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Colonial and post-colonial Zimbabwe's responses to the Spanish Flu and COVID-19 Pandemics: A comparative assessment

Tapiwa P. Sisimayi[a], James T. Muperi[b]

[a] Midlands State University, Zimbabwe

[b] Ntabazinduna Academy, Zimbabwe

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ABSTRACT

The study focuses on the responses of the colonial and post-colonial Zimbabwean authorities to the Spanish flu and COVID-19 pandemics respectively. The colonial authorities had to grapple with the effects of the Spanish Flu pandemic from 1918 to 1920. About 102 years later, the post-colonial authorities (Government of Zimbabwe) were faced with the Coronavirus disease of 2019 (COVID-19) pandemic. The study is a comparative assessment of how the authorities responded to the pandemics using the concept of Disaster Risk Management as a lens of analysis. Desktop research was the major methodology employed for the study to examine the similarities and differences in the responses of the two administrations to these pandemics as well as identify factors that influenced their response strategies. The study draws on a range of sources, including newspapers, journal articles, published books, and government reports, to provide a comprehensive analysis of disaster management in Zimbabwe. The study reveals that the responses by the colonial government and the post-colonial Zimbabwean government are almost similar despite the longish generational gap between the pandemics. This is because the latter has not progressed from the traditional stance of disaster management 102 years later, as it waited for disaster to strike and then responded. The study recommends the adoption of a proactive disaster risk reduction mechanism.

KEYWORDS: Pandemic, Spanish Flu, COVID-19, disaster, Disaster Risk Management

CONTACT: Tapiwa P. Sisimayi sisimayit@staff.msu.ac.zw

Introduction

Since the turn of the 19th century, almost all nations have probably lived through at least one global flu pandemic, but none were more pronounced and contagious than the deadly 1918 strain. The 1918 H1N1 flu pandemic, commonly known by many as the "Spanish Flu," was brief but severe and claimed over 50 million people of all ages globally (Taubenberger & Morens, 2006). The pandemic is generally described as having occurred in four (4) waves. The initial wave, which was less lethal, took place in the spring and summer of 1918 and was followed by the second lethal wave which affected several countries in September-November of 1918. The third wave took place during the spring of 1919, with the fourth known wave occurring in 1920 and hitting a few countries (Beach, Clay & Saavedra, 2020). Robinson (2021) contends that no other outbreak hitherto experienced in global history has approached the intensity levels of the Spanish Flu and it was doubtful if there would be any epidemic disease of similar magnitude in terms of devastation, duration, and coverage. The human cost of the Spanish Flu pandemic was so devastating that many doctors continue to describe it as the "greatest medical holocaust in history" (Arnold, 2020; Smith, 2020), and what Taubenberger and Morens (2006) referred to as "The mother of all pandemics" (p.70).

In the United States of America (USA) alone, the pandemic claimed 675,000 lives (Johnson & Mueller, 2002; Jester, Uyeki, Patel, Koonin & Jernigan, 2018;). The virus' unique severity decimated healthy-grown persons in the age groups of 15 to 34 years (Jester et al., 2018). Statistics for the USA highlight that the average life expectancy was lowered by more than 12 years. There has never been a flu that claimed so much in known flu seasons and can match the carnage of the 1918 pandemic. Svenn-Erik (2003) posits that the impact was dire in the coastal locations, urban centres, and areas with higher levels of transport connections and networks compared to remote, rural, and isolated areas. To avert the ever-increasing infections, the US government put in place non-pharmaceutical interventions (NPI) which included quarantine centres, closure of schools, and banning of public assemblies (Barry, 2007). Moreover, mask-wearing was widely adopted, though, like today, there were many so-called "mask-slackers" who defied the orders. Because of the lack of a vaccine, cities across the USA from St. Louis to San Francisco also implemented indigenous knowledge measures to help stave off infection. These included walks and breaths of fresh air, social distancing in cities like St. Louis and Missouri, and encouraging military

personnel to gargle saltwater since the virus was thought to be spread by the throat and nasal mucus (Martini, Gazaniga, Bragazzi & Barberis, 2019).

India was also one of the hardest-hit countries which suffered the highest mortality. India's death toll was estimated to have been in the range of 10-20 million, and a total population loss of around 13.8 million Britons in British-controlled provinces (Flecknoe, Benjamin & Aidan, 2018; Johnson & Mueller, 2002). India experienced two different epidemic waves; a mild one in the spring or summer of 1918, and a second in autumn or winter which was more lethal than the first one (Johnson & Mueller, 2002; Chowell, 2006). Svenn-Erik (2003) reports that the second wave originated in Bombay in September 1918, instantaneously spreading north and south. Sri Lanka and the northern Indian provinces became infected in October 1918. For India, the pandemic was brought by infected troops returning from the World War and it spread amongst civilians (Patterson & Pyle, 1991; Fee, Brown, Lazarus & Thierman, 2001; Smallman-Raynor, Johnson & Cliff, 2002). The disease quickly spread to the civilian population. The spread was aided by the transportation system as revealed by White (1920), the Sanitary Commissioner, when he reported that, "The railway played a prominent part as was inevitable" (White, 1920). With the absence of vaccines to protect against influenza infections and the lack of antibiotics to treat secondary infections, India depended on isolation, personal hygiene, and the limitation of public gatherings as control efforts.

The severity of the pandemic's mortality was acute in Africa since the continent was under colonial administration. It is estimated that nearly 2% of Africa's population succumbed to the disease within 6 months (2.5 million out of an estimated 130 million) (Africa Centre for Strategic Studies, 2020; Gavrilova & Leonid, 2020). Spanish Influenza in some cases infected 90% of community populations in Africa giving a general mortality rate of 15% (Africa Centre for Strategic Studies, 2020).

For South Africa, the situation worsened as white residents experienced a resurgence of 'sanitation syndrome' due to their belief that black inhabitants were responsible for spreading the infection (Tomkins, 1994; Worden, 1994; Tsoucalas, Antonios & Markos, 2016;), which in itself legitimised legally enforced racial segregation. The pandemic's toll on South Africa is chiefly notable because it was one of the worst-hit African countries with about 5% of its population succumbing to the pandemic (Africa Centre for Strategic Studies, 2020). The infection of Cape Town originated in Freetown, Sierra Leone. South African Native Labour Corps troops aboard two troopships stopped

in Freetown during the height of the outbreak. As soon as they left, Spanish Flu began to appear on board the troopships. The health authorities in Cape Town hospitalized the sick ones when the ships tied up in September 1918. They further confined those who were asymptomatic to a military camp for 48 hours, under less-than-rigid quarantine (Robinson, 2021; Brüssow, 2022). With no cure in sight, much of the response was mitigatory through social distancing and partial quarantines. Schools, churches, markets, and roads were closed, and bans on large public gatherings were implemented. In some instances, empty schools and churches were converted to improvised hospitals (Africa Centre for Strategic Studies, 2020).

The first case of Spanish Influenza was recorded in Southern Rhodesia (now Zimbabwe) in 1918 having been introduced into the country by passengers arriving from South Africa by train on the 9th of October 1918 (Agrawal, 2021; Phimister, 1973). The flu spread quickly in all the urban centres before making its way into the rural districts. Phimister's (1973) paper titled, "*The 'Spanish' influenza pandemic of 1918 and its impact on the Southern Rhodesia Mining industry*", reports that the spread of infections was determined by "the density of the population in any particular centre and the mode of communication with other infected places" (p. 143). To delay the spread of the infection, a travel ban on the African railway was effected, with the prohibition later extended to the Coloureds and Indians for a complete 30 days. Phimister (1973) highlights that the closure of business was effected 10 days after the first case was recorded and, "the epidemic brought the normal administrative, economic and social activity of the territory to a virtual halt and forced the closure of all the large mines and much of the smaller propositions" (p. 143).

In Southern Rhodesia, the infections and mortalities were more pronounced in the mining areas where the mine workers were more concentrated or congested due to crowded housing conditions. The situation was even worse due to the lack of medical personnel as the responsibility to care for the infected solely fell on the compound manager who in some cases would attend to 750 labourers (Phimister, 1973; Ranger, 1986; Tomkins, 1994; Smith, 2020). The mines alone had 19,471 infections and 2,851 deaths (Phimister, 1973). This highlights that the African Natives suffered the highest mortality, and this was primarily due to the living colonial conditions that did not allow for proper hygiene and social distancing. Further to that, underlying conditions were pointed out as the reason for increased mortality. They blamed poor physique and diet as contributing factors.

It would be impossible to gain an understanding of pandemics without recognising the huge leaps in medicine over the 20th century. In 1918, doctors had only just discovered the existence of viruses and were almost certainly unsure whether or not this was the virus that was causing the Spanish Flu pandemic. Moreover, doctors were a long way from the vaccines and anti-viral medications that are now available to help promote a quicker recovery and stem the spread. The source document (Phimister, 1973) reports that some mine workers deserted from the partial quarantines in respective mining compounds and ran to their rural homes, in the process carrying the disease to their rural homes. This indicates that there were no stricter quarantine measures coupled with the lack of legislature to enforce strict measures. The study acknowledges that had mine workers stayed in the mining compounds, the mortality would have been more severe. The study, therefore, compares the response strategies between colonial and post-colonial Zimbabwe to measure if there have been improvements in the management of pandemics (disasters) in contemporary Zimbabwe as well as determine who fared better between the colonial Rhodesian government (colonial Zimbabwe) and the current Zimbabwean government. The study further examines factors that influenced their response strategies. This comparative assessment seeks to raise awareness of the importance of proactive disaster management through effective Disaster Risk Management.

Reportedly, by the 19th of August 2020, more than 22.5 million people had been infected by the 2019 coronavirus disease (COVID-19), first discovered in December 2019 in Wuhan City, Hubei Province (China). Approximately 790,000 people by then had died from the illness (Makoni, 2020; Dzinamarira, Nachipo, Phiri, & Musuka, 2021). The United States of America (USA) had its first confirmed COVID-19 case in late January 2020, while India reported its first confirmed COVID-19 case on January 30, 2020, the same day the World Health Organisation (WHO) first declared COVID-19 a public health emergency (Jha et al., 2021). Having seen the virus spread asynchronously to other regions of the globe owing to numerous transmission sources, the Government of Zimbabwe (GoZ) had three months heads up to plan for, mitigate, and react to the pandemic. Despite having this comparative advantage, the GoZ acted reactively, only to close its borders, and order a nationwide lockdown on March 30, 2020, after recording its first infection.

Even though the World Health Organisation (WHO) declared COVID-19 a global health emergency on the 30th of January 2020, the delay in locking down demonstrates a low-risk perception by the government, and that led to a

lethargic reaction. The lackadaisical reaction was also set against the background of seeing South Africa suffer and being referred to as the most affected African nation (Javelle & Didier, 2021). By failing to close the borders earlier before recording a case, the Government of Zimbabwe failed to learn from its past mistakes and vulnerabilities choosing to be ignorant of the fact that it was the failure to close borders in 1918 that brought the Spanish Flu from South Africa which claimed so many in days.

The problem is that GOZ has not moved from the traditional stance of disaster management, 102 years later, as evidenced by waiting for the first infection before responding. This is against the study's conceptualisation of National Disaster Management which is concerned with prevention strategies dependent on the level of importance assigned to a disaster by national governments. There was a serious slack in preparedness and response as the GoZ waited to record its first case before doing anything. In this globalised world where what is taking place in other countries is frequently visible on social media and news platforms, the Government of Zimbabwe should have learned that; (1) the virus was no respecter of borders and race, and (2) there was a need for a response strategy as opposed to a wait and see approach. The study proposes the adoption of Disaster risk strategies that promote proactive disaster management as recommended by the Sendai Framework for Disaster Risk Reduction (2015-2030).

Scope

The study provides a comparative assessment of the responses of the colonial and post-colonial Zimbabwe administrations to the Spanish Flu and COVID-19 pandemics. The study aims to examine the similarities and differences in the responses of the two administrations to the pandemics and to identify the factors that influenced their responses. The study focuses on Zimbabwe, a country that experienced both pandemics during different historical periods and under different political regimes. This comparative study provides an overview of the COVID-19 pandemic and explores the different approaches taken by other countries, such as Zambia to manage the crisis.

This study covers the response of various countries to the pandemic, including South Korea, the USA, India, and Zimbabwe, and discusses the measures implemented, such as community testing, contact tracing, quarantining, and lockdowns. Comparatively, the study examines the response strategies of the colonial and post-colonial Zimbabwe administrations to the Spanish Flu and

COVID-19 pandemics. Factors that influenced the responses are explored, including political, social, and economic factors. Similarities and differences in response to the pandemic by the two administrations are also analysed to identify lessons that can inform future response strategies.

Conceptual Framework

To appreciate what Disaster Risk Management (DRM) is, one needs to first have an appreciation of disaster management. Disaster Management essentially deals with the management of resources and information towards a disastrous event and is measured by how efficiently, effectively, and seamlessly one coordinates these resources. UNDP (1991) defines it as the development and implementation of policies on disaster prevention, planning, response, and recovery to minimise damage caused by disasters.

When disasters spread nationwide, they become chaotic situations often threatening and disrupting the social order. Disaster alters existing realities that result in the public failing to understand and attribute meaning to unfolding events. This study, thus, defines a disaster as "a serious threat to the basic structures or the fundamental values and norms of a social system, which under time pressure and highly uncertain circumstances necessitates making critical decisions" (Rosenthal, Charles & Hart, 1989, p. 10). From Gilbert's (1998) conceptualisation with the aid of the repression of social vulnerability, it becomes apparent that disasters are a result of inherent vulnerabilities within any society's social processes. The model also shows the possibility of a state of uncertainty thus illuminating the idea of disaster emerging from the inability to identify supposed risks and occurrences. Disaster Risk Management (the application of disaster risk reduction policies and strategies), can only become effective if disaster management acknowledges that national disasters are characteristically different when juxtaposed to Organisation-based disasters. This necessitates the need to design unique response strategies to cater to these varying characteristics (Turner, 1994).

Carter (1991) views DRM as actions that can be categorised into; prospective, corrective, and compensatory disaster risk management (also referred to as residual risk management). IPCC (2012) views disaster risk management as the process of planning, implementing, evaluating, and adapting strategies, procedures, and measures relating to the analysis, reduction, and transfer of disaster risks, to reduce hazards and vulnerability and strengthen the coping

and adaptation capacities of individuals, households, communities, and state structures.

The above definitions necessitate the understanding used in this study, that DRM is a continuous process that involves physical and non-physical measures and takes account of the underlying risk factors within society. As such, this study acknowledges that factors causing disasters can be highly uncertain because the nature of the disaster can change thereby making the extent of the impact unclear. Disasters are thus uncertain occurrences with uncertain progress as they exist beyond our forecast range (Wildavsky, 1998; Gavi, Tapera, Mberikunashe & Kanyangarara, 2021). To avert disasters, there are essentially two categories namely disaster management strategy and the disaster management process. Disaster Risk Management is concerned with prevention and restoration strategies, primarily focused on risks and uncertainties, while the Disaster Management process is focused on mitigation, preparedness, response, and recovery, based on the time of the disaster (Wildavsky, 1988; Drabek, 1990; Khorram-Manesh, 2017; WHO, 2020; Rajabi, Bazyar, Delshad, & Khankeh, 2022). It is, thus, of paramount importance to classify the fundamentals of disaster management systems that need to be equipped to enhance the effectiveness of response mechanisms in seriously strained areas.

This study does not view disasters as isolated occurrences separate from society. Instead, it acknowledges that the impact of disasters on society is frequently provoked and intensified by human activities, particularly in the context of slowly evolving disasters like COVID-19, which pose significant implications for human well-being. This conceptualisation demands a contemporary framework for disaster risk management that incorporates anthropogenic effects to reduce societal vulnerability to extreme events. It is crucial to shift the focus from viewing disasters as solely natural phenomena to understanding them as socially constructed events (Ficara, Wheeler. 2023). Such an approach is rooted in the aspiration to holistically prevent the emergence of new hazards, enhance resilience to natural calamities, and promote sustainable development (Liu, 2022).

From a national perspective, disaster risk must involve varying functions dependent on the level of importance assigned to a disaster. Infectious disease is not new to many nations. Zimbabwe has faced pandemics such as “Spanish” Influenza and severe acute respiratory syndrome (SARS) and, as such, given the mass infections during COVID-19, people often wondered how best to respond to COVID-19 as well as to manage the risk. Managing disaster at a national

level is a convoluted task that requires perpetual analysis and risk management throughout the given disaster. There is a dearth of literature on disaster risk management systems in Zimbabwe on such persistent pandemics as COVID-19.

Methodology

Desktop research is the predominant methodology adopted for this study, Phimister's (1973) paper titled, used as the guiding source document. Additionally, the same also concerns the COVID-19 pandemic. Secondary data sources in the form of journals, policy reports, and newspaper articles, as well as a review of some reports from national and international organisations' documents were used for the study. While existing literature covers comparisons of pandemics like Ebola, Spanish Flu, cholera, bubonic plague, smallpox, and Russian typhus, there are no studies yet about the management of Spanish Flu and COVID-19 by the governments of colonial and post-colonial Zimbabwe. There is a huge difference between the foregoing pandemics in terms of severity, and genetic transmission pathways, and, also apart from cholera, Zimbabwe almost always experienced them when they would have been initially managed elsewhere.

The study, thus, relied on participant observation to collect an abundant amount of data that was valuable for the study. This helped the researchers to have a clear picture of how the authorities in Zimbabwe reacted, particularly at the height of COVID-19 when there was huge uncertainty about its impact, trajectory, and severity.

There were occasions when interviews were also used with selected key informants to gain a fuller picture of their experiences, and views, regarding GoZ's responses to the COVID-19 pandemic. The goal was to enhance the validity of the findings and to gain unique and original data from the source as per the requirements of our study. The comparative nature of the study presents a particular limitation.

Results

The Comparison

The 1918 Spanish Flu and coronavirus share basic similarities in the way they are transmitted, that is, via respiratory droplets and the surfaces they land on. The 1918 Spanish Influenza patient respiratory failure resonates with the COVID-19 respiratory infections a century later. Apart from the longish generational gap between the pandemics, there are overlapping similarities evident in the guidelines and measures adopted to stem the contagion.

Mitigatory measures to curb the spread of the 1918-19 justifiably guided COVID-19's mitigatory measure of promoting non-pharmaceutical interventions, such as physical distancing and school closures as well as partial quarantines (Greenberger, 2018; Honigsbaum, 2020). All this was influenced by the need to save lives as required by disaster response and relief in disaster risk management as mandated by the Sendai Framework (2015-2030).

The first cases of epidemic influenza in Southern Rhodesia were recorded in Bulawayo on the 9th of October, 1918 having been noticed in Southern Africa in the final 15 days of September 1918. At this stage, the source paper reported that the administration was not proactive despite having noticed the severity in neighbouring South Africa "Little advance preparation was made for the epidemic…" (Phimister, 1973 p. 143). The observation of a lack of preparation was also noted by Ammon (2002) and Simonetti, Martini, and Armocida (2021). The same can be said with the GoZ, despite the virus asynchronously spreading to various parts of the world due to multiple contagion sources, the GoZ was not proactive, and only closed the borders and declared a national lockdown on the 30th of March 2020. This lethargic response occurred even though the World Health Organisation (WHO) had declared COVID-19 a global health emergency on the 30th of January 2020. This was against the backdrop of South Africa taking a toll and was labelled the most affected African country (Javelle & Didier, 2021). By failing to close the borders earlier before recording a case, the GoZ failed to learn from its past mistakes and vulnerabilities by being ignorant of the fact that it was the failure to close borders in 1918 that brought the Spanish Flu from South Africa which claimed so many within days. This clearly shows that the GoZ has not moved from the traditional stance of disaster management, 102 years later, as it waited for disaster to strike and then responded. This is against the conceptualised National Disaster Management by the study which

is concerned with prevention strategies dependent on the level of importance assigned to a disaster by national governments.

In 1918, Southern Rhodesia responded to the pandemic by issuing a travel ban on the railway line on October 12th. The move was weakened by racialism as they only banned the railway that was used by Africans. This did not slow the spread as evidenced by a further extension of the ban to the Coloured and Indians. The racial response strategy resulted in 150 fatalities 10 days later. "By the 22nd of October, the situation at Que Que (Kwekwe) was described as serious, with 150 fatalities …." (Phimister, 1973, p. 143). When compared to Zimbabwe's response to COVID-19, though they delayed instituting the ban when they finally initiated the national lockdown, it involved all races/all colours and all modes of transport and this seemed more effective because it took 2 months for the country to record 50 infection cases. As of the 25th of May 2020, after the confirmation of the first case, only 56 cases had been confirmed with only 4 deaths (Government of Zimbabwe, 2020). The mortality rates can attest to the fact that the response mechanism, though delayed somehow, worked as evidenced by the low numbers of cases during the initial lockdown. Numbers only started to increase following the relaxation of the non-racial lockdown.

The first wave, as reported by the source document, only lasted for 22 days, and by the 9th of November, travel restrictions were lifted. Exactly 36 days later, Newton reported that the epidemic was over except for Umtali (Mutare) (Phimister, 1973). Ironically for Zimbabwe, there was an extension and a surge of numbers of infections with the country encouraging the use of face masks. Despite its duration, on the 17th of September, there were only occasional infections and only 135 deaths (Mackworth-Young, Chingono, Mavodza, McHugh, Tembo & Chikwari, 2021; Mahuni, 2023; MOHCC, 2021). In a comparison of the same duration of the Spanish pandemic, Zimbabwe recorded fewer than 4 deaths (MOHCC, 2021). This attests to the fact that the Zimbabwean government as compared to the Rhodesian Administration responded to the disaster more effectively through a continuous assessment of the situation and risk communication.

Also to note is that during 1918, pandemics were a common occurrence, hence we expected Southern Rhodesia to have responded swiftly to the Spanish Influenza by effecting strict quarantines with ease in a country that was characterized by reserves in colonial Rhodesia. This was not the same 102 years later, the GoZ had no experience with outbreaks of infectious disease of this magnitude in decades when the novel Coronavirus struck, but managed to swiftly promulgate

statutory instruments to effect a national lockdown and quarantines. There is no evidence of such requirements in 1918, as the administration ruled by decree. Despite having oppressive freedom, they were unable to implement effective measures. On the contrary, the Zimbabwean government did not have that luxury. On the 28th of March, a week after the first Victoria Falls confirmed case, the government announced its first set of regulations that allowed it to pronounce a 21-day national lockdown through Statutory Instrument 83, the original March regulations cited as the Public Health (COVID-19 Prevention, Containment, and Treatment) (National Lockdown) Order, 2020. This was in line with Disaster Risk Management which necessitates the application of disaster risk reduction policies and strategies to prevent new disaster risks, reduce existing disaster risks, and manage residual risks, contributing to the strengthening of resilience and reduction of losses. At the time of writing, and as the risk management of COVID-19 continues, the GoZ has published 16 more statutory instruments from the initial one aimed at slowing down the spread of COVID-19.

When these viruses attacked, the response mechanism was marred by the limited scope of medical interventions. As such, both the Rhodesian Government and the GoZ resorted to non-pharmaceutical mitigatory measures as they got overwhelmed by the demands on their already strained medical resources. In 1918, it is justifiable to mention that they could not effectively respond through medical technology, yet at the same time, this exposed the lack of preparedness of the GoZ as the country did not have ventilators that could match the population even in the absence of the pandemic. The only option about 102 years ago was to provide care that targeted the symptoms and wait for the person to pull through. But for the 21st century, applying the same approach used 102 years ago reflected a serious lack of preparedness and a lack of mitigatory measures in the health delivery system. When the pandemic struck, the country only had Wilkins Hospital, as a certified health quarantine facility which also was ill-equipped for the impending disaster (Mavhunga, 2021).

Despite response strides on COVID-19, attested expansion of testing services, the establishment of isolation and treatment centres in every district, and quarantining returning residents, Zimbabwe had a heads-up delay time to prepare and learn from first responders like China, the United Kingdom, the USA, and Australia who faced the worst. Despite the heads-up, when it finally came, Zimbabwe was still ill-prepared as the nation was characterized by limited testing capacity, poor contact-tracing systems, limited intensive care

unit beds, shortage of ventilators, insufficient Protective Personal Equipment (PPE), staff shortage and strikes in the health sector, weak and porous borders that led to poor management of returnees in quarantine centres, resulting in absconders (Dzinamarira et al., 2021).

In the midst of these challenges, there was alleged corruption in COVID-19 supply tenders (Gavi et al., 2021; Mahuni, 2023). At the height of the pandemic, as the country joined the rest of the world in fighting the pandemic, many Zimbabweans questioned the state of disaster preparedness of local health facilities. Others had doubts if the country even had a machine to do the testing. Acting Coordinator for the National Microbiology Reference Centre, Xavier Mazarura, cleared these doubts by indicating that there was only one COVID-19 testing centre situated at Sally Mugabe Central Hospital, which received samples from all provinces for testing (Makoni, 2020). This meant that returning residents who were detained in quarantine centres across the country had to wait longer for their release until all dispatched samples were released.

From a critical analysis, one would conclude that in a way Zimbabwe fared less than the Southern Rhodesian Administration which did not have the luxury of modern-day technology provisioned for symptomatic care. Despite the presence of such technology, Zimbabwe is caught off guard due to poor disaster management policy, lack of preparedness, and mitigatory measures displayed by the government's resort to measures used 102 years ago. These militated against the improved provision of symptomatic care in the 21st century. Relatedly, the failure to learn from experience fails Zimbabwe's disaster risk management. As highlighted earlier, they closed the borders too late, the same mistake that was made by the Southern Rhodesia Administration. Secondly, they opened the borders too early and loosened the national lockdown regulations, which resulted in a spike in infections. The country failed to deal with the residual effect of the first wave as demanded by disaster risk management and also failed to remove vulnerabilities as well as to improve capacity as evidenced by the increased infections and mortality that even claimed those in ministerial posts. The second wave could have been better prepared by learning from the 1918 Spanish Influenza dramatic second, third, and fourth waves.

Discussion

COVID-19 emerged within an environment characterised by modern responses to public health pandemics such as decentralised testing, isolation, and treatment centres. Zimbabwe had a heads-up delay time to prepare, and learn, from first responders who had faced the worst. However, when the pandemic finally came, the country was still ill-prepared as reflected by limited testing capacity, poor contact-tracing systems, limited intensive care unit beds, shortage of ventilators, insufficient PPEs, staff shortage, as well as strikes in the health sector, among a host of other challenges. There were also allegations of corruption in COVID-19 supply tenders which created a "deadly partnership" in service delivery and further strained an already fragile health system. The Government of Zimbabwe is yet to release information on the distribution of donations received from non-governmental organisations (NGOs), including ventilators, and other medical equipment. Zimbabwe's response mechanisms were poor considering that we are in the 21st century where technology works as an early warning system (television news channels and social media).

These modern early warning systems were not there in 1918 and at times people did not grasp what was happening in the neighbouring countries. Despite the impending danger, the Zimbabwean government did very little to address the challenges that were occurring in the health sector which was to be the first responder through its health personnel when the disaster struck. The government failed to assign a level of importance to this disaster and also failed to realise that the use of the military as dictated by the Civil Protection Act was not going to help in dealing with infected people.

It also emerged that the GoZ managed to plausibly apply the principle of DRM to prevent new disaster risks, strengthen resilience, and minimise losses. The present administration, which had no experience with outbreaks of infectious disease as was common in 1918 under colonial administration, managed to swiftly promulgate statutory instruments to effect a national lockdown and quarantines. Such requirements were unavailable in 1918 when the Government of Southern Rhodesia (GSR) ruled by decree, and even with that authoritarianism, failed to put effective measures. When these viruses attacked, the response mechanism was marred by the limited scope of medical interventions. As such, both the GSR and the GoZ resorted to non-pharmaceutical mitigatory measures as they got overwhelmed by the demands on their already strained medical resources. While it was justifiable to mention that, in 1918, the

GSR could not effectively respond through medical technology, it is concerning to note the lack of preparedness of the GoZ which still lacked ventilators to match the population even in the absence of the pandemic. In the 21st century, it is untimely for the present government to be applying similar approaches used 102 years ago, which reflects a serious lack of preparedness and a lack of mitigatory measures in the health delivery system.

Who handled the pandemics better?

One would conclude that in a way the Government of Zimbabwe fared worse than the Government of Southern Rhodesian which did not have the luxury of modern-day technology provisioned for symptomatic care. Despite the presence of such technology, Zimbabwe was caught off guard due to poor preparedness and mitigatory measures, and as a result, the government has been resorting to measures used over a century ago against the backdrop of improved provision of symptomatic care in the 21st century. Similarly, the failure to learn from experience fails Zimbabwe's disaster risk management. The decision by the authorities to delay closing the borders was a similar mistake to the one made by the GSR. Secondly, they opened the borders too early and loosened the national lockdown regulations, resulting in a spike in infections. The country failed to deal with the residual effect of the first wave as demanded by DRM and also failed to remove vulnerabilities and improve capacity, which was reflected by the increased infections and mortality that even claimed the lives of those in ministerial posts. The second wave could have been better prepared for by learning from the 1918 Spanish Influenza, dramatic second, third, and fourth waves.

Zimbabwe may draw several lessons some of which are that during the pandemic, corrupt tendencies normally arise at all levels and for Zimbabwe this was even worse as corruption in the country is noted as reaching unprecedented levels (Makoni, 2020; Mavhunga, 2021; Gavi et al., 2021; Mahuni, 2023). Furthermore, a modern disaster management policy that encourages citizen participation and incorporates information communication technology in the management of disasters, is required as there seems to be none in existence at the time of this study.

Conclusion

When comparing the response of the colonial GSR in 1918 to the post-colonial GoZ, it becomes apparent that the former was able to implement certain measures more effectively in the absence of modern technology, even though the Spanish Flu outbreak occurred over 102 years ago. This highlights the lack of preparedness and the failure to be proactive despite having improved resources as compared to 102 years ago. The study also reveals a lack of preparedness and an absence of mitigatory measures in Zimbabwe's health delivery system. Despite having the advantage of modern technology and the opportunity to learn from previous outbreaks, the government was ill-prepared to handle the challenges posed by the pandemic. This was compounded by corruption, there were allegations of corruption and embezzlement of COVID-19 funds and this further strained the already fragile health system. Lessons such as the need to address corruption at all levels to ensure efficient and effective disaster response can be drawn from this analysis. By implementing these lessons, Zimbabwe can improve its disaster response and build a more resilient and effective health delivery system capable of handling future challenges.

Recommendations

The study proffers the following recommendations:

i) *The GoZ should put in place a comprehensive disaster risk management plan that is holistic in approach by catering for all possible disasters even though some take centuries before they strike again.*
ii) *Zimbabwe's Disaster Risk Management needs to move away from the traditional approach of disaster management to more modern approaches that call for mitigation, response and capacity building, and do away with the wait-and-see approach that is outmoded.*
iii) *The GoZ should not politicise Disaster Risk Management. Times of disaster are not times for political expedience but times for a united front.*

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