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Managing the Pandemic in the South Asian (SAARC) Countries

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Abstract

This paper explores the coronavirus pandemic response from a South Asian perspective. When their case numbers were still relatively low, the South Asian Association for Regional Cooperation (SAARC) countries adopted lockdowns at the same time or before India did. On 24 March 2020, when there were just two confirmed cases, Nepal went into lockdown, and Sri Lanka locked down on 22 March, when there were 78 cases. India locked down the day after Nepal, with all countries imposing some form of restrictions on people's movement. This paper draws its data from the first year of the pandemic that loomed in the SAARC nations. The regional cooperation provided by SAARC has allowed the sharing of resources and a strengthening of the region's self-reliance. Notably, the commitment made by India to ensure its neighbours are supplied with vaccines, many of these donated. The eight-member SAARC states are Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka.

This paper draws on the knowledge and perceptions of academics and social workers in the SAARC countries. It provides insight into the responses, impacts, vulnerabilities, and challenges faced by the region and in each specific country since the beginning of COVID-19. This paper also offers a discussion on vaccines, PPE, as well as the role of cooperation across the region. The relationship between India and the SAARC countries and its 'neighbourhood first' policy are also discussed.

Keywords: SAARC Countries; India COVID-19; Pakistan COVID-19; Bhutan COVID-19; Afghanistan COVID-19; Maldives COVID-19; Nepal COVID-19; Bangladesh COVID-19; Sri Lanka COVID-19

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Introduction

South Asian population roughly accounts for a quarter of the population of the world. The South Asian Association for Regional Cooperation (SAARC) is an intergovernmental organisation between countries in the South Asian region. It was established in 1985 to promote regional economic, social, cultural, political, and scientific collaboration between member states, and strengthening self-reliance amongst South Asian countries (SAARC, 2020). The eight-member states are Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. This paper explores the response to the pandemic from a SAARC perspective.

It is well recognised that the novel coronavirus (COVID-19) was first confirmed in Wuhan, China, on 31 December 2019, before spreading to almost every country across the globe. Geographically, China sits alongside several SAARC countries, namely Afghanistan, Bhutan, India, Nepal, and Pakistan. It was hardly a surprise that Nepal was the first South Asian country to have a confirmed COVID-19 case after a male student from Nepal travelled back to the country from Wuhan (Shrestha et al., 2020). His positive infection was confirmed on the 23 January 2020. It quickly spread throughout South Asia, and within seven weeks, all other SAARC countries had reported their first COVID-19 case.

This paper draws on the knowledge and perspectives of regional South Asian social workers and academics, providing country breakdowns of responses, impacts and challenges faced since the onset of the pandemic. It provides a discussion on the role and engagement levels of SAARC as a regional organisation, the supply and demand for protective equipment (PPE), and also the pandemic impacts (Table 1) exacerbated by the natural disasters that occurred in the year 2020 in these countries (see Table 2). In addition, the relationships between India and other countries are also explored, along with its 'neighbourhood first' policy in sharing resources.

Except for Bhutan, the eight SAARC countries have all experienced high numbers of confirmed COVID-19 cases and deaths. The SAARC countries account for 23.9 per cent of the world population distributed across these eight nations of the world and hold just about 3.4 per cent of the land mass. Their combined economy is 4 per cent of the world economy. Figure 1 provides an overview of the region's COVID-19 case rate and death rate as a region as of 12 February 2021. Alongside, Table 1, which is self-explanatory provides further data on each country, its cases and deaths and population data. Once again, the data used in this entire paper mostly holds a cut-off date of 12 February 2021. As stated above, Table 2 shows the timing of various natural disasters in SAARC countries throughout 2020 and the deaths that occurred as a result. It is clear that not only is the region learned to manage the COVID-19 pandemic, but it is also dealt with the devastating impacts of many natural disasters.

This article reflects on each of the individual SAARC countries during the early stages of the COVID-19 pandemic. Each country section discusses the onset and initial responses to COVID-19; the health, social and environmental impacts, and vulnerabilities; welfare system responses; and PPE and vaccination efforts. Following this, it provides a discussion on the role of cooperation across the region and the impact of India's 'neighbourhood first' approach.

The following is a summarised account of how each of these nations went through the pandemic and managed their response.

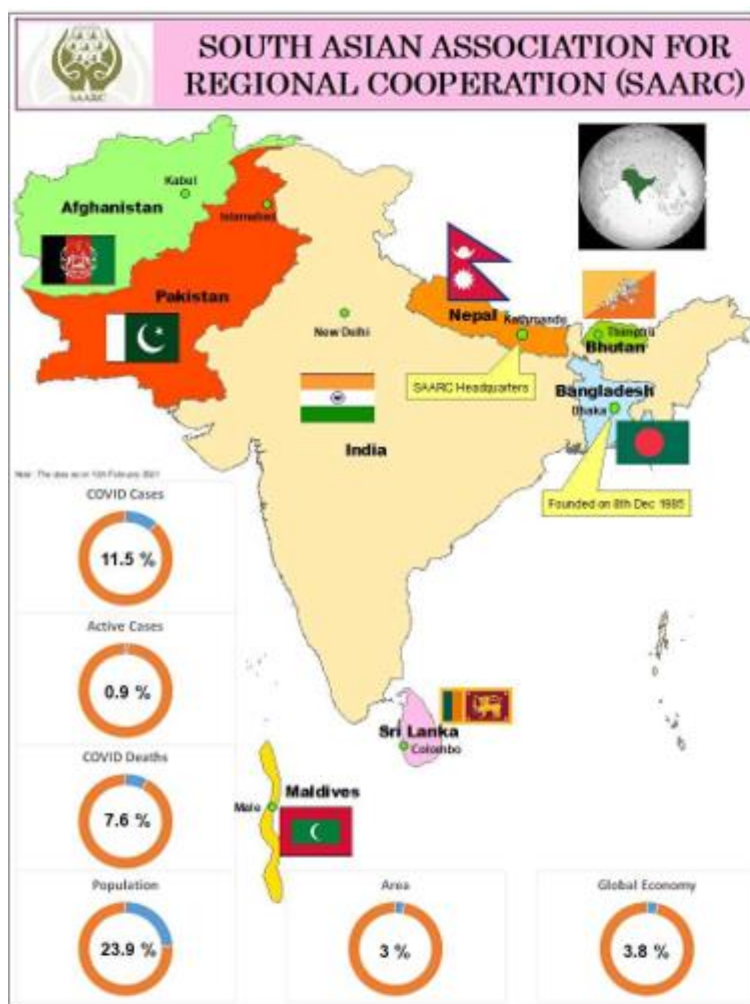

Figure 1: Map of SAARC Countries
Source: Authors

Table1: Details of COVID-19 Cases and Deaths in SAARC Countries			
Countries	Cases	Deaths	Population
India	10,880,603	155,484	1,388,345,614
Pakistan	560,363	12,218	223,514,389
Bangladesh	539,531	8,248	165,698,028
Nepal	272,430	2,052	29,457,453
Sri Lanka	73,116	379	21,468,618
Afghanistan	55,445	2,424	39,463,277
Maldives	17,387	56	546,370
Bhutan	861	1	776,828
SAARC (total)	12,399,736	180,862	1,869,270,577
Source: Data source from Worldometer dated 12 February 2021			

Table 2: Natural Disasters During COVID-19 in the SAARC Countries			
Disaster	**Countries Affected**	**Timing**	**Casualties**
Cyclone Amphan	India, Bangladesh	May 2020	**Over 85**
Flash Floods	Afghanistan	Aug 2020	**Over150**
Cyclone Nisarga	India	June 2020	**6**
Locust attack	India, Pakistan	Jan – June 2020	**0**
Cyclone Nivar	India, Sri Lanka	Nov 2020	**8**
Cyclone Burevi	India, Sri Lanka	Dec 2020	**11**
Kerala Floods	India	Aug 2020	**22**
Assam Floods	India	May 2020	**Over 150**
Hyderabad Floods	India	Oct 2020	**Over 80**
Oil & Gas Leak in Assam	India	May 2020	
Karachi Floods	Pakistan	July – Aug 2020	**141**
Kathmandu	Nepal	July 2020	**102**
Mohmand Marble Mine Landslide	Pakistan	Sept 2020	**18**
Source: Compiled by the Authors			

Bangladesh

Pandemic Onset and Response

Bangladesh took a while to tackle COVID-19 before the identification of the first case on 8 March 2020 (Ruszczyk et al., 2021). To control community transmission, the Government then closed down educational institutions; prohibited social, religious and political gatherings; cancelled state programs and events; and announced a 'general holiday with restrictions on movement' (lockdown) from 26 March 2020 to 30 May 2020 (Chowdhury et al., 2020; Ruszczyk et al., 2021). In addition, the provision of visas on arrival was suspended, limiting international flights and making quarantine compulsory for international travellers (Anwar et al., 2020). Still, the virus spread due to the entrance of overseas workers without proper screening, failure to ensure 14-day quarantine and followed with the declaration of a general holiday for ten days in late March that restricted the movement of public transport and people (Al-Zaman, 2020; Anwar et al., 2020). It was also challenging to ensure a strict countrywide lockdown and social distancing due to high population density, poverty, lack of awareness and people's religious sentiment and negligence (Anwar et al., 2020). The Government finally lifted restrictions on public and private offices, shopping malls and public transport from 31 May 2020 to protect the economy and livelihood (Chowdhury et al., 2020). Instead, it imposed an area-based lockdown for a limited period and it attempted to normalise socioeconomic activities with health safety instructions. In January 2021, the Government again heightened screening and health safety rules at airports and made institutional quarantine compulsory for UK returnees (Abdullah, 2021). By 24 January 2021, 3,555,558 COVID-19 tests were conducted, 531,799 COVID-19 positive cases confirmed, 476,413 recovered, 8,023 died and 23.45 million people received hotline services in Bangladesh (World Health Organization [WHO], 2021).

However, the situation deteriorated, and the daily infection and death rates grew significantly from June 2021 due to the outbreak of the double mutant Delta variant of SARS-CoV-2 (Devnath et al., 2022). The situation has gradually improved since October 2021. The latest updated information (as of October 27, 2022) published on the government website shows that 14,985,855 COVID-19 lab tests were completed, 2,034,729 cases confirmed, 1,978,936 recovered and 29,416 died in Bangladesh as per the Bangladesh Directorate General of Health Services (2022).

Health, Social and Environmental Vulnerabilities

People recommenced movement to earn their livelihood without maintaining social distancing after the withdrawal of the lockdown, all human endeavours began, and people began to flout all the health safety rules, and it appeared that the average citizen was no longer worried about COVID-19; showing disinterest in using masks (Islam, 2020).

The regular and emergency health care services and immunisation programs were almost stalled during the first wave of COVID-19 in Bangladesh. This heightened mass panic and stress. People started noticing discrimination and stigma, with the flow of misinformation and over information creating a climate of distrust that prevailed throughout 2020 and 2021 (Hasan et al., 2020; Paul et al., 2021). The COVID-19-positive patients and their families, doctors and nurses, police, poor workers and migrants were stigmatised for spreading the virus. In some cases, local people opposed the establishment of COVID-19 hospitals and the burial of dead bodies in graveyards (Hasan et al., 2020). COVID-19 impacted mental health, increasing people's anxiety, depressive symptoms and stress (Banna et al., 2022).

Restrictions and lockdowns led people to limited jobs and paltry incomes. The pandemic wiped out 357,000 jobs of readymade garment workers in 2020 due to layoffs and closures (Pandemic wipes out 3.57 lakh apparel jobs: study, 2021). Petty businesses were shut and for some time, hunger prevailed. Direct food aid from the Government and voluntary organisations was not enough. The lockdowns were prematurely lifted as people's poverty and pronounced hunger surfaced all over. Many middle-class families suffered in silence and appeared ashamed to disclose their vulnerabilities (Paul et al., 2020). International migrant workers returned home after losing jobs, while others were stranded. Around 13 million migrants and their dependent 30 million family members suffered through income loss, depleted savings and unemployment (Karim et al., 2020). All educational institutions closed and adapted to online learning; this created a digital divide between the rich and poor and between rural and urban areas (Eusuf & Rabi, 2020; Uddin, 2020).

COVID-19 seriously affected people who were homeless, marginalised, disadvantaged, slum dwellers, labourers, low-income groups, elderly and those with medical conditions. Additionally, people were made more vulnerable in the absence of universal social care programs, home-based care and institutional services outside the cities (Hossain et al., 2020). Violence against women and girls, including domestic violence and rape, increased drastically (Human Rights Watch, 2020). A total of 632 rape cases and 142 attempted rapes were reported in the media, and of those victims, 29 people died as a result of the assault and five died by suicide between April and August 2020 (Rabbi, 2020). Another vulnerable group locally called *Hijra* (transgender) failed to earn their livelihood, experienced psychological abuse, suffered from anxiety about earning money, and faced discrimination in necessary health care from the medicals (Sifat, 2020). The brothel-and street-based sex workers also struggled to survive due to lockdown measures, though they received some limited humanitarian assistance from NGOs, charitable agencies and local government authorities (UNAIDS, 2020).

The COVID-19 pandemic was not the only crisis the Government, humanitarian organisations and communities were responding to, with floods inundating a third of the country in August 2020. These floods heightened the risk of infection, displaced 1.5 million and killed at least 161 people (ABC News, 2020).

Welfare

Bangladeshi Government introduced various stimulus packages of TK1213.53 billion to protect the economy and livelihood with loans and targeted social safety net programs (Finance Division, 2020; Islam et al., 2020; Khatun, 2020). Stimulus packages of TK50 billion were provided to many business owners. Unfortunately, there were many reports of misappropriation of public relief, including business owners not passing on benefits to workers (Al-Zaman, 2020; Kabir et al.,

2021). Several humanitarian groups came forward to serve the COVID-19 patients, bury dead bodies, and provide food items to people who are poor and in need (Islam et al., 2020).

More than one million Rohingya refugees living in congested camps of Cox's Bazar were vulnerable to COVID-19, but the well-organised and coordinated activities and services from the Government, United Nations organisations, and other humanitarian agencies were found effective to avoid a catastrophe in Rohingya camps (Alam et al., 2020; UNHCR, 2020).

Vaccines

Bangladesh received foreign aid from international donor countries and agencies, and assistance of aid to revive the economy and purchase vaccines. The vaccination program started from 27 January 2021. As a gift from India, Bangladesh received 2 million COVID-19 vaccine doses. Another 30 million doses were purchased within the next six months from India (Paul, 2021). Bangladesh began the vaccination schedule in February 2021, and initially the country vaccinated around 16.9 million people free of cost with a priority on frontline health workers and other professionals. The COVID-19 vaccination program was hit hard as India halted exporting COVID-19 vaccines for several months, though Bangladesh managed to collect or purchase necessary vaccines gradually from different sources (Islam, 2021). As of 27 October 2022, the 1st, 2nd and 3rd does of COVID vaccines were given to 136,005,705, 124,001,916 and 57,647,579 people respectively in Bangladesh (Directorate General of Health Services, 2022b).

Afghanistan

Pandemic Onset and Response

Afghanistan was in absolute crisis due to COVID-19. By the beginning of January 2021, almost a third of the entire Afghanistan population was estimated to be infected by COVID-19 (Quilty, 2021). These statistics were even higher in the capital Kabul, where more than half of its 5 million residents were either infected or recovered. Afghanistan confirmed its first COVID-19 case on 24 February 2020, with cases rising quickly as tens of thousands of Afghani workers returned from Iran as the crisis unfolded there (Cousins, 2020). Lockdown measures soon followed. Domestic flights were cancelled, and travel by road was restricted. Schools, education facilities, government buildings and nonessential services were all closed in all provincial capitals, including Kabul (Quilty, 2021). The Government transformed the Afghanistan–Japan hospital in Kabul into the designated COVID-19 hospital, and those seeking the best treatment came to the city for their best chance of survival.

The COVID-19 related death rate is highly contested, with some reporting 1,300 deaths in 2020, whilst experts estimated it to be about 100,000 deaths (Cousins, 2020). Many people failed to come forward for treatment and instead either 'waited out' or suffered and preferred dying at home. Testing capabilities remained at a minimal, with the country completing less than 125,000 tests as of February 2021 due to a lack of tests and the stigma associated with testing. Afghanistan's already weak health system was further compounded by COVID-19, with a shortage of doctors and specialists, and medical supplies. 9 out of 10 medical staff at the Afghanistan–Japan hospital had tested positive. A severe lack of basic infection control and prevention measures had fuelled the spread of infection not only in the community but within hospitals and health centres (Cousins, 2020).

Health, Social and Environmental Vulnerabilities

The continuing crisis in Afghanistan was not only a health crisis but also a welfare, social, financial and food crisis. The average working Afghani is unlikely to be able to afford to stop work to isolate or seek treatment, putting both their health and those around them at risk (Quilty, 2021). The risks of people languishing in poverty was seen to be greater than the risks presented by COVID-19 (Quilty, 2021). The COVID-19 pandemic has incurred significant economic losses. The Asia-Pacific region's GDP is expected to shrink by 1.1% in 2020. Economic disruptions are projected to have pushed 75-80 million people back into deep poverty. However, the

years 2021-2022 proved to be much more difficult, as the extremely contagious Delta and Omicron varieties resulted in additional lockdowns and continued travel prohibitions. The problem was made worse by the poor pace of vaccination rollouts (Inequality of Opportunity in Asia and the Pacific: Pandemic Preparedness - Afghanistan, 2022)

There have been many reports of people dying at home rather than seeking treatment in hospitals out of fear of infection (Cousins, 2020). Many Muslims had also avoided treatment even if COVID-positive, "fearing that if they die, their bodies will be taken away and deprived of a proper Islamic burial" (Quilty, 2021).

Welfare

Afghanistan had no official welfare system to support those financially in need (Quilty, 2021). With so many families slipping into poverty, people turned to harmful strategies with long-term complications, such as stopping education and selling any assets they had (Cancho, 2020).

PPE and Vaccines

Many medical staff frequently worked without PPE, even in the COVID-19 designated hospital (Cousins, 2020). Afghanistan relied on the generosity of the international community to sustain its broken health system, including beginning vaccination programs. 500,000 doses were received as a gift from India on 7 February 2021, and as of 17 September 2022, they have reached a coverage of 26 per cent of their population with vaccination (Afghanistan, 2022).

Bhutan

Pandemic Onset and Response

Bhutan confirmed its first COVID-19 case on 6 March 2020, a 76-year-old US male who travelled to the country via India. He received significant care and attention from professionals and the public and even received a personal visit from the King (Ongmo & Parikh, 2020). His partner was later confirmed also positive. On 22 March 2020, Bhutan closed its borders to all, with the exception of delivery of essential goods from India. The Government swiftly began contact tracing, testing and quarantine periods for those found to be close contacts. Schools and educational facilities closed, and social distancing became the norm. Hand sanitiser quickly sold out across the country, and the health ministry produced and distributed sanitiser made from spirits and glycerine (Palden, 2020).

Bhutan is a vulnerable country, landlocked between India and China. Its population is only 750,000, and it is a popular destination for Chinese tourists. Before the first case was recorded and the lockdowns that ensued, many Bhutanese students had begun returning from countries already heavily infected. Chartered flights were provided to many students and workers stranded overseas wanting to return home. They then had to quarantine in centres for two or three weeks. The Government responded quickly in announcing relief measures and relief-packaged loans.

There was already free healthcare for all citizens, however, the country has a shortage of doctors – with just over 300 across the country (Ongmo & Parikh, 2020). The Ministry of Health has only one ICU consultant and a small number of respiratory specialists and pathology experts. A strict 21-day national lockdown period was announced on 21 August 2020, with nationwide case increases. As a result, a second lockdown period occurred from 22 December 2020.

Health, Social and Environmental Vulnerabilities

The tourism sector was hit hard by the border closures. Approximately 50,000 people are employed in the industry, totalling 16% of the working population (Alvarenga & Soar, 2020). The majority of those are casual employees who do not typically have access to social assistance programs; however, the welfare system of Bhutan has responded by including many of these tourism and informal workers in its recipient.

Welfare

The Bhutanese Government created a tourism stimulus package to support 2,436 people working in the tourism industry (Palden, 2020). Short-term loans and loan interest waivers were

made available, providing relief to more than 112,000 people.

PPE and Vaccines

Bhutan has benefited from receiving 150,000 vaccine doses as a gift from India.

The World Health Organization (WHO) supplied Bhutan with its first testing kits, however, there continues to be a substantial shortage. The country suffered a serious shortage of ventilators and PPE, with India providing some medical supplies.

India

Pandemic Onset and Response

India confirmed its first COVID-19 infection on 29 January 2020, with the eventual moderate rise of infections that occurred because of students returning from Wuhan and Italian tourists widely traveling in India. Several large religious and political gatherings fuelled the infection spread – labelled "super spreaders" — with thousands of cases linked to these events. The Indian Government responded with an array of preventative measures, including a 21-day lockdown period commencing on 25 March 2020, disinfecting public spaces and preparing hospitals to handle an influx of infections (Sharma & Agnimitra, 2020). All gatherings were banned. The lockdown was enforced by Section 144 of the Indian Criminal Penal Code, with offenders punished. At the beginning of the lockdown there were 562 COVID-19 positive patients and nine deaths. By the end of an extended lockdown period on 01 June 2020, India had tallied 190,535 cases. The number of infected Indians peaked in mid-September 2020, after which growth rates and deaths started to decrease. Deaths reported in India were less than 100 fatalities per million, a comparable lower statistic than the likes of US, Britain, Brazil and Spain who, are seeing 600 deaths per million. Some researchers suggested that there was underreporting of deaths. (Sharma & Agnimitra, 2020). Another comparison is that out of 1 million Indians, 5,500 Indians are infected, whereas that rate is approximately 25,000 out of 1 million in the US and Brazil. This indicates a low infection rate — or alternatively low testing or reporting rates.

Health, Social and Environmental Vulnerabilities

The strict closure of typical economic and social life has badly affected migrants in India. This has resulted in a gigantic humanitarian crisis unfolding across India, with hundreds of thousands of informal workers becoming absolutely desolated and facing starvation (Sharma & Agnimitra, 2020). The urban frenzy fuelled by desperation, confusion, and infection fears drove people out of the cities; leaving behind the place where they were chasing their dreams.

Welfare

India's welfare system provides an array of assistance to people experiencing poverty. There are hundreds of initiatives and different funding streams, including subsidised food rations and cooking gas, and cash deposits. As a developing country with 1.36 billion residents, the pandemic has further pushed more people into extreme poverty. However, the problem with implementing the different initiatives and funding streams is facilitating the assessment process and identifying what benefits people are entitled to.

PPE and Vaccines

Like many other countries, India saw shortages in PPE, and even healthcare workers regularly went without protective equipment. India has established itself as an international leader in developing and distributing vaccines, producing 60% of the world's vaccines (Covaxin and Covishield: What we know about India's Covid vaccines, 2021). Currently there are 12 vaccines approved for use in India and there are another 16 in clinical trials in India (India - COVID 19 Vaccine tracker, n.d.). India has made a commitment to playing its part in fighting the COVID-19 pandemic, including supplying countries in need. They have announced that their priority for distribution are their closes neighbours and key partners – notably SAARC countries (Chaulia, 2020).

Nepal

Pandemic Onset and Response

Nepal was the first SAARC country to report a COVID-19 case, occurring on 23 January 2020. Fast forward one year to 24 January 2021 and it has been confirmed in all districts in Nepal with 269,450 infections and 2001 COVID-19 related deaths (Ministry of Health and Population [MoHP], 2020). So far, 2,043,255 tests have been conducted, and 264,137 people have recovered.

To combat the spread of the contagious virus, Nepal went into a national lockdown on 24 March 2020 which was lifted on 21 July 2020 (Pradhan, 2020a; 2020b). All domestic and international flights and long-distance transport services were suspended in 2020 starting March 22 and 23, respectively (Nepal, 2020). International flights recommenced 1 September 2020 and then followed domestic flights on 16 September 2020 (Civil Aviation Authority of Nepal [CAAN], 2020a; 2020b). Later, as a new strain of coronavirus was identified in the UK started to spread across the border, the Government of Nepal [GoN] restricted entry of passengers from the UK from 23 December 2020 until further notice (CAAN, 2020c).

The Nepali people, especially the working-class population, had been furious with the Government of Nepal's inability to handle the crisis. As a result, hundreds of youths in Nepal protested by fasting without food and water as they demanded the expansion of testing, transparency, and accountability in the procurement of medical kits, protection of the frontline health workers, repatriation and rehabilitation of vulnerable migrant workers with dignity, relief to the affected vulnerable marginalized communities of people and cease of RDT tests (DanChurchAid [DCA], 2020). However, the protests also had the opposite impact, with mass gatherings leading to potential virus spread. The dealing of COVID-19 politics led to an early election that sparked even more protests (Aljazeera, 2020; Sharma, 2020).

COVID-19 negatively impacted Nepal's growth rate, with substantial declines related to decreased remittances and reduced agricultural output and tourism. The planned celebration of Visit Nepal Year 2020" was cancelled and was a huge blow to the tourism sector (Prasain, 2020). Sectors most impacted include accommodation and food, arts, entertainment and recreation, and transport and storage (United Nations Development Program [UNDP], 2020).

Health, Social and Environmental Vulnerabilities

Rapid gender analysis on COVID-19 in Nepal has reported that wage workers, farmers, landless women, women working in the entertainment sector or brick kilns, women from Dalit and Madhesi communities, gender and sexual minorities, women from geographically disadvantaged locations, women with disabilities, adolescent girls, women whose husbands are abroad, displaced women, and those living with HIV/AIDS were the most affected by the pandemic (Ministry of Women, Children and Senior Citizens et al., 2020). Workloads of domestic and care workers have increased from the usual six to ten hours to 18-22 hours, increasing stress and anxiety among women and girls.

The International Labour Organization [ILO] estimated that COVID-19 disruption affected 1.6-2.0 million jobs in Nepal (ILO, 2020). Many daily wage workers had lost their jobs and their livelihoods. Most of these people are from the vulnerable and marginalised groups who are impoverished. In their desperation for survival, they unwillingly accepted risky jobs, exposing themselves to trafficking rings. Nepal's porous unofficial border points are significant in smuggling narcotics, weapons and other goods through India. Experts raised concerns that these border points could still be used for the trafficking of humans despite being shut down (Betteridge-Moes, 2020).

Thousands of Nepali migrant workers abroad lost their incomes, and over 2,300,000 Nepalis were forced to return home (Baniya et al., 2020; COVID-19 Crisis Management Centre, 2020). In July 2020, a directive was introduced by the Government of Nepal for the repatriation of stranded Nepali workers, including direction for the Nepali diplomatic missions to collect

information on wage theft and the reason for the return of migrant workers (Ministry of Labour, Employment and Social Security, 2020).

Nepal concurrently faced locust plagues and floods. A swarm of eight-million locusts entered through Nepal's border districts of Sarlahi, Bara and Rupandehi from India's state of Bihar on 27 June 2020 (Pokhrel, 2020). This incident had caused serious concerns, especially for the farmers, as the locust plague implied food shortage and portended famine for the country already struggling with the pandemic (The Himalayan Times [THT] Online, 2021). Additionally, floods and landslides triggered by the onset of the monsoon season led to fatalities and damage in several parts of Nepal (DanChurchAid [DCA], 2020). Through one such disaster on 28 September 2020, 364 deaths had occurred, 317 people were injured, and 104 were missing (DCA, 2020).

Welfare

The Government of Nepal in the budget for the fiscal year 2020/21 allocated NPR 50 billion to provide 5% interest loans for recovery and rehabilitation of the hardest hit sectors due to the pandemic, including tourism, and micro, cottage and small industries (Ministry of Finance, 2020). This initiative was assisted by foreign aid and public entities, however, by late November 2020, only 1 billion of this had been distributed (Shrestha, 2020). The Government of Nepal announced COVID-19 relief package in March 2020 (Nepali Times, 2020). The package included a 25% discount on electricity for consumers who use more than 150 units every month; no penalty until mid-April on delay in payments of utility bills and tax; 10% discount on rice, flour, dal, salt, sugar and oil supplies from Nepal food Corporation; and Salt Trading Corporation for daily wage workers.

The Nepal Rastra Bank [NRB] revised the provision of priority sector lending, widened the concessional credit program and decentralised access to refinancing facilities to help the sectors most affected by the pandemic, including agriculture, tourism, energy, cottage, small and medium industries among others (Nepal Rastra Bank, 2020).

PPE and Vaccines

Nepal received one million doses of the vaccine AstraZeneca Covishield from India as a gift on 21 January 2021, starting administration on 27 January (Gurubacharya, 2021; THT Online, 2021). In the first phase, 430,000 Nepalis who were at high risk of the infection, primarily frontline workers that is, health workers, security personnel, ambulance drivers, and waste management and sanitation workers, among others, received the vaccine. According to the Ministry of Health and Population, the Government of Nepal planned to provide a COVID-19 vaccine to 72% of the total population except for children (DCA, 2020).

In August 2020, the Department of Drug Management of the Government of Nepal gave permission to three private companies to buy the drug 'Remdesivir' an antiviral injection for coronavirus treatment (DCA, 2020). Later, an investigation by Ministry of Health and Population officials found the medication being sold at exorbitant prices, almost eight times the normal price (DCA, 2020).

Maldives

Pandemic Onset and Response

The first COVID-19 cases were reported in the Maldives on 7 March 2020, when two employees at a resort were infected by an Italian tourist who had holidayed there. The resort went into temporary lockdown along with several other island resorts, and the patients were transferred to a quarantine facility. International travel was banned on 27 March for four months (Ministry of Tourism, 2020).

The first local transmission was confirmed on 15 April in Malé, the country's capital (WHO, 2020b). A Public Health Emergency was then declared, and Malé went into lockdown from 16 April to 14 June 2020, with strict restrictions on travel and movement. The Maldivian Government directed $US60 million to its public health response. Quarantine and isolation facilities were set up to accommodate 5,000 people, with many staying in resorts. People were living in paradise but without the freedom of movement. Health facilities were created to

support those with mild to moderate symptoms and a 100-bed intensive care facility to respond to severe cases. On 2 April 2020, The World Bank approved $US7.3 million to ensure that the Maldives has the resources to "prevent, detect, and respond to the COVID-19 pandemic and (for) strengthening its public health preparedness (World Bank, 2020c).

Health, Social and Environmental Vulnerabilities

The Maldives relies heavily on international tourism, with 80% of its economy derived from the tourism sector (UNESCAP, 2020). With travel restrictions preventing this, the economic revenues have diminished with little reserve to draw from. Those still working were able to continue to earn a living, however were put at higher risk of infection due to not being able to avoid coming in contact with others. Women and children experiencing domestic violence were put at a higher risk during lockdown. Women who are lesbian and bisexual were at heightened danger, along with transgender women; all of whom already face significant stigma and discrimination in the Maldives. These women are all more likely to experience coercive forms of violence, such as forced marriages, rape, 'conversion' therapies and honour killings (Hadad-Zervos, 2020).

Welfare

The Government of Maldives has responded to the significant financial impacts of COVID-19 by providing multiple relief packages. These measures have included suspending loan payments for six months and a 40% decrease in energy bills (UNESCAP, 2020). In addition, $US162 million was allocated to relieve businesses and their employees, and additional loan and loan deferral measures had been provided to businesses. India has generously provided financial aid to the Maldives of $US250 million, along with technical and material support. The relationship between the two countries has proven to be resilient and reliable. "India's 'Neighbourhood First' policy and the Maldives' 'India First' policy" has proven successful even in the height of a pandemic, ensuring the region's wellbeing is safeguarded (Maldives thanks India, 2020).

PPE and Vaccines

The Maldives has benefited from gifted vaccines from India and China; 100,000 doses from each. Mass vaccination programs began on the first of February 2021. An additional 700,000 doses reached by March, financed by the Government (Faaiq, 2021).

Pakistan

Pandemic Onset and Response

In Pakistan, the first case of COVID-19 was confirmed by the Ministry of Health on 26 February 2020 in Karachi (Sindh), a student who returned from Iran after pilgrimage/Zyaraat. Every year, about 0.7 million Pakistanis go on a pilgrimage to Iran to visit the Holy Places and Shrines. This visit is normally in the Spring season. On 23 March 2020, both provincial and federal governments executed control and mitigation actions, such as establishing quarantine facilities, closing of borders with neighbouring countries, international and national travel restrictions, prohibiting public gatherings, shutting down educational institutions, and social distancing. Despite all the measures, the situation got worse in the coming months, and by mid-June 2020, cases were reaching up to 6,000 per day. In August and October, the number of cases remained at less than 1,000 per day, but in mid-November, a second wave hit 2,000 new cases daily (International Monetary Fund, 2021).

The Government of Pakistan provided facilities to help its masses, along with new policies and arrangements. To aid its conventional ill-equipped health infrastructure and rapid spread of the virus, the Government had to take many immediate steps and convert a large number of hotels into temporary quarantine centres. It converted 1,800 four and three-star hotels into quarantine facilities and class cars and air-conditioned sleepers of railways into medical wards. These arrangements provided 2,000 beds for handling rapidly growing cases (Gul, 2020).

Health, Social and Environmental Vulnerabilities

Pakistan already had a large population experiencing poverty, with average earnings in Pakistan less than $US4 per day and less than $US2 for those in extreme poverty (World Bank, 2020a; World Data, 2021). All activities were halted due to lockdown. It threatened the livelihoods of all types of workers and a huge number of factory workers and market labourers became jobless. In Punjab alone, 500,000 workers in the textile and garment industry became surplus (Human Rights Watch, 2021). The majority of the workers were from the disadvantaged and remote areas of the country. They were stuck at bus/taxi stops and railway stations, while returning to their homes. This lockdown damaged about 10.5 million jobs, including contract/casual workers and daily wagers (Ahmad, 2020). This environment was equally stressful for employees and employers as the hike in virus was shutting down businesses, industries and marketplaces. Pakistan's GDP was 6.2% in 2018, and 2.5% in 2019, while COVID-19 lowered it to -1.3% in FY 2020, which was the lowest in last 60 years (World Bank, 2022).

Welfare

The Prime Minister introduced *Ehsaas* Emergency Cash program, a COVID relief fund of Rs. 193.96 billion. The program was launched 9 April 2020 (Government of Pakistan, 2020). This initiative received 4.8 billion rupees - 800,000 was from international donors, and 3.8 billion was collected domestically. The Prime Minister also announced two policies regarding the distribution of *Ehsaas* Emergency Cash to help COVID-19-related jobless poor and economically excluded groups. The Government of Pakistan established 17,000 points across country for the disbursement of *Ehsaas* Emergency cash to 12 million families constituting 80 million individuals (Gul, 2020). Pakistan, a country with 220 million people, needed help from the world community to deal with the coronavirus pandemic. WHO helped Pakistan raise $595 million from the world community (WHO, 2020a). The Asian Development Bank provided a loan of $300 million for the public health sector and launched the CARES program for social security of the poor and low-paid groups of Pakistan. The CARES program also received $500 million each from the World Bank and the AIIB (Wang et al., 2020). The State Bank of Pakistan (2020) also reduced the interest rate from 13.25 to 7% from March to June 2020. However, its reduction had a negative impact on pensioners, who received fixed profits from banks on their savings.

PPE and Vaccines

China a mutual partner of Pakistan on several counts, has also offered assistance to Pakistan in matters relating to protective gear, medical apparatus, medical experts, and vaccines. Pakistan received 500,000 doses of the coronavirus vaccine from China, prepared by its firm SinoPharm. This vaccine arrived in Pakistan on 01 February 2021. In Pakistan, COVID-19 vaccination started in early February 2021. Initially, about 8000 trials were taken in Karachi, Lahore and Islamabad (Khan, 2020). Pakistan's Government has allocated $US150 million to secure vaccines from China. The Drug Regulatory Authority of Pakistan (DRAP) has also approved Oxford-AstraZeneca vaccine for emergency use. This vaccine was being prepared in India, and Pakistan received it through Covax, an alliance established by World Health Organization (WHO), Global Alliance for Vaccines and Immunization (GAVI) and Coalition for Epidemic Preparedness Innovations (CEPI) in April 2020 (The Express Tribune, 2021). Pakistan is also part of COVAX, the WHO's system for the provision of vaccinations to poor and low-income countries, so it also expects vaccination support to priority groups constituting almost 20% of the total population (Constable & Hussain, 2021). COVAX helped Pakistan not only in accessing the vaccine, but also provided logistics and training facilities. About 87% of the eligible population of Pakistan is fully or partially vaccinated, with about 298 million doses of different variants of vaccines administered. Out of total population of 220 million, there were 132,055,696 fully vaccinated persons, 139,541,376 who have received their first doze, and 46,877,151 persons

have also received booster dose as of November 2022 (Government of Pakistan, 2022).

Conspiracy theories and fake news in Pakistan hindered vaccinations in the country, similar to previously circulated theories about the polio vaccine. Even two well-known political figures in Pakistan came forward to declare vaccination as a conspiracy against the Islamic world (Khan et al., 2020). There is a massive spread of suspicion and doubt about vaccination, even amongst people who have volunteered for it. For example, one person who received a vaccine for a trial told people that he had heard this vaccination contains a chip which is being inserted into a body related to birth control, but he ignored it and was vaccinated. Other concerns raised on social media include rumours that the vaccine impacted infertility and more extremely, that it would turn humans into animals (Constable & Hussain, 2021).

Sri Lanka

Pandemic Onset and Response

The first COVID-19 case reported in Sri Lanka on 27 January 2020, was a Chinese woman in the country as a tourist. Domestic cases soon followed, with the first locally acquired case confirmed on 10 March 2020 (World Bank, 2020b). The Government of Sri Lanka responded quickly on 20 March 2020, with strict curfew-style lockdown measures across the country with a complete restriction on movement (Hettiarachchi et al., 2020). This curfew was enforced by Police, with the military aiding quarantine centres and contact tracing. All schools and educational facilities were closed, people were instructed to work from home where possible, and international arrivals banned alongside public gatherings (Sri Lanka Tourism Development Authority, 2021). Grocery stores and essential service providers continued to operate, however were restricted to residential deliveries (Hettiarachchi et al., 2020). Testing abilities and contact tracing were increased promptly, and COVID-19 positive patients were given treatment in secure places (World Bank, 2020b). Lockdown measures were enforced until mid-May 2020, when they began to ease slowly.

As of 6 February 2021, Sri Lanka had 69,348 confirmed cases and 356 deaths (Sri Lanka Tourism Development Authority, 2021); however, there is inconsistency in reporting, and statistics may be higher than officially stated.

Health, Social and Environmental Vulnerabilities

The pandemic has resulted in country-wide job losses, with daily wage earners and those already experiencing poverty most impacted (UNESCAP, 2020). It is estimated that 1.9 million daily wage earners were impoverished, along with their households. Manufacturing, tourism, and agriculture industries were most affected. For example, about 1 million tourism sector jobs have been lost. People living marginally above the poverty line, including older people, have also been made highly vulnerable.

Lockdown measures resulted in increased violence against women and children, with both hospitals and domestic violence hotlines seeing increases in cases (Hadad-Zervos, 2020). Vulnerable people were trapped in their homes with violent partners, without the typical systems to respond and without the escape of work. Prior to the pandemic, LGBTI+ people were already facing high levels of stigma and discrimination, and during the pandemic, due to being confined at home, this population was even more vulnerable, with expected increases in violence likely including honour killings, forced marriage, conversion 'therapies' and 'corrective' rape (Hadad-Zervos, 2020).

Welfare

The COVID-19 pandemic has created an additional crisis, including that of country resources. The Sri Lankan Government has reported having allocated Rs. 6.9 billion to aid those experiencing financial loss from the curfew lockdown period, with Rs. 5,000 allocated to each family (Official Website for Sri Lankan Response to COVID-19, 2020). 'Samurdhi' - Sri Lanka's social welfare scheme - already supports up to 4.4 million recipients (Government of Australia, 2020). It was reported that many of those made most financially vulnerable by COVID-19 have no access to these

schemes, with accounts of promised money not being received.

The World Bank provided significant aid, providing cash transfers to 699,915 vulnerable families, including older people, people with disabilities and people with chronic kidney disease in poverty (World Bank, 2020b). Aid organisations such as Human & Inclusion also stepped in to provide financial support, funding 1,000 vulnerable families with disabilities and who are injured through conflict (Human & Inclusion, n.d.).

PPE and Vaccines

There were widespread shortages of PPE across the globe, and Sri Lanka responded by replacing part of its garment industry with the increased manufacturing of PPE for sale in the USA and EU. The World Bank had again provided significant aid to Sri Lanka by financing 300,000 PPE units, 250,000 testing kits, essential medical supplies, and quarantining facilities (World Bank, 2020b).

COVID-19 vaccination programs began in late January 2021, with 4 million doses provided for free through the WHO COVAX program (International Monetary Fund, 2021). In supporting their neighbour, India donated 500,000 vaccine doses in January 2021, and an additional 300,000 doses were gifted in August 2021 from China. Those first vaccinated were health workers, and selected military and Police officers. In order to bring the new coronavirus pandemic in Sri Lanka under control, the government implemented a set of control strategies including social distancing, quarantine, lockdowns, travel restrictions, and isolation of villages. Sri Lanka has been ranked 9th best country in the world for its successful immediate response to tackling the virus.

Discussion and Conclusions

The COVID-19 pandemic has brought together SAARC member states for greater cooperation across the region. On 15 March 2020, SAARC met for its first high-level meeting since 2014, with all countries present via videoconferencing (Fruman & Kaul, 2020). Pakistan's health minister attended alongside the leaders of the remaining nations. The meeting was televised in all South Asian countries and live on YouTube. The leaders discussed collective ways to deal with the pandemic in the region. Among other initiatives, the COVID-19 emergency fund was established, with India's prime minister pledging the first $10 million. This fund is to be drawn on by any member state to meet the urgent costs of responding to COVID-19. As of 12 February 2021, $US26.6 million has been contributed to the fund, with all countries donating between $US100,000 and $US10 million (SAARC, 2021b).

The SAARC countries senior health officials met online on 26 March 2020, several days after their initial meeting to continue these collaboration efforts (SAARC, 2021a). The SAARC finance ministers later met separately on 16 September 2020, using videoconferencing, to discuss the impact of COVID-19 on the region's economy. Additional informal meetings of SAARC ministers continued as the pandemic developed. Representatives from each country were present at every meeting, ensuring regional cooperation.

COVID-19 brought devastating health outcomes to the region, massive slumps in economies and job losses, poverty, and heightened risks for vulnerable groups left without reserve. Countries scurried to find PPE to protect their people and to find ways to understand this phenomenon; what does this mean for their nation? All this was faced whilst experiencing co-occurring natural disasters. The exact loss of life in each country is contested, with research indicating that there is gross underreporting or recognition of COVID-19-related deaths in Afghanistan, Pakistan, India and the Maldives (Shah et al., 2020). The actual loss of the region is unknown.

There are worldwide fears for older people who may be unable to fight the virus. Surprisingly though, amongst SAARC countries, there are significantly high proportions of infected young people (20-39 years of age), for example, 68% in Bangladesh, 45% in Pakistan and 44% in India (Sultana & Reza, 2020). This population faces different challenges when faced with infection – that of job loss and financial devastation – and is faced with the question of whether or not to

return to work to avoid extreme poverty and to risk infecting others. Measures taken in many developed countries to mitigate risks associated with infection prove futile in South Asia, with extreme shortages of PPE to protect even health personnel on the frontline and the inability to socially distance due to high-density populations.

India's generosity to the SAARC members in 2020 and the beginning of 2021 has been overwhelming with its 'neighbourhood first' approach. Despite clear needs within its own borders, India has pledged millions of COVID-19 vaccine doses to its neighbours, strengthening these ties. China too has played into this arena, gifting vaccines to select countries in South Asia. These reinforced relations and cooperation between India and its neighbours are likely to lead to beneficial short-term benefits and long-term collaboration and shared responsibility in advancing South Asia. This vaccine diplomacy was celebrated, with countries putting the regions' needs often ahead of their own, providing a way for SAARC countries to begin to see a way forward in the pandemic.

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The abstract, format and overall—conceptualisation, and finalisation vested with the first author. Individual authors contributed their country perspectives. Rachel Lafain further undertook relevant research, wrote the first draft incorporating ideas and resources of the other authors.

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