

Health Diplomacy as Geopolitical Statecraft: India–China Competition During Covid-19

A Comparative Analysis of Vaccine Maitri and the Health Silk Road

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Abstract

The COVID-19 pandemic elevated health assistance to a primary instrument of geopolitical statecraft. This paper offers a comparative analysis of how India and China — Asia's two dominant strategic competitors — deployed health diplomacy as a calculated tool of soft-power projection during 2020–2022. Through India's Vaccine Maitri initiative and China's Health Silk Road, both nations instrumentalised humanitarian assistance to consolidate regional influence, counter bilateral rivalry, and present themselves as responsible global-health actors. Drawing on Joseph Nye's soft-power theory and neo-realist frameworks, the paper conducts a qualitative comparative analysis of strategic intent, execution, reception, and outcomes across South Asia, Africa, and Latin America. It finds that China achieved greater short-term geographic penetration and supply continuity, while India's credibility advantage — rooted in manufacturing legitimacy, COVAX integration, and vaccine transparency — yielded more durable returns in states sceptical of Chinese vaccine quality. Neither strategy was purely humanitarian; both were instruments of deliberate statecraft at the intersection of health governance and geopolitical competition.

Keywords: Health Diplomacy, Vaccine Diplomacy, Soft Power, Vaccine Maitri, Health Silk Road, India–China Competition, COVID-19, Global South, COVAX.

1 INTRODUCTION

When the World Health Organization declared COVID-19 a pandemic on 11 March 2020, the global order confronted a challenge that was simultaneously medical, economic, and political (WHO, 2020). Vaccines, once available in late 2020, became tradeable geopolitical commodities distributed by strategic calculus as much as by epidemiological need. India and China — bilateral rivals with contested borders and competing regional-influence claims — occupy a singular position in this story. China moved first, deploying PPE through its "Health Silk Road" (an extension of the Belt and Road Initiative) before transitioning to Sinovac and Sinopharm vaccine diplomacy across more than ninety countries. India, leveraging the Serum Institute of India (SII), launched Vaccine Maitri ("Vaccine Friendship") in January 2021, dispatching AstraZeneca-licensed Covishield doses to neighbours, African states, and COVAX partners.

This paper asks: to what extent did India and China conceptualise vaccine assistance as geopolitical statecraft rather than pure humanitarianism; how did domestic constraints — India's second wave and China's vaccine nationalism — shape the reach and credibility of each strategy; and which approach generated more durable diplomatic influence in South Asia, Africa, and ASEAN? The thesis advanced is that pandemic-era health diplomacy was a deliberate, structurally embedded form of statecraft: China's Health Silk Road achieved broader initial penetration, but India's Vaccine Maitri — despite its abrupt suspension — ultimately yielded more resilient soft-power dividends where recipients weighed political conditionality and vaccine-quality uncertainty against India's multilateral legitimacy.

2 REVIEW OF LITERATURE

Health diplomacy scholarship has evolved considerably since Katz and Singer (2007) defined it as the negotiation processes shaping the global health–foreign policy interface. Fidler (2010) showed that health had become securitised and instrumentalised in great-power competition well before COVID-19. Nkengasong et al. (2020) examined China's early "protective-equipment diplomacy" in Africa, while Singh and Dey (2021) offered an early assessment of Vaccine Maitri as a translation of India's pharmaceutical advantage into diplomatic currency. Hotez (2014) anticipated the weaponisation of vaccines through "vaccine nationalism," and Bollyky and Bown (2020) warned presciently of the geopolitical fragmentation of vaccine access. Menegazzi (2022) reads Chinese vaccine diplomacy as a hybrid of commercial interest, soft power, and partner consolidation, while Panda (2021) shows Vaccine Maitri similarly entangling commercial, diplomatic, and humanitarian rationales.

Despite this growing body of work, systematic comparative assessments placing India and China's pandemic health diplomacy within a single analytical framework, and tracing outcomes across comparable recipient geographies, remain scarce. This paper addresses that gap.

3 THEORETICAL FRAMEWORK

Joseph Nye's soft-power theory — the ability to achieve foreign-policy goals through attraction rather than coercion — provides the primary lens (Nye, 2004). Soft power is not automatically generated by benevolent acts; it depends on how recipient audiences interpret them, which is analytically decisive when comparing Indian and Chinese vaccine diplomacy. Neo-realist assumptions about structural great-power competition (Waltz, 1979) supply a complementary lens: both states' declared altruism coexisted with a consistent effort to maximise relative advantage over the other, with India's neighbourhood prioritisation read partly as a response to China's periphery outreach, and vice versa. A third strand, global-health-governance scholarship, examines how the pandemic exposed fractures between national sovereignty, commercial pharmaceutical interests, and WHO coordination — with China initially instrumentalising its WHO relationship and India embedding Vaccine Maitri within COVAX to claim multilateral legitimacy.

4 METHODOLOGY

The study employs a qualitative comparative case-study method, assessing both strategies across five dimensions: strategic intent, operational execution, diplomatic messaging, reception in key recipient geographies, and long-term geopolitical implications. Primary sources include MEA and Chinese MFA statements, COVAX/UNICEF/WHO data, and recipient-government statements; secondary sources include peer-reviewed literature and verified media reporting. Limitations include the opacity of Chinese decision-making, non-uniform recipient-state responses, and the still-unfolding nature of long-term consequences.

5 RESULT: COMPARATIVE STRATEGIC ANALYSIS

India's Vaccine Maitri unfolded through evacuation and hydroxychloroquine diplomacy (early 2020) before its formal launch on 20 January 2021, structured around grant assistance, commercial supply, and COVAX deliveries. Between January and April 2021 India exported roughly 66.4 million doses to over 95 countries — the largest early COVAX supplier — before the catastrophic second wave (April–May 2021) forced a total export halt. The suspension disrupted supply to Bangladesh, Nepal, Sri Lanka, and African partners, and handed China a ready-made counter-narrative of reliability.

China's Health Silk Road predated the vaccine phase, distributing PPE to over 150 countries from February 2020 before pivoting to Sinovac/Sinopharm exports that reached over ninety countries by mid-2021, targeted heavily at BRI partners (Pakistan, Bangladesh, Sri Lanka) and strategically sensitive states (the Philippines). China's centralised apparatus sustained continuity of supply even through India's export halt, but proprietary, less-transparent trial data generated recurring efficacy concerns — as in Chile (56.5% efficacy against symptomatic

infection; Jara et al., 2021) and Thailand — that complicated its soft-power returns in states with independent regulatory capacity. Table 1 summarises the comparative strategic architecture.

Table 1: Comparative Strategic Framework — Vaccine Maitri vs Health Silk Road

Dimension	India — Vaccine Maitri	China — Health Silk Road
Strategic Intent	Reinforce "Neighbourhood First"; project pharmacy-of-the-world identity; counter Chinese influence	Extend BRI soft power; overcome pandemic-origin stigma; consolidate strategic partnerships
Primary Vehicle	Covishield (AstraZeneca-licensed, SII-produced)	Sinovac / Sinopharm (proprietary)
Distribution Channel	Bilateral grants + COVAX (multilateral)	Predominantly bilateral; limited COVAX
Geographic Focus	South Asia, Africa, Pacific, Latin America	BRI partners, South Asia, Africa, ASEAN, Latin America
Approx. Volume	~66.4 million doses (Jan–Apr 2021)	>1 billion doses (2020–2022)
Continuity of Supply	Suspended April 2021 (second wave)	Sustained; no major interruption
Vaccine Credibility	High (WHO EUL; established AstraZeneca trial data)	Mixed (efficacy questions; limited data transparency)
Perceived Conditionality	Low to moderate	Moderate to high
Long-term Soft-Power Return	High in South Asia and Africa (credibility premium)	Mixed; contested in ASEAN and Latin America

Sources: MEA (2021); MFA, PRC (2021); Bridge Consulting (2021); UNICEF (2021); Our World in Data (2021).

5.1 Regional Reception

In South Asia, the most contested theatre, Nepal accepted 1 million Covishield doses in January 2021 before pivoting to 800,000 Sinopharm doses in June 2021 once Indian supply lapsed — a pragmatic hedge rather than an ideological shift. Bangladesh's Serum Institute contract for 30 million doses yielded only 7 million before the halt, compelling a pivot to 12 million Sinopharm doses and reinforcing a Chinese narrative of reliability. Sri Lanka, structurally indebted to China through Hambantota, accepted both suppliers, while Bhutan and the Maldives — largely insulated from Chinese vaccine diplomacy — registered clean Indian soft-power successes. In Africa, India's early COVAX-channelled supply, benefiting from WHO Emergency Use Listing in February 2021, gave it a credibility edge over Chinese doses awaiting equivalent listing, as seen in Kenya's cautious regulatory posture. In Latin America, Brazil's simultaneous procurement of Covishield and CoronaVac amid vocal domestic scepticism illustrated the limits of both countries' soft power in middle-income states with strong regulatory and civil-society capacity.

5.2 Key Findings

Four findings emerge. First, geographic targeting and the speed of diplomatic messaging on both sides indicate deliberate statecraft, not epidemiological need alone — though humanitarian benefit and strategic design were mutually reinforcing rather than contradictory. Second, supply reliability proved more diplomatically valuable than initial speed or pledged volume: India's first-mover advantage converted into liability once exports halted, while China's continuity — even at a slower pace — paid durable dividends in Nepal, Bangladesh, and Zimbabwe. Third,

a credibility–volume tension emerged: Covishield's WHO endorsement and transparent trial data carried more weight than raw dose numbers in markets capable of independent scrutiny, limiting the returns on China's larger volumes. Fourth, India's COVAX embedding functioned as a legitimacy asset, allowing recipients to accept Indian-produced vaccines with lower diplomatic overhead than purely bilateral Chinese deals.

6 RECOMMENDATIONS

Middle and emerging powers pursuing health diplomacy should build contingency and surge-capacity architecture — including secondary suppliers and TRIPS-flexible production agreements — before committing to large-scale export pledges, so that domestic shocks do not convert soft-power gains into liabilities. Embedding bilateral health assistance within multilateral channels such as COVAX should be treated as a legitimacy strategy that complements, rather than substitutes for, bilateral outreach. Recipient states, and the donors courting them, would benefit from transparent, internationally verifiable clinical data as a precondition for durable diplomatic returns, particularly in markets with independent regulatory capacity.

7 FUTURE RESEARCH DIRECTIONS

Future work should track the medium-term recalibration of India–China health diplomacy after 2022, assess the durability of recipient-state "strategic balancing" behaviour, and examine how post-pandemic institutions — the Coalition for Epidemic Preparedness Innovations, the WHO pandemic-treaty process, and G20 health-preparedness discussions — are reshaping the rules under which future health crises will be diplomatically instrumentalised.

8 CONCLUSION

The India–China vaccine-diplomacy competition illustrates with unusual clarity how major powers translate domestic capacity — here, pharmaceutical manufacturing — into external influence through deliberate strategic packaging. India's Vaccine Maitri showed that credible manufacturing capacity and multilateral embeddedness can generate substantial diplomatic capital, but that this capital is only as resilient as the supply chain underpinning it; the April 2021 halt was a strategic failure of contingency planning, not of the underlying export logic. China's Health Silk Road demonstrated the advantages of centralised, sustained, geographically diversified distribution, but its quality-credibility problem and perceived conditionality limited returns in markets with independent evaluative capacity. Neither approach was uniformly superior: China gained ground where India's supply failed; India held or recovered ground where credibility and multilateral legitimacy mattered more than volume. For both powers, COVID-19 was a preview rather than a conclusion — health diplomacy will remain an active instrument of statecraft as future health crises intersect with an increasingly multipolar order.

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