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POLITICAL ECONOMY OF INDIA AND PAKISTAN'S NATIONAL RESPONSES TO COVID-19: A COMPARATIVE ANALYSIS

Wraa Noor Haider
PHD Scholar at SPIR, QAU, Islamabad
wraanoor123@gmail.com

Muhammad Arslan
MPhil Scholar from NDU Islamabad & Independent foreign policy expert
choudharyarslan93@gmail.com

ABSTRACT
The COVID-19 pandemic emerged as a non-traditional security threat that exposed state capacities globally, presenting complex challenges for political leaders managing twin crises. A notable trend observed in South Asia that the damage control and pandemic management was better in Pakistan compared to India, despite differing material attributes. This study aims to provide a balanced understanding of why Pakistan fared better than India by analysing their policy choices, socio-economic considerations and political restraints on state decision-making capacity. Using the 'An Enhanced State Capacity Framework', the article argues that it is not merely economic wealth but political control over resource management by top-tier political actors in crisis situations that matters more.

Key words: COVID-19, national response, economic crisis, health crisis, resource management

INTRODUCTION
Fighting the COVID-19 pandemic has been a global challenge and states have tried their best to meet the dual ends i.e. saving lives of their citizens while trying to minimize the economic burdens and fiscal challenges for national economies. The two South Asian countries, India and Pakistan, were hardly hit by the pandemic and policy-makers in both faced the challenge towards effective damage control amidst the pandemic i.e. limiting the loss of life by providing better health-care facilities while ensuring that the poorest segments of the society do not starve to death due to the restricted economic activity resulting from their chosen response measures. The pandemic unleashed an economic crisis and humanitarian disaster in India. The economic activity collapsed, generating mass unemployment (increasing from 8% in mid-March to 23.4% in April 2020) and pushing 75 million people into poverty in 2020. India's economy shrank by 23.9% in the first quarter of the 2020-21 fiscal year (Younus, 2021). Pakistan's under-funded public health infrastructure and a tepid rate of economic growth made it more vulnerable to the pandemic-induced shocks. Its public health expenditure is among the lowest in the world,

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with 1.2% of its GDP allocated to healthcare in fiscal year 2020 (Al Baraka Bank, 2021). And even before the pandemic, the prospect of finding jobs was elusive and high inflation rate continued to weaken the purchasing power of households; the pandemic couldn't have come at a worse time.

A puzzling observation in South Asia was that the damage control and management of the pandemic were better in Pakistan — the smaller state that is economically weaker and comparatively less developed — than India — the larger state with a flourishing economy and better development indicators. This lies contrary to the expectations given the observable material attributes of the two states. Logically speaking, the stronger or wealthier party would be expected to perform better given the resources at its disposal, and economically weaker state would be expected to face more constraints while responding. Yet the opposite has been observed in case of India and Pakistan. Comparing their response is important to gain insights into the factors that have mattered for dealing with the pandemic other than countries' economic profiles. Studying the causes of such unexpected outcomes would bring forth important answers that may then be built upon for comprehending other relatable cases. The research question this study aims to address is: Why did Pakistan fare better than India in managing the COVID-19 pandemic? This study follows an explanatory research approach and is qualitative in nature. It is based on deductive reasoning as it follows a comparative research design to draw collective inferences. The focus of this article is to present a comparative analysis of India and Pakistan's response by thoroughly examining the two countries' policy choices and explaining how political and economic forces affect the state's decision-making capacity. This article is divided into three main parts. The first part builds the relationship between Political Economy and the Covid-19. The second part deals with the comparative analysis of India and Pakistan pandemic responses. In the last part, Realist approach in Political Economy is employed to provide a conceptual analysis of both countries' response. It applies 'An Enhanced State Capacity Framework' developed by Linda Weiss and Elizabeth Thurbon to explain the nature and levels of their responses from a realist Political Economy perspective. Within this framework, three categories are defined to encapsulate the state capacity for pandemic preparedness: extractive-distributive, transformative and salutary (Weiss and Thurbon, 2021). This research is a notable contribution towards the existing literature on the concerned issue, uncovering the factors responsible for bringing about different national responses to a similar challenge may help the other states redirect their efforts in the right direction for future catastrophes – by working on limiting the constraining forces and bolstering the facilitating ones. This research will be useful for policy-makers to address similar crisis in the future by adopting a different policy perspective.

Political Economy and COVID-19

The COVID-19 pandemic presented itself as the ultimate test of the public choices, political leadership and governance capacities of all affected countries as they battle to tackle the twin crises of COVID-19 – economic and healthcare crises. The complex crisis had three fundamental yet interlinked elements. First, it presented economic and healthcare crises that were interrelated ─ measures to reduce health crisis, such as lockdown measures, led to an economic crisis. In turn, the economic plight constrained the resources available for managing the health emergency. If restrictions for curbing the spread were eased, it threatened greater infections – managing which yet again brought economic strain. Second, the economic crisis evolved from sector to sector over time.

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The sectors impacted first, such as lower consumption, had spill-over effects on other sectors such as the labour market. Third, there was no simple way to predict how both crises would play out with the passage of time, and therefore there was uncertainty about the implications of any chosen policy.

COVID-19 presented a national security threat and controlling it required tackling challenges in three interconnected systems: the public health, economy and politics. Issues in any of these realms tended to have a spill-over effect into the others. Policymakers could not simply intervene in any of these realms while being isolated from others. The national responses were dictated by the interplay of political and economic forces, or the motivations underlying the policy choices they adopted. Managing the economic and health outcomes of pandemic will entail exploring the Political Economy perspective of the states' responses to COVID-19 so as to understand the interaction between political and economic forces within the state that determine the response trajectory. Political Economy views politics and economics as inter-related and interdependent, wherein the polity is influenced by economic developments and the economic sphere is impacted by political developments. The dynamics of state and market are intertwined, and their causal relationship is interactive, interdependent and cyclical (Gilpin, 1987).

Comparing the two responses: Who fared better?

The outbreak of COVID-19 pandemic posed a perplexing challenge for India and Pakistan owing to the contagiousness and lethality of the virus. The two South Asian countries were among the highly vulnerable according to the Pandemic Vulnerability Index (PVI) rankings (Shrestha et al., 2020). Vested economic and political interests influence policy-making in both countries and their governments navigated a perceived trade-off between health-driven lockdowns (strict social distancing and gradual reopening), and commercially-tempted rapid reopening and macroeconomic stimulus packages differently. India's national response to the global pandemic was significant but hindered by deficiencies in certain critical decisions made by Prime Minister Narendra Modi's government. India's huge population of 1.3 billion and its densely populated towns and cities provided ripe conditions for an outburst of public health crisis. A major proportion of India's workforce belongs to the informal sector, making it quite challenging for the government to design and implement effective social safety nets (Jha and Jha, 2020). Firstly, the government delayed the barring of international flights. Since the first case was detected on 30 January 2020, the government acted only after the first reported fatality on 12 March and suspended all international flights to India from 22 March until 31 October (Press Information Bureau, 2020).

Second, it abruptly imposed a 21-day national lockdown that was the strictest in the world (University of Oxford, 2020); with scarcely four hours' notice given to the populace, without any prior preparation, and without giving the states sufficient time to prepare. Consequently, the lockdown generated a mass movement of almost 40 million migrant workers stranded across India on 25 March (Ganguly, 2020). The urban poor and migrants, who were suddenly out of work and had no means to return to their homes, were forced to return to their villages on foot, leading to extensive community spread. PM Modi's government's hasty decision to impose the national lockdown was intended to avert extensive community transmission. In a national television broadcast, Modi stated:

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> A lockdown for a sustained period of time is the only way to break the chain of infection … We have to prioritise what is required for saving lives. 21 days of lockdown is a long time but for the safety of your family this is the only way that we have. (Hebbar, 2021)

However, this model was unsuitable for India's socio-economic conditions and the characteristics of life for most of its populace. It is a densely populated country where one-third of urban populace and a quarter of rural residents live in highly cramped conditions; the implementation of 'stay at home' policies and social distancing measures was quite limited in effect. Indian economist Kaushik Basu mentioned that nearly 4-5 % of the populace "were literally sent off like sprinklers across the nation" (Ganguly, 2020). Some Indian epidemiologists recommended that isolating only "hot zones" where cases had clustered could have averted the community spread. Albeit a state-level lockdown could have been more appropriate, the exact locations of coronavirus hotspots were unknown due to low levels of testing. Even the infections and death rates were likely underestimated due to limited testing in early days of pandemic (Laxminarayan et al., 2020).

From the onset of pandemic, the government failed to ramp up testing capacity and address equipment deficiencies on a national scale, especially during the lockdown period. In mid-March 2020, the daily testing capacity was nearly 1400/day; by the end of July, it had increased to 500,000/day. However, the number of infected cases had reached 1.5 million by then (Ganguly, 2020). Meanwhile, the virus had spread significantly to rural areas where healthcare facilities were scanty and inadequate. The lockdown period was not properly utilized to build a rigorous testing and contact tracing infrastructure, and to provide essential medical equipment on a nationwide basis. The rationale for enforcing a lockdown is not to eliminate the pathogen – which it can't do – but to buy time to augment the capacity of healthcare infrastructure (sufficient investment and preparation of health systems, medical facilities and personnel). Moreover, the dearth of data and information transparency led to under-testing and under-reporting of cases and deaths which hampered an effective response based on evidence-informed policymaking and led to the spread of disinformation. In November 2020, a parliamentary panel report pointed out that data collection systems were unable to dispense "complete, timely and accurate" Covid-related data (Bhatt et al., 2021). Critical data from the second wave – such as the number of positive cases and death rates, daily testing capacity and hospitalization – were not made public.

Furthermore, there was an evident lack of coordination between central and state governments as well as between the government and public health agencies that constrained India's ability to manage the crises. The central government made decisions and issued directives without consulting the state governments and considering their requirements. For instance, the decision to impose the national lockdown during the first wave, reopening the domestic air travel, and fiscal centralisation, disregarded the principles of federalism and overran constitutional lines. Health is a state subject as per the Indian constitution but the national government insisted that states were responsible for essential public health measures and dealing with the pandemic-induced economic shocks. Nevertheless, the central government provided limited funds and restricted their ability to borrow which confined their efforts to spend and effectively deal with the crises.

The government also made several precipitate and contradictory decisions with little consultation with public health authorities. In most countries, the framework of pandemic

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response was led by Centers for Disease Control and Prevention (CDCs); however, in India, the Indian Council of Medical Research (ICMR) was framing the Covid policy and its task force on Covid was headed by clinicians without any background or training in epidemiology. Despite the existence of apex medical institutes—ICMR, All India Institute of Medical Sciences, New Delhi (AIIMS), National Centre for Disease Control (NCDC)—and epidemiological experts in the country, their role was confined to that of an advisory. The NCDC, a public health institute established for communicable disease control and surveillance, became invisible and was nowhere to give briefings or counsel (Krishnan and Nabia, 2021). This disregard for relevant scientific expertise became more evident with the government's decision to use vaccines as an instrument for soft diplomacy (referred to as vaccine diplomacy) while seriously miscalculating domestic needs. With the commencement of the Vaccine Maitri (Vaccine Friendship) programme in January 2021, India exported 66 million vaccines to 94 countries, including its neighbours, African countries and other developing nations, up until April 2021 (according to the Ministry of External Affairs) to propel its vaccine diplomacy (Sanghi, 2021). Of these, 10.61 million were donated; the rest was exported by Serum Institute of India (SII), partially sold to foreign countries and partially as part of its agreement with COVAX alliance (Sanghi, 2021). PM Modi believed that, being the "pharmacy to the world," India was in the best position to lead the charge. Under this initiative, India dispensed a substantial quantity of Covishield doses to Nepal, Bhutan, Bangladesh, Maldives and Sri Lanka, thereby increasing its soft power within the South Asian region. The Minister of External Affairs S Jaishankar, while addressing the Rajya Sabha, said that "the supply of vaccines abroad is based on the assessment of adequate availability at home, and the process was continuously monitored and takes into account the requirements of our domestic vaccination programme" (Choudhury, 2021). However, India's vaccination drive began to stumble during the second wave in April and May 2021 as it faced supply shortages and a sudden shift in its procurement policy (Slater, 2021). At the end of March 2021, the government suspended exports and began importing the Russian vaccine Sputnik V to attenuate the shortfall in domestic production (Slater, 2021). Due to the shortage of supplies, many states halted their inoculation drives for 18-45 years old individuals in India (Sood et al., 2021). The pace of the country's vaccination drive slowed down; as of 18 April 2021, 123.8 million doses had been administered out of a target of 600 million by the end of July (Sood et al., 2021).

The government policy to export vaccines began under the Quad initiative, apparently to counter China's growing vaccine diplomacy. India's vaccine policy not only hampered its national vaccination drive but also caused distress in many low- and middle-income countries dependent on its supplies. "It was all bad planning. India did not give sufficient orders to vaccine companies, to allow them to manufacture enough doses," said Shahid Jameel, Virologist at Ashoka University New Delhi (Bhuyan, 2021). However, S Jaishankar stated that India's repute as the world's largest pharmacy had been reinforced (Choudhury, 2021). It is in these statements that one can comprehend the Modi government's desire to craft a positive political image of India before the world during a pandemic.

By the end of the first wave in January 2021, the government announced that India had tackled the pandemic. Chairperson of the National Committee on Vaccine Strategy Dr Vinod Paul claimed that "most of our highly populated districts and cities have had their run of the pandemic by now … and may have what you like to call herd immunity, to an extent" (Banaji, 2021). It prematurely eased lockdown restrictions, relaxed standard

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public health protocols, and allowed social and religious gatherings, such as Kumbh Mehla and political rallies (Serhan, 2021). In March, the Health Minister asserted that "we are in the endgame of the COVID-19 pandemic in India" (Bhowmick, 2021).

The second wave that began in mid-March 2021 caused innumerable loss of human lives, resulting in economic devastation, the worst public health crisis and a high mortality rate across Indian populace. The government disregarded scientists' early warnings of a second wave. Senior Principal Scientist Rakesh Mishra said, "We kept warning that the pandemic was not over but no one was listening" (Bhowmick, 2021). The first wave impacted the poor and marginalised sections of society more than the middle-class and elites. In comparison, the second wave impacted everyone, including urban elites. Even so, the long-term implications of pandemic will disproportionately affect the former (Bhatt et al., 2021). These are the prime examples where scientific uncertainties, myths and unverified information gained ground among the public, policy-makers, and certain sections of media and scientific community as well.

The first significant national response to mitigate the economic fallout of pandemic came in the form of a combined monetary and fiscal stimulus program. On 12 May 2020, the PM announced a $260 billion (Rs. 20 trillion) economic rescue package under the slogan of 'Atmanirbhar Bharat' or self-reliant India (Taneja and Bali, 2021). India's economic stimulus and relief packages were seen as modest in managing the economic distress and health crisis as the Indian government appeared more inclined towards protecting the national economy. The government was mainly concerned about limiting the fiscal deficit and exhibited reluctance to spend public funds. As per the International Monetary Fund (IMF) report, various components of the relief package were previously allocated to public spending, with overall additional spending on healthcare and social protection measures comprising only 1.8% of GDP (Younus, 2021). Moreover, cash transfer schemes in lower middle-income countries averaged 40% of GDP per capita, whereas in India, it was only 12% (Azim Premji University, 2021). The government opted for deferred spending measures, whereas the situation demanded direct fiscal spending, reflecting a wider restraint on its macroeconomic stance. India's fiscal deficit and current account deficit, called as "twin deficit problem," as well as its dependence on foreign capital may have constrained its pandemic response and led to sacrifices in social welfare (Shahid MG Kiani, 2022, personal communication). Earlier in 2021, these stimulus packages and reopening of economy had an overall positive impact, leading to a nascent economic recovery. But the second wave eroded this economic optimism and India received foreign aid for the first time in the last 17 years, with more than 40 countries stepping in to help (Younus, 2021).

Lastly, the central government missed the window of opportunity between the first 2 waves to reinforce its healthcare system. A parliamentary Standing Committee report in November 2020 highlighted multiple deficiencies in the pandemic response, including scarcity of medicine and oxygen supplies, inadequate public health spending and insufficient preparation of health infrastructure such as ventilators and hospital beds (Bhatt et al., 2021). By December 2020 to January 2021, the government began dismantling containment and Covid-related facilities, the skilled manpower and healthcare infrastructure was diverted to other medical emergencies (Joshi and Mehendale, 2021). "We completely let down our guard, and Covid control and surveillance took a back seat," said Public Health Foundation of India President K. Srinath Reddy (Bhowmick, 2021). The government was ill-prepared when another and more deadly wave emerged. Public Health Expert Prof. T Sundararaman highlighted that the acute shortage of oxygen in hospitals during this period emphasised the lack of

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"flexibility" in the system to ramp up production to meet demand. The government failed to prepare itself for peak and non-peak scenarios (Bhuyan, 2021).

Flawed scientific advice, misleading beliefs and poor communication clouded scientific rationalism within political priorities, contributing to the government's shambolic response to pandemic. Additionally, the absence of a formal institution to coordinate between government agencies significantly undermined India's response efforts.

Despite all odds, Pakistan managed to bend the Covid curve in its favour and fared relatively better than India in dealing with the pandemic. In 2020, World Health Organization (WHO) declared Pakistan among the seven countries from which the world needs to take lessons (Junaidi, 2020). The Lowy Institute evaluated the performance of 102 countries using the available data till 13 March 2021. The study showed that Pakistan ranked 69th and India was at 87th place, depicting a better performance by Pakistan compared to India in the 43 weeks following their 100th reported case. The former Prime Minister Imran Khan's government initiated a number of preventive measures to assist policy-makers, healthcare professionals and researchers, prop up their resources and conceive strategies to fight the pandemic. His government made critical decisions to control the COVID-19 pandemic. Firstly, it took pre-emptive action by closing borders with Iran and China, suspending all international flights from China, and deciding not to evacuate Pakistanis from Wuhan, even before the first case was reported in the country. Secondly, the government formed the National Command and Operation Centre (NCOC) which integrated civilian, military and other state institutions. This provided a roadmap for coordination and mutual planning, creating national consensus on health and financial security, and implementing the decisions of the National Coordination Committee (NCC) on Covid (Hussein, 2020). The government formed a 'National Action Plan' for Covid, serving as a blueprint for the country's pandemic preparedness under the Global Health Security Agenda. Moreover, provincial Task Forces on COVID-19 were formed and chaired by their respective Chief Ministers. The National Disaster Management Authority (NDMA) and Provincial Disaster Management Authority (PDMA) were tasked with leading the operational issues for overall national response. The Health Ministry, NDMA, PDMA, NCOC, and NCC formulated, coordinated, analysed, and implemented national policy efforts for pandemic management. With federal instructions, all provinces managed the Covid outbreaks according to their circumstances (Free and Fair Election Network, 2021). This amalgamation of civilian and military leadership helped the government orchestrate a coherent national response mechanism that effectively managed resources (Shaheen Akhtar, 2022, personal communication).

According to Dr Muhammad Wasif Malik (2022, personal communication), the main difference in the two countries' response was Pakistan's Emergency Operation Centres (EOC) mechanism, also known as the NCOC, which played the most significant role in combating the pandemic. Pakistan began early pandemic preparedness in January, at a time when no cases were reported in the country.

> We immediately recognized that our health system infrastructure lacked the required capacity to cope with the influx of cases, so we began widespread testing and contact tracing when cases began to appear, allowing sufficient time to build our health systems' capacity. (Dr Malik)

In India, the EOC mechanism was missing at the national level, leading to regional variations across states in their pandemic responses. The absence of a formal institution

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for communication, discussion and information sharing between the Center and States aggravated the situation.

As Covid cases grew, a vehement "lockdown vs. livelihoods" debate started and the PM Imran contended against a nation-wide lockdown, stating that the lockdown model implemented by China and Western countries could not be blindly copied in Pakistan "because the situation in the subcontinent was very different" (*DAWN*, 2020). Pakistan is a densely populated country where entire communities often live cheek by jowl, making social distancing measures of limited effect. With 24.3% of the populace living below the poverty line, the most vulnerable citizens regarding lockdowns were the labour class and daily wage vendors (Noreen et al., 2020). Khan's resistance to a strict lockdown model was also due to its potential adverse impact on national economy, despite immense pressure from the media, "cabinet members" and urban elite for a countrywide lockdown. "I said from day one we had a dual problem; we had to save the people from corona and hunger, and those dying from poverty," Khan stated, admitting that his government faced "a lot of criticism" at the start for not enforcing a harsh lockdown like India (*DAWN*, 2020). This focus on catering to the socio-economic needs of people and protecting livelihoods was a significant priority. Former State Minister for Health Dr Zafar Mirza stated that Khan's insistence on protecting livelihoods "guided us on formulating a smart lockdown (SLD) strategy". The government implemented three different kinds of lockdown strategies: general lockdown, smart lockdown, and micro smart lockdowns (MSLD); and allowed an early phased reopening of the economy. The partial lockdown policy was suitable for catering to the daily needs of the labour force which comprises 72.5 million of the total population (Nafees and Khan, 2020). It wasn't feasible for the government to provide adequate support to each daily wage labour so partial lockdowns allowed them to go to their workplace. According to a study based on the WHO 'COVID-19 Strategic Preparedness and Response Plan 2020', Pakistan had a successful control strategy with a lower mortality rate and fewer hospitalizations than its bordering countries of Iran and India during the first wave. Even the WHO praised its successful containment policy (Noreen et al., 2020). Moreover, the government directed all available health resources – health services, manpower, equipment and logistics – towards the containment of pandemic. The NCOC efficiently utilized its existing Polio Eradication Programme as a nation-wide disease surveillance system for tracking and tracing Covid cases at an early stage because no digitally integrated health information system existed at national level other than the polio program (Hussein, 2020). "Community health workers who have been trained to go door-to-door vaccinating children for polio have been utilised for surveillance, contact tracing and care," said WHO Director General (Junaidi, 2020).

The Pakistani government ramped up efforts to build healthcare capacity and infrastructure for the predictable flood of cases. It devised a mechanism for centralized procurement and provision of essential medical equipment to Ministry of National Health Services, Regulation and Coordination (MONHSRC) and all provinces. The government focused on procuring essential medical equipment through the NDMA to meet the increasing demand. The NDMA and NCOC played a significant role in accelerating the procurement, deployment and local production of essential medical supplies (Noreen et al., 2020). Furthermore, the government succeeded in making indigenous Covid-related medical innovations and soon began exporting personal protective equipment (PPE) (Mirza, 2021). Punjab University locally produced Covid protection kits and hand sanitizers for national usage (*ARY News*, 2020). The government launched its first

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domestically developed portable ventilator 'SafeVent SP100' for deployment in hospitals, with the first batch delivered to NDMA (Naseer, 2021).

Pakistan managed to secure a constant supply of 1.2 million vaccine doses from China. "We were facing a serious challenge and were looking for a friend to come to our rescue, and China helped us to overcome the crisis, enabling us to kick off our vaccination drive," said NCOC Head Asad Umar (*Xinhuanet*, 2021). Pakistan was among the first nations to register with COVAX. In January 2021, Asad Umar informed that the "government signed with COVAX nearly 8 months back to ensure availability," and received letter from them indicating a supply of nearly 17 million AstraZeneca vaccines in first half 2021 (*The Express Tribune*, 2021). Its national vaccination strategy was based on the WHO recommended policy of priority-based vaccine allocation. The government had timely assured supplies to ramp up its inoculation drive. In contrast, India started its campaign earlier and had the advantage of being a vaccine producer, but the shifted priorities misguided its vaccine policy and hampered the drive. This clearly exhibits another example of Pakistan's timely response to manage the crisis that helped turn the tide in its favour.

The government and State Bank of Pakistan (SBP) provided timely targeted fiscal and monetary support that helped reduce the scarcity of pandemic-related facilities and services, and alleviate the impact of lockdown on economy and society. Most importantly, the Ehsaas programme, historically the largest and most extensive social protection programme in Pakistan, provided a crucial social safety net to marginalised sections of society. According to a report released by an international organisation, social protection was an essential element of Pakistan's response to the crises. The innovative cash transfer scheme delivered PKR 179.3 billion to 14.8 million households that fall below the poverty threshold (Al Baraka Bank, 2021).

The Ehsaas Emergency Cash (EEC) programme demonstrated how cash transfer programmes can be deployed to counter the socio-economic fallout due to external shocks such as the COVID-19 pandemic. (IPC-IG, 2021)

Furthermore, the government heavily invested in media awareness campaigns and risk communication to educate citizens on preventive measures, i.e. social distancing, personal hygiene, and mask use education; provide updates on Covid-related data, and communicate guidelines and standard operating procedures (SOPs). According to Dr Zafar, three strategic approaches were used: policy statements, social media and public service messages (PSMs) for constant information sharing and risk messaging. A country-wide public awareness campaign was launched in May 2020 through various media formats (print, electronic and social media). An innovative method of consistent risk communication involved sending text messages and ring-back tones to spread PSMs to the public, especially to the unaware populace, since nearly two-thirds of them use mobile phones (Hussein, 2020).

Dr Wasif Malik highlighted that by strengthening the national diseases surveillance system(s) for early detection and tracing; building and strengthening preparedness and health emergency response mechanisms; and establishing an EOC mechanism at national and sub-national/provincial levels; any state could respond well to future Covid waves, disease crises or epidemics, even if its existing health system is fragile – as shown by Pakistan. Dr Malik added that the health crisis unfolded by Covid has necessitated the significance of strengthening of Primary Health Care (PHCs) so that the entire burden is not completely directed towards Tertiary Care Hospitals. Early focus on preventive

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measures, control strategies and risk factors can help avert the spread of diseases at an early stage, and could lessen the burden on the healthcare system.

Both countries' responses reflect the political-economic considerations and restraints underlying the policy choices they have opted for. The trade-off between health and economy, and lockdown versus livelihoods had been largely debated during the pandemic; and the political leadership in these countries have differently navigated this trade-off as deciphered by their statements and policy actions. Pakistan fared relatively better than India in controlling the initial and subsequent waves of pandemic by rightly focusing on four key elements: surveillance, response, management and coordination; and the world has praised its pandemic policy. Pakistan adopted the 'One Government or whole-of-a-government' approach while India implemented a unilateral centralised decision-making approach. Pakistan mounted a concerted national response by utilizing the available resources at its disposal, despite being a resource constrained country. Its national health response was formed by an amalgam of global guidance along with rational local adaptation. In contrast, India's response lacked effective State-Center coordination within a national policy framework that required localised adaptation rather than a unilateral centralised or decentralised decision-making approach. Despite being an advanced economy, India's failure to limit the spread and fatality rates shows the irrational spending preferences of the ruling regime, regardless of the general public's desire for better social security policies and quality public healthcare systems. Ergo, the pandemic crisis has shown that striking the right balance between sustaining livelihoods and curbing the disease is the ultimate test of political leadership. The case-studies show that the meagre economic and health resources, along with the general public's desire for improved healthcare and social security policies, force politicians and policy-makers to innovate for the sake of managing their resources more efficaciously.

Realist approach to Political Economy of national preparedness – 'An Enhanced State Capacity Framework'

To understand the varied national responses of India and Pakistan, the realist perspective within the Political Economy framework is employed. According to realist perspective, political power regulates economic activity which creates the basis for and affects political power. Its central idea is that politics guides economics: the state has complete control over all resources at its disposal and its decisions determine whether these resources are aptly utilized or not, especially in crisis situations. Hence, the state is the central actor vital for regulating economic affairs. As observed in the case of COVID-19, politics and the decisions of political actors have clearly been at the centre of national responses. Political decisions either improved or aggravated pandemic management, sometimes regardless of the strength of public health infrastructure, thereby manifesting the political determinants of public healthcare. As is clear from the national responses of India and Pakistan, technical decisions call for political measures such as what and how policies should be effectuated and enforced, whose advice should be taken, which models of policy formation should be used, and whom to trust in the international arena. More importantly, it involves how to maximize the benefits by using limited (not so superfluous) economic and medical resources, paying special attention to the budgetary restraints of the public sector.

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Political Choice and State Capacity

As per the 'An Enhanced State Capacity Framework', the infrastructural power of the state is specifically the state's capacity to mobilise resources in crisis situations, be it a traditional security threat such as foreign invasion or a non-traditional one like the pandemic. State capacity is at all times enacted through society, by means of negotiation and agreement. Generally, all modern states are endued with infrastructural power to a certain degree. But their capabilities for behaving in different policy realms are certainly not similar (Weiss and Thurbon, 2021). Faced with the present crises, Pakistan has fared better than India in managing the challenges of pandemic. In order to make sense of such unexpected outcomes, three sources/strands of state capacity must be studied (refer Table 1).

- **Extractive-distributive capacity** refers to the state's ability to mobilise economic resources for redistribution. In crisis situations, this form of capacity becomes crucial when the looming threat of bankruptcies and unemployment makes lockdown policy less socially feasible.

- **Transformative capacity** involves the ability of the state to ensure a steady supply of essential medical supplies and equipment.
- **Salutary capacity** comprises the state's ability to redress and counteract the course of its national health emergency. States with underdeveloped transformative and extractive capacities can effectually develop some critical components of salutary capacity in a situation of health emergency. The salutary capacity depends on the state's prior two capacities.

Meanwhile, political choice is a core element of the states' national responses and matters for state capacity for four reasons:

1. The decisions of state/political agents can make institutional weakness less important than it otherwise is.
2. Political choice can assist to compensate for weaknesses by looking for innovative solutions to pressing issues.
3. The decisions of political leaders can enable dormant capacities to be activated.
4. Political decisions can entirely subvert an otherwise effectual strategy and lead to a reversal of fortune.

Table 1. Three Sources of State Capacity for Pandemic Preparedness

Salutary	Extractive-Distributive	Transformative
Containing the spread of virus: border control, quarantine, communicate public health threat, mandate public health measures, test and trace, isolating vulnerable individuals, lockdowns, mobilise health infrastructure, treating the sick, and vaccinate the population.	Providing economic resources to support livelihoods during Lockdown.	Ensuring a steady supply of medical equipment: PPE, ventilators, oxygen, oxygen-related equipment, medicines, vaccines.

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In the previous section, the article analysed the policy responses of the two countries and the socio-economic considerations and political restraints that have likely impacted their decision-making. Through a comparison of the India and Pakistan cases within this three-dimensional framework, the research study intends to show how state capacity is not merely a function of material resources but also of the prioritised choices of the political actors/state agents that have influenced their states' capacity when managing the COVID-19 pandemic. The Salutary, Extractive-Distributive, and Transformative sources of India and Pakistan's state capacities have been analysed below in Tables 2, 3 and 4.

Table 2. India's State Capacity during COVID-19 Pandemic

India's National Response		
Salutary	**Extractive-Distributive**	**Transformative**
▪ **Temperature screening, universal screening and quarantine of incoming int'l passengers** ▪ **Thermal checks at main points of entry** ▪ **ICMR started sentinel surveillance** ▪ **Trace, test and quarantine (TTQ) via symptom-based surveillance model** ▪ **Suspended int'l flights** ▪ **Closure of educational institutions** ▪ **ICMR established National Task Force (NTF) to advise govt on pandemic response** ▪ **National lockdown** ▪ **Shramik Special trains for stranded workers** ▪ **Vande Bharat Mission to repatriate Indians from countries** ▪ **Mobile hospitals** ▪ **Aarogya Setu app – provided risk level information and traces high caseloads areas** ▪ **Phased reopening of national economy**	▪ Rs. 1.7 trillion relief package for poor and migrants ▪ Rs. 20 trillion economic rescue package ▪ Rs. 11.7 trillion Pradhan Mantri Garib Kalyan Yojana (PMGKY) ▪ 'Atmanirbhar Bharat' package provided subsidised food grains to 80 million migrant workers ▪ Public Distribution System (PDS), National Social Assistance Programme (NSAP), Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), and Jan Dhan provided crucial social safety net ▪ Mission Mode Project for social security of eligible workers ▪ 'Emergency Credit Loan Guarantee Scheme' provided emergency loans to micro, small and medium enterprises (MSMEs) ▪ Reserve Bank of India (RBI) slashed repo and reverse repo	▪ Rs. 150 billion COVID-19 Emergency Response and Health Systems Preparedness Package ▪ Produced 150,000 PPE kits/day by May 2020 ▪ Built oxygen plants ▪ National Covid Vaccination Programme ▪ Domestically manufactured vaccines in Jan 2021: Covishield and Covaxin ▪ Provision of Rs. 350 billion for vaccination program in FY 2021-22 national budget ▪ Exemption of custom duties and taxes on vaccines and oxygen ▪ 'Oxygen Express' trains transport medical oxygen nationwide from surplus to deficient regions ▪ Financial support to SII and Bharat Biotech to increase vaccine production: Rs. 30 billion and Rs. 15 billion, respectively. ▪ Imported Sputnik V

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▪ **Began phased vaccination program in Jan 2021** ▪ **Strategy of localized lockdown and micro-containment zones during subsequent waves**	rates to 4 and 3.35%. ▪ RBI provided relief to borrowers and lenders ▪ Scheme of Rs. 150 billion to provide interest-free loans to State govts	

Table 3. Pakistan's State Capacity during COVID-19 Pandemic

Pakistan's National Response		
Salutary	**Extractive-Distributive**	**Transformative**
▪ **Thermal screening at points of entry** ▪ **Health screening of incoming int'l passengers** ▪ **Emergency quarantine measures** ▪ **Suspended int'l flights and closed borders** ▪ **TTQ launched** ▪ **Piggyback on polio program for surveillance** ▪ **NCOC** ▪ **Provincial Task Forces on COVID-19** ▪ **Closure of educational and technical institutions** ▪ **Smart lockdowns, MSLD and nonpharmacological interventions** ▪ **NCOC initiatives: COVID-19 Gov Pk app, Pak Neghayban app and Telehealth helpline for free online doctors' consultations** ▪ **'Integrated Disease Information Management System' for Covid data exchange among provinces to monitor case projections and identify high-risk areas** ▪ **Risk communication and public awareness campaigns** ▪ **$595 million for Pakistan's Preparedness and Response Plan' (PPRP)**	▪ Rs. 1.2 trillion economic rescue package ▪ Rs. 100 billion allocated for Emergency Relief Fund ▪ Relief packages for media and healthcare workers ▪ PM's Corona Relief Fund-2020 ▪ Corona Relief Tiger Force delivered food and rations to poor, and educated public about precautions ▪ Ehsaas programme ▪ Pak Poverty Alleviation Fund allocated Rs. 400 million to Covid Emergency Response Fund – over 59,000 poor families received assistance ▪ State Bank of Pakistan (SBP) launched: 'Rozgar Scheme' to fund salaries and prevent layoffs, 'Debt Relief' scheme to help borrowers reschedule and defer loans, and 'Temporary Economic Refinance Facility' to boost manufacturing investments	▪ Local production of ventilators, PPE kits and sanitizers ▪ Resource Management System –national framework for health resource mapping ▪ SBP launched 'Refinance Facility for Combat COVID-19' to support health sector ▪ Tax-exempt on health safety equipment ▪ Privately imported Sputnik V ▪ Purchased Sinopharm and CanSino vaccines ▪ Yaran e Watan mobilised overseas Pakistani health professionals and resources to fill gaps in public health sector

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▪ **Rs. 70 billion for 'COVID-19 Responsive and Other Natural Calamities Control Program' in FY 2020-21 budget** ▪ **Began phased vaccination program in Feb 2021**	▪ Offices, business centres and hospitals remained open during second wave	

Table 4. Political Choice and State Capacity for Managing Pandemic

Impact of Political Choice	India's Policy Actions	Pakistan's Policy Actions
1. Can make institutional deficiencies more, or less significant.	▪ Delayed int'l flight ban ▪ Failure of nation-wide lockdown ▪ Failure to address testing and equipment deficit ▪ Unable to use lockdown period and breathing space between two waves to prop up health system *The miscalculated policy decisions made the structural deficits to become more apparent*	▪ Pre-emptive measures: suspended int'l flights to China, closed border with Iran, not evacuated Pakistanis from Wuhan
2. Can assist in compensating for institutional deficiencies through innovative solutions to urgent issues	▪ Strategy of localized lockdown and focus on micro-containment zones during the second wave	▪ Smart lockdowns and MSLD strategy ▪ Formation of NCOC ▪ Piggyback on polio program for surveillance ▪ Ehsaas programme ▪ Risk communication and information campaign ▪ Yaran e Watan
3. Can activate dormant capacities	▪ Domestically manufactured vaccines and PPE kits	▪ Local production of ventilators, PPE and sanitizers
4. Can bring about a reversal of fortune	▪ Vaccine Maitri programme (Vaccine diplomacy)	

Quoting Yuval Noah Harari: "Pandemics are no longer natural disasters; they are political failures". This statement is especially relevant in the context of the COVID-19.

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The findings of this research study spotlight the crucial role of political leaders in addressing this complex crisis by carefully and proactively managing the available resources to mitigate the pandemic-induced economic and health shocks. The state's capacity to optimise resources during crises depends largely on its actions during times of relative peace when no imminent threats prevail. Managing the pandemic or other black swan events is not just about resource endowment; it is more significantly about whether countries have robust emergency management capacities and can swiftly respond with effective measures. The sheer quantity of resources available has no direct impact on the effectiveness of pandemic management; rather, the optimal utilization of health and economic resources is key to dealing with a global pandemic.

Conclusion

India's COVID-19 response was driven by PM Modi's desire to prioritise political gain over public health. While managing the pandemic crisis, the Indian government exploited diplomatic opportunities to profile the country's image as a responsible regional power and demonstrate leadership at global level, while also attempting to prevent a major economic disaster with potentially severe domestic repercussions. Howbeit, it faced a herculean task in controlling the virus spread and providing adequate social protection to the poorest segments of society due to misplaced priorities. Had the Indian government focused its efforts on managing COVID-19 and addressing the socio-economic needs of its population, its international image would have been enhanced regardless of diplomatic overtures and projection of its regional and global leadership. Meanwhile, the Pakistani government made substantial interventions to balance protecting citizens from disease and economic hardships, and evidence suggests that these efforts have paid off. Pakistan rightly focused on four key elements: surveillance, response, management, and coordination; and the world has praised its pandemic policy, given its meagre resources and a fractured polity. This study demonstrated that the ultimate test of state capacity is not to assess its capability to provide economic prosperity to its citizens under ideal conditions, but to assess its resilience to unanticipated and exogenous shocks, like political unrest, natural disasters and pandemics. Policy makers had to prioritize policy choices and rationally allocate or adjust their finite resources in such a way that they could achieve the interconnected goals of managing economic crisis and health recovery.

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