



## RESEARCH BRIEF

# WHO GETS PRIORITY FOR COVID-19 VACCINATIONS? ETHICAL AND PRACTICAL CHALLENGES IN SOUTH ASIA

This paper is one of a series of research elements produced by the European Union funded AHA! Awareness with Human Action project that seeks to contribute to the response efforts of the COVID-19 pandemic by preventing conflict and building social cohesion in Pakistan, Sri Lanka, Bangladesh and broader South Asia. The AHA! project is implemented by a consortium of project partners, including the Network for Religious and Traditional Peacemakers/Finn Church Aid, World Faiths Development Dialogue, the Center for Peace and Justice – Brac University, the Center for Communication and Development of Bangladesh, Islamic Relief Worldwide, the Youth Development Foundation, and Sarvodaya.

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## EXECUTIVE SUMMARY

A central challenge during the global COVID-19 crisis has been stark inequalities in care and impact. Nowhere is the need to balance concerns to assure equity and to meet public health priorities so apparent as in vaccination programs. This links both to policies that set priorities for allocating scarce vaccination resources and to communicating information that communities urgently need. Inequitable sharing of vaccines and poor communication detract from the vaccination efforts that are so essential to controlling the pandemic. These challenges are especially severe in South Asia's populous and diverse countries where existing identity-based conflict fault lines isolate and stigmatize certain groups, thus complicating vaccination rollout. Trust deficits hamper programs and adherence to guidelines even with proper messages. Women in particular are disparately impacted by the crisis because of their caretaking roles and lower access to information, particularly in digital spaces.

This brief highlights ethical and practical dimensions of COVID-19 vaccination, focusing on South Asia and Pakistan, Bangladesh, and Sri Lanka, and on issues of equity in vaccine access. Addressed both to policy makers and civil society actors, it summarizes contemporary debates and offers some operational proposals to promote equitable vaccine access in the region.

## ACCESS TO VACCINES

Vaccine allocation and prioritization presents knotty issues in the global response to COVID-19. Disparities in vaccine availability between wealthier and poor nations is widely decried by leaders across the world.<sup>1</sup> Many countries with strong health care systems and ample resources have given priority to their own populations. Delays and disruptions in COVAX, the global vaccine sharing facility, exacerbated caused vaccine shortages in many poorer countries. Priority issues also apply at national levels, with a need to focus on vulnerable groups and to assure transparency.

<sup>1</sup> For example <https://news.un.org/en/story/2022/02/1112722>

This image shows graphically the wide disparities in vaccination rates by region<sup>2</sup>:



In South Asian countries, multiple waves of infection and limited vaccine supplies exact heavy health and economic tolls. Disadvantaged groups, notably rural residents, slum dwellers, prisoners, migrants, and daily wage earners, experience the worst effects of the pandemic. They face distinctive barriers to vaccination. Widespread and increasing vaccine hesitancy, skepticism, and misinformation since the start of the pandemic hinder official vaccination campaigns, further adding to the tensions between authorities and different communities.

## VACCINATION ETHICS ARE COMPLEX

In late 2020, the World Health Organization (WHO) issued a 6-point [Values Framework](#) for global vaccine distribution and a [Roadmap](#) to guide national governments in COVID-19 vaccine allocation and prioritization. WHO provides an unranked list of more than 20 at-risk and high-priority groups, with priority fluctuating based on the existing burden of disease, the stage of COVID-19 infection in the community, the availability of the vaccine, and specific groups' vulnerability to severe illness or death.

WHO's overarching goal for COVID-19 vaccination balances "both the value of producing benefit, broadly construed, through the promotion of human well-being, and the value of ensuring equitable access to these benefits."<sup>3</sup> This approach

<sup>2</sup> <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/vaccination-rollout-and-access/>; data as of March 11, 2022, shows % receiving at least one vaccine dose.

recognizes a diversity of contexts and possible approaches. WHO's goals have, regrettably, not been attained in many countries.

When vaccination of a certain group would fulfill objectives tied to multiple values, there is a clear mandate for prioritization. For instance, frontline health workers bear additional risks because of their exposure to the coronavirus and are vital to the public health response. Failing to urgently protect health workers would represent a moral shortcoming (a failure to honor the value of *reciprocity*) and amplify the overall effects of the pandemic on society (a failure to uphold the value of *human well-being*) by straining the health care system, causing greater loss of life, and bringing attendant economic harm. Thus, frontline health workers are a high-priority demographic for vaccination.

When vaccines are scarce and demand is high, governments face difficult choices. For instance, the elderly are more likely than the general population to experience severe illness or death from COVID-19. However, slum dwellers have numerous risk factors for infection and could be disproportionately affected by the coronavirus due to crowded living conditions, lack of adequate sanitation, poor nutrition, high-risk professions, and, on average, a higher number of dependents. With limited vaccines available, should a wealthier senior citizen receive the vaccine first, or a slum resident who is the primary earner for a large household? Officials must consider such complex questions in order to distribute vaccines equitably and avoid increasing tensions in society.

Economic factors are also significant. Prolonged shutdowns increase unemployment, poverty, and mental and emotional strain, and therefore contribute to broader social problems and inequalities. Should governments prioritize vaccinating workers in core industries so that the economy can restart? Where do migrant workers and low wage earners—people most vulnerable to homelessness and food insecurity—rank in prioritization?

Equity requires taking historical injustices into account. Marginalized communities, such as ethnic and religious minorities, often face greater barriers to accessing public services, higher disease burdens, and poorer living conditions than the general population. In the United States, for example, Black, Latino, and Native American COVID-19 patients have

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3 WHO SAGE Values Framework for the Allocation and Prioritization of COVID-19 Vaccination,” p. 6.

been hospitalized at roughly four times the rate of other infected Americans.<sup>4</sup> How should these variables shape vaccination policy? Gender might also be a relevant factor: Men are at greater risk of severe illness or death from COVID-19, but women in traditional societies are more likely to occupy high-risk professions and have limited access to information and medical care. Should vaccine prioritization aim to offset gender inequality?

In short, vaccination ethics are anything but simple. Leaders must carefully consider the ethical imperatives in the local context, balancing the greatest good for the greatest number of people with the value of equity.

## INEQUALITY, VACCINE DIPLOMACY, AND EFFECTIVENESS IN SOUTH ASIA

South Asia features some of the world's densest cities, largest urban slums, largest refugee and migrant populations, and highest rates of gender inequality. Large segments of society are vulnerable to COVID-19's worst health, social, and economic effects and lack easy access to information. Amnesty International highlights “slum dwellers, Dalits, ethnic minorities, workers including labourers, daily wage earners, sanitation workers, garment workers and tea plantation workers, people in rural areas, prisoners, and internally displaced people” as well as refugees and migrants as some of those most likely to be neglected by official vaccination campaigns.<sup>5</sup>

The origin and relative effectiveness of different vaccines also raise ethical and political questions. Fragile health systems and global supply chain disruptions have compelled several South Asian countries to rely heavily on Chinese vaccines, whose efficacy is being questioned due to a lack of peer-reviewed clinical trial data and recent outbreaks in countries that relied on Chinese vaccines.<sup>6</sup>

In the first three months of 2021, India was a major regional and global vaccine supplier, exporting some 60 million doses of the AstraZeneca vaccine to more than 70 countries. Following a surge in COVID-19 cases in March 2021, India suspended delivery guarantees to Bangladesh, Nepal, and Sri Lanka to meet domestic demand. China, and to a lesser extent Russia,

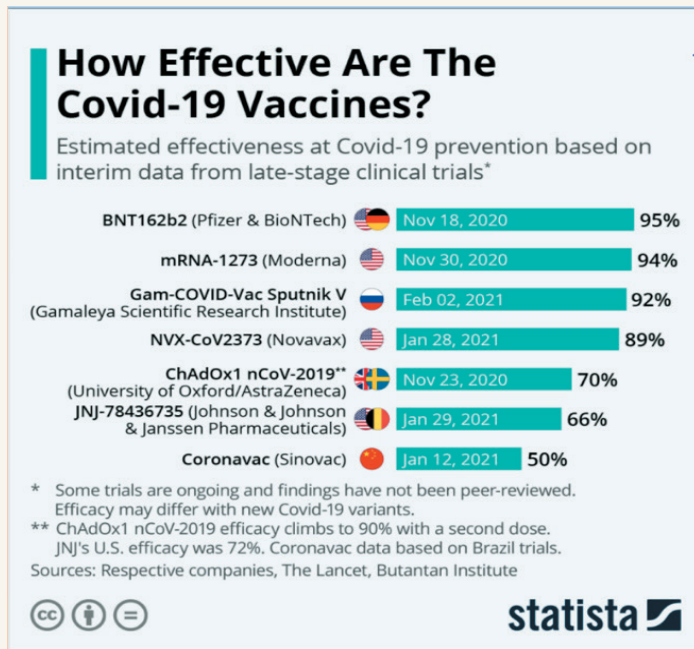
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4 <https://www.cnn.com/2020/11/16/health/cdc-black-hispanic-native-american-coronavirus-hospitalizations/index.html>

5 <https://www.amnesty.org/en/latest/news/2021/04/south-asian-governments-must-ensure-equitable-access-to-COVID-19-vaccines/>

6 <https://www.ft.com/content/dd7ca21d-d779-45d8-aca5-c8f86f94f15e>

have sought to fill this gap. China has supplied (as of late 2021) at least 7.1 million vaccines to Sri Lanka and 1.1 vaccines to Bangladesh, and Pakistan received some 13 million Sinopharm, CanSinoBio, and Sinovac vaccines. Russia supplied smaller quantities of the Sputnik V vaccine to Pakistan, Bangladesh, Sri Lanka, and Nepal.



Effectiveness rates of different COVID-19 vaccines compared. Source: Statista

These vaccine sources are vital for South Asian countries facing shortages, but they raise troubling political questions. China and India are regional rivals, and China has made significant economic investments in Pakistan, Sri Lanka, and Bangladesh. China’s port and infrastructure projects in Sri Lanka, for example, have generated anxiety and criticism over foreign influence in local affairs.<sup>7</sup> While COVID-19 vaccines are welcome in any under-resourced country, there are legitimate concerns that China’s high-volume vaccine supply creates indebtedness and diplomatic leverage over smaller regional countries.<sup>8</sup>

The relative effectiveness of different vaccines also has ethical implications for prioritization. Until recently, South Asian nations could not procure large quantities of the more effective, U.S.-produced Pfizer and Moderna vaccines.<sup>9</sup> Who

<sup>7</sup> <https://asia.nikkei.com/Spotlight/Belt-and-Road/China-s-control-over-Sri-Lankan-infrastructure-reignites-fears>

<sup>8</sup> <https://www.futuredirections.org.au/publication/chinas-vaccine-diplomacy-the-health-silk-road-and-a-global-pledge/>

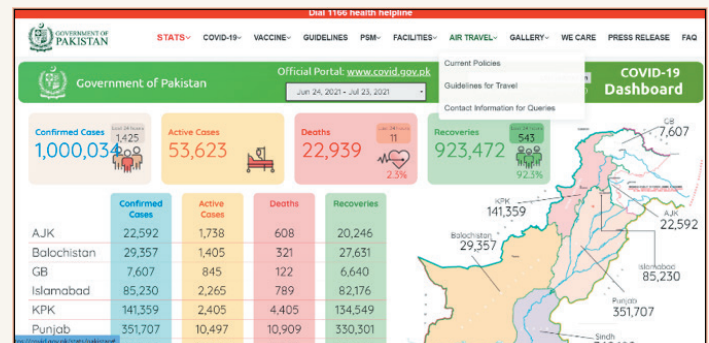
<sup>9</sup> <https://www.biospace.com/article/comparing-covid-19-vaccines-pfizer-biotech-moderna-astrazeneca-oxford-j-and-j-russia-s-sputnik-v/>

gets these more effective shots, and how governments make such determinations, is an important question.

## SELECTED COUNTRY CASES

### PAKISTAN

The Pakistani government began vaccinating frontline health workers with donated Sinopharm vaccines in February 2021. It later administered vaccines from two different Chinese manufacturers, CanSino and SinoVac, and limited supplies of AstraZeneca, Sputnik V, and Pfizer vaccines. Although eligibility has been expanded, vaccination has proceeded slowly due to widespread hesitancy and misinformation, vaccine shortages, and digital barriers to registration. Notions that COVID-19 vaccines cause infertility or even death, or that they contain microchips or alter DNA, are prevalent in Pakistan.



The Government of Pakistan’s webpage for COVID-19 statistics and updates (Source: <https://covid.gov.pk/stats/pakistan>).

As of mid-March, 2022, roughly 59% of Pakistan’s population—had received at least one dose of the vaccine.<sup>10</sup> The vaccine is now available to those age 18 and above, but vaccine hesitancy remains a major barrier.

National ID requirements exclude an estimated 3 million people from the government vaccination campaign—predominantly unregistered Afghan and Rohingya migrants and refugees, but also some rural Pakistanis.<sup>11</sup> The Human Rights Commission of Pakistan found that the pandemic had “exposed the shortcomings of the healthcare sector, both in terms of preparedness and access to facilities,” highlighting the plight of inmates in Punjab Province’s jails, factory workers, and daily wage earners.<sup>12</sup>

<sup>10</sup> <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/vaccination-rollout-and-access/>

<sup>11</sup> <https://www.dawn.com/news/1625073>

<sup>12</sup> <http://hrpc-web.org/hrpcweb/vulnerable-groups-hit-hardest-by-pandemic-in-2020-in-punjab/>

## BANGLADESH

Bangladesh's COVID-19 vaccination campaign stalled in April 2021 after India cancelled its supply of the AstraZeneca vaccine. The country has since diversified its sources, procuring Sinopharm and Sputnik V vaccines and the Moderna vaccine through COVAX. Although Bangladeshis age 18 and above are eligible for vaccination, skepticism, misinformation, and ongoing vaccine shortages remain a serious challenge. App-based registration also poses a barrier for populations without the necessary digital skills or reliable internet access. As of March, 2022, an estimated 77% of Bangladesh's population had received at least one dose of vaccine.<sup>13</sup>

The government is criticized for failing to prioritize the country's roughly 4 million garment workers, who represent a major pillar of the economy and often work in hazardous conditions for low wages. Another highly vulnerable population is the nearly 1 million Rohingya refugees living in crowded camps in Cox's Bazar. Vaccination strategies there are unclear. A national ID requirement initially prevented expatriates from registering for vaccination, but the online portal since accepts passport details as an alternative.

## SRI LANKA

Sri Lanka began vaccinating frontline health workers, police, and armed forces with donated AstraZeneca vaccines from India in late January 2021. After the disruption of the Indian supply chain, it relied largely on Sinopharm vaccines. It has also administered smaller quantities of the Sputnik V and American Pfizer-BioNTech vaccines, and doses of the Moderna vaccine, available through COVAX. The Sri Lankan government has approved China's Sinovac vaccine for emergency use.

As of March 10, 2022 an estimated 79% of the population had received at least one dose of vaccine.<sup>14</sup> Eligible groups included frontline workers, the military and police, teachers, and those age 60 and above. People in the 30–60 age group had been vaccinated in a number of districts.

Amnesty International has voiced concerns about several aspects of Sri Lanka's vaccination campaign, including ad-hoc prioritization, preferential treatment for government officials, opaque communications and planning, and failure to protect

<sup>13</sup> <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/vaccination-rollout-and-access/>

<sup>14</sup> [https://ourworldindata.org/explorers/coronavirus-data-explorer?zoom-ToSelection=true&pickerSort=desc&pickerMetric=total\\_vaccinations&Interval=Cumulative&Relative+to+Population=true&Align+outbreaks=false&country=~LKA&Metric=People+vaccinated](https://ourworldindata.org/explorers/coronavirus-data-explorer?zoom-ToSelection=true&pickerSort=desc&pickerMetric=total_vaccinations&Interval=Cumulative&Relative+to+Population=true&Align+outbreaks=false&country=~LKA&Metric=People+vaccinated)

high-risk populations such as prisoners and garment workers.<sup>15</sup> The requirement of a national ID number for vaccination excluded Sri Lankans who might have lost their ID cards or never registered in the first place, as well as unregistered migrants.

## CONCLUSIONS AND PROPOSALS FOR ACTION

Pandemic and public health responses in South Asia have evolved rapidly. Governments are scaling up domestic pharmaceutical manufacturing, vaccine doses are arriving in larger quantities through bilateral agreements and COVAX, and countries are moving closer to reaching their vaccination targets. All of this is good news for a hard-hit region. However, new challenges lie ahead. The deadlier and more contagious Delta viral variant and then Omicron spread rapidly. Several countries face successive waves of infections, inflicting more fatalities and threatening to drive communities deeper into poverty. If large parts of society are not vaccinated soon, vaccine-resistant mutations of the virus will have time to develop. This could contribute to instability in some of the more conflict-prone countries.

Government officials, NGOs, and community leaders need to coordinate their efforts to ensure that the most vulnerable and marginalized members of society can access the vaccine—those most likely to be excluded from official health campaigns. The following actions could support pertinent interventions.

**1. Reach across digital divides.** Official information campaigns and vaccine registration processes have so far been almost exclusively online or app-based, posing significant barriers for the many people who do not have reliable, high-speed internet access on a mobile device, may not be sufficiently literate to get information and register for vaccination, or lack the digital literacy to navigate online information and appointment systems. People who are rural, low-income, female, elderly, and/or migratory are the most likely to face digital access issues. National ID requirements also prevent large numbers of undocumented migrants, refugees, and rural residents from getting vaccinated. To ensure equitable access to the vaccine, governments can highlight specific measures to strengthen work with community-based organizations to:

- Identify specific demographics most likely to be missed by information campaigns due to digital barriers and/or marginalization;

<sup>15</sup> <https://www.amnesty.org/download/Documents/ASA3742622021ENGLISH.PDF>

- ■ End national ID-based requirements for vaccination or create accessible workarounds for people without a national ID;
- ■ Disseminate vaccine information orally, e.g., through home visits and mosque announcements;
- ■ Increase radio and television campaigns for vaccine awareness and registration;
- ■ Develop simple, accessible alternatives to online registration processes, e.g., by making physical registration forms available at local pharmacies, clinics, and hospitals;
- ■ Equip community volunteers to help semi- or illiterate populations complete paperwork.



**2. Engage trusted sources strategically to overcome vaccine hesitancy and skepticism.** Even as vaccine availability increases in South Asia, rumors and misinformation continue to circulate rapidly. Official campaigns to counter misinformation do little to convince groups that are already mistrustful of the state—particularly in communities that have experienced systematic violence or exclusion. The source of information matters. To overcome vaccine hesitancy and skepticism, religious leaders, educators, and other trusted community sources can:

- ■ Share accurate vaccine information and combat misinformation personally, in their own circles of influence—e.g., through sermons, lectures, and community forums;
- ■ Appeal, as appropriate, to sources of authority other than the government and the scientific community—e.g., religious and cultural rationales for vaccination;
- ■ Demonstrate the need for vaccination and the trustworthiness of vaccines by publicizing their own vaccination.