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The COVID-19 Pandemic in Historical Perspective

Patrice Bourdelais*

Abstract: »Die COVID-19-Pandemie in historischer Perspektive«. This paper seeks to better understand the pandemic by looking at the long term (*longue durée*). It is first recalled that the progressive construction of a horizon of eradication of infectious diseases led the population of rich countries to consider that the great epidemics no longer represented a real danger. A sanitary disarmament of our societies followed. However, the scientific response, its strength and speed, which made it possible to propose a vaccine in less than a year, constituted a real breakthrough, making it possible to envisage a control of the epidemic in these northern countries within a short time. In the face of this breakthrough, however, we can observe a strong permanence of the reactions of populations and societies (incredulity, construction of rumours, instrumentalization by all social and political actors). Finally, after about a century and a half of existence, the parenthesis of freedom of movement during epidemics has closed in the face of COVID-19. The article insists on the importance of the quality of alerts in the control of epidemics since the 14th century and questions the effectiveness of the WHO in this field if a large country does not respect the obligation of immediate declaration. It also questions the entry of humanity in a new pandemic era as a consequence of the demographic growth and the unprecedented scale of exchanges.

Keywords: History of epidemics, epidemics social dynamics, historical horizon of eradication, progress, vaccination.

1. Introduction

Since January 2020, the spread of a new pandemic, COVID-19, has generated a great deal of media coverage and, throughout Europe at least, historians have been enormously solicited to put the new epidemic into perspective. It was often a question of underlining the higher mortality rate of the great epidemics of the past compared to that of COVID-19, and of recalling that the closure of borders and the limitation of people's mobility had been, throughout history, the main response to protect against the spread of epidemics. It was necessary to confirm that epidemics have always led to a systematic

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reinforcement of restrictive measures by the authorities. Then came the time for questions about the reactions of the population, the expressions of fear, and the distrust of the authorities. Then the harshness of daily life came to the forefront, with the spread of unemployment and the difficulty of many families to feed themselves as well as the exacerbation of social inequalities. Journalists expected historians to relativize the pandemic we are living through.

It was necessary to explain and re-explain the biological, epidemiological, environmental, and social logics of the development of epidemics, but also of their disappearance. Among the great pandemics first mentioned by the media were those that are still present in the collective memory: the plague, cholera, and the Spanish flu; then emerged the Hong Kong flu (1968–1970), the last one, before the one we are living, to have travelled the world and caused millions of victims. Behind many questions there was a demand for an explanation: why does a major pandemic once again affect developed countries? How have our societies acted in the past to fight against major epidemics, with what social consequences? The historical perspective has often consisted not only in rectifying the factual errors of our interlocutors but also in questioning the ruptures that have occurred during the recent period and that make any comparison with the past very delicate, even if the reactions of the populations, of the social bodies, and of the states may seem similar. I would therefore like to focus here on the elements that have created, among the populations of rich countries, the feeling of being beyond the reach of major epidemics; this explains the astonishment of European populations and medical circles in the face of the extension and gravity of COVID-19. The strong scientific break with the past, which has been deepened over the last half-century, has not, however, erased the traditional ways in which populations and societies react to a major epidemic. Finally, in the face of the evolution of exchanges and the circulation of people, the information and epidemic control systems, perfected in the 19th and 20th centuries, did not make it possible to avoid the spread of this pandemic. What lessons can be drawn from this?

2. The Construction of a Historical Horizon of Eradication of Infectious Diseases

The stupefaction of the populations in front of the advance of COVID-19, the seriousness of the epidemic, and the mortality that it caused were undoubtedly linked to the conviction that infectious diseases and major epidemics belonged to the past and were only prevalent in poor countries. This is essentially the result of the progressive construction, over more than two

centuries, of a historical horizon of eradication of infectious diseases. The changeover took place in the middle of the 18th century, when the elites began to think that tomorrow could be better than today and that the progress of knowledge would lead to the progress of society as a whole. The draining of the swampy areas had as its main purpose to dispel the endemic fevers that hit the population hard, and the ventilation of rooms and buildings was organized to improve the health of their occupants as well (Vigarello 1999). But the major innovation was the practice of smallpox inoculation as early as the 1720s and, above all, the discovery of vaccine by Jenner. Vaccination against smallpox spread very quickly in Europe and in the rest of the world and represented a major turning point in the fight against one of the epidemics responsible for numerous deaths and debilitation of the bodies. This vaccination even opened the possibility of an unprecedented population growth all over the world. Its successes consolidated the construction of a first historical horizon of epidemic eradication. Doctors at the beginning of the 19th century could thus consider that man had already defeated two major epidemics: the plague and smallpox, and these were only the first two.

Pasteur and the germ theory opened the door to antisepsis and asepsis after the discovery of streptococci (1879) and staphylococci (1880). In the space of a few decades, Pasteur, Koch, their students, and a few others discovered many of the germs responsible for major epidemics (cholera, tuberculosis, typhoid, diphtheria, etc.) and paved the way for the development of serums and vaccines, reinforcing the hope opened by the smallpox vaccine since the beginning of the century (Rosen 2015). This series of discoveries, which, between the 1880s and the First World War, made it possible to significantly reduce epidemic mortality, constituted another moment that left a lasting impression on people's minds, while at the same time building the tutelary figure of Pasteur in France and Koch in Germany. They illustrated in a concrete way the improvements announced by the ideology of progress.

The next step in this triumphant march towards eradication came with the discovery of sulphonamides in 1935, effective against streptococci, and then of the various antibiotics whose use became widespread after the end of the Second World War: penicillin, streptomycin, aureomycin, chloramphenicol (1947), and neomycin (1949). They were used on a massive scale from the 1950s onwards and allowed for an unprecedented reduction in the main infectious diseases that affected a very large proportion of the population. Because of their virtual disappearance, the life expectancy of the French, for example, increased by nine years between 1945 and 1965 (Vallin and Meslé 1988). Such a leap forward had never been achieved in history and one can perfectly understand the optimism that took hold of the medical community, a confidence in the future that was increasingly extended to a very large part of the population as a whole.

This confidence in a future of continuous progress that would allow the disappearance of infectious diseases is expressed in a very affirmative way by a physician, expert of the WHO (World Health Organization) and then academic, Thomas Aidan Cockburn, who, in 1964–1967, published several works that explained how the major epidemic diseases could be eradicated one by one. Cockburn's works have been widely discussed and commented upon (Cockburn 1963). Today, they are the ultimate expression of a hope that goes back to the vaccination against smallpox and the successive discoveries made in the biological and medical sciences, all of which constituted milestones on the then unchallenged path of progress. However, influenza was one of the last major epidemic threats to developed countries, whether it was Russian influenza (1889–1890), Spanish influenza (1918–1920), or Asian influenza (1956–1958) or Hong Kong influenza (25,000 deaths in December 1969 in France alone!). The response in terms of preventive measures was very weak because the symptoms of the disease itself were difficult to identify and its dangers largely underestimated during each epidemic threat. As a result, there were no travel restrictions, no quarantines, and no systematic suspension of school or economic activity. On the other hand, during the 1970s, the industrialization of the influenza vaccine made it possible to launch large-scale vaccination campaigns that significantly limited the possibility of major influenza pandemics spreading (Meslé 2010). So much so that the Hong Kong flu was the last peak in influenza mortality in rich countries until COVID-19 in 2020–2021, 50 years later!

3. The Rise of Perils

However, numerous bacterial resistances to the use of antibiotics began to appear at the end of the 1940s; they were overcome by the development of new families of antibiotics, including rifampicin in 1966. Then came the re-emergence (dengue fever and resistant tuberculosis, for example) or the emergence of new pandemics, the most serious and traumatic of which, HIV, from 1981 onwards, undermined the confidence of the medical community (approximately 26 million deaths since 1981). The list of global health alerts since the 1990s could be long; let us limit it here to the Hong Kong avian flu and the discovery of H5N1 transmissible to humans in 1997 (Tam 2002). The episode of SARS (Severe Acute Respiratory Syndrome), the identification of the coronavirus as a serious danger for humans in 2003 was a moment of great concern so much so that some commentators envisaged the emergence of an epidemic as serious as the Spanish flu (finally, less than 1,000 deaths in the world), the attention to the threat of avian flu (H5N1) in 2008–2009, the return of H1N1 flu in 2009–2010 (at least 300 000 deaths worldwide), the appearance of MERS (Middle East Respiratory Syndrome) in 2012, the Ebola epidemic in

2013-14, the C-19 in 2019 (Bourdelaïs 2006). For each alert, several countries are concerned, and most frequently several continents. In contrast, the major eradication programs launched by the WHO have stalled: only one has succeeded, that against smallpox, whose eradication was made official in 1980,¹ but that against polio has failed for the time being (De Jesus 2007), and it was not until 2011 that the one against rinderpest was successful.²

A better understanding of the logic of living organisms by scientists has, however, quickly shown that the eradication of infectious diseases is simply unrealistic because of the adaptation of bacteria to the substances they are exposed to (Russell 2011). The ability of viruses to mutate and to organize reassortments is infinite and makes this hope carried by the ideology of progress for two centuries illusory in their eyes (Arita, Makane, and Fenner 2006).

Despite these warnings, the sense of security, even invulnerability, of the populations of rich countries grew during the 1980s, 1990s, and 2000s. All the signs showed, however, that the fight against epidemics is never over. But, with the exception of AIDS, the more classic forms of epidemics that unfold over a few months or years did not seem to be able to develop. So much so that, in a seemingly contradictory way, the multiplication of perils, finally under control, reinforced the confidence of the populations of the rich countries as to the efficiency of their global health security system.

It is therefore easy to understand why WHO experts are very vigilant about the emergence of new strains and the possibility of the development of violent pandemics. The focus is now on pandemic control rather than eradication. Indeed, the volume and speed of trade and human mobility (the number of air travellers reached 4.3 billion people in 2018, a doubling since 2006) have fundamentally changed the data of classical epidemiology. Our scientific and health organization means are now far beyond what they were even in the 1990s, yet the competition between humans and other elements of the living world that are also trying to multiply is still very present. However, until 2019, our new means of individual and collective protection had made it possible to avoid the pandemic deaths of the past. A new horizon was defined: that of limiting the effects through controls.

4. A Very Strong Scientific Break but Permanent Social Relations

Putting things into historical perspective cannot ignore the question of continuities and ruptures. In the case of SARS-CoV 2, the scientific progress made

¹ World Health Assembly, May 8, 1980.

² Organisation mondiale de la santé animale, March 25, 2011.

over the last 20 years has resulted in the extremely rapid discovery of the pathogen and the sequencing of its genome (one to two months after the announced start of the epidemic).³ The way it spread was quickly identified and led to the implementation of individual measures to prevent the spread of the disease: masks, hand disinfection, distance between people, and all of the measures now known as “barrier measures.”

In addition, the progress made in resuscitation services and oxygenation allowed many patients to be saved. In one year of the epidemic, management has been optimized, though there is no decisive medical treatment to counter the disease at the time of writing. Above all, the unprecedented financial investment made in order to develop new vaccines has made it possible to offer effective vaccines in less than a year, based on an already well-developed scientific base, in particular with regard to the messenger RNA technique (public investments of 11 billion dollars in the USA and 2 billion in Europe). This is again an unprecedented speed. This has made it possible to launch very extensive vaccination campaigns and to limit the spread of the epidemic in countries where vaccination coverage was sufficient (the examples of the United Kingdom and Israel, and then of the countries of Western Europe, are very eloquent in this respect compared to the regions of the world where vaccination was insufficiently adopted). Without this rapid scientific and medical response in the broadest sense, one wonders how many additional deaths we would have counted and how long the peak period of the pandemic might have lasted.

But in front of these very strong ruptures in the knowledge of the coronavirus and the possibilities to preserve oneself from it, we can note a form of permanence of the social logics. As in all the historical times confronted with strong epidemics, we find two couples of tensions. First of all, between the measures enacted for the preservation of collective sanitary security and the continuation of economic and social life, but also between these measures considered indispensable for sanitary security and the maintenance of public and individual liberties. Numerous debates have developed in democratic countries on these themes during the past year.

The history of plagues, at least since the episode of the Great Plague of 1347–1348, has been marked by the development and reinforcement of measures to limit the risks of importation, particularly in cities. The first weapon was that of early warning, which led to the system of licences that tried to identify ships that were at risk of introducing the disease. It was complemented by the establishment of lazarettos and quarantines that made it possible to keep suspected people and goods away and thus detain them for 40 days, the duration of epidemic diseases according to Hippocrates (Cosmacini 1992). If we add the cordons sanitaire, which, at the land gates of the city, prohibited access

³ Pasteur Institute, Paris, January 29, 2020.

to people from already infected regions, it is obvious that the consequences for economic life in general, for employment in all sectors of activity, and for the survival of families were considerable. As for public and individual freedoms, they were severely limited: regulation of the organization of funerals, prohibition of gatherings, and prohibition of moving from one district to another or from one city to another (Biraben 1975). These plague devices had gradually been strengthened and systematized until the 18th century (the regulatory texts promulgated during the last plague that occurred in Western Europe, that of Marseille and Provence in 1720–1722, are impressive in this regard). At the beginning of the 19th century, they were still maintained, for example, in the face of the dangers of yellow fever imported from the West Indies or Africa and constituted the regulatory framework that applied when the first cholera epidemic arrived in Western Europe in 1831–1832. They were only relaxed because of three changes: a lack of effectiveness of quarantine measures and the organization of cordons sanitaire (the cholera epidemic seemed to cross them); a medical controversy about the nature of cholera, a disease transmitted from human to human or a disease that spreads according to natural and climatic elements; and finally because of the progression of liberal ideology for which the freedom of movement constitutes an essential element of public and individual liberties (Baldwin 1999). Traditional restraints were now seen as emblematic of absolutist regimes or autocratic powers. Of course, the growing international trade also benefited from this.

There are numerous traces of influenza episodes as early as the 17th century, but the successive influenzas that followed the Russian flu (1889–1890, the first one that is well documented) did not lead to a re-adoption of strong constraints on mobility, whether it was the Spanish flu, the Asian flu, or the Hong Kong flu, SARS, or the H1N1 flu of 2009–2010. Such constraints were simply unthinkable. Any form of control over the movement of people and goods seemed to belong to a rigorously bygone era.

5. A Return to the Long History of Humanity

Finally, the great chronological parenthesis of maintaining the movement of people and goods during pandemics was interrupted by COVID-19, which started in China and progressively invaded all continents. China's response, undoubtedly late but very strong, based on the old mechanisms for controlling the movement of the population, was taken up, not by its neighbours (Taiwan, Korea, Japan), but by Italy and then by the various European countries faced with the violence of the contagion. Border closures, travel bans, prohibitions on leaving the house during confinement, promulgation of a sanitary passport... all of this refers to the epidemic control practices of the modern era! It is a return to the *longue durée* (long term) of epidemic

management between the 14th and 19th centuries (Hays and Byrne 2021). This is still quite amazing after a century and a half of maintaining freedom of movement despite the existence of other pandemics. The modes of transmission of the coronavirus, the rapidity of intercontinental exchanges, and the number of passengers on air flights have obviously profoundly modified the epidemiological equation and it cannot be argued that another option would have allowed for better control of the pandemic (by the way, the usefulness of quarantines and confinements has just been empirically demonstrated!). The countries that had hoped to be able to let things go in order to reach a collective immunity had to give up in front of the development of the epidemic (United Kingdom, the Netherlands, Sweden, and the United States in particular).

In this respect, the COVID-19 pandemic has reinserted our societies into the long history of humanity in the face of epidemics. We could not avoid or control this new danger so that we had to face a major health crisis, for which our countries were absolutely no longer prepared, a crisis without precedent for very many generations in the population. Facts such as the massive overloading of the health system, so that it was sometimes difficult to accommodate the sick in hospitals, the surge in the number of deaths, and the regulation of the celebration of funerals (with strict limitation of the number of people present), were met with periods of confinement marked by social, economic, and psychological burdens.

The feeling of security, even invulnerability, of the populations of rich countries had been considerably consolidated during the 1980s and 1990s and had led to a kind of sanitary disarmament (less collective investment to counter possible epidemics, abandonment of personal hygiene practices such as hand washing). The shock in the spring of 2020 was all the stronger. However, there were signs that the fight against epidemics was not over. With the exception of AIDS, a very long-lasting pandemic that has claimed at least 26 million lives worldwide since 1981, the more classic forms of epidemics that develop over a few months or years do not seem to be able to develop. So much so that, in a seemingly contradictory way, the multiplication of perils, finally under control, reinforced the confidence of the populations of rich countries as to the efficiency of their global health security system. This was even more obvious with the emergence in 2009–2010 of an influenza pandemic with the H1N1 virus, the “Spanish flu,” the alert was very strong, large vaccination campaigns were prepared and partially implemented, but the epidemic developed very little in Europe.

Many other dimensions of the reactions of populations to the pandemic danger of today also refer to situations commonly observed in the past, as if anthropological permanencies were found. Here we briefly recall some aspects related to individual and collective reactions. First, the assurance of each individual that the epidemic will not cause such a serious situation in his

or her own country as in neighbouring countries. This attitude had been very clear when cholera was raging in Russia and Poland in 1830–1831. The countries of Western Europe thought that they were safe from the development of the epidemic because of their “high degree of civilization.” The attitude was the same when the Hong Kong flu was approaching in 1968. Less explicitly, the attitude of the French during the late winter of 2020, when the COVID-19 epidemic was raging in Italy and then in Spain, was again rather quiet, as if they did not anticipate that such a serious situation could develop in their own country, despite the declarations of the doctors. Shortly afterwards, the Swedes expressed the same feeling of security towards the southern European countries. Everyone finds many reasons to believe that the epidemic will be less severe at home than in the neighbouring countries. This first stage is followed by a phase of stupefaction and incredulity, which coexists with a minimization of the danger represented by the epidemic. This was expressed during the great epidemics of plague and cholera or even influenza. For example, when cholera arrived in Paris at the end of March 1832, derision prevailed for a time: children played Scélérat-Morbus and wore caricatured masks of the disease during mid-Lenten celebrations, and drinkers at the gates of Paris emptied their glasses while shouting “A ta santé, Morbus!” (cheers Morbus!) which also reflected a certain amount of anxiety (Bourdelaïs and Raulot 1987, 222). At the time of the spread of COVID-19, similar reactions occurred until the extent of the mortality became apparent to all.

The designation of those responsible for the spread of the epidemic was also found: the Chinese as early as January and then travellers in general. During past epidemics, the scapegoats were lepers, Jews, or foreigners. The public rumour was swelling just as social networks spread, but on a large scale and very quickly, the craziest information at the time of COVID. The poisoning of wells by a white powder or foodstuffs on the market stalls was observed. The indictment of the authorities, the rich and powerful, and even the doctors, was quick to follow (Baldwin 1999).

The instrumentalization of the epidemic by all social groups was developing, as was the case during this pandemic. Each profession defended its own interests, including in the health sector: private doctors and nurses and pharmacists mobilized to ensure that patients were not referred directly to hospitals, which were admittedly overwhelmed, and that vaccinations were not only organized in the large centres set up by the public authorities in the name of urgency and efficiency.

The different unions and trades expressed themselves in order to make the most of this difficult period by showing the difficulties they had to overcome. This was the case for restaurant owners and shopkeepers, but also for hospital staff and all those who were in contact with the public, e.g., fire fighters, police officers and teachers, who were starting to ask for compensation and pay rises.... All this because the epidemic was disorganizing in a brutal and

long-lasting way to the economic and social life (we experienced it during the COVID-19 and the confinements or closures of the shops) and gives the feeling to some professions that they are more exposed than others. This is one of the main reasons for the socially differential mortality observed during each major epidemic. The usual excess mortality of the poorer classes is increased by the exceptional conditions of the epidemic and by the fact that the poorer classes are generally also those who have to carry out their daily activities in contact with other people and are all the more exposed to the contagion.

On the political level, if the beginnings of the epidemic gave rise to a sort of sacred union around the general mobilization to be carried out in order to better fight the disease, very quickly, each opposition political party tried to distance itself from the action undertaken, to oppose the most unpopular measures (for example, in the name of respect for public and individual freedoms), to propose other initiatives, so that the management of the epidemic constituted a new field of political confrontation. The stakes are high because the logic of bio-politics leads to the public holding governments responsible for the poor protection of citizens' health.

6. Towards a New Pandemic Era?

The most important question today is certainly whether we have entered a new phase in the development of pandemics. The formation of a pandemic has always been the result of the development or circulation of a new pathogen for humans that finds the possibilities to multiply in the general environment it encounters, what Charles Rosenberg called the configuration, the balance between humans and their environment as opposed to the characteristics of the contamination (Rosenberg 1992). Its geographical extension depends on the organization of the means of transport, their frequency, their speed, and the number of people who travel. Since the evolution towards what has been called the globalization of the economy during the decade of the 1990s, its progressive extension, the unprecedented development of intercontinental tourism and the boom in air traffic, which doubled between 2006 and 2018, a new environment favourable to the spread of viruses to the whole world has been established: most of the world's major metropolises can be reached in an average of 10-12 hours. Every day, the promiscuity in thousands of airplanes between tens of thousands of people during these many hours of flight, and then in airport screening lines, offer new conditions for viruses to multiply. The COVID-19 pandemic is a good example of this: the encounter between a virus that is new to humans, highly contagious and therefore very dangerous, and conditions of reproduction and travel that are very favourable to it.

This global epidemiological system has taken about a quarter of a century to set up; the question is whether we are entering a new era of pandemic replication every three to four years. Historically, increased trade between the eastern and western Mediterranean basins during the population and urban growth of Western Europe in the 13th century created the conditions for the spread of the plague and its frequent return. Cargo ships went to the East to collect not only spices and precious fabrics, but also the cereals that were absolutely essential to feed the rapidly growing urban population. Historians have given a lot of thought to the specific conditions that favoured the great epidemics and sometimes destroyed entire sections of the populations that had never encountered them: Thus smallpox and other European epidemics imported to the American continent by European explorers and settlers; cholera brought out of India through internal wars and English colonization, increased trade between India, the Russian Empire, and Europe; and yellow fever brought out of Africa through the transport of slaves to the West Indies and America and arrived in Europe through increased trade between Africa, the Caribbean islands, and Western Europe in the late 18th century (Snowden 2019).

Today, the general pattern of trade, the population density that favours contact with animal populations and deforestation, industrial livestock farming, and the speed and density of transportation result in the possibility of the coronavirus pandemic we are experiencing. It is difficult to see this general pattern changing very strongly over the next few years and putting up an effective barrier in the way of new viruses.

7. Warning and Control of Epidemics

This brings us back to the crucial importance of alert, which has been highly codified by the WHO since the beginning of the 21st century. Alerting is very old, and its development can be traced back to the 13th century. The system of patents allowed each captain of a cargo ship returning from the Orient to show that he had not called at a port when an epidemic was raging there and that he had not suffered any epidemic deaths on board. This system became more precise little by little, but it was based on the testimony of the consuls of the European cities or nations stationed in the East and on the certification of the port captains. Each port preserved its credibility in order not to be excluded from the points of call, so that the Captain's declaration corresponded, in a general way, to the observed situation. This system became insufficient in the 19th century when Mediterranean commercial traffic experienced a new boom. The Western powers then launched International Sanitary Conferences (the first was held in 1851) whose objective was to obtain from the Turkish Empire and Egypt the establishment of a sort of sanitary safety net

between Alexandria and Istanbul, allowing maritime traffic towards Western Europe to develop without hindrance, without repeated sanitary controls, and of course without quarantine on arrival in European ports. The main idea was to lock up any epidemic as close as possible to its initial area of occurrence in order to prevent it from leaving the country. Of course, this requirement was costly for the countries concerned, but they were not in a dominant position and had to accept these rather difficult, even humiliating conditions.

In the 20th century, the doctrine of the various international institutions in charge of health security remains unchanged. As far as the WHO is concerned, the International Health Regulations (IHR) constitute one of the essential tools in the field of international law. The WHO General Assembly accepted the first IHR in 1951. It created a surveillance system for six serious infectious diseases: cholera, plague, yellow fever, smallpox, recurrent fever, and typhus. It is a regulation of international law that obliges each country to declare certain contagious diseases following a precise protocol. In successive revisions, the concept of a public health emergency of international concern (PHEIC) has been expanded to include new diseases. The latest revision, in 2005, takes into consideration the increasing globalization of trade, which leads to an increase in the international flow of travellers and goods, which can only favour the spread of infectious diseases. The example of the SARS crisis in 2003, and its economic consequences, was a serious alarm. It is therefore necessary to have an effective alert and response network on a global scale. The 2005 revision aims to set up this network covering infectious diseases but also any event that could potentially have international health consequences (industrial or nuclear accident for example). The objective is to ensure maximum protection against the international spread of health hazards while limiting the barriers imposed on international traffic. The IHR is the only legally binding international instrument on health security. However, China does not seem to have rushed to report this new and poorly identified epidemic. If it waited a month before alerting the WHO, this is a breach of the IHR, which are binding on all countries. It is not disputable today that it did not know how to set up the barriers and controls that would have prevented COVID-19 from leaving the country, which is always expected at the international level by the states gathered within the WHO because the institution sets the tempo of the protection measures that each country can take in relation to another. Sebastien Veg even argued that, in the face of COVID-19, the Taiwanese “have done so well because they are not members of the WHO.” The country did not have to wait for WHO decisions to exercise strict control. However, from the beginning, China seems to have exerted strong pressure on the WHO not to recommend controls at the borders of member states, even though it has been applying them inside its country and at its external borders for a short time (Veg 2020). The key to Taiwan’s success has been in speed and anticipation. The cross-referencing of data from the social

insurance system with that of the customs department has made it possible to warn people who have been in dangerous areas in their recent travels (on the island) by text message. Taiwan has also blocked people arriving from the affected areas and placed them in quarantine.

But China is a major economic and political power that implements WHO regulations at its own pace. It is behaving in the same way as the dominant countries have done in the different historical periods observed (Europe and then the United States). Given the variety of China's climates and the richness of its biodiversity, as well as its demographic weight, it is obvious that the lack of transparency constitutes a formidable fragility for the global security system.

Basically, the historical perspective highlights the decisive role of the general environment, production, and exchange conditions as a necessary condition for the deployment of a pandemic. Each era knows pandemics that are adapted to it, and one may wonder if the COVID-19 pandemic does not augur a period where viral pandemic dangers will manifest themselves every few years, imposing or not the return to constraints of interruption or control of exchanges that the population thought were over. Certainly, the populations will get used to the coronavirus on the immune and social level. Researchers of vaccines and therapeutics will continue to move forward. There will probably be a race between science and the recurrent pandemic threats inherent in our current global production and circulation model.

Secondly, the historical perspective highlights the ways in which humans have fought against each epidemic event in the past and the importance of the warning systems that have been perfected since the 19th century and that the WHO is organizing today. It also shows that the dominant powers have always imposed their rules on the less powerful: the Western European countries in the 19th century, the Americans in the 20th century, and the Chinese in the 21st century. The timing of the transparency of announcements is organized according to the interests of the dominant countries. In the extraordinary progress made since the beginning of the 19th century in the control of epidemics, scientific advances have been central in addition to public health policies and the securing of the European space. Finally, the decisive progress of science in recent decades has made it possible to control the epidemic within a year and a half thanks to vaccination (at least in countries with sufficient vaccine coverage), containment, and individual barrier measures. But these sophisticated vaccines have a high cost, which has not yet allowed the development of significant vaccine coverage in the southern countries. In spite of this strong scientific breakthrough, which has allowed the acute phases of the pandemic to be controlled rapidly in rich countries, the reactions of the population (rumours, fanciful accusations), and of professional and political social groups and the different ways of using the epidemic for one's own benefit are more present than ever and constitute a kind of

permanence of the population's reactions in times of epidemics. Even if the detailed situations are quite different, we find again the *longue durée* (long term) of historians! So much so that, during these months of epidemics, they often had the impression of reliving what they had analysed during the epidemics of the past and of being almost able to write the scenario for the following months!

References

- Arita I., Nakane M., Fenner F. 2006. Is polio eradication realistic? *Science* 312 (5775): 852–854. doi: [10.1126/science.1124959](https://doi.org/10.1126/science.1124959).
- Baldwin, Peter. 1999. *Contagion and the State in Europe, 1830-1930*. Cambridge: Cambridge University Press.
- Biraben, Jean-Noel. 1975. *Les hommes et la peste en France et dans les pays européens et méditerranéens*. Paris: Mouton.
- Bourdelais, Patrice. 2006. *Epidemics Laid Low. A History of what Happened in Rich Countries*. Baltimore: The Johns Hopkins University Press.
- Bourdelais, Patrice, and Jean-Yves Raulot. 1987. *Une Peur bleue, histoire du choléra en France, 1832-1854*. Paris: Payot.
- Cockburn, Thomas Aidan. 1963. *The Evolution and Eradication of Infectious Diseases*. Baltimore: The Johns Hopkins University Press.
- Cosmacini, Giorgio. 1992. *Soigner et réformer: Médecine et santé en Italie de la Grande Peste à la Première guerre mondiale*. Paris: Payot.
- De Jesus, Nidia H. 2007. Epidemics to eradication: the modern history of poliomyelitis, *Virology Journal* 4: 70.
- Hays, Jo N., and Joseph P. Byrne. 2021. *Epidemics and Pandemics: From Ancient Plagues to Modern Pandemics*. Santa Barbara, CA: ABC-CLIO.
- Meslé, France. 2010. *Recul spectaculaire de la mortalité due à la grippe: le rôle de la vaccination*, *Population et sociétés*, no 470. Paris: INED.
- Rosen, George. 2015. *A History of Public Health: Revised and Expanded Edition*. Baltimore: The Johns Hopkins University Press.
- Rosenberg, Charles. 1992. *Explaining Epidemics and others studies in the history of medicine*. Cambridge: Cambridge University Press.
- Russell, Clark Donald. 2011. Eradicating Infectious Disease: Can We and Should We? *Frontiers in Immunology* 2: 53. doi: [10.3389/fimmu.2011.00053](https://doi.org/10.3389/fimmu.2011.00053).
- Snowden, Franck. 2019. *Epidemics and Society, from the Black Death to the present*. Yale: Yale University Press.
- Tam, John S. 2002. Influenza in Hong Kong, an overview. *Vaccine* 20, Supplement 2: 77-81. doi: [10.1016/s0264-410x\(02\)00137-8](https://doi.org/10.1016/s0264-410x(02)00137-8).
- Vallin, Jacques, and France Meslé. 1988. *Les causes de décès en France de 1925 à 1978*. Paris: INED-Presses Universitaires de France.
- Veg, Sebastian. 2020. In Pablo Maille, "Il aurait fallu s'inspirer de Taiwan", *Usbek & Rica*, March, 13. <https://usbeketrica.com/fr/article/covid-19-il-aurait-fallu-s-inspirer-de-taiwan-mais-c-est-trop-tard> (Accessed July 15, 2020).
- Vigarello, Georges. 1999. *Histoire des pratiques de santé*. Paris: Editions du Seuil.

All articles published in HSR Supplement 33 (2021):
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Epidemics and Pandemics – the Historical Perspective. Introduction.

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