**Invitation to reflection and engagement on ethical issues related to COVID-19 vaccine distribution**

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Finally, there is a light at the end of the COVID-19 tunnel. There are nearly 200 vaccine candidates currently in development and clinical trial processes. More than ten vaccines are in Phase 3 large-scale trials, from which some very promising results have emerged. Several vaccines have already received emergency or limited authorization, and vaccination programmes are now beginning in some countries. Hopes are rising of an end to the pandemic, to the deaths and suffering it has caused, and to the impacts it has had on all our lives, societies and economies.

However, despite the unprecedented speed with which these vaccines are being developed, tested and approved, they do not offer an immediate or complete solution to the pandemic. Global need and demand will certainly outstrip supply in the short to medium term. There is not expected to be enough vaccine for the world's total population until 2023 or 2024. Consequently, governments, relevant authorities and medical practitioners will be obliged to make difficult decisions on priorities for the rollout and distribution of limited available supplies of this resource.

Since such decisions are fundamentally ethical in nature, religious leaders and organizations have a critical role and responsibility to be engaged in relevant policy discussions.

At the international level, a key concern is for global equity in the distribution of available vaccines, so that poorer countries are not excluded from access to these life-saving products. COVAX – a partnership between GAVI (Global Alliance for Vaccines and Immunization), WHO (World Health Organization), and CEPI (Coalition for Epidemic Preparedness Innovations) – has been established to address this concern, and to offer COVAX-supported countries equitable access to effective vaccines. The majority of high- and middle-income countries have committed funding to COVAX, to assist lower-income countries in accessing vaccine supplies. COVAX aims to provide two billion doses by the end of 2021 to protect high-risk populations in poorer countries around the world, and in the longer term to provide them with enough doses to cover 20% of their populations.

Despite this public commitment to international solidarity, 'vaccine nationalism' remains a serious concern. Direct deals made by high-income (and some middle-income) countries result in a greatly reduced potential supply for equitable global allocation. Many high-income countries have made advance purchases of enough doses of different vaccine candidates to vaccinate their populations several times over.[1] This is a moral issue that warrants comment and action by religious leaders.

At the domestic level, the allocation of limited supplies of COVID-19 vaccines will ultimately be made by each national government according to its own context and assessed risk. Frameworks for the allocation of scarce resources should be based on a clear and specific choice of the priority objective/s most valued in that context. As acknowledged in a WHO-developed Concept for fair access and equitable allocation of COVID-19 health products, "science and/or evidence alone cannot tell us which choice or aim is 'correct' or which aim society should value most. This requires a value judgement, which is the domain of ethics."

In the Christian and Jewish traditions, some of the key scriptural foundations upon which the reflections and actions of religious leaders and communities should be based include the following:

- The God-given dignity and worth of every human being. (Genesis 1:27)
- The commandment to love our neighbours as ourselves. (Leviticus 19:18; Mark 12:31)
- The faith calling to especially care for the weakest and most vulnerable among us. (Isaiah 1:17; James 1:27)

In their engagement in national conversations about vaccine allocation, religious actors should consider the following principles and issues:

- Equity: Available resources should be allocated without discrimination – i.e. without unjustified unequal treatment on grounds of characteristics such as race, ethnicity, colour, gender, sexual orientation, age, religious affiliation, nationality, social status or ability to pay.
- The human right to health: As a matter of international human rights law, every human being has the right *to the enjoyment of the highest attainable standard of physical and mental health.*[ii]
- All measures should be guided by the aim of minimising the number of deaths and preserving as many lives as possible.
- Which objectives should be given most value/priority? Some alternatives for consideration in this regard include the following:
    - Bringing about the swiftest end to the pandemic (i.e. the 'greater good');
    - Protecting the most vulnerable/those at greatest risk of becoming seriously ill if infected;
    - Ensuring that health workers are protected and that the public health system is not overwhelmed and continues to be able to support public health needs;
    - Avoiding general and long-term harm to the economy and to the livelihoods of a majority of people; or
    - The welfare, education and future prospects of young people (who are in general less likely to become seriously ill from the virus).

The choice of which objectives should be prioritized – which may vary between countries and contexts – will define the strategies for allocation of vaccines in that country/context. But whichever choice is made, in a context of limited and insufficient resources, some will inevitably lose out despite having legitimate moral claims. It is therefore of critical importance that the choice itself, the moral justification for that choice, and the process through which that choice is made should be communicated publicly and transparently. Moreover, the choice should be consistently applied, in a non-discriminatory manner - i.e., if the vaccine is allocated on the basis of need/vulnerability, those with similar needs/vulnerabilities should be treated similarly.

Religious leaders should consider confronting publicly the unsubstantiated rumours and conspiracy myths, promoted without evidence, that undermine public trust in health authorities and services and in tested and approved vaccines themselves – and that thereby threaten an effective public health response to the pandemic. In some cases, such conspiracy myths have an explicitly antisemitic basis which should in any event be denounced. Senior religious leaders may wish to consider, for example, being vaccinated themselves in front of the media, ideally together to demonstrate inter-religious solidarity and cooperation, if such a demonstration would help diminish ungrounded fears and 'vaccine reticence' in their communities.

In some countries, relevant authorities may consider making vaccination compulsory, or an essential precondition for access to certain public services or private facilities (including air travel). This is likely to be a controversial measure. However, while resources should in principle not be employed for treatments which a patient does not wish to receive, in the current exceptional context of efforts to control the global pandemic, legitimate public health considerations may justify measures that would otherwise be considered draconian.

This invitation is issued without the intention of prescribing specific approaches for application everywhere, but rather to encourage religious leaders and faith-based organizations to play their proper and needed role in contributing to public policy discussions on these critical issues that every society must consider in this pivotal moment.

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[i] Duke Global Health Innovation Center, Launch & Scale Speedometer: https://launchandscalefaster.org/COVID-19

[ii] International Covenant on Economic, Social and Cultural Rights, article 12(1); Universal Declaration of Human Rights, article 25(1)