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Conceptual and empirical reflection provide more arguments for the centrality of extreme poverty in COVID-19 vaccination: A reply to Abal and Zeledón-Ramírez et al

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Recently Abal[1] and Zeledón-Ramírez and colleagues[2] presented very interesting arguments in relation to my recent article[3] "Extreme poverty first: An argument on the equitable distribution of the COVID-19 vaccine in Peru" in which I propose, through empirical and ethical arguments, that extreme poverty should be considered as a prioritization criterion for COVID-19 vaccination.

Abal mentions that my argument lacks clarity regarding the concept of vulnerability in the population living in extreme poverty, since I apparently only consider "intrinsic reasons" why it is not possible to save as many lives as possible. However, what could Abal mean by "intrinsic reasons"? If by this he means, as indicated in his letter, low immune response or likelihood of contagion, these are health issues only. However, the intrinsic characteristic of the population living in poverty goes beyond that, because in synthesis it is constituted by a wide range of factors that increase their vulnerability. In my article I argue that populations living in extreme poverty are exposed to a high probability of contagion, because they depend on their own actions for survival and are unable to ensure their own safety due to lack of resources (e.g. vaccines, masks and social distancing). The contagion brings as a consequence the disease itself, which would lead to a high probability of death, precisely because of the conjunction of several vulnerability factors, among which stand out: low nutritional level, limited access to health services and the existence of pre-existing clinical manifestations that are very frequent in these human populations,[4] where it is shown that in populations living in extreme poverty, comorbidities are frequent, exposing them to a high risk of death compared to those who are not poor.

I also mentioned that each layer of vulnerability will present itself one after the other, generating a "domino effect", which is catastrophic for this human group. This effect is hardly visible in the general population, since by trying to make "more segmentations" in order to produce different types of possible risk combinations (old age, co-morbidities, etc.) we will be unequivocally reaching populations living in extreme poverty. That is why, in one of the arguments I defend, I emphasize that: "this proposal will not exclude those groups of people who have co-morbidity and/or are over 65 years of age, as they are unequivocally

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CONFLICT OF INTEREST STATEMENT

None to declare.

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part of this key group".[5] Therefore, the argument that populations living in extreme poverty should be prioritized for vaccination is based on the sum of vulnerabilities they face, placing them at a worse disadvantage than other vulnerable groups with higher socioeconomic status.

With regard to the approach of Zeledón-Ramírez et al., who argue in favor of a parallel free-market distribution, while it is an interesting argument, the reality of the free market offers a different picture compared to the theoretical ideals. To give some examples, in March 2020, a shortage of personal protective equipment (PPE) was reported for both health personnel and the general population,[6] which exposed people to a high risk of contagion.[7] However, private initiative generated the resale of this scarce input at a high cost instead of being sensitive to the need of the majority as a matter of social justice. Likewise, in December 2020, the countries that developed the vaccine, such as the USA, the UK, Russia, and China, prioritized the vaccination of their populations (a phenomenon known as vaccine nationalism[8]). In Peru, however, the first batch of 300,000 doses only arrived on March 11, 2021,[9] while more than 100,000 people nationwide had already died.[10] On the other hand, countries such as Pakistan, Honduras, India, Colombia, Mexico and Indonesia approved the entry of private companies to the vaccination process in order to improve the immunization coverage of the population. Unfortunately, in Pakistan, the generation of a parallel vaccine market triggered the sale of this input at a cost of up to 80 dollars for both doses of Sputnik vaccine, while the minimum monthly salary in that country averages 110 dollars.[11] As can be expected, this phenomenon only increased the already existing social gap. These data as a whole reveal that, even in a situation of global health crisis, the private sector will not fail to tilt the greater weight of the balance towards its own interests, leaving aside those who are in the worst economic situation. The same figure can be seen when we turn our gaze to the example of the parable of the factory, in which, if the owner of the factory chooses to vaccinate their personnel instead of themselves, such a sacrifice is minimized in the face of greater access to PPE, better management of health and biosecurity measures, and obviously less exposure to the virus, elements that are disparate when analyzing the situation of their workers.

Moreover, the same owner of the factory, as has happened in the reality with several businessmen and their families, would travel to other countries to get immunized.[12] However, when this phenomenon becomes widespread, instead of providing greater opportunities to the populations with fewer resources, it would leave them in total helplessness by generating a global shortage of vaccines, which would be acquired by the highest bidder. Therefore, these arguments show that, contrary to what Zeledón-Ramírez et al.[13] claim, giving priority to the extremely poor would in no way limit early vaccination for those who are willing to get it for themselves, but could end up causing more harm than good.

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