Fever Dreams: Infectious Disease, Epidemic Events, and the Making of Hong Kong

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Department of History
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Abstract

There is no surfeit of infectious disease or of epidemic events in Hong Kong’s history. Accounts of local outbreaks of malaria, tuberculosis, influenza, cholera, and typhus pepper colonial government archives and newspaper reports. Deadly outbreaks of malaria dubbed the ‘Hongkong fever’ nearly put an end to this colonial project within its first few years of existence and to survive, its administrators borrowed strategies from Britain’s other tropical colonies, implementing afforestation projects and legislating spatial segregation from the local Chinese population. As entrepôt trade grew and Britain’s anchor to the China trade was integrated into imperial networks, local epidemics in ‘insalubrious’ Hong Kong spread through those same networks and so became pandemics. Such was the case when bubonic plague broke out at the end of the nineteenth century, carried through Hong Kong’s port system. In the twentieth century, Hong Kong faced chronic trouble with infectious disease, notably chronically high rates of tuberculosis, and was associated with three global pandemics: H2N2 or the ‘Asian flu’ in 1957, H3N2 or the ‘Hong Kong flu’ in 1968, and then a novel virus, SARS, in 2003. There are many reasons for Hong Kong’s implication in these pandemics, a constellation of the territory’s geographical, climatological, political and social traits. This confluence of factors is particular to Hong Kong and its risks intensified after the 1997 reunification with the People’s Republic of
China. This dissertation narrates Hong Kong’s history through five epidemic events, revealing the medical stakes of the city’s hyperconnectivity as a global hub. At the same time, the project shows that this challenging disease history has molded local society, culture, and identity. Where epidemic events make Hong Kong’s global connections all too evident, collective memory of losses and surviving epidemics is integral to Hong Kong life and history. Its lives of its people, heunggangyahn, are shaped by the chronic presence of infectious disease and their survival of crises—medical, economic, and political—helps shape this distinct, local identity.
Acknowledgments

This dissertation is all about interdependence, entanglements, the connectedness of all beings and institutions. In the course of its composition, I studied many modes of thought, disciplinary conventions, academic protocols and several languages. But by far the most impressive lesson has been to understand how dependent I am on those in my networks, to know how greatly I rely on others in accomplishing my work, in chasing my dreams, and in cultivating a happy life. The great learning of my doctoral training is gratitude.

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My father, stepmother, grandmother Mary and brother live far away but I felt their presence in every day’s work. My hopes are to have lived up to their dreams for me and to one day repay their patience and generosity. When I returned to finish my undergrad after a few years hiatus, I complained on the phone to my no-longer little brother that I was spending long nights in the library because I did not have a computer of my own. He shipped me his own laptop. That machine is long gone but I remember that gesture every time someone asks something of me that seems exceptional. Without those I left in Edmonton when I can here to study half a lifetime ago, the practical challenges of a doctoral degree would have stopped me before I began. My love and gratitude to you.

I held good company along the way. Graduate school can be lonely and insular. The encouragement of my friends makes all the difference. Thank you for your support, for commiserating and for celebrating.

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1 Prologue

French photographer Romain Jacquet-Lagrèze recently released a series of photographs of Hong Kong entitled *Wild Concrete*. The images in this series are of urban Hong Kong, the familiar skyscrapers and housing tenements cast as a background to the main drama of the scene. These photographs cast in starring roles what Jacquet-Lagrèze describes as a “very singular phenomenon”: mature trees growing atop buildings, along the walls, through open window panes, a scene that puts Hong Kong’s incredible built environment at the mercy of nature. The artist suggests,

> Usually wherever human beings are thriving, they always try to keep in control their direct environment. But in this bustling city, trees can grow impressively on residential buildings...it is about nature taking back, it is a demonstration of the tenacity of life in our urban environment.¹

These images capture a key tension in Hong Kong’s history, that between the natural and built environments and the human actors who navigate between. It is not so much that the signature *Ficus microcarpa* can grow on buildings and along walls in Hong Kong but that they do; in spite of the more than one hundred and fifty years of Hong Kong’s existence as a global junction of population flows and world markets, nature prevails.²

A visitor to Hong Kong Island today may marvel at the physicality of daily life in this metropolis. For all but the wealthiest of the territory, ownership of a private vehicle is entirely impractical so people move through the city using a combination of public transportation and muscle power. Flowing together as in swarms, thousands climb Victoria’s steep incline along

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Centre Street in Sai Ying Pun each day, or from Queen’s Road to Conduit Road along the path of the Mid-Levels escalator. The weather is steamy, hot and humid but for the few frigid winter weeks when Hong Kong people shiver in uninsulated buildings. As you ascend or descend the winding one-way streets away from the gleaming towers of the financial and commercial districts, you may notice the moss that grows on masonry walls, birdsong through the cacophony of taxis and buses, or the insect population that is even more industrious than the humans of Hong Kong.

As you navigate between the dense neighborhoods and crowds, you may also be more aware than usual of your body. You may notice perspiration and exhaustion that come of physical exertion and the heat; it takes some time for the hamstrings and pores of newcomers to come to terms with Hong Kong’s sensory and geographical challenges. You will feel the shock of moving between the sticky air close to the harbour and glacial air-conditioning in the rhizomatic web of shopping malls and walkways connecting Central, Wanchai, Kowloon, and the dense residential centres just south of the core. You may experience dyspnea, maybe even have asthmatic symptoms, as your respiratory system does its best with the humidity and air pollution wafting through the Pearl River Delta. You may catch a cold, the flu, a bronchial infection, or a syncytial virus during the rainy season. Don’t fret; you won’t have to look far to find a doctor. Look up as you walk along the major streets and boulevards, and you will see placards—several on every block—advertising the services of Western-style physicians and of traditional Chinese medical practitioners touting a plethora of expertise. You will have your choice of nearly fifty hospitals throughout the territory where you are likely to receive the attention of a physician trained at one of Hong Kong’s two medical schools.

You might prefer to stay close to where you rest your head at night and would then visit the community health centre in your neighbourhood, or you might choose a consultation at one of the dozens of specialist public and private clinics. It might suit you to visit Ko Shing or Wing Lok Streets in Sheung Wan where you can bargain the best price for traditional herbs among two hundred purveyors. A sore limb may take you in search of a bonesetter. With recent laws limiting the scope of practice for these traditional healers, you’ll have to sniff one out. Perhaps he’ll have limited his advertorials to his work as a martial arts teacher but keeps a clinic hidden in Mong Kok, or perhaps the yeYe reclining in the back of a shop, smoking and watching Cantonese soap operas, holds this kind of healing knowledge. If none of these options brings you
comfort, a malingering symptom may drive you to the Wong Tai Sin temple. Here you will practice Daoist rites, honouring Wong Tai Sin as the god of healing. You may have a consultation at the free clinic associated with the temple or buy a prescription from the herbal medicine shop. Take a moment to ponder the elixir of immortality Wong Tai Sin allegedly alchemized out of cinnabar when you leave, passing signs and billboards advertising beauty and youth by Shiseido, SK-II, Chanel. Whatever the case, you are likely to witness the ubiquity of medicine and the pervasive anxiety toward disease in Hong Kong.

If you do catch something, make the best of it. You are part of history now, your case woven into Hong Kong’s history and ecological tapestry. You are the beneficiary and victim of Hong Kong’s unique confluence of built, social, and ecological factors. Indeed, this dissertation situates your experience of infectious disease or of injury caused by the challenges of the local environment in a telling of Hong Kong history that shows the territory as having been molded—defined actually—by acute epidemic events and the disquiet of the presence of chronic infectious disease.

1.1 Thinking about Hong Kong

Histories of Hong Kong tend to mirror, or to seek to resolve, its liminal geographical, cultural and political qualities; Hong Kong history belongs at once to modern Chinese history, to the history of Great Britain, and to other histories, written “within the narrow gap emergent in-between other grand narratives”3. While held in tension between two of the greatest empires in history, Hong Kong is usually written as playing only a minor role in either history. In imperial histories, Hong Kong is in “such a peripheral position, geographically and culturally, to mainland China that the Chinese had little interest in its affairs”4. Once under British rule, Hong Kong becomes a humiliating footnote in histories of the Qing dynasty. In histories of imperial Britain, this tiny territory and its generally peaceable proceedings pale compared to Crown conquests in


India and Africa, referred to even as a “half-Crown” colony. Having returned to Chinese sovereignty in 1997, Hong Kong cannot easily be situated in decolonization or postcolonial historiography for never having gained independence or genuine self-determination. Reams of intellectual fabric have been spun on each of these historiographical looms, some casting Hong Kong as China’s humiliation, as a jewel in the British Crown, as an aborted chapter in a narrative of global decolonization or in theorizing postcolonial interpretations of post-1997 life. Seeing Hong Kong in only any one of these frames, however, produces a monochromatic design. Even in the most contemporary historiographical loom of postcolonialism and the practices of cultural studies which made Hong Kong as an object of fascination immediately before and after the handover are less satisfying of late. The world has watched unique, even bizarre, social movements such as Scholarism or Occupy Central with Peace and Love unfold and in the immediate present a rash of radical actions on the part of “umbrella soldiers” or Hong Kong Localism Power. Just as this “barren island with hardly a house upon it” was undesirable to Britain and insignificant to China until the end of the first Opium War, Hong Kong’s story is always told in a binary to another agent, another country, and at present, in the emerging nativist narratives, to another nation.

‘Hong Kong’ historically refers only to the name of the island ceded to Britain in 1842. The island was inhabited as early as the Neolithic period by Baiyue, non-Han people dominant in southern China and was annexed into Qin Shihuangdi’s first unified China. The first settlement of Han Chinese in the area dates to the Han dynasty when local pearl fishers referred to their haunts as Meichuan. Until colonization, the territory known today as Hong Kong did not have a discrete identity and was divided among other geographical frames. It was part of Bao’an County from 311 CE, encompassing what are today Hong Kong and Shenzhen, one of fourteen districts comprising the department of Dongguan. While densification of the Pearl River Delta region over the last two hundred years has made it a centre for Chinese social, political and economic

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6 香港


8 Ng, *New Peace County*, 3.
life, for a southern Song dynasty princess pursued by murderous Jurchens, Bao’an was as remote a place as she could imagine; she took refuge with the Tang clan in what is today Kam Tin, married a man of the Deng clan, and lived out her life in the hinterland. For Zhao Bing, the seven year-old emperor of the Song house, Kowloon Peak was literally the edge of the world; in 1227, he drowned there, carried over the cliff at Sung Wong Toi in the arms of his teacher, evading his Mongol attackers. The island was reassigned to Xin’an County in 1573 and was made an administrative prefecture of Guangzhou and of Guangdong during the Qing. During the Great Clearance, the area reverted to the administration of Dongguan until the island was ceded to Great Britain under the Treaty of Nanking. With few resources, dubious strategic value, a small semi-settled population, and chronically vulnerable to piratical activity, the British would have preferred Chusan, an established port city to the north which was regarded as “almost paradisiacal” and closer to the Qing capital. After concession, however, Hong Kong took on electric significance, now a space of conjunction and tension between two great empires.

As might be expected, Hong Kong studies have evolved in fairly discrete phases and ideological perspectives. First came the colonial school, mostly British with a few American and other European contributions. These writers were sometimes scholars by training but were often implicated in colonial governance. They describe the heyday of the Canton trade, Britain’s victories in the Opium Wars, and the first years of colonial administration on Hong Kong Island as chapters in the great project of British imperialism. A key example of this vein of scholarship, E.J. Eitel’s Europe in China, reassures its reader that “the Hongkong community has its root in

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10 The imaginings of this boy are imprinted on contemporary Hong Kong. The story goes that the young emperor mused to his teacher, Lu Xiufu, that the eight hills visible in Kowloon represented eight dragons. Liu, flattering the young boy, said, “No, there are nine. You are also a dragon”.

11 Ng, New Peace County, 20.


13 Chusan had been captured by Charles Elliot for Great Britain in 1840 and then traded for Hong Kong in 1841. The trade was seen as a terrible miscalculation and Elliot was recalled, replaced by Henry Pottinger. See Christopher Munn, “The Chusan episode: Britain's Occupation of a Chinese Island, 1840–46,” The Journal of Imperial and Commonwealth History 25, no. 1 (1997): 82-112.
the earlier and smaller community of British and other European merchants with their Chinese
hangers-on…[its] history an unbroken chain of influences connecting the political mission of
Europe with the present politics of Asia”\textsuperscript{14}. This colonial perspective that treats the Chinese
community as background (or obstacle) to the triumphs of imperial Britain is not limited to
nineteenth century writers; G. B. Endacott’s studies and the volumes of the Hong Kong Branch
of the Royal Asiatic Society published after World War II, for example, make invaluable
contributions to local history but can also reflect colonial bias\textsuperscript{15}. The handover to China in 1997
occasioned another wave of nostalgia and reminiscing over the glory of British rule\textsuperscript{16}.

From the other side of imperialist struggle, ethnic Chinese historians have engaged with Hong
Kong from inside the colony and from with the People’s Republic of China (PRC). Studies by
Chinese writers appear only in significant number after the end of the Chinese Civil War and the
resumption of British sovereignty after World War II. Here, two veins are significant. Writers
from the Academy of Social Science in Beijing focused on the Opium Wars, framing Hong Kong
as a humiliation for China. The most extreme of these examples might be Ding You, whose

*Early History of Hong Kong* is a Marxist condemnation of Britain’s exploitation of Chinese
labour\textsuperscript{17}. Some of these were, as Sinn notes, “mainstream Chinese historians” who had come to
Hong Kong after the rise of the Chinese Communist Party (CCP). Where they had previously
thought of Hong Kong as ‘peripheral to ‘real history’, China’s dynastic history, new political
conditions and contexts inspired renewed interest in local history\textsuperscript{18}. Lo Hsiang-lin is
representative of this group\textsuperscript{19}. Other scholars came to live in Hong Kong but worked on projects


\textsuperscript{15} See, for example, the work of James Hayes, Jeffrey Sayer, H. J. Lethbridge, K. M. A. Barnett, David Aker-Jones or Patrick Hase, most of whom are part of the group that Elizabeth Sinn has dubbed the “scholar-officials” in her historiographical essay, “The Study of Local History in Hong Kong: A Review,” *Journal of the Hong Kong Branch of the Royal Asiatic Society* 34 (1994): 147-169.

\textsuperscript{16} For examples of this kind of nostalgia for colonial heydays, see Frank Welsh, *A Borrowed Place: The History of Hong Kong* (New York: Kodansha America Incorporated, 1993) or Martin Booth, *Gweilo: Memories of a Hong Kong childhood* (New York: Random House, 2009).

\textsuperscript{17} You Ding, *Xianggang chuqi shihua* [Early Hong Kong] (Beijing, Lianhe chubanshe, 1983)

\textsuperscript{18} Sinn, “The Study of Local History in Hong Kong”, 148.

\textsuperscript{19} Lo’s most widely cited work is Hsiang-lin Lo, *Hong Kong and Its External Communications Before 1842: The History of Hong Kong Prior to British Arrival* (Hong Kong: Institute of Chinese Culture, 1963)
based on the New Territories where Western influence was less and could be cast as proxies for China. These projects collapsed Hong Kong’s local history into the broader historiography of China\textsuperscript{20}.

As Hong Kong and China moved along their separate paths, differences in politics, society, economic foundations and culture emerged and inspired a generation of scholars who produced local studies, often of urban history or geography\textsuperscript{21}. And as the expiry of the New Territories lease in 1997 approached and with it the end of colonial rule, dozens of new work on politics and society were published in which Hong Kong figures as the third leg of the infamous “three-legged stool”\textsuperscript{22}. These studies are defined by context, the position of the author in relation to the problem, and the timing of publication. Most of them loosely follow a pattern: they assess Hong Kong on the eve of 1997, rate the success or failure of British governance, try to determine the strength of the local economy, stability of society, political will and distinctness of Hong Kong’s local culture from the mainland, and then seek to predict what will come of Hong Kong once China takes rule. Eighteen years after the resumption of Chinese sovereignty, inaccurate predictions discredit some among this wave of publications, but the work at weighing influences on Hong Kong’s development gives them value beyond the task of future forecasting\textsuperscript{23}. Among mainland historians post-1997, a common historiographical imperative is to assert that Hong Kong is inalienably part of China since “ancient” times, denying the historiographical conceit

\begin{itemize}
\item\textsuperscript{20} Sinn names Jen Yu-wen, Jao Tsung-vi and Lin Tien-wei as examples of scholars working in this vein.
\item\textsuperscript{21} D.J. Dwyer, cited later in this project, studied Hong Kong’s urbanization process and bridged scholarly and administrative interests in Hong Kong’s unique industrialization and financialization experiences.
\item\textsuperscript{22} The image of a three-legged stool was used extensively in the media during negotiations of the \textit{Joint Declaration of the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the People's Republic of China on the Question of Hong Kong} in 1984 and then the \textit{Basic Law of the Hong Kong Special Administrative Region of the People's Republic of China} that replaced the colonial \textit{Hong Kong Charter} as the constitutional document of Hong Kong. The image of a stool was deployed to describe relationship between the PRC, Great Britain and Hong Kong as triangular but unequal, never a stable stool but one that wobbled and veered in one direction or another depending on political tides. The legs representing China and Great Britain were longer than that representing the Hong Kong people whose interests were seldom taken into consideration.
\end{itemize}
among colonial historians that paints Hong Kong as coming into existence only once colonized. This imperative appears in academic histories and in overtly political contexts.\(^{24}\)

There are furthermore several thematic considerations in approaching Hong Kong studies. The notion of being *heunggongyahn*, Hong Kong people, first emerged as a socially, culturally, politically and linguistically informed identity distinct from the mainland Chinese or the overseas Chinese of Southeast Asia in the 1960s. The return of Hong Kong to Chinese sovereignty has added extra dimensions of complexity to the issue of Hong Kong identity. The Umbrella Revolution of 2014 demonstrated that the PRC, Hong Kong’s government and Hong Kong people still struggle with the troubled remarriage of the colony and its people to the ancestral homeland. In *Putonghua* the handover was called *hui gui* and in Cantonese *wuiguai* meaning a return but also a regression. The British press favoured the terms ‘handover’ or ‘retrocession’. Neither captures the dynamics of 1997 in full, the former all too casual and the latter evoking a unidirectional legal procedure. Both occlude the tangled and braided strands of identity experienced by Hong Kong people after one hundred and fifty-six years of colonial rule. Both efface the sense of difference professed by many Hong Kong Chinese for whom China is *zuguo*, one’s ancestral motherland, but for whom Hong Kong is home, or the identity of those Hong Kong Chinese with strong connections to Great Britain, or for any of the myriad constructions of identity along this spectrum. Ethnic logics used to rationalize the return to China, for example the “family reunion” metaphors deployed by Jiang Zemin\(^{25}\), further efface the ethic and cultural plurality evident on Hong Kong’s streets today; for generations, Hong Kong has been home to Southeast Asian and African labour diasporas, European and North American expatriate communities, and tens of thousands of Indians, Pakistanis, and Nepalis whose forbearers were instrumental in colonial governance. While the drama is so often cast as a struggle between the two great empires, Hong Kong belongs to a multitude and so should its history.

It has also been the case that study of Hong Kong has focused on its political and economic history—and for good reason. First, as an imperial concession, Hong Kong is a politically

\(^{24}\) The language used in the first chapter of S-Y Liu’s *Xianggang de lishi*, for example, is nearly identical to the language of Article 1 of the *Basic Law*, Hong Kong’s contemporary constitutional document. Both describe Hong Kong as “an inalienable part of the People’s Republic of China”.

charged space. That political significance only exists because of the rapacious economic drives of imperial Britain. If Britain had not sought so intently to expand its command of Asian markets, the trouble and expense of ‘civilizing’ this difficult territory would have been spared. Hong Kong’s had just two assets: its deep harbour, described by architect and topographer William Allom, as “a harbour so sheltered, commodious, and secure, that during the repudiation of our trade from Canton by Commissioner Lin, it became the favourite rendezvous of British merchantmen”\textsuperscript{26}, and its proximity to established centres of trade; situated at the mouth of the Pearl River Delta, Hong Kong’s was the only deep-water harbour between the commercial centres of Shanghai and British Singapore and was just seventy-five miles from Canton. This lucky geography was the colony’s destiny. Second, Hong Kong studies are often founded on the colonial administration’s archives. While the work of reading “against the archival grain”, as taught by Ann Laura Stoler, brings the Hong Kong archives to violent, confusing, desperate and sometimes humorous light, the evidence retained by Hong Kong’s government filters a good deal through its principal concern.

John Nguyet Erni sees Stoler and raises the stakes for studies of Hong Kong. Writing from the interests of cultural studies, Erni does not engage specifically with the content of Hong Kong’s colonial archive. Introducing a special volume of \textit{Cultural Studies} focused on Hong Kong’s postcolonial configuration, he writes, “[o]ne of the underlying principles about ‘reading against the grain’ is to identify points of tension, pressure points in the text, as it were, where the illusion of unity and continuity is hard to cover up”\textsuperscript{27}. Read the archives against the grain, yes, but in a far broader sense, we should look at all of Hong Kong and its history against the grain. The ‘economic miracle’ and the ‘peaceful colony’ are true lies that contain a richer history. It is not what the archives show but how significantly the researcher has internalized the popular narratives on Hong Kong that will determine how centrally they will position the economic history of the territory and to what degree \textit{hevunggongyahn} is portrayed as a kind of \textit{homo fiscus}.

\textsuperscript{26} Thomas Allom and George Newenham Wright, \textit{China, in a Series of Views, Displaying the Scenery, Architecture, and Social Habits of that Ancient Empire}. (London: Fisher, 1843), 17.

Because Hong Kong did not win independence in its version of a decolonization process, it suffers being caricatured as sterile and apolitical but a paragon of economic success and smooth modernization. Many texts contribute to that narrative, glossing over so many examples of engaged public protests, riots, and tacit resistance. Lo Kwai-Cheung snarls at this erasure of resistance, writing, “[a]pparently, all the socio-political energies of the anti-colonial liberation struggles in this city were co-opted into producing irrefutably East Asian ‘Confucian’ capitalization, whose so-called cultural dimension is entirely bound by and reduced to serve economic purposes”28. Failing to acknowledge the ways that Hong Kong Chinese and other minorities did explicitly or implicitly resist exploitation under colonial rule, failing to consider the millions who did contest the return to Chinese sovereignty and have sought to protect the local identity and way of life, failing to note the thousands who protested retrocession by emigrating away from Hong Kong altogether, is to distort Hong Kong’s worthy engagement with its colonial history. But perhaps it is as Abbas suggested just ahead of the handover that Hong Kong has a “…skewed sense of history”, that “[p]art of the meaning of colonialism in Hong Kong is that the city can neither identify nor break with the past. Neither continuity nor discontinuity is available, only an appearance of continuity that is already discontinuous”29. Overemphasizing Hong Kong’s economic success or the political tug-of-war between great empires is a strategy used by many, casually and in formal discourse alike, that creates the illusion of resolving Hong Kong’s identity issues. Still, this brings us up short of seeing the territory’s vibrant, full-colour tapestry.

It is also to forget what is so imminent in experiencing Hong Kong—its extreme, diverse natural ecology. Hong Kong’s climate is hybrid, with tropical and temperate qualities that alternate across seasons. Perhaps this is the inspiration for the many pluralities and paradoxes that arise in its politics, society and culture; even today, Chinese and Western architectural elements are in evidence along with other binaries and complications—the city today feels kaleidoscopic—traditional, modern and (some critics argue) postmodern, colonial, neocolonial and free, Eastern, Western and global, all of the oppositions that sustain an intellectual project seeking to

29 Ackbar Abbas, “Hong Kong: Other Histories, Other Politics,” Public Culture v. 9, n. 3: 300.
conceptualize and capture this place, to put Hong Kong in a broader context while also summing up its singular quality. As early as 1960, Western audiences soaked up these paradoxes at the cinema; the iconic *The World of Suzie Wong* (1960) transported the viewer to the colonial architecture of Central, the wet markets of Wanchai and the rural slums of the New Territories. The film drives to a climax based on the image of Hong Kong’s monsoons, the trade winds that allowed access to the China trade and inspired the colonial project. The winds and rainfall that sustained economic ambitions also caused fatal mudslides in the squatter villages where the refugees from communist China made makeshift homes. Wendy Gan explains how wet and dry speak to colonial relations and structures of power in Hong Kong, describing an encounter between East and West, the feminine and masculine, in the 1950s; she writes

After trawling through the underbelly of Hong Kong, Robert has the privilege of deciding which version of Hong Kong he will choose through his choice of women. Kay O’Neill represents an expatriate vision of Hong Kong where the weather is fine, and even when not, her status as British and affluent shelters her from the elements and the difference of Hong Kong that could threaten that version. Kay possesses a car that insulates her from Hong Kong realities and weather. When we see her waiting for Robert in his hotel room in the middle of a torrential downpour, she is significantly dry as a bone in contrast to the drenched Robert, who has just come in from a fruitless search for [his Chinese lover] Suzie. This dry, protected world is the world of the well-off colonial elite and one that Robert could belong to if he so wished.30

We do not have to reach too far to understand that climate, disease, and the natural world—even in the concrete metropolis Hong Kong grew up to be, are integral to a robust history of this place. Hong Kong people live with the rain, with the intensity of the climate and its challenges. Where else but Hong Kong would planners imagine and build an 800-metre covered outdoor escalator to move tens of thousands to their homes along the steep hills of the Mid-Levels? Nature refuses to be ignored but Hong Kong refuses to bow. The role of nature’s influence on Hong Kong’s


31 Similarly, *Love is a Many Splendored Thing* (1955) and *In the Mood for Love* (2000) use rainfall to demonstrate relations of power in colonial Hong Kong.
development, and that of nature’s unfriendly ambassadors, pathogens, warrants closer consideration.

1.2 Infectious Disease, Epidemics and History

1.2.1 Pathogens and People

This project does engage the political and economy history of Hong Kong, which is inevitable. The goal of the project, however, is to show that other factors, specifically Hong Kong’s particular disease ecology, shaped politics and economy. To gesture, delicately, to Dipesh Chakrabarty’s famous phrase, this project seeks to provincialize Hong Kong’s political and economic histories such as they consign local experience and subjectivity to historical significance as side effects of imperial histories and emphasize the liberal, modernist narrative that Hong Kong only comes into being as a product of empire. Instead, this dissertation tells a history of Hong Kong through the lenses of infectious disease and epidemics, phenomena that emerge at the crossroads of political, social, cultural, natural and built ecologies. This crossroads only becomes visible at a particular site: the human body. Individual and collective experiences of infectious disease tells secrets about societies. Epidemics reveal the ways that the natural and cultivated worlds interact and reveal the space between naïve and organized economies: what is under control, what should be controlled, what is beyond control.

Epidemics reveal essential information about the societies in which they occur. Before there were formal structures of rule or society, before they lived in cities, as they began to cultivate the earth and created markets and currency, human beings and their social forms were guided by infectious disease. All of world history has been shaped by the threat and consequence of infection or contagion, and, where these go unchecked by human or natural limits, epidemics. The knowledge human beings mine on our world is guided by the goal of mastering the constellation of factors that make us so incredibly vulnerable: climate, diet, conditions for shelter, social interaction among our own species and our interactions with animals. There are no boundaries in the exchange of bacteria, viruses, parasites or prions unless humans create barriers. Disease agents respect no marker of social status, race, or gender, only opportunity. All human beings are potential hosts. In this respect, pathogens are the most honest, democratic and revealing agents in our universe.
Societies are shaped, as they begin to coalesce, by disease risk. The ways that societies manage this risk reveals their strengths and weaknesses. In the twentieth century, nation states banded together to create international bodies, first the Health Organization (HO) and then the World Health Organization (WHO), that share the task of studying, dominating, and arresting infectious diseases. For all of the ways in which the politics of this work sometimes undermine its effectiveness or reinforce hierarchies of power and exploitation, this international crusade has made fair progress against the honest pathogen. One of the most prodigious killers, smallpox, has been eradicated and we may soon see the last of poliomyelitis and dracunculiasis.

In the twenty-first century, however, infectious disease is a concern of a magnitude previously impossible. The globalization and trans-nationalization of our working and personal lives and the habits of rapid and mass transportation make the world more dangerous than ever before. Millions of us cross the globe each day making the globe and the entire human population into a single disease ecology. One could, in theory, be exposed to an endemic infection in the morning, carry it home through the evening, incubate the bug without knowing, and seed it in one’s community. In a single day, an entire population can be made vulnerable, whether literally or in the psychological realm. However rare this kind of nightmare scenario might be, the media is ready to create risk wherever the potential occurs. Think of how much we learned about Dr. Craig Spencer’s homecoming weekend in October of 2014. After treating Ebola patients in Guinea, he returned home to his partner, travelled on the A and L subway lines in New York City and went bowling in Williamsburg before becoming symptomatic and being hospitalized. By the next day, Dr. Spencer’s weekend had been replayed in fine detail in newspapers worldwide, the bowling alley had been closed, and thousands of people had offered their opinions in the comments sections of online reports. He had been careful enough, said some. He had been irresponsible, said others. How dare he go bowling after having been in proximity—HAZMAT be damned—to a terrifying virus? Fed reports of outbreaks worldwide—MERS here, Zika virus there—diseases whose epidemiological profiles are still evolving, the public have become armchair experts.

We have learned a great deal about controlling infectious diseases but also recognize that the microbial world evolves, too; a pathogen’s minute, rapid, unanticipated genetic change can produce an emerging disease threat, something novel or a return of an old foe. If we have put smallpox to rest, we are still at war with influenza. If anthrax is within our sights then there is MERS. We have come far but there is much further to go. Contagion, its threat and impact, continues to condition all of human life. Among and between societies, there is no purer or more fearsome token of exchange.

1.2.2 Epidemic Events

The real risk of infectious disease is not contagion, suffering, or death, but the potential of an epidemic. Disease is endemic in all societies. It is a part of human life, and almost any disease, infectious or of lifestyle, can be normalized. Social norms can flex and contract to hold almost any disease experience contingent on the social factors that condition its prevalence, whether HIV/AIDS or obesity. Millions of people in sub-Saharan Africa have acquired immunity to malaria; the infection is considered holoendemic to the region, meaning that most people are “almost continuously infected by P. falciparum, and the majority of infected adults rarely experience overt disease”. There, malaria is a normal part of life. For the tourist who doesn’t bother with prophylaxis, however, the risk is death.

The real trouble is not a disease but the social consequences of an epidemic, the phenomena that sees disease spreads unexpectedly rapidly to an unusually large number of people. The danger of an epidemic is not simply the number of people who fall ill or the number of lives lost. It is rather the pressures that morbidity and mortality apply to social fabrics. By nature, an epidemic arouses anxiety, if not panic. It is a crucible, the test of a society’s formal and informal systems of order and control. An epidemic by definition causes a state of exception. As Charles Rosenberg writes,

[a] true epidemic is an event, not a trend. It elicits immediate and widespread response. It is highly visible and, unlike some aspects of humankind's biological history, does not proceed

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with imperceptible effect until retrospectively "discovered" by historians and demographers.\textsuperscript{34}

Here, the most vulnerable of society may become its preoccupation if the particular contagion is associated with poverty or if the lack of access to medical care furthers the spread of infection. An epidemic can also create new vulnerabilities if associated with groups sharing lifestyle or behavioural traits, pathologizing this or that behaviour, this or that personal quality. Epidemics paradoxically divide and unite societies; anxiety is shared, but not equally. New hierarchies of power emerge that are defined by the perception of one’s capacity to offer protection.

The cost of an epidemic is not wholly measured in the visible suffering and loss it causes, nor is its significance defined just in mortality and morbidity rates. Epidemics have psychological costs; they leave traumatic marks on survivors. Cultures change in response to the trauma. Along with advances in medical knowledge and technology come changes to human behaviour and relationships. Discovery of the transmission pattern of bovine spongiform encephalopathy, for example, caused a raft of conversions to vegetarianism. Progressive understanding of the retrovirus causing HIV/AIDS gave rise to the concept of “safe” or “safer” sex. Epidemics leave behind a film of anxiety and reconfigure social relationships. The episodic and exceptional nature of epidemics turns the outside in and the inside out, casting light on domestic, personal, and intimate practices.

There is no phenomenon that influences, and is influenced by, as many aspects of its historical context as an epidemic. Biomedicine’s claims for universality and certainty, its truth claims, might obscure the social dimensions of all disease and medicine; as Hanson reminds us, “defining a disease remains a social act within a given cultural frame….these meanings reveal the many roles diseases play in framing social thought, institutional responses, cultural values, and individual identity”\textsuperscript{35}. For the social scientist, Rosenberg claims that epidemics “constitute an extraordinarily useful sampling device—at once found objects and natural experiments


\textsuperscript{35} Marta Hanson, Speaking of Epidemics in Chinese medicine: Disease and the Geographic Imagination in Late Imperial China (London: Routledge, 2012), 7, drawing on Charles Rosenberg, “Introduction” in Framing Disease (New Brunswick: Rutgers University Press, 1992), xiii.
capable of illuminating fundamental patterns of social value and institutional practice. Even more than chronic diseases, or by “undesirable yet blandly tolerated social phenomena” couched as epidemics such as alcoholism or obesity, histories of “real” epidemics connect official and unofficial, formal and informal, public and private, natural and built, traditional and experimental elements of a given society.

1.3 A History of Hong Kong in Five Epidemics

There is no surfeit of epidemic disease in Hong Kong’s history. Accounts of local outbreaks of tuberculosis, influenza, cholera, and typhus pepper the colonial government’s annual reports. As we will see, malarial epidemics in the first few years of the colony’s existence nearly put an end to the development of the territory altogether. As entrepôt trade grew and Hong Kong was woven into Great Britain’s imperial networks, epidemics became pandemics, spreading beyond Asia and seeded to all continents. An epidemic of bubonic plague at the end of the nineteenth century spread through Hong Kong’s port system and then on through the world, reaching pandemic status. After plague came two influenza pandemics in which Hong Kong played critical roles, emerging as an epidemiological sentinel post in Asia. In more recent memory, Hong Kong was a key site in the SARS pandemic and has been implicated in several epidemics of avian influenza that threatened to spread globally. The reasons for Hong Kong’s implication in these pandemics or pandemic threats are many, a constellation of its geographical, climatological, political and social traits. This particular confluence of factors is unique to Hong Kong. This preponderance of epidemics in a relatively short history is unique to Hong Kong. This unique history is a point of entry into understanding Hong Kong’s local history on its own particular terms as well as a way of revealing the stakes of global hyperconnectivity, a condition which Hong Kong helped produce. In the introduction to his volume on empire and anxiety, and panic, Robert Peckham recalls Ranajit Guha’s parsing of anxiety from fear in the colonial experience. Fear, says Guha, has an identifiable cause. Anxiety is about being lost in colonial life. In Hong Kong’s history, there is both fear and anxiety of epidemics. They are real, objects of experience and memory,

36 Rosenberg, “What is an epidemic?”, 279.

that left traumatic residue. They are also potential and yet-unrealized; both the first groups of colonizers and Hong Kong people today stand in waiting for the next epidemic, the “big one”, or as Mike Davis puts it, the “monster at our door”\textsuperscript{38}.

1.3.1 The ‘Hongkong Fever’

The first chapter carves a place for Hong Kong in Britain’s imperial history and the histories of imperial and tropical medicine. The geographical position of the island and its climatological character are liminal, suspended between empires and between temperate and tropical worlds. In the early decades of colonial rule, Britain’s hope was to operate a free port and entrepôt that would swing the China trade in the Crown’s favour but the space itself was of minor appeal. Chusan, the ‘Montpelier of China’, was much preferred; “How anybody in their senses could have preferred Hong Kong to Chusan seems incredible”, wrote Lord Elgin\textsuperscript{39}. The tropics were imagined as Heaven and Hell on earth all at once: “rapturous and luxuriant, or Edenic, but also as backward and pestilent, or demonic”\textsuperscript{40}. Key thinkers of the Enlightenment privileged the temperate climate of Western Europe even as the European empires expanded trade along the spice route and established permanent settlements in India, the East Indies, and the Americas. Climate determined and reinforced an implicit hierarchy of civilization. Even as he explored Oriental philosophies, Hegel privileged Europe, writing, “The torrid and frigid zones, as such, are not the theatre on which world history is enacted…All in all, therefore, it is the temperate zone which much furnish the theatre of world history. And more specifically, the northern part of the temperate regions is particularly suited to this purpose”\textsuperscript{41}.

Those who documented their forays into tropical climates, the so-called “tropical geographers”, documented the places they saw and the people they met outside the theatre of world history, the unknown and unknowable. When they arrived at Hong Kong, they met the task of making sense

\textsuperscript{38} Mike Davis, \textit{The Monster at Our Door: The Global Threat of Avian Flu} (London: MacMillan, 2006).
\textsuperscript{39} Quoted in Alex Michie, \textit{The Englishman in China During the Victorian Era} (London: Forgotten Books, 2013; original work published in 1900), 272-3.
of Hong Kong’s climate and ecology, arriving at ambivalent conclusions. On the one hand, they found the island barren, rocky, inhospitable. They also reported trepidation and fear. The epidemic malarial fevers of 1843 that killed two in every seven colonial inhabitants won Hong Kong a terrible epithet, called the “white man’s grave”. The fevers connect Hong Kong’s early history to the concept introduced by David Arnold, tropicality: the “idea, image and exotic other of European invention and imagining”42. Arnold developed this concept in the context of South Asian colonial history, and it has been extensively deployed in studies of the French colonial empires, in the Caribbean, and so on43. It has not, however, been used to explain the way that Hong Kong’s early colonial community understood the deadly fevers or that this was the lens through which they made decisions on how to remodel the natural and built environments. To fight back the ‘Hongkong Fever’, colonials had to start from scratch, razing some of their first settlements, embarking on a hapless mission to determine and contain the source of the infections.

Next, the entire island needed to be redesigned to reflect the beliefs of the day on the salubrity of the tropics. The ‘tropical’ qualities of the island made it dangerous to colonials inhabitants—though malaria did not spare the Chinese, either—and so the government embarked on afforestation projects through the 1870s into the 1900s, creating a new “Nature” to replace Hong Kong’s indigenous qualities. The idea was to make all of Hong Kong into “a giant enclave”, akin to the hills stations of other colonies, “a bounded and self-sufficient zone of leisure, beauty, and productivity”44. In tandem, the government funded a Botanic Garden, connecting Hong Kong to a “chain of independent interchanges”, a transnational network of botanical research and


scientific imperialism\textsuperscript{45}. If Britain had hoped to limits its plans and investments in Hong Kong to the free port and markets promised, the prevalence of epidemic fevers made the complexity of the colony’s human ecology a more urgent and costly consideration.

This chapter demonstrates the ways in which the climate and disease ecology of Hong Kong were conflated with a racial hierarchy through the mid-19th century. The first struggle for the builders of Hong Kong as they sought to build a space that would be safe for their homes and places of work was against nature and disease, but they further interpreted the experience of ‘conquering’ Hong Kong with infectious disease as a societal metaphor. Segregationist tendencies that emerged elsewhere in the empire were asserted in Hong Kong, culminating in the establishment of a ‘cordon sanitaire’ at Victoria Peak which became the residential enclave of the European community. Health was politicized and spatialized from the very outset. The very design of Hong Kong was directed by the fear of disease and all social metaphors incipient.

1.3.2 A Crisis of Intimacy

The second chapter concerns the outbreak of plague in 1894. This is the best studied episode in Hong Kong’s medical history, widely recognized in even general local histories as a critical event. What is more, the outbreak at Hong Kong sometimes appears in other global and regional histories because of the way that Hong Kong’s local crisis spread beyond the colony through the networks of empire, “infective economies”, and became a global pandemic\textsuperscript{46}. After spreading from Yunnan province in China to Hong Kong, plague was then carried by infected rats stowed away on ships to Taiwan, India, Madagascar, Paraguay, South Africa, Hawaii, San Francisco, Australia, the Soviet Union, Siam, Burma, Tunisia, Trinidad, Venezuela, Peru, Ecuador, Bolivia, Brazil, Cuba, and Puerto Rico. The plague finally subsided in Hong Kong in 1912 but persisted around the globe until the late 1950s. The story of the plague pandemic of 1894 is no doubt a crucial occasion in the history of global public health and in studies of global circulations and imperial worlds.


This telling concentrates on the experience of the plague along the opposite current, however. The chapter does not focus on the global implications of the plague or the way in which the plague outbreak connected Hong Kong to the elaborate web of imperial trade and global capitalism. Rather, the focus is on the way that the plague was experienced and managed within Hong Kong’s domestic and community spheres. Building on the scholarship that has emphasized the role played by the Tung Wah Hospital and the Tung Wah Committee, liaison between the Chinese community and the government, this chapter shows the ways that the plague outbreak changed physical and affective relationships within colonial space, both in its customary sense and drawing on Corsin Jiménez’s understanding of space as “another mode of expressing agency, another way to bestow, obtain or elicit meanings from the world…a capacity: and instrument and idiom that we use…inherently political”\textsuperscript{47}.

Before the plague, the Chinese and British communities were able to live their lives with only minimal contact, with many of the necessary trade interactions mediated by compradors whose whole purpose was to connect the two communities. The average person, native or colonial, was free to live according to their own cultural, social and religious mores. Arresting plague changed this. The outbreak challenged the government’s strategy of indirect rule because it demanded a rapid and decisive solution to the spread of disease at risk of European deaths or the quarantine of Hong Kong’s lucrative free port. Deploying the practices of modern sanitation and isolation, the government mandated home inspections, forced relocations from the Tung Wah Hospital to a hospital ship moored offshore, and whitewashing projects aiming to sanitize the “filthy, unsanitary” Chinese neighbourhood of Taipingshan. So doing, government forced an intimacy between British and Chinese that was undesired by both communities. The Chinese in Hong Kong were forced into contact with Western medicine and Western doctors, and British troops and civilians were forced into the homes of the Chinese to conduct inspections and impose sanitary measures. It was a proximity and intimacy desired by none, but a key juncture in evolving social life of the colony.

This chapter explores disease crisis as a crisis of intimacy. The intimacy of medical practices, and the question of how medical encounters are experienced across racial, ethnic, gendered, and

class lines may escape notice in histories that consider social conflict. The production and deployment of power through medical encounters, however, relies on the intimacy—knowledge of another’s experience through observation or through shared confidence. Medical encounters, as interpreted here, are not limited to clinical encounters. In the context of Hong Kong in 1894, public and domestic spaces were recoded as medical spaces. These encounters happen concurrently in psychic space, an invisible territory that a colonizer must, to be effective in subjugating the colonized, successfully penetrate and occupy. In Hong Kong’s history, the plague outbreak of 1894 marks the point at which psychic space was occupied, the epistemic authority of the British government asserted through the invasion of the intimate and domestic spaces of the Chinese.

1.3.3 Interlude: The Problem of (colonized) People

Nearly sixty years passed between the epidemic of bubonic plague and the colony’s next epidemic crisis, an outbreak of H2N2 influenza, dubbed the “Asian flu”. These intervening six decades saw significant change and growth in medical science, ideologies of governance worldwide, and in every dimension of Hong Kong’s development. This chapter serves as a bridge, reminding the reader of all of these changes, and connecting the world of the nineteenth century with the middle of the twentieth.

This chapter explains the development, or lack of development, of public health in Hong Kong between 1900 and 1950. It discusses the debates of the colonial government through these decades as to how much it was willing to invest in public health, public housing and medical services, recognizing after the plague epidemic that the colony’s governing population and its markets were made vulnerable by the threat of infectious disease. With the colony’s population surging and poverty rampant, many perceived the need for action from the government. Commissions were struck and reports delivered, but consensus and action were rare. All of this debate was stopped by the occupation of Hong Kong by imperial Japan between December 25, 1941 and August 30, 1945. The “three year and eight months” reversed many of the gains made in limiting ‘tropical’ diseases in Hong Kong, and multiplied the prevalence of all diseases, but especially malnutrition, deficiency and tuberculosis multifold. After resuming authority in Hong Kong, Britain took up the same problems and debates on the health of the colony but with higher
stakes than ever before as the colony’s population nearly doubled, flooded with refugees fleeing China after the rise of the Chinese Communist Party in 1949.

Debates in Hong Kong’s government after the war were influenced by two paradigmatic shifts. One was the global movement toward decolonization. Worldwide, colonial powers were relinquishing their empires, allowing transitions of their colonies and protectorates to native rule or new nation-state formations. If Britain was to continue to govern Hong Kong as a colony, then it might bear a greater responsibility to the welfare of its people, particularly as the problems of overcrowding and poverty grew more visible by the day. And with overcrowding and poverty, of course, there was the risk of another epidemic just around the corner. Britain could not afford to support Hong Kong’s burgeoning population nor could it afford to allow the Chinese squatters to languish, spreading dissent and disease. Still, no clear path forward emerged.

The second paradigmatic shift was a radical change in healthcare and social insurance policy at home in London. The Beveridge Report of 1942 occasioned the birth of Britain’s welfare state and institutions such as the National Health Service. The Report demanded a new relationship of co-operation “between the State and the individual”. A cradle-to-grave commitment to the welfare of British citizens, assuming the individual’s commitment to care of self and family, was established post-war. The relationship between colonial State and colonial subject did not carry the same responsibility, but the influence of the Beveridge Report was felt among Hong Kong’s administrators. If not welfare for Hong Kong, then should there not still be some minimal security?

Finally, this chapter makes some observations on factors in Hong Kong’s health history that are particular and deserving of note. These are the reliance of the government and people of Hong Kong alike on the services of charitable and community organizations and the enduring popularity of Chinese traditional medicine. The role of the Tung Wah Hospital and its directing Committee is mentioned in the second chapter on bubonic plague, but the Tung Wah was just the best known and most powerful of the community organizations. This chapter introduces the kaifongs, neighbourhood associations that were reconstructed after the Occupation and the end of World War II with support from the government as a means of extending social support through the Chinese community, including medical help, and of limiting political dissent in a hot moment of the colony’s history. Traditional medicine was likewise mentioned in discussions of plague
but this chapter says a bit more about the ways that this tradition is woven in and out of legal structures and ‘legitimacy’. Both of these factors would play roles in managing influenza outbreaks in the decades to follow.

1.3.4  H2N2, 1957: The ‘Influence’ and Hong Kong’s Emerging Identity

In 1957, an outbreak of influenza A passed from China to Hong Kong, caused a serious outbreak locally, and was then spread by steamboat and airplane throughout the world. The intensification and rapidity of international travel coupled with Hong Kong’s increasing population meant that if infectious disease became epidemic in Hong Kong, the colony was likely to face serious trouble and to share it with the world. With the China trade stauched after Mao’s rise to power in 1949, Hong Kong’s economy swiftly transitioned toward industrialization. This transition was dependent on the population of refugees from China, still growing, but who still faced challenges in securing the essentials of life once in Hong Kong. The productive and healthy economy Britain required to support its colony required a productive and healthy labouring population. The funding, or an adequate plan, for managing the large population was yet unformed. As Chinese established permanent residence in the colony instead of sojourning, a stronger sense of local identity followed. The Chinese of the nineteenth-century may have wanted nothing to do with colonial power or institutions, but Hong Kong people, newly-settled and beginning to identify as heunggongyahn, required stable and accessible access to care and clear communication on disease outbreaks from the colonial government. Whether or not either side liked the idea, the interdependence of the people and the state was clear.

The consequences of these population pressures resonated worldwide. The “Asian flu”, an H2N2 variant, escaped Hong Kong and caused altogether four million infections and two million deaths worldwide48. While the PRC had been a key player in establishing the WHO in 1948, it left the organization after the ascent of the Chinese Communist Party the following year. When influenza, or any other potential infectious disease concern appeared in China, global health monitors could not count on notification leaving the international monitoring networks with a crucial blindspot. With Hong Kong sharing a border and many elements of the disease habitat of the Pearl River Delta, cradle of many infectious disease outbreaks, the colony assumed the role

of epidemiological weathervane and sentinel post for the region. Scarcely able to monitor the local population, this international attention only made the gaps in Hong Kong’s public, private and community-based services more clearly apparent.

1.3.5 H3N2, 1968: Cold (War) and Flu

The fifth chapter considers another outbreak of influenza that emerged from Hong Kong and became a global pandemic in 1968. This time, Hong Kong’s implication in the transmission of an influenza virus from Communist China to populations all through the free world (and the USSR) was clearly identified; infections worldwide were attributed to H3N2, the “Hong Kong flu”. This pandemic broke or bent many of the tenets of infectious disease epidemiology. In Hong Kong, it was prodigiously infectious, making as many as five hundred thousand people sick but causing only twenty-five deaths. Elsewhere, the pattern was different; in the United States there were fewer cases proportionally but more deaths. As the two-year pandemic went on, Hong Kong’s role faded from discussion among epidemiologists and the media, leaving only the problem of the epithet. When scientists worldwide knew that this strain of flu had almost surely come, once again, from southern China, why should it be the “Hong Kong flu”, and not the “China flu”? A British Cabinet Paper warning of the coming epidemic and best practices for its containment was even worse, conflating its own colony of more than a century with its Communist enemy in referring to H3N2 as “The Hongkong/Mao Flu”. In the context of the Cold War, these were surely differences that made a difference.

Locally, this epidemic caused anger and frustration. The government was very late in acknowledging the outbreak and for the first time, an anti-colonial, anti-government discourse emerged in the context of medicine and disease. Hong Kong had not been an effective sentinel for global surveillance agencies, nor had the government been an effective sentinel for the local people. The spread of this flu from China should have been anticipated and prevented, said the media. The government was weak. At the same time, the government had just months before been strong, too strong, putting down public demonstrations and protests, proving that it was yet unable or unwilling to meet its minimal commitment to the welfare of its colonial subjects. In

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1968, a time where only a handful of colonies remained worldwide, and in an increasingly wealthy, global hub such as Hong Kong, indifference to the colony’s health was unacceptable.

1.3.6 S/CARS

This project concludes with a chapter on the SARS outbreak of 2003. This was the fifth pandemic to emerge from Hong Kong in a century and a half, and in many ways the culmination of the trauma of these and all of the infectious disease threats that had not come to full epidemic fruition. The SARS epidemic in Hong Kong was unique in at least two ways. First, it was a novel infection. When it arrived in Hong Kong, it was known only as feidian, ‘atypical pneumonia’, the pathogen and etiology unknown. Arresting the spread of this epidemic meant a race to come to know the infectious agent and the means by which it spread. Science, epidemiology, and the public health workers in Hong Kong teemed up against time and the terror of the unknown.

The second aspect of this epidemic that is unique in Hong Kong epidemic history was that SARS occurred after the resumption of Chinese sovereignty. In that sense, this chapter breaks with any typical frames of colonial or imperial medicine; Hong Kong now reconnected to its motherland. In many ways, however, the story of SARS acts much like an episode of imperial medical history, with Hong Kong still an anxious colony and Beijing playing the role of remote metropole. Guangdong and the Pearl River Delta region had been strategically and forcibly connected to Hong Kong’s developed economy over the twenty years before the SARS outbreak. The historical and geographical relationships of the region had been reasserted—before you were Hong Kong, suggested China, you were Bao’an county, Xin’an county. Guangdong and Hong Kong are like “lips and teeth”\textsuperscript{50}. When atypical pneumonia spread through southern Chinese medical systems, however, officials did not notify their peers in Hong Kong. Hong Kong authorities learned of the outbreak the way its people did—through the media, and rumours. Indolent communication with Hong Kong and with the WHO raised a great deal of anti-Beijing sentiment. The lack of communication and power play between the PRC and Hong Kong through the crisis served to highlight the ways in which the reintegration of Hong Kong to China was incomplete or fractured.

\textsuperscript{50} The four character expression is 唇齿相依, literally meaning interdependent.
At the same time, SARS served to show that the separation of Hong Kong and China had always been artificial in a few ways. The disease ecology of the Pearl River Delta had incubated and spread epidemics all through the period of colonial rule. Naming Hong Kong a Crown colony or drawing a border at Lo Wu did nothing to separate the territory from the ecological and climatological factors that encouraged the epidemics of bubonic plague, influenza, and SARS. Hong Kong people came to know themselves as *heunggongyahn* and felt political and social difference from their peers in the PRC, but they had similarly navigated expressions of medical modernity that included modern Western medical science and clinical practices and use of traditional Chinese medicine. This chapter suggests, ultimately, that epidemics have been integral in shaping Hong Kong identity. The proof, here, is in the ubiquity of disease and epidemic narratives as subjects in arts and culture. Hong Kong’s artists and public explore and process epidemics together, in particular the SARS crisis. In what other culture are disease narratives problematized, conceptualized, debated, remembered, or celebrated as they are in Hong Kong? Awareness of oneself as a risk for and of contagion, heightened vigilance, and practices of remembering are markers of *heunggongyahn* as much as any other aspect.

1.4 Questions

Under recently, and notably after the SARS crisis of 2003, there were very few studies produced of Hong Kong’s disease or medical histories. There have been texts produced to commemorate particular institutions including hospitals or medical schools but few studies of the medical culture or history of the territory. This is surprising given several factors. First, the disproportionate number of epidemics in Hong Kong’s history might have drawn the interest of scholars. Next, insofar as Hong Kong was a Crown colony for a century and a half, its histories of epidemics and medicine are both colonial and imperial. Having remained a colony of Great Britain decades longer than most of the major colonial sites, medicine in Hong Kong has been colonial for longer and in more contemporary frames than almost any other example. Colonial medicine in Hong Kong began in the mid-nineteenth century, a time in which the traditional Chinese and existing European humoral traditions were not at all dissimilar; the prejudices of either side were as much about racial and ethnic anxiety as they were about the medicine practiced. In an age when Europeans believed in miasmatic sources of disease, practiced bleeding and used drugs of remarkable toxicity, mistrust of Chinese herbal medicine and acupuncture was a cultural prejudice above anything else.
At the same time, medicine practiced in Hong Kong in 1997, just before the handover, was still colonial medicine. Innovations and discoveries in the laboratories of Hong Kong’s world-class universities or private companies may by the late twentieth century have become part of a globalized culture of knowledge production, but these projects refer back to metropolitan London, still. In 1997, there was still prestige for Hong Kong people in studying at Oxford or Cambridge or the London School of Economics before returning to produce knowledge at home. This very late experience of colonialism is rare, nearly unique to Hong Kong. While the present study does not engage the development of the medical system through the 1970s, 80s or 90s in significant detail, the government moved through that period to create more and more effective institutions of medical care and public health. Hong Kong people, through the same decades, moved toward embracing local identity if not colonial rule. In 1997, Hong Kong was returned to Chinese sovereignty, but does that mean that the medicine practiced in its institutions ceased to be colonial despite its foundations? Or did medicine in Hong Kong somehow escape the condition of coloniality earlier in its history? The questions of race, power, and class that drive studies of colonial and imperial medicine remain valid up to the moment of the resumption of Chinese sovereignty.

At that moment, the discourse shifts, but perhaps not as much as one might think. The return to Chinese rule was contested by many in Hong Kong for whom the colony was the only home they had known and for whom local culture was the only culture with which they could relate. A relationship to Chinese culture remained part of Hong Kong life, festivals and culinary traditions and elements of Confucian social philosophy, but many felt no connection to the PRC, to mainland Chinese, and related to Beijing, the centre of political power, in the way that a colonial subject might relate to the metropole. Many in Hong Kong were ambivalent about the return to

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the PRC and about their relationship to their ethnic and cultural ‘family’ in China, often expressed in images and idioms of disease or bodily loathing. There was discourse, for example, about the growing population of *gangpiao*\(^{52}\), or “Hong Kong drifters”, as well as the emerging trope of the locust. Here, mainland Chinese are depicted as a plague of insects that will consume all of the resources in their path. For some, Chinese migration into Hong Kong was seen as an infection the cosmopolitan and modern Hong Kong social body. In this way, the last chapter and conclusion of this dissertation are studies of imperial relationship and epidemics—but the imperial centre is China and we may finally see Hong Kong engaging in a struggle for decolonization, resigned perhaps to its political annexation to China but resisting colonization of its bodily and medical worlds.

This project engages the questions of a wide array of subfields within history as a discipline and the history of medicine. It cannot claim to be a history of colonial medicine in Hong Kong, or of imperial medicine in Hong Kong, of tropical medicine in the colony, or an environmental history this territory. There are threads of all of these subfields woven together, each chapter contributing and drawing more or less on the concepts and idioms of one subfield or the other. Given the diversity of the infectious diseases considered—malaria, bubonic plague, tuberculosis, influenza, and SARS—and the passing of much time across chapters, treatment of each outbreak is uneven. Or, perhaps better to say, each chapter and each epidemic gets a different focus and so reveals something different; there is little attempt at seeing the commonalities between epidemic events. Instead, each epidemic, and so each chapter, positions Hong Kong differently in the world, in the context of the British Empire, in relation to China, or in relation to international bodies. Each epidemic and chapter captures more or less of the local, sometimes individual personal experiences of sickness or more or less of the movements of global bodies. Each chapter is an event history but the project nonetheless explains something about the whole of Hong Kong’s history. A history of less than two hundred years challenges the boundary of what we might consider the *longue durée*. The integral role of infectious disease and epidemics in shaping Hong Kong’s built environment, political identity, social structures, and local subjectivity appears in the broader view, a reliable continuity.

\(^{52}\)港漂 literally translates to “port drifter”, and is paralleled to the term 北漂 which refers to the young, educated rural population who migrate to Beijing in search of better opportunities.
1.5 Methods

In as much as I have been inspired by interdisciplinary studies, my sources are predominantly historical. I consulted the Public Records Office at Hong Kong for archival and documentary evidence dating back through the 19th century and up to the present. Recently, the Hong Kong Government Reports Online (1842-1941) database that is part of the Hong Kong University Library Digital Initiatives (HKULDI) has made most of the colonial archives available in digital form. I relied significantly on the National Archives of Britain at Kew where the Records of the Colonial Office, Commonwealth and Foreign and Commonwealth Offices, the Records of the Foreign Office and the Records of Cabinet Office are held, as well as on ephemera catalogued along with these holdings.

In Hong Kong, I used the digital and local archives of the Hong Kong Collection at Hong Kong University. This collection holds personal narratives composed by visitors to Hong Kong in its infancy, pamphlets generated by Hong Kong’s government, in particular by public health and sanitation services, as well as the publications of private agencies. Some of the key sources that I accessed in this collection are now available online through the HKULDI database section titled “Hong Kong and the West Before 1860”. In the Hong Kong collection, I spent time looking at conference proceedings for several branches of scholarship relating to medicine and public health. This type of source was especially valuable in teaching me about the long interplay between Western and Chinese medicine in Hong Kong; by tracing discourse between conferences that attempted to reconcile or translate knowledge and theory between the two traditions, I gained insight into Hong Kong’s hybrid medical culture. Research at the Chinese University of Hong Kong’s Institute of Chinese Medicine similarly informed me on the vast interest and number of studies currently underway seeking to “modernize Chinese medicine”. These studies are mostly bench-based but their research designs often conceal political and

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53 I will be watching with keen interest to see developments in the Hong Kong archives. In late 2013, The Guardian reported that the British Foreign Office was hoarding over 1.2 million records that ought to have declassified as per the Public Records Acts on the occasion of 30 years passing. The Guardian reported that the total archive was believed to be “far larger than the combined undisclosed archives of every other government department” and “staggering”. The contents of these secret archives have not been disclosed due to the enormity, but they include records of the Colonial Office, the primary source for Hong Kong related discussion up until the mid-20th century. The contents and significance of these records can’t be known now, but my hope is that they will add depth to Hong Kong’s sometimes patchy records.
epistemological secrets. In particular, they indicate the ways that researchers approach knowledge translation—communication between laboratory, clinic, and the public—when the challenge of translating between medical paradigms complicates the process.

The Hong Kong Public Library was an invaluable research support. Here I was able to view microfilm and some digitized files in the Old Newspaper Collection as well as non-circulating materials produced through the public health services. The publications of the Hong Kong Museum of Medical Sciences and conversations with their passionate staff and volunteers informed my sense of life in the Chinese community at Taipingshan. The Taipingshan Medical Heritage Trail project affirms my view that medical crises were indeed seminal to the evolution of colonial Hong Kong and to shaping the subjectivity of Hong Kong people, the psychic wounds of successive epidemics passed from generation to generation. How many cities make tourist attractions—more than one—that commemorate epidemics or offer guided walking tours retracing disease episodes? Many Hong Kong people, with their masks and sanitized elevator buttons, diligently practicing technologies of the self. This refers to, for Foucault, three things: expertise grounded in scientificity, expertise that “produces a new relationship between knowledge and government, and expertise that operates through self-regulation.” In today’s glamorous Soho or trendy Sheung Wan there remain very few reminders that the area was once the site of a devastating outbreak of bubonic plague, whitewashed once with paint to keep things sanitary, and whitewashed again by development and gentrification. The ghosts of Taipingshan are one’s companions in the archives and in the streets.

In London, I consulted the National Archives of Kew, reveling in unexpected finds in miscellaneous folders that were not reproduced for the Hong Kong PRO and in the wonderful maps collection on site. At the Wellcome Library, I spent weeks reading and transcribing the diaries and letters to family and friends sent back from Hong Kong in its first decades of colonial rule. As I followed their lives in Hong Kong take shape, some of the writers of these documents began to feel like friends. I smile when their voices emerge in this dissertation. It was a particular thrill to find the final exams of Sun Yat-sen, the father of modern China and one of the Hong Kong College of Medicine for Chinese’s first graduates. I spent a long time reading the

54 Nicolas Rose, Inventing Our Selves (Cambridge: Cambridge University Press), 156.
thoughtful correspondende of Sir John Cantlie and spent a long time failing to decipher Sir Patrick Manson’s difficult scrawl. It was during my months of reading at the Wellcome Library in particular, but also at the British Library and at the National Archives, that the history I sought to study became to feel real, long passed but still present. And beyond the time I spend on task, calling up fonds pertaining to my topic, I spend days wandering these archives following my instincts and whims, feeding on medical science, medical history, and medical humanities. These days, particularly those spent exploring at the Wellcome Library and Collection, were the happiest and most fruitful of my doctoral training.
Chapter 2
Malaria, 1843: The ‘Hongkong Fever’

2 Britain’s Chinese Colony

Like so many of its properties, the climate of Hong Kong is liminal. Although it is geographically located within the tropics, the climate is classified as sub-tropical because of the influence of regular cold Siberian air masses. And in spite of being classified as sub-tropical, the climate is temperate for half of the year. As one of the last major additions to the British Empire in the nineteenth century, Hong Kong’s architects hoped to benefit from two hundred years’ experience at building empire in temperate zones, the United States, Canada and New Zealand, South Africa, and South Australia, or from experiences administering the tropical colonies in South America, the Caribbean, Africa, the Middle East, South Asia, or Asia-Pacific.

When they arrived at Hong Kong, the British had no intuition of the economic engine that the colony would become nor did they arrive with plans for the metropolis they would build. Indeed, narratives on the early years of Hong Kong’s colonial history are rather characterized by ambivalence, anxiety and skepticism; many were in fact not confident in the viability of this British enterprise on the periphery of the Qing Empire. In spite of those temperate months, the early colonizers quickly realized that life in Hong Kong more closely resembled a tropical experience than it did life in the ‘temperate zone’ and that they would face all of the challenges of civilizing a tropical space.

China was a new frontier in Britain’s empire and attracted men with commercial interests, ambitions in civil administration, adventurers, and misadventurers. Like their colleagues in the earlier established tropical colonies, the early colonials at Hong Kong encountered challenges in adapting to life away from Britain. Among the worst of these were the fevers inimical to life in the tropics. An outbreak of malarial fever in 1843 was dubbed the “Hongkong fever”, taking thousands of lives and earning yet another nickname for malaria. Unprecedented rates of morbidity alarmingly high rates of mortality fueled anxiety that Hong Kong was exceptionally unhealthy for Europeans; the dangers of disease and the natural environment were a greater threat than clashes with the ‘paper tiger’ Qing dynasty or any other human influence. Fear of the fevers and anxiety about their unknown source were the predominant motivating and explanatory
logics behind the choices the early colonizers made in laying out the foundations of the colony. Unlike other tropical colonies where there were natural and human resources ready for appropriation, Hong Kong offered only its deep harbour and its geographical position in a triangulation of British commerce between Canton, Shanghai, and Singapore. With so much at stake and no guaranteed gains, the deadly fevers in Hong Kong’s first years surely called the wisdom of Britain’s investment into question.

This chapter demonstrates that if Hong Kong’s colonists had ever hoped that the island’s six temperate months could lead strategies of colonial development, that Hong Kong might have been groomed as a “Neo-Europe”. 55, the ‘Hongkong fever’ quickly recast the island as tropical. The colony’s very foundations—the placement its first settlements, design of buildings, the preoccupations and psychology of administrators and planners, and a series of laws conditioning the interactions of the European and Chinese populations—were all shaped by conditions that the early colonizers would have understood as associated with the tropics, or, as Arnold would put it, they came quickly to see their new project through the logic of ‘tropicality’. From the earliest point, the evolution of Hong Kong’s built environment and social world was determined by the interactions of nature, disease, and human agency. As the built environment and social world of Hong Kong coalesced, its early occupants imposed associations between race, climate and disease that founded civilizational hierarchies in other tropical colonies. These were at times irrational in Hong Kong where seemingly everyone, European or Chinese, was vulnerable to the ‘Hongkong fever’. Driven by fear and anxiety, the early colonizers deemed Hong Kong a “white man’s graveyard” comparable to Africa or India. The results were spatial and legal relationships that mirrored the racial and moral hierarchies of imperialism.

2.1 First Impressions

Before the establishment of the British colony in 1842, the territory that is today known as Hong Kong, including the Island, Kowloon, the New Territories and Outlying Islands, was sparsely and transiently populated. In the British metropole, there was little excitement about the

55 For discussion of Neo-Europes, see Alfred W. Crosby, Ecological Imperialism: The Biological Expansion of Europe, 900-1900 (Cambridge: Cambridge, 1986). Here, Crosby explores colonies built in the temperate zones, home to large populations of Europeans and their descendants while geographically very distant from Europe, and engaging the question of why these Neo-Europes tend to produce surpluses of food and to be prolific exporters of food at rates much exceeding neighbouring countries.
concession and it was taken, even, as a matter of play; the young Queen Victoria wrote to her uncle, the king of Belgium, “Albert is so amused at my having got the Island of Hong Kong and we think Victoria [her baby daughter] ought to be called Princess of Hong Kong in addition to Princess Royal.” Hong Kong Island had been the home of fishermen, traders, and pearl-fishers who came and went between their villages and the mainland to trade; the Yao or Yue, pearl-fishers, bearing the earliest influence, and then Tanka, Hakka, Punti, and Hoklo, each contributing to the cultural topography of the region. Based on ruins of a burial site and a small Buddhist temple in the New Territories, K.M.A. Barnett traces Chinese presence in the area back to the early Song dynasty with non-Chinese groups inhabiting the area through the Tang and Yuan dynasties. Imperial records confirm that a Chinese commander was appointed to Tuen Mun in 954 C.E. and a fortress built in 958 C.E.. There are archeological suggestions of an earlier fortress but no conclusive evidence. Extensive agriculture in the region of the New Territories shows that soldiers garrisoned in the area along with their families. These families began to cultivate the land, notably a family surnamed Mo followed by clans surnamed Tang and Chan.

While pointing to the long-standing presence of these ethnic groups, Barnett also affirms the interrelation of the space that became Hong Kong with the history of Canton just seventy-five miles inland. Since most Chinese dynasties had focused on extending the empire westwards, pursuing the rich trade routes leading to India and Central Asia, China’s southern coastal regions remained sparsely populated by soldiers, traders, and political exiles, gaining the reputation of

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58 Barnett claims that the inhabitants of the Hong Kong region were referred to up to that time as “mraan”. The Chinese character Barnett provides for this term is indecipherable in the available reproduction of the journal. Barnett does not specify what items of “Chinese literature” he refers to in the claim. See Barnett, 43.

59 Barnett, 43.

60 Barnett, 47.
being remote from Chinese culture as well as lawless. This was, however, the first region sanctioned for foreigners to take up residence and to conduct trade during the Chinese Sui dynasty. This might be interpreted as an historical precursor to the Special Economic Zones established in the same region by Deng Xiaoping, also with the intention of encouraging foreign investment and trade, nearly 1500 year later. The foreigners who arrived during the Sui were most often Arab, Indian, Persian or Javanese, trading spices for silks, maintaining a sustained presence in the Chinese south from the sixth century onward. The predominance of Cantonese language and culture in Hong Kong is indicative of aboriginal Yue influence in the region, a history that sustains the enduring sense of alterity from the Chinese political and cultural centre across time. By the Tang dynasty, claims Balfour, the admixture of Yue, indigenous maritime societies and the Han garrisons in Canton produced a settled local culture and maritime industry that is now thought of as the region’s characteristic.

The name, Hong Kong, meaning ‘fragrant harbour’, referred only to the Island before the arrival of the British. It came to signify a larger territory only as Britain extended its concessions through the Convention of Peking in 1860 and then the lease of the New Territories in 1898. An early visitor attempted to explain the pronunciation of the name as a “foreign corruption of Heongkong…the vulgar pronunciation in the local patois of Hiangkiang”. Other visitors musing on the inspiration for Hong Kong’s name fixated less on the harbour than on the streams of water that flowed from the Peak to the shore. Neither harbour nor streams, apparently, lived up to the claim of a lovely fragrance. William Charles Milne wrote about his disappointment, the broken promise of a “scented stream…a series of spicy cascades, eau-de-cologne, or lavender water,”---in which case fancy would certainly be more romantic than fact. Allom and Wright found the streams running down the hills of the island very grand but were also skeptical of any promise of perfume, writing,

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62 Balfour, 153.
63 Balfour, 153.
65 Milne, 483.
[t]he purest water, which is seen falling from the cliffs of the Leong-teong, or two summits, in a series of cascades, the last of which glides in one grand and graceful lapse into a rocky basin on the beach… [i]t is from this fountain, "Heang-keang, the fragrant stream, or Hoong-keang, the red or bright torrent, that the island is supposed to derive its name.\textsuperscript{66}

Despite its appealing waterways, Hong Kong’s prospects seemed dim. Few had much good to say for the location, the climate, or the local people. Many observers noted Hong Kong Island’s granite base and its barren, deforested appearance. These observers were often experienced in colonial service and had arrived from posts in other Crown colonies; with tropical sunsets near to memory, Hong Kong failed to impress. The \textit{Chinese Repository} described the island as “exceedingly uneven, rising into numerous ridges and peaks" and bemoaned the lack of arable land\textsuperscript{67}. Register of Deeds William Tarrant also worried about the lack of arable land, noting the lack of trees and barren qualities of the island\textsuperscript{68}. He described the territory as “precipitous and uninviting….Its high hills often terminate in sharp peaks, and are thickly strewed with masses of black rock of primitive formation, frequently piled upon one another in a most remarkable and sometimes fantastic manner, with here and there two or three lower hills covered with gravel and sand”\textsuperscript{69}.

Tarrant’s concerns were echoed by the Austrian explorer Karl Ritter von Scherzer who wrote, “Owing to the barren, treeless surface, which consists for the most part of chains of hills…hardly

\textsuperscript{66} Allom and Newenham Wright, 17.


\textsuperscript{68} Tarrant is an interesting figure in early Hong Kong lore. He has the honour of being one of Hong Kong’s first civil servants and also the dubious honour of being one of the first prisoners of Victoria Gaol. Tarrant’s struggles are a fascinating aside to Hong Kong’s legal foundations and perennial struggles with corruption. Tarrant was known to be a model civil servant and of being highly intolerant of any disreputable behaviour in the British ranks. When he reported that Colonial Secretary Captain (later Major) William Caine’s comprador Lo In Tin was collecting a duty fee on the merchants of Central Market in his employer’s name, Tarrant was suspended from office, accused of plotting against Caine. To exact revenge for this accusation, Tarrant purchased the newspaper \textit{The Friend of China} and for over ten years used the paper as a platform to advance his complaints against Caine’s regime. On the eve of Caine’s return to England, a hero of the colonies, Tarrant published a scathing attack. Caine delayed his return long enough to have Tarrant fined £50 and imprisoned for libel. Altogether, Tarrant spent thirty-two years in Hong Kong, a full one of which was spent in the gaol.

\textsuperscript{69} William Tarrant, “The Government of Hong Kong 1846 and list of Chinese traders in Victoria, in the Autumn of 1845,” in \textit{The Hong Kong almanack and directory for 1846: with an appendix} (Hong Kong: Office of \textit{The China Mail}, 1846), 22.
a twentieth part of its surface is adapted to agriculture.” Milne, a true son of empire born in Malacca to a missionary family, saw the same paradoxes. There were excellent waterways and exotic flora up the face of the mountain, but little arable land “cultivated with rice, peas, and potatoes.” Von Scherzer and George Allgood both compared Hong Kong to another colonial possession, Gibraltar, but found Hong Kong to be perhaps a paler version. Surgeon and naturalist Clarke Abel made his disappointment clear, writing, “Hong Kong….presents few characters of a very picturesque description.” Nothing but the deep harbour and proximity to the Canton trade seemed promising. For every charming feature described, the first visitors warned of at least as many flaws or dangers in the natural environment. This ambivalence stayed with the colony for decades.

2.2 Bad Omens

There were suggestions of other problems, as well. Henry Sirr, veteran of the Indian colonies, was among the first to predict great troubles with disease at Hong Kong. In China and the Chinese, one of the earliest geographies of Hong Kong, Sirr warned that the local environment was dangerous, perhaps the worst in all of China. He stated his anxieties clearly, writing,

The island is as deficient in resources, and insalubrious in climate as it is insignificant in size….The climate of China is, in no small part of the empire, salubrious or adapted to the European constitution, but, of all parts of China, Hong-Kong is the most insalubrious, and the

71 Milne, 439.
73 Clarke Abel, “The Waterfall at Hong Kong, June/July 1816,” in Narrative of a journey in the interior of China, and of a voyage to and from that country, in the year 1816 and 1817: containing an account of the most interesting transactions of Lord Amherst’s embassy to the court of Pekin, and observations on the countries which it visited (London: Orme and Brown, 1818), 62.
variability of the seasons and temperature are exceedingly injurious, and test the strength of the most robust constitutions.\(^\text{74}\)

Sirr’s warning was prescient. Britain had no sooner planted its flag before its men began to fall ill. One veteran of the Opium War reported that even excitement over Britain’s victory and the founding of a new colony was dimmed by “the sickness spread[ing] among men with alarming rapidity, so that, at length, out of our small force, no less than eleven hundred men were upon the sick-list at Hong Kong.\(^\text{75}\) Visitors rarely failed to mention the rampant fevers in their reports and letters, accounts characterized by an extreme anxiety and sense of bafflement. The *Friend of China* discussed the anxiety over the unknown etiology of the fevers, associating the miasma with the island itself:

This, like heat, is an invisible, mysterious agent, but very deleterious to the human constitution. We cannot explain its modus operandi, and how much less do we know the laws which regulate its production, diffusion, and influence; and yet we are fully assured that such a poison is eliminated, from the earth's surface, at certain seasons and places, and that when it comes into contact with our bodies, that we are seized with fever, dysentery, and other disorders, which destroy myriads of people every year.\(^\text{76}\)

With only twenty or so fishing villages on Hong Kong Island at the time of colonization, medical missionaries had not bothered to establish posts on island. Before the construction of the Naval and Military Hospital in 1841, the nearest clinic was at Canton. When the first outbreaks of fever occurred, there were few options for medical care in the colony itself. There was, however, a hospital ship deployed to southern China before the end of the Opium War, the *HMS Minden*, under the command of a Captain Quin. The *Minden* served not only Hong Kong but the whole vicinity of the ‘Chinese Seas’ including two other treaty ports opened in the Treaty of Nanking, Amoy and Chusan. The Inspector of Naval Hospitals and Fleets assigned to the *Minden* was Dr. John Wilson, formerly of British India, whose *Medical Notes on China* provides invaluable

\(^{74}\) Henry Charles Sirr, *China and the Chinese: their religion, character, customs, and manufacturers: the evils arising from the opium trade: with a glance at our religious, moral, political and commercial intercourse with the country* (London: Orr & Company, 1849), 6.

\(^{75}\) Tarrant, 4.

\(^{76}\) *The Friend of China*, 22 June 1844.
context to the medical crises that the tropical geographers, missionaries and administrators
describe. Wilson’s own observations on disease, ecology and local people are flanked by several
commentaries on his book that were published in medical journals of the day77. Like Sirr, Wilson
believed the south China region to be particularly toxic; his descriptions of the areas surveyed by
the Minden debate a malignant agency in the geography and climate he faced.

2.3 The Outbreaks

2.3.1 West Point

By 1843, two barracks had been built for arriving troops. The first was at Chek-chue, called
Stanley, and the next at West Point on the shore beyond today’s Pokfulam Road and Queen’s
Road West. The barracks at West Point had been unpopular with the Commander-in-Chief of the
British Forces in China, Hugh Gough, who foretold future troubles in 1842, writing, “I am
persuaded that the north side of the island of Hong Kong will never be healthy during the hot and
wet season (that is from about the middle of June to the middle of September) for Europeans”78.
Observing sporadic cases of fever among the troops stationed there, Gough further speculated
that the area at West Point was especially malignant, worse than other parts of the island. On this
issue, Gough was at odds with colony’s first governor, Henry Pottinger. Known for his exploits
in India, Pottinger took a broader view of the fevers and high mortality. He attributed the deaths
to a triumvirate of tropical climate, crowded accommodations and the colony’s generally
difficult geography. He testified to this at an inquiry held by Gough on December 9, 1842.
Persuaded by Pottinger, the inquiry concluded, “On the question of locality, the Court is of [the]
opinion that in the North, or Town side of the Island, although the Europeans at West Point
suffered most, still so much sickness prevailed amongst the Native Troops in the other barracks
as to make it impossible to attach much importance to locality only”79.

77 See John Wilson, Medical notes on China (London: J. Churchill, 1846), 161.; “Wilson’s Medical Notes on China”
The Medico-Chirurgical Review and Journal of Practical Medicine, New Series, Vol. IV, April 1-September 30
(London: Highley, 1846), 73.; “Dr. Wilson’s Medical Notes on China”, The Lancet, Volume 47, Issue 1 (London:
Wakley, 1846), 629-630.; “Art. II. Medical Notes on China,” Edinburgh Medical and Surgical Journal, Volume 66
(Edinburgh: A. and C. Black, 1846)

78 Colonial Office (hereafter CO) 129/1:118a, Gough to Pottinger, 7 October 1842.

79 CO 129/1: 166, Proceedings of the Court of Inquiry, 9 December 1842.
A series of outbreaks through 1843 challenged Pottinger’s view. The *Chinese Repository* reported in February that there were 1,201 European and 550 Native rank-and-file troops in Hong Kong living in barracks at either end of the island. The largest contingent among the European troops, the 55th Regiment of Foot, numbered 500 and were barracked at West Point. It was at West Point that Hong Kong’s first true epidemic broke out.

The first fevers are mentioned as arriving along with spring rain in May; West Point reported a rise in the number of patients suffering “severe Remittent and continued Fever.” It was Dr. Wilson who first alluded to ‘the Hong-Kong fever’, noting the way it affected even the strongest of men:

> There is great proneness to relapse; and after the disease has been apparently subdued, and the tendency to recurrence overcome, the subject continues long listless and emaciated, has sallow countenance, with pale lips, and hovers on the verge of jaundice, dropsy, or fatal flux. In enumerating the most prominent symptoms of the recent cases, it was stated that the patient sometimes sunk before the completion of one period of the fever, a statement equivalent to saying that death occurred within twenty-four hours; and this in strong muscular men, who had been in perfect health a few hours before. It seldom happens that disease assumes a more formidable aspect than this.

He concluded that the Hong Kong fever was systemic, though it might not affect every part of the body at the same time. Its influence was particularly strong in the sensory and vascular tissues, slowing, stopping or hastening bodily secretions, and causing paralysis. The “pestilential miasma acted, in many respects, like a concentrated narcotic poison… [striking] at the source of vitality”, bringing death, and leaving scarcely a trace. Responding to Wilson, the *Edinburgh Medical and Surgical Journal* concluded that, “Hong-Kong is in short pre-eminentely an unhealthy situation singularly destructive to European troops and seamen.” While Wilson and

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81 CO 129/7: 182a, Proceedings of the Medical Committee, 15 July 1843.
82 Wilson, 133-134.
83 Wilson, 135-136.
84 Wilson, 135-136.
his contemporaries confidently associated this particularly virulent fever with Hong Kong, no one could locate its cause. Wilson admitted the mystery, noting, “[n]either the morbid phenomena, nor the post-mortem appearances, in these cases, gave any support to the theory of localism, or the doctrine which teaches that there is no such disease as essential fever; that universally it is a symptomatic, nor idiopathic affection.” Identification of the mosquito as the vector of malarial infections was still half a century away. For the time being, Wilson and his interlocutors anticipated, and searched for, a miasmatic influence emanating from some particular bit of Hong Kong’s natural environment.

Between May 20 and July 15, Major-General Saltoun launched an investigation into the 294 cases of fever counted at the barracks of which twenty five cases proved fatal. There was no obvious cause for the fevers, no clear source of evil vapour, miasma, or contamination of the earth near the barracks. Popular opinion was that the barracks should be vacated and the Regiment moved elsewhere on the island. One local newspaper took a stand, stating,

We understand that sickness to a very alarming extent prevails among European Soldiers stationed at West Point…We think there is something obnoxious to the European constitution in this part of the Island, and as it is difficult to trace the immediate cause…we trust the authorities will see the necessity of abandoning the place entirely and this be the means of saving the lives of many unfortunate men who cost the Government upwards of a hundred pounds each for their passage to this country.

This statement reveals two aspects of the mentality of the day. First, the writer’s was concerned with miasma at that locale because of its effect on Europeans, not to human beings in general. Second, the cost of the fevers was measured in pounds and not lives. The imperative that Hong

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85 Wilson, 135-136.
86 CO 129/7: 182a, Proceedings of the Medical Committee, 15 July 1843.
87 Hongkong Eastern Globe, 5 July 1843, as reprinted in the Canton Press, 15 July 1843 as quoted in Christopher Cowell, “The Hong Kong fever of 1843: collective trauma and the reconfiguring of colonial space,” Modern Asian Studies 47, no. 02 (2013): 335. I was not able to locate a copy of the Hongkong Eastern Globe or to retrieve this particular issue of the Canton Press at the time of my research.
Kong create profit for metropolitan Britain and not carry any balance for its administration was a principle that penetrated to the very heart of colonial life. When Hong Kong was made a Crown colony, it became the responsibility of the Colonial Office and the burden of British taxpayers. Unable to pay its own administrative costs in its first years, the colony required a Treasury subvention. This meant that budgets had to be produced a year in advance and sent to London before Hong Kong’s own Legislative Council or other bodies could spend. Even after Hong Kong stopped being paid the subvention, a culture of minimal government, running the colony on a shoe-string, providing none but the most essential of public services, endured. This political and financial culture had repercussions on the health and development of Hong Kong for decades, as will be seen in following chapters.

Saltoun’s investigation concluded on 15 July. At this point he called together the physicians of the colony as an *ad hoc* medical committee. They convened at West Point barracks and conducted an inspection of the built and natural features of the settlement. They found no obvious miasmatic source explaining the fevers but rated a few possibilities. There was concern over the dense greenery all around, the “rank grass and exuberant vegetation”\(^8^9\). Still, there didn’t seem to be quite enough exuberance as to have caused such a serious outbreak, thought some. Others were of the opinion that the barracks had been unwisely positioned away from cooling breezes and some three to four kilometres from Victoria, the colony’s centre. The men of the 55th Regiment therefore had to march between the barracks and the town, and to other locations each day, battling against the heat and humidity. They also took guard duty one in every third nights. Military service in a tropical colony was a demanding and exhausting way of life. But nothing in the findings of the committee’s inspection explained the unusual severity of cases in this outbreak. Visiting his patients, a Dr. Bell discovered a worsening scene; he found his charges, in a state of extreme disability and many of them evidently rapidly sinking under their diseases. Their number amounted to one hundred and forty-four, besides several women and children, and they had not room in the wards even for the common hospital utensils, which were therefore placed outside on the common verandah\(^9^0\).

With no other options, Saltoun ordered the evacuation of the 55th Regiment, the destruction of the West Point barracks, and burial of the dead nearby. Two ships moored in the harbour, the *Judith Allen* and the *Sappho*, received displaced but healthy soldiers while the hospital ship *Minden* received the sick. Disposing of fatal cases was a gruesome concern; without sufficient cemetery

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\(^8^9\) CO 129/7: 182–184, Proceedings.

\(^9^0\) CO129/1 164, Despatches
plots at the ready, the hospital ship pushed the bodies over the deck, into the sea. Vacation of
the barracks took about ten days. West Point had been little short of a disaster. The question then
was where the surviving members of the 55th Regiment of Foot and the replacements of those
lost would live. New barracks were necessary and demand for healthy shelter would grow along
with the colony. Without understanding the causative agent behind the fevers, an amorphous
entity at the time, how could Hong Kong’s planners anticipate dangers ahead?

2.3.2 East Point and Happy Valley

Closing the West Point barracks did not solve the problem of the ‘Hong Kong fever’. Indeed,
fever continued to crop up throughout the colony all through 1843 with concentrations of cases
at the eastern and western edges of the settlements. To the east of the old barracks was the
enclave built by trading house Jardine Matheson & Co. Jardine Matheson had been among the
first to invest in Hong Kong, even before the formal establishment of the Crown colony. Their
base was set west of Victoria near the contemporary Causeway Bay area. The first buildings in
the area were warehouses, called “godowns” in the Asian colonies, followed by an office
building and a residence called East Point One. Another large bungalow was built nearby,
protected by a wall and by armed Native guards, though, as Cowell notes, Jardine Matheson &
Co. held to the practice of storing bullion on anchored ships off-shore to protect it against theft.

The area around East Point is a valley, and had not yet been incorporated into colonial designs.
Commander Belcher, a naval surveyor, had originally favoured the Wong Nai Chung valley as
the centre of Britain’s new colony but a site further west was chosen instead. In 1843, the valley
was still a marshy wetland separating the Jardine Matheson & Co. settlement and the
government and colonial centre of Victoria. That spring, the fate of Wong Nai Chung valley
was a topic of much debate. In just two years, the colony had grown quickly enough that it would
soon outgrow Victoria. Accordingly, the government produced a plan to reclaim and drain the
marshland and then to create a new town centre. The plan submitted by Land Officer Alexander

91 CO 129/10: 475, Woosnam (Pottinger) to Parker, 15 July 1843
92 Cowell offers a lengthy discussion of the architectural qualities of the Jardine Matheson & Co. enclave.
93 Cowell, 339.
94 See Edward Belcher, Narrative of a voyage around the world, performed in HMS “Sulpher”, during the years
1836-1842,–vol. 2 (London: Henry Colburn, 1843)
T. Gordon envisioned a residential enclave for both Europeans and Chinese, though their residences would be kept separate within the settlement. Europeans would take the sea-facing homes and those along a ring road surrounding the new development. There would be a praya or promenade lined with warehouses as had been built at Macau and a canal system to manage the water table in the area.

As Saltoun was busily closing up West Point, fever broke out at East Point, halting any plans for land reclamation or development. And indeed, the outbreak on the eastern side of the colony inspired much of the loathing and bad humour toward Hong Kong expressed by the visitors and residents. There seemed to be something bewitching about Wong Nai Chung, dubbed ‘Happy Valley’ by the Europeans, a place both beautiful and deadly. Unlike other parts of the island, Wong Nai Chung impressed colonials and visitors with its natural characteristics. Henry Sirr, so cautious about Hong Kong, praised the view of Wong Nai Chung from aboard a ship rounding the island from Victoria, writing,

   many picturesque views of the harbour and shipping may be obtained by the lover of nature as he pursues his way; broken rocks relieved by stunted tree, clad in dark green, with occasionally a noble mango or lei-chee tree, the branches dropping under the weight of the delicious fruit, give interest to this panorama of nature.

Sirr lauds Wong Nai Chung as “the most picturesque portion of the Island”, describing the nullahs flowing down from the peak as “pellucid streams”. He praised the efforts of the Chinese at rice paddy cultivation, “manuring and irrigating this artificial soil...the exquisite

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95 Praya, from the Cantonese *hoipong* (海旁) is a term for a waterfront promenade used in colonial Macao and Hong Kong.

96 This term became a euphemism for cemeteries and was attached to the valley after the first outbreak of 1843. Today, Happy Valley houses six of Hong Kong’s oldest cemeteries evincing Hong Kong’s diversity; they are the Jewish, Hindu, Parsee, Catholic, Muslim and Colonial cemeteries. This euphemism was also applied to colonial locales in East and South Africa.

97 Sirr, 5.

98 Sirr, 5.
bright brilliant green of the young paddy present[ing] a most beautiful contrast to the aged rocks; pleasing alike to the artist or admirer of the handiworks of bountiful nature”99.

Sirr’s view of the valley is idyllic, the best of the tropical sublime. Others, however, were preoccupied with the prevalence of miasma and death. Imperial botanist Robert Fortune opined a friend lost to the fever,

[t]he "Wang-nai-chung", that "Happy Valley" already noticed, was another most unhealthy spot. One of my fellow-passengers, Mr. Dyer, and his partner, who came out with high hopes of succeeding in business under the new regulations, went to live in this place, where, in a few days, they were seized with fever, and in a few more that had both gone to "that undiscovered country from whose bourne no traveller returns.100

One by one, the private residences at Happy Valley were afflicted by fever, their tenants succumbing to the sickness or fleeing the area. By 1861, just one dwelling remained at Wong Nai Chung, a final testament to the failure of what Cowell calls “the valley experiment”.101 Following the malaria epidemic of 1843, the merchants loathed Wang Nai Chung to the same degree that the military had grown to fear West Point102. Even for Sirr, charmed by the view, Wong Nai Chung inspired terror:

Alas! sickness and death lurk amid this picturesque scenery, for the exhalations arising from the water produce fever and ague, which too frequently terminate fatally, and some individuals, attracted by the beauty of the scenery, erected some apparently desirable residences, the successive inhabitants of each of these were seized with fever and died. The goodly dwellings were now all deserted and falling into decay; doors and venetian blinds were dripping off their hinges, whilst rank dense tropical weeds are springing up in what had

99 Sirr, 5. It is likely that most of the paddy cultivators at Hong Kong—particularly in the 1840s—were not ethnic Chinese but instead Hakka or Hoklo who had dwelled at Hong Kong longer than the Cantonese Chinese who added great numbers only following colonization.

100 Robert Fortune, A Journey to the Tea Countries of China Including Sung-Lo and the Bohea Hills; with a Short Notice of the East India Company's Tea Plantations in the Himalaya Mountains: With Map and Illustrations (London: John Murray, 1852), 14-16.

101 Cowell, 341.

102 Cowell, 342.
been laid out as flower gardens; the withering sense of desolation and death, which flickers before the mental vision of the spectator, is overpowering. The mind reverts to the occupants who arrived in this distant clime full of health and hope. Where are they now?--Tenants of the cold grave, where no kindred dust commingles with their own, their earthly remains being devoured, before decomposed, by the disgusting land crab.103

Indeed, Wong Nai Chung inspired Sirr’s famous epithet on Hong Kong. Despite the work of the colonial authorities and merchants of the colony, the advice of physicians and military experts long-experienced in tropical colonies, a higher logic governed Hong Kong, he warned: “All around appears to impress on the visitor the sense, that Death is the presiding genius of Hong-Kong”104.

2.3.3 The Aftermath

1844 brought some relief; yearly averages for invalided troops were four times higher in 1843 and mortality 20 percent higher than in 1844105. Dr. Wilson, observing from the Minden, still could not discern the cause of the fevers. An answer was beyond the reach of the European medicine he knew. In the tropics, the tools of the physician were too blunt and crude, he concluded:

The more that is seen of some forms of disease, and the more closely they are studied, including especially the precipitous fevers of the tropics, the more likely is the conviction to come and deepen, that medicine has often but little remedial control over them and grave questions will then arise as to whether artificial appliances, confused and contradictory as they often are, may not prove injurious rather than beneficial—if not curative or tending to cure, will they not become instruments of harm?...One example out of many may be alluded to, namely, the treatment of dysentery in India, though that of fevers in general would not be less in point.106

103 Sirr, 5.
104 Sirr, 5.
105 Wilson, 185.
106 Wilson, 190.
As for the Chinese in Hong Kong, very little was recorded, and there are no comprehensive medical statistics for the colony for decades to come. A. R. Johnston recounts, however, that the “intermittent and remittent fevers and dysentery” affected the Chinese just as severely as the Europeans. He notes also that the Chinese had “no remedies of their own except counter irritation produced by pinching and rubbing with the fingers and with copper cash, in fevers.”

Wilson’s observations on the epidemic predict the crucial role that disease and medicine would play in Hong Kong’s development. While Elliot had proclaimed that the Crown would leave Chinese in Hong Kong to their own customs and traditions, some early-comers to Hong Kong saw the new colony as ripe for a civilizing mission. As Chinese migrated into the colony in search of opportunities to labour, Dr. Wilson hoped that Western medicine would win converts not just to his medicine—which was admittedly ineffective in treating the ‘Hongkong Fever’—but to the European way of life. When medical missionaries built the Hospital of the Medical Missionary Society 1843, Wilson praised their tolerance toward Chinese patients, writing,

Their cherished habits are not violently attacked, their superstitious follies and pagan perversions were not made the subjects of ridicule or contemptuous pity, but they were led to their abandonment by showing them a better system of things, and probing its best superiority through its practical results. Persons who went in wasted, maimed, or blind, came out with renovated vigour or restored sight. Can the Chinese continue long to resist such teaching?

The Lancet agreed with Wilson; “It is indeed a beautiful subject for contemplation,—three or four medical emissaries, setting themselves down at the verge of this enormous empire, holding in their hands the choicest blessings of civilization, attempting to quicken the inertia of the hundreds of millions of China with the active humanity of our profession. Already does the system bear fruit.”

According to Dr. Wilson and his contemporaries, medicine was the empire’s greatest evangelist. As an example, Wilson described a young patient at an ophthalmological clinic, “soon [to] return to his native place, near Canton, to display the fruits of

108 Wilson, 151.
109 “REVIEWS: Dr. Wilson’s Medical Notes on China,” The Lancet, 47, Issue 1 (1846), 629.
what he gained at Hong-Kong. Others will follow, to penetrate further and further into the
country, till the whole empire, it is hoped, shall be pervaded by those real reformers and
benefactors of their fellow men”110.

For Wilson and the men of his time, Western medicine would operate in tandem with the free
port and growing markets that attracted Chinese to the colony. Because of the Crown’s mandate
not to expend money on services for the transient Chinese labourers—less colonial subjects than
a ‘natural’ resource to be exploited—missionary medicine would occasionally bridge the gap
between what the government would offer and what the Chinese community could provide for its
own people111. This reliance on community and charitable organizations in tending to Hong
Kong’s medical needs became an enduring feature of the local medical culture.

In his book, Wilson devotes a full chapter to discussion of the traditional medical practices he
observed over the course of his duties. Like many of his contemporaries, Wilson disdained the
fear of surgery among Chinese112. Some of Wilson’s peers were even more dismissive of the
Chinese medical tradition, resenting even the minor consideration Wilson made of local
practices; the Edinburgh Medical and Surgical Journal dismissed Wilson’s entire consideration
of Chinese medicine as “a matter of curiosity rather than utility” showcased “…to shew the
absurdities and foolish fancies, into which the human mind may wander, when under the

110 Wilson, 182.

111 For discussion of missionary medicine in southern China, see Paul Cohen, China and Christianity: The
Missionary Movement and the Growth of Chinese Antiforeignism, 1839-1939 (Cambridge: Harvard University Press,
1963); Gerald H Choa, Heal the Sick” was Their Motto: The Protestant Medical Missionaries in China (Hong Kong:
Chinese University Press, 1990); William Warder Cadbury and Mary Hoxie Jones, At the Point of a Lancet. One
hundred years of the Canton Hospital, 1835-1935. [With plates.] (Hong Kong: Kelly & Walsh, 1935); John
Dudgeon, The Diseases of China: Their Causes, Conditions, and Prevalence, Contrasted with Those of Europe
(London: Dunn & Wright, 1877); Charles Joseph Bartlett, “Peter Parker, the founder of modern medical missions: a
unique collection of paintings,” Journal of the American Medical Association 67, no. 6 (1916): 407-411 or Yuet-Wah
Cheung and Peter Kong-Ming New, “Missionary doctors vs Chinese patients: Credibility of missionary health
offers insight into the creation of discourse and identity through interactions between missionary doctors and
Chinese in The afterlife of images: translating the pathological body between China and the West (Durham: Duke
University Press, 2008).

112 The absence of surgery in the Chinese medical tradition was a point of contention in several different contexts, in
imperial and colonial contexts, as in Wilson’s text, but also in the context of diasporic communities. This
controversy is noted in government debates in roughly the same period in the United States and Canada. See US
Senate, Report of the joint special committee to investigate Chinese immigration. (Washington, DC: Government
Immigration: Report and Evidence (Ottawa: Order of the Commission; 1885), 311.
dominion of superstition and ignorance”\textsuperscript{113}. While condemning the lack of surgical knowledge in the Chinese tradition, Wilson praised its \textit{materia medica}. The \textit{Lancet} also noted that “scientific medicine may receive some assistance from the Chinese \textit{armamentarium medicum}”\textsuperscript{114}. These are indications of the reciprocal influence of indigenous and imperial medicines in colonial contexts, exemplified also in Wilson’s recommendation of \textit{buchu}, an herb harvested in Britain’s Cape Colony, as the most effective treatment for ‘flux’\textsuperscript{115}. Wilson’s careful descriptions of the acupuncturists’ and herbalists’ tools and appreciation of the longstanding practice of inoculation in China are his concessions to Chinese expertise\textsuperscript{116}. Though Wilson finds much of interest in Chinese medical culture and is complementary in his view of Chinese herbal practices, he determines that the tradition has stagnated as European medicine surged forward; the Chinese had “fallen into a petrified fixedness, which nothing but the most powerful external agents can move”\textsuperscript{117}. These observations were informed by, and reinforced, the civilizing logics that brought Wilson, the \textit{Minden} and all of their peers to China in the nineteenth-century.

2.4 Empire and Environmental Anxiety

As the colonizers sought to establish British interests on Hong Kong soil, the island itself seemed to fight against the inscription of imperial rule with the miasma it allegedly issued. Possible solutions were debated. Fortune recommended afforestation\textsuperscript{118}. Cunynghame thought the very location and essential design of the settlement at Hong Kong was to blame\textsuperscript{119}. Nestling the commercial and residential centre along the base of Victoria Peak prevented healthy circulation of winds, he suggested, trapped humidity through the rainy months. He figured, also, that overcrowding in the barracks was a crucial concern, writing, “I am inclined to think that it was

\textsuperscript{113} “Art. II. Medical Notes on China”, 195.
\textsuperscript{114} “REVIEWS: Dr. Wilson’s Medical Notes on China”, 629.
\textsuperscript{115} Wilson, 15, 223, 224.
\textsuperscript{116} For discussion of China’s history of variolation and the reception of Western inoculations, see Angela Ki Che Leung, “Variolation” and Vaccination in Late Imperial China, Ca 1570–1911,” in Stanley Plotkin ed. \textit{History of vaccine development} (New York: Springer Science & Business Media, 2011), 5-12.
\textsuperscript{117} Wilson, 234.
\textsuperscript{118} Fortune, 5.
\textsuperscript{119} Arthur Augustus Thurlow Cunynghame, \textit{An Aide-de-camp’s Recollections of Service in China: A Residence in Hong-Kong, and Visits to Other Islands in the Chinese Seas} (London: R. Bentley, 1853), 75.
there owing, as well as elsewhere, more to the want of good and sufficient accommodation than any other cause\textsuperscript{120}. Cunynghame debated the two possible sources of miasma identified by Wilson and Dill: marshlands and the rice paddies. Ensuring that future barracks and residences were built at sites with good circulation and exposure to sea breezes and away from the rice paddies would protect the colonists from miasmas released from the earth in both situations. This meant moving south, and up; the logic of “height is right” began to drive Europeans away from the harbour and toward the Peak, a logic that would create residential apartheid for decades. As Cowell observes, there was a kernel of truth to this view of Hong Kong’s disease geography, but only as a predicing factor; as he writes, “[t]he abandoned pits of building sites that pockmarked the rudimentary east-west highway of [the] Queen’s Road...must have proved perfect receptacles of stagnant water for the \textit{Anopheles} mosquito to breed in and transit across”\textsuperscript{121}. The northern regions ringing the harbor were indeed breeding grounds for the mosquitoes that spread the ‘Hongkong fever’, at the time understood as due to miasma.

Even more damning than the reports home from sojourners and soldiers was a report from Colonial Treasurer Robert Montgomery Martin’s memorandum to Lord Stanley, Member of the English Parliament. Viewing Hong Kong three years after its inception and one year after the catastrophic outbreaks of ‘Hongkong fever’, Martin stated:

\begin{itemize}
\item 1st. Hong Kong can never be a colony.--By reason of its limited size, rocky, barren structure; incapability of producing any of the necessaries of life for the consumption of even one day; and "under any circumstances, cannot be expected to afford any considerable revenue towards the payment of its own expenses.
\item 2nd. Hong Kong cannot be viewed as a Commercial Emporium,---By reason of its disadvantaged geographical position; from the far greater facilities for trade afforded by Canton, and by other ports and places in China; by the distance from any populous or productive territory; by the poverty and piratical character of the adjacent islanders and inhabitants; by "the total absence of an import or export trade of any kind," after nearly five years' British occupation, and a large governmental and private expenditure; and by the
\end{itemize}

\textsuperscript{120} Cunynghame, 75.

\textsuperscript{121} Cowell, 343.
Americans, Parsee, "Chinese merchants, or even shopkeepers with the smallest pretension to property," avoiding the island, which "was never actually required by the British merchants, and has become even less so since the opening of the five Chinese ports..."\(^{122}\)

This passage is striking for not only for its abjectly negative view of Hong Kong’s prospects as a colony but because it speaks against Hong Kong’s worth as an economic centre, the whole purpose of the possession. In Martin’s view, the fruits of the first years of colonial administration had failed to meet expectations and he found that, “Hong Kong is therefore useless to England”\(^{123}\). Something had to be done. Governor Pottinger took four months to consider the problem of location, miasma, and epidemic fever. He appointed two surgeons and several representatives of other offices to form a Committee for Public Health and Cleanliness. This Committee produced the Preservation of Good Order and Cleanliness Ordinance in 1844\(^{124}\). This ordinance prohibited littering, disposal of “offensive” substances through drains or sewers, accumulation of filth near one’s home, obstruction of carriage vehicles, abandonment of personal water vessels, “furious” driving, keeping dogs that were savage or who barked, the sale of liquor or tainted food or drink, and a litany of mischievous or antisocial behaviours\(^{125}\). The project of transforming Hong Kong from a miasma-ridden “dog’s hole”, however, required several decades of work, reams of ordinances, and various other types of interventions\(^{126}\).

\[2.4.1 \text{ Acclimatization}\]

Central to histories of the tropics as well as to Arnold’s tropicality as a lens of analysis is the question of acclimatization, the notion that human, animal, and plant life are capable of adapting to changes in climate and geography. Testing this principle was a preoccupation of imperial science with teams of naturalists and scientists decamping to the colonies to collect and taxonomize animal and plant specimens. They brought these specimens back to metropolitan


\(^{123}\) Martin, “Memorandum on Hong Kong”, 29.

\(^{124}\) The ordinance was enacted on 20 March 1844.

\(^{125}\) “Good Order and Cleanliness Ordinance”, *Historical Laws of Hong Kong Online* (Hong Kong: Government Printer, 1984)

centres to study their survival and growth outside of the native environments. In these studies, however, imperial scientists often proceeded from the principle that temperate climates were inherently healthier than the tropics. Many of them had explicit or implicit goals of improving the tropics, using these tests on relocated specimen to allow imperial forces to tame tropical, unknown, wild places¹²⁷. The possibility of civilizing the planet, as well as its people, was a preoccupation throughout the nineteenth century; as Warwick Anderson explains,

As never before, Europeans mobilized the natural world to their economic and cultural advantage. Plants and animals from even the most distant, sultry colonies were forced to endure the northern winters. In an age when the colonial powers were intervening in the world's human order, acclimatization provided a way for scientists to intervene in its natural order: just as the leaders of Europe altered the political geography of the globe, so too did acclimatizers alter its biogeography.¹²⁸

While Hong Kong’s climate and its generous evidence of tropical diseases connected the new colony with contemporaneous discourse on tropical and imperial medicine, the colony’s flora and fauna did not match the image of tropics imported from other colonies. Rather than being lush, green, and home to exotic animals, Hong Kong’s early colonizers encountered a space quite thoroughly denuded, lacking in “tropical” qualities. Hong Kong Island, Kowloon, and what became the New Territories were originally evergreen or semi-evergreen, claim Zhuang and Corlett, but had been cleared before the arrival of the British¹²⁹. Deforestation was nearly complete but for the presence of a few feng shui forests behind outlying villages. With the guiding principle that shade would make the island healthier for Europeans facing tropical heat

¹²⁷ Osbourne notes differences in the English and French views on acclimatization. “In France and its colonies”, he writes, acclimatization “came to signify a rationally forced adaptation to new environments…connoted biological changes at physiological and sometimes structural levels”. In British colonies, acclimatization signified “a transfer of so-called exotic organisms from one location to another with a similar climate…Enthusiasts often used the term "acclimatization" interchangeably with "naturalization" or “domestication”. Hong Kong’s Botanic Gardens and afforestation schemes are in keeping with the observations Osbourne makes on British practices. See Michael A. Osbourne, “Acclimatizing the World: a History of the Paradigmatic Colonial science,” Osiris 15 (2000), 137.


¹²⁹ A natural deforestation of Hong Kong likely occurred between 1300 and 1600 AD followed by periods of cutting and burning of whatever regrowth there was before the arrival of the colonial forces. For discussion of the cycles of Hong Kong’s deforestation and afforestation before colonial projects see Xue Ying Zhuang and Richard T. Corlett, “Forest and forest succession in Hong Kong, China,” Journal of Tropical Ecology 13, no. 6 (1997): 858.
and humidity, the government launched an afforestation project, beginning the “greening” of Hong Kong. Manipulating nature was a strategy that had been used in other tropical colonies to greater or lesser success, in Hong Kong to add greenery, in other cases to clear out the rich density of tropical flora. Gardening projects and botanical gardens played important roles in the creation of colonial spaces, stripping the earth of its native character and replanting curated elements of local flora along with reassuringly familiar elements from the European countryside. Cultivated landscapes became “environmental texts” and “metaphors of mind” that helped colonial arrivals to orient themselves in the disorienting, challenging, or dangerous tropics; as Grove writes, “The garden and the island enabled newness to be dealt with within familiar bounds but simultaneously allowed and stimulated an experiencing of the empirical in circumscribed terms.” A delegate from the Royal Society at Kew, Charles Ford, arrived at the colony in 1871. He was tasked with the rehabilitation of Hong Kong’s environment, or better still, to render it civil. Ford’s task was to make Hong Kong into a new place, one that would evoke health, beauty and productivity through the careful planning and cultivation of plants native to Hong Kong and imported from other locales. The project of creating a new Hong Kong through afforestation “legitimized the instruments of colonial government” in purporting to improve denuded, rocky Hong Kong and the stagnant ditches that were breeding grounds for mosquitoes, not yet identified as the source of the malignant fevers. The shadow of these greening projects, though, was the way that designing and overlaying a new Hong Kong, even one that seemed more salubrious, created “an enveloping but invisible apparatus of power.”

Ford’s work is represented in the Government Gazettes as having principally aesthetic motivations: the planting of trees lining streets, the institution of public gardens, and the

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131 Grove, 14.


establishment of nurseries for both native and foreign species. Ford’s chosen mix of native and non-native species of trees was only variably successful through the 1880s, inspiring him to add even more varieties in the hopes of “[affording] more variety to the future plantations, as probably many kinds of tree not yet used may be found to succeed, and to render the plantations more valuable and beautiful in years to come.” Afforestation and the “greening” of Hong Kong had an element of trial and error characteristic of most imperial acclimatization projects. By valuable, Ford did not necessarily mean profitable for as Corlett notes, “[t]he main justification for forestry in Hong Kong has always been environmental rather than commercial. Commercial benefits are never mentioned in early reports: forestry was intended to make the barren hills of Hong Kong more attractive and the nearby urban areas more healthy.” By 1883, under Ford’s supervision, more than a million trees had been planted and most suitable land on the island had been covered. This was a transcolonial project as the colonies of St. Helena, Mauritius, Calcutta, Ceylon and the Straits Settlements all donated specimens for planting along Hong Kong’s hills. Looking back on his work in 1890, Ford celebrated the transformation of Hong Kong, rating the afforestation programme a success.

2.4.2 The ‘Nerve System’ of Empire

Kew Gardens and the satellite gardens in Britain’s colonies represent the “nerve system” of the British botanical empire, a means by which Britain extended an informal empire. These projections of informal empire extended, as Fa-Ti Fan shows, inside the boundaries of

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137 Corlett assesses Ford’s planning for the planting projects as less impressive in terms of creating coverage; afforestation programs initiated after the Japanese Occupation during the 1940s, repairing damage caused by war, was far more successful in extending tree cover through the territory.

autonomous countries including Qing China. The nearly thirty botanic gardens in the British Empire served interests in metropolitan London as well as locally. In London, an emerging middle class visited the Royal Botanical Gardens at Kew to practice ‘rational recreation’, self-cultivation through the appreciation of plants. By 1850, Kew Gardens attracted 179,627 visitors per year and was seen as a ‘botanical clearing-house or exchange for the empire’. The idea of a botanic garden was first mentioned in a letter from the Governor of Hong Kong to the Deputy Governor in Bengal, suggesting that Hong Kong might pursue something similar to what they had in Bengal. The project began in earnest in 1855, championed by Governor John Bowring. Rather than pitching a public garden as just a benefit to those living in Hong Kong, Bowring situated his intended project in the context of Britain’s botanic empire, writing, “Independently of which I might be able to render services to the Botanic Gardens in India, — to send useful plants and fruits to the mother Country and the Colonies”. Bowring’s request was approved in 1856 but the government took some time to will the funding for its construction; only on November 30 did the British Secretary of State allot £269 to begin the project. Hong Kong’s colonial government added £4,371, a large sum that reflected the challenges of carving into and building boundary walls in the face of Mount Austin’s granite facade. Over the next few years, even more funds were added, an indication of the value that both local and metropolitan officials placed on this paradoxically artificial and natural environment as a space for scientific inquiry and for the wholesome enjoyment of the colonial community. Finding Hong Kong both medically dangerous and depleting, a botanic garden served the purpose of connecting Hong Kong to the imperial botanic nerve system as well as creating a site for recuperation for Europeans weakened by colonial life.


140 Brockway, 81.


143 Quoted from “Letter from Governor, Dr. Sir John Bowring, F.R.S., F.L.S. to Lord John Russell, August 14th 1855” quoted in D. A. Griffiths and S. P. Lau, 58.

144 Griffiths and Lau, 60.
The Director of Kew Gardens, Joseph Hooker, named Charles Ford, already the steward of Hong Kong’s first afforestation campaign, head gardener of the Botanic Garden. Ford reported many challenges in his work. In his first report to Kew, he reported a fair quantity of plants but a lack of variety and a lack of organization. No catalogue of what was planted had been produced. Perhaps holding visions of other lush and diverse tropical spaces in mind, he complained that only orchids and ferns native to Hong Kong were represented. In his first annual report, Ford noted explicitly that the economic dimensions of botanical imperialism were inadequately attended in Hong Kong’s Botanic Garden. The lack of “skilled European assistance”, he noted, made it difficult for the gardens to be of use “to those scientific visitors who make HK a place of care”. In particular, there was no collection of plants “peculiar to China”. Ford advocated strongly for the value of scientific botany in Hong Kong but to little avail. A schism between Ford and his collaborators and the government opened. The government saw no value in botanical research, even economic botany, claims Fan. Plantations, profitable in other colonies, made no sense on mountainous Hong Kong. Promoting the Botanic Garden as a site for cultural events or personal relaxation, however, made sense to the government. As a site of research or economic development, the government failed to see Ford’s point. The government invested little in the scientific or economic botany projects of the Gardens, failing to recognize an opportunity for understanding and making gains of Chinese markets, or of making political inroads into China by way of science.

Hooker, at Kew, saw this as a great failing for Hong Kong and for the Empire altogether. He offered advice to Ford, recommending that he pursue scientific and economy botanical inquiry in Hong Kong, China, and Southeast Asia by whatever means possible. If the colonial government would not support these efforts then Hooker expected Ford to make friends of “traders, merchants, captains, sea surgeons, and others” to make the endeavours possible.

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145 Quoted from “Letter from Charles Ford to Joseph Hooker, 1871” quoted in D. A. Griffiths and S. P. Lau, 58.
147 CO 129/183: General Correspondence: Hong Kong, 11 March 1878, 282–286.
Without a secure base, the British naturalists who came to study Chinese flora largely passed Hong Kong by. Nonetheless, the Gardens were not a complete waste. Until their destruction in 1874 by typhoons and then wrecked again in 1894 during the bubonic plague epidemic, they were said to be very pleasant spaces. Physician James Cantlie wrote that the Gardens had “completely altered the aspect of the island and converted it from a bare rock into a miniature forest”\textsuperscript{151}. It is telling, perhaps that Hong Kong’s very emblem, the \textit{bauhinia}, is a cultivated specimen, a hybrid propagated in the Botanic Gardens and then planted throughout the colony\textsuperscript{152}.

2.5 Tempering the Tropics

2.5.1 Acclimatizing Bodies

The politics of plants were not nearly as urgent as the question of whether the human specimen imported to Hong Kong from Europe could adapt to and survive life in this mercurial climate. The epidemic fevers of 1843 put this worry at the fore of every conversation. Had history occasioned the colonization of Hong Kong earlier, discourse and strategies for planning the settlements might have been very different. The second half of the nineteenth century, coinciding with the colonization of Hong Kong, saw a transition in the general view among imperial powers of the tropical environments they conquered and inhabited\textsuperscript{153}. In earlier times, life in the tropics and had been seen promising to restore health, a cure for consumption and other diseases. By the middle of the nineteenth century, physicians and colonists were ambivalent or turning against the idea of tropical sojourns as restorative to health. In 1846, an influential text entitled “\textit{The Sanative Influence of Climate: with an account of the best places of resort for invalids in England and the South of Europe, \&c}” had been revised and produced in new editions four times by its author, Sir James Clark. A medical journal of the day noted that while it would not

\begin{itemize}
  \item \textsuperscript{151} James Cantlie, “Hong-Kong,” in \textit{The British Empire, Vol. 1: India, Ceylon, Straits Settlements, British North Borneo, Hong-Kong, with an introduction by Sir R. West} (London: Kegan Paul, Trench, Trübner & Co, 1899), 520.
  \item \textsuperscript{152} A controversy over the \textit{bauhinia}'s native or non-native provenance is mentioned in Peckham, “Hygienic Nature”, 26. But S. T Dunn, Ford’s successor as superintendent at the Department of Botany and Forestry stated, clearly, that \textit{bauhinia × blakeana} was a non-native species. See S. T. Dunn, “New Chinese Plants,” \textit{Journal of Botany, British and Foreign} 46 (550) (1908): 324–326.
  \item \textsuperscript{153} See Mark Harrison, \textit{Climates and Constitutions: Health, Race, Environment and British Imperialism in India, 1660-1850} (New Delhi: Oxford University Press, 1999), 11-20. Here, Harrison explains that climate and conditions of the British colonies in India were not perceived as dangerous to the health of colonists for decades into their administration and the social and conceptual shifts that changed beliefs on the interactions of climate and constitution.
\end{itemize}
customarily review a new edition of a well-valued text by a “distinguished” author, the changes to this fourth edition reflected a crucial change in perspective and should be noted. The reviewer at the *Medico-chirurgical Review and Journal of Practical Medicine* wanted to “devote a page or two…for expressing our earnest caution to young medical men against attaching so great an importance to the treatment of many maladies to a change of climate from our own shores to distant countries as has been done, and we fear is, too frequently done”\(^\text{154}\). In particular, the reviewer notes that Dr. Clark disavowed the popular practice of sending invalids to Egypt. There was no particular benefit, decided Clark, and his reviewer agreed. “Some of the very places, which, a few years ago, were so strongly recommended as advisable residences for phthisical individuals are now admitted to be utterly inappropriate”, wrote the reviewer.\(^\text{155}\) Dr. Clark’s revision of his book and the enthusiastic reception offered by his reviewer is but one example of discourse of a growing ambivalence toward or even loathing of tropical climates.\(^\text{156}\)

Chronologically, this conceptual shift coincided with the progressive advance of the British presence in India inland away from the original port stations, a shift that Harrison associates with “…successive phases of European expansion…from what had hitherto been a largely commercial relationship with Indian states, to one of territorial dominance.\(^\text{157}\) Harrison maps this political shift against the rise and eventual decline of climatic determinism. As ambitions in India and throughout the Empire shifted, narratives in colonial medicine shifted too, from discourses on avoiding disease and adapting to local environments in the seventeenth and eighteenth centuries toward sanitation and the responsibility of personal hygiene in the nineteenth.\(^\text{158}\)

As it expanded its territorial dominance in India, Britain built hill stations, resorts set atop mountains where colonists would retreat to nurse their health and to stage the social milieu and

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\(^{155}\) “The Sanative Influence of Climate”, 521.

\(^{156}\) This shift is typical in the French and English empires, but less in the case of the Dutch. As Hans Pols argues, the prevailing view among the Dutch *trekkers* in Batavia, contemporary Jakarta, and among the public at home in the Netherlands, was that acclimatization was a long and unpleasant process but one that could and must be survived in order to preserve the economic treasure of the tropical colonies. For more on this discourse on endurance see Hans Pols, “Notes from Batavia, the Europeans' Graveyard: The Nineteenth-Century Debate on Acclimatization in the Dutch East Indies,” *Journal of the History of Medicine and Allied Sciences* 67, no. 1 (2012): 120-148.

\(^{157}\) Harrison, 3.

\(^{158}\) Harrison, 21.
cultural life of home.\textsuperscript{159} The first hill stations were built as sanitaria in response to the alarming mortality rates of the British troops succumbing to fever and cholera, first in Mahabaleshwar in 1825, then Simla in 1830, and Darjeeling in 1835. Over time, hill stations designed in the image of European country homes with carefully tended gardens, came to serve other purposes.\textsuperscript{160} For one, as they separated colonial populations from native populations who either did or were assumed to suffer less from tropical diseases and climatic insult, the hill stations reinforced discourses of racial difference. Growing anxiety toward native bodies brought an end to optimism about the good effects of tropical environments, reinforcing rationales for every kind of exploitation. Furthermore, since hill stations were centres of political power, their construction demonstrated further penetration of the colonial regime across the geography of India as well as the erasure or assimilation of indigenous power.\textsuperscript{161} As Kanwar and Kenny explain, the hill stations at Simla and Ootacamund became seats of governmental power, the “summer capitals” of the British Raj that entertained both colonials and the Anglo-Indians implicated in the system of local rule, a means of reifying the dance of power between colonial authority and the indigenous elite.\textsuperscript{162} Hill stations were at once, as Kennedy writes, “sites of refuge and…sites for surveillance…places where the British endeavored at one and the same time to engage with and to disengage from the dominion they ruled.”\textsuperscript{163} The retreat to the hills reveals one key


\textsuperscript{160} Indeed, Adamson has argued that the hill stations did not offer significant remediation of ill health. Instead, he suggests that the logic of the hill stations served to entice British troops into colonial service and as such the symbolic power and “magic” of the hill stations explored by Kennedy is all the more persuasive. See George CD Adamson, “‘The languor of the hot weather’: everyday perspectives on weather and climate in colonial Bombay, 1819–1828,” \textit{Journal of Historical Geography} 38, no. 2 (2012): 143-154.

\textsuperscript{161} This was not limited to British India. See, for example, the complex history of Dalat in southern Vietnam, where the paradoxes of power and vulnerability inherent to the very notion of hill stations and colonial retreats is thoroughly exposed. See Eric Thomas Jennings, \textit{Imperial Heights: Dalat and the Making and Undoing of French Indochina} (Berkeley: University of California Press, 2011).


\textsuperscript{163} Kennedy, 1.
rationalization of tropical imperialism: as Europeans embraced the logic of climatic determinism and moved uphill as a defense of their constitutional unsuitability to life and labour in the tropics, they positioned themselves as natural, remote leaders who would dispatch native people to articulate imperial designs for the territory.

2.5.2 Hong Kong’s Moral Geography

Hong Kong was not spared its own instantiation of the logic of the hill stations. After the fever-spoiled barracks were dismantled, a new spatial logic that "height was right" took hold. Instead of creating a resort where colonists could retreat, the colony’s elite moved their homes upward towards Victoria Peak, a verdant area that became the enclave of wealthy, powerful Europeans. Builders and planners pushed new developments up, as high as was possible, based on perception that there had been fewer infections during the 1843 epidemic in buildings higher on the hills of the island. Chinese in the colony had settled in three regions early on, all of them in the basin of the island. One was the ‘Lower Bazaar’ near what it is today Jervois Street and Bonham Strand. A second area with Chinese residences was the ‘Upper Bazaar’. These, together, were Hong Kong’s first Chinatown. Finally, there was Taipingshan, west of Victoria. In 1844, the government forced most Chinese out of the Lower and Upper Bazaars by raising rents, perceiving the need to reserve this space for European commercial interests. From there, Taipingshan became the largest residential settlement of Chinese in the colony. The fact that Chinese and Europeans suffered from the epidemic fevers without great prejudice did not bother those who sought to reinforce residential separation. Hong Kong’s European population had perhaps internalized the philosopher Kant’s eighteenth-century formula, a conflation of civilizational and environmental logics with anxiety toward the tropical Other:

The inhabitant of the temperate parts of the world, above all the central part, has a more beautiful body, works harder, is more jocular, more controlled in his passions, more


165 Evans, 71.
intelligent than any other race of people in the world. That is why at all points in time these peoples have educated the other and controlled them with weapons.\textsuperscript{166}

Still, even those who encouraged the growing segregation between Europeans and Chinese in Hong Kong could not have missed the counter condition to this ‘beautiful body’. Kant’s beautiful body, born in the temperate zone, was vulnerable. Colonizers required retreats from the tropics because they suffered the climate and endemic diseases worse than did native populations. This argument helped rationalize the exploitive practices of colonization in the tropics as well as an emerging moral geography in Hong Kong.

Initially, the Chinese and European communities were mutually pleased to live apart from one another. The eruption of the Second Opium War in 1856 intensified whatever antipathy there was between the two communities, collaborators only in making money. In response, a series of laws further separating Chinese and Europeans were passed. The British demonstrated their mistrust with the \textit{Light and Pass Ordinance} of 1857, imposing a curfew on all Chinese between 8pm and sunrise.\textsuperscript{167} Chinese wishing to circulate after curfew were required a night pass issued by the police and after 1870 also needed to carry a lantern as well. The \textit{Ordinance} further allowed a European acting as a Sentry or Patrol at any time between the hour of Eight in the Evening and Sunrise... [to]...fire upon, with intent or effect to kill, any Chinaman whom he shall meet with or discover abroad and whom he shall have reasonable ground to suspect of being so abroad for an improper purpose, and who being challenged by him shall neglect or refuse to make proper answer to his challenge.\textsuperscript{168}


\textsuperscript{167} The “Light and Pass Ordinance” is formally recorded as “Peace of the Colony Ordinance”. Article 9 of the Ordinances of the Legislative Council of the Colony of Hongkong, 1857. \textit{Historical Laws of Hong Kong Online} (Hong Kong: Government Printer, 1984.) Accessed on 31 January 2016.

\textsuperscript{168} “Light and Pass Ordinance”, 1857.
The *Contagious Diseases Ordinances* were put into effect around the same time as the *Light and Pass Ordinance*\(^{169,170}\). Many of the colonial troops and young merchants came to the colony to make their fortunes before marrying and those who were already married seldom brought their families to settle in the Far East. This encouraged a flourishing brothel culture and all associated concerns. Hong Kong had contagious diseases law before England; the first ordinance passed in 1857 mandated licensing of brothels, physical examinations of women in brothels, and punishments for the prostitutes and brothel owners. The names of prostitutes and brothel owners had to be publically posted in Chinese and in English and women found to have infected clients with venereal disease were to be imprisoned three months for the offence\(^ {171}\). Women were required to present themselves at the office of the registrar-general to avow that they had chosen to work in the sex trade rather than to have fallen victim to slavery or other coercive forces. The British were particularly suspicious of the local practice called *mui tsai*. Here, a family that could not afford to raise a daughter would sell her to another family to whom she would offer her domestic labour in exchange for the essentials of life. Colonial authorities worried that these girls would be sold again to brothels or would be forced into sexual labour but did not intervene until the twentieth century. In the meantime, the government was decisive about limiting the visibility of prostitution and brothels rather than their use. The 1857 ordinance limited brothels to certain areas of the colony, essentially to Taipingshan, and further forbade that brothels along the thoroughfare Queen’s Road face the main street. The limits on brothels were strictly geographical; while there was no law prohibiting a European man from visiting a brothel or enjoying the company of a non-European woman, these encounters had to occur in the Chinese neighbourhoods, not in European society. Onus was placed on local women to subject themselves to scrutiny and to make their names known to the public. Nothing of that ilk was required of a prostitute’s European male client.

\(^{169}\) “Venereal Diseases Ordinance”, Article 12 of the *Ordinances of the Legislative Council of the Colony of Hongkong, 1857*.

\(^{170}\) For discussion of the Contagious Diseases Ordinances of Hong Kong in the broader context of the British Empire, see Philippa Levine, “Modernity, Medicine, and Colonialism: The Contagious Diseases Ordinances in Hong Kong and the Straits Settlements,” *east asia positions* positions 6:3 Winter 1998, 675-705.

\(^{171}\) “Venereal Diseases Ordinance”, 1857.
As two phenomena—the emergence of a Chinese elite and the entrenchment of the spatial logic that ‘height is right’—took hold, the colonial government decided to legislate that segregation. The European District Preservation Ordinance was put into effect in 1888 mandating that the southernmost part of the island, also the highest, be reserved for European residences\textsuperscript{172}. Governor Des Voeux brought the issue to the Legislative Council at a meeting on March 27, 1888. Chinese were migrating into the colony in significant numbers, he said, and were eager to become landlords, something rarely possible in China. The Chinese landlords often tore down European style residences in favour of building Chinese style tenements, tong lau, which could house more people and therefore yield more profit. This threatened to push Europeans out of Victoria, said Des Voeux, forcing land values sky high. He reasoned that the well-being of the Chinese in Hong Kong was dependent on the Europeans, architects of Hong Kong’s “liberal institutions and whose indomitable energy and perseverance has transformed a bare uninhabited rock into a beautiful city and an emporium or trade second to very few others in the world”\textsuperscript{173}. He petitioned the Legislative Council to ratify a motion protecting, “a certain district…in a condition such as to render it possible for Europeans to continue to live there in health [with] nothing in the law to prevent Chinese from living there also so long as their habitation is of a character consistent with that [European] condition\textsuperscript{174}”. This was not prejudicial, he claimed, since it would benefit the Chinese as well as the Europeans. The motion would protect Victoria from overcrowding and would make the city centre a “lung” for the whole of Hong Kong. The area to be protected extended from today’s Sheung Wan and Central districts between Wellington Street and Caine Road\textsuperscript{175}.

Des Voeux presented this segregation as benign, but a bit of context sours that view. Sir John Bowring, Governor of Hong Kong between 1852 and 1859, explained in 1858 that “the separation of the native population from the European [wa]s nearly absolute; social intercourse

\textsuperscript{172} The ordinance was introduced at the 27 March, 1888 sitting of the Legislative Council. See “Legislative Council, No. 11,” Hong Kong Hansard, 27 March 1888: 25.

\textsuperscript{173} “Article 16: European District Reservation Ordinance”, The Ordinances of the Legislative Council of the Colony of Hongkong: 1879-1990 (Hong Kong: Noronha, 1892), 1054-56.

\textsuperscript{174} “European District Reservation Ordinance”, 1888.

\textsuperscript{175} “European District Reservation Ordinance”, 1888.
between the races is wholly unknown”\textsuperscript{176}. Along with the *European District Reservation Ordinance*, the *Regulation of Chinese Ordinance* was passed in 1888. Here, the government extended its control of housing and landownership. The *Regulation of Chinese Ordinance* further limited the Chinese community’s right to hold public festivals and to hang posters, stipulated the terms for night and extended passes, and established some of the punishments to be imposed in the case of infractions\textsuperscript{177}. The context in which these three ordinances emerge casts suspicion on Des Voeux’s rationalization for the segregation of residences. All three ordinances imposed restrictions on where Chinese could conduct their cultural practices—protected by in the *Letters Patent*—as well imposing strictly control over brothels, one of the very few intimate, cultural, or leisure spaces shared between the European and Chinese communities. Des Voeux’s successor, William Robinson, had similar views. Robinson made little effort at veiling his antipathy, once stating “My constant thought has been...how best to keep [the Chinese] to themselves and preserve the European and American community from the injury and inconvenience of intermixture with them”\textsuperscript{178}. Enclavism, enforcing spatial separation between Western and Chinese residences, was the solution. The built environment at Hong Kong was clearly also conceived of as a moral environment.

2.6 Conclusion

The 1843 epidemics of malarial fever were integral to the spatial conception of Hong Kong, suggesting to the colonizers how the built and natural environments of the colony might reinforce or control medical threats. The great mortality rates evident among Europeans in the eastern and westernmost settlements validated the idea that Europeans were more vulnerable in the tropics, and particularly in Hong Kong. The flight of the European population from the mosquito-infested ditches of Victoria toward the Peak established the notion that the Peak should be the refuge of Hong Kong’s rulers. This notion was itself a reflection of the logic of the hill stations already developed in Britain’s other tropical colonies. It was furthermore a practical

\textsuperscript{176} CO 129/51, 254: Letter from Bowring to Russell, 4 September 1855

\textsuperscript{177} “Article 13: Regulation of Chinese Ordinance”, *The Ordinances of the Legislative Council of the Colony of Hongkong: 1879-1990* (Hong Kong: Noronha, 1892), 1028-38.

manifestation of sanitation syndrome, the concept defined by historian of colonial medicine Bill Swanson to explain racial geography or ‘urban apartheid’ resting on the belief that one racial group is responsible for the spread of a particular disease, or of diseases in general\textsuperscript{179}.

The anxiety caused by the first epidemics of ‘Hongkong fever’ rationalized the division of Hong Kong into European and Chinese quarters for the next century. Practices of urban segregation by race did not originate in Hong Kong. Rather, residential segregation was widely practiced in colonial contexts as a means of rationalizing racial and ethnic hierarchies, as a strategy of containing social, political and cultural power, and as a strategy for controlling disease. Or so authorities claimed, for in many cases this practice only exacerbated disease risks caused by overcrowding. Through the fifty years between Hong Kong’s first epidemic of malaria in 1843 and the next major medical crisis—the bubonic plague of 1894—an unspoken cordon sanitaire between the two communities was deployed to justify Britain’s remote and even negligent relationship toward the Chinese. The colonial regime would leave the Chinese to their own customs and limit interactions to the commercial sphere, creating a colonial space but not yet a colonial people.

In Hong Kong's first decades, processes of deterritorialization and reterritorialization are manifold and rich, sometimes even paradoxical one to another. The ‘greening’ of Hong Kong, the afforestation projects carried out under Ford, were well received by most, if not by all. Finding Hong Kong tropical in its disease ecology but barren, rocky, and lacking in flora, the colonizers overlaid a tropical aesthetic. Peckham adds another dimension to our understanding of this process. The afforestation projects were, he says, a means of differentiating Hong Kong from China which was “characterized by…a bareness, a ‘destitution’”\textsuperscript{180}. The Chinese mistrusted green life, “cutting down every tree as though it were a curse…dig[ging] up the roots of every patch of grass’ in a manner reminiscent of foraging beasts”\textsuperscript{181}. The colonial reterritorialization of

\textsuperscript{179} For the first discussion of sanitary syndrome, see Maynard W. Swanson, “The Sanitation Syndrome: Bubonic plague and urban native policy in the Cape Colony, 1900–1909,” The Journal of African History 18, no. 03 (1977): 387.

\textsuperscript{180} Peckham, “Hygienic Nature”, 1193.

\textsuperscript{181} Peckham, “Hygienic Nature”, 1193.
Hong Kong was a reversal of Chinese carelessness. Imperial Britain was creating a new version of the territory through afforestation and acclimatization of non-native flora.

The process of deterritorializing Hong Kong culturally, stripping it of its place in Chinese history and reterritorializing it as a colony of Great Britain also has a very literal dimension. In order to “make” Hong Kong, to transform the barren rock and population of just a few thousand semi-settled fishing families into a profitable commercial centre, Britain needed to attract more people from China. Britain needed a labour diaspora large enough to actualize economic dreams. It was up to the colonizer to indigenize a new local people. In this, Britain was creating a new version of the territory by attracting and economically ‘acclimatizing’ non-native fauna, the migrant labourers coming from Guangdong.

Creating Hong Kong was a struggle to humanize an inhospitable space, to deterritorialize and then reterritorialize a climate and geography that resisted colonization. The greatest challenge to British occupation of Hong Kong was malarial fever, a product of interactions between nature, and between nature and human endeavours. In one telling, the history of Hong Kong begins with a parasite, *Plasmodium falciparum*. *Plasmodium falciparum* find a nice girl mosquito, and they begin a life together. Female mosquitos lay their eggs near stagnant water, lakes, marshes, puddles, or the ditches left alongside poorly designed matsheds or army barracks in humid, tropical colonies. For food, these mosquitos take blood, perhaps from the bodies of the newly arrived colonial community who have minimal immunity to malaria, or from the Chinese labour diaspora where immunity is also scant. From the point that the outbreak began, “whole regiments were nearly swept away, and many of the Government officers and merchants shared the same fate”\(^1\)\(^8\), planning of Hong Kong’s development had to account for this danger. The risk of infectious disease was central to every conception of the colonial project.

\(^1\)\(^8\) Fortune, 4.
Chapter 3
Bubonic Plague, 1894: A Crisis of Intimacy

3 Epidemics and Ambivalence in Colonial Hong Kong

Hong Kong’s second major epidemic spread through the colony in just four weeks in the late spring of 1894. Carried into Hong Kong from China sometime in the early spring, it spread quickly through the colony, concentrated in Taipingshan, the densely inhabited neighbourhood favoured by the Chinese who came to Hong Kong for labour opportunities, moving between the colony and their home villages across the border in southern China. Bubonic plague has the morbid characteristic of spreading so quickly and causing such great fatality that local epidemics burn out relatively quickly. Once enough of the population has died, the epidemic dies out, too. The epidemic in Hong Kong might not have been remarkable but for the fact that at one moment or another in May or June of 1894, a rat infected with plague scuttled aboard a ship in the Hong Kong port and so propelled the infection all throughout the world, marking the flashpoint for a pandemic, outbreaks on a global scale. From first traces to the relief of notification of last cases, the pandemic would span a century and would move across the entire globe, tying together continents with ribbons of death and disease.

The outbreak of bubonic plague in Hong Kong, in view of the global cost of the Third Pandemic, can seem quite small. It caused a rather brief moment of panic and relatively minor loss of life, with about 3000 dead in a population of over 200,000, and the episode would occasion a significant scientific triumph—the discovery of the plague bacillus. This has been the facet of the story that has attracted the most attention, told as a high point in the history of bacteriology and tropical medicine. The local history, how the outbreak shaped Hong Kong, or the fact that the outbreak spread globally from a colonial space where emerging notions of sanitation, colonial and imperial medicine were still in infant stages of concept and practice, deserves attention. What comes before the occasion of the discovery of the bacillus, through that triumphant moment, and what followed this new science into the world was confusion.

The spread of plague through Hong Kong skewered the narrative of the superiority of the British empire as it revealed the European colonists and the colonized Chinese as equally anxious about the nature of the disease they were fighting, uncertain of any effective treatment, and unaware of
how to contain the spread of the disease. Despite the fundamentally unequal relations between the British and the Chinese in Hong Kong, this episode in the colony’s history reveals the two communities in similarly vulnerable positions; both China and Europe had encountered plague over the centuries and had half-satisfying notions of how to defend against an outbreak. The traditional kinship and community practices around sickness and death betrayed the Chinese in this case, hastening the spread of the disease, while the movement for sanitation and hygiene gaining traction in London was only beginning to crest as one of colonialism’s tools. Modern medicine was only beginning, in 1894 to become “through its control of disease…a world factor of limitless power”\textsuperscript{183}. Neither Chinese nor Western medical wisdom offered a thoroughly effective response to this threat.

The epidemic further showed the respective strengths and weaknesses of the two communities in Hong Kong. After decades of half-hearted attempts at imposing public health and sanitation laws in the colony, the British government reaped the results of its strategy of indirect rule and found itself unable to adequately control the Chinese population in either public or domestic settings. At the same time, the Tung Wah Hospital Committee, the Chinese community’s most powerful public organ, similarly ‘lost face’, lost social and political capital. Faced with a familiar but little understood threat, Hong Kong’s liminal geography, transient population, and Britain’s ambivalence toward the Chinese as colonial subjects came to a head. Subduing bubonic plague birthed Hong Kong into a new phase in its politics, delivering the colony into a space where bodies, actual flesh and blood, became the necessary preoccupation of a regime that had preferred, to this point, to have as little to do with the Chinese as possible. This chapter explores a moment where the illusion of hardness, objectivity and universality projected by modern science and the softness of bodies and social capital inverted relations in colonial Hong Kong. Through the plague episode, soft power in the forms of rumour, racial anxiety and the fear of intimate proximity provoked the imposition of hard power in the form of imposing sanitary and surveillance practices, impositions into the psychic space of Hong Kong Chinese.

\textsuperscript{183} John Todd, \textit{Tropical Medicine, 1898-1924}, (n.p.: Published by the author, 1924)
3.1 The Sanitary Movement Comes to Hong Kong

Sanitation emerged as a prominent concern in England in the mid-19th century. The movement for public health and sanitary reform was catalysed by the publication of Edwin Chadwick’s *Report on the Sanitary Condition of the Laboring Population* in 1842. The inquiry had been funded by the author himself, appalled by his investigations into epidemic disease in the impoverished London town of Whitechapel.\(^{184}\) Though mistaken in some of its conclusions, Chadwick’s study was instrumental in shifting British policy toward treating populations and not just individual patients. This would in turn influence administration of the British Empire’s tropical colonies.

As a man of the Victorian age, Chadwick associated disease with miasma, i.e., nefarious vapours. Furthermore, Chadwick was particularly concerned by smells, believing that odours produced disease in human bodies; as he wrote, “All smell is, if it be intense, immediate acute disease; and eventually we may say that, by depressing the system and rendering it susceptible to the action of other causes, all smell is disease”\(^{185}\). He advocated for the institution of a central agency responsible for the administration of public health and to increase supervision of public works with the goal of alleviating poverty-bound disease. These were costly, if reasonable, solutions to the challenges of urbanization. The *Report* was largely rejected at the time of its issue, although Chadwick’s position as Sanitation Commissioner allowed him to implement some of his ideas between 1848 and his dismissal in 1854. By that time, Chadwick had been pushed to the side of discourse in England, his irascible and stubborn temperament alienating him from the governing establishment.

More so even than in urbanizing England, however, sanitary reforms were necessary in the tropics where the miasmas of the sultry environment and habits of ‘uncivilized’ natives engendered fear in colonial administrations and among colonists. Civilizing and taming the

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\(^{185}\) “Metropolitan Sewage Committee Proceedings,” *Parliamentary Papers* (London: HMSO, 1846): 651. Chadwick was not alone in these views on odours, as revealed by a writer in *The Builder*. This author writes, “From inhaling the odour of beef the butcher’s wife obtains her obesity”. See H. Booth, “Suggestions on the chemical characters of contagion,” *The Builder* (London: Joseph Hansom, 16 July 1844), 350.
tropics was necessary to building colonies, and so the colonies became laboratories for the development of public health and public works theory and practice. While Edwin Chadwick had struggled with the nascent London public health establishment, his son was a hero of tropical public works engineering, prolific in the design and implementation of public works in several British colonies. Osbert Chadwick, born in 1844, was admitted as a Member of the Institution of Civil Engineers in 1871. His first colonial posting after joining the military was in India; he arrived in 1868 and had posts at Deasa, Aboo, and Aden districts. He left the service, however, in 1873, to practice civil engineering in the path his father had laid out for him. As a consultant to the Crown Colonies, the younger Chadwick designed and implemented sanitation measures in Australia, Grenada, Malta, Mauritius, Nigeria, and Hong Kong. He was appointed the inaugural Chadwick Professor of Civil Engineering in 1898 at Imperial College of London, a chair commemorating his father’s pioneering work which had been largely unacknowledged in his own lifetime.

3.1.1 Chadwick Jr. Visits Hong Kong

Chinese residential buildings and domestic life were looked on with suspicion from early days in Hong Kong’s history. An 1844 report by the first Colonial treasurer, Robert Montgomery Martin, noted dissatisfaction with the sanitary conditions of Chinese dwellings, associating the Chinese domestic spaces with nuisance and disease. Among the first pieces of legislation passed in Hong Kong, in 1844, was the Ordinance for the Preservation of Order and Cleanliness, regulating the care of buildings, limiting public nuisances, and controlling vice. The Colonial Surgeon’s Report for 1854 suggested that those same issues were still rampant a decade later, and indeed had reached “very great and vital importance.” Colonial Surgeon J. Carroll Dempster identified several further concerns and made recommendations. Victoria was in need

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186 “Osbert Chadwick,” Gracesguide.co.uk.
of drainage, sewerage, paving, and scavenging, he reported\textsuperscript{190}. The dwellings of the Chinese were overcrowded and inadequate in ventilation and drainage, disease was correlated with overcrowding and the lack of cleanliness, ventilation and drainage, the inhabitants of the overcrowded lanes should be compelled to whitewash their dwellings twice a year and also to flush the surrounding pavement and channels each morning. His fifth observation was that “the absence of Sanitary measures in Hongkong leads to the development and dissemination of disease”. It was well-known, he wrote, that,

...damp and dirt, that nuisances of all kinds and particularly animal and vegetable matter in a state of decomposition, are circumstances that favour the propagation of disease. Whatever renders the atmosphere impure, impairs the health, and predisposes the body to disease, and where numbers of sick are crowded together in close, dirty and unventilated rooms, disease spreads with virulence and malignity\textsuperscript{191}.

The Building and Nuisances Ordinances of 1856 was the colony’s response. This ordinance extended the control of buildings as articulated in the earlier laws, but still applied only to European buildings; Chinese tenements were left still unregulated.

These measures failed to control filth or the spread of disease and the consequences only worsened as the colony grew. By the 1870s, the Colonial Surgeon, P.B.C. Ayres’ inspection of the Chinese quarters in Taipingshan resulted in a worrisome report. Ayres “…could not see how [the Chinese houses] could be built on worse principles as regards sanitation”\textsuperscript{192}. The tenements were made of bare brick, not always whitewashed. Floors were made of mud, tiles, concrete, or thin boards, none of these suited to regular washing. The spaces were partitioned into tiny rooms shared by entire families, and to Ayres’ horror, these domestic partitions, eight feet high, were often divided vertically and so occupied then by two families. A house of three stories originally, he wrote, was then used as one of six stories. The upper spaces were accessed with tiny makeshift staircases, one of which caused the death of a European policeman who took a fall.

\textsuperscript{190} The term ‘scavenging’, in Chadwick’s time, referred to street cleaning and removal of waste.

\textsuperscript{191} Dempster, 357-359.

\textsuperscript{192} C. J. Wharry, “Reports of the Colonial Surgeon and Other Sanitary Papers (22 April 1880),” \textit{Administrative Reports, 1880}. 
Falls down unprotected chimneys took more lives, often of children and sometimes adults. Night soil practice offended Ayres who reported that it was collected in “poo poo tubs” emptied between once a week and every second week. Ayres noted that the supply of water for Europeans in the colony was of good quality despite an “unpleasant appearance”, described by an analyst that same year as “usually turbid and yellow”\textsuperscript{193} but that the Chinese had to make due with a limited supply of dirty water\textsuperscript{194,195}. To address the growing troubles, the Surveyor General of Hong Kong sought the counsel of Osbert Chadwick, by then an expert in water systems in the tropics. Chadwick arrived at the colony in 1881 and produced his “Report on the Sanitary Conditions at Hong Kong” the following year.

Most histories of Hong Kong that address the chronic problems of disease, public works, and planning mention Chadwick’s visit as important to the history of the colony or discuss the failure of colonial authorities to address his recommendations in short enough order. Chadwick arrived in Hong Kong with the goal of establishing “a correct idea of the average condition of the dwellings of the working classes, and to avoid concentrating my attention on extremely objectionable instances”\textsuperscript{196}. Once he had done this, through inspections of all quarters of the colony, he took an unexpected step. He sought to engage the Chinese community, hoping to learn about their domestic habits so that “the measures proposed might be suited to them, and have as far as possible a basis, time-honoured custom”\textsuperscript{197}. He acknowledged that sanitation was a foreign concept to the Chinese and that they were accustomed to engaging with colonial authorities in writing, and so Chadwick created a concise survey that he sent to nearly hundred representatives of the Chinese community through the Tung Wah Hospital Committee, two

\textsuperscript{193} Hugh McCallum, “Reports of the Colonial Surgeon and Other Sanitary Papers (6 March 1880),” \textit{Administrative Reports, 1880}.

\textsuperscript{194} McCallum, 1880.

\textsuperscript{195} The practices of nightsoil removal that so concerned Ayres are significant in a broader view of China’s experiences with colonial public health and hygienic modernity. Chinese culture up to the late nineteenth century, nightsoil was viewed not as a public health hazard but as an “integral element of agricultural production and a precious commodity”. The shift away from the latter view toward Western understanding of excrement and its removal in urban contexts is elaborated in Yu Xinzhong, “The Treatment of Nightsoil and Waste in Modern China,” in \textit{Health and Hygiene in Chinese East Asia: policies and publics in the long twentieth century}, edited by Angela Ki Che Leung and Charlotte Furth, 51-72 (Durham: Duke University Press, 2010).

\textsuperscript{196} Chadwick, “Report on the Sanitary Condition of Hong Kong”, 3.

\textsuperscript{197} Chadwick, “Report on the Sanitary Condition of Hong Kong”, 3.
associations of Chinese Medical Practitioners, the Roman Catholic church and the Hakkar and Chinese Christian churches local to Hong Kong.\(^{198}\)

Response to his queries was positive; these groups responded to Chadwick’s survey with “remarks of considerable length, showing much enlightened thought and care”. He found that the subject of his research was well received, given “most intelligent attention… [its] importance recognized, and [facing] no obstruction or apathy”\(^{199}\). Chadwick noted the concerns of the Chinese, worries that reflected the particular quality of colonial rule and values at Hong Kong where profit and opportunity were the motivations of local and colonial populations alike. The Chinese were anxious about increased taxation and “tyrannical interference” of colonial officials, of “squeeze”, wrote Chadwick\(^{200}\). Chadwick’s encounters with the Chinese in Hong Kong were markedly different from those of the colonial authorities who so harshly criticized the native population in their reports. Chadwick clearly saw value in engaging with the Chinese community in the hope of improving the health of the colony as a whole, a posture seldom taken by those administering the colony. The imperative to allow the Chinese to live according to their own customs thus had at least two interpretations. Most colonial administrators, like Dempster, sought to impose hygienic practices on the Chinese by force or law. On the other hand there was Chadwick’s approach which sought to find a common ground between the two communities and which acknowledged that correcting sanitary problems in Hong Kong would require that the boundaries held between European and Chinese domestic worlds, legal and tacit, be breached. The substance of Chadwick’s report reflected his professional perspectives as a civil engineer, but its introduction and Chadwick’s methodology were unusually sensitive to the intimate implications of conducting sanitary reform.

Chadwick’s appraisal of the colony was damning. “The sanitary condition of Hong Kong is defective”, he wrote, and called for “energetic remedial measures”\(^{201}\). Beating down the high death rates, he said, would require complete sanitation, the complete removal of human excreta

\(^{198}\) It is likely that Chadwick is referring to a group of Hakka Christians in Hong Kong when he gives references to “Hakkar”.


\(^{200}\) Chadwick, “Report on the Sanitary Condition of Hong Kong”, 3.

through dry earth, improvements to the local water supply legislated through a Waterworks Ordinance, massive overhaul of housing and a Building Ordinance that was enforced with “more rigour and intelligence than at present”\textsuperscript{202}. Chadwick recommended a sewer diverting sewage from the harbor and, in contrast to the imperative of colonial authorities, ruled a switch to dry-earth toilets impractical. The practice of dumping night soil into drains had to cease, said Chadwick, and so a water carriage system and drainage of all housing was necessary. Another crucial step was the establishment of free public latrines. Administration and implementation of these measures required a sanitary staff and Sanitary Officer that would collaborate with but work autonomously from the Surveyor General. The Sanitary Officer would furthermore need to work with the district watchmen, a Chinese para-police service that maintained order in the local population with the hope of warding off intrusions by the colonial police. The public should have a voice in the matter, wrote Chadwick, and, unique to this time, he included the Chinese of the colony in his interpretation of ‘the public’\textsuperscript{203}.

While his father had attributed the spread of disease throughout London to poverty, Osbert Chadwick focused his criticism on the built environment in Hong Kong, the tenements of Taipingshan that were home to the teeming Chinese population. The relationship between filth, staid water, and disease was still little understood but Chadwick’s intuitions about the crucial danger of contaminated water anticipated major discoveries on the transmission of cholera, typhoid, and malaria years ahead. In 1883, in response to Chadwick’s recommendations, the Order and Cleanliness Amendment Ordinance was passed, and a Sanitary Board was struck to manage public health and sanitation concerns. The government implemented the Public Health Ordinance in 1887 and the Buildings Ordinance in 1889 following Chadwick’s counsel. The first of these empowered the colonial government to close overcrowded and unsanitary buildings, a measure that was during the plague crisis of 1894. These bylaws were modeled after the United Kingdom Metropolitan Building Act, a development of Edwin Chadwick’s Poor Laws established three decades earlier. The younger Chadwick’s expertise in solving planning problems in the colonies built on the work of the generation past, and the flow of knowledge between metropole and colony; as Osbert Chadwick’s biographer writes, “This was not simply a

\textsuperscript{202} Chadwick, “Report on the Sanitary Condition of Hong Kong”, 4.

\textsuperscript{203} Chadwick, “Report on the Sanitary Condition of Hong Kong”, 5.
grand colonial design. Chadwick knew from the work of others, including his father, this would save lives”204.

This juxtaposition of the work of the Chadwicks, senior and junior, illustrates a broader pattern of colonial knowledge production; notions conceived in the metropole were sometimes trialled and tested in the colonies before being put into practice at home. While Edwin Chadwick struggled to convince his peers in London of the imperatives of population health, his son used the tropical colonies to study and implement public health and sanitary models. This is but one example of the pattern that Haynes describes as the “net transfer of resources from the empire…the foundation for the hegemonic authority of the metropolitan specialist science over disease in the tropical world”205. An outbreak of bubonic plague in 1894 tested both modern and traditional principles of disease and containment and the bipolar flow of knowledge between centre and periphery in the production of imperial knowledge.

3.2 A Visitation of the Plague

3.2.1 From a Reservoir Deep in China…

Bubonic plague is one of humankind’s very old foes. Though it is most often discussed and most feared when it flares and spreads across continents, the disease does not disappear between pandemics. It lingers and dances, flaring and fading, limited in its spread by geographical and demographic factors. It is held in abeyance by its own virulence; plague culls populations with low immunity quickly enough to limits its spread until human beings shuttle infected fleas into new populations. Epidemics of plague are common enough in human history, but the three occasions on which plague has become pandemic, reaching most corners of the earth, are most interesting to historians in that they reveal the interconnection of all peoples and places.

204 A biography of Osbert Chadwick was posted to the Internet but subsequently removed. The domain was www.noelfarrugia.com which is no longer available for viewing. See note in bibliography for previous location.

Though the Third Pandemic took off on its round-the-world path from the port of Hong Kong in 1894, the pandemic actually began in southwestern China decades earlier. In the nineteenth century, western Yunnan province was isolated, off beaten trade routes, and host to “enzootic reservoirs” of plague; the area’s warm, humid climate supported a robust yellow-cheested rat population and the accompanying population of *Xenopsylla cheopis*, the rat flea that infamously spreads the plague bacillus, *Yersinia pestis* to human victims. At the time of the Third Pandemic, Western physicians had yet to understand the etiology and vector of transmission. In China, the issues is even more complex. Without recourse to the laboratory tests that might retrospectively confirm infection with *Yersinia pestis*, it is difficult to discern what epidemics among the broad Chinese category of ‘yi’ actually caused bubonic plague throughout Chinese history. Historians looking backwards are guided by two indications—an association with rats, and the tell-tale buboes, extreme swelling in lymph nodes that is characteristic of plague infections. But as Benedict notes, the gazetteers on which historians of China rely on in piecing together disease histories, rarely note the symptoms in evidence in any epidemic, just the year and area in which the epidemic emerged.

Benedict and her colleagues who take an “ecological approach” to disease histories rely on contemporary epidemiological and ecological analysis, looking for environmental factors associated with bubonic plague reservoirs, and drawing correlations to historical records. As Cunningham notes, however, retrospective diagnosis is a fraught endeavor, a process in which historians impose the “best modern thinking about disease and its manifestations… [taking] our models of disease identity as the final, and thereby the only legitimate models.” An historian of the fourteenth-century “Black Plague” pandemic protests even more, writing, “Without argument, historians and scientists have taken the epidemiology of the modern plague and

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206 Most sources claim that the plague emerged first in 1855 in Yunnan. For a thorough discussion of the early spread of bubonic plague through southwestern and southern China, see Carol Ann Benedict, *Bubonic Plague in Nineteenth-Century China* (Palo Alto: Stanford University Press, 1996).


imposed it on the past, ignoring, denying, even changing contemporary testimony, both narrative and quantitative, when it conflicts with notions of how modern bubonic plague should behave\textsuperscript{210}.

Suspicion of bubonic plague in China also emerges when Western travellers observe yi and understand that they are observing the same epidemic in China that they know as the Black Death in Europe. This kind of encounter occurs in the nineteenth century when a French traveller, Emile Rocher, reporting to the China Imperial Customs Service, described Yunnan province as impoverished and depopulated, devastated by war and yangzibing\textsuperscript{211}. Historians and physicians in China described recurring outbreaks of this syndrome which caused fevers, swellings, and bloody sputum\textsuperscript{212}. Yangzibing inspired folklore and poetry, suggesting that the syndrome had been regionally endemic for a long time\textsuperscript{213}. Rocher speculated that yangzibing was in fact well-known in Europe as the Black Plague. What he observed killed 4-6\% of the population at each outbreak and he speculated that it had been carried into Yunnan from neighbouring Burma\textsuperscript{214}. The Hui-led rebellion that Rocher witnessed displaced thousands who took refuge in the southeastern provinces, and the rebellion also summoned imperial troops to the peripheral and isolated province. As these refugee and military populations moved through China, they carried the plague bacillus into more populous and less resistant populations in


\textsuperscript{211} Rocher was most likely observing the consequences of the \textit{Du Wenxiu} Rebellion of 1856-1873. See Emile Rocher, \textit{La province chinoise du Yin-nan}, 2 vols (Paris: Leroux, 1879), 293.


\textsuperscript{213} Benedict, \textit{Bubonic Plague}, 24.

\textsuperscript{214} Rocher, 293.
southern China. The plague was carried into Canton by way of traders or rebels, plague victims in evidence there by 1866\textsuperscript{215}.

### 3.2.2 The Tenements of Taipingshan

The British allowed the free passage of Chinese into and out of the colony long into its administrative tenure in Hong Kong; sitting at the mouth of the Pearl River, in its early years Hong Kong was referred to as the ‘suburb of Canton’\textsuperscript{216}. Transit between the two empires was substantial with 11,000 passengers crossing each week\textsuperscript{217}, four thousand river steamers and eight thousand junks annually\textsuperscript{218}, suggesting that at least five percent of the colony’s population was in flux at any given moment. Transit would increase greatly around the holidays, with four times the usual number of Chinese from Hong Kong arriving in Canton to celebrate the Lunar New Year in early March of 1894\textsuperscript{219}. That year, many holiday revellers found their family and friends in the grips of an unknown sickness, not yet an epidemic but leaving a worrisome number of sick and dying in its wake\textsuperscript{220}. Canton’s ecology supported both the yellow-chested rat and the

\begin{footnotesize}
\begin{enumerate}
\item The problem of understanding plague across paradigms is not just the preoccupation of contemporary scholars, though their insights into the challenges of moving between medical cosmologies and traditions in a sensitive manner are well-recognized. Dr. James A. Lowson produced an account of the bubonic plague in 1894 that included an historical account of the disease in China, or rather attempted to do so. Lowson states that in the “civilized West”, plague has been discussed “times without number”, apparently well understood. In the Far East, with only the exception of Rocher’s notes, “the history of the disease is a perfect blank”. Finding China as having the “unenviable reputation of being the seat of the plague”, Lowson expected to find records in the Chinese medical classics. He asked sinologist. James Dyer Ball to “make careful enquiry” on the matter, but after months of research, Dyer Ball found no mention of plague. See James A. Lowson, “The Epidemic of Bubonic Plague in Hong Kong, 1894,” \textit{Sessional Papers} (2 March 1895): 179.
\item CO 129/263: Ripon to Robinson, 17 May, 1894, #15
\item Simpson, 63.
\item Elizabeth Sinn. \textit{Power and Charity: A Chinese Merchant Elite in Colonial Hong Kong (with a new preface)} (Hong Kong: Hong Kong University Press, 2003), 159 and Lowson, 179.
\item Although some have speculated that the plague came to Hong Kong from Pakhoi, another Chinese seaport with early cases of infection, Occam’s razor points at Canton. An un-named author of the \textit{China Imperial Maritime Customs Medical Reports for the half-year ended 31 March 1889}, for example, notes that “Bubonic plague was rumoured to be in and in the vicinity of Pakhoi during April [of 1888] owing to three persons having died suddenly in a house close to the town and other cases of sudden death having taken place in this neighbourhood. There was not, however, the least foundation for such a report”. By 1894, however, the same source confirms cases in Pakhoi. Lowson, in his report on the plague at Hong Kong, also implicates Pakhoi in the 1894 outbreak in Hong Kong. He claims that Chinese fled Pakhoi for Canton, bringing with them the plague. See Lowson, 179.
\end{enumerate}
\end{footnotesize}
Asiatic rat flea, *Xenopsylla cheopis*, the primary vector of the bacillus, and the dense population of the Pearl River Delta promoted the spread of the disease. The plague was evident as early as February and street cleaning programmes were implemented to try to contain the outbreak. The minimal public health infrastructure in Canton was supplemented by uncoordinated efforts of Christian missionaries and Chinese *shantung*, benevolent societies. These groups were unequipped to manage either the individual cases of infections or the public health menace. The consequences were serious; from February onward, the plague caused 200 to 500 deaths each day, with a total of 60,000 within a few weeks in March. Transmission of plague into Hong Kong was inevitable.

In Hong Kong, 1894 opened with a sense of foreboding. The inadequacy of the colony’s sanitation registered early in January at a meeting of the Sanitary Board. Chinese in the colony had been allotted five gallons of water a day per head for all domestic and hygienic purposes, including drinking, cooking, washing, and street cleaning, an amount “wholly inadequate...in this climate.” Furthermore, the Sanitary Board noted concerns over drainage, passing a motion that the owners of property on Second Street and Third Street in Taipingshan, and Pokfulam Road to the north add drains for sewage. These negotiations and ruminations of the Sanitary Board on how to manage the sanitation and hygiene of the Chinese population suggest a growing preoccupation with Chinese bodies. While they included a handful of the comprador class in government, the British mistrusted the working Chinese. They seemed not to care for sanitation, insisted on their traditional dress, and practiced an occult medicine. The Chinese seemed not to mind living in squalor, and landlords, British or Chinese, made little effort at improving conditions. Overcrowded, poorly drained and contaminated with nightsoil, the government

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221 Benedict, *Bubonic Plague*, 70.
223 CO 129/263: Robinson to Ripon, 17 May 1894, #115
225 “Hong Kong Sanitary Board”, 2.
was particularly concerned about Taipingshan, the neighbourhood west of Victoria to which the British had consigned the Chinese in 1844. The neighbourhood was as an incubator for infectious disease, it was sure, but no one had a clear plan on what should be done.

Though plague had been active in Canton for months, it was not until the last week of April that Police Inspector Quincey of Canton notified the Sanitary Board in Hong Kong of the spreading concern\textsuperscript{227}. The news from Canton provoked little action but the prescient Lau Wai Chuen, then-Chairman of the Tung Wah Hospital Committee, recommended that Hong Kong take precautions. Dr. Philip Ayres, Colonial Surgeon, requested advice on the situation from the British Consul in Canton. Further, he dispatched Dr. James Alfred Lowson, the acting superintendent of the Government Civil Hospital, to go in person to report on conditions in southern China\textsuperscript{228}. Not long after, through the first week of May, cases of sudden and strange illness began to appear in Hong Kong. Lowson returned to on May 7\textsuperscript{229} in time to certify the first plague victim, recorded as “A. Hung” in Lowson’s diary,\textsuperscript{230} on May 8\textsuperscript{231}.

Unsurprisingly, the first cases appeared at Taipingshan. The \textit{Telegraph} opined on the arrival of an unknown disease “...somewhat similar in its effects to the ‘black fever’, which has carried off thousands of the natives of Canton during the past month”\textsuperscript{232}. The paper reported that the number of fatalities was so significant as to merit Daoist prayers and rituals, “with a view to

\textsuperscript{227}“Black plague in Hong Kong: discussion in the Sanitary Board,” \textit{Hong Kong Telegraph}, 10 May 1894, 2.
\textsuperscript{228}“The Threatened Epidemic,” \textit{Hong Kong Telegraph}, 11 May 1894, 3.
\textsuperscript{230}Quoted in Choa, “The Lowson Diary,” 133.
\textsuperscript{231}Choa, “The Lowson Diary,” 179.
\textsuperscript{232}“The Black Plague,” \textit{Hong Kong Telegraph}, 10 May 1894, 2.
driving away the evil spirits credited with the introduction of the fell disease"\textsuperscript{233}. The *Telegraph* reassured readers that though this disease was fearsome enough to elicit hope that the government’s health authorities would be “alive to their responsibilities”\textsuperscript{234}, to date any Europeans illnesses had been caused by known agents; “diarrhoea, phthisis\textsuperscript{235}, bronchitis\textsuperscript{236}, and that it was only the Chinese of Taipingshan succumbing to the new threat\textsuperscript{237}. The *Hong Kong Daily Press* reported the next day that there had been forty deaths in the Chinese community within 48 hours, and that an entire family living on Tank Lane had died. The paper described a panicked scene with houses left abandoned and Chinese fleeing for their ancestral villages across the border\textsuperscript{238}. The *Daily Press* made enquiries at the Registrar-General’s department and learned that there had been no deaths recorded—no Europeans deaths, that is to say, the ones that (were) counted\textsuperscript{239}. The *Telegraph* consoled its readers that there was no risk “where there was no filth”\textsuperscript{240}.

A meeting of the Sanitary Board was called for the morning of May 10. Drs. Ayres and Lowson went to inspect cases at the Tung Wah Hospital\textsuperscript{241}. Chinese living in Hong Kong preferred the Tung Wah, established in 1869, and offering Chinese medicine to those who could pay as well as those who could not. Lowson found about twenty plague victims there, all in bad condition and

\begin{flushleft}
\textsuperscript{233} *Hong Kong Telegraph*, 9 May 1894
\textsuperscript{234} *Hong Kong Telegraph*, 9 May 1894
\textsuperscript{235} Phthisis is an archaic term for tuberculosis, the “White Plague” of the 19th century.
\textsuperscript{236} *Hong Kong Telegraph*, 9 May 1894
\textsuperscript{237} *Hong Kong Telegraph*, 9 May 1894
\textsuperscript{238} Lee also states the Chinese in Hong Kong fled for Canton, but claims they did so to seek Chinese medical treatment rather than be subjected to Western medicine in Hong Kong. He further describes the return to Canton as a “mass exodus” but does not include references that give a sense of the scale of the migration out of the colony. See Pui-Tak Lee, “Colonialism versus Nationalism: The Plague of Hong Kong in 1894,” *The Journal of Northeast Asian History* 10 (2013): 114-15. The departure of Chinese from the colony is noted by the Colonial Secretary. The CS noted the exodus was affecting business in Hong Kong. See “Despatches re Plague”, *Government Gazette* (September 1, 1894), 727 and Mark Harrison, *Contagion: How Commerce has Spread Disease* (New Haven:Yale University), 66 for discussion of how the quarantine on Hong Kong’s thwarted not just shipping but also the yearly labour migration to the Straits Settlements.
\textsuperscript{239} “With reference to the plague the wildest and most unfounded statements are being made”. *Hong Kong Daily Press*, 10 May 1894, 2.
\textsuperscript{240} “The Black Plague”, 2.
\textsuperscript{241} The chronology of this day is recounted in Dr. Lowson’s comprehensive report. See Lowson, 175-236.
\end{flushleft}
all making their homes in Taipingshan. At the meeting later that afternoon, J.J. Francis, the Chairman of the Sanitary Board, queried the nature of the illness, noting that two terminal cases from houses on Bonham Strand were not initially suspected to be plague, and asked Dr. Lowson to compare his experiences in Canton to what Lowson encountered at the Tung Wah. Lowson confirmed similarities in what he observed in the two cities, and confirmed that the colony was indeed facing an infectious disease epidemic associated with “poverty and filth”. Drs. Ayres and Lowson presented a joint report that advised implementing an epidemic protocol including house-to-house visits in search of infected or deceased persons, inspections for general cleanliness, disinfection of the clothing and belongings of all infected persons, flushing and disinfection of drains, provision of special grounds for the burial of plague victims, and relocation of all plague victims from the Tung Wah Hospital to the hospital ship Hygeia.

Another Chinese member of the Sanitary Board, the Britain-trained physician Ho Kai, protested. Ho warned that the Chinese community would not accept treatment aboard the Hygeia, and suggested removing plague victims to another spot ashore. The British members of the Sanitary Board, however, insisted on putting the Hygeia to use, a decision that thoroughly complicated relations between the Chinese and European communities through the crisis.

On May 11, the Sanitary Board nominated a Permanent Committee to address the plague crisis, a measure that legitimized the agenda of the Sanitary Board after decades of stymied reform. The Committee made seven resolutions: 1) a thorough cleansing of the city, 2) cleansing of sewer drains along the Praya, or waterfront, 3) cleansing with sea water of all surfaces of all channels, open drains, alleys, lanes and backyards, 4) household cleansing using fresh water to be imported from the mainland, 5) the construction of a site for a temporary hospital, 6), the distribution of hand bills among the Chinese supporting the sanitary measures, and 7) the quick burial of plague dead and institution of house inspections. These measures, though seemingly benign,

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243 “The Threatened Epidemic”, Hong Kong Telegraph, 11 May 1894, 3.
244 “The Plague in Hong Kong”, Hong Kong Telegraph, 15 May 1894, 2.
245 “The Sanitary Board”, Hong Kong Telegraph, 10 May 1894, 2.
produced more trauma and an enduring change in the relationship between colonizer and colonized in Hong Kong.

3.2.3 The Hygeia

The first order of business was moving sickened Chinese aboard the hospital ship. The utility of the Hygeia had long been questioned. The ship was built by the colonial government for use during epidemics but languished unused for several years and was repurposed as a police station in 1891. Singapore’s Straits Times Weekly put the blame for this waste on the Colonial Surgeon leading the committee that recommended, and then ceased to fund, the hospital ship247. The plague was an occasion for its proper use. On the afternoon of May 11, the Hygeia was moved off Praya West, today’s Des Voeux Road, and was moored at the China Merchant Steam Navigation Company wharf. The same day, the Permanent Committee began attempting to move patients to the Hygeia from the Tung Wah Hospital. Although no one was “moved against his will” claimed a colonial source, the Chinese resisted248. Lowson blamed the Tung Wah Hospital authorities for obstructing the removal of patients, but the resistance really came from the patients themselves, bewildered by the sudden and aggressive measures of colonial physicians and administrators. Desperate to enact the sanitary principle of isolation and seeking to pacify the protesting patients and their frightened community, Dr. Ayres met with the Tung Wah Hospital Committee and conceded to their request that Tung Wah doctors be allowed aboard the Hygeia along with the relocated patients. The Hospital Committee accepted Ayres’ concession and spent the afternoon coaxing Chinese patients aboard the ship with limited success; by the end of the day, only thirty-six patients had been moved to the ship, and two among them died249.

Lowson’s one conciliatory gesture to the Chinese was to encourage Chinese doctors from the Tung Wah to practice aboard the Hygeia. One did visit the ship, but just once, refusing to return after learning that he would have to report to Lowson250. The greatest protest came from the

248 “The Epidemic”, Hong Kong Telegraph, 12 May 1894, 3.
249 “The Epidemic”, 3.
250 “In reference to the present epidemic among the Chinese in Hongkong, arising undoubtedly from nothing wise but the fifth which is characteristic of the masses in this part of the world,” Hong Kong Telegraph, 22 May 1894, 2.
Chinese of Taipingshan when the house inspections began on May 19. Apprehended in their homes by police, official medical inspectors and haphazardly recruited and trained members of the 1st Battalion of the King’s Shropshire Light Infantry, dubbed the “Whitewash Brigade”, some Chinese panicked, blockading their homes and stoning the inspectors. Three women were taken to the Magistracy Court on May 21 for stoning a house-to-house inspector and four men were charged for rioting. The inspections halted that day, but resumed the next, this time with armed guards to smooth the path. On May 22, the Captain Superintendent of Police called for an additional fifty volunteers from the civil population to carry out house-to-house visits throughout the colony.

The next day, Chairman of the Sanitary Board J. J. Francis published a call for volunteers in the Telegraph. He addressed the call to all householders in the colony, “but more especially to the EUROPEAN, AMERICAN, and other NON-CHINESE RESIDENTS”, asking them to perform daily inspections of the kitchens, cook-houses, servants’ quarters and outhouses of their properties, and to disinfect and whitewash all of these spaces. To assure the Sanitary Board of adequate labour power, three hundred members of the Shropshire Light Infantry were called to perform the inspections and whitewashing, a conflation of military and medical influence often seen in colonial administration. Almost none of the volunteers or the redeployed infantrymen had medical training. Accordingly, and perhaps carried away in the high emotions of the moment, they made errors in judging symptoms and removed some people who did not actually have plague. The Western population was thus summoned into action opposite two opponents: the plague and the angry Chinese community. These two opponents were furthermore conflated, raising tensions between the local and colonial populations to new heights in Hong Kong’s history. As the errors of the makeshift public health brigades multiplied, the Chinese grew more incensed and cleverer. Some plotted to evade the inspectors who were prone to erroneously removing non-plague victims from the tenements, or to evade inspectors trying to remove bodies for quick disposal in the ‘dead boxes’. In his memoir, James Cantlie, one of the founders of the

251 “Sanitation among Chinese”. Hong Kong Telegraph, 22 May 1894, 2.
252 “Threatened Riots in Chinatown” Hong Kong Daily Press, 21 May 1894, 2.
253 “The Plague in Hong Kong. Hong Kong Telegraph, 22 May 1894, 2.
254 Sinn, Power and Charity, 166.
Hong Kong College of Medicine for Chinese, recounts the story of a Chinese family that propped up a plague victim at their mah-jongg table in an attempt at avoiding the date of the dead boxes for their friend\textsuperscript{255}.

The inexperience of the household inspectors was not the only problem. At the time of the 1894 pandemic, neither Chinese medicine nor Western medicine had a full understanding of bubonic plague, nor did effective treatment yet exist. The two communities were equally ignorant as to the character of the disease or of how to effectively limit its spread. The Tung Wah Hospital was discredited during the outbreak, but there was no clear evidence that the Chinese medicine practiced there was less effective that what the British wanted to impose on the sick; as Jerome Platt, Maurice Jones and Kay Platt write in 1998,

\textit{[t]o understand why the Chinese were so adamant concerning the treatment of Chinese patients by Chinese doctors is not really difficult. It is too late to persuade a man of the excellence of foreign medicine when death is upon him...there was no reason why the British doctors should be greatly preferred by a patient more anxious about his own life than for the advancement of science.}\textsuperscript{256}

Indeed, the difference in outcomes between those treated with Western and Chinese methods seems negligible; as Platt notes, “for the month from the middle of May to the middle of June the proportion of deaths to admissions in Hong Kong was, under British doctors, 77 per cent, and under Chinese doctors, 76 per cent!\textsuperscript{257}”. Losing autonomous administration of the hospital meant more than losing the practice of traditional medicine for the Chinese in the colony. The Hospital and its Committee lost face, political influence, and autonomy, both with the colonial government, which had up to that point respected the group and medical customs, and in the Chinese community.

\textsuperscript{256} Platt, Jones, and Platt, 48.
\textsuperscript{257} Platt, Jones, and Platt, 48.
3.3 Interventions

Hong Kong histories often focus on the paradoxes, pitfalls and triumphs of Britain’s indirect strategy of rule noting the open port, free markets, and lack of interference in the Chinese community as the characteristic elements shaping Hong Kong’s history and economic success. Charles Elliot’s proclamation at the founding of Hong Kong established a foundation for Chinese cultural and social autonomy within colonial rule\textsuperscript{258}. An addendum issued on February 2, 1841 extended this assurance to the rights of Chinese to practice religious rites, ceremonies, social customs, and to maintain private property and interests\textsuperscript{259}. The Letters Patent of April 4, 1843\textsuperscript{260} further entrenched this autonomy, declaring that when it came to the Chinese community, “the Laws and Customs of China should supersede the Laws and Customs of England”\textsuperscript{261}. This notion of using Chinese mores to govern Chinese people evolved in practice over time. Hong Kong’s Chief Magistrate, for example, adopted traditional Chinese punishments such as the sixty strokes with a bamboo stick imposed on a thief in 1842 with the assumption that a traditional punishment would have greater corrective impact\textsuperscript{262}. Allowing the Chinese significant autonomy was seen as the only way to assure a profitable colony. The point of taking Hong Kong was trade, not conquest, and so its people escaped much of the ‘civilizing’ attention of their colonizers. When need for control rose in the community, the British turned to the Chinese merchant elite and then to their more formal bodies, the Tung Wah Hospital and the Tung Wah Hospital Committee, to mediate between the needs of the Crown and the needs of the Chinese people.

The transfer of patients to the *Hygeia* was a seminal moment in the history of the Tung Wah Hospital Committee and accordingly in the history of Hong Kong. While the Tung Wah had functioned for twenty years as a symbol of Chinese political, social, and medical autonomy in


\textsuperscript{259} Norton-Kyshe, 4.

\textsuperscript{260} Also known as the *Hong Kong Charter*.

\textsuperscript{261} Quoted in Chak Kwan Chan, *Social Security Policy in Hong Kong: From British Colony to China’s Special Administrative Region* (Lanham: Lexington Books, 2011), 65.

\textsuperscript{262} Norton-Kyshe, 12.
the colony, a proud reminder that Hong Kong’s colonization had not made “yellow Englishmen” of the Chinese, epidemic plague compromised the Committee’s prestige and standing; the Hospital, a bastion of Chinese autonomy, was undermined when Lowson commanded the removal of plague patients. The Committee’s cooperation with the colonial government in this case did not register as effective advocacy, its role to this point, but as capitulation.

The epidemic furthermore revealed an emerging chasm among the Chinese elite. Some, like Lau Wai Chuen—a comprador with the Hong Kong and Shanghai Bank, owner of an overseas trading company, Justice of the Peace, and naturalized British citizen—had adopted many Western sensibilities and perspectives. Others on the Committee held fast to the notion of insulating Chinese in the colony from European influence to the greatest possible degree. These representatives were guilty, claimed the Daily Press of fomenting dissent and ‘anti-foreign’ feeling among all Chinese. But, as Sinn shows in her study of the Hong Kong Chinese elite, the situation was not that straightforward. It was not merely resentment of foreign ideas that riled the Chinese in Hong Kong, but rather the sudden incursion into terrains protected as intimate in many cultures: the home, and the individual body.

The instrumental distance that characterized indirect colonial rule transformed into loathing and antipathy under the threat of the epidemic. Literally, the plague forced the government to interfere in the day-to-day business of the Chinese for the first time. Figuratively, it forced the European population of the colony down from the elite confines of the Peak, which they treated as a social, cultural and racial refuge, and across the thresholds of Chinese homes and hospitals. Taking note of the novelty of these interactions helps reveal the stress and subtle offense of the house-to-house visits to both communities. John Pope Hennessy’s tenure as governor, ending in 1882, had introduced contentious ideas about mixing the two communities and the two races, and saw the institution of a Chinese comprador in the legislature, but Hennessy’s liberal views on miscegenation and equality among races had not taken hold. The Chinese and Europeans were unaccustomed to sharing physical spaces beyond those created for trade. They did not, in 1894,

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264 Pope-Hennessey was generally regarded as a renegade in his own time. He is perhaps best understood in his own words, an autobiography discussing not only his views on the realities of colonial Hong Kong but also of his roles in administering India and Mauritius. See James Pope-Hennessey, Verandah: some episodes in the crown colonies: 1867-1889 (New York: Knopf, 1964).
frequent the same restaurants, patronized shops operated by members of their own groups where possible, and had separate entertainment. The two communities were certainly not accustomed to encountering each other in private domestic or psychic spaces. The conflict occurred on a subtle level: the Chinese in Hong Kong had to come to grips with profound violation and humiliation of having their domestic spaces and bodies invaded, foreign mores and medicines imposed by force, and Europeans in the colony had to learn to embody and enact power in a far more intimate and invasive way than ever before in the context of Hong Kong rule.

Furthermore, the government did not understand the significance of the order to remove all sick Chinese from their homes to be treated offshore on the hospital ship. Traditionally in China, medicine is a very social practice, a daily hygiene in Chinese culture. A sick person would visit a local doctor, someone who possibly had learned the art of medicine not through a college but by apprenticeship, entrusted with the wisdom of a respected practitioner, often known personally or by reputation to both patient and doctor. The patient or the patient’s family would prepare the herbal soup or poultice, and the patient would convalesce at home, surrounded by family and neighbours. The very notion of a hospital ship and the modern sanitary tenet of isolation caused confusion and anxiety. Trying to understand the experiences being forced upon them, the Chinese talked amongst themselves, and with their families in Canton. This cocktail of panic and novelty gave rise to rumours.

3.4 Rumours

As the British began to impose invasive plague-fighting measures—home inspections, forced removal of sick and deceased, and Western medical treatments—some Chinese leapt to grotesque conclusions. Among the ideas circulating was that the government intended to poison the entire Chinese community with “medicine”, that the Hygeia was a veritable butcher’s shop where European surgeons would harvest kidneys, liver, and eyes, or that the house-to-house inspections were a front for pillage and theft of Chinese property. Among the most virulent

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265 The one kind of leisure space where racial lines were crossed was of course the brothel, a space that occasioned a second crossing into and sharing of intimate space.

266 The concept of psychic space is discussed later in this chapter.

267 “The Plague in Hong Kong,” Hong Kong Telegraph, 22 May 1894, 2; “A Chinaman’s Letter,” Hong Kong Telegraph, 23 May 1894, 2.
rumours concerned women and children. In the practice of Chinese medicine through the nineteenth century, social mores demanded limited physical contact between male doctors and female patients. In Hong Kong, Chinese women had little opportunity for interaction with Europeans since they rarely participated in either trade or physical labour. The house-to-house inspection visits were terrifying because of the sudden, gendered intimacy of European men in Chinese homes. There were whispers about the sexual proclivities and appetites of Westerners who were now entering, by force, the sleeping quarters of Chinese families. Robinson made light of womens’ fears, noting that “[c]omplaints were made that the privacy of women’s apartments was being invaded…and then it began to be rumoured that the “Foreigners” had sinister and unspeakable designs on the women and children”268. When the government announced that “…[e]very school would be visited by officers who would examine every child and send to the Hygeia anyone having the least boil or pimple on its body, the rumour spread that the government intended to select children from each Chinese school and then to remove their livers, seeking a remedy for the plague in the bile of young people269. Perhaps the Chinese community and the government might have agreed that “women and children were being ‘frightened out of their wits’ by the daily visits of the Military and Police”270. Some rumours were less gruesome but more overtly political, such as the suggestion that the stubborn Governor William Robinson was actually a Frenchman embittered by the Franco-Chinese war of 1884-5 who had purchased the Hong Kong governorship with the aim of introducing plague and wiping out the Chinese community271.

Rumours were often disseminated by way of placards both in Hong Kong where the colonial government worked hard at repressing them and in Canton where Li Hanzhang, Governor-General, was more permissive. The placards accused the colonial government of misdeeds or were generally antiforeign though very few among their targets were able to read the Chinese script in which the placards levied their charges. One at Canton read, “Lately the foreigners in

268 “Despatches re Plague,” Government Gazette (Hong Kong: Colonial Secretary’s Office, 1 September, 1894), 726.
269 “A Chinaman’s Letter,” Hong Kong Telegraph, 23 May 1894, 2; “The Plague in Hong Kong,” Hong Kong Telegraph, 16 June 1894, 2.
270 “Despatches re Plague,” 727.
271 “The Plague in Canton, from our own correspondent,” Hong Kong Telegraph, 2 June 1894, 2.
Hong Kong have gone mad, particularly they are cutting up men’s bodies, removing the liver, testicles and pupils of the eyes. On no account go to Hong Kong. Those who don’t believe this make a great mistake. Others warned of a conspiracy, claiming that Chinese were being fined for using herbal preparations against the plague, warning that the plague dead in Hong Kong were being buried in mass graves and covered in quicklime, or warning that the Chinese were about to set Hong Kong ablaze. The Telegraph warned that the placards at Canton were more strident than those in Hong Kong, threatening that should the foreign consuls at Canton institute sanitary measures such as at Hong Kong the Cantonese would be far less tolerant than their peers in the colony. A “general bloodbath” was promised in the event that Canton institute house-to-house visits. One especially extreme placard posted at Macao blamed the French, said to have the hearts of wolves, of collaborating with a Portuguese lawyer called Jose Da Silva in spreading a poison through the Chinese community. The placard entreated the Chinese to avail themselves of the following:

dynamite, torpedoes and subterranean mines. In the first place his house ought to be burnt down and then they should discharge a pistol aimed at his heart. It is necessary to kill him; and it is only then that the people will live in peace; it is only then that they will not have any more disturbances.

Luise White shows us that it is short-sighted to dismiss these rumours as did the colonial authorities who were annoyed or offended by these cases of colonial resistance rather than concerned; the government resolved to put down this form of protest, to “take effective steps to keep people in order, to admonish them and to prevent any trouble arising.” Rumour and gossip, shows White, reveal the world in which they in which they emerge. White’s work

272 Platt, Jones and Platt, 55.
273 “The Plague in Canton, from our own correspondent”, 2.
274 “The anti-foreign riot in Canton,” Hong Kong Telegraph, 14 June 1894, 2.
275 Good Knowing Society Published by Ming Sing Tong, document lost.
277 Luise White, Speaking with vampires: Rumor and history in colonial Africa (Berkeley: University of California Press, 2000), 5.
explores medical encounters in African colonies, particularly encounters that involve taking blood. In this context, she writes, the rumours and anxieties expressed by Africans confronting unfamiliar medical beliefs and technologies must be taken at “face value”, not reduced to misunderstandings or as deformed interpretations of well-meaning colonial interventions. The extremity—and confusion—of the placards and rumours in Canton and Hong Kong reveal the helplessness and frustration experienced by Chinese through the outbreak who experienced the home visitations and sanitary quarantine as violations of their political, social, cultural, and individual bodies as well as a strategic move against their good health; in a culture where healing assumed the comfort of home and the presence of loved ones, the government’s “benign, not to say paternal” quarantine, isolation, and home visitation practices seemed little short of homicidal.

3.5 The Colony Convalesces

The plague crisis gave fuel to many of the anxieties and resentments towards the presence of foreigners in China. The autonomy afforded Chinese in Britain’s practices of indirect rule should not be interpreted as respect or equality; condescending and abusive attitudes prevailed. Despite the cooperation of Chinese and European interests in Hong Kong, a ‘mutual incompatibility’ and ugly stereotypes existed of ‘Johnnie Chinaman’, “[a] cowardly, easily-led but cunning child who needed a firm hand and frequent punishment to keep him on the straight and narrow...not mature nor civilized enough to be left in charge of himself”. Indeed, for all the autonomy granted the Chinese at Hong Kong, the British rated the Chinese low in the ranking of colonized people; as one colonist at Hong Kong wrote to the metropole, “a Chinaman is not to be dealt with as an Englishman, or even as an Indian or a Malay, might be”. The Telegraph placed blame for the outbreak squarely on the Chinese labouring class, writing, “[t]he present epidemic among the Chinese in Hong Kong, arising undoubtedly from nothing else but the filth which is

278 White, 5.
279 CO 129/263: Robinson to Ripon, 17 May 1894, #115
280 Lowe, 230.
281 Lowe, 230.
282 CO 129/182, 19 Nov 1878, Sir Robert Herbert briefing Sir Michael Hicks-Beach, and PHP, box 8, file 1, unnumbered.
characteristic of the masses in this part of the world…the Chinese coolie-classes cannot understand the necessity for cleanliness in their homes”\textsuperscript{283}. Another author condemned the Chinese resistance, writing that, “[the] usual feeling among the more ignorant classes of Chinese... [is] resentment against any European interference in their domestic affairs...The prime cause of the trouble is simply the inveterate dislike of Chinese for foreign interference. The coolies cannot see any harm in filth, and hate compulsory cleanliness”\textsuperscript{284}. None of these editorials betray any awareness of the assumptions inherent to “compulsory” sanitation or of domestic or bodily autonomy across the cultural chasm.

Just as the incursion of the colonial government into the Tung Wah Hospital destabilized the social order of the Chinese community, the colonial government’s response to the outbreak brought doubt on its own practices. The strategy of indirect rule suddenly seemed inadequate. Failing to have heeded Chadwick’s warnings seemed negligent. When plague arrived in Hong Kong, it was more difficult to think of the Chinese, previously viewed as privileged among Britain’s colonial subjects, as different from any of the other colonized masses. Blaming the Chinese for the crisis at the same time indemnified the colonial project; if Britain has assumed dominion over this piece of China, were the ‘half-civilized’ natives perhaps due a civilizing mission after all? One writer focused on the Kwong Fook I-Tsz, a small temple and ancestral hall in Taipingshan. Normally, an ancestral hall would store tablets commemorating the deceased. When plague hit, the temple’s place at the spiritual centre of the Chinese community made it a social locus. The poorest of the Chinese who fell ill made for the temple, putting themselves at the mercy of the community either to receive treatment or to die in peace. Soon, the I-Tsz was overrun with dead bodies, further spreading infections. This European writer looked upon the I-Tsz with disgust, as evidence that the Chinese failed to care for their own. Uncomprehending of the elaborate and deeply valued ancestral rites of Confucian society, he suggested that Britain’s indirect rule of the colony was an abdication of a moral responsibility to the Chinese, writing,

I do not blame the Chinese for this most deplorable picture of incompetence, cruel indifference, and neglect. The neglect of the sick and dying, especially in cases of contagious

\textsuperscript{283} “Sanitation among Chinese,” 2.
\textsuperscript{284} “Sanitation among Chinese,” 2.
disease, is proverbial in China. If England and Englishmen are any better, it is by the grace of God, and because our opportunities have been more favourable.  

“But I blame myself and dare to blame our Christian civilization”, continued the author, “which has in Hongkong to-day little, if any, more influence upon the natives than it had when we took possession of the island half a century ago”. Here was an advocate for responsibility in the colony, but the paternalistic and exploitive responsibility of imperial norms. The issue also brought out deep cynicism, revealing the dark paradox of colonial domination and dependency. One author asked in the *Telegraph*,

> What is to be done in this matter of the nursing of the natives sick of plague? Should any great improvement take place in the method, leading to much fewer deaths, it must be remembered that the number on hand will be enormously increased, as hitherto the deaths have been almost equal to the admissions, and it is the opinion of some of the medical profession that we are only at the beginning yet.

James Cantlie felt that the matter had been incorrectly framed. The plague, he felt, was “a specific poisoning imported from Canton city or the Kwanglung Province as yet unknown...an imported pest”. For Cantlie, the answer to the plague problem lay not in ‘civilizing’ the Chinese or in investing in public works, but rather in advancing science, a key rationalization of the imperial project at its core. “Filthy we may be; badly drained we may be; overcrowded we may be”, he wrote, but plague was not evidence of these things. Yersin’s discovery of the bacillus two weeks earlier had not yet been proven but would give weight to Cantlie’s view in time.

The plague rumours stirred the consciences of some among colonial population. As rumours circulated about the horrors occurring aboard the *Hygeia*, one European coolie master asked,

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286 “Sanitation among Chinese,” 2.
287 “The plague in HONGKONG,” *Hong Kong Telegraph*, 30 June 1894, 2.
Is it a fact that a Chinese woman was sent on board the *Hygeia* by the Sanitary Authorities supposed to be suffering from the plague, but which proved to be a case of pregnancy? And is it true that the mistake was not found out until it was too late to save the patient’s life? This is the tale told to me by my servants, and two of them have left my employ in a terrible fright to take their wives out of the colony.”

The *Telegraph* dismissed this rumour as “mischievous... [an] ill-considered falsehood” but the questions lingered: was this kind of mistake possible? How would this epidemic be managed? And how would Hong Kong have to change in the wake of this outbreak?

### 3.6 Intimacy: Penetrating Domestic and Psychic Space

It is common in colonial histories to think about medicine as the structures and institutions through which it was practiced. And not just medicine; it is easy to look at colonial states through the lenses of institutions perhaps because they were created so explicitly with the production and dispersion of power in mind. Institutions of colonial medicine, in particular the hospitals and clinics offering or imposing ‘enlightened’ Western medicine display colonial projects as they wished perhaps to be: rational, bureaucratic, and secure, the laboratories of modernity. Imperialists brought with them and worked to ‘acclimatize’ modern medicine, in the nineteenth century still a quasi-systematic set of beliefs and practices. The proponents of modern medicine proudly sought to eliminate the unpredictable and yet powerful influence of traditional medicine, familiar and intimate to colonized people. In spite of the humanitarian elements of missionary medicine, colonial medical institutions and practices were inextricably part of economic, political, and ideological empires. And on the ground, the first priority of medicine in the colonies was the welfare of the colonial population, not the colonized; as Davidovich and Greenberg succinctly argue, “Health was not an end in itself, but rather a prerequisite for colonial development.”

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290 Platt, Jones, and Platt, 35.
To focus only on the institutions of health and medicine created in colonies, however, belies the equally significant shifts in power and embodied subjectivity that occurred through medical encounters in colonial contexts. These encounters happen within physical spaces—hospitals, clinics, hospital ships—but concurrently in psychic space. This concept was developed in the psychoanalytic tradition, understood to be a “meeting point between the mind and the external reality, which allows for creativity, play, symbolization, and meaning-making.” In the context of psychoanalysis, psychopathology is manifest when psychic space is taken over by an “intrusive and deadening internal object.” The concept of psychic space has been useful to postcolonial and decolonization studies where processes of replacing the culture of a colonized people with that of the colonizer, producing a sense of inferiority in the colonized and an impression of the colonizer’s epistemic authority is discussed as the ‘colonization of the mind’.

Some theorists, notably Kelly Oliver, take inspiration from Franz Fanon in arguing that the experience of colonization has profound significance and effect not just in the macro-scale, visible worlds of politics, economics, society, or culture, but on the very bodies of the colonized. In colonial situations, writes Oliver, “the negative affects of the oppressors are “deposited into the bones” of the oppressed…in order to sustain its privileged position.” Oliver continues to explain, “the colonization of psychic space is the occupation or invasion of social forces – values, traditions, laws, mores, institutions, ideals, stereotypes, etc. – that restrict or undermine the movement of bodily drives into signification.”

Ann Laura Stoler also calls attention to the affective oppression of colonized people, theorizing “the...colonial state’s concern over sentiment, the state’s assessment of the intensity of

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292 Referred to by some theorists, alternately, as potential space.
294 Rapoport, 1533.
296 Oliver, 43.
297 As well as the sometimes traumatic confusion experience by colonizers. See, for example, chapter four of Ann Laura Stoler, Carnal Knowledge and Imperial Power: Race and the intimate in colonial rule (Berkeley: University of California Press, 2002). Here Stoler shows that experiences of métissage and affect were in some cases traumatic and destabilizing to metropolitan identities as well as colonized.
“feelings,” “attachments,” and sense of belonging... [as] not metaphors for something else but instrumental as “dense transfer point of power” in themselves.” Stoler focuses on sexual and familial intimacy and proposes that we follow Foucault for whom the history of sexuality and the construction of race are inextricable. Medical encounters in colonial contexts share many of the same properties, consequences, and significance but have not often been interpreted as intimate in nature. Certainly, the telling of epidemic plague in Hong Kong in 1894 reveals an intersection of race, law, cultural custom, bodily subjectivity, and affect. Confrontations between colonizers and colonized people occurred in the streets, at sites symbolic of colonial rule such as a rally or riot at Government House at the height of the epidemic, but most often at the threshold of the domestic spaces of Chinese labourers and their families. Every confrontation between Chinese and Westerner, caught between medical and cultural worlds and fraught with racial anxiety, occurred doubly in the physical and psychic spaces of all parties. For the colonized people, the Chinese, these penetration of psychic space was an enduring wound. The pretence of a colonial relationship that was mutual profitable and autonomous was over.

This medical crisis interrupted and reshaped both mundane and structural relations between colonizers and colonial subjects. All of the baggage of Eurocentric civilizing logics, the rapacious appetites of modern medical scientists for discovery, and the environmental anxiety of Europeans in the tropics was projected onto the Chinese, into their psychic space, infused into their bones. Policies of residential segregation remains in place years after the plague outbreak but the penetration of Chinese psychic space belied any notion that indirect rule protected the Chinese from the affective oppression of colonization.


300 CO 129/263: Ripon to Robinson, 17 May, 1894, #15, discusses a protest at Government House.

301 Japanese, French and German research factions played out the “plague race”, the competition to discover the causative agent, in high drama. Most histories of the Third Pandemic give a good deal of attention to this aspect of Hong Kong’s involvement in the pandemic. For one such discussion that takes into account further intra-racial competitions among researchers, see Lee, “Colonialism versus Nationalism”.
Furthermore, medical encounters can be intimate without necessarily involving tactile contact, actual touch. It is not only the physical proximity of a medical examination or a house-to-house inspection that is experienced as intimate. The powerful collision of medical beliefs and the bizarre rumours these collisions create about the medicine and bodies of the colonial Other occurs in the invisible territory of psychic space. Another way of framing this is to consider the medical encounter as an ‘affective space’, borrowing psychoanalytic framing of ‘effective’ and affective spaces. The former is what colonial institutions and colonial medical encounters were supposed to be: rational and productive. Affective spaces, then, are a symbolic world that is perpetually in process. As Stoler shows, colonial archives report colonial life in ledgers and tables and reports but also capture “uncertain knowledge […] disquiet and anxieties…epistemic uncertainties” in colonial rule. Even in Hong Kong with its promise of autonomy for Chinese customs, epidemic disease brought to life the usual drives of imperial life: to conquer, civilize, exploit, understand, educate, fertilize, and reap. Medical encounters and sanitary practices imposed during the plague crisis, then, represent potent transfer points of racialized power with an intimacy and violence new to Hong Kong’s history.

3.7 Conclusion

When plague arrived, it brought out the worst suspicions on the part of the British who blamed the Chinese for bringing the epidemic into the colony and for propagating it through customary filth and lack of sanitary concern. It might be easy to forget that the British were as confused and afraid of the plague as the Chinese, perhaps more-so in having rejected whatever herbal wisdom European plague fighters had employed during earlier epidemics. While emerging sanitary science would help prevent infections, modern medicine offered little palliation to victims in 1894. At this point, the European view of plague was similarly plural to the Chinese, “a blend of contagionist and environmentalist thinking”. We might forget the relative youth of the modern bacteriology in 1894 or that the plague bacillus would only be discovered as Hong Kong suffered. Even after Yersin’s discovery of the bacillus, tropical medicine had still to determine the vector of transmission and an effective treatment.

303 Benedict, *Bubonic Plague*, 140.
Transmission was the primary interest of all parties attending the British Medical Association of Hong Kong’s meeting in 1896. Some believed it was alimentary while others kept to the miasmatic theory that had been used to explain the Black Plague of the Middle Ages. The dominant narrative, Benedict says, was that plague was a contagious disease associated to the overcrowding and lack of hygienic practices among the Chinese as typical of the outbreak’s epicentre, Taipingshan 304. Dr. Lowson, who had been at the front lines of the epidemic, told the meeting that he suspected that the plague bacillus grew in the human body and dust found in unsanitary homes, and that infection resulted from contact with a contagious Chinese or with the Chinese’s contaminated dwellings. Other believed that the plague was caught through contact with the belongings of an infected person, and explained that this pattern went in one direction only: from Chinese to Westerner 305. In 1896, at the time of these discussions, the influence of germ theorists Snow, Pasteur, and Koch had not yet eclipsed miasmatic understandings of disease. Luminaries in tropical medicine were still at work—between metropole and the colonial laboratories—toward the discoveries in bacteriology and virology that would coalesce into the ‘hegemonic’ modern medicine of the 20th century.

The colonists in Hong Kong recast themselves as police of sanitation and bodily discipline, judging the Chinese for their ability to live in close proximity, to wear winter clothes in layers and avoid laundering them, for their tolerance or indifference toward strong cooking odours, bodily odours, elimination processes and night soil. The erstwhile sanitarians, volunteer house-to-house inspectors, were conscripted into sensory and social confrontations with the Chinese. For their part, the Chinese in Hong Kong were forced into experiences of foreign colonizers in their homes and in the hospitals. The sensory experiences of Chinese traditional medicine, visceral and sensual—pungent herbal formulas being simmered, the tactile ministrations of the acupuncturist or tui na practitioner—were forcibly replaced by the benignity of bleached white walls, the solitude of quarantine, and the threat of the cold point of a surgeon’s scalpel. These sensory encounters challenge the personal boundaries of individuals, forcing an unwanted

304 An irony, though, is that deaths from plague in Taipingshan account for only 10% of the total. 66% of deaths in the first year of the outbreak occurred in Kennedytown, to the far west, also an enclave for Chinese labourers, but escaping the furious scrutiny that befell Taipingshan. See “The Epidemic of Bubonic Plague in Hong Kong, 1894”, 158-59, 390-91.

305 See Benedict, Bubonic Plague, 142, footnote 7.
intimacy between colonizers and colonized. Challenging the domestic, psychic spaces and personal physical boundaries of Chinese became a part of being a colonist in Hong Kong. Medical doctors, merchant volunteers, redeployed Light Infantry—all Europeans could now imagine themselves as supervisors of the bodies and homes of the Chinese. Plague burnt out in Hong Kong by the early twentieth century but wounds in psychic spaces endured and all relationships in Hong Kong were reconfigured.
Chapter 4
Interlude: The Problem of (colonized) People

4 A Bridge

This chapter is different from others in this dissertation in that it does not explore a single epidemic or outbreak of infectious disease in Hong Kong. Instead, the chapter is a chronological and conceptual vessel, a shuttle that transports the reader between periods and paradigms. It might act as a tunnel from the world of 1894, from Hong Kong’s plague epidemic and its politics, to the realities of life in Hong Kong and globally post-WWII when the next infection to emerge from Hong Kong and become a pandemic, the H2N2 variant of the influenza A, appeared in 1957. As global geopolitics changed dramatically between the end of the nineteenth century and the middle decades of the twentieth, epidemiological, bacteriological and virological knowledge changed in as significant a proportion.

This chapter moves its reader through this period of intense and profound change. It explains Hong Kong’s development between 1900 and 1950, the Japanese Occupation of the colony during the Pacific War, and foreshadows Britain’s ambivalence toward this colonial possession after the end of the war. In particular, the chapter elaborates on a vexing thread that runs through Hong Kong’s history: the chronic challenge of creating and imposing effective public health law and practice as well as the apathy and uncertainty typical of the colonial government toward these measures. As we saw in the second chapter, fatal malarial epidemics inspired laws relating to sanitation and cleanliness from the earliest years of colonial rule. When these measures failed to assuage anxieties, experts, notably Osbert Chadwick, were summoned to study the colony’s natural and built environments. They gave their reports on what might be done to make Hong Kong safer and to moderate epidemic risks, essentially to dampen the infectious disease tinderbox Hong Kong had proven to be. The third chapter, narrating the spread of bubonic plague through Hong Kong before spreading worldwide, showed the consequences of the government’s half measures in carrying out the advice of the experts. The government faced the trouble of managing Hong Kong’s risky disease ecology and the Chinese community, which it

306 Chadwick returned to Hong Kong in 1905, finding most of his 1881-2 recommendations not yet met.
perceived as being intractable in converting to modern principles and practices of hygiene. One cost to these long deliberations was time; the colony languished for decades without effective public health law and infrastructure.

These deliberations were informed by paradigmatic changes in the history of colonialism and in the evolution of relationships between states and subjects. The influence of the global movement toward decolonization on Hong Kong’s administrators is discussed in more detail in the following chapter. Here, though, the influence of Sir William Beveridge’s Social Insurance and Allied Services, published at the end of 1942, is of concern. This document is associated with the birth of a British welfare state, a commitment to social security founded on a relationship of “co-operation between the State and the individual.” While the Report spurred Britain’s metropolitan government toward creation of institutions such as the National Health Service and social housing estates, these kinds of reforms did not often reach the British colonies. The relationship between colonial administration and colonial subject remained fraught. Deliberation on whether or not Hong Kong’s Chinese subjects were due any kind of social insurance only became significant when the local population settled, as we will see in the following chapter. The influence of the changes to metropolitan social values weighed on Hong Kong’s administrators, still, and this chapter explains some of the discourse among those charting the course for the colony in the first half of the twentieth century.

4.1 Inter-epidemic Peace

For the government, the plague epidemic had been a failed test. The internal crises—a dawning realization of the investment and infrastructure it might take to keep Hong Kong healthy and profitable—were matched by external concerns. Hong Kong was particularly vulnerable to unstable exchange rates, “the disastrous fall in silver and the trade-killing political troubles in Siam […]” as a centre of transnational exchange. For government, public health and medical

307 See Beveridge, 847.
308 Beveridge never himself used the term welfare states. It is attributed to Benjamin Disraeli who introduced the term in his novel Sybil: or, the two nations.
309 Beveridge, 848.
310 “The Plague in Hongkong,” The Times, 28 Aug. 1894, 6 (story filed on 19 July)
officials responding to the disease ‘on the ground’, however, the epidemic figured as a looming catastrophe coming, as *The Times* declared, “on top of the disastrous fall in silver and the trade-killing political troubles in Siam and Korea”\(^\text{311}\).

The Sino-Japanese War fought in 1894-95 further worried the government even before the epidemic crisis broke out\(^\text{312}\). When plague spread beyond Hong Kong, it moved first to Macao and then Fuzhou, then Singapore and Bombay. From there, bubonic plague moved aboard British steamships to Sidney, Honolulu, San Francisco, Vera Cruz, Lima, Asuncion, Buenos Aires, Rio de Janeiro, Alexandria, Cape Town, Oporto, and Glasgow\(^\text{313}\). Britain’s colonies in Burma, Mauritius, the French colonies of Senegal and Madagascar, and Portuguese Madeira Islands were all infected, revealing the densely interwoven relationships of imperial trade, “empire hav[ing] created new contiguities and provided the requisite pathways for disease to follow”\(^\text{314}\).

Maintaining Hong Kong profitable was one project but another containing its famous tendency toward insalubrity in a richly connected “global thassocracy”\(^\text{315}\).

The broad consequences of this new global disease ecology aside, the same kind of sanitary logic—quarantine and isolation—that Hong Kong’s administrators had roughly imposed on the Chinese of the colony threatened the colony’s economic capacity as well. As Peckham puts it, Hong Kong was defined at this point in its history by “conflat[ed]…pathological and economic idioms”. This is to say that the colony was now perceived as an entrepôt that repackaged and deployed “imported infections” of cholera or plague as well as the traditional wares of the China and opium trades\(^\text{316}\). For the government, the policy of indirect rule resulted not only in a social crisis but even worse than that an economic disaster when the port of Hong Kong was declared

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314 Peckham, “Infective Economies”, 221.

315 This term was coined by Headrick in *Tools of Empire*, 175-6.

an infected port and all vessels coming or departing were quarantined for fifteen days\textsuperscript{317}. Incentives to manage public health and infectious disease risk in the colony only grew more compelling with time.

\section{4.2 Chronic Struggles: Poverty, Complacency, and Tuberculosis}

\subsection{4.2.1 Indirect or Indolent Rule?}

While public health laws were established early in Hong Kong, the government made little and inconsistent effort at fully implementing them which allowed for regular outbreaks of malaria, cholera, and tuberculosis before World War II. This pattern was not unique to health, writes Scott, who finds that the government was “fitful” in implementing and administering health policy, law and order, and justice alike\textsuperscript{318}. The problem was not just the government, however; the implementation of sanitary reform and expansion of public health services was thwarted by tensions within Hong Kong politics and society. Colonial governance in Hong Kong had a primary mandate to encourage trade which mean appeasing the demands of merchants and of the Chinese, the two groups upon which Hong Kong trade depended. Implementing Chadwick’s advice, for example, took thirty years because the government was held in check by competing interests in the colony and its administration\textsuperscript{319}. This helps explain the importance of epidemics in Hong Kong history, catalysts for reform and expansion that had typically been debated for long periods without much action; Scott puts this clearly in noting that instead of the sweeping reforms Chadwick had prescribed, “incremental policies resulted in drift and decline until a health crisis of significant proportions finally produced action. By that time, a new structure of political authority had emerged in which the government’s principal antagonists were incorporated into the system”\textsuperscript{320}. In the first half of the twentieth century, the political tug-of-war

\textsuperscript{317} “QUARANTINE,” \textit{Hong Kong Telegraph}, 23 May 1894, 2.

\textsuperscript{318} Ian Scott, \textit{Political Change and the Crisis of Legitimacy in Hong Kong} (Honolulu: University of Hawaii Press, 1989), 50.

\textsuperscript{319} This refers to the interventions of Sir Ho Kai, member of the Sanitary Board, of the Tung Wah Hospital Committee, and a Western-style physician. While a critic of Chinese medicine, Ho was a powerful advocate for the Chinese community at large. In the context of implementing sanitary reform, he sought to mitigate intrusions or limitations to the Chinese “way of life”, deploying an argument on the cost of sanitary reform to strengthen his argument against a wholesale program of sanitary reform. See Gerald Hugh Choa, \textit{The Life and Times of Sir Kai Ho Kai: a prominent figure in nineteenth-century Hong Kong} (Hong Kong: Chinese University Press, 2000), 75-99.

\textsuperscript{320} Scott, 53.
over sanitary reform was exacerbated by the diffusion of medical and hygienic responsibilities among no fewer than six limbs of government; the Medical, Sanitary, Police, Public Works, and the Education Departments along with the Secretariat of Chinese Affairs all legislated and enforced—variably—legislation involving medicine and disease. This redundancy continued until the 1930s when a Director of Medical and Sanitary Services was appointed to orchestrate the various agencies, boards, public and private hospitals, and community interests.

The appointment of Dr. A. R. Wellington to the position of Director of Medical and Sanitary Services and subsequently to the Legislative Council marked a shift in governmental priorities; the appointment of a public health specialist to the Legislative Council was evidence of growing unease about the health of the colony as tenancy multiplied and housing options failed to grow at an equal pace. Wellington’s appointment and the damning report on the state of health in Hong Kong that he produced in 1930 might have inspired a commitment to improvement but it was nearly a decade before Wellington’s warnings about overcrowding, inadequate sanitary measures, inadequate hospital wards, and the continued threat of epidemic disease were heard. This, of course, echoes the delay that met Osbert Chadwick’s reports before the plague epidemic at the turn of the century. In 1936, the government moved to define and clarify responsibility for medical and public health issues in the colony. The Urban Council subsumed the Sanitation Department while the Medical Department assumed responsibility for a long list of tasks including the supervision of government hospitals and dispensaries, the inspection of Chinese hospitals, support of bacteriological research, and a list of public health programs.

Over the first four decades of the twentieth century, the picture of the colony’s health shifted in response to these measures. As indicated in data compiled by Jones, the tropical diseases that had been Hong Kong’s great enemies—malaria, plague, cholera, dysentery—grew less prevalent in the colony by the 1930s while diseases of malnourishment and tuberculosis became more common. The rise in cases of the latter only reinforced the already well-known crises of poor


housing and poverty in the colony. While the government acknowledged correlations between dwellings and epidemic malaria in the nineteenth century and had targeted the tenements at Taipingshan as incubators of the bubonic plague epidemic at the turn of the twentieth, the chronic struggle against tuberculosis in Hong Kong best reveals the relationship between disease and housing in the colony.

4.2.2 Tuberculosis

Tuberculosis has a unique character in histories of tropical and colonial medicine because it was often as prevalent in Britain as it was in the colonies. Known as the “white plague” for the pallor it causes in its victims, this nickname also recalls the prevalence of tuberculosis throughout Europe where it was cast as a disease of poverty that could be cured through upward mobility; infection rates in a society dropped in correlation to improved housing, sanitation and public education\(^{324}\). While it might have been interpreted as a disease of opportunity by conscientious public health advocates and politicians, the association between poverty and tuberculosis convinced many that this infection was an indicator of class\(^{325}\).

If tuberculosis did not inform on class in Hong Kong, then it did gesture to caste; as the European community sat atop the Peak among trees planted in afforestation campaigns, tuberculosis became epidemic among Chinese labourers in the early twentieth century. As Andrews notes, Robert Koch’s discovery of \textit{mycobacterium tuberculosis} made microscopic examination of sputum a definitive test for the infection. This fractured the catch-all disease concept of “consumption”, a term that could be applied to patients with varied symptoms including chronic coughs, bronchitis, and “hectic fevers” with low specificity\(^{326}\). It is therefore likely that tuberculosis was a problem well before the twentieth century, among the unknown diseases culling the ranks of the both the colonizers and colonized population in the first decades


\(^{325}\) For discussion of the framing of tuberculosis and class, see Mark Harrison and Michael Worboys, “A Disease of Civilization: Tuberculosis in Britain, Africa and India, 1900-1939,” in \textit{Migrants, Minorities & Health: Historical and Contemporary Studies}, eds. Lara Marks and Michael Worboys (London: Routledge, 1997), 117 and Lei, 250.

of colonial rule and compilation of medical statistics. In 1849, the colonial records note one case each of hemoptysis, phthisis, and scrofula, all symptoms associated with “consumption”. By 1900, deaths resulting from the disease would number 845, equivalent to 200 per 100,000. With the “bacillus of Calmette and Guérin”, or BCG vaccine created only in 1906, first used on humans in 1921, and put into widespread use only after World War II. By 1939, deaths due to tuberculosis reached 4,443, or 250 per 200,000, and when it was listed as a notifiable disease in January of 1939, 7,591 cases were noted over the course of that year, raising the ratio to 433.7 per 100,000. Statistics for the three years and eight months during which Japan occupied Hong Kong are impossible to trace, but the post-war conditions of overcrowding promoted the person-to-person spread of the disease, and widespread malnutrition made it easier for mycobacterium tuberculosis to overtake the immune systems of latent carriers and newly exposed. While plague had shocked the colonial regime, tuberculosis nagged, “[sapping] the productivity of workers and thus [acting] as a brake on economic development”.

Medical authorities drew on discourses on personal and cultural habits among the Chinese as they did, at first, when confronting bubonic plague. The Chinese had a “universal and disagreeable habit of spitting [and were] ignorant of the ways in which the disease is spread”. The problem, wrote Dr. Wellington, was spitting, claiming that every death in the colony was matched with “20,000 living incubators of the disease each adding his daily quota of microbes to the stock already existing”. Wellington’s words are memorable in the degree to which they

327 Department of Health, “Historical Summary of TB and Services in Hong Kong,” Tuberculosis and Chest Service (Hong Kong: Government of Hong Kong, 2006)
328 Starling states that there were 4,920 by 1938, but the Government of Hong Kong reports 4,443. Compare Arthur E. Starling, Plague, SARS and the Story of Medicine in Hong Kong (Hong Kong: Hong Kong University Press, 2006) and “Historical Summary of TB and services in Hong Kong”.
329 Starling, 226.
330 Jones, 660.
331 CO 131/101, Annual Medical Report, Hong Kong, 1938.
332 CO 131/85, Annual Medical Report, Hong Kong, 1931.
dehumanize their subjects, but blaming Chinese race and habits was common among both Western and Chinese investigators. In China, one European observer wrote, “Those with TB didn’t care at all about contagion, spitting wherever they pleased, and the opium addicts wiped tears from their eyes.” This habit, while certainly a means by which tuberculosis spread in Hong Kong, got nearly-obsessive attention from the European population because it offended sensibilities. None of the European observers understood that spitting had positive connotations in the traditional Chinese medical world. Excess phlegm is an indication of an imbalance in the body. A TCM doctor, or person understanding their body in a traditional Chinese medical frame, would not seek to suppress a cough but would try to release the toxic secretions from the body. Anti-spitting injunctions were put into effect, signs were posted against the practice “in many public buildings, as well as in tramcars, ferry boats, and other public vehicles” and public lectures given. Popular figures in Chinese politics and society including Sun Yatsen and Chiang Kai-shek spoke out against spitting as an affront to modernity, in the former case, and as a tenet of the New Life Movement in the latter.

Tuberculosis was made a notifiable disease in 1939, and the Director of Medical Services, Dr. Percy Selwyn Selwyn-Clarke, began a personal campaign against its spread. He gave lectures and radio talks and worked with prominent Chinese businessmen to spread information among the Chinese community. Selwyn-Clarke’s framing of tuberculosis paralleled the metropolitan framing of tuberculosis as a disease of poverty; without insurance or relief, the worker could not support his own health or his family, he acknowledged. Selwyn-Clarke’s take on the issue is

333 See Lei, 262-266.
334 See Lei, 262-266.
335 See, for example, the “Joint Report of the Principal Civil Medical Officer and the Medical Officer of Health, for the Year 1910” in Medical and Sanitary Report. Administrative Reports (1910), 11, and “ANNEXE B: Joint Report of the Principal Civil Medical Officer and the Medical Officer of Health,” Medical and Sanitary Reports for the Year 1911, 17. Remarkably similar discussions of the spitting problem are repeated in annual reports for years to come.
336 See discussion of Sun Yat-sen’s concern with modern sanitary behaviour in Yi Hu, Rural Health Care Delivery: Modern China from the Perspective of Disease Politics (Berlin: Springer Science & Business Media, 2013), 47. Concerning Chiang Kai-Shek, the first of the four principles of his New Life Movement was li, decorum. Spitting was a behaviour to be corrected as the Chinese people gave themselves over to his New Life Movement.
337 Jones, 672, paraphrasing MSS BRIT S470, ‘Address delivered on Tuberculosis at the Chinese Methodist Church Wanchai, Hong Kong, 28 January 1940’.
revealing, aligning him with the Beveridge-influenced movement toward welfare rising at home. Selwyn-Clarke stopped short of offering a solution to the poverty under which many Chinese in the colony laboured or of advocating that the colonial government should provide the insurance or relief that the Hong Kong Chinese labourer might have needed to stay healthy. Still, Selwyn-Clarke’s advocacy and more frequent government debate on creating public housing indicate a growing awareness of the urgent need for social insurance in Hong Kong. In part due to the “hard-boiled saint’s” efforts, four hospital and convalescent home were opened specifically for patients with tuberculosis between 1949 and 1957. Selwyn-Clarke also stated publicly that most Chinese were too poor to pay the rent of a hygienic domestic space, implying that the government should take a greater part in addressing the problem. A government commission was struck and gave recommendations on subsiding housing development in Kowloon and creating accessible transportation in the area, but no action was taken before World War II.

4.3 “Three Years and Eight Months”

During the first two years of the Japanese occupation, metonymically known as sam nin ling bat goh yuet, or “three years and eight months, Selwyn-Clarke continued as Director of Medical Services. He petitioned the Japanese governor to continue in his work for the benefit of Chinese and European prisoners of war who might be more trouble to the Japanese in ill-health or dead. He kept the post until he was arrested by the Japanese in 1943, held in solitary confinement for nineteen months and sentenced to death, eventually commuted to three year imprisonment at a second trial. One year into the occupation, the Lancet conveyed a report that before the occupation Selwyn-Clarke had successfully “reorganize[d] the Chinese hospitals and the welfare centre for mothers and children at Kowloon…had obtained registration of dentists and legislation against spitting…and was hoping [in September] to start a public-health diploma course for local

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338 Gauld, 46.


medical graduates. All such projects were waylaid by the occupation, and the *Lancet* was fretfully nostalgic, asking,

> Will the inhabitants still be able to take their choice of Western medicine at Queen Mary Hospital, or Chinese medicine at the Tung Wah and Kwong Wah hospitals? What will be the fate of the pleasant Victoria Hospital for maternity on the slopes of the Peak? Surely the old Government Hospital in among the noises and smells of Chinatown will always be just the same.

Through the occupation, some of these institutions remained partially operational, but public health programs ceased. Infectious diseases went unchecked and diseases of malnourishment increased. Medical Officer Dean A. Smith described the camps, writing,

> Unlike all P.o.W. and many civilian camps, the civilian camp in Hong Kong had a population which was mixed both as regards sex and age. The total never varied widely from 2,500, of whom 1,300 were men, 900 women and 300 children under 16 years of age. All ages from birth to the eighties were represented. Overcrowding was extreme and sanitation poor. Facilities for laboratory investigation were absent and, owing to extreme shortage of supplies, treatment of all cases was difficult and of some impossible.

Smith furthermore noted that “the full range of tropical deficiency diseases was seen”, as well as the quotidian infectious diseases; these included pellagra, beriberi, and cholera. Malnutrition caused neuropathic and ocular diseases in far greater numbers than usual. At the end of the occupation, European and North American prisoners of war were evacuated from the camps in

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341 “Hong-Kong Gone Yellow”, *The Lancet* 239, no. 6175 (1942), 19. To note, Selwyn-Clarke had insisted that a tuberculosis specialist be attached to each maternal health centre.

342 “Hong-Kong Gone Yellow,” 19.

343 Dean A. Smith, “Nutritional Neuropathies in the Civilian Internment Camp, Hong Kong, January, 1942–August, 1945,” *Brain* 69, no. 3 (1946): 209.

344 “Hong-Kong Gone Yellow”, 19.

significant number, about 700 in total. The evacuees reported “severe wasting”, with incidence of beriberi at 68%, tuberculosis at 21%, among many other concerns. No accounts were made of the plights of Chinese or other Asian prisoners of war at the end of the occupation.  

4.4 Post-WWII: Fall of Empires, Rise of Welfare  

4.4.1 The Beveridge Report and a New Paradigm  

In 1943, perhaps motivated by the expense of maintaining the colonies while fighting World War II on several fronts, Britain’s Secretary of State, Oliver Stanley, “pledged to guide Colonial people along the road to self-government within the framework of the British Empire”. Nonetheless, Britain reasserted colonial rule of Hong Kong immediately after Japanese surrender. The expense and trouble of sustaining Hong Kong as a colony were mitigated, however, by the transformation of politics of Asia when Mao Zedong and the Chinese Communist Party seized power after decades of civil war. Great Britain extended diplomatic recognition to the ascendant PRC on January 6, 1950. A torrent of refugees entering Hong Kong from the mainland began as soon as the CCP took power. Accurate numbers for Hong Kong’s post-war population are difficult to discern. The Statistics Department, established in 1947, reported “at least four conflicting estimates of the population by various authorities…ranging from 1,400,000 to 2,000,000 persons” while the United Nations estimated that 1,285,000 people entered Hong Kong between September 1945 and December 1949. Regardless of the exact number, Hong Kong faced what its government described as “The government faced what it called a ‘problem of people’”. The newly arrived Chinese often brought with them very meagre resources and so became squatters in the colony, living several families to one flat or building squatting’s huts in the foothills of Kowloon. Cutting down trees that had been planting in the greening projects to build these makeshift huts set back the forestation projects considerably.

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347 HC C Deb 13 July 1943, vol 391, col 48  
349 Hong Kong Government, Annual Report, Chapter 1, Review: A Problem of People.
and population density coupled with inadequate hygiene and sanitation services amplified known disease risks.

At the same time, a paradigm shift was underway in Britain where it concerned public health, medicine. The *Beveridge Report* became the cornerstone of the British welfare state, setting a course for the transformation of post-WWII British governance and society. The document betrays the traumatic quality of its historical moment, presented to the Commons in December of 1942, in the midst of World War II and at a juncture at which Britain was fighting with few allies. The Report’s first ‘guiding principle’ reveals the anxieties shared by Beveridge and his peers as well as Beveridge’s commitment to a new set of values in governance, stating, “any proposals for the future…should not be restricted by consideration of sectional interests….Now, when the war is abolishing landmarks of every kind, is the opportunity for using experience in a clear field”. “A revolutionary moment in the world’s history”, wrote Beveridge, “is a time for revolutions, not a patching”[^350]. The second principle held that social insurance, as it remediates want, was but one aspect of “a comprehensive policy of social progress”[^351]. The third principle was that social security was in its very nature a relationship possible only through “co-operation between the State and the individual”[^352]. The individual should not fall back on the offerings of the State exclusively but take responsibility for “himself and his family”[^353]. The *Report* committed Britain to the eradication of squalor, ignorance, want, idleness, and disease. The National Health Service was one of the *Report’s* greatest consequences, part of the government’s aspiration to offer a “cradle-to-grave” welfare system having found that the pre-war mix of private, public and charity offerings undesirable. Eradicating the five “Giant Evils” in Britain would best be accomplished in a national system.

For Foucault, always interested in relationships between states and bodies—writ large and individual—saw Beveridge’s *Report* and the policies created under its influence as a “point of symbolic reference…a new series of rights, a new morality, a new economics, a new politics of

[^350]: Beveridge, 847.
[^351]: Beveridge, 847.
[^352]: Beveridge, 847.
[^353]: Beveridge, 847.
the body”\textsuperscript{354}. This was no small issue; for Foucault, the \textit{Report} was evidentiary proof of a transition occurring from 1940-1950 that saw “the body of the individual…become one of the chief objectives of State intervention, one of the major objects of which the State must take charge”\textsuperscript{355}. He interpreted the Beveridge “plan” and the institutions created for its instantiation as a reversal of earlier relations between state power and health; where once the healthy individual was to serve the State, now the State was placed in the service of the healthy individual. This marked another change, a shift away from the logics of hygienic modernity wherein the individual bore the burden and responsibility of practicing cleanliness and hygiene in order to protect their productive capacity. With the State in charge of health, subjects gained the right to be ill and to stop work, a reconfiguration of one’s moral relationship to their body and labour\textsuperscript{356}. Health became an interest of macroeconomics with the Beveridge Plan, wrote Foucault, a major item of the State budget. This required ‘economic redistributions’ that ‘corrected’ inequalities in income. “Health, illness and the body”, he wrote, “began to have their social locations and, at the same time, were converted into a means of individual socialization”\textsuperscript{357}. Finally, he found that Britain’s transformation into a welfare state meant that “[h]ealth became the object of an intense political struggle”\textsuperscript{358}. Foucault called the society in which that new morality and economy emerged a ‘somatocracy’.

4.4.2 Conscience and Self-Conscious Subjects in Post-war Hong Kong

The \textit{Report} enjoyed an enthusiastic response from the public and was eventually, if grudging, acknowledged at Whitehall. New policies, pieces of a total scheme, were implemented. Britain’s European peers including France and the Scandinavian nations adopted similar principles and in some cases more fully realized the concept of a ‘welfare state’ than did Britain. While the first

\textsuperscript{354} Michel Foucault, “The crisis of medicine or the crisis of antimedicine?,” \textit{Foucault Studies} 1 (2006): 6. It is worth noting that in this lecture Foucault refers frequently to “the Beveridge Plan”. There was no single plan associated with William Beveridge’s report, as far as I have been able to ascertain. Beveridge’s document does give specific advice on several topics of reform, but was not explicitly a plan. Carrying out its recommendations required several further plans and studies. We can assume either that Foucault mistranslated the title of Beveridge’s document, a dubious assumption, or that he intentionally attributed the instructional quality of a plan to this report.

\textsuperscript{355} Foucault, 7.

\textsuperscript{356} Foucault, 6.

\textsuperscript{357} Foucault, 6.

\textsuperscript{358} Foucault, 6.
pages of Beveridge’s document refer to ‘persons’ and ‘employees’ among other subjectivities, it is clear by its ‘brass tacks’ second page, titled “The Nature of Social Insurance”, that citizenship is implied in the entitlement to the State’s support. While post-war Hong Kong had ample display of the five “Giant Evils”, Hong Kong people were not citizens and the commitments of the Beveridge plan were never explicitly extended to Britain’s colonial subjects. With the responsibility to social insurance attached to concepts of citizenship and the nation, Hong Kong’s colonial government was not burdened with the same responsibilities. Indeed, the Colonial Office was explicit in limiting the colonies from the Report’s moral logic, stating,

There seems to be some reason for doubt whether the methods of the Beveridge Report are quite suited to colonial conditions. It is designed for an advanced democratic community with a high standard of education and a long experience of social services; such a description is clearly inapplicable to the populations of the African colonies, or even the West Indies.\(^{359}\)

At the same time, Hong Kong’s government had significant expectations of its Chinese subjects. During the plague crisis, for example, Governor Robinson relayed a conversation with Chinese who had gathered to protest the forced relocation of plague patients from the Tung Wah Hospital to the Hygeia. Robinson found most Chinese reasonable once they understood the purpose of house inspections, but this persuasion required that the Governor inform these gentlemen in pretty strong terms that Hongkong was a British Colony and, as they had chosen to reside in it, they must submit to British laws and methods of sanitation, and further that, as I was responsible for the safety of the community, I must positively decline to listen to their requests […that house visitation should cease and that they might take their sick away from the Hygeia and the Kennedy Town hospital altogether]. I further pointed out to them that as residents of Hongkong it was their bounden duty to air the Government in the terrible crisis in which it was placed and not to obstruct it, or to allow their people to obstruct it, in any way whatever.\(^{360}\)

\(^{359}\) CO 859/78/1. Document 1, 4 Orde-Browne, “Social Insurance in the Colonies”, 21 April 1943

\(^{360}\) “Governor’s Despatch to the Secretary of State with Reference to the Plague” (20 June 1894)” Sessional Papers, 1894: 283-292.
The “bounden” responsibilities of the colonial subject were clear, but those of the government to provide infrastructure or social services were apparently not as the limits were debated over decades.

Even in 1957, fifteen years after reforms began in the metropole, Hong Kong had few of those desirable qualities by dint, surely, of the colonial government’s recalcitrance toward social spending. In effect, Beveridge’s logic could not be extended to the colonial subjects of Hong Kong because the economic policies of the colony banished them to what Foucault identified as the medical subjectivity of the eighteenth century, marked by 1. “medical authority [that] is a social authority that can make decisions concerning a town, a district, an institution, or a regulation”; 2) by the appearance of a medical field distinct from diseases, in the colonies best exemplified in hygiene and sanitation; 3) by the emergence of a site of collective medicalization, the hospital, as before the eighteenth century the hospital was not an “institution of medicalization” but a place where the poor prepared for death; and 4) the introduction of mechanisms of medical administration—recording of statistics and data, namely medical surveillance. By Foucault’s definition, we find Hong Kong in 1957 nicely aligned with medicine in Europe’s eighteenth century.

4.5 Reckoning with a Settled Population

If neither epidemic plague nor expert reports condemning overcrowding nor metropolitan discourse alone could push the government to build infrastructure in the colony proportionate to need, the interplay between residential density and disease motivated some action from the colonial government. The bubonic plague epidemic spurred the first deliberations on the government’s role in addressing the twin issues of public health and housing. Fires in the massive squatter settlements pushed the government beyond discussions on the need for public housing in Hong Kong to constructive action. The most famous of the fires was at Shek Kip Mei on Christmas Day of 1953 amid the squatters’ quarters in New Kowloon, just south of Boundary Street and the New Territories. The settlement was made up of six villages, all of them destroyed in the fire. With only two fatalities recorded, this might not have registered as a calamity or serious threat to the social fabric of Hong Kong but for the fact that the fire, within hours, made

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361 Foucault, 13.
homeless a population of 50,000 Chinese, most of them refugees and destitute\textsuperscript{362}. In the aftermath, the government began construction of very large housing blocks to resettle the squatters, a project that “was not meant to be the start of a welfare programme but [it] was”\textsuperscript{363}. Eight permanent six-storey buildings arranged in an H shape, now a very typical design for Hong Kong tenements, were built directly on the freshly-razed site. A second large fire in a different squatter settlement at Tai Hang Tung on 22 July 1954 killed 9 people and left 24,000 homeless\textsuperscript{364}. On that occasion, the government built similar tenements, but this time built more spaces than there were squatters to resettle, a signal that the government was committing to supporting future population growth not merely responding to already-present concerns. The construction of these large housing projects, referred to as Resettlement Estates, is often noted in Hong Kong historiography as a pivot point in British strategies of rule, and so a turning point in the whole of Hong Kong history\textsuperscript{365}.

That narrative was endorsed by the colonial government when Sir David Trench cited 1953 as “the year that social policy came to Hong Kong” as the government accepted that post-1949 refugees from mainland China would become permanent residents of the colony instead of sojourners and that the government would need to respond to the needs of the whole of the populace\textsuperscript{366}. The narrative that 1953 marked the government’s turn toward responsibility for public housing and health was propagated in scholarship to the point that it became the dominant

\begin{footnotes}
\item[362] Alan Smart, \textit{The Shek Kip Mei Myth: Squatters, Fires and Colonial Rule in Hong Kong, 1950-1963} (Hong Kong: Hong Kong University Press, 2006), 173.
\item[363] Steve Tsang, \textit{A Modern History of Hong Kong} (Hong Kong: IB Tauris Publishers, 2007), 204.
\item[364] Tsang, \textit{A Modern History}, 204.
\item[365] Smart advocates that the historiography of the Shek Kip Mei event and the construction of the H-blocks after the fire should be reconsidered. He holds that there had been marked shifts already in British rule, that “continuities are much greater than is usually recognized in the standard accounts”. It was not until the second major fire in 1954, he claims, that the government understood and committed to creating a resettlement scheme rather than acting reflexively in the face of major crises. He argues further that the usual history “[interprets] the past in the context of the future”, framing the construction of the first multi-storey complex as the first instance of public housing. To note, says Smart, there were government subsidized housing projects underway preceding the Resettlement Estates under the auspices of the Housing Society and Model Housing Society projects, as well as the Housing Authority established in 1954. He argues that the fires did not cause the government to amend its practices, but that the housing developments of the mid-1950s were strongly influenced by the government’s interest in developing the New Territories. See Smart, 96.
\item[366] Quoted in Jones, 653.
\end{footnotes}
This narrative has been challenged, however. Notably, Alan Smart has argued the fire at Shek Kip Mei was only one of several stimuli provoking the expansion of government housing project already underway, that the government responded less because of having taken on humanitarian values or as an extension of Beveridge-style social welfare reform in Britain but rather to prevent destabilization of the colony, and that the resettlement projects were further motivated by the government’s interest in developing the New Territories. Jones makes the argument that instead of the Shek Kip Mei fire it was rather the spread of tuberculosis through the 1930s that drew the colonial administration into a more interventionist strategy of rule. Jones makes the point that the government of Hong Kong before World War II had virtually no accountability to the Chinese population. There were very few Chinese members of the Executive or Legislative Councils and those that did hold positions in the wings of the Government were ‘quiescent’, selected not to advocate on behalf of the Chinese but because they could be counted on to represent the interests the government to the Chinese community or to create the impression of Chinese approval of colonial rule. For Jones, this lack of authentic representation meant that any social provisions offered had to be inspired by European “self-interest or...a sense of paternalism”. Jones depicts Hong Kong’s “colonial state...on a gradual learning curve”, the government having begun addressing public health and housing as twinned concerns in the context of fighting tuberculosis as early as the 1930s. These projects mirrored, says Jones, norms established in the metropole and that “to argue that social policy began in 1953 with the public housing projects would be to ignore the discussions and initiatives (some albeit aborted) which had preceded this policy and was not so obviously subject to radical shifts of direction as might be thought...Shek Kip Mei was the trigger but the ideational and policy drift dated back to the pre-war period”.


Smart, 88.

Jones, 660.

See CO 131/68, H. E. Pollock, R. H. Kotewall and W. S. Bailey, Sessional Papers, Hong Kong, *Report of Housing Commission, 1923*, 107-128. Here, the need for more housing is clearly identified as is the need for more affordable housing.
Several factors intensified debate on social services through the early 1950s. Britain’s declining prestige, a global wave of decolonization, and the shift in social policy and values articulated in the Beveridge Report inspired some of Hong Kong’s administrators to reconsider their relationship to the Chinese community. Equally, the Chinese community demanded change, most pointedly through constitutional reform. Still, there was no question of creating a welfare state in Hong Kong to match the growing infrastructure in the British metropole or of expanding modern medical services to all residents of the colony. Very little action, then, was taken. Instead, the government tended to continue to rely on the charitable and voluntary societies that sought to meet Hong Kong’s social and medical needs before the occupation. Yip notes that the government made most of its expenditures on medical services targeting communicable diseases like tuberculosis and cholera, giving little attention yet to “curative” care. This emphasis made sense to the government as the demonstrated consequence of infectious disease outbreaks was, among other things, economic—lower productivity in the factories or international quarantine on Hong Kong’s port would endanger the concerns of both European and Chinese residents.

If not to create a welfare state or to commit to offering comprehensive medical services to all living in the colony, Hong Kong’s government did address public health issues that were practical and obvious. Services rebuilt after the war included Port Health Services, Anti-Tuberculosis Service, Anti-Malaria Service, Social Hygiene Service, Maternal and Child Health and Social Health Service. Together, these services contributed to a significant decline in deaths from infectious diseases, from 30.3 percent in 1950 to 17.1 percent in 1955. While focused on this raft of public health services, the Government invested little into medical

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371 CO129/594/6, MacDougall to Gater, letter of 5 December 1945. In 1946, Governor Mark Young proposed the “Young Plan”. This was intended to introduce minimal but effective representative democracy to Hong Kong and was anchored to the creation of a municipal council to which Chinese and Europeans could be elected and that would be elected by a broad franchise that included settled and enumerated Chinese. The proposed municipal council would take responsibility for social services, education, and town planning. When ill health forced Young out of the governor’s seat after just one year’s tenure, the plan was scrapped.


373 Annual Departmental Report by the Director of Medical and Health Services for the Financial Year 1955-56, Hong Kong: Government Printer, 1956), 6.

374 Annual Departmental Report, 1956, 10.
infrastructure. Despite the burgeoning population, only two specialist hospitals, facilities supporting maternity and mental health, were built between 1945 and 1961. Healthcare in Hong Kong, managed through a web involving the Medical and Health Department, an array of public health and sanitation services, and the voluntary associations of the Chinese community, was buoyed by the ideas of modern public health rhetoric but was substantively weak.

4.6 Shadow Systems: Charitable Organizations and the Kaifongs

Though the 1950s give evidence of a shift in social policy, two enduring elements of Hong Kong’s medical landscape should be noted alongside any infrastructure created by the government. Colonial rule in Hong Kong had always relied on intermediate organizations, Christian missionaries or the charitable associations and community groups of the Chinese community. Heavy reliance on these kinds of groups and their responses in periods of epidemic crisis are among the distinct characteristics of medical history in Hong Kong and a dimension of how colonial medicine was realized in Hong Kong. The first hospital built in the colony was the Medical Missionary Hospital, opened in 1843 to offer Western medicine to Chinese. Its director, Dr. Benjamin Hobson, found that the Chinese in Hong Kong were not enthusiastic about Western medicine but that, still, Chinese coming from “at least fifty miles” were grateful for these free services. The Tung Wah Committee, and its Hospital, were the stalwart representatives of Chinese interests and medical traditions in Hong Kong, acting as advocates for the needs of Chinese and mitigating tensions. The Po Leung Kuk, or Society for the Protection of Women and Children, was founded in 1882 to offer support to orphans and destitute women. These particular charitable organizations have endured and are both politically and socially

375 These were the Tsan Yuk Government Maternity Hospital built in 1954 and a “replacement mental hospital” at Castle Peak built in 1961. See Gauld, 46.


influential but there are dozens of smaller charitable societies that have been part of Hong Kong’s medical history, tending to local or specific needs.

Another category of organizations called kaifongs bear consideration as they played significant roles in managing the burden of the two influenza epidemics after the war, the first in 1957 and the second in 1968. The kaifongs are particularly interesting in that they were supported, politically and sometimes financially, by the government, projections that promoted more support for the growing population but that did not directly compel or commit the government to responsibility. Neighbourhood associations had existed for centuries through southern China, and even pre-war Hong Kong. These organizations re-emerged in greater number and significance after the war in order to allow the government to continue its welfare strategy, which is to say its commitment to minimal intervention and investment. While drawing on Chinese social and political forms and values, the kaifongs were promoted and organized through the Government’s Social Welfare Office under the instruction of the Secretariat for Chinese Affairs. They were put in place to encourage both Chinese elite and the labouring class alike to undertake “constructive activates”, for the latter funding the welfare of the Chinese community and for the latter, sustaining the economic life of the colony. The kaifongs were also, says Chan, a means of depoliticizing the Chinese community, promoting “free enterprise and self-sufficiency” while discouraging political activism. The kaifongs were instrumental in providing relief to the refugees arriving in the late 1950s in the form of charity, free medical services, and loans, small business support, death gratuities, and shelter from typhoons. Their role in helping manage influenza outbreaks, as seen in the next two chapters, is therefore not surprising; these institutions typify the Hong Kong brand of colonial governmentality, the careful titration of self-reliance and supervision that pacified Chinese political foment while allowing the government to propagate its economic interests with minimal investment in social services.

378 Chan, Social Security Policy in Hong Kong, 93.
380 Chan, 94.
381 Chan, 96.
4.7 Traditional Chinese Medicine in a Modernizing Society

Just as the government justified its sluggish efforts at providing public housing with caricatures of the domestic ‘customs’ of the Chinese, claiming that Chinese preferred to live in high density and squalor, the government also used caricatures of the customary ways of the Chinese to rationalize a public medical system that was inadequately small and inaccessible to the great majority of the population. Rationalizations that Chinese preferred to live in close quarters, sleeping one atop another of as was necessary in some squatter’s quarters, were spurious, and racist; Overcrowding was the product of economic hardship, the colony’s own consultants and committees had concluded. The case that Chinese preferred their own traditional medicine and were resistant to Western medicine, however, was much stronger. Encouraging ‘conversion’ to Western medicine was part of the imperial project worldwide. In Hong Kong, this was particularly challenging given the power of the indigenous medicine of China including herbalism, acupuncture, and a range of ritual and self-cultivation practices. British rule of Hong Kong established Western medicine in the region but Chinese medical practices and practitioners persisted and thrived well into the twenty-first century.

Chinese medicine had been practiced in Hong Kong since the colony’s inception alongside Western medicine, “officially recognized…officially regarded and administered as separate systems.” Still observing Charles Elliot’s 1841 imperative that Hong Kong Chinese should be “governed according to the laws and customs of China, every description of torture excepted”, traditional medicine was not regulated by the government until the turn of the twenty-first century; though practitioner’s associations formed, none had the legal standing to establish standards or impose discipline on practitioners. This meant a certain measure of tolerance, and

382 Rockefeller scholar Peter K. Olitzky produced a report on epidemic meningitis in 1918 that concluded that poverty was a significant factor in overcrowding which was itself a factor in rampant disease. Hong Kong’s own Housing Commission highlighted the role of poverty in producing many of Hong Kong’s ills. See Peter K. Olitsky, First Lieutenant M.R.C., U.S.A., “Report on the investigations of the outbreak of epidemic meningitis in Hongkong (17 October 1918)” Sessional Papers, 1918: 61-84.


occasionally curiosity, as the colonial government left the Chinese to their practices. During the outbreak of plague, Charles Ford, Superintendent of the Government Gardens and Tree Planting Department, noted the practices of Chinese who gathered native plants to make a medicinal soup with cooling properties for plague patients. He collaborated with Ho Kai on projects documenting the use of local herbs as medicinal preparations.

The colonial government established medical services in 1843 but did not extend them to Chinese in the colony. The first institution to do so was the Government Civil Hospital. The Civil Hospital opened in 1850 but for decades still received few Chinese patients. Those who did enter this hospital were mostly prisoners or confined to the colony’s lunatic asylum. Three decades after its founding, the Government Civil Hospital was still unpopular among Chinese, the Colonial Surgeon noting that this was perhaps less a question of preference than one of access; the fee of $1 per day was prohibitive to most of the laboring class. The Colonial Surgeon ascribed a cultural explanation rates of hospital visits, even to the Tung Wah Hospital, writing, “Chinese rarely enter a hospital unless they are so ill as to be able to work to support themselves, or are in the last extremity of disease, having a great dislike to any restraint upon their freedom of action.” The subsidy paid by the colonial government to support the Tung Wah Hospital, opened in 1872, sought to resolve worry that Chinese avoiding medical care presented a serious risk to the health of the whole colony. The Tung Wah Hospital offered Chinese medicine at no cost until 1896. In the aftermath of the plague epidemic two years earlier, a government inquiry found that the Tung Wah Hospital failed, brutally, to meet passable standards. A reflection of public fears, the Telegraph was equally scandalized, calling the surgical ward of the Tung Wah a “chamber of horrors.” One report questioned whether the Tung Wah Hospital could fairly be considered a hospital in the European view, “that is, a place for the medical treatment of the sick with a view to their recovery and cure as a result of that

387 J. Murray, “Government Civil Hospital” (22 February 1882), Administrative Reports (3 June 1882).
389 “The Tung Wa Hospital, Its Present Condition”, Hongkong Telegraph, 13 June 1896.
treatment\textsuperscript{390}. This concern—that indigent and moribund Chinese were brought to the Tung Wah to die rather than allowing their passing at home—was a cultural practice misunderstood and underestimated by the colonial authorities. Another was the notion that Chinese were inherently resistant to sanitary and hygienic practices; while Osbert Chadwick’s 1882 report had emphasized the compliance of Chinese with his research, no one following him seemed to find the same good will. In his post-plague appraisal of the Tung Wah Hospital, T. H. Whitehead assumed that the Chinese, “who are wholly indifferent to matters of drainage, ventilation, and sanitation generally”, would allow the newly-sanitized hospital to lapse into “the state of filth from which the place has just been rescued”\textsuperscript{391}. In response to this report, the government placed the hospital under its own administration, supervised by a Dr. Thomson and a Chinese trained in Western medicine, Dr. Chung Boon-chor. From that point, the Tung Wah Hospital offered many Chinese their first exposure to Western medical practices.

Education was quicker than persuasion or demonstration, however. To this end, two institutions were built to teach Western medicine to Chinese. The first was Alice Memorial Hospital, established in 1887, which trained a handful of Chinese in Western medicine\textsuperscript{392}. Alice Memorial Hospital was originally sponsored by Sir Kai Ho Kai, a key figure in negotiating the hybridity of Hong Kong’s colonial medicine. Ho was the son of a Christian Chinese missionary, educated as both a physician and a barrister in the United Kingdom. He trained in medicine at Aberdeen University and was thus allowed to register and practice Western-style medicine in Hong Kong. Ho did not practice as a physician for long, finding that he could not make a living treating impoverished Chinese\textsuperscript{393}; his biographer paints a sorry picture of Ho Kai waiting for patients, “…in his frock coat and wing-collar, waiting in his consulting room otherwise known as surgery…in vain”\textsuperscript{394}. As a member of the Legislative Council and the Sanitary Board, Ho acted as a cultural comprador, moving between racial, ethnic and cultural spheres. His approach to

\textsuperscript{390} T. H. Whitehead, “Report on the Tung Wa Hospital” (17 October 1896), Sessional Papers (17 October 1896), xxi

\textsuperscript{391} T. H. Whitehead, xxx.

\textsuperscript{392} Note, however, that these trainees were not officially allowed to practice Western medicine and were not formally credentialed.

\textsuperscript{393} Choa, The Life and Times of Sir Kai Ho Kai, 49.

\textsuperscript{394} Choa, The Life and Times of Sir Kai Ho Kai, 54.
reconciling the two medical worlds was gradual persuasion, sanctioning the practices of Chinese medicine so long as the essentials of sanitation were observed. Ho recommended a path of careful accommodation. As one example, he condemned the use of soiled linens in the Tung Wah Hospital but challenged his colleagues investigating the Hospital, calling them to recognize the need for Chinese trained in Western medicine who could speak in local dialects. Ignoring this, Ho, understood, would have destabilizing consequences in the colony; in a chilling transcription of a meeting discussing the fate of the Tung Wah Hospital, Ho recounted the story of a coolie whose fractured leg was amputated without consent, the patient unable to understand the surgeons at the Government Civil Hospital. The coolie’s family now regularly came to the Hospital to complain, reported Ho, the coolie having lost his livelihood. Ho’s colleague interjected, “I understand the man himself is pleased?—I do not know that”, ignorant of the practical consequences of this mutilation for a Chinese labourer who would now struggle to support his family, and of the Chinese proscription toward amputation. While himself certain of the superiority of Western medicine, Ho sought to protect the rights of Chinese to have access to traditional medicine, even into the twentieth century as part of the means by which Hong Kong could maintain social and political stability in the colony.

The Hong Kong College of Medicine for Chinese similarly bridged the Chinese community and Western medicine. The College was founded in 1887 and reconfigured as the Hong Kong College of Medicine in 1907. One intention was to train Chinese in the practice of Western medicine, smoothing any cultural and ethnic resistance that might be engendered in a cross-cultural clinical encounter, or, to put it another way, limiting medical and psychic intimacy between the European and Chinese populations. Another was to train Chinese in Western medicine who would then create and staff clinics and hospitals of their own, obviating any need for Britain to spend money building facilities for the Chinese in the colony. The College assured the colony a supply of qualified physicians of Chinese and European ethnicities, perhaps an exceptional case in histories of colonial medicine. Here, we have an institution created for the modern medical education of a native population that also attracted the best students among the

395 “Minutes of Meeting held on Saturday, 18th April, 1896” (18 April 1896), Sessional Papers (17 October 1896), 32.
European population of the colony^{396}. Still, the College was regarded as a second-rate option to metropolitan training, “the examination through which they go there…not equivalent to the minimum course required in England”^{397}. Graduates of the College were even prohibited from registration as “Western-trained” doctors as of the 1892 amendment of the Medical Registration Ordinance.

Practitioners of Chinese medicine were forbidden the title “doctor” and so advertised their services as zhongyi, zhongyishi, guoyi, or tangyi^{398}, in English, they might refer to themselves as ‘herbalists’ whether or not they practiced acupuncture, bonesetting, or other traditional cures^{399}. The government made no interventions into the practice of “purely Chinese methods” by individuals of Chinese race, regardless of training, and protected the rights of Chinese ‘herbalists’ to “recover reasonable charges in respect of such practice”; Chinese medical practitioners in Hong Kong were treated as merchants, unimpeded in the free market of bodily subjects^{400}. Training in the theory and practice of Chinese medicine was much less formal than training in Western medicine at the College, with only a few training schools and night schools operating up to the 1950s^{401}. Among the hundreds of thousands fleeing China, through the 1930s and 1940s, escaping the Japanese occupation, and through the 1950s, escaping Mao and the CCP, were medical practitioners from all over China. The rapid influx of population created both competition and opportunity for Chinese practitioners. Following the sacking of Guangdong in 1942, medical practitioners arriving in Hong Kong established Chinese medicine associations and then private training schools, the Zhongguo guoyi xueyuan in 1947 and the Qinghua xueyuan

^{396} The Hong Kong College of Medicine for Chinese was the foundation for the University of Hong Kong, founded in 1908.
^{399} Practitioners of Chinese medicine in Hong Kong are now licensed and registered but the title “doctor” remains prohibited in the contemporary Chinese Medicine Ordinance (1999).
^{400} Medical Registration Ordinance”, *Chapter 161: The Ordinances of the Legislative Council of the Colony of Hong Kong, 1950*.
^{401} Hokari, 230.
in 1953\textsuperscript{402}. Descriptions of these schools, located in “small apartment buildings” as late as the 1970s suggest a lack of professionalism that is perhaps rather evidence of traditions uprooted from their native contexts, reasserted in a new practical and economic frame\textsuperscript{403}. Practitioners advertised in the colony included “spirit-healers, secular healers, those performing both types of healing…those diagnosing according to non-secular beliefs and vice versa…acupuncturists, “general” therapists using medicine derived from herbal, animal, and mineral compounds, …bonesetters … [specialists] in the diseases of the sexes, and in paediatrics and gerontology”\textsuperscript{404}.

After the war, the Secretariat for Chinese Affairs, the executive agency of the government and its primary channel of communication between the Chinese population of Hong Kong and the government, observed that there was greater interest in Western medicine among Hong Kong Chinese and that accordingly traditional practitioners began to incorporate elements of Western diagnostic science and clinical practice; these hybrid practices included the use of x-rays by bonesetters, the use of modern medical implements in abortions instead of poisonous herbs, evidence of either the hegemony of Western medical thought or of a hybrid medicine reflecting Hong Kong’s broader hybrid qualities\textsuperscript{405}. Access to hospitals, clinics and dispensaries furthered acceptance of Western medicine among the Chinese population\textsuperscript{406}; through the 1950s, attendance at government clinics increased by 154\%\textsuperscript{407}. Still, the government noted “enormous demand” for traditional treatments, but that practitioners in the 1950s faced increased costs of herbs and implements that needed to be imported, more competition among practitioners given that many among the refugees coming to Hong Kong were practitioners of traditional medicine, and the “growing belief in the unbounded efficacy of Western antibiotics and the “miracle” of the “inoculating needle” furthered by intense commercial campaigns promoting use of Western


\textsuperscript{404} Topley, “Chinese and Western Medicine in Hong Kong”, 495.

\textsuperscript{405} Topley, “Chinese and Western Medicine in Hong Kong”, 511. Note that Topley undertook this research in the late 1960s and 1970s. I have not located any studies of the medical culture of Hong Kong in the 1950s, and government data is patchy in the decade following the war.

\textsuperscript{406} Allan S. Moodie, “Tuberculosis in Hong Kong,” \textit{Tubercle} 44, no. 3 (1963): 334-345.

\textsuperscript{407} Director of Medical Services, \textit{The Development of Medical Services in Hong Kong} (Hong Kong: Hong Kong Government Printer, 1964), 4.
When facing an epidemic, Hong Kong Chinese would choose among a wide range of Chinese, Western, legal, illegal, private, and public medical services based on personal beliefs, financial means, and practical access. Rising acceptance of modern medicine in colonial Hong Kong did not discourage Chinese from seeking herbal and acupuncture treatments from traditional practitioners nor did the colonial government fully outgrow its reliance on the medical projects of missionaries and community organizations that were instrumental in containing the influenza outbreaks of the next two decades.

4.8 Conclusion

This chapter connects Hong Kong’s early colonial history with its last decades under colonial rule. The experiences of colonists in the 1840s who interpreted malarial epidemics as miasma and saw Hong Kong through the lens of tropicality have a good deal in common with their peers in other colonial histories of medicine. The discourses they created about these tropical experiences, reporting from the periphery to the imperial centre, is part of Britain’s vast project of imperial knowledge production. The terrors of the 1894 plague are also clearly connected to imperial history, demonstrating so clearly that the way trade networks made empire valuable were also a great vulnerability, spreading disease as readily as profit. The plague episode is also revealing in the frame of colonial medicine. Here, the legal and social relationships between colonizer and colonized people determined treatment of plague to the same degree, if not more, than the medical technologies deployed. Clinical encounters, and medical encounters occurring outside of the determined space of a clinic such as the home visitations, bore influence on relationships between Western and Chinese in Hong Kong for decades to come. These nineteenth-century episodes feel familiar, have parallels in other well-studied colonial histories.

Hong Kong is different, though, in that its history of colonial medicine endures into the 1990s. By that time, circumstances and dynamics hardly resemble the encounters of the 19th century. Relationships evolve across decades and epidemics. The British and the Chinese endured the

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408 Personal correspondence, Secretariat for Chinese Affairs, 1962, noted in Topley, “Chinese and Western Medicine”, 512.

409 With very few exceptions, Hong Kong’s European population limited their care to Western medicine. In times of crisis, however, there are examples of Europeans crossing racial lines and partaking of Chinese herbal treatment, as is noted later in this chapter.
Japanese Occupation together, often incarcerated or put in internment camps together. The government and Medical-Director Selwyn-Clarke advocated first for the needs of Western detainees but also for the general health of the colony\textsuperscript{410}. Fighting off the Japanese was a common cause for everyone in Hong Kong. After the war, the relationship between the colonial government and the colonized Chinese settled into something similar to what it had been before the war but with some new dimensions overlaid. Survivors of the Occupation had a shared survivorship. Social insurance ideology taking hold in Britain called attention to the level of poverty prevalent in the colony, stimulating debate if not substantial action. As the population of Chinese grew rapidly, arriving in Hong Kong as refugees, that poverty was all the more obvious. The chronic prevalence of tuberculosis, in particular, revealed the population pressures that Hong Kong faced.

This chapter helps to bridge the colonial and imperial medicine of the nineteenth century, the frame of tropicality, with the geopolitical contexts of the 1950s and 1960s in which the next two epidemics unfold. With yet no comprehensive public health strategy and inadequate medical support, outbreaks of influenza in 1957 and 1968 cast light on the weaker aspects of British governance of Hong Kong. The significance of the conditions explored in this interlude—most generally the ambivalence and indecision of the colonial government as to how it would manage the health of Hong Kong—comes to light when the influenza epidemics to follow bring Hong Kong scrutiny and responsibility in international infectious disease surveillance.

\textsuperscript{410} The Japanese had several categories by which they separated prisoners in Hong Kong, writes Snow. Americans and Europeans whose nations were part of the Allied forces were interned together. Eurasian, Portuguese and Europeans whose nations fought with the Axis powers or were neutrally-aligned were interned together. Chinese were kept to labour for the Japanese or, if unlucky, interned with the British. See Philip Snow, \textit{The Fall of Hong Kong: Britain, China and the Japanese Occupation} (Cambridge: Yale University Press, 2004), 139.
Chapter 5
H2N2, 1957: The ‘Influence’ and Hong Kong’s Emerging Identity

5 No Longer China, Never Metropolitan

Post-World War II, the global movement for decolonization brought scrutiny to Britain’s administration of Hong Kong, questions about the legitimacy of continued colonial rule. This first decade of ‘cold war’ arranged the world in a new political geography, shifting poles of power and economic dependencies. Within Asia, trade embargoes imposed on the PRC during the Korean War meant a redefinition of Hong Kong’s political and economic significance; whereas it had previously been the entrepôt between East and West, Hong Kong was now a wedge in the door between Western powers, Western markets and Communist China.

In the British metropole, the Beveridge Report of 1942 anchored a commitment to eradicating the five “Giant Evils”: squalor, ignorance, want, idleness and disease. Britain’s developing welfare state was an instantiation of these values and represented, writes Foucault, “a new system of rights, [a] new morality, [a] new politics and [a] new economy of the body in the modern Western world”\(^{411}\). In Hong Kong, all of the five evils were in evidence, intensified by a huge rise in population. Chinese in flight from the CCP arrived in Hong Kong in waves cresting in 1950. For the most part, the refugees stayed, creating a settled population with needs for shelter, food, and medical care that far exceeded existing infrastructure and social services.

While the natural environment had played a great role in shaping the perceptions and decision of colonial practices through the first century of British rule in Hong Kong, pressures arising from the built environment took a greater role. The government faced what it called a ‘problem of people’\(^{412}\). The colony’s population had risen from 600,000 at the end of the Japanese occupation in 1945 to 2,500,000 in 1956, allowing the colony’s survival by way of a transition from a trade-based economy to industrial production. The government noted its reliance on the Chinese refugees who offered “a surplus of labour…new techniques from the North coupled with a commercial shrewdness and determination superior even to that of the native Cantonese,

\(^{411}\) Foucault, 7.

\(^{412}\) Hong Kong Government, 1957 Annual Report, Chapter 1, Review: A Problem of People.
and….new capital seeking employment and security." To maintain a healthy and productive industrial economy, Hong Kong required a healthy and motivated population. In a time in which the exploitive practices of imperialism and colonial rule were debated in the public and Whitehall alike, the colonial government recognized all the more that it would need to invest in services to maintain Hong Kong’s emerging proletariat. Still, that recognition did not result in immediate change. Hong Kong’s social policy changed slowly, in fits and spurts, and in a reactionary manner, in response to crises rising of the five evils.

The consequences of Hong Kong’s population pressures resonated worldwide. An outbreak of influenza, carried into Hong Kong from southern China by Hong Kong Chinese making use of the re-entry permits, occurred in the spring of 1957. The epidemic spread from Hong Kong through Southeast Asia and then throughout the world causing between one to four million infections and two million deaths worldwide. The pandemic, caused by a new variant of the influenza A virus and branded the “Asian flu”, intensified anxiety about medical surveillance on local and global scales. Hong Kong, sharing a border and disease habitat with the southernmost province of the PRC, could scarcely escape that association. From a global perspective, this pandemic established Hong Kong as an epidemiological sentinel for Asia and proxy for the PRC in Cold War epidemiological and medical politics. Locally, the 1957 influenza epidemic reinforced the risks of the government’s recalcitrance in addressing the ‘problem of people’. It furthermore demonstrated the diversity of medical culture in Hong Kong, its underdeveloped public health services, the complexity of managing medical needs through a mix of public and private institutions, and the challenge of two co-existing medical cultures and institutions, traditional Chinese and Western biomedicine, keeping pace. Most subtly, this epidemic contributed to the medicalized elements of local subjectivity and the first evidence of an emerging local identity, heunggongyahn.

413 Hong Kong Government, 1957 Annual Report, Chapter 1, Review: A Problem of People.
414 College of Physicians of Philadelphia.
5.1 The ‘Far Eastern Influenza’ Appears

5.1.1 An Outbreak in China

The first reports of an unusually virulent influenza came from the city of Guiyang in Guizhou province in late February of 1957. By March, reports of infections in Yunnan province surfaced and from there influenza spread through much of China. Chinese scientists worked to identify the strain, isolating viral strains in laboratories in Beijing, Zhangjiakou, Luoyang, and Changchun. Western media did not pick up reports of the outbreaks in China, nor did newspapers in Hong Kong. Influenza is endemic to China as well as many regions of the world, and so not usually worthy of note. Endemic, interpandemic strains are usually mild, more inconvenient than threatening to the affected populations. The flu is a normal part of life until viruses change through antigenic drift, producing variants to which a population has limited immunity. Endemic flu culls elderly populations and waylays productivity in the workplace but an outbreak, as was seen in China in February of 1957, would not normally have been cause for panic. This is important to note; while the last influenza pandemic of 1918-19 was caused by an extremely virulent strain, the virus associated with the events of 1957 was only moderately virulent. Its spread through the world is less a story of a fearsome disease entity than it is a demonstration of the role played by modernity’s vessels in disease diffusion. The full picture of influenza’s spatial epidemiology is still under investigation, epidemiologists working between epidemics and pandemics to understand the contradictions in diffusion patterns among stains. As an historical phenomenon, pandemic influenza H2N2, as it was eventually labelled, is about the

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416 Antigenic drift refers to the tiny changes in the genetics of influenza A and B viruses that happen continually during the process of viral replication. These changes are small and gradual enough that populations often retain immunity, cross-protection, as the immune system responds effectively to the virus that shares most of its antigenic properties with the earlier version until a point at which the tiny changes accumulate and result in a virus significantly different enough that the body does not recognize it and is susceptible. Antigenic drift is what makes it possible for a person to catch the flu several times in a lifetime instead of developing universal immunity. Antigenic shift is a more dramatic genetic change that occurs only in influenza A viruses. It occurs when two or more different strains of a virus combine to form a new subtype with a new haemagglutinin or haemagglutinin and neuraminidase combination. It occurs in the context of an influenza virus prevalent in an animal population infecting humans.

intensification of risk and hastened diffusion rates in the context of a global economy and rapid mass transportation.

5.1.2 Cases Appear in Hong Kong

The flu reached Hong Kong in April. Reports in local Chinese language newspapers surfaced in the second week of the month. One reported on April 12 that an outbreak had occurred in the colony and was serious. It reported the next day that morbidity rates were equivalent to one infection in every family or workplace in Hong Kong\textsuperscript{418}. Another source warned parents to keep their children home from school and to avoid playing outside the home\textsuperscript{419}. This source continued to herald the severity of the outbreak two days later, announcing 300,000 to 400,000, causing long line-ups at hospitals and clinics and disrupting the social and cultural life of the city\textsuperscript{420}. Hong Kong’s medical infrastructure had been stretched to its limits, the \textit{Ta Kung Pao} crowed, with one doctor reporting having treated 100 patients in three hours and many doctors and nurses succumbing to the virus themselves\textsuperscript{421}. Transportation in the colony was impeded with bus and tram drivers falling ill and markets were affected, the price of pork dropping, the price of lean meat rising, and the sale of herbal remedies soaring all in response to the traditional Chinese medical understanding of influenza\textsuperscript{422}. The ‘flu did not suppress entrepreneurial spirit; scalpers capitalized on the opportunity created by the long queues for medical attention, marking up vouchers for medical consultations from $3 HKD to $4 or $5\textsuperscript{423}.

Within the week, the tone of reporting escalated from warning to serious concern. This was a more serious outbreak than the endemic cases that might appear in any given year and a serious threat to the economy and health of the colony. One third of workers at the largest textile factory in the city, between 60-70 tram workers, many car, truck and taxi drivers, postal workers, and medical professionals had all booked off work\textsuperscript{424}. The city existed in a kind of limbo, suspended

\textsuperscript{418}\textit{Takung Pao}, 12 April 1957, \textit{Takung Pao}, 13 April 1957.

\textsuperscript{419}\textit{Wah Kiu Yat Po}, 12 April 1957.

\textsuperscript{420}\textit{Takung Pao}, 15 April 1957.

\textsuperscript{421}\textit{Takung Pao}, 16 April 1957.

\textsuperscript{422}\textit{Kung Sheung Wan Bo}, 16 April 1957; \textit{Takung Pao} 18 April 1957.

\textsuperscript{423}\textit{Kung Sheung Wan Bo}, 18 April 1957; \textit{Takung Pao}, 19 April 1957; \textit{Wah Kiu Yat Po}, April 1957.

\textsuperscript{424}\textit{Takung Pao}, 17 April 1957.
between the hope that infrastructures would hold and fear that the needs of the sick would soon overwhelm support. Night clinics opened and the Kwong Wah Hospital offered extended hours to alleviate the long waiting times for medical attention. The Hong Kong Chamber of Commerce and other industrial and cultural groups opened clinics to offer care to their members and sometimes to non-members, which is one example of the makeshift accommodations the Chinese community would create when governmental systems were overwhelmed by demand.

As always, the Tung Wah Hospital mobilized to open clinics for the Chinese community. 

Kaifongs and mutual aid societies provided service to the shantytowns at Chai Wan and Ho Man Tin. In the same spirit, Wah Kiu Yat Po suggested that civil servants working in medical and janitorial fields take up extra shifts in the clinics to lighten the burdens on physicians. The flu reached prisons, schools, and the British Army base. Doctors cautioned against panic, however, suggesting that the early reports of infections in the hundreds of thousands were ten times inflated. Many students had fallen ill but not enough of them to close schools. Hospitals would stay open over the upcoming Easter holidays and schools would start their break a little early. But for now, the levee would hold.

On April 19, medical authorities announced that the epidemic had peaked. A day of rain had washed away dust and dirt, lessening the spread of the virus. The government added hygienic measures to its support, monitoring the sanitation practices of food hawkers. By the end of the month, reports on the outbreak had trickled down to scant mention and admonitions about the future. The flu would come back, warned one author. It usually comes in waves, and there could

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425Wah Kiu Yat Po, 17 April 1957.
426Wah Kiu Yat Po, 17 April 1957; Wah Kiu Yat Po, 19 April 1957.
427Wah Kiu Yat Po, 19 April 1957.
428Wah Kiu Yat Po, 21 April 1957.
429Wah Kiu Yat Po, 17 April 1957.
430Takung Pao, 17 April 1957; Wah Kiu Yat Po, 17 April 1957.
431Kung Sheung Wan Bo, 17 April 1957.
432Takung Pao, 19 April 1957.
433Takung Pao, 20 April 1957.
434Wah Kiu Yat Po, 21 April 1957.
be another at any time. If not this year, then certainly the next. Hong Kong people should remain vigilant.\(^{435}\)

### 5.1.3 Through the Networks of Empire

Meanwhile, influenza moved from Hong Kong, through Southeast Asia, and then, as had occurred with bubonic plague, to ports worldwide. Taiwan, Borneo, Singapore and Japan reported outbreaks in April and early May.\(^{436}\) When the flu reached Singapore, the next large urban epidemic, the variant’s epidemiological signature began to come into focus. In Singapore, another outpost of the British Empire, influenza was first documented on an outlying island, Pulau Brani, by a rural health officer. Through the first week of May, the virus spread through the colony, with almost 50% of all hospital visit associated with influenza infections.\(^{437}\) While the media in Hong Kong compared this virus to enteritis, suggesting that gastrointestinal symptoms were prominent, cases in Singapore were usually characterized by the sudden onset of fever and cough.\(^{438}\) These were followed by severe headaches, joint pain, nausea and vomiting, sore throat, and giddiness.\(^{439}\) Infection rates strongly favoured young and elderly patients as did more serious complications such as pneumonia and bronchitis.\(^{440}\) Indoor workers suffered fewer infections than did outdoor workers, 20.4% versus 29.8%, and there were significantly higher rates of infection among Asian workers than among Europeans, 29% versus 6%.\(^{441}\) These findings demonstrate the influence of class and race as socioeconomic determinants of health even in a context of a highly virulent outbreak where infection rates could climb as high as 80%.\(^{442}\) Aiming to staunch the spread of the outbreak, Singapore's public health authorities

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\(^{435}\) Kung Sheung Wan Bo, 19 May 1957; Wah Kiu Yat Po, 20 May 1957; Kung Sheung Yat Bo, 10 June 1957; Takung Pao, 10 June 1957; Wah Kiu Yat Po, 10 June 1957.

\(^{436}\) Dunn, F., 1141.


\(^{439}\) K.A. Lim, Hale A. Smith, and J.H. Glass, 791.

\(^{440}\) Ministry of Health, 90-5.

\(^{441}\) Ministry of Health, 90-5.

endorsed the principle: “No movement of persons, no spread of influenza”. Accordingly, they closed schools for about two weeks and counselled everyone to avoid public places\textsuperscript{443}. Public health authorities cancelled elective surgeries to free up medical personnel to treat influenza patients. Community clinics including school, maternal and children’s health clinics, were converted into flu treatment centres. Passengers by air and on shipping lines were inspected at departure\textsuperscript{444}.

5.1.4 From Regional Epidemic to Global Pandemic

Those efforts at containment and quarantine did not prevent the spread of the flu beyond Asia. While the global wave of influenza spread through the port of Hong Kong in the late spring, disquiet over an anticipated epidemic appeared in Western newspapers even earlier. Reports in the \textit{New York Times} and \textit{The Times} (London) in December of 1956 noted 13,000 cases of influenza in Tokyo and 130 deaths\textsuperscript{445}. These were ultimately determined not to be associated with the strain that would move across the globe through the spring but the reports were determined in the claim that epidemics, or even a pandemic, were at hand. When Western media first reported on the outbreak in Hong Kong, the issue was of interest mostly in the way the outbreak was smugly politicized. Communist China, already a political enemy of the West, was also a medical enemy having failed to report outbreaks before the flu spread far and wide. Hong Kong, with its geographical and racial proximity to China, was inadequately prepared, one author suggested. The United States, where a mandatory reporting system had been in place since 1874 and that had included influenza as a notifiable disease after the pandemic of 1918,
would fare better\textsuperscript{446}. This would be evidence of the medical, organizational, and political superiority of the West.

In June, the outbreak spread to India and through Southeast Asia and was dubbed the “Far Eastern influenza virus”\textsuperscript{447}. Representatives of American and British public health services issued warnings that the virus would soon reach local populations, a reflection of the interconnectedness of world systems by this point in the twentieth century\textsuperscript{448}. Epidemiologist Frederick Dunn noted that the epidemic had gone global, become pandemic, in no more than six months. What is more, once the virus reached Hong Kong it took just three months to reach locales as distant as Bolivia and Egypt and three months more to appear at a girl’s summer camp in Doe Lake, Ontario, proximal to no major ports and no large cities. In October, the Far Eastern influenza was reported at McMurdo Station, Antarctica, a place and population as remote as could be imagined. In historical context, Dunn noted, the Russian influenza pandemic of 1889-90 took eleven months to spread throughout the world, and the Spanish ‘flu of 1918-19 about ten months\textsuperscript{449}.

### 5.2 Local Significance

#### 5.2.1 Hong Kong’s Atypical Epidemiological Transition

When influenza broke out in 1957, Hong Kong was at the beginning of demographic transition, from high birth and death rates to low birth and death rates. This transition is predicated on an economic shift from preindustrial to industrial foundations of economy and society. While Chinese merchants had initiated industrial projects in the interwar period, the closure of the border with China in 1951 put an end to the cross-border trade that had been the colony’s mainstay. This accelerated the path toward industrialization and the development of infrastructure in the New Territories that would support factories and the massive refugee population. With these pressures in mind, the colonial government redoubled its interest in


\textsuperscript{449} Dunn, 1141.
enumerating Hong Kong residents; it issued the first Hong Kong identity cards in 1951 and conducted the first thorough modern census in 1961. For at least a time, the rapid growth of the colony seemed to be a positive transformation, with the China Mail asking on the eve of the flu outbreak “is it possible to keep up with such fantastic growth?”

In the spring of 1957, Hong Kong was also beginning a parallel epidemiological transition. Here, infectious diseases are replaced as the predominant causes of mortality and morbidity by diseases of lifestyle: cancer and cardiopulmonary disease. Abdel Omran’s influential model for epidemiological transition posits a linear progression with three stages through which a society moves sequentially. First, the age of pestilence, famine, and wars. Next, the age of receding pandemics. Finally, a society arrives at the age of degenerative and lifestyle diseases. The impetus for transition between each phase is modernization, including the implementation of modern public health and sanitary practices.

Hong Kong’s trajectory does not easily fit into Omran’s schema. In the 1950s, Hong Kong society was highly disparate. Its industrial economy was not yet fully realized and standards of living were tremendously uneven with serious gaps in sanitary and hygienic facilities. The upper class, still dominated by Europeans, enjoyed as high a living standard as could be found anywhere in the metropole while the working class and disenfranchised still struggled to meet basic needs or to practice the “hygienic modernity” that public health campaigns promoted. Despite the extraordinary advances in medical knowledge of the first half of the twentieth century—understanding of malarial transmission, successes in vaccination campaigns against

454 Omran, 744.
smallpox in southern China—Hong Kong was still plagued by old foes. Even as medical knowledge, especially in bacteriology and the use of antibiotic drugs, advanced rapidly, the public health challenges characteristic in Hong Kong—overcrowding, the constant circulation of populations, and the antipathy between European and Chinese communities—left the rapidly modernizing colony with a “Third World health profile”. The cocktail of legislated racial stratification and the government’s laissez-faire posture toward colonial governance stunted medical modernization. The consequence, for better or worse, was further blossoming of the diverse and hybrid medical culture already characteristic of Hong Kong instead of an evening-out or homogenization conjured in projections of Western ‘medical modernity’. Epidemiological transition in Hong Kong unfolded in a less predictable way and later than Omran’s schema would suggest. Matching the service levels of developed countries, even in a post-Beveridge British Empire, was deemed “unrealistic” in Hong Kong.

5.2.2 Mobilizing Against an Epidemic

The Hong Kong media fed the economic reaction to the outbreak, reminding the public of the traditional belief that “disease enters by the mouth”. Pork, contraindicated for diseases of damp-heat, was avoided and devalued in the marketplace and leaner meats rose in price. Carrot soup infused with sapotaceae was recommended causing inflation and drastically short supply of the required ingredients just a day after the recipe was published. Even Western people in Hong Kong tried the Chinese carrot and sapotaceae concoction causing such a demand that farmers in the New Territories pulled their carrot crops prematurely, a first, but not last, occasion in which the Westerners of Hong Kong took medical instruction from the Chinese tradition. Even the pots used to cook Chinese medicinal soups were in short supply and selling


456 Phillips, 19.

457 *The Development of Medical Services in Hong Kong*, 9.

458 “疾病從口而入”. See *Kung Sheung Wan Bo*, 14, April 1957.

459 *Kung Sheung Wan Bo*, 16 April 1957; *Takung Pao*, 18 April 1957.

460 生榄

461 *Kung Sheung Wan Bo*, 18 April 1957.
at inflated prices at the markets\textsuperscript{462}. On the other hand, Chinese in Hong Kong were willing to dabble in Western commercial pharmaceutical preparations. Aspirin was popular in Hong Kong as well as in Singapore where it was advertised specifically as a remedy for influenza\textsuperscript{463}. This was true, too, in Canton where a market for smuggled penicillin emerged\textsuperscript{464}. Toward the end of the crisis, pharmaceutical opportunists grew prominent. \textit{Kung Sheung Yat Po} touted the use of “Axe Brand Universal Oil” made by Cantonese company Liang Jiefu. Just a bit on the tip of the nose before going out would prevent catching the flu, they claimed\textsuperscript{465}. \textit{Wah Kiu Wat Po} recommended the use “Tangtaiping analgesic decoction” in the hope of alleviating the long lines at the clinics\textsuperscript{466}. The same advice appeared the next day in \textit{Ta Kung Pao}\textsuperscript{467}. This advice appears in reporting rather than advertisements but the tone and emphasis on a patented medicine suggests that they may have been sponsored reports.

\subsection*{5.2.3 The Non-Issue of Vaccines}

The influenza virus was first isolated in 1931. A monovalent (influenza A) vaccine was produced three years later and a bivalent vaccine followed in 1942 after the discovery of influenza B in 1940\textsuperscript{468}. The first license for the production of a vaccine for civilians was granted in the United States in 1945, used against an epidemic rising in the winter of 1946-7\textsuperscript{469}. Epidemiologists and virologists quickly observed the complications caused by antigenic drift when trying to formulate effective influenza vaccines. The World Health Organization struck a committee in 1957 at the World Influenza Centre that was charged with coordinating reports from laboratories worldwide and disseminating appropriate information to partner stations. This project signalled that

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\begin{itemize}
  \item \textsuperscript{462}\textit{Wah Kiu Yat Po}; 21 April 1957.
  \item \textsuperscript{463}\textit{Kung Sheung Wan Bo}, 18 April 1957; Advertisement, \textit{The Straits Times”}; 8 May 1957, 18.
  \item \textsuperscript{464}\textit{Wah Kiu Yat Po}, 16 April 1957.
  \item \textsuperscript{465}\textit{Kung Sheung Yat Bo}, 21 April 1957.
  \item \textsuperscript{466}\textit{Wah Kiu Yat Po}, 23 April 1957.
  \item \textsuperscript{467}\textit{Takung Pao}, 24 April 1957.
  \item \textsuperscript{469}P., M. Alberti Crovari, and C. Alicino, “History and Evolution of Influenza Vaccines,” \textit{Journal of Preventive Medicine and Hygiene} 52, no. 3 (2015), 91.
\end{itemize}
influenza was by that time thought of as a global actor whose arrest required global cooperation\textsuperscript{470}.

Widespread use of influenza vaccines, however, remains a goal for public health planners even today. Discussion of vaccines for the flu does not appear in the Chinese media in the 1950s, nor in Hong Kong-based English-language papers despite the first formulation of a vaccine some twenty-five year previously\textsuperscript{471}. The lack of reference to vaccines indicates that their use was not yet established in Hong Kong. But vaccines figured prominently in the Western press, even before the outbreak in Hong Kong: in an article in Changing Times published in January of 1957 predicted a pandemic not far in the future, the author worried that not enough vaccine could be produced in advance of the inevitable outbreak\textsuperscript{472}. The New York Times, like the China Mail using the Reuters wire, reported on the advance of the influenza through Southeast and South Asia and announced that the World Influenza Centre in London was accelerating the process of preparing a vaccine for the variant of influenza in circulation\textsuperscript{473}. Who would have access to these vaccines was in debate. In the United States, the Surgeon-General decided to have all troops vaccinated before offering protection to civilians\textsuperscript{474}. Perhaps in response to public outcry, in hope of meeting market demand, or in response to the instructions of the increasingly influential WHO, several American projects aiming to create and provide a vaccine were announced\textsuperscript{475}. As Blakely observes, international media coverage of the race to create a vaccine ahead of the arrival of the flu on Western soil was framed as an “international race to make an effective vaccine in order to save the United States from the injustices of another influenza epidemic”\textsuperscript{476}. Coverage in the New York Times for the rest of 1957 describes the arrival of the flu in American communities and a hot debate on access to the vaccine, triage of populations waiting for the shot,

\textsuperscript{470} P., M. Alberti Crovari, and C. Alicino, 91.
\textsuperscript{473} “Britain Rushes Influenza Curb,” New York Times, 7 June 1957, 12.
\textsuperscript{476} Blakely, 75.
as well as critique of its efficacy\textsuperscript{477}. While Hong Kong and other colonial and postcolonial nations participated in the processes of international scientific knowledge production including the isolation of the pandemic influenza strain in Singapore, and contributed to research of the vaccine, access to vaccines was not yet a globalized phenomenon\textsuperscript{478}. Accordingly, it was not a matter of discussion in non-Western press.

5.2.4 Framing the Outbreak within Hong Kong

In Hong Kong-based English language newspapers, the first mention of influenza surfaced in January when the same reports published in \textit{Times} (London) and the \textit{New York Times} were reproduced in the \textit{China Mail}\textsuperscript{479}. The outbreak in Hong Kong received scant mention, appearing first in an article announcing both influenza and measles\textsuperscript{480}. In contrast to the reports in Chinese papers, influenza got second billing to the measles, the report tucked away on the back sheet of the paper. From there, the \textit{China Mail} announced the spread of the flu to Macao, Singapore, Malaya, Taipei, and Kuala Lumpur, and predicted eventual outbreaks in Australia and New Zealand. Local conditions in Hong Kong were mentioned in passing, noting the outbreak and the degree to which the colony’s services were strained. The \textit{China Mail} saw the outbreak at some distance, understanding it already as a global phenomenon; Hong Kong’s place in a global context was already as important, if not more important, than what was happening in the colony itself.

The Chinese press, however, reported on the outbreak every day. While the Western press failed to note the passage of the flu into Hong Kong from Canton, this trajectory was clear in the notes of the Chinese reporters. Chinese reporting took educational tones, giving practical advice to the community on how to manage. The advice offered in the Chinese press reveals the plurality of Hong Kong’s medical culture; reporters shifted between Chinese and modern views of the disease and published advice from either viewpoint, even in the same edition of the newspaper.


\textsuperscript{478} Fei-Fan Tang and Liang Yung-Ken, “Antigenic Studies of Influenza Virus Isolated from 1957 Epidemic in China” read before \textit{Third International Meeting of Biological Standardization}, Opatija, Sept. 2-6, 1957, cited in Dunn, 1140-1148.

\textsuperscript{479} \textit{The China Mail}, 1 January 1957.

\textsuperscript{480} “Big Outbreaks Of Flu And Measles In Colony DOCTORS HAVE A BUSY TIME,” \textit{The China Mail}, 15 April 1957.
Warnings are repeated again and again along with the advice that everyone should stay home to avoid infection. Short of avoiding infection, Hong Kong people should seek attention at any of the (overburdened) clinics. But they should hedge their bets, the Chinese press suggests, using traditional preparations—including several patent formulations that were commercially available in case the long waits forced one to take things into their own hands.

That said, both the Western and Chinese press buried reports of the outbreak behind the political and financial news of the day. The media tracked the actions of “Communist China”, heralded passages the Suez Canal, and bemoaned the trials of newly-decolonized countries including Malaya and Ghana. The Chinese papers stopped short of calling for decolonization but media treatment of the influenza crisis reveals the tensions mounting in proportion to Hong Kong’s rising population and changing demography. The Chinese press noted every day that the government-funded hospitals and clinics were oversubscribed. With such long queues, scalpers raised the financial stakes of falling ill. Ta Kung Po, with its close connections to Canton, was most explicit in its critique of the colonial regime, admonishing the government for its slow response to the crisis and its failure to communicate with the public on precautionary measures. Indeed, official communication from medical authorities appeared quite late, about a week into the outbreak, and gave only very basic advice: Hong Kong people should avoid going out, should take aspirin, and should attend government clinics that would have extended hours on the weekends and over the Easter holiday. The most explicit critique of the government’s management of the crisis was published in Wah Kiu Yat Po on April 25. Here, the author reported on sentiment among the Chinese that medical services were inadequate specifically in contending with pandemics or epidemics. The author criticized the government’s slow response to the outbreak and its failure to contain the spread of the flu. In particular, the cost of medical care is identified as a great problem; for the tens of thousands of flu victims who were refugees living in squatter camps, the cost of government clinics was too high, even before the scalpers inflated the price of consultation vouchers. This behavior went unchecked in Hong

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482 Takung Pao, 13 April 1957.
483 Wah Kiu Yat Po, 18 April 1957, 8.
Kong’s free economy. Hong Kong had evolved into a colony with closed borders and a settled population. A greater commitment to health in the colony was necessary. This outbreak of influenza, the first medical crisis following the resumption of colonial rule after WWII despite the global imperative to decolonize, raised the ire of Hong Kong’s colonial subjects.

5.3 The ‘Asian Flu’

The epidemic was interpreted by the *New York Times* as a complication of Hong Kong’s liminal qualities. As the PRC heightened its rhetoric and pushed its people through the Great Leap Forward from 1958-61, refugees continued to slip into Hong Kong creating, “a constant danger because of over-crowded conditions. Fires and epidemics are the worst fears of Government authorities”. Throughout the day” continues this source, “thousands of sick persons have stood in long lines awaiting treatment in clinics. Many women carried glassy-eyed children tied to their backs”. The *Times* also made note of Hong Kong’s weakness in disease surveillance, stating, “[b]ecause this colony does not require reports to be made on virus infections, an accurate estimate of the number of victims was not available”. Statutory notifications were put in place in 1889 in London and to the rest of Britain and Wales ten years later. The same measures were not extended to colonial Hong Kong and the lack of these precautionary measures made an effective response to the epidemic impossible. Further complicating this issue was the fact that practitioners of Chinese medicine were not required to report infectious diseases. Since a significant proportion of the Hong Kong population sought care from traditional practitioners, an epidemic moving through the Chinese population, particularly among those still moving between Guangdong and Hong Kong with re-entry permits, might not catch the attention of medical authorities for some time.

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484 *Wah Kiu Yat Po*, 25 April 1957, 8.
486 “Hong Kong Battling Influenza Epidemic,” 3.
487 “Hong Kong Battling Influenza Epidemic,” 3.
489 Marjorie Topley, “Chinese and Western Medicine in Hong Kong,” 492.
A second frame drew on centuries-old Orientalist tropes. Writers treated the virus as something novel, a “new type of…Oriental influenza”490. Another report described the virus as a “mutant…that sidesteps the natural body defenses against normal influenza virus”491, participating in the manufacture of anxiety when reporting on the manufacture of a vaccine. Reports compared this virus to the Spanish influenza of 1918, warning that it could kill millions if unchecked, and even escalated that claim, suggesting that it could be worse than the last pandemic. Reporters intimated that the exotic provenance of this variant made it more dangerous than endemic strains492. In reality, 1957’s H2N2 was prodigiously infectious but relatively mild both in symptoms and mortality493.

A third frame made military allusions, playing on Cold War anxieties. The New York Times discussed the influenza vaccine, first brought to market at the end of World War II, as a weapon in the “war on grippe”494. The disease, and its vaccine, were couched in the “rhetoric of war”. This was an echo, writes Blakely, of the way the pandemic of 1918 had figured in media of its day495. In 1957, scientists were Cold Warriors treating influenza as a military threat, seeking to “bar influenza” as if it could be denied passage like a refugee, an enemy soldier or spy496. One editorial in the New York Times reveals the tension between the health risks of H2N2 and its power as a symbol of political threat. In the same breath, this author documents H2N2’s low death rate of just 1%, the capacity of ‘advanced’ countries with modern medical systems to fight complications with antibiotics but then threatens, “[o]nly the vaccine, however, can stop Type-A Variant—the omnipotent intruder”497. The Associated Press also fed the Cold War frenzy by disseminating reports that the flu was rampant in Russia while the Singapore Free Press reported

493 While mortality in Hong Kong was relatively low, the global death toll of the 1957 pandemic was significant, reaching two million.
495 Blakely, 68.
496 Furman, 22.
that Russia was in the midst of a successful purge, having quickly brought influenza cases under control.\footnote{144}

A final frame also emerged. While indemnifying Hong Kong’s squalor, its colonial status and dependence on London was not critiqued. The outbreak was identified as a serious threat to the good health of the United States and the world but this was usually framed as a risk of Hong Kong’s proximity to China and communism rather than the failure of a colonial government to manage an epidemic. Calling this strain the “Far Eastern Influenza”\footnote{499} was a reference to the regional origins of the virus and suggested culpability for the epidemic-cum pandemic. The scientific nomenclature, A/Singapore/57, identified the city where the novel neuraminidase was isolated. This scientific nomenclature did not appear in American reports, however. In the context of 1957, at the height of the Cold War, all of Asia was suspect; China was nearly a decade into socialist revolution and the Việt Minh on the offensive in Vietnam. Passing from the PRC and into Western markets, the virus was framed first in the imperial category of the “Far East” and then by the more contemporary “Asia”.

On August 24, the \textit{New York Times} published direction from the Surgeon General that the virus should be referred to as the “Asian Influenza”\footnote{500}. This change can be interpreted as an imposition of at least two post-war, Cold War geopolitical frames on the now-global pandemic. Fairbank and Reischauer reflect on the Eurocentrism of the term “Far East”, writing,

\begin{quote}
When Europeans traveled far to the east to reach Cathay, Japan and the Indies, they naturally gave those distant regions the general name ‘Far East’. Americans who reached China, Japan and Southeast Asia by sail and steam across the Pacific could, with equal logic, have called that area the ‘Far West’. For the people who live in that part of the world, however, it is neither ‘East” nor “West” and certainly not ‘Far’. A more generally acceptable term for the
\end{quote}


\footnote{499}{The first reference that I have located for this name is actually in a Chinese newspaper; it appears on 23 May 1957 in \textit{Kung Sheung Wan Bo}, 5. In the \textit{New York Times}, the first use of this phrasing appears on 4 June 1957. Use of the term in scientific literature is first observed in July in H. M. Meyer, M. R. Hilleman, M. L. Miesse, I. P. Crawford, and A. S. Bankhead, “New Antigenic Variant in Far East Influenza Epidemic, 1957,” \textit{Experimental Biology and Medicine} 95, no. 3 (1957): 609-616.}

\footnote{500}{“New Type of Influenza Officially Called Asian,” \textit{New York Times}, 24 August 1957, 33.}
area is ‘East Asia’ which is geographically more precise and does not imply the outdated notion that Europe is the center of the civilized world501.

Post-war, the United States was ascendant, the dominant world power in many dimensions. Terminology that anchored politics, or viruses, to Europe was out of step.

The shift in terminology to “Asia” also focuses suspicion on Asian nations in this first decade of Cold War, memories of the Korean War scarcely fading. This suspicion was felt acutely in Hong Kong. 1957 was a critical year for the colony; that year, debates over decolonization reached a head, a low point in British legitimacy following the rise of the CCP in 1949. During World War II, Britain had infamously elected not to defend Hong Kong, a gross exaggeration of the imperative that the colony should not be supported by London as well as a strategic decision. At the end of the war, Hong Kong’s value as a buffer between the liberal West and the Communist East justified wresting rule from China, positioning Hong Kong as ‘the Berlin of the East’502. For this reason, American politicians communicated increasing anxiety over Hong Kong matters through the 1950s, worrying about communist influence in the colony while British politicians furthermore worried about American espionage conducted from within Hong Kong. The precarious quality of British rule had several causes, writes Mark; Cold War embargoes against China thwarted the trade that supported both British and Chinese populations in Hong Kong up until World War II, the flow of refugees into the colony overwhelmed the colonial government’s resources requiring that Hong Kong seek international assistance, and certain acts such as the closure of the Naval Dockyard were construed as signals of Britain’s intention to retreat from Asia503. At Whitehall, the question of abandoning Hong Kong was raised. The colony was seen as “at the same time valuable and peripheral”504. In the final tally, the decision to retain the colony was “[f]or political, psychological and economic reasons…in peacetime and in the Cold

503 Mark, 7.
504 Mark, 66.
War”. It was understood, however, that in the event of global war, Britain would devote its resources to more crucial theatres, to Europe505. Anglo-American dialogue over the protection of Hong Kong under the United States’ ‘nuclear umbrella’ encouraged Britain to retain rule through the 1950s despite uncertainty toward the value and practicality of going on506.

All of this signals to the assignment of H2N2 to the broad but geographically determined term, “Asia”. Whether it had origins in Japan where the media first reported flu, whether it had origins in China—an isolate obtained from Dr. Tang Fei-Fan was examined at the WHO World Influenza Center later in the year confirmed China as the origin of the epidemic—or whether Hong Kong’s inadequate government was to blame for failing restrain the regional epidemic, the pandemic was undoubtedly ‘Asia’s fault’.

5.3.1 A Prophecy Come True

In one rather specific way, the Cold War framing of the pandemic was accurate. The rapid spread of the virus from Asia into the United States was not only a consequence of economic globalization or the trade pathways carved by centuries of European imperialism; more contemporary geopolitical configurations contributed directly to the diffusion of the ‘Asian flu’.

The United States Forces-Korea was formed in the wake of the 1953 armistice of the Korean War. Troops stationed in South Korea for its continued defense joined United States Forces-Japan troops on Okinawa, American sentries to the Pacific theatre. The first American victims of epidemic influenza were among these troops with both the U.S. military bases in Korea and Japan reporting cases in April and May of 1957507. From there, naval ships brought the virus to American shores; the first reported outbreaks in American occurred on a navy destroyer at Newport Naval Base in Rhode Island soon followed by reports of outbreaks at the Naval Training Center in San Diego, at Fort Ord in California, and aboard other ships coming from

505 Mark, 66.
506 Mark, 53-54
Asia. Aboard these ships, rates of infection ranged between 18-45%. Civilian cases were confirmed on June 20 when the Public Health Service reported an outbreak among three hundred teenage girls at a conference in Davis, California. From there, the ‘Asian flu’ spread through the United States, between summer camps and jamborees and conferences of every kind, events to which people travelled, stayed in close contact in traveller’s accommodations and then returned home, seeding the virus across the nation. Experts, “essentially all epidemiologists throughout the world” had predicted the global spread of the 1957 flu. It is reasonable to say that it would have spread by other channels—through trade, commercial travel or otherwise. But the historical fact is that the 1957 pandemic reached the United States through its military projections, the very mechanisms intended to defend against ‘Asian’ influences.

5.4 Public Health between Imperial and Globalized World Systems

5.4.1 Functionalism and International Infectious Disease Surveillance

The 1957 influenza pandemic emerged in a novel geopolitical and epidemiological context. It was the first pandemic to occur after the creation of the WHO as well as the first to be studied using modern virological techniques. The WHO was founded as an agency of the United Nations in 1946 and its constitution ratified in 1948, the first “fully empowered international agency in public health, and the first specialized agency of the UN to which every member nation subscribed”. The agency’s first considerations focused on communicable diseases—malaria, tuberculosis, sexually transmitted infections as well concern for maternal and pediatric health. An international, if not yet global, surveillance system for influenza was established in 1947 in advance of the WHO charter, an indication of how seriously public health officials and microbiologists took the threat of future pandemics.

510 Langmuir, 484.
Early WHO efforts at fighting influenza had two foci: surveillance, and the production of vaccines. The surveillance project expanded quickly, with fifty-four monitoring laboratories in forty-two countries joining the network, those in the Americas sending samples of local strains to a laboratory at Bethesda, Maryland and the rest sending their samples to the World Influenza Centre (WIC) in London, U.K.\textsuperscript{514}. As WHO Chief of Endemic and Epidemic diseases Dr. A.M.M Payne noted, it was “almost ironical therefore that the epidemic should originate in an area not covered by the program\textsuperscript{515}. That statement both reveals and conceals truth about Hong Kong’s place in the increasingly global 1950s and increasingly powerful systems of global governance. China had played an integral role in the establishment of the global health governance body. China was one of the four sponsors of the United Nations Conference on International Organization in San Francisco in the spring 1945, the occasion of the creation of the United Nations Charter. Among the Chinese delegation was Dr. Szeming Sze, a medical doctor and diplomat. While the creation of an international health organization was not on the agenda for this meeting, the three delegates with medical backgrounds—Dr. Sze, Brazilian Dr. Geraldo de Paula Sousa and Norwegian Dr. Karl Evang—seized the opportunity to advocate for global governance in matters of health. A declaration by the governments of Brazil and China calling for a general conference on the establishment of an international health organization was presented and unanimously accepted\textsuperscript{516}. China withdrew from the WHO, however, in 1950 when the United Nations recognized the Republic of China and the Kuomintang over Mao’s PRC.

This history suggests that medicine and epidemic prevention superseded the political tensions of the day, that medicine and public health was a neutral space in which cooperation between Cold War enemies was possible. This is not accurate or is at least an overstatement of the case. On the part of the Western powers at the core of the movement for international governance, the United States and Great Britain, a certain suspension of suspicion toward scientists from contentious nations was allowed. The 1950s were a time of great enthusiasm for science and the promises made by technological advances; this enthusiasm allowed more latitude for scientists who might have been assumed to serve the pure, liberal aims of science over any dogma or nationalist

\textsuperscript{514} Dehner, 71.


agenda. As Dehner writes, ‘functionalism’ underpinned the “belief that membership in a
technological and scientific elite transcended national boundaries and served as a model for emerging international formation”\(^{\text{517}}\). Functionalist thought allowed for the very creation of the international governing bodies; the International Labour Organization (ILO), the Food and Agricultural Organization (FAO), the United Nations Children’s Emergency Fund (UNICEF), and the WHO were functionalist experiments, writes Farley, projects founded in the belief that science, and scientists, were depoliticized when working on common scientific pursuits. Given common goals and projects, scientists would overcome boundaries and collaborate\(^{\text{518}}\).

### 5.4.2 Dr. Tang and the PRC’s Retreat from International Health

For nations that had been targets for imperial conquest, where science and medicine had been deployed as tools in civilizing missions, this suspension of suspicion was less freely dispensed. The paradox of engagement and mistrust of Western medicine in China, including participation in the institutions of globalized medical modernity, was tragically personified in the life story of Dr. Tang Fei-fan, the first to isolate H2N2. Tang’s biography mirrors China’s struggles to anchor itself doubly to modernity and to national autonomy through the late Qing and Republican periods. Like many of that time, Tang’s story culminates in tragedy in the paranoid and reactive first decade of CCP rule. Born in 1897 to a father who taught in a traditional school, Tang was exposed to the disquieted rhetoric of the late Qing and early years of the Republic including framing Western science as tool to ‘reinvigorate’ the stagnant Chinese nation. After studying Western medicine in Changsha at Xiangya College of Medicine and learning English, Tang earned an MD degree at Yale University. He subsequently took up graduate study of microbiology at Harvard University before returning to teach in China. Tang was inspired to establish his career abroad but to bring his skills home to China; just as Kitasato Shibasaburo, a student of microbiologist Robert Koch, had brought pride and respect to Japan as the “Oriental Koch”, Tang sought to be or to train an “Oriental Pasteur” for China. Tang’s nationalism was stronger than his respect for professional conventions; when presented to a Japanese colleague in 1935, Tang is said to have refused to shake the Japanese man’s hand, admonishing his colleague

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\(^{\text{517}}\) Dehner, 72.

for Japan’s imperialist aggression toward China. Working in China through the 1930s and 1940s, Tang continued to attract international attention, receiving a Nobel nomination for his culture of *chlamydia trachomatis* and a citation in *Nature* for his innovation and resilience as a researcher under the adverse conditions of war.¹¹⁹

When the Chinese Communist Party came to power, Tang was appointed to several prominent positions including directorships of the Chinese Medical Association and the Chinese Society for Microbiology. Tang’s internationalism, cultivated for the love of his country, won him scrutiny in the context of Mao’s Hundred Flowers Movement bait-and-switch. In 1958, as part of an anti-bourgeois crusade, Tang was denounced as a bourgeois academic, a member of the Kuomintang, an American and international spy, and a traitor to China. He died by suicide on 30 September 1958. His biography maps the confusing and often contradictory shifts in how China understood its engagement with Western science and medicine and their governing bodies.

As Dunn notes, Dr. Tang is thought to have been the first to isolate H2N2. With China outside of the global surveillance network, however, Tang’s information on the virus causing the outbreak in China, and eventually the rising pandemic, did not reach the rest of the world until after the fact. Isolations confirmed in Singapore, the United States and in Australia in May set off the WHO’s formal response, appearing in the WHO’s epidemiological bulletin first on May 23, 1957. Payne wrote in retrospect, “if [China] had [reported the epidemic and epidemiological findings] we should have had two more months in which to prepare.”²²²

5.4.3 Hong Kong as a Proxy and a Sentinel

Hong Kong’s participation in global medicine and public health governance was then all the more important. It could act as a proxy for the PRC which had withdrawn from international

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²²¹ Tang and Liang, 89. Payne also credits a researcher named Chu for isolating the strain at Chanchung and gives Chu, C.-M. (1958) J. Hyg. Epid. Microbiol. Immunol., ii, 1. HSIAO, C., and Ho, C.-C. *Scientia*, Peking, 1957, 12, 373 as references. Neither article was not accessible at the time of writing or is acknowledged in other reports on the subject.

²²² Payne and McDonald, 1009.
health surveillance networks and with which it shared a disease ecology through the Pearl River Delta from which much infectious disease moved. Still, medical surveillance, a key aspect of participation in global public health and infectious disease monitoring, was not easily accomplished in Hong Kong. The colony had participated irregularly in global campaigns and projects through the 1950s. It had accepted aid from the WHO and from UNICEF for a vaccination campaign from 1952-1955; with UNICEF’s help, newborns, schoolchildren “aged about 7 years” as well as “school leavers” were administered the BCG vaccine. This campaign was successful, lowering the infant mortality rate from tuberculosis from 3.5 per 1000 live births in 1952 to “virtually nil” in 1971.

On another count, Hong Kong’s government elected not to participate in a campaign targeting one of the colony’s most significant public health concerns. Aerosolized dichlorodiphenyl trichloroethane (DDT) was a critical technological innovation in the global fight against malaria, among Hong Kong’s greatest health concerns since the colony’s inception. A chronic trouble, malaria had been the target of public health and anti-vector campaigns from 1899 onward. When the Japanese Occupation disrupted the work of the Malaria Bureau, the disease surged again reaching “almost epidemic proportions”. The government decided on a course of aerial spraying of DDT which it carried out in January and February of 1946, covering the city of Victoria, Kowloon Peninsula, and “some suburban areas”. When this programme achieved only minor gains, the government decided against further use of aerosolized DDT. When the WHO launched a global campaign for the eradication of malaria in 1958 that focused on the use of DDT as an anti-vector measure, Hong Kong elected not to participate. Government advisors

524 Allan, 236.
525 Ka-che Yip, “Colonialism, Disease, and Public Health: Malaria in the History of Hong Kong” in Ka-che Yip, ed. *Disease, Colonialism, and the State: Malaria in modern East Asian History* (Hong Kong: Hong Kong University Press, 2009), 24.
526 HKRS 146, D-S No. 1–1, Letter dated June 15, 1946, from Medical Officer in Charge-R.N. Mobile Malarial Hygiene Units Nos. 5, 7, & 9, to The Commodore in Charge, Hong Kong
527 Yip, “Colonialism, Disease, and Public Health”, 22.
528 HKRS 146, D-S No.1–1, Letter dated 6 March 1946 from The Commanding Officer, HMS “Nabcatcher” to Medical Officer in Charge, Malaria Control, Hong Kong: First Report on the Work Performed by the R.N. Anti-Malaria Aero Spraying Unit with Recommendation; and Letter dated May 21, 1956, from J. D. Romer Pest Control Officer, to Hon. D.U.S.: Insecticidal Spraying from Aircraft.
recommended continued use of anti-larval, anti-parasite measures instead, targeting public works infrastructure, sanitary improvements, the destruction of larval breeding grounds and the expansion of screening and treatment protocols. The government also expanded education on the prevention of malaria, sending outreach workers to speak at schools, community centres, and to visit houses in person. As they had supported the government during the influenza crisis, charitable organizations and *kaifongs* assisted in the dissemination of health propaganda. In the matter of malaria, this mix of government and private measures seemed to work for Hong Kong. It was an uncharacteristically independent, local posture for the colony’s government; in this case, the government based its decisions on local knowledge and experience rather than instruction from the metropole or fall into conformity with a protocol put into effect by an international body that did not reflect Hong Kong’s local needs.

Management and treatment of influenza during the 1957 outbreak sheds light on the degree to which a global public health system was, and was not realized in the first decade of the WHO’s existence. In Hong Kong, the outbreak raised questions of access to medical care, of the overburdened and oversubscribed medical facilities, of the responsibility for funding and provision of medical care. It further showed the incomplete ‘conversion’ of Hong Kong people to Western medicine, whether as a function of limited access to government services or because of a return to familiar values in times of crisis. The crisis reinforced the lessons of the Shek Kip Mei fires, revealing Hong Kong as a tinderbox for population-driven disasters. Influenza added to mounting pressure of the government to evolve its policies and practices of rule to reflect a very large Chinese population with newly-permanent roots in the colony and nascent formations of a unique local identity based on their participation in Hong Kong’s economic, social and political life.

5.5 Conclusion

While causing far fewer deaths, in raw numbers and proportionately, the 1957 ‘Asian flu’ pandemic was historically and epidemiologically significant. In one sense, it was a greater pandemic threat than the world had faced before. Commercial aviation grew rapidly after the war

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529 Director of Medical and Health Services, 35–36.

when airlines repurposed ex-military aircraft for leisure and business travel. Where colonialism was formally ended, trade relationships between metropolitan companies and companies in former colonies grew. After the resumption of colonial rule, economic growth in Hong Kong bolstered metropolitan finances. American concerns with containing communism in Asia and the permanent military installations in Korea and Japan created a new disease corridor that was a key factor in potentiating pandemic influenza. The interests of geographically disparate parties worldwide were more enmeshed than ever before and technologies enabling travel assured that the fates of peoples at lengths around the globe were more entwined than in the past. The spread of the ‘Asian flu’ eclipsed the rates of diffusion of earlier pandemics signally the urgency of matching expansion of infectious disease monitoring to the expansion of global connectedness.

This pandemic was also described as “the most dramatic epidemiology phenomenon since the pandemics of influenza in 1918 and 1889-1890”\textsuperscript{531}. Pandemic influenza was understood in very different ways between 1918 and the 1950s; medical science had changed so dramatically alongside the social and economic factors that shaped understanding of the pandemic. Scientists could not see viruses until the invention of the electron microscope in 1933 and did not discover the existence of influenza B until 1940. It was only through the study of influenza samples from 1957 and 1958 that the significance of the two surface antigens, haemagglutinin and neuraminidase, and a nomenclature with which to denote variants was defined. The scientific knowledge emerging between the 1918 and 1957 pandemics supported a wholly different context for study and interpretation. In 1918, the public health strategy for influenza outbreaks was limited to quarantine and self-care. The virus had not yet been identified and there was accordingly no vaccine. In 1957, scientists understood that another influenza pandemic was inevitable and created institutions seeking to anticipate such an event. In 1957, medical science understood the viral nature of influenza, knew that the variant needed to be identified as quickly as possible, that a vaccine could be useful if formulated in time, and did this work within “an almost world-wide network of laboratories which had been organized by the World Health Organization with just such an eventuality in mind”\textsuperscript{532}.

\textsuperscript{531} Langmuir, 483.

In some cases, local responses to the 1957 pandemic were seen as triumphs. In the United States, many saw epidemiological foresight and containment strategies put into effect in positive terms. As one writer summed up the situation, “[t]he accuracy of the predictions, the duration of the advanced warnings and the scope of the effort to control it in this country are unique in the history of organized medicine and public health”533. In other places, including Hong Kong, public health and medical systems were unprepared and overwhelmed by local outbreaks. Whereas previous epidemics were understood as acts of God or nature, the logics of modern public health and state medicine reframed influenza as a predictable and manageable entity. Individuals, institutions, and the state were held variably accountable in different political contexts but the belief that infections could be limited and casualties managed through appropriate action was widespread. In Hong Kong, that responsibility was shared between the government, charitable, community associations, and unregulated private practitioners of traditional medicine. The limits of this solution, made visible in the long queues for medical care and the shortages and inflation of the prices of medicine, provoked unprecedented critique of the colonial government.

The 1957 epidemic brought Hong Kong to global prominence as a site of public health risk and complexity. Scientists and the media recognized that the virus had emerged from China, but it was through contacts with Hong Kong that the virus spread worldwide, carried through trade to India, Europe and the Middle East, and to North America by military personnel. Characterization of Hong Kong as a ‘sentinel’ for the Asian region, then, emerged. That term is particularly evocative in medical contexts. It signifies, first, standing watch. Implicated in the diffusion of bubonic plague in 1894 and now in a global influenza pandemic, Hong Kong was recognized as a priority for surveillance of infectious disease. While only part way through its local processes of modernization, urbanization and industrialization, processes correlated with leadership in public health governance, Hong Kong’s position in the British Empire connected the colony to international public health projects and metropolitan medical values.

Hong Kong’s pivotal character, a threshold of disease traffic, made it a liability but now also a resource. With the PRC now estranged from most bodies of global governance, including from

533 Langmuir, 483.
the surveillance networks of the WHO, Hong Kong could act as a proxy for communist China in monitoring and reporting epidemic disease originating in the PRC. With scientists under attack in the PRC, removed from practices of international knowledge production, Hong Kong stood the best chance of reporting early, supplying samples, and collaborating with virological research. In the context of medicine, ‘sentinel’ can also refer to a sentinel lymph node, the first lymph node or group of nodes to which cancer may spread. The notion of metastasis is an interesting metaphor for both infectious disease and politics in the Pearl River Delta, particular in understanding why Britain, and the United States, could not allow Hong Kong to fall under Chinese influence in the context of the Cold War. Hong Kong’s closeness to China ensured that the colony was likely to become a target for communist aggression, perhaps a target for annexation along with Taiwan, the former an enduring badge of China’s humiliation by Western imperialist powers and the latter the mark of the CCP’s struggle for national and international legitimacy.

In the sense that ‘sentinel’ also refers to a defensive post, a border guard, Hong Kong’s developing medical infrastructure and surveillance was the best hope for preventing future epidemics originating in China from spreading into global pandemics. The influenza pandemic of 1957 put pressure on Hong Kong to manage, or mitigate, the risks of the disease ecology, to act as a border at which infectious diseases, and communist threats, must be detained. This pressure endures to the present day.

The epidemic also influenced Hong Kong’s local medical culture. The emergence of local identity, *heunggongyahn*, is often explained as having emerged in the late 1960s and 1970s when the first generation of Hong Kong Chinese born in Hong Kong after World War II, having lived their entire lives in the colony, came of age. Whereas previous generations were likely to retain ties to their ancestral communities and to be influenced by the political tides within China, whether sympathetic to republican or communist goals, this generation were estranged from the PRC and “free of cloying community ties”534. For these youth, traditional culture “did not have a political and social reality to which it could anchor itself”535. A few years ahead, the excesses of

the Cultural Revolution were experienced as particularly alienating to Hong Kong youth who had grown up as witnesses to “affluent cosmopolitan choice” in the colony and found the “communitarian world next door…utterly foreign”\textsuperscript{536}. \textit{Heunggongyahn} did not disavow their ethnic and cultural foundations or identify as British, but “seemed to formulate:

“Hongkongese” as what might be termed “Chineseness plus”: “Chineseness plus affluence/cosmopolitanism/capitalism” or “Chineseness plus English/colonial education/colonialism” or “Chineseness plus democracy/human rights/the rule of law. Placed geographically, this “plus” was thought of as “Chineseness plus Westernness” or “Chineseness plus internationalization”\textsuperscript{537}.

While the full expression of this identity was not in place until the early 1970s, the public’s response to the ‘Asian flu’ and, in particular, the public view that the government had a responsibility to notify and protect all in the colony signal the beginning of a local political culture and identity. Local identity was supported by participation in social institutions, medical and otherwise. Education took the lead, with the government creating a “massive” school building program focused on primary education and teacher training; during the 1950s, creating as many as 45,000 primary school places were created each year\textsuperscript{538}. This common formation separated Hong Kong youth from their peers in the PRC where formal education was placed second to “re-education” in Marx, Mao and revolution. The colonial government of Hong Kong had initially held to its policy of leaving the Chinese to their own customs, going as far as to discourage English-language teaching. By 1953, however, the balance had shifted to a majority of English-language schools that taught a curriculum nurturing “middlemen in Sino-British trade…able to speak the language of the dual centres of China and Britain but without any strong identification with either country”\textsuperscript{539}.

\textsuperscript{536} Mathews, 7.
\textsuperscript{537} Mathews, 9.
\textsuperscript{538} Government Secretariat Hong Kong Government, \textit{Overall Review of the Hong Kong Education System} (Hong Kong: Hong Kong Government Printer, 1981).
\textsuperscript{539} Ma, 25.
Medical culture was another site of difference between Hong Kong and the PRC. Hong Kong people, in 1957, were engaged in creating medical and hygienic cultures unique to the colony. The government’s assiduous avoidance of expending funds on the Chinese community and commitment to leaving local customs unfettered was most challenged by infectious disease. Government records from 1900 onward are dominated by two concerns in relation to the Chinese: political troubles and health. Epidemic plague occasioned the imposition of certain domestic and hygienic practices on Chinese bodies and the inclusion of Western medicine in the Tung Wah hospital, the nexus for medical culture in the Chinese population. Diffusion of Western medical influence grew from that point. In the absence of a comprehensive, unified public health strategy or treatment protocol presented as a norm by the colonial government, Hong Kong people adapted bits of traditional Chinese medicine both through formal pathways, in consultations with herbalists, but also as practices of self-care. This is indicated in the frequent mention and publication of herbal formulas in the press. Without a welfare system to support the large population and with uneven access to the entire array of medical practices available in the colony, heunggongyahn came to understand the prevention of infections and most treatments as their own responsibility. In relation to that pattern, heunggongyahn came to understand medicine as a commercial site, a market. During epidemics, the cost of both Western and Chinese medicines would fluctuate based on market demand. Scalpers towing the line between entrepreneurship and exploitation commandeered access to treatment.

In the early days of the epidemic, the media began to note self-care or preventative behaviors that Hong Kong people adopted without instruction. Wah Kiu Yat Po reported that students had begun to wear facemasks to school, emulating the hygienic practices of physicians, a practice first noted in Japan during the 1918-19 influenza pandemic. A fortnight later, masks were elevated into fashionable apparel when well-known actor Violet Lin was photographed wearing a black surgical mask to work. While the image might have been arresting at the time, use of a face covering both to protect oneself against catching an infection and to prevent the spread of

540Wah Kiu Yat Po, 15 April 1968, 4.
541Takung Pao, 24 April 1968, 6.
germs to other, became an enduring practice in Hong Kong. This practice did not take off beyond Asia but flourished in Hong Kong; in the twenty-first century, face masks are ubiquitous, worn even when a person is not sick but perhaps has not applied makeup, does not wish to be recognized, or wants to establish a barrier to conversational intimacy. Institutions, including universities, publish guidelines on the use of face masks during disease outbreaks. This visible reference to infection marks an individual as a vector of contagion. Popularization of the mask in during the 1957 influenza outbreak is suggestive of the medicalization of local subjectivities and identity. To live in Hong Kong meant accepting exposure to the epidemiological risks engendered by its climatological, geographical, social, and political character. To survive in Hong Kong demanded a medicalized subjectivity: knowledge of oneself as both threatening and vulnerable to contagion, canny navigation through the diverse market of medical services, and access to the care that was necessary by whatever channel was most accessible.


543 See, for example, the Chinese University of Hong Kong’s discourse on the use of face masks, first requiring them for all staff and students on campus and then relaxing the requirement to having one handy to wear in crowded spots such as on public transportation: http://www.cuhk.edu.hk/health_promote_protect/oldsars/mask.htm
Chapter 6
H3N2, 1968: Cold Wars and Flu

6 Epidemics in the Time of Cold War

There were three pandemics of influenza in the twentieth century. Hong Kong was implicated in the second and lent its name to the third. As was the case in 1957, epidemic flu is believed to have been carried from the southern provinces of the People’s Republic of China into Hong Kong in the summer of 1968 where it quickly overwhelmed the local medical facilities. Hundreds of thousands fell sick, sought medical care from public and private sources, were absentee from work or school, failed to produce goods and offer services, and grew increasingly frustrated with the government. Tens died within just weeks. The survivors internalized the threat of epidemic disease, assimilating the risks of life in an intensely politicized viral hotspot into their individual and common subjectivities. This pandemic was the third in seven decades to be associated with Hong Kong, reaffirming a reputation for sickliness established in the 19th century and an association with influenza that persists today. The colonial government’s response was perceived, less for its lack of success in controlling the local impact of the epidemic and more for its inefficiency in the role of regional sentinel, failing to anticipate the outbreak spreading from China or to have deployed measures to prevent the spread beyond Hong Kong. Perception of the government’s weakness was equally noted in Hong Kong where the media angrily observed a government that had been swift and severe in putting down public demonstrations in the months preceding the influenza outbreak but that struggled to meet its minimal commitment to the health of colonial subjects.

6.1 Tensions within Hong Kong

6.1.1.1 From Opium Entrepôt to Asian Tiger

The 1968 influenza epidemic emerged in a very different context than had the flu of 1957. Hong Kong had changed significantly in the intervening decade in several aspects; industrialization, urbanization, the creation of the New Towns and resettlement estates, and an increasingly fraught relationship between labourers, the government, and the influence of communism both within the colony and in China all shaped the experience of the 1968 epidemic.
The shift away from entrepôt trade and toward light industry began right after the war, with an increase of 36% in the number of industrial enterprises between 1947 and 1950\(^{544}\). Given Hong Kong’s paucity of natural resources, the colony’s entrepreneurs favoured small and medium-sized factories producing buttons, silk and artificial flowers, umbrellas, textiles, footwear, and plastic items. These factories were usually financed and operated by Chinese, either local to Hong Kong or industrialists recently arrived from Shanghai or Guangdong who brought with them the capital needed for expansion independent of government interests. Manufacturing created employment opportunities for the hundreds of thousands of refugees entered the colony from China; by 1966, 40% of Hong Kong’s labour force was employed in industrial work and locally produced goods made up 80% of the colony’s exports\(^{545}\).

Along with industrialization came urbanization. Hong Kong’s geographical limitations, with no expansion of territory possible beyond the New Territories leased in 1898, forced densification of the urban centres—the ‘twin cities’ Victoria and Kowloon—and the areas flanking the port centres, representing only 7% of the colony’s total land area\(^{546}\). Labour opportunities drew Chinese into these centres, and developers of housing projects followed though rental costs continued to climb beyond the means of some 75% of the Chinese population through the 1960s\(^{547}\). The result was domestic density of 2,000 to 2,500 persons per acre and net density of 9,800 persons per acre in the late 1960s, conditions that seemed “incredible, and to a few unforgivable” by analysts at that time\(^{548}\). The benefits of urban density were eclipsed by its pressures in Hong Kong, wrote one author, with “[l]ife too close to raw, unsympathetic architectural details and…conflicts of circulations …high noise levels and poor environmental


conditions” outweighing the promise of a booming population. The city had already earned the reputation of being a ‘concrete jungle’.

To meet the needs for housing the surging population, and with the specific intention of resettling the most destitute of the refugees, the government established the New Towns. These were satellites of the urban areas of Kowloon and ‘New Kowloon’ at the southwest of the New Territories, the most important among them Kwun Tong and Tsuen Wan. The New Towns, set in the rural foothills of the Kowloon mountains, were designed to be ‘dormitory suburbs’. They would offer housing and essential services locally as well as commercial spaces and transportation for the burgeoning population while encouraging economic development. The concept also promised to mitigate some of the city’s more serious public health risks. The idea of colonizing the New Territories for medical purposes was proposed in 1918 by an American virologist studying meningitis. Rockefeller fellow Peter Olitsky, observing dampness and overcrowding in Chinese quarters, advised that the government consider reclaiming land beyond Kowloon and expansion of transit to the New Territories, recognizing that de-locating the Chinese from their places of work would cause significant trouble. The housing projects of the New Towns brought some relief to the problems of density. Despite the commitment made in 1962 to offering medical care to all those who could not afford it on their own, hospitals and outpatient clinics in the New Towns still failed to meet surging need. Making Hong Kong healthy might have seemed to be a Sisyphean task.

6.1.1.2 1966: The Star Ferry Riots

Politically, the colony was more volatile than ever. The image of Hong Kong as apathetic toward decolonization, with local people interested only in entrepreneurial concerns, is a caricature. The

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549 Prescott, 11.
550 Note that Kwun Tong was initially not considered a New Town but part of urban Hong Kong. However its development plan was adapted to the New Towns, becoming characteristic of such, and it is now thought of in the same category as the New Towns.
551 Wigglesworth, 59.
552 CO 131/68, P. K. Olitsky, Sessional Papers, Hong Kong, Report on Investigations of the Outbreak of Epidemic Meningitis in Hong Kong, 1918, 77.
mid-1960s were the most unstable and politically charged period during British tenure; between 1966 and 1968, a rash of dramatic and public assertions of political dissent and demands for better (or alternate) governance overtook the streets and markets. The first major display of public rage unfolded in April of 1966 in response to the announcement of a five cent increase to the first-class fare on the Star Ferry.

Before the construction of the Mass Transit Railway and the Eastern and Western Harbour Crossing bridges, the Star Ferry was the best option for crossing Victoria Harbour between Hong Kong Island and Kowloon. Thousands used the ferry each day, primarily Chinese workers travelling between home and work. In 1965, the government revealed that the Star Ferry Company had considered significant fare increases of between 50 and 100%. Furthermore, in considering the matter, the government had consulted with the Chinese-owned Hong Kong and Yaumati Ferry suggesting that similar increases might be expected in those alternate options as well. Wen Wei Po reported on the public’s anxiety over the threat of the increase and the possibility of a similar increase to fares on other transportation options being similarly raised. Elsie Elliot, a member of the Urban Council with anti-colonial views, compiled a petition bearing 20,000 signatures against the increase. On the April 4, a young man, So Sau-chung, began a hunger strike. So was joined the next day by Lo Kei. The two, with So wearing a jacket on which he had painted the words “Hail Elsie”, attracted a crowd and plenty of media attention. The police responded harshly. They arrested So in the afternoon, provoking a demonstration in front of Government House and a public march through Kowloon.

The situation worsened the next day when So was brought to trial and sentenced to two months in prison. Crowds gathered in his support that evening and violence broke out on Nathan Road with protesters throwing stones and setting vehicles alight. Riot police responded with tear gas and the military with bayonets, eventually imposing a curfew. Riots continued the next day, protestors looting shops in Mong Kok and carrying out attacks on the Yau Ma Tei and Mong Kok police stations. Police deployed tear gas and batons causing one death, four injuries, and hundreds of arrests. The government threatened an even more severe response the next day and the protesters were cowed, leaving the streets nearly deserted after work on April 8. Still, police
arrested 669 that night, for a total of 905 arrests\textsuperscript{554}. Among the rioters, a significant majority were youths, boys between the ages of sixteen and twenty. A survey of one group of these youths conveyed their grim world view, their apathy, political disorientation, and boredom. They reported uncertainty about their prospects for the future and ambivalence toward the government. Their individual circumstances varied to a degree but they shared the belief that Hong Kong Chinese had “no equal treatment”\textsuperscript{555}. The government’s report on the riots painted the two instigators of the riots, Lo Kei and So Sau-Chung, as “misfits or cranks”, but cautioned that,

[i]t would be foolish for Hong Kong society to comfort itself with the thought that it was only the severely under-privileged and discontented who participated in, or passively supported, the disturbances. The great majority of the participants came from the poorer sections of the community but they were not destitute nor were they identified with what are frequently called the criminal classes”\textsuperscript{556}.

The rioters, who typically worked very long hours at industrial or menial jobs without promise of advancement, lacked “opportunity for normal teenage fun, so used the riots as one outlet for this need”\textsuperscript{557}. The youth were not seeking “political or other reasons to cause unrest and trouble in Hong Kong”, the government stressed in the report, perhaps to reassure the public or perhaps to reassure its own representatives\textsuperscript{558}.

6.1.1.3 1967: The Leftist Riots

That estimation surely failed to diminish roiling tensions, however, because the next year brought seven months of explicitly political episodic protests and riots. This began with labour disputes in the spring of 1967 against local companies and, in particular, the Hong Kong Artificial Flower Works in San Po Kong owned by Li Ka-Shing. The company had recently fired


\textsuperscript{555} “Report of the Commission of Inquiry,” 290.


three hundred employees, making it a target for outrage\textsuperscript{559}. Protests were organized by the Hong Kong and Macao Work Committee, a clandestine branch of the Chinese Communist Party. Whether or not the CCP was directly involved in planning the first protests is not clear but Scott notes that all participants were members of the Hong Kong Federation of Trade Unions, closely aligned with Mao’s regime, and members of the HKFTU showed their hand by answering phone calls from Hong Kong officials with quotations from the works of Chairman Mao\textsuperscript{560}.

The confrontation began on May 6 when twenty-one picketers were arrested after clashing with the riot police. With the belief that radical factions within the CCP had by that time succeeded in wresting power within the Foreign Ministry that gave direction to covert Maoists in Hong Kong, the Work Committee took an aggressive stance toward the police. When representatives of the Federation protested the spate of arrests outside police stations, they too were arrested. In response, the Work Committee organized large demonstrations for the next day where demonstrators waved copies of Mao’s Little Red Book and chanted slogans of revolution. Newspapers including *Ta Kung Pao* praised the protestors and attacked the government. School children were sent to protest, while workers from all sectors came together to disrupt life in the colony, disseminating propaganda in many forms\textsuperscript{561}. Word of the protests reached Beijing where the actions of the demonstrators were celebrated and the colonial government was harshly criticized.

Over the next months, protests and police response both escalated. The Hong Kong and Kowloon Committee for Anti-Hong Kong British Persecution Struggle led by Yeung Kwong organized large, frequent protests outside Government House and disrupted transportation services. Protest tactics relied on the sympathy of the public, with leftist businesses, such as newspaper offices, banks, or department stores giving safe haven to rioters pursued by the police. On July 8, a detachment of Chinese militia crossed the border at Shatoujiao/Shia Tau Kok, attacking local police in the village. Five policemen were killed and the post was relieved by the British army.

\textsuperscript{559} Tsang makes the point, however, that conditions at this factory were neither worse nor better than anywhere else. It was simply under these auspices that communist factions in Hong Kong connected their struggles to the Cultural Revolution then underway in China. See Tsang, *A Modern History*, 183.

\textsuperscript{560} “HONG KONG (DISTURBANCES),” *Hong Kong Hansard* (1 June 1967) vol. 747: 266-74.

\textsuperscript{561} See Robert Bickers and Ray Yep, *May Days in Hong Kong: Riot and Emergency in 1967* (Hong Kong: Hong Kong University Press), 175.
Renmin Bao celebrated the clash but the People’s Liberation Army, so active through the
Cultural Revolution, was not deployed thus saving the PRC and Great Britain from direct
engagement. The Hong Kong leftists escalated violence, using bombs and grenades to cause
disruptions all through the city resulting in many deaths including those of an eight-year-old girl
and her four-year-old brother who had picked up a bomb disguised as a present outside their
home at North Point. Altogether there were at least 8,352 bombs, among which were 1,420
real explosives. In mid-July, Maoists transformed the PRC-owned Bank of China building into a
barricade with barbed wire, a gesture that spurred even more aggressive response from the
colonial government.

The government fought back to repress the uprising. It ordered publication bans on pro-leftist
newspapers, raided leftist strongholds, and gathered intelligence against communist cells
believed to be taking instruction from Beijing. Public sympathy tended to follow the government
particularly when the leftists engaged in barbaric or terrorizing acts such as the murder of Lam
Bun, a popular radio commentator who had decried the leftists and their tactics on the air. Lam
and his cousin were burned alive in Lam’s car by a group of “gangsters” posing as a road
maintenance crew. Acts like this inspired emergency measures from the government which
included giving police supernumerary powers and the detention of suspected Maoists. Still the
government managed to keep some of the veneer of normal life in place, as a journalist visiting
in November of that year recounted,

Only slowly does the realization seep in that Hong Kong is a city besieged by local
Communist guerrillas. Ubiquitous gray Land Rovers filled with steel-helmeted riot police
armed with tear gas and carbines constantly prowl the streets. Instead of their usual wares
of Tientsin rugs and carved ivory, the colony's Communist Chinese stores now plaster
their windows with pictures of British police brutality, with crepe-draped portraits of

562 Trea Wiltshire, Old Hong Kong – Volume Three (Hong Kong: Text Form Asia books Ltd., 1997), 12; John M.
the Asian diaspora (Durham: Duke University Press, 2001), 205; Carroll, 156.
slain Communist agitators, and with Maoist slogans urging the city's four million Chinese to "paint Hong Kong red from the earth to the sky".565

Yet his intrepid visitor found the indulgences of colonial life intact,

[a] new generation of Suzie Wongs, more alluring than ever in their mini-cheongsams, still pester fuzzy-cheeked sailors to buy them "one more" tea (masquerading as whiskey). Suits can still be made in twenty-four hours, and shops with showcases bulging with gold, jade, cameras, and watches still offer the luxuries of the world at a fraction of the cost paid elsewhere. The Hong Kong of myth, legend, and travel poster lives on…566.

For those who made their homes in Hong Kong, the costs were dear. Bombings and protests tapered off but did not end completely until December of 1967 when Premier Zhou Enlai gave the order to cease all actions in the colony. This long series of conflicts left the public terrorized and exhausted, costing leftist and anti-colonial campaigns public sympathy. On the other hand, its success in quelling the uprising earned the title “Royal” for the Hong Kong Police Force, an entrenchment of colonial prestige at a time when Britain had given up governing most of its former empire. The Atlantic Monthly’s reporter, while distracted by the women of Wan Chai, managed to observe that the myth of Britain’s invulnerability or entitlement in Hong Kong had been shattered by the events of 1967, writing, “the riots have forced those who live in the colony to face the unpleasant reality that although the anomaly of Hong Kong may have a number of lives, it will not live forever”567. But most keenly, this reporter cited the view of a government insider who claimed that the fate of Hong Kong lie in the hands of the Hong Kong people, that “[o]nce they indicate [presumably through prolonged, massive, and widespread rioting] they want us out, we will leave. We have no imperial, colonial, strategic, or commercial reason for remaining even if Hong Kong were defensible”568. The stakes of government Hong Kong rose each year; every uprising required more and more aggressive policing, every epidemic demanded more and better investments in the health of Hong Kong people. And for their part, Hong Kong

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566 “Reports: Hong Kong”.
567 “Reports: Hong Kong”.
568 “Reports: Hong Kong”.

people had higher expectations of the government than ever before. Under the pressures of rising population and the Cold War, the interests of the colonial and Chinese communities converged more than ever before.

6.2 A New Influenza Breaks Out

July in Hong Kong can feel overwhelming. Temperatures soar, the mercury rising above 30°C most afternoons. The intense humidity of the spring continues and most mornings see thunderstorms. The high heat and humidity coupled with sunshine and little wind, the product of subtropical high pressure areas characteristic of the summer months, are signaled today by intense heat indices, warnings issues by the Hong Kong Observatory. Summer weather is also unstable with frequent monsoons and typhoons that disrupt the bustle and business of the city. The summer of July 1968 in Hong Kong was particularly warm, with 11 days of highs over 33 degree Celsius reported\(^{569}\). This was why, reported *Wah Kiu Yat Po*, endemic flu seemed particularly rampant\(^{570}\). *Kung Sheung Yat Po* reported an outbreak of “heat sickness”, a description that may have referred to heat exhaustion caused by exposure to the elements or to a traditional Chinese medicine syndrome, “summer heat”, associated with high fevers and sweating\(^{571}\). By the next day, however, *Kung Sheung Wan Po* identified the circulating illness as an outbreak of influenza, an “attack” confirmed by medical authorities. There were at least 220 confirmed cases caused by the heat wave, claimed the source. The article reminded the public of the symptoms of influenza and the manners by which it is spread. The photograph of a long line up in front of a clinic that accompanied the article recalled the serious consequences of the last epidemic in 1957\(^{572}\).

\(^{569}\) The Government of Hong Kong Special Administrative Region, “Number of Very Hot Days Observed at the Hong Kong Observatory since 1884, Exclude 1940-1946” *Hong Kong Observatory: Innovate with Science, Serve with Heart.*

\(^{570}\) *Wah Kiu Yat Po*, 21 July 1968, 13. Hong Kong typically experiences two flu seasons, one in the coldest months between December and March and another wave in July and August, the hottest months. See Paul KS Chan, H. Y. Mok, T. C. Lee, Ida MT Chu, Wai-Yip Lam, and Joseph JY Sung, “Seasonal Influenza Activity in Hong Kong and its Association with Meteorological Variations,” *Journal of Medical Virology* 81, no. 10 (2009): 1797-1806 for discussion of the relationship between climate and influenza outbreaks in Hong Kong.

\(^{571}\) *Kung Sheung Yat Bo*, 21 July 1968, 4.

\(^{572}\) *Kung Sheung Wan Bo*, 22 July 1968, 1.
An editorial published the next day echoed reminders of Hong Kong’s disease history, warning that this outbreak could outpace the damages of the epidemic of 1957 given the ever-increasing population. It was essential, the author emphasized, that Hong Kong people take every measure to prevent spreading the flu. Hong Kong people were counselled to attend clinics, many offering extended hours, to eat nutritional foods including fruits and vegetables, to stay hydrated with water, milk and juice, to avoid cold foods and to avoid getting chilled in public places with strong air conditioning. Tucked into the back of one paper was advice to women on sanitation and cooking for the protection of one’s family. Other publications published the same admonition that this flu was the worst in a decade, and a doctor was quoted as recommending “hot lemon tea, aspirin, and a bit of whisky” before taking rest.

Over the course of the week, hot temperatures and the spread of the flu continued. The impact, too, worsened with up to 300,000 cases suspected and line-ups for medical care growing. Throughout the city, family and working life were disrupted, with interruptions to transportation, trains, trams, buses and ferries; the problem was worse, said the Kowloon Motor Bus service, than in 1957. Workplace absenteeism was a critical concern; with one source reporting 600,000 cases of the flu, 40% of government clerks and 55% of blue and white collar workers were out sick. Doctors could not agree; one report quoted a doctor who claimed things were not as dire as the last epidemic and the next morning another paper quoted doctors as saying the situation was significantly worse than in 1957, with a rapid increase in cases. In spite of the incredible claims made in some reports, by July 25, there were only 2857 cases confirmed by

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medical authorities, and among them five fatalities that month; confirmed and reported numbers of cases were in different orders of magnitude.  

By July 27, newspapers reported that the peak of the outbreak had passed. *Kung Sheung Yat Po* published the transcript of an interview carried out by Hong Kong’s public broadcaster, *Heunggong Dintoi*, with the Government’s Medical Authority Vice-Director Choi Wing-yip. Choi said here that the peak had arrived and the outbreak would soon decline. Choi defended the government’s management of the outbreak, saying that as a novel strain there was no vaccine that the government could have offered and that influenza is difficult to cure once infection has set in. Choi said that if medical resources in the colony seemed strained it was because the flu had overcome health professionals too, their ranks in hospitals and clinics now depleted. The evening edition informed the public that queues at clinics were growing shorter and the weather cooler but that Hong Kong people should still practice preventative measures. Experts predicted that the outbreak would be under control the following week. Vice-Director Choi tried to console the public. He guaranteed the government’s continued diligence in helping the sick, saying doctors and nurses would cancel their vacations in order to extend services, but reassured Hong Kong people that this outbreak had significantly lower fatality rates than the outbreak in 1957. Still the return of high temperatures the next week brought a warning from officials that the influenza had not yet died out.  

The second week of the outbreak brought more international attention to the situation in Hong Kong. Much of this attention, however, was accusatory. The Philippines announced a quarantine on visitors from Hong Kong to prevent seeding this strain of influenza in that country. A team of Japanese medical scientists came to Hong Kong to study the epidemic in the hope that they might prevent its spread to their nation. An outbreak of influenza was confirmed to have reached

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584 The strain causing this outbreak had been publicly identified as “Asia A II” two days before. See *Kung Sheung Wan Bo*, 25 July 1968, 1.  
Macao. These reports surfaced as Hong Kong authorities acknowledge one more fatality, bringing the total to six. By the time the epidemic was declared to be finished in the colony, there were twenty-two fatalities altogether. Japanese scientists announced success in isolating a novel strain of influenza and demanded that this new isolate be labelled “Type A3.” Media in Hong Kong reported, shortly thereafter, on a conflict emerging between the local medical community and their colleagues in Japan as the Japanese laboratories refused to share information on the strain they had isolated making it impossible for researchers in Hong Kong to confirm that the newly isolated strain was, in fact, the cause of Hong Kong’s local outbreak.

6.2.1 The Media and the Market

Much of the media coverage of the epidemic in Hong Kong focused on the impact the flu had had on the local economy and labour force. From the very beginning of coverage, the Chinese press reported on the economic consequences of absenteeism due to sickness and on manipulations of the market based on aggravations of supply and demand. Throughout the period of the outbreak, reports surfaced almost every day on the rising price of one commodity or another and while there was great concern expressed in the media for the high rate of infection and rising number of fatalities, the ‘side effects’ of the epidemic were of equal concern. Newspapers in Hong Kong opined almost daily on the rising price of medicines, both traditional and Western. Inflation had occurred during the 1957 outbreak but not in the same proportions; while Kung Sheung Wan Po reported scalpers raising the price of clinic vouchers by 20-40%, the same paper reported inflation rates of up to 150% for Chinese medicine during the 1968 outbreak. New limits on importing traditional herbs and patent medicine from the mainland

588 Wah Kiu Yat Po, 30 July 1968, 4.
589 Wah Kiu Yat Po, 30 July 1968, 2, 3; Kung Sheung Wan Bo, 30 July 1968, 4.
590 Kung Sheung Wan Bo, 10 August 1968, 4.
591 Wah Kiu Yat Po, 15 August 1968 3; Kung Sheung Wan Bo, 17 August 1968, 1; Wah Kiu Yat Po, 18 August 1968, 2.
592 Kung Sheung Wan Bo, 19 August 1968, 2.
594 Kung Sheung Wan Bo, 30 July 1968, 4.
contributed, also, to the incredible rates of inflation\textsuperscript{595}. All industries except medicine suffered during the epidemic\textsuperscript{596}.

The Chinese-language media in Hong Kong also gave air to worries about labour conditions and the plight of workers in the colony. This concern had not been prominent in coverage of the 1957 epidemic. Blue collar workers and their families suffered the most, said reports. Conditions were particularly bad in the New Town of Tsuen Wan\textsuperscript{597}. Few reports cited actual figures on declining productivity or workplace absences perhaps because industrial labour in Hong Kong was frequently still informal or casual, making it difficult to discern clear figures; one report set the drop in productivity at about 4 to 5\%\textsuperscript{598}. The “workers” section of \textit{Wah Kiu Yat Po} often showcased the views of the working class on the influenza outbreak. Labourers felt helpless, stated one article. Working outdoors in the high temperatures made them most susceptible to the epidemic but they had no choice but to work because they were not compensated for time off work sick\textsuperscript{599}. If a worker did get benefits for illness, he was likely to need to spend the entire sum on medical care\textsuperscript{600}. Discussion of the environmental and social issues promoting the spread of epidemic disease was placed in the “workers” section of the paper suggesting that these issues, and the government’s management of them, were the concern of the laboring class. These reports also connected the concerns of working people to the issue of domestic density; if one family member contracted an infectious disease, quarantine was impossible given close living quarters\textsuperscript{601}. Families would take turns staying home sick, putting the stability of families and the health of all at risk\textsuperscript{602}.

There were differences of opinion when it came to the effects of the influenza epidemic on production. One article explored the issue at length, considering both industrial manufacturing

\textsuperscript{595} \textit{Wah Kiu Yat Po}, 31 July 1968, 17.
\textsuperscript{596} \textit{Kung Sheung Wan Bo}, 28 July 1968, 4.
\textsuperscript{597} \textit{Takung Pao}, 29 July 1968, 4.
\textsuperscript{598} \textit{Kung Sheung Yat Bo}, 29 July 1968, 17.
\textsuperscript{599} \textit{Wah Kiu Yat Po}, 24 July 1968, 21.
\textsuperscript{600} \textit{Wah Kiu Yat Po}, 5 August 1968, 10.
\textsuperscript{601} \textit{Wah Kiu Yat Po}, 5 August 1968, 10.
\textsuperscript{602} \textit{Kung Sheung Yat Bo}, 24 July 1968, 5.
and food production sectors. The article concluded that declining production due to workers off sick would be counterbalanced by a supply of new workers who had just left school. This article predicted no impact on production ahead of the Christmas season.\(^{603}\) On the contrary, the left-leaning *Kung Sheung Wan Po* reported that factory production had decreased and that holiday production was likely to suffer delays.\(^{604}\) As the epidemic waned, one article reported delays in 20\% of shipments at the height of the outbreak.\(^{605}\) After mid-August, newspapers fall silent on the topic, though cases of influenza would pop up in Hong Kong until the fall.

### 6.2.2 The Government’s Laconic Response

This outbreak snuck up on the government. The epidemic of 1957-turned-pandemic had cautioned local authorities in Hong Kong and had called attention to the roles Hong Kong might play as a regional sentinel and proxy for China in global infectious disease surveillance. Nonetheless, the outbreak in July of 1968 grew swiftly beyond the government’s reach. The virus had a ‘head start’, had defied early detection or response. Whatever hopes had been pinned on Hong Kong after the 1957 outbreak were unfulfilled when the flu galloped through the colony and then beyond. Dr. W. K. Chang, Senior Medical Officer of the Government Virus Unit acted as a spokesperson for the government to the international community, making an account of what had occurred that summer.

Chang published his report on the local outbreak in the *Bulletin of the World Health Organization* and also published a post-mortem on the outbreak in an American public health journal. He explained to the international community of scientists, physicians, and policy makers that, despite the warnings of the 1957 pandemic, Hong Kong had not implemented mandatory notification of influenza cases; only nine government clinics practiced voluntary notification.\(^{606}\) With notice from these clinics, virologists in the colony could carry out analysis, confirming

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\(^{603}\) *Wah Kiu Yat Po*, 26 July 1968, 17.

\(^{604}\) *Kung Sheung Wan Bo*, 26 July 1968, 4.

\(^{605}\) *Kung Sheung Wan Bo*, 29 July 1968, 4.

\(^{606}\) Another paper of which W. K. Chang is a co-author reports “…[Hong Kong’s]…Epidemiological Office received weekly notification of influenza-like diseases from six outpatient departments and hospitals in the urban area”. It is not possible to account for the discrepancy in Chang’s indication as to how many clinics reported, nine or six. See, N. H. Wiebenga, W. K. Chang, G. R. French, and R. L. Woolridge, “Epidemic Disease in Hong Kong, 1968, associated with an antigenic variant of Asian influenza virus,” *American Journal of Public Health and the Nation’s Health* 60, no. 9 (1970): 1806-1812.
influenza and assessing the threat of a dangerous epidemic caused by a new strain rather than the usual endemic clusters of infections that the colony would see each year, but these nine clinics served only a fraction of the total population. Chang admitted that the 6214 cases reported for the month of July were only a fraction of the projected total number of cases. Most Hong Kong people attended private clinics or Chinese herbalists, he noted. Absenteeism from work was impossible to estimate because most workers were day labourers and nothing could be interpolated regarding rates of infection from those numbers since a desperate worker would only miss work if severely ill. Schools were closed for the summer holiday so paediatric infection rates were impossible to know\textsuperscript{607}. With the available data inadequate and patchy, the full epidemiological picture was obscure. Medical authorities succeeded in isolating the virus strain on July 17, Chang wrote, and identified it as subtype A2 with a haemagglutination-inhibiting titre of 1:640 against the strain collected in the last year’s cases. Recognizing an antigenic shift, the government sent samples to the World Influenza Centre (WIC) in London immediately and then five more isolated strains to the WIC and International Influenza Centre for the Americas in Atlanta\textsuperscript{608}. Hong Kong had done its best to raise the alarm, it was just too slow to do so.

The colonial government’s response, based on Chang’s account, can be characterized as conservative, minimal, and too slow to prevent the rapid spread of infection locally and beyond Hong Kong. Newspapers report efforts on the part of the government to extend services, keeping hospitals open on weekday hours over weekends and adding late night hours, evidence that it recognized the overwhelming number of cases emerging\textsuperscript{609}. Other reports, however, are critical of the overcrowded clinics; one report was flanked with an image of a hospital with a sign in front informing the public that the hospital was full, and to come back earlier in the afternoon\textsuperscript{610}. For the first time in the context of a medical crisis, the media evoked the term gangying, or British Hong Kong, in a critique of the government’s response. This discourse in Hong Kong


\textsuperscript{608} Chang, 151.

\textsuperscript{609} Takung Pao, 27 July 2015, 4.; Kung Sheung Yat Bo, 27 July 1968, 4.

\textsuperscript{610} Kung Sheung Wan Bo, 26 July 1968, 4.
media was the strongest public rebuke to date. Coupled with Dr. Chang’s internationally disseminated report, the Hong Kong government’s administration faced greater scrutiny than ever before.

Critique came from within Hong Kong’s administration, as well. The Urban Council had replaced the Sanitary Board as the body responsible for street cleaning and refuse collection. One of its members told the *Kung Sheung Yat Po* that the government should take more decisive action in slowing the spread of the flu by closing public areas. The government was perhaps concerned about the political effects of imposing limits on public freedoms after the harsh reactions to protests the year before. Or perhaps it was weighing its response against evidence that while highly infectious, the current strain was clinically very mild. In light of the unrest throughout 1967-68, it may have seemed that shutting down public areas would create more disruption to Hong Kong life than would this mild influenza. Precautions against further spreading had been effective in government spaces, at least; in police stations, military bases and prisons, only a small number of workers, civil servants and prisoners had fallen ill.

6.2.3   Treating the Flu with Medicine and Memory

Discourse on the treatment of influenza during the 1968 outbreak shares many aspects of the approach to the 1957 outbreak but there are distinctive elements to consider. The previous outbreak, along with perennial discussion of the dangers of the large population, high density, poor quality housing, and inadequate sanitation in many Chinese areas, reminded Hong Kong Chinese readers of the need for vigilance and precautions. The media also stirred the colony’s healthy appetite for remedies; Hong Kong people had, by 1968, become voracious consumers of medicines, Chinese and Western, as well as of medical discourse. As evidence, the first mention of the outbreak in the Chinese press was accompanied by a warning that the prices of Chinese

611 “British Hong Kong [trans].” *Takung Pao* 27 July 1968, 4.
613*Kung Sheung Yat Bo*, 27 July 1968, 4.
remedies were on the rise, not by discussion of the hospitals and clinics. If not the government, the economy was surely responsive to the suggestion of an epidemic.

Resourceful Hong Kong people might prepare their own herbal soups based on formulas printed in daily papers. With long queues at both Western and Chinese clinics, doctors used the media to encourage people to practice preventative and self-care. Some of the advice was based on traditional Chinese interpretations of health and disease, such as the advice to avoid cold foods or to consume particular fruits and vegetables. Other reports combined the trends connecting traditional Chinese treatments with commercial interests, such as Ta Kung Pao’s recommendation that people use a patent medicine, ganmaodan, or “cold pill”, formulated by Beijing herbal pharmaceutical giant Tongrentang. On another page of the same issue, the newspaper informed its readers that sales of non-prescription drugs from the PRC were brisk. Some advice from the 1957 outbreak was recycled, such as the use of tangtaipingdan a simple analgesic patent medicine. As always, Hong Kong’s charitable and community organizations offered aid, including offers of Changchun tea at the Yan Lo Buddhist Monastery, and a ‘harmonising’ tea on offer free of charge at a morality society.

Mention of Western medical views on treating the flu were relatively few, perhaps by chance, or perhaps in reflection of a growing understanding of the nature of viral illnesses for which prevention exceeds treatment options. Early in the outbreak, when the government first acknowledged the epidemic, doctors used the Chinese newspapers as a means of spreading information about influenza from a biomedical perspective, information that was not yet widely spread among the Chinese population which had highly variable educational backgrounds and contact with Western culture. And so the Medical Authority’s representatives explained the situation in biomedical terms: the various types of influenza, the symptoms of various kinds, and

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618 Takung Pao, 26 July 1968, 3.
619 Takung Pao, 26 July 1968, 6.
620 Kung Sheung Yat Bo, 27 July 1968, 6.
621 Wah Kiu Yat Po, 27 July 1968, 6, 13.
the means by which the virus is spread. The most explicit discussion of the epidemic in Western terms was an interview given by Dr. Choi. In a transcript of the interview published in the *Wah Kiu Yat Pao*, Choi broke down the epidemic in Western medical terms. He explained the nature of viral illnesses and the function of vaccines in their prevention. Framed as a defence of the colonial government then under attack for the perceived lack of action against the outbreak, Choi explained that without an effective vaccine ready in advance of an outbreak, Western medicine had little to offer in treating viral illnesses like this flu. The government’s failure to anticipate or prevent an epidemic in Hong Kong was not because of systematic inadequacies but because antigenic shift, an act of nature, had outrun the limits of local and global infectious disease prevention. The government had not been too slow; a virus like this was too fast, and so out of anyone’s hands.

Recollections and personal memories of the 1957 pandemic loom in all Chinese-language journalism in Hong Kong. Many articles rehashed the previous epidemic, positioned as prominently as on the front page of a daily edition, and appearing as early as the second day of media coverage made the connection between this outbreak and 1957. Editorials warned Hong Kong people about even greater threats they faced; with Hong Kong now a global nexus and one of the world’s most populous cities, epidemics like this were likely to occur more frequently. If not treated ‘properly’, threatened one writer, the situation in 1968 situation could be worse than 1957. The notion of influenza as a chronic but manageable epidemic event, as Dr. Choi portrayed the outbreak, was a frame imposed after the fact. While the government concentrated on identifying the influenza strain and on reporting it to its international partners, the Hong Kong Chinese-language media was not concerned the origins of the virus or of the possibility of a pandemic. Local reports conveyed anxiety more than anything. There was very little support for Hong Kong people with the virus already on the loose. Jobs and livelihoods were imperiled.

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6.3 A Global Infection

From Hong Kong, the virus spread quickly and in every direction, starting in August through Southeast Asia to Singapore, the Philippines, Taiwan, Vietnam, and Malaysia. In September, outbreaks were reported in Thailand, India, Australia’s Northern Territory, and ironically, in Iran where an outbreak surfaced among participants at the Congresses of Tropical Medicine and Malaria. The virus was introduced to Thailand by way of the Korat Royal Thai Air Force Base. American pilots who had been deployed in other parts of Asia where flu had spread returned to the base carrying the virus, passing it then to colleagues returning to the United States. The outbreak spread to Bangkok and then throughout Thailand, monitored by the SEATO Medical Research Library and the Faculty of Public Health at Mahidol University. In India, reports of the flu were first associated with the S.S. Rajula, owned by the British India Steam Navigation Company. This passenger ship reported influenza on board to the Port Health Authority at Madras which relayed the information to the Influenza Centre at the Pasteur Institute at Coonoor. However, of the sixteen passengers on the Rajula with flu-like symptoms, only seven of them were caused by the A2/Hong Kong/68 strain. Indeed, the Hong Kong flu was also isolated at Ootacamund on August 31, a week before the Rajula docked at Madras, indicating that this strain had been seeded at several ports.

6.3.1 A2/Hong Kong/68 in the United States and the United Kingdom

In the United States, the 1968 pandemic was long anticipated. American people, the media, and the U.S. public health system were on watch for an outbreak of influenza and the topic appeared in the news at regular intervals. Discussion in the media focused on vaccines, new antiviral drugs arriving on the market and on preparations for an outbreak that, if not inevitable, was taken for

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629 Veeraraghavan, 400.
Newspapers reported on the benefits of immunization ahead of an outbreak rather than once one had begun. Acknowledging that the vaccines of the time were effective for three to six months, protecting the public required coordination between public health communications strategy, medical authorities, and drug companies. To this end, the Public Health Service Advisory Committee on Immunization Practices was founded in 1967. Around this time, the Center for Disease Control in Atlanta issued a statement warning of a major influenza epidemic that would affect the northeastern United States but that it would not have a significant effect nationwide. This release predicted a peak of cases in the New Year, in January of 1968, rather than the regular distribution of cases throughout the typical flu season, which in the United States was from October to March. These reports sought to predict the course of influenza globally and nearly a year in advance but proved only variably accurate.

Articles published in the American press through the autumn and winter of 1967 balanced two goals: to alert the public and engender compliance with preventative measures and to calm public fears about pandemic influenza. Memory of the 1957 pandemic loomed in America as it did in Hong Kong, and American journalists occasionally evoked the 1918 influenza pandemic and its catastrophic mortality. The decade now passed since the ‘Asian flu’ pandemic gave the impression, wrote some, that the world was due for another battle with the influenza virus. Public health authorities agreed that “one reason for increased anxiety among public health officials this winter is the dormancy for several years of a form of Asian flu that first struck in 1957.” No epidemiological evidence for this anxiety or the claim was given and indeed a novel strain would be a greater worry than the reappearance of the Asian fly to which many had immunity. As predicted, pockets of influenza infections appeared worldwide through the winter of 1967.


635 “Flu Season at Hand”, 6.

636 Virologists later associated H3N2 with equine infections and hypothesized that this variant had caused outbreaks in 1900, and that the pandemic of 1968 was a recurrence of an old strain rather than a novel infection. See Pyle, 135.
Reports of flu in New York surfaced from December of 1967 to January of 1968 with mildly elevated fatality rates but the crisis did not arrive; it was a normal flu season\textsuperscript{637}.

The view was different the next year. The CDC shifted its narrative with an announcement of the arrival of “A2-Hong Kong-68” in September. Having earlier predicted no “widespread outbreaks of influenza in the winter of 1968-9”, the Public Health Service Advisory Committee issued a statement on September 5 predicting that not only was an epidemic certainly coming but that it would be caused by a new variant of the A2 Asian flu for which no effective vaccine was yet available\textsuperscript{638}. The article documented the error of the CDC in predicting a return of the Asian flu. Instead, the CDC announced, there was a new strain, H3N2, in circulation. It was officially named A2/Hong Kong/68\textsuperscript{639}.

The first confirmed cases of the H3N2 variant in the United States were confirmed on September 2, isolated in Atlanta from a Marine who had been deployed in Vietnam. His bunkmate on the Marine’s last night in Asia had just returned from Hong Kong\textsuperscript{640}. The same week, the virus was isolated on the west coast of the United States where twenty-two of twenty-nine students at a Marine Corps Drill Instructors’ School in San Diego gave positive samples\textsuperscript{641}. As the month progressed so did the spread of the flu; there were three additional outbreaks among military personnel in reaches as distant as Hawaii and Alaska reported, all connected to servicemen recently returned from Southeast Asia\textsuperscript{642}. As had been the case in 1957, seeding of influenza through the United States was tied to its military activities\textsuperscript{643}.


\textsuperscript{639}“Outbreak of Asian Flu is Expected This Fall,” 95.


\textsuperscript{641}Sharrar, 361.

\textsuperscript{642}Sharrar, 361.

\textsuperscript{643}That said, the \textit{New York Times} reported that, by mid-September, at least nine cases connected to civilian travel in the “Far East” had been confirmed. See J. E. Brody, “9 Cases of New Asian Flu are Reported in U.S.,” \textit{New York Times}, 27 September 1968, 9.
Robert Sharrar, Chief of the Epidemic Intelligence Service at the National Communicable Disease Center in Atlanta, reported that the first outbreaks in the civilian population occurred in the far extremities of America’s formal territory: in Puerto Rico and Alaska. The first outbreak in the continental USA did not occur until the third week of October when 35-40% of the population of Needles, California, fell ill. Between October 19 and November 9 there were outbreaks in four more western states; the flu finally reached the east coast in the third week of November. Outbreaks were reported in Pennsylvania and New Jersey in the week ending November 16. Outbreaks continued to spread through November and December, and by the end of the year, all fifty states had come down with the flu.

The peak of the epidemic in the United States is thought to have occurred in the last two weeks of December 1968 or the first week of January 1969. Because of the holidays, with schools and many businesses closed, indices on influenza activity such as school or workplace absenteeism are unavailable. In January, cases of influenza continued to pop up in rural areas or where the flu had not yet appeared but unlike in Britain no second wave occurred. An endemic season of influenza B unfolded in parallel in thirty-seven states, most prevalent among elementary school-aged children; in this population, school absentee rates reached 25-45%. Altogether, the chief epidemiologist reported an estimated thirty million cases of influenza due to the H3N2 strain above typical seasonal flu rates of infection, an approximate attack rate of at least 15%, and very likely higher.

The pattern in Britain was similar to what was seen in the United States but with a few unique observations to note. Influenza appeared in Britain every year with epidemics due to A-type viruses occurring every year since 1957 except in 1959-60, 1961-2, and 1966-7. A typical outbreak was reported in London in December of 1967. The Times Medical Correspondent

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644 Sharrar, 362.
645 Sharrar, 362.
646 Sharrar, 364.
647 Sharrar, 364.
648 Sharrar, 364.
649 D. L. Miller, Marguerite S. Pereira, and Mi Clarke, “Epidemiology of the Hong Kong/68 Variant of Influenza A2 in Britain,” BMJ 1, no. 5747 (1971): 475.
reported that London hospitals had been sent into “red alert” with need for beds for patients sick with pneumonia and bronchitis, complications of the flu, far exceeding available places. Still, assured the correspondent, if the virus was an “ordinary Asian A2” strain, the outbreak would come under control soon. Cases were more numerous than usual for that time of year and the flu had claimed the lives of five infants, a significant increase over usual rates of paediatric fatality, but the public was instructed to take employ self-care, to use “good old-fashioned home nursing…rest in a comfortable, warm bed, plenty of bland fluids, and some pain-relieving medicine, such as aspirin.” On that count, The Times noted that both pharmaceutical suppliers and over-the-counter retailers and dispensaries stood to profit from the epidemic, rebounding after a mild winter in 1966-67 reduced profits, at Aspro-Nicholas by £ 90,000.

H3N2 appeared later. The first confirmed victim of the new strain in Britain was a child who had had no known contact with anyone who had recently returned from Asia or other infected regions. This suggests that there were likely other cases that went undetected by epidemiological surveillance. In effect, the new strain may have passed through the United Kingdom without being recognized as such after the winter 1967 season. Through the autumn, more cases associated with Asia and the novel strain came to view, “almost all from persons who had recently arrived from areas where epidemics were in progress, or their immediate contacts.” There were community outbreaks in schools and institutions but diffusion through the population was limited. This changed in early 1969, when a second wave hit Britain. H3N2 infections in 1969-70 followed a more expected pattern, with benefit claims rising in early December of 1969 and peaking in the first week of January. These 750,000 benefits claims outpaced highest numbers recorded during the 1957 outbreak. Through this second wave, deaths due to complications of influenza—bronchitis and pneumonia—rose to a peak of 10,500 at the beginning of January compared with 2,550 the same week the year previous. By the end of

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653 Miller, Pereira, and Clarke, 475.
654 Miller, Pereira, and Clarke, 475.
655 Miller, Pereira, and Clarke, 478.
the month, the epidemic was over\textsuperscript{656} though clusters of cases were reported between February and April\textsuperscript{657}. This second wave of H3N2 was a unique epidemiological pattern that confused epidemiologists seeking to understand and create a ‘narrative’ for this pandemic.

**6.3.2 Understanding the ‘Desultory’ Quality of H3N2**

H3N2 spread unpredictably. Its pattern of diffusion characterized as “desultory”, with low morbidity and mortality rates, surprised epidemiologists. This strain moved across the globe differently than had H2N2, spreading not in “massive frontal waves… [but]…through a process of initial and slow multiple seeding and then diffus[ion] from several epicenters simultaneously\textsuperscript{658}. In its first year of circulation, H3N2 was slower, milder, and less deadly than was expected when a new strain is introduced to populations without immunity. The predicted pattern—an ‘explosive’ epidemic with ‘exceptionally high morbidity and mortality rates’—appeared only in the second year of the pandemic. Furthermore, Britain endured two waves of H3N2, the second more serious than the first, while the United States saw only one wave but a “sharp epidemic during the early winter with large numbers of deaths”\textsuperscript{659}. The reasons for these variations, in Britain and elsewhere, was cause for concern.

The WHO called a meeting in September 1969 to discuss the pandemic. Representatives from various countries presented their findings on the presentation of the new strain in their populations. The general conclusion was that H3N2 had caused a strong outbreak in the United States but that other parts of the world had been more mildly affected. The 1968-9 pandemic ranked third in severity among the three global pandemics of the 20\textsuperscript{th} century. Attendees volleyed arguments for why this might be. Three major questions emerged. First, as Dr. Claude Hannoun of the WHO notes, the diffusion of the 1968 epidemic was irregular “on both macro and more regional geographic scales\textsuperscript{660}”. The spread of the flu from Hong Kong to the United States west coast was very quick, states Hannoun, but diffusion to Kenya, Brazil, Sri Lanka, and Indonesia

\textsuperscript{656} Miller, Pereira, and Clarke, 478.

\textsuperscript{657} Miller, Pereira, and Clarke, 476.

\textsuperscript{658} Pyle, 121.

\textsuperscript{659} Miller, Pereira, and Clarke, 478.

\textsuperscript{660} Hannoun with Craddock, 183.
was delayed until 1969; these nations avoiding the first wave altogether despite the close economic and regional relationships connecting these countries. The southern hemisphere was little affected at all before 1969.

A second question was why the symptoms and mortality rates varied significantly between regional epidemics. The virus caused significant mortality in American populations but was relatively mild in its effects in other parts of the world, a phenomenon unique to this pandemic. Attendees of the WHO conference proposed two hypotheses. One possibility was that there had been two variants active in 1968-69, the more virulent strain moving from Hong Kong to the United States while a milder variant seeded Europe and Britain. Those regions were exposed to the more virulent strain later in the year. Another related hypothesis focused on differential risks, the notion that various populations had been exposed to partial mutations of the A2 virus between 1957 and 1968. In this case, ‘bridging antigens’ offered some protection to populations in Australia and New Zealand.

A third concern of the authorities assembled was the lack of standardization in the surveillance systems on which the global public health community depended. The narrative that had developed around the pandemic of 1968, both in the scientific community and in the media, sought to connect reports of isolated strains of A2 worldwide. These reports, while more substantial and helpful than the posthoc and incomplete documentation of the 1957 pandemic, did not explain diffusion of the virus. The depth and range of epidemiological data varied tremendously between stations, notes Cockburn, potentially causing distortion of the broader epidemiological picture. Cockburn and his team favoured the explanation that the divergence between H3N2’s effects in the United States and in Britain was the data that was collected. They suggested that the methods and filters through which regional epidemics were interpreted and presented distorted the complete, global view. Another possibility was that some external factor rendered the effects of the flu more severe in the United States. Cockburn offered the example of an epidemic in Britain in 1950 at which time the Merseyside region, including the city of

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661 Hannoun and Craddock, 183.
663 Cockburn, Delon, and Ferreira, 348.
Liverpool, was more severely affected than other parts of Britain due to an unusual, excessive cold spell. H3N2’s harsh effects in the United States could be the result of a similar yet unrecognized factor. Researchers applied the adjective “smouldering” to describe the mysterious patterns of the pandemic.

In international debates on the pandemic, Hong Kong receded from view. The half million cases in Hong Kong in July of 1968 were scarcely reported in the American and British media. At the peak of Hong Kong’s outbreak, *The Times* wrote that the “mild” epidemic had sickened “about 400,000 people in Hongkong and neighbouring areas in China”. The virus was expected to reach Britain eventually but vaccines based on the 1957 strain were likely to be sufficient in controlling the epidemic. In the American press, Hong Kong’s outbreak was discussed only in hindsight, once the strain had been isolated, identified as a new variant, and branded the ‘Hong Kong flu’. The only mentions of the plight of Hong Kong people in the *New York Times* was a note that twenty-five had died in the colony. *The Times* noted the work of drug manufacturers working to create a vaccine for a new strain “sweeping Australasia”, a frame that focused attention on the concerns of the British public without acknowledging the troubles of its colony. Indeed this report collapsed Hong Kong into an unusually vast regional category, Australasia, which makes little sense in this context. In hindsight, virologists determined that there was no co-circulation of A/H3N2, the ‘Hong Kong flu’ with A/H2N2, the ‘Asian flu’ of 1957. H3N2 replaced H2N2 and the last reported isolation of A/H2N2 was from Australia from a sample taken in August of 1968, proving this conflation of Hong Kong’s epidemic with Australia’s was erroneous. In November, *The Times* offered a more elaborate account on the outbreak in Hong

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664 Cockburn, Delon, and Ferreira, 348.


667 Brody, 49.


Kong and the actions Dr. W. K. Chang took to notify international authorities. This was the whole of reporting on the colony’s experiences in the metropole: quite little, and quite late. Instead, another discourse appeared to signal the political, social, and economic significance of this pandemic.

6.3.3 The ‘Mao Flu’

There is a third reason for which the ‘Hong Kong flu’ was used as shorthand during the 1968-9 pandemic. By 1968, the practice of labelling a newly isolated strain with the name of the location from which the sample was sent along with a reference to the type of influenza was standard practice. Within two years of the 1968 pandemic, the nomenclature was expanded and formalized by the WHO; the name of any given strain would include the host of origin, human, avian, equine or porcine, the geographic location of the first isolation, the strain number, and the year of isolation. Following this practice, the 1968 pandemic-causing strain was first identified as “A2-Hong Kong-68.” In this sense, the nomenclature assigned to the pandemic-causing strain was not explicitly political. Hong Kong’s participation in identifying the strain, however, and its role in the global surveillance networks and protocols shaping response to the emerging pandemic, however, carry political significance. The 1957 strain was confirmed by Chinese scientists who did not report to international public health bodies and then confirmed in Singapore. In 1968, Hong Kong and WHO authorities still did not have the cooperation of the PRC. Geographical proximity and disease ecology defied political separation, however, and Hong Kong remained at the mercy of its closeness to China. In this instance, it wore the scarlet letter, giving its name to the flu because of its role as a proxy for China, the actual origin of the virus.

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The shorthand also leaned on the example of the previous pandemic. In that case, the southern Chinese origin of the virus had been publicized and acknowledged, but in 1968 the blame was pinned on Hong Kong despite suspicions of Chinese origins. Political distance between Hong Kong and China, and the economic estrangement this caused, had not entirely stopped cross-border traffic. By the early 1950s, both the PRC and Hong Kong had placed restrictions on border crossings; the PRC required exit permits of all Chinese wishing to depart the nation and Hong Kong limited the entry of Chinese to those with identification cards from Hong Kong or Macao or previously established status as subjects of Great Britain. Re-entry permits allowed Hong Kong people to travel between the colony and family villages in China and these travellers are likely to have carried both the virus and news of the initial epidemic across the border. Notice of an outbreak in Canton surfaced in Ming Bo on July 11. Cases of infirmity with flu-like symptoms were rampant, reported the paper. Making things considerably worse, with China in the throes of the Cultural Revolution, Canton had lapsed into panic; the paper reported unburied bodies in the streets and rioting and looting of shops by people terrified of falling ill.

While local wisdom and the press suggested a connection between the appearance of a cluster of cases of respiratory illnesses in Hong Kong between July 7-13 and the outbreak in southern China, W. K. Chang reported to the WHO that Hong Kong had had no warning from authorities in the PRC before influenza appeared in Hong Kong. China had extricated itself from surveillance networks, cooperation with American and European agencies and had withdrawn from the World Health Organization altogether and was unwilling to engage with public health authorities in colonial Hong Kong. It fell to Hong Kong to sound the klaxon, albeit late, and so the virus was branded the ‘Hong Kong flu’.

When the virus and its nickname took off in the United States, Hong Kong protested. The New York Times reported in December that Hong Kong politicians were angry with references to the ‘Hong Kong flu’. Writing from inside Hong Kong, one reporter reminded his audience that

675 Chang, 349.
676 “Increasing Number of Deaths in Guangzhou Might Cause Plagues at Any Time: Frightened People Hoarding Medicine and Food,” Ming Bo, July 11, 1968.
677 “Outbreak of Asian Flu is Expected this Fall”, 95.
“[n]ewspapers here labeled it the “killer flu” after the first half-dozen deaths. They never called it “Hong Kong flu”\textsuperscript{678}. The \textit{New York Times} cited only the comments of ‘city councillor’ Huang Mong-hua who “denounced foreign newspapers and foreign health authorities for tagging it with the colony’s name”. Huang complained, “It is giving Hong Kong a bad name”\textsuperscript{679}. Another source elaborated, quoting Huang who asked, “Why isn’t it called the China flu? The authorities who deal with these things know perfectly well that it originated in China, not in Hong Kong”\textsuperscript{680}. Blakely cites this quote, disseminated widely through the Associated Press service, as evidence of the “tendency for health officials to want to name influenza epidemics with a name other than their own” and the significance of a strain name as a “negative rhetorical framing device”\textsuperscript{681}. In this case, the tension between Hong Kong and China exacerbated or intensified the significance of the strain’s name; there was a good deal more at stake here than reputation.

The fact is that while the flu was not ever called the ‘China flu’ as per Huang’s suggestion, it was many times associated with China in both the media and government discourse. The \textit{Cincinnati Enquirer} published Huang’s quote but absolved Hong Kong of being the source of the virus. The paper added that “Hong Kong papers had carried reports as early as last January of an influenza epidemic that had swept through parts of Red China. Hong Kong doctors say it originated in central Communist China and was brought to Hong Kong travellers in July”\textsuperscript{682}. The \textit{Enquirer} engaged the tension raised by Huang, hedging blame between Hong Kong and China in writing, “In Hong Kong where it did not all start, according to Hong Kong officials anyway, doctors said Saturday that the virus local newspapers call the “killer flu” had run its course”\textsuperscript{683}. On the same page, the \textit{Enquirer} published a tiny note on the availability of “Communist Chinese holiday cards” on sale in British Hong Kong, relaying a typical greeting: “[e]ven those with a firm foundation in Marxism and proletarian struggle must never cease trying to increase their knowledge”. Intentionally or inadvertently, the paper contrasted the colony from the mainland in

\textsuperscript{678} “The ‘Hong Kong Flu’ Began in Red China,” \textit{New York Times}, 15 December 1968, 44.
\textsuperscript{679} “The ‘Hong Kong Flu’ Began in Red China,” 44.
\textsuperscript{681} Blakely, 130.
\textsuperscript{683} “Hong Kong Flu Outlook: Worst Yet to Come,” 3.
one breath but treated the colony, perhaps in light of the riots of the year previous, with suspicion\textsuperscript{684}. Similarly, reports of Huang’s protest against the naming of the flu appeared in one paper at the foot of an article titled, “Red China Defense Hurting” discussing Zhou Enlai’s reports that China’s defence industry was in peril, a story filed by a reporter in Hong Kong\textsuperscript{685}. Just as Hong Kong was to act as a sentinel in infectious disease surveillance, so it might also announce imminent political peril.

None of the reports identified Huang in full. None of the Associated Press reports published his full name, Dr. Denny Mong-hua Huang, or identified him as a medical doctor who had significant experience in treating infectious diseases having completed a Tuberculosis Disease Diploma at the University of Wales, studied at the University of Edinburgh and practiced in Hong Kong’s medical system for fifteen years. None of the reports indicated this expertise, nor did they correctly identify Huang as a member of the Urban Council of Hong Kong, the body responsible for sanitation and hygiene in the colony, nor did they identify Huang as an experienced civil servant who had represented the Hong Kong Government at international medical and public health conferences\textsuperscript{686}. Though only mid-career at the time of the 1968 pandemic, Huang’s service to British Hong Kong won him the Order of the British Empire. The New York Times referred to Huang as a ‘city councillor’ but Hong Kong had no city council, suffrage still twenty years away for Chinese in the colony. While the editorial choices made in framing Huang’s intervention may have served to keep the report concise, they also stripped legitimacy from Huang’s protest. In failing to correctly acknowledge his position in governance and his expertise as a physician specializing in infectious diseases, the Associated Press undermined Huang’s critique of the stigma assigned to Hong Kong as well as the epidemiological finger he pointed at China. The erasure of Huang’s subjectivity continues in contemporary scholarship, curiously; in Blakely’s study of American media framing of the 1968 pandemic, she includes the following paragraph, contrasting naming practices in 1957 and 1968:

\begin{quote}
In naming the 1957 pandemic, the World Health Organization chose a direction (”Far East”) whereas the Surgeon General chose a specific continent (Asia). This could be due
\end{quote}

\textsuperscript{684} “Hong Kong Flu Outlook: Worst Yet to Come,” 3.

\textsuperscript{685} “Flu Name Protested”.

to the fact that during this time period racial blame was used in reference to Cold War mentalities. With the third pandemic, a scientific approach was taken to name the pandemic, but that classification was not used by The Times. Instead, “Hong Kong” was used to name the pandemic, despite objections from Asian officials. Blakely’s use of the term “Asian” to refer to Huang is curiously vague and anachronistic; surely his role in speaking for Hong Kong against conflation with communist China makes ‘Asian’ an unusual conflation for a contemporary author.

6.3.4 Further Conflation of Hong Kong and the PRC

In other cases the geographical proximity of Hong Kong and China was allowed to obscure their political and cultural difference and the two were sometimes conflated. A particularly confusing case appears in the British archives. A speaking note for ministers from the British Cabinet Papers filed in December of 1968 discusses the “Hongkong” or “Mao” Flu. The briefing is strikingly vague given the timing of its composition and circulation. Aside from hedging on which nickname with which to brand the virus or perhaps suggesting it should carry both Hong Kong and the PRC as references, the document indicates that the virus circulating is a variant of the 1957 virus but does not note the scientific nomenclature A2-Hong Kong-68. By the time this briefing was issued, the scientific nomenclature was in wide use elsewhere including in American and British media. The briefing reassures its readers that the variant is clinically similar to previous strains and its symptoms mild. The briefing also hedges on whether or not the flu would significantly impact Great Britain and discusses the quantity of vaccine needed to control the epidemic should it reach British shores. For a document with such a curious title, the contents are quite benign. Two logics are possible in explaining why “Hongkong” and “Mao” were paired in this way; either its British author chose intentionally to conflate Hong Kong and communist China after the lengthy and traumatic pro-communist riots in the colony the year before or the British Cabinet was pointing to the virus’ origin in China while maintaining the accepted framing of the virus as “made in Hong Kong”.

687 Blakely, 130.
688 CAB 151/105 Home information services, speaking briefs on: Hong Kong and Mao influenza.
The latter is not a particularly convincing option as the report contains no discussion at all of this question. The former is equally incredible; despite Britain’s ambivalence toward continuing colonial rule of Hong Kong, it is a stretch to imagine a Cabinet secretary conflating a British colony with its communist neighbour. Other sources were less equivocal; in November of 1968, an Associated Press reporter in Rome filed a story on reports of 200,000 cases of influenza in Rome. This story referred to the ‘Mao Tsetung’ flu, so-called because “[t]he influenza virus got its nickname because it is believed to have originated in China and to have spread through Asia toward Europe via Hong Kong”\textsuperscript{689}. An article summarizing the pandemic from the vantage point of late winter 1969 bore the title, “Hong Kong Flu: Story of the Close Race Between Man and the Virus” but identified China as the source of the strain, stating, “[i]t appeared in Hong Kong from Mainland China last summer and washed through the Far East in a silent, invisible wave”\textsuperscript{690}. These reports reflect the political veil of Cold War relations wrapped around the epidemic event.

6.3.5 ‘Mao Tse-tung’s Flu’ Traverses the Sino-Soviet Split

American intelligence sources present another narrative on the 1968 pandemic as it reached the Soviet Union. There, the connection between the global pandemic and southern China was interpreted as further evidence of Mao’s unreliability and the pandemic was used to further the distance between the titans of the communist world. While the PRC had relied on the Soviet Union for ideological and material support leading up to “liberation” in 1949 and through the industrialization and collectivization drives of the 1950s, the Great Leap Forward modelled on the Soviet “Third Period”, relations cooled significantly in the 1960s. Mao became mistrustful of the Soviets in the late 1950s while the Soviets began to doubt Mao as an ally, a symmetrical devolution of the relationship. Relations were formally severed in 1963. This mistrust extended to medical matters. An epidemic of meningitis swept through China in 1966-67, its spread facilitated by the masses of Red Guards travelling by railway, wreaking social havoc along the way.


The spread of meningitis had been tracked by the American Central Intelligence Agency’s Office of Scientific Intelligence which had been able to predict the course of the epidemic. The State Department sought to take advantage of this opportunity to “reduce tensions” between the United States and the P.R.C. by rescinding the American ban on the export of drugs and medical supplies, notably making available a supply of sulfadiazine, an effective treatment for meningitis. A formal offer of assistance was allegedly extended by the State Department but ignored by the PRC which instead solicited access to sulfadiazine from “Western European and Asian pharmaceutical companies”. As a result, at least several hundred metric tonnes of pharmaceutical materials were transferred to China, enough to protect about 100 million persons. Poor management and political inflammation resulting of the meningitis epidemic further undermined Soviet confidence in Mao’s leadership, and on July 1, 1967, the Soviet Ministry of Health rescinded an agreement on mutual abolition of vaccination requirements for travellers between the U.S.S.R. and the P.R.C. dating back to May 28, 1960.

Influenza A2-Hong Kong-68 arrived in the Soviet Union in February of 1969 according to American intelligence. The Soviet Union had joined the WHO in 1948 but, like the PRC, withdrew the next year. Citing improvement in the WHO’s ‘useful work’, the Soviet Union rejoined the WHO in 1955-56 after the death of Stalin. Given their renewed membership in the WHO, many expected that the Soviet Union would contribute reports on its efforts at manufacturing and distributing a vaccine for new strain. Instead, the Soviets continued to inoculate citizens with a “standard A2” vaccine that would prove ineffective against the pandemic strain. The CIA reported later that this was a gamble on the part of the Soviet leadership which had to acknowledge that it would be unable to produce a new vaccine in time to stop an epidemic. Using the older vaccine was a prayer for partial protection. Cases of the flu first appeared in the middle of December 1968 in Moscow, then in Frunze and Dyushambe,

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692 Carey and Maxfield, 72.
695 Carey and Maxfield, 72.
moving into Central Asia and “Transcaucasia”, and moving then toward Moscow, Leningrad and Tallin. The outbreak spread to the Baltic region, Byelorussia, Ukraine and Moldavia by way of the main railway in February\textsuperscript{696}. Data on the epidemic was collected in eight cities representing different geographical zones and was sent daily to the Regional Influenza Centre. Public health education campaigns on television and in local papers were launched and “flu stations” dispensing cold remedies were set up on street corners, but these measures did little to stop the spread of the virus\textsuperscript{697}. Altogether, one quarter of Moscow’s population was infected, a figure that is assumed to be representative of most other areas\textsuperscript{698}. The epidemic was very costly to the Soviet Union, claim American sources. There were disruptions to military training and industrial production and want medical care and sick benefits, a total of several billion rubles in direct and indirect costs. The Soviets blamed China, calling the pandemic “Mao’s flu”\textsuperscript{699}.

6.4 Conclusion

Despite these controversies over how the virus should be known, scientific papers on the virology and epidemiology of this pandemic referred to the ‘Hong Kong flu’ for years to follow. The characterization of H3N2’s 1968 patterns as ‘smoldering’ can also be applied to the geopolitical moment in which the pandemic emerged and to the relationship between the colonial government and the Chinese community of Hong Kong at the appearance of the outbreak.

In Hong Kong, the epidemic of 1968 was filtered through the lens of experience, understood in reference to the epidemic of 1957. In the decade passed, however, the political culture of the colony had shifted and even an outbreak with clinical signs as mild as the H3N2 virus threatened to send Hong Kong into crisis, the escalation of simmering tensions between Hong Kong people


\textsuperscript{697} The report from Soviet scientists at the D. I. Ivanovskij Institute of Virology in Moscow to the WHO suggests that “prophylactic and anti-epidemic measures performed by public health services exerted some influence on the course of the epidemic and indubitably resulted in a reduction of the sharp rise of the epidemic, in a decrease of fatal cases, and thus in the absence of large epidemic foci”. Given that the rates of infection and fatality are relatively close to those in other countries, including to those in Hong Kong where the epidemic was treated only once it began, the conclusions of the Soviet scientists seem dubious. US intelligence estimated that the epidemic in the USSR caused “…five to six times as much illness as the total of all other infections”. See Ždanov and Antonova and Carey and Maxfield.

\textsuperscript{698} Carey and Maxfield, 74.

\textsuperscript{699} Carey and Maxfield, 76.
and gangying, an increasingly troubled political construct. In 1962, the government had made its first commitment to extending healthcare to all permanent residents of the colony. The government declared, “the policy of government is to provide, directly or indirectly, low cost or free medical and personal health services to that large section of the community which is unable to seek medical attention from other sources”\(^\text{700}\). This was particularly significant in that it included the Chinese refugees who were least able to pay for their own medical needs and presented the greatest risks to public health in the view of the government. In committing to supporting the weakest in the colony, it might have seemed as though the government had broken its rigorous adherence to the principle of leaving the Chinese community to its own business.

Perhaps as expected, the limits of this commitment were quickly reached. The documentation supporting this commitment does not articulate plans for direct or indirect service provisioning, does not define ‘low-cost’, and does not indicate thresholds for proof of need. A white paper released in 1964 suggested that half of Hong Kong’s population could not accord to visit private practitioners and 80% of the population could not afford private hospitals, indications that the responsibility of the government to create public options would weigh heavily\(^\text{701}\). Interpreting these steps as evidence of a shift toward a welfare state in Hong Kong would be an error. The government’s concern was rather to protect its labour force, integral in the colony’s new industrial economy. Despite these limitations to the care the government would offer, and despite the lack of concrete expansions to medicine in the colony, Hong Kong people met the 1968 epidemic with different expectations. Whereas in 1957 the large refugee population had not yet naturalized, in 1968 most of the Hong Kong Chinese had been born there or lived decades of their lives in the colony. While the Chinese who experienced the bubonic plague epidemic in Taipingshan in 1894 feared sanitary inspectors and physicians, Hong Kong Chinese in the 1960s were medically savvy, mixing elements of Western and Chinese medical principles in their understanding of disease and using combinations of Western and traditional medicine in their personal care. It would be an exaggeration to depict the Hong Kong Chinese who experienced the influenza epidemic of 1968 as Westernized or de-Sinicized but the sense of heunggongyahn


\(^{701}\) Development of Medical Services in Hong Kong, 19.
as distinct from Chinese was every clearer, reinforced by the Cultural Revolution in progress just as Hong Kong began its economic miracle. Local people expected an effective response from the modern, liberal government in times of crisis.

Beyond Hong Kong, the 1968 pandemic reaffirmed the importance of global infectious disease surveillance and the role that Hong Kong might play in surveilling the region as a proxy for China. This pandemic showed investigators that surveillance networks needed more than to be comprehensive or geographically representative. In 1968, Hong Kong could only offer a piecemeal view of the local epidemic because of the limited coordination of its local monitoring network. When Hong Kong, through Dr. Chang, did report to the WIC and WHO, epidemiologists were slow to realize the emergence of a novel strain for which no vaccines were prepared or to predict the unusual diffusion patterns that would be manifest around the world. In this episode, Hong Kong’s epidemiological and public health systems underperformed, contributing to a lingering impression of the colony as an infected, infectious space.

Perhaps the narratives would have been spun differently had Hong Kong responded effectively to the regional outbreak. But as it was, Hong Kong failed to meet the expectations of the international monitoring services and Cold War players that the colony could serve as a proxy for China in infectious disease control. If Hong Kong had responded effectively to the appearance of epidemic disease, observers might have stressed the differences between colonial Hong Kong and its Chinese people and the PRC and “red” Chinese. After all, what power did “Hong Kong” really have as an epithet? With more than one hundred years of colonial rule, the public, the bureaucrats and foreign correspondents who composed the documents on the “Hong Kong and Mao flu” or the “Mao Tsetung flu” understood the differences between liberal, laissez-faire life in Hong Kong, by this time a rising industrial power and nascent financial centre, and the People’s Republic, in the thick of the Cultural Revolution. Instead, British, American and Soviet government addressed Hong Kong and China in the same breath, sometimes conflating these disparate political, social and cultural entities and projecting their racial and ideological anxieties onto the H3N2 virus, itself apolitical and opportunistic. The effects of the century’s third influenza pandemic were relatively mild but disease-watchers looked at Hong Kong with anxiety through the decades to follow. An outbreak of avian influenza in human populations originating in Hong Kong in 1997 reinforced associations between the city and the virus. 1997’s outbreak—the first where transmission directly from an avian host to a
human was confirmed—did not spread internationally. It did, however, escalate the
government’s efforts at becoming responsive, effective, and efficient in fighting infectious
disease. This task would require massive government investments but also the incorporation of
Hong Kong people into a renovated vigilant, sanitary social body.
Chapter 7
Severe Atypical Respiratory Syndrome, 2003: S/CARS

7 Novel Epidemic, Established Identities

In the spring of 2003, a novel infection spread from China through Hong Kong and then throughout the world. Once again, Hong Kong was the main stage of an international medical drama, acting as the portal through which a new menace passed as it turned pandemic. Locally, the outbreak reanimated deeply entrenched anxieties borne of past experience, recalling Hong Kong’s past epidemics and calling Hong Kong’s modernities—political, economic, and medical—into question. The expansion of public health and medical services in through the 1980s and 1990s accomplished a great deal in making the colony safer. Indeed, by 2000 Hong Kong was ranked 26th in the world in the Human Development Index with a HDI value approaching 0.9 and a life expectancy of 78.6\textsuperscript{702}. The transition back to Chinese sovereignty in 1997 had unfolded with much fanfare and little evidence of public resistance, local markets slowly recovering as political anxieties resolved. By 2003, it was business more or less as usual in Hong Kong. But when a particularly virulent influenza appeared, some wondered if perhaps the colony-cum-Special Administrative Region had become complacent toward its oldest threat, infectious disease.

There had been warnings that another epidemic, ‘something big’, would eventually come. The five-day weekend to celebrate the handover, with endless fireworks and speeches on July 1 helped to distract the public at home and abroad from lingering worry over a new strain of influenza that had surfaced in the late spring. In May, Lam Hoi-ka, a three-year old boy had died in Queen Elizabeth Hospital of acute respiratory, liver and kidney failure and ‘disseminated intravascular coagulopathy’ meaning essentially that the boy’s blood had curdled. A weeks-long inquiry involving virologists in Asia, Europe and the United States determined that the boy had died of an H5N1 influenza infection, an astonishing and terrifying proposition. To this point, the highly virulent influenza A H5-subtype had been limited to avian populations but virologists at the National Influenza Centre at Rotterdam and the Centre for Disease Control in Atlanta

confirmed that all eight genetic segments of the samples taken from Lam Hoi-ka’s windpipe were avian. This meant that the disease had spread directly from birds to humans, the first confirmation of this kind in epidemiological history and a discovery that signaled dark prospects. What was worse, the boy seemed to have had only very limited contact with poultry and birds; he had had contact only with the pet ducklings in his nursery school. After a cull of 1,600,000 birds was completed, the spread of the virus through Hong Kong slowed and fatalities totalled 18. Still, experts were ill at ease. Hong Kong’s public health and medical systems had contained what could have become the worst influenza pandemic in history this time but it had taken international cooperation and all available resources. No one could not be sure of what would happen the next time.

When SARS appeared in Hong Kong in 2003, it was in this frame: not only was Hong Kong’s safety imperilled but Hong Kong’s position at the crossroads of global markets promised global consequences should the local health care system fail to limit the spread of any epidemic; the pattern that saw the bubonic plague and influenza disseminated worldwide from Hong Kong in the mid-twentieth century would be amplified and accelerated exponentially in the globalized twenty-first century. What was more, the reunification of Hong Kong and China complicated matters; the passage between Guangdong province and Hong Kong had always sustained the development of the region’s population and economy. It had also been a kind of infectious disease superhighway, dubbed “China’s Petri Dish to the World” by Hong Kong politician Christine Loh in the aftermath of the SARS outbreak703. Stopping whatever might come would require cooperation between Chinese and Hong Kong public health and medical systems, a test of the reintegration of Hong Kong and China and, in particular, of the Pearl River Delta region beyond political rhetoric or economic development.

7.1 One Body, Two Systems

7.1.1 Creating a Pearl River Delta Identity

The terms of the resumption of sovereignty in 1997 promised the integration of Hong Kong into contemporary China while protecting Hong Kong's economic and political systems in an oblique

703 Christine Loh, Veronica Galbraith and William Chiu, “The Media and SARS,” in At the epicentre: Hong Kong and the SARS Outbreak, edited by Christine Loh (Hong Kong: Hong Kong University Press, 2004), 198.
strategy dubbed “one country, two systems”. Deng Xiaoping proposed this as a constitutional principle to British Prime Minister Margaret Thatcher in 1984 as the two countries stared down the imminent end of the 100-years lease of the New Territories. Deng proposed in Chapter 1, Article 5 of the *Hong Kong Basic Law* that after the reunification, socialism would not be imposed in Hong Kong and that “the previous capitalist system and way of life [would] remain unchanged for 50 years”\(^{704}\). Speculation on how these terms would be interpreted and put into practice was rampant, particularly where it concerned defining the Hong Kong “way of life”\(^{705}\). For some, losing political autonomy was the greatest fear, for others losing entrepreneurial agency, for still others the sense of localism, the Hong Kong identity. Observing the Tiananmen massacre eight years earlier fuelled “the terror of ’97”\(^{706}\).

The promise of mutually getting richer went a long ways in mitigating doubt and in distracting from any tensions between Hong Kong people and their Chinese neighbours. Deng, as the architect of China’s liberalization process, had identified Shenzhen, close enough as to be visible from Hong Kong’s New Territories, as one of the so-called Special Economic Zones (SEZ) in 1980. The very purpose of the SEZs was to entice foreign investment to China, and several—Shantou, Xiamen, and Shenzhen—were selected because of their historical legacies as treaty ports\(^{707}\). The SEZs, incubators for free market practices while China contemplated its eventual transition from a planned economy, were generally successful. They attracted a great deal of foreign investment to southern China, encouraging foreign investors who were suspicious of sinking funds in the PRC well into the 1990s. The success of the SEZs also helped China prepare for the imminent reintegration of Hong Kong, one of the world’s largest and freest markets.


\(^{705}\) Bangguo Wu, *The Basic Law and Hong Kong - The 15th Anniversary of Reunification with the Motherland.* ed. Wai-Chu Maria Tam (Hong Kong: Working Group on Overseas Community of the Basic Law Promotion Steering Committee, 2012), 92.

\(^{706}\) **jiuqi kongbu, 九龙恐怖**

\(^{707}\) Shenzhen had not itself been a treaty port, being just a tiny village until it was developed in the 1980s. It was chosen as a hologram of Hong Kong, just across the border, a place that could be made to mirror what was useful in Hong Kong history and that could perhaps siphon away what was successful in contemporary Hong Kong.
During the early years of the SEZs, politicians, economists, and entrepreneurs schemed on creating “ShenKong”, the “economic and spatial compression” of the region. Profitable businesses born of the SEZs and savvy investors from Hong Kong found mutual aspirations. These opportunities developed into the discourse of “delta-fication”, a process of deterritorialization and reterritorialization of the market, culture, and social structures across the Pearl River Delta (PRD) that would draw the cities and citizens closer. Planners hoped the concentration of the SEZs in the Pearl River Delta region would have another particular utility: as free market incubators the hope was that the SEZs would potentiate social and cultural integration as business cooperation between Hong Kong investors and Chinese producers flourished. Time, law, and money would connect Hong Kong, Shenzhen, and as many as ten other cities practically and conceptually. Normalization of cross-border exchange, and implied integration of markets, is described by Erni as a shift “...from a paradigm of contrasts to a codified system of bi-directional interdependency”. Cultivated interdependence sustained time, far less than the fifty years of “one country, two systems”, would surely smooth whatever differences the one hundred and fifty-six years of colonial rule had created.

7.1.2 Closing the Metaphorical Distance

Hong Kong’s early colonists may have been underwhelmed by Britain’s Chinese concession but it did have the deep harbour and proximity to Canton, the centre of the China trade. The bubonic plague epidemic of 1894 demonstrated to Hong Kong’s colonial government, however, that the natural and disease environments of Canton and Hong Kong were as closely connected as their markets. In 1938, the governor of Canton, Wu Tiecheng, evoked a Chinese idiom, chungchi xiang yi, to describe the relationship between Canton and Hong Kong. This four character expression evokes mutual dependence, the closeness of lips and teeth. Wu elaborated on the metaphor, stating, “It is as if Hong Kong were a person’s mouth, Canton his throat, and

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710 Erni, 45.
Guangdong his body”711. As Chan observes, “to many Chinese residents in Hong Kong...’China’ meant Guangdong while homeland referred to the ancestral villages in the Pearl River Delta”712. Another popular idiom, Xianggang yijia, suggesting a familial relationship throughout the region, recognizes the intrinsic connection of the two spaces713. The closeness of the relationship between Hong Kong and Guangzhou or Guangdong is not felt through all of China or necessarily associated with “Chineseness”, as Allen Chun notes emphatically714. As Nolde writes, the conceptual and practical distance between northern and southern China implied a civilizational hierarchy that strengthened ethnic and local ties: “The northerner may still hold the southerner, especially the Cantonese, in some contempt, and the Cantonese still speak of people from other provinces as wai sheng jen, “outside province people”715.

Nearly a century after Wu Tiecheng’s deployed the metaphor, chungchi xiang yi began to appear in public discourse supporting the return of Hong Kong to Chinese sovereignty, a counter-argument against the many who felt that Hong Kong had been too much changed, had become too Western or too much its own entity after its long colonial occupation716. In particular, Chief Executive Tung Chee Hwa used this phrase to signal his assent to the reunification; “Hong Kong is not only economically interdependent with the mainland like lips and teeth”, he said, “but also shares the same heritage and culture with the mainland compatriots...I hope Hong Kong citizens understand the treasure of this relationship”717. Tung is quoted in Wen Wei Po as having used the metaphor at least one other time, saying, “[t]he relationship between Hong Kong and Guangdong is like that of lips and teeth. I believe in the future there will be cooperation in many economic

713 香港一家
716 From this point, Canton will be referred to in the contemporary transliteration, Guangzhou.
717 “Stepping toward the Month of Returning”, Renmin Ribao, 2 June 1997
fields, especially in infrastructure.  Central Party leaders deploying an even stronger body metaphor to diminish the significance of Hong Kong’s long separation from China, suggesting that Hong Kong and China were one body: flesh and blood. At the handover festivities, President Jiang Zemin denied the colonial amputation and minimised any social surgery that would follow the resumption of political sovereignty. “Notwithstanding the prolonged separation”, he said, “the flesh-and-blood bond between the people on the mainland and Hong Kong compatriots had never been severed.” The political and legal surgery of reconnecting Hong Kong to the PRC may have proceeded relatively smoothly but reconnecting heunggongyahn to the Chinese social body proved more a subtler task.

7.1.3 Densification of the PRD, Intensification of Disease Risk

Projections of ‘delta-lication’ almost always assumed positive outcomes. There would be economic development and growth, closer associations between China’s nascent entrepreneurs with their cosmopolitan Hong Kong colleagues, and pacification of some of the social and cultural friction between the two societies. One unanticipated and undesirable consequence of the densification of the region and the intensification of traffic between Hong Kong and other nearby cities was the accelerated spread of infectious diseases and the demand for integrated responses between affected territories.

 Unexpectedly, Hong Kong was the origin of the 1997 outbreak, not China; outbreaks of H5N1 influenza were observed on poultry farms in the New Territories before Lam Hoi-ka fell ill but there had been no reports of human or avian outbreaks in China at that time. By December of 1997, avian influenza A/Chicken/Hong Kong/258/97 (H5N1) infected eighteen and killed six in Hong Kong. This outbreak was curbed only by a forced cull of every chicken in the territory

718 Chee Hwa Tung quoted in Wen Wei Po, 3 July 1997.
719 Zemin Jiang, “Speech at the ceremony marking the establishment of the Hong Kong Special Administrative Region of the People's Republic of China,” transcribed in Renmin Ribao, 2 July 1997.
on December 29\textsuperscript{722}. In a morbid parallel to the way that civilian volunteers became erstwhile sanitary inspectors whose duties including removal of sick and deceased plague victims from Chinese homes, the chicken cull required that Hong Kong government employees leave their desks to become avian executioners\textsuperscript{723}. This outbreak was the first time that scientists were able to confirm that an influenza virus had crossed the species barrier, proving animal-to-human transmission. This came as a surprise to virologists who had only previously observed human infections with influenza strains H1, H2, and H3\textsuperscript{724}. This H5N1 outbreak was caused by an avian-to-avian reassortment that was unique in three ways: the confirmed transmission to humans, transmission from domestic to wild fowl such as egrets, and the rapidity of the virological reassortment\textsuperscript{725}. One Hong Kong scientist alluded to the extraordinary character of the situation, describing the virus as “like an alien”, one thousand times more infectious than typical human strains\textsuperscript{726}.

While epidemiologists worldwide mobilized to understand the new influenza strain and the terrifying possibilities of direct transmission between avians and humans, Hong Kong administrators faced another concern. Densely populated both by humans and animals, endemic diseases frequently become epidemic in this cradle of the “Sick Man of Asia”. While it was not widely acknowledged before the avian flu outbreak of 1997, epidemiologists and virologists quickly came to see that the zoonotic factors that founded the influenza epidemics of 1957 and 1968 virtually assured future outbreaks in the PRD. One key was widespread husbandry of poultry in southern China, dramatically increased from the Qing dynasty onward. Whereas ducks

\textsuperscript{722} Lawrence K. Altman, “Her Job: helping save the world from bird flu,” \textit{New York Times}, 9 August 2005. The cull was ordered by Hong Kong’s health minister, Dr. Margaret Chan. As she moved on to international prominence as the Director-General of the World Health Organization in 2006, Chan’s decision to cull chickens was the focus of many of the articles published at the time of her on her nomination. Her expertise or the rationale she used in ordering this cull were rarely discussed but the media seemed astonished by the decisions Chan made in times of crisis.

\textsuperscript{723} R. Ajello and C. Shepherd, “The Flu Fighters: how the people on the frontlines battled H5N1 to a stalemate. Not that the war is over,” \textit{AsiaWeek}, 30 January 1998.


were traditionally raised along rivers and tributaries, from the eighteenth century on they were brought to graze and live instead on rice paddies, significantly increasing the contact of humans with avian diseases. This relationship between humans and ducks, claimed one microbiologist, was the principle reservoir of avian influenza in Asia. With wild waterfowl, the world’s largest population and massive poultry and meat industries, another infectious disease specialist was quoted as saying, “I believe China has the most incredible reassortment laboratory for influenza viruses that anyone could ever imagine,” a dangerous honour. Along with its markets, the delta-ification promised the thorough integration of the PRD’s disease ecology and risk factors. The PRD was “China’s Petri dish to the world.”

In 1997, though, a reprieve; with Dr. Margaret Chan’s aggressive action, the total cull of Hong Kong’s chickens, the spread of this outbreak stopped. Losses were mitigated. Concern over public health risks in China, particularly the unregulated sale of live fowl and minimal standard for the means by which infected bird carcasses were disposed of, was unresolved. A few years later, the respected journal Nature stated Hong Kong’s vulnerability plainly in a way that politicians and administrators could not, writing, “[m]ost of Hong Kong’s chickens come from mainland China, which raises the political sensitive question—on which no-one nature interviewed would comment—of whether inadequacies in China’s export regulation are allowing the virus into the territory.” Post-handover, as mainland suppliers of fowl grew to dominate Hong Kong’s local wet markets, the city’s disease ecology was richer and more dangerous than ever. This economic domination distracts from a full view of the reciprocal and mutual quality of the PRD densification. Shih Shu Mei coined the phrase ‘northbound imaginary’ in theorizing the resumption of sovereignty very differently. While Hong Kong, Britain and the Western world fussed over protecting of liberal values in Hong Kong for fifty years, reintegration put China at

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728 Shortridge, Peiris, and Guan, 71.


730 Alexandra Seno and Alejandro Reyes, “Unmasking SARS: Voices from the Epicentre” in At the epicentre: Hong Kong and the SARS Outbreak, edited by Christine Loh (Hong Kong: Hong Kong University Press, 2004), 7.

risk of ‘northbound colonialism’. Taking colonial Hong Kong back into China meant absorbing its great imperialist humiliation and one of the world’s more voracious free markets. The spatial manifestation of this northbound current was densification of the PRD disease ecology; whatever conceptual or biological threat might enter Hong Kong through the free market or the free port would surely reach the PRC. Anxiety toward Hong Kong as an agent of cultural imperialism—intoxicating Chinese with violence and sexuality through Hong Kong’s famous cinema or seducing Chinese with promises of wealth—had faded by 1997. If anything, all but the Party’s hard left saw Hong Kong as mentoring the rest of China through economic transition. But as always, pathogens and epidemics defy political intent and create their own spatial logics. H5N1 drawn into China through the conduits of ‘northbound colonialism’ was an incredible near-miss.

7.2 An Atypical Epidemic

7.2.1 Feidian in the PRC

*Feidian*, atypical pneumonia, was first reported on November 16 of 2002. The first case was observed in Foshan, a city in Guangzhous province. It next cropped up in Heyuan and eventually in Guangdong by January of 2003. Local authorities were puzzled by these early cases. While pneumonia most often appears in the elderly or immunocompromised patients, this version sickened young, strong patients. One nurse described the index case who was treated in a Guangzhou hospital, a strong 36-year old cook from Heyuan:

> He looked to be in extreme suffering, manic and with a high fever. He vomited and spat all night. All the people in the emergency room were busy taking care of his case...We were already confused that first night. The patient was a strong man in his 30s. Why were all the drugs useless in bringing down the fever?732

In January, Guangdong physicians reported the cases to a local Centre for Disease Control which notified the Provincial Health Bureau. The report was labelled ‘top secret’ which meant an official with adequate clearance was needed to open the document. No one qualified was available for three days. This agency notified Beijing’s Ministry of Health just ahead of the Lunar New Year but at the same moment, everyone was preparing for a week-long celebration

and vacation from work. Because pneumonia is not a notifiable disease, no response came from Beijing. No special measures were put in place for monitoring or study of the outbreak. Feidian did not stop to celebrate the New Year, and continued to spread. Accordingly, rumours circulated by SMS throughout Guangzhou from February 8 onward, speculating on a new form of influenza or even anthrax733.

7.2.2 SARS Enters Hong Kong through “The Metropole”

News of the epidemic broke in Hong Kong on February 10, the same day as in Guangdong734. Newspapers in Hong Kong described scenes of panic as Chinese across the border tried to buy antibiotics including roxithryomycin, face masks, herbal medicines, and white vinegar to use as a sterilizing agent735. The effect of these reports set off a well-conditioned response in the Hong Kong public. As had been seen in the 1957 and 1968 influenza outbreaks, Hong Kong people mobilized in their own defence. Normally robust consumer markets in Hong Kong felt the impact of the panic, failing to meet demand for preventative goods, overloaded by increased demand from mainland Chinese who asked their relatives in Hong Kong to purchase and send supplies736. All of these measures empowered people in different ways. Vinegar was mundane and made the threat seem manageable even as prices rose to over 200-300 yuan737. Antibiotics, even untested or ineffective against atypical pneumonia, conveyed a kind of medical shaktipat, the promise of strong medicine. From a Chinese medical perspective, the epidemic was understood as wenbing, a disease construct discussed in the traditions foundational text, the Huangdi Neijing. The traditional remedy banlangen, root of genus isatis, was an especially

733 Yanzhong Huang, “Implications of SARS Epidemic for China’s Public Health Infrastructure and Political System,” Paper as Testimony before the Congressional-Executive Commission on China, Roundtable on SARS (2003), 3 (no printed pagination).
734 South China Morning Post, 11 February 2003.
735 Huifeng He, “When Sars first spread, Guangzhou residents sought out vinegar,” South China Morning Post, 22 February 2013.
737 “When Sars first spread, Guangzhou residents sought out vinegar”.
popular remedy for “warm diseases”\textsuperscript{738}. In making the unknowable seem familiar, traditional herbal preparations calmed the recipients of the inflammatory texts and emails.

While the public on both sides of the borderer subject to a constant flow of chatter on the epidemic through both private communication and the media, information did not flow freely between official parties. Hong Kong’s Department of Health first learned of the outbreak through the same media reports as its population. The Department of Health reached out to their colleagues in the Municipal Health and Antiepidemic Station and to the Director General of the Department of Health in Guangdong, but telephone calls and inquiries by fax went unanswered. Hong Kong’s Director of Health then tried to communicate with the Ministry of Health in Beijing\textsuperscript{739}. Late on February 11, news of the outbreak, with 305 reported cases and five deaths, was disclosed to the public and to Hong Kong medical authorities\textsuperscript{740}. The WHO was notified after Hong Kong’s Global Outbreak and Alert Response Network (GOARN) and Global Public Health Intelligence Network (GPHIN) made inquiries, having received no response from Beijing\textsuperscript{741}.

Anxiety over the spread of ‘atypical pneumonia’ had not stopped a physician from Guangzhou from celebrating the Lunar New Year or from attending the wedding of his nephew in Hong Kong. Dr. LL felt unwell through the middle of February, treating himself at one point with a round of antibiotics, but rallied and did not suspect he had caught the atypical pneumonia\textsuperscript{742}. On February 21, he travelled with his wife and a friend from Guangzhou to Hong Kong and checked into room 911 at the Metropole Hotel on Waterloo Street in Kowloon. The trio spent the afternoon shopping in the Tsim Sha Tsui district. Dr. LL felt weak but chalked it up to the stress

\textsuperscript{738} Marta Hanson explores the significance of coding SARS as \textit{wenbing}, from its association with southern China, historical provenance of \textit{wenbing} illnesses and the Warm Disease school of diagnosis, to the remedies used to treat SARS. See in particular pages 163-169.

\textsuperscript{739} SARS Expert Committee, “Chapter 3: The Prelude: Events before the SARS Epidemic” in \textit{Report of the SARS Expert Committee Hong Kong: from experience to action}, (Hong Kong: online, 2003), 13. Hereafter referred to as the \textit{Report of the SARS Expert Committee}, or the \textit{Report}.

\textsuperscript{740} Huang, 2.


\textsuperscript{742} Thomas Abraham, \textit{Twenty-first Century Plague: the story of SARS} (Baltimore: Johns Hopkins University Press, 2007), 55.
of the last few weeks and want of a good night’s rest. In the morning his condition was worse, bad enough that he could not attend the wedding. Instead, he walked for five minutes through the commercial maze along Waterloo Road to the Kwong Wah Hospital where he announced to hospital staff, “[l]ock me up. Don’t touch me. I have contracted a very virulent disease”\textsuperscript{743}. Shortly after his admission to hospital, Dr. LL’s sister and brother-in-law, Hong Kong residents, were also hospitalized with symptoms of atypical pneumonia.

Dr. LL lived just over a week in the Kwong Wah Hospital before succumbing on March 4. In this time, he caused the rapacious spread of the infection through the territory’s medical system. The infection passed to nine other people staying on the ninth floor of the Metropole Hotel and to seventy medical staff and seventeen medical students practicing at the Kwong Wah Hospital. He is accordingly the index case for infections in Hong Kong. The guests of the Metropole Hotel were exposed to the SARS virus perhaps when Dr. LL sneezed or coughed in the lift. These guests, exposed to the pathogen, transformed the local epidemic into a pandemic, spreading the virus across the globe. They left Hong Kong before symptoms set in, carrying the pathogen onwards to Vietnam, Singapore, and Canada and creating new clusters of infection. There were, however, no infections in the Kwong Wah Hospital, perhaps a testament to Dr. LL’s warnings when he was admitted and to attending physician Dr. Chi-leung Watt’s prescience in imposing isolation of the patient and the use of top-level precautionary measures among healthcare workers.

7.2.3 Spread through Hong Kong’s Medical System

In Hong Kong, atypical pneumonia was acknowledged as an epidemic on March 10 when seven doctors and four nurses from 8A of the Prince of Wales Hospital fell ill and became absentee from work at the same time\textsuperscript{744}. A 27 year-old man who had visited the Metropole Hotel during Dr. LL’s stay was thought to have seeded this outbreak\textsuperscript{745}. The ward was closed immediately,


and word of the outbreak and closure appeared in Hong Kong news the next day. A group of clinicians, the Prince of Wales’ infection control team, management, and a community physician from the New Territories East Regional Office met that day. Though infections among healthcare workers rose to fourteen, no patients were infected. Further admissions to the ward stopped. A policy requiring that visitors wear surgical masks, disposable gloves, and gowns was put into effect. All infected staff were examined by representatives of the Department of Health. The New Territories East Regional Office set out to conduct an epidemiological investigation by survey, querying clinical, travel, and exposure history as well as contacts in the infected ward. The goal was to determine the case definition and incubation period of the still-unknown infection. Within the day, three cardiothoracic surgeons who had been in Ward 8A the week before had fallen ill. The team conducting the epidemiological investigation began to see patterns in the symptoms of the infection but struggled to maintain contact with the growing population of sick healthcare workers, fifty by the end of the second day of the outbreak at the Prince of Wales. The etiology of the infection remained unknown.

Hong Kong’s Department of Health and Hospital Authority worked together, building a team to investigate the hospital break out and to renovate hospitals spaces with the hope of mitigating risk and containing exposure. Those suspected to have been exposed to atypical pneumonia were assigned to cohort wards and were cared for by a “dirty team”. Patients with no suspected exposure and no symptoms were cared for by “clean teams”. The teams worked in isolation, with no crossover, with the hope of avoiding any cross-contamination between the wards, staff, implements and patients. On Wednesday March 12, a Disease Control Centre was established to act as a clearinghouse for all data on the outbreak. This Centre would consider all incoming data and attempt to convey the full picture of things to the Department of Health. Its initial observations were that the incubation period of the infection was between one and seven days and that it was likely spread through droplets and contact with materials contaminated with bodily fluids. These insights, together with the clinical observations of fever and chills, formed

an initial case definition. From that point, surveillance could begin. The same day, the WHO
issued an alert on the “global” spread of pneumonia. The WHO noted cases of a “mysterious”
respiratory illness that had infected more than fifty hospital staff in Hong Kong, twenty
healthcare workers in Vietnam, and that had caused the death of an American businessman who
had stayed at the Metropole before travelling to Hanoi.\footnote{WHO Media Centre, “WHO Issues a Global Alert about Cases of Atypical Pneumonia,” WHO, 12 March 2003.}

The New Territories East Regional Office established another team including a medical officer
and two nurses who began the project of interviewing patients of Ward 8A. This team hoped to
discern connections that would reveal the source of the outbreak and to anticipate the way
infections might spread from those who had had direct or indirect contact with Ward 8A. A
“cluster meeting on atypical pneumonia” convened twice a day. Non-emergency surgeries were
cancelled as were day services and outpatient clinics. Emergency cases that were not pneumonia,
and therefore not for the “dirty wards,” were diverted to Alice Ho Miu Ling Nethersole Hospital
or North District Hospital.\footnote{SARS Expert Committee, “Chapter 3: The Epidemic”, 27.} That day, Thursday March 13, the international infectious disease
community became involved in surveillance at the Prince of Wales. A representative from the
Centers for Disease Control and Prevention at Atlanta, representing the WHO, Hong Kong’s
Secretary for Health, Welfare and Food, Hong Kong’s Director of Health, and the Hospital
Authority’s Chief Executive met to assess the situation. Local authorities impressed on the CDC
and WHO representatives that local efforts at managing the emerging crisis should be considered
successful to that point. The Hong Kong representatives presented the data they had collected
and stressed that the outbreak was limited to the one hospital, even to the one infected ward, with
no cases appearing in the community. The meeting concluded with a commitment to continue
cooperation between the various limbs of administration and surveillance within Hong Kong and
that all parties would share specimen for study.\footnote{SARS Expert Committee, “Chapter 3: The Epidemic”, 28.} The meeting furthermore stressed the need to
exchange information freely not just between Hong Kong and the WHO and CDC, but to insist
on China’s cooperation. Furthermore, surveillance and information sharing would not be limited
to government bodies alone but would include researchers at the University of Hong Kong and the Chinese University of Hong Kong\textsuperscript{753}.

The Hong Kong press was first briefed on the outbreak on the afternoon of Friday, March 14. The Secretary for Health, Welfare and Food spoke for the investigative taskforce, stressing that an outbreak of pneumonia was in and of itself not exceptional in Hong Kong. There were, he reported, 1,500 to 2,000 cases a month. In half of all cases, the causative bacteria was identified while in the other half, it remained unknown. The current outbreak had attracted attention because it had spread so rampantly among healthcare workers at the Prince of Wales, to a handful also at the Pamela Youde Nethersole Eastern Hospital by this time and to some of those who had cared for an American businessman in Hanoi. At this time, the transmission pattern strongly favoured healthcare workers. There was no evidence yet of an outbreak in the community and so no cause for panic. The spokesperson said that the cause of interest, or concern, was that healthcare workers and their close contacts seemed to be particularly predisposed. The taskforce committed to daily press briefings, to “openness and transparency” in managing the outbreak\textsuperscript{754}. Later that day, investigators confirmed the index case at the Prince of Wales Hospital, an inpatient of Ward 8A. The hospital then ceased all admissions.

Despite the reassurances offered by the local taskforce to local residents, the WHO issued an advisory regarding travel to Hong Kong on Saturday, April 15. In this advisory, the WHO reported cases in Canada, Indonesia, Philippines, Singapore, Thailand, Vietnam, and one case in Frankfurt by way of the United States. There were now altogether over 150 cases\textsuperscript{755}. This advisory gave a name to the novel infection, Severe Acute Respiratory Syndrome (SARS) and Dr. Gro Harlem Brundtland, Director General of the WHO, called it “a worldwide health threat” whose arrest would require coordinated work from all nations\textsuperscript{756}. Whether because of the WHO’s advisory or because of increasing attention in Hong Kong’s media, more cases surfaced within the local healthcare system, six in the space of a week: two in public hospitals, two in private

\textsuperscript{753} SARS Expert Committee, “Chapter 3: The Epidemic”, 28.
\textsuperscript{754} SARS Expert Committee, “Chapter 3: The Epidemic”, 29.
\textsuperscript{755} Not counting whatever number had occurred in the PRC but were not yet reported.
hospitals, and two in private clinics. Despite the work of the investigative taskforce and precautionary protocols put into place, healthcare workers suffered disproportionately through the whole of the crisis.

### 7.2.4 Environmental Anxiety Redux: A Community Outbreak at Amoy Gardens

As Hong Kong’s public health officials worked to contain the spread of SARS through the territory’s medical system, the greatest anxiety was that the infection would spread beyond the medical system and into the community where quarantine and other preventative measures would present incredible challenges. Despite all efforts, cases eventually surfaced in the community signalling a new and even more dangerous phase in the epidemic. Just a few kilometres from the Metropole Hotel is the Amoy Gardens residential complex in middle-class Ngau Tau Kok in Kowloon Bay. The towers, now housing 18 000 people, were built through the 1980s in the high-density style typical of Hong Kong residential towers. The complex is made up of private estates, however, not public housing as is common through the neighbourhood. Each tower has eight blocks facing a central courtyard; viewed from above, the blocks look like eight-petalled flowers planted in precise rows. The surrounding neighbourhood is lively, known for its Cantonese-style street food and for the Yulan Chinese ghost tale festival that takes place in the summer. The area was originally populated by Hakka people and was one of the “four hills of Kowloon” from which granite was harvested for construction in Victoria in the early days of the colony. Through most of the twentieth century, Ngau Tau Kok was zoned for industry and the Amoy Gardens stand on land that was once the site of a soy sauce factory. Like much of Hong Kong, the generic facade of the housing complex betrays little of the incredible density and frantic pace of life within its walls.

By March 15, epidemic panic had reached its peak. This rising panic did not, however, slow the flow of cross-border traffic between Guangdong and Hong Kong. A 33 year-old man from Shenzhen, for instance, often visited his brother in Hong Kong, staying with him in Unit 7 on

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Floor 16 of Block E at Amoy Gardens. The man crossed the border from Shenzhen twice a week for dialysis treating his end-stage autoimmune renal disease at the Prince of Wales Hospital. After such visits on March 14 and March 19, the man fell ill—and then his brother, and then his sister-in-law, and then two of the nurses who administered the dialysis treatment at the Prince of Wales. On both visits to Hong Kong, the man had complained of diarrhoea and made use of the bathroom facilities at his brother’s apartment. Within just one day of the man’s March 14 stay at Amoy Gardens, cases of SARS mushroomed among the residents of the complex. The first cases were found among three families in the complex on March 21.

The bulk of cases surfaced between March 24 and 26. The United Christian Hospital first notified the Kowloon Regional Health Department that it had admitted fifteen suspected cases of SARS from seven Amoy Gardens families on the 26th. Within three weeks, 321 cases within the complex were registered. The outbreak at Amoy Gardens suggested a particularly concerning possibility: that spread of the virus was not limited to close contact but that there was also an environmental method of transmission. The Amoy Gardens cases could all be tied to a common geographical locus but there was no possibility that all 321 victims had had encounters, even brief, with the man visiting from Shenzhen, nor could the rapid emergence of clusters of infection not be interpreted as a second wave spreading from those who had directed contact with the infected man. The quick appearance of clusters of infection that had no direct contact with a SARS patient meant that something in the way the residents of the estate were connected environmentally was to blame; for this, Amoy Gardens was studied as an ‘index building’ or complex, just as the cook from Heyuan or Dr. LL were studied as index cases.

Investigators set out to determine the means by which SARS had spread through the Amoy Gardens complex. Postulating that chronic malfunction of the U-trap drains throughout the

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building must be involved, investigators conducted tests that showed that, indeed, a reflux of air from the soil stack into the bathroom of one unit in Block E might potentially push droplets of contaminated sewage into the bathroom of the unit, then to be picked up by the bathroom’s exhaust fan, and then be carried into the lightwell or airshaft between neighbouring apartments. There was also a possibility that SARS-contaminated sewage droplets passed between units through open windows. What is more, the sewer pipe of one unit on the fourth floor of Block E was found to have a large, visible crack; in this way, contaminated droplets might have been dispersed with every flush of a toilet. The design of the Amoy Gardens buildings amplified this problem; the lightwell design created a “chimney effect” whereby investigators found that a “‘puff’ of droplets...would rise inside the lightwell, expanding laterally as it travelled up the height of the building in a matter of minutes under certain wind conditions.” This meant that Hong Kong people needed to be wary of built environments, too. Avoiding person-to-person contact and the contaminated droplets that might be exchanged through personal contact was not enough protection. Building structures themselves conspired to spread SARS—already perceived as devastatingly contagious—through the Amoy Gardens community.

The cluster of SARS cases in the Amoy Gardens precipitated a new escalation of surveillance. Whereas surveillance had previously been limited to the public spaces of hospitals and clinics, the outbreak at Amoy Gardens inspired the Department of Health to extend its reach into domestic spaces. At first, the Department of Health surveilled “close contacts” of SARS patients

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767 There was also the possibility of an animal vector for the transmission of SARS. Samples of the air, water, animal droppings and other environmental factors were taken from the complex. Few abnormalities were found. One toilet bowl in Block E, a unit inhabited by a SARS patient, tested positive for a coronavirus. Coronaviruses are extremely common, infections that virtually every human being will catch over the course of a lifetime. They are so named for through the lens of a microscope the microbes seems to be encircled by spiked crowns. The human variants of coronaviruses are five in number. The first two-229E and OC43—were discovered through the 1960s, while HKU1 and NL63 were identified in 2007. All four of these cause mild to moderate upper respiratory tract symptoms. A coronavirus was also found in rodent droppings and in two dead cockroaches at Amoy Gardens. Coronaviruses frequently infect animals but since the rodents and insects had no signs of illness, investigators doubted that this indicated an animal or arthropod pattern of transmission. See Stephen KC Ng, “Possible Role of an Animal Vector in the SARS Outbreak at Amoy Gardens,” The Lancet 362, no. 9383 (2003): 570-572 for contemporaneous discussion of a rat vector for the transmission of SARS.
at a distance, by telephone. Hong Kong used its own definition of what constituted a close contact at first, monitoring family members and selected workplace or school contacts but the scope of surveillance was reduced, brought into alignment with the WHO’s definition for close contact which was limited to individuals who had “lived with, cared for, or had direct contact with respiratory secretions of the SARS patient.” In this phase of domestic and individual surveillance, the Department of Health gave seven days of sick leave to all individuals under surveillance and referred anyone with symptoms for immediate assessment. On March 31, Block E, where cases had first appeared, was put under a ten-day isolation order. Residents were not permitted to leave the block nor were visitors permitted to enter. The Department of Health took responsibility for “catering to the daily needs” of the quarantined residents. Block E residents who had fled before quarantine was imposed were called on to self-report and submit to surveillance. The demands placed on “close contacts” were expanded to in-person reports to one of the four designated medical centres established by the Department of Health daily for a period of ten days. At these designated centres, close contacts were examined for symptoms, fevers, given chest x-rays and were referred immediately to government hospitals if any positive signs were noted. The Secretary for Health, Welfare and Food briefed the press, disclosing that observation of the 107 SARS cases at Amoy Gardens indicated “vertical stacking”, spread between floors of the block that implicated building design. Again, the message created great fear among Hong Kong people that nowhere and no ‘way’ of living was safe; they were at the mercy of the virus.

The invasive qualities of surveillance measures increased as the outbreak continued. Four days after the Secretary’s admission to the press that SARS was spreading through elements of the built environment, the Secretary for the Environment, Transport and Works reported that SARS seemed to be spreading through Block E of Amoy Gardens by way of the sewerage and drainage system. This was a possible explanation for the mysterious vertical pattern connecting recent

768 The Report does not indicate the date on which remote surveillance by telephone began.
cases. In response, the Government initiated a far more invasive set of protocols including evacuation of 247 Block E residents who would live out their ten-day quarantines in three government-managed “holiday camps”\textsuperscript{773}. The Food and Environmental Hygiene Department began disinfection and pest control of Amoy Gardens and of nearby public housing complex Ngau Tau Kok Lower Estate where a small number of cases were reported.

After April 10, those who shared the homes of SARS patients were put under home confinement for ten days, with no visitors allowed. Throughout this quarantine, affected families and individuals were visited by public health nurses as well as by police enforcing compliance\textsuperscript{774}. These visits hearkened back to the bubonic plague epidemic of 1894 where colonial police and a hastily-assembled constabulary conducted home inspections, removing Chinese suffering from the plague or dead bodies fated for undignified burials that offended cultural mores. While the domestic contacts of patients were quarantined and supervised at home, those falling under the Department of Health’s broader definition of “close contact” were mandated to continue daily visits to the designated medical centres but on April 25, the broader circle of contacts were put under the same home confinement order as the domestic connections. The government of Hong Kong’s Report of the SARS Expert Committee suggests that these practices were well received by Hong Kong people but for a few logistical objections. For example, the Committee notes that individuals ordered to report to the four designated medical sites complained about long waits for their daily examinations and some were concerned about their safety; with long wait times, groups of people with “high risk” of SARS exposure were corralled into small spaces and held for long waits, ostensibly increasing their risk of exposure\textsuperscript{775}.

The epidemic in Hong Kong ended in early May, the WHO then lifting its travel advisory in Hong Kong in June. The Committee confirmed 1,755 cases and three hundred deaths. Among the three hundred lost, were healthcare workers remembered as the “SARS heroes”\textsuperscript{776}. In China,

\textsuperscript{775} SARS Expert Committee, “Chapter 3: The Community Outbreak in Amoy Gardens”, 46.
it took a full year to be rid of SARS, its epidemic declared to be finished in May of 2004. In China there were at least 5,328 confirmed cases and 349 deaths.

7.2.5 The PRD: Most Natural, Most Dangerous of Reunifications

While most in Hong Kong seemed resigned to the return to Chinese sovereignty on a political level and perhaps fantasized about the potential of the ShenKong or ‘delta-fied’ economy, the social integration of mainland and colony was fraught. Mainlanders were suspected of entering Hong Kong to siphon off the territory’s wealth, sophistication, and prestige. SARS created more chaos in this relationship. Over a century earlier, plague had spread from Guangzhou into Hong Kong infecting both Chinese and British populations, reifying racist social and geographical boundaries, and bringing tensions between the British and Chinese to a head. The SARS epidemic echoed some of this history, this time bringing the apprehensions of Hong Kong people toward their new ‘imperial’ masters in China to the fore. Just six years after the reunification, Hong Kong people and mainlanders were still early in the process of grafting their social bodies.

Poor communication made things immeasurably worse. In keeping with the historical pattern, SARS had spread from China into Hong Kong. Authorities on the Guangdong side were not forthcoming with information as to the number of sick and dead, or as to the treatments that had been proven useful against the mysterious disease. The Committee concluded that the “key to the partnership” between Hong Kong and China was that “stakeholders must work together as equal partners…shar[ing] information openly and in a timely fashion”. The pattern of rumours fuelling paranoia, panic, and antagonism between communities that appeared in the 19th century reappeared in the 21st; while Chinese in Hong Kong and Canton had used placards and posters to accuse Europeans of deception and malicious medicine in treating plague, SMS and internet forums were the media by which information and misinformation about SARS spread a century later. Without official figures or responses to rumoured threats, the Hong Kong media

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777 WHO Media Centre, “Cumulative Number of Reported Probable Cases of Severe Acute Respiratory Syndrome (SARS),” WHO, 21 April 2003.

embellished SARS stories, reviving anxieties about being reconnected to China, again depicting the mainland as a chaotic and uncivilized place.\textsuperscript{779}

In a sense, SARS contributed to the dissolution of lingering separation between Hong Kong and the Pearl River Delta cities. All of China and Hong Kong confronted a common terror. The appearance of SARS in Hong Kong only proved that any epidemic emerging in southern China was likely to cross the border and become epidemic in Hong Kong, and, potentially, vice versa. There were obvious cases, like that of a middle-aged man who travelled often to southern China, visiting Zhongshan on February 22 and admitted to Pamela Youde Nethersole Eastern Hospital on March 3 where he died a fortnight later\textsuperscript{780}. Or, in the case of the Amoy Gardens outbreak where epidemiologists and engineers first recognized the possibility of environmental transmission, 8\% of those infected had visited mainland China between March 17 and 23\textsuperscript{781}. The very high number of infections in Amoy Gardens remains a mystery. These cases are the product of some unfortunate confluence of factors, among them a high proportion of cross-border visits\textsuperscript{782}. As had been the case with the bubonic plague a century earlier, Hong Kong’s once-again porous border supported the spread of an epidemic and made monitoring or soft quarantine between Hong Kong and the mainland virtually impossible. Given Hong Kong’s status as a regional and global hub, any local epidemic was likely to spread beyond Asia and across the globe as had occurred in the influenza outbreaks of the 50s and 60s.

The means by which Hong Kong people first learned about SARS further demonstrates the integration of the city with the PRD region. In the third week of February, as most Chinese celebrated the New Year and as Dr. LL was preparing for his fateful trip to Hong Kong, 7.35 billion SMS messages were sent and received\textsuperscript{783}. The spring of 2003 was remembered for the widespread expression of ‘thumb culture’, \textit{muzhi wenhua}, or the rampant use of SMS messaging.


\textsuperscript{780} SARS Expert Committee, “Chapter 3: Outbreak in Other Healthcare Establishments”, 37.


\textsuperscript{782} Stephen Ng, “The Mystery of Amoy Gardens” in Christine Loh, ed. \textit{At the epicentre: Hong Kong and the SARS Outbreak} (Hong Kong: Hong Kong University Press, 2004): 95-116.

\textsuperscript{783} Quoted in Haiqing Yu, \textit{Media and Cultural Transformation in China} (London: Routledge, 2009), 63.
but also, notes Yu, as the ‘spring of masks’, *dai kouzhao de chuntian*. In the absence of clear and accurate information from their governments, people on both sides of Lo Wu came together to protect themselves with what information, and misinformation, they had; SMS messages acted as an unofficial public health notification system. The incredible scope and influence of this communication undermined the central Party's efforts at limited public discourse on SARS or infectious disease, within the PRC and beyond. It was only, writes Sautedé, “the circulation of subversive messages by mobile phone, the famous short messages (SMS)—in Chinese *xiaolingtong*—really surprised the Chinese government and foreign observers by their volume and independence of tone”. The enduring connections between Guangdong and Hong Kong families and associates meant that Hong Kong was drawn into the informal public advisory system and hysteria well before either government engaged the public.

### 7.2.6 A Tang to Heal the Historical Wound

One unanticipated factor in the suturing together of Chinese and Hong Kong medical worlds was the unexpected efficacy of traditional Chinese herbal preparations in treating SARS. Both epidemics brought traditional Chinese medicine to the attention of medical officials. The use of traditional medicines was in and of itself not surprising. As many scholars have observed, traditional medical knowledge and practice was protected, modified, denigrated, favoured, and rejected at turns through China’s encounter with Western modernity and then Communist rule. While official state policy variably celebrated and pushed traditional medicine aside depending with the political flavour of the moment, Chinese people had never ceased to use familiar remedies; even in 2003, Chinese in both Hong Kong and the PRC were likely to use a combination of biomedical treatment, Traditional Chinese Medicine and culturally-determined “*weisheng* practices” as dictated by means and circumstances.

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In Hong Kong, use of traditional herbal preparations and consultations with acupuncturists persisted as part of daily life, a complementary practice to the biomedicine offered in government hospitals and clinics. Studies indicate that Hong Kong people moved with little conflict between systems, choosing one for a particular kind of ailment and the other when deemed appropriate\textsuperscript{787}. While the Tung Wah Hospital had long closed the herb kitchens of the early 20th century, it continued to offer Chinese medicine to willing patients through outpatient clinics\textsuperscript{788}. Researchers at Hong Kong’s universities conducted laboratory research on herbal pharmacology as part of drug development schemes\textsuperscript{789}. Hong Kong Baptist University had instituted an undergraduate degree program in Chinese medicine just a few years before SARS and at the time of the outbreak, the Chinese University of Hong Kong immediately deployed several of its own Chinese medicine researchers to investigate and experiment with the use of Chinese drugs. Interest in traditional herbal therapies extended beyond universities when the Hospital Authority brought together experts from the universities and local hospitals to discuss the use of Chinese medicine as preventative agent or as treatment\textsuperscript{790}.

At the same time, academics in China had significant investments in bridging the two systems, usually in seeking to prove one, Traditional Chinese Medicine, in the terms of the other, biomedicine, as part of China’s long and complex struggle with Western modernity. In that spirit, China’s State Administration of Traditional Chinese Medicine launched twenty-one clinical trials seeking to determine the efficacy of integrating Traditional Chinese Medicine and Western Medicine in preventing, treating, and rehabilitating SARS patients. Local governments in Beijing,


\textsuperscript{789} For examples of such research currently underway, see http://www.scm.cuhk.edu.hk/en-GB/research/research-item/current-research-projects.

Guangdong, Shanghai, and Tianjin made similar efforts. In all, 3104 of the 5237 confirmed SARS cases in the PRC, or 58.3%, received integrative care.

China had delayed in offering official cooperation with the WHO, joining collaborative efforts against SARS only on March 28. In a gesture indicating a shifting posture toward the international body, the PRC requested WHO support for thirteen further clinical trials in October of 2003, the results of these and others presented at a meeting in October in Beijing. This meeting brought together sixty-eight experts from seven Asian and Western countries. Hong Kong was represented at this meeting and contributed three clinical studies on integrative approaches to preventing and treating SARS. The foreign experts evaluating these studies came to ambivalent conclusions but mitigated their critique of methodological inconsistencies or conclusions. The conditions under which Chinese scientists made their assays were exceptionally difficult. Using Traditional Chinese Medicine to treat SARS was deemed to be safe if not conclusively beneficial. The PRC had garnered much negative attention for its failings in monitoring and reporting during the pandemic and there was strategic value requesting and hosting this meeting. It was a gesture that was both conciliatory and defiant—China would participate in global health governance, but on its own terms. Hong Kong’s role in this research was minimized; with China increasingly willing to collaborate with internationalist partners, dependence on Hong Kong as proxy or sentinel was on the wane.

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795 Marta Hanson explores the proceedings and significance of this conference in her book chapter, “Conceptual Blind Spots, Media Blindfolds: the case of SARS and traditional Chinese medicine”. Here, Hanson notes the failure of Western media to report on the use of TCM in treating SARS patients, the prejudices inherent to Western media coverage of the pandemic, and the complex and diverse practices and politics of integrating medical systems. My discussion of the conference and the issue of integration of TCM and biomedicine here is superficial. Instead, I seek to situate this conference in the broader historical context of the PRC’s participation in global health practices as set up in previous chapters. See also
In a sense, Hong Kong’s fifty-year long separation from the Chinese medical tradition ended not with the handover of 1997 but with the SARS epidemic of 2003. The virus travelled across the border with Guangdong as had so many other outbreaks of infectious and epidemic disease through the territory’s history. Just as the region underwent a process of economic ‘delta-ification’ and its people were inculcated with the notion of a Pearl River Delta regional identity, the SARS outbreak wove Hong Kong into a powerful narrative on China’s hygienic modernity. Integrative medical practices that were organic for the people of both regions mirrored the political integration. Medical integration was furthermore a political lever with which China managed its engagement with the international health community. In a similar sense, Hong Kong’s hundred and fifty-six year separation from the Chinese social body ended not with the implementation of the Basic Law that protected Hong Kong’s difference, albeit ambiguously, but with the experience of a crisis that imperiled every body. While Hong Kong loyalists fretted that the transformation from colony to SAR had brought myriad obvious and subtle efforts at undermining Hong Kong’s autonomy and local identity, the SARS outbreak wove together the personal fates of Chinese and heunggongyahn alike.

7.3 Broken Communication, Fractured Social Body

SARS also brought to light the ways in which the dreams of reintegration had failed. Communication between medical and public health systems in Guangdong and Hong Kong had not been substantively or systematically addressed in the years since the retrocession. Hong Kong’s SARS Expert Committee noted that practices of sharing information on specific infectious diseases including cholera, malaria, viral hepatitis, and AIDS were established between Hong Kong, Shenzhen, Guangzhou, Zhuhai, Hainan, and Macao\(^{796}\), but there was no protocol for notification of emerging or novel infections, such as atypical pneumonia. From the very start of the outbreak, this caused major troubles, particularly in Hong Kong where the history of social destabilization in the wake of epidemics and a reputation as a conduit for pandemic disease weighed on citizens and officials alike. The *Report of the SARS Expert Committee* minces no words on China’s recalcitrance in notifying Hong Kong and global infectious disease monitors, stating,

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\(^{796}\) SARS Expert Committee, “Chapter 9: Collaboration within Pearl River Delta Region and with International Community”, 112.
A pre-requisite to the effective management of major incidents, including infectious diseases outbreaks, is that stakeholders must work together as equal partners. Key to this partnership is the willingness to share information openly and in a timely fashion….The Committee notes that an expert investigation report on the outbreak of atypical pneumonia in the Guangdong Province was produced on January 23rd 2003, and that the authorities in Hong Kong and WHO were not recipients of this report. Public health professionals in DH had been unable to obtain information from their counterparts in the Guangdong Province, and collaboration between clinicians and medical academics in Hong Kong and Guangdong had been patchy and piecemeal.797

In fact, Hong Kong’s inquiry found that a document had been produced by public health officials in Guangdong on February 23 detailing the findings of an investigation into cases of atypical pneumonia. This report was not shared with either Hong Kong’s public health bodies or the WHO, another echo of China’s reluctance to participate transparently in infectious disease surveillance in the influenza pandemics of the twentieth century. The report presented a case description and clinical signs for the atypical pneumonia as well as biomedical and traditional herbal treatment principles, preventative measures including an ironic recommendation of quick notification of all cases. In the view of Hong Kong’s post-mortem investigators, the report should have been shared with “decision makers”, including Hong Kong officials. “Owing to the limited circulation of the report”, found the Committee, “others were not forewarned, and therefore forearmed”798. The intimacy of lips and teeth implied, for the Committee, a mutual responsibility. On the same day that Guangdong’s public health authorities confirmed the epidemic in the press, so confirming the outbreak to Hong Kong authorities, China’s Ministry of Health in Beijing reported 300 cases and five deaths in Guangdong province to the WHO. This notification was a concession of the precarious and serious nature of the situation and to China’s evolving responsibilities as it sought geopolitical and economic integration.799. It is astonishing that these steps were taken at the same time; a major international announcement was extended to the international monitors while Hong Kong officials had their anxieties confirmed in the daily

news. These difficulties in coordinating a response to SARS between Guangdong and Hong Kong reveals the sloppy stitches holding together the reunification.

The PRC government’s secrecy made this problem significantly worse, or made it more obvious than before the crisis. Xia and Ye have characterized media coverage of SARS in three phases. First, prior to April 5, the Propaganda Department forbade official news coverage but rumours ran rampant. A handful of media outlets including Nanfang Daily and Yangcheng Wanbao felt responsible to inform the public but could only do so by reporting on the rumours, sometimes publishing the full text of the SMS messages spreading through China. In this way, these newspapers avoided violating the government-issued publication ban but managed to raise awareness of the rising threat. Through the second stage, between April 5 and 20, the government released information through official medial channels such as Renmin Ribao hoping to subduing rising anxiety. A third stage, report Xia and Ye, saw the government taking a more forthcoming posture. Daily reports for domestic and international audiences were provided and the Chinese media was allowed to report more transparently on the outbreak. Hong Kong’s free press, particular through online channels, raised pressure on the Chinese government to provide credible information. Crisis reporting in Hong Kong was quick and well-organized, “all Hong Kong news sites” creating SARS-specific fora by March 31. For Sautedé, this betrayed a far greater problem; as he writes,

[w]ithout outside pressures, first from Hong Kong’s Chinese language press and the international press, then from the World Health Organization (WHO)—and only because the crisis had taken a dramatic turn which was highly damaging to Hong Kong and then to Peking—,….it seems evident that the Chinese Communist Party would not have been brought around to “communicating”, nor to mention giving out information, as it is doing now. The

802 Christine Loh, Veronica Galbraith and William Chiu, 195.
cardinal role played by the former British colony needs to be underlined here: Hong Kong’s misfortune has been the good fortune of the population of China and the rest of the world.\textsuperscript{804}

7.3.1 An Attenuated Recovery

SARS left a political hangover. Bloggers and newspapers raged against both PRC and Hong Kong officials, taking one side or the other, and condemning them all. Pro-Beijing newspapers focused their anger on Tung Chee Hwa, investing faith in the leadership of Hu Jintao and Wen Jiabao.\textsuperscript{805} Others warned that Hong Kong people could not trust their own government.\textsuperscript{806} Hong Kong people counted on basic accountability from their government, from the Legislative Council in particular. This essential trust is what they traded against the real democracy that a full decolonization process might have offered. Even this degree of accountability, though, was betrayed here. Yeoh Eng-Kiong, the secretary of the Department of Health, Welfare and Food during the crisis, resigned in July of 2004. He was not targeted specifically in the Committee’s Report\textsuperscript{807} but the government hoped his resignation would pacify the public. Yeoh had denied the scope of the outbreak, leaving the public at risk. He played semantic games with the media, allowing conflation of the ‘atypical pneumonia’ spreading from Guangdong with more benign forms of community-acquired pneumonia.\textsuperscript{807} Yeoh’s resignation threatened politicians who saw him as a scapegoat\textsuperscript{808} but the some of the public recognized this for the political performance that it was.\textsuperscript{809}

“One country, two systems” actually seemed like one country, no systems; Hong Kong had neither democracy, nor cooperation with the central government in times of crisis.\textsuperscript{810} Just weeks past the peak of the crisis, the Hong Kong government sought to activate Article 23 of the Basic Law. This was security law that would punish “any act of treason, secession, sedition, or subversion” against the Chinese government and disallowed the influence of “foreign political

\textsuperscript{804} Sautedé, 1.
\textsuperscript{805} Chong-hui Lee, Ming Pao, 24 June 2003.
\textsuperscript{806} Sing Tao, 28 May 2003.
\textsuperscript{807} Xin Bao/hkej.com, 8 July 2004.
\textsuperscript{808} Xin Bao/hkej.com, 8 July 2004.
\textsuperscript{809} Xu Yongxuan, Xin Bao/hkej.com, 10 July 2004.
\textsuperscript{810} Xin Bao/hkej.com, 4 October 2003.
organizations or bodies from conducting political activities”\textsuperscript{811}. The timing of the article’s introduction, animated resistance among many Hong Kong people who understood that their livelihoods, and indeed their physical survival, was now dependent on cooperation and communication with China. One writer encouraged Hong Kong people to use their experience of colonial rule to fight for their interests. The liberal values of the British, including the idea that Hong Kong people were entitled to democracy, should be deployed as resistance to the poor governance of the PRC whether or not the issue was representation or communication\textsuperscript{812}. When Tung Chee Hwa, perceived as a puppet of Beijing, made a visit to Chai Wan where SARS cases had appeared, a local remarked that his visit had made things worse. "We were originally not scared, but you know, once he comes, nothing good ever happens”\textsuperscript{813}. In a poignant editorial, one of Hong Kong’s most impoverished, a cage dweller, claimed that he would rather rely on himself than depend on the government’s protection\textsuperscript{814}. At another time, and in another light, this might have represented a positive element of the Hong Kong spirit—self-reliant, self-sustaining, entrepreneurial, independent. It was also, however, extreme to the point of pathology; the media fanned the flames of public dissent, telling, for example, the sad story of a mother’s hardship, keeping her children home from school since she could not count on the government’s preventative measures to keep her family safe\textsuperscript{815}. Liberal values aside, being unable to depend on Hong Kong's government in times of epidemics was an historical inheritance, a pattern learned from repeated episodes of inadequate communication and poorly managed risk. This, too, was part of the Hong Kong experience and identity.

7.4 Collective Trauma, Hong Kong Subjectivity, Hong Kong Identity

7.4.1 SARS and Collective Memory

For all of the ways in which the SARS crisis was shared between the PRC and the HKSAR, Hong Kong experienced the epidemic on its own terms. The crisis evoked old patterns, past

\textsuperscript{811} “Article 23”, \textit{The Basic Law of the Hong Kong Special Administrative Region of the People’s Republic of China}.

\textsuperscript{812} Cheng Yi, \textit{Xin Bao}/hskej.com, 3 May 2003.

\textsuperscript{813} \textit{Ming Pao}, 18 April 2003.

\textsuperscript{814} \textit{Ming Pao}, 17 April 2003.

\textsuperscript{815} \textit{Ming Pao}, 20 April 2003.
experiences, institutional, and cultural memory. In the aftermath, several research projects took up the issue of post-traumatic stress disorder among SARS victims.\(^\text{816}\) While the evidence of PTSD or PTS symptoms among those who experienced the infection in their physical bodies is strong, the pattern of post-traumatic stress was manifest in the social and psychic spaces of Hong Kong people at the time of the crisis and in the years since. A physician who contracted SARS at the Prince of Wales Hospital but recovered recounted that “[d]uring the crisis, emotion prevailed over rationality”. He suggested that when healthcare workers requested top-level precautions for their personal protection, the authorities should have provided such without debate. The effectiveness of protective gear might be debated after the crisis passed, he writes. In the heat of the moment, managing panic matters most.\(^\text{817}\) Sociologists at Hong Kong University showed awareness of the collective trauma in progress, creating a movement they called “We Are with You” to help the public cope with the epidemic. Co-founder Cecilia Chan told an American newspaper, “[t]his is a very depressive, confusing, unsafe environment…Most people are still in a state of panic and anxiety. Suddenly, there's a feeling that everybody is a carrier. This is an alienating disease. It pushes people apart.”\(^\text{818}\)

After this, some felt Hong Kong would never be the same. One participant on the public forum of the Hong Kong Economic Journal’s website, whether consciously or subconsciously, connected the paranoia around SARS infections to the repercussions of past epidemics, in particular to the plague; the writer described the city’s sorrows, ordinary people afraid and mistrustful of each other, even in the safety of their own beds, while the elites remained ensconced at the “very peaceful peak.”\(^\text{819}\) Another commenter announced the end of the heunggongyahn’s drive for power and success, the very interests that first attracted Chinese into the colony and the values that created Hong Kong’s economic miracle through the 1980s. The trauma of SARS was so great, found the writer that it marked a moment of chance for the whole


\(^{817}\) Gregory Cheng, “Healing Myself: Diary of a SARS patient and doctor,” in At the epicentre: Hong Kong and the SARS Outbreak, edited by Christine Loh (Hong Kong: Hong Kong University Press, 2004), 39.

\(^{818}\) Stephen Friess, “In Hong Kong, SARS deaths infect hearts and minds,” USA Today, 15 April 2003.

\(^{819}\) Gucheng Ye, Xin Bao/hkej.com, 3 May 2003.
of Hong Kong culture. After SARS, Hong Kong people needed to cultivate emotion and affection, not seek to “earn money, enjoy the best”\textsuperscript{820}. \textit{Fearbusters.org.uk} appeared online, a group of 130 people who tried to fight the rumours and panic through participation in internet fora, spreading balanced information and a positive attitude to counteract feelings of mistrust and fear and to help weave the trauma into Hong Kong’s broader narrative. These discourses and initiatives are unique to Hong Kong. They grow, directly, of the many traumatic experiences of epidemics and the way they have shaped the city and the identity of its people on every level.

More than a decade on, the SARS epidemic is recalled and remembered often in public life. Hong Kong is, in general, rich in monuments and museums, well-marked with plaques, ancestral halls, and commemorative placards that orient visitors constantly to the history of the territory; it is a place that consciously strives to remember, perhaps because of its many deterritorializations and reterritorializations. An afternoon’s ramble crossing Lamma Island points a hiker toward the caves in which Japanese soldiers hid before occupying Victoria across the harbour. A visit to the walled village of Fanling Wai in the New Territories, placid and nearly deserted, is punctuated by conservation placards informing the visitor of the Pang family’s history dating back to the Song dynasty\textsuperscript{821}. The Hong Kong Public Library works together with all nine of Hong Kong’s universities in compiling and archiving the Hong Kong Oral History Project, and citizen-led projects like the Hong Kong Memory Project abound\textsuperscript{822}. This collective trait of seeking to remember and to document seems at first like a benign quality. But as Meaghan Morris reminds us, the appetite for history should not be taken for granted. It is not, she writes, “a primal human desire. We have to be taught to want it, to learn that history is the name of something we lack”. Creating history can be a nationalist impulse, she writes, but can also be “organized by transnational constituents of subjectivity and experience”\textsuperscript{823}. In Hong Kong, making memory is a

\textsuperscript{820}赚最多、享受最好

\textsuperscript{821} It is worth noting the controversy over some of the conservation and memorial efforts conducted on the part of the government, particularly in designating areas in the New Territories and Outlying Island for environment preservation to the detriment of the economic interests of the family with ancestral claims to the spot. For discussion of the process of determining the right to ancestral villages, see Kwok-shing Can, “Negotiating the Transfer Practice of Housing in a Chinese Lineage Village,” \textit{Journal of the Hong Kong Branch of the Royal Asiatic Society}, 37 (1998), 63-85.

\textsuperscript{822} See https://www.hkmemory.hk/index.html

defensive practice, protection against the kind of erasure or reterritorialization that has been carried out several times over. The local appetite for history is an impulse of the local subjectivity produced by a history of serial reterritorializations and the desire to protect the local identity that has been claimed.

The memory of SARS is paradoxically near and far away. Local culture is highly medicalized. Thirteen years after the epidemic, hand sanitizer sprays and notices of sanitation schedules posted in elevators and on the doors of public buildings are aesthetically and culturally normal and are no longer jarring. They no longer signal a state of emergency. These practices, and the ambient anxiety of epidemics future, are permanent changes. Hong Kong people take care, knowing the next outbreak of infectious disease may arrive at any time. The heightened state of awareness of one’s body and environment has become—like the appetite for wealth that was normalized through the boom times of the 1970s and 1980s—the Hong Kong way of life. One could argue that when SARS broke out in Hong Kong, the people were better prepared than the government. Practices of “healthism”, defined by Rose as “public objectives for the good health and good order of the social body with the desire of individuals for health and well-being”824, were the inheritance of generations affected by epidemics of disease. Unlike their great, great, great, great grandparents who tried to fight off the house inspections carried out during the plague crisis in 1894, Hong Kong’s government found that in 2003, “the overwhelming majority of the contacts complied with the surveillance at the designated medical centres and home confinement orders825”. At Amoy Gardens Block E, the Owners’ Committee and residents concerned were compliant with “thorough cleansing and disinfection” over the course of a week826. Residents in adjacent blocks performed Foucauldian responsibilization, following guidelines and using disinfectants provided by the government827. The Expert Committee claims that, “[t]hese measures were implemented smoothly, an indication of the wide acceptance by the

general public, probably facilitated by the graduated enhancement approach"\(^{828}\), an incredible understatement if you consider the whole of Hong Kong’s history, narrated through five epidemic events, to be the full picture of ‘graduated enhancement’ that normalized the surveillance, monitoring, and quarantine measures implemented to fight SARS.

From today’s vantage point, it seems, also, that the city is still grieving. Anxiety over future disease outbreaks is mixed with mourning for the outbreaks of the past. There is enduring anger toward the PRC and the continued sense that China has not done enough to combat infectious disease or to build public health communication infrastructure that will protect Hong Kong in the case of an outbreak\(^{829}\). Even the way that the PRC has sought to monumentalize the SARS crisis has irked Hong Kong commentators. When Guangzhou authorities announced a memorial to be built at the 10-year anniversary of the outbreak, one Hong Kong columnist demanded that the memorial note not just those who died of SARS in China but also the whistle-blowers who forced the government to report more transparently on the outbreak and its severity. “A Sars [sic] monument in Guangzhou that honours those who told the truth and exposed the real state of the epidemic 10 years ago could also be a reminder for officials in other places who are still accustomed to covering up all the negative news”, railed one writer\(^{830}\).

Hong Kong SAR’s official SARS memorial is simple and sober. It was placed in Hong Kong Park, a verdant testimony to the enduring legacy of Charles Ford’s afforestation programme nestled between Central and Wan Chai districts. Busy on the weekends, the park has an aviary, a tai chi park, fish ponds and a vegetarian dim sum restaurant as well as facilities for children’s play and the enjoyment of nature. And in the middle, now, is a grove with bronze busts of the “SARS heroes”, the nine healthcare workers who died of SARS infections during the outbreak. Designed by architect Stephen Yeung, the busts do not communicate with each other but rather

\(^{828}\) SARS Expert Committee, “Chapter 3: The Community Outbreak in Amoy Gardens”, 46

\(^{829}\) Just this month, a cull of 15 000 chickens was carried out in Macao. They had been imported from a farm in Guangdong. In Hong Kong, the assumption that poultry from the mainland is dangerous and undesirable is implicit in these reports. The territory’s Secretary for Food and Health Dr Ko Wing-man was “very concerned” about the situation, but Centre for Health Protection controller Leung Ting-hung reassures readers that the risk is being monitored and managed. See Phila Siu, “Macau bird flu case sparks probe into whether Guangdong farm supplied Hong Kong,” *South China Morning Post*. 4 February 2016, and Kinling Lo and Mary Ann Benitez, “Macau culls, bans sale of chickens in flu find”. *The Standard*. 5 February 2016.

\(^{830}\) Ivan Zhai, “Guangzhou's Sars memorial should be a monument to truth,” *South China Morning Post*, 13 April 2013.
face out into the world. Each individual face tells an unvoiced story. There is just one explanatory plaque with little text. The meaning of the monument does not need to be explained to Hong Kong people today, and this monument was not built for tourists.

7.4.2 Processing/Making SARS as Culture

Processing collective, epidemic trauma through art is part of Hong Kong’s culture. Multimedia artist Peter Suart has produced not just one but two dramatizations of the 1894 plague episode, *Fragile* (2011) and *Riders on the Plague* (2014), also the subject of a piece of ensemble musical and physical theatre, *1894 Hong Kong Plague*. When it comes to SARS, artists have been eager to process the trauma in their work, and the Hong Kong public has an enduring appetite for the consumption of SARS art. Sometimes SARS art is about the ghosts of the 299 SARS fatalities and sometimes it is about the survivors. Sometimes, both. This is the case in interpreting a remounting of Lygia Pape’s performance work “Divisor”. In this piece, dozens of people walk together in a grid formation. They poke their heads through a vast white cloth that then drapes across their shoulders and ripples between them. From street level, they appear as individuals clothed in their own clothing, walking in their own unique gaits. But from above, they appear to be one body. The work has been discussed as an ontological commentary, “the mobilization of individuals from “I” to “we” [as] a symbolic negation of the void”, but in Hong Kong, a decade after the SARS crisis, the remounting of “Divisor” takes on further symbolic resonance. In the post-pandemic environment, the play between individual and group stands also for quarantine, for the danger of proximity and paradoxical need for unity and community. The white sheet also evokes a shroud and hospital linens, poignant to Hong Kong viewers.

While film of “Divisor” being performed in Madrid a few years before the Hong Kong staging accentuates the ethereal visual qualities of the piece, footage of the performance at Hong Kong has a different tone. Images of the piece proceeding down Chater Road in Central, the

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831 See “Peter Suart Tells HK Story with One-man Show “Fragile,”” *Peter Suart Tells HK Story with One-man Show “Fragile”* Government of Hong Kong Special Administrative Region, 09 July 2011.


833 There were, to note, two performances of “Divisor” in Hong Kong. The first is discussed here, staged along Chater Road in Central on 17 March 2013 and the second performed on 25 May 2013 along the Western District
financial centre of the territory, evoke menace. From street level, the mass of people draped in the white sheet move unevenly, with participants smiling and laughing a bit awkwardly while helpers move alongside, ruffling the sheet to create the waves suggested in other stagings. But from above, the Hong Kong installation conjures a sense of anxiety. Chater Road is purely a commercial street, home to no one, and one of the smaller arteries in the district. As the installation moves into the afternoon sunlight, it appears as to be chasing, or to have chased, Hong Kong people out of the usually bustling area. There are very few spectators of the piece, as evident in the video at least. Perhaps they have been consumed by a plague represented by the white sheet, or perhaps the sheet is a shroud and the faces peering out are those who have been claimed by the plague. Perhaps the performers of “Divisor” stand for the community divided by quarantine during a pandemic season, part of a community but far enough apart from one another so as not to be able to touch, separated by an antiseptic gauze.

These ghosts of traumatized living and dead are also present in popular director Peter Ho-Sun Chan’s film *Memories of the Spring of 2003*. The film is part of a twelve-part series of one-minute shorts commissioned by the Federation of Hong Kong Filmmakers in April of 2003 called 1:99 Shorts. Funding came from the Information Service Department of the Government of HK SAR. The series was screened altogether just once in August of that year and the shorts were otherwise screened ahead of feature films in all Hong Kong cinemas as the territory recovered from the trauma. The original premise of the project was to make two sets of the shorts, the first to battle SARS and the other to heal Hong Kong once the outbreak had passed. But vice-chairman Cheung Chi-sing explained, ahead of the screening, that the crisis passed far more quickly than anyone had expected when the project began. Accordingly, the directors were forced to edit their messages mid-way through production. Some of the shorts are comedic, like Stephen Chow’s *Hong Kong Sure Win*. In Chow’s signature comedic tone, *Hong Kong Sure Win* normalizes life with SARS; scenes of family supporting their ailing mother at her bedside. She is identified as a SARS victim by the visual symbol of the blue face mask. The camera zooms out and the viewer discovers that the family is not at the mother’s hospital bedside at all but is rather

at home, chatting with their mother by webcam as they play mahjongg. The message is clear: while the implementation of prohibitions on hospital visits beginning on March 28 was initially experienced as harsh and inhumane, life goes on, and Hong Kong will go on. Alan Mak and Andrew Lau’s submission, Hong Kong is the Best, is explicit, splicing images of Hong Kong earlier traumas—the “three years and eight months” of Japanese occupation, cholera, typhoon Wanda, drought, strikes and other calamities—with slogans proclaiming “Hong Kong people: one heart, one soul”, “SARS is not so bad after all”, and “Never give up: Hong Kong is the best”.

The most striking of the series is Peter Ho-Sun Chan’s segment. The film, starring one of Hong Kong cinema’s most recognizable actors, Tony Leung Chiu Wai, begins in an apocalyptic version of Hong Kong. The streets of Central are empty, and covered in snow and ice. It is striking and very beautiful but utterly unlike Hong Kong as we know it. No pedestrians move along the sidewalks, and the black-and-white scheme and icy climate suggest that something horrible has happened to cause this depopulation of the city. Beethoven’s 14th, the Moonlight Sonata, establishes a melancholic, grieving mood as Tony Leung walks through the empty streets. Leung appears as the sole figure outside, unmasked, able to see a few other human beings in the windows of the office towers, notably through the distinctive round windows of Jardine House. The signature Hong Kong Light Buses drive through the streets but now bedecked with flowers, they are recast as hearses. The only moving human figures are a team of medical workers, masked and gowned, who rush a gurney through the streets. They finally collapse to the ground. Suddenly, one of the medical workers pounds his fist against the sidewalk, and the clouds part. The film changes, for a moment and in time with the pounding, from black and white to colour. The other medical workers became to stamp and pound the frozen earth until it cracks, and as they do so the clouds above begin to drift away. The medical team is joined by the army, by tap dancers, and eventually by everyone. Stamping their feet in defiance, unified, the people of Hong Kong bring life back to the city. Tony Leung looks on, a small, appreciative smile spreading over his face as the camera zooms out over Hong Kong now pulsing once more. The effect is stirring, if a bit maudlin. It captures the vulnerability that SARS revealed in Hong Kong. The handover had made the territory vulnerable politically, had set the Hong Kong people on edge, waiting to see how Beijing would interpret the conditions of the Basic Law that guaranteed the markets and

lifestyle of the colonial period. SARS, then, threatened the very existence of the colony, the survival of the markets and people. The film suggests that Hong Kong’s salvation will not be the markets, symbolized by the towers of Central, nor technology, the medical team collapsing in midst of its efforts. Salvation will come, suggests, Chan, by way of the passion of Hong Kong people. Even quarantined, they will come together, a force that can overcome nature.

7.5 Defiance

Para Site is one of Hong Kong’s best-established artist-run, non-profit gallery spaces, founded in 1996. The group is political and contentious, asserting that it was formed as “a crucial self-organised structure within the city’s civil society[,] during the uncertain period preceding its handover to Mainland China”. Para Site is an adaptable entity, existing variously as an exhibition space, Hong Kong’s first visual arts magazine, a “central platform for the development of art writing and of a discursive scene in the city” and as a curatorial training program.

One of Para Site’s major exhibits of 2013 was entitled “A Journal of the Plague Year: Fear, ghosts, rebels. SARS, Leslie and the Hong Kong story”, part of the first Art Basel fair in Hong Kong. Para Site’s chronology-shifting, multi-disciplinary project sought to examine Hong Kong’s “…subjectively internalised history of epidemics”. There were three venues incorporated in the full exhibit but the great majority of works were presented at Para Site’s former permanent gallery space on Po Yan Street in Sheung Wan, just a few metres from what was the epicenter of the bubonic plague in 1894. The exhibit’s description seizes on the very same themes as this dissertation, “representations in the colonial era as an infected land that needed to be conquered from nature, disease and oriental habits in order to be made healthy, modern and profitable”.

The exhibit ricocheted between themes of paranoia, contamination, desire and race, and featured artists as diverse as Ai Wei Wei and Lam Qua. Among the most striking pieces is “Sak Gai (Chicken Kiss)” by photographer Adrian Wong which depicts the photographer kissing a live chicken.

835 See http://www.para-site.org.hk/en/about. While the group was originally self-organized and saw itself as part of an independent civil society, it now states that it is funded by patrons, donors, grants and the Government of the HK SAR.

836 The stagings of “Divisor” were part of the Para Site exhibit.

837 “A Journal of the Plague Year. Fear, Ghosts, Rebels. SARS, Leslie and the Hong Kong Story,” Para Site.

838 Lam Qua is the subject of Chapter 2 of Ari Heinrich’s Heinrich’s The afterlife of images: translating the pathological body between China and the West.
chicken, a clear reference to the panic caused by avian influenza in 1997. The image is part of Wong’s larger project entitled “A Fear is This” that asks, “What is Hong Kong afraid of? Though all cities possess their own local anxieties, perhaps none are as vivid and consuming as those of Hong Kong.” Wong depicts Hong Kong’s gambling dens, temples, and public health system as sites for these local phobias. The image of the man kissing a chicken is startling but particularly so within Hong Kong’s medically-conditioned psychic space. The intimacy between the man and the chicken in the photography is transgressive, but in Hong Kong also reads as imminently dangerous. This could have captured the moment at which H5N1 crossed the species border, or it could show some alchemical moment that precipitated the spread of the SARS coronavirus. The image also has a humourous quality; maybe it’s just a prank, a rubber chicken, so to speak. The image plays on the viewer’s fears, the way they have been molded in Hong Kong’s paranoia. What is a close contact, really, in an environment where infectious disease seems historically ubiquitous and endemic regularly becomes epidemic? During the SARS outbreak, limits of intimacy, definitions of closeness, and thresholds of risk were negotiated and renegotiated as the crisis unfolded. By the end of March, reports the SARS Expert Committee, the Department of Health had adopted international standards set by the World Health Organization for defining close contacts, people who had “lived with, cared for, or had direct contact with respiratory secretions of the SARS patient.” Hong Kong’s own standards, at first, were less strict, less clear, and perhaps inconsistently assessed; a “close contact” was a family member or a “selected” contact at workplace or school. In effect, Hong Kong was comfortable, traumatized by the local history of epidemics, with stricter limitations to personal closeness than global standards that require fluid exchange, domestic intimacy, or a caregiving relationship to constitute risk.

The key piece in the exhibition considers Leslie Cheung and his death by suicide at the height of the SARS crisis. Cheung is a formidable figure in Hong Kong’s cultural and cinematic history, an actor and public figure who captured the heart of Hong Kong in spite of his tendency to flout its traditions and mores. Described by academic, poet, cultural critic, and long-time fan Natalia

Sui-hung Chan⁸⁴² as a “butterfly of forbidden colours”⁸⁴³, Cheung projected a smoldering ambivalence that suited the territory and its liminal qualities marked socially by Cheung’s bisexuality and his physical androgyny. Cheung’s charitable works and charm seduced the territory which treated him as an idol over the course of an uneven but memorable career despite his unconventional social relationships and mercurial character. He was called Gor Gor, meaning ‘Big Brother’, indicating how deeply Hong Kong people identified with this idol.

Cheung took his own life on April 1 of 2003, falling from the 24th floor of the Mandarin Oriental Hotel in Central. A note found in his pocket described a recent history of crushing depression, thanking family, his most recent psychiatrist, Cheung’s partner Daffy Tong Hok-Tak, and actress Lydia Shum. Cheung’s death registered as a deep wound in Hong Kong. The next day, Dr. David Heymann of the World Health Organization gave a press briefing during which he disclosed that the transmission pattern of SARS was more complex than previously known. Experts were seeing clusters of infections in Hong Kong passed on by other means than human-to-human contact. Heymann thus recommended that travel to Hong Kong and Guangdong be postponed⁸⁴⁴. The WHO further requested that travellers inform themselves about the disease and that airports initiate elaborate screening protocols.

Heymann’s warning did not stop Hong Kong people from responding to the second trauma: Cheung’s death. Tens of thousands attended Cheung’s public memorial service on April 7, waiting outside Hong Kong Funeral Home and holding vigil outside the Mandarin Oriental with white flowers: roses, lilies, and carnations. By this time thirty people had died of SARS in Hong Kong. Cheung’s death tipped the balance of emotion in the colony from fear to grief. Despite warnings to the public against contact and the unknown factors behind transmission, Hong Kong people came out of their homes and into the streets to grieve together. Grief over Cheung’s death have been conflated with the thirty SARS victims already lost, a focal point for sorrow and anxiety. Para Site’s images of the crowds that gathered to mourn the death of actor and singer

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⁸⁴² Dr. Chan is better known for her poetry published under the pseudonym Luo Feng 洛楓.

⁸⁴³ Luo Fengzhu, Jinse de hudie : Zhang Guorong de yishu xingxiang (Hong Kong: Sanlian Shudian, 2008).

Leslie Cheung make the same argument as did Peter Ho-Sun Chan when he evoked the power of the Hong Kong people to heal their city. Epidemics run through Hong Kong again and again. Unlike the colonial anxiety that Guha contemplates, Hong Kong people live with fear. Epidemics are real. A heunggongyahn knows that a new flu or novel virus is likely to come. The city also knows how to grieve, how to commemorate, how to go on. These qualities are by now as characteristic of Hong Kong, its history and its people, as are the free market and fulsome economic drive.
Chapter 8
Epidemics are Normal

8 Hong Kong History, Epidemics, and *Heunggongyahn*

This project demonstrates that five epidemic events played critical roles in defining Hong Kong both locally and internationally. Epidemic events early in the colony’s history—malaria in the 1840s and bubonic plague in the 1890s—gave shape to the very foundations of colonial life. Malarial outbreaks decimated colonial ranks, inspiring the spatial design of the colony. Westerners, and in particular the British colonial government, connected the experiences of the spoiled barracks at West Point and the dangers of Happy Valley to imperial knowledge gathered in Britain’s other tropical colonies. They applied enclavist strategies and created afforestation projects hoping to de-tropicalize Hong Kong. They moved their residences south and up and created laws reifying distance from the Chinese whose poverty consigned them to cramped, unhygienic tenements. When bubonic plague passed from Canton to Hong Kong and spread through crowded Taipingshan, colonizers descended on the Chinese neighbourhoods and homes to enforce sanitary measures, breaching the commitment made by Charles Elliot at the colony’s founding that the Chinese should be left to their own customs. Elliot’s proclamation rationalized practices of indirect colonial rule in Hong Kong that created paradoxes of neglect and autonomy for the colonized Chinese people.

Over two hundred years, imperialism and globalization have made Western biomedicine hegemonic in most of the world. Public health policies and campaigns complete the incorporation of unruly or uneven elements of a culture’s medical beliefs, bodily and domestic habits into the dominant system. The fourth chapter, an interlude, shows how British ambivalence toward administration of a colonized population at Hong Kong promoted and helped sustain chronic poverty and overcrowding well into the twentieth century. As Hong Kong’s population halved during the Japanese occupation and then quadrupled postwar, the

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845 The relation of power to subjectivity in medicine and public health figured prominently in Foucault’s theorization of biopower and the clinic, and Nikolas Rose further demonstrates that it is not in spite of multifaceted subjectivity but through the constitution of subjectivity that power can flow. See Michel Foucault, *The Birth of the Clinic* (London: Routledge, 2012) and Nikolas Rose, *The Politics of Life Itself: Biomedicine, power, and subjectivity in the twenty-first century* (Princeton: Princeton University Press, 2007).
pressures of overcrowding and poverty rose in proportion. These conditions promoted chronic
disease and oversubscription to what private and public medical services were available. The
rising paradigm of the welfare state in Britain assumed a duty of the government to the welfare
of its citizens but not to its colonial subjects, leaving Hong Kong and its ambivalent
administrators in limbo for a decade before embarking on the development of the New Towns
and housing provisions.

Outbreaks of influenza in 1957 and 1968 increased pressure on the government in several ways.
First, epidemic flu brought calls for increases to government medical services that would be
accessible to even the poorest of the colony. Epidemics waylaid the labour force and damaged
the economy, consequences that neither Chinese nor British could accept. These outbreaks
helped create demand on the colonial government to transform its policies of limited intervention
and investment and to better support the colonized population; epidemics made it clear that the
government neglected the refugee and labouring Chinese at its own peril. These outbreaks also
had international significance. In 1957, Mao’s China had withdrawn from global health projects
and surveillance programmes. Without China’s participation, monitors could not count on early
warnings of any outbreak spreading from China, associated with so many plagues and epidemics.
Hong Kong, while the “natural floodgate of China” through which epidemics are likely to
spread, had a European government and a modern (if inadequate) health system. For its part in
studying and stopping the 1957 Asian flu, Hong Kong took the role of proxy for China and
sentinel of infectious disease risks for the Asia-Pacific region. In 1968, some of the same
dynamics remained in Hong Kong’s international relations. The chapter relating the pandemic of
H3N2 in 1968, the “Hong Kong flu”, emphasizes the local significance of this outbreak. While
H3N2 was clinically mild and took relatively few lives, this outbreak followed several years of
rowdy discontent among Hong Kong people. When they began to fall sick, to miss work, to lose
security and income, they called on the government to be more responsive and to be more
responsible. Now a settled population for twenty-five years and well into experiences of
urbanization, industrialization, and financialization, Hong Kong people called on the government

846 This is a metaphor used by Tung Chee Hwa in the context of the reunification in 1997. See “Speech by Chief
Executive Tung Chee Hwa at “International Gathering to Celebrate Hong Kong’s Return”, Renmin Ribao, 3 July
1997.
for support. This was a new posture set in contrast to the mutual avoidance and disengagement of the nineteenth and early twentieth centuries.

The project concludes with a consideration of the 2003 SARS outbreak. In its introduction, this text claimed that pathogens are honest, and democratic. In Hong Kong, the rapacious appetites of parasites, bacteria and viruses are among the greatest pressures shaping society, politics, and culture today, but all across its history. Arresting the spread of disease and controlling it when it got out of control defined relationships between communities and gave direction and significance to the colony’s governing bodies. Different kinds of stigma remain after disease episodes. Individual and social bodies are marked, scarred, weakened. Stigma is attached to those who were infected, like Huang Xingchu who had to give up his name and livelihood in order to (more) fully recover from SARS\(^{847}\). In Hong Kong’s Amoy Gardens, 87% of residents responding to a survey reported psychosomatic symptoms after the outbreak. Depression, irritability, and insomnia persisting longer than two weeks were widely reported. Those who suffered these after effects reported something interesting. They did not emphasize the obvious losses, the sick and dead who were part of their community. They reported instead that they suffered because of the particular character of SARS. It was “contagious, mysterious, stigmatized, and required a strict quarantine”\(^{848}\). These descriptions are evocative of the narratives featured in the first chapters of this dissertation, the journals and letters home from colonial adventurers encountering Hong Kong, and malaria, for the first time. The fear of quarantine expressed by the residents of Amoy Gardens is not that different from the fear of quarantine experienced by the Chinese in Taipingshan, either sent to the Hygeia or to the makeshift substitute, a factory converted into the Glassworks Hospital in Kennedytown.

\(^{847}\) Huang Xingchu is the index case of SARS, the first traceable case. Years after his recovery from his illness, he is still haunted by his association with the infection. The restaurant he worked at in Shenzhen closed due to harassment from the public fearful and angry. He returned to Heyuan, and now owns a restaurant in the Linjiang township. But his restaurant is registered under someone else’s name, as Huang frequently changes aliases and mobile phone numbers. For his unwitting role in spreading SARS, the media dubbed him “the Poison Master”. Hounded by people’s curiosity and accusations, he has dropped most connections to his life and friends before SARS; “Have you [the public] ever thought of my suffering and feelings?” he asks. “I’m not Huang Xingchu anymore. I’m fed up of being Huang Xingchu”, he says. He just can’t shake the trauma of those six feverish weeks. See Huifeng He, “A decade on from Sars: Torment of the first patient,” *South China Morning Post*, 1 April 2003.

A few more points deserve mention, if only for future consideration. The first two epidemics discussed here, malaria and bubonic plague, connect Hong Kong to the wider histories of colonial and imperial medicine. They also connect Hong Kong to the tropics, and connect Hong Kong history to the discourse of tropicality. Now, the efforts of early colonizers both to tame and “green” Hong Kong, to make it safer, arable and aesthetic, connect to other European projects. Thinking about Hong Kong in the frame of tropicality does nothing to resolve what is debated as liminal, hybrid or ambivalent in this history. Rather, thinking of Hong Kong as tropical makes this discourse more complex. It becomes more like other colonial histories but also more like itself, the imminence of climate, nature and contagion that is obvious in the lived experience of this place normalized if Hong Kong is tropical.

The influenza outbreaks of 1957, 1968 and SARS suggest a different frame. These three outbreaks share a particular epidemiological characteristic that has historical significance. When they moved through Hong Kong’s population and were reported by its infectious disease monitors, they were novel infections—viral strains first identified in the course of these pandemics. As such, their virological identities are coupled to the occasion of their confirmed (or assumed) first emergence. Following Theresa Macphail’s elaboration of the concept of pathography, Hong Kong is the site or stage in the first chapters of the social lives of H2N2, H3N2, and SARS. The notion of a bacteria, virus or parasite having a social life is increasingly familiar as the solitudes of the sciences and the arts are more often breached in interdisciplinary scholarship. The impression of a pathogen as insentient but intelligent resonates when biologist borrows the jargon of the social scientist, studying a bacteria’s “shared secret ‘public goods’” or studying cooperation and altruism through observation of bacterial sociality. But the current flows the other way, too, Macphail demonstrates; her project “[depicts] influenza viruses as key informants…tied up with far larger political and epistemological questions concerning the agential relationships between human and nonhuman actors.”


Hong Kong’s emerging identity and the subjectivities of its people just as the city was the context for the debut of these viruses.

For Margaret Lock and Nancy Scheper-Hughes, the body is always present as three: the individual embodied self, the social body, and the body politic. The latter is evident as an object of political control: surveilled, regulated and controlled by coercion or biopower. The social body appears as a “natural symbol with which to think about nature, society, and culture”, a model of social harmony or disharmony. The individual body is diversely constituted, and known to others through the testimony of the individual on their particular sensations, experiences, and understanding. Perhaps the social body of heunggongyahn did not have a natural birth despite the contemporary flare of groups identifying themselves as “nativist”.

Hong Kong identity was created first in a binary against the mainland Chinese when the politics of the PRC and British-ruled Hong Kong put an end to the sojourner culture. Regular passage between Hong Kong and China had allowed the Chinese community, predominantly a labour diaspora, to continue to imagine themselves as Chinese instead of colonial subjects. Once forming a settled population in Hong Kong, shared experiences began to mould a new identity.

Rey Chow was the first to spatialize the difference of heungganyahn, referring to Hong Kong as a ‘Third Space’. For Chow, Hong Kong cannot escape its place between empires but, as Wing Law Sang aptly summarizes Chow’s love-letter to her place of origin, Hong Kong escapes regular politics and political metaphors and exists as “a cultural project of self-writing that is fully aware of its own hybridity, a state characterized by its impossibility to return to a native

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854 Beyond the binary, descriptions of Hong Kong identity show the influence of colonialism in the embrace of liberal values of including democracy, free speech, freedom of the press, privacy, and equality. Pride in the free market and in entrepreneurial spirit, too, are long-associated with Hong Kong people. See Eric KW Ma and Anthony YH Fung, “Negotiating local and national identifications: Hong Kong identity surveys 1996–2006,”
past”. But what if the third space is not spatial, even as a space of agency, but is rather the body of a Hong Kong person, a site where politics, culture and nature are held in tension and bloom?

This dissertation has sought to demonstrate that in addition to the epidemic events that had overt and macro-scale influence on the development of Hong Kong, the chronic presence of infectious disease and the collective trauma of five epidemic events in the century and a half since colonization are equally influential in forming local subjectivity in Hong Kong. Subjectivity—but also identity, a subtle but important conjunction. While the definitions of these terms weave together and shift apart in discourse, sharing a good deal of semantic terrain, subjectivity is that upon which power is practiced while identity stands to announce itself. The influence of epidemic events and chronic threat of infectious disease on Hong Kong subjectivities is articulated in every chapter. Living in Hong Kong, contending with the prevalent ecological, climatological, political and social factors, engenders an awareness of disease risks. Again—look up from the street to the signs, myriad and omnipresent through Hong Kong, that tout the services of physicians, herbalists, acupuncturists, massage therapists, bonesetters. This is the evidence of Hong Kong subjectivity as being highly medicalized. The power to which Hong Kong people are subject is plural—the power of nature, and the biopower as healthism and responsibilization that epidemic events inspired. The last chapter on the SARS epidemic of 2003 suggests that Hong Kong identity is equally medicalized now, that being aware of epidemics and infectious disease is not just a part of everyday life in Hong Kong but also the subject of local arts and culture of which heunggongyahn are producers and consumers.

China now participates in the surveillance programmes of the World Health Organization. A recent survey of the WHO warnings attached to China all relate to influenza outbreaks: a report of a human infection with H5N6 on January 11, a case of H7N69 on January 11, and another human infection with H5N6 on January 26. Hong Kong no longer has its own WHO office; it has been taken off sentinel duty. Hong Kong’s complex disease ecology promises that another epidemic will very likely eventually occur. Perhaps a new strain of influenza, maybe a novel

virus. Hong Kong is vulnerable, as always, but continues to transform, to evolve to meet whatever is around the corner. Epidemics are not only critical events in Hong Kong’s history, but woven into the projects and life of the city in productive ways. Anthropologist Theresa MacPhail writes about her conversations with virologists working in local universities. Their projects are similar to those of scientists anywhere else in the world, but MacPhail uncovers ways in which the stakes of these projects and the ways in which they are carried out are unique to Hong Kong. She asks a scientist about the ways that the public cooperates, or does not cooperate, with research:

When I asked Raymond whether or not it is difficult to get farmers to understand the lab’s work and to collaborate in the collection of various types of virus samples, he nods. It had been difficult to convince farmers in the New Territories to allow regular sampling but after outbreaks of SARS and H5N1 avian influenza, the surveillance has become enforced as a legal mandate. It is far more difficult, Raymond explains, to collect samples from farms on the mainland.

Having internalized the traumas of recurring epidemics, Hong Kong farmers understand the stakes of understand, prevention, and of cures. The samples they provide, just bits of soil that may contain information about the zoonotic crosshatch that could produce future influenza reassortments, for example, “connect otherwise disconnected individuals and locations. The relationship between farmers and the scientists in Hong Kong was frequently described to me as “close” and as necessarily “familiar”.

One of the best known names in Hong Kong’s health history, Dr. Gerald Choa, connected Hong Kong’s resilience in global economic instability to its epidemic history, writing,

[i]n recent years, there has been much talk about Hong Kong's resilience, its capacity to recover quickly from one financial crisis after another, becoming even more prosperous each time. We seem to have forgotten Hong Kong's resilience to have survived from the devastations of diseases, such as malarial fever in its infancy, bubonic plague in its

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857 MacPhail, 71.
858 MacPhail, 73.
adolescence and occasional outbreaks of cholera, typhoid fever, dysentery and others all through the years. There was a time when living in Hong Kong was a hazard, for one never knew when life or health would be threatened.\textsuperscript{859}

The closeness and familiarity of the New Territories farmer and the epidemiologist, it seems, is the reason for the resilience to which Choa alludes. Where the next epidemic is always close by, every Hong Kong person is responsible. We can think back now to Henry Sirr’s lamentation for those lost to Hong Kong fever, his loathing of Wong Nai Chung and of the new colony. “Death is the presiding genius of Hong-Kong”, he wrote.\textsuperscript{860} In the way that disease and death guided the making of Hong Kong, Sirr might have been correct in his time. Today, the epithet might be edited to reflect contemporary realities. Current WHO data finds that Hong Kong has the lowest infant mortality rates worldwide, and the longest life expectancy.\textsuperscript{861} The new presiding genius might be survival, or vigilance, or hope. Or resistance—for as Foucault put it, “[t]he first task of the doctor is therefore political; the struggle against disease must begin with a war against bad government. Man will be totally and definitively cured only if he is first liberated.”\textsuperscript{862} What liberation might mean for Hong Kong’s political and medical future is likely to be informed, as was its making, by the influence of nature and disease. “Make no mistake”, warns Macphail writing about viruses in Hong Kong, pathogens “are always at the heart of the multilayered, multiscaled story that is about to unfold.”\textsuperscript{863}

\textsuperscript{859} Gerald Hugh Choa, “The Lowson Diary”, 145.
\textsuperscript{860} Sirr, 5.
\textsuperscript{862} Michel Foucault, Birth of the Clinic: An Archeology of Medical Perception (London: Tavistock, 1973), 33.
\textsuperscript{863} Macphail, 14
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