

# BRITISH COLUMBIA FIRST NATIONS AND THE INFLUENZA PANDEMIC OF 1918-19<sup>1</sup>

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That was the time all that bunch of Indians come out here and they figured if they got off up here in the bush that they would get away from the flu. There was 16 of them come out here ... They had a big camp at Spey Creek ... about 3 miles up river here. They camped there and one of them used to come down here to the house to get milk all the time. Dad would question him about what was the matter with him. He'd sit on the steps here and just shake all over. All he'd say was "sick, sick" all the time. Well there was no reason for him to tell you he was sick. You could see he was sick. But anyway, in a few days he come for a while, for milk and in a while he didn't come anymore. My Dad heard them shooting one night up there. He just thought they were shooting beaver or moose or something that way. But this Indian didn't show up anymore. So, in 2 or 3 days he went to see what was the matter with them. It turned out they were all dead around the camp there. There were just dead bodies lying everywhere. Just where death had overtaken them.<sup>2</sup>

**I**n many ways, the influenza pandemic of 1918-19 is the "forgotten" epidemic; forgotten, at least, by scholars studying British Columbia's First Nations. Much attention has been paid to the timing and severity of late eighteenth- and early nineteenth-century epidemics for what they tell us about proto-historic and early contact culture and population change. Scholars have argued the significance

<sup>1</sup> Special thanks to the participants of The Spanish Flu Pandemic After 80 Years – Reflections on the Influenza Pandemic of 1918-1919 Conference in Cape Town South Africa, September 1998, especially Ann Herring, Terence Ranger, and Lisa Sattenspiel for comments and helpful advice. All errors remain my own.

<sup>2</sup> Ernie Kaesmodel, "Stone Interview" (unpublished interview), Willow River, British Columbia, 8 June 1997.

of these epidemics in softening up indigenous societies for the onslaught of colonization. Few, however, have examined later disease patterns for what they tell us about the nature of cross-cultural relations in the early twentieth century.<sup>3</sup>

At least in part, this academic amnesia is due to an absence of reliable data. For three years, from 1917 to 1919, the Department of Indian Affairs reported that there were exactly the same number of births and deaths each year on reserves across the province (Figure 1). This is clearly impossible, and other government agencies recount different figures. The Vital Statistics Branch reported 670 flu-related deaths among First Nations between October 1918 and June 1919, but it had begun to record vital events among registered Indians just one year before, and officials knew that under-reporting was likely.<sup>4</sup> Meanwhile, locked away in the offices of Department of Indian Affairs in Ottawa, agents' reports, probably the most reliable population data available (although no doubt imperfect), showed numbers of dead at nearly twice the reported figures. Across the province, agents recorded that 1,139 Aboriginal people had died from the flu in British Columbia. They also noted that, given the number who, like the Carrier (described in the above quotation), had fled into the bush, their figures were probably low.<sup>5</sup> Clearly, the flu had been much more devastating among First Nations than the department's own reporting permitted Canadians to know.<sup>6</sup>

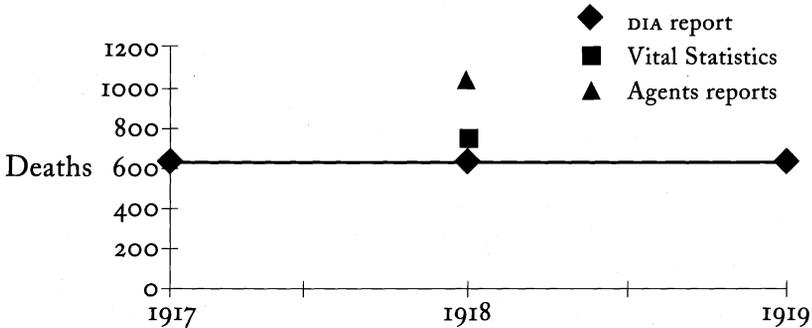
<sup>3</sup> To a certain extent, this is the result of the relative absence of material on twentieth century First Nations history more generally. Some exceptions exist, however, including: Michael Harkin, "Contested Bodies: Affliction and Power in Heiltsuk Culture and History," *American Ethnologist* 21, 3 (1994): 586-604; and Steven Acheson, "Culture Contact, Demography and Health Among Aboriginal Peoples of British Columbia," in *A Persistent Spirit: Towards Understanding Aboriginal Health in British Columbia*, ed. Peter H. Stephenson et al. (Victoria: University of Victoria, 1995).

<sup>4</sup> British Columbia, "Vital Statistics, 1919," British Columbia, *Sessional Papers*, 1920.

<sup>5</sup> National Archives of Canada (NAC), National Health and Welfare, Record Group (RG) 29. vol. 853-096. 1 May 1919.

<sup>6</sup> The reasons for this faulty reporting are unclear. It may simply be a symptom of a larger indifference to First Nations issues, or it may have been an attempt to keep the true impact of this epidemic out of the hands of government critics. Certainly the former chief medical officer for the Department of Indian Affairs, Dr. Peter Henderson Bryce, had tried to embarrass the government when he discovered the tremendous tuberculosis mortality within residential schools. The department may have feared further embarrassment if the flu figures were published. On the other hand, the public was made aware of the devastation the flu was causing on reserves in British Columbia through newspaper reports, something they surely would have read much more avidly than the turgid Department of Indian Affairs reports. Whether intentional or not, the department's figures make studying the impact of the flu in British Columbia a very interesting and intense research question.

FIGURE 1  
Reported Flu Deaths Among First Nations, 1918



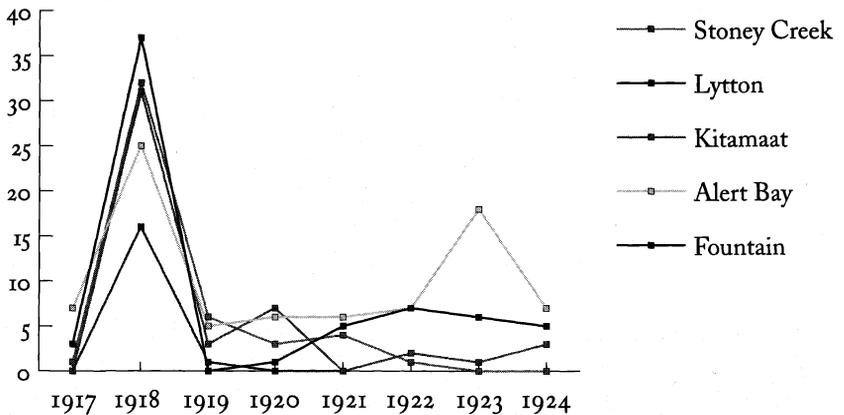
Yet First Nations people have not forgotten the flu, and, in their own histories, the pandemic of 1918-19 stands out along with the earlier epidemics that have caught the attention of so many academics. There are a number of reasons for this prominence. First, like smallpox and other diseases of the past, First Nations writers remember that the flu devastated their communities. Even using the faulty data that we have, it is clear that the Aboriginal population suffered higher relative mortality (as compared to population) than did their non-Native neighbours. The death rate for the flu among the non-Native population in British Columbia was 6.21 per 1,000 people; for the First Nations it was 46 per 1,000 people.<sup>7</sup> Mortality graphs for reserves across the province spike in 1918, with most deaths occurring in the months of October and November (Figure 2).

But there are more to the memories of the disease than the deaths. And that is why the flu appears so prominently in the published histories that First Nations write and address to others outside their own communities.<sup>8</sup> Although these histories do not represent a “pan-Native” perspective, they do share certain commonalities, and one of these is the eminence they give disease episodes like the flu, which they present as key moments in their histories. And this, I believe, suggests that talking about disease provides a useful mechanism for speaking about the nature of Native/non-Native relations in a way

<sup>7</sup> NAC, National Health and Welfare, RG 29. vol. 853-096. 1 May 1919; “Vital Statistics, 1919,” British Columbia, *Sessional Papers*, 1920.

<sup>8</sup> I have focused here on published First Nations histories because these are intended for both a Native and a non-Native audience and provide a means for Native youth who are not connected to systems of traditional teaching as well as non-First Nations people to get a sense of what is important to these writers about their pasts.

FIGURE 2  
*Yearly Deaths Recorded by Vital Statistics*



that is both poignant and concrete. Because, like the smallpox of the past, itself only one of a steady stream of so-called “virgin-soil epidemics” in the early contact period, the flu is remembered primarily because it was emblematic of the times. For, just as smallpox seemed to reveal the danger of contact with Europeans in the early history of British Columbia, so, too, did influenza show that disease could still devastate no matter how “modernized” Aboriginal people had become. Indeed, for some Aboriginal observers, influenza seemed linked to assimilation. In a related way, the influenza epidemic showed the hypocrisy of the Euro-Canadian medical establishment’s claim to supremacy over all other forms of medicine. First Nations responses, then, validated the mixing of medical forms in which they drew on both indigenous and imported understandings of disease, its causes and treatments. In a sense, by looking at the flu from the perspective of what Aboriginal people have said about it, we see that it acts as a kind of touchstone to describe the nature of corporeal relations between Aboriginal and non-Aboriginal peoples in British Columbia in the first decades of the twentieth century.

At the core of this article is an attempt to understand why the flu has been memorialized so prominently in published First Nations-authored histories. A detailed study of available primary sources, both in church and government archives, sought to determine the spread of the disease and its demographic impact. Oral history interviews were conducted to personalize the numbers and to add faces, names, and relationships

to the picture of the flu that emerged from non-Native sources. Then ethnographic work was consulted to try to tease out the ways in which Native authors have used the story of the flu in their histories. And so this article begins by setting the influenza epidemic within the context of First Nations health and healing in the first half of the twentieth century. Then it turns to the specifics of the epidemic, its progress through the province, and the responses first of the non-Native community and then of the First Nations. We find that the First Nations responded in ways that were similar to their Euro-Canadian neighbours but also in ways that were either distinctly indigenous or that showed a high degree of cultural blending. At the core of many responses, however, was an abiding belief in their own notions of disease etiology.

#### THE FIRST NATIONS IN 1918

By the first decades of the twentieth century, the First Nations of British Columbia had been in contact with Europeans for over 100 years. Historically, the Aboriginal economy had been based on gathering, hunting, and fishing in an environment of seasonally rich abundance. The societies of the Northwest Coast, particularly, created sophisticated social structures, complex cultures, and highly developed political systems.

Late in the eighteenth century, imperial inquisitiveness brought navigators and map-makers like James Cook and George Vancouver to the coast. Maritime fur traders followed in their wake, trading metal goods, clothing, blankets, and wealth items to the First Nations for highly prized sea otter pelts. By the early nineteenth century, the maritime phase of the trade was eclipsed by the land-based trade, and fur trading posts were established by the Hudson's Bay Company along the Coast and in the Interior.<sup>9</sup>

Contact brought disease and, beginning with smallpox epidemics in the late eighteenth century and followed by myriad other acute crowd infections, reduced the Aboriginal population considerably by the mid-nineteenth century.<sup>10</sup> Meanwhile, gold rushes of the 1850s and 1860s and the establishment of outposts of mercantile capital at

<sup>9</sup> Robin Fisher, *Contact and Conflict: Indian-European Relations in British Columbia, 1774-1890*. 2nd ed. (Vancouver: UBC Press, 1992), 1-48; Cole Harris, *The Resettlement of British Columbia: Essays on Colonialism and Geographical Change* (Vancouver: UBC Press, 1997), 31-67; Loraine Littlefield, "Women Traders in the Maritime Fur Trade," in *Native People Native Lands: Canadian Indians, Inuit and Metis*, ed. Bruce Alden Cox (Ottawa: Carleton University Press, 1988): 173-83.

<sup>10</sup> Harris, *Resettlement*, 3-30

fur trading posts and fish canneries encouraged the extension of administrative control over the traditional territories of some twenty-nine nations by the 1870s. Joseph Trutch, Gilbert Malcolm Sproat, and Peter O'Reilly all worked, in starkly different ways, to allocate reserve lands to the First Nations. All the rest of the province's land was opened up to settlers and the pursuit of their economic interests. Administratively, the First Nations were divided into a number of agencies (fifteen in 1918) to be supervised by Indian agents appointed by the Department of Indian Affairs. Missionaries earnestly ministered to the First Nations, beginning in the 1850s, and the first residential schools started in the 1890s and furthered the Christianization of the people. By the 1890s, the combination of Aboriginal population decline and the growth of a settler population meant that the First Nations were outnumbered on their own land.<sup>11</sup>

So by the early twentieth century, the First Nations had already undergone considerable cultural change, and much of this change affected their health. Reserve allocations were constantly subject to alteration according to government, settler, or missionary wants. In 1912-15, the McKenna-McBride Commission toured the province conducting hearings on the subject of reserve lands. Many Aboriginal leaders complained to this commission that the reserves were inadequate to their needs. There was not sufficient room to grow crops or raise cattle, and, even if there had been, few reserves had adequate water supplies either for personal or agricultural uses. The people had, at the urgings of missionaries and Indian agents, adopted European-style housing, which the same spokespeople for European "civilization" frequently decried as being overcrowded, under-ventilated, and unclean. Few reserves had adequate sanitation systems.<sup>12</sup> While much traditional food was still available and still popular among the First Nations, traditional subsistence patterns had been abbreviated and adapted to the changing economy of British Columbia.<sup>13</sup> Coastal groups particularly found themselves more often at the fish canneries (numbering nearly fifty in 1911) in the summer and fall than at lineage-controlled fishing sites.<sup>14</sup> Interior and some coastal groups travelled

<sup>11</sup> Fisher, *Contact and Conflict*.

<sup>12</sup> British Columbia, "Proceedings," *Royal Commission on Indian Affairs for the Province of British Columbia*, 1912-15.

<sup>13</sup> James Andrew McDonald, "The Marginalization of the Tsimshian Cultural Ecology: The Seasonal Cycle," in Cox, *Native People Native Lands*, 199-218.

<sup>14</sup> McDonald, "Marginalization," 208; Alicja Muszynski, *Cheap Wage Labour: Race and Gender in the Fisheries of British Columbia* (Kingston and Montreal: McGill-Queen's University Press, 1996), 134.

throughout the summer and fall harvesting berries and hops. Conditions at the canneries and the hopfields left much to be desired. At the canneries, housing was allocated according to race, with Aboriginal people getting only crude shacks, often without adequate sanitation, in which to set up housekeeping for months at a time.<sup>15</sup> At the hopfields of the Fraser Valley, torrential rains could flood latrines and deprive families of dry clothing or habitation.<sup>16</sup> Residential schools contributed to a general state of ill-health among First Nations, as they, through underfeeding, overwork, and various forms of abuse, weakened the children for whom they were supposed to care. Early in the century reports of the Department of Indian Affairs decried “the scandalous procession” that led from the schools to the cemeteries.<sup>17</sup>

At the same time, the government attempted to wean First Nations from their own medicine by appointing departmental physicians to each agency and by outlawing, through an 1885 amendment to the Indian Act, much Aboriginal ceremony. Departmental physicians were, however, a mixed bag. Few saw work among First Nations as a vocation, and most took departmental contracts in order to supplement the meagre incomes to be had from private practice in remote locations in the province. Though some of the doctors were industrious, innovative, and caring, too many were practising medicine on the frontier because no other place would have them. More than one departmental physician would have lost his/her contract with the Department of Indian Affairs for drunkenness, incompetence, or old age had there been another doctor to fill his/her place. Quite often there wasn't, or if there was, the replacement physician was not much better. Few good doctors stayed in these positions, so turnover was high, and long vacancies at posts were common. Even the good doctors, who had a commitment to rural British Columbia, frequently divided their practices with the local non-Native settlement and had a contract with the railroad or church in addition to their work with the Department of Indian Affairs. And, after 1902, when doctors' payment changed from a per-visit basis to a very low fixed salary,

<sup>15</sup> NAC, DIA, Black Series, RG 10 v4045, f351304, various correspondence, 1915, 1916; NAC, DIA, Black Series, RG 10 VIII42, Shannon file, CR 10 pt. H; Tommie Williams to Agent, 30 July 1927; NAC, DIA, Black Series, RG 10 v4045, f351304; Headquarters to Dr. Gregory Amyot, Provincial Health Officer, 7 March 1940.

<sup>16</sup> NAC, DIA, Black Series, RG 10 v4045, f351304, various correspondence, 1910, 1912, 1920, 1922, 1927, 1939; Author's possession, taped interview, Nancy Phillips, 23 March 1993, Chehalis, BC; taped field notes, Frank Malloway, July 1993, Chilliwack, BC.

<sup>17</sup> Mary-ellen Kelm, *Colonizing bodies: Aboriginal Health and Healing in British Columbia, 1900-50* (Vancouver: UBC Press, 1998), 57-82.

there was little incentive to spend more time on reserve when paying non-Native patients beckoned.<sup>18</sup>

All of these factors combined to suppress the health of the First Nations, and the early decades of the twentieth century seemed to offer little hope. Depending on how you count it, the Aboriginal population did not reach its nadir until the end of the 1920s or the early 1930s, and most populations were still declining when the flu struck in 1918. As a provincial whole, Aboriginal deaths overshadowed Aboriginal births in the years leading up to the First World War. In 1913, for instance, British Columbia Native people had the highest death rate of all First Nations (statistics compiled by province) except for those living on Prince Edward Island. That year the Aboriginal death rate in British Columbia was 40/1,000, and this exceeded the Aboriginal birth rate of 36/1,000.<sup>19</sup>

Within two decades the population did begin to grow, and this was attributable, especially at this time, to rising birth rates. Birth rates began to climb early in the twentieth century. Between 1912 and 1915, for instance, the Aboriginal birth rate rose from 25.3 to 27.1 live births per 1,000 population.<sup>20</sup> Accordingly, the number of children in Aboriginal communities grew, and the First Nations started to take on the form of a "young population." In 1915, for instance, fully one-third of the total population of British Columbia's First Nations were under the age of fifteen.<sup>21</sup>

Population recovery in this period was slow because, while birth rates were high, so were death rates – just one indication of high morbidity among First Nations. The neo-natal and postneo-natal death rates were particularly extreme, at least three times higher than those among the non-Native population. As late as the 1930s, in British Columbia an Aboriginal person was between three and four times as likely to die of a communicable disease as was a non-Aboriginal person.<sup>22</sup> Tuberculosis was the greatest contributor to the mortality

<sup>18</sup> NAC, NHW, IHS, RG 29 v2765, f822-1-A901, pt. 1, Paget, memo, 20 January 1915; NAC, NHW, IHS, RG 29 v2728, f811-2, Iver Fougner to Headquarters, 18 February 1929; British Columbia, *Royal Commission on Indian Affairs for the Province of British Columbia*, Stuart Lake Agency, 1915; NAC, NHW, IHS, RG 29 v2767, f822-1-A978, pt. 1, J.C. Rutledge to DIA, 23 August 1946; Richard Geddes Large, *Drums and Scalpel* (Vancouver, Mitchell Press, 1968), 89-90; NAC, NHW, IHS, RG 29 v2767, f822-1-A987, pt. 1, various correspondence, various dates; NAC, NHW, IHS, RG 29 v2766, f822-1-A974, pt. 1, C.C. Perry to Headquarters, 5 February 1934.

<sup>19</sup> P.H. Bryce, "Report of the Chief Medical Officer, 1913," Canada, *Sessional Papers*, 1914, 296.

<sup>20</sup> Canada, Department of Indian Affairs, "Reports," 1912-19.

<sup>21</sup> Canada, Department of Indian Affairs, "Reports," 1915, *Sessional Papers*, 1916.

<sup>22</sup> British Columbia, Vital Statistics, "Summary Tables, 1935, 1940," *Sessional Papers*, 1936, 1941.

rate, and non-Native observers noted with sorrow and fear the rate of young people swept away by the disease. Iver Fougner, the Indian agent at Bella Coola, wrote of the Heiltsuk and Nuxalk: "Many young people have died recently at Bella Bella, I regret to say that there are many sick at Bella Coola with the consumption."<sup>23</sup> And other diseases swept through Aboriginal communities with alarming frequency and tragic results. Measles, whooping cough, diphtheria, mumps, and chicken pox all appeared on reserves and in residential schools throughout the early twentieth century, leaving new graves in their wake.<sup>24</sup>

## THE FLU IN INTERNATIONAL CONTEXT

Amid these waves of infectious diseases, however, the flu of 1918 rises highest. Even within the international context, the 1918 flu epidemic was unprecedented. Conservative estimates put the total dead worldwide at twenty million more than those killed on all the battlefields of the First World War.<sup>25</sup> Despite its name, the "Spanish" influenza was spread through troop demobilization near the end of the First World War.<sup>26</sup> The particular strain of influenza that affected so many

<sup>23</sup> NAC, Department of Indian Affairs (DIA), Black Series, RG 10 v10888, Letterbook, Iver Fougner to Headquarters, 22 April 1913

<sup>24</sup> NAC, DIA, Black Series, RG 10 acc v-1988-89/206, box 10, file 3, Patients' Case Register, Port Simpson General Hospital, 1903-25; NAC, DIA, Black Series, RG 10 v6443, f881-1, pt. 1, Father N. Coccola, various correspondence on students at Lejac, 18 August 1931; RG 10 v6426, f875-1, pt. 3, St. Michael's Residential School, Alert Bay, *Newsletter*, September 1931, March 1934; RG 10 v6443, f881-1, pt. 1, L.H. Rivet, Lejac Residential School, correspondence re students, 31 December 1934; RG 10 v6432, f878-1, pt. 2, G. Forbes, St. Joseph's Residential School, 20 December 1934; NAC, DIA, Black Series, RG 10 v6436, f877-23, pt. 1, P.B. Ashbridge to Headquarters, 15 February 1937; NAC, DIA, Black Series, RG 10 v6467 f888-12 pt. 1, Reports from St. George's Residential School, Lytton, BC, 31 January 1937; NAC, NHW, IHS, RG 29 v2765, f822-1-A901, pt. 3, P.S. Tennant to Headquarters, 6 February 1937; NAC, DIA, Black Series, RG 10 v11142, Shannon File CR 10 pt. C, Mrs. Louie Jack to M.S. Todd, 10 March 1937; NAC, DIA, Black Series, RG 10 v6446, f881-13, pt. 2, R. Howe to Headquarters, 5 November 1942; RG 10 v6430, f876-1, pt. 1, P.B. Ashbridge to Headquarters, 1 May 1939; NAC, DIA, Black Series, RG 10, v1348, Letterbook, I.H. Todd to Headquarters, 22 August 1898; NAC, NHW, IHS, RG 29 v2768, f822-1-A987, pt. 1, P. Byrne to Headquarters, 5 December 1916; NAC, DIA, Black Series, RG 10 v6443, f881-1, pt.1, Correspondence from Coccola, Lejac Residential School, 31 December 1925; BCARS, Thomas Deasy Papers, Add. MSS 1182, vol. 1, file 2, Alfred Adams to Thomas Deasy, 30 October 1933.

<sup>25</sup> C. Graves, *Invasion by Virus* (London: Icon, 1969), 113.

<sup>26</sup> Janice P. Dickin McGinnis, "The Impact of Epidemic Influenza: Canada, 1918-1919," in *Medicine and Canadian Society*, ed. S.E.D. Shortt (Montreal: McGill-Queen's University Press, 1981), 448; Graves, *Invasion by Virus*, 21; F.M. Burnet and E. Clark, *Influenza* (London: Macmillan, 1942), 69; W.I.B. Beveridge, *Influenza: The Last Great Plague* (New York: Prodist, 1977), 42-3; M.M. Kaplan and R.G. Webster, "The Epidemiology of Influenza," *Scientific American* 237, 6 (1977): 89.

people in this epidemic appears to have been a new strain to which no one had immunity. It was, in fact, a virgin soil epidemic on a global scale.<sup>27</sup>

Influenza seldom causes alarm today because, though it has high morbidity, its mortality rates are, generally speaking, quite low. Not so in 1918. That variety of flu identified in 1933 as Influenza A had a morbidity rate ranging from 15 to 50 per cent and a death rate of 1 per cent.<sup>28</sup> Secondary infections were more deadly, and these developed in about 20 per cent of all cases. Streptococcal or staphylococcal infections led to pneumonia, and the deadly combination of flu and pneumonia had a mortality rate of 40 to 50 per cent.<sup>29</sup> In North American cities, the death rate ranged from 8.3 to 24.7 per 1,000 population.<sup>30</sup>

Those who got the disease faded quickly. Some survivors remembered the exact moment when symptoms developed; when their head and back began to ache and when they started to shake uncontrollably. They weakened and collapsed suddenly. People coughed up dark blood and their noses bled profusely. Sometimes they became delirious and had terrifying hallucinations. When pneumonia developed, patients lapsed into a "typhoidal state" characterized by cracked lips, a dry, shrunken, glazed, brown tongue, lint-picking fingers, incontinence and stupor.<sup>31</sup> Just before death, the afflicted turned blue and became exceedingly cold, and their bodies, deprived of hemoglobin, expired. The whole process took between eight and ten days, but in some cases complications arose within twenty-four hours.<sup>32</sup>

The disease began to circulate in March 1918 and was carried quickly around the world as troops demobilized near the end of the First World War. The infection invaded Canada in June 1918, when Canadian troops from England arrived at Montreal. Soon, one-third of the troops were affected, and, as the number rose, they were ordered decamped at Grosse Isle. Other troopships carried the flu to Halifax and Quebec

<sup>27</sup> D. Ann Herring, "There Were Young People and Old People and Babies Dying Every Week: The 1918-1919 Influenza Pandemic at Norway House." *Ethnohistory* 41, 1 (Winter 1994): 82.

<sup>28</sup> McGinnis, "Impact," 453

<sup>29</sup> Herring, "There Were Young People," 81, citing Burnet and Clark, *Influenza*, 88.

<sup>30</sup> Margaret W. Andrews, "Epidemic and Public Health: Influenza in Vancouver, 1918-1919." *BC Studies* 34 (Spring 1977): 21-44.

<sup>31</sup> Herring, "There Were Young People," 81, citing J.W. Walters, "Influenza 1918: The Contemporary Perspective," *New York Academy of Medicine* 54, 9 (1978): 855-64.

<sup>32</sup> Kelm, taped interview, Margaret Gagnon; E.A. Robertson, "Clinical Notes on the Influenza Epidemic Occurring in the Quebec Garrison," *Canadian Medical Association Journal* 9 (February 1919): 156; Jean E. Speare, editor, *Days of Augusta* (Vancouver: Douglas and McIntyre, 1992) 31; BCARS, Margaret Butcher "Journal," Add. MSS 362, 3 November 1918.

City.<sup>33</sup> By September the flu had reached Calgary, and on October 5 it was making news in the Vancouver papers.<sup>34</sup> Fifty cases were reported in Victoria, and the provincial Cabinet passed an order-in-council permitting communities to close all theatres. In the first three weeks of the epidemic, all Lower Mainland municipalities but Vancouver closed schools, theatres, and other public gathering places.<sup>35</sup> On October 8, the *Vancouver Sun* reported eight cases, all of which had been isolated.<sup>36</sup> Early deaths were of returned servicemen, but reports also implicated travellers from the east and from Tacoma and Seattle in the spread of the disease.<sup>37</sup>

Within a week, there were over 240 cases in Vancouver, and university classrooms were being taken over as makeshift hospitals to house those who could not be cared for in their own homes. In Vancouver, as elsewhere, the disease was thought to attack the poor and transient, and medical authorities compelled hotel, lodging, rooming, and apartment house keepers to see that anyone in their buildings who became sick sought medical attention.<sup>38</sup> Deaths seemed concentrated in the crowded Downtown Eastside.<sup>39</sup> By October 17, the *Sun* reported that, in the Vancouver area, there had been 412 civilian cases and 14 deaths reported, and 300 military cases and nine deaths reported. Women were urged to volunteer as nurses and, in Vancouver, where theatres and community halls stayed open, disinfectant manufacturers struggled to meet the demand for their products. By mid-October, Vancouver's schools were shut and a brief city closure soon followed.<sup>40</sup> Within days, the number of civilians infected rose to 619 cases, with 16 deaths.<sup>41</sup> On October 22, Vancouverites learned that nearly 1.5 per cent of the total Vancouver population had contracted the disease, for a total of 1,516 cases and 55 deaths. When the armistice was declared on November 11, officials reported that there had been 3,871 cases in Vancouver, with 390 deaths.<sup>42</sup>

Children seemed to fare better with the disease. Vancouver officials reported that only a handful of children had died, although many had gotten sick. Children of the Point Grey Industrial School and

<sup>33</sup> McGinnis, "Impact," 449

<sup>34</sup> *Vancouver Sun*, 8 October 1918, 1

<sup>35</sup> *Ibid.*

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*, 9 October 1918, 11.

<sup>38</sup> *Ibid.*, 15 October 1918, 1.

<sup>39</sup> *Ibid.*

<sup>40</sup> Andrews, "Epidemic and Public Health," 34.

<sup>41</sup> *Vancouver Sun*, 18 October 1918, 1.

<sup>42</sup> *Ibid.*, 1 November 1918, 9.

the Alexandra Orphanage recorded morbidity rates of 79 per cent but reported few deaths.<sup>43</sup>

Victoria was similarly struck. The disease stormed from October 9 to the end of the month, with total cases nearing 1,000. Victoria, unlike Vancouver, quickly closed its public buildings, but crowds still gathered to greet returning troopships, spreading infection in the process.<sup>44</sup> Throughout the province, the disease spread along rail lines and other transportation links.<sup>45</sup> Towns and ranches along the Grand Trunk Pacific Railway were affected by the disease.<sup>46</sup> Beyond the Lower Mainland and Southern Vancouver Island, the epidemic raged in the lumber camps and mines, where single men, many of them recent immigrants, lived in over-crowded conditions. J.M. Dempsey of the Dempsey and Ewart Logging Company noted that the flu had hit their camps badly but that by 10 November it had abated.<sup>47</sup> Twenty-eight miners, mostly immigrants from Scandinavia and Eastern Europe, at Anyox were buried by Anglican missionaries between 18 October and 5 November.<sup>48</sup> Britannia Mine managers apprised officials that there were over 100 cases there, and the disease affected the men of the lumber camps around Nelson, Rossland, Grand Forks, Prince Rupert, and along the North Thompson River.<sup>49</sup> Every major centre of the province reported cases of the disease. Transient workers and poor immigrants were particularly struck. A Doukhobour community near Grand Forks was reportedly hard hit.<sup>50</sup> In the Fraser Valley, Asian and Aboriginal agricultural workers were among the dead.<sup>51</sup>

## THE FLU IN ABORIGINAL COMMUNITIES

At the same time, the flu spread through the Aboriginal community swiftly. At Nanaimo, the first death was of an Aboriginal woman,

<sup>43</sup> *Ibid.*, 2 November 1918, 3.

<sup>44</sup> *Victoria Colonist*, 15 October 1918, 6.

<sup>45</sup> *Ibid.*, 21 October 1918; Vancouver School of Theology, Anglican Church Archives, Bulkley Valley Parish Register, November 1918; Prince Rupert *Daily News*, 29 October 1918.

<sup>46</sup> Vancouver School of Theology, Anglican Church Archives, Bulkley Valley Parish Register, November 1918.

<sup>47</sup> *Vancouver Sun*, 10 November 1918, 3.

<sup>48</sup> Vancouver School of Theology, Anglican Church Archives, Parish Registers, Christ Church Anyox, 1918.

<sup>49</sup> *Victoria Colonist*, 21 October 1918, 22 October 1918; Kamloops *Daily Telegraph*, 31 October 1918; Prince Rupert *Daily News*, 4 November 1918; Grand Forks *Gazette*, 15 November 1918, 22 November 1918.

<sup>50</sup> Grand Forks *Gazette*, 6 December 1918.

<sup>51</sup> *Chilliwack Progress*, 28 November 1918.

Mrs. Phillip Frenchie.<sup>52</sup> Other members of her family soon followed.<sup>53</sup> Here, again, the disease spread along the railways and steamship routes. And the time could not have been worse, for disease hit just as the canneries were gearing down for the season. At Klahoose, 200 cases were reported and the disease spread from the cannery to the nearby Sliammon reserve.<sup>54</sup> The cannery at Tuck's Inlet was reported to have nearly 100 cases on October 29.<sup>55</sup> When the flu hit the canneries of the north and central coast, many workers returned home, bringing the disease with them. Nisga'a cannery workers returned to their communities in October and were soon immobilized by the flu. They were unable to preserve fish for the winter or harvest their gardens.<sup>56</sup> In all, 92 per cent of the Nisga'a people were stricken with the disease; the mortality rate in the same agency was 27 per 1,000 population.<sup>57</sup> Among the nearby Tahltan, the situation seemed dire. As one missionary wrote of his Tahltan congregants, "One by one, I saw this disease knocking out my flock."<sup>58</sup> The disease came to Bella Bella, according to the Methodist missionary George Darby, aboard the SS *Venture* and spread quickly through the village. Though he tried to quarantine the first ones taken ill, with each new boat from the canneries new cases arrived until even those who were away at camp drying salmon were taken ill. At Bella Bella there were, he estimated, 200 cases and thirty-five deaths. The nearby coastal communities of Klemtu and Oweekano were similarly struck. Kitamaat was infected when a boat from Swanson's Bay brought the disease from the canneries.<sup>59</sup> At Kitamaat, there were two or three burials a day, and those who were well enough to stand helped with the taking out of the bodies. Twenty-nine were dead by 3 November 1918, and a handful more were not expected to live.<sup>60</sup> Forty-five per cent of those who were reported to have died were children under the age of ten.<sup>61</sup> The flu was said to be very bad at Kitwanga, where it came either from people returning from the canneries or was transmitted by travellers along the Grand

<sup>52</sup> *Victoria Colonist*, 18 October 1918.

<sup>53</sup> British Columbia, Vital Statistics, Death Registration, Aboriginal Deaths, reel B13359.

<sup>54</sup> *Victoria Colonist*, 26 October 1918.

<sup>55</sup> *Prince Rupert Daily News*, 29 October 1918.

<sup>56</sup> J.B. McCullough, *North British Columbia News*, 6, 36 (January 1919): 13.

<sup>57</sup> RG 29 v853-096; J.B. McCullough, *North British Columbia News* 6, 36 (January 1919): 13.

<sup>58</sup> F.P. Thorman, "From Liverpool to Telegraph Creek," *North British Columbia News* 6, 36 (January 1919): 17.

<sup>59</sup> "Heavy Toll of Lives from Influenza among Our Indian People," *Missionary Outlook* (March 1919): 33.

<sup>60</sup> BCARS, Margaret Butcher, "Journal," Add, mss 362, 3 November 1918.

<sup>61</sup> British Columbia, Vital Statistics, Death Registrations, Aboriginal Deaths, reel B13359.

Trunk Pacific Railway.<sup>62</sup> At Kispiox, over twenty died from flu-related illnesses.<sup>63</sup> Even the relatively isolated community at Kitkatla suffered eleven deaths from the disease.<sup>64</sup>

At Prince Rupert, the urban Aboriginal population seems to have suffered more than that of the nearby reserves at Port Simpson and Metlakatla. The situation in Prince Rupert was so bad that the medical missionary Richard Large moved his practice from Port Simpson and worked out of the makeshift hospital at the Salvation Army Citadel. In Prince Rupert officials feared that Aboriginal workers in the city, isolated from their families, would die alone and uncared for in the city's various boarding houses. As dead were found in rooming houses in the city, their fears were confirmed.<sup>65</sup> Along the coast, only the Haida experienced relatively few deaths, saved, at least in part, by a quarantine placed on the Queen Charlotte Islands to ensure that there would be no disruption in spruce production, which was considered essential to the war effort.<sup>66</sup>

Along the Fraser Valley and in the Interior, the First Nations were particularly hard hit. At Chilliwack, all the students at Coqualeetza Residential School were affected, and one child, from Skidegate, died.<sup>67</sup> All the children at St. Mary's Residential School also became ill, and there was little that could be done for them. As Lil'wut elder Mary Englund remembers:

We got it. We just stayed right in bed; every girl that was in the convent was in bed. I was so sick then. I tried to fight it, you know, and the nun kept saying, 'you'd better go to bed', she'd say. So finally, I went to bed and she came up stairs and took my temperature. My temperature wasn't too bad, so I went to bed and I just covered up and I stayed right in bed. I'd cover my head and all and just stayed right there. Every once in a while the nun would come by and she'd say, "Are you still alive?"<sup>68</sup>

Here, as well, only one child died. But at nearby Pitt Meadows, forty deaths occurred among an Aboriginal population of 260.<sup>69</sup> Further

<sup>62</sup> Prince Rupert *Daily News*, 2 November 1918.

<sup>63</sup> Vancouver School of Theology, Anglican Church Archives, Kispiox Parish Register, 1918.

<sup>64</sup> Ibid.

<sup>65</sup> Prince Rupert *Daily News*, 17 October 1918.

<sup>66</sup> *Victoria Colonist*, 21 October 1918, 6; NAC, DIA, RG 10 v6422, f869-1, Deasy to DIA, 4 December 1918.

<sup>67</sup> *Chilliwack Progress*, 21 November 1918.

<sup>68</sup> Authors' possession, taped interview, Mary Englund, Lillooet, BC.

<sup>69</sup> NAC, DIA, RG 10 v6422, f869-1, Deasy to DIA, 4 December 1918.

inland, the Lil'wut were affected especially badly by the disease. Fourteen hundred cases were reported, and, by the end of October, seventy-one from that agency were dead. The Fountain reserve alone reported thirty-five deaths.<sup>70</sup> Near Big Bar, a police constable came across a grisly scene where two children lay dead in their beds, as others in the house were too sick to bury them.<sup>71</sup> At Lytton, the Indian agent J.W. McKay recorded that 10 per cent of the population had died, and Annie York remembered that there were "a lot of widows" at Spuzzum after the epidemic.<sup>72</sup> Further north, among the Carrier, the death rate was high. Nearly one-third of the population at Stoney Creek was carried off by the disease; half were under the age of twenty. In one family, three generations were wiped out in four weeks. Seventy-four people died at Nakazdli.<sup>73</sup> Carrier elder Margaret Gagnon remembers that when she was able to get out of bed, her reserve at Shelley was like a ghost town.<sup>74</sup> Cumulatively, there were more deaths among Aboriginal people during that one epidemic than for any full year leading up to or following 1918.<sup>75</sup>

The death rate for the flu among First Nations was over nine times higher than that for non-Natives across the province.<sup>76</sup> Here British Columbia does not appear to have been unique. Death rates in some western American states were even higher, with the flu killing 11 per cent of all Native Americans in Arizona, 12 per cent in Colorado and New Mexico, and 16 per cent in Utah.<sup>77</sup> And, in British Columbia, the disease affected the Native population differently than it did the non-Native population. Usually the flu took those in the prime of life. The reason for this predilection is still being debated among flu

<sup>70</sup> British Columbia, Vital Statistics, Death Registrations, Aboriginal Deaths, reel B13359

<sup>71</sup> Kamloops *Telegraph*, 28 November 1918; Vernon *News*, 7 November 1918.

<sup>72</sup> Andrea Laforet and Annie York, *Spuzzum: Fraser Canyon Histories, 1808-1939* (Vancouver: UBC Press, 1998), 27.

<sup>73</sup> Lizette Hall, *The Carrier My People* (Cloverdale: Friesen, 1992), 20; Bridget Moran, *Stoney Creek Woman: The Story of Mary John* (Vancouver: Tillicum, 1988), 24-5; BCARS, Denys Nelson Papers, Add. MSS 1175, vol. 4, file 1, unpublished biography of Coccola, p. 81, 1924; Margaret Whitehead, ed., *They Call Me Father: Memoirs of Father Nicholas Coccola* (Vancouver: UBC Press, 1988), 173-4; British Columbia, Vital Statistics, Death Registrations, Aboriginal Deaths, reel B13359.

<sup>74</sup> M.E. Kelm, taped interview with Margaret Gagnon, 25 September 1993, Prince George, BC.

<sup>75</sup> NAC, NHW, RG 29 v853-096, May 1919; Canada, Department of Indian Affairs, "Reports," *Sessional Papers*, 1916-20.

<sup>76</sup> NAC, National Health and Welfare, RG 29 v853-096, 1 May 1919; British Columbia "Vital Statistics, 1919," British Columbia *Sessional Papers*, 1920.

<sup>77</sup> United States, *Public Health Report*, 9 May 1919, 1008-1009, cited in V.W. Steele, "The 1918 Influenza Epidemic in Montana," paper distributed at The Spanish Flu Pandemic After 80 Years - Reflections on the Influenza Pandemic of 1918-1919 Conference, 12-15 September 1998, Cape Town, South Africa.

scholars and has yet to be explained.<sup>78</sup> Yet, among First Nations, many children and elders were taken by the disease. At Stoney Creek, the death rate for children under the age of six was 133 per 1,000 population; at Kitamaat it was 224 per 1,000 population. Stoney Creek elders also died at horrendous rates. Put simply, four of the six elders aged over sixty-five reported to be alive in 1917 died in October 1918 (See Chart 1).

CHART 1

*Crude Death Rates (per 1,000 population) by Age:  
Selected Communities*<sup>79</sup>

COMMUNITY	AGE	RATE /1,000	COMMUNITY	AGE	RATE /1,000
<b>Lytton:</b>	<6	1.2	<b>Stoney Creek:</b>	<6	133
	6-15	0		6-15	222
	16-20	59		16-20	294
	21-65	34		21-65	216
	>65	15		>65	666
<b>Fountain:</b>	<6	152	<b>Kitamaat:</b>	<6	224
	6-15	38		6-15	63
	16-20	138		16-21	39
	21-65	202		21-65	25
	>65	190		>65	125

The reasons for this pattern are rooted in the pre-epidemic health conditions among First Nations peoples. In many cases, the flu simply exacerbated pre-existing disease, particularly tuberculosis.<sup>80</sup> This especially affected elders and young people between six and twenty years. For the young people, tuberculosis was often the result of having been taught in a residential school. Peter Henderson Bryce's 1907 study showed that 69 per cent of the young people who had graduated from residential schools on the Prairies were dead within fifteen years,

<sup>78</sup> R.S. Katz, "Influenza Pandemics in Perspective." *Bulletin of the History of Medicine*, 48 (1974):417; K.D. Patterson, *Pandemic Influenza 1700-1900* (Totowa, N.J.: Rowman and Littlefield, 1986): 88, cited in P. Zylberman, "A holocaust in a holocaust: The 1918 'Spanish' influenza epidemic in France and the Great War." Paper presented at the "1918 flu epidemic: 80 years after" conference, 12-15 September, 1998, Cape Town South Africa.

<sup>79</sup> Based on 1917 D1A Reports and Vital Statistics for October and November 1918. Since only slightly more than half of all known Aboriginal deaths due to flu were reported to Vital Statistics, it is safe to assume that the actual figures would be higher.

<sup>80</sup> Canada, D1A, "Report, 1918." *Sessional Papers*, 1919.

mainly from tuberculosis or related complications.<sup>81</sup> Where the flu and tuberculosis compounded one another, death rates were high.

Younger children, too, suffered from lung diseases that made them more susceptible to the deadly secondary infections associated with the 1918 influenza pandemic. In the first half of the twentieth century, 20 per cent of all deaths on Indian reserves were among children under the age of one; of these, 25 per cent died of bronchial-pneumonia. A further 12 per cent of all Aboriginal deaths occurred during the next five years of life. The arrival of the flu put further strains on a population of children that was already weakened by disease, especially disease affecting the lungs. A more potent and deadly combination is hard to imagine. Limited access to medical care and poor reserve conditions (including over-crowding, inadequate access to nutritious food and clean water, and insufficient sanitation) contributed to the higher mortality rate among First Nations in general and, especially, among Aboriginal children.<sup>82</sup>

#### PUBLIC RESPONSE TO THE DISEASE

Throughout the province, people responded in a variety of ways. Many municipalities banned public meetings, closed schools, churches, theatres, and pool rooms. By October 21, thirty-seven municipalities, including Chilliwack, New Denver, and Grand Forks, had enforced such closures. Temporary hospitals were set up, first for those who had no one to care for them, but, later, doctors recommended that all flu sufferers make their way to a hospital in order to prevent complications from arising. Firehalls, schools, churches, even university classrooms provided makeshift accommodation for the afflicted.

Except for basic nursing care, the prevention of dehydration, and attempts at quarantining, there was little that the medical profession could do to stop the disease. There was (and is) no cure for influenza. Attempts to make an effective vaccine were unsuccessful.<sup>83</sup> Many people resorted to patent medicines despite doctors' warnings that such concoctions could be dangerous, showing the rather tenuous hold that allopathic medicine still had over a distressed public. Victoria drugstores, for instance, could not keep up their supply of cinnamon essence and cinnamon bark, both believed to be effective

<sup>81</sup> Kelm, *Colonizing Bodies*, 64.

<sup>82</sup> *Ibid.*, 7-9.

<sup>83</sup> McGinnis, "The Impact," 457-8.

in beating the flu.<sup>84</sup> Patent medicine companies ran huge ads in the provincial newspapers promoting their products as the “only” effective preventive or cure for the disease.<sup>85</sup>

Aboriginal people too responded in a number of ways that fit both within their own and the adopted systems of healing around them. Many availed themselves of non-Native medicine. Evangeline Pete, a Sto:lo elder, remembers going to hospital with her whole family when they got the flu. They stayed for three months. Her brother died there and her father was so weakened by the disease that he died a year later.<sup>86</sup> Others checked themselves into the segregated barracks designated for “Indians” in Kamloops.<sup>87</sup> Fourteen cannery workers made their way to the Port Essington hospital; five died.<sup>88</sup> Some Carrier men were treated at the Prince George Hospital.<sup>89</sup> But many who wanted to use Euro-Canadian medicine were denied the opportunity. Departmental doctors, their allegiances almost always divided, focused their attention during the epidemic on their non-Native patients. Carrier elder Mary John remembers that the departmental physician did not visit Stoney Creek once during the epidemic.<sup>90</sup> In other cases, the shortage of doctors for these positions meant that doctors taken sick or even killed during the epidemic were not replaced. The 1,400 Lil’wut who were taken ill during the epidemic lost their only doctor when Dr. McPhail died of heart failure and no replacement could be found.<sup>91</sup>

Others used their own medicine; some with good results. Heiltsuk people used devil’s club, swamp gooseberry, and water hemlock for relief during the Spanish flu epidemic.<sup>92</sup> The Gitksan also used devil’s club.<sup>93</sup> The səxʷneɔ̃m of the Spuzzum people were diligent in their attempts to cure their people of the dread disease.<sup>94</sup> Tsil’co’tin people brought in a renowned healer called Abiyan.<sup>95</sup> People also used non-

<sup>84</sup> *Victoria Colonist*, 9 October 1918, 7.

<sup>85</sup> See Grand Forks *Gazette*, 25 October 1918.

<sup>86</sup> Sto:lo Nation, Archives, “Evangeline Pete Story,” typescript, n.d.

<sup>87</sup> Kamloops *Telegraph*, 5 November 1918.

<sup>88</sup> NAC, DIA, Black Series, RG 10 acc v-1988-89/206, box 9, file 2, Port Essington Hospital Casebook, 1918; RG 10 acc v-1988-89/206, box 10, file 3, Patients’ Case Register, Port Simpson General Hospital, 1918.

<sup>89</sup> Hall, *The Carrier*, 20

<sup>90</sup> Moran, *Stoney Creek Woman*, 24.

<sup>91</sup> Kamloops *Telegraph*, 14 November 1918.

<sup>92</sup> Margaret Whitehead, *They Call Me Father*, 53-4.

<sup>93</sup> BCARS, Marius Barbeau Papers, Add. MSS 2102, B-F-89.9, Benyon was informant to Marius Barbeau, 1920

<sup>94</sup> Laforet and York, *Spuzzum*, 126.

<sup>95</sup> Terry Glavin and the People of Nemiah Valley, *Nemiah: The Unconquered Country* (Vancouver: New Star, 1992), 90.

Native products in Aboriginal ways, and Aboriginal products in non-Native ways. Tsil'co'tin elder Eagle Lake Henry, for instance, used Lysol and rum to keep the flu away. The rum was administered like a prescription, and the Lysol was added to a water bath like Epsom salts. Eagle Lake Henry and his wife first cleaned their house with the Lysol but then daubed cloths in the disinfectant and hung them on the interior walls of the house, just as cedar might be hung in a house, to purify it.<sup>96</sup> Okanagan people sweat-bathed to cure themselves of the disease. They made tea from the mentholated sage brush of the region, and one observer later described it as "an infallible remedy for the Flu. Made into a strong tea and drinking it hot, effects a cure within three or four days with no after attack of [pneumonia]. It [was] a vile smelling, nauseating liquid."<sup>97</sup> Finally, people responded to the deaths in traditional ways as well, at least until they were overwhelmed by the number of deaths. At Kitamaat feasts followed the first two deaths, but, after that, the dead were buried unceremoniously and feasted later.<sup>98</sup> Others found themselves in deep existential crisis, trying to cope with the desire to heal the sick through shamanic power while remaining faithful to Christian teaching.<sup>99</sup>

First Nations peoples have also responded to the epidemic by incorporating it into their history, into the tellings that they present about the past to themselves and to non-Native audiences.<sup>100</sup> In these histories, we find hints of longer-term Aboriginal responses to the disease, of ways in which the disease has been incorporated into Aboriginal interpretations of the relationship between themselves, their non-Native neighbours, and the government.

The strongest element of all First Nations flu stories involves the ways in which they describe the horror of the epidemic. While mention is often made of the high morbidity and mortality of the epi-

<sup>96</sup> Ibid.

<sup>97</sup> Jay Miller, ed. *Mourning Dove: A Salishan Autobiography*. (Lincoln and London: University of Nebraska Press, 1990), 192

<sup>98</sup> Death Toll," *Missionary Outlook*, 1919.

<sup>99</sup> Jay Miller, "Tsimshian Religion in Historical Perspective: Shamans, Prophets and Christ," in *Tsimshian and Their Neighbours of the North Pacific Coast*, ed. Jay Miller and Carol M. Eastman (Seattle/London: University of Washington Press, 1984), 144-147.

<sup>100</sup> Recently, a number of autoethnographies written by First Nations people have allowed scholars to glimpse Aboriginal perspectives as they choose to present them rather than as ethnographers or others using oral history might present them. Those dealing with the early part of the twentieth century seldom fail to mention the flu. Some detail their interpretation of the event. These latter, which include Mary John in *Stoney Creek Woman*, Christine Quintasket in *Mourning Dove: A Salishan Autobiography*, and Eugene William in *Nemiab: The Unconquered Country*, have been particularly helpful.

demical, most striking are the authors' descriptions of how the disease broke down the boundaries between the living and the dead. Such boundaries, which include the limits between the inside and the outside of the body, are crucial and must be maintained for both individual and social health. The four main causes of disease in Aboriginal etiology relate directly to the breaching of these limits and involve: soul loss, spirit intrusion, object intrusion, and witchcraft.<sup>101</sup> The breaching of these boundaries, then, denotes not just profound physical distress, but the kind of spiritual disorder that can only lead to continued disarray.

Key elements in healing and in funerary rituals relate to the restoration and fortification of these boundaries.<sup>102</sup> Dead bodies must be properly treated for a variety of reasons. First, next of kin must, through purification and the care of their relatives, be protected from the soul of the deceased who may, through loneliness or vindictiveness, cling to the living, causing them to waste away and die. Next, the body itself must be protected from the evil designs of witches who might use its decomposition to cause illness in another. Finally, proper care of the body also ensures the appropriate passing of the soul into its next life. Without that passing, lineages, based as they are on the constant reincarnation of key figures, would simply die out. Proper care of the dead also functions to bind a community together in times of extreme emotion – times that might otherwise cause ill-feelings and social disarray. Graves provide linkages with the land, anchoring the dead and rooting the community to the land that gives life. A situation in which the dead are not properly treated, where their bodies lie unattended and in close proximity to the living, would be perceived to be profoundly dangerous.<sup>103</sup> And this is why much is made of the breaking down of the boundaries around the dead and of the living's unfulfilled

<sup>101</sup>James B. Waldram, D. Ann Herring, T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995), 102–3; Ronald L. Olson, *The social organization of the Haisla of British Columbia* (Berkeley, CA: University of California Press, 1940) 197; Wilson Duff, *Upper Stalo Indians of the Fraser Valley, British Columbia* (Victoria: Provincial Museum, 1972) 112; Aldona Jonaitis, "Liminality and Incorporation in the Art of the Tlingit Shaman," *American Indian Quarterly* 7, 3, (1983), 44–5; Marie-Françoise Guédon, "Tsimshian Shamanic Images," in *Tsimshian*, Margaret Seguin, editor (Vancouver: UBC Press, 1984), 208; Annie York, Richard Daly, and Chris Arnett, *They Write Their Dreams on the Rock Forever: Rock Writings in the Stein River Valley of British Columbia* (Vancouver: Talonbooks, 1993) 114.

<sup>102</sup>Harkin, "Contested Bodies," 591.

<sup>103</sup>There is a great variety of mortuary practices among First Nations, just as there are a number of perspectives on the body. What is discussed here are commonalities that speak to the issues raised in the First Nations histories that deal with the flu epidemic as an important event. For a sampling of material that addresses these issues see: Sergai Kan, *Symbolic Immortality: The Tlingit Potlatch of the Nineteenth Century*. (Washington: Smithsonian

obligations to them in First Nations flu histories.

Secwepemc elder August Tappage hints at this when she contrasts the strength of her grandmother during a smallpox epidemic with her own during the flu:

Well, my grandmother's young brother got this smallpox. They were young in those days. She didn't get it because she stayed away from the others. She was living in an underground house ... "I told you not to go over there," she tells him. "I told you to stay away!"

Well I guess he was dying, see, and it wasn't long til he died. And my granny – I guess she had one of these ladders, you know, to get out of her house, made out of a tree, a limb left on this side and a limb left on that side right up for the feet to go on – well, my granny says she carried him out, yes, over her shoulder and she buried him.

She had quite an effort you know, but I guess she was strong in those days. Anyhow, she lived and they died.

Then the 'flu came, yes. Years after, the 'flu came. It was when the soldier boys were coming home. My grandmother was old then, old and weak, I guess. It took her, yes. She lived through the smallpox, but not the 'flu. That 'flu finished her. I was sick with the 'flu. I couldn't get up and help nobody! I couldn't help granny. I raised up in bed after they told me and I looked out the window. I saw my granny's coffin. It was bouncing around in the back of the rig. They were hauling her down to the graveyard to bury her. About a mile down the hill. I couldn't go. But I saw her go. I saw my granny go.<sup>104</sup>

Tappage clearly laments her inability to ensure the proper care of her grandmother's body in the way that her grandmother had cared for her brother's corpse.

Institution, 1989), 50; Stanley Walens, *Feasting with Cannibals: An Essay on Kwakiutl Cosmology* (Princeton: Princeton University Press, 1981), 63; Jean-Guy A. Goulet, "Reincarnation as a Fact of Life Among Contemporary Dene Tha," in *Amerindian Rebirth: Reincarnation Belief among North American Indians and Inuit*, ed. Antonia Mills and Richard Slobodin (Toronto: University of Toronto Press, 1994), 157; Marie Mauze, "The Concept of the Person and Reincarnation among the Kwakiutl Indians," in Mills and Slobodin, *Amerindian Rebirth*, 1818; Antonia Mills, "Rebirth and Identity: Three Gitksan Cases of Pierced-Ear Birthmarks," in Mills and Slobodin, *Amerindian Rebirth*, 213; Michael Harkin, "Person, Time and Being: Northwest Coast Rebirth in Comparative Perspective," in Mills and Slobodin, *Amerindian Rebirth*, 193, 197, 207-8; M.E. Kelm, Nisga'a Field Notes, 1995; Ralph Maud, ed., *The Salish People: The Local Contribution of Charles Hill-Tout*, vol. 2: *The Squamish and the Lillooet* (Vancouver: Talon, 1978), 36-7; James Alexander Teit, *The Lillooet Indians*, vol. 2, part 5, of *The Jesup North Pacific Expedition* (Leiden and New York: Brill and Stechert, 1906), 270; Laforet and York, *Spuzzum*, 147-9.

<sup>104</sup> Spear, *Days of Augusta*, 30-1.

Portrayals of the dead lying uncared for in close proximity to the living highlight the horror of the epidemic for other First Nations writers as well. Okanagan writer Christine Quintasket describes an even more devastating scene: “Mr. Lane found several homes with corpses lying in the same room where the remaining living members were too weak and emaciated to bury their dead or care for themselves ... Oftimes corpses have rotted in the room where the sick lay moaning in delirium.”<sup>105</sup> Carrier elder Mary John tells that

one of the things which filled me with horror during this time was the mass burial. When the epidemic was at its worst, a number of people died within two or three days of each other and those who were left were too sick to lay out the corpses and make coffins. A large hole was dug in the cemetery, and seven bodies were carefully wrapped and buried side by side. Many years later ... I noticed that the place where the seven people had been buried so many years ago was now a big hole and that the ground around the spot was uneven.<sup>106</sup>

Remnants of the terror, of the unfulfilled obligations to the dead, haunt survivors years later.

The second most common element of First Nations flu stories attributes the flu to non-Aboriginal causes, primarily contact with Whites. On one hand, we know that this is simply an accurate depiction of a pandemic disease that undoubtedly did spread onto Indian reserves from nearby White settlements or by communication along transport lines established by non-Natives. On the other hand, it is also clear that to Aboriginal writers telling about the flu, older indigenous conceptions of disease causation seem apt. In some cases, linking the 1918 flu with the earlier smallpox epidemics, about which stories abound of infected blankets being traded or given to unsuspecting Natives, establishes the connection between pandemic disease and European culpability.<sup>107</sup> In other stories, Europeans, like witches, were seen to shoot disease into the people. Such is the case with the Tsil’co’tin narrative, “The Big Flu.” Here is what Eugene William says about how one man saw the disease coming:

After the disease finally quit, Eugene said his father Sammy Williams’ older brother, named Amed, went to Tsuniah were Sammy

<sup>105</sup>Miller, *Mourning Dove*, 192.

<sup>106</sup>Moran, *Stoney Creek Woman*, 25.

<sup>107</sup>Speare, *Days of Augusta*, 30.

was staying and told him all about the disease that hit Nemiah. Sammy said he couldn't believe what happened. Surprised I guess. Because Sammy said he dreamt about this disease. He was dreaming that some soldiers came over to Nemiah and shot this disease with all kinds of colours through the sky in his dream. That's why Sammy William decided to stay at Tsuniah a little longer.<sup>108</sup>

In this account, Sammy Williams acts as a seer, predicting disaster and being able to take appropriate action to defend himself against it. His account fits nicely into indigenous accepted wisdom concerning witchcraft-related illnesses. With regard to these, illness can be sent into a person either through object or spirit intrusion.<sup>109</sup> In order to confirm the connection between Euro-Canadian culpability and the flu, Eugene Williams, who reports on his uncle's vision, links the disease with the one major confrontation between Tsil'co'tin and Euro-Canadian road-builders, the so-called Chilcotin War, when he says, "this disease came from the Chilcotin War." The Chilcotin War itself was sparked, at least in part, by the smallpox epidemic of 1862 and a Euro-Canadian road-builder's threat that he could make the disease come back. William's statement makes sense only if we place it within the broader context of Aboriginal understanding of disease causation and the linkages they see between epidemic episodes and Euro-Canadian witchcraft and treachery. More gently, Augusta Tappage connects smallpox and the flu in the same story, describing the role that Hudson's Bay Company traders played in the dissemination of the former and returning soldiers in the diffusion of the latter.<sup>110</sup>

The third common element among First Nations flu histories relates to a strong sense of Euro-Canadian betrayal felt by Aboriginal sufferers of the disease. By 1918, most First Nations in the province had heard the admonitions of Indian agents and missionaries, who insisted that if only they would live like White people, if only they would confine themselves to Euro-Canadian allopathic medicine, then they would stop dying at such alarming rates. What the 1918 flu proved to them was, first, that "modernization," whatever non-Natives promised, was no key to health, and, second, that when non-Aboriginal lives were at stake, the resources of the government and its sanctioned medical personnel would go first, not to the First Nations, but to Euro-Canadians. Both, it seems, showed the bankruptcy of Native/non-Native relations

<sup>108</sup> Glavin, *Nemiah*, 91.

<sup>109</sup> Kelm, *Colonizing Bodies*.

<sup>110</sup> Speare, *Days of Augusta*, 30-1.

in Canada. Christine Quintasket's telling makes both points most clearly, but others concur. Of reserve conditions, Quintasket wrote in the language of the time:

The casting aside of the teepee and adoption of modern houses has had an evil effect on our race beyond calculation. Fresh air is lacking. Owing to his former mode of life – in the open and well ventilated teepee – the Indian does not understand how the air can become polluted and deadly, does not understand the value of clean air. In his ignorant and primitive state the Government and misguided reformists thrust upon him a condition unfitted to his needs and bodily comfort.<sup>111</sup>

Similarly, Eugene William attributes the infection to a Tsil'co'tin man who travelled to a nearby White community to buy lumber to build a dance hall for a Christmas dance because their own houses had only dirt floors. In this way, the desire for non-Tsil'co'tin material goods is implicated in the spread of disease.<sup>112</sup>

First Nations historians are also clear that the Canadian government was negligent in its treatment of the flu among First Nations. As Okanagan writer Christine Quintasket put it:

War-worn and exhausted, with her thousands of maimed and health-ruined soldier boys to care for, the government seemed powerless or inert to the condition of the tribesmen ... No aid has been offered the stricken Indians across the Canada border. Relief is sent to foreign lands, not even denied the baby murdering, women mutilating Hun, but none has been forthcoming for the dying, simple minded natives at our very door.<sup>113</sup>

Others also write that help from non-Native doctors was rare. Mary John reports on the absence of any care from the departmental doctor during the epidemic.<sup>114</sup> The other flu stories analyzed here make no mention of Euro-Canadian medical assistance except from the Roman Catholic missionary Nicholas Cocolla who, living on reserve at Stoney Creek, did what he could to help the suffering.<sup>115</sup>

<sup>111</sup>Miller, *Mourning Dove*, 192.

<sup>112</sup>Glavin, *Nemiab*, 90.

<sup>113</sup>Miller, *Mourning Dove*, 192.

<sup>114</sup>Moran, *Stoney Creek Woman*, 24.

<sup>115</sup>Ibid.

The 1918 flu epidemic stands out in First Nations histories along with the earlier epidemics of smallpox, which radically reduced their population. It does so for several reasons. First the morbidity and mortality rates among First Nations were very high. The flu also encapsulates the nature of Native-newcomer relations in British Columbia at this time. First, Aboriginal ill-health more generally, and at the time of the epidemic, was, no doubt, caused by the poor conditions in which many First Nations found themselves. The flu was just one of many waves of infectious disease that swept the province and affected Aboriginal peoples in this era. The cause of the high mortality from this epidemic, along with other outbreaks, can be found rooted in the inadequate reserve allocations, the alienation of water from reserve communities to rail companies and ranches, and departmental parsimony in funding reserve improvements such as sanitation systems. The flu, and the deaths associated with it, have become emblematic of the ways in which colonization itself compromised the health of the people. Second, non-Native medicine could do little for their suffering, despite its claims to supremacy over all other systems. Not only was it impotent in the face of the epidemic, but it was also denied First Nations peoples as departmental doctors directed their attention elsewhere, as segregated accommodation for Aboriginal patients became filled, and as problems with the whole system of DIA-funded health care worsened under the pressure of the epidemic. Finally, we see that First Nations peoples responded in ways that were also grounded in their continued relationship with their own medicine. By combining medicines, by using their own traditional forms in new ways, they were able to face the challenge of the epidemic without an apparent crisis in faith over their own medicine. As First Nations tell their own histories, they craft them in such a way as to communicate what they see as the key issues raised by epidemic episodes. In doing so, they incorporate even these most dreadful aspects of our collective past in ways that affirm Aboriginal perspectives and epistemology.

