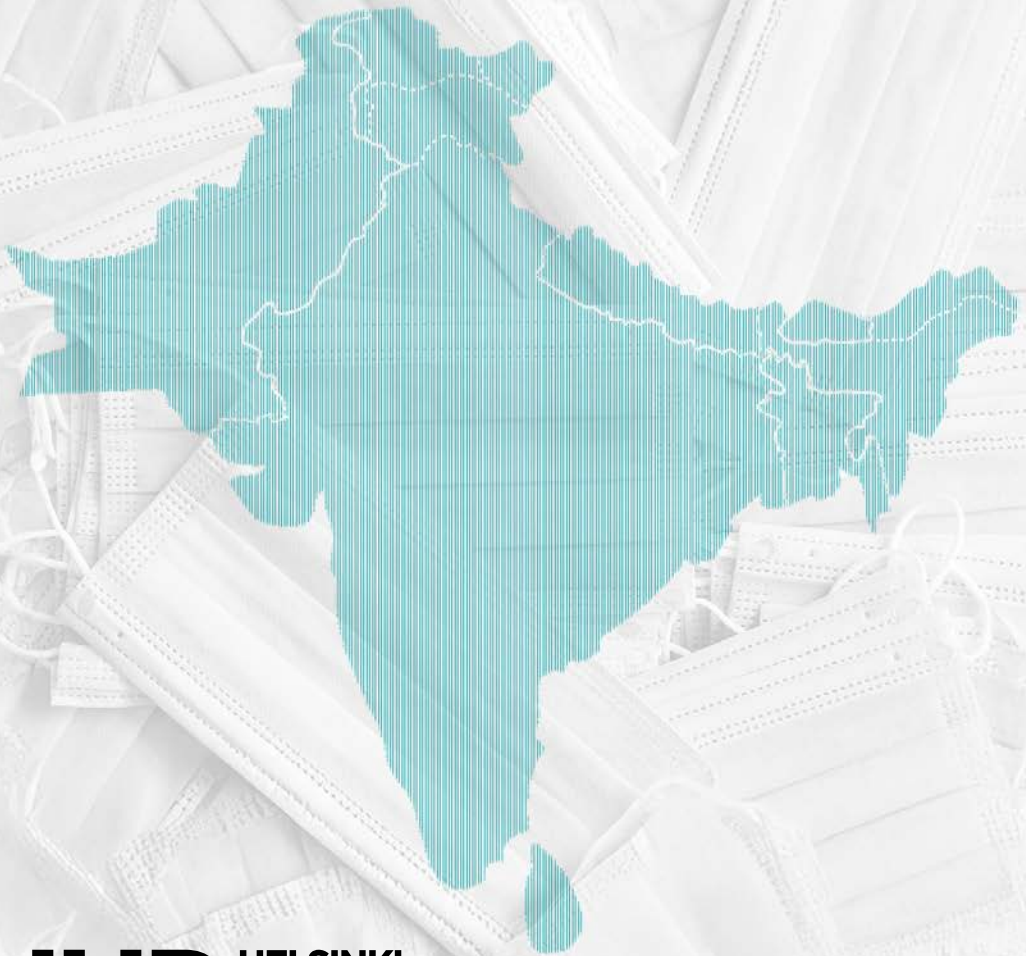


Protecting Workers?

Crisis, COVID-19, and South Asia

Edited by **Kanchana N. Ruwanpura & Wilfried Swenden**



HUP HELSINKI
UNIVERSITY
PRESS

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To Fiona S. Mackay, an academic mentor who brought us together

In memory of Ada Munns – a godmother who held us together

To the many students who crossed our path

And to each other for helping glide through ice

Contents

Figures, Tables and Boxes	vii
Acknowledgements	ix
Contributors	xiii
Chapter 1: Introduction: Protecting the Workers: A Framework for Analysis	1
<i>Wilfried Swenden and Kanchana N. Ruwanpura</i>	
PART I MACRO APPROACHES: THE STATE	23
Chapter 2: Political Dominance, Performance Legitimacy, and the COVID-19 Response in Bangladesh	25
<i>Naomi Hossain</i>	
Chapter 3: COVID-19: How Has Indian Federalism Done?	51
<i>Chanchal Kumar Sharma and Wilfried Swenden</i>	
Chapter 4: Epidemiological and Economic Impact of COVID-19 in South Asia: A Comparative Analysis	79
<i>Muttukrishna Sarvananthan</i>	
PART II MESO APPROACHES: STATE-WORKERS	113
Chapter 5: Citizens' Plight and State Responsiveness in India: Comparing State and Substate Responses in Bihar, Rajasthan, and Uttar Pradesh	115
<i>Himanshu Jha</i>	
Chapter 6: COVID, Crisis, Precarity, and Social Protection in Nepal	137
<i>Jeevan R. Sharma</i>	

Chapter 7: Migrant Workers and the COVID-19 Pandemic: A Case Study of Delhi	159
<i>Papia Sengupta</i>	
Chapter 8: Policy Resilience and Continuing Marginalities: Kerala's Pandemic Response through a Labour Lens	187
<i>Aardra Surendran</i>	
Chapter 9: Mitigating the Ready-Made Garment Sector's COVID-19 Crisis in Bangladesh: Protecting Workers or the Interests of the Industry?	211
<i>Maheen Sultan, Iffat Jahan Antara and Touhidul Islam</i>	
PART III MICRO APPROACHES: WORKERS	239
Chapter 10: Frontline Narratives: Experiences of Healthcare Workers in Pakistan amid the COVID-19 Pandemic	241
<i>Priya Sajjad</i>	
Chapter 11: Liminal Life: Pandemic, Protests, and Worker Voices in Sri Lanka	267
<i>Kanchana N. Ruwanpura</i>	
CONCLUSION	291
Chapter 12: COVID-19 and After: Collaboration and Compromise – Confrontation and Contestation?	293
<i>Kanchana N. Ruwanpura and Wilfried Swenden</i>	
Index	311

Figures, Tables, and Boxes

Figures

Figure 2.1: Responses to the question ‘Where did people in your area seek health services before and during the pandemic?’	37
Figure 2.2: Types of support that people were reported to have received	39
Figure 2.3: Reported problems with social assistance during the pandemic	40
Figure 3.1: Medical and public health expenditure (inflation adjusted) as a percentage of GDP	63
Figure 3.2: Social sector spending (inflation adjusted) as a percentage of GDP	64
Figure 3.3: Labour welfare expenditure (inflation adjusted) as a percentage of GDP	66
Figure 3.4: Fiscal deficit (inflation adjusted) as a percentage of GDP	67
Figure 3.5: Labour welfare spending per capita (mean, 2009–2023)	69
Figure 3.6: Health expenditure per capita (mean, 2009–2023)	69
Figure 4.1: Share of the South Asian population by country (2022)	86
Figure 4.2: Share of the South Asian economy by country (based on 2021 US\$)	88
Figure 4.3: Per capita income by country (US\$), 2021	89
Figure 4.4: COVID-19 cases per million people, January 2020–December 2022	90
Figure 4.5: COVID-19 deaths per million people, January 2020–December 2022	91
Figure 7.1: Per capita income in Delhi, 2011–2012 to 2022–2023	164
Figure 7.2: Monthly income in Delhi before and during the pandemic in 2020	165
Figure 7.3: Gender and employment status in 2019 (pre-COVID) and 2022 (after COVID)	168

Figure 7.4: Job profile of respondents	169
Figure 7.5: Number of respondents who availed themselves of COVID support schemes by various institutions	171

Tables

Table 1.1: Focus of the contributions: state and workers by level of analysis (macro, meso, micro)	9
Table 3.1: State-wise comparison of health infrastructure and pandemic outcomes: estimated excess deaths per 1,000 and vaccination coverage	70
Table 3.2: Correlation and regression results for determinants of estimated excess COVID-19 deaths	72
Table 4.1: Population, GDP, per capita income, COVID-19 cases, and deaths by country	87
Table 4.2: Annual growth of GDP by country, 2019–2022 (%)	94
Table 4.3: Unemployment rate by country, 2019–2022 (%)	96
Table 4.4: Inflation rate by country, 2019–2022 (%)	99
Table 4.5: Remittances in billion US\$ and as a share of GDP by country, 2019–2022	101
Table 7.1: Central government welfare schemes (prior and in response to the pandemic)	166
Table 7.2: Delhi government labour policies (prior and in response to COVID-19)	166

Boxes

Box 5.1: Supreme Court instructions to the central and state governments	119
Box 8.1: Pre-pandemic welfare measures for migrant workers in Kerala	193

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Sweden

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CHAPTER 1

Introduction

Protecting the Workers: A Framework for Analysis

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Abstract

This chapter introduces the purpose and framework of the volume. It seeks to understand how South Asia has been navigating a prolonged and overlaying crisis that became pronounced with a pandemic and then a debt crisis, affecting at least the livelihood of workers. Our framework suggests a two-dimensional (state and workers) and multilevel approach to accommodate contributions ranging from the macro (e.g. encompassing all workers across South Asian borders or within a state) to the micro (e.g. covering garment workers in a few villages). The subsequent thematic chapters are then briefly introduced. These contributions

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adopt myriad approaches (from quantitative data analysis to oral testimonies and ethnography) to capture the dynamic between structures and worker agency in Bangladesh, India, Nepal, Pakistan, and Sri Lanka. They illustrate how uneven geographies and the political economy of development dramatically shape the life chances of the working poor.

1.1 Introduction

The spread of a novel coronavirus (COVID-19) from Wuhan in China to the rest of the world since late 2019 has had profound health, socio-economic, and political implications across the world. According to World Health Organization data, 6.9 million citizens around the globe died from the virus, while an estimated 676.6 million contracted it ('COVID-19 Map' 2024). These figures are likely underestimations owing to a shortage in test and tracing capacity, especially at the outset of the pandemic, or, in some cases, deliberate under-reporting, mainly in authoritarian regimes (Greer et al. 2020).

As we complete this book (April 2025), the world lives with COVID-19, although the intensity of the pandemic is far from current occupations. Returning to 2020, within months after the outbreak of the pandemic several vaccines were developed, with the Pfizer–BioNTech and AstraZeneca vaccines most widely administered. COVID-19 is still widespread (and new mutations continue to emerge) but the virus no longer has the same deadly effect, even though phenomena such as 'long-COVID' are poorly understood. Meanwhile, much of the world's attention is consumed by deadly military wars (Russia, Ukraine, Israel, Palestine) and acts of genocide, with the International Court of Justice ruling in early 2024 that Israel is violating the Genocide Convention (Human Rights Watch 2024). Other lesser-known deadly conflicts involving mass displacement and potential genocide continue too, such as the war in the Amhara region in Ethiopia (*The Guardian* 2024; UN 2023).

And yet, while the COVID-19 health crisis appears to have subsumed for now, the effort it took to fight it has had long-lasting reverberations. Governments forked out billions of dollars to bail out employers and support large sections of the labour force (Yeyati and Filippini 2021). These support efforts mainly took the form of social cash transfers, social insurance payments, and labour market measures, such as subsidising wages, providing public work or activating workers through job retention and training (Leisering 2021, 401).

Although in certain professions a shift to working from home (mainly in services) had become possible due to the development of teleworking platforms, without government support millions of workers or small business owners would have lost their jobs or businesses. This was a consequence of COVID-19-related lockdowns and temporarily disrupted supply chains. Governments also invested disproportionately in health infrastructure, ramping up testing capacity and investment in ventilators, intensive care units, or vaccine development. Thus, despite the prevalence of neoliberal policies across many parts of the world, citizens and companies could not have been 'rescued' without the intervention of the state (UNDP 2024).

This state intervention has come with a price: as we finalise our volume (2025) even most Western governments face budget deficits, considerably worse than before the pandemic. Many are cutting down on capital investment and social support, although austerity policies are political decisions around resource distribution and neglect growing inequality both within countries and around the globe (Mattei 2022). Subdued economic growth and post-pandemic price inflation have been fuelled by what Isabelle Weber (2023) notes as sellers' inflation associated with profiteering that came with rising energy prices following the Russia–Ukraine war. The resulting squeeze on family incomes has also contributed to an increase in inequality and a rise in political support for the populist right, not in the least with the return of Donald Trump to the White House and, in the UK, the Reform Party. Migrants have often been targeted because of these political and

economic developments while long-standing commitments to development aid in the Global South have been undone (Bardhan 2022). This is most starkly illustrated with the dismantling by the Trump administration of USAID in 2025.

The impact of the pandemic and its lasting legacies in the West often pale in significance with the situation across the Global South. In the context of higher poverty rates and weaker state capacity, low- and even middle-income countries have been hit harder by the pandemic. Countries in the Global South also increased social protection, especially through social assistance, which in 2020 accounted for 75 per cent of social protection programmes across South Asia, compared with just 26 and 16 per cent in social insurance and labour measures, respectively (Abdoul-Azize and El Gamil 2021; Leisering 2021). However, there is also wide recognition that these measures were insufficient to protect large sections of the population. Research by Oxfam and Development Pathways shows that in eight out of ten countries worldwide social protection measures did not even reach half of the population (Oxfam 2020, 11). Within lower- and lower-middle-income countries, the weakest section of their societies in particular have been left out, along with migrant labourers, those employed in the informal sector, female workers, landless rural workers, religious minorities, and/or in a South Asia context, especially India and Nepal, workers tied to the lowest caste or *biraderi* segments of their population (Acharya and Christopher 2022).

Furthermore, in recent years cash transfers or social insurance payments in South Asia have relied increasingly on the digitalisation of governance processes and service delivery. Digitalisation has become more widespread, especially in Bangladesh and India, with the expanding base of mobile phone use and internet connectivity. For example, the 'Jhan Dhan' programme in India has sought to expand the delivery of financial services through its linkage with Aadhaar, the world's largest biometric identification system, and mobile phone technology. Under the programme, 80 per cent of Indian citizens have opened bank accounts, linked to Aadhaar IDs through which government payments or subsidised

food can be accessed. Yet a considerable share of the Indian population remains locked out of this process. Digital inclusion bypasses those with more limited access to mobile phone technology, with differences linked to caste, gender, and class (Carswell, Chambers, and De Neve 2018; Parkar and Tawa Lama 2023). Furthermore, during COVID-19 migrant workers were deprived of support for long as both Aadhaar and the Public Distribution System (subsidised food supply) were tied to residency and not place of employment (Carswell, Chambers, and De Neve 2018; see also chapters by Surendran, Sengupta, and Sharma and Swenden in this volume). The need to check fingerprints (rather than face recognition) as part of the ID verification process also put workers at risk during COVID-19. Beyond differential access, authors have pointed at the quality of surveillance facilitated by digitalisation. This is especially the case in the context of South Asia, where countries have adopted authoritarian traits, weak state regulation overall, and insufficient data protection (Parkar and Tawa Lama 2023).

Without adequate health infrastructure and social support, many lives and livelihoods were lost. Several states of the Global South also faced a drop in foreign remittances, foreign direct investment, or other forms of international credit. Some encountered an almost complete loss in revenue from sectors that accounted for a large share of their GDP, for instance tourism, while also facing an acute rise in the cost of energy supply, following the Russia–Ukraine war. Consequently, some countries defaulted on their debt. The causes of the global debt crisis, identified by the UNDP (2022) as likely affecting 54 countries, are also due to structural inequalities that have witnessed rampant reckless lending by financiers and the financialisation of capitalism (Ghosh 2022; Martin 2022; Roos 2019; Standing 2017; Tricontinental 2022). Sri Lanka was one country that defaulted in 2022, requiring going for the 16th International Monetary Fund programme with austerity policies affecting the state's capacity to invest in social relief and health and threaten its level of human development.

Within this context, this volume turns its gaze to the most populous region in the Global South, South Asia, although the geographical reach of the region is contested. The United Nations classifies it as comprising Afghanistan, Bangladesh, Bhutan, India, Iran, the Maldives, Nepal, Pakistan, and Sri Lanka. Other accounts also include Myanmar and Tibet (though others see these as part of Southeast Asia) and many, unlike the UN, exclude Iran (which is relegated more often to the Middle East; Mann 2015, 12). South Asia has been used more frequently since the latter part of the 20th century synonymously with the ‘Indian subcontinent’. Within the region itself, South Asia was more commonly used with the development of the SAARC (South Asian Association for Regional Cooperation; Chakma 2018, 191). Though many (though by no means most) South Asian countries were a part of the British Empire, they also have a shared postcolonial trajectory of nation-building. Yet there are divergent narratives on the meaning of South Asia as an ‘economic’, ‘cultural’, and ‘security region’, reflecting the heterogeneity within countries and across the region. Notably, economic integration is low, in part as a consequence of the tense relationships between India, Pakistan, and Bangladesh since 1947. Beyond their limited political and economic integration, most South Asian countries are marked by internal heterogeneity (based on income inequality and differences tied to caste, religion, language, tribe, or ethnicity more generally). Contributors to this volume seek to understand and unpack this internal heterogeneity and analyse how this affects state–society interactions during times of intersecting crisis.

Indeed, our volume charts how South Asia, home to two billion citizens, has been navigating a prolonged crisis that has shifted from a pandemic to an unfolding debt crisis and analyses its effect on the livelihood of workers across the subcontinent. It brings together several chapters that focus on the macro-response of the state and combines this with perspectives from below, based on testimonies, interviews, or ethnographic field notes with workers from Bangladesh, India, Nepal, Pakistan, and Sri Lanka. The focus lies on how the state responded to health crises and its

provision (or the lack thereof) of socio-economic relief to workers, including migrant workers and workers in the informal sector. These are mostly low-skilled workers. Indeed, while high-skilled workers, mostly in the organised sector, were able to hold on to their jobs during the pandemic, this has not been the case for many low-skilled workers, who in many cases have not been able (or willing) to return to their jobs in the urban centres (see for instance Suresh, James, and Balraju 2020). In seeking to assess the position of workers, the emphasis rests on two aspects that are central to their well-being: health and social protection (including support with food and accommodation) and income/labour protection. The chapters thus consider how these workers were supported (or left behind) in terms of health and socio-economic relief and/or analyse the broader context which has shaped this (lack of support). Unlike many publications on the immediacy of the pandemic, including those with a South Asia focus,¹ we want to trace the temporal dimensions when the worst of the health crisis has subsided but the socio-economic consequences are still plain to see.

An online workshop in February 2023 enabled us to extend and compare our findings with research conducted by scholars with a focus on different parts of India as well as Bangladesh, Pakistan, and Nepal. Therefore, our coverage is as territorially inclusive as was possible at the time, even though we acknowledge that some countries from the subcontinent are missing from our analysis, at least in the individual case study chapters (Bhutan and the Maldives are left out, as well as Afghanistan, a country that underwent significant disruption at the time due to the withdrawal of non-Afghan troops and the takeover by the Taliban, which rendered field research nearly impossible as a result). The contributors to this volume have different disciplinary and geographical backgrounds: they bring together (in alphabetical order) economists, gender scholars, human geographers, international development scholars, political scientists, and social anthropologists. We believe that one of the key strengths of the book lies in its attempt to provide a more holistic understanding of how the pandemic affected

the community of workers by adopting different disciplinary and not just geographical lenses.

1.2 State and Workers: A Two-Dimensional and Multilevel Approach

Despite this multifaceted approach, we analyse the pandemic and its effect on workers from two distinctive dimensions, as set out in [Table 1.1](#). The first of these primarily considers the role of the state: what type of protection does it (fail to) offer and if it does not what may explain this? The second dimension focuses on the workers: how do they organise collectively, how do they seek to influence state policy or access to health benefits, and what may explain their strategies? What is their lived experience of the pandemic and who do they credit or blame for (failing) to support their health and social needs?

Assessing the role of the state and workers in turn requires us to do so from different ‘levels’: macro-, meso-, and micro-level analysis is applied to how we study the state and how we study workers. Concerning the state, a macro-level approach assesses the state’s input at a level of the entire subcontinent or, as is the case in large federal or multilevel polities, such as India, of the federal centre. It focuses on the role of the state across a range of sectors from social to health protection, and possibly in the context of international collaboration, for example as in the case of vaccine procurement and the import/export of vaccines or PPE. Such a macro-perspective enables us to differentiate between states of the subcontinent based on where governments struggled the most to contain the virus and the resultant death toll. It also helps us to locate these instances in which health and social protection in the aggregate have been the most extensive relative to per capita income and where such state interventions have been the most effective (relative to cost). Based on a comparative reading of the state capacity literature, one may expect states to be more performative where they have more infrastructural (revenue-raising and bureaucratic) capacity, are subject to accountability mechanisms

Table 1.1: Focus of the contributions: state and workers by level of analysis (macro, meso, micro)

Focus of the contributions		The state		
		Macro	Meso	Micro
Workers	Macro	(Inter)national and focused on all workers Hossain, Chapter 2 (Bangladesh); Sharma and Swenden, Chapter 3 (all India); Sarvananthan, Chapter 4 (all South Asia)	Substate (meso-level) and focused on all workers Sharma and Swenden, Chapter 3 (all India)	Local, tied to specific city or (factory) sites, but focused on all workers through purposive sampling Sengupta, Chapter 7 ; Surendran, Chapter 8 (India)
	Meso	(Inter)national and focused on specific segment of workers (e.g. RMG, migrant workers) Sharma, Chapter 6 (Nepal) Sultan, Antara and Islam, Chapter 9 (Bangladesh)	Substate (meso-level) and focused on specific segment of workers Jha, Chapter 5 (India)	Local, tied to specific city or factory sites and focused on specific segment of all workers Jha, Chapter 5 ; Surendran, Chapter 8 (India)
	Micro	(Inter)national but very specific segment of workers – testimonies through purposive sampling across the state Sharma, Chapter 6 (Nepal)	Substate (meso-level) but very specific segment of workers through purposive sampling at the sub-state level Sengupta, Chapter 7 ; Surendran, Chapter 8 (India)	Local and very specific segment of workers through detailed testimonies from select number of workers in factory sites, hospital sites or villages Sengupta, Chapter 7 (India) Sajjad, Chapter 10 (Pakistan) Ruwanpura, Chapter 11 (Sri Lanka)

(through processes of free and fair elections and forms of performance legitimacy, for instance through the courts or independent audits), and retain a degree of autonomy, rather than being captured by specific groups in society (leading to forms of neo-patrimonialism or personal corruption).² A macro-level approach can also be adopted with workers, where all workers within or beyond the state are considered in the aggregate, irrespective of the sector in which they are employed, the nature of their employment (formal, informal, blue-collar, white-collar), or personal characteristics associated with their employment (based on gender, race, caste, ethnicity, religion, age, and level of education, among others).

Unlike the macro, a meso-level approach highlights state–society relations. The gaze is still focused on the ‘state’ but the emphasis now shifts to what happens at the subnational level. This is particularly important in the case of large and diverse polities, such as India and Pakistan, where health and social protection policies are often legislated on or implemented at the ‘state’ (India) or provincial level (Pakistan). Furthermore, in studying workers, a meso-level approach shifts the focus to how workers fare in a particular policy segment (e.g. labour protection through labour rights, access to health assistance, vaccines, and income or housing support). Such an approach may also take an interest in a specific category of workers (rather than its aggregate), for example garment workers, and how their interests intersect with personal characteristics (e.g. religious and/or ethnic minorities), migrant workers, or women workers. Meso-level approaches to state and workers can give us a better understanding of which state–society interactions generate stronger worker or labour protections and why. For instance, where land ownership remains more heavily controlled by dominant landed castes, as in much of north India, said castes and state bureaucrats often collide in the suppression of labour rights and redistribution towards landless labourers. In such a setting, dominant caste groups often control access to political and state resources and use them to suppress labour rights.

However, committed bureaucrats operating in such a context of overall relatively weak state capacity (such as the states of Bihar or Odisha in India) may nonetheless ‘innovate’, ‘learn’, and provide tangible benefits to workers (see for instance Jha in this volume). Given the nature of the pandemic as a specific form of ‘disaster’, states may also be able to build on earlier practices linked to similar challenges (from combating the Nipah virus in Kerala to earthquake or cyclone preparedness in Odisha or countries, such as Pakistan or Bangladesh, respectively). Such experiences may have generated a template of ‘crisis management’, ready to be activated when the pandemic struck.

The third level through which we can analyse how the pandemic has affected workers is by adopting a ‘micro-perspective’. Insofar as the scrutiny is directed at the state, the focus rests on the local level and the interaction between the state and society at this level. More particularly, we can observe the success (or failure) of ‘last mile bureaucrats’ in their role as interlocutors between workers and the state, channelling their demands upwards and providing benefits downwards to workers in an impartial or biased manner. A micro-level approach to workers takes the form of testimonies or participant observation with small groups of workers facilitating their voices. These workers may be drawn from specific factory sites and select villages or cities, and approached through purposive sampling. Usually, such bottom-up approaches allow us to assess more accurately where and why workers may or may not succeed in building coalitions with fellow workers; how they experience and navigate the state or the dimensions of powers associated with the work floor (factory, land holding, or service); and how their experiences intersect with gender, race, caste, class, or other characteristics based on their individual or small group reporting. Bringing in a diverse range of worker experiences in myriad spaces reveals the contestations by the working classes and challenges that the labouring poor face.

State–worker interactions as seen from multiple levels and angles enable us to make sense of the capacity for worker voice and engagement (empowerment). Human resource practices on

voice and work engagement are often predicated on the assumption that the state compels employers to build in opportunities for workers' voice. Employers, so HR theory tells us, have an incentive to provide this themselves, since voice has been associated positively with higher job satisfaction, organisational commitment, and job retention (Kwon, Farndale, and Park 2016, 329). However, in South Asia, with a predominantly informal and low unionised work force, opportunities for voice are often not given. Crony capitalism also prevents the state from seeking to impose such practices on employers. Furthermore, as Kwon, Farndale, and Park (2016), observe, even those employers who are committed to such values may find that workers do not seek or dare to exercise them should they clash with more hierarchical sociocultural values. South Asian societies can be marked by relatively high levels of 'power distance', that is citizens accept more easily that power in institutions and organisations is distributed unequally and may reflect status, gender, and caste differentials. Finally, and building on from this, there may be a disjuncture between a state's national work culture, that of an employer and the work culture experienced on the work floor. The latter is also influenced by direct supervisor (line manager)–subordinate relations. Therefore, understanding how, why, and when workers effectively bargain for pay-rises, career opportunities, or job security overall requires a broader engagement with the involvement of the state in social protection, wage-setting, and bargaining; with employer-driven processes facilitating work engagement and participation; and with attitudes and behaviour of workers and their direct line managers on the work floor. The various contributions to this volume by focusing on the state, employment sectors and workers help us to shed light on this triangular relationship or at least parts thereof.

Overall, the chapters adopt myriad approaches to capture the dynamic between structures and worker agency in various South Asian countries to illustrate how uneven geographies and the political economy of development dramatically shape the life chances of the working poor. They also show us that workers

can strike back, assert, and make claims in both minute and substantial ways that need recording to appreciate how labour is an important agent of capitalism.

Few chapters in this volume fall squarely within just one of the nine cells identified in [Table 1.1](#); nonetheless, some tilt more towards an analysis at the macro levels (Sarvananthan), whereas others adopt a focus that leans more heavily to the micro (e.g. Ruwanpura, Sayaad). Macro-analyses tend to study worker rights through the prism of the state, whereas micro-analysis does the opposite, that is, most cases are either situated in the top-left or bottom-right quadrant. Our chapters are a combination of empirically detailed and descriptive to empirically analytical, using a wide range of methods. Taken together, these are both enriching and complementary approaches that provide a better holistic understanding of state–worker interactions in particular settings.

In what follows we raise the most important questions each of the contributions seek to answer and introduce the theoretical assumptions on which they seek to build. In doing so we loosely order the contributions based on where they sit in [Table 1.1](#). In the concluding chapter, we will summarise our main findings and draw connections.

1.3 South Asia, COVID-19, Crisis

We draw on several case studies from the South Asian region for our volume as they help centre how workers, their health and their rights were negotiated during the pandemic and thereafter. Globally many intersecting crises have overlayed each other since the pandemic, as we outlined above. Crises, however, are not new or unusual for South Asia or, indeed, the Global South more generally. Nonetheless, COVID-19 was unprecedented for the region too, as it was elsewhere. During the pandemic, the chaos around medical treatment and facilities laid bare the under-resourcing of public health facilities during the preceding decades of neoliberal policies (Abrams, Polato e Fava, and Kuwahara 2021; Maiti and Locke 2021; Rao et al. 2021). Repercussions were felt by all types

of workers, including medical staff, as our case studies trace and show.

The next three chapters focus on the response of the state to the pandemic, with a focus on the central state. In [Chapter 2](#), international development scholar Naomi Hossain considers the response of the Bangladeshi state to COVID-19. Her chapter looks at the factors underpinning the capacity and commitment of the state to protect its citizens against infection and its wider effects. Most notably, she investigates the effects of three key political features on Bangladesh's COVID-19 performance: first, one-party dominance in the form of the Awami League; second, the significance of performance legitimacy in shaping the COVID-19 response in an increasingly authoritarian setting; and, last, the (in)capacity of the Bangladeshi state to enforce popular policies on its citizens. Her analysis also considers the extent to which the pandemic has left long-lasting legacies on policy innovation, and in turn how these have been shaped by Bangladesh's recurrent exposure to disasters.

In [Chapter 3](#), also adopting the perspective of the state but now both at the macro *and* meso-levels, political scientists Chanchal Kumar Sharma and Wilfried Swenden consider the impact of COVID-19 on the health and social response of the Indian state towards workers. Like Hossain and Sarvananthan, they adopt a holistic perspective regarding a range of state health and social policies affecting workers across the country. In doing so, they take full cognizance of the federal nature of India, in which the centre, although powerful in terms of its legislative and fiscal reach, is vastly outspent by the states in terms of their support for health and social welfare. Sharma and Swenden raise three main questions. First, what was the impact of COVID-19 on centre–state authority and collaboration, also known as ‘intergovernmental relations’, throughout the pandemic? How did the federal structure of the Indian state affect the coordination and decision-making between the central government and the states? Second, how do Indian states differ from each other in terms of their health and social response to COVID-19 and what is the role of existing

health infrastructure and investments in preventive healthcare, political leadership, and wider state–society linkages in explaining interstate variations? Lastly, what has been the enduring effect of the pandemic on the political, administrative, and fiscal (de) centralisation of the state and the willingness of both centre and state governments to invest in health and social policy?

In [Chapter 4](#), economist Muttukrishna Sarvananthan seeks to provide a broad overview of the epidemiological and economic impact of COVID-19 based on evidence from eight South Asian countries. His focus lies on the state and adopts a macro-perspective. He seeks to measure the economic impact of COVID-19 based on GDP growth rates, unemployment rates, inflation rates, and foreign remittances, starting from the onset of the pandemic in 2019 and continuing until the end of 2022. Beyond this, his chapter also seeks to answer what macro data on state interventions (or the lack thereof) can reveal about the so-called ‘lives versus livelihood’ debate. This debate focuses on the trade-off between lives saved because of non-pharmaceutical interventions, at the start of the pandemic in the form of total or partial lockdowns, versus the number of lives ‘lost’ resulting from these very measures, given that universal lockdowns left already poor or sick people unsupported.

While retaining a focus on the state, [Chapter 5](#), by political scientist Himanshu Jha, is situated mainly at the meso level. It mainly considers the COVID-19 responses at the state (Bihar) and sub-state levels (the districts of Bhilwara in Rajasthan and Agra in Uttar Pradesh), three states known for their limited state capacity. In the case of Bihar, some observations are made concerning the local (panchayat) level as well, thus adding a micro-dimension to the analysis. Furthermore, like several other chapters in this volume (Sengupta, Jeevan R. Sharma – though not exclusively – and Surendran), his focus is not on workers in general but on migrant workers, many of whom sought to relocate from the big urban centres in nearby states (mainly Delhi and Mumbai) to their states or districts of origin. Bhilwara, as a centre of a local textile, brick, and mining industry, faced the issue of outbound migration instead.

Jha seeks to understand how local-level bureaucrats and legislative mandates matter to returning migrant workers. He queries how their agency as well as the constraints within which they worked have shaped state responses to the pandemic as well as the ability to be supportive of worker rights. Furthermore, his contribution asks if and how the state can engage in ‘learning, deciding and knowing’, despite its overall weak infrastructural capacity. Finally, he queries whether the pandemic provides further evidence of a ‘weak state’ or instead a strong, resurgent, and autonomous state.

Staying with the plight of migrant workers but in a different national context, in [Chapter 6](#) of this volume development scholar Jeevan R. Sharma focuses on the case of Nepal. Nepal has had a long history of precarity and labour migration (men and increasingly women) to foreign labour markets. In no other South Asian country do remittances account for as high a share of GDP as in Nepal (30 per cent). Yet overall weak state capacity and rights struggles focused on ethnic, regional, or linguistic inclusion have traditionally overshadowed calls for social and economic protection. Sharma asks whether the pandemic may have added to an already precarious social situation or marked an important turning point with firmer commitments towards supporting (the families of) migrant workers. Did Nepali migrants and their extended family and kinship networks bear the cost of the pandemic or did the Nepali state, the destination country, or the employers who benefit primarily from migrant labour step in?

Not too dissimilar in population size from Nepal but taking the form of a union territory in a federal state, political scientist Papia Sengupta turns in [Chapter 7](#) to focus on the plight of migrant workers in the heavily urbanised National Capital Territory of Delhi, India. Drawing on the voices of workers through a set of 25 testimonies, from two industrial sites, Wazirpur and Kapashera, she seeks to analyse how workers experienced the pandemic. Her analysis asks whether pandemic-induced welfare measures were known and accessed by workers, and if so, taking cognisance of the multilevel nature of India, to which government (centre/states) they should be credited. She also considers the effect of

hostile Delhi–central government relations on the quality and accountability of welfare measures provided by the state as seen through the eyes of workers.

In contrast with Delhi, Kerala is a fully fledged state in India and therefore exerts more autonomy in welfare policy. In [Chapter 8](#), labour sociologist Aardra Surendran offers an analysis of labour policy responses in Kerala during the pandemic. Unlike most of the other Indian states, Kerala has a strong welfarist policy milieu, where labour rights and protectionism are considered cornerstones in how the state approaches its citizenry. The fact that these safeguards have been extended to migrant workers also speaks to how political decisions that are inclusive of all classes and social spectrums of a region are viable, even for regions with meagre resources (Rao et al. 2021). Yet testimonies from 25 informal sector workers (not necessarily migrant workers) reveal varied worker experiences during the pandemic. This finding leads her to identify structural inequalities which current and future Kerala labour policies have yet to address.

Moving in [Chapter 9](#) to the case of Bangladesh, Maheen Sultan, Iffat Jahan Antara, and Touhidul Islam shift their focus to the ready-made garments (RMG) sector. With close to 2.6 million workers, RMG is the country's primary export industry and its largest source of foreign currency. Although engaging with the state's response to the pandemic, as Sengupta and Surendran in the chapters before, the focus shifts towards the workers, drawing on interview data, media monitoring, and an analysis of the labour rights of RMG workers. The purpose is to assess who gained and lost from state support and why, and how the efforts of the state to address health and livelihood risks confronting workers may not have borne fruit. This contribution also looks at the lasting effects of the pandemic on RMG workers' rights and welfare.

[Chapter 10](#), by social anthropologist Priya Sajjad, looks at the experience of those frontline workers who took centre stage in fighting the pandemic as a health crisis: healthcare workers (HCWs). She uses an ethnographic lens to draw on interviews with 34 doctors working at public hospitals in Pakistan's capital,

Lahore, between June 2020 and July 2021. Disinformation was at an all-time high in the country and overlaid with stigmatisation and inadequate resourcing, namely insufficient protective gear. She documents the fear and trepidations of HCWs, including that of medical doctors. She investigates how hospital hierarchies are interlaced with class and socio-economic dynamics, and with what effect on the provision of healthcare. Her analysis offers poignant lessons for what happens to medical care when public health facilities have been stripped of vital state resources and medical professionals have been overvalued.

In the penultimate chapter ([Chapter 11](#)), development geographer Kanchana N. Ruwanpura takes us to Sri Lanka. Here the pandemic got overlaid with decades of unaddressed structural inequalities, coming into full force by 2022 and resulting in the country defaulting on its debt for the first time. The country's citizenry (workers included), however, did not take the compounded crisis interlacing their lives without resistance but instead engaged in an unprecedented mobilisation. However, Ruwanpura notes that public protests are not a novelty in Sri Lanka and hence aims to unpick the blithe preoccupation of mainstream commentary that had focused on youth or the middle classes to the neglect of workers, inclusive of agricultural workers (farmers), teachers, and others, that spread from the rural to the urban.³ She does this by focusing on the liminal space that workers in a relatively privileged formal sector of the country ended up occupying through world-making events that were not their own: garment sector workers. Using worker testimonies her purpose is to bring workers into the frame and examine the extent to which their liminality resulted in a conscientisation process that ended up challenging the status quo through public protests.

In the concluding chapter ([Chapter 12](#)), the editors revisit the main findings that can be pulled together from the chapter contributions. We look at state-worker interactions as well as the interactions between different layers of the state and the type of workers (or their employees) in providing health and social care during the pandemic, through the prism of contestation, confrontation,

and collaboration. We finish the volume with an assessment of the lasting legacies of the pandemic and the intersecting crisis that has come to shape this current conjuncture globally.

Notes

- 1 See for instance Barai (2021), Ganguly and Mistree (2022), Swenden et al. (2022), and Yadav and Iqbal 2021.
- 2 On state capacity see for instance Hellmann and Croissant (2023), Migdal (2010), Berliner et al. (2015), and Vom Hau (2012).
- 3 Wijetilleke (2024) makes a similar point in a public television broadcast in the country.

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PART I

Macro Approaches: The State

CHAPTER 2

Political Dominance, Performance Legitimacy, and the COVID-19 Response in Bangladesh

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Abstract

Bangladesh is notably effective at disaster response, as recurrent disasters have frequently been a spur to governmental innovation. However, the COVID-19 pandemic presented a novel kind of disaster, which tested state capacities to protect their citizens worldwide. Based on original data and analysis of its impacts, this chapter explores the factors underpinning the capacity and commitment of the Bangladeshi state to protect its citizens against infection and mitigate its wider effects. Three key features of its political economy shaped Bangladesh's COVID-19 response: 1) the political dominance of the Awami League government; 2) the imperatives of 'performance legitimacy' (or that legitimacy rests on demonstrating that it is delivering economic growth and other economic rights); and 3) the incapacity or unwillingness of

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the Bangladeshi state to enforce unpopular policies on its citizens. The pandemic induced governance innovations and learning, including new digital platforms for broadcasting and listening to citizens. Yet, without free speech and political opposition, mechanisms of accountability are weak and uneven; it is not clear that COVID-19 left a legacy of pandemic preparedness or citizen trust that would help the Bangladeshi state respond more effectively to the next disaster.

2.1 Introduction

A state's response to a crisis – with attention here to the specific case of the COVID-19 pandemic – can be explained by the interaction of the political commitment and the capacities of a state to protect citizens against the crisis. I argue that those who receive state support and protection in a moment of crisis and how that support and protection are delivered, and against which features of the crisis, are shaped by the interaction of 1) the political pressure on ruling parties to act with 2) the feasible options given the resources and institutions available. In this chapter I also outline, however, a focus on how crises can drive change in state capacities if the state is oriented to learning and transformation. In other words, state capacity may not be a given or stable factor, even in the short term: crises may kickstart or accelerate change if the political imperatives make it possible to overcome old obstacles to more effective state action. For instance, a crisis may mean an opportunity to grant new resources or authority to subnational actors that grow their capacities to respond independently in a complex and fast-paced crisis such as COVID-19, which the centre palpably cannot govern alone.

These arguments are developed in this chapter focusing on the political economy of the pandemic in Bangladesh. I first explore the political conditions under which the state responded in the first two years (2020–2021), when the crisis was still novel and governments worldwide were struggling to respond. It sets out a conceptual framework for analysing the Bangladeshi state's

response that builds on work on the political economy of inclusive development (Hassan and Raihan 2017; Hickey, Sen, and Bukenya 2015; Lavers 2022) and the role of political learning from crises in activating political economy dynamics (Hossain 2017a) and of ‘islands of effectiveness’ in state capacity (McDonnell 2017, 2020; Roll 2014). This framework proposes that the Bangladeshi state response was likely to have been conditioned by the political dominance of the ruling Awami League party and its imperatives of earning ‘performance legitimacy’ through delivering welfare to its citizens. It also proposes that, following this analysis through to its logical conclusion, the uneven successes and failures of the Bangladeshi state’s response to COVID-19 reflect the uneven political pressures exerted by different sections of society, as well as unevenly activated state capacities to deliver for those different groups.

To test the propositions of this framework, I draw on selected aspects of the state’s response to the crisis in health, economic stimulus, and social protection. The chapter draws on the theoretical framework to explain why the state failed to provide for groups (such as garment workers); abandoned unenforceable and unpopular lockdown policies; and focused its efforts on delivering COVID-19 vaccines, once available. I then present emerging evidence that the crisis accelerated the development of state capacities for information-gathering and sharing, including platforms and practices for listening and responding to citizen feedback. These capacities proved to be necessary for the state to function during the crisis but also, more specifically, to deliver vaccines, fast. The opening up of new channels for and institutions of citizen feedback is of particular importance in a context in which civic space and the independent media face growing restrictions and threats (Lorch 2021), even while the ruling party needs citizen feedback to know how and what to respond to (Ahmed et al. 2023; Chowdhury and Hossain 2022).

I then conclude the chapter with reflections on the history of crisis-induced state capacity development in Bangladesh and how the COVID-19 pandemic did – and did not – fit that mode.

A specific difference has been the political economy of direct impacts on elites, who were unable to insulate themselves from a crisis that was afflicting the rest of their nation. The urgency and high priority assigned to vaccine delivery should be understood within this context, as should the strengthening of citizen feedback channels that accompanied and perhaps enabled this success.

2.2 Theorising the Political Economy of the Pandemic

Analytical frameworks centred on the role of ‘political settlements’ to explain processes of economic and social development are adapted here to theorise the determinant features of the pandemic response in Bangladesh. Political settlement analyses centre explanations of phenomena on how political power is distributed, and on what ruling elites need to do to maintain or defend that distribution.² To explain official responses to COVID-19, political settlement analysis helps us by drawing attention to the interaction of two broad factors. The first is political commitment: actions to protect the population against COVID-19 and mitigate its social, economic, and other impacts. Political commitment visibly shaped COVID-19 governance across a wide range of contexts. These included: the balance of priorities between controlling the virus and protecting livelihoods and economic growth (Barnett-Howell and Mobarak 2020; CGD 2020; Jamison 2020; Khatun 2021; Piper 2020); the priority assigned to effective procurement of necessary equipment; the generosity and scale of welfare support; the transparency and accuracy of public health information; and the state’s willingness to consult and collaborate widely, produce transparent and accurate public health information, and learn and course-correct (BIGD 2021).

The political commitment of the ruling elite to protect people against COVID-19 interacted with a second broad factor, namely, state capacity. The following capacities of states were particularly evident in COVID-19 responses: 1) capacities to develop and

adjust policy responses rapidly and in a context of limited information; 2) material and human resources, in particular public health infrastructure and clinical services and the resourcing and institutions to scale those up, along with trained and equipped frontline personnel; 3) capacities for communication about COVID-19, including credible channels for public health messaging, authoritative institutions, and feedback mechanisms to bring citizen perspectives into policy; and 4) capacity to enforce COVID-19 policies, including the authority to elicit compliance and sanction non-compliance (see Boin, Lodge, and Luesink 2020; Cheibub, Hong, and Przeworski 2020; Flinders 2020; Hale et al. 2021; Herbert and Marquette 2021; Lipsky 2020; Petersen 2020; Rajan et al. 2020).

State capacity and political commitment have played out in policy responses to COVID-19 in Bangladesh through salient aspects of the pandemic political economy, notably the dominant party system in place during the pandemic, the importance of policy performance for popular legitimacy, and the strength of Bangladeshi society vis-à-vis the state. Bangladesh has a dominant party system, entrenched since the Awami League won a landslide election in 2009. Political power is concentrated among ruling elites from the Awami League party and its affiliates, who have to date faced limited external threats or competitive pressures (Chowdhury and Hossain 2022; Hassan and Nazneen 2017). This dominant party system has shaped institutional incentives and practices of relevance to governance, as well as the policy and political choices made during the pandemic. Imperatives to satisfy party supporters competed with the need to discipline lower-level party functionaries so that they implement relief or health policies properly, as well as to control the policymaking apparatus and politicise the administrative system. The dominant party system also created a hostile attitude towards independent media and civil society and curtailed capacities and incentives to collaborate with organised civil society.

A dominant party may be insulated against popular pressure in the short term but there is strong pressure on the ruling party

to demonstrate development success in the form of economic growth and rising living standards (Ali, Hassan, and Hossain 2020). Provisioning of basic needs, particularly during crises, is considered a primary obligation of the state (Hassan 2013; Hassan and Nazneen 2017; Hossain 2017b). A powerful ‘moral economy’ set of expectations about the rightful behaviour of ruling elites in times of crisis has shaped public policy historically and continues to frame the social contract in Bangladesh (Hassan 2013; Hossain 2017; Jahan and Hossain 2017; Jahan and Shahan 2016). Lacking the legitimacy associated with having come to power through a free and fair election, the present regime emphasises its ‘performance legitimacy’. As the pandemic created an unprecedented global health crisis, closed down much of the world’s economy in the short term, and left in its longer trail a global economic crisis, it posed a severe test of the ruling party’s performance.

The Bangladeshi state has grown in its power to generate and distribute resources and to implement and enforce its policies and programmes, yet remains relatively embedded in and inseparable from social concerns. As a ‘weak state in a strong society’, societal norms, values, and organisations tend to successfully impose themselves on the state, which correspondingly is most effective when it aligns itself with, rather than trying to change or oppose, the wishes of society (Ali, Hassan, and Hossain 2021; White 1999). Yet while in general the Bangladeshi state struggles to impose unpopular policies and programmes on its people, it has a strong track record on responding to the kinds of crises and disasters to which Bangladeshis are highly vulnerable. Indeed, it has been argued that protecting citizens against such disasters is central to the social contract between Bangladeshi citizens and their state, and that failure to act in times of crisis has seen regimes lose legitimacy and power (Hossain 2017, 2018). Bangladesh also has a strong history of success with particular types of public health intervention, including mass immunisation programmes, but these have been notably in collaborations with civil society groups, including Bangladesh’s highly effective non-governmental organisations (NGOs). Such partnerships are less easily forged

under the conditions of political dominance that Bangladesh is currently facing. Nevertheless, it is reasonable to expect that the Bangladeshi state will create or sustain ‘islands of effectiveness’ in responding to specific aspects of the pandemic, by identifying key agencies or programmes as a high political priority, thereby insulating them against corruption, delays, or negligence (see McDonnell 2017; Roll 2014 on how islands or pockets of effectiveness operate within otherwise weak or dysfunctional states). We would expect an effective programme of vaccination to be among the main pillars of the pandemic response. Lockdowns, quarantine, and social distancing are, by contrast, likely to be unpopular with citizens, difficult to enforce, and therefore in general ineffective.

In sum: the political economy context leads us to expect that the government of Bangladesh would have aimed for an effective response to protecting citizens against infection and the broader – including economic and livelihood – effects of the pandemic. However, that response is likely to have been tempered by how political dominance prevents democratic, accountable, and transparent policymaking, and by the uneven capacity of the state to deliver large-scale public health and social assistance programmes. In the next section, we review the main features of Bangladesh’s pandemic response.

2.3 The Official Response to the Pandemic: An Overview

Bangladesh recorded low infection and death rates in the first year of the pandemic, but official claims that this reflected effective pandemic management are less likely to have been true than the facts of the youth of the population and low rates of testing. In early 2021, there was a sharp resurgence of infection and death rates, and it is not clear that the capacity to contain transmission or manage rising caseloads had been strengthened over the previous 12 months (BIGD 2021). The vaccination programme was slow to start, partly due to supply shortages as vaccine-producing countries withheld exports to prioritise the immunisation of their

population. To illustrate this lag, not even 4 per cent of the population had received a single dose by the end of April 2021 (Tayeb 2021). Yet by 2022 Bangladesh was regarded as one of the most successful countries in terms of delivering COVID-19 vaccines across the population (Al Amin 2023; Rahaman 2022; Nazmun-nahar et al. 2023).

The eventual success in delivering the vaccine programme was fortunate because the experience with lockdown – one of the primary tools for containment – had been markedly less successful. Restrictions were announced after the first COVID-19 case was recorded in March 2020. Educational institutions were closed, and a ten-day countrywide shutdown (a ‘public holiday’) was announced (BIGD 2021). The lockdown officially lasted 66 days, during which time public transport and people’s movements remained restricted and public gatherings were banned. Public opinion and expert reactions to the lockdown were mixed, as people debated the trade-off between the risks of loss of livelihood against the possibilities of containing transmission (Rahman et al. 2022). People who were dependent on daily wage incomes that required them to leave their homes or who had lost their jobs suffered. Broad popular sympathy for the large number of people who were vulnerable in this respect led to ‘forbearance’ on the part of public authorities; the military and police were visible but rarely deployed (Ali, Hassan, and Hossain 2021).

Prominent among fears about the pandemic was the fact that the public provision of health services was poor at the best of times, and epidemic or pandemic planning had never been a policy priority, despite the recurrence of smaller outbreaks of communicable diseases. As COVID-19 struck, Bangladesh lacked the policy framework and resource capacity to successfully respond to long-term health emergencies (WHO 2020b). The allocation and distribution of resources for health services, including emergency procurement, were inadequate. Capacities for managing the pandemic were limited and institutions were grossly under-resourced and understaffed; instances of corruption in procurement and manipulation of health statistics further undermined

confidence in the health policy response. The lack of prioritisation and coordination and reliance on overly bureaucratic procedures in an emergency in part reflected the relatively closed nature of the pandemic policy process. The scientific communities and civil society were unevenly incorporated into policy discussions, and health communication between the state agencies and the general public was not fully transparent (BIGD 2021).

The pandemic, and the economic and livelihood crisis that it triggered, also put Bangladesh's disaster and relief management experience to the test. A major effort was made to deliver relief to those who needed it, ultimately involving some half a million actors in relief distribution (BIGD 2021). National and local governments initiated emergency cash payments and delivered provisions to those who were locked down, but there were widespread concerns that these benefits did not necessarily reach those who needed them. Partnerships and coordination between government, NGOs and civil society were limited and weakly organised. The official policy aimed to rely on the construction of digital databases of beneficiaries, partly to enable mobile money transfers to minimise human contact and improve the targeting of social protection, but these 'smart' platforms enjoyed uneven success (Chowdhury and Hossain 2022).

The economic policy response strongly favoured growth-oriented sectors as opposed to social protection for households and individuals or small businesses (Osmani 2021). This was particularly clear concerning the country's main export sector, ready-made garments (RMG): a stimulus package was rapidly made available for the industry, with the assumption that the funds would reach workers who had been laid off or whose factories had closed. That many workers did not receive these payments, which were subject in effect to the discretion of factory managers (Chowdhury et al. 2022), reflects the political power of the garments industry's owners, many of whom are themselves members or supporters of the main political parties, and who routinely garner subsidies and support from the state, even in the face of crises affecting their workers (Hossain 2019; Tighe 2016; see also

Sultan, Antara, and Islam in this volume). The close and mutually beneficial relationships between factory owners and the political class were a feature of the support received by garment workers in other countries. This included countries like Sri Lanka, which is in general seen as an exemplar of good practice in a sector marred by very poor labour conditions and limited rights (Ruwanpura 2022a, 2022b, 2023a).

Overall, the government's economic stimulus package favoured the 'growth sectors' over protecting vulnerable groups. Larger businesses in the formal sector received substantial packages of support, rapidly and easily accessible, while people on low and precarious incomes were patchily and ungenerously supported with, at best, piecemeal cash payments (CPD 2020; Osmani 2021). This bias reflects the influence of business interests in political decision-making at the expense of more direct support for consumption by citizens and communities. It also reflects the stigmatisation of workers required to work through the pandemic, and their treatment by the ruling classes as expendable to protect GDP (Siddiqi and Ashraf 2022), a sacrificing of vulnerable, low-paid people that was witnessed elsewhere in South Asia (Ruwanpura 2023b).

It was not only the nature of the allocations but also how they were delivered that shaped the support people received. The government established relief initiatives during the lockdown, but beneficiary selection and relief delivery processes lacked transparency and accountability. There were perceptions of nepotism and corruption in relief distribution, leading to doubts about whether relief reached the right people (Hebbar, Muhit, and Marzi 2020). Again, the state's inability to guarantee corruption-free social protection, even during a life- and livelihood-threatening crisis, is explained by its limited capacity to police frontline actors within its ruling party, and to ensure they implement state policy by curbing practices of graft, bribery, and nepotism in the delivery of public services.

A good summary of the official response after its first year noted the following features:

[F]irstly, a poorly enforced semi-lockdown of two months; secondly, strict enforcement of three critical mobility restrictions, namely inter-district public transportation, school closure and closure of places of worship, among which the second still continues six months since the outbreak; thirdly, a feeling of being overwhelmed by the health service needs necessitated by the pandemic and a corresponding inability to respond credibly to the service challenge; and finally, a pragmatic decision to strongly tilt towards the 'livelihood' part of the 'life versus livelihood' debate and leave the 'healthcare' part to largely sort itself out. (Rahman et al. 2021, 73–74)

By and large, these features remained in place throughout the pandemic; the eventual reliance on rolling out the vaccine programme reflected the fact that the state lacked either the capacity or the political commitment to undertake alternative, tougher policies to restrict livelihoods and economic activity in favour of protecting lives. The successes with the vaccine delivery, in contrast to more complex policies requiring tough enforcement and sanctions against non-compliance, support the propositions outlined above: that the strength of societal preferences would be likely to prevail over state imperatives.

2.4 Citizen Experiences of the COVID-19 Response

So how and to what extent did the political economy trifecta of political dominance, imperatives of performance legitimacy, and the strength of social over state preferences shape how people experienced the official response to the pandemic? To help answer these questions, and to better understand how citizens experienced the Bangladeshi state's response to the COVID-19 pandemic, a nationally representative sample survey was conducted in early 2023. This survey focused on exploring people's experiences of the health and social protection responses to the crisis, and how the state responded to citizens' needs and demands.³

2.4.1 Health Services

For health services, the survey uncovered a mixed experience of the pandemic: regular curative and facility-based services appear to have been used somewhat less than in non-pandemic times, whereas vaccine uptake was almost universal. This mixed experience makes sense, given that we know health services have been generally relatively weak, although they have improved over time. By contrast, immunisation programmes have historically been strong, as the Bangladeshi state has prioritised the delivery of vertical ‘campaign’-style services that are relatively immune from corruption and weak governance – in other words, preventive services that even a weak state can deliver, as opposed to curative services that are harder to implement.

As the pandemic struck, there were serious concerns about the Bangladeshi health service’s capacity to cope with the crisis. In normal times, the extensive but under-resourced network of public services struggles to provide adequate and sufficiently high-quality services. Most citizens, rich and poor, rely on private health services, and the population as a whole suffers from high ‘out-of-pocket’ expenditures on health (World Bank 2016b). Private providers range from modern allopathic services by for-profit and NGO services, to alternative care providers of a range of types and qualities.⁴ While almost 80 per cent of health spending is on private services, people on lower incomes rely more than richer people on public services and private health spending pushes millions below the poverty line annually. However, there have been improvements in health outcomes and services over the decades and performance on the Millennium Development Goals and the Sustainable Development Goals has been largely positive (Ahsan et al. 2016; El-Saharty et al. 2015; GED 2016; Osman 2016; WHO 2020a). Bangladesh performs better than other countries at its income level (JLN DRM Collaborative 2020).

The survey found that people thought in-person government health facilities were used less in their local area during the pandemic, whereas many private services (pharmacies and ‘village

doctors’) were reportedly more popular (Figure 2.1). However, the local community was also assumed to be less likely to visit private doctors’ offices and hospitals, and more likely to use telehealth services, suggesting that people believed that proximity and availability were the most important factors in determining usage. Just over one third of respondents (36 per cent) reported having personally or for their family accessed government health services during the pandemic, and 2 per cent reported using the (much-praised) telemedicine services.⁵ The *Shastho Batayon* telephone health service logged almost 11 million calls during 2020, and over three million in 2021. However, the survey also showed that almost one fifth of those who did use public health services experienced problems, including long queues and a lack of facility staff or medications. Of those who faced such problems, only one fifth (21 per cent) complained in any way, with most of the

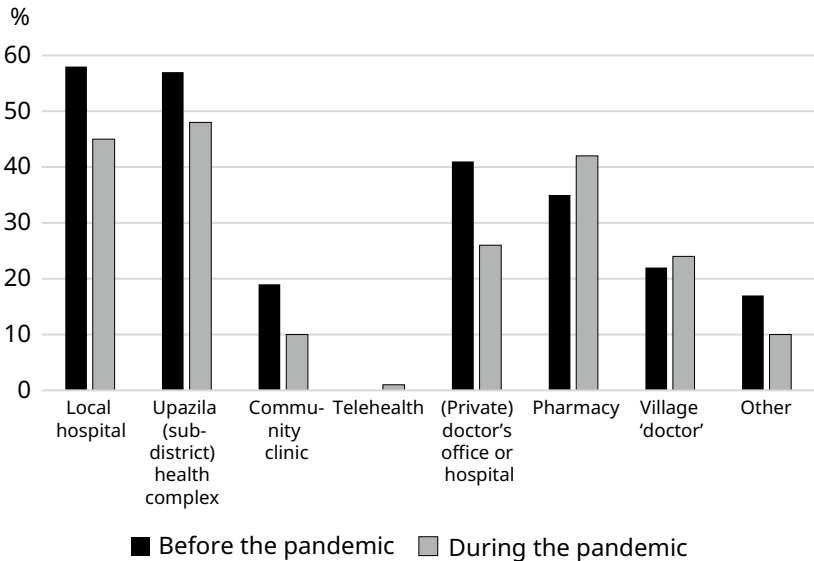


Figure 2.1: Responses to the question ‘Where did people in your area seek health services before and during the pandemic?’ (multiple responses permitted; % of respondents).

rest concluding that the complaint was futile. The fact that many people who resorted to seeking public health services during the pandemic faced problems in doing so, and yet also lacked faith in the scope for a complaint to remedy these issues, points to the continuing problems with frontline health service provision in Bangladesh. These are problems that the pandemic was insufficient spur to address, at least at the time.

By contrast, there was almost universal uptake of COVID-19 vaccines, with 99 per cent of respondents reporting having been vaccinated. Fully 86 per cent of respondents had registered for the vaccine through the app, while the remainder registered in person or during mass vaccination drives. Around 30 per cent of respondents reported facing problems during the process, with the major problem being long queues (93 per cent); 9 per cent of those who faced problems said that vaccines were in short supply. Again, however, the vast majority of those who faced problems (90 per cent) took no action, even though three quarters of all respondents were aware that there were mechanisms for reporting problems with access to vaccines. Overall, it appeared that people had higher expectations of the government provision of vaccines than they did of other health services and that these were met, but people remained at the mercy of government policies and programmes, with limited scope to articulate any grievances or to seek resolution. This difference between routine health service provision and campaign-style provision of COVID-19 prophylaxis on an emergency basis is consistent with the political economy features outlined as part of the theoretical framework that the state struggles to enforce unpopular policies or which require disciplining its supporters. At the same time, the powerful political imperative of protecting economic and social development progress from the effects of the pandemic encouraged the state to invest in delivering vaccines fast and effectively, in what could be termed a 'pocket of effectiveness' that was otherwise not seen in the pandemic response.

2.4.2 Social Protection

The uneven success of relief schemes to protect those suffering from the economic effects of the lockdown and subsequent economic crisis similarly indicates that, while the Bangladeshi state had strong incentives to demonstrate its support for citizens, it was unable to deliver the necessary services because it was unable to hold its supporters to account for delivering them. A remarkable 59 per cent of respondents reported that their families or people they knew had received direct support from the government during the crisis, of which assistance the overwhelming majority had received food, subsidised food, or digital or actual cash (see [Figure 2.2](#)).

However, the old problems that have plagued Bangladesh's social protection programme persisted through the pandemic: problems of possible corruption and leakage, failures to ensure the people who needed it received the support, and lack of

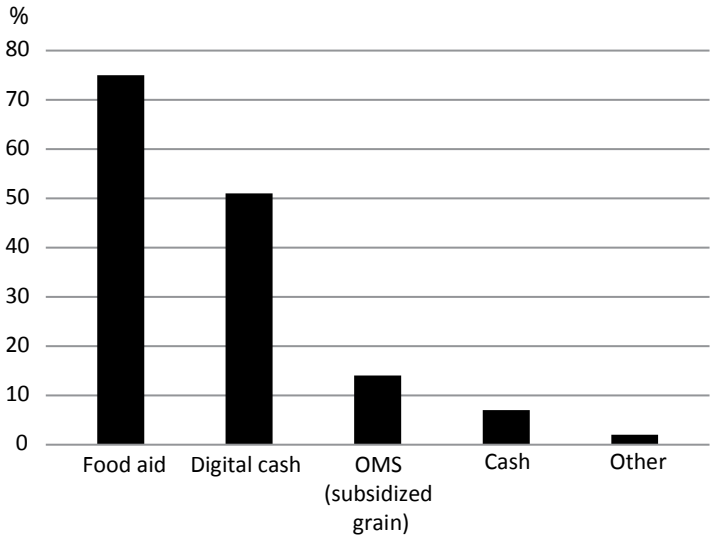


Figure 2.2: Types of support that people were reported to have received (multiple responses allowed; graph shows % of cases in which that form of support was reported)

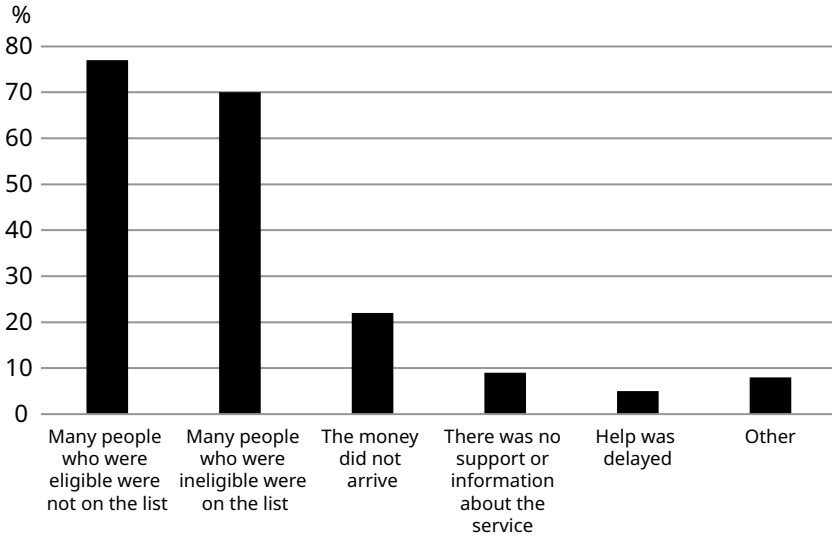


Figure 2.3: Reported problems with social assistance during the pandemic

information and delays marking people's experiences of the ambitious effort. Between two thirds and three quarters of respondents believed the assistance did not reach the people who needed it, while smaller proportions noted that the funds did not arrive or they faced other problems in accessing the support (see [Figure 2.3](#)). What social protection specialists term 'errors of inclusion and exclusion' have long been a significant blight on welfare programmes in Bangladesh, and they appear to have remained so during the pandemic. Nor did costly and much-prized efforts to digitalise databases of potentially eligible beneficiaries succeed in addressing this problem during the pandemic (Hebbar, Muhit, and Marzi 2020; World Bank 2021, 2016a).

2.4.3 Digitalisation and Feedback Mechanisms

The survey of citizens' experiences with the pandemic response also highlighted the uneven achievements of the government's digitalisation efforts. The past decade has seen a concerted effort

to increase the use of digital platforms and systems for governance, including beneficiary databases, feedback and information systems, procurement, and service delivery through the use of mobile money (Hossain 2022). The aims of the 'Digital Bangladesh' agenda include improving the efficiency of governance in general and improving service delivery through more direct outreach from the state to citizens, as well as more direct citizen feedback mechanisms.

The social distancing and lockdown measures of the pandemic appear to have accelerated the process of digitalisation of government business, reducing the use of paper files in favour of online systems and increasing the use of virtual meetings and communications (Ahmed et al. 2023). However, the survey of citizens' experience of the pandemic response strongly suggests that, while they are primed to receive online and digital services (such as mobile money transfers), there is yet some way to go before people are empowered and equipped to register their complaints and provide their feedback about government services, whether online or off.

2.5 Conclusions

The nature and effectiveness of the state response to the crisis were closely shaped by the political effectiveness and state capacity, as the theoretical framework developed from the political settlement theories of Bangladesh predicted. Perennial losers continued to lose unless their interests were championed by powerful insiders or external actors; this was notably true of RMG workers, particularly when export orders were cancelled, and their risks of contracting COVID were discounted because of the need to return to export production as soon as possible, to maintain foreign currency earnings. Meanwhile, factory owners were easily able to attract large subsidies, some of which were used to pay workers' wages. The government wanted to be seen to be enforcing public health measures that it could not maintain because it was unwilling or unable to deliver sufficient social protection so that people could stay at home and observe social distancing. However, facing

strong societal pressure to abandon lockdown, it did so, first by permitting discretion and lax policing of rule-breakers and later by abandoning even the pretence of lockdown.

Even then, tackling the crisis remained a priority, not least for reasons of the pursuit of economic growth and the associated political imperatives. Lacking the means to deliver curative and ameliorative health services at scale, the government bet all its chips on delivering the COVID-19 vaccine as soon as that became available. On immunisation, it had a strong track record, good capacity for immunisation delivery, and also a densely packed population accustomed to vaccine campaigns to deliver it to. It drew on recent learning from its forays into digital governance and citizen engagement to develop effective platforms to track vaccine performance. It seems that the appetite for tracking citizens' concerns and complaints and responding to those concerns has increased in government, which trialled a range of different channels for feedback during the crisis and continues to build those out through the SMART Bangladesh agenda.

Bangladesh's COVID-19 response was indeed driven by the interaction of political commitment and state capacity, and the response ultimately rested on the delivery of COVID-19 vaccines, which was highly effectively achieved. At the same time, the political economy framework needs to take into account the fact that state capacity may not be as slow to change as the literature on administrative or bureaucratic reform might suggest: instead, given the resources, the mandate, and the authority to do so, local government actors engaged far more extensively and systematically in listening and responding to citizens than in the past. COVID-19 galvanised developments in public policy information management and flows within the Bangladeshi state in ways that in turn indicate crisis-induced innovation, a process that is consistent with the country's history.

Notes

- 1 I am grateful for support for the survey reported on here from the COVID Learning, Evidence, and Research (CLEAR) programme in Bangladesh, funded by the UK Foreign, Commonwealth and Development Office and managed by IDS Sussex. Thanks also to all the colleagues at BRAC Institute of Governance and Development who were involved in the preparation of the *State of Governance in Bangladesh 2020–2021: Governing COVID-19 in Bangladesh – Realities and Reflections to Build Forward Better* (BIGD 2021) report, in particular Mirza Hassan and Syeda Salina Aziz. This chapter draws on the theoretical and empirical work undertaken for that project, as well as from the Feedback State project funded by CLEAR/UK Aid. I am most grateful for permission to include those findings. Many thanks also to Kanchana N. Ruwanpura and Wilfried Swenden for valuable feedback that improved the chapter.
- 2 Mushtaq Khan first developed political settlement theories to explain variations in processes of economic development (2018; Khan 2011). The core ideas around the distribution of political power have also been featured in a wider range of analyses including of social sectoral development and economic policies in the developing world (Abdulai and Hickey 2014; Hassan and Nazneen 2017; Kelsall 2020; Menocal 2015).
- 3 Data were collected by BRAC Institute of Governance and Development in April 2023 through face-to-face half hour interviews with adults (50 per cent men, 50 per cent women; 60 per cent rural, 40 per cent urban), using the 2011 census as the sampling frame. The survey used a multistage stratified random sampling strategy, with a sample size of 2,400, distributed randomly across half of all districts. See Ahmed et al. (2023).
- 4 Mainly low-cost homeopathic, *unani* (traditional Persian–Arabic medicine), and ayurvedic (natural medicine from South Asia) services, as well as faith-healers. See for instance Mahmood et al. (2010).
- 5 The *Shastho Batayon* telephone health advice system has attracted considerable praise from health policymakers and practitioners, and is popular with users (Chowdhury, Sunna, and Ahmed 2021; Khatun, Ahmed, et al. 2023; Khatun, Sheikh, et al. 2023); 2 per cent of respondents stated they or household members used the system during the pandemic (not shown in [Figure 2.1](#)), which implies roughly 3.5 million households. As this is based on recall rather than logged data, it may underestimate the numbers of individuals or calls. The system receives calls for a range of issues, and people may have called for other information. These percentages of reported use are provided here only to enable a sense of the proportions of people reported to be using the different health services available. For more information about *Shastho Batayon*, see <http://16263.dghs.gov.bd/report/report.php>, accessed 3 August 2023.

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CHAPTER 3

COVID-19: How Has Indian Federalism Done?

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Abstract

In this chapter, we study the impact of COVID-19 on Indian federalism and how it influenced the health and social response of the Indian state towards workers. Our focus is on three key aspects: first, the impact of COVID-19 on centre–state authority and collaboration throughout the pandemic; second, variations in the health and social response to COVID-19 among different states, which we attribute to factors such as the existing health infrastructure and investments in preventive healthcare, but equally political leadership and state–society linkages in shaping the provision of welfare measures to vulnerable workers; and, finally, the lasting effects of COVID-19 on federal involvement in health and social protection. Overall, our analysis shows that

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India witnessed a centralisation of authority during much of the pandemic, even though approaches varied between the first and second waves. Centre–state coordination was observed but only after the peak of the second wave and after judicial intervention. Our study also shows a lack of investment in intergovernmental coordination mechanisms during and in the aftermath of the pandemic. It argues that these need to be developed more to prepare federal India for future crises of similar magnitude.

3.1 Introduction

When COVID-19 hit in 2020, countries worldwide were prompted to put in place two types of response: first, a response to deal with a health emergency and, second, a response to address the socio-economic fallout, including social welfare to those affected disproportionately by the pandemic, such as individuals who lost their jobs or sources of income. In most countries, an effective response required coordinated action, involving multiple ministries (health, economics, treasury, education, home affairs, defence), healthcare providers (public and private), and local authorities.

In countries with federal systems, intergovernmental (centre–state) coordination became crucial owing to the constitutionally demarcated and entrenched competencies related to crisis management. Federalism can present challenges because coordination is more complex in a context of dispersed authority, especially where it coincides with clear political and policy disagreements. The United States serves as an example, where political polarisation between a COVID-sceptical Republican president and Democratic-governed states led to disagreements on measures like mask mandates, lockdowns, and vaccine promotion. However, federalism can also be beneficial where the decentralisation of health infrastructure enables more localised responses to the pandemic, tailored to the specific needs of substate entities or localities (Chattopadhyay et al. 2021; Hegele and Schnabel 2021; Steytler 2022). This is especially the case for healthcare, which is

at least partially devolved to subnational governments in many federal states.

In this chapter, we examine the impact of COVID-19 on Indian federalism and how it influenced the health and social response of the Indian state towards workers. Our focus is on three key aspects. First, we argue that, irrespective of levels of health spending and state capacity, centralisation and the limited institutionalisation of intergovernmental relations negatively affected the preparedness of Indian federalism for major crises. This is especially so under conditions of one-party dominance at the centre in the context of an overall polarised multilevel party system. Second, we investigate the variations in the health and social response to COVID-19 among different states. We argue that these variations can be attributed to factors such as the existing health infrastructure and investments in preventive healthcare. However, we also emphasise the significant influence of political leadership and state–society linkages in shaping the provision of welfare measures to vulnerable workers. Finally, we assess the lasting effects of COVID-19 on federal involvement in health and social protection as it may offer salutary lessons for the future. By exploring these aspects, we aim to provide insights into the legacy of COVID-19 on Indian federalism, its implications for health and social policy, and how the Indian federal system can be better prepared for future crises of similar magnitude.

3.2 Federalism in Crisis: Centralisation and Centre–State Dynamics in a Polarised Party System

Although all federal systems are marked by a distribution of competencies across levels (national, state, local) of government, major crises are oblivious to the competence ordering under a federal constitution. The pandemic was a global crisis, which required global responses (e.g. on the distribution of vaccines or the potential restructuring of global debt), national actions (to police borders, including interstate borders during the lockdown,

or support the economy) subnational or ‘state’ interventions (since the Indian states control most of health policy), and local initiatives (to streamline the provision of social and healthcare, often in collaboration with grassroot volunteers, civil society, and panchayats). In this chapter we focus on centre–state dynamics, while subsequent chapters analyse specific (substate) actions.

Within India, actions started at the state level first, when Kerala became the first state to report a case of COVID-19 in January 2020. The Colonial Epidemic Diseases Act of 1897 equipped the states with a foundational strategy to face the pandemic. The ‘State List’ under the Seventh Schedule of the Indian Constitution stipulates responsibilities, including public health, sanitation, hospitals, dispensaries, public order, and policing. In response to these obligations, each Indian state established a protocol for contact tracing, isolation, and treatment ahead of the national lockdown on 24 March 2020.

Despite early initiatives at the state level, the central government was rapidly drawn into the management of the COVID-19 crisis. The constitution bestows on the central government exclusive responsibilities related to international and interstate migration, as well as interstate quarantine. In line with these responsibilities, the central government requested thermal screening for passengers arriving from China and Hong Kong at international airports in late January 2020. It also initiated point-of-entry surveillance for all incoming passengers.

As COVID-19 began to cross state boundaries, the centre’s involvement intensified, as it holds the authority to prevent and control the spread of infectious or contagious diseases from one state to another. Furthermore, it shares powers with the states on matters of social security, social insurance, and (un)employment, which are crucial in devising a strong social response to the pandemic (Sahoo and Ghosh 2021, 6).

However, as the COVID-19 outbreak evolved into a national health emergency, the centre extended its engagement far beyond its constitutional mandate. It accomplished this by invoking the National Disaster Management Act of 2005 (DMA). In essence,

this establishes a hierarchical three-tiered structure for disaster management, which consists of the National Disaster Management Authority, led by the prime minister, at the top (supported by the National Executive Committee, headed by the union home secretary), and state and district disaster management authorities at the lower levels.

Despite the apparent division of responsibilities, the Act confers the centre with the power to ‘control, command, and coordinate’ disaster responses across India. This includes issuing directives to statutory authorities, officers, and employees at any level of government (Singh 2021, 284). The application of the DMA hence led to the establishment of a unified command and compliance system. Under this system, the state also acquired the ‘power of requisition of resources, provisions, and vehicles’ from any public authority or individual (*ibid.*, and as per section 65 of the DMA).

The invocation of the DMA resulted in the central government’s powers surpassing those of the states and local governments. This became most noticeable with the imposition of a uniform 21-day national lockdown on 24 March 2020. As a result, states and union territories were obligated to adhere to national directives or, alternatively, to seek written permission from the central government for any deviations. The lockdown’s primary goals were to contain the virus’s spread and allow states time to enhance their health infrastructure.

As soon as the national lockdown hit, two weak and interrelated spots of Indian federalism became immediately apparent: a centrist bias in the structure of federalism and a weakness in the intergovernmental mechanisms to streamline centre–state relations when their coordination is essential (as in the context of the pandemic). Both weaknesses are more visible under conditions of one-party dominance at the centre within an overall polarised multilevel party system.

The legislative and fiscal dominance of the centre creates space for the imposition of policies without the consent of the states, even when these affect areas in which they hold most competence, for example health or social policy. Political factors, for example

a national coalition government in which state-based parties take part, may incentivise the centre to secure the buy-in of states, but these are inevitably weaker when a single party holds a parliamentary majority on its own (as was the case during the pandemic with the BJP holding the centre). Furthermore, in a context of rising political polarisation (and even autocratisation), neither the centre nor state governments controlled by opposition parties may be inclined to seek closer cooperation. Thus, party political posturing can lead to blame games and restrict space for a negotiated compromise. Conversely, the centralised structure and ideology of the national ruling party stops BJP-ruled state leaders from exercising considerable agency within their own party. The result is a form of ‘tacit cooperation’ that may not necessarily serve the interests of their state constituents (Sharma and Swenden 2022).

In this context, the national lockdown faced two criticisms. The first concerns the excessive centralisation of policymaking, which included hospital management and the standardisation of COVID-19 treatment protocols. For example, the Union Ministry issued advisories to states, directing them to order personal protective equipment (PPE) through the Union Health Ministry. This one-size-fits-all approach to lockdown rules, without considering the spread and caseload variations per state, imposed unnecessarily stringent regulations and socio-economic hardships on citizens in less-affected states or localities (such as the states of the north-east and Bihar; Choutagunta, Manish, and Rajagopalan 2021).

This centralisation also extended to the fiscal domain. A central government prohibition on liquor sales deprived the states of a significant source of state revenue. Further, the centre bypassed a critical recommendation from the Finance Commission, an expert statutory body that in February 2020, just a month before the lockdown, recommended distributing an additional 900 million rupees to local authorities to strengthen their role in health, sanitation, and well-being (Datta and Grover 2021, 11).

The centre also delayed the distribution of 300 billion rupees in goods and services tax revenue to the states. Even when states were permitted to borrow an additional 2 per cent of their gross

state domestic product (GSDP) from the market, conditions were attached. Only the first 0.5 per cent of these loans were unconditional, with further borrowing contingent upon states implementing reforms designed by the centre. Subsequently, in the Union Budget 2022–2023, the government reduced the borrowing limit to 4 per cent of GSDP (3.5 per cent unconditional and 0.5 per cent conditional upon introducing power sector reforms), as per the XVth Finance Commission's recommendations. This switch from unconditional loan grants to conditional relief loans, tied to measures like the introduction of 'One Nation, One Ration Card', improvements in business ease, power sector reforms, and urban and local reforms – all central government priorities – marked a first in India's fiscal policy (Rao 2020).

The second criticism speaks to the lack of institutionalised intergovernmental practices to secure the buy-in of the states in central decisions that affect their autonomy (Swenden and Saxena 2017). States were not consulted on the national lockdown despite their responsibility for ground-level implementation. This lack of information sharing added to the chaos, especially among stranded migrant workers (Harriss 2020; Tremblay and George 2021). Approximately 100 million migrant workers, owing to the sudden cancellation of trains on 21 March 2020, were forced to walk, hitchhike, or cycle back to their home states (S. Irduya 2020). The centre could have activated the Inter-state Migrant Workmen Act of 1979, which mandates the registration of inter-state migrants and provides them with wage protection, as well as displacement and journey allowances during migration. With this provision, states could have had better data to protect migrant workers within their jurisdictions (Datta and Grover 2021, 8). Furthermore, the centre did not consult the states once it allowed migrants to travel again in May 2020 and engaged the railways to set up 'Shramik Special' ferry trains. Yet it expected 'origin' and 'destination states' to issue a joint request before allowing workers on those trains. As a result, each state had to collaborate with others to agree on the quota of migrant workers authorised to travel.

Throughout the pandemic, Prime Minister Modi convened over a dozen virtual meetings with state chief ministers and addressed local body heads at least once. However, press reports indicate that these meetings, which the state convened and for which it set the agenda, were not always fully attended, and invitations to speak often favoured BJP or NDA (National Democratic Alliance) state chief ministers. Additionally, several parallel meetings occurred between the home and health secretaries at the union and state levels (Sharma and Swenden 2022).

Aside from vertical (centre–state) intergovernmental relations, instances of interstate cooperation during the first wave were scarce, save for agreements like those between Maharashtra and Kerala on sharing health professionals (Singh 2021, 291). In the context of the pandemic, the National Executive Council, headed by the union home ministry, could have played a crucial coordinating role. However, this body failed to meet between November 2020 and March 2021, thus neglecting to assess preparations for the second wave of the pandemic (Sahoo and Ghosh 2021, 18).

Another potential facilitator for interstate coordination, the Inter-State Council, which comprises the federal government, all state governments, and union territories, was also underutilised. The council's purpose is to advise on interstate disputes, discuss topics of common interest, and facilitate administrative and policy coordination across levels. However, the council met infrequently, with only one meeting taking place under the premiership of Narendra Modi before the pandemic.

While the first wave of the pandemic was marked by a centralised approach and a distinct lack of intergovernmental coordination, the deadly second wave also lacked in coordination, but with an at times absent centre. The country had unlocked progressively between 17 May 2020 and 15 October 2020 (Singh 2021, 287). At that point in time, the low caseload, coupled with a comparatively low mortality rate or high recovery rate, had made the central and state governments complacent. Large gatherings, such as the Kumbh Mela, were permitted to proceed in February–March 2021. Furthermore, both central and state political actors engaged

fully in electoral campaigning for five state assembly elections, disregarding pandemic-appropriate restrictions (Sahoo and Ghosh 2021, 11). This relaxation contributed to the devastating second wave in India, which overwhelmed the capacity of state health infrastructures.

In India's polarised party system, the initial response to the second wave was marked by blame-shifting, with claims that 'health is a state subject and states should have ramped up health infrastructure following the first wave' and subsequent interstate bickering. The centre's initial absence contrasted with its approach during the first wave, which has been described as moving from 'unilateral centralization' to 'unilateral decentralization' or from 'centralized federalism' to a 'fend-for-yourself federalism' (Shannon 1987; Tillin 2021). Amid this change, the COVID-19 crisis spiralled out of control, placing enormous strain on the already underequipped and underfunded healthcare system, which accounts for a mere 2 per cent of GDP (Malik 2022). The system faced a critical shortage of resources, including oxygen (UN News 2022), medication, beds, vaccines (Ellis-Petersen 2021), and even cremation grounds and graveyards (*The Economic Times* 2021a).

During this period, the states' innovative efforts merely served as ad hoc coping mechanisms rather than fulfilling their constitutional responsibilities. The phase was marred by interstate disputes and strained intergovernmental relations. For example, an oxygen supply shortage in April 2021 led to a blame game between the central government and opposition-ruled states, each accusing the other of restricting supplies and mismanaging resources (Sharma 2021).

Tensions ran high across party lines. Punjab's Congress-led government accused neighbouring BJP-ruled states of confiscating its oxygen supplies. Conversely, Haryana's BJP government blamed the AAP government in Delhi for looting oxygen tankers meant for COVID-19 patients in Haryana (*The Economic Times* 2021b). On the other hand, the AAP-ruled National Capital Territory (NCT) of Delhi specifically accused the BJP-ruled Uttar Pradesh of 'hijacking' its oxygen supplies (Schmall 2021). This

resulted in a chaotic situation, with Delhi's NCT even ordering hospitals not to admit out-of-state patients, mostly from Uttar Pradesh, which was later overruled by the lieutenant governor of Delhi, appointed by the central government.

The dynamics in south India took a controversial turn when the BJP-ruled Karnataka deployed earthmovers to block roads and prevent individuals from the opposition-ruled state of Kerala from entering (Ghosh 2021). Conflicts were not limited to BJP versus non-BJP-ruled states; they also arose between non-BJP-ruled states with different ruling parties. A notable example was the dispute between Telangana and Andhra Pradesh. Telangana issued a circular restricting the entry of ambulances from neighbouring states, affecting critically ill patients from Andhra Pradesh. The Telangana High Court later overturned this decision, deeming it discriminatory (Mutha 2021).

Similar interstate disputes and centre–state conflicts were also prevalent during the vaccine rollout. Initially, the central government spearheaded vaccine procurement and distribution, providing free vaccines to the states targeting frontline workers, followed by senior citizens and those aged 45 and above. Simultaneously, the central government, without consulting the states, initiated a strategy of ‘vaccine diplomacy’ – an approach that overlooked the immense domestic demand for vaccinations. As a result, by May 2021, during the peak of the second wave, the full vaccination rate in India was a mere 2.63 per cent, far lower than the figures for the USA and UK, which had fully vaccinated 36 per cent and 27 per cent of their populations, respectively (*India Today* 2021). As the second wave of the pandemic exposed the shortcomings of the initial policy, the government unilaterally rolled out a new Liberalised Accelerated National Covid-19 Vaccine Strategy in April 2021. Under this policy, states were suddenly tasked with sourcing vaccines from the international market and negotiating their own deals with manufacturers, causing disorganised competition and chaos. The unilateral approach taken by the central government in designing and modifying the vaccination policy

strained the principles of cooperative federalism and triggered a blame game between the centre and the states.

The revised policy came under scrutiny from the Supreme Court of India, which questioned its constitutionality and expressed concerns about chaos and uncertainty. It is telling that the Supreme Court intervened in the case of both oxygen supply and the procurement of vaccines. In its order (Suo Motu Writ Petition (Civil) No. 3 of 2021, dated 30 April 2021), it imposed and enforced coordination between the centre and the states on issues, such as the supply of oxygen, beds, medical supplies, and vaccines, and highlighted problems with the distribution of these items to people in need.⁴ The Supreme Court directed the government to ensure the availability of oxygen for medical use and devise a plan for equitable distribution across the country. The court also called for measures to prevent hoarding and black-market activities, and for action to be taken against those found guilty of such activities. Furthermore, the Supreme Court ruled that the central government, rather than individual states, should be responsible for buying and distributing vaccines. The *Suo Motu Writ Petition (Civil) No. 3 of 2021* stands as a seminal legal case, exemplifying the efficacy of judicial safeguards of federalism in the event of the central government's failure to uphold the principles of federalism.

Following the Supreme Court's order, the centre agreed to supply at least 75 per cent of vaccines free of charge to the states, with the private sector's allocation determined by demand rather than a preset 25 per cent quota (Purohit et al. 2022). Local production of COVID-19 treatment drugs was also ramped up, as were efforts to facilitate their import. The government of India imposed export restrictions on Remdesivir and Amphotericin B during the second wave to increase domestic supply. It further redirected industrially produced oxygen towards medical use through temporary restrictions. Indian Railways launched emergency oxygen supply train services to expedite the redistribution of medical oxygen from surplus to deficit regions. Finally, the government also put in place mechanisms for the efficient allocation

and swift distribution of medical and other relief materials India received as foreign aid.

3.3 The (Residual) Effect of the Pandemic on the Overall Quantum and Vertical Balance of Health and Socio-economic Expenditure

The health crisis necessitated extraordinary spending on health services and socio-economic support. These funds were utilised for producing PPE, establishing testing and contact tracing systems, procuring, distributing, and administering vaccines, and expanding hospital capacity – including the supply of oxygen and other medications for treating COVID-19. Additionally, it necessitated socio-economic measures to aid the vulnerable sections most impacted by the pandemic. With these unprecedented health and social expenditures coinciding with a notable economic contraction, two key questions arise: first, how did levels of health and social expenditure evolve during the pandemic and have they returned to pre-pandemic levels since? Second, how has the pandemic affected the financial standing of the centre relative to the states, and to what extent has the centre's changing position been consolidated since?

To answer the first question, we consider three graphs depicted in Figures [3.1](#)–[3.3](#). These show the progress of medical and public health expenditure, social sector spending, and labour welfare expenditure as a percentage of GDP. [Figure 3.1](#) clearly illustrates the surge in central and state public health expenditure in 2021–2022, albeit from a relatively low base. Proportionally, this increase is more significant for the central government – doubling from 0.12 per cent to 0.24 per cent of GDP – than for all states (including union territories with a legislature) combined, which increased from 0.58 per cent to 0.83 per cent of GDP.² It is worth noting that, consistent with the states' constitutional authority in health matters, state expenditure vastly outstrips that of the centre. The graph also reveals that central health expenditure returned to pre-pandemic levels in 2023, while state expenditure

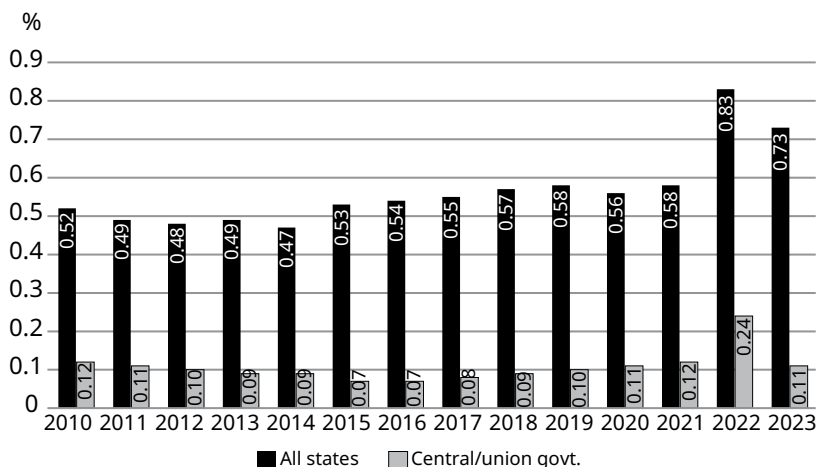


Figure 3.1: Medical and public health expenditure (inflation adjusted) as a percentage of GDP

Data Source: Reserve Bank of India, <https://rbi.org.in/Scripts/AnnualPublications.aspx?head=State+Finances+%3a+A+Study+of+Budgets>

remained significantly higher, despite a drop of 0.10 per cent relative to overall GDP levels since 2022.

In addition to a health response, both the centre and the states also amplified their socio-economic support. This is reflected in Figures 3.2 and 3.3. Figure 3.2 displays total social sector spending, which includes not only medical and public health expenditure but also spending on education, sports, art and culture, family welfare, water supply and sanitation, housing, urban development, the welfare of scheduled castes, scheduled tribes, and OBCs, labour and labour welfare, social security and welfare, nutrition, and natural calamities.

Figure 3.3 reveals a substantial relative increase in labour welfare spending at the central level between 2020–2022, albeit a comparatively smaller increase in absolute terms compared with the states. Similar to the trend in health expenditures, central spending on the social sector has fallen back to pre-pandemic levels and remains well below the level under the Congress-led UPA at the centre (as depicted for 2010–2014 in Figure 3.2).

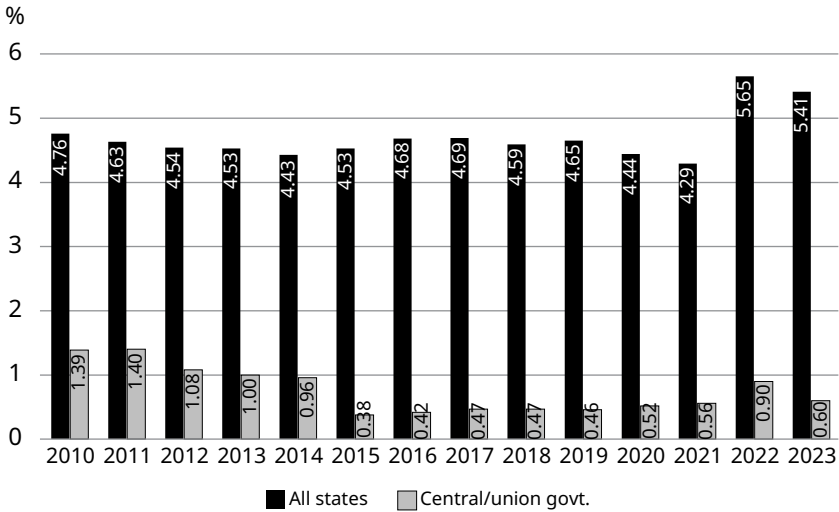


Figure 3.2: Social sector spending (inflation adjusted) as a percentage of GDP

Data Source: Reserve Bank of India, <https://rbi.org.in/Scripts/AnnualPublications.aspx?head=State+Finances+%3a+A+Study+of+Budgets>

It is worth noting that the bulk of the increase in social sector expenditure was attributed to two stimulus packages announced by the centre to cope with the socio-economic fallout of the pandemic. After all, the first few months of the lockdown resulted in 120 million job losses, particularly in construction, trade, tourism, and communication services, disproportionately impacting informal and migrant workers (Jha and Kumar 2020, 46).

The first of these packages, announced in March 2020, was a US\$22.6 billion (0.8 per cent of GDP) stimulus. It included a provision to deliver five kilograms of rice or wheat and one kilogram of preferred pulses per person for three months to 800 million of India's poorest citizens (Ganguly 2020, 112).

The second package, a substantial US\$308 billion stimulus, was declared on 12 May 2020. It included the provision to supply two months of food grains to migrant workers not covered under the National Food Security Act (2013). However, while this stimulus package was touted as representing 10 per cent of GDP, its actual fiscal impact was estimated by the Centre for Budget

and Governance Accountability (CBGA) to be between 1.94 and 2.21 lakh crore rupees, which roughly equates to just 1 per cent of GDP (CBGA 2020).

Indeed, according to interviews with government of India officials, Thomson Reuters reporters stated that the economic stimulus package was purely about liquidity measures, without any additional budget spending (Reuters 2020). These reports were later corroborated by independent analysts who found that the majority of the funds were allocated to existing schemes and plans, rather than introducing new stimulus measures (*The Economic Times* 2020). Overall, the package was inadequate in mitigating the economic impact as it lacked targeted measures, such as direct aid to the poor and those in the informal sector. Consequently, the package fell short in generating its intended impact.

[Figure 3.3](#) illustrates the specific component of expenditure dedicated to labour welfare. This includes regulations on minimum wages and social security provisions, such as pensions or other forms of income support for both organised and unorganised sectors. As labour is a concurrent subject, unlike health and most social sector competencies, the centre has traditionally played a more significant role, despite the overall low expenditure as a percentage of GDP.

As evident in [Figure 3.3](#), both central and state expenditures witnessed a substantial increase between 2021 and 2022. This considerable rise in labour welfare expenditure was tied to the increase of 400 billion rupees in support for MGNREGA, a cost-sharing programme that the centre and the states jointly contribute to, aiming to provide a guaranteed minimum of 100 days of unskilled manual labour in rural areas.

This budget increase was intended to provide income support to 40 million people in June 2020 alone, in stark contrast to the mere 23 million supported between 2013 and 2019 (Raj 2021, 184; see Jha and Kumar 2020 for additional pledges). The measures also included food support for migrant workers who would not typically qualify for food support through the public distribution scheme. However, many domestic migrants were unable to access

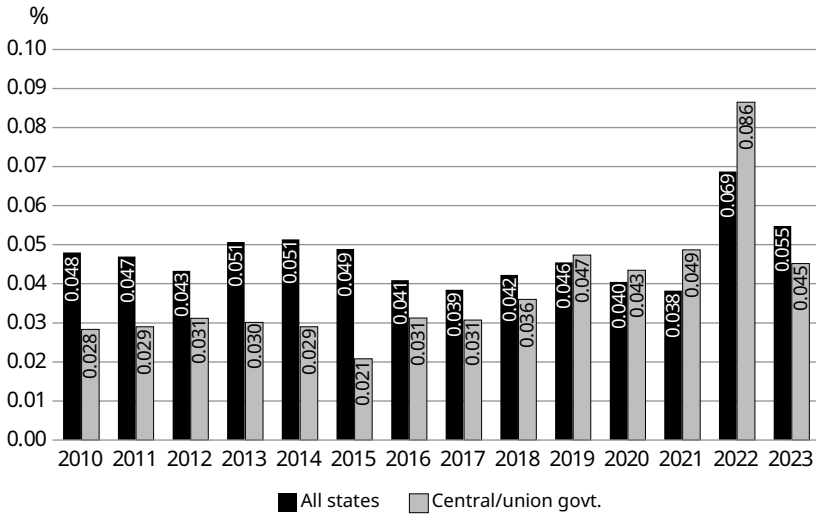


Figure 3.3: Labour welfare expenditure (inflation adjusted) as a percentage of GDP

Data Source: Reserve Bank of India, <https://rbi.org.in/Scripts/AnnualPublications.aspx?head=State+Finances+%3a+A+Study+of+Budgets>

any welfare measures as they were not registered under any welfare board (Swenden et al. 2022). Much like health expenditure and broader social sector expenditure, central levels of expenditure have almost reverted to pre-pandemic levels, while state expenditure remains slightly higher.

Finally, as [Figure 3.4](#) demonstrates, the combined effect of increased social expenditure and reduced revenue – due to an economy contracting during the pandemic – exerted significant pressure on both central and state budgets. The combined fiscal deficits of central and state governments, which indicate their borrowing needs, peaked at 8.8 per cent of GDP in 2021, with about two thirds of this attributable to the centre. These deficits remained above 7.5 per cent in 2023.

This trend corresponds with the rising revenue deficits of both the states and the centre in financial year 2021, which reveal the effects of the revenue shortfall and increased expenditures during the peak of the pandemic. Although both entities have gradually

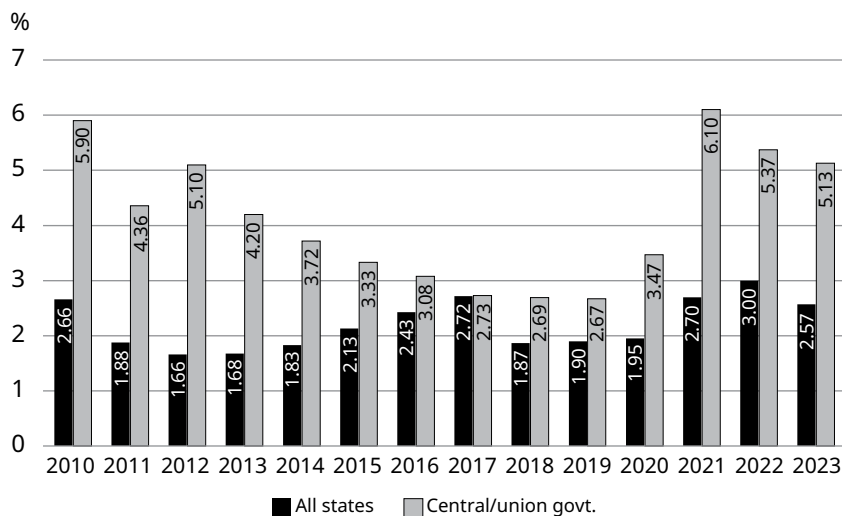


Figure 3.4: Fiscal deficit (inflation adjusted) as a percentage of GDP
 Data Source: Reserve Bank of India, <https://rbi.org.in/Scripts/AnnualPublications.aspx?head=State+Finances+%3a+A+Study+of+Budgets>

reduced their deficits in subsequent years, the centre's pace of deficit reduction has been slower.

3.4 Interstate Variations in the Management of COVID-19

Beyond the interactions with the central government, states have the autonomy to create health and labour welfare policies within their constitutionally assigned scope. Indeed, states have exercised this autonomy, except for during the period of the national lockdown when the National Disaster Management Act was in full operation. The detailed case study contributions in this volume on Bihar (Jha), Delhi (Sengupta), and Kerala (Surendran) demonstrate how each of these states or union territories (in the case of Delhi) crafted its initiatives. These initiatives aimed at containing the virus spread, providing social relief to stranded migrant workers, or ramping up medical infrastructure. However, not all

these initiatives may have achieved the intended effect or aimed at socially progressive outcomes.

For instance, some states used the pandemic as a pretext to relax their labour laws. The NDA/BJP-ruled Madhya Pradesh, Uttar Pradesh, Gujarat, and Himachal Pradesh, but also opposition-ruled states such as Rajasthan, Punjab, and Odisha, increased the maximum number of working hours per day from eight to 12 and the maximum working hours per week from 48 to 72 (see PRS State Legislative Brief for state-wise details at <https://prsindia.org/bills/states/changes-in-work-hours-himachal-pradesh>). This approach is generally seen as a violation of ILO conventions and adversely affects work–life balance, incurring a gender penalty (Sundar 2020). In Uttar Pradesh, this rise in working hours accompanied an exemption from provisions regulating certain health and safety conditions in the workplace, such as ‘disposal of waste and effluents, temperature, dust and fumes, artificial humidification and lighting’ and, more generally, the suspension of protective provisions in 34 labour laws (Sundar 2020, 7).

Overall, there is substantial interstate variation in per capita state expenditure on labour welfare and health. [Figure 3.5](#) illustrates this with reference to 17 major states, which collectively account for more than 90 per cent of the Indian population. This figure is based on the mean per capita expenditure on those items between 2009 and 2023, thus covering the period of the pandemic and the decade before.³

Figures [3.5](#) and [3.6](#) highlight several points. First, all states spend significantly more on health than they do on social welfare. Second, states with higher per capita expenditure on health also generally spend more on labour welfare. For example, Kerala is the top per capita spender on both. In contrast, West Bengal, which is in the bottom third of all states for health spending, ranks lowest in labour welfare expenditure. This is surprising considering that West Bengal, like Kerala, has been governed by the Communist Party of India for much of its post-independence history.

Third, while there is a correlation between per capita spending on health and labour welfare and a state’s overall economic

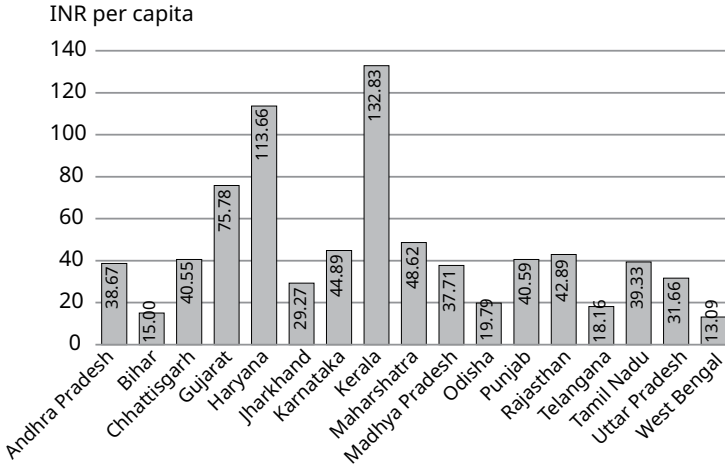


Figure 3.5: Labour welfare spending per capita (mean, 2009–2023)
 Data Source: Reserve Bank of India, <https://rbi.org.in/Scripts/AnnualPublications.aspx?head=State+Finances+%3a+A+Study+of+Budgets>

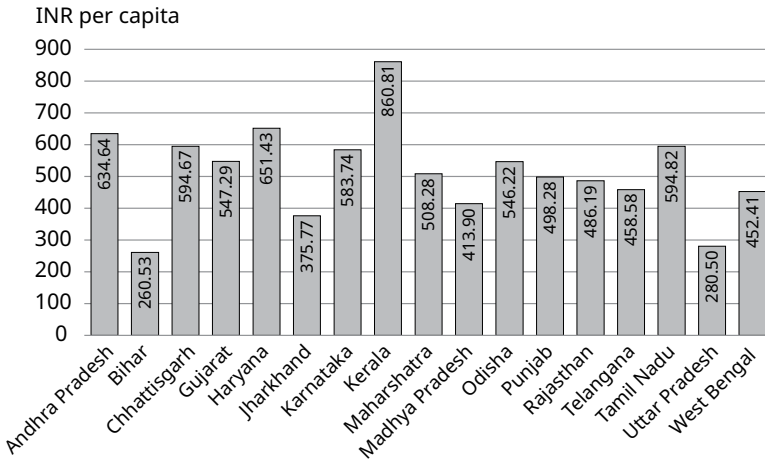


Figure 3.6: Health expenditure per capita (mean, 2009–2023)
 Data Source: Reserve Bank of India, <https://rbi.org.in/Scripts/AnnualPublications.aspx?head=State+Finances+%3a+A+Study+of+Budgets>

performance, as per their state gross domestic product, this is not a linear relationship. ‘Richer’ states like Maharashtra, Gujarat, and Tamil Nadu have lower per capita expenditures on health and labour welfare than Kerala does. Although the economically

poorest states listed (Bihar and Uttar Pradesh) have among the lowest per capita expenditure on health and welfare, Telangana and West Bengal are well below where they should be.

Importantly, higher per capita expenditure does not necessarily lead to better health and social policy outcomes. Given the theme of this chapter, we focus on health outcomes related to the pandemic. [Table 3.1](#) shows how Indian states did, by relating pandemic outcomes (vaccination coverage and COVID deaths) to public health expenditure and health infrastructure. States, including the union territories of Delhi and Puducherry, are listed in alphabetical order. Since officially reported COVID death ratios should be interpreted cautiously, we used excess mortality instead (Hariharan and Surendran 2023).

Table 3.1: State-wise comparison of health infrastructure and pandemic outcomes: estimated excess deaths per 1,000 and vaccination coverage

State	Public health expenditure per capita (from highest 1 to lowest 30)	Health infrastructure index (from highest 1 to lowest 30)	Vaccination coverage (from highest 1 to lowest 30)	Estimated excess deaths per 1,000 (from lowest 1 to highest 30)
Andhra Pradesh	21	18	4	24
Arunachal Pradesh	2	5	21	3
Assam	13	15	16	22
Bihar	28	30	27	30
Chhattisgarh	15	25	11	4
Delhi	7	8	2	18
Goa	1	3	6	26
Gujarat	22	23	5	23
Haryana	16	20	9	19
Himachal Pradesh	10	7	3	8
Jharkhand	26	16	28	1

State	Public health expenditure per capita (from highest 1 to lowest 30)	Health infrastructure index (from highest 1 to lowest 30)	Vaccination coverage (from highest 1 to lowest 30)	Estimated excess deaths per 1,000 (from lowest 1 to highest 30)
Karnataka	19	4	14	20
Kerala	11	13	19	21
Madhya Pradesh	27	28	20	29
Maharashtra	20	27	25	25
Manipur	8	11	26	28
Meghalaya	9	10	29	27
Mizoram	4	6	10	5
Nagaland	6	9	30	16
Odisha	17	19	17	11
Puducherry	5	1	23	17
Punjab	25	22	8	14
Rajasthan	23	26	24	2
Sikkim	3	2	1	10
Tamil Nadu	18	17	15	12
Telangana	29	24	13	9
Tripura	12	12	12	6
Uttar Pradesh	30	29	22	7
Uttarakhand	14	14	7	13
West Bengal	24	21	18	15

Sources: Vaccination coverage: State-wise Covishield and Covaxin Vaccine Doses per capita (Lok Sabha Unstarred Question No. 3410, dated on 05.08.2022); public health expenditure: State Finances: A Study of Budgets, Reserve Bank of India; health infrastructure index has been created by combining HBDE four variables: number of government hospitals per 1,000 persons, number of government beds per 1,000 persons, number of doctors per 1,000 persons (from National Health Profile 2021, Central Bureau of Health Intelligence, Ministry of Health and Family Welfare), and per capita health expenditure (State Finances: A Study of Budgets, Reserve Bank of India, 2020 and 2021); estimated excess deaths – from Hariharan and Surendran (2023).

The ranking of states disrupts any simplistic assumption that high public investment or superior health infrastructure directly translates into better pandemic management outcomes. For example, Goa, Delhi, and Maharashtra, all of which rank relatively high in infrastructure and public health expenditure, nonetheless report elevated excess deaths. Conversely, Jharkhand, Rajasthan, and Chhattisgarh, despite weaker health metrics and middling vaccine coverage, report some of the lowest excess mortality rates. This paradox underscores that the outcomes may be a function of complex interactions between several explanatory factors, such as state capacity, political alignment, and contextual COVID-contingent dynamics.

[Table 3.2](#) presents the results of a multiple linear regression estimating the determinants of excess COVID-19 mortality across Indian states. The analysis reveals that none of the expected determinants – vaccination coverage, public health expenditure

Table 3.2: Correlation and regression results for determinants of estimated excess COVID-19 deaths

Variable	Estimated excess COVID-19 deaths per 1000
Vaccination uptake	-0.0052 (0.0108)
Health infrastructure	-0.9373 (2.5095)
Public health expenditure per capita	0.00012 (0.0002)
Under-reporting (%)	0.0155* (0.0090)
Constant	1.2125 (1.7802)
R-squared	0.1860
N	30

Standard errors in parentheses

*p<0.10, ** p<0.05, *** p<0.01

per capita, or health infrastructure index – has a statistically significant relationship with estimated excess COVID-19 mortality. While the direction of the coefficients for vaccination and infrastructure is negative – indicating their association with lower death rates – the estimated effects are small and not statistically significant.

Only under-reporting shows a statistically significant positive relationship with excess COVID-19 deaths. This may serve as a proxy for weak health systems and administrative capacity, if the inability to accurately record and report deaths reflects underlying deficiencies in technical infrastructure, human resources, and bureaucratic effectiveness.

These findings point to the need for further research that combines both qualitative insights and multivariate quantitative models controlling for broader dimensions such as state capacity (for example, human development, health infrastructure, and labour welfare), COVID-contingent factors (such as population density and urbanisation), and political variables (such as partisan alignment between state and central governments) (see Sharma and Swenden 2026).

3.5 Conclusion

In this chapter, we have demonstrated how India's federal structure, which leans towards centralisation, has witnessed a consolidation of central authority at the centre as the pandemic spread across the states. This response was predictable given the severity and abruptness of the pandemic. However, we underscore the opportunist nature of centralisation and argue that a coordinated (even if centralised) response could have pre-empted several policy missteps and impulsive announcements during the first cycle of the pandemic. In contrast, when the devastating second wave of the pandemic struck, the centre adopted a more hands-off approach, ostensibly to evade any potential criticism. This dramatic shift resulted in decentralised yet uncoordinated responses,

sparking both vertical and horizontal conflicts among various governmental levels.

In terms of crisis-preparedness, our analysis shows that vertical (centre–state) and horizontal (interstate) coordination is needed to manage a national disaster and that the state must invest in the necessary intergovernmental machinery to facilitate this. This is more challenging in the context of a polarised multilevel party system, with an organizationally and ideologically centralist party in control of the centre. Our analysis proposes that any perceived coordination during the pandemic was largely underpinned by tacit cooperation from ‘affiliated’ states while cooperation was largely imposed on opposition-ruled states. The potential for ‘negotiated cooperation’, which could have been instrumental in unleashing a coordinated response, was unfortunately only realised under severe pressure of an unprecedented death toll and judicial intervention. Indeed, the coordinated response after episodes of judicial activism underscore the latent potential of the Supreme Court to compensate for governmental inadequacies, safeguarding the ethos of federalism in times of crisis.

Our study of disparities in the responses and outcomes across different states underscores that a robust health infrastructure, while necessary, does not guarantee effective pandemic management. As evidenced in subsequent case study chapters, it needs to be accompanied by sustained leadership and engagement with all tiers of government and civil society in crisis management.

The final observation is a seeming lack of learning from the pandemic experience. Despite the profound need, there appears to be a lack of resolve to activate formal mechanisms – such as the Inter-State Council – for intergovernmental coordination. With healthcare expenditure reverting to pre-pandemic levels, there is an implicit suggestion that government healthcare facilities may continue to be ill-equipped for large-scale health emergencies. The continued neglect of labour welfare further suggests that the repercussions of any future calamities will likely be borne by the poor, particularly those working in the unorganised sector. Relative to its level of development, India lags in per capita health and

social spending. Apart from better inter-state and centre–state coordination, levelling up public spending on health and social care to levels seen across Southern India would strengthen India’s ability to face future crises of similar magnitude.

Notes

- 1 The Supreme Court found the centre’s vaccination policy ‘prima facie arbitrary and irrational’. When the centre submitted that the court had limited power on policy issues, the court replied, ‘You can’t just say that you’re the centre and you know what’s right. We have a strong arm to come down on this.’
- 2 As a percentage of GDP, India spends less on health than states of comparable levels of development, such as Sri Lanka or even Bangladesh. Going into the pandemic India had fewer hospital beds per person than Bangladesh, Bhutan, Nepal, Sri Lanka, or China and fewer physicians per person than Pakistan, Sri Lanka, and China (Ganguly 2020, 113).
- 3 Comparative studies typically exclude smaller states, union territories with legislative assemblies (also called half-states), special category states, and union territories. This collective includes Jammu and Kashmir, Delhi, Puducherry, Goa, Assam, Nagaland, Himachal Pradesh, Manipur, Meghalaya, Sikkim, Tripura, Arunachal Pradesh, Mizoram, Uttarakhand, and Telangana.

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CHAPTER 4

Epidemiological and Economic Impact of COVID-19 in South Asia

A Comparative Analysis

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Abstract

This chapter provides an overview and comparative analysis of the epidemiological and economic impact of COVID-19 in the eight countries of South Asia. The epidemiological impact is analysed using the total number of COVID-19 cases per million population and the total number of deaths caused by COVID-19 per million population in each country. The economic impact is analysed using the GDP growth rates, unemployment rates, inflation rates, and foreign remittances of the eight countries in South Asia. The chapter is framed within the 'life versus livelihoods' analytical lens using secondary data from authoritative sources. My comparative analyses reveal how Sri Lanka was the country worst affected by COVID-19 in South Asia both in terms of the total number of

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deaths per million population and in terms of economic indicators, and Bangladesh was the least affected country. While the physical and material capacities of the state are essential for crisis management, the governance capacity and emotional resilience of political leadership and decision makers are even more critical in addressing global public health emergencies to effectively mitigate the epidemiological and economic impact of COVID-19.

4.1 Introduction

This chapter seeks to understand the implications of the pandemic for the socio-economic development of South Asia. It attempts to do this by assessing the management of the pandemic against a broader ‘lives or livelihoods’ binary (as framed by politicians, such as the then US President Donald Trump, and the mass media across the world during the COVID-19 pandemic). It aims to present the epidemiological and economic impact of COVID-19 in each South Asian country and triangulate the empirical outcomes with the conceptual framework of analysis to test the validity (or otherwise) of the ‘lives or livelihoods’ binary in South Asia.

Further, using the extant secondary literature as well as data gathered and curated from secondary sources available online, I am guided by the following three specific research questions:

1. Is the ‘lives or livelihoods’ binary valid from a policy perspective?
2. What are the epidemiological (number of infected persons and deaths caused by COVID-19) and economic (growth, unemployment, and inflation) impacts of COVID-19 in South Asia during the first three years of the pandemic (2020–2022)?
3. Do the empirical outcomes in South Asia validate the ‘lives or livelihoods’ binary?

In answering these questions, I first provide a short assessment of how COVID-19 disrupted the economic, political, and societal life across the world and prompted choices that affected lives

and livelihoods. It then confronts the binary with evidence from the ground, based on available data on COVID-incidence and death (which are used as proxies for lives) and economic indicators (which are used as proxies for livelihood). In the conclusion I argue that, while some South Asian states may confirm the assumption that more lives lost today (to save the economy today) cost the economy more tomorrow, there are also cases (most notably the Maldives but also India) that disprove this view. This suggests that other factors (e.g. political instability or the path-dependent effect of erroneous investment and loan decisions that predate the pandemic) may have exacerbated an already perilous economic situation in countries such as Pakistan and Sri Lanka, while affecting other countries, such as India and Bangladesh, less. Strictly speaking, this comparison may be premature because here we are considering the epidemiological data up to the end of 2022, and therefore the future economic outcomes (i.e. after 2022) are still not available for any of the countries under consideration. Therefore, my conclusions herein are tentative and should be treated cautiously.

4.2 Lives versus Livelihoods: A False Dichotomy?

The COVID-19 pandemic has disrupted simultaneously the economies, politics, and societies across both the developed and the developing world. Usually, either natural disasters or human-made disasters or both are always affecting one or more countries or one or more regions or subregions of the world. However, a pandemic, as the term denotes, affects the entire globe. In other words, pandemics cause everyone to be a potential victim or a real victim and therefore leave no 'safe houses', either within nation states or globally. Consequently, the usual support and solidarity from non-affected countries and/or international development partners (e.g. the United Nations) was not forthcoming. This left the pandemic-affected poor countries to fend for themselves with very little (if at all) external support.

The global economy, especially in the developed world, had not fully recovered from the Global Financial Crisis of the late 2000s (Chen, Mrkaic, and Nabar 2019), when the pandemic struck in early 2020. Similarly, most economies in South Asia have encountered economic and political turbulence since the early 2010s; for example, deceleration in economic growth in India and Sri Lanka during the latter half of the 2010s (Central Bank of Sri Lanka 2021; Subramanian and Felman 2019). The pandemic worsened an already bad economic situation by causing a sudden sharp drop in the movement of people, goods, and services across the world at a global level never experienced before in the past.

When the pandemic first struck in China in late 2019, there were no preventive vaccines or curative medicines to combat the coronavirus. Therefore, the only way to mitigate the epidemiological impact of the coronavirus was to restrict or totally prohibit the movement of people within as well as across national borders, wear face masks when outdoors, maintain physical distance between people in public places (aka social distancing), and other quarantine measures. The foregoing, collectively called non-pharmaceutical interventions (NPIs) or epidemiological responses, were imposed to limit the spread of the coronavirus.

Consequently, total or partial lockdowns were imposed within national borders throughout the world. These unprecedented lockdowns caused economic downturns, which in turn resulted in social unrest and political upheavals, in both developed and developing countries (Labott 2021; Lackner, Sunde, and Winter-Ebmer 2021; van der Zwet et al. 2022). There was opposition to such lockdowns, physical/social distancing, and so on in many countries, especially in developed countries where people had never experienced such prohibition/restriction to physical movements and isolation/quarantine mandates. Further, such enforced isolations/quarantines caused psychological distress to many people across the world, especially among the elderly and/or physically or psychologically challenged populations (see Passavanti et al. 2021).

A tweet by the then president of the United States of America, Donald Trump, on 23 March 2020, ‘We cannot let the cure be worse than the problem itself’ (*New York Times* 2020) encapsulated the dilemma faced by the entire world (for a counter-argument see Meyerowitz-Katz et al. 2021). There was a proposition by some politicians, economists, and indeed medical professionals in many countries at the outset of the pandemic that universal (as opposed to targeted) NPIs and quarantine measures imposed universally could be causing more deaths than COVID-19 itself (J. Chen et al., 2025). There was a suspicion that, because of severe universal lockdowns, poor people were unable to earn enough to sustain themselves and their families, and thus were likely to starve to death. Similarly, certain medical professionals cautioned national authorities that universal lockdowns and travel restrictions could prevent people with other illnesses to seek timely medical care that could risk their lives.

It is important to note that the key objective of the epidemiologists and public health professionals was to minimise the spread of the coronavirus and thereby eliminate COVID-19. In other words, the preservation of human life was the key objective of health professionals and epidemiologists. In contrast, the key objective of economic professionals was the preservation of human beings’ material conditions. They argued that, even during a pandemic, people should be able to earn a living, thereby preserving their livelihoods.

Importantly, the physical and material lives of human beings are two sides of the same coin. In other words, one cannot survive without the other. Thus, the ‘lives or livelihoods’ binary is a false dichotomy because both are indispensable for human existence. The real choice for policymakers is *not* lives or livelihoods; instead, it is postulated in the theoretical literature that it is indeed a choice between saving lives today (by way of NPIs or lately by administering the COVID-19 vaccine) to save the economy tomorrow, or losing lives today (in order to save the economy today) to lose the economy tomorrow (Gans 2020; Thompson 2020). The former means that, if a country chooses to strictly enforce NPIs right now

(2020 and 2021), the economy may suffer in the short run but the country may be able to recover soon because of thousands (if not hundreds of thousands) of lives saved now will be able to drive the recovery of the economy later (2022 and beyond). The latter means that, if a country chooses to be lax in terms of enforcing NPIs now in order to save today's economy, it may cause thousands (if not hundreds of thousands) of more deaths now. This in turn could have negative impact on the economy later in the future because replenishment of human resources in general and human capital in particular would take a very long time. Thus, it is a kind of a choice between short-term economic sacrifices for longer-term economic gains versus short-term economic gains for longer-term economic sacrifices. Therefore, at times of public health emergencies, such as the pandemic, health professionals and economic professionals should collaborate and cooperate to sustain and nurture human existence and successfully overcome the pandemic (*The Economist* 2020).

The foregoing theoretical model may be logical. However, empirically, whether this is what happened will be tested by analysing the data on the epidemiological and economic consequences of COVID-19 in eight South Asian countries below. However, it may be a bit premature to test this model because we are using data on selected economic indicators for 2022 only that would refer to 'tomorrow' or 'later' or 'future' in the above postulated theoretical model. As mentioned above, the data on selected economic indicators for 2020 and 2021 refer to 'today' or 'now' or 'present'.

The primary objective of epidemiologists is to contain the reproducibility rate of the coronavirus to less than one, that is, a coronavirus-infected person should not infect one or more other person/s with the virus. This 'flattening the curve' is required to successfully overcome the pandemic (Cleevely et al. 2020, S16).

The primary objective of economic policymakers should be that, for every life saved because of curfews/lockdowns to contain COVID-19, potential lives that could be lost due to starvation and/or inability to seek timely medical care for other serious

illnesses should be less than one. That is, if the potential number of lives that could be lost due to curfew/lockdown is less than one for every life saved owing to the same curfew/lockdown, the curfew/lockdown is justifiable: the total number of lives that could be saved by the imposition of curfews/lockdowns should be higher than the potential lives that could be lost due to starvation and/or lack of timely medical care for other illnesses due to such curfews/lockdowns (Ma et al. 2021). An empirical study undertaken by the National Bureau of Economic Research in the United States estimated that in upper- and lower-middle-income countries deaths prevented by curfews and lockdowns were higher than the deaths caused due to loss of livelihoods, starvation, and so on, and inability to seek timely healthcare for other illnesses. In contrast, in low-income countries the deaths caused by the curfews and lockdowns were considerably greater than those deaths prevented by such curfews and lockdowns (Ma et al. 2021, 3–4).¹ In the next section we confront these assumptions with evidence from South Asia, after providing an initial snapshot of South Asia in terms of geography, population, and economy.

4.3 COVID-19 and South Asia

South Asia consists of eight countries: Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka. South Asian countries are very diverse not only in terms of their geographical/physical size, the size of population, and the size of the economy but also in terms of the hundreds of languages spoken and numerous faiths followed across these countries. South Asia is a tapestry of, inter alia, four Muslim-majority countries (Afghanistan, Bangladesh, Pakistan, and the Maldives), two Hindu-majority countries (India and Nepal), and two Buddhist-majority countries (Sri Lanka and Bhutan).

South Asia comprises the most populous country in the world (in mid-2023), India, and one of the least populated countries in the world, the Maldives. The total population of all eight countries in South Asia, almost 1.9 billion in 2022, is equal to almost a quarter

of the global population (around 8 billion in 2022). One of the striking features of South Asia is that one country, India, dominates the geographical spread, population size, economic clout/magnitude, and the absolute number of the poor people of this subcontinent. Accordingly, India accounted for 74 per cent of the total population of South Asia in 2022, followed by (in descending order) Pakistan (12 per cent), Bangladesh (9 per cent), Afghanistan (2 per cent), Nepal (1.5 per cent), Sri Lanka (1 per cent), Bhutan (0.04 per cent), and the Maldives (0.03 per cent) (see [Table 4.1](#) and [Figure 4.1](#)).

In terms of the size of the respective economies (in descending order), India accounted for 78 per cent, Bangladesh 10 per cent, Pakistan 8.5 per cent, Sri Lanka 2 per cent, Nepal 0.89 per cent, Afghanistan 0.36 per cent, the Maldives 0.13 per cent, and Bhutan 0.06 per cent of the total in South Asia in 2021 (see [Table 4.1](#) and [Figure 4.2](#)). In [Table 4.1](#), the 2021 figures are used owing to the severe downturn inflicted on the world economy following the Russian invasion of Ukraine in February 2022.

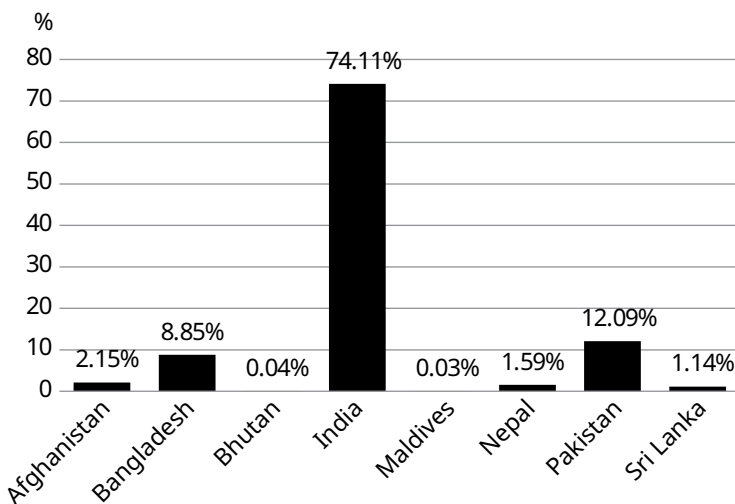


Figure 4.1: Share of the South Asian population by country (2022)

Data source: UNFPA, <https://www.unfpa.org/data/world-population/>

Table 4.1: Population, GDP, per capita income, COVID-19 cases, and deaths by country: 1 January 2020–31 December 2022 (36 months)

	Unit	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka	TOTAL
2022 population	Percentage	2.15	8.85	0.04	74.11	0.03	1.59	12.09	1.14	100.0
	Total (millions)	40.80	167.90	0.80	1,406.60	0.50	30.20	229.50	21.60	1,897.90
2021 GDP	Percentage	0.36	10.18	0.06	77.68	0.13	0.89	8.52	2.17	100.0
	Billion US\$	14.8	416.3	2.5	3,176.3	5.4	36.3	348.3	88.9	4,088.8
2021 per capita income	US\$	369	2,458	3,266	2,257	10,366	1,208	1,505	4,014	
COVID-19 cases	Percentage	0.41	4.04	0.12	88.61	0.37	1.99	3.13	1.33	100.0
	Total	207,585	2,037,125	62,524	44,679,564	185,678	1,001,000	1,575,785	671,891	50,421,152
COVID-19 cases	Per million people	5,088	12,133	78,155	31,764	371,356	33,146	6,866	31,106	26,567
COVID-19 deaths	Percentage	1.25	4.70	0.0	84.65	0.05	1.78	4.89	2.68	100.0
	Total	7,849	29,440	21	530,705	311	11,135	30,636	16,817	626,914
COVID-19 deaths	Per million people	192	175	26	377	622	369	133	79	330

Data sources:

Population: <https://www.unfpa.org/data/world-population/>

GDP: <https://data.worldbank.org/indicator/NY.GDP.MKTP.CD>

Per capita income: <https://data.worldbank.org/indicator/NY.GDP.PCAP.CD>

COVID-19 cases and deaths: <https://www.worldometers.info/coronavirus/#countries>

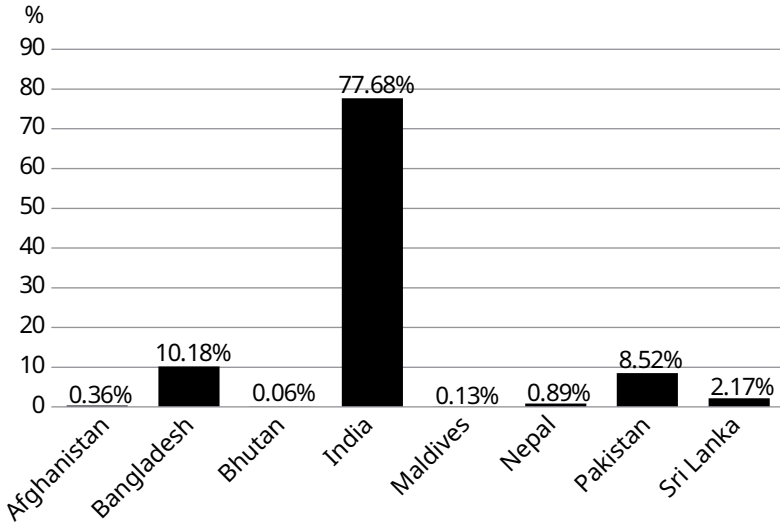


Figure 4.2: Share of the South Asian economy by country (based on 2021 US\$)

Data source: The World Bank, <https://data.worldbank.org/indicator/NY.GDP.MKTP.CD>

In contrast, in terms of per capita income, the Maldives (the tiniest country in South Asia in terms of geographical and population sizes) had the highest per capita income in South Asia (US\$10,366) in 2021, followed by (in descending order) Sri Lanka (US\$4,014), Bhutan (US\$3,266), Bangladesh (US\$2,458), India (US\$2,257), Pakistan (US\$1,505), Nepal (US\$1,208), and Afghanistan (US\$369) (see [Table 4.1](#) and [Figure 4.3](#)). The 2021 figures are used since the 2022 figures are influenced heavily by the Russian invasion of Ukraine, which affected huge rises in fuel prices (including cooking gas) and essential commodity prices such as wheat and sugar; the invasion impacted global supply chains and increased shipping costs.

Before presenting data on the epidemiological impact of COVID-19 in South Asia we need to emphasise that the data on the epidemiological impact of COVID-19 are not entirely reliable globally (Karlinsky and Kobak 2021; Spinney 2021), let alone in South Asia. This could be due to a lack of screening/testing in some countries, deliberate under-reporting and so on (Alvarez

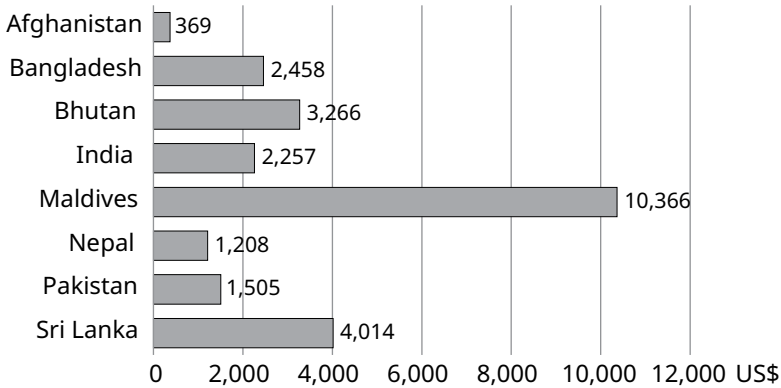


Figure 4.3: Per capita income by country (US\$), 2021

Data source: The World Bank, <https://data.worldbank.org/indicator/NY.GDP.PCAP.CD>

et al. 2023; Richards 2020). The data on Afghanistan could be additionally unreliable owing to its having the lowest governance capacity in entire South Asia due to over four decades of internal strife as well as occupation by foreign armed forces between 1979 and 1989 and again between 2001 and 2021. The absolute number of people infected and killed by COVID-19 in each country should be worked out proportionately to their respective total population. Hence, the data in [Table 4.1](#) provide the numbers of people infected and killed because of COVID-19 per million population in each South Asian country.

4.3.1 Incidences and Deaths Proportionate to the Respective Populations

Accordingly, the Maldives and Bhutan (the two tiniest countries in South Asia in terms of population and land area) had the highest COVID-19 cases (infected people) per million population – 371,356 and 78,155, respectively – which were significantly higher than all other South Asian countries during the first three years of the pandemic (2020–2022). Additionally, Sri Lanka and Nepal, the third and fourth least populous countries in South Asia after the Maldives and Bhutan, had 31,106 (fifth highest) and 33,146

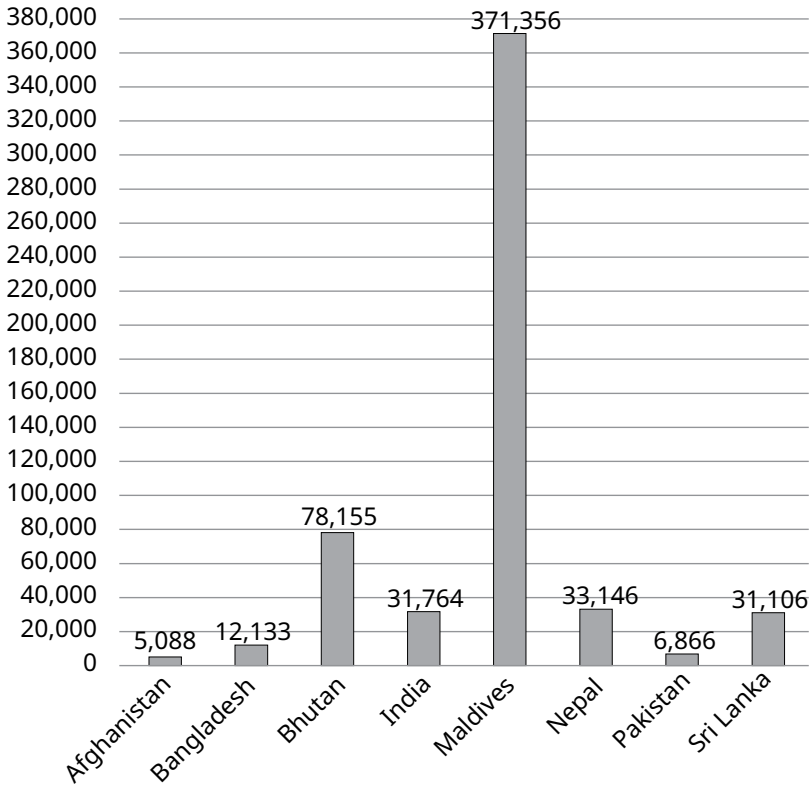


Figure 4.4: COVID-19 cases per million people, January 2020–December 2022

Data source: Worldometer, <https://www.worldometers.info/coronavirus/#countries>

(third highest) cases of COVID-19 per million population during the first three years of the pandemic. In contrast, the four largest countries in terms of population and physical size in South Asia (in descending order) – India, Pakistan, Bangladesh, and Afghanistan – had the lowest COVID-19 cases (infected people) per million population: 31,764, 6,866, 12,133, and 5,088, respectively, during the first three years of the pandemic (2020–2022) (see [Table 4.1](#) and [Figure 4.4](#)).

It follows that the population size or population density did not determine the spread or intensity of the coronavirus in South Asia. Similarly, in terms of the deaths caused by COVID-19 per

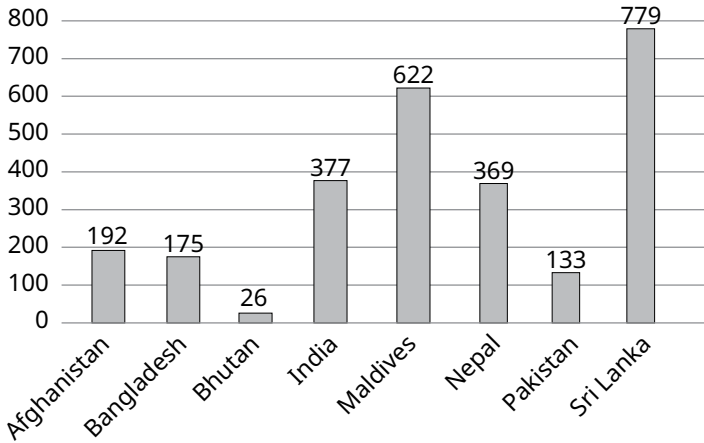


Figure 4.5: COVID-19 deaths per million people, January 2020–December 2022

Data source: Worldometer, <https://www.worldometers.info/coronavirus/#countries>

million population in South Asia, Sri Lanka had the highest (779 deaths per million population), followed by the Maldives (622 deaths per million population) during the first three years of the pandemic (2020–2022). India, with 377 deaths per million people, and Nepal, with 369 deaths per million people, occupied the third and fourth-highest positions respectively in South Asia. Afghanistan (192), Bangladesh (175), Pakistan (133), and Bhutan (26) occupied the fifth, sixth, seventh, and eighth positions, respectively, in terms of deaths per million people caused by COVID-19 in South Asia (see [Table 4.1](#) and [Figure 4.5](#)).

The key takeaway of these results is that Sri Lanka and the Maldives, in spite of having the highest human development index (0.782 and 0.747 respectively, in 2022), the highest per capita income (\$4,014 and \$10,366, respectively, in 2021), and the best healthcare infrastructure in South Asia (including the coverage of universal free healthcare countrywide), had the highest death rates caused by the coronavirus. Therefore, it appears that the responses to and/or the management of COVID-19 by the states in Sri Lanka and the Maldives may have had deficiencies

compared to other states in South Asia. Afghanistan, Bangladesh, and Pakistan had lower shares of COVID-19 cases (infected people) out of the total COVID-19 cases (infected people) in all eight South Asian countries in comparison to their respective shares in the total population of all eight South Asian countries during the first three years of the pandemic (2020–2022). In the other five countries in South Asia, their respective shares of COVID-19 cases (infected people) of the total number of COVID-19 cases in South Asia were higher than their respective shares in the total population of South Asia during the first three years of the pandemic. As a corollary, the same results hold for the deaths caused by COVID-19 in South Asia as well.

One of the main conclusions of the foregoing empirical results is that neither higher per capita income nor human well-being nor relatively superior health infrastructure (including the coverage of universal free healthcare countrywide) insulated Sri Lanka and the Maldives from the devastation of COVID-19. Another key takeaway is that the claim by a section of the Indian media and certain political elites in 2020 that the Muslim population in India were ‘superspreaders’ of the coronavirus was not corroborated by the facts in three out of four Muslim-majority countries in South Asia, barring the Maldives (Kaur and Ramaswamy 2020).

4.3.2 Economic Impact of COVID-19 on South Asia

In addition to the direct economic impacts of COVID-19 caused by curfews and lockdowns, there were indirect economic impacts of COVID-19 due to the social and political consequences of COVID-19. For example, domestic and intimate partner violence against women increased enormously throughout the world during the lockdowns caused by the pandemic. In South Asia, women in India, the Maldives, Nepal, and Sri Lanka experienced a sudden upsurge in domestic and intimate partner violence during the early period of COVID-19 (Hadad-Zervos 2020; Maji, Bansod, and Singh 2022). This domestic and intimate partner violence

negatively affects the tangible and intangible economic contributions made by women in poorer households.

Similarly, political upheavals contributed to regime changes in Afghanistan in August 2021, Pakistan in April 2022, and Sri Lanka in July 2022. In Afghanistan, it was a violent takeover of political power by the Taliban. In Pakistan, the regime change was caused by a no-confidence motion against the ruling political party and the prime minister. In Sri Lanka, a popular uprising against the president and the ruling government caused the president to flee the country in July 2022 and resign from abroad. In all the foregoing cases these political changes caused further economic damage, in addition to what damage had already been caused by the pandemic. Owing to brevity of space, the indirect economic impacts of social and political upheavals in South Asia are not covered in this chapter, as we focus on the direct economic impact of COVID-19 in South Asia in terms of the annual growth in gross domestic product (GDP), unemployment, inflation, and foreign remittances.

4.3.3 Impact of COVID-19 on Economic Growth

In terms of annual economic growth, growth rates of GDP plummeted in every single South Asian country barring Bangladesh in 2020 (the first year of the pandemic). While the economies of Afghanistan, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka shrank in 2020, only the economy of Bangladesh posted a modest growth (3.4 per cent) in 2020. The Maldives had the highest contraction of the economy (−33.5 per cent) in 2020 (most probably explained by the fact that over 50 per cent of the GDP of the Maldives derives from tourism, which was probably the worst-affected economic sector globally due to the pandemic), followed by India (−6.6 per cent) and Sri Lanka (−3.5 per cent). The economies of Afghanistan, Bhutan, and Nepal each shrank by over 2 per cent in 2020. Pakistan experienced the smallest contraction in GDP (−1.3 per cent) in 2020 (see [Table 4.2](#)).

Table 4.2: Annual growth of GDP by country, 2019–2022 (%)

	2019	2020	2021	2022
Afghanistan	3.9	-2.4	-20.7	N/A
Bangladesh	7.9	3.4	6.9	6.9
Bhutan	4.4	-2.3	4.1	4.5
India	3.7	-6.6	8.7	7.5
The Maldives	7.1	-33.5	41.7	11.9
Nepal	6.7	-2.4	4.2	3.9
Pakistan	2.5	-1.3	6.5	4.0
Sri Lanka	-0.2	-3.5	3.3	-7.8

Data source: The World Bank, <https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=8S>

In 2021, six out of eight South Asian countries bounced back, posting positive economic growth (the Maldives, with 41.7 per cent, and India, with 8.7 per cent, leading the pack, and Sri Lanka posting the lowest growth in South Asia, of 3.3 per cent), barring Afghanistan (-20.7 per cent – primarily due to the forcible takeover of the government by the Taliban in August 2021) (see [Table 4.2](#)).

In 2022, Sri Lanka was the only country in South Asia to post the worst-ever shrinking of the GDP, by 7.8 per cent (see [Table 4.2](#)). The current forecast is that Sri Lanka is expected to be the only country in South Asia to experience a shrinking of GDP (by around 3.0 per cent) for the second consecutive year in 2023. In the first quarter of 2023, the Sri Lankan economy had already contracted by 11.5 per cent (CBSL n.d.).

The key takeaway of the annual economic growth (or lack thereof) performance of South Asian countries during the first three years of the pandemic (2020–2022) is that Sri Lanka was the worst-affected country in terms of economic growth. However,

this may not be entirely due to the impact of COVID-19 but because of underlying structural weaknesses over a long period of time. A catalogue of policy errors (including corruption and inconsiderate investment projects) since the election of the executive president in November 2019 may also have been causal factors (Sarvananthan 2023).

4.3.4 Impact of COVID-19 on Jobs

Owing to widespread furloughs and retrenchments because of the pandemic, unemployment soared worldwide at a level not seen since the Great Depression of the 1930s (Hevia and Neumeyer 2020). In developing countries, real unemployment rates are difficult (if not impossible) to measure because of pervasive ‘disguised unemployment’ and ‘underemployment’. Moreover, unemployment data in developing countries are not very reliable because of very weak and varied measurements undertaken in different countries. In contrast, in developed countries, because of social security/welfare schemes, it is much easier to estimate unemployment rates. Most developing countries cannot afford such social security/welfare schemes. Therefore, the following rates of unemployment in South Asian countries should be treated cautiously (i.e. most likely these are significant underestimations). This stark reality is demonstrated below in the case of Sri Lanka; this may be the case in other South Asian countries as well but that is beyond the scope of this chapter.

According to the World Bank, Nepal, Afghanistan, and India had the highest double-digit unemployment rates in 2020 (the first year of the pandemic), at 13.1 per cent, 11.7 per cent, and 10.2 per cent, respectively. Pakistan, with 6.5 per cent, had the fourth-highest unemployment rate in South Asia in 2020. The Maldives (5.3 per cent), Bangladesh (5.2 per cent), Sri Lanka (5.2 per cent), and Bhutan (5.0 per cent) had the same unemployment rates in 2020 (see [Table 4.3](#)). The unemployment rates in Afghanistan, Bangladesh, India, Nepal, and Pakistan in 2020 were the highest during the 30 years between 1991 and 2020. In Sri

Table 4.3: Unemployment rate by country, 2019–2022 (%)

	2019	2020	2021	2022
Afghanistan	11.1	11.7	N/A	N/A
Bangladesh	4.4	5.2	5.1	4.7
Bhutan	2.7	5.0	3.9	3.6
India	6.5	10.2	7.7	7.3
The Maldives	4.6	5.3	5.3	4.9
Nepal	10.6	13.1	12.2	11.1
Pakistan	4.8	6.5	6.3	6.4
Sri Lanka	4.7	5.2	5.2	6.7

Data source: The World Bank, <https://data.worldbank.org/indicator/SL.UEM.TOTL.ZS>

Lanka, the entire loss of employment in 2020 was among women, as noted below. The unemployment rates in all South Asian countries continued to be higher in 2021 and 2022 than in 2019 (the year before the pandemic) (see [Table 4.3](#)).

In Sri Lanka, the Central Bank is the custodian of the Employees' Provident Fund/Employees' Trust Fund (EPF/ETF) accounts of private sector employees. According to the annual report of the Central Bank of Sri Lanka for 2020, in 2019 there were 2,914,000 EPF accounts that were 'active', a number that dropped to 2,033,000 in 2020. This means that, in terms of the number of 'active accounts' in the EPF, there was a drop of 881,000 – 30.2 per cent – which was unprecedented. As a corollary, the total number of employers registered with the EPF dropped from 94,171 in 2019 to 70,552 in 2020, denoting a drop of 25.1 per cent. Similarly, the total number of ETF accounts that were active in 2020 dropped by 100,000, from 2,600,000 in 2019 to 2,500,000 in 2020 (–3.8 per cent). The total number of employers registered with the ETF declined by 6,619 from 82,375 in 2019 to 75,756 in

2020 (–8.0 per cent) (Central Bank of Sri Lanka 2021, Statistical Appendix Tables 40, 41).

These huge drops in registered employees/employers cannot be entirely explained by fluctuations in the usual business cycles of the private sector economy and/or the retirement of private sector employees during 2020. Even if we assume that only 500,000 of the 881,000 total falls in EPF accounts was due to the pandemic, this is still nearly triple (275 per cent) the loss of employment (181,600) reflected in the quarterly labour force surveys. More importantly, the labour force surveys account for both formal and informal sector employees/employers, whereas the employees/employers in the EPF/ETF accounts are entirely formal sector employees/employers.

The number of employees/employers in the EPF/ETF accounts pertains to formally registered employees/employers. Hypothetically, if we add 500,000 to this formal sector employment loss of 500,000, to account for informal sector job losses, it appears that at least one million jobs could have been lost in Sri Lanka in 2020, which was 12.2 per cent of the total labour force of around 8,180,693 in 2019. Similarly, the official unemployment rates for all the South Asian countries mentioned above could be huge underestimations.

Furthermore, according to the 2019 annual report of the labour force surveys and the 2020 annual bulletin of the labour force surveys in Sri Lanka, there was also a gendered outcome (DCS 2020, 2021). Specifically, the number of employed females dropped by 185,650 in 2020 in comparison to 2019 (2,811,796 to 2,626,146), the number of employed males increased marginally by 4,051 (5,368,896 to 5,372,947) in 2020 in comparison to 2019. These gender-segregated statistics could reveal at least two critical results: first, significantly more women than men could have been retrenched by their employers as a result of the lockdowns, curfews, and mobility restrictions caused by the COVID-19 pandemic, which appears to have been the case globally (Alon et al. 2020; Andrew et al., 2020; Craig and Churchill 2021; O'Donnell et al., 2021; Seck et al., 2021; Tejani and Fakuda-Parr 2021). Second,

a significant number of women would have voluntarily given up their jobs in order to look after their children, who were confined to homes owing to the closure of schools and preschools for prolonged time periods and a lack of child-care services, which again appears to have been the case globally. On a balance of probability, in Sri Lanka, the latter could have significantly outweighed the former, because the increasing number of women abandoning their jobs may have forced employers to hire an increasing number of men as replacements (Meegaswatta 2021). This is reflected by the fact that there was a marginal increase in the number of employed men (4,051) in Sri Lanka during 2020 (compared to 2019), despite the pandemic.

4.3.5 Impact of COVID-19 on Cost of Living

The prices of commodities (especially food) and goods skyrocketed in most developed and developing countries during 2020, 2021, and 2022, primarily because of disruptions to the domestic and global supply chains of goods and services as a result of NPIs such as lockdowns, closure of wholesale and retail markets, internal and international travel restrictions, closure of airports and seaports, and so on, and later due to the Russian invasion of Ukraine in February 2022 (supply shocks).

Hence, the cost of living in most countries increased substantially in the first three years of the pandemic (2020–2022). However, global prices of certain commodities declined substantially because of a lack of demand (demand shocks) (del Rio-Chanona et al. 2020, S95–S96; Hevia and Neumeyer 2020, 5, 7–8). For example, a barrel of crude oil dropped to lower than US\$50 in 2020 because of the worldwide transport and travel restrictions. However, it picked up in 2021 and was trading at over US\$80 per barrel in September 2021 and increased significantly after the Russian invasion of Ukraine in February 2022. Similarly, global prices of coal and natural gas skyrocketed during the latter half of 2021 and during 2022 from depressed prices in 2020 and the first half of 2021. The pent-up demand for goods and services (in the

aftermath of the pandemic) also pushed the cost of living to new highs in both developed and developing countries.

However, as in the case of employment and unemployment rates, estimations of inflation in South Asian countries have serious methodological and practical shortcomings. Therefore, the following data should be treated cautiously. According to the World Bank, Pakistan had the highest inflation rate (9.7 per cent) in South Asia in 2020, followed by India at 6.6 per cent, Sri Lanka at 6.2 per cent, Bangladesh at 5.7 per cent, Afghanistan and Bhutan at 5.6 per cent, and Nepal at 5.1 per cent. Ironically, the Maldives had deflation (−1.4 per cent) as opposed to inflation in 2020 (see [Table 4.4](#)), which means the demand shock (for example, due to the complete loss of tourism in 2020) outstripped the supply shock to its economy. In Bhutan, India, and Sri Lanka, inflation in 2020 almost doubled compared to 2019. However, in Nepal and Pakistan, inflation slightly declined in 2020 compared to 2019. The inflation in Bangladesh in 2020 was almost the same as in 2019 (see [Table 4.4](#)).

In 2021, inflation continued to rise in Bhutan (7.3 per cent) and Sri Lanka (7.0 per cent) but declined slightly in all other countries

Table 4.4: Inflation rate by country, 2019–2022 (%)

	2019	2020	2021	2022
Afghanistan	2.3	N/A	N/A	N/A
Bangladesh	5.6	5.7	5.5	7.7
Bhutan	2.7	5.6	7.3	N/A
India	3.7	6.6	5.1	N/A
The Maldives	0.2	−1.4	0.5	2.3
Nepal	5.6	5.1	4.1	N/A
Pakistan	10.6	9.7	9.5	19.9
Sri Lanka	3.5	6.2	7.0	50.4

Data source: The World Bank, <https://data.worldbank.org/indicator/FP.CPI.TOTL.ZG>

for which data are available. In 2022, inflation rose in all four countries for which data are available, astronomically in Sri Lanka and Pakistan, where it reached 50.4 per cent and 19.9 per cent, respectively (see [Table 4.4](#)). Both Sri Lanka and Pakistan have been undergoing acute public debt and currency crises since early 2022. Whereas Sri Lanka defaulted on its external debt repayments in April 2022, which continues to date, Pakistan was staring at a possible default at any time during 2023. Afghanistan, Bangladesh, Nepal, and the Maldives are also experiencing severe strains on their respective balance of payments. Thus far, only India and Bhutan appear to be insulated from a possible balance of payments crisis in South Asia.

4.3.6 *Impact of COVID-19 on Remittances*

With rapid globalisation since the early 1990s, international migration for work has accelerated, thereby making remittances from nationals working abroad a significant source of foreign currency earnings to a vast number of low- and middle-income countries around the world. All South Asian countries, barring just the Maldives, are substantially dependent on remittances from their nationals working overseas, especially in Middle Eastern countries. Official data report foreign remittances flowing through the official channels of the banking and financial sector in their respective country. However, a larger amount of foreign remittances flow through informal channels, which in South Asia are called *hundi/hawala* (Wilson 2005).

While foreign remittances contribute significantly to foreign currency reserves and GDP in Nepal (more than 20 per cent of GDP), Sri Lanka (high single-digit), Pakistan (high single-digit), and Bangladesh (5–6 per cent of GDP), they also make moderate contributions in Afghanistan (about 4 per cent of GDP), Bhutan (about 3 per cent of GDP), and India (about 3 per cent of GDP).

With the closure of borders across the world for a prolonged period during 2020–2021 due to COVID-19, it was feared that the vital flow of foreign remittances to many countries would be

negatively affected. However, in South Asia, except in Afghanistan and Sri Lanka, foreign remittances from nationals working abroad in fact increased during the pandemic in terms of absolute amounts (in United States dollars) remitted as well as a share of their respective GDPs. Even in Afghanistan and Sri Lanka, the sharp decline in remittances through official channels was caused not by the pandemic per se but by the fall of the government in Afghanistan in August 2021 and the consequent freezing of the country's foreign assets. In the case of Sri Lanka, arbitrarily pegged exchange rates amid the foreign exchange and public debt crisis drove foreign remittances to informal markets.

While Bhutan (33 per cent), the Maldives (25 per cent), Bangladesh (18 per cent), and Pakistan (17 per cent) experienced

Table 4.5: Remittances in billion US\$ and as a share of GDP by country, 2019–2022

	2019	2020	2021	2022	Annual average 2020–2022
Afghanistan	0.83 4.4%	0.79 3.9%	0.30 2.0%	0.35 N/A	0.48
Bangladesh	18.36 5.2%	21.75 5.8%	22.21 5.3%	21.50 N/A	21.82
Bhutan	0.06 2.2%	0.08 3.6%	0.07 2.9%	0.10 N/A	0.08
India	83.33 2.9%	83.15 3.1%	89.38 2.8%	100 N/A	90.84
The Maldives	0.004 0.1%	0.005 0.1%	0.005 0.1%	0.005 N/A	0.005
Nepal	8.24 24.1%	8.11 24.3%	8.23 22.7%	9.29 N/A	8.54
Pakistan	22.25 6.9%	26.09 8.7%	31.31 9.0%	29.87 N/A	29.09
Sri Lanka	6.75 7.6%	7.14 8.4%	5.52 6.2%	3.60 N/A	5.42

Data source: The World Bank, <https://data.worldbank.org/indicator/BX.TRF.PWKR.CD.DT?locations=8S>

a significant rise in total foreign remittances received in 2020 compared to 2019, Sri Lanka experienced just a 6 per cent rise. However, in absolute amounts, remittances to Bhutan, the Maldives, and Sri Lanka increased only slightly. On the other hand, Afghanistan (−4.82 per cent), Nepal (−1.58 per cent), and India (−0.22 per cent) experienced a drop in total foreign remittances received in 2020 compared to 2019 (see [Table 4.5](#)).

If we consider the average annual total amount of remittances received by each country during the first three years of the pandemic (2020–2022) and compare them to the remittances of each country in 2019, the average annual foreign remittances of all South Asian countries during the first three years of the pandemic increased, except in Afghanistan and Sri Lanka. The foreign remittances of Afghanistan dropped from US\$0.83 billion in 2019 to an average of US\$0.48 billion per year (−42 per cent) during the three years 2020–2022. In Sri Lanka, foreign remittances dropped from 6.75 billion dollars in 2019 to an average of 5.42 billion dollars per year (−20 per cent) during the first three years of the pandemic (see [Table 4.5](#)).

4.4 Conclusion: The ‘Life vs Livelihood’ Binary Revisited

In this concluding section, I evaluate the empirical validity (or not) of the ‘lives or livelihoods’ binary in South Asia based on the earlier presented epidemiological and economic data about all eight South Asian countries and assess the implications thereof for policy responses and state capacity. However, I acknowledge that it is still premature to empirically test this properly because the empirical data (both epidemiological and selected economic indicators) cover up to 2022 and therefore the future economic outcomes after 2022 are still not available. Hence, the following conclusions could be just tentative and may not be authoritative.

As we mentioned above in the conceptual framework, the real choice is between saving lives today to save the economy tomorrow and beyond and losing lives today to lose the economy

tomorrow and beyond. If we apply the foregoing theoretical choice, the countries that have experienced a higher number of deaths caused by COVID-19 proportionate to their population size *should have* performed worse in terms of key economic indicators (GDP growth, unemployment, inflation, and foreign remittances) in the subsequent years.

The empirical data noted above derived from the five tables reveal that the postulated theoretical model has not been realised in all the countries of South Asia. The postulated theoretical model appears to have been tentatively empirically valid in certain countries but not in others. This anomaly could be because of some exogenous factors other than the lack of enforcement of the NPIs and/or the unreliability of casualty data of COVID-19 (both incidences and deaths).

The Maldives had the highest COVID-19 cases per million population (371,356) in South Asia and the second-highest (after Sri Lanka) COVID-19 deaths per million population (622) during the first three years of the pandemic (2020–2022) and had the worst drop in GDP in 2020 (–33.5 per cent). However, the Maldives bounced back remarkably to post the highest GDP growth among the eight South Asian countries in the next two consecutive years, in 2021 (41.7 per cent) and 2022 (11.9 per cent). The unemployment rate in the Maldives remained the same in 2021 (5.3 per cent) but declined in 2022 (4.9 per cent) compared to 2020 (5.3 per cent). Therefore, the postulation that losing lives today (in 2020 and 2021) would save the economy today has been only partially realised in 2021 in the case of the Maldives. Similarly, the postulation that losing lives today would lose the economy tomorrow has not been realised in the case of the Maldives, at least in 2022. The economic data beyond 2022 are still not available.

Sri Lanka had the fifth highest number of COVID-19 cases per million population (31,106) in South Asia (after the Maldives, Bhutan, Nepal, and India) and the highest COVID-19 deaths per million population (779) during the first three years of the pandemic and had the third lowest drop (after the Maldives and India) in GDP in 2020 (–3.5 per cent). Though Sri Lanka posted a modest

GDP growth of 3.3 per cent in 2021, it recorded the second lowest growth in South Asia in 2021 after Afghanistan (−20.7 per cent). In 2022, Sri Lanka posted the lowest GDP growth in South Asia (−7.8 per cent), a pattern that is expected to repeat itself in 2023 as well. The unemployment rate in Sri Lanka remained the same in 2021 (5.2 per cent) but increased in 2022 (6.7 per cent) compared to 2020 (5.2 per cent). In the case of Sri Lanka, the postulation that losing lives today (i.e. in 2020 and 2021) would save the economy today (i.e. in 2020 and 2021) appears to have not been realised.

India had the third highest (after Sri Lanka and the Maldives) death toll per million population (377 – less than half that of Sri Lanka) as a result of COVID-19 during 2020–2022, and the fourth-highest COVID-19 cases per million population in South Asia (after the Maldives, Bhutan, and Nepal), but had the second-highest drop in GDP growth (−6.6 per cent), after the Maldives (−33.5 per cent), in 2020. However, the Indian economy bounced back with the second-highest GDP growth (after the Maldives) in 2021 (8.7 per cent) and 2022 (7.5 per cent). The unemployment rate in India declined to 7.7 per cent in 2021 and further to 7.3 per cent in 2022 from 10.2 per cent in 2020. Like the Maldives, the postulation that losing lives today would save the economy today and lose the economy tomorrow and beyond has not been realised in the case of India either.

As noted above, despite the Maldives having the highest and Sri Lanka the second-highest per capita income in South Asia, Sri Lanka having the highest human development index and the Maldives the second highest in South Asia, and both having among the best healthcare infrastructure in South Asia, they have relatively underperformed in managing the COVID-19 pandemic.

This indicates that physical and material state capacity to manage a global public health emergency, while necessary, may not be sufficient to successfully mitigate the epidemiological and economic impact of such a global public health emergency. Beyond physical and material state capacity, the emotional capacity of the political leadership and the governance capacity of the state

in general could have been of greater value in this global public health emergency.

In the first week of March 2020, then President of Sri Lanka Gotabaya Rajapaksa declared defiantly: ‘Even when we encountered many deaths per day during the civil war, we never shut down the country or economy.’ However, when he imposed an indefinite curfew on 20 March 2020 he confidently stated, ‘We will defeat the coronavirus pandemic in the same way we defeated terrorism’ (Abenante 2021).

Indian Prime Minister Narendra Modi expressed similar triumphalism. Speaking at the annual Davos Dialogue of the World Economic Forum, held virtually on 28 January 2021, he boasted: ‘Today, India is among the countries that have succeeded in saving the maximum lives. The country, which comprises 18 per cent of the world’s population, has saved the world from disaster by bringing the situation (COVID-19) under control’ (NDTV 2021). However, the devastation caused by the Delta variant of the coronavirus in India shortly afterwards is now a matter of historical record.

The triumphalism of leaders such as Modi and Rajapaksa, along with the defiance of the latter, was not unique. In early 2020, the presidents of the United States and Brazil and the prime minister of Great Britain also dismissed COVID-19 as just another viral flu. In the end, the USA recorded the highest number of COVID-19 deaths, with over a million lives lost, while Brazil registered the second-highest death toll, exceeding 700,000.

This overconfidence was not limited to politicians. On 13 March 2021, *The Economist*, in an article titled ‘India Seems to Have Suffered Surprisingly Few Deaths from COVID-19: What Explains Its Apparent Success?’, quoted a customer of an upmarket hairdresser in Delhi, who remarked, ‘We’ve killed it. COVID came to India, but we were so grubby and diseased it just bounced off, rolled over, and died’ (*The Economist* 2021). In stark contrast, many countries led by women mitigated the impact of COVID-19 far more effectively than their male counterparts. Jacinda Ardern, then prime minister of New Zealand, stood out among a cohort

that included the leaders of Bangladesh, Germany, Iceland, Norway, Taiwan, and others (Aldrich and Lotito 2020).

Reflecting on the pandemic, Dr Vinh-Kim Nguyen, a global public health specialist, observed: ‘What I have learned about pandemics is you have to be very humble. There is no mission-accomplished moment’ (Fletcher 2020). Echoing this sentiment, US Secretary of State Antony Blinken remarked on 5 April 2021: ‘This pandemic won’t end at home until it ends worldwide’ (Department of State 2021).

Both the epidemiological and economic data presented in this chapter indicate that, in terms of both the deaths caused by COVID-19 and the economic impact of COVID-19, Sri Lanka was the worst-affected country in South Asia and Bangladesh was the least affected country. Ironically, Sri Lanka was and is a model for human development in the aftermath of the Second World War, drawing plaudits from Nobel laureates such as Amartya Sen in the 1980s and 1990s. In contrast, Bangladesh, which was once infamously characterised as a ‘basket case’ by Henry Kissinger (Tripathi 2021), has confounded development theorists.

Notes

- 1 A more detailed discussion on the theoretical and practical possibilities of the macroeconomic impact of COVID-19 is given in Sarvanathan (2024).

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PART II

Meso Approaches: State–Workers

CHAPTER 5

Citizens' Plight and State Responsiveness in India

Comparing State and Substate Responses in Bihar, Rajasthan, and Uttar Pradesh

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Abstract

The novel coronavirus pandemic has emerged as one of the most serious humanitarian crises of our time. The unprecedented scale and speed of the outbreak took the world by surprise; within just five months (from December 2019 to April 2020), the virus spread to 171 countries, infecting over a million individuals. This chapter illustrates how, in India, the pandemic has resulted in a significant loss of livelihoods, particularly for those already on the margins of society. The lockdown specifically caused millions of migrant workers in urban areas to lose their jobs and homes. Government estimates indicate that over ten million migrant workers were forced to return to their home states. Through the analysis of two

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city-level cases and one subnational case, this chapter highlights the role of local bureaucrats and state governments in managing the crisis. In particular, the subnational government of Bihar is examined, as it dealt with the considerable influx of returning migrant workers during the COVID lockdowns.

5.1 Introduction

The COVID-19 pandemic spread quickly and dramatically. By 15 February 2020, India had confirmed three cases, a figure that soared in just two months to 34,863 by 30 April 2020. The first wave occurred from March 2020 until January 2021, starting with six cases on 2 March and peaking at 96,793 on 17 September, before falling to 11,528 daily cases by 31 January 2021. A more severe second wave struck between March and April 2021, with daily cases rising from 11,563 on 1 March 2021 to an unprecedented 402,110 by 30 April, marking some of the world's highest levels. At the height of the crisis, in September 2020, India recorded 0.84 deaths per million people – slightly above Germany, the UK, France, and Canada, yet significantly lower than the USA, which registered 2.48 deaths per million. Importantly, by 30 January 2021, India had the lowest COVID-related mortality rates (Jha 2022). The notable drop in cases and fatalities following the September peak surprised state officials. Acknowledging that India's reported figures are approximate, with some models suggesting higher counts, is essential. A revised estimate proposed that COVID-related deaths ranged from 3.1 to 3.4 million between 2020 and 2021 (Jha 2022). While this situation posed grave concerns for a densely populated nation of 1.4 billion, the death rates remained relatively low, given the population's size and diversity.

At the start of the pandemic, the prime minister (PM) introduced the Janata Curfew (People's Curfew), urging citizens to remain indoors for 14 hours. Following this curfew period, he declared a nationwide lockdown lasting 21 days, commencing on 24 March 2020 (PIB 2020). This lockdown was subsequently

extended in phases – first until 3 May, then until 17 May, and finally until 31 May 2020.

The lockdown, considered the world's most stringent, lasted for 68 days. The phased planning of the lockdown demonstrates that the state's responses adapted to the evolving situation. Initially, the stringent measures effectively reduced the virus's transmission, but they also created two artificial pressure points. The first of these, explored in the chapter by Sharma and Swenden in this volume, affected the relationship between central and state governments, even though cooperation was vital to navigate the alternative legal pathways mentioned earlier. For instance, the Epidemic Disease Act (EDA) and the Criminal Procedure Code are administered by state authorities, while the Disaster Management Act grants the central government authority over the states (Jha 2022).

Second, the lockdowns imposed by the government resulted in a significant increase in migrant workers returning to their home states. Estimates suggest that over ten million migrant workers were on the move during the lockdown (Rajan and Bhagat 2022). These individuals faced various mental and physical hardships, particularly the imminent loss of their jobs and difficulties in securing transport. Many had to walk hundreds of miles or seek alternative means, such as bicycles, to escape both the pandemic and the lockdown. As a result, numerous migrants found themselves stranded. A widely reported account illustrates the challenges encountered during this period – 15-year-old Jyoti Kumari, who, along with her injured father, became stranded in Gurugram, a major city in the National Capital Region known for its large migrant population. Ms. Kumari cycled 1,200 kilometres, averaging 100 kilometres each day, to reach her hometown, carrying her injured father on her bicycle's carrier (Ray 2020). The migrant crisis is replete with stories like hers. Many migrant workers, particularly daily wage labourers, experienced severe disruptions to their livelihoods during the lockdown in urban areas. One worker recounted, 'I have a one-year-old daughter and a mentally distressed husband. I need to buy medicine for them, but I have

no cash' (Dhorajiwala and Narayanan 2020, 3). Others conveyed their fear of isolation in the city: 'Being alone in a city is terrifying. I would not want myself or my children to endure that again, especially when we have no one to rely on' (IHRB 2020, 19).

The movement of people between different states posed challenges for both central and state authorities. In March 2020, numerous migrants travelled through Gurugram, Haryana, towards Delhi, eventually gathering at the Ghazipur border before proceeding to Uttar Pradesh (UP), with many aiming for Bihar in the east. While transportation options were available, confusion prevailed over whether these were designated for migrants or essential services. Consequently, numerous individuals were often denied access to these vehicles (*Live Mint* 2020).

On 26 May 2020, the Supreme Court of India addressed the escalating migrant crisis. It instructed both central and state governments to provide reports on their initiatives to improve deteriorating conditions (Supreme Court of India 2020). In their responses, both authorities acknowledged that since 1 May 2020, they had initiated special Shramik (labour) trains and buses to transport migrants at no cost. State governments and the railways supplied food, shelter, and relief camps. A total of 5.1 million individuals were moved by these special trains, and 4.1 million workers were returned to their home states via bus. Unfortunately, these state-sponsored travels worsened the difficulties faced by migrant workers, as the trains frequently deviated from their scheduled routes by hundreds of kilometres and were overcrowded, with limited access to water (Sridhar 2020). Reports indicated that around 80 migrants lost their lives during their journeys to their destinations (M. Sharma 2020). Subsequently, on 28 May 2020, the Supreme Court issued clear instructions to the central and state governments (see [Box 5.1](#)).

Coordination between central and state governments in addressing the migrant crisis faced numerous challenges, including transportation, shelter, food supply, and the management of millions of individuals crossing state borders to return to their villages while adhering to COVID protocols. As the situation

**Box 5.1: Supreme Court instructions to the
central and state governments**

1. No fare either by train or by bus shall be charged from any migrant workers. The railway fare shall be shared by the States as per their arrangement as submitted by the learned Solicitor General and in no case any fare should be asked or charged from any migrant workers by the States and the Railways.
2. The migrant workers who are stranded at different places in the country shall be provided food free of cost by the concerned States/Union Territories at different places which shall be publicized and notified to them during the period they are waiting for their turn to board the train or bus.
3. Initially, as stated by the learned Solicitor General, the originating State shall provide water and meal and during the journey, the railways shall provide meal and water to the migrant workers and same facilities shall be extended when the migrant workers are transported by bus. The State shall take care of providing necessities water and meal during the period of transportation either in the bus or in the camps on the way.
4. We further direct that the State shall simplify and speed up the process of registration of migrant workers and also provide help desk for registration at the places where they are stranded.
5. The State shall try to endeavour that after registration the workers should be asked to board the train or bus at the earliest and complete information should be publicized to all the concerned regarding mode of transport.
6. We further direct that those migrant workers who are found walking on the highways or roads shall be immediately taken care by the concerned State/Union Territories

and they shall be provided the transport to the destination and all facilities including food and water be provided to those found walking on the road.

7. The receiving State, after the migrant workers reach his native place, shall provide transport, health screening and other facilities free of cost.

Source: SC Record of Proceedings in Problems and Miseries of Migrant Workers, Suo Motu Write Petition (Civil) No (s).6/2020, May 28 [Web] https://api.sci.gov.in/supremecourt/2020/11706/11706_2020_34_24_22239_Order_28-May-2020.pdf

evolved, 2,226 orders issued by both central and subnational governments contributed to the confusion (COVID-19 Government Order Tracker n.d.). Following a severe second wave, subnational governments implemented COVID-specific orders to enhance preparedness. These announcements outline clear legal pathways aimed at resolving existing uncertainties. For example, in May 2023, the Bihar government's Department of Health introduced COVID-related regulations known as The Bihar Epidemic Diseases, COVID-19 Regulation 2023. These regulations define administrative roles and authorities, establish standard operating procedures for healthcare facilities, impose penalties for concealing infections, and set district-level protocols (*The Bihar Gazette* 2023).

This chapter will examine COVID management at the subnational level (i.e. state and local), focusing on the effects of local bureaucracy and the collaboration between subnational governments and the central government. While notable flaws in centre-state coordination and centralisation are evident (Singh 2020), also discussed by Sharma and Swenden, elements of cooperative federalism are apparent throughout different phases of the pandemic response. I will first address pandemic management concerning migrant workers in Bihar. Next, I will analyse the district

level, paying special attention to Bhilwara in Rajasthan and Agra in UP. Bhilwara's substantial migrant workforce, which primarily supports the textile, brick kiln, and sandstone quarry sectors, provides valuable insights. In contrast to Bihar and Agra, Bhilwara faced challenges with outbound migration rather than instances of stranded migrants arriving. During May 2020, many migrant workers, primarily from Bihar, protested in Bhilwara for safe travel as factories were shut down and their wages ceased after April 2020. Property landlords insisted on rent payments, further compounding their hardships (Hussain 2020). Lastly, I will present some comparative analysis at the local (*panchayat*) level, particularly regarding Bihar.

5.2 COVID-19 Management at the Subnational Level

5.2.1 *Migrants and COVID Management in the State of Bihar*

The lockdown from March to May 2020 compelled many migrant workers to return to their hometowns after losing their jobs and facing uncertain futures. Approximately 2.5 million migrants returned to Bihar during the lockdown (Pathak 2022). This situation posed a potential crisis for the state owing to the anticipated rise in COVID-19 cases associated with these returning migrants. Coupled with already strained administrative resources, the influx of these migrants exacerbated existing public management issues encountered by local authorities. How did Bihar tackle these significant challenges?

Before the national lockdown, Bihar implemented a lockdown from 22 March to 31 March. The state conducted health screenings for all international and domestic travellers and released communiqués to increase awareness and stipulate preventive measures against infections. The Bihar State Health Society issued advisories in February 2020. On 13 March, the government closed venues for large gatherings, including schools and shopping

centres. All gatherings were prohibited and the health infrastructure was bolstered with an additional 100 ventilators in government hospitals and the establishment of COVID testing centres in the capital. Health department officials had their leave cancelled, a crucial step considering there was one hospital bed for every 9,000 residents in the state. Two key aspects are highlighted: the Bihar Epidemic Diseases, COVID-19 Regulation 2020 allowed the state to manage COVID autonomously, granting authority for mass screenings, mandatory isolation of suspected cases, localised lockdowns, and legal repercussions against those who concealed symptoms or failed to adhere to the regulations.

The regulation empowered key personnel overseeing COVID responses at the district level, including the district magistrate (DM), civil surgeon, additional chief medical officer, subdivisional magistrate, and the overseeing medical officer, to make vital decisions and take essential actions. For example, clause 3 allowed officials to hospitalise or isolate individuals who had recently visited COVID-affected areas or were suspected of being in contact with infected persons. This clause also authorised them to enforce mandatory hospitalisation and isolation. The state administration was permitted to enter premises if they suspected the presence of a symptomatic individual, which allowed for either quarantining the site or the individual in a designated facility, depending on the circumstances. If an individual refused, the DM had the authority to act under section 133 of the Code of Criminal Procedure (1973) or employ other necessary coercive measures.

The situation in Bihar highlights the crucial role of policy learning in addressing COVID-19. In July 2020, Pratyaya Amrit took the position of principal health secretary. Amrit's new role was informed by a successful disaster management stint in the state, such as the adept handling of the devastating Kosi River floods in 2008. Renowned for his skill in managing complex departments, Amrit has been instrumental in revitalising struggling sectors, such as road and bridge construction and electricity reforms, across the state. His previous experiences with policy learning significantly influenced his appointment to lead the state's pandemic

response. Meanwhile, the state administration acknowledged that the pandemic presented new challenges, necessitating substantial policy adaptations and improved coordination. As Amrit noted,

I have been in the disaster management department for almost four years and have been part of the Kosi River flood disaster team (one of Bihar's most devastating floods which occurred in 2008) and other disasters in Bihar. But this is different from the floods and other disasters we have faced in the past. (Rediff Interview)

For instance, Amrit assembled a focused core team that achieved success in various scenarios. They also introduced a three-tier fund distribution system that effectively addressed past crises. Moreover, insights from earlier policy innovations played a vital role in establishing an integrated call centre with a dedicated hotline at 104, which served as the primary point for related issues. The COVID Call Centre 104 handled inquiries about COVID and directed citizens to appropriate health facilities for additional care or testing as needed. It was designed to collaborate closely with the newly established state surveillance unit. The decision to create the 104 COVID call centres was inspired by a similar ICT-driven innovation from 2007, known as the Jaankari call centre – a name that translates to 'information' in Hindi. Jaankari was a pioneering ICT governance initiative that enabled residents from any part of Bihar to submit a right to information (RTI) application via the call centre (Jha 2018). This marked the first instance of any state in India conducting an experiment to implement RTI. The integrated call centres in other states also served as useful references. Additionally, lessons from the per capita household pulse polio campaign informed a similar COVID screening strategy across four districts in the state (Niti Aayog 2024, 12).

In an earlier discussion referencing Hecló (1974), I noted that a vital aspect of developing policy responses is the exchange of ideas among various stakeholders in the state (Jha 2023). This exchange occurs after the state's 'learning' phase, which promotes better understanding and informed decision-making (Hecló 1974, 305).

The Bihar CoVID-19 Emergency Response Team was established within the health department (Government of Bihar Order 2020), with assistance from senior bureaucrats responsible for coordinating and managing the pandemic response.

The substantial influence of the administrative state is apparent in its management of the influx of migrants from various regions of India. By May 2020, 500,000 migrants had arrived, alongside over 1,000 confirmed COVID-19 cases. The Disaster Management Department conducted a comprehensive analysis of testing rates among these migrant workers and their origins, which informed the establishment of a three-tier quarantine system (Thakur 2020). A similar three-tier model was introduced by the Kerala government (Verma 2020).

Migrants from major urban centres in northern and western India, identified as coronavirus hotspots, were classified as 'Category A' and quarantined at the block level. Those from smaller towns were categorised as 'Category B' and quarantined at village centres. Asymptomatic migrants were allowed to return home after completing a 14-day quarantine period. All migrant workers were registered at the block level, linking their bank accounts and Aadhaar cards to the Public Financial Management System (PFMS) to facilitate exit assistance for migrant labourers (Government of Bihar 2020).

The November 2020 state elections intensified existing management issues. Growing concerns over virus transmission during large campaign events and voting led the state to declare a high alert status. New measures were implemented to penalise violations of COVID protocols, resulting in the arrest of 6,740 individuals for non-compliance on the first day of enforcement. Authorities swiftly imposed fines amounting to 0.337 million rupees within just 24 hours. To increase awareness, the state health department published full-page newspaper advertisements urging residents to wear masks. Furthermore, local authorities were granted the power to act against high-profile individuals.

The mobility demands of residents in Bihar resulted in cooperation between states. Relationships among subnational entities

formed the foundation for both collaboration and conflicts. For example, states joined forces to assist stranded workers and students attempting to return to Bihar. To streamline these initiatives, various states appointed nodal officers to coordinate with Bihar's Department of Disaster Management (Order of Disaster Management Department 2020). However, such cooperation occasionally ignited tensions between states. At the height of the pandemic, the DM of Kaimur, Bihar, received a notification from the DM of Chandauli in UP, indicating that approximately 50 private vehicles were transporting Bihari students from Kota, Rajasthan, back to Bihar (Kumar 2020). Kota, known for its many coaching institutes for competitive exams, attracts a significant number of these students.

The response of the Bihar state administration to COVID-19 reveals four important insights. First, it highlights the development of a strong state capable of making independent decisions, showcasing the empowering role of the government. This autonomy is underscored by an incident of authorities imposing a police case on three members of the legislative assembly for flouting Covid norms (Thakur 2020). Second, the establishment of task forces and their regular meetings to strategise demonstrates the state's active approach in addressing policy uncertainties (Jha 2022). Third, the initiatives to empower and manage uncertainties draw upon lessons learned from successful past policies and best practices (Jha 2022). Lastly, the state's policy responses have evolved alongside the pandemic, indicating continuous adjustments to the changing circumstances.

The policy changes implemented during the first wave did not yield clear or effective results, possibly owing to the evolving public management strategies related to the pandemic at the time. During the second wave, the Bihar government's actions were markedly inconsistent. The Patna High Court questioned the government for misrepresenting the state's health infrastructure, oxygen supply, and COVID-19 death counts, calling it an 'infodemic'. In response, the state health department established district committees to verify and rectify the reported death tolls (Rajesh Kumar

2021). The situation deteriorated as migrant workers returned from various regions of India (Manoj 2021). The worsening situation during the second wave was reported from various districts. Villagers pointed out that very few doctors visited already scarce health centres and people were unaware of the risks. A former member of the village committee said:

Though the exact cause is not known as villagers did not undergo test, at least 26 people of my village have died in the last 20 days. I am 50-year-old, but I have not seen so many deaths in my village in such a short time. Some of the victims had cough, fever and breathing problems. Not to talk about the poor and illiterate, even some educated people of my village do not wear mask regularly or properly. (as reported in the *Times of India* news story by Ruchir Kumar, 2021)

The absence of a long-term policy framework resulted in an inadequate response during the second wave. Despite the existing lessons from the first wave, there was no substantial policy response during the second wave, leading to minimal new infrastructure and weak oversight measures. Like the national government, the state government found no justification for a lockdown, even as Bihar faced the added challenge of returning migrants from urban centres.

5.3 COVID Management at the District Level

A strong administrative state was also evident at the district level, particularly in Bhilwara (Rajasthan) and Agra (UP).

5.3.1 Bhilwara (Rajasthan)

After the first COVID-19 case involving a private doctor was reported on 18 March 2020, the potential for widespread community transmission posed a significant public health challenge for Bhilwara, a town of approximately 2.7 million residents (Golechha 2020). Bhilwara, recognised as a hub for the textile industry and

home to a large migratory population, encountered additional difficulties in managing the movement of migrants. To curb the outbreak, the administration implemented five key strategies. First, under the EDA, the district administration acquired the authority to take control of all hospitals, hotels, and private buildings to facilitate effective COVID containment efforts.

The district administration also implemented a multisectoral strategy, collaborating with relevant departments such as public health, the police, local municipalities, the local disaster management task force, and community organisations. A curfew was enacted in the town under section 144 of the Code of Criminal Procedure, prohibiting gatherings of more than five individuals. Borders were closed to isolate the town from neighbouring areas, restricting the movement of people. Furthermore, proactive contact tracing and cluster mapping were carried out, enabling the administration to target specific clusters and establish buffer zones to impede the spread of the disease. In addition, 2,232 survey teams were dispatched to both urban and rural regions for large-scale surveillance and thorough screening.

Each supervisor managed a group of ten teams, concentrating screening efforts in identified epicentres and among migrant populations. This screening was conducted in two phases. The first phase, from 21 to 28 March, involved a door-to-door survey to identify individuals exhibiting influenza-like symptoms, leading to the identification of 19,000 cases that were subsequently quarantined by the district administration. A comprehensive list was compiled detailing the names and addresses of those with COVID-like symptoms. In the second phase, additional surveys and screenings were conducted for those on the initial list, facilitating further isolation of cases. This follow-up phase was executed from the village to the block level, and within 24 hours a new list was prepared for continuous monitoring. The monitoring team reported directly to the additional DM, a senior official within the district administration. Lastly, the district swiftly bolstered its health infrastructure by acquiring hotel rooms and educational hostels to establish quarantine centres. The public health facilities

in hospitals were expanded by increasing the bed-to-patient ratio, and four private hospitals were secured for the establishment of COVID wards.

In Bhilwara, the responsiveness of the bureaucracy ignited the political will of the chief minister. The testing and tracing efforts were particularly robust in Bhilwara. As a result, the administration deemed it necessary to seal the borders. However, simply closing the city borders proved inadequate; the entire district required sealing. Rajiv Bhatt, the DM managing the situation, convinced the chief minister.

Initially, we thought to seal just the city, but then we realized it would be necessary to seal the entire district if we have to contain the spread. Hence on March 19, the district was locked down. Entire state machinery was at our disposal, thanks to the CM actively monitoring the situation, which helped us get quick orders to halt the town's buses and trains. (T. Sharma 2020)

Bureaucrats played a crucial role in effective pandemic management, underscoring the state's underlying rationalities. Notably, Rajendra Bhatt, the DM of Bhilwara, is credited with the town's success. The collaboration between the DM, the superintendent of police, and various district administrators showcased the state's intricate manoeuvring in planning the containment strategy. Bhatt's extensive local knowledge significantly contributed to policy learning. As Bhatt stated, 'I've worked in the cooperative service all my life ... I know how the supply and demand works in the rural and urban parts of Rajasthan, so all that experience was very useful to me' (Dhingra 2020). This was corroborated by another administrator who was on the team: 'The fact that he has so many years of experience and he is so embedded in the system in the State helped ... He would give directions, and we would just follow, and everything went on smoothly' (Dhingra 2020).

The harsh lockdowns and strict tracing and tracking measures imposed by authorities adversely impacted marginal workers living on the brink. They faced job loss, severe food shortages, and

considerable uncertainty. A Bhil Adivasi worker from the sandstone quarry in Bijolia shared their experiences:

This is a mining area and we are all very poor. All work in the mines has stopped ... The police and the administration have said 'stop work', and people have no money. Cities and banks are closed and people cannot get any cash. We are not able to get food services. Section 144 is imposed and we cannot go out of our homes. (Yadav 2020)

The local government in Bhilwara implemented measures to mitigate the adverse effects of the pandemic lockdown on economic activity. It introduced concessions, including flexible working hours, customised electricity and water supply options, transportation support, and a dedicated financial package for migrants (TNN 2020).

5.3.2 Agra City (*Uttar Pradesh*)

Like Bhilwara, Agra – situated in western UP and famed for its iconic Taj Mahal – effectively navigated the initial wave of the pandemic. Various municipal departments collaborated through the existing Smart City Integrated Command and Control Centre. This initiative included the establishment of cluster containment areas within the city. For example, a potential hotspot was secured within a three-kilometre radius, augmented by an additional five-kilometre buffer zone. Prabhu N Singh, the DM of Agra, highlighted the effectiveness of this strategy. After the detection of first six cases (3 March), '[w]e focused on the door-to-door survey, identification of infected cases and placing them in quarantine. The outcome is that the cases testing positive now are mostly those already in quarantine' (Chaturvedi 2020).

The Agra model underscores the significance of policy learning. The household survey conducted by the city administration drew on insights from a previous polio vaccination campaign in both its methodology and approach (Qureshi 2020). In these containment zones, urban health centres catered to incoming patients,

while a team of over 1,000 carried out household screenings for 0.93 million homes. This strategy proved effective, particularly in densely populated cities like Agra, which experienced early community transmission. The city government prioritised rigorous contact tracing and isolation measures to manage this outbreak, implementing these strategies early in the pandemic when only six cases had been confirmed by early March 2020.

5.4 COVID Management at the Grassroots: The Role of Village Administration

The panchayats, the lowest administrative unit at the village level, represent a vital component in the implementation chain. During the height of the pandemic, the PM conducted video conferences with village heads (sarpanches). The PM credited the panchayats for effectively promoting the Do gaj Duri (six feet distance) campaign to ensure social distancing. In Kerala, these village governments played a crucial role in enforcing quarantine measures and conducting testing and screening (Sahoo 2020; Surendran in this volume). Kerala's strong tradition of decentralised governance has contributed to its proactive village governments. In Odisha, the chief minister enhanced the authority of village heads by granting them DM powers under the relevant provisions (Sahoo 2020). In contrast, while Bihar's panchayats are generally weak with limited capabilities, they displayed increased dynamism during the COVID crisis.

In Bihar, the elected village head (mukhiya) collaborated with local authorities to raise awareness and secure logistical support. The villages, especially in Bihar, experienced a significant influx of returning migrants from urban areas. The initial step involved elevating awareness and directly reaching out to the families of the returnee migrants. Some mukhiya from villages in the Rohtas and Samastipur districts shared their insights: 'So far, no positive cases of COVID-19 among migrant workers have come to our notice. But we are maintaining a strict vigil on them and ... we are alert

and keeping a close surveillance on returning migrants to the villages' (Ramashankar 2021).

A study conducted during this period revealed that the village administration played a crucial role in managing the local pandemic. This administration, in collaboration with the mukhiya, selected buildings for quarantine, arranged tracking and testing for incoming migrants, organised logistics such as food for the quarantine centres, and facilitated transport to nearby hospitals for the sick. They also issued job cards under the Mahatma Gandhi Rural Guarantee Scheme and ensured the direct benefit transfer of 500 rupees from the central government, alongside a one-time 1,000 rupees from the state government (Sarma and Telidevara 2020).

The emergence of a robust and independent state at the village level challenges the prevailing belief that village governments, particularly in regions like Bihar, are dominated by exploitative networks of vested interests. During the pandemic, village administrations demonstrated remarkable insularity – an established trend in southern states but significantly absent in weaker states like Bihar. Specifically, Sahapur village in Gaya District harnessed traditional knowledge systems to protect itself from COVID waves, effectively maintaining enforced lockdowns with limited external interaction (Chaurasia 2022).

In UP, the most populous subnational state in India, a campaign titled 'Mera Gaon Corona Mukta' was launched to reduce COVID-19 cases (Times Now Bureau 2020). The campaign focused on screening, testing, and vaccination, supplemented by monetary rewards for the three most successful villages. This initiative proved effective, with UP reporting fewer than nine cases on 10 September 2021. Following UP's success, other states also adopted the model. Initially, the campaign involved all village-level healthcare workers and institutions to conduct door-to-door screenings, supported by an awareness initiative named 'COVID Samvedikaran Abhiyan' (COVID Sensitisation Campaign) (Raina et al. 2021).

5.5 Conclusion

I contend in this chapter that the abrupt onset and severity of a pandemic like COVID-19 should be regarded as a critical juncture for policy learning (Sinha 2023). The public management of the pandemic in India has highlighted limited, short-term, albeit targeted policy interventions. For instance, most measures regarding stranded migrant workers concentrated primarily on relief and transportation efforts to alleviate immediate challenges. Such a fragmented and reactive policy approach will prove inadequate if the world faces a similar pandemic and humanitarian crisis again. The situation of migrants underscores the necessity for a unified policy framework at both subnational and central levels. The reliance on disparate policy lessons resulted in adverse outcomes during the second wave. Bihar's lack of preparedness was evident through its inadequate infrastructure, testing, and surveillance when confronted with another influx of migrant workers during the second wave (Ray 2021). As the pandemic progressed, the policy tools and objectives from the first wave did not provide substantial insights for the second wave. In this later phase of the pandemic, the absence of effective policy learning generated uncertainties, causing the state administration to struggle.

The lessons learned from the pandemic should lead to a sustainable and cohesive policy framework. Furthermore, the policy tools and objectives ought to be robust enough to adapt to pressing challenges while providing implementers with sufficient flexibility. Notably, an expert group was established under the Niti Aayog (Policy Commission) to draft a report titled 'Future Pandemic Preparedness and Emergency Response – A Framework for Action' (Niti Aayog 2024). This report outlines strategies for managing a pandemic during the critical 100 days following its emergence, focusing on governance, policy options, finance, data management, infrastructure, capabilities, and partnerships beyond the state. The expert group also advocates for a dedicated Public Health Emergency Management Act. Nonetheless, these recommendations must be seamlessly integrated into a unified policy

framework to prevent gaps and shortcomings. For instance, the report overlooks the migrant crisis and fails to provide recommendations for addressing such issues in a pandemic context.

Second, the public management of the pandemic in urban and rural areas underscores the capacity of local bureaucracy. Integrating local bureaucracy allows adjustments to existing policies that resonate with grassroots realities, promoting policy innovation within the current politico-legal framework. This was evident in the subnational cases examined in this chapter. Subnational examples emphasise the importance of local bureaucracies in implementing targeted policies that operate within the existing legal framework. In such scenarios, the central framework supported local bureaucracies rather than hindering them. Furthermore, managing the migrant crisis enhanced interstate cooperation while also being a source of conflict.

The public management of COVID-19 underscores the need for a comprehensive long-term policy that reflects the lessons learned. This is especially crucial for regions with limited capacity, necessitating adjustments and coordination across various levels of government.

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CHAPTER 6

COVID, Crisis, Precarity, and Social Protection in Nepal

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Abstract

Nepali young men and women have sought to escape from difficult economic situations at home as migrant workers in the far-flung economies of India, the UK, the Gulf, East Asia, and other global destinations, often on paradoxical terms of precarious employment and widespread reports of ill-treatment, with profound consequences for those left behind. The COVID-19 crisis had an immediate intimate impact on Nepali migrant workers' welfare and protection, prompting their return. Briefly, it interrupted outmigration flows and had a negative impact on migrant households given that over half of Nepali households sent a family member to work abroad and received remittances. Yet, within a few months, migration and remittance flows had resumed because economic conditions at home remained dire and there were no financial opportunities. Furthermore, while there was a 'sudden visibility' of migrants and their precarity in media reports

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calling for protection and some speculation on whether the pandemic would prompt massive return migration, evidence from Nepal was anything but clear.

6.1 Introduction

On 7 September 2020 the *Nepali Times* reported: ‘Three months after nearly 400,000 Nepali workers returned from India following the COVID-19 lockdown, many are now headed back because they have not been able to find jobs in their home country’ (Nepali Times 2020c). The report quoted a male Nepali migrant who had returned from Gujarat in India: ‘With the joblessness and fear of the virus, we thought it was better to die in our own land near our families than in a foreign country.’ However, it was not long before he and many thousands like him found that they were stuck between a rock and a hard place. In Nepal, there were family expenses but no earnings and the savings were gone. He crossed into India on 7 September 2020 after hearing that his friends had safely returned to their workplace. He was to try to get a train to Mumbai, where he had relatives. He did not have a confirmed job but was planning to stay with them while he looked for one. The report quoted him: ‘Everything is uncertain, but the likelihood of finding a job is higher there than here, and I am glad I have an Indian Aadhaar card as without it, I would not have been allowed back.’ He was admitting that he might have to return to Nepal if there are no jobs in Mumbai, highlighting the precarity in rural Nepal, where, despite perceived risks, poorer households are left with little choice but to search for work via migration.

Judith Butler (2015) has defined precarity as ‘the politically induced condition in which certain populations suffer from failing social and economic networks of support more than others, and become differentially exposed to injury, violence, and death’ (2015, 33). Here, precarity allows us to understand the suffering of certain population in the context of abandonment of social and economic support and networks. In recent scholarship, precarity has been widely discussed as a condition of millennium

capitalism to refer to economic insecurity, systematic exploitation and increased marginalisation from the loss of economic and social protection in the context of the impact of neoliberalism in the labour market (Standing 2011). Yet we know that precarity has been a historical reality in Nepal. Thus, any discussion on the suffering of migrant workers in the context of COVID-19 crisis should be located in the specific historical and structural context of Nepal.

Unlike in the West, a very different history of capitalist development has largely prevented the development of a formal state-sponsored social protection system in Nepal (Piper et al. 2017; Sharma 2021). Lack of industrialisation and a weak absorption of labour in the service sectors has further forced large numbers of people, both young men and women, to migrate in search of foreign employment as a livelihood strategy to address precarity in Nepal. This has been supported by the Nepali state's policy of externalising its economy, which started with the recruitment of Nepali men as Gurkhas in the British Army and has expanded so much that migrant remittance has become the lifelines of Nepal's national economy, with a contribution of over 30 per cent of Nepal's GDP (Hutt 2020; Sharma 2021). This exclusive reliance on migrant remittances, while working to make the Nepali economy and household livelihoods resilient from various economic, political, geological, and environmental fragility and shocks, including key support to maintain Nepal's balance of payment, has simultaneously fuelled Nepal's dependency on global financial volatility.

Global crises, such as the COVID-19 pandemic or economic recession, have an impact on the livelihoods and incomes of already fragile Nepali households, particularly given that Nepal is heavily dependent on international labour migration, with evidence suggesting that almost half of the households have at least one migrant worker abroad and receive remittances (Adhikari et al. 2022). Travel restrictions and lockdowns brought immediate uncertainties to the lives of the low-income migrant workers, including those stranded in different destinations as well as in the border points with little support. Additionally, the onset of the

pandemic meant that the aspiring migrant workers were forced to navigate uncertain futures.

It is in this context that I seek to assess the impact of the COVID-19 pandemic on Nepali migrants and the economic hardships and uncertainties associated with it. I argue that the COVID-19 crisis had an immediate intimate impact on Nepali migrants' welfare and protection, and prompted return migration. It interrupted outmigration flows and had an immediate negative impact on migrant households, given that over half of Nepali households sent a family member to work abroad and received remittances. Yet, within a few months, migration flow had resumed because there was no economic opportunity at home. Thus, while there was 'sudden visibility' of migrants and their precarity in media reports, this did not result in major initiatives to address migrant precarity.

6.2 Macroeconomic Context and Pre-existing Precarities

A quick look at Nepal's macroeconomic indicators offers some impressive gains. Nepal's GDP increased from US\$500 million in 1960 to US\$3.63 billion in 1990 and then to US\$42 billion in 2023 (World Bank 2023). Similarly, per capita income in 1960 was US\$50, which increased to US\$1,400 in 2023 (World Bank 2023). Likewise, there have been notable improvements in different indicators of welfare and social development, which is mainly due to increased household income from remittance inflows (Lokshin et al. 2010).

Despite notable economic growth, declining poverty rates, and improvement in welfare indicators, recent evidence shows that a significant number of people (56 per cent) in Nepal were in the near-poor category, indicating their vulnerability (Sijapati 2017). Reports from UNICEF (2009) and FAO (2008) show that shocks associated with the food price increase in 2008 pushed 6.5 million to 10.5 million people, or as many as 30 per cent of Nepal's population, into hunger. This had increased from at least two million

in 2005 figures (Koehler 2011, 5), indicating the vulnerability of Nepali households to global economic volatility and shocks.

Historical and ethnographic evidence show that precarity has been an existing economic reality in Nepal pushing people to out-migrate in search of livelihoods. Thus, Nepali migrant workers' journey to their chosen destinations of work has been a livelihood strategy undertaken to mitigate precarity at home (Sharma 2021). Without any systematic social protection, migration itself has thus evolved as a form of social protection for many households using remittances to secure their basic needs and livelihoods. Yet migrant workers and their families are regularly exposed to new forms of precarity and costs associated with labour migration.

First, exploitative socio-economic relations of production and extractive state policies have created conditions for the impoverishment of the peasantry prompting them to out-migrate in search of livelihoods (Blaikie et al. 2002; Regmi 1976, 1978; Shrestha 2001). In the 18th and 19th centuries, the destitution of the peasantry was maintained through three key interrelated domains of power: unequal distribution of land, use of forced labour, and extraction of rent (Regmi 1976). Land distribution was unequal and was based on loyalty and caste-based patronage networks. This benefited high castes and people with networks in the ruling class, marginalising those already impoverished.

Additionally, the rulers benefited from the recruitment of labour for their territorial expansion of the Gorkha empire and during various episodes of war (Regmi 1988). Poor peasants were mobilised not only to engage in the battlefields but also to serve as porters to help transport goods, weapons, and other supplies. Labour was also forcibly recruited to build roads, temples, palaces, and other buildings for the ruling class, and this was unpaid. The various systems of tax collection by the Nepali state generated a steady flow of income to the landowning class (Regmi 1978). Such harsh economic conditions meant that many peasant families were forced to out-migrate in search of labouring jobs, including outside Nepal (Shrestha 2001). In the 19th century, Nepali men facing economic insecurities began to travel across the border to

Sikkim, Assam, Darjeeling, Bhutan, and Burma (now Myanmar) looking for work in coal factories. They were also employed as porters and as tea plantation, domestic, and construction workers, among other occupations within and outside Nepal (Hutt 1997). The recruitment in the British Army, which formally started after 1816, did offer employment opportunities for men from certain hill ethnic groups, although they would be engaged in life-threatening and dangerous work while being away from their families and farms.

Second, multilayer exclusion based on caste, ethnicity, gender, and class has been central to the history of nation-state formation in Nepal which was ruled by Hindu kings and Rana oligarchs for over 200 years and dominated by Nepali-speaking high-caste groups from the hills (Gellner et al. 1997; Lawoti 2005). The persistence of group-based inequalities, based on gender, caste, and ethnicity (DFID/World Bank 2006), has a strong impact on economic insecurity and the distribution of poverty in Nepal. Varieties of social and political movements since the 1990s have fiercely challenged the exclusionary and extractive history of the Nepali state. However, the concerns of these social and political movements have primarily been on exclusion related to ethnicity, caste, gender, or religion and not on how these intersect with broader class issues and the extent to which market forces, such as intensification of labour migration, have deepened precarities (Sharma 2021).

Third, major demographic shifts have occurred in Nepal owing to a transition from a high-mortality, high-fertility society to a low-mortality, low-fertility society within a relatively short period resulting in a large working-age group (NPC and UNICEF 2017). In theory, this demographic shift offers a window of opportunity. However, the lack of job creation has meant that Nepal's demographic dividend has been largely missed. The liberalisation of Nepal's economy in the 1990s was not accompanied by job creation. Jobs in the formal sector of the economy were limited to the civil service, NGOs, and limited private sector jobs in banks and financial institutions. The agricultural sector remained

unproductive and stagnant. Job creation in the national economy has been sluggish primarily owing to a lack of industrialisation and poor absorption of labour in the service sector.

In the 1980s and 1990s, the growth in the industrial sector was around 7.81 per cent and 7.28 per cent, but this has significantly decreased to around 2.98 per cent (Basnett et al. 2014). These statistics explain the inability of the Nepali state to create jobs and instead its policy to externalise its economy exporting its manpower as migrant workers in the foreign labour market. Thus, young people have little choice other than to outmigrate in search of work opportunities. Here, we can see how Nepal's demographic dividend played an important role in reducing poverty, improving health and education, and feeding the dependent population (Lokshin et al. 2010). Yet its excessive dependence on foreign employment for the working-age population has brought critical vulnerabilities including uncertainties around the care of those left behind.

6.3 COVID-19 and Its Impact on Nepal's Labour Migration

Migration in search of work is an established livelihood strategy in Nepal (Hitchcock 1961; Macfarlane 1976; Pfaff-Czarnecka 1995; Whelpton 2005). Not only has migration offered cash income in the form of remittances and supported farming activities but it has also offered a much-needed passage for young people who do not want to remain left behind in a situation of joblessness and boredom and are subject to the undesired label of *faltu* (useless) (Sharma 2018). Over a long period, this practice has evolved into what is called a 'culture of migration' (Sharma 2018). Migration is associated with an ability to earn money, commonly known as *kamaune* in the local idiom (KC 2014). While historically, migration from Nepal has been associated with landlessness, destitution, and precarious socio-economic conditions resulting from age-old feudal practices, it is simultaneously driven by a desire to partake in consumer activities. Known as *badhyata* in literary

writings and public culture, the former is seen as a form of compulsion in precarious conditions generated by extractive state policies, landlessness, and the feudal caste system. The latter is often referred to as *rahar* in Nepali public culture, a form of desire to experience the world outside and take part in consumer activities associated with earning and spending.

In recent years, the number of Nepalese migrants currently working in foreign countries is estimated at 3.2 million, of whom over 90 per cent are men (CBS 2018). Between 2009 and 2019, the government of Nepal issued approximately 5.9 million labour permits for work in 154 countries (MoLESS 2020). Of the 500,000 labour permits issued in 2018 and 2019, 30 per cent were for Malaysia, 27 per cent for Qatar, 20 per cent for Saudi Arabia, and 13 per cent for the United Arab Emirates (MoLESS 2020). These numbers do not include those who migrate through unofficial channels, including smuggling through dangerous routes, or those who travel across the border in India in search of work. While there are no official numbers available on Nepali migrants in India, mainly due to the open border, it is estimated that around 1.5 million Nepalis work in India (Sharma 2013, 2021).

Officially recorded remittances increased from 2 per cent of GDP in 2001 to 30 per cent in 2015, one of the highest shares in the world. The share of remittance in GDP was \$7.5 billion in 2020 and increased to \$8.2 billion in 2021 (World Bank 2020a). The widespread prevalence of migration and its impact on Nepal's remittance economy has been documented and acknowledged in recent years (Seddon et al. 2002). Studies document that about half of rural households have at least one overseas migrant at any given point (Adhikari and Hobley 2015; Sunam 2014).

Labour migration is mostly funded through high-interest loans, and reports of deception and wage theft are very common, the weight of which not only puts them in a weaker financial situation and loss of assets and dignity but also leads to a negative impact on their physical and mental health. Many find themselves in a context of poor living and working conditions rampant with ill-treatment resulting in poor health and death (Sharma 2021).

Various reports have indicated widespread ill-treatment of migrant workers in overseas destinations, such as the Gulf States and Southeast Asian countries. Various reports indicate that anywhere between three and five dead bodies of migrant workers arrive at Nepal's Tribhuvan International Airport daily. According to data collated by Nepal's Foreign Employment Board, between 2008/2009 and 2021/2022, a total of 10,666 Nepali migrant workers died overseas, of whom 'natural causes' account for 2,077, 'cardiac arrest' accounts for 1,474, 'heart attack' 733, and 'other causes' 2,875 (GON 2022). In 2021/2022, the government data show that 207 people died of COVID-19. These statistics do not capture those who migrate through unofficial channels. Despite social security provisions in different bilateral labour agreements, Nepali migrant workers are regularly stripped of their economic and social rights and protections.

The coronavirus pandemic of 2020 made visible the plight and precarity of Nepali migrant workers in overseas destinations and their families back in Nepal like never before. The images of Nepali migrants desperate to return home but stranded at the India–Nepal border owing to the lockdown were widely circulated in social and mainstream media (Sharma 2020). At the immediate level, the public debate focused on the criticisms of the Nepali government, in particular its inability or unwillingness to repatriate stranded Nepali migrants abroad, as well as the widespread fear associated with those returning with the virus and the criticisms of inadequate testing and quarantine facilities for those returning to Nepal. At a broader level, the public anxiety focused on the potential negative impact of the pandemic on the remittance-dependent economy as well as on the opportunities and challenges associated with the reintegration of a potentially large number of returnee migrants.

The COVID-19 crisis suddenly interrupted outmigration flows, creating immediate anxieties for departing and aspiring migrants. Official data show that a total of only 36,433 labour permits were issued to aspiring migrant workers during 2019/2020, compared to 508,828 during the previous fiscal year (FY), 2018/2019

(Ghimire et al. 2022, 137–38). The migration process undertaken by 328,681 aspirant migrants with pre-approval was suspended (IOM 2020). Owing to the COVID-19 travel ban, there was a steep drop in the outflow of Nepali migrant workers to Malaysia, that is, from 39,167 in 2019 to nine in 2020 (GON 2022). Yet this turned out to be a short interruption. The numbers have since bounced back to the previous levels and the pandemic did not make a long-term impact on the number of migrants leaving Nepal. From a low of 166,689 (72,072 new approvals and 94,617 renewals) in 2020/21, the number of labour approvals issued in 2021/2022 rose to reach 630,089, nearly matching the record numbers of 2012/2013 and 2013/2014 (GON 2022). Nonetheless, it disrupted the migration journeys of thousands of departing and aspiring migrants during the height of the pandemic. Owing to the pandemic, as the labour-permit processing works were interrupted, many were left in limbo as many had already paid fees to the migrant recruitment agencies. Others had already secured employment and were thinking of leaving soon but could not do so owing to travel restrictions (Ghimire et al. 2022).

Remittances became even more essential for migrant-sending households in Nepal during the COVID-19 pandemic. It was widely speculated that Nepal would witness a steep decline in remittance inflows following the pandemic (GON 2023). Pokharel (2021) suggested that the country's imports, balance of payments, consumption, deposit, loans, and interest rates would be affected. However, data from the Government of Nepal show that the value of remittances in the next 15 months of the pandemic exceeded those in the 15 months before pandemic (Pokharel 2021). While the pandemic did not result in a dip in remittance flow to Nepal on the scale of what the World Bank and other leading authorities were initially warning, as we discuss below there were widespread reports of job losses and abandonment of migrant workers. 'As labour migration is often undertaken to support family livelihoods and secure children's futures, the pandemic risked jeopardizing these plans. It is no wonder that migrants who remained abroad were concerned about supporting their families during

the crisis and continued to send remittances, even by borrowing money' (Adhikari et al. 2022, 429). This increase was also due to the nature of remittance transfers due to the pandemic. While migrant workers previously used informal channels, such as *hundi*,¹ to send money or brought back consumable goods like TVs, gold, phones, or laptops, this was replaced by formal transfers of remittance during the pandemic and thus they were reflected in the official records (Pokharel 2021).

Moreover, the spread of the virus and lockdown meant that many migrant workers had their jobs lost and wages withheld, and had limited support for social distancing, testing, and vaccination in the destination country. One survey found that the pandemic led to job losses and a deterioration in working conditions for Nepali migrants (Adhikari et al. 2022). According to this survey, 19 per cent of respondents had been laid off and 18 per cent had been forced to take unpaid leave with no guarantee of returning to their jobs. An additional 28 per cent reported cuts in working hours. About 51 per cent said that their employer paid for food and shelter, while 44 per cent relied on their savings and, to a lesser extent, on support from friends and relatives. Migrant workers living in crowded accommodation with inadequate access to water faced significant problems. Segregation and isolation of migrants in their places of residence were reported by those working in the Gulf states like Qatar. The countries where Nepali migrant workers were working enforced lockdowns and domestic restrictions including the closure of shops, industrial areas, and businesses, cancellation of issuance of visas and labour permits, cancellation of pre-approved permits for foreign employment, and bans on large gatherings, leaving the migrant workers with little or no support from the governments (Bhattarai et al. 2022, 65; GON 2022). A news report by the BBC Nepali Service quotes a Nepali migrant worker employed as a construction worker in the UAE on the fear of job security:

The [UAE] government has announced that to protect their companies, they may reduce salary, impose forced leave or lay people

off from their jobs. Due to this, Nepali migrants working in UAE, including those with 'secured jobs' are also fearful that their jobs will be lost and they are also looking to return to Nepal. (Bashyal 2020)

With the economic slowdown following the lockdown, many businesses in migrant destinations that employed migrant workers struggled to continue operations, with manufacturing and service sectors being the most impacted. Reports suggested that, after COVID-19 became a global pandemic in 2020, employment in jobs typically held by Nepalese migrants declined by 30 per cent in the UAE and Malaysia and by 20 per cent in Qatar and Saudi Arabia (Adhikari et al. 2022, 423; Rimal 2021). Another newspaper report, by Mandal (2020a), suggested that about 280,000 Nepalese had already lost their jobs in these countries by March 2020 because of the pandemic and therefore wanted to return home (Adhikari et al. 2022, 423). Citing Mandal (2020b), Adhikari et al. (2022, 423) write that 'by April 2020, 127,000 Nepalese migrants from Malaysia and the Gulf had to be urgently evacuated, and an additional 407,000 were expected to return from 37 different countries'. Reports talk about migrant workers being laid off and forced to take unpaid leave, and employers not offering food and shelter. Equally, the pandemic's impact on migrants was gendered. A report in the *Nepali Times* cites a Nepali domestic worker in Lebanon:

'My Brother told me over the phone that he is bored as there is not much to do. I, on the other hand, have not had a moment free since the curfew started. Her employer's entire family was now at home all the time because of the lockdown ... Usually, the family used to go out for dinners on Thursdays and Fridays, and I had it relatively easy, but now they are home all the time'. She added in Nepali: '*Kam ko matra overtime, dam ko chahi chaina overtime*'. (The work is overtime, but the money is not.). (*Nepali Times* 2020a)

Hence, as the pandemic began to hit globally, reports of Nepali migrant workers desperate to return home in the context of global lockdown began to appear in news reports. In the absence of any social security in the migrant destination along with the concern for family members left behind and for their own health, it was only natural that they were keen to return home to be with their family during uncertain times. Following the government of India's announcement of a nationwide lockdown on 24 March 2020 with only four hours of advance notice, leaving migrant workers abandoned and insecure, it was only natural that many Nepali migrants attempted to return home using trains and buses in search of security (Sharma 2020). Yet the travel restrictions and the lockdown meant that the same was not possible for Nepali migrants in other international destinations. 'The Nepali government initially (starting from 20 June 2020) sent free repatriation flights to 30 countries but stopped later as it was not considered financially viable' (Ghimire et al. 2022, 138). According to the *Nepali Times* (2020b), by the end of July 2020 the government had only been able to bring back one in ten stranded workers, which was about 30,000 workers (Adhikari et al. 2022, 423). On 16 April 2020, Nepal's Supreme Court ordered the government to take care of the health needs of Nepali migrant workers living in foreign countries and to repatriate vulnerable Nepali workers from foreign countries. Again, given the slow progress, on 17 June 2020 Nepal's Supreme Court ordered the government to use the Foreign Employment Welfare Fund to repatriate Nepali workers stranded abroad. By January 2021, as per the government records, a total of 235,907 Nepali citizens from 86 countries had returned to Nepal via rescue flights (GON 2022, 20).

In March 2020 alone, around 500,000 crossed the border from India and were initially stranded at the border for several days when the Nepali government restricted their entry (Adhikari et al. 2022, 423). Distressed and stranded at the India–Nepal border, Nepali migrant workers returning from India, when interviewed by journalists, spoke about the humiliation, difficulties, and uncertainties, and many vowed never to return to work in India.

On 7 April, the Supreme Court of Nepal ordered the government to bring all Nepali citizens stranded at the Indian border willing to come home and quarantine them (GON 2022, 20). Various newspaper reports show that the returnee migrants faced harassment from police on their return journey, and did not have access to adequate basic services such as shelter, food, or water. And some returnees were stigmatised as the carriers of virus (Adhikari et al. 2022).

Politicians, intellectuals, and policymakers in the capital spoke enthusiastically with nationalistic sentiments about how this return would open opportunities for reviving rural agriculture and employment opportunities in Nepal. Rhetoric aside, within three months, many of these returnees from India had begun to return to India in search of work, despite the rapid rise in coronavirus cases there (Sharma 2020). Adhikari et al. (2022) also show that, despite problems that led to their return, slightly more than 50 per cent of migrant workers surveyed had made plans to go back abroad to work. The main reasons were: a lack of employment opportunities in Nepal (57 per cent), poverty (28 per cent), low income (10 per cent), and family pressure (2 per cent).

Despite provisions in bilateral labour agreements, migrant workers were not always offered social protection and this precarity became pronounced during the pandemic owing to the sudden loss of jobs. Many migrant workers reached out to diplomatic missions in labour destination countries in large numbers as they were stranded without food and no hope of income (Bhattarai et al. 2022). In the context of Nepali migrant workers in India, although the 1950 Nepal–India Treaty of Peace and Friendship allows for the free movement for people of Nepal and India and explicitly states that both the countries should provide the citizens of each country with equal treatment, in practice Nepali migrants in India did not receive protection as most lacked identity and social security documents (Adhikari et al. 2022, 428–29; see also Sharma 2018). Consequently, when the Indian government imposed a lockdown, it was only natural for these migrants to attempt to return home.

6.4 Social Protection

The specificity of Nepal's economic history has meant that state-sponsored social protection systems have been largely absent. While Nepal has witnessed impressive political and social movements calling for rights, justice, equality, and inclusion (focusing on ethnic, regional, and linguistic groups), particularly in the last three decades, one linking these to questions of economic survival or social protection (for those subjected to destructive market forces, including through labour migration) has been limited or non-existent (Sharma 2021). Unlike in Western countries, where the impact of market liberalisation on livelihoods was cushioned by social security systems and the market was managed with extensive regulation (Polanyi 1944), in Nepal state-sponsored welfare has been barely existent or minimal despite enduring joblessness and precarity (Khatiwada and Kohler 2014). This absence has been a key factor in forcing Nepali households to embark on migration journeys to mitigate precarity.

It was only in the early 1990s that Nepal saw the initiation of a piecemeal approach to state-sponsored welfare. What started as an old-age pension in 1994 worth 100 Nepali rupees per month, introduced by Nepal's CPM-UML-led government in 1994, has in recent years increased to 4,000 Nepali rupees per month. There are now social security grants for widows and the disabled. In the last two decades, there has been an increase in the investment by the government in social security provisions that have primarily been introduced with the technical support of bilateral and multilateral donors.

The Social Security Fund was established in 2011. Nepal's most recent constitution (2015) guarantees social protection to the poor and vulnerable (UNICEF 2020). As a result, there were approximately 76 schemes operating by 2020 (UNICEF 2020). The budget allocation for social protection in Nepal increased from six billion Nepali rupees in FY 2014/2015 to an estimated 188 billion Nepali rupees in FY 2020/2021, that is, from 9.81 per cent of Nepal's total government expenditure in 2014/2015 to 12.80 per cent in 2020/2021 (UNICEF 2020).

Recognising that migrant workers face various forms of insecurity, the government of Nepal established a dedicated agency, the Foreign Employment Board (FEB, previously called the Foreign Employment Promotion Board), in 2008. As a part of its work, the FEB oversees a contributions-based welfare scheme aimed at providing economic assistance to the families of migrant workers when they fall ill or in the event of the worker's death, and economic assistance to migrant workers in the event of injury or when they need to be rescued. The scheme also offers support with the transport of dead bodies of migrant workers die overseas. In 2020 it was estimated that the welfare fund in FEB held six billion Nepali rupees (US\$50 million) but there was widespread criticism that the government did not initiate action to make use of this fund for migrant workers' welfare during the pandemic (Adhikari et al. 2022).

During the COVID-19 pandemic, the government of Nepal introduced a few welfare measures to address the economic impact of the crisis. The government's response to anxiety around joblessness was to state publicly that its flagship employment programme, the 'Prime Minister's Employment Programme', which offered 100 days of waged employment, would be extended to those in need of work. Yet the government lacked the fiscal capacity to fund such an initiative at scale. The government action plan included subsidised loans to encourage those unemployed to start their own businesses (World Bank 2020b). The government instructed local governments to provide food to needy groups, and several self-organised voluntary groups set up community kitchens. Similarly, the government instructed the diplomatic missions to work to ensure that Nepali migrants were paid their due wages and benefits. However, there is no evidence to suggest that these initiatives were successful and benefited the needy. In the absence of specific support from the government of Nepal or the host governments, it is the social networks for migrant workers welfare, and cultural organisations based in different destination countries, that were seen active in providing support in the forms of shelter or food to migrant workers.

6.5 Conclusion

This transfer of the demographic dividend as overseas labour migration has significant costs. First, the system of migrant labour means that it is the destination economies that benefit from the surplus population from remote rural areas of Nepal, in addition to the economic and political elite in Nepal who benefit from the rent produced by the migration and remittance industry. Second, migrant workers are subjected to widespread exploitation, ill-treatment, injury, and death during transit, and while working in the destination. Third, while the Nepali state benefits from remittance transfers, which make up a third of Nepal's GDP, and the economic and political elite benefit from their economic returns (from recruitment, foreign exchange, and import-based consumption), outmigration also has a detrimental impact on those left behind. Migrant workers can work, earn, and remit only because women left behind look after the household and offer insurance at times of old age, illness, and eventual retirement, when the migrant body becomes redundant, having exhausted their usefulness in a precarious economy overseas. Thus, the migrants and their left-behind households, particularly women, are subjected to multiple layers of precarity.

Evidence suggests that, while COVID-19 or global inflation has not slowed down migration or the remittance that flows into Nepal, the pandemic made the long-standing precarity and suffering of migrant workers visible. In the absence of social protection from the state, international and other actors, migrants, and their families largely relied on social and political networks to deal with insecurities. While Nepali migrant households embark on transnational livelihoods, the emergent provision of social protection in Nepal remains largely confined to the nation except in exceptional situations, such as death or when migrants need to be rescued. In the context of precarious employment and life, the individual migrants rely on their households and extended family and kinship networks.

Notes

- 1 An informal method of money transfer from one location to another involving trusted agents at both ends. It is widely practised in Nepal and other parts of South Asia and the Middle East.

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CHAPTER 7

Migrant Workers and the COVID-19 Pandemic

A Case Study of Delhi

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Abstract

The chapter critically analyses the pandemic measures adopted towards migrant workers in Delhi to investigate their consequences. This is important given the high density of migrant workers from neighbouring states. Utilising oral testimonies of workers and document analysis of the Delhi government's special programmes, the chapter analyses the case of the government of the National Capital Territory of Delhi through three lenses: state support, pandemic inequities, and vulnerability. This is undertaken by using narratives of migrant workers in Delhi and their experiences of the pandemic and how it affected them. I used qualitative methods based on long oral testimonies of 25 migrant workers in the two industrial sites of Wazirpur and Kapashera.

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These accounts were collected between December 2021 and June 2022, which coincided with the lowering of the first wave in 2021 and just in the aftermath of the devastating second wave in 2022. This was a period of pain, loss, and suffering for the poor and marginalised. This chapter gives a nuanced perspective from below, that is, how the workers experienced policies on the ground: the hardships of the pandemic was felt by everyone but many of these workers lost jobs and family members to the virus. Others, who were fortunate not to lose a family member, lost out on the possibility of vertical mobility.

7.1 Introduction

The COVID-19 pandemic had an everlasting and deep impact on the global society and economy. It has once again opened up the pressing question of inequalities among people while facing global, health, and environmental crises. The novel coronavirus affected everyone but its impact was felt most by the vulnerable communities of workers, economically unstable classes, the homeless, and contractual and unprotected labourers who work without any social security measures provided by their employers and contractors (OECD 2022). Various reports by international and national agencies highlighted the ‘differential impact’ of the COVID-19 pandemic: (racial, national) minorities, migrants, the homeless, refugees, frontline workers, and those employed in low-paying jobs were the worst hit (Crosley et al. 2021; Ferreira 2021; Misra and Gupta 2021; OECD 2022).

Most governments across the world undertook stringent measures to manage the COVID-19 pandemic, resulting in a rise in centralised governance and authoritarian decision-making policies undermining democratic discussions. In many cases, the pandemic became the shield for already weak democracies to make stringent and undemocratically reached decisions, leading to increased authoritarianism (Ludden 1996). The pandemic also provided a veil for charismatic leaders with centrist tendencies to pass legislation and executive orders in the name of ‘pandemic

management' to curb the rights of their citizens to question the state.

I focus on the impact of COVID-19 on Delhi, the capital city of India, and the measures taken by both central government and the Delhi government to curb and control the pandemic and provide welfare schemes and food support for the migrant workers. The rationale for studying the case of migrant workers is that they faced the major brunt of the pandemic (Al Jazeera 2020; Bandyopadhyay, Banerjee, and Samaddar 2022; Duggal et al. 2024; Kumar, Metha, and Mehta 2020). Given the large concentration of workers who migrate to Delhi for work, the plight of these workers, who were taken by surprise regarding the intensity and degree of the national lockdown, was a sore sight. They could not go back home owing to public transport being stalled; some of them walked for hundreds of kilometres to reach home. While some made it, others were not so fortunate. More than 8,700 people, many of them said to be migrant workers, were mowed down on railway tracks in 2020 despite passenger train services being severely curtailed by the nationwide lockdown (PTI 2021). According to Khan and Arokkiaraj (2021, 14), the migrants were left without sufficient legal protection as:

[t]he Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979 aimed to protect migrant workers during their recruitment and transportation against abuse and exploitation by unregistered contractors ... has been poorly implemented. In 2020, it has been subsumed under the Occupational Safety, Health and Working Conditions Code, where it is applicable on establishments that employ five or more employees which renders migrants working in micro units outside the ambit of the law. (Khan and Arokkiaraj 2021, 14)

While the repercussions of the pandemic were felt in almost all economic sectors, the worst affected were the workers in the unorganised sectors like the construction, textiles, mining, and food sectors, who were left completely stranded with the sudden announcements of national lockdown across countries. However,

for migrant workers, it was a twin blade: they lost their livelihoods in the city without substantial support from the state to return home safely. In many cases the wages of the workers were not paid, leading to contractors indulging in ‘wage theft’ (Foley and Piper 2021, 468). The migrant workers who migrated to the cities for work were not even considered when deciding on the lockdown of all states and union territories. This lockdown was announced by the Indian government for 21 days starting from 24 March 2020, with a deadline of a mere four hours for its implementation (Press Information Bureau of India 2020).

The Indian prime minister made a statement on 24 March 2020:

From midnight tonight onwards, the entire country shall go under complete lockdown, a total ban is being imposed on people, from stepping out of their homes for a period of 21 days. He said this decision was taken from the experiences of health sector experts and experiences of other countries and that 21 days is essential to break the chain of infection. He added that this will be a few levels more than Janata-Curfew, and also stricter. He said this decision is vital in order to protect the country, and each of its citizens against Corona Pandemic. Discussing the economic impact owing to the Pandemic, the Prime Minister said, ‘The nation will have to certainly pay an economic cost because of this lockdown. However, to save the life of each and every Indian is our topmost priority. Hence, it is my plea to you to continue staying wherever you are right now in the country.’ (PIB 2020)

There was complete chaos, with millions reaching the interstate bus terminal in Delhi to return to their hometowns. The government defended its decision on total lockdown as pertinent in the face of the health crisis, while several leaders and politicians opposed the sudden manner of its implementation with a complete shutdown of public transport as a whimsical reaction without proper planning about how it would impact the millions of migrant workers across India (*Al Jazeera* 2020). India faced the worst of the second wave of the pandemic by mid-2021, with the death toll crossing 400,000 and 30.45 million cases since the end

of 2020 (*Al Jazeera* 2021). *India Today* reported the second wave of COVID-19 deaths as the ‘worst tragedy’ since India’s partition in 1947 (*India Today* 2021). India’s lockdown was extended well beyond the 21-day initial period and only started to ease in May 2020. This lockdown, though many argued that it was critical, hurt India’s economy and led to a large-scale loss of employment affecting livelihood (Chatterjee and Dey 2023; Dhingra and Machin 2020; He et al. 2023). Consequently, the pandemic’s effects were not felt equally on all; it became a highly unequal pandemic, especially for the poor migrant workers (Bandyopadhyay 2022; Samaddar 2020; Yavorsky et al 2021).

7.2 Delhi: A Migrant Hub in North India

The Economic Survey of Delhi highlights that, while its population increased by 101,000 from natural births, migration added 283,000 people to the city in 2021 alone (Economic Survey of Delhi 2022, 407). Delhi’s demographic structure and its rural-urban area division have undergone a marked shift between 1990 and 2020; the rapid pace of development with India’s neoliberal and open-economy policy, established in 1991–1992, saw a significant rise in foreign investment by multinational corporations in and around Delhi. The per capita income in Delhi has more than doubled in the past decade, except in 2020–2021, when it suffered a decline due to the pandemic ([Figure 7.1](#)). The massive increase in economic development coupled with better services and welfare schemes have been attracting more and more people across India to come to Delhi for better jobs, service conditions, education, healthcare, increased wages, and access to water and electricity. The urban area share of Delhi has also increased largely in the last two decades, with high-speed urbanisation and the state-of-the-art public transportation that is the Delhi Metro.

Delhi’s global rank is third in urban area and it is the capital of India, which makes it attractive as both the central and the state governments invest huge sums in Delhi’s beautification and development. Even though the pandemic marred the growth of Delhi, it

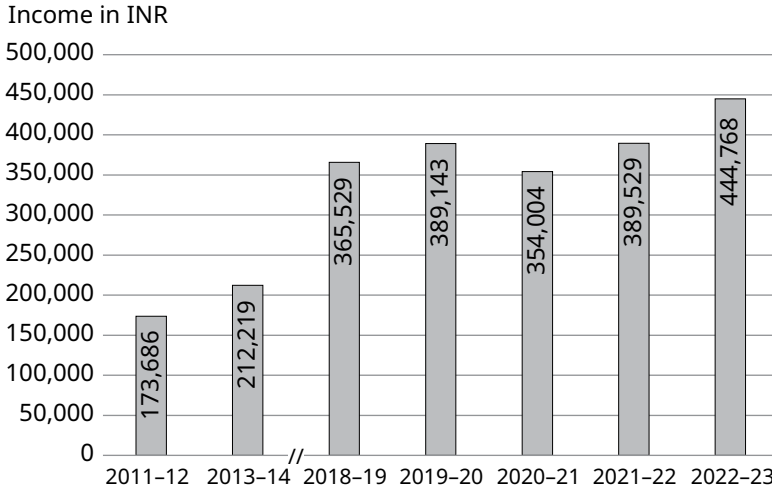


Figure 7.1: Per capita income in Delhi, 2011–2012 to 2022–2023

Source: Constructed by the author from Delhi Economic Survey Highlights, <https://delhiplanning.delhi.gov.in/planning/economic-survey48388>

was resilient enough to bounce back: the employment survey conducted by its government in 2020 and published in January 2021 shows that the average monthly income witnessed a marginal shift in figures between income before the pandemic and during the pandemic (Figure 7.2). In this survey of Delhi's employment, Hindus comprised 86.2 per cent of households, while 11.4 per cent are Muslim, 1.8 per cent are Sikh, and 0.6 per cent are of other religions (Centre for Market Research and Social Development 2021, 47). Studying the head of the households in Delhi, the survey found that the majority of respondents (53.5 per cent) had been staying in Delhi since their birth, 43.7 per cent for more than five years; 2.2 per cent had migrated to Delhi in the previous one to five years and just 0.5 per cent had done so in the previous year alone. Migration status analysis of monthly household expenditure shows that 27 per cent of non-migratory households had an average monthly expenditure of 30,000 rupees and above. Monthly expenditure drops considerably for migratory households surveyed: 71 per cent of households who migrated to Delhi more

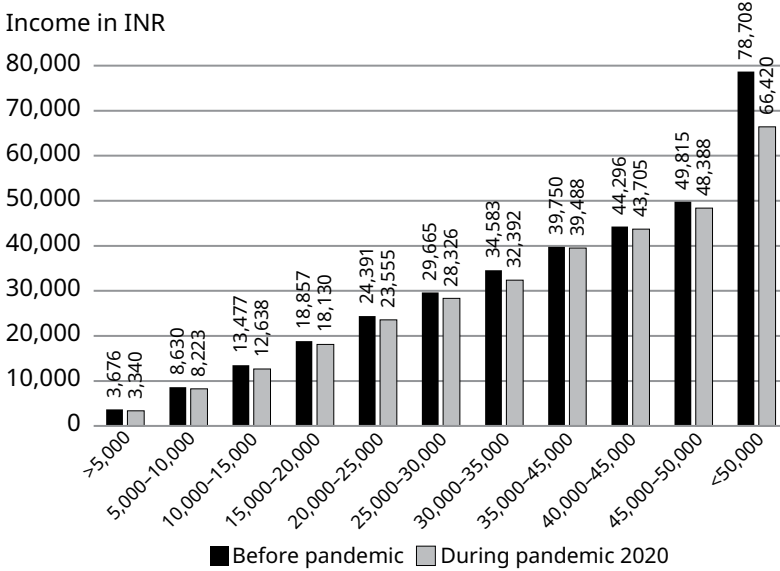


Figure 7.2: Monthly income in Delhi before and during the pandemic in 2020

Source: Employment Survey in Delhi 2020. Govt. of NCT Delhi, https://ddc.delhi.gov.in/sites/default/files/reports/delhi_employment_survey_report.pdf

than five years ago had an average monthly expenditure of less than 20,000 rupees, but this percentage increased to 77 per cent for households who migrated the previous year. Of those migrant households who migrated to Delhi one to five years before the survey, 41 per cent had a monthly expenditure of 20,000 rupees and above (Centre for Market Research and Social Development 2021, 48).

The Delhi government passed relevant legislation and policies related to workers during the COVID-19 pandemic. I will highlight the policy measures existing in Delhi before the advent of the pandemic in 2020 and the measures taken by the Delhi government during this period in response to the workers' issues, especially migrant workers, who were worst affected by the pandemic. Before discussing the welfare measures, it is important to understand the structure of labour mechanisms and rules in India.

Table 7.1: Central government welfare schemes (prior and in response to the pandemic)

Pre-COVID-19 schemes for labour	COVID-19 schemes for all including labour
Grant-in-aid scheme for women labour	Pradhan Mantri Garib Kalyan Yojana
Grants-in-Aid Scheme are sanctioned directly to NGO for elimination of child labour	PM Cares scheme for children who lost both parents due to COVID-19
Rehabilitation of bonded labour	Free ration of 5 kg grain and 1 kg pulses for all workers and poor till November 2020 under the National Food Security Act
Group insurance schemes for power loom workers	

Table 7.2: Delhi government labour policies (prior and in response to COVID-19)

Prior to COVID	Response to COVID
Aam Aadmi Mohalla Clinics (free community health clinics)	Delhi Epidemic Diseases, Covid-19 Regulations 2020
Delhi Swarozgar Yojana (Delhi self-employment scheme)	Free Ration Scheme
Jai Bhim Mukhyamantri Pratibha Vikas Yojana (Chief Minister Scheme for housing for labourers)	Rescue, Repatriation and rehabilitation of Child labour with a budget allocation 2020–2021: 10 lakh rupees
	The Delhi government also announced 50,000 rupees for families with COVID deaths and 2,500 rupees per month for children orphaned by the death of their parents until they attain the age of 25 years, and the state will provide free education to such children

Source: Constructed by author from www.delhi.gov.in

Labour legislation in the Indian federation is two-tiered, that is, under the central and state governments (see Tables [7.1](#) and [7.2](#)). Delhi, being the capital city, has a special status conferred on it in subject matters within the state and concurrent list.

Focusing on the significance of the COVID-19 welfare schemes for workers in Delhi, I aim to examine and evaluate schemes of both the central government and the Delhi government on three parameters: outreach, accessibility, and delivery information. To investigate the issue, oral testimonies of 25 migrant workers were collected through a face-to-face conversation method based on their perception, experience, hardships, welfare schemes, and any other aspect (or concern) they wanted to share. Thus, this study, unlike numerous scholarly articles, does not merely investigate the welfare schemes introduced in India during the COVID-19 pandemic using state or international agency data but highlights the views and opinions of the target population, in this case migrant workers. In doing so, I utilise a bottom-up approach to the community and what they felt about their time as migrant workers in Delhi during the pandemic. Hence, I intend to open a discussion on policymaking and welfare mechanisms for migrant workers during the health crisis. I use document analysis to examine the pandemic welfare policies of both Delhi and the central government to understand the policies specifically targeted towards workers and migrant workers in the capital city of Delhi. Further, oral testimonies collected during the fieldwork will be used to analyse how these schemes benefited or failed to meet the needs of workers and the degrees of accessibility.

The Delhi government conducted a post-pandemic job survey in March 2021 jointly prepared by the Delhi Directorate of Economics and Statistics and the Centre for Market Research and Social Development. This report highlighted the severity of the job crisis in the national capital:

The survey found a sharp surge in the unemployment rate of Delhi, from 11.1 per cent in January–February 2020 to 28.5 per cent in October–November, and a drastic dip in the share of women

in the workforce, including a large percentage of graduates and postgraduates. The survey revealed that the pandemic and the lockdown have dealt a severe blow to the share of women in the workforce, pushing up the unemployment rate in this category to 54.7 per cent from 25.6 per cent. However, the report noted with concern that as many as 83.1 per cent of female respondents contacted for the survey were out of the labour force altogether. (Anand 2021).

7.3 Recounting the Pandemic: Voices of the Migrant Workers in Delhi

Data show that, of the 25 respondents interviewed, all were employed in 2019 (before the pandemic); all the male labourers were employed as of 2022 or after the lockdown was eased. However, many became jobless during the pandemic lockdown. By contrast, out of ten female workers, only six were employed, while four remained unemployed. Among the 15 male respondents, five said that they were paid less than in pre-COVID times. (See [Figure 7.3.](#))

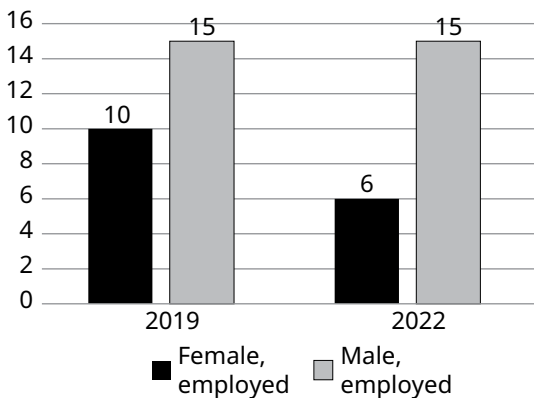


Figure 7.3: Gender and employment status in 2019 (pre-COVID) and 2022 (after COVID)

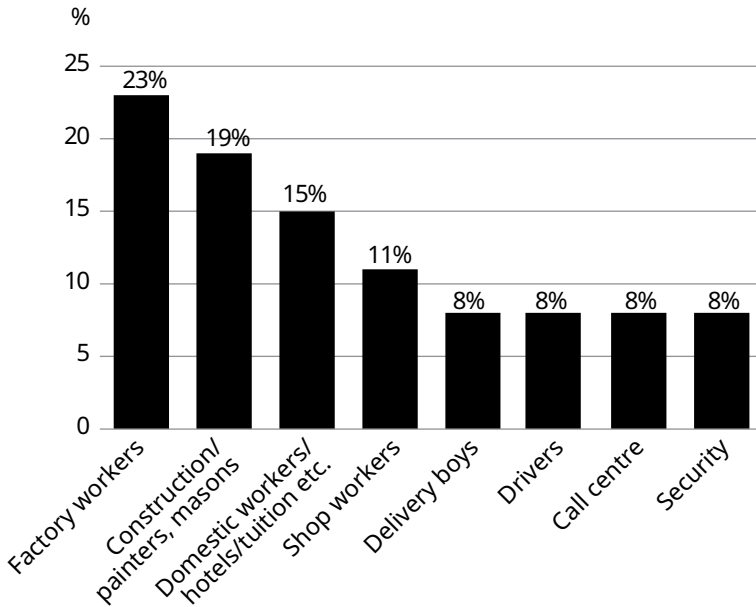


Figure 7.4: Job profile of respondents

The job profile of the migrant workers interviewed for the research, detailed in [Figure 7.4](#), shows that most of the workers worked in factories in or around Delhi as Kapashera and Wazirpur both are border areas between Delhi and Haryana. Kapashera houses the famous Maruti car factory, one of the major employers in the area, while Wazirpur hosts several steel factories.

One respondent, Anita, aged 25, narrated her story:¹

We (me, my husband and two kids) used to run a small hotel in Rajasthan but the lockdown led to its closure and after one month all our savings dried up. We could not pay the rent and the kids were starving. It was then we decided to come to Delhi as we were hearing that in Delhi, the government was providing free ration and medicine. So, we took a bus in May 2020 and came to Delhi. Thanks to the decision my kids did not die of hunger.

She heard from her relative staying in Delhi that the government was providing food and other support for the migrants, and she decided to come to Delhi as her savings depleted in the first three months of the pandemic from March to June 2020. She asserted that, had she stayed in Rajasthan, her child, who developed COVID-19 would have died owing to a lack of medical facilities. At least in Delhi, the government provided them with medicines and food at their doorstep with regular monitoring of the sick child through phone calls and in case they needed any other help.

On the question ‘Did you avail of government COVID-19 support schemes? Which ones: Central, Delhi state or others?’, most respondents – that is, 21 out of 25 – availed themselves of COVID support schemes. Nineteen respondents availed themselves of Delhi government schemes, while 13 used central government schemes. It is interesting to note that those who availed themselves of the central government schemes also took up the Delhi government welfare schemes for COVID-19, which included food supplies and some basic medicines, such as paracetamol. Apart from the government support schemes, many non-governmental organisations, such as charitable foundations, religious institutions like gurudwaras, temples, and so on, and civil society bodies also provided food, medicines, water, and clothes to the labourers during the lockdown. There was overlapping utilisation of support by migrant labourers provided by various agencies. Many said that several family members queued up for food in different places. Thus, depending on the distance from the place they were staying and their health, they went to collect food supplies (see [Figure 7.5](#)).

Vimala ji, another respondent in her mid-50s, said that:

We were fortunate as we had ration cards from Delhi and our Aadhaar address is also Delhi, so we could draw ration from Delhi government as well as the Central government but those who did not possess these documents were given ration once a day which was mostly not sufficient for them. Many used to skip dinner.

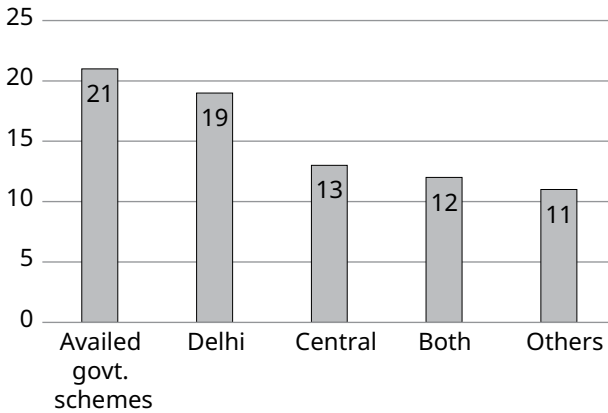


Figure 7.5: Number of respondents who availed themselves of COVID support schemes by various institutions. ‘Others’ includes NGOs, charitable institutions, religious organisations, and so on.

Aadhaar is a numeric-data-based identity card for Indian citizens bearing the residential address of the person. The government has made Aadhaar mandatory to access welfare and healthcare schemes in general. Although during the pandemic it was said not to be a mandatory criterion for accessing food, workers who possessed the ration card, a card specifically meant for the public food distribution system, with a Delhi address could take up food support from both the Delhi and the central government.

Another respondent, Parvati, aged 45 years, expressed her helplessness during the pandemic lockdown. All the five members of her family who had jobs before the pandemic struck were left jobless. She could not pay five-month rent and, on top of it, even though she was entitled to a provident fund in her employment, she was unable to get the claim processed for a year. With her three family members falling sick with COVID-19, she exhausted all her savings in the first two months. She conveyed that they were solely dependent on the ‘state ration system’, as she termed it. She was visually looking pained when she said:

The kitchen used to be empty. I always used to ensure that my family had enough to eat even if we could not afford better clothes. But the pandemic shook me deeply, I could not serve food on my children's plates. The only food we had was due to the free food grains supplied by the Delhi government. The it was not enough but at least we survived.

Kundan, a 23-year-old man who worked in a medicine shop, commented that during the first few days of the lockdown the shop was closed. He said that:

I did not get paid, later the shop was allowed to open as the sale of medicine had risen due to the pandemic, but I still faced major problems in travelling to my place of work as there was no public transport available due to the lockdown. I did avail food support provided by the Delhi government and the central government as well.

The stories of Parvati and Kundan voice the physical weakness and the mental trauma that the workers underwent. The pandemic hit hard and, with members of the family falling sick, starvation or half-full stomachs and tiredness due to the pandemic all added to their agony. Death became a regular visitor in their neighbourhood. They lived in slums with no proper sanitation or roads. Most of them had problems collecting water from the community hand pump as the pandemic norm of social distancing and the fear of the contagious disease left them in a dilemma. Getting water from the pump, which used to be a regular practice that they did not think much about before COVID-19, became a huge burden.

Some of the migrant workers who went back home owing to the fear of the pandemic suffered doubly: from the exhaustion of walking long distances, at times without food and water and carrying their family members, especially infants and elderly parents, and with the humiliating treatment they got on arriving to their villages. Amit, a 26-year-old from Uttar Pradesh, walked back home for nearly 200 kilometres. This resonates with newspaper

reports (Bisht 2020). After reaching home, they were stigmatised and sprayed with disinfectant. The village head belonging to the upper caste did not allow them to enter the village owing to fear of virus transmission as he had walked from the city. He confided that it was humiliating and hurtful as he and his family had faced so many hardships walking for such a long distance, at times without water and on reaching the village, which is their home, they were addressed as 'coronavirus', a slur that hurt him. The village authorities also ordered the spraying of disinfectants on them. He felt very humiliated and helpless not to be able to save his family from such an insult and inhumane treatment.

Two other respondents, Naveen and Kunal, both in their twenties, also had to walk back home in the absence of public transport as even railways were stalled for the first time in the history of independent India. Naveen walked for 350 kilometres with his family including an old mother of 72 years whom he had to carry, while Kunal walked for 200 kilometres to his village. Kunal said that even his own family back home was apprehensive about taking him back home as he has travelled a long distance, and they thought he must have been exposed to the virus. Therefore, the migrant workers suffered from the pandemic as it led to job loss and, with no public transport, they were left stranded and vulnerable to the virus. Not to forget the discrimination they faced by their village authorities of being sprayed with disinfectant and treated as 'outcastes' for travelling from the city, which was presumed to be 'dirty with the virus'. *The Guardian* reported that 'an estimate of 10 million workers were forced to walk home' (*The Guardian* 2022).

Most respondents did not know what lockdown meant and had never heard the term 'quarantine' in their lives. Five of the respondents said they thought it would be something like a curfew for a few days, but none anticipated its intensity and that it would drag for months. Some also responded that they did not know that the country and public transport would come to a complete halt, and that they would not be able to go back home, leaving them completely stranded.

Vilas, a worker in a chemist's shop, had a unique account to tell. As the chemist's shop, being an emergency service, did not close, he and other workers were called to come to work. He said that, due to the lockdown, very few of them could reach the shop. He walked for 15 kilometres to reach his workplace:

My family was getting very tense, but I still kept going due to two reasons: one if none of us go then how will the patients receive medicines during the pandemic and second so that I don't lose my job and keep getting my wage. However, I faced a lot of harassment by the police who would check me every day for a travel pass which I possessed but it was difficult to renew it as it could only be done online, and I could not charge my mobile data due to lack of money.

Farman was 16 years old when the pandemic hit Delhi. He had gone to school and worked in his free time at his father's mechanic shop. Within three months of the pandemic, the shops shut permanently owing to no customers and non-payment of rent. He left school and started seeking frontline healthcare jobs as many people left these jobs owing to fear of contagion. He got a job at a state-run dispensary but could not go back to school, where he had been a good student, dreaming of becoming an engineer someday.

Suraj, a 21-year-old respondent, had to leave his studies and start working as a delivery boy as both his parents lost their jobs due to the pandemic. His mother used to work as a cook in the neighbouring group housing society and his father was a gardener in the same housing society. However, with social distancing norms and the fear of the contagion, his parents were asked not to return to work till the pandemic was over. People in the society were scared that Suraj's parents lived in the slums, which were looked upon as areas of disease and as unhygienic. Hence, they lost their jobs. Suraj was disappointed that his parents lost their jobs but he was relieved that by knowing how to ride a bike he could get a job as a delivery boy.

These stories of migrant workers and their children's dreams for a better life through education were shattered by COVID-19. Two of the female respondents said they got their daughters married to have fewer mouths to feed. The daughter of the first respondent, Durgawati, was just 15 and Rama's daughter was 17 years old. When asked if they did not have to spend more money for the wedding, they both revealed that, owing to restrictions on the number of people gathering for weddings during the pandemic, they saved considerable amounts of money getting their daughters married. On the question of whether educating their daughters would have empowered them, they responded with dismay. Education does not get jobs these days, so they argued, and by getting their daughters married they had fewer people to feed. These narratives provide evidence that the pandemic was in many cases gendered, with women and girl children bearing the largest brunt of it. The marriage of the underage girls in both cases may seem unreasonable from the researcher's perspective but the fact that the respondents were happy as the 'girls got settled' and 'were already on the family way' made both the mothers proud. The story may have been different from the perspective of the girls who were married. This resonates with the situation of girls in Ebola-affected areas in Africa (Bandiera et al. 2019).

Most interviewees were positive regarding the accessibility of accessing COVID-19 support schemes provided by the state. Even though it was not easily accessible, they queued for more than two hours every day to access food supplies; they were at times not supplied as food ran out before their turn came. They were positive that without state support they would have perished without food, water, and medicines. During the time of lockdown, most responded that the Delhi state agencies provided food without asking for identity cards or ration cards (Aadhaar). Yet the situation changed after that and in the absence of jobs and identification documents some of them had to starve. Hence, some did not avail themselves of state support but rather took advantage of non-governmental agencies and other charitable institutions,

which provided food without asking for identification documents even after the lockdown was eased.

Almost all migrant workers whom I met and conversed with suffered a loss of income due to the pandemic, except one respondent, Aman, who worked in a small family-run call centre. The owner of the call centre in which he was employed ensured that all his employees were paid full salaries during the pandemic. His company also gave him a laptop so that he could work from home. Such a rendition of humanitarian behaviour was heartening to hear after the endless stories of pain, loss, and trauma.

7.4 A Disparate Pandemic

An essential takeaway from the fieldwork in Delhi is that the pandemic was not felt uniformly among the migrant workers. The impact was gendered, with female workers facing long-term consequences on labour market displacement (Allard et al. 2022). The pandemic increased the burden of unpaid work for women, who, given the patriarchal norms of society, had to do more unpaid homework such as cooking, cleaning, and caring (Chauhan 2021; Deshpande 2020; UN 2020). The pandemic exacerbated the domestic burden on women while reducing their economic standing. Female migrant workers faced greater sexual and domestic violence (Krishnakumar and Verma 2021; Maji et al 2022). As the findings of my study show, while men returned to jobs after the lockdown, women mainly stayed at home to take care of their family members and the sick. In cases where they went out to resume their earlier jobs, they were mostly not retained. Subsequently, wage inequality and unpaid care work pushed more women out of employment. A study conducted by the Centre for Sustainable Employment at Azim Premji University in India showed that 61 per cent of men remained employed, compared to only 19 per cent of women. Moreover, 47 per cent of women suffered a permanent job loss during the lockdown (Azim Premji University 2021, 6). Paradoxically, one study found the reverse, that is, men suffered greater job loss than women (Afridi,

Dhillon, and Roy 2023). This could possibly be due to the lower percentage of female workers in India overall and their diminishing participation in the labour force. India ranks 142 out of 146 countries worldwide in terms of women's economic participation and opportunity (Global Gender Gap 2024, 16).

Female workers not only felt the heavy economic burden but also suffered from disparate health measures (Lewis 2020). A surprising finding was the greater loss of life expectancy among females in India in the year 2020 than among men (Gupta et al. 2024). Surprisingly, this was the first time that female life expectancy fell compared to men's. Though official records showed more male casualties due to the pandemic, the Indian Council for Medical Research found that women were more likely to be tested COVID-19 positive, if they managed to be tested (Rukmini 2020). Mostly, women went out to buy essentials and took care of the sick at home, leading to greater chances of them being infected with the virus. The effects were not just on health; girls' education also declined due to the COVID-19 pandemic, especially the education of girls in rural areas (Nandi et al. 2023). This resonates with the stories of Durgawati and Rama in the earlier section of this chapter, who married off their young daughters to reduce the burden on their household due to the pandemic and both the girls were pregnant at the time of my interview.

The present study did not specifically question the caste and religious identity of the migrant workers as most of them were not comfortable with the question. Yet many studies reported that lower-caste workers and those belonging to religious minorities suffered greater injustices during the pandemic (Bloomberg 2020; Mondal and Karmakar 2024; Patil 2021). The pandemic not only re-established the already-existing inequalities but made them even sharper, with the gap between the regular and migrant workers further deepening. Hence, the pandemic had a disparate effect on the migrant worker population.

7.5 Public Welfare Support and Migrant Experiences

In times of crisis such as the COVID-19 pandemic, support in the form of food schemes, essentials, medicines, and shelter is vital for all citizens but most for the poor, labourers, and migrants. The data prove that all migrant workers accessed either food supply, cooked meals, shelter homes, night shelters, and medicines from the special COVID-19 schemes of Delhi and the central governments. This also indicates how the state must take responsibility for providing public health and subsidised essentials. Public welfare schemes during the crisis are intrinsic for people to sustain and survive. Studies also showed how coordination is critical among multilevel governments. This seemed missing at least in the first phase of the pandemic lockdown (Misra and Gupta 2021, 731; Chanchal and Swenden in this volume). In times of crisis, political parties should leave politics behind and come together to work in a unified manner for the welfare of the people. The pandemic or any other such crisis is not blind to identity; its effects are adversely felt on women more than men, on contractual workers and daily wagers more than full-time confirmed workers, and on the marginal castes and minorities more than the upper caste and class, underlining the inequities in the pandemic (Rolland 2020; Samaddar 2020).

Migrant workers are the most vulnerable population within the working-class community. They are powerless, without any rights, and desperate for work, without which they starve. Often, they do not speak or understand the local language of the state they migrate to. This leads to greater exploitation and incomprehensibility of information especially during emergencies such as the pandemic. Scholars have highlighted this issue of workers and minorities not understanding the state/official language in which pandemic-related information was imparted (Sengupta 2024). Without unionisation or state support, and in extreme poverty, the migrant workers have become modern-day slaves. They are underpaid and overworked (*The Guardian* 2022). Not only did

the pandemic lockdown adversely affected the physical health of the migrants and their families; they were equally impacted psychologically, so much so that, while hearing public interest litigation, the Supreme Court of India responded that ‘trained counselors and/or community group leaders belonging to all faiths will visit the relief camps/shelter homes and deal with any consternation that the migrants might be going through’ (Chander et al. 2021, 826).

While Indian people were facing the unprecedented brunt of the pandemic, the central and Delhi governments were at loggerheads on various issues, most prominently competing for ‘who does better’ tag about the pandemic welfare policies. The surmounting frictions between them led to the passing of an amendment in the Indian Parliament curbing the legislative powers of the elected government of the National Capital Territory of Delhi and placing the centrally appointed lieutenant governor as the government executive head of Delhi since March 2021, overriding the powers of the elected government of Delhi (NCT of Delhi Act 2021). This led to confusion among the bureaucracy regarding jurisdiction and legislation, which adversely affected pandemic support schemes.

The International Labour Organization (ILO) stated that migrants faced exclusion, poor implementation, lack of awareness, and a difficult application process for the governmental schemes providing affordable housing, food, and cooking oil subsidies under the public distribution system; the affordable public health-care system rendered the low-income migrant communities insecure (International Labour Organization 2020). The ILO report on migrant workers ‘Locked Down and In Limbo’ called for the protection of migrant workers’ rights, recommending including migrant workers in all COVID-related health and recovery packages and services, along with free grievance mechanisms so that they do not face discrimination (International Labour Organization 2021).

All workers – and more so migrants – need state support in matters of food security, healthcare, shelter, and water; without these welfare schemes from the state they remain the most

vulnerable during crises. Many workers I interviewed were commuting interstate, that is, from Kapashera, which is on the border between Delhi and Haryana. Some of them had to commute long distances on foot as, even after the lockdown was eased, the state borders remained closed. The state is accountable for the health and welfare of its citizens but the migrant workers in India often have no legal protection in matters of domicile as they are mostly on the move. Although the Indian state introduced the ‘labour card’, a majority of those interviewed were not aware of it and a few who knew could not avail themselves of it owing to a lack of online access to fill the form. There is a need to take cognizance of this community as they remain vulnerable to less pay, non-payment of wages, and reduced or no access to education and healthcare. They are citizens of the country and have the right to life, which entails a life free of fear and discrimination.

7.6 Conclusion

The COVID-19 pandemic led to certain special measures being introduced by the central government of India and the states to face pandemic-induced precarities, such as free rations, free medicines, and other necessary supplies. Yet, had there been better welfare policies in place, the pandemic could have been better handled for the marginalised workers. Migrant workers are the most vulnerable section of the Indian society as often they find it difficult to establish their identity in the areas they work. This in turn leads to their inability to access the public distribution system. This, coupled with the ‘intersectionality of vulnerabilities’ in terms of caste, gender, ethnic, and linguistic identity, adds to their lack of access to the government schemes of social welfare (Yarovosky 2021). The government of India introduced certain schemes for the welfare of the unorganised workers in the aftermath of the pandemic such as the Pradhan Mantri Shram Yogi Maan-dhan (PM-SYM) (2019). This is an old-age protection and social security scheme where the central government matches the contribution of the subscriber (PM-SYM). This scheme was not a

new one but to increase its effectiveness and reach the government enhanced the scheme to facilitate awareness and overall uptake.

Special schemes should be introduced for women and girls as they remain the most vulnerable and are further burdened in times of emergency with taking care of domestic work while working to earn a livelihood (European Union 2021). The central government introduced e-Shram cards for migrant workers; this is an identity card to access social welfare schemes (e-Shram 2021). During my fieldwork, workers shared the issue of internet availability and conveyed that they were unable to register as most did not have a smartphone. The government should establish enrolment centres for facilitating registration, in the manner that was done for Aadhaar cards. Although several policies exist on paper, what is required is the training of personnel to disburse healthcare without discrimination on grounds of economic status, caste, gender, and other identities. This remains a constant issue in India's healthcare sector.

The constitutional norms and rights are often not for those who cannot afford legal services. The precarity of migrant workers remain a major policy issue for India to delve into. The migrant workers may be unwanted and undermined by the middle and upper classes but they remain indispensable for the development of urban cities and the social life of society. One can only be hopeful that the state becomes more careful and well-equipped to reduce their vulnerability.

Notes

- 1 All names of respondents have been changed to protect their anonymity.

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CHAPTER 8

Policy Resilience and Continuing Marginalities

Kerala's Pandemic Response through a Labour Lens

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Abstract

This chapter provides an analysis of labour policy responses during the COVID-19 pandemic in the Indian state of Kerala. Kerala's proactive measures, rooted in a strong welfarist policy environment, are notable for their focus on labour rights and protectionism, even for migrant workers. At the same time, workers' experiences of policy revealed the persistence of pre-existing inadequacies in welfare coverage, the complexities of civic voluntarism, and gendered inequalities.¹ Through testimonies from 25 informal workers, the chapter uncovers disparities in labour protection and highlights vulnerabilities. While Kerala's response

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demonstrates political will and fiscal support, it also highlights structural and implementation challenges. This chapter suggests a need to address complacency in labour policy by identifying structural inequalities.

8.1 Introduction

The kit was a real help; I don't know what I would have done for Vishu or Onam otherwise. But to help my siblings and friends I had to mortgage my jewellery. Who will pay my loans now?

We took a body from the general hospital to a town 40kms away, wearing the PPE kit for more than 24 hours. We even conducted the rituals. We manufactured sanitisers, we were engaged in cleaning roads. We supplied food thrice a day, every day. Our experience as RRT (Rapid Response Team) members is immense and limitless. But no one acknowledges it.

The Indian state of Kerala was globally appreciated for its handling of the pandemic, as it managed to arrest mortality rates amid mounting figures in the rest of the country. The state government garnered praise for its two-pronged approach of focusing on the health impacts while introducing protectionist welfare policies for everyone in the state, including migrant workers. This was in significant contrast to the panic-stricken or antagonistic responses towards labour by both the central and other regional governments. While states like Gujarat and Uttar Pradesh responded by increasing the length of the workday, some responses, like in Uttar Pradesh's Bareilly district, amounted to public humiliation by spraying down migrant workers with disinfectants on the streets during the lockdowns.

Kerala's status as a frontrunner in responding to the pandemic also implied that most of the evaluations have been celebratory of its efforts, perhaps rightly so. At the same time, post-pandemic studies have not yet focused on pre-existing lacunae in Kerala's development trajectory – the inadequacies in welfare coverage for

the most marginalised sections, the complications within civic voluntarism, and the much-contested place of women within the model. It is in exploring these interstices that workers' responses like the ones presented as epigraphs acquire significance. They demonstrate the strengths of the state's approach, as well as the many layers of continued marginalisation for certain sections. They illustrate the value of protectionist policy in providing immediate relief, as well as the struggle to find long-term solutions. The benefits of unionisation are evident in many reflections, as are the anxieties of the unorganised sector. In this chapter, I ask: is it possible to catalogue the significance of state capacity in responding to the pandemic without ignoring extant marginalities within development history? Can civic voluntarism be unpacked through its cost to workers? How do we evaluate the place of women workers within these efforts? A more granular understanding of these issues is offered here by reviewing workers' experiences of policy during and after the COVID-19 pandemic against the backdrop of the larger examination of state responses to the pandemic in South Asia analysed in this volume.

With a view of understanding specific worker experiences within a pro-labour policy environment and understanding intersectoral and gender variations in the effectiveness of labour protection, testimonies were gathered from 25 local workers over four months from January to April 2022 in Kerala's capital city, Thiruvananthapuram. The sample consisted of 15 men and 10 women between 25 and 65 years of age, who operated at different levels of informality (including self-employment) within the labour market. The workers were initially identified through purposive sampling, followed by snowballing. Interviews ranged from 20 minutes to an hour and were sometimes also organised as group discussions. By specific trades, the workers were auto drivers, headload workers, pick-up truck drivers, sanitation workers, petty shop owners, electricians, and street vendors. My assessment is supported by a review of state policy, government orders, media coverage, and the social media activity of administrators.

I begin by providing the context of Kerala's development experience and the specific background of labour policy in Kerala. Following this, the larger context of preparedness and a pro-labour attitude is elaborated by describing the pre-pandemic policy environment. In the next section, I review policy response to the pandemic and link this with worker experiences through their testimonies. This is followed by an evaluation of the continued efforts to deal with the fallouts of the pandemic. I conclude with a discussion of the important lessons learned from the Kerala experience and the many questions facing the state as it combats the long-term impacts of the pandemic.

8.2 Labour and the Kerala Model – the Pre-Pandemic Picture

What do we already know about the Kerala experience? Kerala's development achievements, frequently referred to as the 'Kerala model' – characterised by high HDI performance along with low GDP growth – now have the status of a dictum within development literature. Heller's (2000) characterisation of the sociopolitical context of this kind of state intervention within the rubric of 'public action' is also now well known. Notwithstanding the numerous criticisms of the model, its key features – the presence of robust state-civil society trust, high investments in health, education and welfare from the early days of state formation, and the sincere political will to strengthen participatory governance mechanisms – continue to be acknowledged as important in its contemporary history (Franke and Chasin 1994, 2000; Kannan 2023; Raman 2010). While the relative significance of each of these features is a matter of vigorous debate among scholars, the pandemic provided the last of a series of renewed platforms for this evaluative exercise – the state had recently battled two disastrous floods and one epidemic in the 2018–2019 period (Ali and George 2021; Devika 2016).

The literature on the state's handling of the pandemic also follows and reiterates many of the themes identified above. One strand

focuses on policy continuities such as the centrality of welfare in the state's approach to citizens; the presence of a well-established public health infrastructure; the culture of political accountability and transparency; and the preparedness of the state concerning disasters (Chathukulam and Tharamangalam 2021; Jalan and Sen 2020). Another strand focuses on policy innovations (administrative, technological, communicative, fiscal) introduced in the context of COVID-19 and its efficacy (Peter, Sanghvi, and Narendran 2020; Sarkar 2020). The third strand focuses on the political will of the state to create a fiscal environment for recovery and its consequences; challenges faced by the state, criticisms of the nature of the state approach, and the lacunae and the potential trajectories that lay ahead (Joseph and Pillai 2022; Kodoth 2021; Paul, Jacob, and Philip 2020; Ramakumar and Eapen 2022).

In 2020, the Kerala State Planning Board (KSPB) pegged the size of the workforce in Kerala at 12.7 million, comprising 9.37 million men and 3.34 million women (unless specified, all figures here are from the QAS 2020 survey). Out of these, 37.8 per cent were self-employed, 34.5 per cent were formalised workers, and 27.7 per cent were casual workers. There has been a rise in the share of organised employment within the total employment in Kerala, which has been attributed to a sharp increase in urban female employment, particularly within manufacturing. However, the service sector employs almost 60 per cent of women workers (PLFS 2017–2018), of whom 9 per cent are in household services including domestic work. Compared to the national average, the state has a higher proportion of workers under regularised employment arrangements (34.5 per cent for Kerala, as opposed to 24.3 per cent for the country in 2018), and a larger share within this receiving some form of welfare protection (17.4 per cent in Kerala against the national average of 12.3, and, for women, 27.5 per cent in Kerala against the national average of 11.1).

The specific character of Kerala's workforce is also related to its unique history of pro-labour legislation. The state ensures the setting and timely revision of minimum wages in over 80 sectors, making it one of the leaders in wage rates and conditions in the

country, and a reason for the influx of migrant labour. At close to 700 rupees, in 2020–2021 Kerala reported the highest daily wage for male non-agricultural workers anywhere in rural India, which was almost double the national average (RBI 2022). In 1977, the state was the first in the country to set up a workers' welfare board and to standardise welfare and social security provisions for unorganised workers. It has in place over ten different welfare schemes, some of them among the earliest in the country. Starting in 2016, the incumbent Left government took further legislative and administrative measures to strengthen the labour rights of regular workers. The government passed ten pieces of legislation and regulatory frameworks over the four years between 2016 and 2020, strengthening workers' rights on wages, maternity benefits, industrial disputes, and contract labour.

Relatedly, the supportive attitude of the state government and the public towards migrant workers in Kerala is in stark contrast to other states in India. Even before the pandemic, Kerala had made important policy strides in housing, health, education and inclusion for migrant workers since the late 2000s ([Box 8.1](#)).

The QAS 2020 estimated that the biggest job and income losses due to the pandemic would be within the casualised segments of workers and for self-employed workers, most of the latter being migrant workers. The government thus anticipated issues on the specific characteristics of labour in the state. The first of these was the regular payment of wages in the absence of regular production and revenues. Second, the nature of the workforce in Kerala posed some peculiar difficulties – the central government's relief package held that the government would pay the employer's and employee's share of the provident fund contribution for the months of lockdown. Since this was applied only to firms employing fewer than 100 workers where at least 90 per cent of the workers earned less than 15,000 a month, it left out most manufacturing establishments in Kerala, which has better wages and working conditions than the national standard. It also implied that the funds for these contributions had to be mobilised by the state government. Third, with regard to casually employed or self-employed workers, the

Box 8.1: Pre-pandemic welfare measures for migrant workers in Kerala

1. Inter-state migrant workers welfare scheme (2010)
2. Aawaz (2017) (Hindi for 'voice') – a health insurance scheme for migrant workers for claims against accidental death, disability due to accident and treatment benefits
3. Apna Ghar (2017) (Hindi for 'our home') – housing scheme envisaged to provide good-quality hostel accommodation on a rental basis to interstate migrant workers.
4. Changathi (2017) (Malayalam for 'friend') – literacy programme for migrant workers, also to integrate children of migrant workers into the public schooling system in the state

bulk of the policy initiatives were reliant on social security protections by registering them under welfare boards. However, the inability of the state to get workers registered with welfare boards has been a consistent issue (even at the national level). Fourth, consistent with global and national patterns, women generally worked for lower wages even before the pandemic and had relatively limited social protection. Fifth, the 0.6 million migrant workers in the state had to be prioritised separately and their welfare had to be ensured through food security, housing arrangements, and medical care. In addition to labour-specific issues and provisions, there were two other corollary concerns. The first was the question of universalising healthcare provision and vaccination for every resident in the state, and the second was the safe return of non-resident Keralites, many whom worked as migrant labourers in the Gulf countries.

The state's strategy to provide support to labour thus had to be differentiated and targeted vis-à-vis different sections – regular workers, migrant workers, the self-employed, and casual workers.

It also had to integrate the strengths of the existing policy framework with emergent constraints. Interventions concerning labour had to address the specificities characterising the workforce in the state while maintaining continuity with the larger environment of pro-labour and welfarist slant of policy. This process is examined in detail in the next section.

8.3 Welfare during the Pandemic: Continuities, Discontinuities, and Marginalities

In this section, I review policies designed to tackle the pandemic and examine workers' experiences about them. Responses have been subcategorised as general welfare policy that affected labour, policy specific to labour, and initiatives for migrant workers.

8.3.1 General Welfare Policies

State response for general welfare had four main foci – universal access to food, access to shelter, low-cost or free medical care, and access to information. All 25 workers in the sample reported receiving the government-sponsored subsistence (*athijeevana*) kit consisting of 17 essential items, and the Onam kit, consisting of 11 items in August 2020, in addition to regular access to the public distribution system throughout the first and second waves. Other measures that were accessed widely were free treatment at all public health facilities and discounted treatment at private hospitals (20), welfare board allowances (13), welfare pensions (10), and food from community kitchens (14).

I depended entirely on ration provisions and the community kitchen. ASHA workers (community health workers) visited our house regularly. We received lots of masks and sanitiser. Someone from the panchayat would call and check on us every day. Councillors from the left and the right worked in tandem and ensured there was no conflict.

In the early weeks of the lockdown, reports of administrative high-handedness and insensitivity from the police had surfaced in the media. Workers reported protesting against some of these attacks on livelihood, which eventually petered out:

In Paripally and Attingal, police upturned the carts of women fish vendors. We intervened by conducting protests. Now the police engage very helpfully. Some of them are women. Earlier, the police used to harass us to sell fish to them at discounted rate. Goons as well. Now they are all afraid of us.

In echoing these sentiments workers were registering how they were asserting their interests and rights – their economic emancipation, which also is achieved in conjunction with political rights. Similarly, scholars have noted the shifting trajectory of responses from fishing workers in Kerala to the government's efforts at containment of the pandemic, moving from support to protest (Jament et al. 2023). The complexity of worker responses here was a result of the increasing intensity of the imposition of lockdown measures as the pandemic progressed, and the livelihood impacts that followed. Government response in this case was a mixture of suspicion, tolerance, and eventual efforts to address the concerns of workers, as evidenced in the response above. The consistency of worker protests all over South Asia during the pandemic has been identified elsewhere as a part of this project (Surendran, Ruwanpura, and Sengupta 2024). However, in stark contrast to the responses of state governments elsewhere, the government of Kerala had allowed for protests of up to ten people in July 2020, in an amendment to the Epidemic Diseases Act. This was later quashed by the High Court as violating central government guidelines (OnManorama 2020).

Government strategy featured four elements – consultation, planning, communication, and public participation. A plan of action was devised through sustained consultation with academic and professional bodies. The 'Quick Assessment Report' cited above on potential losses to the economy and possible ways ahead was compiled by the KSPB in March 2020; a 'National

Consultation’ on ‘Methodologies for Measuring State-Level Economic Losses in the Context of the Covid-19 Pandemic’ was held in May 2020. The government also teamed up with the Kerala division of the Indian Medical Association to devise a specific strategy for private hospitals and COVID-19 care.

The Kerala State Planning Board was also central to the second aspect of the strategy, which focused on anticipating fallouts. It initiated the prioritisation of plan schemes for 2020–2021 by sequencing schemes already proposed in the budget based on the immediate need and availability of resources (Kerala State Planning Board 2021, 227). Kerala was the first state government to announce an economic relief package, ahead of other states and even the central government, to address the anticipated economic impact of the COVID-19 pandemic. Out of 20,000 crore rupees, 13,200 crore rupees were set aside to disburse welfare pensions in advance for two months in March 2020 and 100 crore rupees were allocated for financial aid for families that were not eligible for welfare pensions. In the subsequent two months, 2,000 crore rupees were disbursed as loans through Kudumbashree (a state-supported self-help group initiative in Kerala), with the government bearing the interest component. Another 2,000 crore rupees were set aside to provide jobs under the Employment Guarantee Scheme (KDR 2021, 227).

Transparent communication at all levels is the third distinctive feature. The state’s task force on COVID-19 met every day from March 2020 to March 2021. The chief minister addressed the people through a daily press conference at 6.00pm from March 2020, updating them about COVID figures, elaborating on measures taken, and answering media queries. These press conferences went on to become a distinct feature of Kerala’s response to the pandemic. All the 25 workers interviewed reported tuning in to the chief minister’s daily updates, some describing it as a ‘source of assurance’ during uncertain times. The culture of increased communication and transparency was also visible throughout the administrative machinery, as district administrative officers, heads of police, medical officers, and community organisers all

took to providing up-to-date information, useful guidance, and morale-boosting messages through social media and the consistent publication of information about people to contact in the event of various emergencies. The state also launched mechanisms for psychosocial support using mental health helplines, named *Ottakkalla, oppamundu* (Malayalam for ‘you are not alone, we are together’).

The fourth feature of public participation and local government initiative ensured an environment of public care. The government extended credit facility for employment generation by providing loans worth 2,000 crore rupees to self-help groups under Kudumbashree. Women workers from Kudumbashree produced masks and sanitisers, organised community kitchens, coordinated crops and supplies for the community kitchens through local farmers collectives, and organised public health campaigns. Food was prepared in 1,165 community kitchens and provided to nine million beneficiaries. The central role played by local self-government functionaries, volunteer teams, and community work organised by Kudumbashree was mentioned explicitly by at least half of the respondents.

Civic voluntarism was a key component of the pandemic response and was often led by local government functionaries and populated by unionised workers. All workers who were organised in the sample also reported being part of voluntary activity during the pandemic. While some were part of informal groups gathering provisions to distribute among workers not registered with welfare boards, most were part of neighbourhood organisations that assisted in the distribution of relief.

We conducted ‘Biriyani challenge’ and collected money to buy and provide tablet and phone for engineering students. Headload workers unloaded all vaccine and medicine in the medical college and government hospital for free.

The Rapid Response Team (RRT) was an initiative under the local self-government agencies in each local ward to constitute such local teams of volunteers.

When the lockdown was imposed, many even from high-income families with only elders faced dire situations as their helpers and maids couldn't reach them. We helped everyone. We also fed animals that were left to starve as shops shut down. No one was left to starve. We cooked, packed and distributed food thrice a day for 1600 people. We would start cooking and packing food from 5.00 am.

However, the implications of civic voluntarism on incomes and survival are heavy, and some workers felt that such work was unrecognised by the government and the public.

We cremated 36 dead bodies in this ward, almost all of them were workers and political workers. We arranged cremation without charging them any amount even for PPE kit. While government employees like nurses get salary for their covid work, RRT volunteers didn't even get recognition for the service they provided.

All this evidence from different sects of workers suggests that voluntary initiatives by workers were also key in mobilising effective responses, although there has been little or no official recognition of the role of such institutions. Then, as reviewed above, consultation, planning, communication, and participation were key to the government's strategy. The universality of welfare provisioning – the food kit and public distribution services, access to healthcare and medical supplies, the availability of health workers and local government functionaries – were reflected in workers' recollections of their experiences. Civic voluntarism emerged as the key dynamic within participation but also indicated policy fissures in acknowledging these contributions. I have written about the historical tendencies within policy voluntarism elsewhere (Surendran 2020).

8.3.2 Labour Policy and Workers' Experiences

The state government followed a two-pronged strategy of addressing the concerns of both employers and workers through relief packages for capital infusion and interest subvention. A special

cell was started in the Labour Commissionerate to coordinate the activities of the department. In the war room created in the Government Secretariat, 15 key officials of the Labour Department were deployed. For employers, the government adopted an approach of leniency featuring interest concessions, extensions on payments, loan moratoriums, and rent waivers (KDR 2021).

The central feature of protectionary measures was the direct cash transfer for workers registered under welfare boards. All registered workers were provided with 1,000 rupees as immediate relief. The government increased the existing social welfare pension for retired and unemployed workers and distributed it initially as a lump sum for four months and eventually regulated its distribution every month. Workers in different sectors were provided varying sums ranging from 1,000 rupees to 5,000 rupees as immediate financial assistance. Interest-free loans ranging from 5,000 rupees to 10,000 rupees were also offered to workers in specific welfare boards. Farmers were supported through reimbursement of losses and pensions through welfare boards (KDR 2021).

In my sample, 13 out of the 25 workers interviewed were members of welfare boards organised under the state government. Eight out of the remaining 12 were women, pointing to the inadequacy of registration efforts to reach women workers. For local workers in the informal sector, membership in the relevant welfare board was crucial to access pensions and other forms of protection, but 12 workers we spoke to were not members of any welfare board. The reasons behind this varied from time constraints to advance fees and taxes:

Some have not registered with the Welfare Board as the process is time-consuming. We must go with RC book, Aadhaar, Ration card, and License and have to go to the bank in between as part of the process. We will lose almost half a day's income. When we take a new vehicle, we have to pay tax and welfare fund contributions for a total of five years in advance. People often don't register to avoid paying Rs.10,000–13,000.

I paid Rs.18000–19000 as insurance premium but couldn't make any income after paying the insurance. We also must pay a considerable sum as welfare fund contributions per year. The government should take steps to waive or extend the deadline for these payments.

The emergence of welfare boards as the dominant frame of policy for informal labour in India has been viewed as a move away from a rights-based understanding of labour concerns, as these quotes by the workers underline. According to Agarwala (2008), they mark a shift in the relationship between state, labour, and capital. Elsewhere in India, the absence of an environment of worker mobilisation implies that welfare boards have effectively become labour's only hope for any form of state protection. Even here, the effective functioning of welfare boards is dependent on getting workers to register under the boards, an effort that has only witnessed middling success in a few states and sectors. While Kerala's history with welfare boards precedes the national shift in policy orientation, bringing all workers under the protection of welfare boards has been a challenge in the state as well, as seen in the response above. Recognising the inadequacy of registration of workers under welfare boards, the government launched a scheme to increase membership. The initiative aimed to provide 6,802,984 workers with membership in 16 different boards with 943.20 crore rupees as immediate assistance (KDR 2021). The outcomes of this effort are not yet available.

Unionisation was another crucial feature in mediating access to policy. Unions appeared to be significant not only in protecting their members and ensuring access to benefits but also for voluntary activity and mobilising funds. However, for women workers employed with private firms, possibilities of both unionisation and membership in welfare boards appeared inaccessible. In my study, 14 workers were not members of any trade union, nine of whom were women. Testimonies were consistent with existing knowledge about the vulnerability of women in the lowest rungs of the labour hierarchy. In some cases, this was also combined

with the pressures of doing unpaid work masked as voluntary service.

We don't have unions, if we unionise, we will lose our jobs. It will not be straightforward; they will accuse us of not doing our work properly. Can you imagine hearing that, after dealing with all that medical waste for those months without any extra payment because we were generally in charge of cleaning? We cannot even talk about our difficulties at work. We are nobody. No-one listens to us.

Thus, workers registered under welfare boards and those organised under unions all reported receiving welfare benefits, direct cash transfers, and other forms of support respective to their boards. The experience varied for unorganised and unregistered workers.

Another area of concern was the inadequate periods of moratorium granted by the government on loans, and the informal credit cycles this forced workers into. All workers reported having at least one loan and the responsibility of credit repayment and unanimously noted that the three-month loan moratorium announced by the state government was insufficient. Banks and informal lenders had been harassing them after this period as a matter of routine.

I have a home loan of 12 lakhs. We had to arrange money from several sources to repay interest. This was mostly from friends and chit funds (rotating credit community associations), not from banks – banks won't lend without collateral.

My life now is a race from *blade man* to *blade man*.

Blade man is a colloquial term for the predatory money lenders notorious for their cutthroat attitude towards each other as well as to the community they serve. The inability to access formal sources of credit and the consequent reliance on informal sources – both predatory and non-predatory – is a universal feature of marginalised communities. These exploitative relationships

become particularly heightened during economic downturns, reflecting extreme forms of vulnerability as seen in the responses above. While the state government responded by requesting the centre for increasing the moratorium on loans following the second and third waves of the pandemic and organising consultations with banks, workers' responses reflect the continuing crisis.

8.3.2 Initiatives for Migrant Workers

Kerala's dignified treatment of migrant workers during the pandemic also received media attention. Even though migrant workers were not interviewed as part of this project, a profile of state response has been generated through policy analysis and interviews with administrators. As evident from all the interviews with labour administrators, migrant workers were a strong priority of the state. They almost exclusively spoke about them even when asked about the department's general approach to labour.

Migrant workers were provided with food and other provisions during the lockdown period, and relief camps were set up to ensure better facilities. In May 2020, the Labour Commission reported that 434,280 guest workers were sheltered in 21,556 camps across the state; 434,280 migrant workers were beneficiaries of the community kitchen (KDR 2021).

Migrant worker helplines were set up in all districts using multilingual university students as volunteers who would give them information about disease control, containment protocol, and updates on travelling back to their states. Trained counsellors were engaged in the district call centres for migrant workers in distress. The labour commissioner would travel throughout the state and meet workers from March to June 2020. Some of these interactions revealed shortcomings with the arrangements, such as workers' desire to cook their meals according to their cultural preferences, following which the department switched to delivering provisions and cooking gas to labour camps.

I recorded audio messages in Bengali, Assamese, Oriya and Hindi, to reassure workers at the beginning of the helpline calls. I would also send out video messages on Whatsapp and go live on Facebook. I toured the state nine times in three months. It makes a big difference if you are there yourself. (Secretary, Department of Labour)

Data about guest workers sheltered in camps were collected using spreadsheets, utilised in June 2020 during the subsequent coordination of the movement of migrant workers to their home states through Shramik trains. Student and youth volunteers undertook these activities as well. By mid-June 2020, a total of 205 trains had departed from Kerala, carrying about 289,703 guest workers to their native states.

Our focus was to get them out of the state with minimum complications. It was a huge task, we had a big map of the country on the wall of the war room. I discovered towns I did not know existed. I remember not sleeping for weeks. (Additional Labour Commissioner and member of the migrant worker taskforce)

The attention paid to migrant welfare is unique to Kerala's approach to labour, and much in contrast with the national experience. However, queries about specific measures for local and unorganised workers met with vague responses. Most of the administrators interviewed stated that local workers are all under the umbrella of welfare boards, which was the primary mode of disbursement of cash benefits. Kudumbashree was also suggested as an important avenue of women's employment and loan disbursement during the pandemic. Testimonies, however, clearly reflect the inadequacy of coverage of welfare boards, particularly for women workers.

8.4 Continuing Efforts and Challenges: The Pandemic in Retrospect

Writing on the crises unleashed by the pandemic focuses on confronting the multiple obstacles to economic recovery and mounting public debt. These have also established the deeper vulnerabilities that Indian workers have been pushed into (Abraham, Basole, and Kesar 2022; Breman 2020; Jha and Kumar 2020). Sectoral and intersectional differences within the workforce and existing inequalities have deepened, particularly for women workers, informal labour, and historically marginalised sections (Abraham, Basole, and Kesar 2022; Patil 2021). The impact of the lockdown imposed following the pandemic on employment and income loss, and the relatively slow pace of recovery for India are documented by Sharma and Swenden (in this volume; see also Kakarlapudi and Shagishna 2023). Surely, the most important questions facing the state against this backdrop are about future trajectories. What continuities can we see in ongoing and future state policy orientation for labour?

The most important challenge is boosting production and generating employment. The withdrawal of the national government's welfare support and its inability to provide a fiscal stimulus to the economy are commonly understood as important reasons for the slow post-pandemic recovery in India (Ghosh 2020). Where does Kerala stand on these counts? The specific economic impact of the pandemic on Kerala is noteworthy, as the state continued to have very rigorous lockdowns, unlike many other Indian states even after the first wave. Consequently, the growth in the unemployment rate in Kerala after the second wave (April to June 2021) was over 10 per cent, almost three times the national average for the same period (Kakarlapudi and Shagishna 2023). However, it is also noted that 12 out of 18 states in India have returned to pre-pandemic unemployment levels in April–June 2022, Kerala being one among them.

In analyses of subnational responses to social security and welfare spending across India, scholars have described Kerala's

spending as ‘exceptionally high’ when comparing the growth of actual spending between 2019–2020 and 2020–2021 (Joseph and Pillai 2022). Consistent with general economic trends, Kerala’s economy also recorded a massive contraction both after the first and the second waves. However, in the *Economic Review of the State* (2021), the KSPB notes that the contraction was controlled to some extent through the two economic stimulus packages of £200 million announced in March 2020 and June 2021, respectively. In July 2021, a supplementary package of £540 million was announced specifically to support small industries (Economic Review 2022, vii).

The vulnerability of women workers has been highlighted across scholarship on Kerala during the pandemic (Rajan et al. 2023, Ramakumar and Eapen 2022). This is reflected in workers’ testimonies as well. Interestingly, Kerala was the only state that recorded a decline in women’s unemployment during the pandemic, which has generally been understood as a distress-driven trend. We are yet to completely understand whether the drop in female unemployment is correlated with the heightened participation of SHG-led community kitchens during the first wave. In conjunction with the discussion on the distress-driven rise in women’s unemployment, this also raises questions about employment possibilities in disaster management and the positioning of women workers within this framework.

8.5 Conclusion: Learning from the Kerala Experience

India’s national response to the pandemic which further worsened the condition of workers has been explained in two broad ways. The first underscores the ‘legacy issues’ of the economy – informalisation, poor working conditions, slow employment generation, and accelerated neoliberalisation – as exacerbating the impacts of the pandemic on workers. The second points at the systematic breakdown of state support for labour within India’s larger development history, and the declining political will in

providing workers' rights for fear of business-unfriendly posturing within labour policy. From a labour perspective, over and above questions of public health and quarantine protocols, it was the implementation of strict lockdowns without prior preparation or larger consultation that rendered conditions particularly bad for workers in general and migrants in particular (De Haan 2020). A team of Oxford scholars pointed out that India topped the world in terms of the stringency of the lockdown but was at the bottom of the pile in terms of providing welfare support to workers or fiscal measures for employment generation post-lockdown (Joseph and Pillai 2022). Kerala's journey counter to these trends demands closer attention for its pointed departure from the national experience. This departure is at the intersection of three trajectories within Kerala's experience. The first is the strong welfarist policy environment and the focus on labour rights, which had already made the state a frontrunner on labour protectionism, enabling it to leverage this framework in strengthening support. The second is the innovative policy response during the pandemic, which is characterised by the four aspects of consultation, planning, communication, and public participation. The third is the continuing effort to deal with the economic and social fallouts of the pandemic and to identify the inadequacies in the adopted approach.

The consistent presence of a rights-based approach to worker welfare has been the central element of Kerala's policy response to labour before, during, and after the pandemic. The state has displayed foresight in both strengthening or accelerating existing protections and paying special attention to migrant workers – sharply in contrast with the rest of India. This was achieved through consultation and planning, targeted action for different sections of workers, civic voluntarism, and local government action, the role of the state in creating collective confidence within the population, and in continuing fiscal support through its willingness to spend on labour protection and stimulus packages.

However, existing challenges have resurfaced and newer challenges have emerged, both at the structural and the implementation levels. The state's response is assessed here considering

pre-pandemic legacies but also to identify gaps from the perspective of complications within the model, as pointed out earlier. I did this by outlining the initiatives of the government during the pandemic and juxtaposing them with worker testimonies about their experience of policy. Worker testimonies indicate that some sections of the workforce did get left out of the ambit of labour protection, that the coverage of welfare boards is not adequate, and that specific forms of frontline work were not adequately recognised or compensated. I highlighted that these experiences are starkly gendered as women workers continue to be subject to vulnerability. Discussions about local workers with labour administrators revealed some policy complacency, particularly for women and informal workers who were not unionised or registered under any welfare board. I have argued that, while the state's experience is strongly rooted in policy continuities, innovations, and the political will to address structural inequalities, the inability to address existing constraints has led to sections of the workforce being marginalised within welfare provisioning.

Notes

- 1 Fieldwork for this study was co-ordinated by Rahul N of the Institute of Management in Government (IMG), Thiruvananthapuram. I sincerely thank him for his contributions.

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CHAPTER 9

Mitigating the Ready-Made Garment Sector's COVID-19 Crisis in Bangladesh

Protecting Workers or the Interests of the Industry?

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Abstract

Bangladesh's ready-made garments (RMG) sector is the country's primary export industry and the largest source of foreign currency, employing around 2.59 million workers. However, its exposure to global volatility and crises was vividly demonstrated during the

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COVID-19 pandemic. Faced with order cancellations, factory closures, and widespread unemployment, the government swiftly responded with a financial stimulus package to cover workers' wages. Despite these efforts, RMG workers experienced job losses, reduced incomes, health risks, and various other insecurities. We take a political economy lens to explore the interests, incentives, and relative power of various stakeholders. The chapter seeks to understand the allocation and implementation of the financial stimulus packages, examining who gained and who lost, and why. It discusses health and livelihood risks confronting workers and the challenges of retaining employment, safeguarding earnings, and having their voices heard. We undertake an analysis of policy responses and their accomplishments and challenges. The chapter draws upon interview data, ongoing media monitoring, and secondary literature related to labour rights and the RMG sector. It concludes with a discussion of the implications for workers' welfare and rights in the post-pandemic economic landscape, where Bangladesh, much like other South Asian economies, remains susceptible to potential global economic downturns.

9.1 Introduction

South Asia is currently facing a protracted crisis transitioning from the COVID-19 pandemic to an unfolding debt crisis. While economies worldwide are grappling with these challenges, workers in specific economic sectors are experiencing varying effects on their livelihoods, health, and overall well-being. To comprehend these changes, it is crucial to examine the macro-response of the state as well as the perspectives of the workers.

The RMG sector stands as the largest export industry in Bangladesh, employing around 2.59 million workers (Sultan and Antara 2021; Sultan, Antara, and Islam 2023), contributing 81.82 per cent of the country's total exports and 9.25 per cent of gross domestic product (GDP) in the fiscal year (FY) 2021–2022 (Bangladesh Bank 2022). The broader context shaping the nature of support by the state to the RMG sector includes the global economic relations

of the RMG sector (Saxena 2020; Siddiqi 2015), the state's nature, and its interactions with employers and workers. In recent years, democratic backsliding, shrinking space for civil society, including independent union activities (Hassan et al. 2021), and the emerging threat of a debt crisis due to rising fuel and energy costs have been observed.

We seek to understand how the RMG sector and its workers were affected by COVID-19, the measures the government and other key players took to mitigate the damage, and the response. We will highlight the health and livelihood risks faced by workers, as well as the challenges of retaining employment and safeguarding earnings. Adopting a political economy lens, we aim to explore the roles of various actors and stakeholders to mitigate the crisis while prioritising their incentives and interests.

We draw on research conducted by the BRAC Institute of Governance and Development (BIGD) between April and May 2020 with 20 key informant interviews with labour leaders (both men and women) based in different areas of Dhaka district (Ashulia, Narayanganj, Gazipur, and Dhaka city) to gather their views on the stimulus package and lockdown governance during COVID-19 (Sultan et al. 2020). We also utilise secondary data, including social media and print media reports, along with interview data from 33 respondents, including RMG workers, trade union leaders, and allies of the labour movement, collected between 2021 and 2023.

We begin by setting the political economy context. [Section 9.3](#) will examine the impact of the COVID-19 crisis and the global economic crisis and inflation on the RMG sector. [Section 9.4](#) explores the policy responses to the pandemic by the state and various actors and analyse how employers, brands, and trade unions responded. [Section 9.5](#) will discuss how the workers coped with the fallout of the pandemic and the more recent economic crisis, particularly in terms of jobs, income, nutrition, and health. This will lead us to conclude with a discussion of the gaps in providing security and welfare for workers that emerged during the pandemic and the subsequent economic crisis.

9.2 Context

Until mid-2024, the Bangladeshi state could be characterised as a dominant-party state (Hassan and Raihan 2017). The Awami League emerged as the *de facto* dominant party in the 2018 national elections, solidifying its control over the state with minimal organised political opposition. The state's increasing control in favour of the private sector is evident by how the Industrial Police and Detective Branch operated, and how the surveillance imposed on trade union activities (Sultan and Antara 2021). These developments have restricted labour's ability to organise, protest, and voice their demands.

The RMG sector, which emerged in the 1980s, stands as the leading formal export sector. The Multi Fibre Agreement quota played a significant role in its establishment, growth, and maturation (Saxena 2020). Even with the crisis brought on by COVID-19, the industry achieved record-high export earnings of US\$42.6 billion in FY 2021–2022 (BGMEA n.d.). The growth of the RMG sector has been facilitated by the deepening relationship between the state and the private sector, with significant government support.

As the national economy has grown, the influence of the private sector has also expanded. The increasing presence and control of business actors in formal political institutions have become evident, underscoring the strength of RMG entrepreneurs (Hassan and Prichard 2013). The present parliament reportedly includes 50 members of parliament (out of a total of 350) who are RMG industry owners, and several ministers and advisers are also RMG industry owners. The power and influence of the industry's associations, the Bangladesh Garment Manufacturers and Exporters Association (BGMEA) and Bangladesh Knitwear Manufacturers and Exporters Association (BKMEA) are such that neither the government nor trade unions can effectively counter their sway (Sultan and Antara 2021).

While the labour movement has historically been a key political force, changes in political power and growth-oriented policies

prioritising privatisation and capital interests have diminished its influence and elevated the importance of business–state relations (Tighe 2016; Sultan and Antara 2021). Labour unions in Bangladesh have traditionally maintained close ties with political parties, seeking patronage and support from them (Ashraf and Prentice 2019; Tighe 2016). Nevertheless, trade unions in the RMG sector have gradually evolved into more professional and organised entities, enabling them to negotiate more effectively with the government and employers, both domestically and internationally. This progress has occurred despite the state's lack of promotion of labour organisations, the right to association, and collective bargaining (Siddiqi 2016).

9.3 Impact of COVID-19 on the RMG Sector and Subsequent Global Economic Crisis

COVID-19 has significantly disrupted the global economy, resulting in a substantial decline of 8.98 per cent in global exports in 2020 (World Bank 2020). The Bangladeshi economy particularly felt it when it faced economic challenges as the pandemic-induced lockdown persisted, leading to increased financial burdens and a decrease in GDP (Bodrud-Doza et al. 2020). The country's export industry witnessed a sharp 17 per cent decline in FY 2019–2020, with an 18.12 per cent drop in RMG exports. The RMG sector faced order losses amounting to US\$3.16 billion and an 85.25 per cent reduction in export earnings in April 2020, resulting in the closure of several factories (Hassan et al. 2021). According to the Centre for Global Workers' Rights, 23.4 per cent of suppliers experienced a significant number of order cancellations, with 5.9 per cent facing complete cancellations; and 398 BGMEA factories and 130 BKMEA factories temporarily ceased operations (Hansen et al. 2021).

A survey by the Centre for Policy Dialogue (CPD) highlighted that the industry encountered delays in payment and refusals of payment by buyers for raw materials. Only 1.8 per cent of suppliers were assured of receiving payment for raw materials from

buyers, and 15.9 per cent of suppliers claimed they had to accept reduced prices for orders. Small and medium-sized factories, heavily reliant on a limited number of buyers, were particularly affected as they could not renegotiate with their buyers (Moazzem and Taznur 2021).

However, the industry quickly recovered and achieved record-high export earnings in FY 2021–2022, as mentioned earlier, contributing to 86.05 per cent of the country's total exports (Sultan and Antara 2021), a trend that continued until the end of 2022. This marked a remarkable growth of 35.60 per cent compared to the post-pandemic year of 2021 (Export Promotion Bureau 2022). Officials from both BGMEA and BKMEA attributed this recovery to the clearance of a significant number of deferred payments and a surge in demand following the relaxation of COVID-19 restrictions (Hossain 2023). Factory shutdowns in Vietnam and India due to COVID-19, the crisis in Myanmar, and wage hikes in China also led buyers to shift their orders to Bangladesh (Munni 2021).

Nevertheless, the economic effects of the pandemic have extended into 2022 and 2023. As reported in the World Bank Global Economic Prospects 2022, global trade slowed in the first half of 2022 owing to the lingering pandemic, disruptions in major Asian ports, and lockdowns in key Chinese cities. Additionally, Russia's invasion of Ukraine and its repercussions resulted in severe physical and logistical dislocations and significant adverse spillovers for South Asia (World Bank 2022, 8). The same report identified risks for South Asia, stating that increasing energy prices in a region heavily reliant on energy imports, and where in certain economies a large portion of the budget is allocated to subsidies, could worsen inflation and current accounts and thus deter investment in social protection and productivity enhancing activities (World Bank 2022).

9.4 State Responses to the Pandemic and the Roles of Various Actors

For the state, the paramount concern was safeguarding the RMG sector, the primary foreign exchange earner. Factory owners were focused on protecting their businesses, retaining their orders, ensuring timely delivery, and seeking state assistance to mitigate their financial losses and risks. While brands and buyers prioritised safeguarding their interests against losses, public outcry and pressure led some of them to take measures to ensure that suppliers were not overly penalised, and workers were not victimised. Brands like H&M, Primark, and Marks & Spencer made efforts to support the industry. Under pressure from BGMEA, the Bangladeshi government, and labour rights activists, by March 2020 several major brands had reinstated 90 per cent of their initially cancelled orders (Mridha 2021).

Trade unions played an active role in raising demands and increasing awareness of the economic, social, and health crises faced by workers. However, their effectiveness was limited by internal divisions and politicisation, which impacted their ability to present unified demands. While the government made a point of consulting them, ultimately the views of employers prevailed on factory closures and openings, lay-off wages, retrenchments, and health precautions.

Despite the existence of national plans and the National Social Security Strategy (NSSS), which emphasised the importance of preparedness for disasters and economic shock (GED 2020), the COVID-19 pandemic revealed the absence of viable long-term plans or strategies for such risks or disaster situations. Consequently, the actions taken in response to the pandemic unfolded rapidly without a well-established framework. We will now review key measures implemented for the sector in response to COVID-19, namely the financial stimulus package for the sector, lockdown measures, and health guidelines.

9.4.1 *Special Stimulus Packages and Other Social Protection Measures*

On 25 March 2020, the prime minister (PM) declared a national lockdown in the form of a general holiday from 26 March and a series of measures to safeguard citizens' health and livelihoods (Sultan and Antara 2021). Because of its contribution to the national export earning, the RMG sector was identified as a key priority for support, with the PM announcing a stimulus package of 50 billion takas (US\$595 million) to cover workers' salaries (Sultan and Antara 2021; *The Daily Star* 2020). The stimulus package was structured as an interest-free loan for export-oriented employers, intended solely to cover wages and benefits for workers in April, May, and June 2020. Payments were made directly to workers' bank or mobile financial service accounts, after efforts were made to open such accounts (Sultan and Antara 2021).

In addition to the specific stimulus package, the RMG sector was also able to access funds equivalent to US\$3.53 billion, established for large industries and services, where loans were provided to affected industries (Moazzem, Shibly, and Chowdhury 2021). As indicated by its name, only larger firms were eligible to access this fund (Sultan and Antara 2021). Other facilities for factories included loan payment moratoriums and extensions for utility bill payments.

Strong ties between political and industrial elites led to concerns about who would truly benefit from the COVID-19 stimulus package, where unions contended that the beneficiaries were most likely to be employers rather than workers. (Sultan and Antara 2021). As mentioned by a trade union activist, '[w]e want the good of the owners. But owners look at us like slaves. Instead, if they looked at us like friends, then workers would never be so oppositional' (Trade union member, 2020). Even among employers, discrimination was evident. The government's stimulus package was primarily accessed by large and medium-sized factories, leaving smaller factories with limited access to financial support (Moazzem and Taznur 2021).

While the government's response to mitigate COVID-19 affect in the RMG sector was intended to support workers, larger factories and their owners tended to be the actual beneficiaries (Sultan and Antara 2021). Unions, for instance, said: 'But government should take specific policy and guidelines to utilize the package properly. From past experience it is always proved that owners always try to deceit workers and utilize this sort of benefit for making more money. So there always will remain a doubt on their intention' (Trade union member, 2020). The BGMEA president later acknowledged that it alleviated the immediate financial pressure on owners, allowing them to prioritise negotiations with buyers.¹

Despite the government's efforts to protect the sector, workers did not receive sufficient institutional support from either employers or the government. Provisions outlined in the Bangladesh Labour Act (BLA) regarding layoffs and retrenchments could not be effectively implemented, as a significant proportion of workers are non-permanent or lack formal employment contracts, rendering them ineligible for benefits provided by the BLA. Even workers with permanent contracts who were aware of their entitlements encountered challenges in accessing their rights, as the enforcement mechanisms were weak. Trade unions that would typically negotiate on their behalf were few and weak, and their activities were disrupted by COVID-19.

9.4.2 Nationwide Shutdown

Following the closure of schools, the first measure implemented to control the pandemic was a nationwide shutdown, which commenced on 26 March 2020. However, certain essential services were exempted from the shutdown. General expectations were that factories would be closed to minimise health risks to workers. However, the declaration of holidays for the country did not make it clear whether it applied to the RMG sector (Sultan and Antara 2021). Consequently, factories attempted to reopen on 4 April 2020, instructing workers to return. Workers who had left

for their home villages tried to return but, as public transport was not operational, had to do so on foot or by using whatever informal transport they could find.

Faced with an outcry in the media at the sight of thousands of workers ignoring the lockdown and returning to the urban centres, the government declared that factories would remain closed until 14 April 2020. Workers were then forced to make the return journey to their village homes. Many who had managed to return were not allowed into their homes by landlords, fearing infections. The entire journey to and from their village homes was marked by fear and stigmatisation of workers from the communities they passed through. People in their hometowns refused to let them in owing to their recent presence in Dhaka city and the fear of the coronavirus. Consequently, they found themselves in a situation where they could ‘neither survive in the city nor find shelter’ in their hometowns (Labour rights activist, 2020).

This entire incident illustrates the limited value that was given to the welfare and safety of the workers, by the state, employers, and also the general population (Siddiqi and Hasan 2022). This was protested by trade union leaders, to no avail.

The workers were victims of false information and poor management. They were not told that they shouldn’t leave Dhaka when the ‘holidays’ were announced; they were told to get back to work by factories or other workers on the 5th [of April], which is why they travelled to Dhaka despite the lack of transport. Upon entering, they faced harassment by police and landlords for coming back and yet were not definitively told that factories would be closed until BGMEA’s announcement on the 4th evening. (Trade union leader and activist, 2020)

As infection rates did not decrease sufficiently, the government extended the shutdown seven times, until 30 May 2020, to curb the spread of the virus. Pressure from RMG owners led to an exemption for factory operations during the extension from 25 April to 5 May 2020, with ‘provisions made for the health and safety of workers’ (Adhikary, Hasan, and Bin Habib 2020). They

allowed businesses to resume operations on a limited scale starting from 10 May 2020. RMG owners argued that their industry was essential for the health and even survival of the Bangladesh economy and advocated for the workers to be considered essential workers without providing them with the protection needed for their survival (health, nutrition, or income). Effectively, they were considered expendable (Siddiqi and Hasan 2022).

The government declared holidays for all government and private offices. It did not say that people would not be paid. On the one hand, it is a lockdown, and everyone should stay home. On the other, factory workers should go to work. Then it is as if there are two policies in the same country. That is not right. The government has to take responsibility for everyone (Trade union leader 2020, as quoted in Sultan and Antara 2021, 171)

The situation worsened in 2021 as the COVID-19 crisis deepened, prompting the government to enforce strict lockdown measures in April of the same year. However, garment factories were permitted to remain operational after employers convinced the government of the sector's crucial role in sustaining the economy (AFWA 2021). Employers also feared that halting production would lead to order cancellations by brands, with production shifting to countries like China or Vietnam. This decision made work conditions challenging for workers, as employers discontinued transportation services, and unions raised alarms over the inadequate implementation of safety protocols in the factories, putting workers and their families at significant risk.

Factories have set up a checking station at the gate. They give hand sanitiser and a mask to the workers. But that's it. Workers are waiting in line to enter the factory. Moreover, inside the factory, there is no scope for social distancing, so how would they prevent infection? Workers take public transport, which is highly crowded too. (Trade union leader)

9.4.3 Health Guidelines

The BGMEA developed a safety manual for its member factories, with a primary focus on the health of workers. The manual included guidelines for medical facilities, the establishment of a COVID-19 task force, workplace isolation, and the installation of self-isolation and quarantine facilities (AFWA 2021). The guidelines emphasised the necessity for factories to obtain authorisation from local and national government bodies before resuming operations. Additionally, the safety guidelines recommended that factories provide transportation facilities for their employees and conduct temperature checks before entering the premises (UNICEF 2020). The Department of Inspection for Factories and Establishments (DIFE) also prepared a comprehensive guideline for workplaces (DIFE 2020).

However, despite the existence of safety guidelines, many garment factories across the country frequently disregarded them. Most factories did not have sufficient space to ensure adequate distancing. As noted by a trade unionist, ‘It will be very difficult to maintain distance in factories. The space between workers in factories is less than a foot. How can they ensure the minimum six-foot distance?’ Common measures taken by employers included the installation of handwashing facilities at entrances and the enforcement of mask usage. The adequacy of these measures was questioned:

Workers situation is very vulnerable. Factories are not taking any health, hygiene measures for them. They just instructed how to wash their hands and leg before entering the factory. Some factories are providing mask. Before the coronavirus outbreak some factories were providing transport for their workers, but now that service is not also available. (Trade union member).

There were discussions with the government about providing vaccines at the factory level during working hours, but this initiative was only implemented in a few pilots.

Although trade unions played a significant role in raising awareness among workers about the health risks posed by COVID-19 and promoting hygiene practices, efforts were insufficient to meet the needs (Sultan et al. 2020). Some trade unions raised funds and provided food to workers in areas where government support was lacking, but the assistance fell short of meeting overall needs.

The BLA does include provisions for healthcare for workers. However, these provisions do not specifically anticipate the needs that arise during a pandemic. In situations where wages are low and savings are insufficient, covering individual healthcare costs becomes extremely challenging (Sultan, Antara, and Islam 2023). National data indicate that individuals often must bear significant out-of-pocket expenses for healthcare, which RMG workers, with their limited incomes, struggle to afford. This situation has led to indebtedness or the inability to seek necessary treatment. COVID-19 has highlighted the importance of implementing health insurance for workers (Sultan, Antara, and Islam 2023).

9.5 RMG Workers Coping with COVID-19

9.5.1 *Layoffs and Retrenchments*

The immediate effect of the pandemic was a wave of layoffs and retrenchments among factory workers. Media reports and labour leaders indicated widespread job losses, forced terminations, and instances of workers being coerced into resigning or signing blank paperwork (Munni 2020; Uddin and Kashem 2020). A survey of 610 enterprises conducted by the CPD and Mapped in Bangladesh (MiB) between October and November 2020 revealed that half of the factories surveyed had fewer workers in September 2020 than in December 2019, and 13.9 per cent of workers reported loss of jobs during this period (Moazzem, Shibly, and Chowdhury 2021). Based on the CPD survey, the Bangladesh Institute of Labour Studies reported in September 2020 that approximately 324,684 workers may have lost their jobs (Islam 2020).

From March to May 2020, apparel workers experienced an estimated loss of US\$502 million in wages, with 82 per cent reporting a decrease in income from April to May 2020 compared to February 2020 (Saxena 2019). Many retrenched workers remained unemployed and struggled to meet their basic needs. The existing minimum salary of 8,000 takas was already insufficient but wage cuts forced workers to further reduce costs, deplete savings, and borrow money to sustain themselves amid income and job losses.

The situation was aggravated by workers not receiving any compensation from their employers; a significant portion (72.4 per cent) of furloughed workers were not paid during this period and 80.4 per cent of dismissed workers were denied their severance pay (ILO 2020). According to the BLA, workers need to have one year of continuous employment to be eligible for compensation in case of layoffs, leaving 20 per cent of laid-off workers without any form of compensation.

But what we are hearing from talking to workers and other trade unions is that workers are being terminated, retrenched. Or workers that have only worked for six months and haven't become permanent yet [or the Bangladesh laws do not cover them]; these are the places owners are taking chances. They are keeping signatures on white [blank] papers. So that they don't have to give the money from the package to the workers. They are going to show losses, cancellation of shipments, inability to pay wages to access the package. (Labour rights activist)

This led to great financial uncertainty. As stated by a trade union member, '[w]orkers are not getting salary of last month and when they can receive their salary is also uncertain. Workers are in great financial crisis at this moment. Moreover, their health and wellbeing are on high risk.' Buyers also refused to provide partial salaries or severance payments, with 72.4 per cent of workers being denied any form of payment or entitlements (Anner 2020). According to the CPD-MiB survey, only 3.6 per cent of factories paid outstanding salaries and compensation (Moazzem and Taznur 2021).

Amid factory shutdowns without prior notice, trade unions, on behalf of the workers, carried out numerous protests, engaged in lobbying, and participated in negotiations to secure their salaries and due wages. These trade unions played a pivotal role in advocating for workers' rights, pushing for full and timely payment of wages, as well as urging against retrenchment through formal letters. However, owing to the politicisation and fragmentation of trade unions, they were unable to reach a consensus on the amount of lay-off wages. Some unions demanded full wages for layoffs, while others sought 80 per cent or wages only for the working period. As a result, owners provided only 65 per cent as lay-off wages.

However, protests by workers also increased their risks of contracting COVID-19: 'Workers are doing protests now for their salary. They came on the road and did not maintain any rules to keep social distance. This increases the risk of spreading Coronavirus among them and from them to others' (Labour rights activist).

The overall fear of losing their jobs and entitlements made workers afraid to speak out or protest because of a fear of losing jobs during a volatile period. National-level federations, such as the United Federation of Garments Workers and Bangladesh Sromik Shangati, used legal measures, including sending letters on labour rights violations to government agencies, such as DIFE, the Industrial Police, and BGMEA. These efforts persuaded government agencies to exert pressure on owners' associations to address labour rights violations. Consequently, some workers received their due wages, and some factories increased adherence to health and safety guidelines (Antara and Syed 2020).

9.5.2 Low Wage Rates

The wage rates in the Bangladesh garments industry are among the lowest in the world, and high inflation, particularly in food, energy, and housing, means that, in real terms, wages have declined (Sultan, Antara, and Islam 2023). Even before the pandemic they were insufficient to cover basic needs, leaving workers

with no reserves to overcome shocks such as the COVID-19 pandemic. The national surveys jointly conducted by BIGD and the Power and Participation Research Centre during the pandemic found that RMG salaries dropped by 16 per cent in June 2020 and recovered to a decrease of 5 per cent in March 2021 (Rahman et al. 2021, 81). Monthly wages of dismissed workers who were unable to find jobs in the garment industry in 2020 fell dramatically: from US\$110 to US\$37 by the end of 2020 (AFWA 2021). This significant decline forced workers to accumulate more debt to cover their basic needs in 2020, with 99 per cent of the workers reporting that they had taken on debt during the pandemic (AFWA 2021, 136).

Recent analysis shows that a family of four needs at least 22,421 takas per month for food alone, which is three times the average pay of RMG workers (*The Daily Observer* 2022). Many workers also lost pay or were retrenched during the COVID-19 pandemic. A study conducted by Fair Wage and Karmojibi Nari in February 2021 found that the monthly income of RMG workers had significantly decreased during the COVID-19 pandemic, with most retrenched workers still struggling to survive (Hossain, Akter, and Ahmed 2021). The average income of a worker before the pandemic was 10,313 takas per month, including overtime, but during the lockdown it dropped to 5,425 takas (Sultan, Antara, and Islam 2023).

Workers surveyed in Bangladesh in 2021 by AFWA had worked an average of 3.15 years in the same factory but earned poverty-level wages, leaving them without savings to see them through the crisis. As a result, they adopted coping strategies such as 1) reducing consumption, 2) increasing indebtedness, and 3) selling assets (AFWA 2021, 145).

The Wage Board for the RMG sector was formed in March 2023 and is supposed to propose a new minimum wage by October 2023. This has allowed workers and trade unions to mobilise around demands for higher wages, both to compensate for the economic hardship and losses due to COVID-19 and to compensate for the very high inflation experienced since 2022 due to

global economic pressures. Various labour groups have formulated various demands for a minimum wage between 23,000 and 25,000 takas, taking out processions, organising demonstrations, and engaging with the employers and government decision makers. However, the weakness and politicisation of the trade union sector is apparent in the fact that the various factions have not been able to agree on a common demand but are influenced by the different political streams that they feel accountable to rather than to their constituents, the workers.

9.5.3 Challenges of Ensuring Nutritional Needs

The nutrition of garment workers has been significantly affected by job and income losses during the pandemic, exacerbating an already unsatisfactory situation. According to health experts, RMG workers in Bangladesh require a minimum of 3,364 kilocalories per day (Faruque et al. 2013). However, in June 2022, Bangladesh Garment Workers Solidarity reported that workers' daily calorie intake was less than 2,000 kilocalories (Chandan 2022). Another survey, by AFWA Bangladesh in 2021, highlighted that the daily per capita food consumption of a worker is 1,950 kilocalories, costing 120 takas. AFWA (2021) reported how this fell below poverty-line thresholds for consumption, which is at 2,122 kilocalories, as established by Bangladesh's Household Income and Expenditure Survey in 2016.

The CPD estimated that the current cost of food requires a garment worker to spend at least three times their wage to meet the minimum calorie intake for a family of four, which amounts to 22,421 takas (*The Daily Observer* 2022). This was confirmed by the UC Berkeley–BRAC survey, which revealed that 77 per cent of 1,057 workers found it difficult to feed their families, while 69 per cent consumed fewer protein-rich foods between February and May 2019 (Rabbani, Saxena, and Islam 2020).

The rising costs of food owing to inflation and the negative effect on workers' nutrition have continued in the post-pandemic period and have created widespread unrest. Globally, the

worldwide price hike and inflation brought on by the pandemic and later the Ukraine crisis have sparked riots. Hossain and Hallock (2022) report 12,500 protests in 148 nations from November 2021 to October 2022, fuelled by price hikes, inflation, and resource shortages. These protests demanded the adoption of economic policies that would help ordinary people and expected governments to guarantee affordable access to basic needs. Governments in several countries have blamed companies for generating excessive profits by purposefully shifting the blame to the Russia–Ukraine war (Hunnicut and Renshaw 2022). In Bangladesh, too, the government accused seven firms of destabilising the market by excessively increasing the prices of necessary commodities with the goal of profiteering (Shibli 2022).

9.5.4 Health Risks and Costs

The health needs of COVID-19 for the entire population have been recognised since the outbreak in 2020. However, the health of RMG workers received less priority. Despite the ongoing pandemic, employers were able to argue for the priority reopening of their industry as an essential export sector, effectively making factory workers essential workers. As neither the government nor employers were willing to provide them with salaries to maintain their livelihoods without working, workers had no options other than to work to survive. Both BGMEA and DIFE formulated health guidelines for factories to follow and established COVID-19 monitoring teams to visit the facilities. However, this did not consider that workers would be living at home and travelling to work, exposing them to infection in the community.

Similar to the low-cost, crowded, and unhealthy living conditions described for Sri Lankan workers, Bangladeshi RMG workers are compelled to live in cheap accommodation that could not allow for maintaining safety procedures against COVID-19 infections (Prentice et al. 2018; Ruwanpura 2022). As mentioned, most factories could not provide transportation to work. COVID vaccination for workers was not prioritised. Therefore, even full

enforcement of safety measures within factories would have had limited impact, as other dimensions of workers' health were not accounted for.

During the early stages of the pandemic, workers experienced illnesses, mental stress, and financial hardships (Giorgi et al. 2020). However, many workers were initially unaware of the safety precautions implemented by factories, such as handwashing, body temperature monitoring, and maintaining physical distance. Furthermore, over time, the implementation of these practices gradually declined (Hossain, Akter, and Ahmed 2021).

Both the government authorities and employers' attitudes and practices regarding workers' health reflected discrimination and class biases. Although the BGMEA started off by reporting on the number of COVID-19 cases in member factories, this soon stopped. The lack of testing among workers and reporting prevents us from making any statements about whether workers were affected or not. There were no reports of factories being shut down for COVID-19 infections. Siddiqi and Ashraf (2022) have highlighted the discriminatory attitude by owners and authorities towards workers' health with a statement made by the then president of BGMEA, who declared that 'sromikder shorire ekta alada shokti thake', which roughly translates as 'working-class bodies possess a distinct kind of strength'.

Although factories associated with major brands had some measures in place, workers still expressed concerns about the risk of getting infected. In a survey, 59 per cent of workers believed they were 'somewhat likely' or 'very likely' to contract the virus at their workplace, while only 29 per cent thought they would contract it at home (Rabbani, Saxena, and Islam 2020). Labour activists reported instances where workers who exhibited coughing or fever symptoms were instructed by management to go home and return only if they could provide a negative test report (IHRB and Chowdhury Centre for Bangladesh Studies at UC Berkeley 2021). However, testing was slow and costly. Several interviews also mentioned the mental stress of workers in terms of the fear of becoming infected by COVID-19 or losing jobs due to it.

9.6 Conclusions and Emerging Priorities

The global economic crisis introduced an additional layer of challenges for workers and the RMG sector in Bangladesh, compounding the existing difficulties caused by the COVID-19 pandemic. On one hand, it reinforces many of the long-term effects of the pandemic, and, on the other, it highlights the need to address the sector's institutional weaknesses exposed by COVID-19. Despite the RMG sector's significant economic importance, both the industry and its workers remain highly vulnerable to various shocks and crises. The lack of long-term planning and strategies to address economic shocks and disasters has made the sector ill-prepared to handle such situations. While the government responded promptly to protect the industry, the interests of workers were secondary, and they lacked institutional support.

At the global level, it became evident that brands and buyers also lacked institutional mechanisms to protect their suppliers and workers. Neither the state nor the industry took responsibility for the well-being of the workers. The financial stimulus provided to cover workers' salaries was a piecemeal approach that benefited employers more than the workers themselves. The weakness in civil society voices and democratic processes, which could have raised concerns and sought accountability from the government and employers for their inaction and neglect towards workers' needs, only compounded the crisis. Like buyers and brands, factory owners were primarily concerned with protecting their businesses and incomes. Overall, the industry's response to the crisis was inadequate. Suppliers' limited negotiation power with buyers and brands, combined with narrow profit margins, made it challenging for the industry to allocate resources for both business and worker support during the crisis.

Trade unions faced numerous challenges during the pandemic that hindered their ability to fulfil their responsibilities. Mobility restrictions, politicisation and fragmentation, and a lack of recognition and support from the government and employers limited their ability to effectively address the needs of workers.

In terms of health and nutrition, workers were already vulnerable before the pandemic owing to low wages and limited access to healthcare services. The COVID-19 crisis further exacerbated these issues, and the recovery of health and nutrition status has been hindered by global, translating into national, inflation. Insufficient wages to cover basic needs have led to inadequate nutrition, limited access to healthcare, and increased mental health issues due to worries and stress.

In conclusion, the COVID-19 pandemic and the subsequent global economic downturn have highlighted the pressing need to expand social protection measures and explore joint financing mechanisms involving brands, employers, government, and workers. The COVID-19 crisis has highlighted the necessity of providing employment insurance for formal sector workers. The NSSS, approved in 2015, initiated discussions and initiatives to integrate universal social protection for the elderly and establish unemployment insurance that incorporates formal employment policies and social insurance schemes. Recognising the risks faced by the RMG sector, the need for such social insurance schemes, which would allow individuals with sufficient income to invest in additional protection against life-cycle risks, was already acknowledged within the NSSS framework. Making health insurance mandatory for workers and scaling up successful pilot programmes should be prioritised.

Another priority issue is increasing the minimum wage to a decent or living wage level to ensure that workers can meet their daily needs and can save for future needs and contingencies. Otherwise, they will not be able to provide for the nutrition, healthcare, and housing required to ensure that minimum living standards are met, and they can productively contribute to the RMG sector while enjoying basic human rights.

All actors in the global value chain must acknowledge and fulfil their responsibilities in providing basic rights to workers at the bottom of the chain. This includes brands, employers, governments, and trade unions working together to ensure fair wages, safe working conditions, and social protection for workers.

Collaboration and collective efforts are needed to address the vulnerabilities and gaps exposed by the pandemic and to create a more equitable and sustainable garment industry.

Notes

- 1 See BGMEA, 'Message from BGMEA President: COVID-19 | Industry Response & Support from Honorable Prime Minister', YouTube video. <https://www.youtube.com/watch?v=zEHduifpH5k&feature=youtu.be>

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PART III

Micro Approaches: Workers

CHAPTER 10

Frontline Narratives

Experiences of Healthcare Workers in Pakistan amid the COVID-19 Pandemic

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Abstract

This chapter provides insights into doctors' experiences during the COVID-19 pandemic in Pakistan from June 2020 to July 2021. Drawing on interviews with 34 doctors working in Lahore's public hospitals, it explores their everyday challenges within an already strained public healthcare system. It foregrounds issues often overlooked in state-led COVID-19 policies, including misinformation, stigmatisation, and the lack of adequate protective equipment, and situates these 'unshared' experiences in a wider socio-cultural context. The chapter unpacks how uncertainties about the virus, flaws in health initiatives, and intersecting inequalities, particularly along lines of class and hospital hierarchy, shaped doctors' working lives. Notably, doctors in lower socio-economic

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positions, compounded by lower professional ranks, faced heightened risks and constraints. The chapter contributes to debates on state intervention and healthcare infrastructures by arguing for more comprehensive policies that address structural conditions and recognise frontline workers' specific struggles.

10.1 Introduction

The first COVID-19 wave in Pakistan lasted from late May to mid-July 2020 and was unsparing in placing the country's under-resourced healthcare system under extreme strain. The number of infections reached an alarming high of 154,760 in mid-June 2020 (OCHA 2020). Significant worries about the virus, false information, stigmatisation, insufficient hospital capacity, and a lack of personal protective equipment (PPE) emerged in hospitals. These are all aspects that state-led COVID-19 policies did not contextualise. Further, longer working hours, poor work–life balance, exposure to patients, the danger of contracting and spreading the virus, witnessing the illness or death of family, friends, and co-workers, and the stress, anxiety, and burnout accompanying these events plagued the lives of healthcare workers (HCWs), including doctors, nurses, and other medical personnel. Recent research has examined emotional and psychological distress and problems, for example the consequences of poor policy implementation, PPE shortages, high workloads, poor work–life balance, uncertainty, and occupational burnout, 'shared' among doctors in different contexts across the world (Ayar, Karaman, and Karaman 2021; Pattnaik, Samanta, and Mohanty 2021; Romate and Rajkumar 2022; Sun et al. 2021).

However, what is often missing is their unique, 'unshared' experiences and how these experiences are embedded in a wider sociocultural context and impacted by existing structures (Boamah et al. 2022). Unshared experiences were influenced by factors such as seniority in the hospital hierarchy, class, and gender, making working during the pandemic particularly challenging for junior doctors. For instance, many junior doctors, irrespective of gender,

who were underpaid or not paid at all, were compelled by senior doctors to work in COVID-19 wards. Female junior doctors faced additional challenges, with some continuing to work despite being pregnant to avoid interrupting their medical training. Moreover, a lack of work–life balance negatively affected many female doctors owing to increased working hours and heightened care responsibilities at home. This highlights the persistence of structural violence within hospitals, worsening working conditions and posing challenges for doctors and nurses of lower rank and socio-economic background, particularly for women.

I started collecting data on doctors' experiences at the beginning of the first wave of COVID-19 in June 2020 and interviewed them up to the fourth wave in July 2021. I conducted semi-structured interviews with 34 doctors based in four public hospitals in Lahore. In their institutional capacities, they are seen as performing tasks related to treatment, therapeutics, and curative care. Outside their institutional medical functions, they remain anonymous and concealed. Therefore, what is also frequently overlooked is that the healthcare system is also made up of people – the HCWs – who have their own perceptions, feelings, fears, backgrounds, and contexts. Individual experiences of fear and risk anxiety can diminish the efficacy and quality of care. Furthermore, comprehending their experiences is necessary to inform interventions for support during public health crises.

Gender intersects with class and other vectors of inequality, worsening the situation for individuals facing multiple forms of marginalisation (Crenshaw 1991). These intersectional inequalities were further exacerbated during the COVID-19 pandemic (Ho and Maddrell 2020). In Pakistan, where gender, ethnic, and class disparities are deeply rooted, the combined impact of these factors created severe challenges, particularly for women in health-care. Although I collected qualitative data on female nurses' and doctors' experiences during the pandemic, this chapter emphasises class and occupational hierarchy as primary lenses. However, gender played a critical role in worsening their experiences. For example, a female doctor belonging to a lower occupational

hierarchy and an ethnic minority group experienced marginalisation on multiple fronts. Moreover, women in Pakistan, a patriarchal society, bear a disproportionate burden of care responsibilities, including managing children, elderly family members, and household duties. During the pandemic, these societal expectations clashed with extended professional hours, leading to a significantly poorer work–life balance and greater stress.

The intersection of gender and regional developmental disparities alongside class is another dimension that deserves attention. Female HCWs in underdeveloped or rural areas faced additional hardships due to limited resources, inadequate housing, weaker support systems, and heightened patriarchal norms (Raza et al. 2023). This remains a critical avenue for further exploration to understand the compounded inequalities faced by marginalised groups in Pakistan.

In the following sections, I unpack the insights shared by the doctors regarding the challenges posed by the COVID-19 pandemic and the various facets intertwined with their first-hand experiences of navigating the crisis in Pakistan.¹ First, I explore how the uncertainties surrounding the virus, such as its mode of transmission and treatment options, affected both their professional duties and personal lives daily. Second, I analyse state-led health initiatives, which, while well-intentioned, often suffer from poor implementation. Lastly, I investigate the ramifications of existing inequalities and social divisions, drawing connections to the frontline experiences of doctors. Specifically, I scrutinise current economic disparities to illustrate how classism and hospital hierarchy intersect, mutually reinforcing each other and influencing both the medical care provided and the daily lives of HCWs. The repercussions were particularly severe for doctors occupying a socio-economically lower position, stemming from lower professional ranks coupled with belonging to lower socio-economic classes. Despite their relative privilege within the broader population, these doctors still faced compounded intersectional inequalities during the pandemic. They became easy scapegoats for higher-ranking doctors, often being assigned COVID-19 patients,

further exacerbating their challenges and highlighting the complex dynamics within the healthcare system.

10.2 'Out of Hand' Situations: Uncertainty and Leaping into the Unknown

While coping with uncertainty and fear brought on by disease spread and mitigation in hospitals, doctors were also confronted with the implications of sociocultural realities and divisions. If not addressed, uncertainty can impact doctors' levels of inquiry, patient safety, and resource utilisation (Koffman et al. 2020, 211). Early phases in Pakistan were characterised by slow redeployment of medical staff and facilities, a lack of health supplies, low testing intensity, open mosques, false information on social media, and low local adherence to preventive measures (Ali, Sadique, and Ali 2021; Tavakkoli et al. 2022). Hence, the COVID-19 pandemic was viewed by doctors as a period when the 'crisis of our certainties' was made apparent in the face of this rapidly spreading, unknown disease (Romiti and Talerico 2021, 3562).

Doctors had to face numerous unanswerable questions. What kind of care will the patients receive? What is the virus's means of transmission? Why do some individuals only have minor symptoms or none, while others have severe or fatal symptoms? The absence of information and inconsistent application of policies about these issues left doctors suspended in uncertainty. For instance, several treatments in their experimental stages, such as convalescent plasma therapy, were prescribed despite the lack of complete proof of efficacy, and doctors had to work around unconfirmed results of nasopharyngeal swabs and chances of false-negative or false-positive results.

Although doctors are skilled at treating illnesses, they faced a great lot of uncertainty during the initial wave of COVID-19 when support and aid from the government were insufficient. According to Douglas (1992), the response to risk and uncertainty is to assign blame to some people, especially the marginalised or individuals flouting existing beliefs, reflecting their social standing.

People tend to desire assurance in the face of ambiguity by turning to authorities who can offer proof and explain parts of the pandemic. Trust towards those authorities is lacking in Pakistan, and existing social fissures can provide a basis to examine who is typically blamed and othered. For Dr T, 29, a surgery resident at a semi-government hospital in Lahore, the local population was mostly to blame for the rise in cases. During our phone conversation on 20 June 2020, he explained:

After the first case was reported, the public [*awaam*] as well as the doctors, were in denial. Testing kits were acquired after two weeks when the situation had gotten out of hand. Moreover, a lockdown was announced overnight, creating a lot of panic ... Pakistan also has a non-existent and ineffective public health system. The denial on the part of medical professionals, along with ineffective policies made by the government and hospitals, escalated the spread of COVID-19 throughout the country.

Dr T stated that they received no formal training when the COVID-19 outbreak was declared a pandemic in March 2020. The government was unable to offer sufficient support at the time when doctors required guidance, tools, and resources to help them respond to the mounting cases. Hence, hospitals were forced to design their protocols amid the confusion over the virus's origins, symptoms, and treatment. Dr T said, sounding frustrated:

Doctors lacked policies and effective channels to deal with the unprecedented pandemic emergency. They also lacked awareness and required knowledge and helpful resources to deal with positive and suspected COVID-19 patients. Patients with comorbidities were put at risk, along with the doctors. Since the protocols were not timely devised by the Ministry of Health, hospitals had to take the responsibility to make policies, which is not supposed to be their job. The delayed, confused, and inefficient response to the pandemic resulted in an exponential increase in COVID-19-positive cases in Pakistan.

Dr T was someone referred to as an ‘Insafian’ youth, a term commonly used in Pakistan to refer to a supporter of Imran Khan’s political party, the Pakistan Tehreek-e-Insaf (PTI). PTI is well renowned for having a support base that unwaveringly supports them and reveres former premier Imran Khan, a charismatic populist. Raja (2022) argues that PTI is a ‘cult’ that is ‘morphing into a political religion’: even though they are not homogeneous, they have several traits in common. Primarily hailing from the educated middle and upper-middle classes, they strongly identify with their Muslim faith, exhibit wariness towards Western influences, and vocally oppose corruption within Pakistan’s elite, spanning political, business, and landed classes. The internationally and nationally acclaimed figure of Imran Khan has emerged as a spokesperson for their concerns, given his educational background and widespread recognition (Khan 2017).

The main worries of the public are inflation and a lack of jobs and healthcare – and, while financial corruption cannot be disconnected from these issues, the elevation of moral claims can hijack the priorities of a low literacy population. Dr T idolised Imran Khan in his social media posts, just like Insafians, and expressed his opposition to financial corruption. Dr T did not, however, discount the terrible governance and ineffective management of the federal and provincial administrations that emerged during the initial wave. He referred to the cracks in the government’s approach to the epidemic while blaming locals for the rise in COVID-19 cases:

Government [*hakoomat*] and *awaam* are responsible for the spread of Covid-19, as no one is ready to take responsibility [*zimmadari*] or care about limiting the virus’s spread. People are in denial, and they do not accept it if they contract the virus. It is because of illiteracy and lack of awareness among the greater percentage of the population.

Like other doctors interviewed during the first wave, Dr T made sense of the uncertainty roused by the escalating COVID-19 caseload by finding flaws in how the government and locals were

responding to the pandemic. He believed that uncertainty was brought on by both the growing number of COVID-19-infected patients and family members:

We had a rigorous workload and the highest risk of contracting the virus as we were the first in the line of defence against Covid-19. One of the biggest fears I have is the possibility of transmitting the virus to my family and putting them at risk as well.

I called Dr T again five months later, during the second wave in November 2020, to ask him about his hospital experience at the time. He sounded somewhat more assured about the level of medical preparedness this time around since there were protocols in place to treat patients who tested positive for COVID-19, and there was a sufficient supply of PPE for the doctors. His perspective had also slightly evolved. He was more outspoken about the government's attempts to 'do their best', thus placing all the responsibility for the second wave on the locals. A few months into the pandemic, Dr T was especially concerned about the shortage of viable treatments for ill patients:

The government tried their best to develop proper infrastructure for testing and treatment. But people hide their symptoms or lie, do not get tested and then transmit the virus. Even Khadim Hus-sain Rizvi showed all the symptoms.² He was a suspected corona case, but his tests were not done, and his corona-positivity was denied. Patients who pass away in hospital emergencies are not tested, so the data is not credible. Doctors are also not aware of the medicines that can be effective in treating COVID-19, and there is no definite treatment yet. Handling patients is the most important role that doctors are playing during the pandemic. People still don't follow preventative measures. If they contract the virus, their families do not isolate themselves, and they continue transmitting the virus to more people.

Dr T's remarks have several facets. First, he claimed that the disregard for preventive measures is what was driving increased cases and deaths while ignoring the government's poor policy execution

because he supported PTI. Second, he briefly discussed the difficulties that doctors, particularly those at the bottom of the hospital hierarchy, had when forced to treat patients in the face of uncertainty. Romiti and Talerico (2021) argue that embracing ambiguity in routine clinical practice is the best course of action when dealing with a setting rife with uncertainties. They contend that to combat disinformation and mistrust, it is crucial to inform patients about the limitations of current understandings regarding the pandemic and the associated challenges. Nonetheless, the government's response has also contributed to lingering questions about the pandemic. Health crises encompass a wide range of factors, including new variations, uncertain results of biological interventions, and real knowledge regarding treatments and hazards. They are also political since they depend on how governments mobilise coordination, funding, resources, tracking, travel and border control, awareness, and community involvement, among other things, in the face of uncertainty.

Dr T may have attributed the spread of the virus to the locals owing to political loyalty or the respite when cases and fatalities declined in August and September 2020. Yet the state has the major duty of formulating and carrying out policies, as well as arming institutions with resources and readiness, amid emergencies like the COVID-19 pandemic. Both institutions and governments frequently shift the blame for policy failures onto the local population. The locals were told to take precautions and follow preventive measures. They were instructed that it was their duty to protect themselves and prevent the spread of the disease. However, at the same time, the provincial and federal governments let Muslim cleric Khadim Rizvi's funeral take place. While tens of thousands of Rizvi's supporters gathered close together and went in a procession to the funeral site, very few wore masks.

Governments, according to Dowding (2020), exploit the idea of personal accountability to hold people accountable for the state of society, even if it is their policy failure that has led to the problems we are currently experiencing. To avoid impeding economic activity, the administration at the time disregarded the risk of a

lockdown and permitted Rizvi's burial to go on as scheduled without enforcing COVID-19 regulations. Also, large crowds gathered for political campaign rallies without any consideration for safety precautions.

PM Imran Khan tweeted about PDM's³ protest (*jalsa*) on the same day when Rizvi's funeral procession took place. Numerous comments under his tweet highlighted how the funeral was allowed to be held. Many also tweeted videos of thousands of locals swarming Minar-e-Pakistan with captions, such as 'Who will be responsible for this?' and 'What about the funeral happening in Lahore? Where are the authorities? Why did you allow this to happen?' The country was already dealing with an increase in cases at the time of the superspreader incidents, adding to the pressure on doctors. Hence, it becomes necessary to ask how the government's response to the pandemic is closely linked to the experiences of doctors owing to the PPE shortage, weak implementation of preventive measures, and lack of support that added to their sense of fear of infecting themselves and others as well as burnout.

10.3 Missing the Basics

At one of Lahore's oldest and biggest public hospitals, Mayo Hospital, Dr Z, 32, was assigned to the isolation ward for COVID-19 patients. To start our phone interview on 22 August 2020, I asked him about the difficulties facing Pakistan's public healthcare system. According to Dr Z, the 'basics' of the nation's healthcare system were lacking. I enquired further to find out the 'basics' he was referring to. He argued that political meddling produced breaches in the healthcare system and provision of resources:

The government does not have any policies and cannot provide basic facilities. It failed on so many levels and put its burden on already overwhelmed doctors and hospital administrations who played the most important role in tackling the virus, but it has always taken undue credit. If you visit public hospitals, you realise

how the situation is different from what is shown. Political interference in the healthcare system leads to chaos. Even if you try to do good, you will not be able to settle in this workplace.

Political involvement was linked to the privileged position of federal and provincial ministers receiving preferential treatment, leaving people with low incomes behind since they could not afford private care and were not prioritised in public hospitals. Dr Z contended that the level of care that patients received relied on their capacity to pay; depending on how much they paid, they might receive the bare minimum of care. Notably, in a public hospital in Pakistan, patients are required to personally cover expenses for services, such as X-rays, CT scans, and ultrasounds. In a succinct reflection, Malik (2015, 4) highlights the healthcare situation in Pakistan:

Medicines and other essential supplies associated with healthcare accessed at public hospitals usually have to be purchased privately. Out-of-pocket payments for medicines account for over 50% of total out-of-pocket payments. Even to access free services at public hospitals, people have to visit the private clinics of the physicians who are allowed dual practice at these hospitals. At these private clinics, they pay the doctors a fee to obtain recommendations for admission or treatment at the government healthcare facility.

Dr Z also firmly believed that doctors were forced to fight on the front lines without even the most basic protection, arguing that the government saw them as 'disposable'. The doctors in COVID-19 wards had to work non-stop with little pay and inadequate availability of PPE. Also, social distancing was not a luxury that medical workers could afford owing to their proximity to patients. When I questioned Dr Z about the level of medical preparedness at Mayo Hospital, he gave me a brief overview of the pandemic's early stages:

We had no idea what PPEs were. We realised the seriousness when our colleagues and frontline doctors started getting sick.

No matter where you were, all the patients were directed to the hospital where I work. In one ward of 30 doctors and nurses, we were given only two PPE kits and masks per person. We could not deny treatment to patients, and we carried on working despite the fear. We were directed to carry on our duties, but doctors were scared for themselves and their families and started refusing to practice.

Doctors continuously warned of deplorable conditions in the hospitals, going on strikes and protesting the government's inability to provide PPE and facilities, such as isolation wards for infected doctors. Without proper PPE, doctors feared treating COVID-19-infected patients owing to the risk of contracting the virus. They delegated their tasks to junior doctors or refused to come to work entirely. Dr Z also spoke with frustration about the government's inability to provide simple facilities and resources necessary to treat patients.

Further, with open disdain, Dr Z commented on the unchecked dissemination of COVID-19-related misinformation by senior politicians and officials, causing people to take pandemic measures lightly. For instance, in his address to the country on 17 March 2020, PM Imran Khan urged citizens not to fear and compared COVID-19 to the flu, with a 97 per cent recovery rate. However, two weeks later, on 8 June 2020, at another news conference, he criticised the locals for failing to take measures and mistreating COVID-19 like the flu. Owing to his contradictory statements, many of my participants did not perceive and understand the level of danger that the pandemic posed for their lives. There was, first, a gap between what the citizens were told and what the state authorities reported, and second there were occasions (such as these) characterised by a lack of consistency, coherence, and inter-reliability between statements given in a short period. While doctors coped with the increasing patient load during spikes resulting from scepticism about the virus, Dr Z stated that the following effects of misinformation proliferation permeated their daily work lives:

Wrong information did us more harm! There is a lack of coordination between the government and doctors, so you find, on the one hand, people who follow preventative measures, but on the other hand, there is a person of higher authority claiming that there is no Covid-19. This creates a sense of confusion among people. Undermining the threat of Covid-19, PM Imran Khan's statement about the virus being 'like a normal flu' took away from the seriousness of the pandemic. I got infected with Covid-19 earlier, and even a month later, my recovery is slow. I have not yet achieved my pre-Covid-19 lung capacity. I pray no one gets Covid-19. It is worse than the flu. The government was supposed to spread Covid-19 awareness. Instead, we had rumours about the government being funded by the WHO and being paid Rs. 2,000 for each patient who died of Covid-19. People were not going to take Covid-19 information seriously. They stopped coming to hospitals to be treated and stopped getting tested. Many people had a perception that their Covid-19 results would always be positive if they got tested. There was also an immense stigma associated with those who got infected. Hence, people would come to us when their conditions had worsened. If they had been diagnosed at an early stage, we could have treated them better.

It falls within the government's ambit to protect its doctors from harm in the face of crises as they protect people's health. However, during the pandemic, doctors felt let down by the federal and provincial governments because of their lack of preparedness for the COVID-19 pandemic. The perplexing state-led response and the muddled way the government announced lockdowns offered inadequate protection to the doctors who continued attending to patients despite the constant danger associated with not having proper PPE. My interviews with the doctors laid bare the challenges and distress they experienced due to critical shortages of PPE and necessary resources (e.g. ventilators and medicine), failures in policy implementation, mistrust towards doctors, and proliferation of misinformation. Moreover, my conversations with

them highlight the burnout and overwork they endured amid the pandemic.

10.4 Class Biases and Organisational Hierarchy in Hospitals

Organisational control – direct, indirect, and internalised – is equal to class control in that it revolves around maintaining the status of those in power and ensuring that employees comply (Acker 2006). This control is made possible by hierarchical organisational power. Crises, like the COVID-19 pandemic, show where society and organisations have fault lines and inequalities (Perry et al. 2021). Although the causes of inequalities might vary, class, gender, and ethnicity are frequently occurring factors. Class practices – stemming from enduring and systematic differences in access to and control over resources – are intrinsic to most organisations and are complicated by differences in occupational hierarchy. I found that frontline doctors, often ranking lower on the organisational hierarchy, believed that they had greater responsibility yet were paid less. Moreover, decades of political corruption have left Pakistan's health sector underfunded, inadequately regulated and resourced, and unable to deliver high-quality care. The consequences include poor health outcomes, particularly for the disadvantaged, and unfavourable personal and professional experiences for doctors.

The elites, on the other hand, who are privileged because of their financial wealth or status, were able to exploit their position to get PPE, COVID-19 vaccinations, and treatments before they were ever made available to frontline doctors. Similar privilege based on seniority levels was noticeable in the hospital, where senior, wealthier physicians avoided duties in COVID-19 wards and forced junior doctors to check infected patients.

It is not news that doctors in Pakistan are underpaid, particularly in public hospitals (Mir et al. 2015). Many medical professionals in the public health sector were selected to move to places like Karachi and Lahore, where the number of patients

was increasing and doctors were required to fill in. Doctors came from a variety of backgrounds, with many relocating from rural to urban areas. Their hardships were worsened by the city's high rents, the lack of transportation choices during the initial wave, inconsistent wage payments, and broken government pledges to help doctors financially. Dr R relocated from Chakwal to Lahore in March 2020 to finish his house job in a public hospital's cardiovascular unit. He was given a top-down directive to keep working his shifts and treat patients with chest congestion and breathing issues when the ward was changed to an COVID-19 intensive care unit (ICU). The disparity in PPE supplies alarmed Dr R. Prices for masks, gloves, and hand sanitisers had skyrocketed owing to their extreme demand. Dr R reflected on this and voiced his irritation at the political elites using N-95 masks while the medical professionals attending to them were using the flimsy surgical ones:

During the first wave, the supply of PPE at this hospital was not regular, and doctors had bare minimum protection. I had to buy my mask and PPE and reuse them by sanitising and washing them repeatedly. The cost of a disposable surgical mask went up to Rs. 500, and prices of N-95 masks were exorbitantly high. The government gave us nothing. Due to a shortage of sanitisers, we had to use surgical spirits to sanitise our hands. My hands were all bruised. Rich patients would walk in wearing N-95 masks, and I would be in my surgical mask, trying to stretch its lifeline to as many hours as I could until it had to be binned.

It took months before doctors had easy access to PPE, but the elite had access to hospital beds, PPE, masks, and COVID-19 vaccines when even those working on the front line faced severe health risks and disruption due to infection. Dr R stated with frustration and worry in his voice:

We claim that everyone receives the same level of treatment, but it is quite the opposite. Even government officials' housekeepers wore N-95 masks, and doctors working in the Covid-19 ICU did not have access to proper masks. Their guards and drivers also

got vaccines before doctors who are directly exposed to the virus. Top politicians like Shujaat Hussain, leader of the political party PML-Q, received the highest level of care and treatment in a public hospital in Lahore, where a poor person is refused a simple blood test. The case with ex-PM Nawaz Sharif is similar. He was also receiving the best treatment at an already under-resourced public hospital, and now he is in the UK receiving treatment there.

Dr R preferred the interview to be in person rather than online or over the telephone. I visited the public hospital where he worked during the second wave of COVID-19 on 25 October 2020. It was nearly 10.00pm and he had asked me to come to the cardiovascular ward, located on the second floor of a building painted white. The entire time I was there, I felt fearful of contracting the virus, frenziedly hoping that the two disposable surgical masks I had on would protect me. Upon entering the ward, I met a guard in khaki who directed me to wait in the doctor's room after telling him I was there to meet Dr R. While passing through the ward, I glanced at the patient beds, filled to the brim. On the cracked floor outside the ward, attendants lounged in plastic chairs and slept on straw mats. Most of them did not have masks on, and for those who did their masks lay just below their noses. In his thirties, Dr R sported a green cap and navy-blue scrubs. He was on his shift but available for a quick interview. Patients and nurses continued to drop by to speak with him.

A few minutes into the interview, a patient with obesity and heart disease walked into the room. He was wearing a black *shalwar kameez* and an eye-catching golden watch. The way that Dr R attended to him sheepishly showcased a power dynamic at play. He offered him tea and coffee before examining his breathing. 'I will recommend you to my supervisor. It is difficult to get an appointment with him, but I will speak to his assistant to let you in first. I will inform you about the time as well,' Dr R said coyly. Once the patient had left, Dr R bemoaned the fact that, because of their wealth, connections, and resources, the elites were always

the first to receive medical attention. More patients entered the room but they were not treated with the same level of respect. It was obvious that class prejudice, pervasive in society, operated even in hospitals.

Dr R elaborated on the Sehat Insaf card, a health-based programme under the PTI's flagship policy (Sehat Sahulat Programme) that aimed to provide critical care (*sehat*) coverage justly (*insaf*) at recognised public or private hospitals for up to one million rupees per family every year. Cardholders were also eligible for free COVID-19 therapy throughout the pandemic. The health card was designed for the poor locals who could not afford medical care and frequently had to sell their property or livestock or take out loans to pay doctors, pushing them farther into poverty. The eligibility requirements, however, are set at a monthly income of about 9,000 rupees and possession of Computerised National Identity Cards (CNICs), suggesting that the significant portion of the population living in poverty and those who lack the necessary documentation to apply for CNICs are ineligible for the programme.

Recurrent complaints from locals who are sent to private hospitals but cannot pay the difference because of the exorbitantly high care expenses are a major drawback of the programme. For instance, in Khyber Pakhtunkhwa, tensions continue to arise over stakeholders' varied interpretations of access dimensions, with the programme's acceptability hindered by limited options for patients to choose hospitals accepting *sehat* cards. This contributes to increased travel costs and delayed claims payments (Khan et al. 2023). Further, Hasan et al. (2022, 7) write: 'There had been reports of families travelling from remote districts to provincial capitals for specialised treatments such as chemotherapy and have been denied due to incompatibility between the treatment costs and financial limits set in the system.' Most private hospitals do not accept the card for treating diseases covered under the scheme, and private and public hospitals place patients on long waiting lists. Dr R emphasised that the government authorities had mishandled the health programme:

Let me tell you about the *Sehat Insaf* cards! Government officials of this country were fooling their domestic workers and selling the cards to them by cutting off Rs. 10,000 from their salaries and taking credit for getting their health insurance sorted. Therefore, a worker getting Rs. 20,000 now only got Rs. 10,000, which is way below minimum wage. Government officials completely used the lack of awareness and literacy among domestic workers to their advantage. That is how the scheme was unrolled.

Class prejudice in hospitals can negatively affect the standard of treatment that patients get. The level of care provided by doctors is influenced by one's financial and social capital. Medical care is never impartial; neither was it during the COVID-19 outbreak because of existing economic inequalities (Ali and Ali 2022). With COVID-19, there could potentially be considerable class variations in mortality and morbidity because of existing inequalities.

Another COVID-19-related incentive seemingly comprehensive on paper is that of the government approving an honorarium equal to one month's salary and COVID-19 allowances for the doctors who worked directly with COVID-19-infected patients in all provinces in 2020. However, doctors, appallingly underpaid, said that it was difficult for them to get the incentives and risk allowances that had been promised by the government. The doctors did not benefit from the qualifying requirements because the incentives could be transferred if they worked 96 hours a month in a COVID-19 medical facility (such as a COVID-19 triage centre, ward, isolation room, or quarantine centre) and assisted in treating positive patients.

While the government had established a limit of 84 working hours, the guidelines required them to handle the burden of COVID-19-infected patients for six hours each day, which is less than the limit. Moreover, the criteria did not take into consideration doctors who tested positive and were after that unable to practice. Doctors were, therefore, angry with the government for promising incentives that they were unable to get. Dr R reiterated the medical professionals' anger in their desire for bonuses:

Doctors who worked with Covid-19 patients should have been rewarded. If they were rewarded for their efforts in fighting the virus and treating infected patients, they would have performed much better.

Financial hardships are a reality that doctors face in the public sector, especially those low in the ranking, like house officers, who are below medical officers (MOs) in the hospital hierarchy. In April 2021, for instance, there was local news about a young doctor committing suicide after failing to receive a salary for four months. Dr Qadir Nawaz Jakhrani was posted in the COVID-19 ward at the Taluka Headquarters Hospital in Kashmore, Sindh. Since his relatives and friends anticipated that the incident would be politicised, his death was not covered by the media. Dr Jakhrani killed himself in his bedroom by hanging from the ceiling fan, leaving his wife and three kids in a terrible situation. According to Javed (2021), there were nine MOs in the hospital where Dr Jakhrani worked, but only four came on duty because the other five would pay *kharchis* (bribes) – up to 40 per cent of their salaries – to the district health office (DHO). Dr Jakhrani was the family's primary provider and had not received his salary since December 2020. This illustrates how the lives and deaths of economically disadvantaged individuals, particularly those marginalised by systemic issues, can be manipulated or ignored by those in power, as evident in the failure to pay Dr Jakhrani his salary for four months. Additionally, the corruption within the DHO, where five out of nine high-ranking MOs avoided duty by paying bribes, highlights how unequal power dynamics and corrupt practices exacerbate the vulnerabilities of those genuinely committed to their roles. This situation reflects not only the failure of the public healthcare system to protect its workers but also how biopolitical mechanisms can render their suffering invisible.

Those who are lower on the hospital's hierarchy take it particularly hard because they are given more duties and obligations. They were forced to execute tasks during the pandemic that should have been handled by senior medical officers, and as a result they

worked over their scheduled hours without getting paid. The effects are particularly negative for a house officer who moved from a rural to an urban centre to serve during the pandemic, is at the bottom of the organisational structure and lacks financial assistance. Dr A, who, like Dr R, had travelled from a rural region to finish her house job in Lahore, made just 60,000 rupees per month. She told me about the harsh working conditions in the hospital. Her hospital duty would start at 8.00am and she had to work extra hours after her shift ended without taking any breaks. She remarked, horrified, 'I have destroyed my stomach due to drinking too much coffee so I can stay awake throughout my shifts.' She used the slang word *ragda* to describe the struggles that house officers face:

The junior staff faces immense *ragda*. If a senior doctor even senses that a house officer is keen to work, they will be treated like a donkey. I would cry every day and tell my father on the phone that I cannot keep up anymore with the increasing working hours. I have established boundaries now and told the ward head that I will not work beyond the nine-hour limit. Hence, junior doctors must suffer a lot.

She talked agitatedly about her time working with senior physicians in the pulmonary department during the pandemic, calling them 'unfair' for stockpiling supplies that might have prevented junior doctors from contracting the virus:

Even if the government tried supporting us ... it was the senior doctors – especially medical superintendents (MS) – who would hoard everything for themselves and their families and not let such essential supplies reach us ... They would protect themselves without concern for us, and we would work in the COVID-19 ward on their behalf. You cannot say anything if you are lowly ranked among medical staff members. Twice in front of me, patients have died due to the negligence of a senior doctor, but we cannot utter a word.

Doctors had to labour in an atmosphere that was fraught with problems like rankism, irregular pay, and unmet government promises, in addition to being on the front lines. The effects of these challenges were felt more acutely by doctors who had just graduated from medical school and those who had moved from rural areas because the reality of living in costly urban cities was a rude awakening for them during the pandemic when they were forced to work in wards brimming with COVID-19 patients. PPE kits, hospital beds, and medication were available according to one's class privilege. The doctors who were at a greater risk of contracting the virus were among those who could not afford them. The morale of young physicians, who had to work additional shifts because of their low rank in the hospitals and financial hardship, may have been improved had they received government awards. An added blow to the doctors' experiences came with the combination of condescending attitudes towards doctors, ranking low in the hospital hierarchy and regressive norms. Class inequality, therefore, benefits those who occupy key positions in the hospital hierarchy and benefit from societal disparities. Many of those on the front lines were doctors from lower classes and ranks, living from pay cheque to pay cheque.

10.5 Conclusion

In Pakistan, the government's management of the pandemic, marked by repeated mistakes and policy implementation failures, had significant consequences. These challenges compounded with HCWs enduring anxieties related to shortages in PPE, salary cuts, a lack of risk assessments, and the proliferation of misinformation. In circumstances of uncertainty – such as public health emergencies – assurance is sought in expertise, practical knowledge, and experience of relevant professionals. Unfortunately, when trust should have been the key to overcoming uncertainty brought about by the pandemic, already-prevalent mistrust towards doctors exacerbated scepticism towards medical professionals and scientific information. Moreover, the already understaffed system

was stretched beyond its capacity. Coupled with a less-than-optimal number of staff members to operate effectively, daily confrontation with patients' violent attitudes, interrupted medical training, and losses in earnings, the situation for doctors was especially dire in Pakistan, particularly during the first two waves, when not much was known about the virus's origin, symptoms, and treatments. Compounding doctors' vulnerability to the virus and infection were prolonged working hours that gave rise to feelings and experiences of burnout.

In addition, othering, blaming, stigmatising and scapegoating became a means of disposing of unwanted anxieties and explaining who got COVID-19 as the fear of infection intensified. Representations of 'the other' that arise during crises intensify the distinction between the decorous 'us' and disruptive 'them' so that the self is not infected in a moral sense (Douglas 1966; Joffé 2009). In numerous instances, class differences were clear indicators of existing inequalities, directly impacting doctors' experiences during the pandemic. For many, there was also a residue of lingering but highly impactful impressions of injustice that arose primarily from the lack of support provided by the government and hospital administration.

While this chapter discusses a specific dimension of inequality, considering the socio-economic status and seniority levels, further exploration will unveil the compounded challenges faced by doctors daily when intersecting vectors of inequality, such as gender, ethnicity, and religion, come into play. The pandemic has starkly highlighted these pre-existing issues, which persist and disrupt the lives of doctors. For instance, female doctors grappling with both medical responsibilities at the hospital and unpaid caregiving duties at home owing to domestic responsibilities face particularly heightened difficulties. When compounded with challenges like online schooling for their children or the inability to travel during lockdowns during the pandemic, their problems are further exacerbated. The need for comprehensive research into these multifaceted inequalities is evident to develop targeted

interventions and support mechanisms for doctors facing such complex and interconnected challenges.

The state must acknowledge the challenges faced by doctors. It is inadequate to leave them to navigate these challenges alone without an awareness of the problems stemming from information gaps and the uncritical adoption of policies. Considering that the pandemic is just one among several potential disasters, including the severe consequences of climate change witnessed in 2022, it becomes crucial for the state to assess the effectiveness of its programmes, identify structural inequalities, and contextualise policies to align with the conditions and needs of healthcare professionals.

Notes

- 1 Pseudonyms have been used to safeguard anonymity and ensure confidentiality.
- 2 The second wave of COVID-19 began in November 2020 following the death of Khadim Hussain Rizvi, an Islamist preacher, blasphemy law activist and leader of the Tehreek-e-Labbaik Pakistan (TLP), on 19 November 2020. Authorities did not disclose the cause of Rizvi's death, and no COVID-19 test or autopsy was conducted either. Newspapers and media channels confirmed that Rizvi had breathing difficulties before he died.
- 3 Founded in September 2020, the Pakistan Democratic Movement (PDM) is an alliance of opposition parties that opposed Prime Minister Imran Khan, alleging poor governance and mismanagement of the economy and foreign policy.

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CHAPTER 11

Liminal Life

Pandemic, Protests, and Worker Voices in Sri Lanka

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Abstract

This chapter hopes to uncover how apparel sector workers tried to make sense of multiple crises unfolding in Sri Lanka – a pandemic followed by a debt crisis. While the pandemic was unpredictable, public protests underpinned by a debt crisis were decades in the making. Nonetheless, how workers experienced these unfolding crises and moments of hope (protests) are frequently left outside the frame of analysis, with blithe preoccupations with an undifferentiated category of youth as the face of protests. In a country where class, ethnicity, and gender (as a minimum) are prominent registers that shape social life, it is also important to take our gaze to workers – the backbone of Sri Lanka’s economy who toil through unprecedented upheavals. Using worker testimonies and interviews, this chapter hopes to bring out how worker lives were

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upended and how they negotiated a liminal phase through this period.

11.1 Introduction

Students, young people play key role in ousting president. (De Alwis reporting for *University World News*, 2022)

Insight: How a band of activists helped bring down Sri Lanka's government. (Ghoshal and Jayasinghe reporting for Reuters, 2022)

Proud to be Sri Lankan and a Youth. (Perera, Groundviews 2022)

Many young people have taken part in the demonstrations and launched a social media campaign with a simple message: 'Gota go home,' which became a trending hashtag on Twitter. (Ramakrishnan reporting for *Deutsche Welle*, 2022)

Young Sri Lankan protesters turn to books as 'weapons' of change. (Raymond reporting for *Arab News*, 2022)

Youth-inspired protests rock strategically located Sri Lanka. (Samath reporting for News Decorder, 2022)

The above news headlines are snippets of how the media covered Sri Lanka's *aragalaya* (people's protest) during the summer of 2022. In what was broadly read as an unprecedented moment in Sri Lanka and world history-making, the coming together of the country's citizenry was read from the optic of the youth and their role in public mobilisation. From the West to the East, and including Sri Lanka, the reportage covering the mass mobilisation and public protests was hence largely framed as a youth uprising. Perera (2022) declared she had never been more proud to be Sri Lankan. Students and youth were an important part of the public mobilisation and offered inspirational illustrations of creativity and protests. The other optic that often came to the fore in media accounts was how the middle classes led the protests.

All these reports cover an important part of the story of public mobilisations witnessed in Sri Lanka from the end of March to early July 2022. However, often it is an ahistorical account that displaces that of the country's protest culture, which labour scholars from Jayawardena (1972) to Kearney (1971) have penned. Equally knotty is the vector of youth. This optic ignores the heterogeneous citizens across the age, ethnicity, and class spectrum that came together in 2022. Satkunanathan (2022a) was one of the few commentators to puncture the Colombo and youth-centric narrative by underlining the 240 protests occurring throughout Sri Lanka on 14 April 2022. The World Socialist Website also stresses the motley group, from youth to workers to rural farmers, who came together to seek system change to unpick the class angle that also needs further analysis (Socialist Equality Party 2022). A similarly optimistic and hopeful perspective on the coming together of diverse generational and socio-economic groups as a momentous and historic occasion when Sri Lankans become civic-minded citizens is captured by Samararatne (2024).

It almost took another year for commentators in the popular media, blogosphere, and magazines to take a broader perspective and acknowledge both the sweeping possibilities (and pitfalls) of the *aragalaya* and the wide and expansive constellation of people, classes, communities, and groups represented (Gunawardena 2023; Senanayake 2023). Even as the *aragalaya* was simultaneously both chaotic and organically organised, placing unbounded optimism on youth or the middle classes as the driving force of political struggles is to displace other political and economic struggles ongoing for decades. Namely, working classes as much as minority groups and, especially, minority women have been contesting state violence and repression, with Kumari Jayawardena (2010) establishing how perpetual ferment and popular revolts go back to colonial times.¹ Skanthakumar (2023) goes further to draw linkages to Sri Lanka's long and proud history of revolts in the post-independence period, which includes the *hartal* of 1953, when workers, rural farmers, and city poor allied to revolt against massive hikes in prices. More critically, Wijetilleke in *Face to Face*

(2024), a media talk show, firmly places the genesis of the *aragalaya* on worker mobilisation and indeed its pivotal role at the end (see also Surendran, Ruwanpura, and Sengupta 2024). From a temporal perspective, the injustices inscribed in colonial times and their capital-centric expressions in contemporary times are an everyday struggle. Working classes and low-income ethnic communities are contested in their daily life repeatedly, while more extraordinary moments like the *aragalaya* capture collective protests.

The call from protesters to work towards system change is still a work in progress. Devana Senanayake (2023) closes her article by saying:

The ‘system change’ people demanded is still a possibility. The past provides evidence that it is not a matter of ‘if’ but a matter of ‘when’. However, there is still work to be done to translate the protests into a sustainable movement that resembles a vision for a better country birthed at the protests.

This is an apt place to start this chapter. It requires us to broaden our optic to record and register everyday struggles faced by working classes who face grave injustices in the socio-economic and political spheres to get their collective voices heard but are often given scant attention (see also *Face to Face* 2024; Jenkins 2024; Perera 2018; Surendran, Ruwanpura, and Sengupta 2024). My chapter is an attempt at unsettling dominant readings by both the right and segments of the left to typecast Sri Lanka’s *aragalaya* as youth- or middle-class-led and a call to listen to worker voices about their role in the protests and how they negotiated a liminal space. It is also an attempt to draw links between strikes, riots, and mass struggles because they as Clover (2016) notes, are ‘practical struggles over reproduction within production and circulation, respectively’ (2016, 46). He is making explicit how protests are an upshot of people’s inability to access consumption goods for the life-giving task of caring that occurs in families of all shapes and forms – as I hope to show in the country. I draw on worker testimonies and connect them to published reports in Sri Lanka

around the pandemic and workers, especially in the apparel sector, to illustrate these connections. I focus on the role of workers and their experiences during the unfolding debt crisis and how they may have fed into public protests. Before doing so, I turn to conceptualisations and writings around liminality, as this will anchor the framing for my chapter.

11.2 Liminal Life: Invisible and Inchoative

Liminality was popularised by Victor Turner (1969) in his anthropological work about how rituals oversee transitions for people and communities, where liminality signifies detachment or passing through or suspension between two fixed points. Such transition moments or thresholds also offer possibilities for comradeship during the fragmentation and multiplicity of structural ties that surface during ritual processes. Along with liminality, Turner's (1969) writings also make space for *communitas*, which he ascribes as spontaneous, instinctual, and instantaneous and is accessible 'only through its juxtaposition to, or hybridization with, aspects of social structure' (1969, 372). In Turner's reading *communitas* is an acute or intense point of the community, which comes about through a shared common experience, where the sense of solidarity, equality, and togetherness is fostered. *Communitas* also offers an aspect of potentiality as it rips open the crevices and edges of structures and emerges from beneath with the prospect of leveling the crowds or society, even if momentarily.²

In Turner's (1969) view, liminality is a moment when people temporally extricate themselves from their social statuses, thus inviting new possibilities to arise from the subjunctive mood it creates. In this regard, liminal phases are antithetical to existing social structures and hierarchies because rites and rituals enable participants to experiment with alternative social relations or invent new ones.

Formerly, these ideas were limited to studies of culture, rituals, and rites of passage by anthropologists; yet they are now increasingly taken up in the other social sciences to give expression to

suspended moments in social life and encapsulate ambivalences around political subjectivity. Liminality is now often used in the social sciences as a canopy to denote states of ambiguity and transition as well as grey and blurred spaces, giving traction to the Latin roots of *limins* or *limen* as a temporal state of ambiguity, paradox, and confusion (Azim and Salem 2022; Banfield 2022; Conlon 2011; Purser 2012; Sweeney 2009; Turner 1969).

However, for Turner (1969) *communitas* is also part and parcel of liminality, although *communitas* has less traction in recent readings and writings, which limits the web of social relations that moments of suspense can bring about. Banfield (2022), for instance, notes how social science scholarship is increasingly deploying liminality in a ‘singular fashion to a growing array of spaces and places rather than being explored with its varied spatialities and processes of spatialization’ (2022, 611).³ She is alluding to the need to look at the connections and intersections between spaces and places rather than being focused on any one particular arena. However, even in her reading, the focus is much more on liminality per se rather than how liminality and *communitas* interact and intersect with each other.

Nonetheless, liminality has gained a footing in the social sciences and a cursory review underlines how this conceptual apparatus is deployed across mobility, asylum seekers, diplomacy, and home-schooling during the pandemic to labour studies (Azim and Salem 2022; Conlon 2011; O’Reilly 2018). Within geography, for instance, liminality has been used to denote the subjectivity and spatiality of diplomacy that occurs in the corridors of power and how quasi-official diplomacy becomes an arena for building a sense of *communitas* to foster transformative agendas (McConnell 2017). Political subjectivity-making outside core diplomatic spheres is given weight by drawing attention to liminal spheres, where ‘creativity and aspiration’ are taken seriously (Connell 2017, 150).

Similarly, in labour studies, there is a call to ‘extend liminality into places of production’ (Sweeney 2009, 582), especially where worker rights are neither protected nor denied formal

employment rights. Hence, the study of labour contractors, day labourers, and precarious workers, for instance, has been a focus (Purser 2012; Sweeney 2009). This research is most germane to my research, partly because labouring bodies are the focus. However, in being attentive to places of production, the sphere of social reproduction, where life is produced and where value generation starts is rendered invisible (Arslan 2023; Hartmann 1981; Humphries 1977; Katz 2001; Stevano et al. 2021; Weeks 2018 (1998)). In this chapter, I bring to the fore the social reproductive sphere as also one where liminality became the norm during the pandemic, which morphed into a debt crisis.⁴ A liminal life that workers had to negotiate.⁵ The use of worker voices helps ascertain how their liminal lives may have also been a likely catalyst for the public protests – or the *communitas* – that came with the *aragalaya* (people's struggle).

As I illustrate in the sections to come, unlike the original conceptualisations of and deployments of liminality, which assume two fixed points, the experiences of women workers caught between at least two major crises – a pandemic followed by a debt crisis – meant that there was less certitude around where lives in suspended mode may find themselves after this transition phase. Before we get to worker voices, a few notes on the fieldwork methods.

11.3 Muddled Methods: Researching during Crisis Times

The chaos and realities of gathering data during pandemic times – and in the case of Sri Lanka compounded by an economic crisis – were made evident throughout the 18 months of the BA-GCRF research project. Flexibility and shifting methods became the order of the day and more so than usual in a bid to gather data in ways that were meaningful to capture the experiences of workers. The varied experiences of gathering data reflected the class politics and predicament that workers found themselves in as we all navigated crisis conditions in Sri Lanka. As well as echoing

writings on field methods that accentuate the need to accept failure and be adaptable when doing fieldwork (Biswas 2022; Dutta 2020; Saxena 2023), the pandemic and the debt crisis that followed in Sri Lanka itself required frequent invention.

I started with collecting written testimonies from workers at the height of the pandemic (July–September 2020), which was before the success of our BA-GRCF-funded grant. Working together with a labour rights organisation (Women’s Centre), where I have had a decade-long association, we reached out to 20 workers to get their written testimonies. The highly literate and educated workers that Sri Lanka’s garment sector works with are also the resource that I drew upon at the inception when we requested that workers write testimonies on their experiences during the initial phase of the pandemic (Ruwanpura 2022a, 2023, 2024).

After this initial period, during the next phase of data gathering for the BA-GRCF grant, I started with in-person interviews at the end of 2021 and the start of 2022. In this initial phase, ten workers were interviewed and included spending time at a workshop. During these interviews, I gave workers a wide scope to outline their experiences since the pandemic. Some interviews were held in the south of Sri Lanka (Koggala) after a workshop hosted by the Women’s Centre around sexual politics, others at the premises of the Women’s Centre, and at the homes of workers I had got to know during the 2008–2019 period.⁶ The interviewees worked in factories both within and outside free trade zone (FTZ) areas and were spread across the south of the country: Biyagama, Horana, Katunayake, and Koggala.

Amid the initial phase (2022), COVID cases in Sri Lanka began to rise and, for both their protection and mine, we shifted to doing Zoom interviews – after establishing contact with workers who were open to being interviewed. The severity of the digital divide became glaringly evident when during some interviews we had to move from using Zoom to using WhatsApp or simply mobile phone calls because their data packages did not have the bandwidth to carry on a long Zoom meeting – with or without the camera on. In other instances, several workers were present

in the same Zoom room to speak with me, and these sessions felt like a mishmash of pseudo-focus group discussions. On occasion, workers interjected and spoke over each other, and at other times each worker took their turn to offer their experiences and accounts. Given the varied nature of these experiences, when I left Sri Lanka after this round of interviews, in conversation with the Women's Centre, we decided to return to gathering written testimonies.

During this same period, the financial crisis in Sri Lanka also started to bite severely, with inflation starting to soar and economic insecurity becoming acute. This meant workers were becoming anxious about their job security and seeking a time for them to speak with me during what was an uneasy period seemed inappropriate and even crass. It was more sensitive to let them write down their experiences, in their own time, and a decision was made once again to return to gathering written testimonies. There were 18 written testimonies gathered with new workers, while as the debt crisis became acute we also returned to a handful to gather their evolving experiences.⁷

These different data collection points meant that we gathered worker experiences through various cycles of crisis in Sri Lanka. It also meant that this *mélange* of methods during the pandemic and then a debt crisis was also responding specifically to the realities of working through pandemic waves, economic challenges, and a debt crisis but also to the actualities of doing research in the Global South, where flexibility and the unbounded nature of gathering data become obvious (Biswas 2022; Dutta 2020; Ruwanpura 2022a; Saxena 2023). This adaptability, however, helped gather a rich body of information from workers through an extended period.

In analysing the empirical material, I started by reading the testimonies, listening to recorded interviews, and reading transcriptions several times to evaluate them for pronounced and repeated themes in the lives of workers during these cycles of crisis. While we were able to return to a subsection of workers to get their views on intersecting and interlocking crises, a limitation of relying on written testimonies especially was that we were not able to do any

follow-up lines of questioning. Another is that the quality of testimonies varied, with discernible distinctions between the statements provided by workers in the north of the country and the rest of the country – with those in the north (war-torn) areas providing scant accounts. The length of written testimonies varied from one page to six, with three pages being the average. In presenting and analysing this data in the sections to follow, I maintain research and ethical protocols and use pseudonyms throughout. In this chapter, I also only draw on specific themes around liminality and how workers lived in a state of suspense at various times during overlapping crises.⁸

11.4 Freedom Within: No-Work Euphoria!

The most reported and analysed state of being for garment sector workers from Bangladesh to Cambodia, India, Sri Lanka, and Vietnam is that they felt lost with the onset of the pandemic and feared the worst in terms of not knowing when workers could return to work. In this volume, for instance, Surendran, Sengupta, and J. Sharma outline the disorientation that came with the pandemic. Fear, listlessness, insecurity, stigma, and depletion are the registers frequently mentioned in writings coming out of the pandemic for garment workers (Ruwanpura 2023, 2024; Saxena 2024; Siddiqi and Ashraf 2022; Wickramasingha and De Neve 2022).

In Sri Lanka, feelings and anxieties were also reported by workers, as I elaborate in the next section. However, some workers came to this place through feelings of exhilaration and freedom that came with being off work – which they initially thought would be a temporary feature and would not last too long. The relief from workplace drudgery was welcomed, as shared by Priya:

For those of us, who were habituated into a working life, our immediate experience of the corona pandemic was one of freedom. We did not realize the gravity of the pandemic until later. So, at the start we were happy with our liberty, to be free from work. However, this joy did not last for long, when we were confined to

our boarding rooms for endless days and our usual bonus payments for April were withdrawn. (Priya, Wathupitiwala FTZ)

The freedom from work and being able to idle with their boarding mates or community were seen as a fitting interruption to the grind of labouring life, partly because there was confusion and disinformation on what the coronavirus may mean to daily life. As Priya mentioned, it was only later that the gravity of the pandemic and its disruption to their livelihood started to sink – and any bliss they felt quickly started to dissipate. The no-work euphoria then was short-lived. Nonetheless, it was a moment and phase in which workers relished and embraced the ambiguity and uncertainty because it came with the freedom to not work.

However, for some workers being off work was not a continuous issue, as they were called back to work within a short period. Returning to work within a short space may be partly explained by the fact that the Sri Lankan apparel industry quickly shifted from manufacturing fashionwear to personal protective equipment (PPE), and workers were encouraged to volunteer back to work (Ruwanpura 2022b; Wickramasingha and De Neve 2022). Moreover, factories located in rural areas away from the zones continued operations, as they were at the start seen as risk-free and located far away from Colombo and other larger cities in the country. In these instances, workers were euphoric or relieved that they managed to hold on to their jobs and work continued without disruption, given work stoppages in other factories and various realms of life that circulated in the news and social media.

Dhammi, a helper at a factory in the south of the country, said about her experiences at the start of the pandemic: ‘Our factory closed for a few days at the start; however, then we got a message saying that work had begun.’ Workers based at factories in the north of the country said how they continued manufacturing, with references made to the production of PPE. Mani, who worked for a factory in Kilinochchi, said: ‘Since we worked continuously at the factory ... we lived away from the children, and we were unable to spend time to look after them.’ The freedom

that came from having days off work or from keeping jobs, however, was also one of suspense and uncertainty. Even though it was a period in which workers embraced their fortune against a milieu of difficulties for working-class communities, in their sharing of their lives during the unfolding crises in the country they were also underlining how their lives were upended. Cut off from family, friends, and community, leading to a liminal life, became their reality. This suspense from their everyday life, even while working, led to social liminality (Purser 2012). For workers, it became an intervening period where transition, suspense, and ambiguity were normalised, with workers reporting deteriorating work conditions since then, especially around wage deflation.

The euphoria of being off, work stoppage for a short period, or keeping jobs amid a pandemic, however, came with further labour subjugation in terms of a fall in wages. All those who worked through the pandemic noted that even though they were occupied and producing PPE or garments, their wages were no more than the basic wages.⁹ This drop in their monthly wages and its deleterious effects on their lives were reported across the country and worsened with the debt crisis (Rabel and Ruwanpura 2024; Ruwanpura 2023, 2024; Wickramasingha 2023). It is this suspended state of being for all workers across the country through interconnected crises that offered the basis for a critical consciousness to ripen and for workers to be part of the *aragalaya* that came about. To quote Purser (2012, 31) to appreciate better how 'labour is subjugated, dependency is cultivated, and precarious and degraded conditions of employment are normalized', the next section of the chapter turns to how, as workers' freedoms were stripped away, they were thrown into a liminal space.

11.5 Freedom Without: COVID, Debt, and Drifting

The greater preponderance of workers in the country found themselves adrift. Informal sector workers, making up some 70 per cent of Sri Lanka's working population, were particularly

hard hit, as were this group in India, Nepal, and Pakistan, as Surendran, Sengupta Sajad and J. Sharma illustrate for us in this volume. In Sri Lanka, formal sector workers, inclusive of those in the apparel sector, found their lives in disarray. The hardships of apparel sector workers went beyond the difficulties of making their wages meet monthly household expenses, which became particularly acute during the debt crisis. The apprehension that came with the debt crisis was preceded by the pandemic period, where the workers' lives were suspended because of how COVID-19 outbreaks were handled (see also Fernando 2020; Ruwanpura 2022b; Saxena 2024; Wickramasingha 2023; Wickramasingha and De Neve 2022).

In the sections below I trace a few illustrations around how pandemic management, economic difficulties, and financial hardship started to be the daily grind of workers. Pandemic management by a militarised task force meant that workers often felt harassed, unheard, and isolated from their families and communities. Numerous workers who were afflicted with the coronavirus wrote in their testimonies how they were mishandled and mistreated. Bimali, a 27-year-old worker from Vavuniya (in the north of Sri Lanka), said: 'I could not find anyone to look after my daughter who was five years old when I was in quarantine for 14 days ... During that period of isolation, I suffered a lot without even access to water to drink.' In this testimony, when Bimali said 'without even water', she was accentuating not just her difficulties but also the anxiety she had to endure. She goes on to say that 'the relief package provided by the government reached me only after the isolation was over.' A 46-year-old worker from the Katunayake area, Rasika, wrote that 'during the pandemic, I too succumbed to CoVID. However, no one with oversight for pandemic management, i.e. the Public Health Inspector (PHI), came to visit me ... For 14 days, I was isolated and as I was unable to access food and water – and became terribly helpless.' She stridently went on to write: 'The government has to take sole and total responsibility for our predicament', underlining both her vulnerability and frustration with the government for placing workers in this mess. These

moments illustrate how the absence of the government and the state in crisis moments pushed workers into a state of suspense – a phase where workers not only struggled but also developed a consciousness around the denial of their citizenship rights. Kernels of awareness were primed through the multiple and intersecting crises.

If the pandemic was not challenging enough for working communities living in a state of abeyance, the debt crisis followed threw them off the precipice in terms of accentuating their grievances around living. The wage losses – or wage theft, as AWFA campaigns have called out – that came with the pandemic caused distress and violence that extended from the shop floor to their daily lives (AWFA 2021a, 2021b; Kumarage 2024; Saxena 2024). Although the tripartite agreement in Sri Lanka was laudable and initially permanent workers had their jobs protected, wage losses faced by workers had a bearing on their inability to meet their monthly expenses. All workers across the country recounted how the drop in wages placed them in a shaky situation, where their daily meals were curtailed. By the time the debt crisis hit with rising inflation, their situation deteriorated further, as many testimonies document:

We didn't get any support from the government. We became helpless, as we had to purchase groceries on credit from the local cash and carry – especially as food prices started to soar with the pandemic. For this situation, both the factory bosses and the government need to take the blame. (*Dharshi*, a 48-year-old worker from Katunayake, western Sri Lanka)

Our factory reduced our wages with the onset of the pandemic. We had great difficulty living with a loss of wages, as we couldn't even pay our boarding fees. Those days if we could have one meal a day that was an achievement. I had to pawn my jewellery to send money to my mother. (*Therika*, a 37-year-old worker from Koggala, southern Sri Lanka)

Now we do not get overtime work. Since we do not have a proper basic salary, we are dependent on overtime and incentives. Factory management says that our factory does not have enough orders. However, when we consider the production targets, it is very high and sometimes we must skip our lunch to achieve the daily target before 5:00 pm. Factories are trying to reduce the number of workers and get the maximum output from the remaining workers.

Before the crisis, we received nearly Rs 38,000.00 with overtime and allowances. However, we are now getting only Rs 22,000.00 – which is not enough to fulfil even our basic needs, such as food, medicine, and transport. (Mani, a 36-year-old worker from Kili-nochchi, northern Sri Lanka)

The detailed account provided by Mani offers a comprehensive critique of the structures of inequity that made their living difficult with their wage losses. She outlined how life from work to home that was thrown into the air at the start of the pandemic was exacerbated during the debt crisis. Her statement surpasses and elaborates what Dharshi and Therika outline in their testimonies, which accentuate that wage loss meant toppling their ability to simply live and how they had to scramble from here and there. For instance, the need to pawn jewellery was recurrently raised, as other studies for Sri Lanka and the region note (see also Herath 2022; Kumarage 2024; Rabel and Ruwanpura 2024; Siddiqi and Ashraf 2022; Saxena 2024). The upending of their lives, as they knew it, threw them into a state of desperation coupled with annoyance and frustration with the government and the factory owners. In their inability to afford to eat, pay for their rental accommodation, or purchase medicines, workers lived in anticipation and sharpened insecurity. Often workers felt that their lives were adrift without any possibility of an anchoring that they were familiar with from their working past. Although never a bed of frangipani or lotus flowers, most workers were able to just about live, and some even participated in local community-saving

schemes (*seetu*), which toppled with the pandemic and exacerbated by the economic crisis.

These moments help exemplify how living in suspense increasingly became the norm for working-class communities in unprecedented ways. In that liminality, workers also became more conscious of their common predicament and challenges faced across the country. The kernels of rebellion also stemmed from this period. In many testimonies, workers pointedly placed the onus on the government; many said that the government, corruption, and patronage politics were the main perpetrators that worsened their lot dramatically. Others more squarely weighed in by locating responsibility on both the business and government sector alike, which is captured when Dharshi said, ‘both the factory bosses and the government need to take the blame.’ In doing so, she gave voice to how factories were withholding bonuses from 2019, which was for work they performed before the pandemic set in. Several testimonials underlined how not getting their bonuses for the time before the pandemic was simply unfair and unjust. A few workers were astute enough to point out that factories are reliant on a smaller labour cohort while production has remained the same, with each worker producing more. By writing about them having to manufacture more, workers were hinting at how their productivity was going up while their wage packets were falling, both in real terms (when inflation is considered) and nominally.

The vignettes I draw upon cut across the country to underline the similarities around how workers consistently found themselves living in suspense, anxiety, and a sense of foreboding. Without any sense of transition from one place to another, the liminality they experienced, I also contend, is a factor that led them to take to the streets and join public protests, although there was variation within the country. Once communities across the ethnic divide had similar experiences, those in the south of the country started to appreciate the rights abuses and economic hardships minority communities in the north and the east of the country had endured over decades (CPA 2023; *Daily Financial Times* 2023; Silva, Dhammalage, and Nilafdeen 2023). For workers in the

north (and east), where rights abuse, war, and trauma have been inscribed for communities over decades, their hardship intensified during the crisis period from 2020 to 2022 (Satkunanathan 2022a, 2022b). Workers started to call out the nature of collusion between the government, state, and capital that pushed workers into a state of constant anxiety and insecurity. The liminality experienced by workers that came from the state–capital complicity was going beyond the pale. As the CPA (2023) study reports, in the rest of the country there was a growing awareness of the common hardships, and people in the war areas of the north and east are likely to have endured these privations for decades. Sri Lanka’s polity has a long way to go in working towards reconciliation and justice, inclusive of economic redistributive justice. However, as a consequence of living in uncertainty and suspense – or liminal space – working-class people across the country started cultivating a sense of *communitas* that began to transcend ethnic rifts in the country. If only for a moment, as a recent editorial for the *Daily Financial Times* in Sri Lanka (2023) mentions, the study by the CPA (2023) is key in stressing that community cohesion came from the recognition that economic injustice is also a register that matters for all communities.

11.6 Concluding Thoughts

From the liminal life that workers were thrown into in Sri Lanka through multiple crises, a sense of commonality of struggles and community arose. *Communitas*, as Turner (1969) notes, is about how ‘the interstices of structure, in liminality; at the edges of structure, in marginality; and from beneath structure, in inferiority’ are broken through (1969, 372). The experiences of the country’s working-class subjects amid multiple crises brought together liminality, marginality, and inferiority to the fore, amply flooding social groups, who prop up the economy, with heightened emotion and effect. As their lives were stripped into a bottomless hole, their experiences of the wretchedness they were sucked into fed into a sense of indignation about the grave injustices

and economic deprivation they had to stumble into and struggle through. Their outrage was evident in the testimonials, and this rage was given expression through the collective fury that poured into the streets of Sri Lanka during the *aragalaya* (people's struggle), which extended beyond Colombo.

In reading the *aragalaya* in Sri Lanka, Devaka Gunawardena (2023), à la Thompson (2013 [1963]), makes an important point when he calls for an expansive understanding of class by underlining how it is mediated by 'complex people with contradictory identities, beliefs, and habits [and] any attempt to define the class without an understanding of (how) social struggles mediate class structure is useless, if not counterproductive' (2023; see also Clover 2016). In this chapter, I have attempted to resurrect class from facile readings of the *aragalaya* as fronted only by youth and the middle class, carelessly downplaying the role of the working classes in this movement for systematic change. Such analyses make the *aragalaya* irrelevant to social struggles wanting system change and are caricatured as not exemplifying solidarity politics, which ironically in the country has come from both the right and (segments of) the left (see also Gunawardena 2023).

The need for expansive readings of class, which must also draw in the sphere of social reproduction, facilitates radical promise of what the subjunctive mood may offer. It is as Turner (1969) remarks in his readings of *communitas*: 'Maximization of *communitas* provokes maximization of structure, which in its turn produces revolutionary strivings for renewed *communitas*' (1969, 373). Said differently, acknowledging how social reproductive (read: caring) spheres were stretched and continue to be neglected during the intersecting crisis was a catalyst for protest, and this needs registering. Likewise, 52 per cent of Sri Lanka's populace (i.e. women) must be part of the system and structural change because it is in maximising structures from production to social reproduction that *communitas* can be amplified.

Sri Lanka's system change then is yet to come. However, the liminal life working classes were thrown into still permeates and persists in the country calling for a renewed community where

socio-economic justice, inclusive of a place for care, needs to be a cornerstone of the system change as much as political justice. As I revise and conclude this chapter, it is fair to say that these underpinnings and inscriptions of hope propelled the country's seismic political shifts in the presidential and general elections held in late 2024. From a liminal space, the bulk of the *communitas* is looking for change and an equitable social contract.

Notes

- 1 Protests and struggles, including the role of youth from working-class and/or rural communities, for instance early youth insurrections, are outlined by others (de Alwis 1997; Hughes 2013; Kearney 1980; Satkunanathan 2022b).
- 2 In existing scholarship and my understanding of Turner's work liminality is read to lead to *communitas*. However, it is no foregone conclusion that the inherently destabilising nature of liminality implies heightened community; there is the potential to also provoke enmity and fragmentation – which is research that needs to be done (my thanks to Wilfried Swenden for raising this point and John Harris and Roger Jeffery for a robust discussion around it).
- 3 My colleagues Jonas Lindberg and Ioanna Petridou suggested the need to consider multiple liminalities co-existing during crisis moments and how it may mean *communitas* emerging from the reactionary right too. An insight worthy of further exploration elsewhere is the tensions that come about owing to liminal spaces.
- 4 I am not suggesting here that the pandemic is the sole cause of the debt crisis in Sri Lanka but I use the word morph more loosely to indicate the debt crisis followed the pandemic. The underpinnings of Sri Lanka's debt crisis are long in the making and include integrating into the global economy on unfavourable terms, the financialisation of capitalism – that is, reliance on international sovereign bonds to repay loans, odious debt, and investing in white elephant infrastructure projects, among others (Chandrasekhar, Ghosh, and Das 2024; Gunawardena, Kadirgamar, and Kadirgamar 2023; Nicholas and Nicholas 2023; Ruwanpura 2025; Sornarajah 2022).
- 5 The analytical framing this chapter draws upon, however, is that of liminality and *communitas* rather than social reproduction, as this writing is done elsewhere (see Ruwanpura 2023, 2024). For more recent writings on social reproduction amid the pandemic, see especially 'A Special Issue on Feminist Economic Perspectives on the COVID-19 Pandemic' in *Feminist Economics* (2021).

- 6 The locations of the interviews – a workshop and the premises of the Women’s Centre – do mean that the workers who engage in outreach activities are likely to have a higher degree of conscientisation. However, in my conversations with them there was no definitive sense that all workers had the same or similar awareness partly because some of the workers attending such sessions were accompanying their peers or did so out of curiosity.
- 7 The entire project also gathered data a group of ten state officials and civil society activists. This chapter, however, does not draw on this empirical material.
- 8 Other papers published or under review have analysed for themes around the multiple spheres of social reproduction, depletion through social reproduction and the collective mobilisation that came about.
- 9 The wage drop was an outcome of a negotiated tripartite arrangement involving unions, where in exchange for protecting jobs and avoiding retrenchment, workers would ‘be paid 50 per cent of their basic wages or LKR 14500 (US\$77), whichever is more beneficial’ (IndustriALL 2020).

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Conclusion

CHAPTER 12

COVID-19 and After

Collaboration and Compromise – Confrontation and Contestation?

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Abstract

Our concluding chapter pulls together the main contributions to this volume. By shifting our analytical lens away from macro-scale analysis of the global, national, or regional crises, we underline the centrality of focusing on the state and the mundane. We show that how labour rights were protected helps us better understand the state and its operations. By focusing on workers, we gave primacy to a constituent agent, labourers, who are the backbone of the South Asian economy. In terms of understanding state–societal relations via labouring classes, we underscored how collaboration,

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compromise, confrontation, and contestations were crucial registers simultaneously drawn upon by worker collectives and/or workers. Economic, political, and social injustices cutting across the world may have had South Asian manifestations. However, the rallying call from workers is looking for a social contract that tackles global inequities and places the lives of people at the core of a socially just world.

12.1 Introduction

The point of departure for our research project was the pandemic, an unprecedented health crisis with major socio-economic ramifications. As we bring this volume to a close, we do so in unpredictable times. COVID has morphed into a broader ‘polycrisis’ marked by geopolitical tensions, debt, autocratisation and ecological distress in South Asia and beyond. In our volume, we seek to capture changing dynamics through a pandemic and intersecting crisis in South Asia.

Geopolitically, the world stands at perhaps the most dangerous inflection point since the end of the Cold War. The replacement of Western hegemony with a multipolar world order led to greater instability and a rise in military conflict (Kupchan 2012). Concurrently, the commitment of the West to ‘liberal, democratic values’ and ‘human rights’ is challenged from within and from outside: from within because the political landscape of the USA, much of continental Europe, and Britain has been marked by the advance of the populist far right (Mudde 2019), and from outside because the West stands accused of practising ‘double standards’: while it invokes democracy and human rights as key reasons to fight Russia’s invasion of Ukraine, it does not enforce the same standards on Israel in its response to the Hamas attacks of 7 October 2023. This response, with more than 25,000 casualties – including many women and children, so the ICJ (2024) established – violates the Genocide Convention. Furthermore, the Russia–Ukraine and Israel–Hamas wars crowd out attention for equally deadly conflicts across the world, not least in Ethiopia or Southern Sudan.

Finally, the West (and its associated institutions of the ‘Washington consensus’) are seen as imposing neoliberal economic reforms on the Global South that have failed to deliver *inclusive* growth and sustainable development (Stiglitz 2017).

This geopolitical instability has also affected South Asia. The rise of China (and the partial energy dependence of some South Asian countries on Russia) may have eroded support for liberal and democratic rights in the region, as has the weakened support and ‘double standards’ of the West (for instance the threat of withdrawal of US military support for Ukraine, if not for the mineral deal). Since 2014, Bangladesh, India, Pakistan, the Maldives, and Sri Lanka have all witnessed autocratisation and/or militarisation (Widmalm 2021). Furthermore, the afterlife of the pandemic for countries in the Global South is one of ballooning budget deficits and, in acute cases, debt default. Diwan and Rodrik (2024) remark how ‘pre-pandemic growth have been replaced by debt distress, balance of payment tensions, rising poverty, and regress on the SDGs ... and governments are facing tough trade-offs on which essential services to cut.’ In South Asia, at least three countries— Bangladesh and especially Pakistan and Sri Lanka – have witnessed an unfolding debt crisis.

At the same time, in India, host to the largest ‘democracy’ in the region, there are vistas of hope. Apart from staving off a debt crisis, the less-than-expected victory for Modi’s BJP in the 2024 general elections and the return of coalition government at the centre may well hem in *some* of the populist and authoritarian tendencies marking India’s governance since the past decade. Similarly, in both Bangladesh and Sri Lanka, public mobilisation has peacefully initiated regime change, with the presidential and parliamentary elections in Sri Lanka solidifying people’s call for system change. Within the wider region, people and communities then are also rejecting a politics of hate and division camouflaging growing inequalities and under-resourcing of public resources over decades (Abram, Polato e Fava, and Kuwahara 2021; Ghosh 2022; Maiti and Locke 2021; Rao et al. 2021). These world-unmaking events shaped the backdrop within which we bring our

volume to a close. How we have come to this conjuncture in South Asia, where hope persists alongside glaring inequalities and religious and ethnic chauvinism is predicated upon the very experiences of its people.

The main purpose of our volume was to bring together chapters that probed into interlinked registers of COVID-19 and crises. Crises, however, are not new to the region. These often take the form of ecological disasters: from cyclones and flooding in Bangladesh and India (e.g. Odisha, Kerala, Assam), to tsunamis (Sri Lanka) or earthquakes (Afghanistan, Pakistan). Ethnic war and violence have marked Sri Lanka, the Kashmir region, and the north-east of India, and much of Pakistan (mainly Baluchistan and the Khyber Pakhtunkhwa region) and Afghanistan. Crises provoked a state and civil society response: either towards more encompassing protection or sometimes owing to a lack of state capacity or power imbalances and resulting 'state-capture' outright discrimination.

In our volume, we orient away from global, national, or regional crises to focus on the mundane that matter in the lives of people; and we do this via the most immediate source that sustains people: work and livelihoods. Hence we have aimed to probe how labour rights were protected through the pandemic and how it may help understand the state. By focusing on workers, we have given primacy to a constituent agent – labour – that is the backbone of the South Asian economy. The chapters also attempted to draw relevant connections and analyse the current political and socio-economic crisis as underpinning and/or exacerbating the pandemic and its effects. A few of the chapters in this volume, in mapping variations in state responses to labour rights and worker health, also proceeded to link it to the differences in state structure (unitary, federal, and so on) and regime type (militarisation, autocratic democracy) and assess implications on the ground. Our contributors drew on mixed methods, quantitative data, and qualitative data – where the latter ranged from testimonies to documents to oral histories and qualitative interviews. Creativity around gathering empirical data through a

pandemic became a necessity, but using these varied methods also helped to provide an analysis of the political economy of development in the region. As we sketch in the next section, what South Asia witnessed during this time was that relations between workers and the state ranged from collaboration to confrontation and contestation, reflecting their (in)capacity to mobilise and navigate the (semi)democratic context of the subcontinent.

12.2 Collaboration, Compromise, and Contestations?

Despite the recurrence of the crisis in South Asia, the pandemic was unprecedented in terms of territorial coverage (affecting all parts of the region) and depth. The health and resulting socio-economic crisis was harder to fight as the chaos around medical treatment and facilities laid bare the under-resourcing of public health facilities during the preceding decades of neoliberal policies in the region (Bhaskaran, Dutta, and Naidu 2022; Maiti and Locke 2021). The pandemic thus compelled South Asian governments to change gear dramatically: in every country, governments found that they had to adapt, drop cherished dictats on an absent role of the state, and instead take an interventionist role. That said, each country initially had a different trajectory – with some countries, such as Bangladesh and Sri Lanka, faring better than others at the inception, as Basu and Srivastava (2021) draw out. In both countries, stronger public health facilities equipped these states to weather the pandemic more successfully, at least initially. However, over time, some of these early gains lost momentum – with, in the case of Sri Lanka, militarisation and endemic corruption being causal factors propelling the community transmission of COVID-19 by the end of 2020 (Ruwanpura 2022; Swenden et al. 2022). Furthermore, the federal set-up of India (and the predominant role of the subnational ‘states’ in health provision) made for important ‘within-country’ variations. For instance, the pro-welfare approach of the state of Kerala resulted in active mechanisms to protect workers and their health ([Chapter 8](#) by Surendran in

this volume). In contrast, in Sri Lanka, there is little subnational variation owing to the unitary nature of the country with weakly placed provincial councils (Swenden et al. 2022).

In our volume, we have drawn on several case studies from the South Asian region to extrapolate and understand better how workers and their health and rights were negotiated during the pandemic and thereafter. Structural factors affecting working-class distress against a backdrop of intersecting and interlocking crises were a long time in the making, as the chapters in this volume outline.

Naomi Hossain ([Chapter 2](#)), Chanchal Kumar Sharma and Wilfried Swenden ([Chapter 3](#)), and Muttukrishna Sarvanathan ([Chapter 4](#)) in our volume trace the nature and shape of state-level mediation, with the complexities and contradictions that came with it. [Chapter 2](#) that opens Part I is on Bangladesh by Naomi Hossain. She considers how the Bangladeshi state responded to the pandemic and how despite the one-party dominance of the Awami League and its progressively authoritarian tenor had to protect economic rights, even as the state's incapacity was exposed during the pandemic. However, the legacies of responding to disasters in Bangladesh before the pandemic meant the state had to recurrently learn and transform its policies over time. These experiences placed Bangladesh in a stronger place to respond to the pandemic and its outbreaks because the institutional regime in the country had recurrently improvised. Coordination, collaboration, and compromise across various state institutions, however imperfect, was not a novelty for Bangladesh. The improvisation with policy instruments during the pandemic in turn also had a lasting bearing on the policy realm to come in the country.

The centralised state is the focus of [Chapter 3](#), this time focusing on India. Chanchal Kumar Sharma and Wilfried Swenden focus on a range of health and social policies adopted by the Indian state during COVID-19 at the central and state levels, given the country's federal structure. They illustrate how the authoritarian proclivity of the incumbent prime minister (Modi) provoked a tendency towards centralisation and consolidation by central

authorities as community transmission across the states took place. From the viewpoint of the authors, the lack of coordination and collaboration was opportunistic by the Modi government, which took to unilateral rolling out of policies without consulting the states, only to retreat from some of its commitments at the onset of the second wave, leaving the states to fend for themselves. In an overall adversarial climate, the centre and opposition-ruled states were ill-prepared to coordinate the distribution of oxygen supply, medical assistance, and vaccine distribution during this phase, forcing the Supreme Court to step in. In their view, in a sense, it is the contestations between the centre and the states that resulted in several policy missteps during the first cycle of the pandemic – and not necessarily simply the severity and scale of COVID-19. The absence of investment in robust intergovernmental institutions and the return of health and welfare expenditure to pre-pandemic levels suggest that India may not be well prepared to handle a similar health crisis in the future.

The broad overview provided in [Chapter 4](#) offers an indication of all eight South Asian countries and gives a birds-eye view of how both the region and each country fared. In his contribution, Muttukrishna Sarvananthan examines what (central) governments across eight South Asian countries have done through ‘non-pharmaceutical interventions’ to save the physical and material lives of citizens across all eight countries. He argues that these interventions were often falsely presented as choices between saving ‘lives’ and saving ‘livelihoods’. Based on reported casualties, countries with higher per capita income or HDI did not necessarily report the lowest per capita casualties; in fact, the reverse was often true. Furthermore, Muslim-majority states such as Bangladesh and Pakistan reported comparatively low death rates, despite Islamophobes in non-Muslim-majority states (especially India) depicting Muslims as ‘superspreaders’. Sarvananthan also shows that Sri Lanka and Afghanistan left the pandemic as the economically most weakened countries in the region, though this may have been the result of corrupt and misguided policy choices in the former under the Rajapakse regimes and the takeover of

politics by the Taliban in the latter. Overall, Sarvananthan shows at best mixed support for the view that ‘livelihoods saved today’ (owing to the comparative weakness of pharmaceutical and non-pharmaceutical interventions, such as lockdowns) should have propelled a faster economic recovery tomorrow. There is no clear relationship between per capita reported death rates during the pandemic and economic recovery rates following on from the second wave. Sri Lanka (with high per capita reported death rates) did not recover economically, while Bangladesh with lower per capita death rates registered considerably higher recovery rates.

12.3 Collaboration and Compromise? State, Society, and Workers

The chapters focusing on state-level policies and the national level demonstrate how contestation, collaboration, and compromise came to be – and were important vectors that shaped policy responses. However, when we move the optics from the state to state–worker relations, we witness fluidity and disarray. The complexity of grounding policies amid a pandemic is brought into full view. The chapters in this volume that take the analysis to the meso level examine how layers of the state interacted with each other and with workers in collaboration, compromise, and contestation.

[Chapter 5](#) looks at state and substate responses across Bihar, Rajasthan, and Uttar Pradesh, and in the case of Bihar it also involves observations from the panchayat level. By offering detail across the various levels of the state, Himanshu Jha draws out what the sudden loss of livelihood meant for people living on the margins. Migrant workers were especially affected and felt the impact of the pandemic most, given the haphazard policy changes and reversals at the start. Nonetheless, he shows how local-level bureaucrats negotiated constraining and unprecedented circumstances to respond in a supportive way towards migrant workers and uphold their rights. His favourable reading of multilevel state institutions and their interactions with workers highlight

the difficulties faced by state bureaucrats and how they learn and adapt to trying conditions. The analysis provided underlines how state institutions and actors across the scale are learning, deciding, and knowing entities, a triad that facilitates cooperation between the centre and the states. Especially in the case of Bihar, he traces how this cooperative ethos worked out, given the high proportion of inbound migrant workers. When the optic is taken away from the national-subnational (centre–state) dynamic, we are presented with an analysis that unsettles the narrative of the state as a static behemoth but presents it as shaped and enacted by civil servants. Their very social location, inclusive of being directly affected by the pandemic, also shaped interactions with workers and their rights. This adds a layer of depth and nuance to a birds-eye view of the state through the prism of centre–state relations.

Cooperation, compromise, and collaboration, however, were not foregone conclusions. Several of our chapters also present how this spirit and ethos of cooperation and collaboration came with cracks – and, in some parts of South Asia, the workers fell through the cracks while in other countries they hung on a thread. The meso-level analysis provided in the chapters in Part II then shows a gamut of experiences.

How the crisis resulted in the worsening of the precarity of migrant workers owing to limited social protection in Nepal is the focus of [Chapter 6](#) by Jeevan R. Sharma. He illustrates how younger generations have sought migration to other countries, whether India, the Middle East, Southeast Asia, or elsewhere, to become migrant workers and earn a living. However, most of these migrant working communities are aware that migrant work is a treacherous and often precarious path, compounded by their ill-treatment. The fact that younger people opt to migrate notwithstanding this knowledge resulted in dramatic consequences for both workers and their families during the COVID-19 pandemic. The shocks to rural households that came with the loss of livelihoods, deaths, and uncertainty around workers' whereabouts and location all illustrate historical continuities of precarity when

no social protective mechanisms are in place for workers who are the backbone of the country.

From a state-centric view, [Chapter 7](#) by Papia Sengupta brings us to the centre of India: Delhi. As the national capital city, Delhi is home to large swathes of migrant workers from neighbouring states who through informal labour keep the metropole ticking. The central import of migrant workers to Delhi was recognised through various support schemes provided to this underclass by either the central or union territory government, as is outlined in the chapter. Using primarily extended and repeated conversations with 25 workers, Sengupta shows how, despite such schemes, multiple inequities caused untold vulnerabilities to the workers. She uses relevant secondary quantitative data and draws on the stories of migrant workers to probe their awareness of these schemes and to which government they are attributed. In tracking workers, she also had repeat conversations with them over two waves of the pandemic and in this regard captures temporal dynamics that migrant workers had to contend with. She also incorporates dynamics that extend to migrant worker family lives in the face of job losses or bereavement. Her chapter makes the case for supporting migrant workers through effective policies that are enabling rather than disabling (as requesting proof of identity papers tends to be).

The state of Kerala in India was an outlier in effective pandemic management at the inception, and yet contestations and antagonism were the backdrop within which Kerala managed the pandemic. In [Chapter 8](#), Aardra Surendran offers an analysis of labour policy responses in Kerala, a southern state of India, during the pandemic. Kerala is a state rooted in a strong welfarist policy milieu, where labour rights and protectionism are considered cornerstones in how the state approaches its citizenry. The fact that these safeguards also extended to migrant workers speaks to how political decisions that are inclusive of all classes and social spectrums of a region are viable, even for regions with meagre resources. Despite this often-considered laudable trajectory of equitable social welfare provisioning, her findings reveal

how the persistence of pre-existing gaps in welfare coverage coupled together with the reliance on civic voluntarism and gendered inequities had varied experiences on informal sector workers. She shows, using testimonies from 25 informal workers together with documentary analysis, how disparities in labour protection heighten vulnerabilities. Structural factors coupled with the challenges that come with implementation result in varied worker experiences during the pandemic; as such she argues for structural inequalities to be addressed if protective labour policies are to have a grip on worker lives, especially during unexpected calamities.

Like in India, in Bangladesh too there were vistas of a collaborative spirit between state and society. The Bangladeshi state commenced initiatives to benefit various segments of society and sectors. One of the most prominent proposals was to protect workers in the country's largest employment generator: the ready-made garment (RMG) sector. Employing nearly 2.6 million Bangladeshi workers, focusing on how these workers fared during the pandemic was crucial to upholding labour rights in the country but also protecting the industry itself. In [Chapter 9](#), Maheen Sultan, Jahan Antari, and Touhidul Islam, underline how the sector was severely affected by the global volatility that came on the back of the pandemic, where order cancellations led to factory closures and widespread unemployment. In contrast to neighbouring Sri Lanka, for instance, being a large manufacturer hurts countries like Bangladesh and India because bulk buying and manufacturing is the norm. They trace how the government had to step up with financial stimulus packages to cover worker wages. Yet those labouring for the RMG experienced many setbacks ranging from job losses to drops in income and health risks, to name a few. The government's allocation mechanisms benefited stakeholders of the garment sector in varied ways, but the interests of employers were often being upheld at the expense of workers. Based on an evaluation of policies implemented, and drawing on interview data, media reports and secondary literature, their chapter shows how Bangladeshi workers ended up bearing the burden of the pandemic and the economic crisis that followed.

12.4 Confrontation and Contestation: Workers and Their Agency

The scale of the pandemic necessitated collaboration and compromise between the South Asian states and various societal segments, such as employers and workers organised through unions or in other ways. However, sometimes these interactions reflected power asymmetries. For instance, in Sri Lanka, a laudable tripartite initiative brought together the state, employers, and unions in a compromise to ensure that industries, especially the garment industry, could continue operations through the pandemic. However, this original compromise quickly became unstuck. The employers' commitment to protecting (limited) industrial sector jobs, although at no more than basic wages irrespective of whether workers were employed or not gave way to less beneficial arrangements. This was the result of other structural inequalities, including corruption in the country (Barnett et al. 2021; Ruwampura 2022).

In our volume, similar efforts at compromising between various societal actors is a running thread through many chapters, although not all have salubrious endings. Our volume calls attention to both the state and workers to shed light on the dynamics between institutional regimes (democracies, electoral autocracies, or militarised regimes), the economic structure, and labour agency to illuminate the uneven geographies that became pronounced during the crisis. Trajectories of the political economy of development in earlier decades especially started to bear upon the working poor in acute ways across the region, dramatically shaping their life chances – in terms of both the risks to their health and lives and their livelihood prospects.

Workers across sectors and industries felt the tumultuous effects of the pandemic, often exacerbated by policy choices made by their respective governments. However, the pandemic impinged various social groups in diverse ways and shook institutional regimes within South Asia in notable and significant ways. Workers were not always passive recipients in this process. Using

their agency, several chapters in our volume describe instances where workers from farmers to youth to teachers and industrial workers were unafraid and indignant even to assert their rights. From Bangladesh to India to Sri Lanka, public protests with an ongoing pandemic were also part of the national political fabric. Indian farmers protesting for months amid a pandemic to push back on controversial agricultural reforms by the Modi government in late 2020 caught global attention and compelled it to repeal contentious farmer bills (Al Jazeera 2024; BBC 2021, 2024). During the same time, similar agitations took place in Bangladesh and Sri Lanka. These public protests underline how worker agency is ever present and recurrently publicly raises its collective rights – as it has done historically to claim worker rights (Suren-dran, Ruwanpura, and Sengupta 2024).

The agitations witnessed in public spaces during the pandemic also find expression at the micro scale in nuanced and differentiated ways. Priya Sajjad ([Chapter 10](#)) traces how frontline health workers in Pakistan came under duress from the start of the pandemic. Yet she illustrates how there were numerous instances where medical workers were compelled to collaborate with authorities, even as at other times they had to reluctantly contend with a dwindled-down resource base. She shows how the chaos that came with the pandemic was not simply because of the novelty of the coronavirus and its scale but also resulted from decades of underfunding or weakening of the social floor that bore upon various types of workers. Medical workers found themselves in precarious positions within hospitals. Even as they were versatile in how they managed with meagre resources, they were also contesting the lack of protective health gear – scrubs, gloves, masks, and so on. The rich ethnography of this chapter adds depth and offers a multilayered perspective on what it was like to be on the medical frontline in Pakistan. The chapter also underlines significant hierarchies within the medical profession. The constant concessions and contestations made by Pakistani medical staff and medical frontline workers, in particular, are likely to have resonance elsewhere and beyond South Asia. The chapter helps make

a strong case for policies that are both comprehensive, properly funded and systematic, if medical staff are to be genuinely valued – not just in South Asia but elsewhere too.

How workers assert their claims in the public sphere is the focus of the last chapter, which took us to Sri Lanka. Public contestation and the hope generated by it is the focus of Kanchana N. Ruwanpura's writing ([Chapter 11](#)). In the case of Sri Lanka, the pandemic got overlaid with decades of unaddressed structural inequalities, which came into full force by 2022, when it defaulted on its debt for the first time in its history. The country's citizenry (workers included), however, was not taking the compounded crises interlacing their lives without resistance. Instead, the country witnessed public mobilisation at an unprecedented scale in recent history. However, she notes public protests are not a novelty in Sri Lanka – which is historically home to a protest culture. Reflecting decades of political violence, political injustice, and economic inequalities in the country, Sri Lanka is home to agitations ranging from public cries of mothers and parents traumatised by and searching for their missing children to labour protesters (Satkunanathan 2022; Skanthakumar 2023). Collective protests marked the social and political polity during the pandemic and afterwards as the country defaulted on its debt. In taking a longer view of the *aragalaya*/the struggle (as it came to be known in 2022 in Sri Lanka), her chapter illustrates how workers too underpinned the public protests. Confrontation and contestations over economic and political injustices linked to local political regimes overlaid with global inequities in the financial landscape gave hope that another world is needed and indeed should be possible. System change (implying both regime change and a substantive change in economic policy) became the rallying cry of these public protests. Using worker testimonies, she seeks to bring workers into the frame. She illustrates how the upending of their working lives resulted in them living through a state of suspense – liminal lives became them and their lives. Living liminal lives infused workers with a sense of spirit that connected their daily struggle with the national struggle that workers were eventually part of.

Using the case of Sri Lanka, she offers a thin veneer of hope that must occupy public consciousness as the region and the world go through months and years of turmoil.

12.5 Concluding Comments

In this volume we have sought to illustrate and analyse how effective worker protection requires alignment across scales of governance. Each chapter shows how the central state, substate, the local level, and its intermediaries operate with and across each other, while also engaging with macro, meso and micro dimensions, such as unions, civil society, and worker initiatives. However, their efficacy in offering worker protection during crisis is reliant on the convergence of ideals, interests, ideology, and commitment among actors at all levels of government towards citizenry, inclusive of workers. To derive these conclusions and demonstrate how South Asia has been navigating the pandemic, and more in particular how the pandemic has affected the livelihood of workers across the subcontinent, we adopted different levels of analysis and drew on a variety of methods. These ranged from analyses at the level of the state (with a focus on how the state addressed – or failed to address – worker rights about health and social welfare) to examining how workers experienced their material conditions, accessed welfare support, and mobilised against the state.

By and large, our findings support the view that the pandemic exacerbated deep structural inequalities in labour relations across South Asia, even though the health crisis coincided with accelerated state support for workers, including the most ‘vulnerable’ sections thereof, mainly informal labour, women, and migrant workers. However, intrastate (intergovernmental) relations and state–worker relations were marked by a myriad of patterns. Sometimes, these patterns were confrontational. For example, concerning intrastate relations we can point to the interactions between the central Indian government and opposition-ruled states during the second and third waves of the pandemic. Concerning workers, we can highlight the Sri Lankan workers’ protests during the

popular uprising in 2022. Sometimes these patterns were collaborative, as in efforts of the Bangladeshi and Sri Lankan states to reach out to garment sector workers during the onset of the pandemic, or as in Kerala's extension of protective rights to migrant workers. Decentralised governance and more discretion to street-level bureaucrats (as evidenced in the case of Bihar) sometimes engendered compromise solutions that at least temporarily protected the needs of workers.

At the same time, episodes of collaboration or 'compromise' did not necessarily narrow existing power inequalities in broader employer–worker relations (and the ability of the former to 'capture' the state). This was made evident from the collusion between garment sector employers and the state in the case of Bangladesh, or from the extent to which frontline healthcare workers in Pakistan were treated unfairly by the state and their senior colleagues in the health sector. In all of this, the weak 'unionisation' especially of informal and migrant labour across the region (with few exceptions) as opposed to 'formal labour' has remained a bone of contention, and puts it at a comparative disadvantage. The return of the state to pre-pandemic levels of expenditure on health and welfare or – given the debt crisis in several South Asian states – to levels *below* that of 2019 gives cause for concern.

And yet; acknowledging the semi-authoritarian context of several South Asian states, the chapters in our volume also chart possibilities for change and transformation. Crises may instil hope, resistance, and social mobilisation for change. The various testimonies or ground reports in this volume remind us that socio-economic justice and the clamour for it do not fade away even in the materially darkest of times. Crises co-exist with spaces of hope. Engendered worker rights have to be part of a social contract to enable equitable and ecological futures including in South Asia. As scholars, we need to labour towards making that aspiration realisable.

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Index

Note: The following abbreviations have been used: *b* = box; *f* = figures; *n* = notes; *t* = tables

A

- Aadhaar (identity card) [4–5](#), [124](#), [138](#), [199](#), [302](#)
migrant workers in Delhi [171](#), [175](#), [180](#), [181](#)
- Aam Aadmi Mohalla Clinics (Delhi) [166t](#)
- AAP (Aam Aadmi Party) (India) [59](#)
- Aawaz (‘voice’) (health insurance scheme for migrant workers) (Kerala) [193b](#)
- accountability [8–9](#), [26](#), [31](#), [34](#), [230](#)
- Adhikari, Jagannath et al. [148](#)
- Afghanistan [6](#), [7](#), [296](#), [299](#)
epidemiological/economic impact of COVID-19 on [85–86](#), [88–95](#), [99–102](#), [104](#)
- Agarwala, Rina [200](#)
- agency [2](#), [12](#), [16](#), [56](#), [304–307](#)
- Agra City (Uttar Pradesh) [15](#), [121](#), [129–130](#)
- agriculture and agricultural workers [18](#), [142–143](#), [150](#), [197](#), [199](#), [305](#)
- alcohol sales [56](#)
- ambulances [60](#)
- Amhara region (Ethiopia) [2](#)
- Amphotericin B (COVID-19 treatment drug) [61](#)
- Amrit, Pratyaya [122–123](#)
- Andhra Pradesh (India) [60](#)
- Apna Ghar (‘our home’) (housing scheme) (Kerala) [193b](#)
- aragalaya* (people’s protest) (Sri Lanka) [268](#), [269](#), [270](#), [273](#), [278](#), [284](#), [306](#)
- Ardern, Jacinda [105–106](#)
- Arokkiaaraj, H. [161](#)
- Ashraf, Hasan [229](#)
- Asian Wage Floor Alliance (AWFA) [226](#), [227](#), [280](#)
- Assam (India) [296](#)
- AstraZeneca [2](#)
- athijeevana* (government-sponsored subsistence kit) (India) [194](#)
- austerity policies [3](#), [5](#)
- authoritarianism [2](#), [5](#), [14](#), [160–161](#), [295](#), [298](#), [299](#)
- autocratisation [56](#), [294](#), [295](#), [296](#), [304](#)
- autonomy [10](#), [16](#), [17](#), [57](#), [67](#), [122](#), [125](#)
- Awami League (Bangladesh) [14](#), [25](#), [27](#), [29](#), [214](#), [298](#)
- AWFA *see* Asian Wage Floor Alliance
- Azim Premji University (India) [176](#)

B

- badhyata (consumer activities) [143–144](#)
- Banfield, Janet [272](#)
- Bangladesh [25–26](#), [42](#), [276](#), [295–300](#), [303](#), [305](#), [308](#)
- citizen experiences of COVID-19 response [35–36](#), [37f](#), [38](#), [39f](#), [40f](#), [41](#)
- cost of living and impact of COVID-19 on [99t](#)
- economic growth and impact of COVID-19 on [92](#), [93](#), [94t](#)
- epidemiological/economic impact of COVID-19 on [80](#), [81](#), [85](#), [86f](#), [87t](#), [88f](#), [106](#)
- importance of ready-made garment (RMG) sector [214–215](#)
- incidences/death proportionate to population [90f](#), [91](#)
- jobs and impact of COVID-19 on [95](#), [96t](#)
- official response to pandemic [31–35](#)
- post-pandemic emerging priorities [230–232](#)
- ready-made garments (RMGs) workers and impact of COVID-19 on [211–213](#), [215–217](#), [223–229](#)
- remittances and impact of COVID-19 on [100](#), [101t](#)
- state responses/actors' roles and pandemic [217–223](#)
- theorising political economy of pandemic [26–31](#)
- worker protection [2](#), [4](#), [6](#), [7](#), [11](#), [13](#), [14](#), [17](#)
- Bangladesh Garment Manufacturers and Exporters Association (BGMEA) [214](#), [215](#), [216](#), [217](#), [219](#), [220](#), [222](#), [225](#), [228](#), [229](#)
- Bangladesh Garment Workers Solidarity [227](#)
- Bangladesh Institute of Labour Studies [223](#)
- Bangladesh Knitwear Manufacturers and Exporters Association (BKMEA) [214](#), [215](#), [216](#)
- Bangladesh Labour Act (BLA) [219](#), [223](#)
- Bangladesh Sromik Shangati [225](#)
- Basu, Deepankar [297](#)
- BBC Nepali Service [147–148](#)
- beds and bedding [59](#), [61](#)
- bed-to-patient ratios [128](#)
- beneficiary databases [41](#)
- BGMEA *see* Bangladesh Garment Manufacturers and Exporters Association
- Bharatiya Janata Party (BJP) (India) [56](#), [58](#), [59](#), [60](#), [68](#), [295](#)
- Bhatt, Rajendra [128](#)
- Bhatt, Rajiv [128](#)
- Bhil Adivasi (India) [129](#)
- Bhilwara (Rajasthan) [15](#), [121](#), [126–129](#)
- Bhutan [6–7](#), [85–86](#), [88–91](#), [93](#), [95](#), [99–104](#)
- BIGD *see* BRAC Institute of Governance and Development (BIGD) (Bangladesh)
- Bihar COVID-19 Emergency Response Team (India) [124](#)
- Bihar Epidemic Diseases, COVID-19 Regulation 2023, The (India) [120](#), [122](#)
- Bihar (India) [11](#), [15](#), [67](#), [300](#), [301](#), [308](#)
- state/substate responses [116](#), [118](#), [120](#), [121–126](#), [130](#), [132](#)
- Bihar State Health Society [121](#)
- bilateral labour agreements [150](#)
- bilateral/multilateral donors (social security) [151](#)
- biometric identification systems [4](#)
- biraderi* [4](#)
- birth rates [142](#), [163](#)

- BJP *see* Bharatiya Janata Party (BJP) (India)
- BKMEA *see* Bangladesh Knitwear Manufacturers and Exporters Association
- black-market activities [61](#)
- blame-shifting [59](#)
- Blinken, Antony [106](#)
- BRAC Institute of Governance and Development (BIGD) (Bangladesh) [43n3](#), [213](#), [226](#)
- Brazil [105](#)
- bribery [34](#)
- British Army [139](#), [142](#)
- Buddhist-majority countries [85](#)
- budget deficits [3](#)
- buffer zones [127](#), [129](#)
- bureaucracy [8](#), [10](#), [11](#), [79](#), [301](#), [308](#)
 Bangladesh [33](#), [42](#)
 India [73](#), [116](#), [120](#), [128](#), [133](#)
- Butler, Judith [138](#)
- C**
- call centres [123](#), [202](#), [203](#)
- Cambodia [276](#)
- Canada [116](#)
- capital investment [3](#)
- capitalism [5](#), [12](#), [13](#), [138–139](#)
- cash transfers [3](#), [4](#), [34](#), [199](#), [201](#), [203](#)
- caste system [4](#), [6](#), [10](#)
 Delhi (India) [173](#), [177](#), [178](#), [181](#)
 Nepal [141](#), [142](#)
- casual workers *see* informal sector workers
- CBGA *see* Centre for Budget and Governance Accountability (India)
- Central Bank (Sri Lanka) [96](#)
- central government schemes [170](#)
- Centre for Budget and Governance Accountability (CBGA) (India) [64–65](#)
- Centre for Global Workers' Rights [215](#)
- Centre for Market Research and Social Development (India) [167–168](#)
- Centre for Policy Analysis (CPA) [283](#)
- Centre for Policy Dialogue (CPD) [215](#), [223](#), [224](#), [227](#)
- centre-state authority and collaboration [14–15](#), [120](#), [160–161](#), [298–299](#), [301](#), [302](#), [307](#)
 India [51–62](#), [73](#), [74](#)
- Centre for Sustainable Employment (Azim Premji University) [176](#)
- Changathi ('friend') (literacy programme for migrant workers) (Kerala) [193b](#)
- charitable institutions [175–176](#)
- Chhattisgarh (India) [72](#)
- child labour [166t](#)
- China [2](#), [54](#), [82](#), [216](#), [221](#), [295](#)
- chit funds (rotating credit community associations) [201](#)
- Chowdhury Centre for Bangladesh Studies (UC Berkeley) [229](#)
- citizen feedback [27](#), [28](#), [29](#), [35–36](#), [37f](#), [38](#), [39f](#), [40f](#), [41](#), [306](#)
- citizen trust [26](#)
- civil society [29](#), [30](#), [33](#), [54](#), [74](#), [307](#)
- class and class biases
 Pakistan [243](#), [244](#), [254–261](#), [262](#)
 Sri Lanka [267](#), [268](#), [269](#), [270](#), [273](#), [284](#)
- clinical services [29](#)
- Clover, Jonathan [270](#)
- cluster mapping and containment [127](#), [129](#)
- CNICs *see* Computerised National Identity Cards (CNICs) (Pakistan)
- coal industries [98](#)
- coalition governments [56](#)
- collaboration [19](#), [28](#), [293](#), [297–303](#), [308](#)
- collective bargaining [215](#)

- Colonial Epidemic Diseases Act (1897) (India) [54](#)
- command and compliance systems [55](#)
- commodity prices [88](#), [98](#)
- Communist Party of India [68](#)
- communitas [271](#), [272](#), [273](#), [283](#), [284](#), [285](#), [285n2–n3](#), [285n5](#)
- community-saving schemes (*seetu*) [281–282](#)
- compliance/non-compliance [29](#)
- compromise [294](#), [297–303](#), [308](#)
- Computerised National Identity Cards (CNICs) (Pakistan) [257](#)
- confrontation [18](#), [294](#), [297](#), [304–307](#)
- conscientisation processes [18](#)
- construction industries [147–148](#), [162](#)
- consultation [28](#), [195](#), [198](#), [202](#), [206](#)
- contact tracing systems [62](#), [127](#), [130](#)
- contestation [18](#), [294](#), [297–300](#), [304–307](#)
- contract labour [178](#), [192](#)
- convalescent plasma therapy [245](#)
- corruption [95](#), [282](#), [297](#), [299](#), [304](#)
 Bangladesh [31](#), [32–33](#), [34](#), [36](#), [39](#)
 Pakistan [247](#), [254](#), [259](#)
- cost of living [98](#), [99t](#), [100](#)
- COVID-19 (coronavirus) [2](#), [3](#), [4](#), [105](#), [160](#), [293–297](#), [307–308](#)
 Bangladesh [25](#), [26](#), [29](#)
- collaboration/compromise/contestations [297–300](#)
- epidemiological/economic impacts
 on South Asia [13–19](#), [79–81](#), [85](#), [86f](#), [87t](#), [88f](#), [89f](#)
 Nepal [145–146](#), [148](#), [152](#), [153](#)
 Sri Lanka [274–275](#), [276](#), [279](#)
 state/society and workers [300–303](#)
 workers and their agency [304–307](#)
- COVID Call Centre 104 (India) [123](#)
- ‘COVID Samvedikaran Abhiyan’ (COVID Sensitisation Campaign) (India) [131](#)
- CPA *see* Centre for Policy Analysis
- CPD *see* Centre for Policy Dialogue
- cremation grounds [59](#), [198](#)
- Criminal Procedure Code (India) [117](#), [122](#), [127](#)
- crisis-induced innovation [42](#)
- crisis management [11](#), [13–19](#), [294](#), [296](#), [297](#)
 Bangladesh [26](#), [27](#), [30](#), [31](#)
 epidemiological/economic impact of COVID-19 on [80](#), [84](#), [91–92](#), [104–105](#)
 India [52](#), [54](#)
 interstate variations in India [67–68](#), [69f](#), [70–71t](#), [72t](#), [73](#), [74](#)
 research work during crisis times in Sri Lanka [273–276](#)
 state and substate responsiveness in India [115](#), [116](#), [125](#)
- crony capitalism [12](#)
- crude oil [98](#)
- curative medicines [82](#)
- curfews [84–85](#), [92](#), [105](#), [116–117](#), [127](#)
- currency crises [100](#)
- ## D
- Daily Financial Times [283](#)
- daily wage labourers [117](#), [178](#)
- data protection [5](#)
- Davos Dialogue of the World Economic Forum (2021) [105](#)
- death and death rates [31](#), [58](#), [299](#), [300](#), [301](#), [302](#)
- Delhi (India) [162–163](#), [166t](#), [172](#)
- incidences/rates proportionate to populations [89](#), [90f](#), [91f](#), [92](#)
- India and federalism [70–71t](#), [72t](#), [73](#), [74](#)
- Kerala (India) [188](#), [198](#)
- Nepal [142](#), [145](#), [152](#), [153](#)
- Pakistan [242](#), [258](#)
- South Asia [79–80](#), [81](#), [84–85](#), [87t](#), [89–90](#), [91f](#), [92](#), [103–106](#)

state/substate response in India [116](#), [125](#)
 debt crisis [1](#), [5](#), [6](#), [53](#), [204](#), [294](#), [295](#), [308](#)
 Bangladesh [212](#), [213](#), [223](#), [226](#)
 South Asia [100](#), [101](#)
 Sri Lanka [267](#), [271](#), [273](#), [274](#), [275](#), [278](#), [279](#), [280](#), [285n4](#)
 decentralisation [52](#), [59](#), [73](#), [130](#), [308](#)
 Delhi Directorate of Economics and Statistics [167–168](#)
 Delhi Epidemic Diseases, COVID-19 Regulations (2020) [166t](#)
 Delhi, National Capital Territory of (India) [15](#), [16–17](#), [159–163](#), [180–181](#), [302](#)
 federalism [59–60](#), [67](#), [70](#), [72](#)
 gendered and disparate pandemic [176–177](#)
 migrant hub in North India [163](#), [164f](#), [165f](#), [166t](#), [167–168](#)
 migration and public welfare support [177–180](#)
 voices of migrant workers [168f](#), [169f](#), [170](#), [171f](#), [172–176](#)
 Delhi Swarozgar Yojana (self-employment scheme) [166t](#)
 democracy [294](#), [295](#), [304](#)
 Department of Disaster Management (Bihar) [125](#)
 Department of Health (Bihar) [120](#)
 Department of Inspection for Factories and Establishments (DIFE) (Bangladesh) [222](#), [225](#), [228](#)
 developed/developing worlds [81](#), [82](#), [95](#), [98](#), [99](#)
 Development Pathways [4](#)
 DIFE *see* Department of Inspection for Factories and Establishments (DIFE) (Bangladesh)
 digitalisation [4–5](#), [26](#), [33](#), [40–41](#), [42](#)
 diplomatic services [150](#), [152](#), [272](#)
 direct aid [65](#)

disability [151](#)
 Disaster Management Act (India) [117](#)
 Disaster Management Department (India) [124](#)
 disaster and relief management [25](#), [33](#), [55](#), [122](#), [123](#), [205](#), [217](#), [263](#)
 discrimination [172–173](#), [179](#), [181](#), [218](#), [229](#), [296](#)
 disguised unemployment [95](#)
 disinfectant sprays [173](#), [188](#)
 disinformation [18](#), [249](#), [252–253](#), [261](#), [277](#)
 district health office (DHO) (Pakistan) [259](#)
 district magistrates [122](#)
 Diwan, Ishac [295](#)
 doctors [241](#), [242–246](#), [247](#), [249](#), [250–251](#), [252](#), [253–255](#), [258–261](#), [262–263](#)
 Do gaj Duri (six feet distance) campaign (India) [130](#)
 domestic and intimate partner violence [92–93](#), [176](#)
 dominant-party states [214](#)
 door-to-door surveys [127](#), [129](#), [131](#)
 Douglas, Mary [245–246](#)
 Dowding, Keith [249](#)

E

East Asia [137](#)
 Ebola virus [175](#)
 economic effects [15](#), [39](#), [306](#)
 Bangladesh [213](#), [215](#), [230](#), [231](#)
 impact on South Asia [88f](#), [92–93](#), [94t](#), [95](#)
 Kerala (India) [204](#), [205](#), [206](#)
 Nepal [139](#), [141](#)
 economic growth [3](#), [140](#), [163](#), [216](#), [295](#)
 Bangladesh [25](#), [28](#), [30](#), [33](#), [34](#), [42](#)
 South Asia [82](#), [93](#), [94t](#), [95](#)
 economic relief packages [7](#), [196](#)
Economic Review of the State (Kerala State Planning Board) [205](#)

Economic Survey of Delhi (2022)

[163](#), [164f](#), [165f](#)

Economist, The [105](#)

education and educational institutions [32](#), [35](#), [177](#), [180](#)

effectiveness: islands/pockets [27](#), [31](#), [38](#), [41](#)

electoral processes (free and fair) [10](#), [30](#), [59](#), [124](#)

electricity supplies [129](#)

elites [28–29](#), [30](#), [153](#)

Pakistan [254](#), [255](#), [256–257](#), [260](#)

emergency cash payments [33](#)

emergency procurement [32](#), [38](#)

Employees' Provident Fund/Employees' Trust Fund (EPF/ETF) (Sri Lanka) [96–97](#)

employers and employment [12](#), [199](#)
Delhi (India) [168f](#), [169f](#), [176](#)

impact of COVID-19 on [95](#), [96t](#), [97–98](#), [99](#), [138](#), [204](#)

Nepal [142–153](#)

Employment Guarantee Scheme (India) [196](#)

employment insurance [231](#)

empowerment [11–12](#)

energy supplies and prices [3](#), [5](#), [225](#)

enforcement [14](#), [25](#), [29](#), [35](#), [103](#), [124](#), [219](#), [222](#), [229](#)

Epidemic Disease Act (EDA) (India) [117](#), [127](#), [195](#)

epidemiological impacts [15](#), [79](#), [80](#), [89](#), [90f](#), [91f](#), [92](#)

e-Shram cards (India) [181](#)

Ethiopia [2](#), [294](#)

ethnicity [6](#), [10](#), [142](#), [254](#), [262](#), [267](#), [269](#), [270](#)

ethnographic studies [2](#), [17–18](#)

exclusion [40](#), [142](#), [179](#)

exploitation (labour) [141](#), [178](#)

extractive industries [141](#), [142](#)

F

Facebook [203](#)

Face to Face (talk show) [269–270](#)

factories and factory owners [282](#)
political dominance in Bangladesh [33–34](#), [41](#)

ready-made garment industry in Bangladesh [212](#), [215–216](#), [217](#), [218–223](#), [224](#), [229](#), [230](#), [303](#)

Fair Wage [226](#)

false information [241](#), [242](#), [245](#), [252–253](#), [261](#)

false-negative/false-positive results [245](#)

family financial aid [196](#)

FAO *see* Food and Agricultural Organization

Farndale, Elaine [12](#)

federalism [14](#), [51–53](#)

centralisation/centre-state dynamics in India [53–62](#), [73](#), [74](#), [120](#)

female workers [4](#)

'fend-for-yourself federalism' [59](#)

fertility rates *see* birth rates

Finance Commission (India) [56](#), [57](#)

financial services [4](#), [139](#), [142](#), [201](#), [202](#), [306](#)

fingerprint verification [5](#)

fiscal deficits: India [56](#), [66](#), [67f](#)

fishing workers [195](#)

Food and Agricultural Organization (FAO) [140](#)

food security [140](#)

challenges of ensuring nutritional needs in Bangladesh [223](#), [225](#), [226](#), [227–228](#), [231](#)

Delhi (India) [161](#), [162](#), [170](#),

[171–172](#), [175–176](#), [178](#)

India [64](#), [65](#), [128](#), [129](#)

Kerala (India) [193](#), [194](#), [197](#), [198](#), [202](#), [205](#)

Sri Lanka [280](#), [281](#)

foreign aid [62](#)
 foreign currency [17](#), [41](#), [100](#), [211](#)
 foreign direct investment [5](#)
 Foreign Employment Board (FEB)
 (Nepal) [145](#), [152](#)
 foreign exchange rates [101](#), [217](#)
 foreign labour markets [16](#)
 foreign remittances [5](#), [15](#)
 formal sector employment [97](#), [142](#),
 [191](#), [231](#), [279](#), [308](#)
 for-profit health services [36](#), [43n4](#)
 France [116](#)
 free trade zone (FTZ) areas [274](#)
 frontline workers [17–18](#), [29](#), [38](#), [60](#),
 [160](#), [174](#)
 Pakistan [244](#), [247–248](#), [251](#), [254](#),
 [255](#), [261](#), [305–306](#), [308](#)
 fuel prices [88](#)
 fund distribution systems [123](#)
 funerals [249–250](#)
 furloughs [95](#), [224](#)
 ‘Future Pandemic Preparedness and
 Emergency Response – A
 Framework for Action’ (Niti
 Aayog) [132](#)

G

garment sector *see* ready-made gar-
 ments
 gender inequalities [68](#), [307](#)
 Delhi (India) [167](#), [168f](#), [175](#),
 [176–177](#), [178](#), [181](#)
 Kerala (India) [189](#), [191](#), [193](#), [199](#),
 [200](#), [203](#), [204](#), [205](#), [207](#), [303](#)
 Nepal [148](#), [153](#)
 Pakistan [243–244](#), [254](#), [262](#)
 South Asia [92–93](#), [96](#), [97–98](#)
 Sri Lanka [267](#), [269](#), [273](#), [284](#)
 Genocide Convention [2](#), [294](#)
 geographic factors [12–13](#)
 geopolitical instability [294–295](#)
 Germany [106](#), [116](#)
 Global Economic Prospects (2022)
 [216](#)

Global Financial Crisis (GFC) (2008)
 [82](#)
 global economy [30](#), [82](#), [100](#), [141](#)
 ready-made garment sector [212](#),
 [213](#), [215–216](#), [227](#), [230](#), [231](#),
 [285n4](#)
 Global South [4](#), [5](#), [6](#), [13](#)
 Goa (India) [72](#)
 governance [295](#), [307](#), [308](#)
 Bangladesh [26](#), [28](#), [29](#), [36](#), [41](#), [42](#)
 Delhi (India) [160–161](#), [165](#), [166t](#)
 Kerala (India) [190](#), [195](#)
 Pakistan [247](#), [249](#)
 South Asia [80](#), [89](#), [104](#)
 graft [34](#)
 Grants-in-Aid Scheme (India) [166t](#)
 graveyards [59](#)
 grievance mechanisms [179](#)
 gross domestic product (GDP) [15](#),
 [16](#), [34](#), [212](#), [215](#)
 India [59](#), [62](#), [63f](#), [64f](#), [65](#), [66f](#), [67f](#),
 [69](#), [75n2](#), [190](#)
 Nepal [139](#), [140](#), [153](#)
 South Asia [79](#), [87t](#), [93](#), [94t](#), [100](#),
 [101t](#), [103](#), [104](#)
 gross state domestic product (GSDP)
 [56–57](#)
 GSDP *see* gross state domestic
 product
 Guardian, The [173](#)
 Gujarat (India) [68](#), [69](#), [138](#), [188](#)
 Gulf States [137](#), [145](#), [147](#), [193](#)
 Gunawardena, Devaka [284](#)
 Gurugram (India) [117](#), [118](#)

H

H&M [217](#)
 Hallock, Jeffrey [228](#)
 Hamas [294](#)
 handwashing facilities [222](#), [229](#)
hartal (1953) (Sri Lanka) [269](#)
 Haryana (India) [59](#)
hawala (remittances) [100](#)

- HCWs *see* healthcare workers
- HDI *see* human development index
- healthcare for other illnesses [84–85](#)
- healthcare workers (HCWs) [17–18](#),
[241](#), [242](#), [243](#), [244](#), [261](#)
- health expenditure: India [53](#), [62](#), [63f](#),
[64f](#), [65](#), [66](#), [67f](#), [68](#), [69f](#), [74](#), [299](#)
- health infrastructure [3](#), [5](#), [7](#), [8](#), [10](#), [298](#)
- Bangladesh [222–223](#)
- citizen experiences in Bangladesh
[36](#), [37f](#), [38](#)
- Delhi (India) [170](#), [171](#), [180](#)
- India and federalism [52–53](#), [59](#), [67](#),
[70–71t](#), [72](#), [73](#), [74](#), [299](#)
- Kerala (India) [191](#), [193](#), [194](#), [198](#)
- Pakistan [242](#), [247](#), [251](#), [252](#)
- South Asia [91](#), [92](#), [104](#)
- state/substate responses in India [120](#),
[122](#), [125](#), [126](#), [127–128](#), [132](#)
- health insurance [193b](#), [223](#), [231](#), [258](#)
- health outcomes [70](#), [72](#), [144–145](#),
[254](#), [296](#)
- Bangladesh [212](#), [213](#), [217](#), [227–](#)
[228](#), [231](#)
- health and safety (workplaces) [68](#),
[222–223](#), [225](#), [228–229](#), [262](#),
[296](#)
- health screening [54](#), [121](#), [122](#), [123](#),
[127](#), [130](#), [131](#)
- health statistics [32–33](#)
- Hecló, Hugh [123](#)
- Heller, Patrick [190](#)
- high-skilled workers [7](#)
- Himachal Pradesh (India) [68](#)
- Hindu-majority countries [85](#), [164](#)
- hoarding (supplies) [61](#)
- homelessness [160](#)
- Hong Kong [54](#)
- hospitals and hospital management
[56](#), [62](#), [122](#), [128](#), [250–251](#)
- class biases and organisational hierarchy in Pakistan [241](#), [242](#),
[243](#), [244–245](#), [254–261](#), [262](#)
- Hossain, Naomi [228](#)
- hotspots [124](#), [129](#)
- Household Income and Expenditure
Survey (2016) (Bangladesh)
[227](#)
- housing support [10](#), [193](#), [194](#), [225](#),
[228](#), [231](#)
- human development index (HDI)
[91](#), [104](#), [106](#), [299](#)
- humanitarianism [115](#), [132](#), [176](#), [294](#)
- hundi* (informal money transfer)
[100](#), [147](#), [154n1](#)
- Hussain, Shujaat [256](#)
- ## I
- Iceland [106](#)
- ICJ *see* International Court of Justice
- identity cards *see* Aadhaar (identity card)
- ILO *see* International Labour Organization
- IMF *see* International Monetary Fund
- immunisation *see* vaccines and vaccinations
- imports and exports [8](#), [17](#), [33](#), [41](#)
- ready-made garment industry in
Bangladesh [211](#), [212](#), [214](#),
[215](#), [216](#), [218](#), [228](#)
- inclusive/exclusive development [27](#),
[41](#)
- incomes and income support
schemes [6](#), [7](#), [10](#), [150](#)
- Delhi (India) [170](#), [171f](#), [175](#), [176](#)
- India [73–74](#), [75n2](#), [75n3](#), [132–133](#),
[216](#), [295–296](#), [299](#), [301](#), [303](#),
[305](#)
- centralisation/centre-state dynamics
[51–62](#)
- Delhi as a migrant hub [163](#), [164f](#),
[165f](#), [166t](#), [167–168](#), [177](#)
- district level COVID-19 management
[126–130](#)
- effect of pandemic on health/socio-economic expenditure [62](#),
[63f](#), [64f](#), [65](#), [66f](#), [67f](#)

- epidemiological/economic impact of COVID-19 on [81–82](#), [85–86](#), [88](#), [90–93](#), [94](#), [95](#), [99–100](#), [102–105](#)
- impact of lockdowns [115–118](#), [119–120b](#), [121](#)
- interstate variations in management of COVID-19 [67–68](#), [69f](#), [70–71t](#), [72t](#)
- Kerala [205](#), [206](#)
- migrants and COVID-19 management at subnational level [121–126](#)
- Nepal and [137](#), [138](#), [144](#), [149–150](#)
- Sri Lanka and [276](#), [279](#)
- village administration and COVID-19 management [130–131](#)
- worker protection [2](#), [4–5](#), [6](#), [7](#), [8](#), [10](#), [14–15](#)
- Indian Council for Medical Research [177](#)
- Indian Medical Association [196](#)
- Indian Railways [61](#)
- ‘India Seems to Have Suffered Surprisingly Few Deaths from COVID-19: What Explains Its Apparent Success?’ (*The Economist*) [105](#)
- India Today [163](#)
- industrial disputes [192](#), [270](#)
- Industrial Police and Detective Branch (Bangladesh) [214](#), [225](#)
- inequality (structural) [3](#), [17](#), [18](#), [142](#), [293](#), [295](#), [304](#), [306](#), [307](#), [308](#)
- Delhi (India) [159](#), [160](#), [176](#), [177](#), [178](#)
- Kerala (India) [188](#), [204](#), [207](#)
- Pakistan [241](#), [243](#), [244](#), [254](#), [258](#), [262–263](#)
- infection rates [31](#), [32](#), [229](#)
- India [115](#), [116](#), [120](#), [124](#), [129](#), [130](#)
- Pakistan [242](#), [244](#), [248](#), [250](#)
- South Asia [79](#), [80](#), [81](#), [87t](#), [89](#), [90f](#), [92](#), [103](#)
- inflation/deflation rates [15](#), [153](#), [247](#), [275](#)
- Bangladesh [213](#), [216](#), [226–228](#), [231](#)
- South Asia [79](#), [99t](#), [100](#), [103](#)
- informal sector workers [7](#), [17](#), [64](#), [65](#), [101](#), [279–280](#), [307](#), [308](#)
- Kerala (India) [189](#), [191](#), [192](#), [193](#), [200](#), [204](#), [205](#), [207](#), [303](#)
- information-gathering and sharing *see* policy learning
- in-person government health facilities [36–37](#)
- institutionalisation [53](#), [57](#), [304](#)
- intensive care units [3](#)
- intergovernmental coordination mechanisms [52](#), [58](#), [74](#), [75](#)
- intergovernmental relations *see* centre-state authority and collaboration
- internal heterogeneity [6](#)
- International Court of Justice (ICJ) [2](#), [294](#)
- international credit [5](#)
- international development partners [81](#)
- International Labour Organization (ILO) [68](#), [179](#)
- International Monetary Fund (IMF) [5](#)
- internet connectivity [4](#)
- Inter-State Council (India) [58](#), [74](#)
- Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act (1979) (India) [57](#), [161](#)
- interviewing and interview data [17](#), [159](#), [189](#), [213](#), [273–276](#), [286n6](#)
- Iran [6](#)
- isolation mandates [222](#), [279](#)
- India [122](#), [127](#), [130](#)
- Pakistan [248](#), [250](#), [252](#)
- South Asia [82](#), [83](#), [84](#)
- Israel [2](#), [294](#)

J

Jaankari call centre (India) [123](#)
 Jai Bhim Mukhyamantri Pratibha
 Vikas Yojana (Chief Minister
 Scheme for housing for
 labourers) (Delhi) [166t](#)
 Janata Curfew (People's Curfew)
 (India) [116–117](#), [162](#)
 Javed, Haniya [259](#)
 Jayawardena, Kumari [269](#)
 'Jhan Dhan' programme (India) [4](#)
 Jharkhand (India) [72](#)
 job losses *see* unemployment
 job retention/training schemes [3](#), [12](#)
 job surveys [167–168](#)

K

kamaune (ability to earn money) [143](#)
 Kapashera (industrial site, India) [16](#),
[159–160](#), [169](#), [180](#)
 Karmojibi Nari [226](#)
 Karnataka (India) [60](#)
 Kearney, Robert [269](#)
 Kerala (India) [11](#), [17](#), [124](#), [130](#),
[187–190](#), [296](#), [297](#), [302](#), [308](#)
 continuing efforts and challenges
 post-pandemic [204–205](#)
 federalism [54](#), [58](#), [60](#), [67](#), [68](#)
 lessons learnt from pandemic expe-
 rience [205–207](#)
 pre-pandemic labour model
[190–192](#), [193b](#), [194](#)
 welfare services during the pan-
 demic [194–203](#)
 Kerala State Planning Board (KSPB)
[191](#), [195](#), [196](#), [205](#)
 Khan, Asma [161](#)
 Khan, Imran [247](#), [250](#), [252](#), [253](#)
 Khan, Mushtaq [43n2](#)
kharchis (bribes) [259](#)
 Khyber Pakhtunkhwa (Pakistan) [257](#)
 kinship networks [153](#)
 Kissinger, Henry [106](#)

Kosi River flood disaster [122](#), [123](#)
 Kota (Rajasthan) [125](#)
 KSPB *see* Kerala State Planning
 Board
 Kudumbashree (a state-supported
 self-help group initiative)
 (Kerala) [196](#), [197](#), [203](#)
 Kumari, Jyoti [117](#)
 Kumbh Mela (India) [58](#)
 Kwon, Bora [12](#)

L

'labour card' (Delhi) [180](#)
 Labour Commissionerate (Kerala)
[199](#), [202](#)
 labour force surveys [96–97](#)
 labour markets [3](#), [4](#), [10](#), [16](#), [33–34](#)
 COVID-19's impact on labour
 migration in Nepal [139](#),
[143–150](#)
 labour permits [144](#), [146](#)
 labour policies [17](#), [68](#), [141](#), [166t](#), [167](#),
[187](#), [302](#)
 pre-pandemic model in Kerala
[190–192](#), [193b](#), [194](#)
 workers' experiences in Kerala
 (India) [187](#), [198–202](#)
 labour rights [274](#), [293](#), [296](#), [302](#), [303](#)
 ready-made garment industry [212](#),
[217](#), [224](#), [225](#)
 labour studies [272–273](#)
 labour welfare expenditure: India [62](#),
[65](#), [66f](#), [67](#), [68](#), [69f](#), [73](#)
 Lahore (Pakistan) [17–18](#)
 landless rural workers [4](#), [10](#)
 land ownership and distribution [10](#),
[141](#)
 layoffs [217](#), [219](#), [223–225](#)
 Liberalised Accelerated National
 Covid-19 Vaccine Strategy
 (India) (2021) [60–61](#)
 liberalism [139](#), [294](#), [295](#)
 life expectancy [177](#)

liminality [270](#), [271–273](#), [276](#), [278](#),
[282](#), [283](#), [284](#), [285n2–n3](#),
[285n5](#), [306](#)

liquidity measures [65](#)

livelihoods, loss of [52](#), [64](#), [79](#), [81](#),
[139](#), [277](#), [296](#), [299–301](#), [304](#)
 Bangladesh [32](#), [33](#), [34](#), [35](#), [212](#), [213](#),
[228](#)
 Delhi (India) [162](#), [163](#), [171](#)
 India [115](#), [117](#), [121](#), [128](#), [131](#), [195](#)
 ‘lives versus livelihood’ debate [15](#), [35](#)
 South Asia [79](#), [80](#), [81–85](#), [102–106](#),
[299](#), [300](#)

living standards [30](#)

loans [57](#), [145](#), [152](#), [218](#), [224](#), [257](#)

Kerala (India) [188](#), [196](#), [197](#), [199](#),
[201](#), [202](#), [203](#)

local authorities [52](#), [53](#), [58](#), [152](#), [206](#)
 COVID-19 management at district/
 village level [121–131](#), [133](#)

lockdowns [3](#), [15](#), [300](#)
 Delhi (India) [161–163](#), [168–176](#),
[178](#), [180](#)
 impact in India [115–118](#), [119–](#)
[120b](#), [121–122](#), [126](#), [128–129](#),
[131](#)
 India and federalism [52](#), [53](#), [54](#), [55](#),
[56](#), [57](#), [58](#), [64](#), [67](#)
 Kerala (India) [188](#), [192](#), [195](#), [198](#),
[202](#), [204](#), [206](#)
 Nepal [138](#), [139](#), [145](#), [147](#), [148](#), [149](#),
[150](#)
 Pakistan [246](#), [250](#), [253](#)
 political dominance in Bangladesh
[27](#), [31](#), [32](#), [33](#), [34](#), [35](#), [39](#), [41](#), [42](#)
 ready-made garment industry in
 Bangladesh [213](#), [216](#), [217](#),
[218](#), [219–221](#), [226](#)
 South Asia [82](#), [84–85](#), [92](#), [97–98](#)
 ‘Locked Down and In Limbo’ (In-
 ternational Labour Organiza-
 tion) [179](#)
 ‘long-COVID’ [2](#)
 low-income countries [4](#), [100](#)

low-income workers [34](#), [139](#), [160](#),
[179](#), [251](#), [270](#)

low-skilled workers [7](#)

M

macro-level approach [1](#), [8](#), [9t](#), [10](#), [13](#),
[14](#), [15](#), [307](#)

Madhya Pradesh (India) [68](#)

Maharashtra (India) [58](#), [69](#), [72](#)

Mahatma Gandhi National Rural
 Employment Guarantee Act
 (MGNREGA) (cost-sharing
 programme) (India) [65](#), [131](#)

Malaysia [144](#), [146](#), [148](#)

Maldives, The [6](#), [7](#), [295](#)
 epidemiological/economic impact
 of COVID-19 on [81](#), [85–86](#),
[88–89](#), [91–95](#), [99–104](#)

Malik, Muhmmad Asher [251](#)

manufacturing industries [148](#), [191](#),
[192](#), [204](#)

Mapped in Bangladesh (MiB) [223](#),
[224](#)

marginalisation
 Delhi (India) [160](#), [180](#)
 Kerala (India) [189](#), [201](#), [204](#), [207](#)
 Nepal [139](#), [141](#)
 Pakistan [243–244](#), [245](#), [259](#)

Marks & Spencer [217](#)

marriages [175](#), [177](#)

Maruti car factory (Delhi) [169](#)

mask mandates [52](#), [124](#), [299](#), [300](#)
 Bangladesh [221](#), [222](#)
 Kerala (India) [194](#), [197](#)
 Pakistan [249](#), [252](#), [255](#), [256](#), [305](#)
 South Asia [82](#), [83–84](#), [103](#)

mass displacement [2](#)

mass struggles [270](#)

maternity benefits [192](#)

MDG *see* Millennium Development
 Goals

medical care and expenditure: India
[62](#), [63f](#), [67](#), [193](#)

- medical staff [14](#), [17–18](#)
 mental health [178–179](#), [197](#)
 Bangladesh [229](#), [231](#)
 Pakistan [242](#), [243](#), [244](#), [245](#),
 [259–262](#)
 Sri Lanka [279](#), [282](#), [283](#)
 ‘Mera Gaon Corona Mukht’ (COV-
 ID-19 campaign) (India) [131](#)
 meso-level approach [8](#), [9t](#), [10](#), [14](#),
 [15](#), [307](#)
 ‘Methodologies for Measuring State-
 Level Economic Losses in
 the Context of the Covid-19
 Pandemic’ (National Consul-
 tation) (India) [195–196](#)
 MGNREGA *see* Mahatma Gandhi
 National Rural Employment
 Guarantee Act (India)
 MiB *see* Mapped in Bangladesh
 micro-level approach [1](#), [8](#), [9t](#), [11](#), [13](#),
 [307](#)
 Middle Eastern countries [100](#), [301](#)
 middle-income countries [4](#), [85](#), [100](#)
 migrant labourers/workers [161](#), [300](#),
 [301](#), [302](#), [307](#), [308](#)
 COVID-19 management at sub-
 national level in India [115](#),
 [117](#), [118](#), [121–126](#), [127](#), [129](#),
 [130–131](#), [132](#), [133](#)
 India and federalism [54](#), [57](#), [64](#), [65](#),
 [66](#), [67](#)
 Nepal [137–138](#), [139](#), [140](#), [141](#),
 [143–144](#), [154](#)
 public welfare support [178–180](#),
 [181](#)
 voices of workers in Delhi (India)
 [168f](#), [169f](#), [170](#), [171f](#), [172–176](#)
 welfare initiatives in Kerala (India)
 [187](#), [188](#), [192](#), [193b](#), [202–203](#),
 [206](#), [207](#)
 worker protection [4](#), [5](#), [7](#), [15](#), [16](#), [17](#)
 militarisation [32](#), [295](#), [296](#), [297](#), [304](#)
 Millennium Development Goals
 (MDG) [36](#)
 mining industries [162](#)
 Ministry of Health (Pakistan) [246](#)
 mobile phones [4–5](#), [33](#), [41](#), [181](#), [274](#)
 mobilisation (social/public) [18](#), [160](#),
 [200](#), [230](#), [295](#), [306](#), [308](#)
 Sri Lanka [268](#), [269](#), [270](#), [286n8](#)
 Modi, Narendra [58](#), [105](#), [116](#), [295](#),
 [298](#), [299](#), [305](#)
 money lenders (‘blade man’) [201–202](#)
 money transfers [33](#), [41](#), [154n1](#)
 monthly household expenditure
 [164–165](#)
 ‘moral economy’ [30](#)
 mortality rates *see* death and death
 rates
 mukhiya (elected village head) (In-
 dia) [130](#), [131](#)
 Multi Fibre Agreement (Bangladesh)
 [214](#)
 multilevel approach [8](#), [9t](#), [10–13](#)
 multisectoral strategies [127](#)
 Mumbai (India) [15](#), [138](#)
 Muslim-majority countries [85](#), [92](#),
 [245](#), [247](#), [299](#)
 Myanmar [6](#), [216](#)
- ## N
- National Bureau of Economic Re-
 search (United States) [85](#)
 National Capital Territory (NCT) *see*
 Delhi
 National Democratic Alliance (NDA)
 (India) [58](#), [68](#)
 National Disaster Management Act
 (DMA) (2005) (India) [54–55](#),
 [67](#)
 National Disaster Management Au-
 thority (India) [55](#)
 National Executive Committee (In-
 dia) [55](#), [58](#)
 National Food Security Act (2013)
 (India) [64](#)
 National Social Security Strategy
 (NSSS) (Bangladesh) [217](#), [231](#)

natural gas [98](#)
 NDA *see* National Democratic Alliance
 negotiated cooperation [74](#)
 neoliberalism [3](#), [13](#), [139](#), [163](#), [206](#),
[295](#), [297](#)
 neo-patrimonialism [10](#)
 Nepal [2](#), [4](#), [6](#), [7](#), [16](#), [137–140](#), [153](#), [279](#)
 COVID-19's impact on labour
 migration [143–150](#)
 epidemiological/economic impact
 of COVID-19 on [85](#), [86f](#), [87t](#),
[88f](#), [89f](#), [92](#), [93](#), [94t](#), [103](#), [104](#)
 impact of COVID-19 on cost of
 living [99t](#), [100](#)
 impact of COVID-19 on jobs [95](#),
[96t](#)
 impact of COVID-19 on remit-
 tances [100](#), [101t](#), [102](#)
 incidences/deaths proportionate to
 populations [89](#), [90f](#), [91f](#)
 macroeconomic context and pre-
 existing precarities [140–143](#)
 social protection [139](#), [151–152](#), [301](#)
 Nepal-India Treaty of Peace and
 Friendship (1950) [150](#)
 Nepali Times [138](#), [148](#), [149](#)
 nepotism [34](#)
 New Zealand [105–106](#)
 NGOs *see* non-governmental organi-
 sations
 Nguyen, Dr Vinh-Kim [106](#)
 Nipah virus [11](#)
 Niti Aayog (Policy Commission)
 (India) [132](#)
 non-compliance [122](#), [124](#), [125](#)
 non-governmental organisations
 (NGOs) [142](#)
 Bangladesh [30](#), [33](#), [36](#), [43n4](#)
 Delhi (India) [170](#), [171f](#), [175](#)
 non-pharmaceutical interventions
 (NPIs) *see* lockdowns; mask
 mandates; quarantines; social
 distancing

Norway [106](#)
 NSSS *see* National Social Security
 Strategy (NSSS) (Bangladesh)
 nurses [243](#), [252](#)

O

Occupational Safety, Health and
 Working Conditions Code
 (2020) (India) [161](#)
 Odisha (India) [11](#), [68](#), [130](#), [296](#)
 Onam (government-sponsored sub-
 sistence kit) (India) [194](#)
 'One Nation, One Ration Card'
 (India) [57](#)
 one-party dominance *see* political
 dominance
 oral testimonies [2](#), [167](#), [168f](#), [169f](#),
[170](#), [171f](#), [172–176](#)
 organisational hierarchies [241](#), [242](#),
[243–245](#), [254–261](#)
 Othering [262](#)
 Ottakkalla, oppamundu (mental
 health helpline) (India) [197](#)
 out-of-pocket payments [251](#)
 Oxfam [4](#)
 oxygen supplies [59](#), [61](#), [62](#), [125](#), [299](#)

P

Pakistan [245](#), [261–263](#), [279](#), [295](#), [296](#),
[299](#), [305](#), [308](#)
 class biases and organisational hi-
 erarchy in hospitals [241](#), [242](#),
[243–245](#), [254–261](#)
 cost of living and impact of
 COVID-19 on [99t](#)
 economic growth and impact of
 COVID-19 on [92](#), [93](#), [94t](#)
 incidences/deaths and COVID-19
[90f](#), [91f](#)
 jobs and impact of COVID-19 on
[95](#), [96t](#)
 'out of hand situations' and disease
[245–250](#)

- population/economy [81](#), [85](#), [86f](#),
[87t](#), [88f](#), [89f](#)
 provision of basic resources [250–254](#)
 remittances and impact of
 COVID-19 on [100](#), [101t](#)
 workers protection [2](#), [6](#), [7](#), [10](#), [11](#),
[17–18](#)
 Pakistan Democratic Movement
 (PDM) [250](#), [263n3](#)
 Pakistan Muslim League (Quaid-e-
 Azam Group) (PML-Q) [256](#)
 Pakistan Tehreek-e-Insaf (PTI) [247](#),
[249](#)
 Palestine [2](#)
 panchayats (local level governance)
[15](#), [16](#), [54](#), [121](#), [130](#), [194](#), [300](#)
 pandemics [1](#), [2](#), [4](#), [6](#), [7–8](#), [13–19](#), [81](#),
[106](#), [132](#)
 Park, Jong Guy [12](#)
 participant observation [11](#)
 Patna High Court (India) [125](#)
 patriarchal societies [243–244](#)
 patronage politics [282](#)
 payments (manufacturers) [215–216](#)
 PDM *see* Pakistan Democratic Move-
 ment
 people's protest *see aragalaya* (peo-
 ple's protest) (Sri Lanka)
 pensions [65](#), [151](#), [196](#)
 per capita expenditures and income
[140](#), [299](#)
 Delhi (India) [163](#), [164f](#), [165f](#)
 India and federalism [68](#), [69f](#), [70](#),
[72t](#), [73](#), [74](#)
 South Asia [87t](#), [88](#), [89f](#), [91](#), [92](#), [104](#)
 Perera, Oneli [268](#)
 performance legitimacy [10](#), [14](#), [25](#),
[27](#), [30](#), [35](#)
 personal corruption [10](#)
 personal protection equipment (PPE)
[8](#), [18](#), [28](#), [56](#), [62](#)
 Kerala (India) [188](#), [198](#)
 Pakistan [241](#), [242](#), [248](#), [250](#), [251](#),
[252](#), [253](#), [254](#), [255](#), [261](#), [305](#)
 Sri Lanka [277](#), [278](#)
 Pfizer-BioNTech [2](#)
 PFMS *see* Public Financial Manage-
 ment System (India)
 pharmacies [36–37](#), [54](#), [174](#)
 places of worship [35](#)
 PML-Q *see* Pakistan Muslim League
 (Quaid-e-Azam Group)
 point-of-entry surveillance [54](#)
 Pokharel, Dilli Ram [146](#)
 polarised party systems [52](#), [53–62](#), [74](#)
 police forces [32](#), [54](#)
 policy innovation [14](#), [123](#), [133](#), [191](#)
 policy learning [27](#), [28](#), [41](#), [74](#), [178](#),
[194](#)
 states and substates [122–123](#), [125](#),
[128](#), [129](#), [132](#), [133](#)
 polio campaigns [123](#), [129](#)
 political accountability and transpar-
 ency [191](#)
 political commitment [28](#), [29](#), [35](#), [42](#)
 political dominance [14](#), [25](#), [27](#),
[29–30](#), [31](#), [35](#), [53](#), [55](#), [298](#)
 political economy of development
[12–13](#), [26](#), [28](#), [30](#), [42](#), [304](#)
 political institutions [214–215](#)
 political learning [27](#)
 political legitimacy [29](#), [30](#)
 political settlement analysis [28](#)
 'polycrisis' [294](#)
 population density [73](#), [116](#), [163](#)
 South Asia [85](#), [86f](#), [87t](#), [90](#), [91](#), [103](#)
 populism [3](#), [294](#), [295](#)
 postcolonialism [6](#)
 poverty [4](#), [11](#), [36](#), [257](#), [295](#)
 Bangladesh [226](#), [227](#)
 India [64](#), [65](#), [160](#), [178](#)
 Nepal [138](#), [140–141](#), [142](#), [143](#), [150](#)
 South Asia [81](#), [83](#), [86](#), [93](#)
 'power distance' [12](#)
 Power and Participation Research
 Centre [226](#)
 PPE *see* personal protection equip-
 ment

Pradhan Mantri Garib Kalyan Yojana scheme (Delhi) [166t](#), [180–181](#)
 precarity [138–139](#), [140](#), [141](#), [151](#), [153](#), [180](#), [181](#)
 preparedness [11](#), [26](#), [217](#)
 India [53](#), [74](#), [120](#), [132](#), [190](#), [191](#)
 Pakistan [248](#), [251–252](#), [253](#)
 press conferences [196](#)
 preventive services [15](#), [36](#), [51](#), [53](#), [82](#), [121](#)
 Pakistan [245](#), [248](#), [249](#), [250](#), [253](#)
 price inflation [3](#), [228](#)
 Primark [217](#)
 Prime Minister's Employment Programme (Nepal) [152](#)
 priority balancing [28](#), [32](#), [33](#), [42](#)
 private health services [36](#), [37](#), [52](#), [61](#), [128](#), [194](#), [196](#), [251](#), [257](#)
 private sector employees [96–97](#), [142](#), [214](#), [215](#)
 production [272–273](#), [282](#), [284](#)
 profiteering [228](#)
 property landlords [121](#)
 protectionism (labour) [17](#), [302](#), [303](#), [307](#), [308](#)
 Kerala (India) [188](#), [189](#), [199](#), [206](#), [207](#)
 provident fund contributions [192](#)
 psychological distress [82](#)
 PTI *see* Pakistan Tehreek-e-Insaf
 Public Distribution System (subsidised food supply) (India) [5](#)
 Public Financial Management System (PFMS) (India) [124](#)
 public gatherings [32](#)
 Public Health Emergency Management Act (proposed) (India) [132–133](#)
 Public Health Inspector (PHI) (Sri Lanka) [279](#)
 public health sector [13](#), [18](#), [297](#)
 Bangladesh [28](#), [29](#), [30](#), [31](#), [37](#), [38](#)
 expenditure [62](#), [63f](#), [70–71t](#), [72t](#), [75](#)

 India [52](#), [54](#), [127–128](#)
 Kerala (India) [197](#), [206](#)
 Pakistan [246](#), [254](#), [257](#), [259](#)
 South Asia [83](#), [84](#)
 public mobilisation [197](#), [268](#), [269](#), [270](#), [295](#), [306](#)
 public protests [18](#), [268](#), [269](#), [270](#), [285n1](#), [305](#)
 public transport [32](#), [35](#), [57](#)
 Puducherry (India) [70](#)
 Punjab (India) [59](#), [68](#)
 Purser, Gretchen [278](#)

Q

Qatar [144](#), [147](#), [148](#)
 qualitative data [296](#)
 Quality Assessment Study (QAS) (2020) (Kerala) [191](#), [192](#)
 quantitative data analysis [2](#), [130](#), [296](#)
 quarantines [31](#), [54](#), [222](#), [279](#), [299](#), [300](#)
 India [122](#), [124](#), [127](#), [129](#), [131](#), [173](#), [206](#)
 Nepal [145](#), [150](#)
 South Asia [82](#), [83](#), [84](#), [103](#)
 Quick Assessment Report (India) [195](#)

R

Rajapaksa, Gotabaya [105](#), [299](#)
 Raja, Raza Habib [247](#)
 Rajasthan (India) [15](#), [68](#), [72](#), [121](#), [126–129](#), [300](#)
 rankism [241](#), [242](#), [243–245](#), [254–261](#)
 Rapid Response Teams (RRTs) (India) [188](#), [197](#)
 ration cards and rationing [57](#)
 Delhi (India) [166t](#), [170](#), [171](#), [175](#), [180](#)
 Kerala (India) [194](#), [199](#)
 ready-made garments (RMG) [1](#), [10](#), [17](#), [18](#), [162](#), [212–213](#), [230–232](#), [303](#), [304](#), [308](#)

- challenges of ensuring nutritional needs in Bangladesh [227–228](#)
 health risks and costs in Bangladesh [228–229](#)
 impact of COVID-19 on sector in Bangladesh [215–217](#)
 importance of ready-made garment (RMG) sector in Bangladesh [27](#), [33–34](#), [41](#), [214–215](#)
 layoffs and retrenchments in Bangladesh [223–225](#)
 lockdowns in Bangladesh [219–221](#)
 low wage rates in Bangladesh [225–227](#)
 no-work euphoria in Sri Lanka [276–278](#)
 liminality in Sri Lanka [267](#), [274](#), [279](#)
 stimulus packages/social protection in Bangladesh [218–219](#)
 recovery rates [58](#)
 Reform Party (UK) [3](#)
 refugees [160](#)
 regime types and changes [93](#), [296](#), [306](#)
 regional development [244](#)
 relief packages [192](#), [199](#), [202](#), [203](#), [279](#)
 religion and religious minorities [4](#), [177](#), [262](#)
 Remdesivir (COVID-19 treatment drug) [61](#)
 remittances [16](#)
 impact of COVID-19 on [79](#), [100](#), [101t](#), [102](#), [103](#)
 Nepal [137](#), [139](#), [140](#), [141](#), [143](#), [144](#), [145](#), [146](#), [147](#), [153](#)
 repatriation [149](#)
 reproducibility rates [84](#)
 resurgent states [16](#)
 retired workers [199](#)
 retrenchments [95](#), [97](#), [217](#), [219](#), [223–225](#), [226](#)
 revenue-raising [8](#)
 rights of workers [15–16](#), [17](#), [34](#), [192](#), [206](#), [280](#), [301](#), [302](#), [305](#), [307](#), [308](#)
 right to information (RTI) [123](#)
 riots [270](#)
 risk assessments [261](#)
 rites and rituals [271](#)
 Rizvi, Khadim Hussain [248](#), [249](#), [263n2](#)
 RMG *see* ready-made garments
 Rodrik, Dani [295](#)
 Romiti, Giuila Francesco [249](#)
 RRTs *see* Rapid Response Teams
 rural areas [144](#), [150](#), [177](#), [244](#), [277](#), [301](#)
 Russia [2](#), [3](#), [5](#), [294](#), [295](#)
 Bangladesh and [216](#), [228](#)
 South Asia and [86](#), [88](#), [98](#)
- ## S
- SAARC *see* South Asian Association for Regional Cooperation
 Sahapur village (Gaya District) [131](#)
 Samararatne, Dinesha [269](#)
 sampling and sample surveys [11](#), [189](#)
 Bangladesh [36](#), [37f](#), [38](#), [39f](#), [40f](#), [41](#), [43n3](#)
 sanctions [29](#)
 sanitisers [194](#), [197](#), [221](#), [255](#)
sarpanches (village heads) [130](#)
 Saudi Arabia [144](#), [148](#)
 scientific communities [33](#)
 SDGs *see* Sustainable Development Goals
 Sehat Insaf card (health-based programme) (Pakistan) [257–258](#)
 Sehat Sahulat Programme (Pakistan) [257–258](#)
 self-employment [152](#), [189](#), [191](#), [192](#), [193](#)
 Senanayake, Devana [270](#)
 senior citizens [60](#)
 service sector industries [148](#)

- Seventh Schedule (Indian Constitution) [54](#)
- severance pay [224](#)
- Sharif, Nawaz [256](#)
- Shastho Batayon (telephone health advice system) [43n5](#)
- shelter homes and night shelters [178](#), [179](#), [194](#), [203](#)
- Shramik (labour) trains and buses (India) [57](#), [118](#), [203](#)
- shutdowns *see* lockdowns
- Siddiqi, Dina M. [229](#)
- Singh, Prabhu N [129](#)
- Skanthakumar, Balakrishnan [269](#)
- SMART agenda (Bangladesh) [42](#)
- Smart City Integrated Command and Control Centre (India) [129](#)
- ‘smart platforms’ [4–5](#), [33](#), [41](#)
- smuggling (human) [144](#)
- snowballing [189](#)
- social contracts [30](#)
- social distancing [31](#), [41](#), [130](#), [147](#), [251](#), [299](#), [300](#)
- Bangladesh [221](#), [222](#), [225](#), [229](#)
- Delhi (India) [172](#), [174](#)
- South Asia [82](#), [83](#), [84](#), [103](#)
- social insurance [3](#), [4](#)
- social protection
- Bangladesh [216](#), [218–219](#), [231](#)
- Nepal [139](#), [141](#), [150](#), [151–152](#), [301](#)
- social reproduction [273](#), [284](#), [286n8](#)
- social sciences [272](#)
- social sector expenditure: India [62](#), [64f](#), [66](#)
- social security [65](#), [95](#), [145](#), [149](#), [160](#), [192](#), [193](#), [204–205](#)
- Social Security Fund (Nepal) [151](#)
- social support and protection [3](#), [4](#), [5](#), [7](#), [8](#), [10](#), [12](#), [52](#)
- citizen experiences in Bangladesh [30](#), [31](#), [33](#), [34](#), [39f](#), [40f](#), [41](#)
- socio-economic expenditure: India [62](#), [63f](#), [64f](#), [65](#), [66f](#), [67f](#), [68](#)
- South Asia [1](#), [4](#), [5](#), [6](#), [12](#), [145](#), [216](#), [293](#), [295–296](#), [297](#), [299](#), [307](#)
- COVID-19 pandemic [13–19](#), [79–81](#), [85](#), [86f](#), [87t](#), [88f](#), [89f](#)
- economic impact of COVID-19 on [92–93](#), [94t](#), [95](#)
- impact of COVID-19 on cost of living on [98](#), [99t](#), [100](#)
- impact of COVID-19 on jobs [95](#), [96t](#), [97–98](#)
- impact of COVID-19 on remittances [100](#), [101t](#), [102](#)
- incidences/deaths proportionate to populations [89](#), [90f](#), [91f](#), [92](#)
- lives versus livelihoods dichotomy [80](#), [81–85](#), [102–106](#)
- South Asian Association for Regional Cooperation (SAARC) [6](#)
- Southern Sudan [294](#)
- spatialization [272](#)
- Sri Lanka [2](#), [5](#), [6](#), [18](#), [34](#), [85](#), [228](#), [267–271](#), [283–285](#), [295–300](#), [303–308](#)
- concept and writings around liminality [270](#), [271–273](#)
- economic impact of COVID-19 on [92](#), [93](#), [94t](#), [95](#)
- epidemiological/economic impacts of COVID-19 on [86f](#), [87t](#), [88f](#), [89f](#)
- garment sector and no-work euphoria [276–278](#)
- impact of COVID-19 on cost of living [99t](#), [100](#)
- impact of COVID-19 on jobs [95](#), [96t](#), [97](#), [98](#)
- impact of COVID-19 on remittances [100](#), [101t](#), [102](#)
- incidences/death proportionate to population [89](#), [90f](#), [91f](#)
- ‘life vs livelihood’ binary [79–80](#), [81](#), [82](#), [103](#), [104](#), [105](#), [106](#)
- researching during crisis times [273–276](#)

workers and drift/debt [271](#),
[278–283](#)
 Srivastava, Priyanka [297](#)
 starvation [84–85](#)
 state capacity development [296](#), [298](#)
 Bangladesh [27](#), [28–29](#), [31](#), [32](#), [35](#),
[41](#), [42](#)
 India [53](#), [73](#), [125](#), [132](#), [189](#)
 South Asia [102](#), [104](#)
 state-level policies [293](#), [300–303](#)
 state regulation [5](#), [8](#), [9t](#), [10–13](#), [14](#), [18](#)
 states *see* subnational actors
 state support and protection [26](#), [35](#)
 stigmatisation [18](#), [34](#), [150](#), [173](#), [220](#),
[241](#), [242](#), [262](#)
 stimulus packages [33](#), [34](#), [64–65](#),
[205](#), [206](#)
 Bangladesh [212](#), [213](#), [217](#), [218–](#)
[219](#), [303](#)
 strikes [270](#)
 subnational actors [26](#), [297](#), [298](#), [300](#),
[301](#)
 centre-state authority and collabora-
 tion in India [52–53](#), [55–56](#),
[56–57](#), [59](#), [62–63](#), [65](#), [66](#)
 COVID-19 management at dis-
 trict/village level [118](#), [120](#),
[121–131](#), [133](#)
 variations in management of
 COVID-19 in India [67–68](#),
[69f](#), [70–71t](#), [72t](#), [73](#), [74](#)
 suicide [259](#)
 Suo Motu Writ Petition (Civil) No. 3
 (2021) (India) [61](#)
 ‘superspreaders’ [92](#), [250](#), [299](#)
 supply chains [3](#), [88](#), [98](#)
 Supreme Court (India) [61](#), [74](#), [75n1](#),
[118](#), [119–120b](#), [178](#), [299](#)
 Supreme Court (Nepal) [149](#), [150](#)
 surveillance [5](#), [127](#), [132](#)
 Sustainable Development Goals
 (SDGs) [36](#), [295](#)

T

Taiwan [106](#)
 Talerico, Giovanni [249](#)
 Taliban, The [7](#), [93](#), [94](#), [300](#)
 Tamil Nadu (India) [69](#)
 taxation [56–57](#), [141](#), [199](#)
 teachers [18](#)
 Telangana (India) [60](#), [70](#)
 telehealth/telemedicine services [3](#),
[37](#), [43n5](#)
 temperature checks and monitoring
[222](#), [229](#)
 testimonies *see* written testimonies
 (research)
 testing and testing rates [31](#), [62](#), [88](#),
[229](#)
 India [122](#), [124](#), [128](#), [130](#), [131](#), [132](#)
 Nepal [145](#), [147](#)
 Pakistan [245](#), [246](#), [248](#), [253](#)
 textile industries *see* ready-made gar-
 ments (RMG)
 Thompson, E.P. [284](#)
 Thomson Reuters [65](#)
 Tibet [6](#)
Times of India [126](#)
 tourism [5](#), [93](#), [99](#)
 tracing and tracking rates [128–129](#),
[131](#)
 trade unions *see* unionisation
 traditional knowledge systems [131](#)
 transition moments *see* liminality
 transmission *see* infection rates
 transparency [31](#), [34](#), [196–197](#)
 transport and travel [18](#), [35](#), [139](#)
 Bangladesh [219–220](#), [221](#), [222](#), [228](#)
 Delhi (India) [161](#), [162](#), [163](#), [173](#),
[174](#)
 India [117](#), [118](#), [121](#), [124–125](#), [128](#),
[129](#), [131](#), [132](#), [149](#)
 Pakistan [255](#), [262](#)
 South Asia [82](#), [83](#), [98](#)
 treatment protocols [56](#), [244](#)
 Trump, Donald [3–4](#), [80](#), [83](#)

Turner, Victor [271](#), [272](#), [283](#), [284](#)
two-dimensional approach [8](#), [9t](#),
[10–13](#)

U

UC Berkeley-BRAC survey (2019) [227](#)
Ukraine [2](#), [3](#), [5](#), [86](#), [88](#), [98](#), [216](#), [228](#),
[294](#), [295](#)
uncertainty [61](#), [277](#), [278](#), [283](#), [301](#)
Pakistan [242](#), [245–250](#), [261](#)
underemployment [95](#)
under-reporting [88](#)
UNDP *see* United Nations Development Programme
unemployment rates [15](#), [79](#), [247](#)
Bangladesh [212](#), [223–225](#), [226](#),
[231](#), [303](#)
Delhi (India) [160](#), [162](#), [163](#), [167–](#)
[168](#), [171](#), [173](#), [174](#), [176–177](#),
[302](#)
Kerala (India) [192](#), [199](#), [204](#), [205](#)
Nepal [146](#), [147](#), [148](#), [150](#), [151](#), [152](#)
South Asia [95](#), [96t](#), [99](#), [103](#), [104](#)
UNICEF [140](#)
unilateral decentralization [59](#)
Union Budget (2022–2023) (India) [57](#)
Union Health Ministry (India) [56](#)
unionisation [304](#)
Bangladesh [213–215](#), [217–221](#),
[223](#), [225](#), [226–227](#), [230–231](#),
[307](#), [308](#)
Kerala (India) [189](#), [197](#), [200–201](#)
United Arab Emirates (UAE) [144](#),
[147–148](#)
United Federation of Garments
Workers (Bangladesh) [225](#)
United Kingdom (UK) [60](#), [105](#), [116](#),
[137](#)
United Nations Development Programme (UNDP) [5](#)
United Nations (UN) [6](#), [81](#)

United Progressive Alliance (UPA) [63](#)
United States (US) [52](#), [60](#), [85](#), [105](#),
[116](#), [294](#), [295](#)
unpaid leave [147](#), [148](#)
unpaid work [176](#), [201](#)
unshared experiences [241](#), [242](#), [243](#)
unskilled manual labour [65](#)
UPA *see* United Progressive Alliance
urban health centres [129](#)
urbanisation [7](#), [15](#), [16](#), [18](#), [163](#), [181](#),
[191](#), [220](#)
India [57](#), [63](#), [73](#), [115](#), [117](#), [124](#),
[126–130](#), [133](#)
Pakistan [255](#), [260](#), [261](#)
USAID [4](#)
utility bill payments [218](#)
Uttar Pradesh (India) [15](#), [59](#), [60](#),
[68](#), [118](#), [121](#), [125](#), [129–130](#),
[172–173](#), [188](#), [300](#)

V

‘vaccine diplomacy’ [60](#)
vaccines and vaccinations [2](#), [3](#), [8](#), [10](#),
[82](#), [83](#), [131](#), [147](#)
Bangladesh [27](#), [28](#), [30](#), [31–32](#), [35](#),
[36](#), [38](#), [42](#), [222](#), [228](#)
India [52](#), [53](#), [59](#), [60–61](#), [62](#), [70–71t](#),
[72t](#), [75n1](#), [193](#), [299](#)
Pakistan [254](#), [255–256](#)
ventilators [3](#), [122](#), [253](#)
vertical ‘campaign’-style services [36](#),
[38](#)
Vietnam [216](#), [221](#), [276](#)
‘village doctors’ [36–37](#)
virtual meetings and communica-
tions [41](#)
virus transmission [245](#), [297](#), [299](#)
Bangladesh [31](#), [32](#)
India [117](#), [124](#), [126](#), [130](#), [173](#)
voice [11–12](#), [16](#), [193](#)
ready-made garment workers in
Bangladesh [212](#), [214](#), [230](#)

- migrant workers in Delhi (India) [168f](#), [169f](#), [170](#), [171f](#), [172–176](#)
- liminality in Sri Lanka [270](#), [273](#), [282](#)
- voluntary sector [54](#), [152](#)
- Kerala (India) [187](#), [189](#), [197](#), [198](#), [200](#), [201](#), [202](#), [203](#), [206](#), [303](#)
- vulnerability [259](#), [262](#), [279](#), [302](#), [307](#)
- Bangladesh [230](#), [231](#), [232](#)
- Delhi (India) [159](#), [160](#), [173](#), [178](#), [180](#), [181](#)
- Kerala (India) [187](#), [200](#), [202](#), [204](#), [205](#), [303](#)
- ## W
- Wage Board (Bangladesh) [226](#)
- wages [3](#), [12](#), [57](#), [65](#)
- Bangladesh [212](#), [216](#), [217](#), [218](#), [223](#), [224](#), [225–227](#), [231](#), [303](#)
- Delhi (India) [162](#), [176](#), [180](#)
- Kerala (India) [191–192](#), [193](#), [199](#), [204](#)
- Pakistan [255](#), [258](#), [261](#), [262](#)
- Sri Lanka [278](#), [280–281](#), [282](#), [286n9](#)
- water supplies [129](#)
- Wazirpur (industrial site, India) [16](#), [159–160](#), [169](#)
- ‘weak state’ [16](#)
- weather preparedness [11](#)
- Weber, Isabelle [3](#)
- welfare policies and services [16–17](#), [53](#), [68](#), [297](#), [299](#), [307](#)
- Bangladesh [27](#), [28](#), [40](#), [213](#), [220](#)
- Delhi (India) [161](#), [163](#), [166t](#), [171](#), [177–180](#)
- Kerala (India) [187](#), [188](#), [191](#), [193b](#), [194–203](#), [204–205](#), [206](#), [302–303](#)
- Nepal [140](#), [151–152](#)
- West Bengal (India) [68](#), [70](#)
- Whatsapp [203](#), [274](#)
- wholesale and retail markets [98](#)
- widows and widowers [151](#)
- Wijetilleke, Kusum [269–270](#)
- Women’s Centre (Sri Lanka) [274](#), [275](#), [286n6](#)
- worker protests [195](#), [306](#), [307–308](#)
- workers [270](#), [293–294](#), [296](#), [298](#), [302](#), [306](#), [307](#)
- agency and COVID-19 [304–307](#)
- Bangladesh [217](#), [229](#), [230](#)
- India [51](#), [53](#), [178](#), [191](#), [200](#), [205–206](#)
- Nepal [142](#), [143](#), [144–145](#), [147](#)
- workers protection [1](#), [6–8](#), [9t](#), [10–13](#), [15–16](#), [17–18](#)
- Sri Lanka and drift/debt [278–283](#), [284](#)
- state/society and COVID-19 [300–303](#)
- working from home [3](#), [176](#)
- working hours [68](#), [147](#), [242](#), [243](#), [258](#), [260](#), [262](#)
- working overseas *see* remittances
- work-life balance [68](#), [129](#), [242](#), [243](#), [244](#)
- World Bank [94t](#), [95](#), [96t](#), [99t](#), [101t](#), [146](#), [216](#)
- World Economic Forum [105](#)
- World Health Organization (WHO) [2](#), [253](#)
- World Socialist Website [269](#)
- written testimonies (research) [11](#), [275–276](#), [279](#), [281](#), [284](#), [296](#), [306](#)
- ## Y
- youth-centric mobilisation [268](#), [269](#), [270](#)
- ## Z
- Zoom (interviews) [274–275](#)