A Sociological Perspective on the COVID-19 Crisis in Pakistan

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Like other countries, Pakistan is also dealing with the global Coronavirus pandemic as both a public health emergency and a crippling economic crisis which will have long-term social impacts. This is not like any natural disaster, terrorist attack or economic shock we have ever experienced before, and governments around the world are scrambling to devise appropriate responses that will save both lives and livelihoods. The unprecedented challenge forces us to re-think what relationships exist between the individual and collective, what is private and what is public, and what vulnerability and resilience look like.

A fundamental insight of Sociology is that economic activity, like public health and any other facet of social life, is shaped by institutional arrangements, norms, beliefs, and structured inequalities that shape access to power and resources. As the federal and provincial authorities in Pakistan make decisions about lockdowns, quarantines, industrial shutdowns and social protection measures, there is a lot of guidance that social science research has to offer.

The Logic of Social Distancing

The lockdown first implemented in Sindh and then extended to the rest of the country is based on scientific models of how the virus is transmitted and backed by China's experience in controlling the epidemic in Wuhan. The theory of "flattening the curve" has been widely disseminated in international and national media outlets. Yet reports indicate that the lockdown and accompanying social distancing measures are proving difficult to implement across Pakistan. It is easy to shut down schools, universities and businesses but harder to regulate other public spaces and social behavior in private settings. We hear of continued gatherings in mosques for Friday prayers, of families and friends getting together for routine meetings, of crowded marketplaces in non-elite urban neighborhoods, of desperate congregations where food rations are being distributed.

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It is not enough to simply label this behavior as irrational, reckless or stemming from a lack of education and civic sense that we so easily attribute to poorer segments of the population. Flattening the curve means limiting the number of deaths and avoiding an overburdening of healthcare systems, based more on projections than on ample data. The extreme measures necessary to achieve these outcomes have very real consequences for social life, economic activity, and mental health, and these trade-offs are often frustratingly hard to calculate.

In order to voluntarily and comprehensively practice social distancing, you need to believe that concrete, immediate individual-level sacrifices in your day-to-day life will result in intangible benefits for collective health and well-being in some indeterminate future. You need to have faith that not visiting your elderly parents or not fulfilling your religious obligations by praying with your congregation is ultimately for their benefit. Above all, you need to trust that the state is acting for the common good and that the lives of all citizens are valued equally.

In Pakistan, citizens' perceptions about the state and the efficacy of service delivery by state institutions are largely based on distrust and negative experiences. A population fragmented across class, ethnic, religious, sectarian, and other bitterly-fought divisions does not find it easy to practice social cohesion and solidarity, or to imagine how the actions of one group are inter-connected to the security and health of another. Systematic neglect of the healthcare and education infrastructure, and the undermining of scientific research and enquiry over decades, mean a diminished public appetite for reasoned debate and a skepticism towards scientific expertise. On top of that, those living in dense informal urban settlements in Karachi and other cities simply do not have the space or facilities required for self-isolating[2].

However, a protracted and effective lockdown might become vital in the coming weeks and months if the number of confirmed cases and deaths in Pakistan begins to climb. Revamping the healthcare system and putting in place policies that prioritize citizens' welfare will yield results in the long-term. More immediately, the government needs a clear and coordinated public messaging campaign that spells out the risks of widespread transmission of the Coronavirus and why staying at home is a necessary public health strategy. Accurate reporting of numbers matters, while confused and conflicting statements by the political leadership further undermine public trust and need to stop.

[2] Karachi Urban Lab, *Why the COVID-19 Crisis is an Urban Crisis*
https://www.dawn.com/news/1544933

Enlisting the support of community networks and local-level leadership and rendering the message legible to different linguistic and ethnic groups are also important. It is urgent to provide a guaranteed basic income and enhanced social safety net for vulnerable social groups who are facing lost or diminished earnings, before we ask them to make more sacrifices for the common good.

THE STRENGTH OF COMMUNITY TIES

There is a good amount of sociological research available on disaster preparedness, management and recovery, drawing lessons from cases as diverse as the Indian Ocean Tsunami of 2004, Hurricane Katrina in 2005, the SARS and Ebola epidemics, and recent earthquakes in many countries including Pakistan[3]. Whether the roots of a disaster are natural, technological or economic, it is inevitably the social and political arrangements that shape who bears the brunt of the damage, how quickly the crisis is contained or exacerbated, and what the aftermath looks like.

A key finding of this literature is that community resources and networks can make all the difference in how robust the response and recovery efforts in a disaster are. Whether it is for delivering essential supplies or information, helping in safe and reliable evacuation efforts, or providing extra attention and care to the most vulnerable members, it is those with local ties and knowledge who can move fast and effectively to assist external organizations. Similarly, public health services also rely on community participation and support as in the case of basic healthcare delivery through the Lady Health Workers program or community-supported vaccination drives for the polio eradication campaign in Pakistan.

In the current COVID-19 crisis in Pakistan, this means that we would do well to enlist the support of existing organizations that have a history of working on the ground with specific communities. This would be important for successful awareness campaigns but also for the door-to-door delivery of food rations, screening and medical aid, and other forms of targeted relief. The government needs to partner with credible and vetted community groups, NGOs, charity services, religious organizations and others for this purpose. Creating a new organizational network from scratch, such

[3] For instance, see Kathleen Tierney, *The Social Roots of Risk: Producing Disasters, Promoting Resilience*, Stanford University Press, 2014; Eric Klinenberg, *Heatwave: A Social Autopsy of Disaster in Chicago*, University of Chicago Press, 2002; and the Social Science Research Council, *Understanding Katrina* https://items.ssrc.org/category/understanding-katrina/

as the Prime Minister's Corona Relief Tiger Force consisting of volunteers, is an experiment that we cannot afford during a time of crisis.

GENDERED DISPARITIES

It is often women who are disproportionately affected by adverse events or a deterioration in collective well-being, and we are finding similar patterns emerging during this pandemic. The loss of jobs in the informal economy is one mechanism through which this is happening. An inability to meet daily subsistence needs of families is a source of stress for any individual in low-income groups, but for women this can also translate into reduced autonomy, respect and decision-making roles within the household. The gendered division of household labor means that, across all income groups, the additional burden of care-giving, cooking and cleaning, securing clean water, and looking after children who are no longer going to school falls mostly upon women even when they have the luxury of being able to carry out paid work from home. Familial and community support networks for assisting with childcare or emotional sustenance are also not available.

The increased risk of domestic abuse and violence is another consequence, already being reported from the United Kingdom, China, France and other countries[4]. Being socially isolated and forced to stay within the confines of home means women, children, young people and elderly dependents are even likelier to face emotional, verbal and physical abuse from family members who wield authority over them. Patterns of gendered relations persist even during periods of great social uncertainty and anxiety. We can catch a glimpse of this in reported incidents of harassment that Pakistani female doctors are facing while they work through this emergency[5].

Policymakers, governmental and non-governmental organizations, and community groups all need to recognize the unevenly distributed impacts of the current public health and economic crisis, and to build adequate protections. This is especially true because many crises in the coming future are going to take on similar contours and we need to be prepared to deal with them, whether it is catastrophic climate changes or new diseases and threats that easily travel across borders.

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[4] World Health Organization, *COVID-19 and violence against women: What the health sector/system can do* https://www.who.int/reproductivehealth/publications/emergencies/COVID-19-VAW-full-text.pdf

[5] Sonia Ashraf, *Even during a pandemic, female doctors are facing harassment* https://images.dawn.com/news/1184941