

**History Matters:
A Comparative Exploration on the Spanish Flu and the
COVID-19 in India**

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Abstract

The history of the world is the history of pestilences, epidemics and pandemics, affecting humanity – storylines of getting bogged down and bouncing back to crises. The influenza pandemic of 1918–1919 has been called the greatest medical holocaust in history and the mother of all pandemics. The country that faced the greatest devastation in terms of human mortality from influenza is India. After a century, India has been hit by COVID-19, the greatest pandemic of the contemporary times, exposing systemic failures in the functioning of the statecraft. This article is a comparative exploration of the two pandemics along survey of historical sources and secondary scholarship to finally forge the critical discussion: are we in a better position to tackle crisis? Lessons from previous pandemics, most importantly the Spanish Flu of 1918 can be significant in terms of analysis and assessment of strengths, weaknesses, opportunities and threats of the country – then and now. This article conveys the larger rationale of looking back to look and move forward in terms of crafting just, inclusive and resilient policies from a diseased to a desirable (non)Anthropocene.

Keywords: Spanish Flu, COVID-19; India; SWOT; history

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Introduction

The history of the world is the history of pestilence, epidemics and pandemics, affecting humanity – storylines of getting bogged down and bouncing back to crises. The word ‘quarantine’ is derived from the Italian *quaranta*, meaning ‘forty’. Frank M. Snowden (2019) explains in *Epidemics and Society: From the Black Death to the Present* that the practice of quarantine originated long before people understood what, exactly, they were trying to contain. Moreover, the period of forty days was chosen not for medical reasons but for scriptural ones, “as both the Old and New Testaments make multiple references to the number forty in the context of purification: the forty days and forty nights of the flood in Genesis, the forty years of the Israelites wandering in the wilderness...and the forty days of Lent.” From bubonic plague to small pox to cholera to avian influenza to recent pandemics like Ebola, SARS, MERS, etc. the world has been ravaged time and again only to re-emerge as a resilient system. However, the frequency in the disruption of pandemics, shaping and in turn getting shaped by the Anthropocene are warning signals, pushing us to rethink our strategies towards resilience planning. It is imperative to turn to the pages of history to learn more about the pandemics of the past, to devise strategies of the present, and remain ever more prepared for the future. This article is based on a comparative exploratory study between the Spanish Flu of 1918 and the COVID-19 within the Indian context.

That the 1918 Flu was a pandemic finds clear justification in the most recent book (2017) on the topic: *Pale Rider: The Spanish Flu of 1918 and How It Changed the World* by Laura Spinney. Spinney (2017) pointed out, “In 1918, the Italian-Americans of New York, the Yuptik of Alaska and the

residents of the Persian shrine city of Mashed had almost nothing in common – except for a virus.”

The influenza pandemic of 1918–1919 has been called the “greatest medical holocaust in history” (Waring, 1971: 33) and the “mother of all pandemics” (Taubenberger and Morens, 2006). In *The Great Influenza: the Story of the Deadliest Pandemic in History*, historian John M. Barry (2005) estimated that globally, the 1918 pandemic killed more people in a year than what the Black Death of the Middle Ages killed in a century. More people died in this flu in 24 weeks than the fatalities caused by HIV/AIDS in 24 years! The country that faced the greatest devastation in terms of human mortality from influenza is India (Johnson and Mueller, 2002). The enormous numbers of casualties and people sickened by the virus had consequences that lingered through successive generations at least till the middle of the 20th century (Almond, 2006; Johnson and Mueller, 2002; Mazumder et al., 2010; Mills, 1986; Morens et al., 2009).

After a century India has been hit by COVID-19, the greatest pandemic of the contemporary times, exposing systemic failures in the functioning of the statecraft. Indian socio-political complexities have made her situation extremely challenging, which is evident during the second wave of the crisis. Lessons from previous pandemics, most importantly the Spanish Flu of 1918 can be significant in terms of analysis and assessment of strengths, weaknesses, opportunities and threats of the country – then and now. This article conveys the larger rationale of looking back to look and move forward in terms of crafting just, inclusive and resilient policies from a diseased to a desirable (non) Anthropocene.

The Outbreaks

The 1918 pandemic was caused by an H1N1 virus with genes of avian origin. Although there is no universal consensus regarding where the virus originated and it is commonly called the Spanish Flu, the 1918 pandemic likely began in Kansas and killed between 50 and 100 million people worldwide. ²During the early months of 1918, the virus incubated throughout the American Midwest, eventually making its way east, where it travelled across the Atlantic Ocean with soldiers deploying for WWI (Fig. 3). M. Chunn who completed her thesis entitled *Death and Disorder: The 1918-1919 Influenza Pandemic in British India* in 2015, has recently written a more popular piece tracing the route of the virus:

“Introduced into the trenches on Europe’s Western Front, the virus tore through the already weakened troops. As the war approached its conclusion, the virus followed both commercial shipping routes and military transports to infect almost every corner of the globe. It arrived in Mumbai in late May.”

In *An unwanted shipment: The Indian experience of the 1918 Spanish flu*, the Stanford University Professor Amit Kapoor (2020) describes:

“A ship carrying Indian troops reached the shores of Bombay on the 29th day of May in 1918. It remained anchored to the city’s docks for about 48 hours. The world was on its last leg of the First World War, so the Bombay ports were usually busy with the movement of troops and goods back and forth from England. The

ship, thus, remained an inconspicuous visitor on its waters among the humdrum of activity around it. However, the city was not prepared for some unusual cargo that had come unbeknown to anyone on the ship: lethal strains of the H1N1 influenza virus right from the trenches on the Western front."

An element of racism can be traced in the colonial attitude about the outbreak of the disease. The British authorities differed over the source of the infection. Though the then British Health Inspector J.S. Turner believed that the people on the docked ship were carriers of the disease and they brought the influenza to Bombay, yet the government believed that the crew had caught the flu from inside the city itself. In *Western Medicine and Public Health in Colonial Bombay 1845-1895*, medical historian Mridula Ramanna (2002) shed light on the perils of racism evident in colonial India: "This had been the characteristic response of the authorities, to attribute any epidemic that they could not control to India and what was invariably termed the 'insanitary condition' of Indians." Local newspapers complained that the British officials stayed in the hills during the emergency throwing common people to face crisis by themselves.

There is scientific controversy on the origin of COVID-19. It was projected that in late 2019, someone at the Huanan seafood market in Wuhan was infected with a virus from an animal. From that first cluster in the capital of China's Hubei province it became a global pandemic affecting almost every country in the world. There is uncertainty on the animal from which the virus has been transmitted. While some studies demonstrate that it has high level of similarity with viruses found among pangolins (Cyranoski, 2020), others have compiled evidences to suggest that it is bat-borne (Zhou et al., 2020).

Scientists assume that it is likely that the virus came from bats but first passed through an intermediary animal in the same way like the 2002 SARS outbreak – moved from horseshoe bats to cat-like civets before infecting humans. The World Health Organization (WHO) declared it to be a global pandemic on March 11, 2020 with massive rate of human transmission simultaneously across different parts of the world. The first case of the 2019–20 coronavirus pandemic in India was reported on January 30, 2020 from Kerala, which rose to three cases on February 3. The affected people were students who had returned from Wuhan, China.

Transmissions at Clock-speed

J.S. Turner, remarked that the disease came “like a thief in the night, its onset rapid and insidious” (quoted in Biswas, 2020). Originally being spread from the port (of Bombay), Indian transportation system played an important role in the diffusion of the disease. “The railway played a prominent part as was inevitable,” remarked the Sanitary Commissioner (1920). From the hilltops of Shimla to the isolated villages of Bihar, no part of the country remained unaffected. The speed and extent of the fatalities were overwhelming.

Bombay remained the entry point of the disease. There were two distinct epidemic waves, a mild one in the spring or summer of 1918, and a second and much more lethal one in the autumn or winter. The second wave originated in Bombay in September 1918, simultaneously spreading north and south, and reaching Sri Lanka and the northern Indian provinces in October 1918 (Patterson and Pyle, 1991).

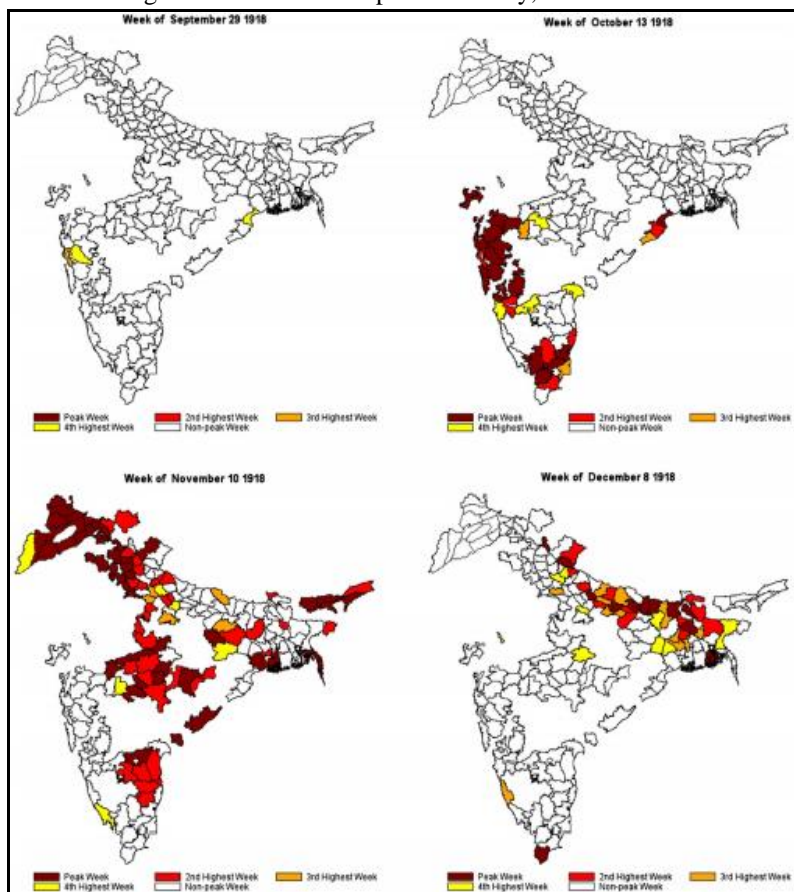
It was the first to experience the first and second waves of the epidemic, with an autumn wave that was shorter and more

pronounced than those for the other cities like Madras and Calcutta. Madras experienced the wave slightly later and in a less (albeit still) pronounced manner, and Calcutta experienced a prolonged but altogether less prominent second wave. That there is a direct correlation between location, timing, duration, and severity of the pandemic had been manifested through the progress of the pandemic across British Indian cities. The provincial death rate in the Bombay Presidency was a relatively high 54.9 people per thousand inhabitants (Sanitary Commissioner Report, 1920).

The most detailed study and robust analysis of the speed and duration of the virulent autumn wave of the disease as it evolved and diffused throughout India has been conducted by Chandra and Kassens-Noor (2014), estimating weekly deaths through computational statistics in 213 districts from nine provinces: Assam, Bengal, Bihar and Orissa, Bombay, Central Provinces, Madras, Northwest Frontier Province, Punjab, and United Provinces for the five-year period from 1916 to 1920.

Different regions of India experienced successive episodes of peak mortality. The week of October 13, 1918 shows the early regional peaks in the western province of Bombay, the south-eastern province of Madras, and a small area on the eastern coast of India near the important Hindu pilgrimage site of Puri. Four weeks later, the epidemic peaked in the Central Provinces and the northwestern province of Punjab (week of November 10). Finally, another four weeks later, the epidemic peaked in the northern and eastern parts of the United Provinces, Bihar, and Bengal (week of December 8). This last set of peaks appears more scattered and sporadic than the more synchronous peaks seen in Bombay, Madras, the Central Provinces, and Punjab.

Figure 1: Districts with peak mortality, 1918-1919



Source: Chandra and Kassens-Noor, 2014: 2

The above four maps are striking in that they demonstrate that over time (a) the severity of the epidemic diminished (b) the velocity (average time to death) of the wave slowed down (c) the wave grew longer in duration and (d) the eastern portions of India were the last to experience the pandemic (Chandra and Kassens-Noor, 2014) (Map 1). The severity of the wave was

negatively correlated with the length and variance of the wave, suggesting that waves that lasted longer tended to have lower peak mortality weeks. Weather might also have played an important role in the spread of the pandemic. Humidity hypothesis by Shaman and Kohn (2009) and Shaman et al. (2010) suggest that absolute humidity constrains both influenza virus survival and transmission efficiency. Bengal and Bihar were least severely affected. Bombay had a paucity of rains and the summer monsoon ended early which might have triggered the virus spread during autumn. Calcutta, which had a wetter and longer summer monsoon than Bombay, may have been spared the virulence of the pandemic because of higher humidity.

On 4 March, 2020, 22 new cases came to light, including those of an Italian tourist group with 14 infected members. The transmission escalated during March, after several cases were reported all over the country, most of which were linked to people with a travel history to affected countries.

Different incidents (religious and social gatherings) triggered the disease to travel from one stage to the other. A Sikh preacher who returned from travel to Italy and Germany, carrying the virus, attended a Sikh festival in Anandpur Sahib between March 10 and 12. Twenty-seven COVID-19 cases were traced back to him. Over 40,000 people in 20 villages in Punjab were quarantined on March 27 to contain the spread. On March 31, a Tablighi Jamaat religious congregation event took place in Delhi. The location emerged as a new virus hotspot after numerous cases across the country were traced back to the event. Over 9,000 missionaries may have attended the congregation, with the majority being from various states of India, and 960 attendees from 40 foreign countries. According to Ministry of Health and Family Welfare (MoHFW), 4,291 out of 14,378 confirmed cases were linked to this event in 23 Indian states and

union territories till April 18. The cases kept increasing and within a short period of time, India reached the third stage of community transmission. An Indian Council of Medical Research (ICMR) research found that 40 among a total of 104 (over one-third) COVID-positive cases in a sample of 5,911 severe acute respiratory illness (SARI) patients had no history of international travel or contact with any known COVID-19 case. The sampling was done from 41 sentinel surveillance sites across 52 districts in 20 states/union territories. The 40 cases with no apparent link to identifiable source of infection were from 36 districts in 15 states, and that is a large fraction (69%) of the identified districts for surveillance (Ramachandran, 2020).

Though subsequent phases of the Indian lockdown could arrest transmission, the second wave between March and May 2021 with the peak period affecting 4 lacs people on a daily average in early and mid-May also led to the proliferation of COVID in rural quarters.³ The mutant varieties remained woe nation-wide leading to rapid outspread of the disease and in some cases compromised immunities and reduced effectiveness of the vaccine. India's complacent attitude during the intermittent period and violation of COVID-19 protocols through mass social and political (election) gatherings led her to encounter the avoidable disaster and its multi-faceted implications apart from and along with loss of lives and livelihoods.

Unfortunately, the weather factor or the humidity hypothesis does not seem to hold ground in the disease transmission. A nine-page report submitted to the White House by the Standing Committee on Emerging Infectious Diseases and 21st Century Health Threats of the U.S. National Academy of Science, Engineering and Medicine entitled *Rapid Expert Consultation on SARS-CoV-2 Survival in Relation to*

Temperature and Humidity and Potential for Seasonality for Pandemic COVID-19 mentions:

“Although experimental studies show a relationship between higher temperatures and humidity levels, and reduced survival of SARS-CoV-2 in the laboratory, there are many other factors besides environmental temperature, humidity, and survival of the virus outside of the host, that influence and determine transmission rates among humans in the ‘real world’.”

Implications across Provinces/States, Cities and Communities

The pandemic affected a third of the world's population and claimed between 50 and 100 million lives. The focal point of the epidemic in terms of mortality was India, with an estimated death toll range of 10–20 million, and a point estimate of population loss of 13.8 million for the British-controlled provinces, more than all the casualties in World War I. India lost 6% of its population.

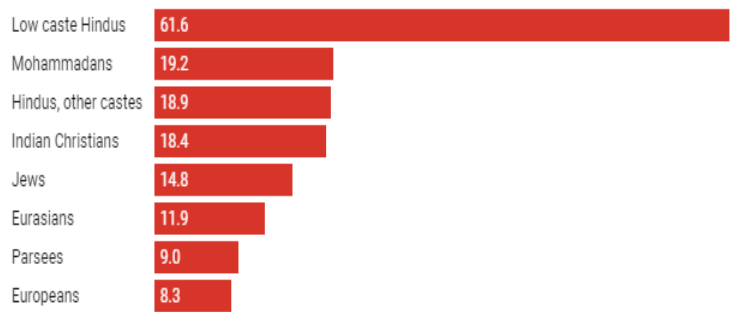
The northern and western provinces of India saw death rates between 4.5% and 6% of their total populations, while the southern and eastern provinces (where the virus had a late entry), lost between 1.5% and 3%. In terms of severity, Bombay, the Central Provinces, and parts of Madras were hardest hit. Calcutta had a mild surge. In Bombay, 768 people died in a single day on October 6, 1918. Nearly every house in Bombay has some of its inmates down with fever. The severity and mortality in cities were much higher. Spinney (2017) mentions:

“It led to famine in large parts of the country, so the flu is going to pick on people who are already weak. On top of that a lot of doctors were away at the war. Death rates were higher in cities than in country areas as a rule. Bombay was a very unhealthy place at the time because you have refugees flooding in from the countryside who were starving. Population of the city was swollen and there was also cholera, because of the refugee problem.”

The highly infectious Spanish Flu had swept through the ashram in Gujarat where 48-year-old Gandhi was living, four years after he had returned from South Africa. He rested, stuck to a liquid diet during "this protracted and first long illness" of his life. When news of his illness spread, a local newspaper wrote: "Gandhi's life does not belong to him - it belongs to India" (Spinney, 2017).

The 'colonial divide' had severe ramifications manifested through spatial inequities across 'white' and 'black' settlements. While the British inhabited spacious houses with gardens and yards, the lower classes of city-dwelling Indians lived in densely populated areas. The rich colonizers could employ household staff to care for them in times of health and sickness. They were only lightly touched by the pandemic and were largely unconcerned by the chaos sweeping through the country. In his official correspondence in early December, the Lieutenant Governor of the United Provinces did not even mention influenza, instead noting "Everything is very dry; but I managed to get two hundred couple of snipe so far this season." To the Indians, it was devastation beyond redemption. The fatalities across the social divide clearly brings out structural inequities in colonial India (Figure 2).

Figure 2: Higher mortality rates among poor and vulnerable communities



Source: A 1919 British Report summarizing the previous year's death tolls per 1,000 people in Bombay, cited in Chandra et al., 2012.

The Health Officer for Calcutta remarked on the stark difference in death rates between British and lower-class Indians: “The excessive mortality in Kidderpore appears to be due mainly to the large coolie population, ignorant and poverty-stricken, living under most insanitary conditions in damp, dark, dirty huts. They are a difficult class to deal with.” Among Indians in Mumbai, socioeconomic disparities in addition to race accounted for these differing mortality rates. In Mumbai, almost seven-and-a-half times as many lower-caste Indians died as compared to their British counterparts - 61.6 per thousand versus 8.3 per thousand.

Again, India was the only country where more women than men died across all age groups. Spinney (2017) explains:

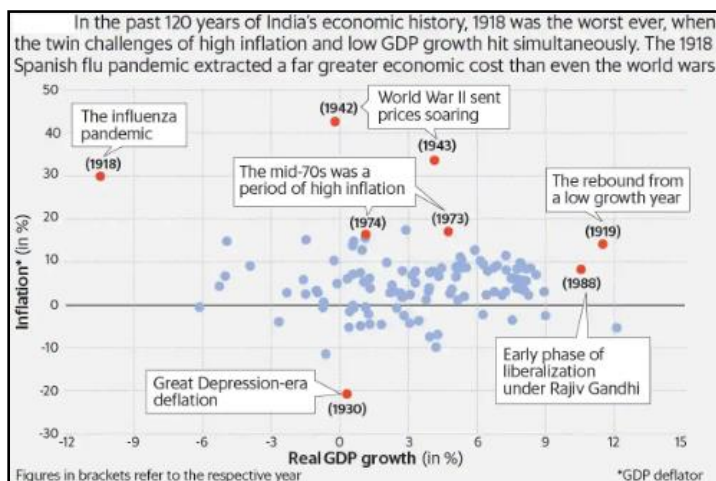
“One theory is that women tended to eat less well. Boys and men were given priority where food was concerned in many households. Women were also more likely to nurse the sick. Not only were they more exposed to the disease as a rule but they were also less resistant

because they were more likely to be malnourished. There may have been a factor of vegetarianism, it is not clear.”

Bodies piled up. There was not enough firewood to cremate them. A delayed and failed monsoon led to a drought and famine-like situation, leaving people underfed and weak, making matters worse. Many migrated to the cities triggering the rapid transmission of the disease. Nearly every household was the Hindi poet, Suryakant Tripathi, popularly known as Nirala, wrote in his memoirs that “Ganga was swollen with dead bodies.” And it was not just Ganga that was clogged up with bodies, but all rivers across India. “The burning ghats and burial grounds were literally swamped with corpses; whilst an even greater number awaited removal” (quoted in Chunn, 2020).

In the last 120 years of recorded economic history in India, 1918 was the worst (Figure 2). Recorded growth in real gross domestic product (GDP) was the lowest (-10.5%) while inflation was near all-time highs, a cocktail much worse than any other tragedy that has hit India—including the world wars or the Bengal famine. 1918 was a unique phase in India’s macroeconomic history and a supply-side shock as people had to stay home.

Figure 3: The GDP compared to other big events



Source: Central Statistics Office, OECD, retrieved from <https://www.livemint.com/>. Accessed on April 27, 2020.

The implications of COVID-19 are highly un-uniform across different regions and social communities. The different states qualify differently in terms of performance encompassing preparedness and other factors pertaining to response to the crisis. By the end of April there are 35,000 positive cases with 1150 deaths. The state of Kerala performed well with a very good recovery rate and a quick reduction in transmission. Karnataka relied on numerous voluntary organizations to spread awareness and mobilize emergency health. Karnataka has identified 18 government hospitals and 27 private hospitals in Bengaluru for COVID-19 patients. The coverage in the districts beyond Bengaluru is fairly poor, with only 34 hospitals in 28 districts designated to treat positive cases. And this also makes evident the partisan approach and the divide between cities and rural districts. Despite posting impressive recovery from a sharp

spike in COVID-19 cases, Tamil Nadu is worried about losing a battle as lack of adequate testing kits has hampered aggressive testing during the lockdown. After initial denials and reckless statements, the Chief Ministers of both Telangana and Andhra Pradesh have attempted to rise up to the COVID-19 challenge and its economic fallout. Lockdown failures, charges of data suppression on cases and deaths, very low testing, lack of protective equipment for health care workers and the need to have at least some sections of industries up and running are some of the issues West Bengal is wrestling with. After the initial slow response to the sudden migrant onrush, the Delhi government has retrieved lost ground to launch containment and surveillance measures, besides providing relief to the stranded migrants. Odisha has been able to keep a lid on the coronavirus infection through a strategy involving setting up of response teams, enforcing containment measures, ramping up testing, and using effectively the experience gained in handling natural disasters.

Again, COVID-19 is very urban-centric. The more urbanized states are among the top ten states impacted by corona. These are Maharashtra (45% urbanization), Gujarat (43%), Delhi (98%), Rajasthan (25%), Madhya Pradesh (28%), Tamil Nadu (48%), Uttar Pradesh (22%), Andhra Pradesh (29%), Telangana (39%) and West Bengal (32%). While Rajasthan, Madhya Pradesh and Uttar Pradesh are less urbanized than the national urbanization average, they have been catapulted into this list on account of their geographic and demographic size as well as the presence of large cities such as Jaipur, Indore and Hyderabad in their fold (Jha, 2020). Ten cities of India had over half the coronavirus cases. These cities comprised Mumbai, Delhi, Ahmedabad, Indore, Pune, Jaipur, Hyderabad, Chennai, Surat and Agra. Their share as a total percentage of cases increased over time. If we take the figures of 30 April, Mumbai and Delhi,

the two largest Indian cities alone had about 30% of all the cases in the country.

The implications of COVID-19 have been diverse across different social classes and communities with their own sets of challenges and coping mechanisms to adapt and adjust to the crisis.

Working class (including India's 'floating' population)

Box 1: Dharavi: Mumbai's ticking bomb

"If we don't die from the disease, we will die of starvation," says a woman, 45, who lives in the sprawling Geeta Nagar slum near the World Trade Centre in Mumbai. "They (police) have been patrolling our lanes ever since the lockdown started. They allow us to go to shops only within the slum. Those shops charge us three times the price for rice or *dal* (pulses). We heard the Prime Minister saying all food will be available at fixed price. But the shopkeepers charge us whatever they want. It is robbery."

Barely 100 metres away are buildings that house some of the richest in the city. "Physical distancing and lockdowns are for the rich. In the beginning, we thought it was temporary. If we do not get work when the lockdown lifts, there will be a rebellion," argues another male resident of Dharavi.

Source: Ethnographic account of A. Katakam (2020)

The lockdown caused untold hardship and suffering to migrant workers, dependent on daily wages. It disrupted their daily work and their ability to earn wages. It created panic and resulted in their mass exodus to their villages on foot. Even those who were in shelter homes were being herded together, which exposed

them seriously to the virus. The lockdown and the subsequent government orders to prevent their reverse migration had subjected migrant workers to unimaginable distress and misery. While the government ordered that employers should pay wages to all the labourers employed by them, the private sector companies might not be able to fulfil these directives as many of them were on the verge of closure. The condition in India's slums is painstaking (Box 1).

Farmers

To understand the impact of COVID and the nationwide lockdown on the rural sector, the Foundation for Agrarian Studies (FAS) canvassed a set of questions among 43 residents of 16 villages in 10 states across India. The respondents represented a cross-section of village society—from large landlords to agricultural and manual workers, from ASHA (Accredited Social Health Activist) workers to individuals engaged in large and small businesses and other non-agricultural activities. The questions sought broadly to understand how a three-week lockdown period, which sought to pare down economic activity to a minimum, impacted the life, work and economic status of rural families. Two patterns have emerged in respect of the impact of the lockdown on agriculture. In rain-fed villages, this is normally the lean season and there is no standing crop, so there is little direct effect on agricultural operations and production. In irrigated villages, this is the harvest period, normally the busiest time of the year, and a peak work season for agricultural labour. In such villages, where the harvest is either just over or will begin this month, respondents report a dramatic drop in work, whether on the fields or in non-agricultural activities. In villages where harvesting is yet to begin,

particularly in the wheat belt of Bihar, Punjab, Uttar Pradesh and Madhya Pradesh, landowners use combine harvesters or family labour for harvesting operations. In West Bengal, there is a concern about adequate labour for the harvest of boro paddy due in May. In Bihar, because workers cannot migrate or have returned to their villages, their numbers have increased in the village labour force, forcing wages down. Moreover, non-agricultural economic activities that usually absorb surplus labour in the lean agricultural period like construction activity, businesses, brick-kilns, have almost totally stopped. In West Bengal, the breeding and sale of fish in village ponds is an income-earner in the lean season. Although there is good local demand for fish, this year this avenue of employment has been restricted severely by movement restrictions and the partial closure of markets.

The massive contraction in employment and incomes for manual labourers in the lockdown period had an almost immediate impact on the quantity and quality of the dietary intake of rural families, aggravated by the malfunctioning of the public distribution system (PDS) in different states. It is not just a matter of having less money in the wallet for food. Poor farming families have been hit by the rise in prices of vegetables and other commodities. With a few exceptions, including Tamil Nadu and Kerala, rations in states comprised only cereals. The only two states that reported distribution of cooked meals during the lockdown period were Kerala and Punjab. In Kerala, Kudumbashree-run kitchens provided food for migrant camps, while in Punjab the long tradition of *langars* serving free food was reinforced during the COVID-19 crisis.

Students

Lakhs of school students are staring at an uncertain future, not knowing when their derailed career plans will get back on track. Over 31 lakh students taking the Class X and XII board examinations conducted by the Central Board of Secondary Education (CBSE) have got stuck midway because of the pandemic. Another 2.5 lakh students of who take the exams conducted by the Council for Indian School Certificate Examination (CISCE) find themselves in a similar predicament. In addition, over 15 lakh students who were to appear for their Joint Entrance Examination (JEE) Advanced test and another 14 lakh who were to appear for the National Eligibility cum Entrance Test (NEET) for admission to medical colleges across India suddenly find themselves grounded. Lakhs of students who take the school board exams conducted by the State education boards are on the same boat.

The National Institute of Open Schooling (NIOS), in collaboration with the CBSE and the National Council of Educational Research and Training (NCERT), has been working on projects to make academic content available to learners across India through the digital medium or through the direct to home (DTH) mode. Four DTH TV channels on the *Swayam Prabha* bouquet of channels is yet another initiative of the NIOS. Channel 27 and *Panini* are dedicated to secondary classes while Channel 28 and *Sharda* are dedicated to senior secondary classes and Channel 30 and *Gyanamrit* use sign language. Channel 32 and *Vagda* are platforms to foster interactive sessions and exchanges. The switch to and progress made in the DTH mode and online platforms are quite impressive. But it has a long way to go. Moreover, millions of students being affected due to lack of access to digital infrastructures sharply manifests the irony

associated with the socio-digital divide scenario (Bhowmick and Kaushik 2020).

People with special needs

The pandemic and the lockdown have worsened the existing barriers, leading to further curtailment of the independence of disabled people (Awasthi, Chattopadhyay and Kumar 2020). Public health system has become much more inaccessible for persons with disabilities, with hospitals refusing to attend to other medical conditions in the wake of COVID-19. Guidelines issued by the Department of Disability Affairs in the COVID-19 situation have failed to address gender issues. Purchase and maintenance of wheelchairs, aids and appliances, services of caregivers, hiring of private transport owing to inaccessibility of public transport all entail additional expenditure. In a situation of continuous lockdown, boredom, loneliness, fear and anxiety have gripped large sections of society. The loss of employment and livelihood, loss of housing, depletion of support mechanisms and gender-based violence is also having an adverse impact on mental health.

Preventive Strategies and Socio-Economic Challenges

With not much medical progress in vaccines and antibiotics worldwide, control efforts during the 1918 Flu were limited to non-pharmaceutical interventions such as isolation, quarantine, good personal hygiene, use of disinfectants, and limitations of public gatherings, which were applied unevenly. Citizens were ordered to wear masks, schools, theatres and businesses were shuttered and bodies piled up in makeshift morgues before the virus ended its deadly global march. In India, people were

instructed to remain in homes and take adequate rest. Knowledge of the pandemic reached the eastern part of the country via conferences held on the topic. This allowed design and proliferation of simple social distancing measures which were enacted. Early detection through influenza awareness of inspectors and doctors were conducted, lowering virulence in the later stages of the epidemic (Sanitary Commissioners Report, 1920). "The colonial authorities also paid the price for the long indifference to indigenous health, since they were absolutely unequipped to deal with the disaster," argues Spinney (2017), the author of *Pale Rider: The Spanish Flu of 1918 and How It Changed the World*. She draws our attention to the fact that there was also a shortage of doctors as many medical practitioners were away on the war front. However, different volunteering organizations set up dispensaries, removed corpses, arranged cremations, opened small hospitals, treated patients, raised money and ran centres to distribute clothes and medicine. Anti-influenza committees were formed by citizens.

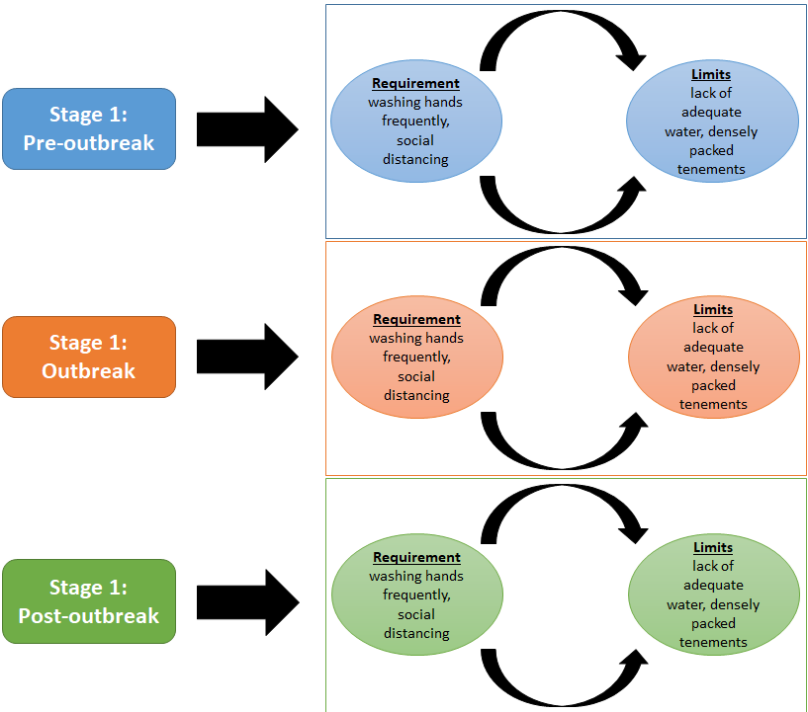
So far as COVID-19 is concerned, keeping in tune to the WHO guidelines, the MoHFW, Government of India clearly chalked out protective measures to fight the contagion. The country declared series of lockdown and is continuing awareness through both offline and online modes and formats.

In *The impact of COVID-19 in informal settlements – are we paying enough attention?* The Institute of Development Studies, Sussex researcher Annie Wilkinson (2020) drew our attention to how the most marginalized people are not in a position to adhere to the preventive measures being prescribed by the health department. "As we in the global North brace ourselves for the coronavirus pandemic we are being told to wash our hands (for 20 seconds!) and self-isolate if sick. But what if you cannot do either of those things? One billion people

live in slums or informal settlements where water for basic needs is in short supply – let alone 20 seconds worth – and where space is constrained and rooms are often shared. Yet discussion about vulnerability in these contexts has been startlingly absent” (Wilkinson, 2020). This is highly valid in the densely packed informal settlements of the Indian cities.

Mukherjee and Sen (2020) argue that COVID-19 in the slums and squatters of Indian metropolises like Mumbai, Delhi, Chennai, Kolkata, etc. presents a classic case of ‘wicked problems’ – a tangled mess of thread where it is difficult to know which to pull first. Often labelled by city authorities as ‘informal’ or ‘illegal’, these settlements do not receive basic services such as piped water, sanitation or electricity. They are not served by primary healthcare facilities or regular solid waste collection, yet these settlements often house over half of a city’s population, being the only affordable option for many residents. Squatters can be the worst sufferers from the outbreak of coronavirus with continued and spiral effects during the pre-outbreak, outbreak and post-outbreak stages (Figure 3).

Figure 4: COVID-19 challenges in Indian urban informal settlements



Source: Mukherjee and Sen, 2020

(Note: The circular arrows between ‘requirements’ and ‘limits’ for each stage suggest that the problem will recur unless interventions are effectively planned and implemented.)

Past, Present and Posterity: The Way Forward

A multi-layered (descriptive) strengths, weaknesses, opportunities and threats (SWOT) analysis for the two scenarios within the Indian sub-continent is significant for this comparative exploration to address if we are better prepared to tackle the crisis and the way forward.

Strengths

1918 Spanish Flu: The demographic size and density and lower rates of travel within and across nations implied less transmission rate and also ensured greater effectiveness of home stay measures. Different historical sources suggest that the dying numbers further triggered nationalist mobilization when participants in the Indian struggle for independence were motivated to free the nation from the shackles of imperial rule which was apathetic towards fatalities caused by the pandemic as part of its exploitative bureaucratic machinery.

COVID-19: Any sovereign country remains in a much better position to respond to crisis, and India is not an exception. Within her emerging economic context, the country has seen profound advancement in terms of technology including medical apparatuses and arrangements. The functioning of various technological institutes geared to national benefits during disasters and disease scenarios, in tune to global guidelines including the WHO has drawn global applaud and appreciation.

Weaknesses

1918 Spanish Flu: It occurred during the pre-antibiotic era, and there was simply not enough medical equipment to provide to the critically ill. The country lacked access to prophylactic measures which was not part of the colonial agenda for a long period of time. Economic historian Amiya Bagchi (2005) has discussed this in his book *Perilous Passage: Mankind and the Global Ascendancy of Power*. The high mortality in healthy people, including those in the 20-40-year age group, was a unique feature of this pandemic. The influenza also affected

more women who were relatively undernourished and cooped up in unhygienic and ill-ventilated dwellings, nursing the sick. The mortality rate of Indian children was also high. Public health provision was massively underpowered (Spinney, 2017). As India faced this scourge in 1918, scientists lacked the technology that would allow them to see the virus that caused it.

COVID-19: The skyrocketing numbers of the Indian population and increasing mobility within and across borders along with a fast pace of life as part of the global mass culture are huge challenges to control the transmission rate and arrest the spread of COVID-19 through the successful implementation of preventive measures including social distancing and quarantine. With COVID being mainly urban-centric and with Indian megacities brewing with multi-faceted problems including densely packed slums with lack of water, sanitation and hygiene (WASH) facilities, the crisis can be catastrophic.

Opportunities

1918 Spanish Flu: The voluntary organizations came forward consisting of people from diverse social strata. "Never before, perhaps, in the history of India, have the educated and more fortunately placed members of the community, come forward in large numbers to help their poorer brethren in time of distress," a government report mentioned (quoted in Biswas, 2020). Again, Spinney (2017) elaborates:

"This is where you see a lot of local and caste organisations mobilizing, coordinating themselves and stepping in a magnificent manner. In political terms, what was interesting was that it got grassroots

organisations talking to each other and going out into remote areas and coming into contact with people like Adivasis and different parts of the communities. It created a lot of bridges. Certain historians argue that it mobilized the grassroots and connected it up to the national movement. National organizations were providing the resources, the money, medicines, blankets and so on with which the local organizations went out to help the population. So, you see this kind of coalescence of the whole movement.”

COVID-19: The medical realities are vastly different now. Although there is still no cure, scientists have mapped the genetic material of the coronavirus, and there is the promise of anti-viral drugs, and a vaccine. The information and communication technology (ICT) is playing a crucial role in awareness and mobilization strategies and also tracking and deployment of essentials. India's emerging expertise and excellence in artificial intelligence (AI), big data, cloud computing, etc. can be a game changer in the war against pandemics. The *Aarogya Setu* App created within a very short time is just one of the examples of the several other forthcoming ones. The community organizations and good Samaritans traversing the country have come forward to help the vulnerable and the most marginalized communities. Thousands of Indians are finding ways to help the vulnerable by sewing masks, holding donation drives, feeding stray dogs and countering fake news.

Threats

1918 Spanish Flu: The World War I context already laid the catastrophic context on which the pandemic was posed. “In that particular situation it wasn’t in the virus’ interest to moderate its virulence. There was no evolutionary pressure to do that. So it just raced through the trenches, killing as it went. And then when you get those troops finally going home, if they survived, they take the virus with them,” says Spinney (2017). The war ended on November 11, making it worse because soldiers returned to different corners of the world. “It is hard to think of a better vehicle for spreading a lethal respiratory disease,” says Spinney (2017). The colonial scenario made the situation worse for the Indian population who were exposed to racist torture and ostracism as everyday lived realities. “In no other civilized country could a government have left things so much undone as did the Government of India did during the prevalence of such a terrible and catastrophic epidemic” (Young India, 1919).

COVID-19: There is much reason to have rational hope for India in terms of waging the corona war, but there are apprehensions against reckless optimism and we should be wise to collectively understand today’s complex scenario and provide solutions from an integrated perspective beyond myopic or sectoral recommendations. In today’s world of ‘infodemic’ it is quite challenging to reach a consensus, leave aside the political!

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1. It is believed that though the infections were noticed across military camps but countries in the midst of World War I—Britain, Germany, France and the US, it was kept a secret in the beginning. However, Spain, which was not a party in the war, reported the outbreak of the disease accurately. So, it seemed to have emerged in Spain, and hence it was named as the ‘Spanish Flu.’

2. For state-wise expert opinions on “rural realities” and the COVID crisis, please refer to panel discussions and reports under the aegis of IMPRI:
<https://www.impriindia.com/tag/rural-realities/>.
Accessed on June 12, 2021.
3. <https://www.nap.edu/read/25771/chapter/1>. Accessed on April 29, 2020.