WHAT’S IN A NAME?
THE PLAGUE & THE BORDERS OF GLOBAL-LOCAL PUBLIC HEALTH (SURAT, INDIA, 1994)

Kavita Sivaramakrishnan
SMS Department, Mailman School of Public Health, Columbia University
The framework & argument

- What does the reemergence of infectious disease threats such as the plague represent in the context of changes in global health?
- What is in a name?
- What is the role of ideas, ideologies and power relations?
Epidemics and boundaries

- The boundaries of authority and control at various levels
- The boundaries of state and citizenship
- The boundaries between past and present epidemics
- The boundaries between ideas and paradigms of disease causation and interpretation of public health challenges
From Epidemic Routes to Endemic Disease Threats
Global health surveillance and mapping endemic disease threats

World Distribution of Plague, 1998

- Countries reported plague, 1970-1998
- Regions where plague occurs in animals
Introduction: Globalization & Infectious Disease Threats
Public health & popular anxieties
What happened during the epidemic?

August: 80 suspected cases of bubonic plague in village of Beed, Maharashtra

21 September: Initial cases of pneumonic plague in Surat city, Gujarat, an industrial city of about 2 million inhabitants, many of whom are migrant industrial labor

24 September: the Indian Govt. informs WHO of the outbreak under the International Health Regulations & Indian Epidemic Diseases Act (1898) declared in Surat

October-November: Cases spread to Delhi-Mumbai-Kolkata with 5,150 suspected cases and 53 deaths of which 49 deaths from Surat

Visa restrictions and quarantines imposed by SE Asian and Middle Eastern countries and trade losses estimated at $1.7 billion
The Roadmap

I. What’s in a name? Introduction to the outbreak and its puzzle

II. Global-local intervention: The WHO and the Surat plague

III. Controlling disease & its interpretations: The Indian state and the Surat plague

IV. The view from the locality: The Gujarat province

V. The plague and the public
I. What’s in a name? Introduction to the outbreak and its puzzle

- “There is plague in Surat…I hesitate to call it an epidemic..” Dr Nakajima, Director General, WHO correspondence

- “..experts of India’s National Institute of Communicable Disease who had reached Surat confirmed…the plague diagnosis”. Indian Government Report

- “The disease cannot be the plague, and was more likely to be pneumonia” statement by Chief Minister of Gujarat, the state where Surat is located (Quoted in the The New York Times, 25 September 1994)
II. Global-local intervention: The WHO and the Surat plague

- The WHO constituted an International Investigation Team to visit Delhi and Surat
- Terms of reference for this team were supported by the the International Health Regulations (IHR)
- Findings of WHO team Report: “Yersina Pestis (Plague) is the likely causative agent of the Surat outbreak…(however) the identification of plague as cause of the outbreak cannot be established in the absence of confirmed isolation from clinical materials…”
“The Government of India has not looked favorably to date on receiving a neutral WHO team... [however] unless you have some independent source of information on the epidemic I worry that your credibility might be compromised if you go to India”. Fax from Dr Uton Rafei, the Regional Representative, WHO, SEARO to Dr H.Nakajima, WHO Director General, Washington, D.C., October 1994.
The WHO & the International Health Regulations (IHR)

WHO & plague disclosure in SEA in 1970-80’s

- The growing marginalization of the IHR by the 1980’s
- Historical experience of voluntary disclosure of plague in South East Asia (SEA) region: Case of Mongolia, Vietnam, Burma, India (1967)
- Closure of SEA plague surveillance units & WHO’s surveillance role minimized
The WHO’s new role perception

- The re-emerging disease agenda in global health
- “Since, with the end of the Cold War and liberalized markets, the domestic and international spheres of public health policy are becoming more intertwined and inseparable...(there is ) the need for collective action based on notions of shared human security that centered around the control and surveillance of communicable diseases as a matter of preventive diplomacy.”
The WHO’s new role & the plague as an illustration of global threats

“the outbreak of plague in India... was of global concern....there is an urgent need to link local surveillance units to a global network ” Nakajima, DG, WHO, Opening address

“While there were many technical lessons to be learned from the outbreak of plague... the meeting as a whole should also focus on more generic issues which would apply to any disease with epidemic potential.” Quoting Ralph Henderson, Asst Director General, WHO
III. Controlling disease & its interpretations: The Indian state

- Persistent doubts in the public domain regarding the origins & nature of the outbreak
- The setting up of the Technical Advisory Committee (TAC), Government of India
The setting up of the Technical Advisory Committee (TAC), Government of India

- It examined the issue of ‘presumptive diagnosis’, to initiate “prompt action to identify the causative agent” in the epidemic.

- It concluded, “That the pneumonic outbreak in Surat was due to Y.pestis is now established beyond doubt. Its origin is still unclear.”
“the plague (has been) ...a setback to the success story of the control of infectious diseases and this reversal process in today’s global village...can be traced to multiple factors such as economic development, industrial growth, environmental change and newer ones like the increased speed of travel and trade between countries and microbial adaptation.” TAC Report
“Even though one of the worst pandemics in history occurred in India, and about twelve million people died between 1896 and 1930, only a few strains from these years have survived in various culture collections…”

“The ribotypes and 25 KD protein band so distinctively seen in the Surat strain are not pre-existent [and this] needs to be explored first.”

Quoted in the TAC Report
IV. The view from the locality: The Gujarat state

The Gujarat Plague Committee Report on the epidemic:

- Not plague at all but lower respiratory tract infection or possibly, meliodosis- due to squalor, industrialization and a recent dam break & floods
- No bubonic plague definitively proved at Surat and no infectious secondary cases either
“Industrial development estates in Surat [have]...labour/slum colonies with large immigration of workers from other Indian states...[a lack of] organized adequate health services, pollution control units or housing programmes for their staff...[all these are] ....a sad story of rapid development encouraged by Government without any thought regarding aspects related to human welfare and health...”

V. The plague and the public

- The boundaries of Colonial and Post Colonial authority:
  “Historians familiar with contemporary accounts of the Great Indian plague that killed some 12 million ‘natives’ between 1896 and 1930 will be forgiven for being overwhelmed with a sense of déjà vu. ... If anything the renewed experience with plague suggests that the government remains all pervasive but characteristically incompetent. [though] it is blessed with every conceivable power and law...”

“Nothing is eradicated, epidemics are reappearing, reborn and they cause panic only when revealed by their true name...such as the rechristening of ..(a recent) epidemic”

K B Sahay, How strange blaming it on Surat, The Indian Express, November 1994
Disease, hygienic spaces and Indian modernity

- “in the eyes of the occidental correspondents, globalizing India has given way to medieval India...[that aims] to project the latent inferiority of the East...After all, however many plague cases surfaced in the US, the latter would never be described an inherently abnormal, disease ridden fantasia.” Sagarika Ghose, Plague as example of Orientalism, Times of India, 7 October 1994

- Of migrants as human bombs and middle class dreams of distinct hygienic spaces

- Of bioterrorist neighbors and porous borders
Summing up: Surat and global-local borders and boundaries

- What is the role of the state? The centrality of the state as the arbiter of defining disease identities in the context of pressures from above & below

- What are the competing visions of public health and disease threats? Competing ideas regarding public health threats amongst local, national and transnational actors

- Public perceptions reflect histories of colonialism and coercion and stereotypes about the urban poor and their migration
As of 14 March 2005, the team has reported a total of 130 suspect cases, including 57 deaths in Zobia, Bas-Uélé district, Oriental province. These figures are based on the current situation and a retrospective analysis of cases since 15 December 2004. No cases of bubonic plague have been
Suspected plague in the Democratic Republic of the Congo

7 November 2006

As of 29 September 2006, WHO received reports of a suspected pneumonic plague outbreak in 4 health zones in Haut-Uele district, Oriental province in the north-eastern part of the country. The local authorities have now reported 1174 suspected cases including 50 deaths. More than 50 samples
Clinical plague infection manifests itself in three forms depending on the route of infection: bubonic, septicaemic and pneumonic.

* Bubonic form is the most common form of plague resulting from the bite of an infective flea. Plague bacillus enters the skin from the site of the bite and travels through the lymphatic system to the nearest lymph node. The lymph node then becomes inflamed because the plague bacteria, Yersinia pestis or Y. pestis, will replicate here in high numbers.
24 November 2010 -- As of 20 November 2010, the Haitian Ministry of Public Health and Population (MSPP) reported 60,240 cumulative cholera cases including 1,415 deaths at the national level. The case fatality rate in hospitals at the national level is 2.3%, with 67% of the deaths occurring at health services level and 33% at community level.
“... the liberalization policy of the present government has resulted in the cut-back of investments in certain sub-sectors of health. During the early 1990s (1990-91) the health budget was slashed...and it was communicable diseases which really bore the brunt of this cut-back. Even supporters of the new economic policy were quick to point that the indiscriminate cutback on health would further marginalize the poor.” 

“Trucks in hundreds meant to remove garbage have ...been out on the roads for various other errands... The rag pickers have learnt the art of spreading the heaps all over the collection-dumps only to attract the beasts and the birds. The stench is spaced out... [and with the passage of time] the garbage will continue to rise in mountains. The filth will continue to spread out in all directions...”
I look at several kinds of borders and boundaries therefore-overlapping actors, ideas and settings.

1. Of the process of setting of boundaries or drawing definitive conclusions regarding the name, nature and origins of an epidemic— in the case of Surat neither the WHO, the Indian Government or the state or provincial government of Gujarat that appointed scientific investigations in to the matter definitively stated the nature and origins of the plague. There were debates as to whether it was pneumonic plague or asymptomatic pneumonia or meliodosis. My work is not about the science of laboratory facilities in India or the contamination of samples and why scientific proofs failed— but it is about what the debate about the disease tells us about various actors and participants in global, national and local public health based on the social lens through which actors like the WHO, the Indian Government, the state government of Gujarat and the urban middle class public in India interpreted and responded to the epidemic.

For the power to christen or name an epidemic to build consensus around it - as “Acts of agreement” (Rosenberg) is critical to negotiating its ‘boundaries’. In the absence of clear conclusions- it is a challenge to validate policies, protocols during an outbreak. On the other hand, In the case of uncertain diagnoses, epidemics also create a contested and ambivalent space, where the axes of power and legitimacy to declare or ‘name’ epidemics and their interpretations become deeply contentious.

2. The International health regulations framed in 1969 were the governance framework that was invoked at the time of the plague— and this talk will map the challenges in applying these regulations and illustrate in turn what this tells us about the changing role and mandate of the WHO in these years- as a prelude to the SARS. And also speak about Indian responses that typified issues of sovereignty and disease disclosure. At a national level, we will discuss the centralizing tendencies of the Indian state in administering the Epidemic Diseases Act and in controlling disease surveillance information from the province or the state. Ambiguities about the plague and its control made it possible for the state government we will see to challenge these power relations in health governance. 3. The third theme is about distinct visions of public health challenges— about the rise of anxieties regarding globally re emerging infectious disease epidemics in the 1990’s amongst transnational actors, what it tells us about their agenda and responses and challenges during the plague posed by the Indian state to these visions of public health threats, mostly associated with the developing world and in turn the visions of public health epidemics and their causal origins at the level of the locality or amongst the state authorities in Gujarat—all of these reflected different interests and tied up with different roles and responses that each of these actors would envisage for themselves.

4. Finally, the last theme that I explore is about discourses in the public domain during the plague— urban, English media reports— that reflected anxieties at once about the plague but also older preoccupations about hygiene, overcrowded populations and newer concerns about globalization— in particular the introduction of SAP’s and issues of Government role in health, visions of India’s boundaries and threats to these from the region—and for whom the govt. would orient health services— in terms of who are citizens and who are simply populations without rights— in Surat or Delhi.

Public health governance structures had their origins in quarantine laws that were enacted as far back as 15th century in the Italian city states and by 19th century ships had to get Bills of health stating that the ships last port of call was free from epidemic diseases and the states diplomatic representative resident in the foreign country had to certify Bills of health to ensure accuracy popular in the 17th century. By 1851 systematic diplomatic processes cam in place to facilitate infectious diseases cooperation— new governance regime due to cross border microbial traffic.
Gujarat Plague Committee Report

- Not plague at all but lower respiratory tract infection or possibly, meliodosis- due to squalor, industrialization and a recent dam break & floods
- Spread of plague from Beed to Surat to be established
- No bubonic plague definitively proved at Surat and no infectious secondary cases either
- Case definition problematic as all those admitted to Civil Hospital, Surat were declared suspects
“Trucks in hundreds meant to remove garbage have ... been out on the roads for various other errands... The rag pickers have learnt the art of spreading the heaps all over the collection-dumps only to attract the beasts and the birds. The stench is spaced out... [and with the passage of time] the garbage will continue to rise in mountains. The filth will continue to spread out in all directions...”
Globalization & infectious disease threats

Emerging and re-emerging infectious diseases: 1996-2004

- Ebola and Crimean Congo haemorrhagic fever
- Influenza H1N1
- Lassa fever
- Monkeypox
- Nipah Hendra
- Riftvalley fever
- New variant Creutzfeldt-Jakob disease
- SARS coronavirus
- Venezuelan equine encephalomyelitis
- Yellow fever
- West Nile fever
- Cryptosporidiosis
- Leptospirosis
- Lyme borreliosis
- Escherichia coli 0157
- Multidrug-resistant Salmonella
- Plague

Smallpox is dead!

Source: WHO

The magazine of the World Health Organization - May 1980
From Epidemic Routes to Endemic Disease Threats
I. The WHO & the Surat investigation

1903 International Sanitary Conference replaced conventions and regulations entered into force.

1951 WHO adopted the International Sanitary regulations and dubbed them as International Health Regulations (IHR).
Post plague role of the WHO: Further challenges

- Enquiry from Health Advisor, Government of India regarding diminished WHO role in disease surveillance vis a vis CDC & World Bank (1995)
II.
Naming epidemics: Surat and global-local visions and boundaries

- The centrality of the state as the arbiter of defining disease identities in the context of pressures from above & below
- The overlapping and yet competing perceptions of disease and its causal origins that emerged amongst local, national and transnational actors
- The Surat outbreak as a singular event with plural perspectives & political projects and the challenges to the playing out of global health agenda in national settings