The City and the Disease: Locating State Strategies and Public Response

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> "Pandemics are not going away. There is no doubt more to come. A pandemic might come from an old and familiar foe such as influenza or might emerge from a new source—a zoonosis that has made its way into humans, perhaps" - Christian W. Mc Millen

The post Cold War era was marked by the onset of globalization – time space compression as stated by David Harvey, which accelerated the production of finance, goods, services and movement of people. (Harvey 2018,54.) Among the various factors of globalization, diseases, epidemics and pandemics have an important role to play, as these issues influence the very process of globalization. Social scientists regard such events as intriguing as they pose new questions about our collective future. The current pandemic of COVID-19 brought the globalised world to a grinding halt. By mid April 2020, 2,004,383 cases are reported and the death scale has touched 126,811. (World meter 2020)

This paper attempts to understand the role of state and response of the public in dealing with epidemics by comparing epidemics in two different historical periods- colonial Bombay and globalised Mumbai.

History and Disease:

There is a close relationship between epidemics and history, as every major epidemic or pandemic alters the course of history. Understanding epidemics from the perspective

of history is an endeavor to know the big picture of 'historical change and development' (Harrison 2004, 5). Prior to the modern age, epidemics were often understood as divine retribution. Several inter connected developments unfolded during the renaissance in the sphere of politics, economics, science and technology. The rise of nation states and modern economy created bureaucratic machinery for the maintenance of law and order. (Foucault 2009, 256) Urban centers became the sites of production and exchange. Public Health has been treated as a common good and the collective responsibility of the state. The rise of bacteriological and epidemiological sciences helped in understanding the interconnectedness between disease and population. Modern medical discourses of health, hygiene and sanitation became integral part of the bureaucratic machinery of nations which turned population into the object of medical surveillance. Epidemics were perceived as a threat to the population which in turn could have ramification on the society and political economy. (Jackson 2017, 134)

During the nineteenth century studied epidemics such as cholera, typhoid, small pox, plague through the prism of miasma theory. It triggered sanitary reform movement all across Europe and urban areas became the target of sanitary reforms, quarantine measures and public hygiene practices. There was an explosion of medical surveillance practices in Europe. (Foucault 2002, 140-141) Global capitalism, modern means of transport and trade led to a widespread of diseases. The colonial state imposed the same practices in the colonies. Though biological in origin, an epidemic's impact on society is enmeshed in its socio-economic, political and cultural structures.

Bombay and the Bubonic Plague (1896)

Nineteenth century witnessed the rise of colonial Bombay as a prominent industrial centre with trade links across the world. The trade and textile industry led to the influx of migrant population to the city. However, this development was marked by disparities of class, infrastructure, health care and sanitation, ramifications of which were evident during the Bubonic plague epidemic. (Ghadge 2018)

Plague was first recorded in September 1896 from the city of Bombay (Deshmukh 1988, 479). The colonial government was initially reluctant to take action fearing the impact of quarantine measures on international trade. (Chandavarkar 1992, 207; Pati and Harrison

2009, 2) The stakes of the British Empire in the international political economy and the discussion about plague in the Venice sanitary convention played a vital role in prioritizing anti-plague initiatives. (Dutta 2009,77-78; Arnold 1993,205) The government identified the sick, moved them to the hospitals, segregated their contact into health camps and disinfected localities (Chandavarkar 1992, 207). Plague research committee was formed with Dr Waldemar Haffkine as a member who discovered a vaccine. (Verma 2020) Initially there was only one Arthur Road hospital. The government enacted the Epidemic Disease Act of 1897. Inspection checkpoints and detention camps were set up at railway stations (Chandavarkar 1992, 208). Military personnels were enlisted along with medical practioners to conduct door to door inspection – mainly to identify bodies with glandular enlargements. Their touch was considered as violation of bodily privacy. (Arnold 1993, 214)

The intrusive measures often led to riots. Exodus from the city caused the further spread of the disease. (Arnold 1992, 216) Eventually the government realized the need to involve educated Indians as public health volunteers. (Echenberg 2010, 75) Leaders of the working-class movement like Narayan Meghaji Lokhande also played a pivotal role during the epidemic. (Kadam 1995, 151) It took two decades of research to understand the role of rat fleas in the spread of the epidemic According to Ira Klien, natural immunization rather than medical policies may have curbed the spread of the epidemic. (Klein 1988, 754-755) David Arnold considers 'the natural limits set on its spread by a variety of zoological and ecological factors, such as the geographical distribution of certain species of rat fleas and the growing immunity of rats to the plague bacillus' as the reason for the decline of plague. (Arnold 1993, 235-236)

Almost 124 years after the outbreak of the plague epidemic, the city is attacked by the Covid- 19 pandemic. The present Mumbai is governed by a democratic state structure that has a functional public health system. There is clarity about the origin and trajectory of the current pandemic. There is a coordination between World Health Organization and India in dealing with the crisis. The state has deployed a blend of old and new legal, administrative and medical strategies and techniques to combat the pandemic.

Mumbai and Covid -19

The first reported case of Covid-19 in India had a direct link to Wuhan. (Livemint 2020) The World Health Organization (WHO) Director General, Dr Tedros Adhanom Ghebreyesus warned the countries with weak public health system to be on alert. (Newey 2020) Debates started in India whether its health care system is robust enough to deal with the pandemic. Apart from medical infrastructure other issues of concern that could strain the health infrastructure were population density, crowded cities, urban slums and internal migration. (Menon and Acharjee 2020)

On 11th March, 2020 immediately after WHO declared COVID-19 as pandemic (WHO, 2020), the Indian state swung into action by halting the issuance of visas. The government took initial steps by launching awareness campaigns. The Brihanmumbai Municipal Corporation (BMC) began monitoring passengers exiting the Chhatrapati Shivaji Maharaj International Airport.(Indian Express 2020) The Epidemic Diseases Act, 1897 was invoked as 'The Maharashtra COVID-19 Regulations 2020.(Government of Maharashtra Public Health Department 2020) The BMC initiated a digital initiative by launching GIS map of Covid-19 affected areas and used drones for monitoring the streets. (Moneycontrol.com 2020; Hindustan Times April 17 2020) Isolation wards were arranged in several hospitals. Massive program of medical testing was initiated.

The fear that the state authorities constantly grappled with was how to insulate the slums from COVID-19. The 2011 census states the total number of slums in Mumbai city as 1,135,514 with a population of 5,2,06,473. The slums account for 41.84% of total population of Mumbai city (Census of India 2011) The main reason why slums have become a matter of concern for the state and civil society is primarily due to its population density. However, the government has tried to implement measures that will prevent the rapid spread of the virus.

As we compare the two epidemics, we find certain similarities and differences. In both cases, the disease posed a challenge to the state system where state has played an interventionist role. The techniques of surveillance like observation, registration, quarantine, segregation and hospitalization were used in both ages. The policies of the colonial state underwent drastic transformation as they met with hostility and violence. However, there were sections of people who did not oppose the policies of the colonial state. (Chandavarkar 1992, 217-218) Eventually, the British realized the need to include Indians as

mediators in their medical operations. In the present pandemic, it is the condition of the public health infrastructure rather than the state's medical strategies causing concern to the public.

In the early days of the plague outbreak the etiology of the disease was unknown. The medical professionals were accorded greater importance alongside bureaucrats. (Arnold 1993, 208-209) The role of rat fleas as disseminators of plague was discovered in 1908. Till then, state firmly believed that it was the unhygienic conditions and human bodies which caused the disease. Waldemar Haffkine discovered a vaccine which was slowly and gradually administered. (Arnold 1992, 233) The policy of hospitalization was often forceful during the plague epidemic which caused unrest among the people. Hospitals were perceived as 'places of torture and places intended to provide material for experiments' (Chandavarkar,1992, 229). According to some scholars the reaction to western medicine was not always one of rejection (Chandavarkar, 1992, 231). However David Arnold argues that the initial years of the epidemic exposed a 'crisis of confidence in western medicine and public health' and though met with resentment it 'paved the way for greater commitment to the idea of public health' with the realization that western medicine had to adapt to the Indian milieu. (Arnold 1992, 237) In the current pandemic the scientific community is well aware of the etiology of the disease. Scientists across the world, and WHO are developing a vaccine. Nonetheless, the inadequate medical infrastructure in India remains an obstacle at large. Medical staff and the police are working without adequate personal protective equipment which puts their health and safety at risk. (Shukla 2020) The initial apprehensions about the condition of public hospitals in Mumbai were effectively addressed by the state. (Shelar 2020; Dhote 2020) A closer look at the health care budget in India could probably give detailed insights to analyze the attitude of the state towards public health.

Epidemics perpetuate existing social hierarchies. In the colonial period the social and religious prejudices also played a role in the attitude of the people towards hospitalization (Arnold 1992, 229) Some scholars believe that it was the doubt on the intention of the doctors and desire to live with their families which caused people to resent hospitalization (Jackson 2017, 179). In April 1897, Kesari reported an incident where Brahmin man who lived only on milk while in hospital instead of food, as it was serve by person from the lower caste. (Arnold 1992, 213) The government was finally compelled to permit religious and caste leaders to erect plague hospitals at their own expense. (Gatacre 1897, 3-4) Thus caste prejudice shaped the Indian attitude towards hospitals.

COVID-19 has also brought to the fore social prejudices and discrimination. In Uttar Pradesh, quarantined patients refused to eat food prepared by lower caste. (Elsa 2020) In Mumbai, a person refused to accept grocery delivered by a Muslim delivery agent. (Rao 2020) During the Bubonic plague, the municipal workers like scavengers, sweepers and drivers of municipal vans were declared as providers of essential services and were prohibited from leaving the city. (Dossal, 2005, 3898) In the current pandemic too, the Indian government has deemed sanitation and cleaning to be essential services, which must continue during the lockdown. (Sur, 2020) The state is struggling to provide adequate safety equipments to the sanitation workers. The bulk of the sanitation workers who are exposed to the dangers of the disease in both cases belonged to the lower caste.

The relation between poverty, squalor and disease was entrenched in the colonial hygienist discourse. Thus, the poor and the working class living in unhygienic conditions were considered as the carriers of the plague bacilli. (Kidambi 2004) The poorer localities became the target of the disinfection policy and incurred resistance from the working class. However, the need to provide better housing to the urban poor as part of urban restructuring was realized. This led to the formation of The Bombay City Improvement Trust in 1898 which undertook projects to design better housing. Congested habitation is just as much a concern for the present crisis as well. The Ministry of Health Affairs enacted the policy of defining containment zones where several positive cases of covid-19 are found. The aim is to contain the disease within a defined geographic area by means of quarantine, physical distancing, isolation, testing suspected cases and spreading awareness among the public. (Patranabis, Gandhi, and Tandel, 2020) Dharavi is spread over 240 hectares and has a population of 8,50,000. The correlation between spread of Covid-19 cases and the declaration of containment zones by the BMC reveals a structural relationship between epidemics and poverty. A house in any slum in Mumbai is of 250 square feet with minimum 10 people living in the house (Hindustan Times, April 12 2020). Thus, the idea of 'physical distancing' seems impossible. While the state has been making efforts to deal with the issues of slums, the present crisis has brought to the fore the harsh realities of urbanity – 'each global city has a global slum'. (Sassen 2011)

The issues of migrants of the city surfaced in acute ways during times of crisis. Between early October 1896 and the end of February 1897, fearing the epidemic and the colonial policies several fled the city, bringing the commercial and industrial life to a standstill. (Arnold, 1992, 207) A century later, the city still continues to be largely dependent on a huge migrant population. After the extension of lockdown by the Centre, thousands of migrants flooded

the streets of Mumbai as they wanted to return to their native places. For the poor and the migrants working in the unorganized sector, the lockdown announcement has caused loss of wages. (Agarwal, Jain 2020) Neither the Centre nor the state governments anticipated the gravity of the situation of the migrant population. The Maharashtra government immediately ran relief camps and food supplies to prevent the migrants from crowding the roads and railway stations. (Bavadam, 2020) The colonial governments concern with the exodus of workforce was more to do with the commercial repercussions along with preventing the spread of the disease, while the present governments' immediate concern centers solely on containing the epidemic.

Conclusion

The modern world of nation state and capitalism has been shaped by the outbreak of epidemics and pandemics. As remarked by Mark Harrison, 'the control of disease became one of the most important functions of the state, along with the protection of its people from external aggression' (Harrison 2004,5). The developments in the 19th century testifies the fact that controlling the spread of epidemics, conserving the health of the population and expansion of medical policing was critical to the consolidation of nation state system in Europe and colonization process outside Europe. If railways, steamers and industries were vital to the sustenance to the 19th century geopolitics and capitalist expansion then medicine and statistics became essential elements of biopolitics. Sanitary conferences and institutionalization of western medicine had deep linkages with 19th century state practices and industrial capitalism since pandemics had the potential to destroy sovereign borders and disrupt trade routes. In fact, the purpose of the first International Sanitary Regulations (ISR) adopted 1851 in Paris was to protect international trade and travels of the colonial powers in the backdrop of cholera epidemic. (Geisecke 2019) Thus, the overall measures undertaken by the colonial state to control the plague epidemic in the city of Bombay can be located in the larger context of world politics of that time. The twentieth century witnessed the expansion of the concept of public health from national to international level. This was seen through institutions like League of Nations Health Organization and World Health Organization. In the twenty first century, the character of the WHO is reflecting the current realities of globalization. The revised International Health Regulations (IHR -2005) of the WHO aims to prevent and control the spread of cross border infectious diseases, at the same time protect the flows of global trade and travel. The new

regime makes government accountable to its own citizens and the global community and also demands establishing core public health capacities to deal with infectious diseases. (World Health Organization International Health Regulation 2005) WHO has been facing criticism in the handling of COVID-19 crisis. Critics have raised issues relating to the growing influence of China in the funding of WHO and in 'public health colonization of the world'. (Subramaniam 2020)

The COVID-19 crisis has been shaped by the nature of global politics, thereby raising an important question. Is the pandemic a crisis of globalization or a crisis demanding a robust global response and co operation? The global efforts to halt the pandemic will depend upon the actions taken at the local, regional and national level. The globalization project driven by neo liberalism failed to take into account the issues of the developing nations and its marginalized groups, indigenous people, ecological crisis. The mere focus on finance capital, consumerism and technological fetishism led to elision of global socio-economic inequalities and vulnerabilities and cities have become the micro-realities of the same. A lot of discussion and debates will occur on how the post Covid-19 world in general and Mumbai in particular will take shape. The need of the hour atleast for India is to move towards universal health care for all and redesigning cities on the principles of social justice. A new global social contract is needed based on the values of accountability, transparency and the participation of the multitude to make the planet hospitable for mankind.

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