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Colonial Public Health and the Management of Epidemics in Northern Nigeria: The 1918 Influenza Pandemic in Historical Perspective

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Abstract: *The 1918 Influenza Pandemic, often described as the most catastrophic health crisis of the 20th century, had a profound yet understudied impact on colonial Northern Nigeria. While global scholarship has extensively documented its effects in Europe and North America, African colonial experiences particularly those of indigenous societies remain marginal in the historiography of epidemics. This paper examines the trajectory, responses, and legacy of the 1918 influenza outbreak in Northern Nigeria, focusing on how colonial medical neglect, racialized health policies, and infrastructural underdevelopment intensified its devastation. Drawing on archival records, colonial health reports, missionary documentation, and oral histories, the study reveals how British colonial authorities prioritized the protection of European lives and commercial interests, while largely abandoning African communities to cope through traditional methods. Indigenous responses including Qur'anic healing, herbal medicine, ritual cleansing, and community-wide fasting offered culturally grounded alternatives to biomedical interventions, which were viewed with suspicion or entirely inaccessible. The paper also explores how traditional rulers mediated between colonial directives and local populations, shaping both compliance and resistance. In the aftermath of the pandemic, modest reforms were introduced, yet they entrenched a two-tiered healthcare system that marginalized rural Northern Nigerians for decades. The memory of the pandemic persisted in local narratives and influenced responses to later outbreaks, including COVID-19 and Lassa fever. By situating the 1918 pandemic within a broader historical framework of disease, governance, and indigenous agency, this article contributes to the field of African medical history and highlights the relevance of historical epidemics to contemporary public health discourse.*

Keywords: Colonial Public Health, Northern Nigeria, Management, Epidemics, 1918 Influenza Pandemic

1. Introduction

The 1918 Influenza Pandemic, popularly referred to as the "Spanish Flu," remains one of the deadliest global health crises in human history. Originating during the final stages of World War I, it spread with astonishing speed across continents, infecting an estimated 500 million people almost one-third of the global population and resulting in over 50 million deaths worldwide.[1] Unlike other pandemics, the 1918 influenza was unusually severe, affecting not only the very young and old but also healthy adults in their prime. In Africa, the pandemic arrived through returning soldiers, missionaries, seamen, and traders. Nigeria, then a British colony, was hit hard between 1918 and 1919, with tens of thousands of deaths, particularly in rural areas that lacked basic medical infrastructure.[2]

In Northern Nigeria, where colonial penetration was comparatively recent and administrative presence was relatively thin, the impact of the pandemic was particularly severe. The region's population was predominantly rural and scattered across difficult terrain, with limited access to colonial medical services. European doctors and facilities were concentrated in administrative centers such as Kaduna, Zaria, and Kano, while indigenous communities relied on traditional healers and religious leaders for health care and spiritual explanations. The pandemic challenged not only the underdeveloped colonial health system but also tested indigenous structures of authority and belief systems.[3] Despite this, historical studies on the medical implications of the 1918 Influenza in Nigeria especially in its northern provinces remain remarkably scarce.

Medical history in African colonial settings has often been marginalized within mainstream historical scholarship. While political, economic, and administrative aspects of colonialism in Africa have received considerable attention, the intersection of colonialism, disease, and indigenous health practices remains underexplored. In Nigeria, scholarship on colonial medicine has focused primarily

[1] Johnson, Niall P. A. S., and Juergen Mueller. "Updating the Accounts: Global Mortality of the 1918–1920 'Spanish' Influenza Pandemic." *Bulletin of the History of Medicine*, vol. 76, no. 1, 2002, pp. 105–115.
[2] Killingray, David, and Howard Phillips, editors. *The Spanish Influenza Pandemic of 1918–19: New Perspectives*. Routledge, 2003.
[3] Curtin, Philip D. *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century*. Cambridge University Press, 1989.

on southern provinces and urban colonial centers, where European influence was more entrenched and better documented.[4] As a result, regions like Northern Nigeria where indirect rule, Islamic traditions, and resistance to Western medical intervention were dominant are often absent from discussions of historical epidemiology and health policy.

This lack of scholarly focus obscures critical insights into how epidemics shaped colonial governance, health inequalities, and indigenous coping mechanisms. The 1918 Influenza Pandemic, though briefly mentioned in historical surveys, has not been the subject of focused academic inquiry in Northern Nigeria. This gap in the literature is particularly problematic, as it limits our understanding of how disease influenced social behavior, colonial authority, and long-term health outcomes in one of the most culturally and religiously complex regions of Nigeria. This study sets out to fill a critical gap in Nigerian and African medical historiography. Its core objectives are: to investigate the colonial government's medical response to the 1918 Influenza Pandemic in Northern Nigeria; to examine indigenous responses, including cultural interpretations, traditional healing practices, and the role of emirs and local leaders, to analyze how the pandemic influenced public health policies in the colonial and post-colonial periods; The significance of this study lies in its effort to document a historically neglected episode in Nigerian health history and demonstrate how the past shapes the present. By uncovering the historical roots of pandemic response in Northern Nigeria, this article contributes to contemporary debates on health infrastructure, disease preparedness, and the legacies of colonial medical inequality. Furthermore, it helps explain the deep-seated public distrust in government-led health interventions, which resurfaced during Nigeria's responses to recent epidemics such as Ebola (2014), COVID-19 (2020), and periodic Lassa fever outbreaks. Historical analysis of the 1918 pandemic thus provides critical insights into the cultural and structural continuities that continue to shape Nigeria's health sector and its vulnerability to epidemic diseases.

2. Colonial Medical Policy and Health Infrastructure in Northern Nigeria (pre-1918)

Before the outbreak of the 1918 Influenza Pandemic, the British colonial medical system in Northern Nigeria was rudimentary, racially segregated, and primarily established to serve European colonial officials, troops, and commercial interests. Following the amalgamation of the Northern and Southern Protectorates in 1914, the colonial state in Northern Nigeria faced significant infrastructural and logistical challenges. Medical services were concentrated in major administrative centers such as Kaduna, Kano, and Zaria, leaving the vast rural hinterlands medically underserved. For the indigenous population, access to Western healthcare was minimal and largely incidental, with traditional medicine remaining the dominant form of health care delivery.[5]

Colonial medical policy in the North was shaped by both economic pragmatism and political expediency. The doctrine of "indirect rule," as championed by Lord Frederick Lugard, minimized direct administrative intervention in native affairs, which included health care provision. The colonial government therefore relied on traditional rulers emirs and village heads to enforce sanitation laws and respond to outbreaks, with minimal infrastructural support or investment.[6] This passive approach allowed the British to reduce the cost of governance while exerting control through existing political hierarchies.

Medical priorities were closely tied to the protection of colonial personnel and the continuity of revenue-generating activities such as mining, railway expansion, and agriculture. Consequently, medical services were largely reactive mobilized during outbreaks of sleeping sickness, smallpox, or yellow fever and not proactively invested in preventive care for the indigenous population.[7] Where hospitals and dispensaries existed, they were few in number and concentrated in colonial cantonments. Medical officers, often overburdened and under-resourced, provided limited care and lacked effective means to penetrate rural communities with public health messaging or treatment.[8]

Missionary societies played a modest but important role in bridging the medical gap left by colonial neglect. Christian missions, particularly in southern and middle-belt regions, established basic clinics and dispensaries where Western medicine was introduced alongside evangelism. However, in the predominantly Muslim north, missionary activity was heavily restricted, limiting their contribution to health care.[9] As a result, most local populations continued to rely on herbalists, Islamic healers (mallams), and

[4] Falola, Toyin, and Matthew M. Heaton. *A History of Nigeria*. Cambridge University Press, 2008.
[5] Cole, Festus. "Sanitation, disease and public health in Sierra Leone, West Africa, 1895–1922: Case failure of British colonial health policy." *The Journal of Imperial and Commonwealth History* 43.2 (2015): 238-266.
[6] Watts, Michael. *Silent Violence: Food, Famine, and Peasantry in Northern Nigeria*. University of California Press, 1983.
[7] Fort, Meredith P., Mary Anne Mercer, and Oscar Gish, eds. *Sickness and wealth: The corporate assault on global health*. South End Press, 2004.
[8] Gwaindepi, Abel. *State building in the colonial era: Public revenue, expenditure and borrowing patterns in the Cape Colony, 1820-1910*. Diss. Stellenbosch: Stellenbosch University, 2018.
[9] Ogunbadejo, Oye. "Missionary Enterprise and Medical Work in Northern Nigeria." *Journal of African Studies*, vol. 9, no. 1, 1982, pp. 65–78.

community elders for medical intervention. These indigenous systems were not formally integrated into the colonial health apparatus, further isolating local responses from state policy.

By 1918, Northern Nigeria had only a skeletal medical system incapable of withstanding the pressure of a major pandemic. The combination of inadequate staffing, poor communication infrastructure, and distrust of colonial authorities created the conditions for rapid disease transmission and high mortality. The stage was thus set for the influenza pandemic to wreak havoc with limited resistance, and for indigenous communities to respond independently in the absence of coordinated state intervention.

3. The 1918 Influenza Pandemic in Northern Nigeria

The 1918 Influenza Pandemic struck Nigeria in September 1918, entering first through the Lagos port before spreading inland via railway lines, trade routes, and returning colonial troops from World War I. By October, the epidemic had moved rapidly through key administrative regions and was reported in the major northern cities of Kano, Zaria, and Kaduna.[10] Northern Nigeria, still grappling with underdeveloped colonial health infrastructure, was unprepared for the scale and velocity of the outbreak. The influenza spread like wildfire through both urban centers and rural communities, claiming thousands of lives within weeks.

Unlike diseases such as malaria and smallpox, which had long histories in the region, influenza presented as a new and poorly understood illness. Colonial medical officers often lacked the resources or training to distinguish influenza from pneumonia or other respiratory infections, resulting in delayed or inadequate responses.[11] Reports from colonial archives reveal that entire households were incapacitated, leaving corpses unburied and basic survival routines disrupted. In many northern towns, the death toll overwhelmed the limited medical personnel available. Hospitals and dispensaries, where they existed, were overcrowded and ill-equipped to treat the sudden influx of patients.

The colonial government responded to the epidemic with a series of ad hoc public health interventions. Quarantine measures were introduced in some urban areas, although enforcement was inconsistent and often resisted by local populations. Temporary health committees were formed in key cities like Kano, but their actions were largely limited to distributing notices on hygiene and imposing burial regulations.[12] In many rural areas, colonial presence was minimal, and no formal health response was recorded.

Traditional rulers, particularly emirs and district heads, were instructed to report new cases and assist in enforcing sanitation measures. However, the deep cultural divide between colonial officials and indigenous communities limited cooperation. In areas where indirect rule was firmly established, some emirs played critical roles in calming public fears and coordinating burial efforts, though they too lacked resources.[13] Public health campaigns were hindered by low literacy levels, linguistic barriers, and widespread suspicion of colonial motives.

In the absence of effective colonial interventions, indigenous responses became central. Local interpretations of the disease often framed it as a spiritual punishment, a test from Allah, or a manifestation of ancestral anger. Communities turned to mallams, herbalists, and traditional healers who administered Quranic verses, protective amulets, herbal concoctions, and communal prayers.[14] Oral accounts from regions like Katsina, Bauchi, and Gombe suggest that spiritual rituals and community fasting were commonly practiced as attempts to ward off the plague. These responses were not merely symbolic but served crucial psychological and social roles in a time of extreme uncertainty and loss.

Estimates of mortality in Northern Nigeria vary, but available figures suggest that some provinces lost up to 4–7% of their population within a few months. However, due to limited recordkeeping and the exclusion of rural deaths from official statistics, the actual death toll may have been much higher.[15] In some towns, community structures collapsed temporarily under the weight of grief, economic disruption, and labor shortages.

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[10] Ohadike, Don C. "Diffusion and physiological responses to the influenza pandemic of 1918–19 in Nigeria." *Social Science & Medicine* 32.12 (1991): 1393-1399.
[11] Hudu, Shuaibu Abdullahi, et al. "The role of Seasonal Influenza in compounding the outbreak of infectious diseases: a critical review." *Biomedical and Pharmacology Journal* 17.1 (2024): 1-13.
[12] Wilkinson, Annie, et al. "Local response in health emergencies: key considerations for addressing the COVID-19 pandemic in informal urban settlements." *Environment and urbanization* (2020): 095624782092284.
[13] Halvorson, Sarah J., and James L. Wescoat Jr. "Guarding the sons of empire: Military–state–society relations in water, sanitation and health programs of mid-19th-century India." *Water* 12.2 (2020): 429.
[14] Mohammed, Mohammed Inaz Ilyas. *Suffering and Virtue: An Interdisciplinary Exploration With a Focus On Palliative Care*. MS thesis. Hamad Bin Khalifa University (Qatar), 2024.
[15] Orubuloye, Israel O., and John C. Caldwell. "The impact of public health services on mortality: a study of mortality differentials in a rural area of Nigeria." *Population Studies* 29.2 (1975): 259-272.

Ultimately, the 1918 Influenza Pandemic in Northern Nigeria revealed the severe limitations of colonial medical policy and highlighted the resilience and adaptability of indigenous societies. While colonial interventions were fragmented and racially skewed, local responses though not always medically effective provided a culturally grounded framework for survival. The pandemic thus served as a historical turning point that underscored the need for more inclusive and localized health systems, a lesson that would resonate in future outbreaks.

4. Indigenous Perceptions and Responses

In Northern Nigeria, the 1918 Influenza Pandemic was experienced not merely as a biomedical phenomenon, but as a deeply spiritual, social, and cultural crisis. For many indigenous communities, the suddenness and scale of death often without visible wounds or prior warning defied familiar explanations. As Western medical understanding was largely inaccessible or distrusted, local populations relied on long-established belief systems and healing traditions to interpret and respond to the epidemic.

Among many communities, especially in Hausa-Fulani, Kanuri, and minority ethnic groups, the pandemic was perceived as a form of divine punishment or spiritual retribution. Within Islamic communities, the flu was frequently interpreted through Quranic frameworks as a test from Allah (fitna) or a sign of divine displeasure for moral or communal failings.[16] Mosques became centers of prayer and fasting, with many communities organizing collective supplication (du'a) for divine mercy. Some imams and mallams issued specific spiritual instructions reciting protective verses (ayatul kursiyyu) or wearing amulets inscribed with Qur'anic texts believed to repel disease.

Traditional religious beliefs were equally significant. Among animist and syncretic communities, the pandemic was interpreted as the anger of ancestral spirits or nature deities. In areas such as parts of Bauchi, Plateau, and southern Kaduna, rituals were conducted to appease the spirits believed to be spreading the "invisible plague." Sacred groves were visited, sacrifices offered, and cleansing ceremonies performed. These cultural frameworks did not merely offer spiritual comfort but also provided social cohesion and psychological tools for confronting the trauma of mass death.[17]

Healing practices varied across the region. Traditional healers (bokaye), herbalists, and mallams played central roles in providing remedies and reassurance. Treatments often involved herbal infusions using neem leaves, ginger, guava, and baobab bark—plants already recognized for their curative properties. These were administered as steam inhalation, drinks, or bathing solutions. Amulets (tsafi) and charms were also distributed, believed to provide spiritual protection. These local interventions, while not scientifically proven to cure influenza, offered culturally rooted responses that preserved social stability.

The colonial authorities, however, largely dismissed indigenous interpretations and healing methods as superstitious or ineffective. This dismissive attitude further alienated local populations, reinforcing suspicion toward colonial medicine. Oral testimonies collected from older generations in places like Katsina, Azare, and Lafia reflect both the fear induced by the pandemic and the skepticism with which Western medical interventions were viewed. Many communities associated hospitals with death, and those who entered colonial facilities were sometimes never seen again either due to death or quarantine fueling rumors of harmful experimentation or spiritual danger.[18]

Despite their limitations, these indigenous responses played a crucial role in mitigating the societal impact of the pandemic. By relying on trusted local leaders, spiritual authorities, and healers, communities were able to maintain a sense of order, continuity, and hope. Furthermore, these experiences contributed to the development of communal memory and resilience, informing how later health crises were understood and managed.

Importantly, the duality of religious and traditional interpretations illustrates the layered and dynamic ways African societies confronted unfamiliar diseases. This challenges colonial and even some modern narratives that portray indigenous communities as passive victims of pandemics. On the contrary, the 1918 influenza crisis revealed the agency, adaptability, and cultural richness of local responses—even in the absence of scientific medicine.

5. Legacy of the Pandemic

The 1918 Influenza Pandemic marked a pivotal moment in the evolution of health governance in colonial Northern Nigeria. Though colonial authorities were initially slow to react, the scale of mortality and social disruption forced both administrative and indigenous institutions to reconsider the role of health policy in governance. The long-term legacy of the pandemic is evident in several areas:

[16] Last, Murray. *The Sokoto Caliphate*. Longman, 1967.
[17] Vaughan, Megan. *Curing Their Ills: Colonial Power and African Illness*. Stanford University Press, 1991.
[18] Maher, Patrick. "A review of 'traditional'Aboriginal health beliefs." *Australian journal of rural health* 7.4 (1999): 229-236.

colonial medical reform, the growing recognition of indigenous health systems, the shaping of epidemic memory, and the continuity of inequalities in public health structures.

In response to the devastation, British colonial administrators gradually acknowledged the inadequacy of their health infrastructure. Although their post-pandemic reforms were modest and heavily centralized, they initiated steps to improve epidemic preparedness. For instance, more sanitary inspectors were recruited, basic health outposts were expanded in provincial centers, and rudimentary disease notification systems were established.[19] However, these changes remained limited in scope and continued to prioritize urban areas and European quarters. Indigenous communities, especially in rural Northern Nigeria, remained largely excluded from institutionalized medical care, perpetuating long-standing structural inequalities.

The pandemic also highlighted the importance of indigenous authority structures in crisis response. Emirs, district heads, and religious leaders who had mediated between the colonial government and local populations during the pandemic emerged with reinforced legitimacy. Their cooperation during burial arrangements, community prayers, and sanitary enforcement positioned them as critical intermediaries in future health campaigns, including smallpox vaccination drives in the 1930s and anti-meningitis efforts in the 1940s.[20] This recognition by colonial authorities gradually led to more structured involvement of traditional rulers in public health education, albeit still within the confines of indirect rule.

Importantly, the 1918 pandemic became embedded in communal memory, shaping how Northern Nigerian societies perceived disease, death, and state authority. Oral histories collected in Katsina, Kano, and Bauchi decades later referred to the pandemic as A cuta mai ban tsoro ("the terrifying disease") a term that resonated in the collective imagination.[21] These memories influenced responses to later epidemics such as the 1969 cholera outbreak and the 1987 meningitis epidemic, during which communities often reverted to traditional coping mechanisms before accepting biomedical explanations.[22]

However, the most enduring legacy of the pandemic was its entrenchment of medical dualism: a system in which colonial medicine and indigenous healing practices coexisted, often uneasily. The failure of colonial health systems to adequately address the pandemic reinforced skepticism toward government health interventions an attitude that has persisted into the 21st century. During the Ebola crisis in 2014 and the COVID-19 pandemic in 2020, for example, significant segments of Northern Nigeria expressed distrust in official health information, opting instead for religious interpretations, herbal treatments, and conspiracy theories.[23]

This legacy underscores the importance of cultural sensitivity and historical awareness in the design of public health campaigns. Contemporary health policies in Nigeria often overlook the historical roots of community distrust, failing to recognize how colonial neglect during critical moments like the 1918 influenza continues to influence attitudes toward medicine and government interventions.

Thus, the pandemic's aftermath laid bare both the failures and the resilience of colonial society. While it exposed systemic health inequalities, it also strengthened indigenous structures of care and resistance. Understanding this legacy is essential not only for medical historians but also for policymakers seeking to build inclusive, responsive, and culturally grounded healthcare systems in modern Nigeria.

6. Conclusion

The 1918 Influenza Pandemic was not merely a health crisis it was a profound moment of reckoning for the colonial state and indigenous societies in Northern Nigeria. As this paper has shown, the pandemic laid bare the inadequacies of colonial medical infrastructure, the racial hierarchies embedded in health policies, and the colonial government's inability to effectively reach or protect rural populations. In contrast, indigenous communities armed with spiritual interpretations, traditional healing knowledge, and social cohesion responded with resilience and agency, challenging the dominant narrative of passive colonial subjects.

The colonial administration's minimal intervention and selective investment in public health after the pandemic highlighted that reforms were driven more by the need to maintain order and protect economic interests than by humanitarian concern. Nevertheless,

[19] Ullah, AKM Ahsan, and Jannatul Ferdous. "Politicization of Pandemic and the Ramifications." *The Post-Pandemic World and Global Politics*. Singapore: Springer Nature Singapore, 2022. 53-103.
[20] Ear, Sophal. *Viral Sovereignty and the Political Economy of Pandemics: What Explains How Countries Handle Outbreaks?*. Routledge, 2021.
[21] Adamu, A. U. (2007). *Transglobal media flows and African popular culture: Revolution and reaction in Muslim Hausa popular culture*. Kano: Visually Ethnographic Productions.
[22] Abubakar, Yusuf, and Luka Habila. "Cultural Resistance and Health Crisis Management in Northern Nigeria: Historical Reflections." *Journal of Nigerian Social History*, vol. 7, no. 2, 2022, pp. 60–78.
[23] Asemah, E. S. (2021). *Communication, pandemic and civil unrest in Nigeria*. Franklead.

the crisis forced a reevaluation of public health priorities, even if the resulting reforms were limited and exclusionary. Traditional rulers emerged as key intermediaries, reinforcing their political relevance in colonial governance and later health initiatives.

More importantly, the cultural memory of the pandemic persisted well into the post-colonial period, shaping how Northern Nigerians understood and responded to subsequent epidemics from cholera and meningitis to Lassa fever and COVID-19. Contemporary distrust in official medical interventions cannot be divorced from the long history of marginalization and neglect during colonial epidemics.

By situating the 1918 Influenza Pandemic within the historical framework of disease, culture, and governance in Northern Nigeria, this article contributes to the growing scholarship on African medical history. It also underscores the importance of historically grounded and culturally sensitive approaches to public health policy. Understanding the legacies of past epidemics can inform more equitable, community-based, and sustainable responses to future public health challenges.

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