pacific,” 14. 
\(^{46}\) Ibid., 22. 
\(^{47}\) Scarr, Fiji, 118. 
\(^{48}\) The Inter-State Commission, “British and Australian Trade in the South Pacific,” 42–46.
on this inland route for AUSN steamers, but local ships such as the Fiji Shipping Company’s *Adi Keva* or the merchant J. M. Hedstrom’s *Tui Cakau* and *Tui Vulagi* dominated internal trade. Their visits occurred irregularly and the trade itself faced little oversight from colonial or local authorities. Such extensive and distributed port infrastructure was necessary. In 1918 few roads existed in Fiji; most trade and government moved by boat. Any potential quarantine would have to cast a wide net.

The First World War came to Fiji as it touched all British possessions. Suva served as a mustering point and logistical base for Australian/New Zealander action against German possessions in the Pacific during 1914. European residents of Fiji sent the First Fiji Contingent of 57 men into action in 1915, followed by the Second Contingent in 1916. Casualties amongst these all-European groups, as with most infantry units on the European fronts, were high. Of the First Fiji Contingent nine were killed and 31 injured in the battles of the Somme. The British armed forces turned away Fijians but Ratu Sukuna found acceptance, a wound, and military honors as a volunteer in the French Foreign Legion. Other Fijians served in the Maori volunteer units out of New Zealand and in 1917 the British accepted a contingent of 100 Fijian workers for dock duty at Calais. The only combat seen in Fiji itself consisted of the seizure of a launch from the German raider *Seeadler* whose crew was searching for a new ship after grounding theirs in the Society Islands. Combat troops were not the only contribution made to the war effort. Many of the best physicians and administrators joined the military. Skilled professional doctors and bureaucrats became scarce.

The war also altered Fiji’s economics, most significantly through the seizure of German businesses and the overall reduction in global trade. With the destruction in

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49 Scarr, *Fiji*, 119.
50 Ibid., 120.
Flanders’ beet fields the price of Fijian sugar rose, producing larger profits for many involved in the trade. While workers’ wages surged, they did not match the price rises in other commodities driven by wartime shortages. Thus the average Indo-Fijian emerged from the war less economically secure than they entered it. This relative reduction in wages led to diminishing reserves of necessities such as staple foods. This absence would lead to fatal complications during the impending epidemic. Reliant on their subsistence horticulture, Fijians were generally less tied to the cash economy; therefore for them the war had a less significant impact.

By November 1918 Fiji had been British for more than a generation. The plantation production of sugar, supplemented with copra, generated most revenues for the colony through levies on trade and shipping. Power resided in the colonial administration while hereditary chiefs exercised authority locally and addressed traditional issues. The Indo-Fijians served as laborers and low-level merchants. Suva and Levuka (and to a lesser degree Nadi) received most external trade aside from the privately-run sugar ports such as Lautoka. By Pacific island measures, significant infrastructure existed on the archipelago, though limited to the trade hubs. Outside of these areas Fijians lived in traditional villages and Indo-Fijians on plantations or small farmsteads. The war brought in additional investment and spurred infrastructure development. Increased exposure over time to foreign pathogens meant devastating epidemics occurred more rarely than in the immediate post-contact period. With the approach of peace in Europe, and of the steamship Talune, Fiji’s social fragility rarely surfaced. Fiji presented a stable and increasingly affluent face.

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51 Ibid., 121.
Medical History and Infrastructure

Trade drove the creation of an extensive transport and processing infrastructure, and a large government presence by the standards of the Pacific islands, but in other ways Fiji was very much an undeveloped colony. In matters medical the plantations cared for their workers (to varying degrees) and the colonial Medical Officers would address problems amongst the European population. Native Medical Practitioners served some villages starting early in the 1900’s. Access to care varied but for many Fijians medicine was little different from pre-cession times. What care was available in the villages was based around traditional methods and predicated on historical experience of disease.

Early visitors to Fiji reported on local traditions around infectious diseases. After a wound from a sharp object, Fijians were strongly advised to not bathe, wash the hair, or cut nails or hair for fear of tetanus. To cool fevers ill individuals lay in streams or their families would bathe them in cool water, and while temporarily comforting this habit frequently led to deterioration in the condition of the stricken. Disease was often seen as a result of disobedience to cultural norms or the supernatural actions of another.

Some surgical interventions were practiced. Fijian healers used coka losi to treat a range of illnesses in men. This procedure involved the placement of a reed with a thread attached into the urethra and an incision in the perineum to allow access to the thread. Once accessed the thread would be worked back and forth to encourage bleeding. While having no obvious therapeutic value Fijians attributed many cures to the use of the procedure. In this the traditional remedies shared traits

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52 Miles, Infectious Diseases: Colonizing the Pacific?, 9.
with many long-standing elements of western medicine such as bleeding, cupping, and the use of heated coins.

While Fiji in the era before European contact demonstrated no experience of most diseases endemic to Eurasia, infectious illness occurred on the islands. Reports of leprosy and yaws (a disease related to syphilis) emerged with the first European settlers.⁵⁴ Both of these illnesses featured in local oral histories, suggesting that they infected Fijians long before European exploration. The United States Exploring Expedition, which visited Fiji in 1840, reported yaws as present in the native population but found no sign of the venereal diseases soon to become common in any port welcoming mariners.⁵⁵ According to Hercus filariasis also appeared in early discussions of Polynesian health issues and he argued for its endemic nature in Fiji.⁵⁶

Fiji shared the experience of most societies in the Pacific in that contact with outsiders brought new continental diseases against which the indigenous peoples held little resistance. Epidemics of one type or another raged through Fiji in the late 1700s and the 1800s, tempered somewhat by the limited contact between the perpetually warring Fijian kingdoms scattered across the archipelago. As in so much of the Pacific, the advent of European contact ushered in a period of serious population decline and social disruption.

The introduction of previously unknown pathogens kept pace with increasing contacts involving traders, missionaries, and explorers. Dysentery first appeared following an American shipwreck, the Argo, in 1800 (some evidence points to 1803).⁵⁷ Dr. W.H. McDonald reported on an oral tradition stating: “before the dysentery came, every village was crowded with men: there was no space among them so

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⁵⁴ McDonald, “Diseases in Fiji; Presidential Address 1959,” 63–64.
⁵⁵ Miles, Infectious Diseases: Colonizing the Pacific?, 54.
⁵⁷ Scarr, Fiji, 9.
crowded were they. From that time our villages began to empty.” Measles arrived at least as early as 1875. Between 1884 and 1891 Fijians suffered through three epidemics of pertussis, one of meningitis, one of dengue fever, and one of influenza. Measles recurred in 1903, finally penetrating the far Polynesian island of Rotuma in 1911 where one quarter of the population died. Hercus listed poliomyelitis, mumps, rubella, dengue, infectious hepatitis, varicella, and intestinal worms as additional infections imported by Europeans or Indian laborers into Fiji and neighboring islands.

Influenza visited Fiji repeatedly before the 1918 pandemic. An outbreak described as ‘malignant and obstinate’ swept the islands in 1839. In 1885-6 influenza, combined with dengue and dysentery, caused more than 1,000 deaths. The year 1891 witnessed the return of influenza, accompanied this time by pertussis, for a further 1,500 deaths. Introduced by a passenger from Melbourne, it also infected Samoa and Rotuma. After 1891 colonial medical staff described influenza as endemic to Fiji, appearing regularly but not in epidemic form, without producing significant mortality. Colonial medical officers and the inhabitants of Fiji thus recognized that influenza had become endemic to the islands but the outbreaks were generally of a mild type. In 1917, the year before the pandemic under study, Fiji reported 1,211 hospitalizations for influenza.

Simple avoidance became a common strategy to deal with the rise of new disease in Fiji. During the 1875 measles a local teacher described conditions in the

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58 McDonald, “Diseases in Fiji; Presidential Address 1959,” 66.
59 Ibid., 67–68.
61 McArthur, Island Populations of the Pacific, 8.
62 Chief Medical Officer, Fiji, “Epidemic Influenza,” April 27, 1893, C.P. 14/1893, National Archives of Fiji.
63 McDonald, “Diseases in Fiji; Presidential Address 1959,” 67.
64 Chief Medical Officer, Fiji, “Report on Medical Department for the Year 1917,” August 16, 1918, 6, CSO M.P. 5634/18, National Archives of Fiji.
villages: “The healthy congregate together; the sick are left to themselves for very fear.” As many Fijians attributed the measles infection to deliberate intent on the part of the Europeans they refused western medicine or offers of hospitalization, a reluctance they carried forward into the next century.

Traditional Fijian views of disease and ill-health involved the intercession of spirits and the breaking of taboos on the part of the sufferer. This belief in behavior influencing disease was common throughout Polynesia and helped to encourage the fatalism towards disease within the Fijian population that so puzzled European administrators and settlers. As early as the first dysentery outbreak there were reports of Fijians fleeing infected villages upon presentation of illness. Suspicion of disease as a hostile act by others colored Fijian views of the epidemics, and contributed to their unwillingness to follow European medical advice or avail themselves of what European medical infrastructure existed on the islands. Individuals in hospital would receive guards to prevent them from leaving at the first opportunity.

Apathy in the face of cultural calamity and the belief in disease as a supernatural attack features in administrative assessments. Alexander Barrack of Savusavu reported during the 1875 measles that the Fijians “...likewise seem quite indifferent about one another, and unless some white person is near, neglect the sick, and sit and look at them dying for want of a drink or a bit of food.” Other contemporaneous reports detail finding sick families left behind in otherwise abandoned villages. These are the reactions of a culture encountering this type of rapid, lethal epidemic disease for the first time. Diseases endemic before European...
contact moved slowly and did not generally cause rapid mortality. Fijians in the period 1800-1900 underwent wrenching cultural change and horrific depopulation, in large part from the disease introduced by the new visitors. Fear, apathy, avoidance, fatalism, mercy killings, suspicion of the treatments offered by those that brought the illness; all these are understandable in the context of the times. Yet the Europeans in Fiji, so accustomed to such diseases at home, looked upon the Fijian reactions as confirmation of their barbarous and unfit natures. This lack of mutual understanding made attempts at amelioration of these epidemics significantly more difficult.

The single greatest disease calamity to strike Fiji during the historic era was the measles epidemic of 1875. Over the course of three months, between one quarter and one third of the Fijian population died. Entire villages disappeared and many of the most influential chiefs lost their lives at a critical political juncture, shortly after the fall of the Cakobau regime and the Cession. After the epidemic waned the survivors emerged weakened, prone to further illness, and depressed. When looking for answers many saw the hand of sorcery or deliberate genocide by the new colonial rulers. This helped to trigger rebellion and internecine warfare, further weakening the local political structure at an already vulnerable time.69 These outcomes helped shape the Fijian experience of the 1918 influenza pandemic.

The 1875 measles epidemic demonstrated the vulnerabilities of Fijian ports. When the Dido, bearing the infection, reached Fiji the regulatory agencies in local ports consisted of the customs and tariffs agents of the Ratu Cakobau government and their immediate successors. No medical inspections of ships’ crews took place. Ships came and went according to the whim of their captains. Ports such as Levuka became well known for the tradition of locals boating out to meet all incoming ships;

69 Ibid., 1.
clambering aboard to instigate trade, check news, and generally greet the newcomers. The three years of the independent Cakobau government saw no effort to change these practices, and the Provisional Government in 1875 had not been in place a sufficient period in which to make changes. Given the absence of epidemic disease at the time of the Cession the new government’s failure to place quarantine regulation at the top of their agenda evokes little surprise. The first evidence of codified and enforced quarantine regulations appeared in February 1875, during the height of the measles epidemic, when the New South Wales Quarantine Regulations were adopted. Despite such legislation the tradition of local residents of the ports boarding incoming vessels continued until physically prevented by port authorities.70

Upon the creation of the British Administration of Fiji in late 1874 Dr. John Cruickshank (R. N., Retired) received a provisional appointment to the new position of Chief Medical Officer (CMO) for Fiji. When the measles struck he had held the job for little over two months and had no staff or infrastructure in place to begin quarantine or other disease control efforts. He faced a situation with few palatable options and little personal power when the H. M. S. Dido entered Levuka harbor on the 12th of January.

The Dido bore the former King Cakobau and his two sons back from Australia, returning from a visit commemorating the cession of Fiji to the British. Unfortunately it also coincided with a viciously virulent measles outbreak in Eastern Australia. Never having been exposed to measles previously, Ratu Cakobau became ill in Sydney, received treatment and recovered slowly. His sons fell ill on the return voyage aboard the Dido, and their recovery began upon their arrival at Levuka, where a large crowd welcomed them. By a deadly coincidence a gathering of the major chiefs and hill tribes of Viti Levu awaited the Administrator of Fiji in Navuso,

70 Ibid., 4.
a meeting he planned to attend after welcoming back Ratu Cakobau. Given measles’ incubation period of nine to twelve days, and infectious period of four to nine days, every exposed visitor to this conference had adequate time to finish their business and return home before falling ill. Even the most remote parts of the colony were concurrently infected.

The fact that Ratu Cakobau and his sons survived their infections demonstrates that Fijians, with careful nursing, could endure the measles. In this case European medical staff provided care, working from a medical tradition with a long history and extensive experience in addressing such illness. Fijians without access to such care and information found survival much more difficult.

Upon arrival in Levuka Dido flew no yellow flag to indicate illness on board. Boarding occurred immediately, led by port workers and Administrator Edgar Leopold Layard, who held responsibility for direct control of the Fijian colonial structure under the aegis of Gordon, the Governor and High Commissioner of the BWPT. Layard was accompanied by J.B. Thurston, the Colonial Secretary. The ship’s doctor informed the party that all Fijians aboard were sick with or recovering from the measles, but that their convalescence progressed well. Layard asked about keeping the ill on board and received an answer that this was not possible for the chiefs. No other discussion of isolation, quarantine, or local warning appears in the reports. While this discussion took place the Fijian crew of the government boat boarded the ship. Shore boats began to come aside and boats from Dido received permission to go ashore. Within ten minutes Ratu Cakobau and his sons left the ship.

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For the next two weeks Cakobau, still recovering, received parties of well-wishers from throughout Fiji, who then returned to their homes bearing the contagion. The leaders of the hill tribes of Viti Levu, having attempted little commerce with the coastal people and thus avoided the worst of previous epidemics, awaited the arrival of the *Dido* (bearing Administrator Layard) at their meeting scheduled shortly after Ratu Cakobau’s homecoming. This meeting, including 69 chiefs not present at the original Cession,73 occurred to encourage the traditionally recalcitrant hill tribes to submit to the new government. Cakobau’s oldest son, still recuperating, addressed the meeting hoping to convince the gathered leaders of the need for cooperation: “Now under the Queen’s rule we, with the exception of one little cloud, have a clear and open sky. You are that little cloud, and that little cloud must clear itself away.”74

The meeting served as an entry point for the epidemic into the isolated interior peoples. Upon dropping anchor the ratings from the ship, many still convalescing from measles themselves, mingled freely with the gathering. At the conclusion of the meeting those attending proceeded to carry measles into the hills. Within the next two weeks two more ships arrived from Sydney, both showing measles infections aboard. No quarantine or isolation measures met either at Levuka. All 69 chiefs who attended the meeting died in the subsequent epidemic. The hill tribes saw the infection as a deliberate ploy and resumed warfare against the coast and the new government. Lacking their leaders and facing British weapons the resistance in the hills of Viti Levu fell after a final series of assaults in 1876.75

By mid-February measles spread throughout the archipelago. On the 25th of February the colonial government adopted quarantine rules, based upon those of

73 Scarr, *Fiji*, 75.
75 Scarr, *Fiji*, 76.
New South Wales, with an addendum that enforcement would be absolute. The Harbor Master began meeting all ships at the reef opening for Levuka (then the dominant port for foreign trade in Fiji, soon to be eclipsed by Suva) in order to assess conditions aboard. No private ships could approach the arriving vessel until after the newcomer obtained such clearance. Unfortunately the imposition of these rules, potentially effective if properly timed, occurred once the disease already raged throughout Fiji. When considering internal quarantine Secretary Thurston wrote: “People talk of isolation; they might as well talk of setting a barricade against the east wind.”\textsuperscript{76} External quarantine became moot as well. As the disease coursed throughout Fiji the outbreak shut down the harbor in Sydney, the main foci of infection to the rest of the ‘British Pacific’. No further Australian ship would arrive at Levuka until late May.

The social measures for disease control included the conversion of public buildings into hospitals, urban areas divided into geographic zones of responsibility for volunteers, and simple disease treatment instructions printed and distributed in Fijian and Hindustani. The weather did not cooperate, with six weeks of constant rain during the height of the epidemic. The weather and the poor food, lack of sanitation, and in many cases, presence of unburied bodies led to outbreaks of dysentery and pneumonia. These produced greater mortality than the primary measles.\textsuperscript{77} Voluntary companies worked in European areas; records carry no mention of such actions in Fijian regions.

Given the situation Fijian reactions are understandable. Despair and depression, as well as the Fijian assumption of the deliberate infection of Cakobau

\textsuperscript{76} Derrick, “1875: Fiji’s Darkest Hour--An Account of the Measles Epidemic of 1875,” 7.
\textsuperscript{77} Ibid., 10.
and the introduction of the disease, feature repeatedly in the stories of witnesses. In those locations with European medical facilities many Fijians refused to be treated, fearing for their safety. Mass graves and latrines for those with dysentery (a common secondary infection during the epidemic) appeared in developed areas, but the more isolated islands coped with an unknown series of diseases with no resources and scant information. Distrust and resistance met recommendations from the embryonic central government.

The final tally showed at least 35,000 dead out of a total population of roughly 150,000. The advent of European rule thus coincided with the death of a quarter of the population and a very high proportion of native political leaders and their heirs. The distrust engendered, and the inability of Europeans to understand what they saw as an apathetic, child-like response in a people who had never faced such a disease event, poisoned relations between the two communities. European medicine and methods did not prove themselves. Quarantine application occurred too late, despite the risk of potential infection. By the time officials took measures the period of prevention passed and the government faced a crisis of treatment and amelioration. Father Rougier summed up the Fijian experience of European disease:

After fifty years of contact with civilization, the physique of the Fijian, naturally robust, has become sickly. (W)ith the arrival of sailing vessels and steamers the door was opened to all the disease germs of the Old World. The dismayed Fijian sinks beneath the invasion of a thousand different diseases for which he is not prepared. He always clings to his old methods and medicines and prefers to die, rather than make use of our European remedies against European distempers....

The 1875 measles is merely the most dramatic example of the range of illnesses that penetrated the archipelago by ship after European contact. Because the

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78 Ibid.
79 Ibid., 1.
80 McDonald, “Diseases in Fiji; Presidential Address 1959,” 72.
danger came from a known direction, those seeking to prevent recurrence of disease looked to quarantine for assistance. While the first attempts at quarantine in Fiji during the colonial period began during the 1875 measles, Sir William MacGregor’s arrival as the colony’s first CMO several months later saw the first organized system put in place.81 Horrified by the after-effects of the measles and dysentery epidemics, MacGregor promulgated rules for all ports in Fiji and attempted to have staff appointed to each major trading site. The legislation passed but sufficient funds were never appropriated to hire physicians to enforce the quarantine, which likely significantly reduced its efficacy.

Opposition to these efforts came from trading groups and their allies amongst colonial officials and continued throughout MacGregor’s tenure. In 1879 Sir Robert Herbert, Permanent Under-Secretary for the Colonies, ascribed this problem to the prevalence of European traders who: “for a few shillings profit would readily risk the extermination of thousands by disease.”82 The costs of prevention and quarantine would inevitably eat into already tenuous profit margins. Traders therefore searched for ways around any efforts at quarantine.

When reviewing the 1891 influenza epidemic two years after the event the CMO of Fiji argued that commercial considerations must affect every question of quarantine, that Fiji did not have the means for an effective quarantine against influenza, and that no other countries were attempting it. He admitted that quarantine might have stopped the introduction of disease, but that quarantine would have had an intolerable impact on Fiji’s food supply.83 Not only would

82 Ibid., 28.
83 Chief Medical Officer, Fiji, “Epidemic Influenza,” 8.
quarantine be difficult to implement and damaging to trade, but it could lead to famine.

Despite opposition, quarantine imposition occurred successfully in Fiji pre-1918, most notably for smallpox. According to the WHO:

Although measles was brought to Fiji in 1875 and killed about 25% of the indigenous population, smallpox never occurred there, which was surprising in view of the large introductions of laborers and their families from India. Nevertheless, it was the fear of the introduction of smallpox that led in the 1880s to the training of young Fijians as vaccinators, and ultimately to the establishment of the Fiji Medical School.84

When in 1905 a steamer appeared with laborers from Madras, of which nine showed a disease similar to smallpox, the ship incurred immediate quarantine and the isolation of cases at Makuluva, a small island outside of Suva Harbor later used as a prison. All cases and contacts received containment orders here, and within a fortnight six new cases occurred.85 While this illness turned out to be varicella (chickenpox) rather than variolla (smallpox), the infrastructure for successful quarantine clearly existed. The incubation period for smallpox is roughly 12 days from infection to display of first symptoms, followed by a seven to ten day period of infectiousness. Therefore quarantine efforts for smallpox required detention for at least a fortnight after arrival, significantly longer than the 48-96 hours needed for influenza detection.

Plague (Yersinia Pestis) also concerned authorities, especially after outbreaks during 1899 in Honolulu and 1900 in Sydney and New Zealand. To prevent the spread of plague-carrying fleas from ships entering Fiji no vessels docked near the wharf, and the lighters that served them further out in the harbor went through

85 McDonald, “Diseases in Fiji; Presidential Address 1959,” 70.
extensive fumigation. Import bans of plague-susceptible animals or fodder for such were enacted. Rat killing and village/town clean-up initiatives began. Isolation camps sprang up in case of an outbreak, including the facility on Makuluva.\textsuperscript{86} All of these measures withered as the danger abated and resumed when trading partners or South Asian ports would experience a recrudescence.

Both of these illnesses were better understood, and seen as greater threats, than pandemic influenza. Given the understanding at the time of the cause of each, their exclusion was more easily accomplished and more actively sought. Influenza was neither confidently identified to a source organism nor enough of a constant threat to make a broad exclusionary policy worthwhile.

Quarantine was not the only medical tool available at the time, and some efforts were made in multiple areas to improve the health of the new colony. Efforts were stymied during MacGregor’s time in Fiji because of severe shortages of staff and the same quality issues that plagued much of the Pacific medical establishment. In 1875 Fiji hosted four colonial doctors. By 1883 this had risen to eight, to drop back to four a year later.\textsuperscript{87} They were responsible for a population of over 100,000 spread over 300 islands. These physicians, and the few private doctors extant, frequently represented the least capable of their profession, at a time when doctor’s credentials were not standardized and meant little. Even so, MacGregor attempted to improve the quality of the local medical care by promulgating rules forbidding the hire of anyone as a doctor, apothecary, or dentist who did not hold verifiable qualifications.

In the 1880’s the Fijian government, at the urging of MacGregor, began the training of Native Practitioners (NP) at a school which in 1929 developed into the Fiji

\textsuperscript{86} Ibid.
Medical College (figure 5).\textsuperscript{88} Despite rigorous, if limited, training these workers were considered ancillary staff rather than full physicians (graduates were recognized as physicians after the class of 1963). Their willingness to patrol distant, rural areas and work in hub hospitals served to expand the reach of the medical infrastructure on Fiji. While not physicians, the NP acted as assistants and proxies for the few MDs present on the islands. In 1918 Fiji employed forty-four NPs, mostly in very rural sites. Eight of these died during the epidemic.\textsuperscript{89}

(Figure 5: First graduating class of the Central Medical School of Fiji, 1888\textsuperscript{90})

\textsuperscript{89} McDonald, “Diseases in Fiji; Presidential Address 1959,” 68.
By 1900 the Fiji Board of Health had promulgated rules allowing for the declaration of a disease as infectious and notifiable. Not only did such declaration require that any cases be reported to the Board, it allowed for the isolation of such cases, disinfection of possessions, closure of premises, and other steps as needed to counter the disease.\(^91\) The Regulations of 1915 listed notifiable diseases as: “cholera, plague, yellow fever, small pox, diphtheria, typhoid fever, croup, puerperal fever, dysentery, pulmonary tuberculosis, measles, mumps, whooping cough and any other disease which the Governor may see fit…”\(^92\)

As the colony became wealthier and more important within the Empire the medical system developed apace. The Fijian medical infrastructure in 1918 included eighteen medical districts, each with their own District Medical Officer (DMO).\(^93\) Combined with the Chief Medical Officer, the Senior Medical Officer (SMO), the Indian sub-assistant Surgeon, and the Medical Superintendent of the Leper Asylum this gave the Fijian government 21 doctors under its aegis, at full complement. Three of these worked in Suva, as well as a private practitioner.\(^94\) Three hospitals were run by the CSR; built, staffed, and maintained for their workers, all in the Labasa Medical District.\(^95\) Other sugar companies staffed independent hospitals as well, notably the Vancouver-Fiji Sugar facility in Tamanua.\(^96\) The Medical Department served to advise a Board of Health charged with the welfare of the colony and made up of the CMO, the Inspector-General of Constabulary, the Commissioner of Works, the

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\(^91\) A Montgomerie, “Public Health (Regulations by the Board of Health Respecting Infectious Disease),” August 9, 1900, C.P. 25/1900, National Archives of Fiji.

\(^92\) D.R. Stewart, “Regulation of the Native Regulation Board, No. 1 of 1915,” June 30, 1915, C.P. 15/1915, National Archives of Fiji.


\(^94\) “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” June 27, 1919, 5, C.P. 30/19, National Archives of Fiji.

\(^95\) Chief Medical Officer, Fiji, “Report on Medical Department for the Year 1917,” 16.

\(^96\) Chief Medical Officer, Fiji, “Accounts of the Vancouver-Fiji Sugar Co. Ltd. for Services Rendered During the Influenza Epidemic,” February 22, 1919, CSO M.P. 1388/19, National Archives of Fiji.
Native Commissioner, and three other appointed members. Amongst other powers the Board was able to isolate or quarantine individuals and goods thought to be infectious.97

The presence of the more extensive medical infrastructure in Fiji explains, according to some respondents, the relatively mild experience of infectious disease in the years between the 1875 measles and the 1918 influenza. Ten years after the 1875 measles Colonial Surgeon Corney, described the measles situation:

….the cases always come to the knowledge of a District Medical Officer, are well looked after, and nourished by suitable food and drink administered by a European; and out of all those which have occurred in Fiji since the close of the 1875 epidemic, there has been only a single death, and that an infant.98

While epidemic measles tends to strike in roughly 20-30 year cycles (when enough people without immunity enter the population to support the rapid spread of the disease) the occurrence of only a single death among the cases over the intervening ten years suggests a functioning medical system and outreach network.

A medical infrastructure effective by local measures was in place on Fiji as the Talune approached that November. There was institutional knowledge of quarantine and its application, though strong forces inveighed against its application in a comprehensive manner. Influenza had been judged 27 years earlier to be not amenable to quarantine application. Yet the influenza of 1918 was different from that of 1891. Could the severity of this outbreak influence the medical leadership in Suva to reconsider their position?

98 Corney, “The Behaviour of Certain Epidemic Diseases in Natives of Polynesia, with Especial Reference to the Fiji Islands.” 85.
The Fijian Epidemic

News of the influenza pandemic appeared in general war reportage from Europe and around the world, and featured frequently in the Fiji Times and Herald (hereafter the Fiji Times) throughout the waning months of the year alongside copies of bulletins from infected countries regarding coping with the disease. The editorial staff later described their “anxiety weeks before it (the influenza) reached here.”99

The European administrators of Fiji knew of its approach, but the memories of the devastating events of 1875 faded with the passing of the survivors and the rotation of colonial staff. As elsewhere, the medical authorities on the ground generally refused to believe that influenza could be as deadly as these recent reports suggested. Thus no preparatory work took place, and no activation of the machinery of quarantine and medical response. Influenza remained a non-reportable disease, and the local Board of Health saw no reason to interrupt daily life and what small contributions Fiji was making to the continuing war effort because of rumors and newspaper reports.100 In the post-mortem analysis of the epidemic in Fiji the Senior Medical Officer described the view of the medical authorities:

The alternatives presented to us here were (1) a recognition that the prevention of its introduction was not practicably possible; (2) a more or less rigid quarantine, which would almost certainly fail to prevent its admission but would delay it, would put great difficulties in the way of trade and communication, but would absolve the health authorities from most of the possibilities of criticism; (3) an efficient quarantine; this quarantine would have to be against ships from Vancouver, Sydney, and probably Auckland.101

The fact that there is no explanation given as to why efficient quarantine was not chosen suggests that he saw it as so prima facie absurd as to need no justification.

100 “The Epidemic I,” Fiji Times and Herald (Suva, Fiji, January 3, 1919).
101 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 8.
Either the officer was seeking to explain his refusal to recognize the seriousness of
the threat in as positive a manner as possible, or we take him at his word and accept
that he did indeed see what was coming and simply saw no total benefit to the
imposition of quarantine methods.

Nearly two-thirds of colonial revenues came from exports. Some of these
exports, particularly fruit, could spoil if forced to wait in quarantine. Many
businesses would be unable to pay the wages and ship’s costs for vessels lying in
quarantine for a week during each export cycle, even for less perishable goods. The
economic impact would have been considerable.

After the fact the Fiji Times would ascribe the lack of action to economic
pressures:

We know what was the big obstacle before the Medical Department--it was
the fact that the merchants of the town, some of them, would probably think
they had a legitimate grievance against the Department for its over-plus of
care. Here it would be a case of the layman against the professional man, and
had the Medical Department nicely availed itself of the services of the press
instead of turning a cold shoulder towards those services, the public could
have easily been shown how necessary rigid quarantining was.\footnote{102}

It is not clear how much of this was after-the-fact moralizing and how much reflected
the true feelings of the economic elite in Fiji, but it is clear the colony relied upon its
exports for financial stability. In 1918 Fiji exported 63,000 tons of sugar and 19,000
tons of copra, which were certainly less perishable than fruit but still subject to
increased shipping costs due to quarantine delays. In combination with fruit the

\footnote{102 “The Epidemic; II.”}
custom fees and taxes on these exports brought in the vast majority of the 371,000 GBP revenue for the colony that year, against 342,000 GBP expenditure.¹⁰³

Logistics would have been an issue in any quarantine. Fiji in 1918 had three ports of entry for outside ships: Lautoka, Suva, and Levuka. Despite little shipping in its final month, 1918 saw a total of 180 ships from outside the archipelago visit at least one of these ports, or 15 per month. The total tonnage of these vessels was 336,954, and this does not include intra-colony trade ships.¹⁰⁴ Quarantining all of these vessels would have been a significant undertaking.

The obstacles to implementing a truly rigorous quarantine were significant and perhaps even insurmountable given the political confusion and economic climate of the time. The colonial administration, however, had made efforts to empower the CMO to act as needed to protect the population of Fiji. Quarantine regulations were in place during the last months of 1918. These been enacted in 1911 as Ordinance #22 in the Schedule of Regulations.

Several weaknesses in the regulations’ ability to cope with an influenza outbreak are apparent. As in most other locales at the time influenza did not feature as a reportable disease; making the duty of ship captains to report its presence, and the willingness of Health Officers to act upon such reports, questionable. The Health Officer did have the capability of declaring any disease as epidemic, and open to more severe measures, if he judged it to be necessary but the officers in Fiji seemed to discount the reports from overseas regarding the severity of the influenza and

¹⁰³ Governor Cecil Rodwell, “Address by His Excellency the Governor to the Legislative Council of Fiji, on 27th June, 1919,” June 27, 1919, C.P. 1/19, National Archives of Fiji.
refused initially to nominate it as a significant, epidemic illness. Influenza did not receive such a designation until November 16, 1918, 12 days after the arrival in Suva of the *Talune*.

Acknowledgment as an epidemic illness held no guarantees of effective action. The Quarantine Regulations of 1911; Section 6(a) allowed for quarantine under observation for only two days. The section went on to grant the Health Officer the power to allow passengers from an infected vessel to go home for a residential, ten-day surveillance. No provision existed in the Regulations beyond the vague statements of Medical Officers’ discretion to allow enforced isolation during this time. The home-based surveillance mandated in the Regulations frequently involved daily meetings with the Health Officer at his office, suggesting a definite freedom of movement.

Despite such obstacles the spread of influenza in Europe and North America throughout the latter half of 1918 brought calls for the application of quarantine in Suva harbor. The response of both Governor Hunter Rodwell and CMO Lynch reflected fatalism; they argued that if the ‘flu had reached Germany and the United States, how could they stop it from reaching Fiji? Yet by early October the *Fiji Times* had begun calling for the implementation of quarantine and planning for potential infection.

This approach colored an opportunity for final preparatory action with the arrival of the *Niagara*, thought by many to be the source of New Zealand’s influenza

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107 May, “An Ordinance to Consolidate and Amend the Law Relating to Public Health.”
109 “The Epidemic I.”
epidemic, out of Vancouver on the 9th of October. Upon docking in Suva the ship’s master reported 83 cases aboard of “Fever of Unknown origin but probably influenza”. She received permission to stay at the wharf for an extended time. The Port Health Officer (PHO) imposed quarantine and two passengers landed under surveillance. This allowed them the run of Suva, but fortunately neither passenger showed symptoms of influenza. No infection by the 1918 pandemic strain developed at this time. The lack of significant problems following this first exposure of Fiji to the dreaded new influenza likely strengthened the Medical Officers’ belief that the influenza of late 1918 did not represent an unusual type and did not warrant the disruption that quarantine would inevitably cause.

The next major passenger steamer to arrive was the USSCo. Talune. The Talune held berths for 175 passengers and fifty-six crew. Her normal route through the Pacific islands involved leaving New Zealand and calling at Fiji, Samoa, American Samoa, Tonga, and a return to Fiji before steaming for New Zealand. Departing New Zealand on October 30th, she left Auckland in the midst of an epidemic, and her passengers began to show signs of illness almost immediately. Two crewmembers had been left behind due to severe influenza infection.

The Talune arrived in Fiji on November 4th, sailing out of an Auckland known to the authorities in Fiji to harbor the pandemic strain of influenza. Five cases of influenza were declared by the Captain of the ship, John Mawson, upon arrival. Captain Mawson nonetheless signed the Bill of Health for his ship, stating there was no infectious disease aboard. After the fact he would testify that he was not aware

110 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919.”
111 McDonald, “Diseases in Fiji; Presidential Address 1959,” 69.
113 N. H Brewer, A Century of Style : Great Ships of the Union Line, 1875-1976 / N.H. Brewer (Wellington, NSW :: Reed, 1982), 211.
114 “The Epidemic I.”
that influenza was infectious. After inspection, the PHO consulted with Dr. Lynch and judged these cases to be of an ordinary type and mild. A mild form of influenza had been circulating around the archipelago for weeks, most likely the first wave of 1918, and the Medical Officers in Suva declared the cases aboard to be of similar type. Explaining that the Paris Convention regarding quarantine required the free movement of well individuals, the CMO refused any restrictions upon the passengers aside from daily visits to his office for ongoing assessment. The CMO signed the Bill of Health for the Talune. Cargo was disembarked freely. Passengers to Suva were allowed to leave the ship, albeit with instructions to present daily to the Medical Officer for inspections. Residents of Fiji from outside Suva were ordered to stay in a hotel in Suva and present for daily evaluations, as it was clear there was illness aboard. This ensured, though unintentionally, that they travelled extensively around the port in the first few days after landing. Passengers not for Suva and ship’s crew were restricted to the ship.

The next day the Talune left Suva, bound for Levuka. A similar process took place there, with local people meeting the boat in the harbour and passengers being allowed off and into town. Once again crew and passengers not for Levuka were held aboard, and once again the Captain and the PHO signed the Bill of Health despite such measures and the ill aboard ship. Bill of Health in hand, signed in

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116 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 3.
117 “Influenza in Fiji; What Is Being Done,” Fiji Times and Herald (Suva, Fiji, November 8, 1918).
119 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 3.
121 Ibid., 8.
both Suva and Levuka, not to mention Auckland, the Talune left port bound for Samoa.

Less than 24 hours after the Talune’s arrival in Suva the first arriving passenger developed influenza of a “severe and epidemic variety”, followed quickly by two others. The first notice in the Fiji Times came on November 6th, with a piece describing cases which were not believed to be Spanish Influenza and instead were described as the mild, New Zealand variety, suggesting that its author was not clear on the recent infection of New Zealand with the pandemic strain. Those ill were told to take aspirin and go to bed.122 Within the week cases were appearing daily in significant numbers. These cases were not linked to the Talune in government reports, however, leading to confusion as to the origin of the disease in Suva.123 It should be recalled that the period of incubation in the body is generally 48-72 hours, and individuals can be infectious for 24 hours before feeling the effects of the virus.

After the fact the lack of response by the health authorities would be the subject of much recrimination, not least by the Fiji Times. While some of these accusations are inevitable after any tragedy, there are interesting points raised which warrant review. A quick summation of Health Officer actions at this time is revealing. The CMO believed that infection of Fiji was inevitable. He argued that no reputable warnings occurred sufficient to cause extensive preparations in advance of the arrival of the new influenza variant. This point faced refutation by the editor of the Fiji Times who presented a record of just such stories.

Initial warnings were sounded in the Times in mid-September, with the reprint of articles discussing quarantine in the United States. The issue of September 26th

122 “Influenza in Suva,” Fiji Times and Herald (Suva, Fiji, November 6, 1918).
123 Chief Medical Officer Lynch, “Report on the Medical Department for the Year 1918,” June 27, 1919, 4, C.P. 31/19, National Archives of Fiji.
featured warnings about influenza in the Pacific coast cities of North America, and includes mention of presumed Fiji government preparations.\textsuperscript{124} By the arrival of the \textit{Niagara} on October 9\textsuperscript{th} the newspaper was pushing for direct action in Suva and the colony as a whole to prepare for infection. A week later, news appeared of the mortality from influenza in Capetown and other South African cities.\textsuperscript{125} The edition of October 24\textsuperscript{th} featured an editorial calling for the government to distribute information in all local languages on influenza and its treatment.\textsuperscript{126} On October 25 stories appeared regarding the outbreak of “Spanish Influenza” in Japan,\textsuperscript{127} and on the next day ominous reports emerged of the new influenza in Auckland. Calls began for further action as the disease would rapidly spread from New Zealand to Polynesia.\textsuperscript{128} With the arrival of the \textit{Talune} on November 4, these calls became demands for quarantine of those aboard.\textsuperscript{129}

The \textit{Times’} articles hardly served as the only warning of the approaching maelstrom. The overseas cable carried reports beginning in late September of the pandemic’s spread in Europe and North America. Further warnings issued upon arrival of the pandemic in South Africa, India, and New Zealand reached Fiji via administrative channels.\textsuperscript{130} Australia’s quarantine under John Howard Cumpston, Director of the Federal Quarantine Service, continued in full force at this point. By extension Australia also quarantined those Pacific dependencies controlled from Melbourne.

\textsuperscript{124} “Influenza Epidemic; September 26,” \textit{Fiji Times and Herald} (Suva, Fiji, September 26, 1918).
\textsuperscript{125} “The Influenza Scourge,” \textit{Fiji Times and Herald} (Suva, Fiji, October 17, 1918).
\textsuperscript{126} “The Epidemic III,” \textit{Fiji Times and Herald} (Suva, Fiji, January 6, 1918).
\textsuperscript{127} “Spanish Influenza; Still Spreading,” \textit{Fiji Times and Herald} (Suva, Fiji, October 25, 1918).
\textsuperscript{128} “Spanish Influenza; October 26,” \textit{Fiji Times and Herald} (Suva, Fiji, October 26, 1918).
\textsuperscript{129} “The Epidemic I.”
\textsuperscript{130} “Telegram Received from the Governor General of South Africa,” October 12, 1918, A2, 1919/452, Archives of Australia.
Even if the influenza turned out to be a mild form, as expected by the medical establishment in Fiji, its demonstrable infectiousness and extraordinary prevalence in infected countries still caused concern in those observing its approach. Still, Fiji already had influenza present in the colony and it did not demonstrate the vicious form of the newspaper reports. Some Fijian Medical Officers later explained their response by suggesting that the absence of pandemic descriptions in the professional medical journals led them to believe that the newspaper articles were exaggerated. Others could reference the actions of the medical establishment in 1891 as evidence of the pointlessness of quarantine efforts against ‘flu. All the hard evidence seemed to point at a mild outbreak, and if it was going to be worse there seemed little to be done.

The Medical Officers chose to await the arrival of the influenza before instigating most public health measures, in some cases out of a belief in the inevitability of infection, in others due to a misunderstanding of its severity. Actions to ameliorate the epidemic occurred as these assumptions proved false, but only after the epidemic ravaged Suva and spread throughout Fiji. No activation of preparations for a quarantine site or public isolation measures began.

Those preparatory efforts made proved minimal. The District Medical Officers (DMOs) received notification and a request to alert their Native Medical Practitioners. All health providers were given basic information regarding influenza and asked to watch for cases. To the Secretary of Native Affairs went the task of alerting the village chiefs. This was accomplished by way of a circular distributed to the Bulis to post publicly. The treatment was summed up in two phrases: ventilation

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131 DMO Taveuni, “Influenza in Taveuni District,” February 7, 1919, CSO M.P. 1671/19, National Archives of Fiji.
133 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 4.
and fortification. The fact that this circular was laced with terms such as ‘aperient’ raise questions of how much value the average English speaker would have found in this notice, much less the Fijian or Hindustani speaking population (figure 6). To Australia went a request for influenza vaccine, of which 40 doses arrived before the Talune. No further planning by the medical authorities is recorded.

Seven days after the first arrival of the Talune, and just as the influenza was beginning to present new cases daily, the government sanctioned events which drew individuals from everywhere in Fiji to Suva, allowing the disease to spread aggressively. The timing of these celebrations reflects an uncomfortable resonance with Fiji’s greatest modern disease tragedy, the measles epidemic of 1875. Just as the return of Cakobau inspired representatives from across Fiji to meet him and his infected sons, so the events of early November brought together Fijians and Europeans from across the archipelago. These were the Armistice celebrations. Influenza was still seen as merely a mild threat, despite its nascent spread beyond Suva. The end of the War, however, was a significant event.

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134 G.W.A., Chairman, Board of Health Lynch, “Notice, Spanish Influenza,” November 12, 1918, CSO M.P. 9470/18, National Archives of Fiji.
135 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 4.
NOTICE

Spanish Influenza

It is hereby notified, for general information, by direction of the Central Board of Health that, owing to the prevalence in certain countries of an epidemic disease known as Spanish Influenza, and the possibility of its appearance in Fiji, the Board desires to inform the public of the leading symptoms of the disease, and the measures that should be adopted for safety by those attacked.

SYMPTOMS.

The leading symptoms are, suddenness of onset, with intense, severe, headache, pain in back and limbs, high temperature, with possibly shivering; pain in the eyeballs, catarhal symptoms, sore throat, cough, vomiting, and perhaps diarrhoea. The disease, with high fever, has a short period of incubation, about two or three days, and under ordinary circumstances, without complications, lasts from three to five days; after which, if the attack has been a severe one there is usually a period of debility which may last for several days.

The Complications most to be feared are Pneumonia, Bronchitis, and in this Colony Diarrhoea and Dysentery. In most cases, with care, these may be avoided.

TREATMENT.

It is advised that with the presence of any of the symptoms named anyone attacked who is unable to procure medical care shall consider that Influenza is the cause. To quote a known authority, the treatment may be summed up in two sentences—

1. Free Ventilation.
2. Fortify the power of resistance.

For carrying out the former, we take the safest step to prevent such complications of Pneumonia, and also to limit the spread of the disease to others; for it is by over-crowding that it will spread, and by over-crowding will such a complication as Pneumonia become a serious menace to all. Therefore, rest in bed in a well-ventilated room.

In regard to the use of drugs, it may be said that indiscriminate use of such drugs as quinine and aspirin will do harm, and that, unless unavoidable, drugs should not be taken except on medical advice.

A light nutritious diet and an aperient in the early stages, with a full and stimulating diet in convalescence will aid recovery.

G. W. A. LYNCH,
Chairman, Central Board of Health.

12th November, 1918.

(Figure 6: Influenza Information Pamphlet Issued by Fijian Government, 12/11/18)
At roughly 9PM on 11 November 1918, news reached Suva by wire that the World War had ended. As reports spread, people poured into the streets for makeshift processions and general celebration. By Sunday the 12th the hotels overflowed, thanksgiving celebrations proceeded in the churches, and seemingly every homeowner in Suva hosted a public or private event. Monday the 13th became a public holiday with a public celebration and procession to which the government invited all residents of Fiji. Nine days into the presentation of a massively contagious epidemic Fiji saw its largest public celebrations in years, perhaps in modern history. The events of November 11-14 functioned as an incredibly effective incubator and dispersal system for the virus. Yet given the Fijian identification with Britain and the sacrifices by all during the preceding four years, stopping such celebrations completely surely lay outside the powers of the Government of Fiji. Many visitors were still enjoying these revels in Suva when 90 sick Fijian laborers disembarked from the Talune in town.

To avoid paying and berthing laborers on the long hauls between Fiji and New Zealand, the ships of the Union Steam Ship Company established a pattern of hiring on laborers in Fiji for the fortnight’s swing from Suva to Nuku’alofa, Apia, and Pago Pago. Upon the return to Fiji the workers disembarked before the ship steamed on to Auckland. On the 4th of November the Talune took on 90 Fijian laborers. Upon her return on the 14th she disembarked 90 infected, ill individuals to further feed the epidemic. Fifteen of these laborers were to die in the coming weeks. Even more local Fijians came aboard to handle the final unloading of cargo from Samoa, as the original 90 were generally too ill to assist. These workers then helped spread the illness around the archipelago, most notably a contingent of 40 who returned to Rewa.

137 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 4.
The Fijian laborers discharged from the Talune received orders for housing in a hulk lying in the harbor without bedding or medical supervision, and on the 15th moved to the immigration depot at Korovou, not yet declared a quarantine station. The PHO issued isolation orders for the men. Not two days passed before the Fiji Times commented on the free flow of friends and relatives into and away from the depot. The same piece in the Times includes the statement from the CMO explaining that “the men were placed there under a mild form of quarantine. They were seedy and were put there for observation and medical attention if required.” ‘Seedy’ apparently includes the two deaths already among the group when this statement was made and the score desperately ill. Six more died within two days, while family and friends streamed through. By the 18th isolation had begun to be enforced.

The ship was also said to be under a ‘mild form of quarantine’, but this seemed to have little impact on her operations. Loading and unloading continued as normal. The new labourers hired for these operations to replace those ill and removed to quarantine were not kept away from the infected crew and passengers, nor were they in any way controlled after completing their work.

Indigenous residents of the capital remembered the previous epidemics, even if the medical authorities suggested calm. As disease incidence increased in Suva throughout the first half of November a considerable exodus of Fijians to their home
villages began, and these migrants brought infection with them. This process continued without official comment or interruption.

By the return of the *Talune* to Suva, and especially after the ineffective isolation of the 90 sick laborers who disembarked there, a successful quarantine of the colony as a whole was out of the question. Confining the infection to Viti Levu had been a possibility with isolation of the original passengers and their close contacts upon the first presentation of the “serious, epidemic form” mentioned on November 5, as well as the sick laborers from the *Talune*’s return voyage. Most of these passengers either lived in Suva or would be resting there for a day or more before continuing to their plantations. Their house staff and the dock workers would have required isolation as well, but as the *Talune* arrived on a Monday very few of these exposed would have left overnight to locations outside of the Suva area (a very different case than if the ship had berthed on a Friday or Saturday). Secondary ring isolation would not have been necessary 24 hours after first exposure thus giving the medical authorities an opportunity to stop the epidemic with this group. The successful *cordon sanitaire* imposed on southern Taveuni is an example of the potential for locally imposed quarantines, which will be discussed later in this section. No instructions to district health officers encouraged such action, and local quarantines faced active discouragement by the central authorities due to their negative impact on trade.

Conjecture aside, by the end of the Armistice celebrations the health authorities in Suva acknowledged the spread of disease in the town. After an initial request from the Central Board of Health to the Governor on November 7th, and

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144 McDonald, “Diseases in Fiji; Presidential Address 1959,” 69.
another on November 15th, influenza entered the list of reportable diseases on November 16th by pronouncement in the Royal Gazette. By the 18th, Armistice celebrations had been curtailed and the declaration of influenza as a reportable disease announced to the public. By this declaration, which made influenza an infectious disease under the Public Health Ordinance of 1911 and the amendments of 1915, the government adopted broad powers for itself and its representatives in the further islands (DMOs, primarily) to act in the interest of the public health in combating the disease. The most significant authority in this struggle resided in the Governor and the Board of Health.

The declaration of influenza as an infectious disease was significant in that Medical Officers of the ports used its absence from the list as the stated reason for allowing ashore the passengers from Niagara and Talune. Terming the influenza an infectious disease exposed those infected by a disease so designated to more effective and complete restriction for up to ten days.

The period between the Armistice and the pronouncement saw the departure of several ships partially crewed by Fijians. These ships carried the infection with them throughout the Pacific. The USC Atua, arriving in Sydney from Suva on November 15th, had seven Fijian hands die of influenza within a day of arrival. When the ship sailed another eight remained convalescent in quarantine. Only four of the original 19 Fijian crew were healthy enough to remain aboard ship. This is despite inoculations (of a type unspecified), ‘close and careful examination by Dr. F. L.

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145 Central Board of Health, “Resolution from Central Board of Health,” November 7, 1918, CSO M.P. 9448/18, National Archives of Fiji.
146 Rodwell, “Proclamations 31 and 32 of 1918, Fiji Royal Gazette.”
147 “Influenza, November 18, 1918.”
148 May, “An Ordinance to Consolidate and Amend the Law Relating to Public Health.”
149 Manager for Fiji, “Union Steamship Company to the Acting Secretary for Native Affairs, Fiji,” December 2, 1918, CSO M.P. 9522/18, National Archives of Fiji.
Harden’ of all passengers and crew before embarkation, and the refusal to embark several due to their illness.\(^{150}\)

The possession of a wireless station would seem to grant an advantage once influenza was recognized as epidemic in Fiji. Approaching ships could be queried of their health status and warned of the situation in the port they approached. However, due to wartime shipping censorship such contact was forbidden until late in November, by which time it had become a moot point for Fijians.\(^{151}\)

The ability to react does not necessarily produce the impetus to do so. Three days passed after the acknowledgement of influenza as an infectious disease before regulations promulgated regarding the power to close schools and public locales such as theatres and bars became active. Aside from articles in the Fiji Times advising the use of quinine as a prophylactic against the illness, no other action was taken in the interim.\(^{152}\) The 19th, by which time there were already 400 to 500 cases in the Suva area,\(^{153}\) also saw the Governor adopting regulations allowing for the isolation of stevedores working infected ships, the closure of public and private gathering places (theatres and schools closed voluntarily by the 20th),\(^{154}\) the ability to designate sites for isolation facilities, the power to imprison those violating isolation and closures,\(^{155}\) and the creation of additional and simplified educational handbills in Fijian, Hindustani, and English describing the view of the Health Board on symptoms and treatment of influenza. These notices ran in the Fiji Times as well, starting November 20th.\(^{156}\) The isolation of stevedores accomplished little (and actually later proved

\(^{150}\) “Flu Notes, December 7, 1918,” Fiji Times and Herald (Suva, Fiji, December 7, 1918).
\(^{152}\) “Influenza, November 16, 1918.”
\(^{153}\) “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919.”
\(^{154}\) “Influenza in Suva,” Fiji Times and Herald (Suva, Fiji, November 20, 1918).
\(^{155}\) “Fiji Royal Gazette, 19 November 1918” (Government Printing Office, Suva, Fiji, November 19, 1918), R.G. 19/11/1918, National Archives of Fiji.
\(^{156}\) “Influenza in Suva.”
harmful when men could not be found to work the ships that straggled in) but the handbills served to alert the population to the significance of the problem. CMO Lynch sent a note to all DMOs the following day authorizing the use of private hospitals in their districts once the provincial facilities were full, but only with a “wise discretion” due to potential costs.\footnote{Chief Medical Officer Lynch, “Treatment of Spanish Influenza in Private Hospitals,” November 20, 1918, CSO M.P. 9628/18, National Archives of Fiji.}

By this time the Governor had also sent a note to all Districts discouraging Fijians and Indo-Fijians from traveling to slow the spread of the affliction. However, the note excused those traveling on business or for matters of ‘real importance’.\footnote{Governor Cecil Rodwell, “Influenza Epidemic - Steps Taken to Prevent Unnecessary Travelling by Natives,” November 19, 1918, CSO M.P. 9665/18, National Archives of Fiji.} Given the room granted for interpretation the request had little impact.

On the 21\textsuperscript{st} of November, seventeen days into the epidemic in Fiji, the government set aside the Korovou depot to serve as a quarantine center for those infected.\footnote{Governor Cecil Rodwell, “Minutes of a Meeting of the Executive Council,” November 18, 1918, CO 85/29, Fiji, Minutes of the Executive Council 1918-1922, National Archives of the United Kingdom.} Korovou sits astride the trade routes between Levuka and Suva, on the east coast of Viti Levu. Despite these actions the death count from influenza in Fiji reached at least 100 by the end of the month, with an estimated 3,000 infections.\footnote{“Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919.”}

Criticism became fierce. Having been told by the CMO on the 17\textsuperscript{th} of November that comment from the press regarding the Medical Department action on the epidemic would be “exceedingly foolish”, the Fiji Times issued a scathing editorial on the 19\textsuperscript{th}. This piece reviewed the actions taken up by the government, the perceived insufficiencies of the quarantine efforts, and the lack of preparations. Attacking the failure to quarantine the Talune and commenting on the current strict
incoming quarantine, the piece alleged that no clear government policy regarding the epidemic existed and concluded:

We do not believe that the strictest measures have been put into operation, we do not believe that all reasonable precautions have been taken; consequently we do believe that the Health Department has failed in its duty to the people of these islands, and we say this despite the fact that this view will be held by that Department to be an ‘exceedingly foolish’ one. 161

Suva’s population demonstrated an infection rate approaching 90% by the end of the third week of the epidemic. 162 The medical infrastructure in Fiji, despite being relatively advanced for the region, had little effect against an outbreak of this scale. While efforts proceeded to assemble skilled staff to treat those presenting at the Colonial Hospital, including the use of medical students, the trained practitioners fell ill as rapidly as those they treated. On November 28 the Fiji Times could report that all but one nurse and most of the domestic staff at Colonial Hospital were unable to work due to illness. People presenting to hospital were asked to bring their own mats and pillows as the facility’s supplies were stretched to the limit. 163 The same day saw an editorial telling people that due to staff shortages they would not receive adequate care at the hospitals in the Colony and to stay at home for treatment if in any way able. 164 A call for volunteers went out, as well as a plea to participate in the organized relief actions rather than individual efforts, and those willing and physically able to tend the ill immediately found work. As elsewhere, the most crucial need was for nurses and support staff to keep the patient alive long enough for the body’s immune system to respond. Physicians were almost redundant, the greatest need being for bathers, feeders, and bed-changers. Requests for assistance sent to Australia and to New Zealand, both coping with their own versions of the

161 Editor, Fiji Times and Herald, “Exceedingly Foolish.”
162 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919.”
163 “Influenza Outbreak, Critical Period,” Fiji Times and Herald (Suva, Fiji, November 28, 1918).
164 “The Duty of the Public,” Fiji Times and Herald (Suva, Fiji, November 28, 1918).
pandemic, garnered little response. Both states agreed to send staff when possible, but a complete lack of shipping due to the war and subsequent dockworker strikes stymied Australian efforts to help while New Zealand was unable to spare staff for several weeks until the epidemic abated. Three nurses had been chartered to leave Sydney for Suva on November 28\textsuperscript{th} at the request of High Commissioner Rodwell, and three more on December 11\textsuperscript{th}, but could not find passage (though they did eventually bill the Fijian Government for more than 100 GBP for their weeks of waiting).\textsuperscript{165} No outside assistance arrived before mid-December.

As happens in emergencies the bureaucracy and its processes fell to the wayside. By late November the main hospital in Suva no longer recorded any information regarding patients presenting for care. Within a week the proliferation of smaller makeshift hospitals put paid to any pretense of tracking patients and their families. Hospitals for Suva’s population appeared in the Marist Boy’s School and the Methodist Mission Girls’ School, followed quickly by the Boys’ Grammar School, the Draiba Native Rest House, the Drill Hall, and the Nasinu Queen Victoria Memorial School.\textsuperscript{166}

Despite these temporary facilities the numbers needing direct care grew greater than capacity. Volunteers in Suva discovered individuals and entire families too ill to provide for themselves.\textsuperscript{167} This feature of the influenza recurred worldwide, with many deaths related to malnutrition and lack of care during convalescence. In urban areas the density of population allowed for some systematic attempts at outreach and relief. Suva’s Voluntary Workers Brigade embodied such efforts, with the division of the capital into sectors of responsibility, each under a designated

\textsuperscript{165} J.C.L. Fitzpatrick, “Minute for His Excellency the Governor,” November 28, 1918, CSO MP 781/19, National Archives of Fiji.


\textsuperscript{167} “The Influenza Outbreak; More Serious Aspect,” Fiji Times and Herald (Suva, Fiji, November 26, 1918).
leader. The leaders organized staff to visit each home and distribute food, medicine, and clean bedding, as well as evaluate whether inhabitants needed to be moved to hospital care. Leaders also held the authority to purchase and requisition relief supplies. The CMO spoke of entire families too ill to feed themselves and asked for volunteers to bring forth “soups, milk, arrowroot, and sago” for distribution to the ill. Such a pattern, including central food kitchens, seemingly independently emerged repeatedly across the globe during the pandemic. Whether this simply reflects a naturally efficient way to address the problem or if Suva residents acted on information from those regions earlier infected is not noted. Supervisory authority was eventually vested in a committee led by the acting Colonial Secretary. However, local accounts suggest that the committee, the Central Board of Health, quickly found itself relegated to the background with the Volunteer Committee assuming most of its functions.

By the 28th of November most of the Municipal Council and its employees, including sanitation workers, were too ill to function. Most prisoners and warders at the gaol were ill, and the remainder was assisting at the local hospitals. The constabulary was similarly affected.

Vaccination efforts were a priority. The 40 doses of vaccine sent by Australia were supplemented with additional serum by early December, and by the 7th of that month government and medical workers were receiving the inoculations. There is no information in the Colonial Government records of the efficacy of the vaccinations, but as the vaccine was made from bacterial cultures from ill

168 “Influenza Outbreak, Critical Period.”
169 “The Epidemic III.”
170 “Influenza Outbreak; Situation in Suva,” Fiji Times and Herald (Suva, Fiji, November 28, 1918).
171 “‘Flu Notes, December 7, 1918.”
individuals, and the disease itself was viral in nature, it would be surprising if the shots provided more than reassurance and sore arms to their recipients.

Church closures were announced on the 28th, though services continued out of doors. Previous days had seen the reduction in newspaper deliveries and the cessation of some inter-island travel due to sick employees of shipping firms. The Carnegie Library was shuttered. The Colonial government followed with the closure of business offices and banks.

Not all citizens saw the epidemic as a catastrophe. The Fiji Times featured ads for such cures as quinine-laden tonic water; eucalyptus oil, camphor, eumenol jujubes, and syrup of the hypophosphites. The same paper ran editorials critical of citizens with motorcars profiteering by offering rides to relief workers at inflated rates. The presence of dozens of players per day on Suva’s tennis courts during the height of the epidemic also aroused negative comment.

Education efforts continued in late November with a newspaper article quoting advice from the New Zealand Board of Health. Printed in English, without Fijian translation, it offered basic advice on staying in bed and keeping up the strength of those infected, as well as homilies such as: “5. Don’t depress yourself by looking at the bad side.” The piece, ending with the exhortation to: “BE CHEERFUL. DON’T WORRY. DON’T WORRY.” would run through early January. The press derided these measures as too little, too late, and totally uninformative. In their words: “it was not until people were dying like flies that they realized what had been

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172 “Influenza Outbreak; Situation in Suva.”
173 “The Influenza Outbreak; More Serious Aspect.”
174 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 1.
175 “Influenza! Influenza!,” Fiji Times and Herald (Suva, Fiji, November 20, 1918).
176 “Influenza.,” Fiji Times and Herald (Suva, Fiji, November 28, 1918).
177 “Influenza Outbreak; Good Work Being Done,” Fiji Times and Herald (Suva, Fiji, November 30, 1918).
178 “If You Get It,” Fiji Times and Herald (Suva, Fiji, November 28, 1918).
let loose among them.” The local paper in Suva also printed exhortations for the use of masks, particularly by workers. Apparently the use of such items was seen by some as cowardly, and their general adoption a difficult proposition. The heat and humidity of tropical Suva may have also contributed to their low uptake.

The small, colonial town of Suva lacked significant reserves to draw upon in this time of crisis. The disposal of the dead became an immediate concern due to the wish to avoid secondary epidemics. Gaols served as recruiting depots for grave-diggers but anecdotal reports suggested that prisoners became markedly unwilling to continue duties when one of those ready for interment woke, rose up, and staggered off. Nonetheless burials went on, quickly turning first to multiple bodies per grave and then to mass graves when individual plots could not meet demands. The community reached a difficult juncture when, by November 26th, the bread cart for the main bakery in town was requisitioned to carry corpses. The apology and request for patience on the part of hungry Suvans that ran in that day’s Fiji Times demonstrates just how deeply the crisis disrupted daily life.

Despite all of this Suva’s and Fiji’s government attempted to keep a façade of normality. On November 28th the Mayor sent a cable to Sydney stating that “the outbreak here was not one to cause alarm, that only two Europeans had died, and that in the case of natives the deaths were often due to ignorance or carelessness.” The Governor of Fiji sent telegraphic notice to the Secretary of State for the Colonies that the epidemic had reached its peak on November 29, December 3, December 17,

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179 “The Epidemic; II.”
180 “Influenza Outbreak; Good Work Being Done.”
181 Manager, Suva Cemetery, “Manager, Suva Cemetery to the Honourable A/g Colonial Secretary,” February 25, 1919, CSO M.P. 1458/19, National Archives of Fiji.
182 “Local and General, November 26th,” Fiji Times and Herald (Suva, Fiji, November 26, 1918).
183 “Influenza Outbreak; The Work Being Done,” Fiji Times and Herald (Suva, Fiji, November 29, 1918).
and finally on December 27.\textsuperscript{184} When the managers of the two banks in the capital approached the Colonial Office to suggest a shutdown, freeing their workers for relief duty, the Administration officials agreed it was a good idea, but asked if they could return with the proposal in writing.\textsuperscript{185}

**Outside of Suva**

Rural regions did not escape the problems seen in Suva. In these areas the disposal of bodies became a critical concern. One respondent described the bodies along the bush roads ‘piled like copra’.\textsuperscript{186} As time passed government instructions were issued allowing local authorities to bury bodies wherever appropriate. Many of these gravesites were unmarked.\textsuperscript{187}

Transport became a major issue as food supplies dwindled throughout the islands. Fijians still in villages with gardens maintained a certain reserve ‘on the vine’ (in this case generally in the form of root crops that could remain buried over time) and fared better than the Indo-Fijians who generally depended on store-bought imported food such as rice and flour. In areas of recent drought or storm damage both groups suffered equally.\textsuperscript{188} Here is one of the few instances where the *girmit* Indo-Fijians still on plantations fared better than their free compatriots; most plantations had imported food stocks such as rice, though this hardly made up for the rapid disease spread within the dormitory style housing. The authorities in Suva recognized that infrastructure collapse threatened starvation throughout the islands. In late November a circular had been issued from Suva asking for the preparatory

\textsuperscript{184} Colonial Secretary, Fiji, “Telegraphic Correspondence Relating to Influenza Epidemic,” January 1919, CSO M.P. 473/19, National Archives of Fiji.
\textsuperscript{185} “Influenza Outbreak; More Hospitals in Being,” *Fiji Times and Herald* (Suva, Fiji, December 2, 1918).
\textsuperscript{186} Collier, *The Plague of the Spanish Lady*, 154.
\textsuperscript{187} “Gravity of the Situation,” *Fiji Times and Herald* (Suva, Fiji, December 9, 1918).
\textsuperscript{188} Diamond, “Fiji and the Spanish Influenza Pandemic: A Paper Delivered to the Fiji Society on 8 July, 1969,” 12.
storage of food in villages, though the epidemic was already rife in most. One of the Administration’s first responses once the capital emerged from the worst of the epidemic involved the shipment of emergency food throughout the archipelago via whatever conveyance could be requisitioned, an effort partially crippled by the lack of healthy crews. Even the Medical Department’s barge was out of service, leaking in Suva harbour. December 9 saw most Indo-Fijian food stores exhausted. Price gouging (in some cases food doubled or trebled in price) was reported within the next week. By December 17th the Governor was voicing concerns for Suva’s own food supply, given the continued Australian shipping strike. The Colonial Government began to set prices on essential items such as bread, to prevent profiteering during the crisis.

While Suva kept the headlines, as Fiji’s administrative center and the location of the Fiji Times, in less than a fortnight influenza appeared in other communities. Levuka reported illness on the 17th of November, Rewa the 18th. The epidemic reached the Navua district by the end of the month. After Navua, infection appeared in Serua, Namosi, and Beqa. By the 30th influenza was prevalent on every major island and in every major town, save the southern half of Taveuni. The DMOs reported with horror the speed of the epidemic through their regions. DMO Rewa described: “On Dec 1st and 2nd the thing exploded and laid low the whole countryside. There was no one to be seen on the roads, and no one in the fields”.

From DMO Navua came this report: “The disease spread with such rapidity that by

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189 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 4.
190 Chief Medical Officer Lynch, “Chief Medical Officer to the Commissioner of Works,” July 24, 1918, CSO M.P. 7108/18, National Archives of Fiji.
191 “Gravity of the Situation.”
193 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 2.
194 Governor Cecil Rodwell, “Minutes of a Meeting of the Executive Council,” January 31, 1919, CO 85/29, Fiji, Minutes of the Executive Council 1918-1922, National Archives of the United Kingdom.
the first week of December there were thousands of cases, and the whole life of the
district was paralyzed and disorganized. Whole families were simultaneously
stricken down, causing the utmost misery, want and suffering….“

The timeline varied by locale, yet the basics of the epidemic matched what
others reported around the globe: A 7-10 day period of increasing cases after the
initial exposure, then a huge spike of ill individuals overwhelming local
infrastructure. Given that front line medical staff usually acquired the virus early in
the epidemic due to their high exposure level, followed by police and other officials,
the organization of the community collapsed. Public buildings, especially schools
and churches, quickly converted into hospitals. Volunteers picked up the duties of
sick officials and cared as best they could for the ill. The outbreaks generally
developed more severely in urban areas, but the urban areas also concentrated the
resources needed to distribute to the ill. Dangerously ill residents of the villages and
remote plantations faced greater obstacles to accessing care, and frequently waited
until the urban outbreaks had been controlled to see staff and supplies shifted to
their regions. They did have the notable advantage of local food sources, if any were
well enough to gather such.

The hospital facilities generally degraded the further from the cities one
travelled. As late as December 22nd, a member of the Australian Relief Party in
Nausori would describe conditions at the local Indian Hospital as: “Beyond Belief.
Sixty or more Indians mostly pneumonics-lying on the bare floor- or squatting.
Sanitary conditions absent, urine, ?, spitum everywhere. Not one had been seen for
ten days before I took over.” Only when he went in and cleaned the hospital,
opening new wings and beginning care, would the local Indo-Fijian population

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195 District Commissioner, Navua, “Brief Report on the Provinces of Serua and Namosi with Reference to the
Recent Epidemic.,” December 30, 1918, CSO M.P. 39/19, National Archives of Fiji.
present themselves for assessment and treatment. He told of individuals in the last stages of starvation, with bi-loval pneumonia, staggering through the doors. Even so, survival rate in these patients approached 60%.\textsuperscript{196} Lt. Colonel Jennings would personally take on responsibility for a European hospital with 40 patients, an Indo-Fijian hospital with more than 60, and a Fijian facility with 50 for which to care.

Efforts were made to slow or stop the spread to the villages. By November 29\textsuperscript{th} there were strict instructions forbidding travel between the villages, even those closely contiguous and those apparently clear of the infection. Quarantine of trade between the islands went into effect in early December, with the first prosecution on December 11.\textsuperscript{197} As late as December 30\textsuperscript{th} villages in the Lau District had not yet been infected, though they would later be struck.\textsuperscript{198}

In many locales the most serious stage of the epidemic lasted one or two months. Continued outbreaks occurred in settlements that managed to avoid the initial wave of infection.\textsuperscript{199} Only two regions of Fiji escaped infection altogether: Makogai, the institutionally quarantined colony for sufferers of Hansen’s disease; and the southern half of Taveuni.

In Ba the disease first struck the European and Indo-Fijian populations, with the first death being a girmit worker on December 5th. The local planters banded together to fight the infection, inspecting housing and ordering Europeans to wear masks in public.\textsuperscript{200} The CSR staff was praised for their efforts in fighting the

\begin{itemize}
\item [197] Acting Collector of Customs, Suva, “SS Fiona Discharging Cargo Without Reporting at Custom House”, December 11, 1918, CSO M.P. 10071/18, National Archives of Fiji.
\item [200] “Influenza: Country News,” Fiji Times and Herald (Suva, Fiji, December 5, 1918).
\end{itemize}
epidemic.\textsuperscript{201} Two days later there had been deaths in all three ethnic groups, and several hundred cases were reported in the area.\textsuperscript{202} By December 23\textsuperscript{rd} Ba reported heavy mortality amongst the European, Indo-Fijian, half caste, and foreign worker groups, but relatively light impact amongst Fijians. Rain-swollen rivers and streams hampered relief work.\textsuperscript{203} As elsewhere in Fiji the epidemic began to fade with the New Year.

In Colo East the 20\textsuperscript{th} of December had seen the death of three local Bulis and the sickness of every police officer, interpreter, and scribe working for the colonial government. The phone lines, which were the most efficient route in requesting assistance, soon failed because of three weeks of incessant rain.\textsuperscript{204} Colo East was isolated until ship travel became possible again.

The illness reached Navua via steamers from Suva in the third week of November. By early December there were thousands of cases in the district. With all medical and government staff ill, arrangements for a local committee to address needs did not occur until December 12\textsuperscript{th}. Food quickly ran short, especially milk and sago.\textsuperscript{205} Navua reported that influenza dead were being buried “indiscriminately”.\textsuperscript{206} The District Commissioner reported by the end of December that the disease was still spreading due to “The Natives continually moving from house to house” and that

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\textsuperscript{201} “Influenza,” Fiji Times and Herald (Suva, Fiji, December 23, 1918).
\textsuperscript{202} “Influenza Epidemic,” Fiji Times and Herald (Suva, Fiji, December 7, 1918).
\textsuperscript{203} “Influenza.”
\textsuperscript{204} M.W. Gaddy, “Reports on Influenza Epidemic in Colo East,” December 20, 1918, CSO M.P. 10153/18, National Archives of Fiji.
\textsuperscript{205} “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 21.
\textsuperscript{206} Acting Inspector General of Constabulary, “Burial of Dead Bodies in Navua District,” December 23, 1918, CSO M.P. 10352/18, National Archives of Fiji.
“There is little news from the hills and what there is is not good. It is very difficult to know what to do to help them.”

Labasa, the centre of the CSR’s operations, fared better due in large part to the company’s infrastructure. Most deaths in the area were Indo-Fijians, though the first cases were two Fijian crew of a local transport ship. The CSR quickly put in place measures to slow the spread by preventing workers from entering Labasa town itself unless ill, establishing inhalation stations, and opening secondary hospitals. For all of that the distance from Suva left the area with a shortage of food and medicines, exacerbated by the collapse of the distribution network. This food shortage was listed as a cause of the relatively high death rate despite the presence of company medical care. Additionally, all the stores in Labasa closed due to illness or absence of stock, though the grain mill continued to function.

Kadavu reported that all communications via land and sea were disrupted. There was no means of distributing stockpiled food, and Fijians were seen crawling toward town to secure rice for their families. All business was suspended, and no news penetrated the area. The directives sent by the Medical Department which reached the area roughly contemporaneously with the ‘flu were not distributed further. The District Commissioner could not tour the province to assess the damage as he was unable to find eight healthy men to work as oarsmen. By the 9th of December supplies had begun to arrive from Suva, mainly foodstuffs.

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209 “‘Flu at Labasa,” Fiji Times and Herald (Suva, Fiji, December 24, 1918).
210 “The ‘Flu’ at Kadavu,” Fiji Times and Herald (Suva, Fiji, December 31, 1918).
211 District Commissioner Kadavu, “District Commissioner Kadavu to the Hon. the Colonial Secretary,” December 7, 1918, CSO M.P. 10155/18, National Archives of Fiji.
The second town of Fiji, Levuka (figure 7), faced many of the challenges of Suva. The community had been directly infected from the *Talune* and had required temporary hospitals and centralized food kitchens for the urban population. Levuka suffered the closing of businesses and public places, and the cessation of port activity. By the end of December the hospitals and kitchens had been shuttered and business was slowly returning to normal. In his report on the epidemic in the region the DMO praised the old men of the district as the unlikely saviors, as they did not seem to fall ill. He also mentioned the great volume of ripe breadfruit available which prevented the famine that struck other areas. The prison crews from the local gaol buried most bodies without supervision, as few constables were healthy and those on duty had to deal with the unruly sailors from seven foreign vessels docked and unable to leave.

(Figure 7: Levuka, 1906)

212 “Influenza. December 27.,” *Fiji Times and Herald* (Suva, Fiji, December 27, 1918).
In Suva the end of the year also brought a return to something like normality. By the end of December citizens were reminded of the need to report every case in town, so as to speed the declaration of Suva as a ‘Clean Port’ and the departure of those travelers marooned by the town’s infected status.\textsuperscript{215} The legislation allowing local quarantines based upon these declarations was implemented, with significant punishments for violations.\textsuperscript{216} The Rewa Hotel ceased its operations as a hospital and was cleaned, disinfected, and ready for guests by January 4\textsuperscript{th}. Things were not quite the same, however, as the lack of shipping led to a shortage of meat and butter.\textsuperscript{217}

Communities slowly recovered but the disease continued its spread through the countryside. Rural areas suffered hunger as their local supplies diminished and outside aid was directed to Suva and Levuka. In Nadarivatu rifle cartridges were carried in by visiting relief columns who reported on an absence of fresh meat and the presence of famine. The cartridges were dispensed with instructions to shoot and eat any birds.\textsuperscript{218} With a lower density of population and almost complete lack of transport infrastructure, remote areas such as the highlands of Viti Levu weathered the outbreak without assistance.

A group of Australian doctors and orderlies provided aid during the outbreak in Fiji, if somewhat by accident. Arriving on November 30\textsuperscript{th}, two doctors and several orderlies of the \textit{Encounter} relief party sent by Sydney to Samoa were left in Fiji to arrange passage to Tonga to offer assistance there. With the failure of multiple

\textsuperscript{215} “Influenza. December 27.”
\textsuperscript{216} “Fiji Royal Gazette, 24 December 1918” (Government Printing Office, Suva, Fiji, December 24, 1918), R.G. 24/12/1918, National Archives of Fiji.
\textsuperscript{217} “Local and General; January 4th.,” \textit{Fiji Times and Herald} (Suva, Fiji, January 4, 1918).
\textsuperscript{218} Chief Medical Officer, Fiji, “Cartridges Purchased for Nadarivatu During the Influenza Epidemic,” March 31, 1919, CSO M.P. 75/19, National Archives of Fiji.
attempts to secure passage to Tonga, the party chose to remain in Fiji and was dispatched to rural areas in need of support.219

Australia also attempted to provide food to avert the potential famine engendered by the epidemic. Unfortunately the seaman unions in Australia were in the midst of a bitter strike, and no crews could be found. Despite appeals to the union and to the public for a volunteer crew, a ship could not be loaded and dispatched until January 17th, which arrived the 23rd.220

A medical relief party arrived from Auckland in mid-December, with 5 doctors, 4 nurses, and 24 assistants aboard.221 This party was distributed amongst the worst hit areas outside of Suva, including Navua, Rewa, Savu Savu, Labasa, Lautoka, Ba, Levuka, Ra, and Bua.222 In several of these locations they stepped in for staff still laid low by illness.

Recovery and Consequences

By the end of January the epidemic in Fiji had generally run its course, aside from a brief recrudescence in the Nadi district in April. Suva was declared clean on January 9th.223 January 31st saw the governor reporting the epidemic as over and the departure of the New Zealand aid contingent.224 No other recurrences are noted in 1919.225

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219 "Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919," 5.
220 Controller of Shipping, "Fiji Shortage of Foodstuffs," January 21, 1919, A2, 1919/224/6, National Archive of Australia.
221 "Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919," 2.
222 "Distribution of Relief Party," December 17, 1918, CSO M.P. 10199/18, National Archives of Fiji.
224 "Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919," 2.
225 Acting Chief Medical Officer, Fiji, "Report on the Medical Department for the Year 1919," 4.
The recovery revealed that the various ethnic communities of Fiji had different experiences of the epidemic. Estimates of infection reflect the significant difference in prevalence between Europeans and indigenous Fijians. Roughly eighty percent of Fijians were believed to have been infected, while less than forty percent of Europeans were thought to have demonstrated influenza symptoms. As most Fijians still lived in traditional villages they remained far from medical and other relief efforts. Even when available, many Fijians chose to reject European medical care (some fled hospitals as soon as they could rise). Given the lack of efficacy of many European treatments against influenza it is hard to judge the impact of this bias against the hospitals. Fijian treatments recorded by relief parties entering the more remote areas of the islands ranged in style and efficacy. Frequent references were made to Fijians walking in the rain or bathing in the sea while febrile, or consuming large quantities of cold water, all actions likely to worsen their condition. Some Fijians fled the site of influenza deaths to escape supernatural ailments, and died without care in the jungle.\(^{226}\) Captain A.H. Hallen of the New Zealand relief party described the use of young coconut water, spells, and native drugs as not harmful, but he was horrified by the use by some elder women of clearing the throat with a finger (without washing between clients, of course) and of penetrating the vagina or rectum with a finger and then declaring the likelihood of death based upon what they felt.

Fijian traditional practices might have contributed to mortality, however the high rate of infection within the native Fijian community presents a puzzle. Two possible solutions are offered by Mamelund: that due to isolation the rate of acquisition of the 1889-1890 influenza (thought to produce some resistance to the

\(^{226}\) “Notes on Influenza Epidemic in Relation to Fijian Character and Mode of Living,” n.d., 2.
1918 strain) was low, or that the Fijians lived in high-mortality communities.\textsuperscript{227} The latter communities would see the deaths of large portions of population cohorts at young ages and thus reducing the number of community members with a strong immune history, shortening the time needed to ‘refresh’ the population with a high enough proportion of non-immune members that an epidemic could again develop. Others blamed the high mortality on the Colonial government policy of encouraging settlement in nucleated villages, thus concentrating the population and easing the spread of illness.\textsuperscript{228} Indo-Fijian infection rates were similar to Fijians, increasing in the plantations and dropping in the farmsteads.

Many Europeans blamed the resulting high Fijian mortality upon the Fijian responses to the epidemic. Reports abounded of the apathy seen in Fijians regarding their care and the difficulty in arousing interest in participating in relief efforts. Dead went unburied in some villages, in others the entire family would join and lie down with the ill individual in the home.\textsuperscript{229} On December 3\textsuperscript{rd} Governor Rodwell sent a cable to the British Secretary of State stating: “Chief difficulty lies in inducing natives who are naturally bad subjects to take elementary precautions upon being first attacked and to submit to treatment necessary to febrile condition.”\textsuperscript{230} The DMO for Navua would write:

\begin{quote}
The General behaviour of the native population, both Fijian, Indian, or Polynesian, was deplorable. They not only showed no willingness to help themselves, but they refused to help one another unless forced to do so, with a very few exceptions.\textsuperscript{231}
\end{quote}

\begin{footnotes}
\item [227] Sven-Erik Mamelund, “Geography May Explain the Adult Mortality from the 1918-20 Influenza Pandemic” (University of Oslo, n.d.), 8.
\item [228] “Notes on Influenza Epidemic in Relation to Fijian Character and Mode of Living,” 2.
\item [230] “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 1.
\item [231] Ibid., 21.
\end{footnotes}
Some were even more direct. The Fiji Times’ correspondent in Kadavu wrote: “It is only in such times of dire stress that the public get to know what all planters and others already know, and that is what a contemptible, unfeeling, and miserable race the Fijian is generally.” This opinion was repeated in foreign newspaper reports of the Fijian epidemic, with a Press Association bulletin of December 28th averring that “the natives absolutely refused to assist in fighting the epidemic or attending the sick or convalescents, even refusing to bury their own dead.” However other correspondents countered this impression with praise for Fijian efforts such as: “The natives have been very obedient in carrying out instructions given with a view to preventing the spread of infection...” Reports emerged of Buli ordering the construction of latrines next to every home so the ill would not have to go far, and bathing the convalescents themselves.

Other correspondents saw much of the mortality as tied up in the methods of food gathering of the average Fijian. Village dwellers kept no food at home, going to their garden or the local store for every meal. If they were too ill to work their garden, that left the store, but few Fijians had monetary reserves. The tradition of “kerekere”, where relatives and neighbors could ask for whatever you might have, also discouraged stockpiling of supplies.

Traditions drove other behaviors inexplicable to European observers. Some villages were reluctant to carry supplies to other groups due to ancient enmities or recent slights. Charity and empathy drove caregivers to provide the ill with whatever they requested, even if it was likely to worsen their condition. Finally, interfering in

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232 “The ‘Flu’ at Kadavu.”
234 District Commissioner, Bua, “Influenza Outbreak,” January 8, 1919, CSO M.P. 10152/18, National Archives of Fiji.
235 District Commissioner, Nadroga and Colo West, “Influenza Epidemic in Nadroga,” January 18, 1919, CSO M.P. 10149/18, National Archives of Fiji.
236 “Notes on Influenza Epidemic in Relation to Fijian Character and Mode of Living,” 4.
the disease process was not always welcome and could lead to a sense of reverse obligation. In a saying retained from the measles epidemic of 1875: “You have kept me alive: I was not particularly anxious to be kept alive. In your hands be it. Persevere in well doing. Continue to feed me and save my life.”237 With these traditions in place it is scant wonder that some Fijians appeared to do little to help their neighbors. Once again, however, there was dispute. The CMO argued that the village system was the saving grace of rural Fijians, and that in urban areas the lack of blood-ties left families to die unaided.

Indo-Fijians were often tarred with the same brush, with the exception that they were seen to care for their families. Aside from this solicitousness to blood relations, many correspondents described them as heartless.238 The absence of close ties also left them without assistance when they fell ill.

Death rates amongst the various ethnicities reflected these vulnerabilities. In earlier January reports began to reach Suva. Nadroga had lost three Europeans, 114 Indo-Fijians, and 95 Fijians. Nadi saw the deaths of two Europeans, 140 Indo-Fijians, and 230 Fijians. The Laukota district lost four Europeans, 142 Fijians, 189 Indo-Fijians, and 40 half-castes. A partial list from Navua spoke of the deaths of two Europeans, 14 half-castes, 46 Fijians, 10 other Polynesians, and 272 Indo-Fijians. Finally, partial numbers from Rewa had seven European deaths, 476 Fijian, and 477 Indo-Fijian.239

There were successful attempts at quarantine and isolation. Makogai, due to its special circumstances, enforced a rigid quarantine, escaping infection

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237 Ibid., 7.
238 Green, “Influenza Epidemic on the Rewa.”
239 Acting Colonial Secretary, “Influenza Epidemic; Reports from All District Commissioners as to Number of Deaths,” January 9, 1919, CSO M.P. 10403/18, National Archives of Fiji.
completely. As the leper colony for Fiji it received few visitors at the best of times and engaged in little trade with the outside world aside from an occasional supply ship meant to supplement what could be grown by the residents. The Medical Officer in charge personally supervised the weekly supply run to Levuka and prevented contact with anyone. As the epidemic worsened throughout Fiji, volunteers from Makogai worked at relief efforts on the mainland. Yet Makogai did not reside in splendid isolation as ordered. W. L. Parham tells of slipping ashore from boats to steal coconuts in May, 1919, while the epidemic still worried officials in Fiji.

Two planters on Taveuni managed to enforce a *cordon sanitaire* across the southern half of the island, strictly policing it with their employees and trading vessels. The residents of the area appointed a guard to patrol their self-declared isolation. Their actions kept the area disease free and saved an estimated 600 lives. CMO Lynch mentioned the absence of disease there, as it has been “rigidly isolated from the rest of the island.” Little information on this effort resides in the archives at Suva, but the southern half of Taveuni was the first area in Fiji to be declared a ‘clean area’ under the 1911 public health ordinance. This declaration occurred on December 23rd, 1918, more than two weeks before Suva was so described and four months earlier than Nadi. Since as of December 16th no cases had occurred in the quarantined area, it is likely safe to assume that no disease

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241 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 6.
244 “The ‘Flu’ at Taviuni,” *Fiji Times and Herald* (Suva, Fiji, January 6, 1918).
246 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 6.
247 Colonial Secretary’s office, “Notice; 23rd December, 1918,” December 23, 1918, M.P. 10283/18, National Archives of Fiji.
248 Colonial Secretary’s Office, “Notice; January 8th, 1919,” January 8, 1919, M.P. 10283/18, National Archives of Fiji.
249 “Influenza; Country Districts,” *Fiji Times and Herald* (Suva, Fiji, December 16, 1918).
occurred in this region. The *Fiji Times* correspondent in Taveuni attributed the effectiveness of this effort to the fact that the District Commissioner and DMO were both stricken early in the epidemic and could not argue the planters’ decisions to forbid transit to anyone across their properties. Complaints arose from vendors in infected areas that their clients in the clean areas were not allowed through, but as a whole the author held up Taveuni as an example of a successful quarantine effort.\(^{250}\) The north end of the island suffered at a rate comparable to the rest of the archipelago.\(^{251}\)

Some villages withdrew into voluntary isolation in an attempt to avoid infection. Even the more remote villages by this time engaged in cash-crop production at the expense of local food crops. As they ran low on food they sent groups out for additional items, with these exposures demonstrating tragic results.\(^{252}\) As late as March, 1919 some villages had escaped infection via local quarantine, though in some cases the District Officers forced such communities open out of the belief that infection was ultimately unavoidable due to “the carelessness of natives...”\(^{253}\)

Isolation did serve to protect the residents of the Lau and Yasawa islands. These groups, separated from the rest of Fiji by oceans and connected by little economic activity, managed to avoid the epidemic for a time. Throughout the period 1918-1922 no cases of influenza were reported in the Lau group.\(^{254}\) The Yasawas were

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\(^{250}\) “Influenza Taveuni,” *Fiji Times and Herald* (Suva, Fiji, December 24, 1918).

\(^{251}\) “The ‘Flu’ at Taviuni.”


\(^{253}\) District Commissioner, Colo North, “Spanish Influenza,” March 23, 1919, CSO M.P. 10154/18, National Archives of Fiji.

not infected until they sought help following a destructive hurricane in February 1919.\textsuperscript{255} Rotuma delayed infection until well into 1919.

Fiji failed to assist others in quarantine efforts. No report of infection with influenza emerged from Suva until ten days after the initial departure of the \textit{Talune}. Within these ten days the \textit{Talune} docked in both Western Samoa and Tonga, spreading the contagion further.\textsuperscript{256} More ships left to scattered destinations in the days leading up to the November 16\textsuperscript{th} declaration of influenza as reportable, none of which reflected infectious disease on their Bills of Health.

The aftermath of the epidemic brought changes. April saw both the final cases of the 1918 variant influenza in Fiji and the establishment of two isolation stations for quarantine purposes. These islands, Makuluva and Nukulau (figure 8), were run by the Colonial government but paid for from fees gathered from shipping companies at a rate of ten shillings per day.\textsuperscript{257}

By May 1919 W. L. Parham reported the following quarantine measures in place for a steamship trip from Auckland to Suva:

1. Permit required to purchase ticket.

2. Six pound surcharge per person to cover quarantine costs in Fiji.

3. The ship was met by a Medical Officer who directed all aboard to quarantine at the depot on Nukulau Island due to the possible illness of two crew members. (Nukulau was a former resort island and the conditions were very agreeable)

\textsuperscript{255} "Troubles of Islands," \textit{Ashburton Guardian} (Ashburton, NZ, March 4, 1919).
\textsuperscript{256} Melissa McLeod, "A Review of Non Pharmaceutical Interventions at the Border for Pandemic Influenza" (Dissertation, University of Otago, Wellington, 2007), 32, (Wellington School of Public Health).
\textsuperscript{257} H.W. Harcourt, "Quarantine Regulations" (Government Printing Office, Suva, Fiji, April 16, 1919), CSO Papers for 1919, page 102., National Archives of Fiji.
Though the strictures seem rigorous, Parham’s father noted that there was a launch with supplies every day from Suva, with no protections taken to prevent the crew from returning to town infected. In a reflection of the problems preventing initial adoption of quarantine, the shipping companies began to complain immediately of disruptions and fees, while passengers accused the shipping companies of ‘extortionate’ quarantine levies.

(Figure 8: Nukulau Quarantine Station, Fiji)

258 Reeve and Parham, On Fiji Soil, 17.
260 G. Wright, “Protests Against the Extortionate Charges Made by the Union Steam Shi Co. for Quarantine Fees.,” May 22, 1919, CSO M.P. 3450/19, National Archives of Fiji.
The epidemic influenza of 1918-1919 killed 5-6% of the population of Fiji in eight to ten weeks, if the 8,000 to 9,000 person mortality estimates are accepted. These numbers are approximations, as in most districts residents sought no medical assistance and many deaths were not recorded. Incidence and mortality was heaviest in young adults, with males more likely to become ill. Children under 15 were generally infected but had a good prognosis. Those between 15 and 45 years of age proved to be the worst affected, with those over 45 years of age showing increasing resistance to the illness. Pregnant women died in large numbers. Few elders died in the epidemic. The official estimates show a total mortality of 8,145 out of a population of 163,792, for a rate of roughly 5%. Death rates varied greatly by ethnicity. Europeans suffered a rate of 1.41%, Half-castes 2.75%, Indo-Fijians 4.17%, Fijians 5.66%, and others a rate of 6.93%. The total population of Fiji was estimated on December 31st, 1919 as 163,847, a decrease of more than 2,000 from two years earlier.

These numbers are all estimates, since death registration broke down early in the epidemic. By March, 1919 the Colonial Administration was threatening legal action against those that had not declared someone in their household who had died of influenza. Nonetheless no final accounting of the epidemic losses has ever been considered authoritative.

The most obvious impact of the epidemic in Fiji was demographic. Since those of reproductive age, 15 to 45 years, suffered the greatest mortality population growth was slowed significantly. Over the course of the next 30 to 40 years the reproductive

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265 Ibid., 5.
266 Acting Chief Medical Officer, Fiji, “Report on the Medical Department for the Year 1919,” 1.
capacity of the Indo-Fijian population diminished by one tenth, and that of the Fijians by one eighth. In 1919 the Fijian birth rate declined by twenty-two percent from the average of the two preceding years, and the Indo-Fijian birth rate by nineteen percent. By 1956 Fiji’s population increased to the most commonly estimated level of immediately before the measles in 1875.

The Indo-Fijian population suffered significant dislocation, due to the lack of family structures beyond the immediate nuclear families developed by the imported workers. Without several generations of family in country, the deaths of the adults left no one to care for elders or children, necessitating the Colonial government and the mission groups to step in. Before 1918 ended new Indian Orphanages were opening under the aegis of the Methodist Mission.

Trade suffered as the deaths and debility caused by the epidemic drove up labour costs throughout Fiji. Much of the fruit trade, which operated on a narrow margin, became uneconomical when one day in quarantine could ruin an entire load of bananas. The quarantine could be on either end of the trade chain. Several shipments of fruit were lost while Fiji-loaded ships waited for the Australian quarantine system to clear them. Similarly, the CSR and competitors were accused of raising the price of sugar significantly to recoup their losses and increased costs from the epidemic.

268 McDonald, “Diseases in Fiji; Presidential Address 1959,” 69.
269 McArthur, Island Populations of the Pacific, 34.
270 Ibid., 354.
272 “Fiji’s Fruit Trade,” Evening Post (Auckland, N.Z., April 2, 1919).
274 “Price of Sugar,” Grey River Argus (Grey River, NZ, July 5, 1919).
Beyond the number of deaths there were specific bureaucratic questions to be considered. Who paid for the cemetery pegs used? In those graves where multiple bodies were placed, who had the right to raise monuments over them? The private hospitals attempted to charge the colonial government for services rendered, so who was responsible for these accounts? In the event by mid-1919 the Colonial Government had spent 11,550 GBP (worth 414,000 GBP in 2010) in special influenza expenses in excess of the standard amounts budgeted for the medical department.

Fiji was not as devastated by the 1918 influenza as Tonga or Western Samoa, but still failed to exclude the virus in the model of American Samoa. Mortality rates in the archipelago were roughly 1/5th those of Western Samoa, yet five times that of New Zealand. With the best infrastructure in the region and the largest contingent of medical professionals, why did Fiji still lose one out of every twenty residents to the outbreak?

The Fiji Times, after a long review of the epidemic and the local government response, savaged the government response. The Board of Health was termed a failure, having chosen not to use its considerable powers in any meaningful way until far too late. This failure was laid not at the feet of the Board members, but at those of the Medical Department who advised the Board. The Times called for the appointment of a commission of enquiry with the power to investigate all aspects of the epidemic, especially the failure of quarantine and the lack of preparation despite repeated warnings.

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275 Manager, Suva Cemetery, “Manager Suva Cemetery to Commissioner of Works,” December 27, 1918, CSO M.P. 182/19, National Archives of Fiji.
276 Manager, Suva Cemetery, “Manager, Suva Cemetery to the Honourable A/g Colonial Secretary.”
277 Chief Medical Officer, Fiji, “Accounts of the Vancouver-Fiji Sugar Co. Ltd. for Services Rendered During the Influenza Epidemic.”
278 Acting Receiver-General, Fiji, “Special Warrant for Expenditures in Connection with the Influenza Epidemic,” June 19, 1919, CSO M.P. 4033/19, National Archives of Fiji.
279 “The Epidemic III.”
The Legislative Council also suggested perceived governmental failures in their response to the Governor’s Address in 1919, referring to “an easy entrance into Fiji owing to insufficient and ineffective preventative measures.” No investigative commission was ever appointed. CMO Lynch, responsible for the local response to the epidemic, left on pre-retirement in July 1919. He never returned. In what might be seen as a comment on the Colonial medical staff reaction to the epidemic, he was not replaced by his second-in-command, Dr. Montague. Instead a doctor from the colonial service in Uganda with significantly less experience became the next CMO.

Governor Rodwell attributed the mortality to other factors. These included the depletion of the medical and governmental infrastructure by four years of war, the failure of the transportation network due to illness amongst the crews and the breakdown of his personal launch, and the labour strikes in Australia and New Zealand preventing rapid assistance from being dispatched. More than any other factor, however, he blamed the behavior of the Fijians themselves. This refrain, laying the blame for the tragic outcome at the feet of a perceived cultural failing in both Fijian and Indo-Fijian groups, was loudly repeated by various Europeans. Had these cultures simply been of a higher moral standard, the argument suggests, they could have taken better advantage of the benefits of civilization (including medical care) brought by the Colonial Administration. Instead they avoided hospitals and refused assistance in relief efforts. The failure in Fiji, according to this argument, was the Fijians.

280 J. M. Hedstrom, “Reply to the Governor’s Address,” July 1, 1919, C. P. 35/1919, National Archives of Fiji.
282 Campbell, A.W. et. al., “Doctors of Fiji to Governor Rodwell”, September 25, 1919, Despatches to the Secretary of State, CSO Vol. 47, National Archives of the United Kingdom.
283 Governor Cecil Rodwell, “Governor Rodwell to the Secretary of State for the Colonies,” January 25, 1919, CSO M.P. 492/19, National Archives of Fiji.
284 “Influenza Epidemic, Correspondence with the Secretary of State Respecting 1918-1919,” 7.
If there was a disconnect between Fijian and Indo-Fijian response to the epidemic and perceived best practice it might well be traced back to the actions of the Europeans themselves. Fijian attitudes toward illness and mistrust of European medicine had its roots in the impact of diseases brought to Fiji by European traders and missionaries. Be it the lingering fears from the 1875 measles or the social disruptions from the loss of perhaps 60% of the population in 150 years of contact, Fijian society was traumatized. What traditional authorities remained in 1918 were under the direct control of the British, and when the Colonial apparatus became confused and static in response to the crisis there were not indigenous social forces strong enough to fill the gap.

The Indo-Fijians were taken from a palette of ethnic and religious groups inhabiting the subcontinent. When disaster struck they had little more in common with their fellow girmit workers than with the indigenous groups or their European employers. Without the support of extended family networks and resilient social structures they fell back on their own resources and had no reason to help others. This self-reliance also meant that Indo-Fijians could expect little help from their neighbors. Unfortunately the economic conditions of the War had left little reserve for these families to rely upon.

The Medical Officers were working from a limited understanding of influenza. Its means of transmission and causative organism were in dispute. With a mild form of the disease already present in the colony there were doubts that a second outbreak of a more virulent form was possible, not to mention likely. Some believed infection was inevitable. Imposing quarantine could significantly impact the financial state of the colony without any guarantee of success. The CMO and his advisors made a decision with the data at hand, and held to their view until the
epidemic was so far entrenched in Fiji that mere survival often eclipsed efforts at organized response.

Fiji was not unique in this infection and experience of the pandemic of 1918. Yet Fiji had a specific set of complications that drove the intensity of the influenza. The weather was bad. Between the 6th and the 18th of December nearly a half meter of rain fell. Villages were waterlogged and homes shut tight, preventing ventilation. The broad ethnic and linguistic divisions made educational efforts more complex and resource intensive. The replacement of the High Commissioner in early October left the upper tier of the Colonial government in disarray, and the decision in 1916 to rid the colony of the Native Affairs Department was still felt as disruption at the local level. The war was a distraction and resource drain, while the Armistice celebrations provided a perfect means of spreading disease. The fact that Fiji provided the workers for the Talune’s travels created multiple injections of influenza carriers into the islands, potentially increasing the proportion of the populace ill at the same time. None of these factors was the proximate cause of the death rate in Fiji, but acting together alongside the bureaucratic and cultural factors they drove the ‘flu into the heart of the islands. Recovery would take years.

The Talune continued on her way. Apia was her next stop. Western Samoa was about to claim its unenviable place in the history of infectious disease.

285 "Notes on Influenza Epidemic in Relation to Fijian Character and Mode of Living," 1.
286 McArthur, Island Populations of the Pacific, 32.
Chapter 3: Western Samoa

(Figure 9: Samoan Times, 7 December 1918)
The 6th of November found the *Talune* back at sea, steaming away from Levuka on her monthly sweep through the islands. Within a day she was due to reach Apia, the capital of New Zealand-occupied Western Samoa. The quarantine restrictions in Fiji did not slow her progress, and the workers newly loaded from Suva faced no isolation from ill crew members. As disease continued to spread below-decks the ship sailed through beautiful seas, toward as yet untouched ports.

Western Samoa suffered the greatest known proportional mortality of any state from the pandemic of 1918-1920. Three months after the visit of the *Talune* at least a quarter of the population was dead (figure 9), with rates higher in men than women, and greater lethality amongst young adults than any other demographic group. The Western Samoan epidemic changed the social structure of the islands, drove new political movements, and ensured the continued division of the archipelago. The severity of the epidemic in Samoa, even when compared to the decimation of Fiji and Tonga, had its roots in the unique cultural, demographic, political, geographic, religious, and colonial nature of Western Samoa in 1918. Samoa was both more vulnerable to infection and more likely to suffer devastation once the infection arrived due in part to its unique political structure. The nature of the government and the economics of Western Samoa worked against any effective response to the epidemic. Western Samoa would stand as the most brutal example of the power of the 1918 virus, and the societal elements which drove its lethality.

To understand the vulnerability of Western Samoa to the pandemic, and the severity of the local epidemic within the colony, a brief review of recent Samoan history must be undertaken. Geography, culture, and demography within Western Samoa shaped the colony’s vulnerability to the spread of infection. Finally, a description of the course of the epidemic within Western Samoa and the responses,
both local and foreign, will illustrate the perceptions of those in authority and how these assumptions drove the course of the influenza visitation.

**Samoa before Partition**

The Samoan archipelago is made up of a number of relatively high volcanic islands lying almost parallel to the equator at roughly fourteen degrees south. These islands are surrounded with coral reefs, limiting access to much of the coastline. Water tends to be scarce inland due to the porous nature of the volcanic rock. Where it does form into streams and flow into the sea, it has carved openings in the coral. Thus for reasons of both water and sea-access settlement in Samoa has traditionally been in a ring upon the coastal strip of each island, concentrated around streams and springs. The north coast of Upolu possesses the greatest number of suitable sites, and has traditionally supported the most concentrated population in the archipelago.\(^1\)

Before the modern day there had been no significant ‘highland’ settlement on any of the islands, unlike Fiji, due to the lack of water and thus arable soils. This settlement pattern encouraged the growth of small city-state like polities based upon those villages with the most abundant water supply and access to the fishing areas of the open ocean.\(^2\) With the village as the basic unit of government, the political history of Samoa has been fractious. This local identity fostered competition, often violent, between Samoan villages that saw themselves as distinct from their neighbors at a fundamental level.

Traditional Samoan society is based around the extended family, termed the ‘*aiga*.’ Each *aiga* selects a *Matai*, or family leader, from within its ranks. He (*Matai* were nearly always male) is responsible for representing the family in public and

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\(^1\) Ibid., 98.
directing its operations and the distribution of its property in private. He can be removed, or choose to step down, but the role is usually for life. When taking the role of Matai the office-holder takes the family name as his title. For example, the head of the Mataafa family is known as Mataafa, with his first name attached afterwards at times to designate the particular office holder. Amongst the Matai are two classes, the Ali’i, or Chiefs, and the Tulafale, or Orators. The Orators determine the suitability of Chiefs for office, act as viziers, and retain the lore regarding titles and offices as well as cultural traditions. The Chiefs hold governing authority, but at times have been dominated by their Orators.

(Map 3: Samoa³)

Within the Samoan system villages were governed by the council of Matai representing the families traditionally resident in that village. These councils acted as

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local judicial, executive, and legislative bodies, and wielded the authority to banish or otherwise punish offending members. Groups of villages would band together for defense and trade into districts, but there was no equivalent executive body at the district level, just a Fono (council) in place to allow consultation. With no strong executive above the village level, larger hierarchal systems such as the kings of the Hawaiian Islands could not develop, and dominance by an individual of the entire archipelago was both rare and brief. Due to the combination of geography and culture the village remained the ultimate expression of political identity, even as Samoa developed a higher population density than the neighbors due to a surplus of arable land in the coastal areas of the large islands. This agricultural potential, and the surplus population it allowed, was centered in the western islands of Upolu and Savai’i.⁴

Though villages formed the most common functional political unit, they did not exist in isolation. The geographically mandated ring pattern of settlement allowed villages to maintain close contacts with those on either side. Groups of villages would form sub-districts with their own Fono, but these held little power. These sub-districts were grouped into even more amorphous districts, of which the most heavily populated island, Upolu, had three. While these districts did not serve as seats of power, they did bestow titles. With these Upolu titles, and the single main title of less populated Savai’i, came great social status and the potential for political leadership. Only the concurrent holder of these four titles could be named Tafa’ifia or king. This position was empty far more than filled, and once obtained had no infrastructure or other support in place to assist in utilization of the titular powers. The titles were not hereditary, so the kingship splintered upon its holder’s death. Samoa remained chronically politically divided.

⁴ Howe, Where the Waves Fall, 231.
By the time of European contact two districts of Upolu granted their titles to the Sa Tupua family, and the other to the Sa Maleitoa, who also held the significant title of Savai‘i. These two families formed the core of rival political factions, frequently at violent loggerheads (occasionally with multiple claimants to a family title). Conflict and rivalry allowed for the penetration of outside forces into the Samoan political structure.

The first European visitor to the Samoan archipelago was recorded as the Dutch explorer Roggewein in 1722. The next European explorers were French; Bougainville in 1768 and La Perouse twenty years later. Bougainville gave the islands the title of “The Navigator Islands” due to the large number of canoes and dugouts he encountered in their waters. Reports to European capitals spoke of both the beauty of the islands and the savagery of their occupants, helping to minimize the number of European visitors for more than a century. By 1791 the British made contact, and the London Missionary Society, led by John Williams, established a large and active presence in Samoa by 1830. The United States’ Exploring Expedition made the earliest reliable charts of the group in 1839.

The middle of the nineteenth century found the traditional competition for land, economic power, and political position between the dominant chiefly factions continuing. The struggle had reached a new level of intensity, however, with these factions now supported by the colonial interests of Germany, Britain, and the United States. Apia developed in the 1830s as the major expatriate settlement in Samoa and the centre of foreign political power. As this settlement lay outside any Samoan village there was no traditional structure for the town. The Consuls of Hamburg

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6 S. M. Lambert, MD, “Health Survey of Western Samoa with Special Reference to Hookworm Infection” (Rockefeller Foundation, International Health Board, August 18, 1924), 3, RG 5.2, Series 245, Box 22, F. 134, Rockefeller Foundation, International Health Commission.
(later Germany), Britain, and the United States, all based in Apia, cooperated in its governance. By 1879 a Municipal Board was established, dominated by the Consuls, and remained in place through 1899. From the beginning, Apia existed as an outside entity separate from Samoan structures.

A drought and near-famine in the 1860s led to large-scale alienation of land in the western islands. Land rights were traded for foodstuffs, assistance on the creation of irrigation systems, and the classic coin of support (directly and through weapons provision) in political conflicts. These parcels, purchased by Hamburg based entities in the main, created the core of the plantation system that would dominate Samoan economic life for the next sixty years. Copra-producing plantations did more than change the economic state of Samoa; they altered the ethnic balance through the importation of labourers from China and Melanesia. They also gave the Consuls reason to seek a more settled government for the entire archipelago, rather than just their base in Apia, to protect these burgeoning commercial interests.

Multiple claimants set about making themselves Tafa'ifa with support from outside factions. The civil wars that followed encouraged further involvement by foreign powers as the plantation economy grew and the competition for colonies accelerated. Believing that they could not independently resist outside intrusion, many Matai sought to join an existing empire for protection. To do so they needed the authority to negotiate an accession. In 1873 the Matai established a bicameral legislature of a sort, with the Taumua as the upper house and the Faipules as the people’s representatives.

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8 Ibid., 9.
The petition from the “Chiefs Taimua and Faipule” presented to the first Governor of Fiji, Sir Arthur Gordon, in April 1877, named several reasons why the chiefs wished to fall under British protection and possibly full control. They argued that without outside help there would be war across Samoa; that Samoa would be at the “mercy of some bad and unprincipled persons”; and that it was necessary to protect Christianity, life and property, and good government. These moves were encouraged by British residents who had supported Fiji’s incorporation into the Empire in 1874, and who were concerned regarding American encroachment in Eastern Samoa. The response was not positive. In late 1877 the British Secretary of State for the Colonies, Earl Carnarvon, wrote to Gordon, explaining the Government’s decision to decline sovereignty over Samoa. He praised Gordon’s prudence in dealing with the petitioner group of Faipules that travelled to Levuka to enlist his help in the petition. While noting that combining Samoa with the Fijian Governorship might reduce costs of both, he explained that:

Her Majesty’s Government are, as at present advised, strongly opposed to annexing or assuming the Protectorate of the Navigators’ Islands in any shape or form whatever, and they are unable to entertain at the present time any proposals for the further extension of the Crown’s sovereignty or protection over Islands of the South Sea.

Instead a Deputy Commissioner, answering to the Governor of Fiji, arrived to demonstrate Britain’s friendly interest in the welfare of Samoa. The next year saw a treaty with the United States, who refused annexation but guaranteed respect for and protection of sovereignty in exchange of rights at Pago Pago harbour. By 1879 all

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10 Taimua and Faipule of Samoa, “The Taimua & Faipule of Samoa to Governor Sir A. Gordon,” April 3, 1877, AAEG, 950, 4/C, 311/1/2, 1A, Archives New Zealand, Wellington.
three interested powers negotiated treaties with Samoa protecting their rights and pledging support against aggression by outsiders.

The three consular powers established a Board consisting of the Consuls to govern their citizens in Apia, while outside of the foreign center the traditional chiefs still wielded control. Still, matters were not stable. As early as 1879 the Acting High Commissioner in Fiji reported to London that civil war in Samoa was imminent.\(^\text{13}\) In 1887 the German consul unilaterally named the Tamasese claimant king, dissolved the Consular government of Apia, and tried to seize the town in the name of the new King. Though Apia remained independent consular relations were irrevocably damaged. By 1888 the US and British consuls openly backed one claimant to the supreme title while the Germans backed another.

The continuing conflict clearly threatened the autonomy of the Samoan people and their hold upon their lands. Foreign support encouraged and deepened the divisions amongst the Samoans. March of 1889 found three American and one British warship in Apia Harbour with guns trained upon three German combat vessels. An early start to the First World War might have occurred then, in the remote Pacific, had the weather not intervened. One of the strongest cyclones ever recorded in Apia struck, destroying two American and two German vessels and severely damaging the third ship of each contingent. Only the British vessel escaped unharmed. In notable contrast to some European descriptions of Samoan behavior in 1918, Samoan men during this cataclysm tied ropes to their waists and dove into the raging seas to rescue sailors, regardless of their nationality.\(^\text{14}\)


This conflict could not continue. Not only had the Great Powers nearly come to blows over issues surrounding the Samoan Kingship, the Samoans themselves were better armed and found greater financial support for warfare than at any time in their history. What seemed like minor efforts in the halls of Washington DC or Berlin translated to vicious combat on the ground, with villages razed and inhabitants slaughtered. As Apia divided into warring camps commerce slowed, then stopped. The Samoans were on a path to either lose their nation or destroy it. Delegations were sent to the Consular Powers of the United States, Great Britain, and Germany, seeking a solution.\textsuperscript{15}

The resulting 1889 conference, The Berlin Conference on Samoan Affairs, placed the islands under the joint protection of the three Consular Powers (now termed Treaty Powers). Though the extant Tafaʻifia was to remain upon his throne, the three Treaty Powers appointed Foreign Officers to administer the islands, supposedly in conjunction with the royal government.\textsuperscript{16} The goal was to create a government that protected the interests of the three Treaty Powers without committing them to further involvement in Samoa while also ending the fratricidal conflicts that so impacted trade.

Given the chaos regarding land ownership that reigned before the Treaty, (at one point the claims included several times more land than the total area of the islands) the Powers chose to act first upon land issues. They appointed an International Land Commission, and all titles involving alienation of land had to be cleared through it before retaining validity. Many, if not most, were deemed invalid.

\textsuperscript{15} Norman Macdonald, “Norman MacDonald to William Massey, Prime Minister,” March 2, 1918, 1, AAEG, 950, 4/C, 311/1/2, 1A, Archives New Zealand, Wellington.
\textsuperscript{16} Ibid.
The remaining claims and divisions formed the basis for later land governance decisions in both German and American Samoa.\textsuperscript{17}

The laws of King Malietoa, promulgated in 1892, show the clear influence of the consuls. Fines were to be levied in U. S. Dollars. The laws addressed theft, perjury, and bribery (as well as blasphemy) but ignored most traditional Samoan concerns.\textsuperscript{18} Less than a justice code, they instead served as framework for business to prosper in the islands, protecting contracts and enshrining the existing rights of the consuls in Apia.

Conflicts were not resolved, however, simply tamped down. The Samoan political factions were not ready to surrender their claims on the basis of outside demands, and both they and the Treaty Powers were happy to manipulate each other to pursue their goals. Conflict again broke out, first at the village level then at the district. The Treaty held for less than a year.

With the death of King Malietoa in 1899 the simmering conflicts between the Treaty Powers and their Samoan factions erupted into civil war. Though the Treaty of Berlin stipulated an election for the next King, the supporters of rival claimants organized their own elections and chose, not surprisingly, their preferred candidates. These candidates, from the Mataafa (German supported) and Tanumafili (American and British backed) families gathered their supporters and conflict increased. The civil war took on a new dimension with the deaths of British and American sailors in combat with Mataafa’s forces in April, 1899.\textsuperscript{19} American and British warships in turn

\textsuperscript{17} Ibid., 2.
\textsuperscript{18} King Malietoa, “Laws Issued by King Malietoa Providing for the Punishment of Criminals,” April 9, 1892, Box 1; Series 6, General Interest File 1872-1948; Records of the Governor’s Office; Records of the Government of Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
shelled Apia, then held by the Mataafa faction. Seizing Apia, these forces declared martial law.\textsuperscript{20}

Again seeking to avoid Great Power conflict, the Treaty Powers chose to solve the situation through arbitration. Establishing a Peace Commission, the provisional government disarmed the Samoan factions and brought in King Oscar of Sweden to determine sovereignty and claims for war damage. King Oscar found generally in favor of the Germans on war losses; and removed British and American interests from Western Samoa (Upolu and Savai‘i), British and German interests from Eastern Samoa (Tutuila and Manu‘a), and strengthened British positions elsewhere in the Pacific. New Zealand, which had advocated extending British rule via their own good offices over Samoa for the previous two decades, was stopped from intervening in this settlement only by concurrent involvement in the Boer War.\textsuperscript{21} This agreement, the Washington Convention, set the political shape of the archipelago up to the current day.

Western Samoa before the Epidemic

Dr. Wilhelm Solf, formerly the chief administrator of Apia for the Treaty Powers, stayed on as the first Governor of German Samoa (figure 10).\textsuperscript{22} Having used the accession and maintenance of a single king to create a Western Samoan polity out of the warring groups, the question became how to keep it together. As argued by Ian Campbell, Solf and Germany as a colonial power originally sought direct rule by Europeans down to the village level but, upon finding this impracticable, chose to leave Samoans in power at the village level with Europeans ruling indirectly from

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\textsuperscript{20} Ibid., 5.
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above. Coming from centralized nations with extensive bureaucracies, the new colonial rulers sought to build a similar system in Samoa.

The Germans recognized that the greatest outside influence upon the Samoans were the British and French missionary groups, not the Imperial political structure. While not inherently hostile to the German administration, the missions found little incentive to help alter the social hierarchy they spent seventy years negotiating. Rather than trying to force a social change in a potentially hostile environment, the German government concentrated upon economics and politics.

In pursuit of this end, Solf chose to change the nature of the power structure in Samoa to prevent rival factions from gaining power. By seizing the fine mats, the items of traditional power exchange, and redistributing them himself; and further by eliminating the representative bodies of chiefs and personally appointing all members of a new body; the Imperial Governor sought to create a power structure both subservient and locally effective that would facilitate a permanent German presence in Samoa.\(^{23}\)

The German government established a new style of paramount chieftaincy in the place of the traditional structures. When the Taumua and Faipule objected, the titles were abolished and many titleholders banished. In their place he created a Fono of Faipules, filled with chiefs that were also paid German employees in local government. The first Mau or ‘opinion’ rising in 1908-09 developed in reaction to this. While quite vocal, this original Mau failed to alter or slow Solf’s reforms. When Mataafa died in 1912 the Germans abolished his paramount chieftaincy, as well as the four regional titles which traditionally led to the Tafa’ifa title. Instead, the leading

Tamasese and Maleitoa became High Advisors to, and employees of, the Imperial government.\textsuperscript{24}

(Figure 10: Raising the German flag at Mulinu’u, Samoa, 1900\textsuperscript{25})

\textsuperscript{24} Keesing, “The Mandated Territory of Western Samoa and American Samoa,” 14.
Samoa had already become the centre of the German mercantile empire in the Pacific. The German administration favored the development of large plantations with the interests of the Deutsche Handel und Plantagen Gesellschaft (DHPG) known as the German Firm, dominating. Roughly nineteen percent of the land in Samoa, the richest and most arable swathes, formed European-owned plantations staffed with Chinese and Melanesian labour as Samoans did not volunteer for such work. Copra was the main product (figure 11), and the DHPG controlled half of copra production. The officers of such large firms lived in Germany, the returns were transferred back to German banks, and their continued survival necessitated political support in Berlin. These plantations, as opposed to Samoan or expatriate small farmers, would offer unconditional support to the Imperial Government.

The German administration did not seek to ‘improve’ conditions for the Samoans under their control. Measures to stop the violence between political groups; the seizure of weapons; the establishment of a system for determining land ownership and preventing the further alienation of Samoan land; and a continued ban on gambling and alcohol were the extent of their social engineering outside the political realm. Even this suite of modest efforts proved controversial for Solf’s opponents in Berlin, who accused him of ruling Samoa “with flowers in his hair”, a remark which charmed the completely bald Solf to no end.

Cooperation existed between the two Samoan Governments, to the point of the German and American administrations implementing joint policies. They issued one notable joint decree of 1906 to reduce the size and frequency of malagas, processions between villages and islands that involved feasting and serious

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26 Ibid., 9.
29 Rowe, *... Samoa Under the Sailing Gods*, 83.
disruption, in the eyes of the government, of agricultural schedules. Other joint efforts involved alcohol control and the disarming of rival political factions. Travel between the two colonies continued on a common and casual basis. They shared missionary groups, family ties, and traditional ceremonies. They also shared disease.

(Figure 11: Copra plantation, German Samoa\textsuperscript{30})

Health and History in Samoa

The health history of the Samoan Islands is not very different from that of the Polynesian and Melanesian neighbours. Local diseases abounded, with yaws being the most dramatic. Early explorers noted elephantiasis in the Samoans, secondary to filariasis.\(^{31}\) Visitors recounted leprosy, parasitic diseases, conjunctivitis, TB, skin diseases, pulmonary diseases, and spinal deformations as common. The standard slate of outside diseases caused havoc as foreign contact became more pronounced. Pertussis struck in 1848. Dysentery came in waves, and measles arrived with horrifying mortality in 1893.\(^{32}\) Further visitors brought mumps and diphtheria. Due to stringent and clearly effective quarantine procedures, smallpox never gained a foothold in Samoa, but nearly every other major contagious disease made an appearance.\(^{33}\)

Influenza likely arrived in the islands by way of missionaries in 1830, carried amongst the passengers of the mission ship *Messenger of Hope*, and recurred yearly for a decade. Severe outbreaks developed in 1837 and 1846 and influenza maintained a fairly consistent presence thereafter.\(^{34}\) The disease reappeared in 1891, with reports reaching Sydney of influenza of a severe type and a large number of deaths amongst Samoans.\(^{35}\) Fanny Stevenson described the fear of the disease amongst her Samoan staff and friends. She also speaks of their knowledge of epidemic disease and the use

\(^{31}\) Lange, “A History of Health and Ill-Health in the Cook Islands,” 45.


\(^{33}\) Ibid., 201.

\(^{34}\) George Turner, *Samoa, A Hundred Years Ago And Long Before* (Gutenberg Project, 2004), http://www.gutenberg.org/etext/14224.

of isolation as a way to avoid infection. Yet, as will be seen, knowledge of isolation as a control for infectious illness contrasted with cultural practices around disease.

Isolation and quarantine were fixtures of German policy in Samoa. Receipts show quarantine charges levied against even intra-colonial shipping, such as the Samoa Shipping and Trading Co. Ltd. The Fiji Times praised the Imperial Government for sparing neither labour nor expense to enforce their smallpox quarantine in 1913, including the successful quarantine of a ship with more than 1200 indentured servants aboard in Apia Harbour, and held in contrast the ineffective quarantine measures in place in Sydney. A review of the German regulations for quarantine just prior to the First World War show an extensively detailed list of actions performed with each ship that entered port, including a twenty-three point questionnaire that had to be signed by the Captain, First Officer, and Ship’s Doctor.

Yet for all the efforts regarding quarantine the Imperial German government provided little direct medical assistance to the Samoan people. During the period of German rule in Samoa there was a basic 15 bed hospital for European patients, two large wards for indentured workers, and no functioning facilities for Samoans. There were two government funded physicians for the garrison and government workers, and a private physician under contract to treat indentured workers, but all other inhabitants were required to seek the care of private providers. For most Samoans this meant no modern care whatsoever.

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37 Parkhouse & Brown, “Parkhouse & Brown, General Merchants, to Dr. Schultz, Acting Imperial Governor,” June 30, 1906, Papers of the Imperial German Government of Samoa, Museum of Samoa.
38 “Smallpox Quarantine in German Samoa,” *Fiji Times* (Suva, Fiji, July 29, 1913).
39 Acting Governor Schleitwein, “Ordinances Relative to Quarantine,” February 13, 1913, G, 21, 11/, Inwards despatches to and from the Governor relating to Samoa - General Files - 6 February - 9 October 1919, Archives New Zealand, Wellington.
40 S. G. Trail, “Medical Service,” March 19, 1920, 1, IT, 1, 518, EX 89/2, 1, Medical Service, Archives New Zealand, Wellington.
The Christian missions in Samoa, as throughout the Pacific, attempted to fill this gap. These efforts received the support of the Imperial Government, with Governor Solf writing to Berlin:

The Missionary, the Doctor, the Craftsman; this is the ideal brotherhood for the performance of the purpose of missions. Some good religious and educational books, a set of tools and a box of soap and medicine is a better outfit than shiploads of Bibles and religious tracts.\textsuperscript{41}

In medicine as in most social fields, the imperial government was happy to let the missions take the lead. However, the ill-will between the Catholic and London Missionary Society (LMS) missions was, in the continuing words of Dr. Solf, a constant source of dissention. Switching religious adherence to facilitate access to particular medical facilities became a common practice in the islands.

Traditional medicine persisted despite the attempts of the missions to eliminate its practice. Early visitors commented upon the Samoans’ facility with surgery.\textsuperscript{42} The only local medicines were emetics, but bleeding and topical treatments were available.\textsuperscript{43} Western medicine served many Samoans as a last resort, to be accessed only when traditional methods had failed.

Strong social rules guided the treatment of illness. Meetings of local \textit{Matai} as well as medical providers were often required to decide upon care. When a treatment was settled upon, travel and/or home care required village involvement and great social activity. Frequently the costs for food and entertainment of those there to

\textsuperscript{41} Dr. Solf, “Report by Dr. Solf to the Imperial Colonial Office in Berlin,” November 21, 1907, 4, G, 21, 10/, Inwards Despatches to and from the Governor Relating to Samoa, General Files,, Archives New Zealand, Wellington.
\textsuperscript{42} Lange, “A History of Health and Ill-Health in the Cook Islands,” 66.
\textsuperscript{43} Turner, \textit{Samoa, A Hundred Years Ago And Long Before}. 
support the patient could be ten times that of the care itself. Illness and healing held great social import.

**New Zealand and Occupation**

The fifteenth year of German rule in Western Samoa saw a weakened traditional power structure in the midst of a reform meant to further reduce its authority vis-à-vis the colonial government. Education and health were left to the missions, with no notable improvement since the advent of German rule. Planters funded by and working for large plantation corporations based in Germany dominated the economy, with a strong trader presence in Apia to handle the extensive agricultural commerce. Samoans controlled their villages, farmed at a subsistence level, and looked to the missions for guidance. Then came the war.

Following the advent of hostilities with Germany in August, 1914, the British asked New Zealand to occupy German Samoa. The Admiralty considered the presence of a German wireless station on Samoa with a range of roughly 1500 miles a serious risk to British naval forces. Given New Zealand’s desire to make their place in the Pacific and long interest in Samoa as a colony, action was quick.

Instructions were simple. Go to German Samoa; stop the German wireless station from operating. Establish a British wireless station. And, for all other contingencies: “When you have seized the islands you will take such measures as you may consider necessary to hold them, and to control the inhabitants.”

The invasion and occupation went smoothly. A flotilla of transports and warships from the British fleet met with French and Australian forces in New

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Caledonia. Sailing onwards to Fiji, more men were enlisted as well as certain Samoans living in Fiji who would act as ambassadors for areas outside Apia.

The armada reached Apia on the morning of the 29th of August. In response to an ultimatum the senior German official present stated that he could not take responsibility for surrender in the absence of the Governor but that no opposition would be offered to a landing. The next day the occupying forces raised the flag of Great Britain over the Government House in Apia (figure 12). Colonel Logan, in charge of the invasion force, met with the local chiefs to establish a new governing agreement. He also accepted the parole of the German officials in Apia, and with some exceptions retained them in their positions.46

Logan (figure 13) was a sheep-farmer from the South Island of New Zealand who had served with the Mounted Rifles in the Boer War. He was described as efficient and hardworking, and friendly to the point of indulgence towards the Samoans. For most of his tenure in Samoa he was well thought of locally. Yet he also valued obedience, and was unable to countenance criticism, opposition, or setbacks. These character traits would come to define his response to the greatest crisis in recent Samoan history.47

While the German response to the occupation was not violent, there were episodes of resistance. New Zealand forces arrested Commander R. Hirsch of the Imperial German Army for sabotaging the wireless station in Apia by disabling the engines powering the site.48 Forecasting sabotage of the most militarily useful asset in Samoa, the invading forces carried replacement parts and the wireless station was

46 Colonel Robert Logan, “Colonel Robert Logan to the Right Honorable the Prime Minister of New Zealand,” September 2, 1914, 2, AAEG, 950, 1/B, 311/4/10, 1, Archives New Zealand, Wellington.
47 Ross, New Zealand’s Record in the Pacific Islands in the Twentieth Century, 116.
48 Colonel Robert Logan, “Colonel Robert Logan to His Excellency, the Governor of Fiji,” August 30, 1914, AAEG, 950, 1/B, 311/4/10, 1, Archives New Zealand, Wellington.
functional within a matter of days. The Chinese indentured labourers working the plantations of Upolu and Savai‘i also posed a risk, as they had been on short rations for more than a month as the advent of war interrupted trading patterns. Logan sent out troops to prevent disturbances, and ordered planters to restore full rations, using supplies brought by the invasion force if necessary. 49

(Figure 12: The raising of the British flag in Apia, 30 August, 191450)

49 Logan, “Colonel Robert Logan to the Right Honorable the Prime Minister of New Zealand.”
50 Wikipedia contributors, “German Samoa.”
The German officials in Samoa quickly distanced themselves from the new government, and those that might have wanted to stay in their positions were ordered removed by Wellington. Logan found himself forced to appoint those non-German Europeans at hand for critical positions. The British Vice-Consul became the Native Secretary. Traders became administrators. Most positions were filled with soldiers, none of whom had any experience governing, but then neither did Logan. He chose to keep on the German-created Samoan police force, and the Samoan

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officials who manned the lowest levels of the bureaucracy. For these officials, and the village residents, little changed with the occupation.  

Logan’s view of the Samoan populace reflected a deep paternalism. His descriptions of the Samoans frequently compared them to children and stressed the need for firmness and a dominant role in order to garner respect. His final report in 1919 sums his views as follows:

It must always be remembered that their civilisation is of recent growth and too much must not be expected of it, as in all recently civilized peoples their minds are in many respects similar to those of children, combined with the deep cunning of the uncivilized.

These assumptions informed his own version of the German system of rule. Under New Zealand control the family members still elected the Matai, who would elect the chiefs, who would elect Pulenuu (magistrates) for districts. The Pulenuu elected the Faipule, or members of Parliament. Yet years of German rule had gravely weakened the traditional structures of this system. As Solf’s policies reduced the traditional power of the titles he took to personally granting, the new recipients could claim less obedience and respect in the villages and beyond. Logan built his new colonial political structure upon a traditional power base that was eroding by the month.

New Zealand never held a concrete position in Samoa. Few trading links existed between the two island groups before the occupation, and few developed during the war. New Zealanders owned none of the large plantations. Most trade went originally to Germany, and with the war exports were routed to the United

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54 Masterman, Sylvia. *An Outline of Samoan History.* (Apia, Western Samoa: Western Samoan Education Department, 1958), 43.
55 Logan, “Report By Col. Logan.”
States. The three main mission groups were based either in Australia or Britain. The one large trading group not owned by Europeans, that of the mixed heritage O. F. Nelson, was led by a man at first neutral towards and then increasingly hostile to New Zealand rule.  

Arguments arose over the status of Western Samoa under New Zealand suzerainty. Individuals involved in Samoan affairs since before the Berlin Conference of 1889 argued that Germany never annexed Western Samoa, but instead imposed a Protectorate and that the said Protectorate could be taken up by New Zealand, but New Zealand had no rights under existing treaties to annex the islands or make them colonies. These arguments carried over into the discussion of Samoa as a Mandate under the League of Nations.

Logan felt quite sure of the Samoans’ desire to remain under British (and by his not necessarily correct assumption, New Zealand) rule. As late as January 1918 he listed the four reasons he felt that the Chiefs of Samoa would choose the status quo: An English Society had brought the gospel to Samoa; the badge of Samoa had been added to the Government Ensign, a sign of respect never accorded by the Germans; the Faipule were consulted by the Government before changes regarding regulations impacting them were made; and finally that the love of the British for them was extended to justice in that Samoans could win cases against Europeans in court, which had not been the case under German rule.

Logan also felt he had the support of the Samoan elites regarding the Chinese workers in the colony. The Chinese, in fact, were to be removed from Western

57 “The Tragi-comedy of Samoa,” 1935, 4, AEFZ, 22g17, 5727, 151, 162/ 0004-0005, Archives New Zealand, Wellington.
58 Macdonald, “Norman MacDonald to William Massey, Prime Minister,” 3.
59 Gov. Robert Logan, “From the Administrator of Samoa to the Governor-General of New Zealand,” January 30, 1918, AAEG, 950, 4/C, 311/1/2, 1A, Archives New Zealand, Wellington.
Samoa. Logan judged them to be a threat and they elicited his oft-mentioned distaste for miscegenation. With the support of the Samoan Chiefs he began removing them from the colony shortly after his arrival but, given his already tenuous standing with the planters, removing their entire working population in a single act was not an option. Instead, the number of labourers allowed to re-indenture at the conclusion of their contracts shrank gradually, and all those who were not allowed to do so, or chose not to do so, were ordered out of the colony at their employers’ expense no later than mid October 1918.

The presence of indentured labourers points to the trade-focus of the Western Samoan economy. Logan would proudly comment after his departure from Western Samoa that every year he was Governor Western Samoa ran a budget surplus. This trade was significant. In 1916 the colony exported more than 235,000 British Pounds (GBP) worth of products, to seven countries, and imported nearly 200,000 GBP from seventeen markets. The same year saw the port of Apia visited by 104 foreign vessels. In 1917 317,000 GBP in goods were imported, and 320,000 GBP exported. That year ninety-nine foreign vessels docked. Commerce continued to grow during the war. Though imports and exports were nearly balanced in value in 1917, their destinations were not. Three quarters of exports went to the United States, while New Zealand took a negligible amount, less than Australia. Imports came chiefly from the United States, New Zealand, and Australia as well.

Infrastructure grew with the expansion of economic activity under New Zealand rule. With total trade growing yearly, a corresponding growth in trading

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60 Collector of Customs and Taxes, “Trade and Commerce and Shipping of the British Militarily Occupied Territory of Samoa for the Calendar Year 1916” (LMS Printing and Publishing Department, Malua, Western Samoa, 1917), D.O. 113, National Archives of the United Kingdom.
61 Collector of Customs and Taxes, “Trade and Commerce and Shipping of the British Militarily Occupied Territory of Samoa for the Calendar Year 1917” (LMS Printing and Publishing Department, Malua, Western Samoa, 1918), D.O. 113, National Archives of the United Kingdom.
networks and stores in Apia occurred. The Administration established a road
building program. The horse-drawn carriages of the German Administration gave
way to motor vehicles, speeding trade and ensuring rapid dissemination of
information, and later illness, throughout the islands.63

The planters were not content, however. Logan’s policies of gradual removal
of Chinese and Melanesian labour and the increasing use of Samoans on the
plantations failed. The Samoans showed little interest for plantation work and
labourers grew scarce. He also assisted in the prosecution and seizure of the DHPG
for continuing to trade with German firms via intermediaries. Its closure crippled
several local supply firms. Export duties were put into place and labour laws
strengthened. Planters’ pocketbooks suffered from these actions, and they became
increasingly vocal in their opposition to Logan’s rule.64 Bankruptcies became
common as the war dragged on.65

Agriculture remained mostly subsistence under New Zealand guidance.
Fishing provided the main protein source, and ongoing cultivation of small plots
near homes for varieties of taro, breadfruit, manioc, sugar cane, and cassava
provided the rest of the diet. It should be noted here, and will become important in
the narrative of the epidemic, that most of these foods either did not store well, or
were only harvested on an as-needed basis and not stored in the home.

Medical infrastructure under the New Zealand administration did not
appreciably expand, unsurprisingly given the demands of the Western Front. A
Rockefeller Foundation assessment in 1916 found two physicians in Upolu, both
working at the single fifty-bed hospital in Apia. This facility served first the

63 Logan, “Report By Col. Logan.”
64 Ross, New Zealand’s Record in the Pacific Islands in the Twentieth Century, 118.
65 Davidson, Samoa Mo Samoa, 93.
occupation force, and then Samoan patients as room allowed. The correspondent notes that the roughly 15,000 inhabitants of Savai‘i had no significant health services whatsoever. By 1918 there were four medical officers in Western Samoa, at varied levels of expertise, and a permanent nursing staff (of four) only at the hospital in Apia. As with so many other physicians in the Pacific at this time, quality was not uniformly high. The best went to the war in Europe; and many of the remainder were very old, very new, or alcoholics. A Dr. Sorely, sent to Western Samoa to work in 1916, remained only until the Talune arrived the following month and was immediately sent home for insobriety, a charge he readily admitted to.

With the expansion of infrastructure came an expansion of medical services. Early 1918 saw four doctors stationed in Apia, one on the far side of Upolu, and two on Savai‘i. The Hospital in Apia expanded to feature three wards, one each for Whites, Chinese/Melanesians, and Samoans.

There was a quarantine law in place. In proclamation #51 of 1917 Logan ordered that all ships from overseas be met by a Principal Medical Officer (PMO) or a designate who would assess conditions onboard and determine whether the vessel could continue into port. With this clearance the Harbourmaster could grant pratique and the ship could dock in Apia. No one aside from the Harbourmaster and the PMO was to be allowed aboard ship until pratique had been issued. The only exceptions were to be Western Samoan Government vessels and friendly ships of war.

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These policies seemed to be justified by the continuing increase of the Western Samoan indigenous population. The census of July, 1917 showed the following population distribution for Western Samoa: European, 1656; Samoans, 35,404; and other Polynesians, 431; for a total of 37,491. Note that the remaining Chinese labourers were not added to this total nor were members of the New Zealand garrison or Government Officials and their families.⁶⁹

Relations with American Samoa were generally good, despite Logan’s expressed distaste for Americans due to their delayed entry into WWI. Comments regarding his refusal to do business with or otherwise engage with Americans, and his view that Americans in Western Samoa were inciting a takeover of all of Samoa by Washington, were testified to by members of his staff.⁷⁰ Logan’s personal view of the United States comes through in his correspondence, with frequent descriptions of his unease with trade flows directed to America.⁷¹ Nonetheless, in October of 1918 he hosted Governor Poyer of American Samoa in his home for two nights on the occasion of an American Red Cross fund raising concert.⁷²

The view of American dominance risking New Zealand’s position in Western Samoa was echoed by commercial interests. The Burns Philp company out of Australia, which had filled many of the economic gaps left by the departure of the DPHG, publicly voiced concerns that American traders and the US Navy sought to

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⁶⁹ British Military Occupation of Samoa, “British Military Occupation of Samoa Census,” July 1, 1917, IT, 1, 511, EX 88/7, 1, Archives New Zealand, Wellington.
⁷¹ Logan, “Report By Col. Logan.”
dominate the Western Samoan export market.\textsuperscript{73} No evidence was offered, aside from the increasing flow of exports to the United States during the war.

The missions continued to play their central role in the life of Western Samoa, and maintained their competition with each other. Education remained the realm of the churches, and villages vied with each other to make the grandest donations to their denomination of choice. The guiding councils of many missions were made up of Matai, making them a secondary political organ. Even those such as the Roman Catholics who eschewed lay clergy remained major power centres within the culture. The missions served as crucial elements of the hybrid culture Western Samoans developed under colonial rule. The Bishop of Samoa died on the 27\textsuperscript{th} of October, 1918, leaving the Roman Catholic missions in Samoa leaderless as November began.\textsuperscript{74}

**The Epidemic in Western Samoa**

As 1918 worked towards November and the Talune steamed its way towards Apia, warnings arrived. The Governor-General of South Africa had telegraphed Auckland on October 12\textsuperscript{th} speaking of the seriousness of the outbreak in southern Africa.\textsuperscript{75} By October 19\textsuperscript{th} the press in New Zealand was discussing the fact that more US citizens died of the influenza than had died on the battlefields of France. Yet no warning passed on to the Pacific colonies, either from Britain or New Zealand. They were left to fend for themselves. Harry Griffin, a LMS missionary in Malua 12 miles outside Apia, reported his knowledge of the deaths in South Africa. Under oath he described his concerns regarding the influenza in Africa and discussions with colleagues of fears that it would come to Samoa weeks before the arrival of the

\textsuperscript{73} Boyd, Mary, “Coping with Samoan Resistance After the 1918 Influenza Epidemic: Colonel Tate’s Problems and Perplexities,” *The Journal of Pacific History* 15, no. 3 (July 1980): 160.
\textsuperscript{74} Logan, “Confidential Despatch No. 13, Logan to Liverpool.”
\textsuperscript{75} Earl of Liverpool, “Telegram from the Governor-General of New Zealand to the British Secretary of State for the Colonies,” November 21, 1918, AD, 1, 988/, 49/891, Medical - Influenza Outbreak 1918 - General file, Archives New Zealand, Wellington.
Talune. According to Mr. Griffin the prospect of influenza infection, and the danger of the new variant of the disease, was well known in Samoa before its arrival in early November.76

Traveling with a clean Bill of Health from Auckland, despite the illness there, Captain Mawson chose to ignore the warnings of his Fijian experience. Yet even he, or at least the Company agents on board, expected to be quarantined in Apia. Passengers from Suva to Apia paid twice the standard fare on this sailing, and when they asked were told that the remainder was for their maintenance in quarantine at Apia. No quarantine occurred. No refunds were given.77

A week before the Talune arrived concerns emerged outside the Administration.78 Citizens spoke of the pandemic in Europe and North America. It was understood locally that most infectious disease had to come by ship. The exact day of the Talune’s arrival was unknown to the general populace of Samoa due to wartime restrictions on publishing ships’ schedules. But that it was en route was in no doubt.

On November 6th the Government of New Zealand gazetted influenza as an infectious disease subject to all Public Health laws and quarantine regulations. As a New Zealand-occupied territory the rules applied equally to Western Samoa. The wireless station at Apia was operating without incident. No notice was sent. No warning was given.

The Talune reached Apia on Thursday, November 7, 1918. At the time she docked at least six passengers were ill with influenza, with one soldier being carried

78 “Influenza at Samoa; How the Disease Got Its Hold.,” Evening Post (Auckland, January 10, 1919).
off ship by stretcher. No note of their illness occurs in the ship’s log, or mention of
the quarantine at Suva and Levuka. Captain Mawson produced clean bills of health
for the vessel from both Auckland and Levuka, the second despite the partial
quarantine imposed there. No mention of quarantine was made by the Captain to the
Port Officer during the ship’s inspection. Nor was there an understanding,
seemingly, of the fact that bills of health apply to the departure port, not the
passengers aboard the ship carrying them. The complete inspection by the Port
Officer took place between the anchor dropping at 9:35 AM and the beginning of
cargo unloading at 10:50. The Talune left Apia on November 8th, bound for Tonga.

In Apia no restrictions regarding the ship followed its clearance. Samoans
were allowed aboard to meet friends, and arriving passengers were placed in cabins
recently held by the desperately ill. Despite a shouted warning (confirmed by
multiple witnesses) in Samoan from someone aboard the ship that “On this boat
there is sickness!” six major chiefs boarded the ship to meet guests and relatives.
Four would be dead before the end of the year. Loading and unloading proceeded
unhindered. Sick passengers who left the ship received no instruction and fended for
themselves.

The Port Officer who went aboard the Talune, Captain Atkinson, had no
previous experience as a Port Health Officer and was not operating under
instructions from the then- absent Principal Medical Officer. This was representative

82 Congregational Union of New Zealand, “Influenza Epidemic in Samoa: Deputation from the Congregational
Union of New Zealand and Other Religious Bodies to the Acting Prime Minister,” April 22, 1919, 3, IT, 1, 146/, EX 8/10, 1, Medical - Samoa Epidemic Commission 1919, Archives New Zealand, Wellington.
of the port health infrastructure. According to later sources, when it came to issues of port regulations:

The utmost confusion reigned. One department carried out the law as laid down by the Tripartite Government Regulations, 1891-1894; another, those brought into force by the German Government, while the Principal Medical Officer considered he was working under New Zealand regulations. This is significant as section 8 of the 1891 regulations listed influenza as an infectious disease liable to quarantine when it presented on an arriving ship, but the German Blatt of 1913 did not.

Atkinson saw his role as being to assess for risks to the safety and health of both the ship and shore, and only if a serious threat was noted were the quarantine regulations to be enforced. Even in this case, he understood that the sick would be landed and isolated, but given the lack of a quarantine facility the exact location of such isolation was a significant question. According to Atkinson’s later testimony, he was told that many people aboard the Talune had developed ‘colds’ during the journey, and several were also recovering from seasickness caused by a rough crossing from Fiji. He claimed that no mention of influenza was made, and that when he took the temperature of those suffering from a ‘cold’ he found them normal. He did not take the temperature of those not reporting ill. The Rev. Cane would testify that he was not stopped by Dr. Atkinson despite being very unwell, “in a perfect state of prostration”, and unaware of much of what was happening.

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84 Captain Atkinson, “Influenza Epidemic, Summary,” March 8, 1919, AD, 35, 2/4, Despatches from the Administrator of Samoa to the Governor-General, March-October, 1919, Archives New Zealand, Wellington.
85 F. L. Atkinson, “Influenza Epidemic,” undated, G, 21, 11/, Inwards despatches to and from the Governor relating to Samoa - General Files - 6 February - 9 October 1919, Archives New Zealand, Wellington.
Had quarantine functioned in this case it is not clear where the infected and exposed might have been sent. No permanent quarantine area operated in Samoa. Col. Logan claimed that there were no military tents in Upolu with which to establish even a temporary quarantine area.87 Yet the Rev. Hough stated that the Mission House in Muliniuu was available, had been offered to the Administration for this purpose, and could have held sixty people.88

Captain Mawson, in his later report to the Union Steamship Company regarding his voyage and the pandemic, stated that when he left Auckland there was no concern about influenza and that port officials there regarded it as insignificant. He admitted to being quarantined in Suva, but noted that his steward told the Western Samoa Port Health Officer about this. Finally, he stated that there were no seriously sick individuals onboard when he reached Samoa, though “quite a number of people were complaining of feeling unwell”.89 When questioned regarding his signature on multiple documents averring that his vessel was free of infectious disease, Captain Mawson stated that he was unaware that influenza was infectious.90

Joining Captain Mawson on this, his final trip as Captain of the Talune, was his replacement. Captain Arthur Davey was to take the ship from the next voyage forward. In his testimony to the Samoan Epidemic Commission he revealed some inconsistency. His statement posits that he had no hesitation declaring the ship illness free to the Port Officer, yet two paragraphs later he spoke of coughs and fevers, which he and Captain Mawson put down to “ordinary influenza and did not

89 Captain Mawson, “Mawson, Captain, to General Manager, Union Steamship Company,” May 2, 1919, AD, 1, 988/, 49/891/10, Medical - Influenza - Fiji - Outbreak of, Archives New Zealand, Wellington.
90 Mawson, “Declaration of John Mawson.”
trouble about it”.

The First Officer on board also confirmed in testimony that there was influenza on the ship. Mawson later leveled accusations against Davey stating that he advised Mawson to conceal the illness on board because he was anxious to take over his new command and did not relish the delay of a spell of quarantine in Apia.

Those passengers intending to leave the *Talune* had to wait until the last moments before her departure, as the stewards aboard were too ill to assist their debarkation and officers needed time to recruit local workers. Passengers described being concerned that they would be quarantined since there were so many obviously sick amongst them. Of those who left the ship, two were dead of influenza within four days.

According to O. F. Nelson, the Reverend Cane walked into his office from the *Talune* about an hour after she began debarkation. He is described as looking terrible, foaming at the mouth and drawn. When asked of his situation, he told Mr. Nelson that he had acquired the Spanish influenza in Auckland, had become ill four days before the departure of the *Talune*, and had yet to recover. Mr. Nelson also described other infected passengers and their movements about Apia, including a C. Churchward who had traveled with her family to Auckland only to find the influenza there. Immediately returning to Apia, she brought the illness with her. At a social function in Apia that night word spread that a servant girl of Mrs. Churchward’s, who had travelled to and from Auckland with her, had died of the

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92 Ibid., 10.
94 “Influenza at Samoa; How the Disease Got Its Hold.”
influenza at their home. Two days later Mrs. Churchward’s brother, who also joined her on her travels, died.96

As the crew unloaded the mails from the Talune’s hold, word of the outbreak in Auckland began to spread. News of its virulence appears in the November 9th issue of the Samoa Times. The same article mentions what apparently the Port Officer could not discover, that the Talune had enough illness aboard to have required quarantine in Suva.97 Captain Atkinson stated that by the time this was known it was too late to impose control measures, for by then the Samoan passengers had dispersed around Upolu and Savai’i by boat.98

Four days after the arrival of the Talune illness appeared in Savai’i.99 When cargo ships came from Savai’i to Apia on the 13th and the 14th of November their crews were too ill to return. Communications were cut until the 18th when the Governor sent his private launch for news. Returning two days later it reported dreadful suffering amongst the indigenous population.100

Cultural elements helped speed the spread of the disease. When questioned as to why the LMS chose to keep students at a school where influenza had already appeared, the Rev. Cane spoke of it being safer than returning home to the villages where “they all live on the communal system, and when one is sick everyone wants to see the person and find out what is the matter.”101 Col. Logan told of entering a home where twenty Samoans had lain together with their heads covered and the air “unspeakably foul.” After rousing and removing these individuals he discovered

96 O. F. Nelson, “O. F. Nelson to the Hon. E. Mitchelson,” April 26, 1919, 1, IT, 1, 146/, EX 8/10, 1, Medical - Samoa Epidemic Commission 1919, Archives New Zealand, Wellington.
97 “Local and General News, November 9, 1918,” The Samoa Times (Apia, Western Samoa, November 9, 1918).
98 Atkinson, “Influenza Epidemic, Summary.”
99 “Influenza at Samoa; How the Disease Got Its Hold.”
that only three were ill, the rest merely frightened or acting in support of their family members. Lieutenant Grey of the Australian Relief force described the same situation in Savai’i, where “When a native fell ill he lay down in his hut, and his family, having pulled down the blinds …lay down with him in sympathy”. He went on to discuss how when the fever would reach its peak many victims would bathe in the sea, leading to pneumonia.

The design of traditional Samoan homes also encouraged disease spread. The two main islands of Samoa are large enough to host large insect populations, and the woven walls in the *fales*, when lowered, were meant to exclude mosquitoes. They also kept air flow to a minimum. With the walls lowered, in the poorly ventilated space airborne diseases such as influenza spread very rapidly.

In Samoan society when someone became seriously ill friends were expected to visit. Messengers would be sent to distant villages as soon as illness appeared to allow the proper visiting and gifts to occur before the victim passed. This helps to explain the families gathering about the ill in support. However the same sources speak of the extreme generosity of Samoans towards the ill, a trait not mentioned frequently in descriptions of the 1918 epidemic.

Finances were also impacted by timing. N. A. Rowe recounts a story that he claims to have heard from several sources shortly after his arrival in Western Samoa in 1922. In early November the LMS was engaged in its annual donation cycle, where individuals and villages would compete to donate the greatest amount to the church. Leaving Apia several days after the arrival of the influenza, LMS ministers worked their way sixty miles west to Mulifanua, gathering funds and likely spreading illness

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104 Turner, *Samoa*, A Hundred Years Ago And Long Before.
in their wake. With their return several days later they found the villages ravaged by illness and their parishioners begging for the return of funds recently given to allow the purchase of food, as most were too ill to work their gardens and plantations. No funds were returned.\textsuperscript{105}

A week after the arrival of the \textit{Talune} epidemic pneumonic influenza raged across Upolu. The death toll began to climb shortly after the Armistice parade on the 12\textsuperscript{th} of November, where O. F. Nelson fell ill. He reported a four month convalescence. He also described how given the prevalence of the disease in Apia a public meeting to consider responses convened on the 16\textsuperscript{th} of November, at which body disposal options were discussed and many businesses offered their plants as assistance. Whether a public meeting to discuss an infectious disease epidemic contributed to its spread warrants no mention in the narratives of the time.\textsuperscript{106}

Eventual morbidity amongst indigenous Samoans is estimated at ninety percent.\textsuperscript{107} Given the weeks to months-long convalescence, this means ninety percent of the indigenous population almost concurrently unable to perform the most basic of tasks during prime taro planting season. Economic and social life ground to a halt.

The Administration was at a loss. On the 15\textsuperscript{th} of November a series of instructions from the Apia health authorities appeared for the district medical officers, often contradictory and impossible to carry out under current conditions. When on the same day the missionary Mr. Hill approached the PMO for advice on how to treat his parishioners, he was told to “use my common sense.”\textsuperscript{108} Disorganization amongst the medical staff is a common refrain amongst witnesses to

\textsuperscript{105} Rowe, \textit{... Samoa Under the Sailing Gods}, 93.
\textsuperscript{106} Nelson, “O. F. Nelson to the Hon. E. Mitchelson,” 2.
\textsuperscript{107} Tomkins, “The Influenza Epidemic of 1918–19 in Western Samoa,” 185.
\textsuperscript{108} Congregational Union of New Zealand, “Influenza Epidemic in Samoa: Deputation from the Congregational Union of New Zealand and Other Religious Bodies to the Acting Prime Minister,” 3.
the Samoan Epidemic Commission (SEC). Due to the scale of the situation most physicians limited their efforts to the areas they could reach within a day, leaving most of Upolu and nearly all of Savai‘i without medical support.

The quarantine against Western Samoa by Pago Pago also first appears in the *Samoa Times* on November 16th, along with a mention of an epidemic of Spanish influenza in Apia. Preceding this piece a note described 50,000 deaths from the ‘flu in the USA, and offered suggestions on how to avoid infection. These consisted of gargling and ‘nasal douching’ with a product called Dobell’s Solution,\(^\text{109}\) drinking plenty of water, keeping in good condition, not sleeping in closed rooms, and getting plenty of fresh air.\(^\text{110}\) Good advice for general good health, but of little utility in cases of epidemic influenza. The last ship to depart for Pago Pago from Apia in 1918 was the *Fealolani* on November 4th. Trade would not resume until February, 1919.\(^\text{111}\)

The first casualty of the garrison troops in Western Samoa occurred on the 16th of November with the loss of Private R. D. Ross. The report regarding this death notes that fifty percent of garrisoned troops were currently affected by the outbreak.\(^\text{112}\) The few military medical staff on the island not ill themselves faced more patients than they could effectively assess just within the walls of the garrison compound. Seven members of the garrison died from the outbreak. The *Talune* returned thirty-three members of the garrison to Auckland in early January, all medically unfit because of severe influenza infection.\(^\text{113}\)

\(^{109}\) An aqueous solution of sodium borate, sodium bicarbonate, phenol, and glycerol used as an antiseptic.


\(^{112}\) Colonel Robert Logan, “Cable from Administrator, Samoa to Defender, Wellington,” November 16, 1918, AD, 1, 988/, 49/891, Medical - Influenza Outbreak 1918 - General file, Archives New Zealand, Wellington.

\(^{113}\) Director of Base Records, “The Director of Base Records to the Director of Movements and Quartering,” January 7, 1919, AD, 1, 950/, 49/70/164, Medical - Evacuations troops returning to New Zealand “Talune”, Archives New Zealand, Wellington.
Efforts to relieve the civilian suffering began soon after the meeting of the 16th. Logan divided available healthy Europeans between food delivery and corpse disposal duties and divided Apia into districts for service provision, each district staffed and provided with transport. Maj. Richardson and the garrison staff established kitchens and tried to relieve the incipient starvation in the area around Apia. Captain Atkinson arranged the medical staff to care for those they could reach, but the small number of staff and huge group of ill guaranteed that most never saw the services of a physician.

O. F. Nelson, later a leader of the Mau, spoke highly of the actions of the European residents in Western Samoa and their efforts on the Samoans’ behalf. In Western Samoa, as in so many other locales, expatriate Europeans suffered far less from the disease than did native groups. The War Diary of the Occupation Forces in Samoa list the same entry for every day, November 16-December 2: “Serving food and medicine to Natives and burying the dead.”

Logan personally toured the north side of Upolu, and sent representatives to the south side, hoping to induce the local population to bury their dead. These tours involved taking what food and medicines could be loaded onto the vehicles and touring the villages. In his own testimony, Logan described the difficulty of this task and how he quickly was reduced to threatening to burn any house containing corpses of local Samoans if the villagers did not bury their fatalities.

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115 In this context referring, as throughout the rest of this paper, to the Western Samoan rising against New Zealand rule as opposed to earlier Mau episodes in Samoa or the American Samoan Mau.
117 Rupert W. Westencott, “War Diary by Officer Commanding Samoa Garrison,” December 1918, 2, 6, 21, 11/, Inwards despatches to and from the Governor relating to Samoa - General Files - 6 February - 9 October 1919, Archives New Zealand, Wellington.
This theme of apathy amongst the indigenous population, just as in Tonga and Fiji, is a common refrain. General Skerman, the PMO, in his testimony to the Samoan Epidemic Commission (SEC) described his dilemma:

What was against us was the peculiarities of the country, the want of notification of disease and death, the want of means of communication, and the apathy of the natives. They were too ill to assist and if they were not ill they thought they were. We could not get any of them to wake up and try and assist each other or get food.\(^{119}\)

Similar reports reflecting the cultural dissonance between the garrison and the Samoans are exemplified by the discussion of efforts around the landing of food on Savai’i. Soldiers present spoke with disgust at the refusal of Samoans to help with the unloading and transport of the food, even if they were not ill themselves. Testimony to the SEC relates anecdotes of Samoans on the beach telling soldiers that since the food is for the sick, and the sick can’t help, why should they work in their place?\(^{120}\)

The Administration came to acknowledge that they lacked the resources to address the epidemic. November 20\(^{th}\) saw the first formal request for outside help from the Administration in Western Samoa. Logan cabled to Wellington, informing the New Zealand Government that influenza had appeared in a virulent form, and asking for assistance.\(^{121}\) The Minister of Defence in a statement the following day said that New Zealand was not in a position to spare medical men at this time, due to their own problems with influenza, but that a steamer should clear Sydney within days bound for Apia.\(^{122}\) The next day Prime Minister Massey could announce that Australia would be sending the H.M.S. *Encounter* with nine doctors, 35 orderlies, and


\(^{120}\) Samoan Epidemic Commission, “Testimony of Private James Meckin,” June 2, 1919, 179, IT, 1, 146/, EX 8/10, 3, Influenza Epidemic, 1918-1919, Archives New Zealand, Wellington.

\(^{121}\) “S.O.S. Signal from Samoa,” *Ashburton Guardian* (Ashburton, NZ, November 21, 1918).

\(^{122}\) “Samoan Garrison: An Outbreak of Influenza,” *Ohinemuri Gazette* (Ohinemuri, N.Z., November 22, 1918).
“tents, drugs, vaccine, and other articles sufficient to meet all needs”. She sailed on the 23rd of November.

The same day on which Logan requested aid from Auckland also saw a telegram to Apia offering assistance from Governor Poyer in Pago Pago. The absence of the illness there left the entire Naval Medical team present available for posting to Western Samoa. Every member of this contingent, including several doctors and numerous orderlies, nurses, and pharmacists, volunteered for this duty. Col. Logan claimed at first to never have received such a telegram, then to not have understood the contents, but many witnesses attribute his fury at the quarantine by Pago Pago to be the cause of his complete disregard for the offer.

Medical staff in Western Samoa was severely limited pre-war, and had been further reduced by the needs of the Western Front. While some commentators argued that there were sufficient medical supplies but insufficient logistics for their distribution, most agreed that the stock of medicines and other basics was grossly inadequate for the task at hand. And while many physicians worked to their utmost, including Captain Atkinson who worked for days while feverish, not all fit the heroic mold. One of the two doctors on Savai’i, Dr. James, reportedly refused to leave his residency and insisted that all sick residents must visit him there. Others testified that he seemed to be under the influence of drugs, drink, or both.

Yet for the influenza patient, doctors and medicines failed to provide much succor. Medicines were non-specific, and physicians could not identify the causative organism and thus properly treat the affliction. Skilled nursing care, supportive efforts aimed at stabilizing the patient until their own bodies could repel the invader,

became the best predictor of survival for those worst afflicted. Western Samoa’s
government sent multiple requests to Wellington for nursing support due to the lack
of trained staff on the islands, but these requests were delayed first by New
Zealand’s own outbreak, then by the expedited departure of the next monthly
steamer to Samoa, sent early to carry supplies to Fiji. The only support the
government could offer Logan involved advice to not release those nurses currently
on the island, suggesting he retain them until the outbreak abated.127

Gruesome anecdotes from aid workers and visitors abounded:

One of the places where the ravages of the epidemic were early apparent was
the populous village of Vaimoso. On inspection at this village an appalling
state of affairs was disclosed. Every house was closed up with mats, and
inside in the gloom the suffering of the inmates was pitiable to behold. Some
lay writhing on the ground, some were covered with mats, sweltering in
agony beneath he covering; others lay in silence. Here and there a sheet or
tapa cloth covered a form recumbent and still, indicating only too well that the
fell disease had finished its work.128

Others reported that “Samoans died on the roads, the beaches, and near water holes,
where they went to bathe their fevered bodies”.129

Medical efforts were often confused, if noble in intent. Exhausted by walking
throughout Apia to deliver food and nursing care to those laid low, a group of
women volunteers opened an auxiliary hospital to bring together their patients and
make care more efficient. At first supportive, the next day General Skerman ordered
the facility disbanded, claiming no need as there were places open in the General

127 L. Wood, “L. Wood, Matron in Chief, Memorandum for the Director-General for Medical Services,
Wellington,” December 10, 1918, AD, 1, 939/1, 49/65/1, Medical-Nurses-Samoa-Correspondence, Archives New
Zealand, Wellington.
129 “Influenza at Samoa; How the Disease Got Its Hold.”
Hospital. Many Samoans, however, refused to use the General Hospital and the volunteers returned to visiting homes throughout Apia.\textsuperscript{130}

Disseminating information throughout Western Samoa became difficult as the illness spread. Shops closed and the standard trade routes saw no traffic. The only newspaper in the colony was in Apia and appeared weekly. This paper, the \textit{Samoa Times}, stopped publishing for several weeks during the height of the epidemic due to a lack of workers and the death of its owner. Word of mouth worked, as always, but spread the illness as quickly as news. General Skerman printed up a list of instructions regarding appropriate care and how to avoid relapse that was translated into Samoan and distributed to the villages. No drug suggestions were made, and it was tailored to the level of potential volunteers in the villages. Skerman later expressed doubts that the pamphlets reached most of the villages before the worst of the disease struck.\textsuperscript{131} These pamphlets also took little account of traditional Samoan practices, instead couching their suggestions in assumptions of European attitudes towards food, sanitation, and hygiene.\textsuperscript{132}

Relations with American Samoa continued to sour. When on November 23\textsuperscript{rd} Col. Logan sent his launch \textit{Tahutu} with mail for Pago Pago (to be placed on a steamer headed for Vancouver) it was refused entry. When asked if they could enter to merely transfer mail, Gov. Poyer replied that any entry into the harbour would mean a five day quarantine. The mails returned undelivered, infuriating Logan.

On November 28\textsuperscript{th} Logan cut off wireless communications with Pago Pago without notifying the Americans of his intent.\textsuperscript{133} Logan would later claim he did so to save the single wireless operator for excess strain, but the operator in question stated

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\textsuperscript{131} Samoan Epidemic Commission, \textit{"Testimony of General Skerman,"} 93.
\textsuperscript{132} Herda, \textit{"Disease and the Colonial Narrative: The 1918 Influenza Epidemic in Western Polynesia,"} 136.
\textsuperscript{133} "Samoan Epidemic; Report of Royal Commission."
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that he was not under undue stress. The SEC attributes the action to Logan’s continued resentment regarding the quarantine against Apia in place in Pago Pago.\textsuperscript{134}

Governor Logan received a message from the American Consul Mitchell on December the 7\textsuperscript{th} that included a note from Governor Poyer citing the risk of the influenza spreading and the insufficient resources in American Samoa to cope with an outbreak. Noting that he acted with the approval and support of the Western Pacific High Commissioner in Suva, Poyer asked that Logan refuse clearance for any ship leaving Western Samoa for American Samoa until ten days after the recovery of the last influenza case in Western Samoa.\textsuperscript{135} Logan responded with a terse acknowledgement and the statement “The contents have been noted.”\textsuperscript{136}

By early December complaints started to reach well-placed ears in Auckland. In a letter to Logan’s superior, the Minister of Defence, the President of the Auckland Chamber of Commerce notes that with the end of the war complaints related to Logan that gathered over the previous two years regarding incompetence should be addressed, and he argued for the clear incapacity of Logan to face the current crisis.\textsuperscript{137} Minister Allen responded that Colonel Logan had done “extraordinarily well” at “very difficult work”.\textsuperscript{138} No action was taken.

\textsuperscript{135} Governor J. M. Poyer, “Governor Poyer to the Administrator, Colonel Robert Logan,” December 7, 1918, Communications/Consuls (National Archives Microfilm Publication T1182, roll 32); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
\textsuperscript{136} Colonel Robert Logan, “Logan, Colonel Robert to Mitchell, the Hon. Mason, Consul for the USA,” December 10, 1918, Communications/Consuls (National Archives Microfilm Publication T1182, roll 32); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
\textsuperscript{137} Robert Burns, Esq., “Robert Burns, Esq. President, Auckland Chamber of Commerce to J. Allen, Minister of Defense for New Zealand,” December 2, 1918, ITI 31, EX 1/18, 1 Criticism of Samoan Administration, Archives New Zealand, Wellington.
\textsuperscript{138} Secretary of Defense J. Allen, “J. Allen, Minister of Defense to Robert Burns, Esq., President of the Auckland Chamber of Commerce,” December 7, 1918, ITI 31, EX 1/18, 1 Criticism of Samoan Administration, Archives New Zealand, Wellington.
Estimates of the death toll on Upolu reached into the thousands as November ended.\textsuperscript{139} Communications throughout the colony slowed to a trickle, trade stopped, and what medical infrastructure there was available had long since reached and exceeded capacities. Logan refused to speak with his nearest neighbor, Auckland could offer no aid to its garrison, and a shipping strike crippled Australia. Bodies were decaying quickly in the tropical heat. Yet still the situation worsened.

A drought that coincided with the epidemic struck the colony, interrupting rainy season planting. Livestock, without any well workers to care for them, broke through fences and scattered in search of water. The ice plant in Apia, so critical for helping the feverish, was unable to operate due to a lack of water. Many homes saw domestic tanks dry up, preventing appropriate hygiene and laundering.\textsuperscript{140}

Famine followed drought. In this case logistics were certainly to blame. Food in adequate quantities was present on Upolu and Savai‘i, but harvesting, transport, and preparations for households where every adult was ill proved to be deadly barriers.\textsuperscript{141} Traditionally food in Samoa was harvested as needed, as is common in tropical climates, and cultural norms called for giving away any surplus, rather than accumulation.\textsuperscript{142} Each home had little food storage. The garrison established a communal kitchen once sufficient staff recovered, distributing soup and imported rice by motorcar in the area around Apia.\textsuperscript{143} As the scale of the problem became clear, the garrison and other volunteer groups attempted to distribute food throughout the colony, first across Upolu via every motor vehicle and pack horse in the Apia area,

\textsuperscript{139} “Native Mortality: Thousands Die at Samoa,” \textit{Ashburton Guardian} (Ashburton, NZ, December 3, 1918).
\textsuperscript{140} “The Epidemic,” \textit{The Samoa Times} (Apia, Samoa, December 14, 1918).
\textsuperscript{141} Crosby, \textit{Epidemic and Peace}, 235.
\textsuperscript{142} \textit{Western Samoa: Land, Life and Agriculture in Tropical Polynesia} (Christchurch, N.Z: Whitcombe & Tombs, 1962), 233.
\textsuperscript{143} “Terrible Visitation: Islands Swept by Influenza.”
then Savai’i and the smaller islands by boat. These efforts were often too late, as in the height of the illness no boats had sufficient crews to sail. General Skerman noted that during the worst three weeks of the influenza only two boats left Apia.

Once the crews recovered aid distribution quickened. Fortuitously the presence of nearly the entire population in a coastal ring around each island, so amenable to the spread of the disease, also facilitated relief efforts as much larger quantities of food could be delivered by sea than via the rudimentary roads in the colony. Milk was one item in short supply, sought to feed the growing number of infants orphaned by the epidemic, and the requested emergency shipment was hampered by the lack of an Auckland crew willing to travel to Apia due to fears of infection. As the Sydney Daily Telegraph reported (Figure 14):

At one time, 80 or 90 percent of the [Samoan] people were lying helpless, many died from starvation who might probably have recovered, for even when rice, milk, and other items were sent out and delivered, the survivors were too weak to prepare and apportion the food. In the small town of Apia and its environs, nearly seven hundred were buried.

The New Zealand troopers with their motor-trucks are doing wonderful service day after day gathering up the dead, who are simply lifted out of their houses as they lie on their sleeping-mats. The mats are wrapped around them, and they are deposited in one great pit at Vaimea after it was found impossible to get laborers to dig individual graves. There are no mourners, there is no ceremony. As fast as the different motor-trucks come, the bodies are placed in the pit by heroic workers, many of whom are quite unfit and who have to quit as they themselves become infected. Most of the great chiefs of Samoa have been buried.

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144 “Appalling Scenes: The Epidemic at Samoa.”
146 Governor-General Liverpool, “The Governor General of New Zealand to the Administrator of Samoa,” December 5, 1918, AD, 1, 988/1, 49/891/3, Medical - Influenza - Samoa - Outbreak of, Archives New Zealand, Wellington.
147 Iezzoni, Influenza 1918, 92.
Yet survival for many residents meant avoiding contact with others, not helping in the volunteer outreach. The *Samoa Times* describes an overheard strategy for not becoming infected: “Every day I took a dose of quinine and other things and every day I disinfected the house with Lysol. And besides, while the epidemic lasted I stayed indoors: never went on the road the whole time.” The *Times* comment on this strategy, and the “ethics of the devil underlying it” is described as “unprintable”.

Disposal of corpses became a pressing issue as mortality soared. The Rev. Cane described the villages outside Apia and on Savai’i as ‘fortunate’ as there were usually one or two men strong enough to dispose of corpses in shallow graves, individually. According to Cane, no Samoans in the Apia area assisted at all. While the garrison worked in the early stages to gather and bury the dead, as the troops fell ill desperate procedures developed. Chinese labourers were brought in to help and sailors from American and British ships in the harbour, waiting to load trade goods, were drafted into the effort. Residents of the local leper colony worked at corpse disposal. Col. Logan and Rev. Cane laboured together one day to bury 13 bodies themselves. Despite the very strong Samoan burial taboos mass graves rapidly came into use. These housed at least 550 corpses in the Apia area and were served by the carts travelling the communities of Upolu daily. Homes where entire families died were, in some cases, simply razed with the corpses inside. Oral histories from the time describe dogs eating corpses in public spaces. The *Fiji Times* reported that

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150 Ibid., 25.
152 “Appalling Scenes: The Epidemic at Samoa.”
in the Alepata district of Upolu soldiers were dispatched to shoot every dog and pig in sight to prevent their consumption of corpses before their burial.\textsuperscript{154}

According to N. A. Rowe, Commissioner Gillespie told him of visiting one village, served by both an unnamed Protestant and a Catholic mission, where he found corpses still littering the grounds. When he approached the Protestant mission and asked why the bodies had been left to rot he received the reply that the mission had buried all of its own dead, but the unburied were Catholics. Only when he sent to his truck for cans of petrol with which to burn down the Protestant mission did efforts commence to bury the Catholic dead.\textsuperscript{155}

**Epidemic Impact and the Mau**

Help finally arrived with the appearance of the HMAS *Encounter* out of Sydney on December 3\textsuperscript{rd}. She landed five Medical Officers, twenty-seven orderlies, three naval assistants, drugs, and varied stores. These men divided into groups of six assisting a doctor and were sent with supplies throughout the islands. Captain Thring of the *Encounter* repeatedly mentioned his inability to get up to date information or feedback on the crisis from Colonel Logan, and his frustration with this state of affairs.\textsuperscript{156} The ship remained under strict quarantine against the rest of Apia, allowing off the assisting parties only after they had been inoculated with the vaccine currently available, and allowing onboard no locals whatsoever.\textsuperscript{157} The *Encounter* left the next day with assistance aboard for Tonga, leaving Surgeon Gray in

\textsuperscript{154} “The ‘Flu at Tonga: Over 1,000 Deaths; Some Gruesome Sights.,” *Fiji Times and Herald* (Suva, Fiji, January 28, 1919), 3.

\textsuperscript{155} Rowe, *... Samoa Under the Sailing Gods*, 128.


\textsuperscript{157} Ibid., 5.
charge in Western Samoa. At that time the ship’s captain sent a message to Melbourne reporting roughly 6,000 Samoan dead and 21 European deaths.\textsuperscript{158}

The damage within families could be crushing. In a single obituary notice of mid-December (figure 15) O. F. Nelson lists the loss of his sister, his mother, his only brother, and his sister in-law.\textsuperscript{159} A week later the Meredith family listed seven adult victims in a similar note.\textsuperscript{160} As the young adult and middle aged members of families died, older children were pulled from school to fill those roles, both male and female. Thus the educational level of the entire society was reduced for a generation.\textsuperscript{161}

(Figure 15: Obituary from *Samoa Times*\textsuperscript{162})

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\textbf{OBITUARY.}\\
\textbf{DAVID.}—On 25th November at Safune, Savaii, Jose-phin, the dearly loved wife of Felix David and daughter of the late August Nelson Seur, aged 37 years.\\
\textbf{NELSON.}—On 24th November at the residence of her son, Sina, the beloved mother of O. F. Nelson and widow of the late August Nelson, seur., aged 50 years.\\
\textbf{NELSON.}—On 27th November at Palauali, Savaii, August, beloved and only brother of O. F. Nelson, aged 29 years.\\
\textbf{NELSON.}—On 30th November, at the residence of her father, Jane, widow of the late August Nelson, junn., and beloved daughter of S. H. Meredith, aged 10 years.
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\textsuperscript{158} Naval Secretary, Australia, “Naval Secretary to Secretary, Prime Minister of Australia’s Office,” December 4, 1918, A2, 1919/701, Archives of Australia.

\textsuperscript{159} “Obituary, 14/12/18,” The Samoa Times (Apia, Samoa, December 14, 1918).

\textsuperscript{160} “Obituary, 21/12/18,” The Samoa Times (Apia, Samoa, December 21, 1918).


Families with members scattered throughout Polynesia faced great uncertainty. Rumours flew that the situation in Tonga and Fiji was worse than that in Samoa, and confirmation or refutation of fears could come no faster than the monthly steamer from New Zealand. Once again, the Talune, the plague ship, was eagerly awaited to glean some news from outside the archipelago.

Given the particular age distribution of mortality from the 1918 influenza, the dead came from the most active cohorts of society. The LMS reported forty-three pastors dead on Upolu alone, and the infection of every LMS missionary in Samoa as well as their spouses. Six out seven LMS District Schoolmasters died, 103 pastors-in-charge out of 220, and twenty-nine of the thirty members of the Native Advisory Council, the local leaders of the Samoan Church.

This mortality amongst the twenty to forty year old population carried predictable effects. The number of orphans ballooned far past the ability of the weakened social net to absorb. Advertisements began appearing in the Samoa Times, seeking foster parents for infants and children, some offering payment in return.

Total deaths listed December 14th on Upolu reached 4274, with several districts yet to report. Upolu had already lost more than twenty percent of the local population. As the article in the Samoa Times noted: “Whole families have been decimated: among the permanent residents one fails to hear of anyone that has not suffered personal bereavement.” The editor goes on to say that “in actual fact the worst fears (regarding the epidemic) are being realized.” Logan would later attribute

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163 “Local and General News, December 14, 1918,” The Samoa Times (Apia, Western Samoa, December 14, 1918).
165 “Wanted,” The Samoa Times (Apia, Western Samoa, January 25, 1919).
166 “The Epidemic.”
the high death rate to the Samoans’ “failure to treat themselves reasonably” and by their going to bathe while still ill.\textsuperscript{167}

In many areas the Australian Relief Party quickly took over relief operations. Captains Garrett and Gumming served on Savai’i, which had been isolated from Upolu since the beginning of the outbreak.\textsuperscript{168} Savai’i’s death rate appears to have been lower than Upolu, roughly twenty percent as compared to twenty-six percent. A lower population density (roughly sixty percent of the population of Upolu while being nearly fifty percent larger) and larger proportion of agriculture devoted to foodstuffs (as opposed to copra and cocoa on the Upolu plantations which drove taro gardens further away from villages) helped to slow the spread of the disease and reduce the number of deaths from starvation.

The economic impact ranged widely. Many merchants lost their factors in the villages, forcing the hire and training of new staff. Ships lay at anchor in the harbour for weeks, waiting on dockworkers to unload or load them. Port operations did not resume until mid-December.\textsuperscript{169} Retail operations in Apia started to reopen a fortnight earlier, as staff and shoppers gradually recovered. After two months without public entertainment the theatres were allowed to reopen on Saturday, the 11\textsuperscript{th} of January, appropriately enough featuring three comedies after a deeply dark time.\textsuperscript{170}

The \textit{Samoa Times} of December 21\textsuperscript{st} reported “encouraging signs of recuperation”, “a noticeable improvement in morale”, and with the exceptions of two small districts the lack of any new cases on Upolu for a fortnight.\textsuperscript{171} The last reported cases of influenza from the initial outbreak in Western Samoa were noted on January

\begin{thebibliography}{171}
\bibitem{167} Logan, “Despatch No. 14, Logan to Liverpool,” 3.
\bibitem{168} “In Savaii,” \textit{The Samoa Times} (Apia, Samoa, December 21, 1918).
\bibitem{169} “The Epidemic.”
\bibitem{170} “Local and General News,” \textit{The Samoa Times} (Apia, Samoa, January 11, 1919).
\bibitem{171} “The Late Epidemic: Encouraging Reports of Recuperation,” \textit{The Samoa Times} (Apia, Samoa, December 21, 1918).
\end{thebibliography}
Infections would occur again in 1920 and regularly thereafter, but the influenza involved was the relatively mild type. It would take the old, and the very young, and the ill, but not to any unusual degree.

With this sense of returning control came the resumption of government actions beyond mere crisis response. Citing the risk of a reappearance of the epidemic amongst the Samoans, quarantine regulations were implemented against other areas deemed infected. Two men received fines and jail time for breaking quarantine off a ship from Suva.\(^{173}\) By the 11\(^{th}\) of January a system for transmission of mails between Apia and Pago Pago emerged as well, despite the ongoing quarantine. The inter-island steamers would cast a boat adrift outside the quarantine zone, where it would be met by American Post Office workers. After removing the mails, the boat would be set adrift again, and then retrieved by the steamer’s crew.\(^{174}\)

Total deaths in Western Samoa for the year 1918 are reported as 8,437, or nearly 7,000 more deaths than births.\(^{175}\) Of these 7,542 are listed as deaths among native Samoans from the influenza.\(^{176}\) O. F. Nelson disagrees with these numbers, arguing instead for much higher than twenty-five percent mortality and suggesting that of the dead three quarters were able bodied male adults.\(^{177}\) Total deaths from the influenza of 1918-1920 are estimated by the Samoan Epidemic Commission to be above 8,500.\(^{178}\) The LMS estimate runs higher, to roughly 9,000, though the sources

\(^{172}\) Consul Mason Mitchell, “Mason Mitchell, American Consul to Governor J. M. Poyer, American Samoa,” February 13, 1919, Communications/Consuls (National Archives Microfilm Publication T1182, roll 32); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.

\(^{173}\) “The Decision,” The Samoa Times (Apia, Western Samoa, December 28, 1918).

\(^{174}\) “Shipping, January 18, 1919,” The Samoa Times (Apia, Western Samoa, January 18, 1919).

\(^{175}\) Lambert, MD, “Health Survey of Western Samoa with Special Reference to Hookworm Infection,” 10.

\(^{176}\) Governor R. W. Tate, “Report of the Governor-General’s Visit to Apia,” July 23, 1919, 4, IT, 1, 25/, EX 1/11, 1, Administration of Samoa - The Governor-General’s Visit to Apia, Archives New Zealand, Wellington.


used to make this estimate are not made clear.\textsuperscript{179} Hermann Hiery argues that the death rate was almost certainly higher than the 8500 listed by the Commission. He notes that mortality figures for early 1919 seem unreasonably low and attributes this to the impending release of census figures for Western Samoa and the desire of the New Zealand government to show a steady increase in Samoan population as evidence of good governance.\textsuperscript{180} Even the lower numbers give a death rate of thirty percent for adult males, twenty-two percent for adult females, and ten percent for children. Among \textit{Matai} the rate was forty-seven percent, among Roman Catholic catechists sixty-five percent, and the LMS Council of Elders lost ninety-seven percent of their membership.\textsuperscript{181} Only six of the thirty \textit{Faipule} survived.\textsuperscript{182}

The \textit{Faama'i}, as the influenza came to be called, served as a dividing point in Samoan history. For years afterward the terms used to describe the age of Samoans described not only chronology, but indicated whether they were born before or after the epidemic.\textsuperscript{183}

The death rates amongst the Chinese workers are not listed separately. Notes in the \textit{Samoa Times} state “the mortality rate among Chinese coolies in the Apia District due to the epidemic turned out to be rather more severe than was at first believed.”\textsuperscript{184} The report for the Governor-General of New Zealand in 1919 lists 1166 indentured labourers in Western Samoa and describes openings for thousands more, a result of both epidemic mortality and Logan’s policy of reducing Chinese numbers.

\textsuperscript{179} Congregational Union of New Zealand, “Influenza Epidemic in Samoa: Deputation from the Congregational Union of New Zealand and Other Religious Bodies to the Acting Prime Minister,” 4.
\textsuperscript{181} Ward, \textit{Man in the Pacific Islands; Essays on Geographical Change in the Pacific Islands}, 202.
\textsuperscript{182} Tomkins, “The Influenza Epidemic of 1918–19 in Western Samoa,” 181.
\textsuperscript{183} Hiery, \textit{The Neglected War}, 174.
\textsuperscript{184} “The Epidemic.”
The same report gives the total number of surviving Europeans and half-castes in the colony as 1660.185

In testimony given to the SEC on June 2nd, 1919, General Skerman noted that New Zealand had still not formally notified him that influenza was an infectious disease and subject to Public Health and quarantine laws.186

With the worst of the epidemic past, attention could turn to the causes of the disaster. Logan quickly became the focus of the Samoans’ wrath, particularly when word emerged regarding the declined offer of help from American Samoa and the quarantine of the Talune in Suva. Confronted by the surviving faipule, Logan blamed the entrance of the disease upon the clean bill of health from Fiji.187 This did little to calm the situation. These remarks, and the lack of sensitivity to the losses of the Samoans that they suggest, eventually destroyed what remaining credibility Logan held in Western Samoa. The calls for his removal grew louder by the day.

Not all comment regarding Logan was negative. Despite his conflict with several members of the LMS mission, especially the Headmistress of the girls’ school, Miss Moore, the Rev. Hunt of the Congregationalist Union of New Zealand attested that “we have testimony from different missionaries who frankly, willingly, and gladly state the fact that otherwise he and his officials did all that was humanly possible, and that Colonel Logan himself did magnificent work”.188 Magnificent or not, Logan left Apia; replaced in late January by a new Governor, Robert Tate.

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188 Congregational Union of New Zealand, “Influenza Epidemic in Samoa: Deputation from the Congregational Union of New Zealand and Other Religious Bodies to the Acting Prime Minister,” 10.
By early February Logan would give interviews to Auckland papers describing his successes in Samoa but noting that the greatest difficulty was that “workers were particularly hard to get just now”. In his formal report to Wellington Logan mentioned that labour shortages stemmed from the deaths of at least 3,000 adult male Samoans, and were “unfortunate”. Once again Logan appeared callous to the losses of those under his care. His temporary return to Auckland soon became permanent, and Tate received a formal posting to Apia.

Upon Tate’s arrival, his first report home was gloomy. His reports of bitter resentment and considerable unrest link these feelings directly to the failure to prevent the introduction of influenza into Samoa. Approached in January by the surviving faipule, he answered their questions regarding the failure to exclude Talune by pointing out the clean Bill of Health from Fiji and that news of the Auckland epidemic was in the papers in the hold of the Talune, not accessible until after she docked. Not satisfied, the representatives demanded to know why both Auckland and Suva gave clean bills of health to the ship when it carried obvious illness. They demanded a stronger inspection system for all incoming passengers and more effective Medical Officers for Samoa.

Tate responded by pointing out that half of the deaths in the epidemic were due to starvation and neglect of families, areas more the responsibility of the chiefs than the Administration. He described feeling the need to treat them firmly, although he grants that they had the right to know why influenza was allowed to enter

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189 “Future of Samoa, An Optimistic Opinion.”
Western Samoa.\textsuperscript{191} Perhaps not surprisingly, the chiefs did not take their scolding in stride. The two groups separated to continue the discussion at a later time.

On January 27\textsuperscript{th} Tate received an invitation to a *Talolo* (a ceremony of welcome) and a *Fono* or conference with the Samoan Chiefs and *faipule*. This meeting occurred on the 28\textsuperscript{th} of January and after greetings the chiefs rapidly moved on to business. The three main complaints regarded the entry of the *Talune* with the influenza onboard, the actions of Colonel Logan during the epidemic and the Government’s refusal of help from Pago Pago during the outbreak. Tate expected to receive a petition asking for rule over Western Samoa to be transferred from New Zealand to the United States.\textsuperscript{192} The petition for change of rule was submitted, but in an amended form asking for either direct British or American rule, but not New Zealand governance.\textsuperscript{193}

Tate’s response was vague, deliberately so, as he lays out in his correspondence.\textsuperscript{194} He refused to address the claims against Logan, insisted that what help could be given Western Samoa was being given, and deferred discussion of changing governance until the situation stabilized.\textsuperscript{195} The gathered representatives and chiefs left the meeting with nothing resolved.

His reports of the meeting showed Tate’s initial refusal to accept the epidemic as a cause of unrest. He writes that “I do not believe that the Epidemic has materially affected the respect and regard which the natives had for Colonel Logan”. Instead, he,
and other officials in Auckland, laid the blame for the unrest at the feet of the failure of local business ventures and their sponsors’ desire to deflect attention. Tate himself notes that his local advisors did not share this view.

The chiefs withdrew the petition on the 13th of February. By the time Tate reported this, he seems to have gained a greater insight into the impact of the influenza in Western Samoa. He stressed to his superiors the need for a thorough examination of the matter by a Royal Commission, and the necessity of fixing responsibility.

The situation with American Samoa still carried the taint of Logan’s bitterness towards Poyer. After being approached by the chiefs of Tutuila offering to gather help for the children left orphans in Upolu, Poyer expressed hesitation. After having his first offer of assistance rebuffed, he would not make another unless he knew it was welcome. He asked the Consul in Apia, Mitchell, to informally approach the new Administrator and sound him out on this matter. Thus, what aid was available between the Samoas was still slow to be offered and awkwardly used.

April brought a deputation representing the London Missionary Society, the Congregational Union of New Zealand, and the Methodist Missionary Society to the Office of the Acting Prime Minister James Allan in Wellington to discuss the Samoan epidemic. Terms such as “deplorable lack of precautionary measures”, “official negligence”, and “strong and indignant protest” were offered up in support of a

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196 Tate, “Native Unrest.”
197 Ibid.
198 Governor J. M. Poyer, “John Poyer, Governor, to Consul Mitchell, March 5, 1919,” March 5, 1919, Communications/Consuls (National Archives Microfilm Publication T1182, roll 32); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
demand for “an immediate investigation into the matter with a view to fixing the responsibility of the official neglect and dealing adequately with the offender.”

In the same month O. F. Nelson spoke to several New Zealand journalists, arguing that the outbreak had “prejudiced New Zealand in the eyes of the natives for while the epidemic had raged in what was formerly German Samoa the American area had been free.” Logan, in his official report, described a population previously deeply contented with British rule emerging from the influenza “gloomy and discontented.” Even the former colonial rulers used the experience of the influenza as a riposte. In December, 1919, when questioned regarding the beneficence of German rule in the Pacific, former Governor of German Samoa Dr. Schultz praised the Imperial German policies and noted that nothing like the calamity of the influenza outbreak in Western Samoa had occurred in any German possessions.

With pressure building from both Tate within Western Samoa and the many critics outside the colony the Government of New Zealand agreed to appoint a Royal Commission of Enquiry into the epidemic in Western Samoa. This group, consisting of George Elliot, O.B.E.; Thomas Wilson; and Lieutenant-Colonel William Moorhouse, M.B.E.; would review:

1. The circumstances and causes of the introduction of influenza into Western Samoa in late 1918.

2. The voyage of the Talune from Auckland to Apia and the failure of public health measures en route.

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200 “Control of Samoa; Views of Inhabitants,” Ashburton Guardian, April 23, 1919.
Whether government negligence or default played a role in the introduction of influenza into Western Samoa.\textsuperscript{203}

The Commission left for Western Samoa in mid-May, travelling, appropriately, on the \textit{Talune}.\textsuperscript{204}

Official testimony to the Commission was defensive. Logan blamed the Rev. Paul Cane for infecting Apia, suggesting that his lapse in reporting his illness allowed the disease to spread. He also noted that he received no notification from New Zealand via wireless of the approach of the pandemic, instead reading about the disease in New Zealand in the papers brought by the \textit{Talune}.\textsuperscript{205} Dr. Atkinson testified that the Captain of the \textit{Talune} lied regarding conditions in New Zealand and stated that those onboard had no more than a mild cold. He denied that he saw any truly ill people on board at all.\textsuperscript{206} Captain Mawson denied any inappropriate action.

The findings of the SEC surprised few. Blame was apportioned between Auckland for lack of notification, Logan for lack of action, and Captain Mawson for not declaring illness aboard. Logan was not to return to Western Samoa, and action was to be taken to support orphans of the epidemic. Better reporting of infectious disease across the Pacific territories and better screening for ships entering Western Samoan harbours was mandated.

These suggestions received quick response, at least in writing. In late October 1919 New Zealand began to send a weekly summation of disease activity to Western

\textsuperscript{203} "Samoan Epidemic; Commission of Enquiry," \textit{Evening Post} (Auckland, N.Z.; May 10, 1919).
\textsuperscript{205} "How the Islands Were Infected," \textit{Evening Post} (Auckland, N.Z.; July 10, 1919).
\textsuperscript{206} Ibid.
Samoa via wireless.207 Yet when the Governor-General of New Zealand the Earl of Liverpool visited in 1919 he noted that port health inspections at British and New Zealand ports in the Pacific were still much less stringent than at American facilities, and that “It seems impossible to me that a Port Health Officer can convince himself by a mere glance at the passengers of a ship who walk past him they are fit or not fit to land.”208 The state of quarantine facilities in 1920 warranted a single line in the Chief Medical Officer’s Report: “The existing arrangements for quarantining are unsatisfactory.”209 Yet this same year saw the promulgation of a much more extensive and detailed Quarantine Order for Western Samoa. Published in April, 1920, this order went through four full pages of very detailed instructions for the inspection, disinfection, and if necessary quarantining of vessels, and the penalties awaiting those who might interfere with these processes.210 And the quarantine process, developed to protect the indigenous population, was seen by Samoans as inequitable. When a potentially infected ship came to port European passengers for Apia could disembark as long as they would agree to visit the hospital daily. Samoan passengers for Apia faced isolation.

In the words of Mr. Hills, a missionary with more than 30 years in Samoa before the outbreak:

I am speaking words of soberness when I say that Britain, through her representatives here, has lost more in prestige during the last month than she had gained by the four and a half years of the occupation....Who can blame them for comparing this with the punctilious care shown by the Germans in all quarantine matters?...Speaking personally the whole thing seems to have

207 Governor-General Liverpool, “The Governor General of New Zealand to the Administrator of Samoa,” October 23, 1919, IT, 1, 146/, EX 8/10, 1, Medical - Samoa Epidemic Commission 1919, Archives New Zealand, Wellington.
been a huge bungle from beginning to end – a blunder which amounts to a crime.\textsuperscript{211}

This dissatisfaction and anger towards New Zealand amongst Western Samoans developed into the \textit{Mau}, or ‘strongly held opinion’. This movement sought at first to simply remove direct New Zealand control from Samoan institutions, but gradually changed to embrace full independence. Over time the \textit{Mau} developed an entire suite of shadow government services. In the 1920s its anger was expressed via boycotts, work stoppages, and protests.

Between the \textit{Mau}, the epidemic, and the policies of Logan and his successors the plantation economy stagnated. With the repatriation of Chinese and Melanesian indentured workers, and the severe shortage of willing staff among the Samoans, plantations not owned and worked by the Samoans themselves went to seed. What little copra produced by 1920 in Western Samoa went to the United States, shipping not being available to move it towards the antipodes or Great Britain.\textsuperscript{212} The shift in trade toward the United States encouraged more concern in the New Zealand Administration regarding traders as a potential fifth column working for an American takeover, and discouraged additional help for the plantation owners.

Bills from the epidemic began to pile up. The Australian Government sought repayment for the expenses of the \textit{Encounter}, a sum the Samoan Administration did not have. In order to avoid opening old wounds and further exacerbating ill-will in Western Samoa, the New Zealand Government agreed to take on this expense.

\begin{footnotes}
\footnote{Congregational Union of New Zealand, “Influenza Epidemic in Samoa: Deputation from the Congregational Union of New Zealand and Other Religious Bodies to the Acting Prime Minister,” 2.}
\footnote{“Labour Shortage in Samoa,” \textit{Auckland Evening Post} (Auckland, N.Z.), March 1, 1920.}
\end{footnotes}
Though marketed as a gift to the Samoans, it was accepted by them as a long belated acknowledgement of responsibility for the events of the epidemic.  

In response to a 1921 letter of concern from former Western Samoa resident Robert Stout, The Secretary of External Affairs, Ernest Lee, defended New Zealand’s rule in Western Samoa on several points. He argued that there was no Mau nor friction between the Samoans and the New Zealand Government, that in fact conflict of this type was much worse in American Samoa, that these troubles in American Samoa and not the resentment from the influenza epidemic was the reason for agitation in Western Samoa, and that the prohibition of alcohol sales created ninety percent of the ill will toward New Zealand in Western Samoa. The Mau likely would have challenged several of these points. In fact unrest was much more severe in Western than American Samoa and no evidence shows unrest being imported from East to West. As to prohibition, it is not even mentioned in the Mau’s demands at the time. Throughout the 1920s Logan’s actions and failures during the epidemic were consistently listed as the primary complaint of the Mau. When the information given to the Prime Minister regarding Western Samoa was based upon such errors, it is unsurprising that conditions on the ground deteriorated rapidly.

In fact, several elements of the epidemic and its consequences helped inspire and maintain the Mau. The large number of deaths in Western Samoa, in stark contrast to the successful quarantine maintained in American Samoa, underlined the failure of the colonial power to protect and provide for Western Samoans in a time of

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214 Ernest Lee, “Ernest Lee, Secretary of External Affairs to the Right Honorable the Prime Minister of New Zealand,” March 10, 1921, IT 31, EX 1/18/1, 1, Archives New Zealand, Wellington.

215 Herda, New Countries and Old Medicine, 40:51.
crisis. Logan’s statements after the epidemic, including direct attacks upon the character of surviving members of the Western Samoan elite, further inflamed ill-will towards the colonial structure in the islands. The slow recovery from the economic dislocations of the epidemic exacerbated by severe labour shortages related to the high mortality in the working age population prevented economic improvement from damping the protest fires. The colonial government’s epidemic response portrayed the relatively new New Zealand administration as ineffectual while the disease concurrently struck down many of the Western Samoan elites who had vested interests in the maintenance of the colonial regime. These factors helped undercut future efforts at re-establishing New Zealand’s moral and physical authority amongst the western Samoan population.

By 1929 the Mau claimed to represent nearly ninety percent of Western Samoans. Throughout the 1920’s non-violent protest by the Mau complicated efforts by the colonial government to restore pre-epidemic economic and political conditions. Increasing tensions led to the tragedy of ‘Black Saturday’, December 28, 1929, when New Zealand police fired on Mau protestors. Eleven Samoans and one police officer died, with one of the Samoan casualties being the High Chief Tupa Tamasese Lealofi III.

In March, 1930, High Chief Tuimalealiifano addressed a Mau protest gathering at Vaimoso: “You said that the Government of New Zealand is very kind: I have seen myself and I have experience of it. It is not. Many Samoans, many thousands of

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216 There was a movement in the 1920’s termed the “American Samoan Mau” but it had very different goals and motivations. This movement will be discussed in the next chapter.
217 Davidson, Samoa Mo Samoa, 97.
Samoans have been buried in the earth.” Occasionally violent, the Mau would continue to advocate for independence for decades. In the words of James Davidson:

“The Epidemic, while weakening the forces of an older traditionalism, had provided the people with a new reason for resentment of the administering authority; and such resentment is one of the classic bases of colonial nationalism.”

A half-decade after the outbreak the medical infrastructure in the islands reflected only slight changes from pre-epidemic days. While Apia now received a weekly bulletin on the wireless from the New Zealand Health Department, the only quarantine station was on Upolu and “is small and the location not satisfactory” according to the International Health Board. A new quarantine order had passed in 1920, expanding the number of “infectious diseases” to include influenza, polio, and several others but as the most virulent forms failed to reappear over time enforcement became lax. Influenza epidemics recurred in Western Samoa during 1928 and 1934. These outbreaks, and those that followed, have been mild influenza with traditional presentations.

The 1918-1919 influenza epidemic killed, by the lowest estimates, between one fifth and one quarter of Western Samoans. While small locales reported higher death rates from this outbreak, no nation, colony, or other similarly sized polity suffered so. New Zealand, the colonial master of Western Samoa, demonstrated a mortality of

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220 Davidson, Samoa Mo Samoa, 97.
221 Lambert, MD, “Health Survey of Western Samoa with Special Reference to Hookworm Infection,” 10.
222 Governor-General Liverpool, “The Samoa Quarantine Order, 1920,” April 1, 1920, Box #1; Series #6, General Interest File 1872-1948; Records of the Governor’s Office; Records of the Government of Samoa, RG 284; National Archives, Pacific Region, San Francisco, CA.
less than one percent. Neighboring islands reported losses under ten percent. American Samoa, as will be discussed in the next chapter, lost no one. What factors drove this deadly variance from the mean?

Physical factors were the most powerful, and least mutable by official action. Western Samoa’s geography forced settlement in a ring around the coast. This pattern allowed for quick sequential passage of information. Where word of mouth travels, so does airborne illness. The limited amount of useful land, the richness of the land due to the volcanic soil, and the wealth of the fishing opportunities offered at the coastal reef breaks around which villages clustered allowed for a much higher population density than other western Polynesian states. In cases of airborne illness higher population density equates to not just greater total numbers infected, but generally to greater proportional morbidity throughout the population. More people in a smaller area allows for less chance to escape exposure. Available agricultural options did not lend themselves well to storage, a problem accentuated by the tropical climate. The lack of food storage in a culture suffering from a long-convalescence, universal-morbidity disease like the 1918 influenza drives starvation. Even malnutrition will increase mortality as victims’ systems become too weak to recover properly and fend off secondary infections. The islands’ environment mandated these patterns; little alteration of them was possible.

Cultural elements drove much of the mortality, and were also unlikely to change due to official intervention. The end of warfare in Samoa after 1899 allowed for a demographic bubble as a generation reached adulthood without the mortality both directly and secondarily caused by violent conflict. As the 20-40 year old age group was most vulnerable, a higher proportion of this age within the population led to a greater overall mortality. Traditions around disease mandated close contact with the ill, aiding the spread of influenza throughout families and kin groups. The nature
of Samoan political structure, with the village being the highest level entity with true executive power, meant that villages rarely came to the aid of each other. Instead, these small village-states kept what resources they had in the (almost universally correct) assumption that they would have to cope with a similar scenario soon.

Even in situations where a village had been lightly touched by illness and could assist neighbors, the village political focus and the gradual erosion of traditional authority vested in the chiefs caused by German and New Zealand policy left few arbiters available to determine how resources should be distributed. By attempting to move a decentralized traditional political system towards centralization and bureaucracy, both Germany and New Zealand were complicit in creating a hybrid system with few of the strengths and many of the weaknesses of both parents. The inherent fragility of this structure was quickly exposed under the strain of crisis.

Colonial policy was the final element driving excess mortality in Western Samoa. The relatively low population of non-natives on the islands provided a smaller core of possible assistance once the epidemic was established. Throughout the colonial empires in the Pacific, Europeans and North Americans suffered much less significant morbidity and mortality from the 1918 influenza than indigenous groups, and in many locales served as the main avenue of assistance for ill native populations. Policies adopted in German Samoa to prevent land alienation certainly served to protect Samoan culture, and the expulsion of the Chinese under Logan did help reduce the power of the plantations versus the village copra producers, but such actions also eliminated the less influenza-vulnerable segments of the population at the one time when they may have been most useful. The lack of clear instructions from Auckland, and the absence of warning regarding the Auckland outbreak or the

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225 Jordan, Epidemic Influenza, 206.
designation of influenza as a notifiable disease, left the Western Samoan Administration blind at a moment of crisis. The nature of Col. Logan himself further complicated the issue, with his response under stress and seeming strong distaste for Americans driving a series of decisions that potentially worsened the impact of the epidemic once it gained a foothold.

The example of government failure in coping with the influenza outbreak that held the greatest direct impact, and that most avoidable, lay in the operation of the Port of Apia harbour health system and the lack of quarantine for the *Talune*. Quarantine for Western Samoa, a colony with strong commercial ties, would have been expensive and controversial, but not particularly difficult. Foreign shipping used one port, not multiple sites as in Tonga and Fiji. There were two islands to quarantine, not dozens or hundreds. Yet under the wartime administration and through a combination of inexperience in the harbour health authorities, lack of political direction in Apia, and deliberate falsehoods from the captain of the *Talune* quarantine was not even attempted. Nothing could have done more to prevent the mortality of the 1918 influenza in Western Samoa than preventing its entrance to the colony.

Nearly twenty years after the *Talune* brought influenza to Samoa, the memories remained fresh. When a ship left Auckland in the midst of a polio outbreak, she received landing rights in Rarotonga, Tonga, and Fiji. Yet much to the indignation of the Europeans on board, at the instigation of the Western Samoan *Mau* she was refused landing rights in Apia. The Government may not have learned from the epidemic; medicine in the Pacific may still not have been practicing due diligence; but the *Mau*, that child of the ‘flu, was going to take no chances.226

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In 2002 then New Zealand Prime Minister Helen Clarke apologized publicly, in Samoa, for the “inept and incompetent early administration of Samoa by New Zealand.” Celebrating forty years of Samoan independence, this event marked the first public acknowledgement by the New Zealand Government of their failures and contrition regarding the former Western Samoa.

Chapter 4: American Samoa

Unlike the locations of the preceding chapters American Samoa did not suffer directly from the 1918 influenza pandemic. In fact, it is held up as one of a tiny number of polities, all island states, which avoided any influenza infection at all between 1918 and 1920. The other islands spared were in isolated corners of the globe and/or hundreds of miles from the nearest source of infection. St. Helena, the Comoros, and some Alaskan islands had minimal contact with non-local individuals and could control or avoid infection.¹ New Caledonia received partial protection under the Australian quarantine system.² American Samoa, in contrast, is a short journey from Upolu, the main population center of the Samoa archipelago and the site of the globe’s highest fatality rate from the 1918 ‘flu. On a clear day, they can be seen from each other’s shores. Strong social and familial ties bound the two colonies; and travel between them was regular, even commonplace. So how did American Samoa, despite such proximity, avoid infection?

American Samoa successfully implemented a quarantine that excluded influenza throughout the years of the pandemic. A combination of political, economic, and social elements within the territory allowed for quarantine to be put in place and maintained, when efforts failed in other island states. It is this combination of factors, and the mechanisms of the quarantine itself, which must be evaluated to understand the course of influenza in the islands more severely affected.

² Tomkins, “The Influenza Epidemic of 1918–19 in Western Samoa,” 184. Some sources, such as McLeod et al. list New Caledonia as a successful quarantine. Others, such as Dr. Sandra Tomkins and Dr. Norma McArthur argue that the New Caledonian quarantine was penetrated before 1920.
American Samoa consists of the eastern portion of the Samoan archipelago. North of Tonga, it lies in the torrid zone of the tropics, with consistently warm temperatures and little seasonal variation. The wet period, between November and April, brings the risk of cyclones.

Approximately forty miles to the southeast of Upolu, Western Samoa, lies the island of Tutuila. Tutuila is the largest island in American Samoa, the most populated, and the location of Pago Pago, the administrative capital of the territory. Seventy miles further east lie the Manu‘a group; the major islands of which are Ofu, Olosega, and Ta‘u. Two miniscule islands complete the American Samoa group: further east sits Rose Atoll, an uninhabited wildlife refuge, while far to the north is Swains Island, sparsely populated and also claimed by Tokelau.

(Map 4: The Samoas³)

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Tutuila encompasses roughly fifty-two square miles of land, most of which is extremely rugged. A chain of sharp peaks covered in jungle dominates the island. The main geographical feature of note is Pago Pago Bay, one of the best harbors in the South Pacific. The desire to use this anchorage as a coaling station for their steamships drove United States interest in Samoa and the eventual incorporation of American Samoa into the Pacific territories of the US in the early twentieth century. Pago Pago remained an American naval base until 1951.

(Map 5: American Samoa)

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4 West, *Political Advancement in the South Pacific*, 123.
5 Ibid.
American Samoa: 1899-1918

To enter Pago Pago Bay by ship, as the required first stop for all foreign visitors and traders entering American Samoa in the early twentieth century, was to enter a nearly untouched bit of paradise. Jagged cliffs of black volcanic stone rear sharply on either side, covered in overlapping layers of tropical greenery. Rainmaker Mountain dominates the harbor area, earning its name through the creation of a microclimate bringing more than 500 cm of rain per year. Birds call in numbers large enough to drown out the sounds of the port. The heat seems to slow time as well as people.

A few small fishing settlements occupied the entry to the sinuous bay in 1918, serving as sentries to the villages grouped around the harbor itself. The lack of arable flatlands or hills suitable for terraced agriculture on Tutuila forced most habitations to occupy the water’s edge, a practice which continues and that led to widespread damage and loss of life in the 2009 tsunami. Even in the early 1900s land suitable for building was at such a premium that the quarantine station was built upon Goat Island, connected to shore by a causeway that led directly to the grounds of the Governor’s residence (figure 16).

By 1918 the population of Tutuila, and thus of American Samoa as a whole, had come to center about the Bay and the US Navy facilities there. What had previously been a number of small communities grew into a single entity named after the largest component village, Pago Pago. The town developed as an adjunct of the naval base, and pictures from the era show a community bearing the visual cues of a military town. Utilitarian buildings, dormitory housing, and mess halls formed
the core of the main settlement of note in the territory. The only other harbor of value on Tutuila is Leone, on the southern coast.\(^7\)

Less than fifteen percent of Tutuila’s total land is considered arable, and throughout the island much of this is steeply angled.\(^8\) Tutuila’s limited arable land kept population low, 6,185 out of a total population in American Samoa of 8,058 according to the 1920 census.\(^9\) Historically Tutuila residents travelled to Upolu to engage in trading, mass meetings, and warfare.

(Figure 16: A view of the governor’s mansion in Pago Pago from the Goat Island Quarantine Facility\(^{10}\))

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\(^8\) West, *Political Advancement in the South Pacific*, 124.


American Samoa’s outlying islands are stunningly beautiful but held little of note. The Manu’a islands are quite small and thinly populated. Ta’u is roughly fourteen square miles. Ofu and Olosega, separated by a small, easily forded channel, present less than four square miles combined.11 In 1920 they had a combined population of 1,873. None of these islands possesses a good anchorage or harbor.12 In the modern day reaching them is still difficult, and, in the case of Ofu and Olosega, at times impossible.

The history of the Samoan islands before their formal division in 1899 has been addressed in the previous chapter. It is appropriate here to review events in American Samoa from the division through November, 1918, when the ‘flu struck Samoa. The differing courses taken by the eastern portion of the archipelago, under American rule, and the islands in the west under first German then New Zealand domination produced administrations with quite divergent aims. Though the pandemic period saw both portions of Samoa under English-speaking military rule, the structures in place bore limited resemblance to each other. These differences stepped to the fore with the appearance of disease.

The convention dividing the Samoan islands was drafted in 1899 and ratified by the U.S. Senate on February 13, 1900. A brief document consisting of only four articles and six paragraphs, it granted the United States control over all islands of the group east of longitude 171 W, and the German Empire all islands to the west of this line. The convention also annulled any previous treaties signed with outside powers by any Samoan government or official, and specifically the agreement of Berlin, 1889,

11 Evans, American Samoa, 12.
12 West, Political Advancement in the South Pacific, 124.
between the eventual colonial powers and Britain.\textsuperscript{13} The document made no mention of the views of the Samoans.

Further clarification of the status of American Samoa came in an Executive Order of February 19, 1900, placing the islands under the control of the Navy. Signed by President McKinley, it reads as follows:

The island of Tutuila, of the Samoan group, and all other islands of the group east of longitude 171 west of Greenwich, are hereby placed under the control of the Department of the Navy for a naval station. The Secretary of the Navy shall take such steps as are necessary to establish the authority of the United States and to give to the islands the necessary protection.

On the same day, the Secretary of the Navy issued the following order naming and determining the governmental structure of the Station:

The island of Tutuila, of the Samoan group, and all other islands of the group east of longitude 171 west of Greenwich, are hereby established into a naval station, to be known as Naval Station, Tutuila, and to be under the command of a Commandant.\textsuperscript{14}

Thus American Samoa joined the rapidly multiplying body of American military bases in the Pacific, alongside Guam, Hawaii, and the Philippines.

From the beginning of direct American rule eastern Samoa became a military dependency. The political leader was a Commandant, not a Governor. The islands were not seen as a major source of commodities of any kind,\textsuperscript{15} aside from a bit of copra. They were a strategic asset and a coaling site for American shipping, boasting an excellent deep-water harbor in an area of the Pacific Ocean that had previously seen little American military presence. American Samoa as an American

\textsuperscript{13} Evans, \textit{American Samoa}, 10.
\textsuperscript{14} Ibid.
\textsuperscript{15} Kunitz, \textit{Disease and Social Diversity}, 56.
administrative entity existed to extend the reach of the U. S. Navy, and any development or local political considerations were secondary to that goal. The navy had no issue with its new station remaining a quiet and forgotten backwater.

The Commandant of Tutuila was charged with the care of local inhabitants. The first Commandant’s orders instructed “you will at all times exercise care to conciliate and cultivate friendly relations with the natives.” This clause was repeated in the orders of each Commandant through 1918.  

Historian Ian Campbell argues that this initial ambiguity in mission and powers did not deter the naval Commandants from acting more aggressively in protecting the welfare of the Samoans under their control than did the German administration in the west. Land sales by Samoans to non-Samoans were immediately banned, as was the sale of liquor, except to foreigners with written permission from the administration. Inter-territorial malaga, large traditional processions between villages and islands seen by both the American and the German administrations as a drain on resources, were forbidden except with administration approval from 1902. This was enacted in cooperation with the German administration of Dr. Solf as part of a drive to revitalize agriculture and reform the local economy. The same year saw efforts begin to improve agricultural yields. A government school, meant to give a non-sectarian option for education in a territory where all education was handled by missionaries, began work in 1904.

Starting in 1905 the American Commandant also carried the title of Governor, with responsibility for non-military affairs. This title, granted by the president, became the source of civil authority, and the orders of the Governor in civil matters did not face naval review. A single individual therefore carried two different titles,  

16 Evans, American Samoa, 10.  
sets of responsibilities, and authorities to answer to. The Commandant ruled in matters military, responsible to the Navy; the Governor in civil fields, answering to the Executive branch of the United States government. Yet even on the military side of the administration outside supervision was minimal. In 1902 the Department of the Navy stopped reviewing all regulations issued by the Commandant, instead accepting a right and role of amendment when needed.

The convention, while removing British and German claims to American Samoa, did not grant sovereignty to the United States. Unlike in Western Samoa few recent wars had been waged locally (requiring the trade of land for modern weapons) and the land was ill-suited to plantation agriculture so little land had been alienated into foreign hands. The absence of this irritant helped facilitate talks toward formal cession, which occurred through agreements with the primary chiefs of the various islands. The chiefs of Tutuila signed a formal document of cession on April 17, 1900, and those of the Manu’a group did so on July 15, 1904 (though the high chief of the Manu’a group, the Tu’i Manu’a, presented a letter to the Commandant accepting American rule on 13 March, 1900). These documents had not received congressional approval as late as 1918, but had been signed and acknowledged by the President. By 1921 Governor Evans described the following points regarding the status of American Samoa to be “established” via “decisions of the various departments rendered from time to time”:

1. It is not foreign but domestic territory
2. Samoans are not “citizens of the United States” but owe allegiance to the flag.

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18 Evans, American Samoa, 10.
19 West, Political Advancement in the South Pacific, 132.
21 West, Political Advancement in the South Pacific, 132.
3. Vessels owned by Samoans are not entitled to registry but are entitled to fly the flag.

4. Neither the Constitution nor the laws of the United States have been extended to them, and the only administrative authority existing in them is that derived medially or immediately from the President as Commander in Chief of the Army and Navy of the United States.\footnote{Evans, \textit{American Samoa}, 11.}

American Samoans were thus under the direct control of the United States military as representatives of the President. The Commandant held the same authority over them as he wielded over the troops under his remit. In 1918 they held none of the constitutional rights accorded citizens, and were not due the protection of American laws. Regulation #5 of 1900 stated that the laws of the United States would be in force in American Samoa unless expressly modified,\footnote{Ibid., 14.} but such modification could take place without consultation. Samoans could not vote, nor send representatives to Washington D.C. Sovereignty disappeared with the acts of cession, despite questions surrounding the right of the traditional chiefs to make such a decision. Any rights that rose in the place of sovereign authority were those granted by the Commandant, revocation of which could occur without recourse. While a severe limitation of the rights of the Samoans living under the American flag, this absolute authority in the islands became crucial for the successful implementation of quarantine in 1918.

Those serving the commandant in positions of authority were mostly US Navy officers. A naval officer served as chief customs officer for the civil government. The station’s executive officer became sheriff of the territory and supervised public safety. A naval supply officer served as treasurer for the territory;
the station chaplain as the head of what eventually became the Education
Department; and the station public health officer supervised all health issues in the
islands, including the hospital, smaller clinics, village sanitary conditions, and all
quarantine regulations as these gradually developed. From 1919 the public works
officer for the station filled the same role for the civil government and was thus in
charge of infrastructure development.

These naval officers generally spent two years at the station, as did the
Governor. The short terms of these officers did much to prevent the development of
fiefs and the power struggles so common in colonial administrations staffed with
career civil servants. Negative consequences accrued as well, as colonial officers
would be transferred just as they became skilled in their roles. Given the climate and
range of tropical ailments present, American Samoa was considered a hardship
positing within the military, and few serving there aside from the highest ranking
officers brought families with them.

Within the civil government of the islands the Secretary of Native Affairs was
a civilian executive, acting for the Governor in all matters concerning native issues
and officials. Since direct governance was left in traditional hands, with some
supervision, this meant nearly all non-military business within the territory. The
United States had no dedicated office for colonial affairs or trained corps of
specialists meant to govern and exploit the colonial territories. Those filling civilian
positions in the colonial territories had limited traditions, institutional knowledge,
and infrastructure to draw upon as compared with the European powers. Not seeing
itself as a colonial power, the lack of a professional colonial service in the United
States government seemed unremarkable to its officials.

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24 Ibid., 13.
25 Campbell, Worlds Apart, 225.
Commandant Benjamin Tilley, taking power in 1900, developed a system of indirect rule to address civil needs.26 The basic civil division was the county, fourteen divisions based roughly upon traditional high-chieftainships, and governed by a county chief. This chief technically received appointment from the Governor, but in most cases authority remained vested in the traditional holder of the high-chief’s title under Samoan custom. From this group of county chiefs three district chiefs held sway, one over each of the traditional divisions within the group: Eastern Tutuila, Western Tutuila, and the Manu’a group. Below the level of the county lie the 52 village chiefs, or pulenu’u, chosen by the heads of family within the villages (matai) and who faced confirmation by the civil authority.27 Police and local magistrates were Samoan.

Regulation #5 of 1900, the first organic law in American Samoa, held that Samoan customs not in conflict with the law shall be preserved and that local (Samoan) officials retained responsibility for issues of local interest.28 The lack of a large foreign population and the negligible level of land alienation (less than two percent before laws were enacted in 1900 to prevent further sales) in place before the cession facilitated this policy of rule through indigenous agents as there were minimal vested parties working against it.29 This policy of rule through traditional structures reflected the US Navy’s desire to have the station run in peace, with as little impact on the local population as possible. This was a policy of neglect, but hopefully of a benign form. The actions of the officials in American Samoa often worked against this hoped for laissez-faire ideal.

27 Ibid.
28 Evans, American Samoa, 14.
Although the Governor held authority unchallenged within the territory and enacted all laws and regulations, a consultative meeting, or *fono*, of Samoans occurred yearly and included delegates from all islands in the group. After local conferences delegates would attend the fono to advise the Governor and suggest new laws or changes to existing rules. The fono served as a site for general discussions and a time for traditional reconfirmation of titles and allegiances.\(^{30}\) The Governor traditionally made a yearly tour of the villages, making himself available for local concerns and suggestions.\(^{31}\) Commander John Poyer, U.S. Navy, served as Governor throughout the early pandemic period, holding power from early 1915 until June 10, 1919. He was succeeded by Commander Warren J. Terhune, U.S. Navy, who served until his suicide on Nov 3, 1920.\(^{32}\)

Even while discussing the differences twenty years of foreign rule bequeathed to the two Samoas, it is crucial to note how interconnected they remained. In the early twentieth century the two Samoas were unified religiously, culturally, and historically. Samoans travelled between the islands freely, and as long as they did not use ships large enough to require harbor facilities they could do so without attracting government attention. Funerals, births, and rituals surrounding chieftaincy drew large parties across the nominal borders. Intermarriage was common as Samoan tradition required exogamy, which was difficult to achieve in the limited population of American Samoa, particularly in the higher classes.\(^{33}\) The borders defined economic spaces, and were used by the colonial powers, but until active measures were taken to ban the large travelling parties they had little impact on the Samoan lifestyle. The foreign demarcations were just that, foreign.


\(^{32}\) Evans, *American Samoa*, 34.

\(^{33}\) Schultz, Dr., “Samoan Laws Concerning Family, Real Estate, and Succession.” (Imperial Government of Samoa, May 23, 1912), 20, Box #1; Series #6, General Interest File 1872-1948; Records of the Governor’s Office; Records of the Government of Samoa, RG 284; National Archives, Pacific Region, San Francisco, CA.
Aside from contacts with Western Samoa, American Samoa was largely cut off from the outside world. In 1918 no cable communication linked American Samoa to the larger world. The nearest commercial station was at Suva, in Fiji. Radio communications via the naval service were available but, due to the needs of wartime, private and commercial usage was severely restricted.\textsuperscript{34} Trade was minimal, and consisted of copra for export and basic supplies for import. Most of this small volume of trade was with the United States, Australia, or New Zealand. Since the administration, at the request of the chiefs, handled the yearly sale of copra, traders and their interests had little place in Pago Pago. Aside from branches of a few Apia traders, Pago Pago supported very little mercantile activity.

This stands in contrast to the economics of Western Samoa. Though both Samoas focused upon copra production (a brief flirtation with cotton during the American Civil War came to an unsuccessful conclusion), in Western Samoa it was grown on plantations, staffed with largely imported labor, and sold under the aegis of the private plantation owners. This meant that growers were competing against each other, which drove down prices. Since the Samoans in the West either worked for the plantations or grew small amounts on their private land they had no input into pricing and gained little from the trade. In American Samoa all copra was grown on village land and sold en masse by contract. This avoided competition between growers and allowed the majority of revenues to remain in Samoan hands and under their control.

The entry of the United States into the First World War had little impact on the trade relationships in American Samoa. In 1914 the Apia headquarters of the Deutsche Handels und Plantagen-Gesellschaft der Sudsee-Inseln zu Hamburg (DPHG), which traded and operated plantations throughout Western Samoa, shifted

\textsuperscript{34} Evans, American Samoa, 33.
its liquid assets to the small Pago Pago office. This consisted of running a boat full of Imperial German marks across the straits between Tutuila and Upolu. Claiming that all merchandise imported and sold by their store came from the United States or Australia, it continued to operate as normal throughout the American participation in the war and was not declared forfeit by the US government until the war had actually ended, on November 19, 1918.\textsuperscript{35} Given that the letter had to wend its way from Washington D.C. to Pago Pago via land and steamer mails, no action was taken until well into the next year. Throughout the war years trade and commerce, in their much attenuated American Samoan forms, proceeded as during peacetime.

The absence of significant trade made missionary efforts the major foreign influence in the eastern Samoan islands.\textsuperscript{36} As with many Polynesian cultures Christianity took strong root in the Samoan group and government reports described the population as overwhelmingly religious. The four main denominations present in 1918 were, in order of number of adherents: London Missionary Society (LMS)(mainly Congregationalist), Roman Catholic, Latter Day Saints (Mormon), and Wesleyan.\textsuperscript{37} Missionary groups served as the primary source of education and ancillary medical staff, particularly outside of Pago Pago. The LMS also had large numbers of adherents in Western Samoa, and yearly meetings in Apia would draw representatives from throughout the archipelago. Students from American Samoa attended school in the West. The religious groups reinforced and maintained the cultural bonds that linked the Samoan territories, especially in the absence of other foreign influences.

\textsuperscript{35} Chief Walter D. Denegre, “Walter D. Denegre, Chief, Division of Insular Possessions to Governor of Samoa,” (Alien Property Custodian, Washington DC, November 19, 1918), German Firm Seized (National Archives Microfilm Publication T1182, roll 40); Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
\textsuperscript{36} West, Political Advancement in the South Pacific, 130.
\textsuperscript{37} Evans, American Samoa, 24.
This lack of outside contact facilitated the maintenance of traditional customs. For example, the 1921 report of Governor Evans describes the people as “generous and hospitable to a remarkable degree”. He attributed the survival of this “admirable trait” to the lack of foreigners in the territory, whose presence might have stamped out such behavior through abuse of confidence.\(^{38}\) With this in mind medical staff in American Samoa became concerned with the opening of the Panama Canal in 1914. Realizing that Pago Pago was directly in line between the canal and Australia, they saw the end of the benign isolation that had protected Eastern Samoa from some of the worst impacts of foreign contact.\(^{39}\)

The administration of the territory struggled to keep naval personnel and Samoans separate, aside from official duties. This reflects in part the racial and religious mores of early twentieth century America, a time when the military was still strictly segregated and Jim Crow laws were in place in much of the nation. It also reflected fears of contamination in a more physical sense. In an order of September, 1913, Governor Stearns declared that “Single men having sexual intercourse with females while on liberty will report immediately to sick quarters upon returning to duty. Failure to do so will be considered a punishable offense.”\(^{40}\) Whether this prevented disease is not noted, but these orders also served to protect the local traditional systems by discouraging fraternization.

### Health and Medical Infrastructure

The territorial administration took great pride in the health and hygiene efforts within American Samoa. Between cession in 1900 and the 1920 census the

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\(^{38}\) Ibid.

\(^{39}\) H. L. James, “Pathology Of Samoa,” *Journal of the Polynesian Society* 22, no. 86 (1913): 85.

\(^{40}\) Governor Clark D. Stearns, “Order of September 2, 1913” (Government House, Pago Pago, September 2, 1913), Box 8; Regulations and Orders of the Government of American Samoa, 1900-1946; Records of the High Court; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
population of the islands increased by forty-one percent, an achievement attributed by Governor Evans to local factors in conjunction with “sanitary supervision, education, and ample facilities for free medical treatment”. Campbell argues this point, stating that while medicine was free for Samoans from 1900 forward, those natives capable of paying were charged for care in government facilities. Government sources merely refer to a controversy, suggesting that it was resolved in 1921 with free health care decreed for all American Samoan residents. Details aside, the improvement in public health standards was notable and greater than those over the same time period in Western Samoa. Campbell further posits that this difference stemmed from the shorter term of American officials, the fundamentally liberal stance of the naval officers in charge, and the lack of any need for propaganda value from colonial achievements or room for colonists from the metropolitan center; unlike the German Samoan regime through to 1914.

Whether Campbell is right that American Naval officers were more liberal in outlook than Imperial German Colonial officers is beyond the scope of this work. The absence of a significant settler population, and any pressure from the metropole to take colonists, did allow the local government to shift resources to the care of the native population that might otherwise be spent supporting and developing infrastructure for transplants from North America. There was no pressure to lure colonists to Tutuila for economic development, and thus development efforts proceed with native needs in mind, rather than the desires of potential settlers. Those natives living away from Pago Pago might have access to a physician in the village yearly, and a travelling nurse or orderly on a monthly basis.

41 Evans, American Samoa, 25.
Communicable diseases common to Polynesia as a whole were endemic within the territory. Filariasis, yaws, dengue, and varied parasites recurred regularly (or were nearly omnipresent in the case of parasitic infections). The islands had faced ship-borne epidemics since European contact, most notably measles in 1893 and 1911. In late 1901 a mild influenza outbreak occurred. Vaccination for smallpox was compulsory from 1903 and seemingly effective, with no outbreaks noted after the advent of American administration. A potential measles epidemic was stymied in 1908 when a ship arrived in Pago Pago with a case onboard, triggering a rigid quarantine. The islands exhibited no malaria, cholera, yellow fever, dysentery, plague, or leprosy between 1900 and 1918.  

That said, the resident of the portion of the archipelago under US control had broad experience with ship-borne illnesses and quarantine measures necessary to stop them.

When the station ship U.S.S. Abarenda arrived in April, 1900, there was no practicing physician in American Samoa. Missionaries provided some medical care, at varying levels of skill, as did the ship’s doctors of visiting vessels. The ship’s surgeon, E. M. Blackwell, became the first staff of what became the Public Health Department of American Samoa, applying for funds in 1900 to build a dispensary and begin care for the native population. These requests were denied and the doctor continued providing care on a makeshift medical skiff, though a dispensary was constructed four years later. In 1904 a further unsuccessful request was forwarded to Washington for funds for a native hospital.

A Board of Health for the territory began work on December 31st, 1909, inspired by the discovery of hookworm in the majority of the native population. This Board, made up of naval officers serving in the Station government, drafted health regulations; originally focusing on sanitation and disease control. By 1911 funds had

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44 Evans, American Samoa, 25.
been set aside from fees levied upon the native population and station coffers for construction of the Samoan Hospital. The new facility followed the Samoan traditions of health care inasmuch as relatives provided food and most unskilled nursing care.\textsuperscript{45} The year 1914 saw the dissolution of the Board of Health in favor of the Department of Health with a much broader remit, including all aspects of quarantine and water quality control.\textsuperscript{46}

Efforts toward the control of communicable disease and the general health of the population of American Samoa were the responsibility of the senior medical officer at the naval station, who also served as the territorial health officer by default. In 1918 the naval medical personnel served as the care providers for the entire native population, the few foreign civilians in place, and the military contingent. There were no private physicians as the native population received free care and there were insufficient numbers of foreigners to support alternatives to the naval staff. Importation of opium and any other drugs or medicines faced legal sanction unless approved by the territorial health officer.\textsuperscript{47} Compulsory vaccination could be ordered by the health officer.\textsuperscript{48} As the naval medicine infrastructure grew, references to missionary medicine declined, and then ceased altogether. By 1918 missionaries still served as the main caregivers in the Manu‘a group, but Tutuila was under the care of the Navy. The health officer also worked with village chiefs to ensure hygiene in and around homes and villages.\textsuperscript{49}

\textsuperscript{47} Evans, \textit{American Samoa}, 15.
\textsuperscript{48} Ibid., 16.
\textsuperscript{49} Ibid., 21.
Colonial health care infrastructure centered on Pago Pago, with the station dispensary (accessible by military personnel) and the Samoan Hospital (from 1912) both located on the grounds of the naval station. The Hospital staff was comprised of a dedicated naval medical officer, four naval nurses, and two native hospital corpsmen (orderlies). Beginning in 1914 the Hospital also trained local women in nursing. Once qualified, these nurses would work the wards at the Hospital and visit the villages, providing direct care and education to the more remote portion of the territory. They also hosted daily clinics at the Government School in Pago Pago. If needed, chief pharmacists’ mates and naval petty officers also served both the military and native population.

Much of the energy of the medical staff was channeled into education. Samoans were discouraged from taking up western styles in dress or housing, as the traditional forms proved themselves significantly more benign in a tropical climate than their American counterparts. A document published by Health Officer George F. Cottle, USN, in 1912 was meant to teach school children “so that when they grow up they will be more healthy than people in Samoa now and so they will be more ready to obey a doctor’s orders when they go to him than people now are.” The pamphlet included information on why Samoan houses were healthier than western-style homes in Samoa, the dangers of spitting and the legal sanctions against it, dental care, and the common diseases of Samoa along with their origins and prevention.

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51 Evans, American Samoa, 26.
52 Lambert, A Doctor in Paradise, 221.
The need for a quarantine station for Pago Pago was recognized early, but funds remained an issue. In June, 1901 a steamer from San Francisco arrived in American Samoa with a case of varicella (chicken pox) aboard, causing the first local quarantine.54 One benefit of a naval administration proved to be an institutional knowledge base regarding quarantine practices. The Health Officer received orders in early 1902 to board all incoming ships and determine whether pratique (clearance to enter port due to the absence of infectious disease) would be granted, before any other individual could approach the vessel.55 A year later the administration completed a miniscule quarantine station on Goat Island, in the midst of Pago Pago harbor.56 A clarification of quarantine rules including the flying of the yellow flag until pratique was granted was published as Health Regulation no. 3 in 1910.57 These actions can be seen as an extension of the ferment in the United States regarding public health provision following the successes of the military in controlling Yellow Fever and the campaign against Hookworm (which would carry over directly to American Samoa under the aegis of the Rockefeller Foundation).58 As the modern public health infrastructure developed in the center, the periphery gained as well.

55 Commandant Uriel Sebree, “U. Sebree, Commandant; Order No. 10, United States Naval Station Tutuila, Office of the Commandant,” January 10, 1902, Box 8; Regulations and Orders of the Government of American Samoa, 1900-1946; Records of the High Court; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
Early the next year the Department of Health designated the naval officer serving as Health Officer of Pago Pago the official quarantine officer for American Samoa, a position filled by the subordinate naval physician serving as Health Officer of Tutuila in his absence.\textsuperscript{59} By 1911 the Health Officer had drawn up plans for a significant increase in capacity at the quarantine station, then only a three room home occupied in normal times by the Sanitary Inspector, though funds were again not allocated.\textsuperscript{60} Use was limited. 1913, for example, saw the station used three times in conjunction with passengers trans-shipping from smallpox infected ports.\textsuperscript{61}

This was not an unusual situation in American Samoa. Although the number of passengers bound directly for Pago Pago was small, individuals on the steamers out of Sydney, Auckland, San Francisco, and Vancouver would frequently disembark in Tutuila and catch small packet ships to Apia for further transfers. The four major ports from which ships visited Pago Pago all experienced smallpox outbreaks in the early 1900s.

Quarantine could also be used intra-territory. In 1903 the Health Officer requested, and the Commandant granted, that vessels from Manu’a be subject to quarantine regulations when entering Pago Pago.\textsuperscript{62} No explanation was given for the

\textsuperscript{59} Governor William M. Crose, “William Crose, Governor; Order of February 24, 1911,” February 24, 1911, Box 8; Regulations and Orders of the Government of American Samoa, 1900-1946; Records of the High Court; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.

\textsuperscript{60} Health Officer, American Samoa, “Report of Health Officer of Tutuila and Manu’a for Six Months Ending June 30, 1911,” June 30, 1911, Medical Reports, 1899-1913 (National Archives Microfilm Publication T1182, roll 37); Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.

\textsuperscript{61} Senior Medical Officer, American Samoa, “Senior Medical Officer, Annual Sanitary Report for the Year of 1913;,” January 12, 1914, 4, Medical Reports, 1899-1913 (National Archives Microfilm Publication T1182, roll 37); Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.

extension of quarantine to intra-territorial traffic, but it suggests recognition of the risk posed by ship-borne infections.

The measles outbreak of 1911 gave the territory a chance to refine its quarantine measures. Following cases in Tonga in November, 1910, the Dawn (a German vessel permanently based in Western Samoa) brought a case to Apia, where the ship was immediately quarantined. Leaving before quarantine was complete the Dawn came to Pago Pago, where she again was quarantined. Orders had been issued by this time refusing landing privileges in American Samoa to any natives who had been in Tonga within the past month.\(^63\) After twenty-two days in quarantine the Dawn was released on January 6\(^{th}\) only to demonstrate a new case. The case was sent to the quarantine station on Goat Island, and the Dawn again placed in quarantine along with another ship, which had unloaded beside her that day. Both ships were released from quarantine after an extended twenty-four days and no further cases. The additional days deemed necessary due to the appearance of the disease after the traditional twenty-two day quarantine on the first ship.

In the meantime Apia had been re-infected by the monthly Union Steamship Co. freight ship out of Auckland, and once the Dawn began carrying passengers again between Tutuila and Upolu, the infection quickly spread to Pago Pago. Rigid quarantine measures were again imposed, including internal quarantine between infected and clean villages, but to no avail.\(^64\) Manu’a did manage to avoid infection until April 30 by imposing quarantine against both Tutuila and Upolu. Eventual

\(^63\) Governor William M. Crose, “William Crose, Governor to the Samoa Shipping and Trading Co, Pago Pago, December 24, 1910,” December 24, 1910, Box 1; Series 6, General Interest File 1872-1948; Records of the Governor’s Office; Records of the Government of Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.

\(^64\) Governor William M. Crose, “William Crose, Governor to Secretary of the Navy;” (Office of the Governor, American Samoa, March 3, 1999), Box 1; Series 5, Annual Reports on Government Affairs, 1902-1956; Records of the Governor’s Office; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
mortality from this outbreak was 24 per 1,000 residents of Tutuila and 27 per 1,000 in the Manu’a group.65

Shippers have traditionally seen quarantine as a hindrance to their trade, and despite the small commercial presence in the colony the administration in Pago Pago found itself under pressure to reduce quarantine rules. During the 1913 quarantine against smallpox that closed Apia and Pago Pago to passengers who refused isolation and cargo that was not fumigated with sulphur upon receipt, the Oceanic Steamship Company (OSC) out of Sydney wrote to Governor Stearns in protest. The OSC’s ships ran between Sydney and San Francisco, stopping at Pago Pago six days after leaving Sydney, now an infected port. Two weeks was considered the safe isolation time for smallpox contacts. Noting that the lack of communications with these distant ports left shippers unwilling to send cargoes until confirmation of the end of quarantine was received, the managing agent suggested less rigid measures would be appropriate, such as fumigation in the departing port rather than the receiving. Failing this, the agent predicted “all-round hardship if we are not able to take cargo for Samoa.”66 Of course, no mention was made of the potential for infection during the voyage and the stops at multiple ports en route.

During this same smallpox outbreak in Australia and New Zealand, a ship landed passengers in Apia before the requisite fourteen days had passed, a period considered necessary to be cleared for smallpox. Despite the assurances of both the vessel’s captain and the Apia Port Officer that they saw no risk, the Health Officer for

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66 Managing Agent, Oceanic Steamship Company, “Managing Agent, Oceanic Steamship Company to C. D. Stearns, Governor;” August 21, 1913, Box 4; Series 15, Subject Files, 1900-1958; Records of the Governor’s Office; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
Pago Pago, Surgeon C.F. Ely USN, wrote to the Governor asking that Apia be declared an infected port. In his words: “There is only one safe rule to follow in quarantine work and that is, if there is any doubt give the dangerous disease the benefit.”

Despite these words of caution, the isolation of American Samoa did weigh against rigid quarantine. Because of the need for supplies, Governor Stearns issued an order on September 15, 1913, that requests for cargo imports from infected ports would be considered on a case-by-case basis. Adequate provisioning of what was primarily a naval supply station took precedence over disease control concerns. If this conflict in priorities were to be resolved, quarantine procedures needed to be reviewed.

Governor Stearns stressed the need for a larger quarantine facility (figure 17), stating in a letter written in mid 1914 that the small house on Goat Island could handle no more than eight individuals. This had become a great inconvenience as all trade from Australian and New Zealand ports had been under quarantine due to smallpox since August, 1913. He argued that the delay imposed by ships having to wait to enter quarantine impacted supply delivery to the territory as well as profits for the shipping companies. Clearly pressure from the shippers had been brought to bear. The request for funds to expand quarantine facilities was rejected by the Navy and the Federal Government.

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(Figure 17: Proposal for increasing capacity of Quarantine Station on Goat Island, Pago Pago Harbour, 1911\textsuperscript{69})

\textsuperscript{69} Health Officer, American Samoa, “Report of Health Officer of Tutuila and Manu’a for Six Months Ending June 30, 1911.”
Early 1913 heralded influenza’s return to the islands, in its traditional form of a disease of the old and very young. The infection came by ship, but no single vessel was identified as the source. The Health Officer issued a set of recommendations in connection with what turned out to be a mild visitation of the illness:

1. Do not allow well children or old people in the vicinity of those ill with a cold.

2. As the disease is transmitted from the sick to the well by the discharges from the mouth and nose they should not be scattered carelessly about. Old pieces of cloth should be used to receive them and afterwards burned.

3. Bring all cases of colds to the hospital at once in order that they may receive treatment early.

4. Very young children should not be allowed to run about scantily clad, especially in a cold wind or rain.

5. Careless spitting about the house should not be permitted.\footnote{Health Officer, American Samoa, “Report of Health Officer for September 1913,” October 2, 1913, 2, Medical Reports, Miscellaneous (National Archives Microfilm Publication T1182, roll 37); Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.}

These instructions continued to serve as the baseline for influenza prevention in the territory until after the 1918 pandemic passed. It is notable that no provision for quarantine is made in the instructions. Influenza at the time was simply not seen as a serious threat, and ships entering Pago Pago were not to be delayed over a case of the ‘flu.

Pago Pago served as the only legal port of call in American Samoa, despite some efforts to have Leone, on the south coast of Tutuila, receive shipping as well. There was no need for a second port, nor the infrastructure necessary to move goods
from Leone to the rest of the territory. In this sense the town served the same role as Apia to the west, the portal to the outside world. Yet in a smaller territory with fewer residents such control could be more complete. All passengers and freight were processed at the naval station, and any cargo bound for the United States had to depart from these facilities.\(^71\) No landings of any kind by ships from outside the territory were allowed outside Pago Pago Bay. This policy stood since the beginning of American rule and no local opposition to it is found noted in the records of the station.

By 1918 regular freight and mail service came via ships on the San Francisco-Hawaii-Samoa-Australia run, averaging one ship per month in each direction.\(^72\) Ships bound for Apia, with a much greater volume of freight in and out-bound, would on occasion make a side trip to Pago Pago, and inter-islands ships would pass frequently between American and Western Samoa. The total number of vessels from overseas ports that entered Pago Pago harbor was relatively small: fifty-five in 1911, sixty-two in 1912, and sixty-five in 1913. Trade was limited due to the small population and lack of desirable resources. Copra was the only significant export in 1918, and that year total imports were less than a quarter million US dollars in value, divided in source between the United States mainland and Australia/New Zealand.\(^73\)

At the beginning of 1918 the quarantine facilities in American Samoa remained vestigial. The station on Goat Island could be converted into a quarantine facility within 2 hours, with a maximum capacity increased to ten individuals. The port could offer disinfection, fumigation, and rat-removal services to ships, but traditionally fumigation of cargo would take place in hulks, ships no longer suited for use that were anchored permanently in harbor as storage sites. There were no

\(^{71}\) Evans, *American Samoa*, 15.
\(^{72}\) Ibid., 31.
\(^{73}\) Ibid., 33.
hulks in the harbor large enough to fumigate significant cargo loads in a single batch. Since most ships were only in the harbor only a matter of hours, no isolation housing was available for crew or cargo handlers. Instead, crew of quarantined vessels would remain on the ship moored offshore surrounded by guards posted on boats to ensure no contact with land. Given the lack of establishments catering to visitors ashore, few sailors would have regretted missing landfall in Pago Pago.

Passengers originating from infected ports/ships for Pago Pago or trans-shipping elsewhere were placed in the quarantine facility, up to its capacity. No acutely ill passenger or their contacts were allowed to land unless they were residents of American Samoa, in which case they would be isolated in either the station dispensary (capacity fifteen) or the Samoan Hospital (capacity 120) depending on race. The station dispensary was not to be used to treat native Samoans following the Samoan Hospital’s completion.

Quarantine: Epidemic Averted

While American Samoa continued in its glorious isolation, the influenza of 1918 spread around the globe. The second wave devastated Europe and North America in the northern hemisphere autumn and spread out along intercontinental trade routes. By the time it struck Auckland the world press recounted anecdotal horrors, even if the full scale of the pandemic was yet unclear. It was clear the disease would reach the Pacific islands, and soon.

No formal orders came from Washington or the Navy for Governor Poyer regarding quarantine or influenza response in late 1918, but he read the papers that came twice monthly and reviewed the daily radio briefings. Acting upon his own

74 Governor J. M. Poyer, “J. M. Poyer, Governor to International Health Board”, May 26, 1917, Box 1; Series 6, General Interest File 1872-1948; Records of the Governor’s Office; Records of the Government of Samoa, RG 284; National Archives, Pacific Region, San Francisco, CA.
initiative, he ordered quarantine against all traffic from outside the colony.\textsuperscript{75} Governor Poyer later rejected suggestions that he had received warnings or orders from any official source.\textsuperscript{76}

Governor Poyer could act from a different base than his equivalent, Col. Logan, in Apia. The Governor of American Samoa had been a nearly autonomous dictator for eighteen years. Quarantine declarations over that time came from the naval station and had never been questioned or countermanded although shippers might complain. The trading community remained small, and had minimal political power in the colony. Governor Poyer found that he was free to act proactively and without fetters. So he acted.

In Apia Col. Logan faced the litany of problems discussed in the previous chapter. He led an interim military government with no strong tradition of place and a history of only four years. Autonomy was not a hallmark of his administration, and he felt he could not act without some form of guidance from Wellington. The economic interests in Western Samoa were large and influential, even if most still carried German names. These interests ensured that he would have to weigh any decision to implement quarantine with a great deal of caution. The administration in Apia was indecisive and without leadership. So Logan did not act.

Before the \textit{Talune} reached Apia, and weeks before the full horror of the influenza experience in Western Samoa became clear, Governor Poyer received a warning shot across his territory’s bow. The regular mail/freight ship, the S.S. \textit{Sonoma}, arrived at Pago Pago from San Francisco via Honolulu on November 3, 1918. Basic quarantine measures had already been ordered by the Governor, and the \textit{Sonoma} became the test case. Since leaving San Francisco there had been fourteen

\textsuperscript{75} Crosby, \textit{Epidemic and Peace}, 237.

\textsuperscript{76} Herda, “Disease and the Colonial Narrative: The 1918 Influenza Epidemic in Western Polynesia,” 136.
influenza cases aboard, and one death. Two individuals still demonstrated pneumonias. These cases were taken ashore and placed in strict isolation at the base dispensary while the three passengers bound for American Samoa were moved to a home quarantine of five days. All possessions were fumigated and the passengers endured regular temperature checks and isolation. No other passengers or crew were allowed ashore or to have contact with residents of the territory. These measures proved adequate and allowed the Health Officer to see the where weaknesses in the system existed. No infections occurred from this initial visitation.77

November 7th saw the Talune steam into Apia, and the beginning of the decimation of Upolu and Savai’i. By November 14th letters were reaching Rev. Kinnersley of the LMS in Leone, Tutuila, from a friend in the American colonial administration regarding the scale of the pandemic in Western Samoa. This correspondence with Mr. Cartwright, an official in Pago Pago with access to the radio messages sent by the American Consul in Apia, traces the growing realization of the problem and the risk posed by the pandemic. By the 14th quarantine was already in place against Upolu, and any passenger for Western Samoa was warned that they would not be allowed back for an undetermined amount of time. Despite the approaching LMS conference in Apia, to which dozens of American Samoans would usually journey, travel was not recommended. Mr. Cartwright noted his surprise at the speed of spread, only a few days having passed since he had first heard of its presence.78 By the 19th Mr. Cartwright could state that the quarantine was tighter in Pago Pago while the disease spread rapidly in Apia.79 On November 22nd described

77 Crosby, Epidemic and Peace, 237.
the quarantine as absolute. When the vessel *Dawn* approached Apia from a run to Pago Pago she was told not to enter, and a party of Europeans rowed to her outside the harbor. After informing the crew that they had buried 100 people in Apia alone that day they asked the ship to not land at either Upolu or Savai’i.

The first mention of the quarantine appeared in Apia’s weekly paper in mid-November. The *Samoa Times* ran a brief note on Saturday, November 16th describing the conditions of the quarantine in Pago Pago. No further comment was attached.

By November 23rd conditions in Upolu reached a crisis. Following reports from the American Consul in Apia via radiograms, Governor Poyer ordered a complete quarantine on all vessels from Western Samoa (figure 18). The order asked that people remain calm and explained what measures were to be taken. This included a ban on all travel to the colony, arguing that the Western Samoans faced enough problems without sending over additional potential victims. The notes of Surgeon Lt. Francis Grey of the Royal Navy, commander of the Samoa Relief Expedition sent from Australia to Apia during the pandemic, tell a different story. He claimed that against Col. Logan’s will Commander Poyer sent 40 American Samoans to Apia during the height of the outbreak there. Grey suggests that they were immediately isolated, inoculated with the vaccine he had brought to Apia, and held for several days. He further claimed that one month later they were still clear of infection. No other mention of this informal experiment presents in the papers of either administration, or in the records of the missionary groups, and thus it seems unlikely. Sending healthy natives into a raging pandemic against the will of the recipient country would surely produce some comment, if only a bureaucratic aside.

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80. “Local and General News. the Samoa Times, November 16, 1918.”

Even the simple transfer of mails and a single resident of Apia from the clean port of Pago Pago to Apia required several radiograms and the extensive intervention of the Consul.\textsuperscript{82}

(Figure 18: A copy of Governor Poyer’s order announcing the quarantine against Western Samoa.\textsuperscript{83})

\textsuperscript{82} Mason Mitchell, “Mason Mitchell, American Consul, Apia to Governor Poyer, Pago Pago,” December 10, 1918, Communications/Consuls (National Archives Microfilm Publication T1182, roll 32); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.

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Following the quarantine order, relations between the two colonial administrations in Samoa soured. Free movement between the two Samoan entities had been a given, the close cultural and family ties making it almost a necessity. Weeks before the quarantine order Apia had hosted a concert fundraiser for the American Red Cross, including housing a large contingent from Pago Pago. To have this link cut seems to have deeply offended Col. Logan, perhaps reflecting perceived ingratitude following his recent gestures towards the American community.

Several days after the quarantine order the regular bi-monthly mail steamer came through Pago Pago, and Col. Logan sent his personal ship with a parcel of mail bound for San Francisco. Governor Poyer described himself as astounded at this arrival, given the recent communications and clear quarantine order. Meeting the ship outside the harbor, the Governor communicated from two boat-lengths away, informing the master of the craft that any landing would incur a five day quarantine for both his crew and the mail in question. When the master asked if they could transfer the mail without coming ashore, the Governor replied in the negative, stating that as long as the steamer sat in Pago Pago Harbor he was responsible for its well being and all quarantine rules would apply. The boat returned to Apia without sending off the mails. Col. Logan broke radio communications with American Samoa soon after this incident, though Geoffrey Rice suggests that the radio cut may have been due to a breach in protocol rather than the mail boat controversy. He reports that when Governor Poyer offered assistance to Apia he informally channeled the offer through the American consul there rather than through standard formal

84 Governor J. M. Poyer, “John Poyer, Governor, to Rear-Admiral R. M. Doyle, USN,” January 25, 1919, Box 1; Series 6, General Interest File 1872-1948; Records of the Governor’s Office; Records of the Government of Samoa, RG 284; National Archives, Pacific Region, San Francisco, CA.
85 Rice, Black November, 200.
channels. By this date Col. Logan had come to blame much of the unrest in Western Samoa upon American machinations. An already chilly diplomatic situation deteriorated rapidly.

December 7, 1918 brought a request from Governor Poyer that Apia refuse clearance of any vessel headed to Pago Pago until ten days after the recovery of the last ‘flu case in Western Samoa. Pago Pago implemented a blanket ban on ships from Western Samoa and any other island under the jurisdiction of the Western Pacific High Commission. While Governor Poyer stressed the reasons for these actions as well as the approval of the High Commissioner in Suva in his note, these measures were unlikely to have smoothed any ill-will in Apia. This refusal of assistance and loss of communications meant that three doctors and almost thirty trained assistants of various medical backgrounds were idle in Tutuila while the epidemic raged 40 miles away. In fact, all serving American and American Samoan medical officers, nurses, and corpsmen, despite the risk to themselves, had volunteered to go to Western Samoa to assist the fight against the pandemic.

In Apia the local representative of American Samoa and the quarantine process was Mason Mitchell, American Consul. Mitchell acted as the primary means of communication between the two Samoan administrations. He normally held the responsibility for issuing Bills of Health, allowing ships leaving Apia to enter Pago Pago Harbor. As per instructions transmitted from Governor Poyer’s office on December 7, 1918, he refused to issue any further bills of health until ten days after

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88 Mason Mitchell, “Mason Mitchell, American Consul, Apia to Robert Logan, Administrator of Western Samoa;,” December 7, 1918, Communications/Consuls (National Archives Microfilm Publication T1182, roll 32); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
the recovery of the last confirmed case of influenza in Western Samoa. In the meantime he assisted as he could with pandemic response in Apia itself.91

The pandemic’s virulence in Apia also directly impacted American Samoa. A number of children from the territory who attended mission schools in Upolu died during the outbreak. The LMS lost the majority of its senior leadership for Samoa, based in Upolu, leaving the protected elements in Tutuila and Manu’a without guidance. On a less serious note a significant number of teachers from Tutuila were stranded in Upolu by the quarantine, stopping schools for several months. Other American Samoan visitors became stranded as well, causing stress to themselves and their families. But there was not a single influenza illness in American Samoa, not a single death.92

The native community in American Samoa complained about certain elements of the quarantine. Following an argument that native passengers would flee to their villages and thus be out of reach of the medical officers, healthy natives coming off quarantined but not infected vessels were sent to the Native Hospital for five days of isolation and observation. White passengers who lived in Pago Pago could go home under the same circumstances, and spend their isolation there. Despite native complaints, the justification regarding difficulty tracking and monitoring natives leaving potentially infected ships was offered by Governor Terhune during the 1919 Fono and the policy remained in place. He argued that while the basic quarantine restrictions were the same for whites and natives, whites came in voluntarily to the doctor in Pago Pago twice a day after the initial quarantine. He went on to say:

“Since the natives would scatter all over the island, it is necessary to retain them at the Samoan Hospital to allow the Health Officer to supervise them during the quarantine period”. He ends his discussion of the issue with a suggestion that they are showing ingratitude: “Our methods have saved your lives from influenza, and are admired everywhere in the world.”

Governor Poyer acknowledged concerns extending beyond official vessels travelling the Apia-Pago Pago route. American and Western Samoa, artificial constructs of colonial convenience, existed in the same cultural space. Samoans had been sailing between the islands for centuries before the Europeans arrived, and no natural obstacles presented to stop such transits in late 1918, potentially avoiding Apia and Pago Pago entirely. If Samoans chose to sail between the islands without visiting the ports, there would be little to stop them and no means of tracking their passage. Considering the scale of mortality in Western Samoa, a refugee flow to the American controlled islands in the east would hold no surprise, nor would attempts of American Samoans caught in Western Samoa to return home to their families.

With the support of the chiefs of Tutuila, who received official reports of the carnage forty miles across the water, a patrol system for all of Tutuila developed. American Samoans patrolled the waters surrounding the island throughout the day and night, preventing landings and directing all boats toward Pago Pago and quarantine. The three District Chiefs of American Samoa: Mauga, Satele, and Tufele, were later recommended for Presidential medals in recognition of their efforts in enforcing the quarantine and these patrol measures. The recommendation for the medals stated that:

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93 Governor Warren J. Terhune, “Governor’s Remarks, 1919, Fono Day,” November 12, 1919, Box 1; Series 13, Speeches and Ceremonies, 1908-1956; Records of the Governor’s Office; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
When quarantine restrictions, and island patrol regulations, were established, these chiefs cooperated with zeal and intelligence; and the fact that no case of influenza broke out in our islands, whereas in other Samoan Islands actually within sight the mortality exceeded ten thousand, is attributable, in no small measure, to the influence exerted over the natives by these chiefs.......The fact that American Samoa escaped the INFLUENZA, whereas Western Samoa, the Fijis, and other Polynesian groups suffered losses of from thirty to forty percent, has enormously promoted American prestige in the Pacific......These chiefs would take the utmost pride in wearing such decorations, which would serve as incentives for many years to all natives in authority to labor painstakingly in carrying out the Governor’s Regulations bearing upon sanitation and hygiene.94

Over time the regulations regarding quarantine changed. By January of 1919 any ships from Apia who wished to enter Pago Pago had to sail without native or part-native crew members, had to enter during daylight hours, and were asked not to enter if a ship was already under quarantine there. Mail satchels and non-native passengers wishing to come ashore from any port faced a five day quarantine, Samoan natives faced a nine day quarantine.95

This difference in treatment between Samoan and non-Samoan individuals continued when in early March the first visitors from Apia were allowed to enter Pago Pago under close medical supervision. These travelers were non-Samoan, and the Governor continued a ban on native travel. Arguing again that it would prove impossible to keep natives from disappearing into the villages and avoiding medical supervision, he asked Consul Mitchell to continue to prevent native travel between

94 Governor Warren J. Terhune, “Warren Terhune, Governor, to President via Secretary of the Navy;” (Government House, Pago Pago, June 12, 1919), Box 1; Series 5, Annual Reports on Government Affairs, 1902-1956; Records of the Governor’s Office; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.

95 Consul Mason Mitchell, “Mason Mitchell, American Consul, Apia to John Poyer Governor,” January 22, 1919, Communications/Consuls (National Archives Microfilm Publication T1182, roll 32); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
the Samoan groups.\textsuperscript{96} As of March 4 white passengers could come to Pago Pago if they agreed to avoid contact with natives and provided they remain in the vicinity of the station for a five day observation period. The complete ban on Samoan travel began to lift on March 27 when entry to natives was allowed following a five day quarantine on board the vessel that brought them to Pago Pago.\textsuperscript{97}

The resurgence and gradual decline of the third wave of pandemic influenza in 1919 continued to alter these restrictions, with July 20\textsuperscript{th} seeing the resumption of the complete ban on native travel and the requirement for white passengers to serve quarantine aboard their arrival ship before entering Pago Pago.\textsuperscript{98} In August white men in groups no larger than five were allowed to quarantine for five days aboard the station vessel, white women and children having to quarantine for the same period aboard their incoming vessel, male natives of American Samoa in groups no larger than thirty-five could sit their quarantine aboard the station vessel, and finally women and children in groups no larger than fifteen will be isolated for five days at the Samoan Hospital. Groups were to sail only every ten days.\textsuperscript{99} Priority for return accrued first to teachers and other essential American Samoan personnel stranded in Apia. No records are available that discuss the rationale behind these changes. Perhaps they were a matter of seeking the least intrusive quarantine that still acted effectively and met the sexual and racial mores of the day.

\textsuperscript{96} Poyer, “John Poyer, Governor, to Consul Mitchell, March 5, 1919.”
\textsuperscript{98} Governor J. M. Poyer, “John Poyer, Governor, to Consul Mitchell;,” July 20, 1919, Communications/Consuls (National Archives Microfilm Publication T1182, roll 32); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
\textsuperscript{99} Governor J. M. Poyer, “John Poyer, Governor, to Consul Mitchell;,” August 13, 1919, Communications/Consuls (National Archives Microfilm Publication T1182, roll 32); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
The quarantine was still in place in mid 1920, having increased in complexity. According to the Samoan Epidemic Commission, visiting from New Zealand in June, 1919, procedures were as follows. Passengers disembarking in Pago Pago faced a careful physical, five day home isolation, and daily visits with temperature monitoring by the medical staff. Ships hoping to enter Pago Pago Bay were required to present a document listing the temperature of all passengers and crew upon departure from San Francisco or Sydney, and temperatures were taken daily while the ship was in American Samoa. Regardless of the health of all on board, or the recorded temperatures, all ships went into five day monitored quarantine. Any passengers transferring in Pago Pago for smaller boats to Apia also faced five day quarantine. Other, less effective measures in place included fumigation of mail, spraying of the nostrils and throat of all passengers and crew, and the masking of cargo handlers. Fumigation of fomites (inanimate objects suspected of carrying disease organisms) was common, as has been seen in the discussion of the response to the pandemic in other states, but completely useless due to Influenza’s failure to survive long periods outside the body. Vaccination for ‘flu had occurred in April 1919, using a vaccine supplied by the Navy (and completely useless due to the inability to identify and isolate the influenza virus), and all military and most natives received the jab. Evidence of influenza vaccination became mandatory for anyone wishing to travel from Pago Pago to any other island group, including Western Samoa, in late April.

Come mid-1920 the system for monitoring individuals wishing to travel between Apia and Tutuila became bureaucratic rather than anecdotal and episodic, requiring medical examination and passes for the limited spaces available on the controlled boats that were allowed to bypass the quarantine. This system was

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100 Samoan Epidemic Commission, “Report from Pago Pago, June 21-23.”
designed and originally administered by Consul Mitchell. Over time the numbers became too large for him to cope with individually and instead those wishing to travel had to apply in person at the Apia hospital on the day of sailing for examination.  

**Success and Consequences**

With the end of the influenza pandemic in 1921 quarantine restrictions were relaxed but not eliminated. Many of the lessons learned quickly faded, unsurprising given the constant turnover in staff. Goat Island lost its quarantine station, which became additional housing for naval personnel. At the same time the number of ships coming to Tutuila harbor increased significantly, to 85 over the course of 1921, and the construction of large capacity fuel tanks (as oil replaced coal for the Navy) in 1922 encouraged yet more traffic, all in a port without a quarantine station. The presence of plague in Australia and influenza in London and Apia caused the Governor to return Goat Island to quarantine station use in 1922, as eighty-six ships visited the harbor. The next decade saw frequent use the quarantine regulations that had proved so valuable. They saw revival against Western Samoa due to influenza in 1922, measles in 1926, influenza in 1929, dysentery in 1931, and polio in 1932.

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102 Mitchell, “Mason Mitchell, American Consul, Apia, to Warren Terhune, Governor,”.
103 Senior Medical Officer American Samoa, “Senior Medical Officer, Annual Sanitary Report for the Year 1921”, March 10, 1922, 12, Medical Reports, 1914-1924 (National Archives Microfilm Publication T1182, roll 38); Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
105 E.P. Huff, “E. P. Huff, Quarantine Instructions in Care of Measles on Naval Station;” (Government House, Pago Pago, September 15, 1926), Box 14; Series 15, Subject Files, 1900-1958; Records of the Governor’s Office; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
There is little dispute about the efficacy of the quarantine. Some argue that a version of the Spanish Influenza penetrated into American Samoa in late 1920, but caused no deaths.\textsuperscript{109} Without the ability to identify the viral strains present, it can never be known if an attenuated version did enter the colony. What is known is that there were no deaths matching the pattern of the 1918 influenza, and no influenza-linked significant illnesses through the end of 1921.

Quarantine protected the territory from the pandemic, and praise for its efficacy and minimal impact came from many directions. The territorial government claimed that the quarantine involved no interruption of freight or mail service for the territory.\textsuperscript{110} Given the small amount of trade occurring at the time and the absence of the term ‘delay’ from this claim it might be justified. The Auckland \textit{Evening Post} printed a letter from an American living in Apia who stated that “no one here blames Governor Payer (sp) for keeping the boat from Apia from infringing his regulations.”\textsuperscript{111} The Samoan Epidemic Commission visited American Samoa and the unloading of a ship was observed, as well as evidence regarding the offer of help to Colonel Logan gathered. The final report offered high praise to Governor Poyer and the American administration for their conduct.

\textsuperscript{106} Stephen V. Graham, Governor, “Stephen Graham, Governor to Colonel Allen;” (Government House, Pago Pago, August 1, 1929), Medical Reports, Miscellaneous (National Archives Microfilm Publication T1182, roll 37); Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
\textsuperscript{110} Evans, \textit{American Samoa}, 26.
\textsuperscript{111} “Auckland Evening Post, Influenza at Samoa; How the Disease Got its Hold; January 10, 1919,” \textit{Evening Post} (Auckland, N.Z.; January 10, 1919).
The largest missionary group in American Samoa, the LMS, sent a telegram thanking Governor Poyer and his medical staff for the “prompt and energetic methods adopted by them to prevent the spread of the Spanish Influenza in that part of Samoa.” They expressed interest in the welfare of the Samoans under American supervision, as the LMS had been the first to bring Christianity to Samoa.\textsuperscript{112} Ironically, it was the LMS that first brought influenza (an earlier pandemic form) in 1830 to the Samoan islands upon their missionary ship \textit{Messenger of Hope}.\textsuperscript{113}

Unlike the Western Samoan experience, the pandemic in American Samoa did not act as a touchstone for a movement towards independence. America Samoa did experience the rise of a \textit{Mau} movement within the territory in the 1920s and 1930s, but this movement was radically different in source and aims from that raging in Western Samoa. The American Samoan \textit{Mau} did not seek separation, instead striving for representative government and American citizenship. Specifically, \textit{Mau} members sought the end of naval rule in the territory and the establishment of a civil government under continuing American rule.\textsuperscript{114}

Having emerged from the epidemic relatively unscathed, and fully aware of the devastation wrought in Western Samoa, American Samoan elites sought a more complete normalization of their status as Americans rather than a separation from the colonial power. The demands of the American Samoan \textit{Mau} included a locally promulgated set of laws, American citizenship, a civilian governor, an American Samoan legislature, the right to appeal to American courts, budgetary support, and


\textsuperscript{113} Crosby, \textit{Epidemic and Peace}, 239.

\textsuperscript{114} NARA, “T 1182 Records of the Government of Western Samoa.”
free trade and travel between the Samoas. Some of these goals were achieved, and some have still not been reached, yet there has not been a consistent push for independence in the manner of Western Samoa. In the aftermath of the epidemic American Samoa sought closer relations, not separation, from the colonial rulers.

The one notable moment of unrest occurred between April and November of 1920, and had a source in intra-garrison intrigues than in Samoan grievances. Disputes arose between the Governor and his second in command Lieutenant Boucher regarding possible corruption and judicial rulings that some Samoan groups saw as anti-Samoan. These groups joined with Boucher and an American merchant, Arthur Greene, to challenge the Governor. The end result of this period of disturbance was the suicide of the troubled Governor Warren J. Terhune, who had succeeded Governor Poyer, the temporary accession of a committee of chiefs and junior officers during which time no work was completed and copra exports stopped, and the eventual deportation or discharge of the American leaders with the arrival of Governor Waldo Evans and a Court of Inquiry. The chiefs involved kept their positions and were reintegrated into the existing system.

One anecdote stands out of the reports regarding Samoan views of the different fates of Western and American Samoa. A Mr. Boteler wrote to Governor Poyer to report that he had heard the crew singing a Samoan version of the “Star Spangled Banner”. Upon asking the Captain for a translation, he forwarded it to the Governor’s office:

There are two islands in the south Pacific, Tutuila and Upolu,

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116 Court of Inquiry, American Samoa, “Proclamation of Findings of Court of Inquiry for American Samoa” (Government House, Pago Pago, February 1921), IT, series 1, box 451, record no. Ex 83/5, Archives New Zealand, Wellington.
Tutuila under the American flag, Upolu that of New Zealand.

God has sent down a sickness on the world,

And all the lands are filled with suffering.

The two islands are forty miles apart,

In Upolu, the island of New Zealand, many are dead

In Tutuila, the American island, not a one is dead.

Why? In Tutuila they love the men of their villages;

In Upolu they are doomed to punishment and death

God in Heaven bless the American Governor and flag.\textsuperscript{117}

So why did American Samoa prove to be the only polity in western Polynesia to implement an effective quarantine? Scale was an issue, with a small land area, small number of islands, and a small population helping to make such an effort manageable. A small foreign population and minimal trading presence prevented the formation of a strong anti-quarantine bloc. The exposure of the Samoan Islands came late enough that some warning was available. The Samoans themselves had a strong cultural memory of epidemic disease and thus an incentive to avoid its repetition.

Two remaining factors proved to be the most important, however. By leaving in place a local administration based on traditional Samoan chiefly structures the American Governors had a functional set of allies to turn to. The small number of Americans in the territory precluded a US navy patrol to enforce the quarantine

\textsuperscript{117} S. Boteler, “S. Boteler to John Poyer, Governor,” January 27, 1919, Government Affairs (National Archives Microfilm Publication T1182, roll 34); Subject files, subgroup 1, 1900-1942; Records of the Government of American Samoa, 1900-1958; Records of the Government of American Samoa, RG 284, National Archives, Pacific Region, San Francisco, CA.
outside of Tutuila. The ability to turn to the local chiefs, and their willingness to build and man the patrol system, proved vital to controlling access between islands inhabited by a strongly seafaring culture. It is difficult to see how anyone aside from Samoans could have prevented Samoans from making the journey from Upolu to Tutuila. One missed landing on a secluded beach would have negated all the efforts of Pago Pago.

Finally, the independent nature of the American Samoan administration allowed for rapid action as needed to protect the population. The absence of a professional colonial service, the technical status of Pago Pago as a naval base and the general neglect American Samoa received from Washington D.C. all served to allow Governor Poyer to read the situation and act upon it as he saw fit, without waiting for instructions or permission from the United States. Seeing the risk of the influenza pandemic he acted without hesitation. It is unlikely that an administrator in any of the other colonial structures in Polynesia could have behaved so. Much depended on the quality of the Governor and his ability to read approaching risk, but that would have meant little had his request been buried in the bureaucratic flows. No one cared about American Samoa in the United States, so long as the ships were fueled and the copra sold. No warnings were sent or instructions on how to deal with the pandemic’s approach. In this one circumstance, due to a convergence of factors, none was needed.

This success was not foreordained. Territories with the same mix of isolation, governance, and health care fared very differently. Guam demonstrates how easily the course of the pandemic could have been tragic.

Guam shared many attributes with American Samoa. Though settled much earlier than Samoa, and colonized much earlier (by Spain in the mid 17th century) it
shared the isolation and rugged beauty of the deep Pacific. Roughly three times larger than the combined size of American Samoa’s isles, Guam in 1918 boasted a population of 14,124\(^{118}\) to nearly 8,000 in American Samoa. Like American Samoa the entire island was a Naval Station. Seized from Spain in 1898, Guam was separated from the rest of the Marianas and turned over to the governance of the Navy who used it as a stopover for ships bound to and from the Philippines. Medical infrastructure was provided by the Navy as an adjunct to care for the military and in cooperation with missionary groups. As in American Samoa there was a single commercial port that served as the conduit to the outside world and was controlled by the military. There was little economic activity outside of copra production.\(^{119}\) Both were ruled by naval appointees with little oversight from Washington.

The histories of the two naval stations diverged. The Spaniards sought to disrupt and change traditional cultural elements, unlike the American Samoan administrations’ attempt to co-opt existing structures. A great deal of intermarriage occurred, leaving a strong-part European population to contest the power of the Naval administration.\(^{120}\) The main missionary presence on the island was Roman Catholic, with a different colonial tradition than the Congregationalist groups who dominated in Samoa. Anne Hattori argues that this combination produced a strong dissonance between the Chamorro natives of Guam and the American colonial presence. The Chamorro reflected many of the traits of the recently defeated enemy, while maintaining Micronesian cultural elements fully foreign to the new occupiers. This sense of separation encouraged a medical system in Guam concerned with the protection of the military staff from contamination by contact with Chamorros.\(^{121}\) While the administration in American Samoa looked at Samoans as charges in need

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\(^{118}\) Hattori, *Colonial Dis-ease*, 27.
\(^{120}\) Hattori, *Colonial Dis-ease*, 14.
\(^{121}\) Ibid., 19.
of protection, Guam’s medical establishment saw the native population as another source of risk.

With the spread of the pandemic in late 1918 no protective measures were enacted in Guam. Despite working with the same advantages of single-port economy and military control of the island seen in American Samoa, no precautions were taken. Even with the growing toll of American servicemen felled by the pandemic globally, no guidance had emerged for military outposts regarding appropriate measures, much less orders. Whether by plan or by default, the Governors/Commandants were left to their own judgments and devices. Captain Roy Campbell Smith, Governor of Guam in October 1918, chose the same course as Robert Logan in Apia. He chose not to act.

On October 26, 1918, the USAT Logan, carrying troops from Manila, docked in Guam with the pandemic festering in her holds. It quickly spread throughout the island. The new Governor/Commandant of the Station arrived on November 15, 1918 to find an island collapsing under the strains of the illness. He established quarantine stations at Cabras Island and Agana, but it was far too late. Nearly every soldier and civilian on the island fell ill and while the navy lost only a single man, the fatalities amongst the Chamorro reached 857, or nearly six percent of the island population. The administration seemed little worried by the phenomenal death rate. The next annual report of the Governor only dedicated two lines to the pandemic, and actually asserted that the health condition on the island had improved over the previous year.

123 Rogers, *Destiny’s Landfall*, 143.
124 Ibid.
With a different administration, with less support from the local chiefs, or with a bit of ill-luck this could have been American Samoa’s fate. The particular government and economic structure of the Naval Station facilitated effective quarantine, but was not sufficient. A working relationship with the indigenous population, a medical infrastructure dedicated to their protection, and a Governor able to act before a crisis struck prevented American Samoa from following Guam in becoming just another sad statistic of the pandemic years.

By 1926, influenza had again visited Tutuila. For three weeks in August and September travel between districts and villages were sharply curtailed, the residents of the naval Station were forbidden to leave and government work reduced to a minimum. Church meetings and choir practices were forbidden. Schools were closed. The medical officers toured constantly with food and drugs, but otherwise traffic stopped. The outbreak was not severe, but the reaction was. American Samoa had somehow dodged a bullet. The memory informed the culture for decades to come.
Chapter 5: Tonga

“How your heart will have ached for our poor Tongans. It was a terrible time and it swept over us just like a dreadful hurricane leveling everything before it.”¹

The Rev. Rodger Page, December 23, 1918

The *Talune* steamed away from Apia harbour, leaving illness behind that would fire the urge for independence while scarring an entire generation of Samoans. She would return to Fiji, but first was due to swing south to stop at three Tongan ports. From north to south these were Neiafu, in the Vava’u group; Lifuka in the Ha’apai group; and on November 12th Nuku’alofa, the largest community on Tongatapu and the capital of the physically scattered but culturally homogenous state of Tonga. Each of these ports served the foreign trade, or the few ships which passed for such in Tonga.² To each of these ports she brought the *Mahaki Faka’ahua*, the disease that kills.³

There were reasons to believe that these beautiful islands might avoid the worst of the outbreak. Their populations were small and scattered. Little foreign trade occurred so links with the outside world were few and there would be no trader faction to inveigh against preventative measures. The population was deeply homogenous, with a monarchy ruling over a united (if riven with squabbles amongst the nobility), monolingual empire. Each family had a plot to farm, so the possibility of mass debility causing famine was lessened. The medical infrastructure as planned was well distributed and reasonably staffed for the place and time; with doctors on

² Dawson, “Memorandum for H. M. Colonel Patterson from C. M. Dawson, Major,” 60.
each main island group supported by nurses, dispensers, and the efforts of the local missions.

These factors failed to protect the Tongans. Certainly, the epidemic on Tonga was less severe than that visited upon Western Samoa. Mortality was approximately eight percent of the population (figure 19), not the quarter lost in Apia’s realm. Fiji, however, suffered less than Tonga despite the advantages the Kingdom held in organization, cultural stability, and room for independent political action.

(Map 6: Tonga⁴)

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The state, in Tonga, simply disappeared for six weeks during the height of the influenza. Tonga in 1918 was a monarchy founded upon a structure of traditional chieftainship. Though the British had a significant say in the policies and direction of the nation via the Consul on site, and the missions attempted to guide policy from the pulpit, final decisions and authority rested in the hands of the Queen and her cabinet. In the words of Elizabeth Wood-Ellem: “the Queen failed this first serious test of her leadership. Her government broke down and took no action whatsoever to ameliorate the effects of the epidemic, either locally or nationally.” More than any other case discussed in this work, the governing apparatus of these islands, both the traditional and the more modern forms grafted upon the old systems, simply failed. It was not a matter of poor decisions being made; no decisions were made. Even the Royal Family was abandoned to their own devices. If a state can be defined by its government, Tonga as an entity ceased to be from mid November through the end of 1918. It was this failure, more than any other, which explains Tonga’s relatively high losses.

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5 McArthur, *Island Populations of the Pacific*, 82.
Tonga before the Epidemic

Tonga is a nation of three archipelagos and scattered additional islands. Tongatapu in the south has the largest island, the largest population, and is the seat of power for the nation. Tongatapu itself is a generally low island with broad beaches and a significant reef. Nuku’alofa’s harbour caught the eye of Wesleyan missionaries, leading to the fusion of scattered villages into what is today barely a town, and in 1918 was still a small settlement. Also included in the group is the much older and higher island of ‘Eua, with its own traditions quite separate from Tonga as a nation. North of Tongatapu sits the Ha’apai group of small, sandy islands. With little arable land Ha’apai supports only a small population. Northernmost is the Vava’u group, more arable than Ha’apai and thus more populated, but without the size or populace of Tongatapu. Three islands lie outside of these main groupings: Niuafo’ou, Niuatoputapu, and Tafahi, all to the north of Vava’u. Between Vava’u and Nuku’alofa, the southernmost port in the islands, is roughly 200 miles. There are 176 islands in the state, of which fifty-two are currently inhabited. Total land area in Tonga is just over 700 square km, and Tongatapu comprises nearly half of this area.

Tonga has great climatic and geographic variation between the component small island groups, and significant political autonomy developed between them. Trade supported Vava’u, with its proximity to Samoa and Fiji, while agriculture was a mainstay in Tongatapu. As the European colonial empires developed in the Pacific, Vava’u and to a lesser extent Ha’apai felt the influence of German traders and diplomats based in Samoa. Tongatapu fell solidly into the British camp, and was the

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political hub for the nation. Despite Tongatapu’s centrality, the ruling family of Tonga, the Tupou dynasty, is originally from Ha’apai.\(^8\)

In pre-European contact western Polynesia, Tongans were the most ambitious sailors with trade and conquest networks that stretched much further than the Samoans or Fijians.\(^9\) This was driven, in part, by the dearth of resources and arable land in Tonga itself, encouraging Tongans to act as go-betweens between the relatively larger and richer Fiji and Samoa.\(^10\) The chiefly lines of these three states still boast of family connections forged centuries before the Europeans arrived in Polynesia. According to both Shineberg and Latukefu it was this expansionary urge, represented by Tongan warriors returning from wars in Fiji in the late 1700s,\(^11\) which destroyed the equilibrium of the Tongan state and saw it divided into the warring camps encountered by Cook and other European explorers.\(^12\)

Early contact with Europeans featured the same three elements that would drive changes throughout Polynesia: guns, missionaries, and disease. Tasman visited in 1643, with no further recorded European incursions until Cook’s visits of 1773-1777. Cook was so taken with the response he received in Tonga that he dubbed them the Friendly Islands, though William Mariner claimed that in fact the Tongan chiefs had wanted to kill Cook but could not agree on a plan.\(^13\) Missionaries arrived in 1799, driving suspicions regarding the Europeans’ intent and rumours (apparently spread by European and American beachcombers) of their plan to infect Tongans with disease in order to facilitate a British takeover. These missionaries lost three

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\(^8\) Ibid., 94.
\(^10\) Ibid.
\(^11\) McArthur, Island Populations of the Pacific, 68.
\(^12\) Latukefu, Church and State in Tonga, 10.
\(^13\) William Mariner, An Account of the Natives of the Tonga Islands, in the South Pacific Ocean (Edinburgh: Printed for Constable and co., 1827).
colleagues to an attack in 1799 and were evacuated to Sydney the next year. It was not until 1826 that permanent European presence began to develop. This presence was heralded by the establishment of a mission in Nuku’alofa staffed not by Europeans, but by Tahitian converts.

By 1806 the ruler of Vava’u was able to use guns from the captured British privateer Port au Prince, along with the Europeans needed to man them (including the aforementioned William Mariner), in his internecine conflicts. Armed with weapons his countrymen could not counter, he seized control of Tongatapu without a single loss to his forces. Unlike in Samoa where the presence of Europeans drove division, the conflicts engendered by Tongans’ contact with outsiders created a unified state in the wake of a final internal struggle.

The mid 1800s saw the consolidation of power in Tonga under the Tu’i Kanokupolu. The Kanokupolu chiefly line had served as the warlords for the Tu’i Tonga, the High Chiefs of Tongan antiquity, but eventually assumed the hau or secular power while the Tu’i Tonga lineage remained as a ritual head. Armed with outside weapons and controlling Vava’u and Ha’apai, the Tu’i Kanokupolu Taufa’ahau had earlier converted to Christianity and made gestures to support of the growing missionary presence in Tonga and they in turn reinforced his claims to control the archipelago. The missionaries also inveighed against customs that supported and justified the power of the nobles. Coming from the British tradition the missionaries saw a strong, centralized monarchy as the most amenable

14 McArthur, Island Populations of the Pacific, 68.
17 Latukefu, Church and State in Tonga, 2.
18 Ibid., 66.
government for a developing nation.\textsuperscript{19} Thus both Taufa‘ahau and the missions worked to reinforce the monarchy and diminish the nobility.\textsuperscript{20}

In 1852 Taufa‘ahau openly took power throughout the island groups, formally displacing the Tu‘i Tonga after years of \textit{de facto} rule, and beginning a set of radical changes within the Tongan system including the abolition of serfdom and the promulgation of a constitution. With the adoption of the constitution and the conversion of Tonga to a formal kingdom in 1875 he ruled under the name of George Tupou, reflecting his respect for the LMS and the British monarchy.\textsuperscript{21}

The missions, particularly the dominant Wesleyan mission, became strong political players of their own account. A Wesleyan missionary, Rev. Shirley Baker, became a confidant of the king and helped guide his actions in reducing the Mission’s authority in Tonga relative to the monarchy. After having been recalled to Australia by the Wesleyan Missionary Society Mr. Baker returned to Tonga at the king’s request and in 1881 was named Premier. At this point issues arose between the king and the Wesleyan Church such as the Church’s dispatch of a two to three thousand British Pound cash surplus abroad every year, a huge sum for a state of Tonga’s size and level of development. As relations between the mission and the King soured, Mr. Baker helped to establish a Free Church of Tonga, following the Wesleyan tradition but under the king’s control and helping the Tupou dynasty to take on some of the religious authority of the Tu‘i Tonga line. The king also held a \textit{fono}, at which his will that his subjects join the Free Church was expressed.\textsuperscript{22}

\textsuperscript{19} Ibid., 83.
\textsuperscript{20} Ibid., 31.
\textsuperscript{21} Linnekin, “New Political Orders,” 195.
\textsuperscript{22} Sir C. Mitchell, “Report by Sir C. Mitchell, High Commissioner for the Western Pacific, in Connection with the Recent Disturbances in and the Affairs of Tonga” (Her Majesty’s Stationery Office, London, July 1887), 4, WPHC 8/IV/1, 1229014, University of Auckland, Western Pacific Archive.
As the split deepened, the power of the monarchy was turned towards harassment of those that had not joined the Free Church. In Ha’apai many were imprisoned or forced off their lands. With an assassination attempt that nearly killed the children of Mr. Baker, simmering tensions boiled over. Free Church militias were allowed to run rampant and ransack the homes of non-members. When the High Commissioner of the Western Pacific High Commission (WPHC, the British colonial structure for the western Pacific and the body to which the British Agent and Consul to Tonga reported) came to investigate in 1890, he called for the restoration of the Wesleyan Church and ordered the deportation of Mr. Baker, still technically a British citizen.23

Given that Tonga was an independent nation dealing with a deeply internal matter why was the WPHC High Commissioner and Governor of Fiji able to intervene? Britain’s representative stepped into the dispute and resolved it by deporting the Tongan Prime Minister to Auckland and exile. Clearly, by 1890 Tonga had lost a degree of autonomy, at least vis-à-vis Great Britain. This trend began in 1879 when Britain and Tonga signed a treaty of friendship and trade. Though treaty relations began with France twenty-four years earlier, they never held the weight of the British ties.24 Agreement was reached on the exercise of justice and extradition regarding the citizens of each country, and Tonga agreed to not enter into closer relations with any other nation than those codified in treaty with Her Majesty’s Government.25 One important clause allowed for the trial under British justice of British citizens in Tonga. In the event, not even the Prime Minister was immune from this clause.

23 Ibid., 12.
24 Latukefu, Church and State in Tonga, 166.
25 “Treaty of Friendship Between Her Majesty and the King of Tonga,” June 1879, WPHC 21/10, University of Auckland, Western Pacific Archive.
By the final decade of the nineteenth century Tonga had trading treaties with several nations, expanding upon King George’s government’s “Most Favored Nation” status with Great Britain and France. The Treaty with Britain was updated and simplified in 1891, but aside from publication in Tongan no real changes were made.\(^{26}\) The United States and Germany had both shown interest in Tongan affairs, though to a lesser degree than in neighboring Samoa whose resources tempted traders. With the resolution of the Samoan crisis in 1899, the Berlin Treaty that divided Samoa also granted Britain exclusive interest in Tonga.\(^{27}\)

Following the agreement in Samoa, a further Treaty of 19 May 1900 established a British protectorate over Tonga. In the words of the New Zealand Solicitor General’s Office:

A British Protectorate is territory which, although it has never been annexed by the British Crown so as to become part of the Empire, has been placed by treaty or otherwise under the control of the British Government. As between the Protectorate and other States, British control is absolute, excluding all direct relations between Foreign Governments and the local Government of the Protectorate.\(^{28}\)

More to the point; the British representative to Tonga, Basil Thomson, took advantage of the chronic turmoil in the islands and the agreement of the Imperial German government to not counter British influence there to force this “impulsive,

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\(^{26}\) “Treaty of Friendship Between Her Majesty and the King of Tonga” (Government Printing Office, Suva, Fiji, June 2, 1891), WPHC 21/50, 5003030412, University of Auckland, Western Pacific Archive.

\(^{27}\) Thomas Victor Roberts, “The Memorial of Thomas Victor Roberts,” April 21, 1912, 3, AAEG, 950, 229/C, 303/9/1, 1, Archives New Zealand, Wellington.

faction-ridden little kingdom” to agree to British supervision without committing to full accession into the Empire.  

The British Protectorate provided the Tongans the protection of the Crown overseas while they remained Tongans at home. It granted Britain the jurisdiction over all foreigners within Tonga, a site for a fort, and the right to place a coaling station within the archipelago. Control of Tonga’s foreign affairs fell under the WPHC in Fiji, and local British representation was through a Resident or Consul appointed by the WPHC. Laws governing a Protectorate were made by British Order in Council and covered all matters aside from offenses against local laws, customs, taxes, and traditions not already covered by British law. Notably, quarantine fell under this proviso and was specifically left to local control.  

The political autonomy of the Tongan monarchy declined further in the first decade of the 1900s, as the WPHC became more involved in Tongan affairs. The British consul in 1903 recommended the deposition of King George Tupou II in favour of his father, Tu’ipelehake, who consented to the idea “in order to save the flag”. Though the coup did not occur, complaints from Tongan factions and European economic interests became louder. Responding to complaints of corruption in the Tongan Government, Sir Everard im Thurn, the High Commissioner of the WPHC, travelled to Nuku’alofa for consultations. Warning the King of the concern regarding Tongan internal affairs held by the British Colonial Office he began an investigation with full access grudgingly granted by the King himself. The course of

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29 Wood-Ellem, *Queen Salote of Tonga*, 8.
31 Wood-Ellem, *Queen Salote of Tonga*, 27.
this investigation involved the arrest and deportation of both the Premier and Treasurer.\textsuperscript{32} Tonga had seen two Premiers deported by the British in a generation.

Finding validity in some of the complaints, im Thurm intervened directly in the government through powers granted him in a rider attached to the Protectorate agreement and signed by the King and 21 leading chiefs and nobles. The rider mandated the monarch to consult the British Consul on matters of State and to heed the Consul’s advice where offered.\textsuperscript{33} When presenting this rider to the Government, im Thurm described his proposition as:

I therefore said I would speak more plainly to the King, even in the presence of the Chiefs; that the real choice before them all as Tongans was between, on the one hand, frank acceptance of the guidance which the British Government was offering, or, on the other hand, immediate loss of their King and, eventually, of their independence.\textsuperscript{34}

The Government of Tonga accepted the High Commissioner’s suggestions.

In many ways Tonga became an appendage of Fiji and the WPHC rather than an autonomous state.\textsuperscript{35} By 1918 discussions between the Secretary of State for the Colonies and the WPHC High Commissioner spoke openly of controlling the internal finances of Tonga.\textsuperscript{36} In fact, by this point the young Queen Salote had been instructed to pass proposals dealing with the Kingdom’s finances through the office of the

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\textsuperscript{32} Everard im Thurm, “Report on Tongan Affairs” (Edward John March, Suva, Fiji, March 15, 1905), 2, WPHC 8/IV/4, University of Auckland, Western Pacific Archive.
\textsuperscript{34} Im Thurm, “Report on Tongan Affairs,” 9.
\textsuperscript{35} James H. Young, “James H. Young to William Maealiuki, Governor of ’Eua,” September 15, 1873, 5, General Holdings, Cabinet 1, Drawer 1, Tongan Palace Archives.
\textsuperscript{36} Secretary of State for the Colonies, “Secretary of State for the Colonies to High Commissioner, Western Pacific,” March 4, 1918, Western Pacific Archives, 47, WP.12, 48, 980 of 1918, University of Auckland.
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Consul before submission to her own Privy Council.\textsuperscript{37} This had been agreed by mid 1918.\textsuperscript{38}

(Figure 20: King George Tupou II\textsuperscript{39})

\textsuperscript{37} Consul McOwan, “Consul McOwan to High Commissioner Escott,” October 20, 1917, 43, CO 934/1, National Archives of the United Kingdom.

\textsuperscript{38} High Commissioner Sir Bickham Escott, “High Commissioner Escott to Consul McOwan,” April 3, 1918, 47, CO 934/1, National Archives of the United Kingdom.

The Tongan Government during the reign of George Tupou II (ruled 1893-1918) (figure 20) and the first years of his daughter Salote’s time on the throne was made up of the monarch, their Privy Council and Cabinet, the Legislative Assembly, and the judiciary. The Privy Council and Cabinet were appointed and served at the monarch’s pleasure, while the Legislative Assembly included the Cabinet Ministers, 33 nobles who held hereditary titles bestowed by the monarch, and 33 representatives elected by the populace.40

For all the increased democratic trappings, Tonga was in the early 20th century still very much a traditional monarchy. Only the chiefs (born to rank) and the nobles (those commoners appointed to higher status by the King) held full rights under the system. Even after death these divisions remained. Traditional teaching, only somewhat modified by the theology of the Christian missions, held that nobles and chiefs progressed onward after death but commoners were reborn as vermin.41 Commoners bore the name of kainangaefonua, or eaters of the soil, to reflect this low status.42 Social stratification was severe.

Over the nineteenth century the King gradually absorbed the powers of the Tu’i Tonga, leaving it of merely ceremonial, ethical, and genealogical import.43 The last holder of the title abolished its powers in 1844,44 bowing to the authority of Taufa’ahau, but the line kept its supporters. Thus, to some factions of the nobility the Tupou dynasty were seen as usurpers, and not bearing the dignity of the High Chief’s office. By the accession of Queen Salote in 1918 the Tupou were in firm control, but opposing factions of nobles could influence decisions as significant as the

41 Im Thurm, “Report on Tongan Affairs,” 3.
42 Latukefu, Church and State in Tonga, 9.
43 Im Thurm, “Report on Tongan Affairs,” 3.
44 I. C. Campbell, Island Kingdom; Tonga Ancient and Modern (Christchurch, New Zealand: Canterbury University Press, 1992), 94.
choice of husband for the Queen. Much of the Royal Government’s energy and funds were spent manipulating the factions to ensure social stability. Yet the nobles had lost authority with their people, and their roles within the social structure were in question. Opposed by both the monarchy and the missionaries, their role in society shriveled.

This left the government little flexibility to address the demands of the Consul who became progressively more powerful throughout the early years of the Protectorate. After the intervention of im Thurm, the monarch was obliged to seek advice and have decisions vetted by the Consul, giving him a veto power over government activity. The British representative in Tonga changed in 1917, creating perceived opportunities amongst the nobility for new alliances and potential reform/retrenchment. Consul H.E.W. Grant retired in June. He was replaced with Islay McOwan, formerly the Inspector General of Constabulary and Prisons in Fiji. This man would control the Tongan Government for a decade.

McOwan would play a central role in the Tongan influenza epidemic, and deserves a moment’s reflection. He had been trained by the WPHC and prospered in Fiji, serving for some months as a temporary Consul to Tonga earlier in the decade. His large frame gave him chiefly poise amongst the Tongans, unlike some of his fairly petite predecessors, and he was athletic as well. Physically, he was suitable to be an important man. He was also considered quite intelligent and perceptive. According to the Rev. Collocott of the Free Wesleyan Church of Tonga: “His mind was keen and incisive, quickly grasping the essentials of problems presented to him. His temper was firm and patient, his interest in the welfare of Tongans and

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45 High Commissioner Sir Bickham Sweet-Escott, “Bickham Escott to King George Tupou II.” (Pacific Manuscript Bureau, June 20, 1917), Tonga Government: Papers Relating to the Reign of King George Tupou II, 1908-1918, PMB 507, reel 6, Turnbull Library.
foreigners genuine and deep.” These traits would serve him well, as it would be difficult to exaggerate McOwan’s role in the approaching crisis.

The almost benign neglect Tonga functioned under was a reflection of slight economic value. Tongan trade was minimal. Traditional and constitutional bans on the sale of land, and the right of every man to a parcel of land to work, prevented the rise of a plantation economy as there were no large, contiguous parcels to be leased (outsiders’ only option). Working through the local chiefs, some copra was grown in a nearly feudal pattern, supervised by the missions, and with the crop being sold to German traders (until 1916). The patchwork of small plots encouraged the continuation of subsistence agriculture. The lack of a major export in turn reduced the need for outside trading firms to have permanent presences in the country, minimizing the need for European settlement. Without resources or trade of value, Tonga could be safely secured, and ignored.

Trade was impacted by the war. According to the Tongan Prime Minister in mid-1918:

Since the war broke out our trade has been seriously hampered. Other neighbouring nations have sent trade commissioners to Tonga to try and establish trade relations with us, but as Premier I have not encouraged them. We want to maintain our close association with the white race.

Tonga’s long-time relations with Germany made loyalties flexible. At the onset of WW I Tonga originally declared neutrality in order to protect economic ties with

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46 Wood-Ellem, Queen Salote of Tonga, 77.
49 Prime Minister Tu’ivakano, “A Talk About Tonga,” July 16, 1918, 2, WPHC, Tonga, 134, 16/7/18, Interview with Premier of Tonga, Archives New Zealand, Wellington.
German traders, with the blessing of London. This continued until 1916, when the British Government decided upon the liquidation of the largest German firm, the DHPG, throughout the Pacific.\textsuperscript{50} As in Western Samoa, the DHPG was the largest trading concern in Tonga before the advent of the War. In particular the Vava’u group was influenced politically, and strongly economically, by German interests. With the end of German trading in Tonga, British concerns attempted to fill the role but with limited success.\textsuperscript{51} Total imports for 1917 were valued at only 114,290 GBP, while total exports reached 125,442 GBP.\textsuperscript{52} Western Samoa had imports of 317,000 GBP and exports of 320,000 GBP that same year.\textsuperscript{53} Trade income had only begun to recover in 1918. This was not for lack of effort on the part of the Royal Government. Every Tongan man was required to plant 200 coconut trees on his allotment of land within a year of his taking possession.\textsuperscript{54}

This scant economic activity brought little contact with the larger world. Few ships actually visited Tonga. In 1918 the archipelago’s three ports had a total of thirty-five foreign merchant ships enter: seventeen in Nuku’alofa, fifteen in Vava’u, and three in Ha’apai. Of these thirty-five, however, several might have visited more than one port, further shrinking the total number of outside contacts.\textsuperscript{55} Once again, in comparison Western Samoa was visited by ninety-nine ships in 1917, and 104 in 1916.\textsuperscript{56} With this minimal trade came a small European population. White residents,

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\textsuperscript{50} Secretary of Defense J. Allen, “Memorandum for the Rt. Hon. W. F. Massey,” March 1, 1918, 3, IT, 1, 459/, EX 83/3/6 Tonga - General, Archives New Zealand, Wellington.
\textsuperscript{51} Dawson, “Memorandum for H. M. Colonel Patterson from C. M. Dawson, Major,” 59.
\textsuperscript{52} R. W. Dalton, “Reports on the Trade of Western Samoa and the Tongan Islands” (His Majesty’s Stationery Office, 1919), 50, Archives New Zealand, Wellington.
\textsuperscript{53} Collector of Customs and Taxes, “Trade and Commerce and Shipping of the British Militarily Occupied Territory of Samoa for the Calendar Year 1917.”
\textsuperscript{54} The Inter-State Commission, “British and Australian Trade in the South Pacific,” 16.
\textsuperscript{55} John Masterton, “Trade and Navigation Report, 1918” (Tongan Royal Gazette, September 9, 1919), C/O 676/2, National Archives of the United Kingdom.
\textsuperscript{56} Collector of Customs and Taxes, “Trade and Commerce and Shipping of the British Militarily Occupied Territory of Samoa for the Calendar Year 1917.”
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or *papalangi*, numbered only 571 in 1925. Nearly a quarter of these were businessmen; and their families, Government employees, and missionaries made up most of the remainder. In comparison with neighbors in Fiji and Samoa, Tonga was deeply traditional and relatively isolated.

While this isolation protected traditional ways of life and offered some protection from imported pests and diseases, the lack of revenue and economic activity produced a stagnant infrastructure. Without the impetus of trade, there was no capital to improve transport and communications networks. Tonga remained the most technologically and physically primitive state in western Polynesia in 1918. The medical system, while well designed on paper, demonstrated this same lack of development.

**Health History and Infrastructure**

Early Tongan medicine was based around spiritualism and the ability of priests to influence gods regarding the health of individuals. Given the multiplicity of gods within the Tongan pantheon, there were several choices available. If one priest’s actions seemed to have little impact, another could be consulted. In some cases, particularly when chiefs were involved, these prayers involved sacrifices. When ill-health struck a high chief an infant might be strangled and presented with the prayer, or in more minor cases the last knuckle of a finger was amputated and offered as a symbol of respect and support.

Many illnesses were seen as a result of disobedience, helping disease become a method of social control. Acting against the superiors in the family or village could bring ill-health. There were other factors driving disease, including inappropriate or

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57 Wood-Ellem, *Queen Salote of Tonga*, 76.
ill-timed dietary choices, but disobeying the chiefs, elders, and/or priests was the main route of illness. The violation of the taboos around such subjects produced suffering in the form of disease. When behavior was determined to be the cause of illness, the family and neighbors would offer no assistance to the ill. Instead, the priests would be consulted and only upon their recommendation would the family or traditional healers become involved in care.

Yet Tongan medicine was not completely dominated by priests. Native healers, often entire families, practiced surgery ranging from war-wounds to circumcisions; herbal medicine; and the setting of bones through manipulation and splinting. The Honourable Ve’ehala speaks of families of healers that specialized in midwifery or pediatrics. Physical causes of illness were thus recognized, but the spiritual world still held the greatest hope for successful treatment.

Much more so than in Samoa, isolation factored in caring for the ill in Tongan society. Many illnesses were seen as hereditary and signifying weakness within the blood line. Because of this illness was at times a family secret, and the stricken hidden away to both prevent recurrence and defend the family’s reputation. While not the best outcome for the ill individual, these actions did protect the society as a whole in the case of infectious outbreaks. Diseases of infectious type were certainly present before European contact.

Cook speaks of encountering a disease during his first visit to Tonga: “they told us that it affected the head, throat and stomach and at last kills them.” Other

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62 Honourable Ve’ehala, “Tongan Medical Folklore (’Alo ’Eva Lecture),” 2.
63 Finau, “Traditional Medicine in Pacific Health Services,” 93.
64 Miles, Infectious Diseases: Colonizing the Pacific?, 90.
early visitors describe widespread tetanus, yaws, dysentery, parasites, and something similar to Salmonella.65 The United States Exploring Expedition, visiting in the late 1830s, describes: “Influenza, colds, coughs, and consumption; glandular swellings, some eruptive complaints, fevers, and some slight irregular intermittents”.66

The early Wesleyan missionaries, who began to arrive soon after the dawn of the nineteenth century, brought basic western medical techniques with them. Though not formally trained, and often in doubt of their own skills, they found their offerings in demand and of use in converting the Tongans.67 Shineberg suggests that this lack of confidence might have made them more effective, as many of the treatments used in Europe at this time had a high mortality rate attached.68 Shineberg also describes the Tongans as using missionary medicine as a last resort where nothing else had worked, and thus being pleased by any significant recovery.69 In 1857 a Wesleyan missionary by the name of Lee attempted to practice medicine from Hihifo, Tonga, using a pot of mercurial ointment, some beeswax, and a medical book. By his own description “I am yet a very poor physician…” and he went on to note that since several Tongans had been seemingly cleared of consistent pain similar to what he suffered, he allowed a Tongan healer to shave his head and “yielded to the importunities of the native and tried Tongan medicine.”70 Despite their poor training and likely limited efficacy, Shineberg also attributes the decision of Taufa’ahau to

65 Ibid.
68 Ibid., 297.
become Christian to the successful intervention of a missionary in the chief’s illness. The first officially-trained western medical man recorded in Tonga was George Miller, a ship’s surgeon who married a Tongan woman and settled in the islands sometime in the 1840s. He later became a missionary but was best remembered for his care of the local population. A shortage of formally trained doctors would be a steady condition of Tongan health care for a century.

Population-level efforts to prevent infectious disease began with the quarantine regulations imposed as a reaction to the 1875 measles epidemic in Fiji. In the words King George Tupou: “When the news of the epidemic in Fiji reached Tonga I enacted regulations regarding visiting ships as it is done in civilized countries…” Despite the absence of government medical officers to carry out said instructions they became law in October, 1882. They came into practical application in 1886 when a Dr. Buckland became Tonga’s first medical officer. The measles did reach Tonga in time, striking in 1893 and killing roughly five percent of the population. The survivors were said to be so demoralized that they nearly suffered a famine as well. But in comparison to the thirty percent mortality in Fiji eighteen years earlier the Tongan public health measures seem to have some efficacy. Measles struck again in 1910 accompanied by typhoid fever, prompting an unsuccessful plea for a public health notification system for the state. The 1910 outbreak also led to school closures throughout the kingdom, a potential practice run for 1918. As early as 1894 the Tongan government put aside the islet of ‘Ufa for use as a quarantine

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71 Shineberg, “He can but Die”: Missionary Medicine in pre-Christian Tonga’, 289.
73 Ibid., 7.
74 Field, *Black Saturday*, 47.
76 Senior Medical Officer, Tonga, “Senior Medical Officer, Tonga to Premier, Tonga,” December 5, 1910, Tonga Government: Papers Relating to the Reign of King George Tupou II, 1908-1918, PMB 507, reel 2, Turnbull Library.
station, though there is no evidence that it was ever developed. There are mentions in correspondence during 1916 of refusal of pratique, but no description of causes or practices.

By 1907 there were permanent medical officers in Tongatapu, Ha’apai, and Vava’u, a distribution of resources which would continue well into the 20th century. The first official medical report to the Tongan government, also issued in 1907, listed multiple conditions of concern. Yaws and other skin conditions competed with tuberculosis for most severe infectious disease while hygiene issues in the villages were decried. The same year also saw the introduction of mass vaccination, starting with smallpox (3,800 Tongans that year), as well as the opening of Tonga’s first hospital. While vaccination had been introduced by missionaries much earlier, this was the first recorded attempt to inoculate the population as a whole. This report echoed a common refrain of many doctors in the Pacific that the shortage of good doctors drove locals into the hands of poor physicians or native healers. Such views are common in the contemporary medical reports, but physicians actually had little to offer to those suffering from many conditions in the early 20th century, aside from their own version of the moral advice being transmitted through traditional routes. Their presence served more of an educational and organizational role than a therapeutic.

A medical infrastructure developed in the other island groups as well. Early 1909 saw the completion of a hospital in Vava’u; 1910 in Ha’apai; in 1913 a dispensary opened in ‘Eua; and Niuatoputapu received their first permanent medical

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78 Premier of Tonga, “Premier of Tonga to Unidentified Merchants.” (Pacific Manuscript Bureau, November 6, 1917), Tonga Government: Papers Relating to the Reign of King George Tupou II, 1908-1918, PMB 507, reel 5, Turnbull Library.
station, a dispensary, in 1914. All of these facilities were government run, though frequently under the control of local nobles. These facilities were plagued with problems, especially a shortage of supplies and trained personnel during the war years of 1914-1918. Complaints against the main hospital in Nuku’alofa grew so loud as to require the king to appoint an investigative Commission in late 1917 to review the charges. Similar enquiries had occurred before, with the most recent being a formal investigation of the behavior of the Medical Officer, Vava’u, in early 1916. When the Talune approached in 1918 there were doctors in Nuku’alofa and Vava’u (the Ha’apai position being unstaffed); dispensers in Mua, ‘Eua, Niuatoputapu, and Niuafo’ou; and locally trained medical students in each of the three main island groups. This seeming abundance of medical staff was well used, as Tongans continued their tradition of visiting multiple medical personnel if the first answer was insufficient or unpalatable.

Other aspects of Tongan infrastructure did not keep up with the developing medical system. Most notably, Tonga lacked a wireless connection to the outside world such as those in Apia and Suva. Without any connection Tonga was dependent upon ship-borne news, and at risk from whatever else the ship might bring. There had been discussions regarding installing a link, but in 1914 the Tongan government decided it would be too expensive, and handed responsibility to the British while offering them a site if they would pay construction costs. In April,

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80 Ibid., 9.
82 Chief Medical Officer, Tonga, “Chief Medical Officer, Tonga to Hon. The Premier, Tonga,” February 22, 1916, PAMBU 507, reel 5, #258/16, Hocken Library.
84 Honourable Ve’ehala, “Tongan Medical Folklore (‘Alo ‘Eva Lecture),” 3.
1918, the Colonial Office determined that the cost of a station in Tonga would be too high during wartime.  

Dr. N. J. Bailey, the acting CMO for the Kingdom and the only doctor in Tongatapu, left for Fiji two days before the arrival of the *Talune*. Dr. Bailey had begun his career in Tonga in mid 1917 as the physician for Ha’apai, leaving this post to take up the role of acting CMO in 1918. His former station in Ha’apai had not been filled by November, 1918, an omission which would cost the local population severely. He left for Suva in the hope of obtaining a treatment for sores caused by yaws, a cure which required he visit in person to procure. He departed on the 11th of November, intending to be away a few days. As events unfolded his absence was for more than a month.

Dr. Bailey himself is an example of the issues surrounding medical personnel in the Pacific. Dr. Lambert, a later colleague in Tonga, would state that Dr. Bailey’s degrees were forgeries, and that he learned his craft as a hospital wardsman. Reportedly his first obstetric case was the delivery of the Crown Prince, at which he was happy to allow the Tongan midwife full latitude to practice. These accusations might have little merit, as Lambert then goes on to accuse him of leaving for Fiji to escape the pandemic “for which he was completely unprepared”. Every other source has Bailey leaving days before he could have known of the epidemic in neighboring

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86 Secretary of State for the Colonies, “Secretary of State for the Colonies to High Commissioner, WPHC,” April 3, 1918, Western Pacific Archives, 47, WP.12, 48, 793 of 1918, University of Auckland, Western Pacific Archive.
87 “Scourge at the Islands.”
88 Premier Tu’ivakano, “Premier Tu’ivakano to Consul McOwan,” March 1, 1918, WPHC, High Commissioner, 32/1918, University of Auckland, Western Pacific Archive.
89 Premier Tu’ivakano, “Premier Tu’ivakano to Consul McOwan,” January 21, 1919, BCT 1/4, 1919, 6-226, University of Auckland, Western Pacific Archive.
islands. But Lambert’s summation of a later career deeply undistinguished and an eventual return to Tonga for a life of beachcombing is correct.90

(Figure 21: Queen Salote Tupou, shortly before her ascension91)

90 Lambert, A Doctor in Paradise, 190.
Politics in Tonga were already in a fevered state before the appearance of the influenza. With the death from tuberculosis of Taufa’ahau (George) Tupou II on April 5th, 1918, aged forty-three and after a reign of twenty-five years, the crown shifted to his daughter, Salote. Salote, barely eighteen (figure 21), had been educated in New Zealand and was comfortable both with English and its speakers. She married Prince Tungi, Governor of Vava’u and with the passing of the King the highest ranked chief in Tonga. Her father’s death meant that she was the new Tu’i Kanokupolu, and due all the honors of the office, though to some eyes still inferior in status to her husband’s line (he being the direct descendant of the last Tu’i Tonga). At the time of her accession she was pregnant (described in diplomatic cables as a ‘delicate state of health’) and the coronation could not take place until after her expected delivery in July. McOwan was not initially complimentary in his description of the new Queen:

The Queen is very young and inexperienced and is incapable, in my judgment, of discharging the duties devolving upon her and some difficulty may be experienced from Her Majesty’s inability to distinguish between good and bad advice where the interests of the Kingdom are concerned.

However she moved quickly to assert her position; declaring a six month period of mourning for her father, the longest remembered in Tongan history and much longer than the traditional 100 days previously given to the higher office of Tu’i Tonga. In doing so, she was emphasizing both the power of her line and its dominance over the followers of the former Tu’i Tonga line. The title of Tu’i Tonga had been abolished in 1865 as the last holder had died and the Tupou dynasty solidified its claims, and the descendants of the final Tu’i Tonga were given a new, lesser title of Kananiuvalu.

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92 Consul McOwan, “Consul McOwan to the High Commissioner for the Western Pacific,” April 12, 1918, 5, Microfilm, 47, WP-12, reel 48, WPHC Inwards Correspondence 1015/1918, University of Auckland, Western Pacific Archive.
93 Wood-Ellem, Queen Salote of Tonga, 47.
Salote’s husband Tungi was the holder of this title, and was supported by partisans of the old line as the true ruler. Their marriage served to bring together the lineages, but under the authority of the Tupou. It was not until the end of this six month period, October 11, 1918, that her coronation occurred. Thus, she had a scant month to put her house in order before the epidemic would arrive.

Though McOwan harboured doubts about Queen Salote upon her rise, once she had convinced him of her merits he became a solid ally and protector. She used this support to convince the Tongan elite of her authority with the British, whereupon they granted her more recognition, which in turn impressed the British and secured her position. This alliance with McOwan gave the young queen the flexibility she needed to begin reforming the Tongan state. This mutual reliance would develop over time, and the epidemic struck before it had grown past its most nascent stage. The Queen and McOwan demonstrated little cooperative effort throughout the outbreak, beyond her willingness to allow McOwan full latitude to organize the relief effort.

The Epidemic in Tonga

November 1918 found a Tonga with a young, untested monarch. The nobility was weakened and divided along family and religious lines. Resources were stretched thin following the loss of revenue from German trading companies and the government’s attempts to make donations to the British war effort. The Consul was experienced, but unsure of the value of the Queen. Without wireless communications Tongans might have read of the influenza pandemic in the papers that arrived monthly, but could have no knowledge of the illness already sweeping through Fiji and the role of the Talune in its spread. As the ship approached Vava’u on November 10th, there were no concerns. Quarantine matters had been placed under Tongan
control in the Protectorate agreement, and had not developed from there. Dr. Bailey had left for Fiji on the 10th to restock diminished supplies, leaving a Dr. Semmens in Vava’u as the only physician in the islands, and the last line of defense against the ‘flu.

According to Captain Mawson of the Talune Dr. Semmens was told that the ship was carrying many influenza cases but replied that quarantine was useless as there were already many sick ashore. Whether these were victims of the first, milder wave of influenza in 1918 or another local malady is not clear. The Captain further claims that under his initiative he refused shore leave to the Fijian labourers on board so as to not spread the illness, a step he avers to have taken throughout Tonga.94 Beyond this, Mawson reported no effort on the part of the Medical Officer to isolate the Talune or her passengers, a testimony somewhat at odds with Dr. Semmens’.

The Medical Officer at Vava’u was formally asked in late December, 1918, why he had granted pratique to the Talune. His answer included multiple reasons: under Tongan law influenza was not reportable or quarantinable, the ship carried clean bills of health from Auckland and Apia, Vava’u already had influenza circulating (though in a “mild form”), most sick passengers were recovering, the Medical Officer refused landing to anyone obviously ill and refused permission for locals to board the vessel (a claim challenged by Captain Mawson), and that influenza is very difficult to quarantine. He went on further to regret that he was not legally allowed to fumigate passengers coming off of the ship. He claimed to have instructed Captain Mawson not to dock in Nuku’alofa if any serious cases of influenza developed.95

94 Mawson, “Mawson, Captain, to General Manager, Union Steamship Company,” 2.
95 A. W. Semmens, “A. W. Semmens to Premier of Tonga,” January 6, 1919, BCT 1/4, 1919, 6-226, University of Auckland, Western Pacific Archive.
Dr. Semmens then offered an interesting argument, one which was repeated in other locales. He argued against the airborne spread of influenza as “Hundreds in the Tongan Islands had no personal contact, especially in the outlying islands distant 10-12 miles and they were all attacked simultaneously and the villages the same.”96 Whether contact occurred that he was not aware of, or there is another explanation, is unknown; but he believed that the presentation ruled out airborne spread. Thus, he believed that quarantine and other isolation efforts were pointless.

Consul McOwan, upon being sent a copy of this letter by the Premier, was not complimentary. He suggested that Dr. Semmens “either has not seen or does not understand the quarantine law” and that any disease likely, in the opinion of the Medical Officer, to impact the health of Tongans could be a reason for quarantine. He went on to question how any doctor could not have heard of the more serious form of influenza circulating by November, 1918; and that the successful quarantine in Australia brought into question Semmen’s opinion on influenza’s inability to be isolated. Finally, the Consul suggested further education for the doctor in question.97

The Talune continued on to Ha’apai, reaching the middle group on November 11th. There was no physician in the islands and had not been for some time, Dr. Bailey having moved to Tongatapu as Acting CMO. As would be the case in other locations in Tonga, the presence of putative medical infrastructure was rendered moot by the absence of skilled providers. As the end of the war in Europe approached the ship unloaded and took on her cargo and passengers, leaving behind pestilence where no help was present. After the Talune docked on Monday afternoon she was boarded by

96 Ibid.
97 Consul McOwan, “Consul McOwan to the Premier of Tonga,” January 6, 1919, BCT 1/7, 1918, University of Auckland, Western Pacific Archive.
the acting Port Health Officer and the Customs Officer, both Tongans. The next morning both were ill. The following Monday both were dead.98

The Talune reached Nuku‘alofa the following day by which time the ship was riddled with illness. According to the testimony of the Talune’s Chief Officer 70 of the Fijian labourers were lying upon the decks, sweltering with fever and too ill to work. Seven of the ten sailors aboard were unfit to crew the vessel due to influenza.99 Reports describe Captain Mawson ordering that everyone on the ship get dressed and feign health to facilitate the unloading of the ship, just as in Apia.100 Mawson testified that there was no medical officer in Nuku‘alofa (Dr. Bailey being marooned in Suva) but that he reported the health conditions aboard ship to the Collector of Customs. The Collector only asked that the same rules regarding the Fijian labourers used in Vava‘u be employed in Nuku‘alofa, as this was the only advice of a physician on the matter.101

In the absence of Dr. Bailey no restrictions were placed upon the Talune, aside from the limits on access for her sick Fijian labourers. Thus, at all three stops in Tonga the public health system, even when there was a Medical Officer present, did not recognize the ship as a threat and no intervention occurred. A ship whose crew was too ill to sail, and whose stevedores were prostrate on the deck deep in fever, sailed through the safety net like a breeze through a veil.

Within two days of her departure from Nuku‘alofa cases of influenza began to appear. On November 15th the first recorded death from the influenza epidemic of a

98 “The ‘Flu at Tonga: Over 1,000 Deaths; Some Gruesome Sights,” 3.
100 Herda, “Disease and the Colonial Narrative: The 1918 Influenza Epidemic in Western Polynesia,” 136.
101 Mawson, “Mawson, Captain, to General Manager, Union Steamship Company,” 2.
Tongan resident in Tonga occurred with the passing of Tevita Tualau, age 21. By the time the gravity of the situation was understood, the disease had spread the length of Tongatapu.

With the absence of the CMO the Tongan Dispensers and medical students attempted to treat the population, though their efforts were limited by the drug shortage which had sent Dr. Bailey to Fiji. As these workers quickly fell ill their places were taken by missionaries. Once the mission workers themselves fell to the disease and depleted their medicine chests medical services stopped. By November 25th there was one healthy Tongan dispenser for all of Tongatapu.

Tonga simply shuddered to a stop. Travel ceased, and the roughly 30 islands in Tonga inhabited at the time became slowly isolated from each other and the outside world. Without crew, ships could not sail and without workers ships were not loaded. Markets and stores closed. Even the bells of the churches fell silent, as no one emerged to ring them. All stores were closed except Burns Philp and plantations went to weed and seed. Despite requests from Chiefs, no labour was available to load steamers sitting in the harbor waiting to take on cargoes.

There were no Tongan newspapers, so the chronicle of the epidemic is present in individual testimonies. Similarly, the lack of a newspaper prevented information regarding the illness and potential treatments from reaching the communities scattered across the islands. Word of mouth carried disease as quickly as news. Where the centre would be, silence reigned.

104 Ibid.
105 Wood-Ellem, *Queen Salote of Tonga*, 54.
106 Premier of Tonga, “Report of the Premier of Tonga for the Year 1918” (Tongan Royal Printer, May 2, 1919), 14, CO 861/1, National Archives of the United Kingdom.
The Tongan Government took a cautious tone in response to the epidemic. In the notes of Privy Council business for November 14, 1918, when the first infections would have become visible in Nukuʻalofa, is the following remark: “Influenza Epidemic—Office closed until 9th Decr 1918.” In the face of the spreading epidemic the government closed and went home. The nobles and chiefs would care for their own, and those on the other side of the social divide would have to fend for themselves and their families. The government closed completely on the 20th of November along with most businesses. The Consul, finding no assistance from the Government, took responsibility and organized the relief response.

McOwan describes a Nukuʻalofa where nearly every Tongan in the city and surrounding villages were prostrate. “A very small band of Europeans” were left to feed not just the European population but also nearly all Tongans in the region. All trade came to a standstill and with this communications with other island groups ceased. The Medical Department suffered from “complete disorganization.” Later in the epidemic the only reported sound in Nukuʻalofa was the creak of the cart full of the dead, which the recently arrived Australian Relief party led through the capital.

The Rev. Collocott, living near Nukuʻalofa, described the scene:

The head Tongan dispenser in NukuʻAlofa fell ill, and the hospital, with its stock of medicines, was closed. The disease spread everywhere. The people,

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108 McOwan, “Consul McOwan to High Commissioner Rodwell,” 2.
109 Consul McOwan, “Consul McOwan to High Commissioner Rodwell,” December 6, 1918, BCT 1/9, 1918, University of Auckland, Western Pacific Archive.
110 “Scourge at the Islands.”
112 Herda, New Countries and Old Medicine, 40:46.
accustomed to go several times a week to their gardens. Lay sick and without food in their homes….Coo Baker, who was living in Lifuka with her two sisters, happened to be in Nuku’Alofa. Day by Day, and far into the night, she strove, almost past human strength, to win the sick back to life…..As she walked along the dark and empty roads swarms of hungry dogs, whom no one was able to care for, crowded after her….A young German, Carl Riechelmann, sick himself, rode daily to the help of others, till he fell from his bicycle and was taken home to die…..A Tongan man, ill and haggard, came to the mission house for medicine. Rodger Page told him he should be at home in bed, and the man, crying, “But it’s for my child,” fell unconscious on the verandah….In a Tongan home relief visitors found a tiny mite of a girl, who seemed no more than four or five years of age, nursing grandparents, parents, brothers, and sisters…..

On the 23rd of November the Reverend Collocott conferred with the Consul, describing the spread of the illness and the fact that most Tongans were either too ill to care for themselves or quickly moving in that direction. The Consul met with the Premier and other government officials, found no assistance, and organized a group of Europeans to begin relief work in the capital. As soon as it became known that there was assistance being organized, requests poured in that quickly overwhelmed the nascent relief effort. The first soup kitchen established proved inadequate, so a second then a third emerged. Visiting committees began canvassing the town, checking conditions and distributing food. Medicines were rationed.

Queen Salote would, 40 years after the events, relate to Elizabeth Bott Spillius: “There was no social life—people crept in to their houses to die.” “Some died because they were too weak to get food.” “People were buried like dogs – no ceremonies, just bundled into the graves.” “The people were so distressed by having

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113 Wood-Ellem, *Queen Salote of Tonga*, 54.
114 McOwan, “Consul McOwan to High Commissioner Rodwell,” 44.
their dead buried in pits together that they were going round digging them back up again.”

The Palace (figure 22), which could reasonably have been expected to mount and be the centre of the most vigorous relief effort, was nearly abandoned. The Queen was mildly ill, but able to take care of her desperately ill husband and their newborn son. Aside from these members of the Queen’s immediate family only two staff remained, one of whom was considered a madman. This man, Fakafuli, was aged and like so many of his generation seemed immune to the worst effects of the influenza. The Royal family depended upon him to roam the deserted streets of Nuku’alofa for food. A story appears in several accounts of his mysterious ability to make chicken soup for weeks for the Royals as they recovered, without depleting the Palace’s three hens. Apparently the neighbors were too ill to mind or notice their losses. The single cow in the Palace grounds provided nutrition for the heir and allowed the Queen time to tend to her husband, who lay seemingly on the verge of death in a feverish coma.

Fakafuli also served as the only source of news for the Palace. After a night of roaming the capital conjuring chickens he would return to the Palace to wake the Queen with cries relating the names and numbers of dead throughout Tongatapu, a cry that became an early morning fixture in the disease-swept town. In the absence of a newspaper or a government Fakafuli produced the voice of authority.

116 Ibid., 9.
If there is any fact that testifies to the grave shortage of trained assistance in Tonga, it is that three days passed before a comatose Tungi, the Royal Consort and the highest ranked chief in Tonga aside from the Queen, received a visit from a medical professional. In this case it was Coo Baker, a European nurse present in Nuku’alofa. A daughter of Shirley Baker, the missionary and Premier so central in Tonga’s late nineteenth century history, she lived with two sisters in Ha’apai and happened to be visiting Tongatapu when the epidemic struck. She became a hero during the epidemic in Tongatapu, despite her “determination to use the family

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silver even when there was nothing to eat with it” according to one observer. She taught the Queen how to roll the heavy Tungi onto his side and bathe him with cold water, then left to care for others. After two days of baths the fever broke and a confused Tungi came to awareness in an empty Palace, stark naked.118

Tungi’s next set of requests demonstrate how parlous the food situation was, even for the Royal family. When he asked for fish he was told there was none, as no one was well enough to go fishing. When he asked for bread he was rebuffed as no one was well enough to make bread. He eventually demanded a pig, and Fakafuali with the other servant obediently tracked down and slaughtered a pig, preparing it on the grounds of the Palace and earning a written rebuff later from the Consul.119

The Consul quickly found the need to impress American, British, and Fijian seamen into body disposal duties. Corpses had lain for days in sealed rooms in the tropical sun, and no form of coercion could summon Tongan assistance in their burial. These manuao (off-shore men) gathered bodies from the homes where there was no family to perform the rites, or where they were all too ill to engage in the quite complex rituals around the Tongan dead.120 The initial burials occurred in single graves, but mass burials soon became necessary. Yet these mass burials were so distressing to Tongans that some died after rising from their sick beds to try and retrieve the corpses of relatives. In the other islands of the group death rates were even higher and no one was left to dispose of corpses.121 By the 25th only two police officers were well enough to report to work in the Capital.

Why was there so little Tongan involvement in the relief effort? Many reporters describe morbidity rates above ninety percent leaving nearly no one to

119 Ibid.
120 Fanua and Webster, Malo Tupou, 26.
121 McOwan, “Consul McOwan to High Commissioner Rodwell.”
offer assistance. There is also the matter of traditional Tongan views of disease, attributing blame for illness to the person who has become ill, or seeing illness as weakness and bringing shame to the family. In these cases nursing would take place at home, out of the public eye. In the absence of medical staff traditional Tongan healers were unable to offer assistance, as they focused upon the physical arts of surgery and childbirth.

 Possibly more crucial is the absence of leadership from the nobility. Tonga in 1918 was in ways still a feudal culture. Initiative was expected from the nobility, and in the absence of action by the nobles commoners would observe without participating. The nobles were split between factions of the Wesleyan church, between support for different chiefly lineages, and by geography. The nobility had lost much of their direct power over the country as first the Tupou dynasty consolidated power with the assistance of the missions and then as British control tightened, leaving some resentful and withdrawn. A responsibility to the commoners was not an element of Tongan governance, and the divisions made support for other nobles unlikely. Noble families cared for themselves. The country was left to its devices.

 Still the deaths continued. The week of November 25 saw 310 deaths reported in Tongatapu, November 28th recorded 55 deaths in Nuku’alofa alone.122 Out of the 67 students enrolled at the Free Wesleyan Church of Tonga’s Tupou College 11 died in the epidemic.123

 Ha’apai bore the some of the worst impact of the epidemic in Tonga. The Fiji Times describes the infection as moving through the area “like a brushfire.” Reports

122 Herda, New Countries and Old Medicine, 40:46.
123 Tupou College Council, “Abstract of Report of Tupou College Council, 1919” (Free Wesleyan Church of Tonga, 1919), MSS A 817 Miscellaneous Papers 1883-1924, Archives of the Free Wesleyan Church of Tonga.
describe every Tongan in Ha’apai as ill with very few left to assist with relief.\textsuperscript{124} Of Vava’u there is no significant mention in the record of the epidemic until the toll came to be counted.

The Baker sisters (daughters of Shirley Baker and sisters to Coo), particularly Beatrice, took it upon themselves to care for the Tongans of Ha’apai, while their sister Coo worked in Tongatapu. Providing drugs out of their own stores and tending directly to the ill, they worked throughout the island group. Yet the only official record that remains of their efforts is a series of letters from the Tongan Government thanking them but refusing to reimburse their claims for drug costs as the Tongans in the area considered the drugs to be gifts, not something deserving of repayment.\textsuperscript{125}

By the 29\textsuperscript{th} the Consul’s relief operations had extended into the hinterlands of Tongatapu, carrying food and medicine for distribution by village mayors. The next day supplies were dispatched for neighboring ‘Eua.\textsuperscript{126} The soup kitchens in the capital finally closed on November 30\textsuperscript{th} as Tongans were increasingly able to join the relief effort. With staff recovering the dispensary at the hospital reopened.\textsuperscript{127}

The Queen’s yacht \textit{Onelua} had been dispatched to Fiji on November 25\textsuperscript{th} to request help, and to retrieve Dr. Bailey, who had been stranded there since his departure shortly before the outbreak. On November 29\textsuperscript{th} High Commissioner Rodwell received a letter from Consul McOwan carried aboard the ship describing the situation in Tonga. This note described a ninety-five percent infection rate

\textsuperscript{124} “The ‘Flu at Tonga: Over 1,000 Deaths; Some Gruesome Sights.,” 3.
\textsuperscript{125} Beatrice Baker, “Beatrice Baker to Consul McOwan,” May 17, 1919, 1, MS Microfilm 0213, WP-17, Tonga, HBM Commissioner and Consul, General Correspondence Inwards, 1918-1921, 275/1919, University of Auckland, Western Pacific Archive.
\textsuperscript{126} “Consul McOwan to the Premier of Tonga,” 45.
\textsuperscript{127} McOwan, “Consul McOwan to High Commissioner Rodwell,” 46.
amongst Tongans in Tongatapu, including most of the government and Royal family. The Consul reported that he was not ill, and had taken charge of affairs.128

The dispatch of assistance to Tonga from Fiji could be described as comic, had not the consequences been so dire. The ship was loaded with supplies and the good doctor, and prepared to sail for Tonga. Dr. Bailey had tried to leave on the 26th of November in the Ranadi but was unable to depart due to illness among the crew.129 Unfortunately, by the time the Onelua was ready to sail there were no sailors well enough to man her. McOwan was left without a response and thus ignorant of his letter’s fate and unsure if the WPHC staff in Suva were aware of his plight.130

The Australian Relief Expedition arrived in Suva the following day. Rodwell asked the Australians aboard HMAS Encounter headed to Samoa to detach some men and stores for help in Tonga. The commander agreed, splitting off a supply of stores and nine men to travel from Fiji to Tonga aboard the SY Ranadi. They were due to sail December 1.131

By the time the Ranadi, staffed with sailors and supplies, left Suva on December 1 the pandemic was at its most virulent. Yet rather than providing succor, the boat suffered what the Fiji Times termed “an accident to her machinery” and on Thursday the 5th she “crawled back into the port this morning.”132

On December the 6th the HMAS Fantome, part of the Relief Expedition, was slated to depart for Tonga with the supplies and staff from the Ranadi. However her

128 Governor Cecil Rodwell, “Draft Telegram, High Commissioner to Secretary of State,” December 2, 1918, Western Pacific Archives, 47, WP.12, 54, MP 3277, University of Auckland, Western Pacific Archive.
129 Governor Cecil Rodwell, “High Commissioner Rodwell to Resident McOwen,” November 30, 1918, Western Pacific Archives, 47, WP.12, 54, University of Auckland.
130 McOwan, “Consul McOwan to High Commissioner Rodwell,” 45.
131 Governor Cecil Rodwell, “High Commissioner Rodwell to Resident McOwen”, December 1, 1918, Western Pacific Archives, 47, WP.12, 54, University of Auckland.
132 “Influenza Epidemic: Tonga Relief,” Fiji Times (Suva, Fiji, December 5, 1918), 3.
crew experienced a ‘fresh outbreak’ of influenza, according to its commanding officer, and was unable to travel as planned. After this the decision was taken to attempt no further relief expeditions to Tonga due to the shortage of operable vessels and hale crews.

Help did arrive, in the form of a portion of those Australians sent to Samoa. Finding the situation in hand in Apia, most of the Relief Expedition traveled to Savai’i, with the remainder travelling on to Nuku’alofa. Capt. Thring, commander of the expedition and captain of the *Encounter*, sent his last surgeon, Capt. Bradfield, and five orderlies with all remaining supplies aboard ship ashore on December 5th. These men eventually moved to Ha’apai, where there had been no doctor throughout the epidemic. Upon the return of the *Encounter* to Suva the Captain could report that the Consul had done good work in Tonga and the situation was much improved.

During their time in Nuku’alofa, these sailors were given the task of gathering the dead. In order to bear the role of moving bodies that had lain unburied in the tropical heat for days or weeks, heroic whisky rations were distributed. Children remember deeply drunk, though somber, men moving through a city that normally saw very little alcohol use. Though Dr. Bradfield and his men were then sent to Ha’apai, they served throughout the archipelago. By the 18th of December they were sent to ‘Eua, whose small population had been ravaged for weeks without outside assistance.

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133 Lieutenant Marr, “Lieutenant Marr to Governor Rodwell,” December 7, 1918, Western Pacific Archives, 47, WP.12, 54, University of Auckland, Western Pacific Archive.
134 Royal Australian Navy and Sea Power Centre, “Publication.”
135 McOwan, “Consul McOwan to High Commissioner Rodwell,” 49.
136 Captain Thring, “Captain Thring to High Commissioner Rodwell,” December 9, 1918, Western Pacific Archives, 47, WP.12, 54, University of Auckland, Western Pacific Archive.
138 Consul McOwan, “Consul McOwan to Premier, Tonga,” December 18, 1918, BCT 1/7, 1918, University of Auckland, Western Pacific Archive.
As well as medical supplies, the Consul requested a wireless operator from Suva. Communications continued to be via the slow and loss-prone method of ship-borne letters, and the Consul wished direct contact with the WPHC. While a reasonable request, with communication by letter having been delayed through the frequent breakdowns and failure to sail, it was a confusing one. High Commissioner Rodwell would write back that as Tonga did not have a wireless set, and Suva could not send one, the request for an operator would seem futile. This must have frustrated McOwan, as two days earlier he had asked Captain Thring of the *Encounter* to land his wireless set, which the consul understood had been sent for Tonga’s use. The Captain declined in the face of a lack of a skilled wireless operator in Tonga.

Mention of the Tongan epidemic begins to appear in the Fiji and New Zealand papers in late November. On November 30th forty deaths were reported. The *Fiji Times* of December 6th describe the dispatch of help to Tonga (with little effect). It also mentions a letter from Tonga stating that the epidemic was under control, and the subsequent division of those relief supplies meant for Tonga amongst Fijian districts. Such sentiments might have been a bit premature, as reports published on December 9 in New Zealand describe: “The epidemic is abating in Nukualofa. It is still prevalent in the country.”

Food continued to be a major concern. As early as December 6th, McOwan stressed that Tongatapu only had food stocks for a month, and the failure of shipping

139 Governor Cecil Rodwell, “High Commissioner Rodwell to Consul McOwan,” December 6, 1918, Western Pacific Archives, 47, WP.12, 54, University of Auckland, Western Pacific Archive.
140 McOwan, “Consul McOwan to High Commissioner Rodwell.”
142 “Influenza Epidemic: Tonga,” *Fiji Times and Herald* (Suva, Fiji, December 6, 1918).
143 “Influenza Epidemic: ‘Flu Notes,” *Fiji Times and Herald* (Suva, Fiji, December 7, 1918).
144 “Bad Reports from Fiji,” *Poverty Bay Herald* (Poverty Bay, N. Z., December 9, 1918).
due to the illness of dockworkers and sailors put Tonga at risk for starvation.\textsuperscript{145} Fortunately, the pattern of subsistence agriculture practiced on Tonga allowed for quick food gathering as soon as a member of a family was well enough to rise. There were deaths facilitated by hunger, but mass famine on the Samoan model did not occur.

Trade stagnated. The 19\textsuperscript{th} of December saw a letter from the Burns Philp representative in Tonga to the Royal Government asking for labour to load ships sitting at the wharf in Nuku‘alofa, in some cases for the past month. The letter stresses the difficulty in getting ships to stop in Tonga at all, and ended with a barely veiled warning of dire consequences to future trade if labour was not immediately produced.\textsuperscript{146} Despite these threats, the ships continued their unloaded vigil in harbour until the epidemic had passed.

Mid December found the Tongan Government still in crisis. Upon discovering that his letters had not been reaching the Queen or the Privy Council, Consul McOwan sent a letter to the Premier demanding the letters be forwarded.\textsuperscript{147} Once the Queen’s family had recovered, she had to be dissuaded from touring Tongatapu by McOwan, who argued that the burden of a royal visit with its attendant rituals and demands of food and gifts was intolerable for communities still full of the desperately ill. He asked instead that the Government resume normal operation in Nuku‘alofa.\textsuperscript{148}

\textsuperscript{145} McOwan, “Consul McOwan to High Commissioner Rodwell.”
\textsuperscript{146} Burns Philp, Co., “Burns Philp, Co. to Premier, Tonga,” December 19, 1918, BCT 1/2, 1918, 677-718, University of Auckland, Western Pacific Archive.
\textsuperscript{147} Consul McOwan, “Consul McOwan to the Honorable The Premier Nukualofa,” December 18, 1918, BCT 1/7, 1918, University of Auckland, Western Pacific Archive.
\textsuperscript{148} Consul McOwan, “Consul McOwan to Queen Salote,” December 9, 1918, BCT 1/6, 1914-1918, University of Auckland, Western Pacific Archive.
Aftermath and Accusations

McOwan was scathing in his assessment of assistance offered by the Tongan chiefs during the crisis:

The most discouraging feature of the outbreak was the apathy and indifference of the native chiefs to the suffering and distress of their people and I regret to say that the Premier was no exception. On the day that the relief work was started he was out driving in his motor car apparently quite recovered. I appealed to his assistance in obtaining labour for the work of burying the dead but the same afternoon he sent a message to me that he was unable to obtain any men. From that time until conditions had considerably improved I neither saw nor heard of him again... 149

He continued, describing watching two men (Fakafuli and his assistant) roasting a pig in front of the Palace on a day when not a single Tongan could be found to help with relief work, and that he had revised his estimate of the Tongan character as they had shown themselves “incapable of deep feeling and unfitted for the high responsibilities of self-government.” Earlier, in a letter dated December 4th, he stated that “Tongan officials who rendered any assistance were very few and their help intermittent.”

The Premier himself sent McOwan a letter apologizing for his inaction, attributing it to illness. He goes on to say: “I am aware of that indifference was displayed by many that should have been the first to come to the assistance of the sick, and I am unable to account for this state of affairs.” The Premier noted that he had ordered every Tongatapu noble, as of December the 9th (as the epidemic was dissipating), to render and obtain aid for those still sick. 150

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149 McOwan, “Consul McOwan to High Commissioner Rodwell,” 40.
150 Premier Tu’ivakano, “Premier’s Office to Consul McOwan,” December 12, 1918, 51, CO 225/164, Western Pacific 1919 Vol. 1, National Archives of the United Kingdom.
With the year closing, the epidemic reappeared in Tonga, driving a request from McOwan to the WPHC for more medical assistance. To meet this need the Australian Relief Squadron’s doctors were retained in Tonga rather than being sent back to the *Encounter* for reposting to Samoa or Fiji.\(^{151}\) This further outbreak slowed by early January.

News of the deaths in Tonga spread throughout the Pacific. The *Fiji Times* of January 2, 1919 published estimates of mortality described as “a twelfth of the population”. However the disease was reported as abating, and the Australian contingent would soon be leaving.\(^{152}\) Other sources differ, with the *Samoa Times* reporting on January 4th that 870 Tongans had died, and suggesting that the light mortality was due to sanitary conditions in the archipelago.\(^{153}\) Later figures reported include 800 deaths on Tongatapu, 420 in Vava’u, 400 in Ha’apai, fifty in Eua, and an unknown number at Keppel Island due to the loss of the cutter Janet that was sent to survey impact of the epidemic there.\(^{154}\)

Other mortality estimates for the 1918-1919 influenza in Tonga range between 1,000 and 2,000 souls. Lambert gives a number of 1,595, while Wood lists 1,000.\(^{155}\) According to the Rev. Rodger Page, Tongatapu lost 800, Vava’u 400, Ha’apai 413, and ‘Eua forty-three for a total of 1656 but he felt that these numbers were incomplete. He also noted the large number of miscarriages that were not counted in the total, but which laid waste to pregnancies throughout the islands.\(^{156}\) Available estimates

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\(^{151}\) Consul McOwan, “Agent Consul Tonga to WPHC,” December 22, 1918, Microfilm, 47, WP-12, reel 55, WPHC Inwards Correspondence General, MP 2873/18- 3045/18, 2925/18, University of Auckland, Western Pacific Archive.


\(^{154}\) “The ‘Flu at Tonga: Over 1,000 Deaths; Some Gruesome Sights.,” 3.

\(^{155}\) Lambert, *A Doctor in Paradise*.

\(^{156}\) Page, “Letter to Mr. Crosby,” 23/12/18a.
suggest that somewhere between 4.2 and 8.4 percent of Tonga’s population died in the 1918-1919 outbreaks.

Prominent deaths from the epidemic included the Queen Dowager Takibo, only twenty-five years old and only months after the death of her husband; Mrs. Watkin, the wife of the President of the Free Church of Tonga, two of the Rev. Fathers of the Roman Catholic Mission, and several other European residents.\(^157\) Three members of the Tongan Legislative assembly died, including the Governor of Ha’apai, as did five major nobles.\(^158\)

Queen Salote Tupou and her government expressed their thanks to the Consul in a declaration issued December 23\(^{rd}\), 1918, as the influenza still raged in some regions of the country:

Her Majesty Queen Salote Tubou and the Privy Council of the Kingdom of Tonga desire to express their high appreciation of and deep gratitude for the unceasing energy and unsparing efforts of Islay McOwan, Esquire, His Britannic Majesty’s and Consul in coping with the recent severe influenza epidemic. They further desire to record their conviction that it was due to his prompt initiation and organisation of relief measures that the large death rate was prevented from assuming still more alarming proportions.\(^159\)

The Tongan Government was not the only administration hoping the end had been reached. By January 8\(^{th}\) the WPHC High Commissioner Rodwell felt comfortable enough with the situation in Tonga to cable the Colonial Office that “the epidemic may now be regarded as over as far as Tonga is concerned.”\(^160\)

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\(^{157}\)”Local and General News.”

\(^{158}\)Queen Salote Tubou, “Address of Her Majesty Queen Salote Tubou” (Tongan Royal Gazette, July 15, 1918), 63, C/O 676/2, National Archives of the United Kingdom.

\(^{159}\)Queen Salote Tupou, “Queen Salote Tupou to Islay McOwan, H.B.M’s Agent and Consul,” December 23, 1918, BCT 1/3, 1918, 80-729, University of Auckland, Western Pacific Archive.

\(^{160}\)Governor Cecil Rodwell, “Rodwell, High Commissioner to Colonial Office,” January 8, 1919, 1, CO 225/164, Western Pacific 1919 Vol. 1, National Archives of the United Kingdom.
Food shortages continued after the infection had abated. The 1919 Report of the Tupou College Council notes that “In common with the rest of Tonga and the neighboring groups we feel the food shortage that is one of the direct results of the epidemic.”\(^{161}\) In part this was due to the persistence of the shipping strike in Australia, which also prevented the travel of some colonial officials and missionaries such as the Rev. Collocott.\(^{162}\)

The epidemic prompted more than angry accusations and notes of condolence. In 1919 the Tongan Government, working with the WPHC, decided to finally fund a wireless station, in the hope of avoiding future calamities through a more effective warning system.\(^{163}\) Communications with the outside world had become a priority. In early 1919 Consul McOwan wrote to the Premier asking what steps would be taken to reopen the quarantine station at Nakaha’a, though as it was not used during the 1918 outbreak it is unclear when it was first closed.\(^{164}\) While this reopening did not occur, the Tongan Government did seek advice on fumigation procedures against influenza.\(^{165}\)

Influenza returned to Tonga in mid-year, 1921, prompting both Suva and Apia to quarantine all passengers coming from Tongan ports. This quarantine was not lifted until October 14, 1921.\(^ {166}\) A thousand cases were reported with some deaths.\(^ {167}\) The lessons of the 1918 clearly offered little protection.

\(^{162}\) “The Minutes of the Tongan District Synod,” July 4, 1919, MSS A 817 Miscellaneous Papers 1883-1924, Archives of the Free Wesleyan Church of Tonga.
\(^{163}\) Premier of Tonga, “Report of the Premier of Tonga for the Year 1918,” 14.
\(^{164}\) McOwan, “Consul McOwan to the Premier of Tonga,” 2.
\(^{165}\) Scott, “Premier’s Instruction Book: Oct 1918-July 1919,” 03/10/19.
\(^{166}\) Chief Financial Officer, Fiji, “Minute Papers 4511 of 1921, Administration of Fiji. Forwards Copy of a Wireless Message from the Premier, Tonga, Reporting Outbreak of Influenza” (Administration of Fiji, August 3, 1921), M. P. No. 4511/21, National Archives of Fiji.
\(^{167}\) “Influenza in Tonga: Four Deaths in a Week,” Evening Post (Wellington, N. Z., August 23, 1921).
Relative to Samoa, Tonga’s experience of the epidemic was mild. Why did Tonga seem to escape the devastation visited upon Samoa? The *Samoa Times* attributed it to the “excellent sanitary conditions prevailing in the group.”  
Rodwell attributed it to the work of McOwan. J.B. Watkin, the President of the Free Church of Tonga, echoed these sentiments (including other Europeans as well), as did the Tongan Government. The Wesleyan Church of Tonga expanded the thanks to McOwan, other Europeans, the crews of the ships who assisted, and the Australian Relief team. They thank all specifically for the medical care, food distribution, pharmaceutical availability, and the internment of the dead.

The factors listed at the beginning of this chapter suggest that Tonga was indeed well situated to survive an event like the influenza pandemic, at least in 1918. Yet the best numbers seem to suggest a roughly eight percent mortality rate, hardly a success in most situations and definitively higher than Fiji. What drove this death rate?

Foreign reports blamed the shortage of drugs in part for the high mortality. Influenza was not responsive to the drugs available in 1918, however, so this seems to be an inadequate argument. The actors present in Tonga held a range of views as to where fault lay.

McOwan himself thought the absence of preparation and lack of food drove most deaths, an element he blamed squarely upon the nobles’ refusal to mobilize support for the commoners. McOwan also blamed the lack of warning due to poor

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168 “Local and General News, January 4, 1919.”
169 Rodwell, “Rodwell, High Commissioner to Colonial Office.”
171 Rev. Rodger Page, “Rodger Page to Consul McOwan,” January 3, 1919, Microfilm, 47, WP-12, reel 55, WPHC Inwards Correspondence General, MP 2873/18- 3045/18, 132/19, University of Auckland, Western Pacific Archive.
172 “Scourge at the Islands.”
communications with other states, and argued that undoubtedly Fiji would show a lower death rate than Tonga or Samoa due to the warnings Suva received about the spreading influenza.\textsuperscript{173} He also faulted the performance of the Tongan medical staff, describing the response of the Medical Department as a “complete failure.”\textsuperscript{174}

Unsurprisingly physicians took another view. Dr. Bailey argued that the dirty homes and unsanitary habits of the Tongans were only revealed by the influenza epidemic, as well as contributing to it.\textsuperscript{175} Dr. Semmens of Vava’u blamed the lack of wireless communications with the outside world.\textsuperscript{176} Dr. S. M. Lambert, a visitor after the fact, attributed the death rate to weakening of the people from yaws, dysentery, and typhoid, which he further attributes to poor sanitation.\textsuperscript{177}

The actual causes are hard to glean from the limited records available. The \textit{Talune} stopped in at three ports in Tonga, more than in any other state and thus cancelling the benefits of isolation. Only one physician was in the islands at the time of infection, and he was stranded in the far north once travel ceased. The Chief Medical officer was marooned in Fiji by a continuing cycle of failure and ill luck. Most Tongans lived on Tongatapu, the largest island and the site of the best transport network, allowing the disease to spread quickly.

The Tongans were unable to access medical assistance and their traditional views on disease and local healers were not designed to counter this type of epidemic. Morbidity rates were high enough to prevent much assistance between family groups, even had this been culturally appropriate. Disease was hidden, or ignored.

\textsuperscript{173} Consul McOwan, “Consul McOwan to Captain Thring,” December 12, 1918, BCT 1/5, 1918, 1 July-27 December, University of Auckland, Western Pacific Archive.
\textsuperscript{174} McOwan, “Consul McOwan to High Commissioner Rodwell,” 48.
\textsuperscript{175} Herda, “Disease and the Colonial Narrative: The 1918 Influenza Epidemic in Western Polynesia,” 138.
\textsuperscript{176} Semmens, “A. W. Semmens to Premier of Tonga.”
\textsuperscript{177} Lambert, \textit{A Doctor in Paradise}, 196.
It was the absence of a response from the government, notably from the nobility, which guaranteed the inactivity of the populace. The government quite literally just went home. Had the Consul and certain other outside elements not been present the death toll would likely have been much higher, as many would have succumbed to hunger and deteriorating hygienic conditions. In a state without a newspaper the traditional networks carried information and instructions, and these ceased to operate with the abandonment of the nobles’ administrative roles. No directives were distributed. No instructions produced. The Tongans were either cared for by foreigners, or if not in contact with any outsiders were left to their own resources. The nobility’s divisions and self-focus contributed directly to the mortality rate throughout the country.

Tiny Neiafou, where months would pass without a visit from a trading vessel, seems to have been spared the outbreak. When in mid January, 1919 the Talune steamed by and sent the mail ashore in a sealed tin, they included an enquiry asking if the islanders had “had the sickness?” The reply received, in the midst of all the devastation throughout the rest of the archipelago, was “what sickness?”178

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178 “The ’Flu at Tonga: Over 1,000 Deaths; Some Gruesome Sights,” 3.
Conclusion

By 1921 the pandemic had receded from the Pacific, never yet to return in as virulent a form. In each of the states under study, aside from American Samoa, the consequences had been severe. Recovery would take decades. Population studies demonstrated long-term demographic changes in each territory infected reflecting the high incidence of disease and death in the young adult age cohort. Influenza had an impact on politics, island economies, and medical systems.

Pacific island states faced unique challenges in controlling infectious disease. Isolation, demographic and geographic factors, shifts away from subsistence to plantation economies with reliance upon imported food, weak colonial structures with disrupted traditional elites, and connection to world trade routes with only tenuous (aside from Fiji) communications to outside sources of information made these states vulnerable to infection. In 1918 each of the states under study held a reduced colonial infrastructure as resources were shifted to the European theatres of the First World War. The local physicians were not always well trained and, like their contemporaries across the globe, had scant idea of how to respond to the sudden calamity that unfolded before them. The four states under study attempted a wide range of social measures for control of the 1918-1920 influenza pandemic. Their success or lack thereof depended more upon physical, political and economic variables than indigenous cultural or health factors.

Fiji had significant public health infrastructure and warning of the influenza’s approach, yet the colonial medical staff discounted the risk and faced strong economic pressure to avoid quarantine measures. Fiji also had the largest and most diverse population of the states discussed in this thesis, thus complicating education
and outreach efforts, as well as strong recent memory of a devastating measles epidemic which did nothing to develop indigenous faith in the colonial medical system. Though Fiji possessed more arable land than any nearby state, food imports were necessary to supplement local production since much of the agricultural acreage and available labour had been turned towards non-food crops for export and the *girmit* labour did not share the local diet. In the absence of these imports the epidemic exacted a greater toll amongst these workers and urban dwellers. Fiji’s political structures, colonial and traditional, were under pressure and in the midst of significant change, which delayed and weakened the eventual administrative reaction to the crisis. Roughly five percent of Fijians died.

At the same time Fiji demonstrated the most effective government response of the three infected states. Assisted by the relatively large colonial presence, well developed medical system, and the supplementary medical resources of the large plantations, aid reached most locations in the archipelago before the end of the year. After the initial shock the administration in Suva reached out to the DMOs to determine need and distribute aid. In addition, sites such as Makogai and southern Taveuni demonstrated the potential efficacy of localized quarantine efforts. Fiji was vulnerable and suffered greatly, but the colonial administration eventually mounted a significant response and the long-term political consequences of the epidemic in Fiji were minor.

Western Samoa had a military garrison with little governing experience and a plantation economy that served the population poorly in this crisis. The German administration had weakened the traditional elites of Western Samoa but had not replaced them with a strong colonial presence, a pattern not improved under New Zealand rule. In the absence of any instruction, warning, or support from Wellington, Colonel Logan felt unable to act as the crisis broke across his domain. As an arm of
the colonial government, the medical officers present also chose to wait for instructions, losing an opportunity to exclude the illness. The plantation owners supported this decision as they faced significant economic strains if isolation measures were put into place. Such factors prevented an American Samoan-style quarantine from being implemented. The prevalence of plantation agriculture, which had replaced much of the near-village subsistence farming, also meant that local food supplies were often further from the villages and for cultural reasons many Samoans had no significant food storage. These economic and agricultural factors led to significant famine across the group during the convalescent period.

Geography, demography and culture also drove the course of disease in Western Samoa. Geography in Western Samoa mandated that settlement be in a ring around the coastline of the two large islands, but also provided sufficient food to support a dense population. These settlement patterns in turn drove rapid spread of the disease by facilitating their spread through closely placed villages and along trade routes. Though the road system was in its infancy, the well-used system of trails linking coastal villages as well as water routes allowed the disease to be spread efficiently by those infected persons who had not yet become ill. The rapid spread of disease ensured that the large majority of the population was concurrently ill and unable to assist each other, even if cultural considerations (also, in part, driven by geography) would have allowed such.

Western Samoa experienced the highest known death rate from the 1918 outbreak with one quarter of the population succumbing. Given that most of these deaths occurred in the fifteen to forty-five year old age group the colony’s most productive population cohort was cut in half. Many local teachers, political elites, and religious leaders were lost to the epidemic, leading to political instability and the
rise of a new, younger, and embittered class of Samoan leadership. Protests against New Zealand’s control of the islands began soon after the epidemic abated.

Despite the country’s small area and population, Tonga suffered horribly. The Talune stopped in three ports, ensuring nearly concurrent infection for all three major island groups in the territory. The lack of communications between the groups and between Tonga and the outside world meant that no warning or information regarding the epidemic could be passed to unexposed areas before the infection reached them. The only doctor in the territory was at Vava’u in the far north, away from the largest population concentrations. Traditional Tongan responses to disease proved ineffective when faced with quick-acting respiratory infection.

None of these elements carried the same impact as the collapse of the government in the face of the epidemic. Weakened and seemingly made ancillary by the rising monarchy and the British Protectorate, the nobles and chiefs retreated to care for their own (and die in large numbers) when the epidemic struck, leaving the mass of commoners to their fate. Neither the Protectorate nor the monarchy had the resources to fill the vacuum thus created. This collapse eviscerated a political system in which traditional titles, responsibilities, and deference to status still played a large role. In the absence of the traditional political elite most of the populace received no guidance or support in the first six weeks of the epidemic, and suffered accordingly. Somewhere between four and eight percent of Tongans were killed. Due to the absence of organized relief efforts outside of Nuku’alofa the true number of dead will never be known.

Tiny American Samoa, a mere fifty kilometers from Western Samoa, was perhaps the only polity across the globe to experience no mortality from the influenza pandemic. A small, homogenous state under US navy control, quarantine
was successfully implemented and maintained for years, preventing the infection from reaching the island group in its most virulent form. Quarantine was made possible by the small size of the territory, the government control of trade which funneled foreign ships through a single port, and especially the support and assistance of the local chiefs. It was the presence and power of the chiefs, left in place by an administration determined on a policy of benign semi-neglect, which allowed American Samoa to successfully implement the orders of Governor Poyer. Certainly, the twenty years in which the US Navy had ruled the colony granted the naval officers some insight into how to effectively govern the territory and the laissez-faire approach to the Station taken by Washington allowed the Governor to act freely on his best judgment, but these factors would have carried negligible impact had the local population actively refused to implement quarantine policies. The cooperation of the chiefs coupled with an administrator willing to act allowed American Samoa to emerge unscathed from the pandemic. This success has helped maintain American Samoa as an American territory while Western Samoa successfully demanded independence from New Zealand.

A range of social, political, and economic factors determined outcomes as each of these states were exposed to influenza. These differences between the states, not their broad similarities, serve to illuminate their experience of epidemic disease. The social, the cultural, the political, the physical, and the medical are inextricably intertwined. Only by comparison can the experience of each state be fully understood.

Bashford argues in *Imperial Hygiene*\(^1\) that public health efforts in colonial states were not primarily driven by the desire to protect the indigenous populations. Instead, these practices served to assert control over local populations, protect

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\(^1\) Bashford, *Imperial Hygiene*. 
colonial administrations, and aggressively define and differentiate between ethnicities and nationalities. Given these points, the health infrastructure of colonial states, or at least that portion funded and staffed by colonial governments, could not be expected to be effective when all residents of the colony or dependency were at risk. These structures would instead move to protect the colonial presence and colonial citizens present in the state, followed by the economic and political interests of the colonizing state, with the needs of the indigenes that fell outside of these categories a tertiary concern.

In the case of the states under study in this thesis, however, this broad picture is not completely applicable. In each state the colonial presence, generally Europeans and North Americans, voluntarily put themselves at risk of illness to provide succor to a desperately ill population. Certainly, these colonizing groups suffered disease at lower rates than the native populations of the island groups, and dominated the resources necessary to provide relief to those suffering. Yet their willingness to put themselves at risk to help the ill seems to suggest a more complex relationship than that of a predominately self-interested imperial presence. Even in American Samoa, where no disease penetrated, the entire medical staff of the naval station volunteered to work in Western Samoa. The relief efforts of both Fiji and Western Samoa were initiated and in the majority staffed in the early days of the pandemic by members of the colonizing class, and in Tonga nearly all relief services were provided by outsiders. Australia, with little direct interest in the outcome of disease in Western Samoa or Tonga (though with strong financial links to Fiji) sent assistance in the form of supplies and personnel. Bashford argues for a general trend in public health relations between the colonized and the colonizers which the particular narrative of Fiji and western Polynesia in 1918-1920 does not seem to support.
Tomkins’ discussion of the epidemic in Western Samoa\(^2\) (as well as throughout British Africa\(^3\)) fits the reports of the epidemic, and certainly matches the findings of the SEC with much greater precision. In her analysis the colonial governments had the potential to avoid infection via communications and quarantine, yet they were powerless to treat the disease after exclusion failed or was not attempted. Their confidence in the superiority of the western medical model led to crucial delays in response and helped ensure the devastation which followed. This model can also be applied to Fiji. American Samoa stands in repudiation of these points, but only as an anecdote. In the two most populous island groups, Fiji and Western Samoa, the colonial apparatus failed to protect the population it claimed to shelter. Tonga’s systemic collapse was domestic in origin, and thus the evaluation of the colonial impact is more indirect.

Yet as mentioned in the first chapter of this work, Tomkins focuses almost entirely upon the political. It is the work of Kunitz which provides a theoretical framework for examining these epidemics. Kunitz argues that the range of context can be more important for understanding the progression of a disease through a society than the nature of the disease as an independent actor.\(^4\) Politics, geography, cultural norms, social stressors, agricultural patterns, and many other such factors drive a community’s experience of and response to an invading infection. He goes on to argue that interventions meant to prevent or cure such infections also have strong impact upon disease course, which has been vividly demonstrated in the stories of the epidemics of each island group. It is this recognition that illness has both a natural and a social history, and that both must be understood to grasp the course and social impact of a particular disease, that this thesis is based upon.

\(^2\) Tomkins, “The Influenza Epidemic of 1918–19 in Western Samoa.”
\(^3\) Tomkins, “Colonial Administration in British Africa During the Influenza Epidemic of 1918-19.”
\(^4\) Kunitz, Disease and Social Diversity, 5.
As an example, in the 1918-1920 pandemic in Fiji and western Polynesia the strength of the colonial governments bore directly upon the local outcome of the epidemic. The US Navy’s unchallenged dominance of American Samoa allowed for a quarantine to be imposed quickly without opposition from within the colony or from Washington DC. American Samoa may have been unique in this regard, with nearly no commercial presence in the archipelago to demand protection or argue against quarantine. Nonetheless Fiji, with a strong colonial administration spread throughout the islands, was able to recover from a confused initial response to develop a relief effort which eventually reached throughout the archipelago. Tonga, with almost no colonial presence, was unable to marshal broad local autonomy into an effective response to the disease, instead relying upon the rump European presence. Western Samoa demonstrates the weakness of the colonial structure most vividly, with a local colonial authority manifestly unable to prevent the disease or the famine which followed. Yet the New Zealand presence in Western Samoa did not focus upon self-preservation, instead attempting to alleviate the suffering of all residents of the islands, though with varying success. In each of the infected cases support and resources were first deployed in the towns, centers of colonizing populations, but there is no evidence that these resources were triaged to preferred populations over indigenous residents. Though the failure to prevent infection rests with the colonial administrations in Fiji and Western Samoa, in none of these cases can public health be seen more as an instrument of control and racism than support and succor. Indeed, the power of the colonial naval outpost in American Samoa succeeded in protecting all the people of that polity from the ravages of influenza. Without the American Navy and its commitment to quarantine the outcome might have been devastatingly different. The colonial infrastructures were frequently over-confident and incompetent, but they did not demonstrate heartlessness.
This is one example of the interplay of the social and natural histories of which Kunitz speaks. One could just as easily highlight agricultural patterns, geography, or a multitude of other elements which came into play. These would each be accurate, and informative, but not complete. The synthesis of such elements is where the true narrative lies, and where lessons for the future might reside.

There is a difference between public health policy over time and the reaction to a medical crisis such as the influenza pandemic. Actions in time of crisis cannot be used to define the tenor of an entire colonial effort, yet it is these responses to stress which have the greatest short-term impact and are remembered most clearly. In assessing colonialism in the Pacific humanitarian considerations have been characterized by some as an excuse for the colonial presence and thus insincere. It is undeniable, however, that in the face of intense suffering and calamity many of the colonizers showed compassion and took risks to assist with no thought of gain. Many decisions taken by the colonial administrations during the influenza pandemic appear wrong in retrospect, but few were truly callous towards the populations they ruled. This does not in any way justify the oppression and inequities of colonialism, but is instead a recognition that some organs of the colonial administrations did attempt, at certain times, to work to the benefit of the colonized.

A decade after the pandemic swept across Oceania the impact could still be felt. January 1928 saw the posting of telegraph operators to all three major island groups of Tonga, as well as Niuatoputapu and Niuafoo, for the first time. Communications had proved to be a critical vulnerability for Tonga in 1918, and this had finally been addressed. In 1929 New Zealand policemen fired into a crowd of Mau protestors in Apia, killing several including the High Chief Tupua Tamasese.  

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After this event the push for independence became constant and irrepressible. The same year saw the passage of the Ratification Act of 1929, in which the United States Congress ratified the original treaties of cession for American Samoa. This Act provided for continued American rule, and a local American Samoan Mau in the 1930s would push for more rights for Samoans within the American system.7

In June of 1928 the first flight occurred between Hawaii and Fiji, continuing on to Australia.8 Opening up first Fiji, then all of Oceania to rapid transport this flight was a harbinger of the end of isolation for the islands. Though another decade or more would pass before air routes were established, they had been shown to be possible. In an age of air travel, quarantine was a distant dream. Now, indeed, would attempts to isolate entire island groups be exercises in futility of the sort declared by the Fijian medical officers in 1918.

The Talune continued to serve the trade routes of Polynesia until 1921, when USSCo. records show she was taken out of service.9 By 1925 she had been stripped of all equipment, and her hulk was sunk in 1926 to form a breakwater for the growing port of Waikokopu, New Zealand.10 This port, in Hawkes Bay on the North Island, has since fallen into disuse and little of its infrastructure remains. The Talune now guards an unused harbour, excluding the worst of the sea’s destructive power. In 1918 her exclusion saved many American Samoan lives, while her welcome brought death to thousands of Fijians and Polynesians. The lessons learned, and the Talune, fade with each passing year.

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