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Executive Summary

India’s ‘COVID Diplomacy’ has drawn considerable attention from foreign policy observers and analysts. However, there does not exist a single source which accurately represents the totality, depth and diversity of India’s actions in this regard. This report provides a cross-spectrum, analytical overview and typology of India’s ‘COVID Diplomacy’, highlighting key insights and implications for India’s global health diplomacy more broadly. This report finds that:

- India’s COVID diplomacy has been directed towards addressing both the immediate and direct health implications of the pandemic, as well as its longer-term socio-economic consequences. It represents both continuity and change in established patterns in its global health diplomacy.

- India’s COVID diplomacy may be organised into three clusters of activity: the transmission of ideas (normative contributions), the flow of resources and services (material contributions), and the sharing of expertise (knowledge contributions).

- Normative contributions have included advocating for health as a global public good, emphasising cooperation as a mode of engagement in global health governance, and articulating a new vision for health multilateralism (and multilateralism more broadly).

- Material contributions have included supplying qualified medical professionals, medicines and emergency medical equipment to partners, unlocking new funding streams for bilateral and multilateral partners through innovative financial mechanisms, and facilitating the repatriation and evacuation of Indian (and citizens of other countries) from overseas.

- Knowledge contributions have included disseminating technical expertise and knowledge through on-line and on-site training, generating public information resources to dispel ‘fake news’ and developing collaborative health research initiatives.

- India’s COVID diplomacy represents five new ‘trends’ in India’s global health diplomacy: an explicit geopoliticalisation of global public health, the proliferation of new actors and agents of Indian global health diplomacy, the elevation of ‘Indianness’ as a core tenet of Indian global health discourse, the recognition of self-reliance as an emerging principle of global health governance, the deepening of relations with the Indian diasporic medical community, and the strategic mobilisation of digital and social media to advance global health diplomacy aims and agendas.

- While India’s COVID diplomacy is expected to yield goodwill, enhance India’s global stature and improve its relations with partners in the longer-term, certain domestic factors may present challenges to the materialisation of this vision.

“Factoring the domestic into diplomatic calculations will be critical to India’s longer-term success as a responsible health power of the twenty-first century”
1. Background

In recent weeks, India’s ‘COVID diplomacy’ has drawn considerable attention from foreign policy observers and analysts. This is hardly surprising, given the energy, velocity and ambition with which the Indian government has delivered on different aspects of this agenda. While various analyses have outlined the constitutive actions and gestures of India’s COVID diplomacy, there exists no single source which accurately represents its totality, depth and diversity. This report builds on existing analyses and commentaries to further advance our understanding of India’s COVID diplomacy. It will provide a cross-spectrum, analytical overview and typology of India’s COVID diplomacy to date and use this as the basis for extrapolating key insights and implications for India’s global health diplomacy, more broadly. And finally, this report will briefly illuminate the tensions presented by India’s COVID diplomacy, particularly when viewed in relation to India’s domestic response to COVID.

2. Situating India’s ‘COVID Diplomacy’

Development diplomacy allows countries to advance bilateral relations with partners by transmitting knowledge, expertise, resources, values and networks that ostensibly serve the latter’s developmental agendas (Gulrajani, Mawdsley, Roychoudhury 2018). Using soft power instruments and resources, development diplomacy relies on both state actors and non-state actors, often but not necessarily working in formal partnership, for its execution and success. As well as Heads of State, Ministries and government agencies, diplomats will often enrol actors such as non-governmental organisations, think tanks, business associations, multinational corporations, citizens and start-ups into their development diplomacy initiatives. At the same time, non-state actors may participate in development diplomacy initiatives independently of the state apparatus. In this report, we treat India’s diplomatic response to COVID-19 as an illustration of Indian development diplomacy, and more specifically, of its global health diplomacy.

Although the concept of ‘global health diplomacy’ was officially institutionalised by the United Nations only in 2009, it has existed as a practice for much longer (Kickbusch 2013). Indian state and non-state actors, for example, have been involved in global health diplomacy since India’s independence in 1947. In 1956, India dispatched a delegation of 200 doctors to help Burma manage its healthcare sector, and the following year, sent a medical mission to Palestine via the United Nations Relief Works Agency (UNRWA) (Chaturvedi 2016). Indian diasporic communities, with support from the Indian missions, have also been involved in the delivery of health assistance in their respective local communities. In 1963, the Indian community in Addis Ababa, with support from the Indian mission, set up the Gandhi Memorial Hospital for gynaecology and obstetrics to commemorate the 25th anniversary of the then King Haile Selassie I (Embassy of Ethiopia n.d.).

In academic literatures, global public health diplomacy has variously been defined a framework that encourages multilateral cooperation and investment in global health (Reed, Goosby and Kevany 2019); an assemblage of negotiation processes that involves multiple actors across multiple levels to manage the global policy environment (Kickbusch and Behrendt 2017; Ilona Kickbusch; Gaudenz Silberschmidt; Paulo Buss 2007); and as an educational field or tool that simultaneously improves global health and international relations (Adams, Leslie, Novotny 2008; Katz et al 2011). Common to these definitions is an understanding of the interdependent nature of public health, and the need to develop transnational strategies in response to public health risks.

An analytical review of the academic and gray literature suggests that India’s global health diplomacy to date has broadly taken place along four main axes: social, economic, political and humanitarian. The social dimension of India’s global health diplomacy has involved efforts to widen global access to medicines and vaccines and improve healthcare infrastructures in partner countries. It includes, for example, the supply of anti-retroviral and anti-malarial medicines to the Global Fund to Fight AIDS, TB and Malaria by Indian pharmaceutical companies such as Ranbaxy, Strides and Cipla (Horner 2020). In fact, Indian companies manufacture between 60 to 80 percent of all vaccines procured by agencies of the United Nations (Chaturvedi 2016). The social dimension of India’s global health diplomacy also includes financial contributions to
global health initiatives, such as the Gavi.\(^1\) In terms of bilateral assistance to strengthen partner countries’ healthcare facilities and infrastructures, India has funded the establishment and operational maintenance of hospitals and specialised clinics in Afghanistan and Nepal and provided ambulances to Nepal and Mozambique (Chaturvedi 2016), to provide just a few examples.

The economic dimension of India’s global health diplomacy has involved the provision of medical goods and services to meet the healthcare requirements of partner countries. Since its establishment in 2009\(^2\), India has offered telemedicine and tele-education services to African nations under the Pan-e Africa Network. While not a formal component of diplomacy, Indian healthcare professionals settled overseas - whether doctors, physicians or nurses - have been a great asset for India due to their proven skill, acumen and record of hard work. As noted by the Foreign Secretary of India, Harsh Vardhan Shringla, ‘Respect for Indian medical professionals and Indian medical expertise is not restricted to the United States. We have worldwide brand recognition in the healthcare industry.’ (Ministry of External Affairs 2020). In recent years, there has been increasing governmental interest to promote India as a preferred destination for medical treatment for patients from overseas. In particular, it has sought to cultivate and expand the global market for Indian traditional systems of medicine such as Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH). To that end, the Indian government has set up a cross-departmental institutional platform to promote medical and wellness tourism in India.\(^3\)

Politically, India’s global health diplomacy has contributed to the democratisation of systems of global health governance. At the World Trade Organisation (WTO), India has consistently championed members’ rights to safeguard public health goals against the trade interests of multinational companies. India has defended its right to issue compulsory licenses\(^4\) for the production of generic versions of patented medicines, and has withstood pressure from the United States to dilute those provisions in its domestic intellectual property laws which serve to uphold these rights (Sen 2018). India’s political engagement on these issues has been instrumental in enabling it to act as ‘pharmacy of the world.’ Its engagement within Southern multilateral forums such as the BRICS (Brazil, Russia, India, China and South Africa) and IBSA (India, Brazil, South Africa) has also allowed it to advance its position on key global health agendas. For example, at the BRICS Health Ministers Meeting in 2019, BRICS nations reaffirmed their political commitment to ‘promote access to safe, quality, effective and affordable, essential medicines, vaccines, diagnostics and other medical products’ and make ‘full use of TRIPS flexibilities’, to protect '[their] policy space against TRIPS plus provisions and other measures that impede or restrict such access’ (Declaration of the IX BRICS Health Ministers Meeting 2019) - in line with positions previously adopted by India in other multilateral spaces.

\(\text{“India has defended its right to issue licenses for the production of generic versions of patented medicines, and has withstood pressure from the United States to dilute those provisions in its domestic intellectual property laws...”}\)

Furthermore, India has on several occasions directed its global health diplomacy towards providing

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1 In 2018, India doubled its contribution to the GAVI Alliance, committing USD 8 million for the 2018-2022 period (Gavi n.d.)
2 Following budgetary issues and a perceived lack of ownership by African partners, the Indian government suspended the provision of services in 2017 and handed over the project to the African Union Commission. However, a recent evaluation of the project has revealed continued partner interest in Indian expertise. The Indian government has therefore offered to provide technical and financial assistance to African partners for five more years (Mishra 2020). The ups and downs of the Pan-e Africa Network caution against using headlines and official statements to assess the actual provision and effectiveness of interventions; and also points to the very substantial challenges faced by all development partners, particularly in cases like that of India, which has sought to rapidly innovate, scale up and expand its development partnerships.
3 The National Medical and Wellness Tourism Board, established under the Chairmanship of the Minister of Tourism, comprising representation from the Ministries of Health, Commerce, External Affairs, AYUSH and Home Affairs, offers one such institutional platform (Press Information Bureau 2018).
4 When a government allows someone else to produce a patented product or process without the consent of the patent owner. It is one of the flexibilities permitted by the TRIPS Agreement (World Trade Organisation n.d.).
relief to both Southern and Northern partners trapped in humanitarian crises, whether conflict situations, an outbreak of disease, or natural calamities. For example, in response to Hurricane Noel, in Haiti, in November 2007, India donated medicines valued at USD 50,000 (Ministry of External Affairs 2013). In response to Hurricane Katrina in 2005, in New Orleans, India offered to supply essential medicines as well as fly in a medical team from the Indian Army Medical Corps, comprising a surgeon, an anaesthetist, doctors, nurses and paramedics, to complement local efforts on the ground (Ministry of External Affairs 2005).

3. India’s COVID Diplomacy

In many ways, India’s diplomatic response to COVID-19 reflects existing patterns in its global health diplomacy. At the same time, the peculiarity of this virus, the magnitude of its geographical reach, and the multi-dimensional nature of its impacts and implications (social, economic and humanitarian; as well short, medium and longer-term) have prompted India to respond in ways that perhaps differentiate its current approach from diplomatic responses adopted in the past. As such, this report invokes the concept of ‘India’s COVID diplomacy’ to tease out India’s diplomatic efforts to manage the immediate, medium and longer-term implications of the pandemic, and emphasises where and how it represents continuities, novellies and ruptures.

3.1. Summary and Typology

This section organises and presents the full range, scope and diversity of India’s COVID diplomatic actions to date, to the extent that publicly available information makes it possible to do so. It draws on official sources such as ministerial websites, official press statements, official speeches, and content generated by the Indian government on digital and social media. It also draws on information available in the Indian and international media, as well as analyses, commentaries, webinars, online interviews and reports generated by Indian think tanks, foreign policy observers and non-governmental organisations. It organises this information by activity-type, noting three main clusters of activity: the transmission of ideas (normative contributions), the flow of resources and services (material contributions), and the sharing of expertise (knowledge contributions).

3.1.1. Normative Contributions

Normative contributions include the transmission of ideas, values and norms aimed at amplifying India’s soft power, through both action and discourse. COVID-19 has provided India with a strategic opportunity to further socialise into the international community norms and values which it has long championed in and through its global health diplomacy, as well as its diplomacy, more broadly.

1. Cooperation and reformed multilateralism:

From the very outset, India’s response to the pandemic has been to emphasise cooperation and multilateralism as key guiding principles, even as others have sought to openly challenge these principles. For example, in response to President Trump’s decision to cut the budget of the World Health Organisation (WHO), the Indian government reinforced its own resolve to stay focused on the global pandemic response (Laskar 2020). The Indian government⁵ has to date also refrained from publicly holding China directly responsible for the spread of the virus (Kantha 2020), unlike the United States presidency which, in addition to blaming China, has invoked racially-encoded discourses to amplify its position. In fact, in the initial days of the pandemic, India’s official response was to express solidarity with China.

While India continues to champion cooperation and multilateralism as principal modes of engagement on issues of global health governance, it has also used COVID-19 as an opportunity to push for its reform. At the G20 Virtual Summit on 26 March 2020, for example, Prime Minister Modi advocated for reform of the WHO, recommending that it invest more in early warning capacities. Advocating for the reform of global health governance is also in line with India’s broader aspiration to reform the institutions of global governance more generally. India has thus used COVID-19 as a strategic opportunity to also push for multilateral reform. It has already declared this⁶ to be coined the acronym ‘NORMS’ (‘New Orientation for a Reformed Multilateral System’) to capture its commitment to the reform of institutions of global governance.

⁵ Somewhat at odds with the Indian public’s own response. See: Serhan (2020).
⁶ In keeping with the current administration’s tendency to mobilise catchphrases and acronyms to define its foreign policy approach, it has
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India has also seized this moment to showcase its capability to steward this future, reformed multilateral order. Upon being elected to the UNSC, India's Permanent Representative to the United Nations, T.S. Tirumurti, stated in a video: ‘We are confident (that) in the COVID and post-COVID world, India will continue to provide leadership and a new orientation for a reformed multilateral system.’ India has often projected its own flagship, multilateral initiatives as representations of what a more equitable multilateral order might look like. At the recently convened NAM videoconference, Modi highlighted the International Day of Yoga, the International Solar Alliance and the Coalition for Disaster Resilient Infrastructure, as initiatives that are ‘more representative of today’s world’ (Modi 2020).

2. Health as a global public good:

India continues to reinforce and champion the idea of access to medicines for all, in line with an established tenet of its global health diplomacy. To that it has co-sponsored two resolutions at the UN General Assembly, on 2 April 2020 and subsequently on 20 April 2020, calling for fair, transparent and equitable access to essential medical supplies and potential vaccines for COVID-19. Similarly, at the General Council Meeting of the WTO held earlier this year, India appealed for flexibility in global Intellectual Property Rights (IPR) agreements to ensure affordable access to essential medicines and vaccines by all countries (Mohanty 2020). It has also co-sponsored a resolution at the World Health Assembly, similarly calling for a relaxation in intellectual property issues to enable universal, timely and equitable access to medicines. India’s aspiration to reinforce its identity as a global supplier of affordable pharmaceutical drugs has manifested in and through gestures such as its export of Hydroxychloroquine (HCQ) to 133 countries (MEA 2020), its decision to act as the global mass manufacturer for the COVID-19 vaccine currently being developed at the University of Oxford, and its self-identification as the ‘pharmacy of the world’ in various multilateral spaces such as the Online Summit of NAM Contact Group.

3.1.2 Material Contributions

Material contributions entail the flow of resources and services to governments, multi-stakeholder initiatives, multilateral bodies and local communities. Specific activities include providing financial support, supplying qualified, medical professionals and healthcare workers to overburdened healthcare systems overseas, supplying emergency medical equipment to partners, and facilitating the repatriation and evacuation of Indian (and citizens of other countries) from overseas.

Resources

1. Medicines and equipment:

Both Indian state and non-state actors have supplied medicines and medical equipment to governments and communities in partner countries. The Indian government has supplied HCQ to a total of 133 countries spread out across South Asia, North America, South America, the Caribbean. India has also delivered medicines to partners through various naval missions. As part of Mission SAGAR, the Indian Naval Ship (INS) Kesari, delivered essential medicines to Mauritius, Madagascar, Comoros and the Seychelles. In the case of Mauritius, the consignment was India’s second, containing not only essential medicines but ayurvedic medicines as well. Indian diplomatic missions overseas have also been involved in the provision of medicines. For example, received it on a commercial basis. As of June 2020, India supplied medicines to 133 countries (446 million HCQ tablets and 1.54 billion Paracetamol tablets), also via grants and commercial sales (Ministry of External Affairs 2020).

On 25 March 2020, India’s Directorate General of Foreign Trade placed hydroxychloroquine (HCQ) on restricted items list. On 4 April, it issued a blanket ban on the export of HCQ. It revoked the ban on 6 April 2020. On 4 April 2020, the Ministry of Commerce banned the export of hydroxychloroquine. This decision was later reversed on 7 April.

As of April 2020, India supplied the HCQ drug to 55 countries: 21 of these countries received HCQ in the form of a grant; the remaining 34 countries

“India has also seized this moment to showcase its capability to steward this future, reformed multilateral order”
in the United States, the Indian Embassy collaborated with the Indian American community of doctors to ensure that elderly Indian visitors had reliable access to the prescription medication they required (ANI 2020). Indian non-governmental actors have also led initiatives to provide medicines and equipment to communities overseas. For example, in response to an urgent appeal made by Iran’s only Zoroastrian politician, Dr. Shernaz Cama, of Lady Shri Ram College and the Parzor Foundation activated her domestic and international Parsi networks9 to assemble and arrange for the dispatch of medicines and equipment to Tehran (Desai 2020). Even as the Indian government refrained from formally offering assistance to Iran through its bilateral channels, the Indian Parsi network stepped in to offer what it could, garnering appreciation from the Iranian Foreign Minister.

2. Human resources:

Indian healthcare professionals, including doctors, nurses and medical experts have been at the forefront of the pandemic response all over the world. India has dispatched military doctors to the Maldives and Kuwait to help these countries manage the pandemic: 15 doctors and paramedics to Kuwait, and an Indian Army team of six military doctors and eight paramedical personnel to set up quarantine and testing facilities in the Maldives. India has also dispatched a delegation of 88 nurses, affiliated with the Aster DM Healthcare group of private hospitals in Kerala, Karnataka and Maharashtra, to offer additional human resource capacity to the United Arab Emirates’ already overstretched healthcare system. Although not a formal element of COVId diplomacy, Indian migrant nurses – and in particular, nurses trained in Kerala – have played a critical role as frontline responders in countries such as the UK, where their contributions have also been publicly applauded by some parliamentarians (Sreerag 2020). While nurses trained in Kerala have always enjoyed a strong reputation overseas (World Health Organisation 2017), the particular success of the “Kerala model” has enhanced their popularity and generated a surge in demand for their services overseas. In addition to requests from the UAE, a private hospital in Saudi Arabia has requested the Department of Non-Resident Keralites Affairs (NORKA) of the state government of Kerala for its assistance in the recruitment of nurses from Kerala. NORKA has also been recruiting nurses for the Health Ministry of Saudi Arabia.

3. Financial contributions:

Indian investments in multi-stakeholder and multilateral initiatives have unlocked new resources and funding streams to support efforts to address both the immediate and longer-term consequences of the pandemic. For example, at the recently held Global Vaccine Summit, India pledged USD 15 million to Gavi. India also initiated efforts to set up a SAARC Emergency Fund, to which it has made the largest contribution, of all member states, of USD 10 million. The New Development Bank (NDB) of the BRICS, of which India is a founding member, has established an Emergency Assistance Facility to help its members meet both their emergency and longer-term economic recovery needs (NDB 2020). The NDB has also issued a USD 1.5 billion 3-year COVID-19 Response Bond in the international capital markets. In May of this year, India contributed USD 2 million to the severely under-resourced United Nations Relief and Works Agency (UNRWA) – of a total pledged amount of USD 10 million for the next two years – to enable the agency to continue its core operational work, including in the field of health, for Palestinian refugees. And finally, India recently announced a USD 2 million contribution to ‘ISA-CARE’ to support the deployment of solar power in health centres in 46 Small Island Developing States (SIDS) and Least Developed Countries (LDC) member states (Jayakumar 2020).

Services

1. Food supply and delivery:

As part of Mission SAGAR (Security and Growth for All in the Region), the Indian Naval Ship (INS) Kesari delivered 580 tonnes of food to the Maldives. India has also dispatched two separate consignments of food aid to Afghanistan, containing donations of approximately 5000 and 10,000 metric

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9 Which included prominent figures from the Indian Parsi community, such as Dr Cyrus Poonawala, Chairman of Poonawalla Group (which includes the Serum Institute of India) and Dr Yusuf Hamied, Chairman of pharmaceutical company, Cipla.

10 Under this programme, it has already issued a USD 1 billion COVID-19 Emergency Loan to South Africa, as well as to India.

11 Its proceeds will be used to finance emergency assistance loans to the Bank’s member countries and sustainable development activities more broadly.
tonnes of wheat respectively, of a total pledged donation of 75,000 metric tonnes (ANI 2020).

2. Vaccine manufacture:

AstraZeneca, the manufacturing partner for the vaccine currently being developed by the University of Oxford, has finalised a licensing agreement with the Serum Institute of India to supply one billion doses of the vaccine to low-and-middle-income countries (AstraZeneca 2020).

3. Repatriations and evacuations:

Perhaps one of the most significant components of India’s COVID diplomacy has been its role in facilitating the safe return of stranded Indian citizens, and at times, the citizens of other nations as well. The repatriation mission, named the Vande Bharat Mission, has taken place across multiple phases, with each phase extending the mission to a different geographical region. While the Indian government initiated the mission in early May, calls for the repatriation of Indian citizens from overseas emerged much earlier, most notably from Kerala: a state that is home to approximately 1.89 million emigrants currently residing in the Gulf (Rajan and Zachariah 2019). Under the Vande Bharat Mission, India has facilitated the repatriation of Indian citizens via flights operated by the national carrier, Air India, and through naval missions led by the Indian Navy under ‘Operation Samudra Setu’. From almost day one, Indian commentaries have drawn parallels between the Vande Bharat Mission and the evacuation of Indian citizens from Kuwait in 1990, with many observers noting that the Vande Bharat Mission has now surpassed the Kuwait operations as the largest evacuation ever to have been conducted.

Aside from issues of scale and logistical complexity, a notable difference between the two operations has been on the issue of financing. Whereas the Indian government sponsored the return of Indian citizens from Kuwait in 1990, citizens returning to India via the Vande Bharat Mission are required to bear their own expenses. This distinction has led officials to characterise the current operation as a repatriation rather than an evacuation. While the commercial nature of the Vande Bharat Mission has provided financial relief to the government, as well as a severely under-resourced Air India, it has also prompted questions around its affordability for many migrant communities settled abroad (Xavier 2020).

These concerns notwithstanding, Vande Bharat Mission has served as an important site for the projection of Indian state power and soft power. In particular, Operation Samudra Setu, has allowed the Indian Navy to once again showcase its power and capability to conduct highly effective and successful evacuations. At a discursive level, official narratives have consistently underscored the scale and magnitude of the operation, and the Indian government’s wherewithal to conduct such an operationally complex operation. Such narratives have served to reinforce India’s image as a highly responsible, capable and efficient humanitarian actor.

4. Debt relief and currency swaps:

The Indian government has expressed an interest in providing financial assistance to help partners cope with ancillary fiscal pressures triggered by COVID-19. For example, it has provided debt relief to the Government of Mozambique by suspending debt repayment on concessional loans worth USD 700 million, issued by the EXIM Bank of India (Bhatia, 2020). It has also activated a currency swap of USD 150 million for the Maldives, as part of a USD 400 swap agreement signed in July 2019 to help the

12 Recent reports suggest that Vande Bharat has facilitated the return of 6.87 lakh Indians from overseas since its launch in early May (Press Trust of India 2020).

13 India has also coordinated evacuations during COVID-19. In the early weeks of the pandemic, prior to the Vande Bharat Mission, the Indian Air Force facilitated the evacuation of Indian citizens from Iran and China, two of the most severely affected countries at the time.

country deal with revenue losses from the tourism sector (Roche 2020). Sri Lanka has requested India for a moratorium on the USD 2.9 billion debt it owes this year, as well as for a currency swap facility, all of which appear to be under consideration by the Indian Ministry of External Affairs. At the bilateral level, India has extended bespoke Lines of Credit to make resources available for the continuity of essential services during the pandemic period. For example, in June 2020, the EXIM Bank of India, under the guidance of the Indian government, issued a USD 215.68 million Line of Credit to Malawi, to finance various drinking water supply schemes (Bhatia 2020).

3.1.3 Knowledge Contributions
Knowledge contributions include disseminating technical expertise and knowledge through a combination of on-line and on-site training, generating public information resources to dispel ‘fake news’ and pseudo-scientific claims related to COVID-19, and developing collaborative research initiatives.

1. Sharing expertise:

Various organs of the state machinery have been engaged in the dissemination of Indian knowledge and expertise to partners: from the central government, to the Indian Navy, to sub-national entities such as the Government of Kerala. In several cases, the Ministry of External Affairs has adapted existing development partnership infrastructures to organise pandemic-specific learning, training and exchanges. It has extended a number of virtual Indian Technical and Economic Cooperation (ITEC) courses on COVID-19 prevention and management. Its e-ITEC course, ‘COVID-19 Pandemic: Prevention and Management Guidelines for Healthcare Professionals’ has been offered to health care workers from various parts of Africa, including Nigeria, Kenya, Mauritius, and Namibia (Mishra and Pant 2020), and to 150 health care professionals from SAARC countries. It has also offered an e-ITEC course on good governance for international civil servants from 18 countries, and plans to introduce an e-ITEC course specifically for Latin American partners in the near future. Indian-supported multilateral initiatives have similarly been activated to offer COVID-related bespoke training to healthcare professionals in partner countries. For example, an IBSA Fund-supported e-learning initiative that was established in 2015 to provide online training to healthcare workers in Northern Vietnam has been adapted to include training modules of direct relevance to the treatment of COVID-19 (United Nations Office for South-South Cooperation 2020). Among new infrastructures set up to facilitate online learning and exchange is the ‘SAARC COVID 19 Information Exchange Platform’ or COINEX.

Other state actors involved in the dissemination of Indian knowledge and expertise include the Indian Navy and Indian State governments. Indian naval medical teams, for example, have provided vital medical expertise and knowledge to partners via on-site, interactive exchanges with local health-care professionals. As part of Mission SAGAR, two 14-member Indian Navy medical teams had been stationed at Mauritius and Comoros to tour local hospitals, provide training to medical personnel, and share COVID-19 management techniques. The State government of Kerala has also emerged as a global voice for pandemic management, earning international praise from all quarters including the United Nations. In June of this year, the Health Minister of Kerala, K.K. Shailaja, was invited by the United Nations Office for South-South Cooperation (UNOSSC) to share lessons, insights and best practices from the Kerala experience (United Nations Office for South-South Cooperation 2020).

2. Undertaking joint research:

India has activated existing bilateral research initiatives to support and advance new collaborative research on COVID-19. For example, the Indo-US Science and Technology Forum (IUSSTF) has issued a call for proposals to advance COVID-19 related research (Press Trust of India 2020). Similarly, the Australia-India Strategic Research Fund (AISRF), at the behest of the Indian and Australian Prime Ministers, recently issued calls for joint research projects on various dimensions of the COVID-19 response (Department of Science and Technology, Government of India 2020). These collaborations include advancing research in areas such as preventive technologies, data analytics and AI applications, as well as in Indian plant-based, ‘traditional’ systems of medicines. For example, Ayurvedic practitioners and researchers from India and the United States are reportedly planning to initiate joint clinical trials of Ayurveda formulations against the novel coronavirus (Press Trust of India 2020).
3. Managing information flows:

India is one of thirteen countries currently leading a United Nations-supported global communications campaign, ‘Verified’, to prevent the spread of misinformation and fake news in relation to COVID-19. It has co-authored a cross-regional statement endorsed by over 130 States, urging people across the world to spread fact-based advice and reliable information to counter the ‘infodemic’ that has accompanied the pandemic (Ministry of External Affairs 2020). India’s decision to join this campaign takes place in a context where many members of the Indian public, the mainstream media, as well as members of the ruling party itself have wrongly accused the Muslim community of wilfully spreading the virus.

4. Observations and Analysis

From the section above, it is clear that India’s COVID diplomacy both reinforces and unsettles existing patterns in its global health diplomacy. In this section, we analyse the particular ways in which India has interrupted established trends to chart out new directions in Indian global health diplomacy.

4.1 Geo-politicising Global Public Health

Whereas India has traditionally mobilised its foreign policy apparatus to advance various aspects of the global health agenda, Covid-19 has revealed an emerging interest in strategically mobilising global public health to advance its national security objectives and economic interests. India’s COVID assistance to the island countries of the Indian Ocean, under Mission SAGAR, and to countries such as Myanmar, might for example, be interpreted as a strategic move to consolidate its presence in the geopolitically sensitive region of the Indian Ocean region (Brewster 2020; Ray Chaudhury 2020; Pandalai 2020; Roche 2020).

India’s decision to restrict assistance to specific countries might similarly be interpreted as an expression of geopolitical calculus. The Indian government appears not to have offered any material assistance to Iran (beyond facilitating the repatriation and evacuation of its own citizens) despite Rouhani’s direct appeal for material support earlier this year - purportedly due to the perceived risks of violating US sanctions and diluting relations with Arab partners in the Gulf (Singh 2020). India has facilitated complex repatriations and evacuations, and provided health assistance to large swathes of the globe, including both developing and developed countries, arguably to build political reputation and improve and strengthen bilateral relations with partners. Official government discourse also reflects a growing appetite to bring global public health agendas and national security interests closer together: India is often described as a ‘net provider of health security’ and a potential ‘healthcare power’ (Shringla 2020). India’s global public diplomacy today thus involves a careful negotiation between normative and humanitarian health agendas on the one hand, and more strategic and material foreign policy interests on the other.

4.2 Pluralising and Democratising Health Diplomacy

India’s COVID diplomacy has come to rely upon a highly evolved matrix of actors and partnerships, in line with the WHO’s recommended ‘whole of society’ approach. Examples include the Indian Parsi community’s partnership with the Iranian mission in New Delhi to deliver humanitarian assistance to Yazd in Iran, or the State government of Kerala’s collaboration with the Health Ministry of Saudi Arabia to facilitate the recruitment of Keralan nurses. In addition, a number of public-private joint ventures have emerged as critical vehicles for Indian global health diplomacy. For example, Aster DM Healthcare group, a private healthcare conglomerate, collaborated with the UAE embassy in New Delhi, the Indian consulate in the UAE as well as the UAE’s Ministry of Foreign Affairs and International Cooperation to facilitate the deputation of an Indian delegation of nurses to the UAE.

15 Assistance has been extended to countries in South Asia, North America, South America, the Caribbean and Central Asia and Africa.
Indian actors have also engaged in triangular partnerships, a funding arrangement involving a partnership between DAC donor(s), a ‘pivotal’ country and recipient country (McEwan and Mawdsley 2012). For example, the Indian NGO, the Public Health Foundation of India (PHFI), in partnership with the UK-supported Global Development Centre conducted a four-part webinar series to train health professionals in Asia and Africa (Public Health Foundation of India n.d.). Each of these examples serves to illustrate the growing heteropolarity (McConnell and Ho 2017; Constantinou and Der Derian 2010) of Indian global diplomacy, in which different actors and stakeholders are coming together in diverse and complex ways to advance common diplomatic ends.

4.3 Performing ‘Indianness’

India’s COVID diplomacy has taken on a distinctly socio-cultural dimension, a reflection, perhaps, of a gradual but growing convergence between cultural rhetoric and diplomatic practice. India’s COVID diplomacy has relied upon the mobilisation of historical and cultural discourses to (re-)imagine and legitimise particular representations of Indian identity or ‘Indianness’. For example, Indian officials have invoked ideas from Sanskritised scriptures, and in particular the idea of Vasudhaiva Kutumbakam (or ‘the world is one family’), at multilateral health convenings, such as the Global Vaccines Summit. Additionally, India has sought to popularise the role of Indian traditional medicine systems in boosting people’s natural immunities, in and through international spaces such as the recently convened NAM Summit, the BRICS Foreign Affairs Ministers Meeting, and at the United Nations. International partners are also increasingly incorporating Indian cultural rhetoric into their narratives and actions.

In a written request to Modi to supply HCQ to Brazil, President Jair Bolsonaro invoked the Ramayana, comparing the drug to the holy medicine, Sanjeevani. On International Yoga Day, the Russian Ambassador to India acknowledged yoga as a great gift of India, and commented on its potential to build resilience against diseases. The United Nations has also begun to advocate yoga as a means to cope with COVID-related anxiety and stress.

These discourses and actions have emboldened India to perform and project an Indian identity, or an Indian ‘brand’, that is ostensibly pre-colonial and pre-Islamic in character. India has also sought to encode the idea of ‘Indianness’ into narratives that define it in relation to its imagined political ‘others’, namely the United States and China. Observers of Indian foreign policy have, for example, contrasted the ‘Indian way of being collaborative and constructive’ with Beijing’s ‘overbearing geopolitical jostling’ (Pandalai 2020), its ‘less than effective’ health diplomacy (Chakrabarti 2020) and its ‘arrogant, aggressive and irresponsible’ style (Pant 2020). These narratives also seemingly resonate with emerging government discourse highlighting the ‘India Way’ as an approach that claims to be free of self-centredness or mercantilism (Jai Shankar 2020), in what may reasonably be construed as an implicit reference to the Chinese approach.

4.4 Amplifying Engagement with the Indian Diaspora

The Indian government has proactively amplified its engagement with Indian diasporic communities involved in the pandemic response. For example, in a virtual interaction with a group of select Indian Americans, the Indian Ambassador to the United States stated: ‘Needless to say, Indian-Americans are leading this country in the fight against COVID-19. Whether as healthcare workers, doctors, scientists, business owners – you are leading the charge against COVID-19 and your contributions will not go unacknowledged.’ He further went on to describe the community as ‘global strategic partners’ with whom India has had close ties in various fields such as science and technology (The Times of India 2020). In his address to the American Association of Physicians of Indian Origin (AAPI), Modi similarly applauded the contributions of Indian American doctors, using it also as an opportunity to raise the ‘homeland’s’ (McConnell and Ho 2017) profile within this community. Such gestures, or ‘diaspora strategies’ (McConnell and Ho 2017; Cohen 2017; Gamlen 2008), illustrate the current administration’s interest in deepening its engagement with the Indian diaspora as diplomatic actors to serve its political and national agendas. As strategies that complicate the territorial premise of such concepts as the nation-state or national identity, diaspora strategising or diaspora diplomacy (McConnell and Ho 2017; Rana 2009) during COVID-19 has allowed Modi to consolidate an interpretation of Indian identity as something that is geographically diffuse and extra-territorial, in line with positions previously adopted by him.
At the same time, COVID-19 has revealed the limitations of unequivocally treating the Indian diaspora as a source of Indian soft power. After certain sections of the Indian diaspora in the UAE made inflammatory and Islamophobic comments online, accusing the Muslim community for the spread of the virus, several high-profile officials from the UAE protested. While Prime Minister Modi responded almost immediately with a conciliatory tweet to limit the extent of the reputational damage caused, domestic Islamophobia has also been widespread, and politically inflamed by some within the administration, emboldening diasporic communities overseas to express polarising and communal sentiments with impunity. It remains to be seen whether, how and to what extent growing internationalisation of religious polarisation and communal divisiveness might eventually undermine, if not harm, India’s relations with Muslim majority partners in the future (Ganguly and Blarel 2020).

Finally, the Indian government has also used Twitter as a performance space to enact, emphasise, and legitimise certain narratives and ideas. It has used Twitter to assert its role as a ‘voice for the developing world’, enabling it to reinforce its allegiance to the principles of South-South Cooperation, and a broader commitment to what it regards to be an indispensable element of the ‘India Way’. The Indian government has projected state power and demonstrated its capacity to provide global leadership in the midst of a crisis by frequently retweeting messages of gratitude or appreciation by partners who have benefited from Indian assistance. And finally, it has been able to engage in digital diaspora diplomacy by addressing Indian diasporic communities via videoconferencing or highlighting their contributions to the COVID response.

4.6 Promoting Atmanirbharta (self-reliance)

Whilst COVID-19 has prompted India to reinforce its commitment to cooperation and multilateralism, it has also unlocked a strong interest in promoting self-reliance, or atmanirbharta, as a parallel, though not necessarily contradictory, guiding principle. COVID-19 has brought about the realisation, as it has for other parts of the world, that pre-pandemic global supply chains are no longer tenable (Bhaskar 2020). In the context of health, it has translated into a particularly deep recognition of India’s excessive dependence on China for key ingredients required for the manufacture of pharmaceutical products. Some observers have argued that atmanirbharta is simply an extension of a philosophy that was already visible, and in action, when India decided to withdraw from Regional Comprehensive Economic Partnership (RCEP) in 2019 (Bagchi 2020).

To pre-empt the allegation that India has taken a turn towards protectionism or isolationism, the Indian government has sought to publicly present self-reliance and multilateralism as mutually reinforcing categories. It has done so with the aid of narratives which suggest that a self-reliant, export-oriented India is also more likely to import from other countries, and therefore act in ways that are consistent with ‘internationalism’ (Malik 2020; Shringla 2020). Such narratives have also appeared in official declarations proclaiming that ‘India will grow, but grow with the world’.

4.5 Harnessing Social and Digital Technologies

India has harnessed a range of digital and social media technologies to execute, display and narrativise its COVID diplomacy. It has used digital tools and online spaces to initiate and conduct virtual summits at the global, regional and bilateral levels, execute COVID 19-related ITEC training programmes, establish digital information hubs to capture regional trends, and established web portals to help facilitate the repatriation of Indian migrants from overseas. The Indian government has used social media tools, in particular Twitter, to display to international and domestic publics alike, the full breadth of its COVID diplomacy in action. For example, the External Affairs Minister has frequently overviewed virtual meetings held with counterparts all over the world, shared details of repatriations undertaken and successfully completed, and provided real-time updates of assistance delivered to partner countries.

“COVID-19 has revealed the limitations of unequivocally treating the Indian diaspora as a source of Indian soft power”
5. Tensions and Challenges

While India’s COVID diplomacy is expected to yield goodwill, enhance India’s global stature and improve its relations with partners in the longer-term, certain domestic factors may present challenges to the materialisation of this vision. Observers argue that India’s initial inattentiveness to the plight of its domestic migrants at the same time that it devoted considerable energy towards the repatriation of Indians from overseas has complicated external perceptions of it (Haidar 2020; Surie 2020). While India’s purported success in containing the spread of the virus during the early stages of the pandemic initially served as an important source of Indian soft power (Malik 2020), its deteriorating domestic situation16 has arguably unsettled its overall image as a global leader in pandemic management.17 Whereas India deployed diplomatic tactics, including COVID diplomacy, in the form of material support to the UAE to redress the fallout caused by the communalisation of the pandemic, it remains to be seen whether and to what extent this goodwill will ensure India against future potential diplomatic damage caused by growing Islamophobia in India. All of these examples illustrate the extent to which domestic factors have the potential to unsettle, if not unravel, the soft power ambitions of India’s global health diplomacy.

Concluding Remarks

India’s COVID diplomacy has been both multi-dimensional and multi-layered. It has taken place across three planes of activity, the normative, material and technical; and has responded to both the immediate, health-related implications of the pandemic as well as its longer-term, socio-economic consequences. Even as India continues to champion health as a global public good, its health diplomacy agenda has expanded to include greater attentiveness to the pursuit of geopolitical interests and the global promotion of indigenous systems of medicine and well-being. While India continues to embrace its identity as the ‘pharmacy of the world’, it has increasingly sought to emphasise its role as a ‘net health security provider’ (Shringla 2020) and a ‘first responder’ in the region (Pandalai 2020; Ray Chaudhury; 2020 Bagchi 2020). India’s COVID diplomacy has revealed the growing prominence of new actors in the Indian global health sector, from the private sector to non-governmental organisations to sub-national governments who operate in and through hybrid partnerships and multi-stakeholder alliances.

Finally, India has showcased the diverse range of financial, social and digital instruments available to agents of Indian global health diplomacy. Despite what is arguably a new direction for Indian global health diplomacy, challenges do remain. As COVID-19 has made evident, the soft power effects of Indian global health diplomacy, or development diplomacy more broadly, are likely to be distorted by domestic lapses and failures in public health, social development, and minority protection. Nevertheless, COVID-19 has illustrated the potential for new capabilities to amplify India’s image and reputation in the field of global public health. Factoring the domestic into diplomatic calculations, however, will be critical to India’s longer-term success as a responsible health power of the twenty-first century.

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17 Of course, sub-national governments, such as the State government of Kerala, may continue to serve as templates and examples of best practice in pandemic management.
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