

# THE COVID-19 PARADOX IN SOUTH ASIA

Relevant for: Developmental Issues | Topic: Health & Sanitation and related issues

The oldest and largest democracies in the world are often compared. This time is different. The first person tested positive for [COVID-19](#) on January 21 in the United States and on January 30 in India. Roughly three months later, on April 20, the total number of infections was 7,23,605 in the U.S. and 17,265 in India, accounting for 31.2% and 0.75% of the world total, while the number of COVID-19 deaths was 34,203 in the U.S. and 543 in India, making up 21.7% and 0.33% of the world total. The share of the two countries in world population, by contrast, is about 4% and 18%, respectively.

It is even more surprising that a comparison with South Asia — Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka — yields similar results. In Nepal too, it was in late January that the first person tested positive for COVID-19, though it was end-February or early-March in the other countries. On April 20, South Asia, with a share of 23.4% in world population, accounted for 1.25% of infections and 0.5% of COVID-19 deaths in the world.

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Before the pandemic, it would have been impossible to predict, let alone imagine, such a reality. Income per capita in South Asia is just 16% that of the world, and a mere 4% of that in industrialised countries. One-third of the world's poor live in South Asia, so absolute poverty is high and nutrition levels are low. Population density in the subcontinent is among the highest in the world. The poor, who live cheek by jowl in urban slums and in cramped spaces in rural areas, are most susceptible to a virus that is contagious. Public health systems and facilities are perhaps the worst in the world.

The outcome, then, is puzzling, if not paradoxical. Compared with North America, Western Europe and East Asia, or their own population size, the number of infections and deaths in South Asia is far lower. Of course, it is plausible to argue that, unlike those parts of the world, South Asian countries are in the early stages where community transmission has not gathered momentum. An explosive growth in infection numbers could yet surface later, or in a second round. But it is simply not possible to assess probabilities or make predictions. However, evidence available so far does suggest some flattening of the curve in India, Pakistan, Bangladesh, and Sri Lanka. Infection numbers in Maldives and Nepal are in double-digits and Bhutan's infection numbers are in single digits.

How can we explain this situation in which, so far, South Asia has fared better than many other parts of the world? Past experience of the Spanish influenza in 1918, when India accounted for 18-20 million of the estimated 50 million deaths in the world, or conventional thinking even now, would have led to the opposite conclusion. There are two possible explanations.

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First, the reality might be much worse than the statistics suggest because the total number of infections is almost certainly underestimated, as testing has been nowhere near enough, given the scarcity of testing kits and the massive size of populations. Improved statistics might change the numbers but cannot transform the asymmetry emerging from the above comparisons.

Second, the lockdowns imposed by governments in India, Bangladesh, Pakistan, Sri Lanka and Nepal, which started in the last week of March and continue until April 27 or longer, have clearly

made a difference. The lockdown in India, straddling its vast geography, is perhaps among the most stringent in the world. The common purpose was to break the chain of transmission through physical distancing, which has two dimensions. For one, it confined people to their homes. But this created physical distancing only for the privileged living in homes that have spaces and doors. It was impossible for people in urban slums in mega-cities, where migrant workers lived in cramped spaces, often as many as 10 to a room. For another, it meant that people could not move within cities or across States. Migrant workers could not return to their villages, and citizens or foreigners who might carry the virus could not come from abroad. It did strangle potential chains of community transmission, reducing the geographical spread of the virus through contagion, and flattening the curve compared with what it would have been without a lockdown.

This obvious explanation is necessary but not sufficient because other countries which have imposed lockdowns, say in Western Europe, with public health systems that are far superior, have not managed to slow down the phenomenal spread in the number of infections as much. The impact of diseases can and does differ across countries, possibly attributable to differences in cultures, immunities, or even climates. I am not an epidemiologist or a virologist. But as a social scientist, it is possible to observe an association of attributes.

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It has been suggested that countries which have mandatory BCG vaccinations against tuberculosis are less susceptible to COVID-19 morbidity and mortality. Compare, for example, the Iberian Peninsula countries, Spain and Portugal. On April 20, the former had around 1,96,000 infections and 20,500 deaths, whereas the latter 20,200 infections and 700 deaths. Is it only a coincidence that BCG vaccinations are mandatory in Portugal but not in Spain, or that the U.S. and Italy, both ravaged by COVID-19, never had universal BCG vaccination programmes? Obviously, it is only scientific investigation that can establish cause and effect.

But the BCG vaccine seems to have a stimulating effect on the immune system that goes well beyond tuberculosis. For that reason, perhaps, some countries are running trials of BCG against COVID-19, or thinking of it as a means of protecting health workers. Similarly, countries are buying hydroxychloroquine in large quantities from India, as a prophylactic for health workers and for treatment of COVID-19 patients. In South Asian countries, universal BCG vaccination is mandatory, while immune systems of people have a lifelong exposure to malaria. These could provide possible explanations for the relatively limited spread of COVID-19 in South Asia so far.

Obviously, lockdowns have also mitigated the spread. In doing so, they have saved lives, but at the same time, they have also taken away livelihoods. In South Asian countries, almost 90% of the workforce is made up of the self-employed, casual labour on daily wages, and informal workers without any social protection. The lockdowns have meant that hundreds of millions of people who have lost their jobs, hence incomes, have been deprived of their livelihoods, imposing a disproportionate burden on the poor and those who survive just above the poverty line. For them, the trade-off between getting sick and going hungry is no choice. Livelihoods are an imperative for preserving lives.

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The problem will not vanish after lockdowns are lifted. Economies that have been shut down for six weeks or longer will be close to collapse. In the short-run, it will be a matter of survival for households and firms and stabilisation for the economy. Economic growth will be zero or negative this year. In the medium-term, it will be about recovery. That will take time. Rapid economic growth in the past 25 years had enabled South Asian countries to bring about a

significant reduction in absolute poverty, even though it was associated with rising inequality. Alas, absolute poverty will increase once again, while economic inequality will rise further.

*Deepak Nayyar is Emeritus Professor of Economics at JNU and former Vice Chancellor of the University of Delhi*

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