

The Forgotten Mortality: The Empire of Epidemic and the Silent Legacy of Influenza in Bombay

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Abstract: *The origins of the 1918 influenza pandemic – which claimed more than 50 million lives worldwide – has long been the subject of intense debate. While medical researchers have identified the Midwestern United States, France, and China as possible points of origin, the military context of the pandemic has largely been overlooked. Conversely, military historians have paid little attention to a disease that vividly reveals the reciprocal relationship between the battlefield and the home front. This paper re-examines the debate on the origins and global spread of the 1918 influenza within the context of the First World War, while also bringing into focus its intersections with social, medical, and military history. By employing post-pandemic health planning as an analytical lens, the study seeks to understand the transformation of colonial power and governance in the late colonial period. It evaluates how colonialism operated through public health initiatives and how such processes reshaped the balance of power between colonial authorities and indigenous actors.*

Keywords: 1918 Influenza Pandemic, Influenza Virus, Bombay Presidency, Vaccination, Colonial Governance, Power Dynamics

THE EPIDEMIC

Far o'er the breadth of the land
Marches the Harvester grim
Reaping the youngest and best,
The fairest and fittest for life.
Behind him is wailing and tears,
Desolate homes, and the stench
Of corpses unburied, unburnt,
Fouling the sun and streams.
Thus by the million they die,
Untended, deserted, forlorn.

In palace and hovel the Death
 Stalks and destroys at its will.
 Behold in the fields how they lie –
 The fields that the forests fence round. –
 Shelterless, naked, unfed,
 Bare to the shivering stars,
 Tormented with fever and thirst;
 They wait not in vain for release
 In the fields, that are ruined and dry.
 See in the palace they die;
 No care and no wealth may forefend
 This Death from the halls of the great.
 In street and in forest the sounds
 Of their anguish rise up in the night –
 The wail of a continent's woe,
 Of a continent's anguish and death.¹

Introduction

Any discussion of health and public welfare in twentieth-century colonial India, particularly in Bombay, cannot overlook the influenza pandemic of 1918. In early summer 1918, newspapers in Bombay reported the emergence of a new disease in several parts of the world, commonly referred to as "Spanish Influenza." Initially, these reports attracted little public concern. This changed, however, once it became evident that the disease, rapidly spreading across countries, had reached India. First detected in Bombay, it came to be locally known as "Bombay Fever."²

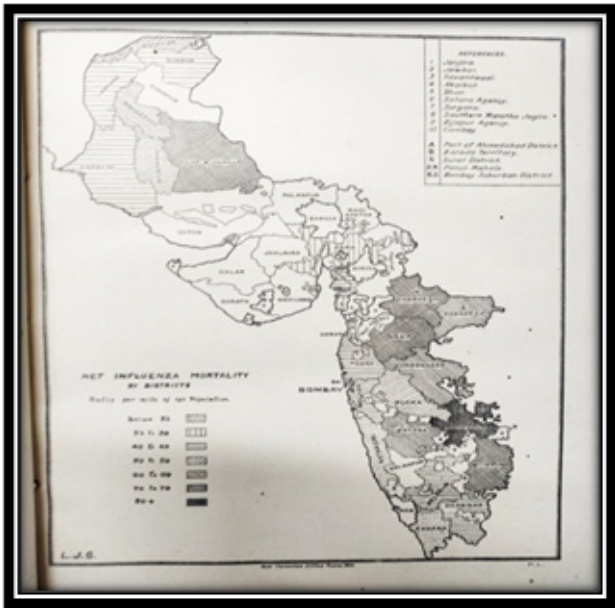


Figure 5.3 "Don't cough without covering your mouth. Flu is passed on like this!"

Picture Note: "Don't cough without covering your mouth. Flu is spread this way!" Source: Geoffrey W. Rice, "Japan and New Zealand in the 1918 Influenza Pandemic: Comparative Perspectives on Official Responses and Crisis Management" 89.

By June 1918, the city had effectively turned into what *The Times of India* described as “a huge incubator of the germs of disease.” This characterization reflected the prevailing climatic and environmental conditions—high temperature and humidity—which facilitated the spread of infection.³ The failure of the southwest monsoon that year further exacerbated the situation. Arriving in the city during the final phase of the First World War, this pandemic was responsible for the highest mortality rates recorded in the colonial period. Its impact profoundly shaped interwar debates on public health and sanitation. The 1918 influenza pandemic is widely regarded as the greatest single demographic catastrophe of the twentieth century, with a death toll exceeding the total number of casualties in the First World War.⁴

The pandemic began around March 1918 and spread across the globe in three distinct waves. The first wave occurred in March–April 1918, the second in August, and the third in 1919. Among these, the second wave proved to be the most devastating. Originating in Europe, it rapidly spread across war-ravaged regions, then extended through Asia and North Africa before reaching Australia. The Americas were also severely affected, with massive loss of life.⁵



Picture Note: Influenza motility rate by districts ⁶

Historical Context and Impact in India

The impact of the influenza pandemic in India was catastrophic. Approximately 12 million people died, with some estimates reaching as high as 18 million, primarily due to influenza, pneumonia, and respiratory complications. This

figure represented nearly 4 percent of India's total population as recorded in the 1911 decennial census. In the Central Provinces alone, about 915,000 people perished – a figure comparable to the combined deaths in Britain and the United States.⁷ The disease is believed to have entered India in May–June 1918 through troop ships arriving in Bombay and Karachi carrying infected soldiers. This triggered the first, relatively mild wave of the pandemic, during which the elderly and children were most vulnerable, although overall mortality remained comparatively low. However, from September to early December, a far more lethal second wave swept across the subcontinent. This phase disproportionately affected adults between the ages of 20 and 40, and mortality rates among women exceeded those among men.⁸

On 6 October 1918 alone, 768 influenza-related deaths were officially recorded in Bombay city – surpassing even the peak mortality figures of the plague epidemics of the 1890s and early 1900s.⁹ Across the Bombay Presidency, more than one million deaths occurred during October and November. The Indian physician N. H. Choksy observed that “by reason of its rapid spread, the enormous number of its victims, and its wholly lethal character, influenza reached a degree of horror before which even the terrors of plague seemed trivial.” Although the global spread of influenza coincided with the First World War, there is no definitive evidence establishing a direct causal relationship between the war and the disease. Influenza was not a “war disease” per se, and in fact proved more devastating in regions distant from the main theatres of war. Nevertheless, there is substantial evidence that wartime troop movements and global mobility significantly facilitated its rapid dissemination.¹⁰

Scholarly engagement with public health in India has largely remained confined to the nineteenth century, with relatively limited attention paid to the period following the First World War. Except for the works of scholars such as I. D. Mills, Mridula Ramanna, and David Hardiman, the influenza pandemic has received insufficient analysis.¹¹ Valuable insights into its spread and impact in the Bombay Presidency can, however, be gleaned from the 1918 report of the Sanitary Commissioner of the Government of Bombay, which provides detailed statistical and epidemiological data. Like the plague epidemic of 1896, influenza spread rapidly across the country, sparing very few. Both urban and rural areas were affected, but mortality and suffering were significantly higher in rural regions.¹²

Unlike the plague, which initially affected urban areas before gradually spreading to rural regions, influenza wreaked its greatest devastation in rural India, particularly during the second wave. The Health Commissioner of the Central Provinces noted that influenza “spread with extraordinary rapidity, paralyzing towns and almost wiping out villages.” Combined with acute shortages of food and clothing in October and November, it created a catastrophe of unimaginable proportions. A key distinction between plague and influenza lay in public perception and response. Plague was a familiar and deeply feared disease, its memory embedded in European history since the Black Death. It

was also widely discussed in Islamic medical traditions and the Unani system. Consequently, stringent governmental measures—such as forced evacuations, segregation camps, vaccination drives, and body inspections at railway stations—provoked widespread fear and resentment.¹³

Influenza, by contrast, carried little prior cultural or political baggage. There was no anticipatory panic, and it received minimal attention in Unani or Ayurvedic texts; indeed, it was often noted that classical Ayurvedic treatises made no mention of such a disease. Although India had experienced an influenza outbreak in 1890, it had not been nearly as lethal, and the medical community failed to derive adequate lessons from it.¹⁴ As a result, India remained largely unprepared for the pandemic of 1918–19. Furthermore, while plague spread gradually, influenza advanced with extraordinary speed. Its incubation period ranged from just 6 to 48 hours, and its high infectivity facilitated rapid transmission in workplaces, cinemas, markets, schools, public transport, households, and densely populated slums. Contemporary reports frequently described the population as “utterly helpless,” and likened the pandemic to an “avalanche” beyond the control of any state apparatus. The Health Commissioner of India observed that trains were overcrowded with passengers fleeing infected areas, many of whom were already ill.¹⁵

Debates on the Origins of the Influenza Virus

Historically, pandemics have tended to spread along the most active networks of human communication. Just as the sixth-century plague in the Byzantine Empire and the fourteenth-century Black Death spread along trade routes, the 1918 influenza pandemic also followed global circuits of movement, unfolding in three waves:

- **First wave (Spring 1918):** Lower mortality but widespread infection
- **Second wave (Autumn 1918):** The most severe and lethal phase
- **Third wave (Winter 1918–19):** Continued but less intense spread¹⁶

Three principal theories have been proposed regarding the origin of the pandemic:

1. **European Theory (France/Britain):** Virologist John Oxford suggests that the disease originated in 1916–17 in military camps at Étaples (France) and Aldershot (England), initially manifesting as “purulent bronchitis.”
2. **American Theory (Kansas):** John Barry and others argue that the outbreak began in March 1918 in Haskell County, Kansas. However, evidence indicates that severe respiratory illnesses had already appeared in other U.S. military camps months earlier.
3. **Chinese Theory and the Chinese Labour Corps (CLC):** This is often considered the most compelling hypothesis. In November 1917, a mysterious and highly contagious respiratory disease spread in

northern China, initially misidentified as pneumonic plague.¹⁷

The British and French governments, in order to sustain the war effort, recruited approximately 95,000 labourers from northern China, collectively known as the Chinese Labour Corps (CLC). These workers were transported by ship to Vancouver in Canada and subsequently conveyed in sealed trains across the continent to the Atlantic coast, from where they were dispatched to Europe. During the winter of 1917–18, influenza-like illnesses were reported among Canadian troops assigned to guard these labourers.¹⁸ Upon their arrival in France, a significant number of Chinese workers admitted to the “Chinese Hospital” at Étaples succumbed to pneumonia and acute bronchitis. This outbreak of 1916–17 has been interpreted by some scholars as a possible precursor to the 1918 pandemic. Notably, its clinical manifestations—such as facial discoloration, described as “heliotrope cyanosis”—closely resembled the symptoms observed during the 1918 outbreak. The influenza pandemic of 1918 stands as the deadliest pandemic in modern history, claiming between 20 and 50 million lives worldwide within a span of just one year. Due to the limited development of virology at the time, the causative virus could not be preserved in laboratories. Consequently, for decades, its genetic structure and the reasons for its exceptional virulence remained a scientific mystery.¹⁹

This mystery was eventually addressed by Jeffery Taubenberger and his research team, who employed the methods of molecular archaeology. They successfully recovered viral genetic material (RNA) from two principal sources:

- **Archival tissues:** Lung samples of American soldiers who had died of influenza during the First World War, preserved in formalin.
- **Permafrost samples:** The body of a woman buried in the frozen ground of the Brevig Mission in Alaska, whose remains had been naturally conserved in permafrost conditions.

From these samples, scientists were able to extract fragments of RNA and reconstruct the viral genome using reverse transcriptase polymerase chain reaction (RT-PCR) technology.²⁰

For virologists, the 1918 pandemic represents not merely a historical tragedy but also a profound evolutionary puzzle. Edwin Kilbourne, in his analysis, argued that the virus broke all known records in both transmissibility and mortality. From a virological perspective, it functioned as a “perfect pathogen.” Kilbourne’s interpretation highlights several key features:

- **Evolutionary Novelty:** The 1918 virus was not the result of a routine seasonal mutation. Rather, it constituted an entirely new subtype, possibly acquiring the ability to transmit directly from birds to humans.
- **Antigenic Shift:** The virus underwent major alterations in its surface proteins (antigens), rendering the human immune system incapable of recognizing and combating it effectively.²¹

A particularly striking aspect of the virus was its ability to infect deep lung tissues. While typical influenza strains are confined to the upper respiratory tract, the 1918 strain penetrated the lungs, causing severe tissue destruction. Kilbourne attributed this to the coordinated function of the virus's eight gene segments, which enabled rapid replication within host cells. One of the most unusual features of the 1918 pandemic was its mortality pattern. Typically, epidemics produce a "U-shaped" mortality curve, with higher death rates among children and the elderly. However, in 1918, mortality was highest among individuals aged 20 to 40, producing a distinctive "W-shaped" curve.²²

According to Kilbourne, this anomaly can be explained by the phenomenon of the cytokine storm—an excessive immune response in which the body's mechanisms turn against itself. The 1918 virus triggered an overactivation of the immune system, leading to severe inflammation and extensive lung damage.²³ This explains why young and otherwise healthy individuals, particularly soldiers with robust immune systems, were disproportionately affected. Their bodies reacted so aggressively to the virus that it resulted in fatal respiratory failure. One of the most alarming symptoms of the 1918 influenza was heliotrope cyanosis. In severe cases, fluid accumulation in the lungs led to acute oxygen deprivation, causing patients to suffocate. Due to the lack of oxygen, the skin—particularly the cheeks and lips—would turn a purplish or lavender hue. This striking discoloration became one of the defining clinical markers of the disease and symbolized its extremely lethal nature.²⁴

Overall Impact of the Pandemic and Rising Mortality

According to historians, on 29 May 1918, a ship carrying Indian soldiers arrived at the port of Bombay (present-day Mumbai). It is widely believed that this vessel introduced the H1N1 virus into India. From Bombay, the disease spread rapidly along postal and commercial networks, reaching regions as distant as Shimla and remote villages in Bihar. The magnitude of the catastrophe was vividly captured by the poet Suryakant Tripathi Nirala, who recalled that the Ganges River was filled with corpses and that even firewood for cremation was in short supply.²⁵

India was unique in experiencing higher mortality among women than men. This has been attributed to chronic malnutrition among women and their increased exposure to infection while caring for the sick.²⁶ In Bombay city, mortality rates also varied sharply across social groups: among lower-caste Hindus, the death rate was 61 per thousand, compared to 18.9 among upper-caste Hindus and only 8.3 among Europeans. The pandemic precipitated not only psychological distress but also a prolonged social and economic crisis.²⁷ As a result, agricultural production declined significantly, and labour shortages led to a 19 percent reduction in cultivated land in the Bombay Presidency. High mortality also triggered a sharp decline in financial returns, with stock market values falling by as much as 26 percentage points. Despite the severity of the

crisis, the colonial government responded with notable inadequacy, even deeming the large-scale isolation of patients “impracticable.”²⁸

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CHAPTER V.—AGE.

Subsidiary Table No. 53.—Actual recorded age-distribution of 1,000 of each sex, 1881 to 1921, British Districts.

Age-period.	Males.					Females.				
	1881	1901	1901	1911	1921	1881	1901	1901	1911	1921
0—4	27	34	21	23	20	24	30	21	25	20
5—9	24	31	18	20	17	21	27	18	22	17
10—14	22	29	16	18	15	19	25	15	20	15
15—19	20	27	14	16	13	17	23	13	18	13
20—24	18	25	12	14	11	15	21	11	16	11
25—29	16	23	10	12	9	13	19	9	14	9
30—34	14	21	8	10	7	11	17	7	12	7
35—39	12	19	6	8	5	9	15	5	10	5
40—44	10	17	4	6	4	7	13	3	8	4
45—49	8	15	3	4	3	5	11	2	6	3
50—54	6	13	2	3	2	4	9	1	4	2
55—59	4	11	1	2	1	3	7	1	3	1
60—64	3	9	1	1	1	2	5	1	2	1
65—69	2	7	1	1	1	1	4	1	1	1
70 & over	1	5	1	1	1	1	3	1	1	1
Unspecified	7	1	1	1	1	6	1	1	1	1

344. The "Influenza epidemic also caused a disturbance by selecting females proportionately more than males, and certain age-periods proportionately more than others. The following figures bring out this selection.

Subsidiary Table No. 54.—Selective death-rate of Influenza.

In this Table "Specific Death-rate" means the death-rate per mille per annum in each age group as calculated from the Registrar's Tables 1911.

Estimated Influenza mortality "means not mortality from Influenza, from November 1918, shown as a per mille rate on the number of persons in each age group from the 1911 census. From Influenza rates are taken straight from the Registrar's Tables in his 1918 Report.

	0—4	5—9	10—14	15—19	20—24	25—29	30—34	35—39	40—44	45—49	50—54	55—59	60—64	65—69	70 & over
MALES.															
Specific death-rate.	27.6	20	20	20	47	72	102	102	102	102	102	102	102	102	102
Estimated Influenza mortality.	4.2	2.6	2.7	2.6	5.1	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3
FEMALES.															
Specific death-rate.	27.1	20	20	20	49	72	102	102	102	102	102	102	102	102	102
Estimated Influenza mortality.	4.2	2.6	2.7	2.6	5.1	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3

Picture Note: Actual recorded age-distribution of 1,000 of each sex. 1881 to 1921, and Selective death-rate of Influenza. Bombay(Male and Female)²⁹

In 1918, the prevalence of other epidemic diseases in the Bombay Presidency was relatively low. Consequently, estimates of excess mortality likely understate the true number of influenza-related deaths. October recorded the highest mortality, with the Provincial Sanitary Commissioner noting that deaths during that single month approximated the total annual mortality of an unhealthy year. Due to incomplete data for November, the preliminary estimate of approximately 900,000 influenza deaths between September and November is likely conservative. This figure corresponds to a mortality rate of 45.9 per thousand of the total population.³⁰

The first outbreak in Bombay city, beginning in June, lasted only four weeks. A health official observed that within this brief period, the disease claimed 1,600 lives, resulted in the loss of at least one million working days, and caused widespread suffering and economic disruption. After a two-month lull, a second and far more severe wave struck. From 10 September onward, daily mortality rose sharply, peaking at 768 deaths on 6 October. Of these, 161 were officially attributed to influenza, 461 to respiratory diseases, and 161 to “fever of unknown origin.”³¹

Between 10 September and 10 November, total deaths rose from a normal

figure of 14,678 to 20,258—an average of 326 deaths per day. If sustained throughout the year, this rate would have produced an annual mortality of 121.76 per thousand of the population. Of the 20,258 deaths, 9,752 were women. Given that there were only 55 women for every 100 men in the city, this statistic underscores the disproportionately high female mortality rate—a pattern observed across many parts of India. Notably, 36 percent of deaths occurred among individuals aged 20 to 40.³²

Mortality rates across communities were as follows: lower-caste Hindus (61.6), other Hindus (18.9), Muslims (19.2), Parsis (9.0), Jews (14.8), Indian Christians (18.1), Eurasians (11.9), and Europeans (8.3) per thousand.³³

Category	Sub-category / Group	Population	Last Week Deaths	Corresponding Week (Last Year)
Diseases	Respiratory System	—	623	180
	Influenza	—	252	0
	Ague & Remittent Fever	—	88	34
	Debility	—	75	65
	Old Age	—	65	47
	Nervous System	—	50	31
	Digestive System	—	29	6
	Diarrhoea	—	27	31
Communities	Jains	20,465	46	—
	Brahmins	53,666	52	—
	Lingayats	1,179	12	—
	Bhatias	7,780	7	—
	Hindus (other castes)	547,112	655	—
	Hindus (low caste)	54,235	146	—
	Mussalmans	179,346	300	—
	Parsees	50,931	36	—
	Jews	6,597	6	—
	Native Christians	41,273	78	—
	Eurasians	4,183	4	—
	Europeans	11,894	10	—
	Buddhists	578	6	—
Wards	Fort	—	114	—
	Mandvi	—	159	—
	Bhuleshwar	—	21	—
	Girgaum	—	142	—
	Byculla	—	348	—
	Parel	—	167	—
	Mahim	—	202	—
	Railways & Homeless	—	15	—

Age Groups	Under 1 year	—	257	166
	1–5 years	—	152	43
	Above 5 years	—	949	366

Table Note: Weekly Mortality Statistics Influenza Epidemic: Bombay Death Roll ³⁴

Influenza spread rapidly in institutional environments such as prisons. In the Bombay Presidency’s prisons (housing 10,644 inmates and 2,987 staff), infection rates were 347.9 per thousand among prisoners and 320.7 among staff. Mortality rates stood at 35.9 per thousand for prisoners and 25.1 for staff, with case fatality rates of 10.3 percent and 7.8 percent respectively. Based on these indicative figures, it is estimated that approximately nine million people were infected across the Presidency in 1918.³⁵

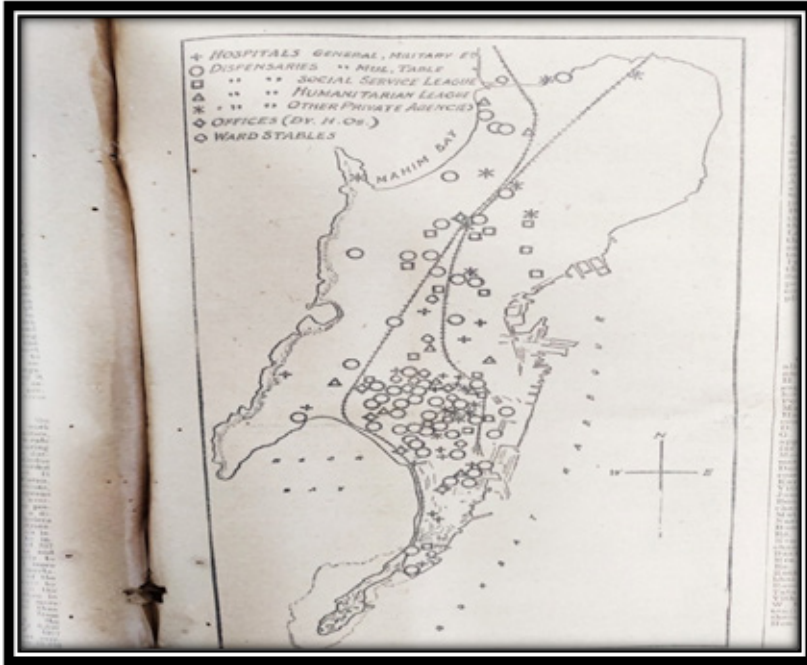
Post-Pandemic Public Health Reforms: State and Voluntary Initiatives

The pandemic witnessed an unusual collaboration between government health officials and voluntary organizations in the Bombay Presidency. These groups played a vital role in fundraising, distributing medicines, establishing temporary hospitals, and later promoting vaccination. Organizations such as the Hindu Medical Association, Bombay Medical Union, and Arogya Mandal were particularly active. However, relief efforts remained largely confined to urban areas, leaving rural populations severely underserved due to the lack of infrastructure and resources.³⁶

Several emergency measures were introduced:

- The development of “pneumonia jackets” (cotton-padded garments) for poor patients
- Distribution of health advisories in vernacular languages such as Marathi and Gujarati
- Closure of cinemas and theatres to limit transmission³⁷

The disease also reached the Sabarmati Ashram in Ahmedabad, where Mahatma Gandhi himself contracted influenza. The contemporary newspaper Praja Bandhu remarked that Gandhi’s life was not merely his own but a national asset, and therefore his proper treatment was of utmost importance. The devastating scale of the 1918 pandemic exposed the inadequacy of existing public health systems. Consequently, between 1919 and 1935, major reforms were undertaken in Bombay’s public health infrastructure. The number of permanent municipal dispensaries and hospitals was increased to better prepare for future crises.³⁸



Picture Note: Map of hospitals and dispensaries set up as a part of relief measures in Bombay City during the Influenza Epidemic of 1918 ³⁹

The city's densely populated "chawls" (tenement housing) experienced the highest rates of infection and mortality. This compelled the colonial authorities to focus on improving housing conditions and reducing overcrowding.⁴⁰ The Bombay City Improvement Trust (BCIT) played a key role in promoting healthier housing designs with improved ventilation and sanitation. The pandemic also heightened public awareness regarding the right to health, placing pressure on local governments to invest not only in epidemic control but also in the prevention of endemic diseases. Significant investments were made in drainage systems and in combating diseases such as cholera.⁴¹

Contemporary medical knowledge was limited; physicians did not recognize influenza as a viral disease and instead misidentified it as a bacillary infection leading to ineffective treatments. Only after the identification of the influenza virus in 1933 did medical approaches begin to change. The shortage of trained nurses during the pandemic contributed significantly to mortality, prompting later emphasis on nursing education and the development of skilled healthcare personnel. Malnutrition also played a critical role, as undernourished individuals possessed weaker immunity and were more susceptible to severe illness. No specific drug treatment proved effective during the pandemic.

However, patients often recovered with adequate care, rest, and easily digestible nutritious food. In regions such as Delhi, as elsewhere in India, the disposal of the dead posed a major challenge. The scenes witnessed by those who worked to combat the epidemic in 1918 left an indelible mark—one that remains impossible to forget.⁴²

A Pandemic More Lethal than War: Mortality among European and Native Soldiers

The convergence of millions of soldiers and labourers from five continents on French soil created a “global platform” that facilitated the worldwide spread of the virus. Several factors contributed to its exceptional virulence. The extremely poor sanitary conditions and harsh environment of trench warfare provided ideal circumstances for viral proliferation. At the same time, the use of poisonous gases in warfare weakened soldiers’ lungs, enabling influenza infections to progress rapidly into pneumonia. Furthermore, the widespread presence of pigs, ducks, geese, and horses alongside troops in northern France likely contributed to viral reassortment, whereby human and animal influenza strains combined to produce this highly lethal variant.

Date	Mortality	Date	Mortality
September 6	110	September 17	259
September 7	111	September 18	278
September 8	113	September 19	314
September 9	110	September 20	270
September 10	119	September 21	389
September 11	138	September 22	360
September 12	149	September 23	437
September 13	166	September 24	592
September 14	168	September 25	577
September 15	151	September 26	459
September 16	219		

Table Note: Daily Mortality in Bombay (September 1918)⁴⁴

During the Meuse-Argonne Offensive of September–October 1918, more soldiers died from influenza than from combat. While approximately 26,000 American soldiers were killed in battle, nearly 45,000 died from influenza during the same period. This stark contrast demonstrates that the pandemic was more destructive than military conflict itself. The trenches and overcrowded military camps provided ideal conditions for rapid transmission, while poor hygiene, malnutrition, and the physical strain of war weakened immune resistance. Warships and troop trains further accelerated the spread of the virus across national borders.⁴⁵

Statistical evidence reveals that by the end of 1896, influenza incidence had

begun to decline. However, in 1897, three sudden monthly increases were recorded—in March, June, and October–November—followed by a sharp decline in hospital admissions in December. Over an eight-year period, the highest number of cases occurred in March and April, while August recorded the lowest. Approximately 82 percent of total cases occurred during the first six months of the year, with only 18 percent in the latter half. Compared to 1896, conditions improved in 1897: the average daily number of patients declined from 61 to 10, and the average duration of illness fell from 28 days to 13 days. These figures pertain to European soldiers.⁴⁶

Year	European Troops (Adm.)	European (Death)	Native Troops (Adm.)	Native (Death)	Prisoners (Adm.)	Prisoners (Death)
1890	33.4	0.3	67.3	0.4	78.6	0.7
1891	5.5	0.04	7.0	0.9	19.0	2.6
1892	12.7	0.1	14.1	1.5	56.7	12.0
1893	1.3	—	6.2	0.6	40.9	3.4
1894	3.4	0.01	7.0	0.6	41.3	3.7
1895	7.8	0.03	7.0	0.8	20.3	4.4
1896	11.5	0.11	10.7	0.3	37.6	6.0
1897	4.0	0.01	5.4	0.4	8.4	2.1

Table Note: This table organizes the admissions (Adm.) and death rates for European troops, Native troops, and prisoners over an eight-year period.⁴⁷

In contrast, influenza incidence among Indian soldiers declined significantly. In 1897, only 695 cases were recorded, representing 5.4 per thousand, compared to 1,369 cases (10.7 per thousand) in 1896. Since the initial spread of the disease in India in 1890, the 1897 figure represented the lowest recorded incidence. Across the entire period, peak infection rates occurred in April and March, while the lowest were observed in September and October. The specific figures for 1897 were as follows:⁴⁸

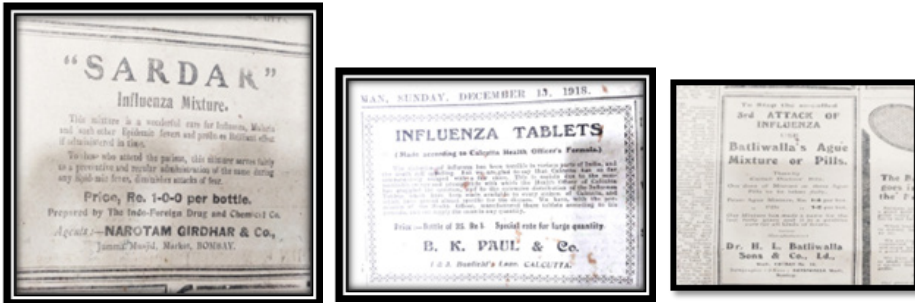
- Highest month: April (117 cases)
- Second highest: March (100 cases)
- Total cases: 695

Although native (Indian) soldiers were somewhat more affected than European soldiers, their infection rates remained significantly lower than those observed among prisoners.

Medical Developments and Limitations

Although the government attempted to develop a vaccine, these efforts were unsuccessful due to the limited contemporary understanding of viral causation.

Nevertheless, the colonial administration undertook certain measures. Official reports indicated that influenza vaccine production was being expanded as widely as possible and that existing supplies were adequate. Orders were placed for new equipment to facilitate production. However, vaccine development required considerable time, and although the Government of India did not wish to impose unnecessary restrictions on distribution, it considered it essential to estimate demand accurately.⁴⁹



Picture Note: Provides a fascinating glimpse into the medical response to the 1918 Influenza Pandemic (Spanish Flu) in India.⁵⁰

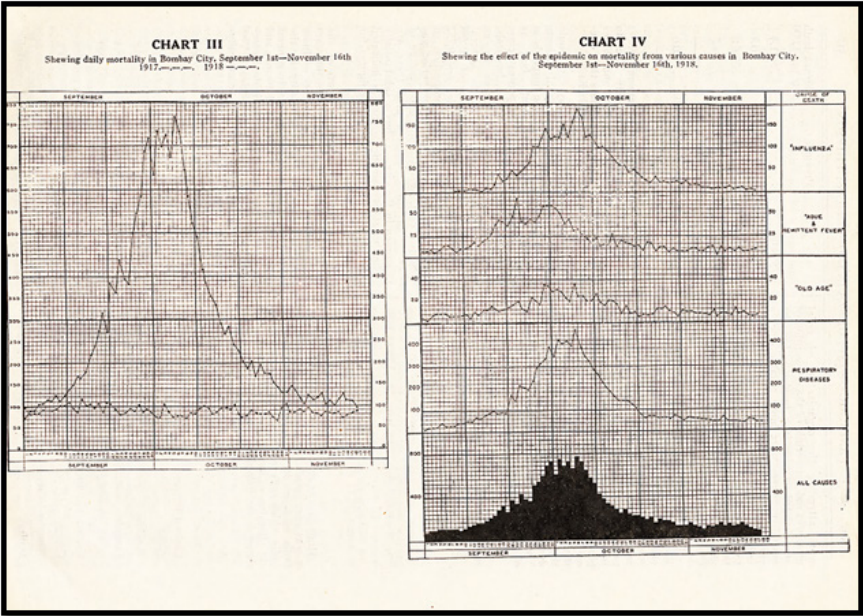
Local governments were encouraged to provide vaccines free of charge to local bodies and qualified medical practitioners. Applications for supply were required to bear the counter-signatures of Surgeons-General, administrative medical officers, or Sanitary Commissioners, in accordance with existing regulations. Precautions were also emphasized to prevent unqualified individuals from administering inoculations. The regulatory framework established for plague inoculation was considered applicable to anti-influenza vaccination as well. Civil hospitals and dispensaries were recommended as major centres for vaccination campaigns. Given that the efficacy of the influenza vaccine remained largely uncertain, reliance solely on vaccination as a preventive measure was deemed unwise. Accordingly, local authorities were urged to implement additional measures outlined in the Sanitary Commissioner's memorandum of 16 April.⁵¹

Conclusion: A Forgotten Catastrophe

A review of the 1918 influenza pandemic reveals that, although it inflicted a profound scar on India's social landscape, it gradually faded from official and political memory. The pandemic was not merely a crisis but also a stark exposure of the inadequacies of the colonial state. While grand memorials were erected to commemorate war casualties, the deaths of ordinary people received little recognition. From the correspondence of Mahatma Gandhi to the personal grief recorded by Suryakant Tripathi Nirala, contemporary accounts demonstrate

that this catastrophe remained largely confined to the realm of “private tragedy,” overshadowed by political turmoil and the struggle for survival.⁵² In contrast to governmental indifference, the active role played by voluntary organizations stood as a powerful testament to humanitarian commitment. In *Man-Eaters of Kumaon*, Jim Corbett described how the overwhelming number of corpses during the 1918 pandemic led to bodies being abandoned in forests, where they were consumed by leopards that subsequently became man-eaters.⁵³ This account underscores both the scale of the disaster and the administrative breakdown of the time.

In conclusion, the pandemic occupies a unique place in Indian history—not merely as a disease outbreak but as a “forgotten grief.” Despite ongoing efforts to recover its historical significance, the immense loss of life has yet to receive adequate recognition, overshadowed by the rise of nationalism and the tensions of colonial rule. Above all, the profound psychological trauma inflicted by the pandemic left a lasting imprint, shaping public health awareness and political consciousness in the decades that followed. For this reason, the characterization of the 1918 influenza as a “forgotten pandemic” remains, at best, only partially valid.



Picture Note: Chart III: Daily mortality in Bombay City, September 1–November 16, 1917–1918; Chart IV: Effect of the epidemic on mortality from various causes in Bombay City, September 1–November 16, 1918. Source: E. S. Phipson, “The Pandemic of Influenza in India in the Year 1918,” *Indian Medical Gazette* 58, no. 11 (November 1923): 518.

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