Palacký University Olomouc

University of Clermont Auvergne

University of Pavia

MASTER THESIS

Right to Health for Migrants in Pakistan

Aaleen Mehboob

Supervisor: Lucie Macková

GLODEP 2022

Right to Health for Migrants in Pakistan

Aaleen Mehboob

Supervisor: Lucie Macková

Declaration

I hereby declare that this thesis entitled “Right to Health for Migrants in Pakistan” has been composed solely by myself as a prerequisite for the completion of the Erasmus Mundus Joint Master Degree in International Development Studies - GLODEP. I confirm that this thesis is the product of my own work except where indicated otherwise throughout the thesis by reference or acknowledgement.

Olomouc, Czech Republic

31 May 2022

Aaleen Mehboob

UNIVERZITA PALACKÉHO V OLOMOUCI

Přírodovědecká fakulta

Akademický rok: 2021/2022

ZADÁNÍ DIPLOMOVÉ PRÁCE

(projektu, uměleckého díla, uměleckého výkonu)

Jméno a příjmení:	**B.A. Aaleen MEHBOOB, BA (Hons)**
Osobní číslo:	**R200683**
Studijní program:	**N0588A330003 Development Studies and Foresight**
Specializace:	**Development Studies and Foresight – specialization in Global Development Policy**
Téma práce:	**Right to Health for the Migrants in Pakistan**
Zadávající katedra:	**Katedra rozvojových a environmentálních studií**

Zásady pro vypracování

The right to health for migrants through the perspective of human rights helps curtail discriminatory practices. It is estimated that more than 3 million undocumented and stateless people live in Pakistan. Social, political, and economic exclusion renders the vulnerable groups more exposed to the possibility of not getting vaccinated in the pandemic and risking an infection. This thesis will explore inclusive vaccine plans/strategies &, international best practices to safeguard those outside the ambit of the system, with a contextual analysis pertaining to Pakistan. It will employ a mixed-method analysis of the challenges faced by the undocumented in choosing to access vaccinations and administrative issues in recording or maintaining data.

Rozsah pracovní zprávy:	**10-15 tisíc slov**
Rozsah grafických prací:	**dle potřeby**
Forma zpracování diplomové práce:	**tištěná/elektronická**
Jazyk zpracování:	**Angličtina**

Seznam doporučené literatury:

https://www.dw.com/en/no-covid-jabs-for-pakistans-undocumented-people/av-58568442
https://reliefweb.int/sites/reliefweb.int/files/resources/60b8d6d84.pdf
https://apps.who.int/iris/bitstream/handle/10665/344793/WHO-2019-nCoV-immunization-refugees-and-migrants-2021.1-eng.pdf
https://picum.org/covid-19-vaccines-undocumented-migrants-international-guidelines/
https://migration.iom.int/sites/default/files/public/reports/Pakistan%20Migration%20Snapshot%20Final.pdf
https://www.sciencedirect.com/science/article/pii/S0264410X1930845X
https://www.mdpi.com/2075-471X/5/1/9

Vedoucí diplomové práce: **Lucie Macková, M.A., Ph.D.**
Katedra rozvojových a environmentálních studií

Datum zadání diplomové práce: **21. ledna 2022**
Termín odevzdání diplomové práce: **30. května 2022**

L.S.

doc. RNDr. Martin Kubala, Ph.D.
děkan

doc. RNDr. Pavel Nováček, CSc.
vedoucí katedry

V Olomouci dne 20. ledna 2022

Acknowledgements

It has been a challenge to feel like a student again 5 years after completing my undergraduate degree. Soon after I graduated in 2015, I started working as a civil servant in Islamabad, Pakistan, where I learned to draft official correspondence on behalf of the Government of Pakistan. I think in the process, I also disconnected with a personalized writing style. While academic writing is also technical and somewhat calculated it gave me a chance to reconnect, reflect and write.

In the final semester of my Master, wherein, I wrote this thesis I moved from one country to another with my husband for work. It required us to find a new life/home in Vienna, Austria. It has been quite a journey to continue seeking and learning how to belong. This thesis, in a way is about the legality of belonging and the privileges it accrues. Therefore, it also carries in it, an idea very close to my heart.

In this process, which carried within it waves of transformation at a personal and professional level; the guidance of my thesis supervisor Ms. Lucie Macková is what helped me to continue. I can never thank her for her patience, and feedback which has helped shape this thesis. Her conduct has been an example for me to aspire for as a professional, she was humble and humane in her approach even in times, I was not a perfect student.

I dedicate this thesis to my father who gave me an education & the will to build a life, my mother who invested her life in raising a family, my husband whose companionship is the most beautiful blessing of my life & lastly, my maternal grandmother who taught me to love & forgive.

I would also like to thank my friends; you know who you are and my beautiful cousin Wisha for proofreading my thesis.

Abstract

COVID-19 brought the world to a standstill, urging everyone to do their part to curtail the spread of the virus as no one was safe unless all of us were safe. Yet, those outside the privilege of clear citizenship status, in the precarious territory of statelessness, faced discrimination globally in accessing immunization services against COVID-19. Vaccination was primarily rolled out for legal residents of a country, with its records tied to identification documents. This research assesses the impact of a COVID-19 vaccination policy devised for Pakistani citizens on the undocumented Bihari, Bengali and Rohingya migrants in Karachi, Pakistan. The central objective of this research is to inductively explore the migrants' perception of COVID-19 and its treatment. The concerns and constraints of the humanitarian actors working in Karachi and a policy expert working at the national level are further employed to analyse the issue from the vantage point of those who could act as change-makers.

Keywords: undocumented migrants, statelessness, COVID-19, vaccinations, Pakistan

Table of Contents

List of Abbreviations

CAR	Commissionerate for Afghan Refugees
CNIC	Computerized National Identity Card
COVAX	COVID-19 Vaccines Global Access
GAVI (Gavi)	Global - Vaccine Alliance
INGOs	International Non-Governmental Organizations
IOM	International Organization for Migration
IPS	Institute of Policy Studies
LMIC	Lower Middle Income Country
NADRA	National Database and Registration Authority
NCOC	National Command and Operation Centre
NDVPs	National Deployment and Vaccination Plans
NGOs	Non-Governmental Organizations
NIC	National Identity Card
PCA	Pakistan Citizenship Act
SDGs	Sustainable Development Goals
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

List of Figures

List of Tables

1. Introduction

1.1 Statelessness and the Right to Health

Migration in essence is defined as movement from one place to another within or across a state/country but, in general, signifies a move from where one essentially belongs. This idea of belonging is what creates a sense of identity in modern nation-states symbolized through passports and identification documents. The status of citizenship once acquired/accorded to an individual is what renders membership to a person in democratic societies. It is the citizen who on the basis of this membership is able to enjoy the variety of civil, political and social rights within a country. The most important right bestowed on a citizen is the right to participate in law making; because a democratic state requires all its citizens to participates, it necessitates that those who reside within those geographical confines belong to it (Castles & Davidson, 2000).

While books like, The Next Great Migration (Shah, 2020) wherein the author extensively documents that it is but natural for living things to move; be it human, animals, insects, or plants. Migration is a complex phenomenon with many facets and definitions categorizing types and kinds of migration. In this research, we focus on undocumented migrants which the International Organization for Migration defines as “a non-national who enters or stays in a country without the appropriate documentation. Undocumented migrants may even, in the long term, be at risk of statelessness if it becomes impossible for them to obtain any evidence of their nationality” (International Organization for Migration, 2019).

In 2018, the United Nations High Commissioner for Refugees (UNHCR) estimated that there are over 12 million stateless persons around the world, those who are already in the precarious terrain of not being recognized legally anywhere. An exact figure remains a challenge to ascertain, as data collection in this regard has remained a precarious, often neglected, exercise. In Pakistan alone, it is estimated that currently, there are 3.5 million stateless individuals; it is their legal status under national law which hampers their access to, healthcare services in addition to other services. While international and national laws are created to protect human beings, often the absence of an identification document legalising where one belongs, denies many individuals their basic human rights.

Leave No One Behind exudes the transformative ethos of the 2030 Agenda for Sustainable Development. It vows to end discrimination/exclusion and reduce the inequalities and vulnerabilities of the marginalized. COVID-19 made the world realise that the question of

global health will be answered collectively as none of us will be safe until we are all safe. Yet, the policies adopted by modern nation-states in providing COVID-19 vaccinations often excluded strategies to include undocumented migrants.

In the beginning of 2020, when the global coronavirus outbreak brought the world to a standstill there were no vaccines, testing was limited, massive lockdowns were imposed, and grave misinformation was surrounding it. Today, the world is beginning to heal from COVID-19 as restrictions requiring social isolation & curtailing movement have largely been lifted. In general, vaccines for COVID-19 are seen as an effective remedy to prevent life threatening symptoms, hospitalization, and death from the current variants of the virus (World Health Organization, 2022).

The emerging research on the policies adopted to vaccinate citizens and its exclusionary impact on those left in the vague territory of statelessness, serves as a worthy area of research. Thus, this research, developed into an inductive exploratory endeavour which employs qualitative research techniques to focus on the right to health of undocumented Bihari, Bengali & Rohingya migrants rendered stateless in Pakistan.

We shall critically explore the rationale for formulating a vaccination policy exclusively for the citizens of Pakistan as the registration was closely tied to having Computerized National Identity Cards (CNIC). It shall try to understand the migrants' perception/reality of the disease itself; its requisite treatment and impact on their lives. Probing further the concerns/constraints of the humanitarian actors working on the ground and the policy experts as strategists for the vaccination plans.

In what follows, we shall first shed light on the aims of this research. We then present the context of the legal/administrative hurdles which have rendered the Bihari, Bengali & Rohingya as stateless individuals in Pakistan. It will give the reader a fair idea of how the absence of a legal identification document known as the CNIC impacts their daily lives and in turn, their right to getting a vaccination.

The literature review summarises the dominant theories on the right to health for undocumented migrants and narrates the general hurdles they face in accessing health care services especially immunization services. This serves as a foundation to highlight specific examples of discriminatory vaccination policies for COVID-19, focusing eventually on Pakistan. Once the gap in the literature is highlighted, we shall gain an understanding of the

method and methodology employed in this research, followed by a discussion of the findings/results.

1.2 Aim of the Study

The aim of this thesis is to understand the impact of a COVID-19 vaccination policy on the undocumented Bihari, Bengali and Rohingya migrants residing in Karachi, Pakistan. The impetus of this exploration stems from the fact that the vaccination policy caters exclusively to Pakistani citizens as access to the vaccination is closely tied to having a CNIC.

In this context, to approach the aim of this study in-depth semi-structured qualitative interviews were conducted to understand the perspective of the undocumented migrants themselves, the policy makers devising the policy, & the concerns of the advocacy and humanitarian actors working on the ground in Karachi with the population of interest.

Thus, the main research question is:

- What is the impact of the COVID-19 vaccination policy on undocumented migrants in Pakistan?

The undocumented migrant population identified for this research is based on a study commissioned by UNHCR named *Statelessness in Pakistan: A Study of Bengali, Bihari & Rohingya Communities in Karachi 2014* (Farhat & Ali, 2018). This study was conducted by the Institute of Policy Studies, Islamabad (IPS). It highlights the legal situation of 3 communities residing in Karachi i.e., Bihari, Bengali and Rohingya using a quantitative survey. It employs a quantitative survey of a total of 1,258 interviews along with 12 focus group discussions with respondents (men & women) from these communities. Thus, this study is used as a source to inform and inspire further research on these marginalized migrants. It also sheds light on the specific areas/localities within Karachi which house these communities. The chapter that follows explains the legal and administrative hurdles faced by these communities.

In lieu of this research, the first line of inquiry delves into an exploration of the understanding of COVID-19 by the migrant itself and its impact on their lives. The main research question is further analysed through the following sub-questions to develop a critical assessment of the COVID-19 vaccination policy of Pakistan:

- What is the perception of COVID-19 amongst the migrants?

- What is the impact of COVID-19 and the vaccination policy on the undocumented migrants?
- What are the practical hurdles/concerns of the humanitarian actors & policy makers working on these issues?

The aim of this qualitative research thus, has been to identify themes/patterns regarding the reality of COVID 19 in the minds of the above-mentioned communities based in Karachi and the concerns of change makers i.e., policy makers and activists in fostering actions to help the undocumented attain their right to health.

2. Statelessness in Pakistan

2.1 The Dilemma of Bengali, Bihari & the Rohingyas in Karachi

It is paradoxical that these communities identified as Bihari, Bengali and Rohingya in Pakistan seem to have a nationality attached to their identity but are stateless or at the risk of becoming stateless in legal terms. It is important to mention that their nationality is a seen as mark of their descent in this instance, it does not necessarily entail citizenship to a or any country.

Internationally, the focus has been on the fact that Pakistan has since the past 40 years hosted one of the largest refugee populations of Afghans. However, here too, even with the support of the United Nations via the UNHCR and other international stakeholders, the number of Afghan Refugees in Pakistan has been a point of contention with Pakistani figures varying from the figures shared by UNHCR. Pakistan, in this case, takes into account the official number of refugees registered by UNCHR (over 1.4 million) (UNHCR – The UN Refugee Agency, n.d.), the number of refugees registered in agreement with the Afghan government as per the Commissionerate of Afghan Refugees (over 700,000) (Haq, 2021) and undocumented Afghan Refugees (over 1 million) bringing the total number to over 3 million Afghan Refugees. With the recent political developments in Afghanistan, it is still expected that many more undocumented individuals from Afghanistan will cross the border into Pakistan. Exact figures in this case remain pending, with estimates continuing to vary. But it is evident that the Afghan question has always held national and international significance.

The Bengali, Bihari and Rohingya communities in Pakistan are often totally marginalised & not highlighted in the national conversation surrounding migration predominantly thus, for the purposes of this study we focus on their settlements in Karachi. They either do not have the necessary documentation to ascertain their proof of citizenship or the legal provisions under Pakistan's national laws do not facilitate their claim to adequate documentation. Even if by now second or third generations of these communities have permeated the economic, political, and social fabric of Karachi and across Pakistan, they may be denied many rights accorded only to a citizen.

The most vulnerable migrant groups i.e., farmworkers, asylum seekers, undocumented migrants, & smaller migrant groups (e.g., for certain countries of origin, occupations, and ethnic groups); present the need for data collection which will further inform the inquiry in this field (Schenker et al., 2014). The reason why this question of their statehood persists requires

a review of Pakistan's legal and administrative frameworks that still has gaps which could continue to give rise to or perpetuate statelessness.

2.2 Pakistan's Legal Framework Regarding Citizenship

To provide a general context of how this set of people are rendered stateless it is necessary to briefly review the specific provisions under the law prevalent in Pakistan. The Pakistan Citizenship Act (PCA) of 1951 is the basic law that defines the essential criteria for the acquisition of citizenship of Pakistan as well as its loss, deprivation, and renunciation. It consists of 23 sections. Section 16-A, introduced in 1978 after more than 6 years of separation from erstwhile East Pakistan which led to the creation Bangladesh, provided for the loss of Pakistani citizenship by persons arriving in Pakistan after December 16, 1971 without any official agreement of the federal government (Farhat & Ali, 2018). The PCA, which laid down the reasons for citizenship of Pakistan to be accorded to individuals, was further supported by relevant and subordinate legislations which have been supported by judgements of superior courts, albeit in a limited number which require further interpretation.

2.3 Pakistan's Administrative Framework Regarding Citizenship

Even with the inclusion of Section 16-A in the PCA, there was no functioning mechanism to implement the automatic citizenship loss or retention under the section. The National Identity Card (NIC) at that time (till 2005) was manually issued without extensive scrutiny as to the applicant's eligibility for citizenship under the written law. In 2005, when the National Database and Registration Authority (NADRA) was established, a citizen verification campaign was launched, and a Computerised National Identity Card (CNIC) was issued.

This was the first time that people from the Bengali and Bihari community, many of whom had been able to attain the manually issued NICs were now asked to produce documentary evidence for being eligible for Pakistani citizenship. After 40 years of living in Pakistan, such documentary evidence was difficult to produce for many families who were settled in the country for many decades and had established their roots in the country.

The temporal gap between Pakistani and Bengali written law could be a possible reason why statelessness could arise further. Individuals that left Bangladesh before December 15, 1972 and arrived in Pakistan after December 16, 1971 without a federal government agreement lost Pakistani citizen and were ineligible to acquire Bangladeshi citizenship, thus being

rendered stateless. This gap has remained unaddressed in both countries to date. Furthermore, Bangladeshi citizenship could be denied to Bengalis or Biharis who had resided in Pakistan for a long period of time vide Article 2-B of the Bangladesh Citizenship Order, 1972 (Farhat & Ali, 2018).

2.4 Current State of Play in Karachi

As mentioned in the previous section, in 2014, a seminal study was commissioned by UNHCR to highlight the perils of statelessness and to protect stateless people in Pakistan. It estimated the presence of 3.5 million Bengali, Biharis and Rohingya residents alone, across Pakistan who were possibly stateless or at the risk of being stateless (Farhat & Ali, 2018). They conducted over 1250 interviews & 12 focus groups to assess the state of statelessness within these communities in Karachi. The summary of these endeavours details a critical snapshot of the estimates of statelessness in Karachi which stymie opportunities for the development of these communities.

Table 1

Estimates of Statelessness in Karachi

No.	Estimates of Statelessness in Karachi
i. Person with a CNIC	over 90% Biharis & 56% Bengalis, who currently hold a CNIC are at the risk of refusal for renewal since, proof of eligibility of citizenship is not available. They are at **risk of becoming stateless;**
ii. Persons without CNIC	18% of Bengalis and 5% Biharis do not have proof of eligibility of Pakistani citizenship thus, remain at **risk of statelessness**. Moreover, 23% Bengalis and 4% Biharis still retain their Bangladeshi citizenship but are not recognized by the Bangladeshi authorities, terming them as "undetermined nationality" thus remain at the **risk of statelessness;**

iii. Stateless/likely Stateless	These include a significant number of Bengali and Biharis who are caught in the temporal gap between the written laws of Pakistan and Bangladesh and therefore **are stateless**. Within this ambit, it is also useful to note that over 300,000 Rohingyas who are not recognized by Myanmar, Pakistan and Bangladesh are most likely stateless and continue to reside in Pakistan.

Source: Author based on S. N. Farhat and R. Ali, 2018.

In light of the above, the criteria for citizenship can likely be fulfilled by a large number of individuals who clear the criteria for citizenship under the PCA (e.g., by birth in the territory, descent, naturalisation, marriage and via certain circumstances of migration and incorporation of territory). That said, the stumbling block in this remains providing proof of their families' arrival in Pakistan, and due to the lack of documentation ascertaining their arrival date or year of arrival in Pakistan exist in the unclear territory.

The study conducted by IPS (Farhat & Ali, 2018) highlights the case of Bengalis, Biharis and the Rohingyas who by not having access to a CNIC are being considered irregular migrants, and thus, they continue to be denied basic services like healthcare, access to education beyond middle school, are not being able to register marriages, apply for legal residency and gain long term employment. They have also been the target of extortion schemes and undue detention for immigration related reasons and continue to be provided limited cover under the ambit of the law. This study served as an inspiration to explore the vaccination policy launched by Pakistan for COVID-19 whose registration is strictly tied to having a CNIC. Thus, providing a useful area for research as the gap on this issue which lies in the domain of migration & health could prove useful for policy makers in addressing the concerns of the stateless.

3. Literature Review

The global outbreak of COVID-19 has disproportionately affected marginalized communities, especially migrants across the world who found themselves unprotected/overexposed to the infection (Armocida et al., 2021). It is a well-documented fact, that reaching migrant population for routine vaccinations pre-pandemic has been a challenge (Van der Werf et al., n.d.); undocumented immigrants/migrants, also referred to as illegal, irregular, and noncitizen, are observed to be underutilizing the health systems (Hacker et al., 2015). The fact that undocumented migrants are unable to access healthcare in its primary or tertiary forms, not only endangers their lives but also puts public health at risk in general.

In the context of COVID-19 vaccinations, the added caveat of stringent identification documents and tracking mechanisms renders an all-inclusive plan for COVID-19 vaccinations even more complicated. This is true for undocumented migrants as, initial eligibility criteria devised for vaccination depends on various factors including place of residence, employment & migration status in addition to age – metrics mostly employed for citizens (Schwartz & Zheng, n.d.). Exclusion of irregular migrants from COVID-19 vaccination plans not only endangers the idea of public health in a pandemic, but also demands a critical overview of their rights vis-à-vis the reality on the ground (World Health Organization, 2022)

This literature review aims to present an analytical snapshot of major approaches on the right to health for migrants clarifying what essentially creates exclusionary policies. It then narrates the general barriers to accessing health by migrants, specifically immunizations. Once the theoretical foundation is laid, it delves into an overview of specific vaccination plans rolled out by various countries, subsequently focusing on Pakistan.

3.1 Approaches on the Right to Health for Undocumented Migrants

An inquiry into the of right to health of those rendered undocumented can be meaningfully explored by unpacking the theoretical approaches in the existing literature. People have and will always be on the move. Thus, the question of access to health care services to migrants will always remain central to the idea of global health. Migrant health is a critical area of concern evident from the major international treaties like the Global Compacts on Migration and Refugees (2018), the Sustainable Development Goals (2015), the Global

Consultations from the International Organization for Migration (2010) and the World Health Organization (2017).

When it comes to migrants and refugees, health systems are expected to respond to their immediate and longer-term health needs (WHO, 2016; EPRS, 2016). While all governments have committed to achieving universal health coverage, migrants lacking documentation can often face severe challenges if they do not have the evidence required to claim their basic rights. These rights find their legitimacy based in national and international laws (Onarheim et al., 2018).

The interpretation of what is overarchingly guaranteed within the ambit of international law to migrants by sovereign national states, creates a paradox for those who reside within the ambiguity of statelessness.

3.1.1 National & International Law – A Paradox for the Undocumented

Article 12 of the International Covenant on Economic, Social and Cultural Rights, necessitates states certain specific legal obligations to ensure access to healthcare for all persons, including asylum seekers & undocumented migrants (United Nations, 2000). The justification for providing the right to health and access to healthcare are juxtaposed with various national, regional, and international agreements some of which are mentioned above.

While international human rights law fundamentally guarantees right to accessing health as a basic right regardless of a person's legal status within a country. The dynamics of how services, in particular welfare, are accorded to individuals within a state stem from stricter interpretation of rights/privileges. Citizenship is what lends legitimacy to the rights and privileges given to a person within a state. Often the practical aspects of administrative & other legal requirements take precedence over human rights even over public health concerns (Piccoli, 2016; Huma Network, 2009).

Citizenship is the operative word here. Health systems, in principle, may be considered universal with states pledging to leave no one behind in the Sustainable Development Goals. Reality is far from these idealized goals; national laws often restrict the provision of health care services to only members of the community according to rules established by their local laws & social customs. National laws on the right to health and access to health care show great variation from the European Union as a collective to individual EU member states. The same holds true for United States and many Asian states.

In the European Union alone, while some countries offer free access to primary and secondary care, others restrict access to emergency care alone. At the same time, there is another category comprising of countries in which for immigrants even emergency care is not freely accessible, as in Sweden and Finland (Cuadra, 2011). Often, in developed or developing countries eligibility to benefit from a health insurance scheme stems from citizenship or having a recognized legal status. In this context, undocumented migrants are almost always excluded (Onarheim et al., 2018a).

National policies excluding undocumented immigrants from receiving health care were the most commonly cited barriers to health care (Hacker et al., 2015). Thus, de jure, the services accorded to migrants may derive legal strength from human rights perspective but de facto, what they receive is rooted in national laws which even if inclusive in spirit, may in practice be discriminatory.

WHO lauds France for its health system's fairness & responsiveness in the distribution of health, and in its financing (WHO, 2000). While France has been able to devise in theory an all-inclusive health system which caters to the needs of all individuals residing within its territory. It still does not guarantee respite from the bureaucratic and administrative barriers that an undocumented migrant may face in receiving these services.

In Germany, we see that undocumented or irregular migrants can access health services but only in case of acute and chronic health needs. Other than emergency services, all other medical treatments require payment before and after care. If migrants want to make a claim, it could be reported to the immigration offices. Thus, these administrative requirements often induce fear of deportation, this renders many children not being able to get even routine immunization plans (Médecins du Monde, 2013). While in Berlin, anonymized health vouchers have been distributed, lack of necessary information/documentation/fears of authorities bars migrants to access health services.

Italy recognises the right to health for all those residing within Italy. Health as a subject for policy making is devolved to its regions, which have varying policies internally, with some regions restricting rights and others extending them (Olivani and Panizzut, 2016). This, in turn, creates confusion and fear among undocumented populations as ambiguity regarding law and procedure prevails. These policy distinctions which naturally present themselves in the internal functioning of a state overshadow the promise of provision of basic healthcare as a matter of human rights. The right to health is what obligates states to provide highest attainable standard

of health for persons within a country, this is the spirit of international law - regardless of citizenship (Onarheim et al., 2018).

3.2 Barriers to Accessing Health Care, Specifically Immunization

A review of the studies documenting the barriers in general faced by undocumented migrants in accessing healthcare highlights three main hurdles – issues in the policies at the national level, issues in the general system of health of a country and then issues experienced or perceived by migrants themselves in actively accessing health services (Hacker et al., 2015).

In the area, concerning national policies, as clarified above, despite pledging internationally, basic rights to all humans, regardless of the legal status of a person; national governments face different kinds of challenges. Foremost challenge is in priority setting as they face dilemmas in deciding who to include, which kind of services to provide and how to cover out-of-pocket expenses (Onarheim et al., 2018). This indeed is cited as one of the most common and far-reaching barriers in providing health services to undocumented migrants. These barriers may manifest in legal impediments disallowing medical practitioners to extend services to illegal residents in a country or not providing undocumented migrants with the option to gain health insurance.

Health system barriers manifest in multiple ways which in turn complicates access to health services for undocumented populations. These barriers entail external resource constraints which may deter an individual to seek a medical service; out of pocket expenditure on the service provided, transportation costs to receive the service, work conflict that results in losing daily wage. Furthermore, lack of translation services to adequately communicate and issues reflecting cultural competency were reported to be 36% of the barriers in the existing literature (Hacker et al., 2015).

Lastly, the undocumented migrant as an individual internalises shame, stigma, fear of deportation and thus, may avoid seeking medical help altogether. Undocumented immigrants reported avoiding their health care needs and depicted a behaviour to avoid medical services until health issues were critical enough to seek services. This was observed in countries as diverse as France, the US, and Denmark (Hacker et al., 2015). A major and often neglected barrier is the language barrier, this is what hampers essential communication which is a necessary component of receiving medical services. Undocumented immigrants explained that the emergency room physicians did not fully believe or understand their symptoms (Chandler et al., 2012).

In this context, in a pandemic, the safety of irregular migrants who already underutilize the health system as discussed above demands attention. While COVID-19 itself does not discriminate in its spread, the impact of the pandemic is not shared equally by all (World Health Organization, 2021). The existing literature which documents the frequency of vaccine preventable diseases, and vaccination coverage among irregular migrants and refugees in Europe clearly highlights disparity. This leads to lower immunization numbers amongst migrant populations when compared to individuals who are born in Europe. Pre-pandemic, immunizing people especially those in the ambiguous category of irregular migrants has been a formidable challenge. The existing literature documents the following hurdles which renders low immunization among the undocumented (Mipatrini, 2017);

- Vaccines which require multiple doses at regular times/intervals are difficult to administer for migrants on the move without necessary documentation;
- Health and administrative authorities do not have the required information and often the necessary resources to have data on the immunization status of migrants;
- Undocumented migrants may themselves refuse registration with medical authorities due to fear of deportation;
- Migrant face vaccine hesitancy, acquire misinformation on what the vaccine is for and face cultural competency issues while dealing with a medical professional.

In similar vein, pre-pandemic, a comprehensive review of the literature summarises the following in terms of the issues in the policies devised for immunizing migrants, the vaccine delivery practices usually adopted and the barriers to accessing and utilization of these services in the European region alone (Vito et al., 2017).

- It is rare that national immunization plan also shed light on specific strategies for migrants;
- Fewer than one third of the European countries had specific/clear directives on immunizing migrants including women & children;
- Lack of necessary human/financial resources, & cultural mediators who in turn engage migrants to receive vaccination serve as major barriers in implementing immunization plans which eventually also hampers necessary data collection required for future course of action.

In this regard, WHO specifically recommends countries to devise migrant specific policies strategically enhancing outreach for immunization especially those who are undocumented. But a careful analysis of many national immunization policies documents exclusionary practices. A survey of COVID-19 vaccination plans adopted by many EU members states alone will serve as a pivotal argument in highlighting the gap in not only describing discriminatory practices but also how it impacts the marginalized within a country in a pandemic.

3.3 Vaccinations for COVID-19

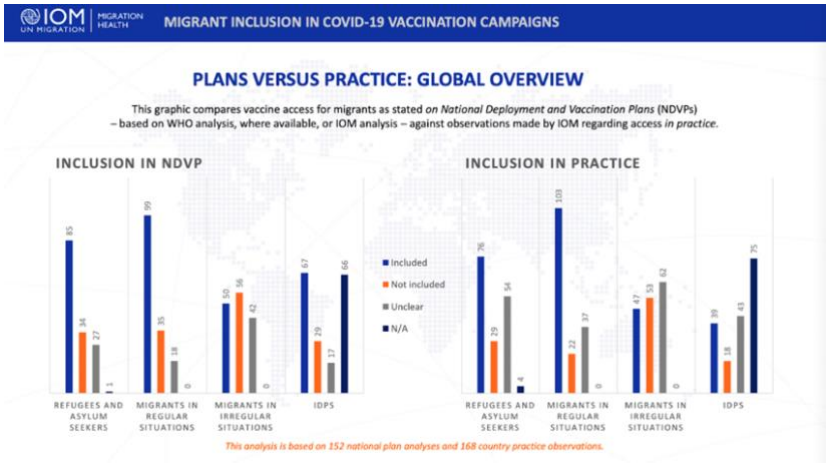
Once COVID-19 vaccinations were available for usage, all countries developed strategies and plans to immunize their population. The general directives given by international organizations pertaining to the right of migrants and refugees called for inclusive vaccine plans and strategies. These inclusive strategies are essential to reduce disease and death burden of COVID-19. Especially, in the case of undocumented migrants as they face exclusion from health systems and often reside in highly deprived areas which may not be reached in the regular vaccination plans (Deal et al., 2021a). Therefore, certain target groups which are at increased risk from COVID-19 should be able to benefit from early vaccination during the period of vaccine supply constraints (World Health Organization, 2021).

While these directives in essence guide policy makers, in practice many nations do not give vulnerable groups priority from the outset. International human rights law requires that ‘vulnerability’, if used as a criteria for ensuring priority access to COVID-19 vaccines, must also consider medical vulnerability (e.g. comorbidities) along with socio-economic vulnerability, and attend to intersectionality (Sekalala et al., 2021).

In view of this, a glance at the preliminary data collected by International Organization for Migration (2021) depicting migrant inclusion in vaccination plans sheds light on the discriminatory practices which leave stateless individuals at the risk of not receiving COVID-19 vaccines.

Figure 1

Migrant Inclusion in COVID-19 Vaccinations - Plans Versus Practice: Global Overview



Note. By International Organization for Migration, 2021, Migrant Inclusion in COVID-19 Vaccination Campaigns IOM Country Office Review.

Thus, the existing frameworks/mechanisms and proposals for COVID-19 vaccine allocation have shortcomings from a human rights perspective. Inclusion of migrants in practice is evidently quite low globally, especially those who are migrants in an irregular situation left in the grey zone with unclear policies in terms of the national vaccination plans. The same is also explored by Lighthouse Reports (2021), which is an investigative reporting agency working primarily in Europe. It has highlighted in its extensive coverage of a vaccination policies in countries across Europe i.e how opaque, confused, or transparent vaccination policies have been in terms of migrant inclusion. The metric of assessment is based on the criteria mentioned below:

Table 2

Criteria for Migrant Inclusive Vaccination Policies

Criteria for Migrant Inclusive Vaccination Policies	
• **Transparency**	How clearly the policy itself mentions undocumented people. Malta, Spain, Ireland, Poland, Belgium, France, &

	Austria are the countries who were opaque in terms of their policy.
• **Undocumented Access**	How accessible the vaccine is for migrants; policy plans and public statements often can generate a confusing rhetoric whether an undocumented person will have access or not. Most European countries scored moderately due to their unclear referral to people included in the vaccination plan i.e "all people within a country" or "residents".
• **Identification and Residency**	The condition to get vaccinated is relegated to residency status in a country or having an identification document which, in turn, is a factor to determine access. France, Estonia, Greece, Germany explicitly requests identification documents which could restrict access to the vaccine.
• **Marginalised Access**	Assess if priority access was given to other vulnerable groups in vaccine plans like those who are in prisons, who do not have permanent housing or are without internet access as these groups are seen as politically less risky. In general, all countries in Europe were more accommodating to other marginalized groups than the undocumented.
• **Privacy Guarantees**	Many countries were advised to generate awareness of privacy guarantees to enhance vaccine uptake among these migrants; undocumented migrants could avoid getting the vaccine due to fear of being deported by the authorities. However, here too, many European countries including Belgium, France, Italy, Estonia, Slovakia to name a few, devised vague policies which could deter many to get vaccinated.

Source. Lighthouse Reports, 2021

3.4 Pakistan's Covid-19 Response & Vaccination Plan

Pakistan's response to the pandemic was led through the National Command and Operation Center (NCOC) which was created in April 2020 (Zaidi, 2020). It was the principal body overseeing the policy and implementation response of the national COVID-19 efforts in Pakistan, a country with over 220 million citizens, it analyzed, collated, and processed all information collected across the country.

Soon after NCOC's formation, Pakistan began its vaccination program, which as per its policy is able to vaccinate all citizens above the age of 12. The criteria for vaccination hinged on providing one's Computerized National Identity Card (CNIC), once a citizen is registered, they would get a message notifying their appointment and further necessary steps. As COVID-19 cases increased, more and more citizens were actively encouraged to get vaccinated at the earliest. However, due to the CNIC requirement, a sizable number of stateless and irregular migrants were not able to get vaccinated and were even refused vaccinations throughout various vaccination centers (*Stateless Persons Denied Vaccination in Pakistan*, 2021).

People who lacked CNICs but were registered either through the Commissionerate of Afghan Refugees (CAR) or by the United Nations High Commissioner for Refugees (UNHCR), were included in the national vaccination drive since they possessed some form of identification (Latif, 2021). However, a large number of Bengali, Bihari, Rohingya and other stateless individuals, estimated to be nearly 3 million, continued to be missed out in the national vaccination drive in its initial phases.

In July 2021, the Chief Minister of Sindh, Mr. Murad Ali Khan, announced that the requirement to present CNIC in order to get vaccinated in the province's capital, Karachi, was being lifted (Jajja, 2021). As per the new requirements, in case someone could not present their CNIC, they could get registered by getting their biometrics done at the vaccination center and get their valid mobile numbers registered. The Sindh government had also proposed that the number on the vaccination card (subsequently issued after vaccination was complete) could be considered as a unique identification number but, more information has not been made available regarding this proposal since. The strategy to even include mobile numbers is not clear as often undocumented individuals do not have the numbers registered in their own name, as the procedure to acquire a valid mobile number is also linked to one's identification document.

The NCOC had provided daily COVID-19 related facts and figures via its website covid.gov.pk with an area-wise breakdown. That said on this website, clearly differentiated information to present vaccination numbers of undocumented migrants separately from Pakistani citizens is not available. Moreover, further breakdown like city wide COVID-19 number have been inconsistently available as well with the capital, Islamabad, or provincial capitals like Karachi having data available more regularly.

On April 01, 2022, the Government of Pakistan announced that since COVID-19 indicators were at an all-time low and since vaccination rates were high, the NCOC had completed its objective and was to be discontinued. Since its closure, the NCOC's website records the last available data (as of 25 April 2022) highlighting 1,527,956 confirmed cases, 3,446 active cases, 30,369 deaths and 1,491,141 recoveries.

While a country heals from COVID-19, a sizeable population has been left behind. Thus, in spite of a remarkable increase in the number and quality of scientific publications in recent years, migrant health remains an emerging and largely unexplored area of research with many unanswered questions (Ingleby 2009; Argeseanu Cunningham et al., 2008). Thus, rigorous and timely research in the domain of migration is urgently needed to foster understanding of the underlying causes and effects (including the health of migrants) of this phenomenon. It shall help in formulating evidence-based policies and interventions to protect and advance the right to health of migrants in the communities of origin and destination (Kahanec and Zimmermann 2008).

The emerging research on COVID-19 documents lower COVID-19 vaccine uptake in established marginalized groups, but it requires further exploration to understand vaccine hesitancy and barriers to vaccination in migrants (Deal et al., 2021b). The gap thus, identified provides the necessary justification to assess the effectiveness of Pakistan's COVID-19 policy for those rendered outside the ambit of clear citizenship status but, also explore how migrants understand and perceive COVID-19.

4. Research Method and Methodology

4.1 Methodology

The philosophical underpinnings of this research are grounded in an inductive approach to explore emerging patterns/understanding of three marginalised communities residing mostly in Karachi. The objective is to unpack their reality/understanding of COVID-19, their access to its treatment and the impact of the pandemic on their lives. Furthermore, concerns and constraints of the humanitarian actors working on the ground and policy experts devising the policy are also gathered to develop a holistic analysis. Thus, to serve the purposes of this inquiry, this study uses in-depth semi-structured interviews which were logistically possible, in contrast to other qualitative methods based on ethnography and participant observation.

While, initially the research question was designed with the intention to do a mixed method analysis, lack of data and resource constraints were critical in finally deciding on a purely qualitative study. Qualitative tools, in areas of research like migration and health where previous inquiry is scare, are very useful. They help in generating a more in-depth and nuanced understanding of human behaviour through which reality is meaningfully constructed (Schenker et al., 2014).

Thus, in-depth semi-structure interviews served as a feasible instrument/means to approach the exploration of this study. Interviews would help understand how the subjects of this study conceptualise and reflect on the topic of research themselves, which in turn provides the researcher with a deeper understanding of the social context & the reality of the population of interest at large. It also paves the way to further identify important questions for research in the future.

Interviews are done with three different set of participants i.e., migrants, humanitarian actors and policy experts, as mentioned above to ensure triangulation of critical information and gather alternative perspectives as the research evolves (Schenker et al., 2014.). This also served as a means to not get influenced by the understanding of one or two individuals and reduce bias in the course of this research.

Lastly, it was critical to design a comfortable and transparent mechanism to execute the interviews with the migrants especially, if I could not physically conduct the interviews myself due to geographical constraints. Positionality is a notion in research that the researchers own

position in the social structure and the institutions affects the ways in which the world is understood (Johnston et al., 2000, p. 604). In the days leading up to the interviews the community focal point highlighted that telephonic interviews of a faceless female may not generate authentic communication amongst the participants thus, an alternative, a hybrid of sorts may be devised to enable authentic communication.

In this situation, a male colleague, who has experience in conducing qualitative field work volunteered to assist and physically visited these localities while I joined telephonically. This served as a practical solution to address what the gatekeepers highlighted as a potential problem. It is pertinent to mention that this strategy was employed only for the interviews which were to be conducted with the migrants. While the interviews with the professionals were conducted by me telephonically.

4.2 Method

This research is premised on 15 in-depth semi-structured interviews of undocumented Bengali, Bihari and Rohingya migrants settled in three localities of Karachi, Pakistan who are between 35 to 70 years of age. The three localities chosen i.e. Orangi, Kemari & Baldia are representative of the large settlements of the population of interest in Karachi. A concise profile of the respondents can be seen attached in **Appendix A**. The names mentioned are pseudonyms for the purposes of confidentiality. The localities have been selected from the study conducted by IPS (2018) which comprehensively documents the residential hubs of these communities. This study served as a relatively recent and very large database of undocumented population living in Karachi. It also sheds light on the lack of accurate and up-to-date statistical information about undocumented migrants residing in Pakistan.

The thesis then delves into the analysis and concerns of the humanitarian organisations working on the ground and government officials vis-a-vis the right to health of those left behind while the world begins to heal from COVID-19. Hence, another set of four in-depth open-ended interviews was conducted with professionals & policy makers. Profile of the professionals interviewed is not disclosed as it might reveal their identity.

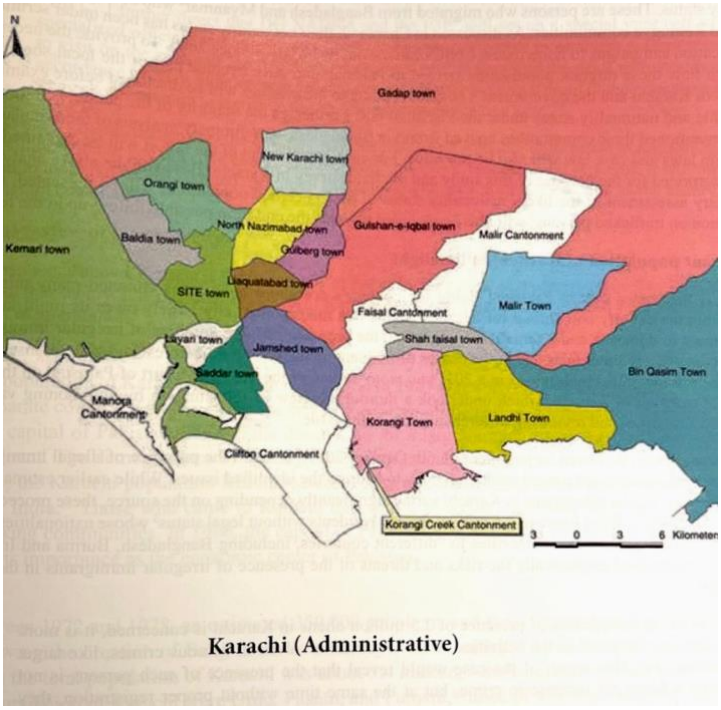
Since this research explores the concerns of the undocumented migrants who reside within closely knit communities, a selective/purposive sampling has been employed to undergo a conscious selection of migrants from clearly identified localities. It also ensures that the respondents are representative of an age range which encapsulates migrants rendered stateless

either at the time of separation of East Pakistan, across the border movement owing to unrest/hostility in their country of origin or 2nd/3rd generation migrants born in Pakistan. This sampling criteria also helped in maintaining a gender balance & can be seen attached at **Appendix B.** The interview questionnaires employed in the study for both the migrants and professionals are placed at **Appendix C**.

It was clear that to access these populations who are often sceptical of outsiders some trusted aides would have to be approached who can help in accessing these communities. The expectation was that this will not only create a point of contact but lead to a snowball effect for inclusion of further participants especially female participants. Contacts from within the community can also help researchers in accessing information which could negatively impact the research, for example, rumours about the objectives of the study (Deren et al. 2005). This additional information could also enhance participation in the study which would eventually, impact the quality of the data collected and also ensures communities acceptance of the study.

Figure 2

Depiction of localities chosen for research



Note. From "Statelessness in Pakistan: A Study of Bengali, Bihari & Rohingya Communities in Karachi 2014" by S. N. Farhat and R. Ali, 2018.

4.3 Research Limitations & Ethical Considerations

Data collection for this research was done in two separate and distinct phases based on the practical requirements and logistical constraints of this study. Firstly, a lot of time and effort was invested in ensuring that the participants are comfortable in sharing their views for which an informed consent was employed. A clear description of the research was given along with the right to remain confidential.

Undocumented migrants often reside in close-knit communities and may not be comfortable opening to an outsider regarding their view on COVID-19, which since its inception was surrounded by a lot of conspiracy. Migrants are not likely to provide genuine responses about their legal status unless this information is collected by a trusted organization (Deren et al. 2005). This led to a dilemma that emerged during the process of conducting this research that the field interviews with the migrants had to be conducted in person in contrast, to the initial plan to do them telephonically.

The contact persons who had a trustable linkage with these communities advised me not to do telephonic interviews as it would not help the migrants open up. Thus, my colleague, who is an experienced development anthropologist engaged with trusted aides who helped in gaining access to the interviewees. This strategy also helped in getting permission to interview some females as it would not have been possible if a faceless individual interviewed them telephonically or virtually which could further complicate accessibility issues and also render the research void of a representative sample. On the other hand, virtual meetings were conducted by me with all the participants representing INGOs/NGOs and government officials due to their availability in various regions.

The interviews with the migrants were conducted in-person in March/April 2022 with the help of a colleague based in Karachi. As explained above, I was not able to travel to Karachi myself during my brief visit owing to the political unrest in Pakistan. Therefore, we aimed in designing a strategy which ensures that the participants feel safe, are able to physically see the people documenting their words during the research and do not feel threatened about revealing their nationality or status.

The existing literature on migration research emphasizes that the interview process of migrant populations especially merits special attention. It is imperative that to capture a true sense of the migrant's reality the role of the interviewer cannot be undermined as how the interviewer identifies herself/himself impacts the engagement created during the process. In

other words, it could influence the finding. Thus, in the context of this research the inclusion of my colleague served useful as he, himself represents a marginalized community in Pakistan. Having some field work experience himself, his presence helped male participants to engage comfortably snowballing in to inclusion of other participants.

Lastly, what transpired as an unexpected hurdle was that government officials/policy experts were not forthcoming to the idea of being interviewed even if I assured them confidentiality in the presentation of my findings. It became a challenge to even get an interview, thus, initially while, the plan was to at least interview two government officials in the end only one interview was conducted telephonically in May 2022. On the other hand, the professionals from the INGOs & NGOs were not reluctant to participate but required strict confidentiality & non-attributability due to the nature of their job. These interviews were also conducted telephonically in April 2022. These addressal of these concerns rendered the findings from these experts to be presented in a narrative form encapsulating their perspective/analysis.

5. Research Findings and Discussion

In this section, we shall unpack and assess the research findings based on the in-depth semi-structured interviews conducted with the undocumented migrants, the humanitarian actors & the policy experts. The first set of findings pertains to the migrants' perspectives/lived realities of the pandemic. The objective is to understand how the migrants perceive the virus, their knowledge about the treatment of COVID-19 and its impact on their already marginalized existence. The analysis will be informed by the well-documented concerns of low immunization rates amongst undocumented migrants pre-pandemic.

The findings then proceed towards the context-specific concerns and challenges in the case of COVID-19, through the interviews conducted with humanitarian actors working on the ground in Karachi, and government officials and policy experts at the national level in Pakistan. It is pertinent to reinforce that the vaccination policy was devised at the national level, while the guidelines for implementation were relegated to the provincial governments for implementation.

It is pertinent to mention that throughout the thesis, the word COVID-19 has been used consistently when specifying the name of the disease. However, the migrants interviewed for this research referred to the disease as *corona*, which is how it has been recorded in their responses.

5.1 The Migrants' Reality – Responses by the Undocumented

In the context of COVID-19, the data gathered in the initial days of the pandemic documents lower vaccination rates in recognized minority populations. But attention has not been paid to understanding the causes of concerns with regard to vaccine hesitancy in migrant groups (Deal et al., 2021). Thus, an exploration of the mindset of undocumented migrants in Karachi highlights the following interesting revelations. The ideas shared by the migrants have been thematically organized in terms of the basic questions explored in this research. The themes have been devised to make sense of the responses given in view of the questions asked, which helps categorically summarize the findings below.

5.1.1 Ideas about COVID-19

In response to the primary question, which tries to assess how COVID-19 was perceived by these migrants living in closely knit communities, some interesting and paradoxical points of view were recorded. Out of the 15 people interviewed, only two women confirmed that they did not know anything about COVID-19. While four respondents shared that although they do know about the virus, they were certain that it is a rumour. Lastly, the remaining nine affirmed that they know about the virus and believe it to be a real disease.

The responses given shared a common word which was interesting to detect and recognize as a recurring part of all explanations. Almost everyone stated that whether they know about COVID-19 or not, they have never "seen" it, which creates some doubt in their minds about its authentic form. Sab (40) gives an interesting explanation when inquired about her perception of COVID-19 and the pandemic:

> *Corona is not real, I have never seen it, corona is a rumour at best. In all cases, what can a human do? God creates diseases and it is only He who can cure it. What can I do? If God created corona, then only God can treat it. I do not need to worry about getting an injection. If I am bound to die from anything or this disease I will. Corona is not real and if you say that there is a pandemic, God will fix it. But I have not seen corona and I am not scared of it.*

Similarly, Bina (45) a housewife, who lives with her husband and children, shared that she does not know anything about COVID-19. She thinks it is not a real disease for her as she stays home all day. Thus, it cannot harm her. When asked about her kids who go to a local religious school known as a *madrassa*, whereby, they could potentially bring the virus home or her husband who goes out of the house daily to earn a living, she responds that if her family tells her that she has corona, then she will listen to them. But she insisted that she has not seen corona herself and is certain that no one in her family suffered from this disease. But if her family tells her that she is suffering from it, she will trust them. However, before she agrees to get the treatment, she will also seek permission from the religious leader in their vicinity as she would not know what those medicines are made of.

Shams (37) emphasized that:

> *Corona is a rumor, I have not seen this disease. I already suffer from many health issues. I am not scared of corona. But the Government is saying that corona is here so I am hearing all this in the news.*

This is a glaring indication that closely knit communities probably did not recognise COVID-19 as a genuine disease. The women (four out of five interviewed were home-makers) disregarded COVID-19 as a real disease in two cases, one woman thought it to be a rumor, and it was only Hina (50), a maid, who was certain that COVID-19 existed.

Hina (50), a maid who worked as a cleaner in a gated residential area and was interacting with educated employers, clarified that she "saw" corona. She explained that her employer caught it and was locked in a room for 15 days. Thus, she believes it to be true. This small detail exemplifies that contact with people other than their own community was a source of information different from what was available in her own circles.

Hina (50) adds further:

> *I have seen corona, it is a terrible disease. My employer also purchased masks for me and instructed me to curtail my movement in the city so as to not catch the virus and spread it more.*

The remaining respondents who affirmed that they knew about COVID-19 pertained to two sets of categories; those who knew about it but were sure it was a rumour and those who thought it was a real disease. Interestingly, words like "seen" and "heard" were used to explain their perception of COVID-19. Those respondents who stated that they knew about COVID-19 and considered it a real disease shared that they "heard" about COVID-19. Some explained that COVID-19 is real because the Government of Pakistan is "saying" that COVID-19 is a disease. Moreover, the most typical responses embed a sense of disbelief requiring evidence although, during the pandemic, the awareness and outreach messages were aggressively televised, and notified through mobile/telephonic messages. These are mediums to which these communities also have access, but they did not do much to alter their reality. COVID-19 at best was hearsay, as Anwar (37) said.

> *I have not seen corona, but I have heard from friends that a waba ["a seasonal disease"] is in the air. The Government is also saying that there is a disease which is killing people, so I know about the corona, it is a virus, people are dying from it. But I have not seen someone myself ill with it but I know it is not a rumour. I believe it is true.*

On the contrary, Aziz (60) explained that

> *Corona is a rumour, not a real disease. I already suffer from breathing issues, I know that corona is just flu and cough. It does not need an extra injection to be cured.*

The word "seen" occurs in the responses almost repetitively. This could also signify that even if people suffered from the virus, its symptoms were not distinguishable from common flu and cough for many.

5.1.2 Ideas on taking the COVID-19 vaccination

The second line of exploration was to discover if these undocumented migrants would consider taking the vaccine or were hesitant to take the injection. It was clear from most interviews that it cannot be assumed that COVID-19 is unanimously being recognised as a disease. This, in turn, makes one rethink if these migrants should be probed about taking a vaccine. It is only logical that if a disease is not even considered real or distinguishable from what they suffer from already in the form of flu or cough why would they take an injection for it. Nevertheless, since many respondents expressed that they had heard of COVID-19, it seemed interesting to unpack their understanding further about what they knew about its treatment. This line of questioning is what sheds light on the paradoxical understanding of COVID-19.

When the respondents were asked if they know about a vaccine, the common name given to it was a *teeka* (injection). Those who knew about COVID-19, shared that they have heard that the Government is giving people a *teeka*. Thus, first, line of inquiry was to assess if they know about the concept of a vaccine. The question asked was regarding if, in their lifetime, they have received vaccine for polio, measles, hepatitis C, i.e. routine immunization services. Almost all of them said that, in the past, they have received injections for different diseases but were not sure what those injections were for except for polio.

There were two different observations made about the responses on knowing about the vaccine for COVID-19 and subsequently if they would be willing to take it. Some of the respondents who thought COVID-19 was not a real disease, when explained that there is a pandemic and there is an injection/vaccine used for its treatment, were willing to take the treatment only because the Government was giving it. This is also understandable as many of these localities were routinely visited for polio/hepatitis C vaccinations carried out quite

extensively in Pakistan to fight these diseases. It could be a possible reason to trust the process of getting an injection, even if, they may not exactly know what it could be for.

Aziz (60) explained:

> *Corona is not a disease, it is a rumour. I have taken its vaccine as people came in our neighbourhood, they announced that they are being given for free. My friends were going so I went with them. Everyone said that it is good for health so I trust them. I live alone, I have no family. It is good to be safe. These people did not ask for my identification and also gave me a card, my friends say, I can go anywhere in the city with this card so I am happy.*

It is paradoxical that someone who does not think COVID-19 is a real disease is comfortable with getting the vaccine. On the other hand, the respondents who claimed that they know about the COVID-19 and also the vaccine, clarified that they cannot access this option because they do not have the CNIC which is required to get the vaccine. Many respondents, who were second-generation migrants and struggling to get their identities legalized in Pakistan, had a clearer understanding of the procedural aspect of getting the vaccine. Omar (35) shared:

> *I want to get vaccinated, it is not something I can decide, I do not have my CNIC, I am trying to get it. But before I have it, I do not think I can get the vaccine. It is not my choice to get it or not; for now, I cannot get it. Some people told me that they can now register my phone number and vaccinate me. I do not need the CNIC but I will not risk going to a centre just to come back without getting the injection.*

Amir (32) highlights:

> *Nothing is bigger than life, why will I not want to keep my family safe if it depends on an injection. But it is not my choice, we do not have the required documentation. My daughter was very ill a few days ago, it was difficult to get her treated for a serious disease. We cannot access a good hospital already. The Government launched a scheme to give Sehat Cards (Health Cards), but we cannot get those either. I will not refuse a service for my betterment but in this case, I am not sure if I will be able to get the vaccine.*

However, those respondents who thought COVID-19 is a rumour and not a real disease, even a conspiracy for some, were mostly keen to get the vaccine. When inquired why they

would get treatment for a disease they did not think was real, the answers mostly revolved around the explanation that if the Government gave it to them, they would take it.

Saif (32) explained that:

> *Corona is a conspiracy, I have not seen it. I will not get vaccinated but my wife is vaccinated. An NGO came to vaccinate in our neighbourhood so she went with our friends. But if I was not at work, maybe I would get it, too. But in reality, CNIC is the issue, vaccine is not an issue. If they vaccinate me without CNIC I will get it also. But I have heard that NADRA is asking for more documents.*

Muharram (35) highlights his fear saying:

> *I am scared of the vaccine, I have heard that it can affect my masculinity. But in the city they have now checkpoints which could curtail movement. I will get it if it is necessary to get the vaccine. I have not seen corona, I am also scared of the vaccine but what can I do? If it is important for my life, I will take it.*

It is interesting to discover this pattern that while many respondents may not take COVID-19 as a serious threat for their health, many of them were willing to take the vaccine if it eased their movement in the city. It could also be extrapolated from these responses that if these communities were engaged in the larger socio-cultural life of the city they lived in, they probably would have had different views on how they perceived COVID-19.

Many respondents were open to the idea of taking the vaccine and due to their experience of taking routine vaccinations had a sense of trust towards these injections being beneficial for them. Thus, we realized that ideas on what COVID-19 is as a disease were more comprised of a sense of doubt. The ideas on taking the vaccine were more consistent, and even those who needed convincing highlighted that if their family and local religious leaders emphasized getting the vaccine, they would do it.

5.1.3 Ideas on the impact of COVID-19

Barring the four women who were homemakers, almost all the respondents were daily wagers. They are in a precarious situation to earn what they eat every day. All the respondents did not have a CNIC, which already impacts the work-related opportunities they can access

without legal documentation. Those respondents who shared that they know about COVID-19 and its treatment clarified that due to not having a formal identification, they could not attain good jobs in good companies. In addition to the CNIC, they were also being asked to get vaccination cards. Thus, COVID-19 situation added an additional layer of marginalization.

Ali (35) gives an emphatic account:

> *Not having the CNIC is already a big issue for me. I cannot get a decent job. No good company is willing to give me a contract. I work in an oil workshop but no nice company is willing to hire me. My brother and I are trying to get our identification cards made so we can get vaccinated because now we also need this to prove that we are safe to work with. I will not be able to enter a big factory if I don't have my CNIC.*

Mostly the male respondents were the primary breadwinners in their homes, while the females were homemakers. Those who commuted outside of their designated community localities described problem in their movement due to checkpoints requiring CNIC and additional requirement for vaccination documents. One of the female respondents who worked as a cleaning lady clarified that she cannot get a vaccine due to not having a CNIC, but her employer will only allow her to enter the house if she can get vaccinated. This is a direct impact of the pandemic on their marginalized existence. It also reflects that whether or not these individuals understand COVID-19 as a real disease themselves, the understanding of those outside of their circle is impacting the opportunities they may get.

Bakir (45) expressed that he cannot work anywhere in the main city centre but only in the mountains far away from his home. He explained that it is God that takes care of him. Due to COVID-19 whatever chance he had of finding a better job are now non-existent. He added further:

> *I never faced any serious medical issue, God has been kind to me. But now, I cannot even think of entering a big hospital. Today, they want this vaccine card which I do not have, corona as a disease is not an issue for me. It has made things more difficult for me.*

Nimra (40) shared that:

Corona can do nothing, I am already living a difficult life. All the welfare schemes by the Government are for people with CNIC, this corona is a small hurdle for me. I don't know why God made us like this but we are getting by with whatever we can do.

The responses given by the migrants in a way carry a sense of comparison of their current lives with the pre-pandemic situation. They share the challenges they faced pre-covid as a point of comparison for the marginalization they already faced and what has been now added due to COVID-19. The pandemic is impacting their lives and reducing the opportunities they can access but, most respondents shared the impact of not having a CNIC as their primary issue which gives birth to all the other issues.

5.1.4 Ideas on access to the vaccine

With regards to the line of inquiry pertaining to the willingness to take the vaccine, it was observed that most respondents wanted to take the vaccine. In some cases, they may require some convincing but overall, they were of the view that vaccines in general, at least, the ones they had taken in the past, are supposed to be good for them. However, the respondents who recognized COVID-19 as a real disease clarified that they will take the vaccine if the Government asks them to do it but cannot get it as they do not have the CNIC. It was emphasized that it is not their choice to make, they cannot themselves get it if the authorities deny it to them.

Respondents like Saif (32), who thought COVID-19 was a rumour, were clear that if the Government gave them the vaccine, they would receive the jab. His wife was already vaccinated via an NGO vaccinating in their neighbourhood. This sheds light on the matter that, if easily accessible, those people who are not extremely reluctant may get vaccinated.

While anti-vaccine protests are premised on the right to choose what one would like to put in their body. In the case of undocumented individuals, there is no choice or is very limited, as many may not qualify to choose. It is a common perception that people may resist taking the jab. But in the course of this research, many undocumented migrants who are young and work daily to earn a meal described that if the vaccine is given to them without any pre-conditions they shall not resist taking it.

It was an interesting notion to consider that accessibility was more important than the treatment itself. While almost no one was able to distinguish COVID-19 from common flu or

cough, they were willing to take the vaccine if asked to, given without any hassle, free of cost, without any dent on their routine work.

An international humanitarian organization administered vaccines to undocumented individuals in specific localities in Karachi, where this organization already had a footprint immunizing undocumented migrants for hepatitis C. When given the permission to vaccinate undocumented migrants, this INGO made announcements in the local mosque through religious clerics and invited people to get their doses through mobile vaccination services in their locality. Shakoor (49) explained:

> *I eat at night what I earn in the morning. I cannot go to a hospital to then be told to go away. I will take the vaccine, I have heard that vaccine had many side effects, it could also affect my manliness but if due to the vaccine I can get work, I can move in the city, I will take it. But I will take the vaccine if they come to my doorstep if I know that if they are being given without CNIC only then, I cannot go to waste my day.*

Hafeez (45) had this rationale,

> *We are already denied many social protection schemes, I cannot access any welfare, why will I deny what the government says is for my health. If they come to give the vaccine, I will take it.*

The interviews highlight that accessibility is a key criterion for the migrants. Daily wagers cannot risk losing their daily income to go to vaccination centres where they may fear rejection due to a specific requirement. If the service is provided in a manner that ensues trust in them then most respondents were more open to the idea of taking a vaccine.

5.2 Concerns of Humanitarian Actors

For the purposes of this research, three professionals from the humanitarian sector were interviewed. Two professionals were representing an international humanitarian organization with an extensive history in providing medical assistance to marginalized communities and relief work in times of crisis. One professional was an activist from a local non-governmental organization to provide legal respite to those who lived in the periphery of statelessness. The analysis of these actors was pertinent to consider as they worked with these communities directly and were the first to raise their voices to include undocumented migrants in Karachi's vaccination plan. It is pertinent to mention that in these interviews, to maintain confidentiality,

the respondents were assured that no direct quotes would be used, which made them comfortable to express themselves freely. Thus, this section presents their analysis in the form of narration summarizing their views.

Experts representing the INGO explained that in the past, they had carried out hepatitis C vaccinations in some localities of Karachi, which housed undocumented migrants. Once the formal COVID-19 vaccination plans were announced, they themselves approached the Health Department of Government of Sindh to allow them (INGO) to also vaccinate migrants without documentation, along with routine COVID-19 vaccinations for Pakistani citizens.

Representatives of the INGOs highlighted that they had a footprint in these areas. Thus, the local leaders recognized their work and the health department also trusted their analysis. Therefore, they were allowed to employ mobile vaccination centres to reach these migrants. Mobile vaccinations played a crucial role in curtailing accessibility issues for those daily wagers who otherwise would not risk earning their wages to go to a major COVID-19 vaccination centre. Announcements were made to encourage the migrants to get vaccinated through the religious clerics who had considerable influence over these people and were crucial in encouraging them to come out of their homes to go to the mobile vaccination set-up.

The medical officer involved in giving vaccinations to undocumented migrants expressed that most people were quite positive towards taking the vaccine. He explained that these migrants routinely see vaccination drives happening in their locality and that is why trust professionals who visit them. Maybe if this was a completely new organization it would have been a challenge to administer vaccines as easily. These professionals unanimously agreed that vaccines have to be made accessible in the respective localities known to house migrants; otherwise, it could be quite a task to go to a centre away from their home which requires money for transportation and the additional burden of losing the wage they could have earned.

It was also interesting for these professionals to share that often the migrants would come to the mobile centre, and while getting prepped to take the jab also ask that it will not have any side effects. They were definitely exposed to conflicting notions about COVID-19 but were more often than not interested in getting vaccinated. Many would consider the vaccination cards as a form of identity document accorded to them which could make their lives easier.

In connection to the management of records, representatives of the INGO clarified that for now, they maintain two different set of records. They shared that they are answerable to the

Government for the doses they administer. Thus, they simply record the number and name clarifying to the Government how many doses have been used and how many more are required. The Government has also eased up restrictions on usage of CNIC as the only form of documentation to register for vaccines, which makes the process easier. But some were uncertain if the migrants will continue to visit for all doses required to be fully vaccinated. Thus, they were of the view that advocacy and consistent efforts were required as once they were present with their mobile vaccination set-up, they vaccinated hundreds of individuals.

The representative from the local advocacy NGO expressed his/her concern that many of the issues that these migrants face are administrative. Lack of proper documentation hampers almost everything they do in Pakistan; from getting married to registering their children for high school examinations, everything becomes a struggle. In the case of COVID-19 vaccination, the voices of concern were raised from the beginning and gradually, INGOs and local activists were able to get these barriers reduced. But systematically, these hurdles have to be addressed at a higher level to help these individuals build a life. He/she clarified that these migrants play a role in the economy and most of them have spent all their lives in Pakistan or were born in Pakistan. Thus, solutions have to be found beyond COVID-19.

5.3 Circumstances of the Policy Makers

Once migrants and representatives of humanitarian organizations were interviewed, the final set of semi-structured in-depth interviews were conducted with two government officials who were involved extensively in strategizing the vaccination policy of Pakistan against COVID-19. It was not a conscious plan to interview government officials at the end, but it so happened that by the time they were available, the rest of the interviews had been finalized. It is also interesting to mention that while both of them were assured about confidentiality and non-attributability, one of the respondents refrained from including his/her analysis in the research. Thus, we effectively rely on the observations/analysis provided by one of the lead experts in devising the vaccination policy of the Government of Pakistan.

Officials who worked in the public sector and were engaged in practically devising steps and plans for the vaccination policy had a completely different reference point to explain the struggles they faced. These economic and administrative issues informed the decisions they took. It was interesting to realise that the gaze of the professional experts from the humanitarian & public sector varied immensely in their concerns and solutions.

Regarding the interview with the policy expert, the first set of inquiry pertained to his/her own analysis of the vaccination policy that was devised in the early days of COVID-19. He/she preferred to first present the context in which decisions were being made. He/she explained that in the initial days after the vaccines were being made available in the international market; there was a lot of confusion as to how to procure them. Gavi, the Vaccine Alliance (GAVI) via COVID-19 Vaccines Global Access (COVAX) was identified as primary contact which would deal with LMICs like Pakistan to initiate market commitment. But in the rush to find solutions, states have to also recognize their own resource constraints in a struggling economy due to which a lot has to be managed in practical terms. She highlighted that the intention to address problems in itself cannot resolve administrative, economic and political issues.

At the same time, bilateral negotiations were initiated with different countries to acquire the vaccines as the condition in Pakistan with COVID-19 was worsening. In this state of a global health emergency, Pakistan's primary objective was to attain the vaccine from parties who were willing to sell them at reasonable rates. Thus, it was clear that in the initial days, Pakistan would not be able to procure large consignments so it was a logical choice to devise a plan where vaccinations were first made available only for the frontline health workers.

All the major bodies and actors in the public sector including were critically and actively engaged in gathering relevant information to devise a suitable strategy to vaccinate people in Pakistan. He/she expressed that in a time of crisis, it was commendable how everyone was motivated to actively engage. After procurement, a huge concern was the usage of accurate data; 2017's census was used as the baseline to gather estimates for doses that will have to be administered. The initial breakdown after health workers pertained to elderly population aged 75 and above.

He/she clarified that data was a source of concern; NADRA, the central face for having data on all Pakistani citizens highlighted that in Pakistan people do not often, officially register deaths unless required in specific official matters. Thus, the estimates shared could vary once vaccines were rolled out. After frontline workers, vaccines were gradually made available for people aged 75 and above, which transitioned in to it being available for people aged 65 & above if vaccines were still available.

Resource constraints and the market reality of how inequitable the distribution of the vaccine itself was is also a factor that made countries devise policies adapting to the crisis.

WHO had started asking countries to share their forecasting for their National Vaccination Plans (NDVPs) as to how will they buy the vaccines i.e. if they had the requisite funds. Meanwhile, negotiations were underway with COVAX, Russia and China. The expert narrated that there were many political reasons which impacted how practically plans were made. While negotiations were being finalized with COVAX, it became controversial that the vaccine manufacturer was based in India, and it was being portrayed that vaccines made in India were being used for Pakistan instead of India. This protracted the timeline to finalize negotiations. Pfizer was only dealing with rich countries in the initial days. In this context, China gave Pakistan the vaccine to mitigate this health emergency, which was a welcome step in the crisis. While pre-qualification for the vaccine made by China was not at that time done by the WHO, Pakistan adopted it as per its guidelines.

Data management was a crucial component, and it was important to record the data as transparently as possible. Vaccines were limited and the plan was to only vaccinate frontline health workers and the older people who were more at risk. It was for this purpose that the age criteria was required which could be verified through the CNIC. Otherwise, without any kind of formal identification and with a lot of fear surrounding the virus the people who were largely at risk as compared to other age groups may not have received the vaccination shots in time.

In terms of how vaccines were to be provided, he/she explained that adult vaccination centres exclusively for the people who were to be catered were set up. In the first few months according to the expert, ID cards were a stringent part of vaccine registrations but gradually, once vaccines were available in abundance and uptake was high, these restrictions were relaxed. The expert was of the view that it was not a choice to exclude anyone; even the question of Afghan refugees was settled through the Proof of Residence (POR) cards issued to them by CAR and UNHCR. Thus, according to his/her experience, Pakistan had also assured international donors of inclusive vaccination strategies and with time restrictions were relaxed for almost all people residing in Pakistan.

Vaccine hesitancy in the case of COVID-19 did exist but the fear of the pandemic itself drove people to get vaccinated. Media played a crucial role in disseminating information. Grave death tolls recorded in some European countries led people to take COVID-19 seriously. The mass deaths in India in the 2nd or 3rd wave led people to go to vaccination centres and waited in long queues to take the jab. He/she explained that there were many different reservations with regards to what the vaccine could do to people; that they could become aliens, not be able to produce children or if they took Pfizer, they would expire within 2 years. Despite all this,

the data depicts that around 80 percent of the eligible population has been vaccinated at least once. He/she stressed that measures were taken to encourage people to take the vaccine but was of the view that nobody can be forced at the end of the day. While there could be many procedural glitches, but maximum efforts have been made to ensure everyone can get vaccinated; in a health crisis, there was no conscious plan to discriminate was what the expert emphasized.

6. Conclusion

This study employed a qualitative research design using in-depth semi-structured interviews as its instrument of exploration. In total, 15 undocumented migrants were interviewed from three communities i.e Bihari, Bengali and Rohingya residing in Orangi, Kimari and Baldia localities of Karachi, Pakistan. The sample is evidently small from a statistical point of view, but the focus has been on generating data which has depth in its quality to capture a sense of the migrants' reality about the pandemic and its impact on their lives.

Furthermore, there are three interviews conducted with professionals from INGOs/NGOs working on the ground in Karachi for migrant rights and an interview with a policy expert from the Government of Pakistan who played a key role in devising the COVID-19 vaccination policy. This helped to triangulate the data from the vantage point of those who interact with the topic of interest as change-makers. These interviews helped to add a more nuanced dimension to the issues assessed in this research.

It would be safe to admit that an evident limitation of this study has been the logistical constraints. The monetary cost of commuting to these localities in Karachi led to a conscious selection of respondents residing in areas closer to each other. While the gatekeepers served as a conduit to access the migrants, still, the sample contains more men than women, because it was a challenge to seek permission to talk to women.

Initially, it was considered to present a monetary reward to the respondents as an incentive to participate, but the trusted aides advised against this as it could catapult into a money-making endeavor hampering the selection of respondents as per the sampling criteria. However, utmost care was accorded to attract participants who were comfortable to be interviewed once the details of the study were shared.

The interviews once transcribed employed a constant comparison method to unpack line by line the responses given. The data gathered was also color coded, to develop a visual impact of what was shared and also to excavate themes/patterns, sub-themes and interconnected cultural references in the data. This part of the research was most interesting as it brought forward a richer sense of the migrants understanding and also captured a well-rounded sense of professionals who could address these concerns.

It is important to see that the research findings are presented within the context of COVID-19, and the pandemic which led to the creation of a unique set of circumstances for

these migrants to face. While this outbreak, altered life drastically for those who could enter any door pre-pandemic, what the pandemic effectively changed for these undocumented individuals was adding another layer of marginalization. It seemed as if in their long list of issues, this outbreak did not hold a priority. The respondents often explaining their understanding of COVID-19 as something they had heard about, lacking a sense of evidence as they could not distinguish the symptoms of COVID-19 from common flu and cough. This in turn is explained by the limited testing done to determine the health impact of COVID-19 in migrant populations in countries like Pakistan, India and Bangladesh (Chakraborty & Bhabha, 2021).

While the virus itself does not discriminate in its attack on a living being, infectious diseases are known to affect migrants living in overcrowded localities or camps disproportionately. But the interviews conducted for this research reinforced the observation emerging on the issue that migrants did not seek medical care unless the symptoms for COVID-19 are critical/fatal (Chakraborty & Bhabha, 2021).

The literature on the issue of immunization of migrants especially irregular migrants argues that exclusion of migrants from vaccinations plans in itself hampers formulation of novel solutions and strategies to access these populations (Armocida et al., 2021). The data collected sheds light on the fact that most of these migrants would have taken the vaccine if they did not have to choose between earning a wage or getting a preventive treatment. Vaccination campaigns in principle were supposed to consider hard to access population by strengthening health systems, to address the barriers in immunization (Bartovic et al., 2021).

An interesting point of reflection after interviewing professionals from the INGOs was that even if they took the lead to vaccinate undocumented migrants in some localities in Karachi, they emphasized that once provincial health authorities were approached to gain permission, they did not face any resistance. This does lend force to the argument that probably at the policy level there was no intent for exclusion but, in real terms, due to the political exclusion of these communities the authorities were unable to give these communities a clear solution to vaccinate and record their data. INGO administering vaccines clarified that they maintained a bifurcation of the data for their own record but at least, at the national level those distinctions were not being made.

On the other hand, while the policy expert working at the governmental level clarified that there was no intention to exclude anyone, resource constraints and inequitable distribution

of the vaccine in the international market shaped the decisions and guidelines for vaccination roll-out in the initial phase. While in its guidelines, GAVI COVAX emphasized to facilitate coverage of 20 % of the high-risk population based on the country & its population breakdown, giving priority to health workers and high at risk groups for severe disease or death. It had clarified that further doses in the early days would be made available based on availability of the vaccine, financing, a country's demand, capacity, and potential threat of outbreaks. A humanitarian buffer was also established to cover 5% of vaccine doses procured through the COVAX facility available to cover high-risk populations in humanitarian settings (World Health Organization, 2021).

These prescriptions were at play when countries were developing their strategies for vaccinations, but in practice the policy could not capture these nuanced concerns in its narrative even if actions were taken to some extent to include migrants.

Many of the respondents who were interviewed for the purposes of this research were 2nd generation migrants, born in Pakistan. Yet, they did not belong to it legally. Globally, the number of citizens who do not belong is increasing, which gives more strength to the argument that the criteria of belonging in a nation-state has to focus less on the nation or the cultural aspect of having an identity; but with globalization on the rise, citizenship may also be accorded from the context of residence within a country (Castles & Davidson, 2000). At least, those who are stuck procedurally, owing to a lack of document, but effectively raising families in Pakistan may be willfully extracted out of this situation. The same was also highlighted by the local humanitarian activist that the government needs to review what it requires procedurally from these undocumented individual for the basic facilities to be provided to them. During the interviews, some of the respondents explained that their unclear citizenship status deprives them of accessing welfare scheme for income support or eligibility to get a health card, then the vaccine in question, is just another subject added to that list.

7. Bibliography

Argeseanu Cunningham, S., Ruben, J. D., & Venkat Narayan, K. M. (2008). Health of foreign-born people in the United States: A review. *Health & Place, 14*(4), 623–635. https://doi.org/10.1016/j.healthplace.2007.12.002

Armocida, B., Formenti, B., Missoni, E., D'Apice, C., Marchese, V., Calvi, M., Castelli, F., & Ussai, S. (2021). Challenges in the equitable access to COVID-19 vaccines for migrant populations in Europe. *The Lancet Regional Health – Europe, 6*. https://doi.org/10.1016/j.lanepe.2021.100147

Bartovic, J., Datta, S. S., Severoni, S., & D'anna, V. (2021). Ensuring equitable access to vaccines for refugees and migrants during the covid-19 pandemic. *In Bulletin of the World Health Organization* (Vol. 99, Issue 1, pp. 3-3A). World Health Organization. https://doi.org/10.2471/BLT.20.267690

Castles, S., & Davidson, A. (2000). *Citizenship and Migration*. Routledge.

Chakraborty, R., & Bhabha, J. (2021). *Fault Lines of Refugee Exclusion: Statelessness, Gender & COVID-19 in South Asia*. 23(1), 237–250. https://doi.org/10.2307/27040050

Chandler, J. T., Malone, R. E., Thompson, L. M., & Rehm, R. S. (2012). "No Me Ponían Mucha Importancia." *Advances in Nursing Science, 35*(2), E24–E36. https://doi.org/10.1097/ans.0b013e31825373fe

Cuadra, Carin B. 2011. 'Right of Access to Health Care for Undocumented Migrants in EU: A Comparative Study of National Policies', European Journal of Public Health 22(2): 267–71.

Deal, A., Hayward, S. E., Huda, M., Knights, F., Crawshaw, A. F., Carter, J., Hassan, O. B., Farah, Y., Ciftci, Y., Rowland-Pomp, M., Rustage, K., Goldsmith, L., Hartmann, M., Mounier-Jack, S., Burns, R., Miller, A., Wurie, F., Campos-Matos, I., Majeed, A., & Hargreaves, S. (2021). Strategies and action points to ensure equitable uptake of COVID-19 vaccinations: A national qualitative interview study to explore the views of undocumented migrants, asylum seekers, and refugees. *Journal of Migration and Health*, 4. https://doi.org/10.1016/j.jmh.2021.100050

Deren S, M Shedin, CU Decena, and M Mino. (2005). "Research Challenges to the Study of HIV/AIDS among Migrant and Immigrant Hispanic Populations in the United States." Journal of Urban Health 82(2 Suppl 3): 13–25

European Parliament Research Service (EPRS). (2016). 'The Public Health Dimension of the European Migrant Crisis'. Briefing, January 2016.

European Centre for Disease Prevention and Control, (2018). *Public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA*, European Centre for Disease Prevention and Control. https://data.europa.eu/doi/10.2900/154411

Farhat, S. N., & Ali, R. (2018). *Statelessness in Pakistan: A Study of Bengali, Bihari & Rohingya Communities in Karachi 2014*.

Hacker, K., Anies, M. E., Folb, B., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: a literature review. *Risk Management and Healthcare Policy*, *8*, 175–183. https://doi.org/10.2147/rmhp.s70173

Haq, M. (2021, August 7). *Pakistan shuts door to further Afghan refugees*. Nikkei Asia. https://asia.nikkei.com/Politics/International-relations/Afghanistan-turmoil/Pakistan-shuts-door-to-further-Afghan-refugees

Huma Network. (2009). *Access to Health Care for Undocumented Migrants and Asylum Seekers in 10 EU Countries: Law and Practice.* http://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf

Ingleby D. (2009). "European Research on Migration and Health: Background Paper." International Organization for Migration. http://www.migrant-health-europe.org/files/Research%20on%20Migrant%20Health_Background%20Paper.pdf

International Organization for Migration. (2019). *Glossary on Migration INTERNATIONAL MIGRATION LAW N° 34* (pp. 223–224). https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf

International Organization for Migration. (2021). *MIGRANT INCLUSION IN COVID-19 VACCINATION CAMPAIGNS IOM Country Office Review*. https://www.iom.int/sites/g/files/tmzbdl486/files/our_work/DMM/Migration-Health/iom-vaccine-inclusion-mapping-17-may-2021-global.pdf

Jajja, S. (2021, August 2). *Citizens without CNICs eligible for Covid-19 vaccination in Karachi*. DAWN.COM. https://www.dawn.com/news/1638388

Johnston, R. G., Gregory, D., Pratt, G. (2000) Dictionary of Human Geography. Massachusetts: Blackwell Publishers.

Kahanec M, and KF Zimmermann. (2008). "Migration and Globalization: Challenges and Perspectives for the Research Infrastructure." Institute for the Study of Labor (IZA) Discussion Paper No. 3890.

Latif, A. (2021, May 22). *3M in Pakistan lacking IDs may miss out on COVID-19 jabs*. Anadolu Agency. https://www.aa.com.tr/en/asia-pacific/3m-in-pakistan-lacking-ids-may-miss-out-on-covid-19-jabs/2250754

Lighthouse Reports. (2021). *Vaccinating Europe's Undocumented: A Policy Scorecard*. https://www.lighthousereports.nl/investigation/vaccinating-europes-undocumented-a-policy-scorecard/

Médecins du Monde. (2013). Access to Health Care in Europe in Times of Crisis and Rising Xenophobia: An Overview of the Situation of People Excluded from Health Care Systems. Paris: Médecins du Monde

Mipatrini, Daniele. S. Paola. S. Santino. R. Giovanni. (2017). Vaccination in Migrants & Refugees: A Challenge for European Health Systems. *Taylor & Francis Online*, 59–68.

Olivani, Pierfranco, and Daniela Panizzut. (2016). 'Attuale legislazione sanitaria Nazionale per gli immigrati irregolari e attuale fruibilità di tale legislazione a livello regionale'. Naga – Associazione Volontaria di Assistenza Socio-Sanitaria e per i Diritti di Cittadini Stranieri, Rom e Sinti Onlus. https://www.simmweb.it/attachments/article/973/Report_LEGIS_Naga_2019.pdf

Onarheim, K. H., Melberg, A., Meier, B. M., & Miljeteig, I. (2018). Healthcare is not Universal if Undocumented Migrants are Excluded. *BMJ Global Health*, 3(5), e001031. https://doi.org/10.1136/bmjgh-2018-001031

Piccoli, Lorenzo. (2016). *Left out by the State, Taken in by the Region? Explaining the Regional Variation of Healthcare Rights for Undocumented Migrants in Italy, Spain, and Switzerland.* Nccr – on the Move', Working Paper Series No. 10, Neuchatel, Switerland. https://nccr-onthemove.ch/wp_live14/wp-content/uploads/2017/01/nccrotm-WP10-Piccoli-Healthcare-Rights.pdf

Schenker, M. B., Castañeda, X., & Rodriguez-Lainz, A. (2014). *Migration and Health: A Research Methods Handbook* (First ed.). University of California Press.

Schwartz, J. L., & Zheng, A. (n.d.). *COVID-19 Analytical Snapshot #67: Migrants' access to vaccines Clinical Outcomes Of A COVID-19 Vaccine: Implementation Over Efficacy by AD Paltiel.*

Sekalala, S., Perehudoff, K., Parker, M., Forman, L., Rawson, B., & Smith, M. (2021). An intersectional human rights approach to prioritising access to COVID-19 vaccines. *BMJ Global Health*, 6(2). https://doi.org/10.1136/bmjgh-2020-004462

Shah, S. (2020). *The Next Great Migration: The Beauty and Terror of Life on the Move*. Bloomsbury Publishing.

Stateless persons denied vaccination in Pakistan. (2021, June 11). [Video]. YouTube. https://www.youtube.com/watch?v=RBRfxExnJ5A

UNHCR - The UN Refugee Agency. (n.d.). *Pakistan*. https://www.unhcr.org/pakistan.html

United Nations. (2000). 'General Comment N. 14 The Right to the Highest Attainable Standard of Health (Art. 12)'. Adopted at the Twenty-Second Session of the Committee on Economic, Social and Cultural Rights on 11 August 2000.

Vito, E., Parente, P., de Waure, C., Ricciardi, W., & Poscia, A. (2017). *A Review of Evidence on Equitable Delivery, Access and Utilization of Immunization Services for Migrants and Refugees in the WHO European Region*. World Health Organization.

World Health Organization (WHO). (2000). The World Health Report 2000 – Health Systems: Improving Performance. Geneva.

World Health Organization (WHO) Regional Office for Europe. (2016). 'Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region'. Working document, Copenhagen.

World Health Organization. (2021). *COVID-19 immunization in refugees and migrants: principles and key considerations Interim guidance*. https://apps.who.int/iris/bitstream/handle/10665/344793/WHO-2019-nCoV-immunization-refugees-and-migrants-2021.1-eng.pdf

World Health Organization. (2022, March 16). *Coronavirus disease (COVID-19): Vaccines*. https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-(covid-19)-vaccines

Zaidi, M. (2020, August 20). Is NCOC our Covid-19 miracle? *The News International*. https://www.thenews.com.pk/print/706668-is-ncoc-our-covid-19-miracle

8. Appendices

APPENDIX A: PROFILE OF THE MIGRANTS

- Saba (Bihari) is a 40-year-old female who resides in Kemari as a housewife with her family.
- Bakir (Benagli) is 45-year-old, single male, who resides in Kemari working as a daily wager.
- Shams (Rohingya), 37-year-old male, resides in Kemari with his family working as a laborer.
- Nimra (Bihari), 38-year-old female, reside in Orangi with her family as a housewife.
- Amir (Bihari), 32-year-old male, who resides in Orangi as a daily wager with his family.
- Ali (Rohingya), 35-year-old male, who resides in Kemari with his family and work in an oil workshop .
- Hina (Rohingya), 50-year-old female, who resides with her family in Kemari and works as a maid.
- Bina (Bihari), 45-year-old female who is as a housewife and resides in Baldia Town.
- Aziz (Bengali), 60-year-old male, who lives alone in Baldia town and works as a laborer.
- Shakoor (Bengali), 49-year-old male, who is married and resides in Kemari Town.
- Saif (Bengali), 32-year-old male, who works as a daily wager and lives in Baldia Town with his family.
- Abdul (Bengali), 60-year-old single male, who works as a daily wager and reside in Orangi Town.
- Muharram (Rohingya), 35-year-old married male, who works as a daily wager and lives in Baldia Town.
- Hafeez (Bihari), 45-year-old male, who works as a daily wager & lives with his family in Orangi.
- Sakina (Bengali), 30-year-old female, who is a housewife & resides in Kemari.

APPENDIX B: CRITERIA FOR SAMPLE SELECTION

The sample was selected with respect to the following predetermined criteria:

- 1st or 2nd generation undocumented migrants from Bihari, Bengali and Rohingya communities;
- Near even selection of male and female respondents;
- Both individuals married and single to be included;
- Sample variation across age range 37 - 70 years old;

APPENDIX C: INTERVIEW QUESTIONNAIRE

Interview Questions for Migrants

Name:

Age:

Gender:

Family Status:

Job:

Neighborhood/Locality:

1. Where are you from?
2. How long have you lived in Pakistan?
3. Do you know about COVID-19? *(Inquire if they think it is life threatening?)*
4. Do you know anyone who was seriously ill with COVID-19?
5. Do you know if COVID has any treatment? *(Inquire if they know about the vaccine?)*
6. Are you comfortable with the idea of getting the vaccine? *(Inquire if they have received vaccine of any sort in the past?)*
7. Have you been vaccinated?
8. Has anyone in your family been vaccinated?
9. If yes, ask how and if no ask why? *(If the answer is no, probe further and unpack the reasons for not getting vaccinated.)*
10. Why have you not tried to get vaccinated as it is being given for free without identification documents in Karachi?
11. If you get sick with COVID and cannot go to work, will it have a serious economic impact on you or your family?
12. If a health worker comes to your doorstep will you take the vaccine?
13. Do you think COVID is a concern for you and your family?

What is your analysis of the Government's vaccination policy and vaccination implementation plan?

Interview Questions for Policy Makers

Name:

Occupation:

1. How successful do you think the vaccination plan has been in fighting COVID-19?
2. Do you think that the current policy will be able to transparently vaccinate and record the data in general for the citizens of Pakistan?
3. Are undocumented migrants residing within Pakistan a cause for concern?
4. What are the main challenges due to which undocumented individuals have not been catered at the policy level in the vaccination plan?
5. What do you think is a suitable model to vaccinate migrants without documentation?
6. In the context of vaccine hesitancy in Pakistan, do you think there has been adequate advocacy to get everyone vaccinated?
7. Does the fact that a person is not vaccinated will it impact their ability to earn a minimum wage?
8. The government has recently eased restrictions put in place to control COVID, do you think those left behind will ever be catered?

Interview Questions for NGOs

Name:

Occupation:

1. What is your analysis of the Government's vaccination policy and vaccination implementation plan?
2. Do you think that the current policy will be able to transparently vaccinate and record the data in general for the citizens of Pakistan?
3. What are the main challenges due to which undocumented individuals have not been catered at the policy level in the vaccination plan?
4. What are the general hurdles faced by undocumented people in accessing healthcare?
5. Do you think undocumented people are reluctant to get vaccinated in the context of vaccine hesitancy in Pakistan?
6. What do you think is a suitable model to vaccinate migrants without documentation?
7. The government has recently eased restrictions put in place to control COVID, do you think those left behind will ever be catered?