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LESSONS FROM THE PANDEMIC ON ACCESS TO HEALTH: A FEMINIST INTERSECTIONAL PERSPECTIVE ON SOUTH AMERICA

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FEMINISTS
FOR A PEOPLE'S
VACCINE

CONTENTS

PANORAMA OF THE COVID-19 PANDEMIC IN SOUTH AMERICA: DEEPENING INEQUALITIES

On February 26, 2020, the first case of COVID-19 in South America was identified in the city of São Paulo, Brazil. A few days later, on March 7, the first death from COVID-19 was reported in Buenos Aires, Argentina. In both cases, these were people who had recently returned from trips to Europe, and who had access to private healthcare (Alvarez & Harris, 2020; BBC News Mundo, 2020; UNA-SUS, 2020). The initial reports of COVID-19 cases in the region shared elements that were easily recognizable as indicators of social class. These would be confirmed as crucial elements for understanding the dynamics of the spread and impact of the virus, in intersection with other key dimensions of social structures in South America.

During the first three months of the pandemic, 3,959 people died from COVID-19 in São Paulo, the largest city in Brazil. While 1% of them lived in neighborhoods where the median household income exceeded 4,000 dollars, 66% lived in neighborhoods where the median household income was lower than 600 dollars (Assis & Moreno, 2020). The income here is an indicator of inequalities in terms of access to health care, housing conditions, possibility of social isolation, being able to stop working or to work remotely, among other factors, which are heavily marked by the experiences of class, gender, race, ethnicity and nationality. The overlap between these and other expressions of structural inequalities are a key element of the background needed to understand the context that led South America to be announced by the World Health Organization (WHO) as the epicenter of the epidemic in May 2020 (DW, 2020; PAHO, 2020).

In many Latin American countries, the pandemic followed a similar flow, marked by two major waves: the first in 2020, between March and July, and the second in 2021, between January and June, when the vaccine already existed, but was not yet available to a large part of the populations in the global South. In June 2021, another WHO communiqué announced an extremely worrying scenario in South America, marked by the intense transmission of the disease, the spread of community transmission and the pressure on previously weakened health systems. While North America, Europe, Asia, Africa and Oceania recorded a weekly average of 100 new daily cases of COVID-19 per million people, South America exceeded 300 new cases per million people per day (Faria, 2021). After identifying under-reporting and

updating the figures for COVID-19 deaths, Peru ranked as first in the world in terms of COVID-19 deaths per capita (The Guardian, 2021).

The American region accounted for almost 25% of cases of COVID-19 worldwide and for 43% of deaths from COVID-19, despite representing 13% of the world's population (WHO, 2024). In the Americas, 55% of cases were registered in North America, but 62% of all deaths occurred in Latin America and the Caribbean. South America accounted for 36% of cases (19.6% in Brazil, 9% in the Southern Cone and 7.4% in the Andean region) and 47% of deaths (24.3% in Brazil, 15% in the Andean region and 7.7% in the Southern Cone) (PAHO, 2022).

The brutal impact of the COVID-19 pandemic in South America has highlighted many of the historical problems faced by the health systems in the region, such as underfunding, overload, privatization and fragmentation, which hinder a robust and coordinated response, essential in times of health crisis (CEPAL, 2022). In March 2020, when the COVID-19 pandemic spread, the response capacity of the health systems was already compromised by existing demands (Litewka & Heitman, 2020). Healthcare workers, most of whom were women, were particularly affected, both directly by COVID-19, but also by the overburden of work and the consequences of the precarious context on their physical and mental health (OHCH, 2020). Many existing health services were compromised, interrupted or postponed, generating significant side effects on the health of the population and aggravating already existing situations of vulnerability.

The interaction of historical exclusions with the onset of the COVID-19 pandemic was marked by unequal access to healthcare and is reflected in the higher mortality rates recorded among people living in poverty, indigenous and black populations, as well as in the particular effects on the physical, mental and social health of neglected populations (PAHO, 2022). This paper seeks to identify the main challenges to ensuring the right to health during the COVID-19 pandemic, considering that the experiences and knowledge of marginalized populations can significantly contribute to understanding how the intersections of structural inequalities operate, as well as to reflect on the necessary transformations to guarantee the dimensions of availability, accessibility, acceptability, and quality in the access to healthcare.

INTERSECTIONALITY IN THE SOCIAL DETERMINATION OF THE HEALTH-DISEASE-CARE PROCESS

The role of social inequalities is the starting point in this paper for understanding the impacts of the pandemic on the right to health in South America. In this sense, the Social Determinants of Health (SDoH) perspective has been theoretically consolidated as a challenge to biomedical approaches to public health, which isolate health-disease processes from their relationship with broader social dynamics and processes. However, the SDoH model, promoted by the WHO's Commission on Social Determinants of Health, has been criticized for its limitations in incorporating fundamental dimensions for understanding health inequalities, particularly in the contexts of the Global South (Borde *et al.*, 2015).

In the field of Latin American Collective Health, the approach of the Social Determination of Health-Disease-Care Process (Borde et al., 2015, 2019) highlights the need to go beyond recognizing the social factors that impact health inequalities, by incorporating into the analysis the power relations that solidify social hierarchies and the resulting exclusions and marginalizations upon which the system of inequalities is based. More than acknowledging existing and measurable inequalities, as the SDoH model does, it is about advancing towards identifying and addressing the structural causes of these inequalities, which requires understanding class, race, ethnicity, and gender as analytical categories within the matrix of colonial/modern capitalism domination (Quijano, 2005). From this perspective, the dimensions of class, race and gender are not treated as accessory elements, or specific areas that only concern the inclusion of marginalized groups in existing health systems to guarantee their access. In the Social Determination model, the health-disease-care process is "an integral part and expression of social processes and the configuration of power in specific territories" (Borde & Hernández, 2019), thus equity will only be possible through the transformation of the very system that reproduces inequalities.

Aiming to advance the understanding of how the interactions of inequality dimensions operate in the context of the COVID-19 pandemic in South America, the concept of intersectionality is adopted as a theoretical tool that describes the overlap of multiple power relations in reinforcing and creating new forms of exclusion. In this sense, intersectionality demands "to radically reimagine" (Elnaiem, 2021) public

health praxis, based on an understanding of how structural factors and political decisions impact the various social groups in exercising the right to health (Bowleg, 2021; Humphries et al., 2023).

According to the decolonial feminist Ochy Curiel (2018), Black feminist thought teaches us that lived experience is an important source of knowledge. More than analytical categories, it is the awareness of lived reality that allows for the interpretation of how the matrix of oppression operates, "with its structural expressions, ideologies, and interpersonal aspects". In this sense, the interplay between racism, colonialism, classism, and heteronormative patriarchy can be observed through four factors:

- structural elements, reflected in legal frameworks and institutional policies;
- disciplinary aspects, present in bureaucratic hierarchies and surveillance techniques;
- hegemonic elements, which refer to dominant ideas or ideologies;
- interpersonal aspects, reflected in the discriminatory practices of everyday experiences.

In the following sections, an effort is made to identify these characteristics in the context of access to health care in South America during the COVID-19 pandemic, within the constraints of time and the availability of information reached by desk research. To this end, relevant studies and documents published on the subject were utilized, both from the academic field and by international and civil society organizations.

THE RESPONSE TO THE COVID-19 PANDEMIC IN SOUTH AMERICA AND THE BARRIERS TO THE RIGHT TO HEALTH

As a contribution to the reflection on the social determination of the health-disease-care process during the context of COVID-19 in South America, from an intersectional perspective, this paper addresses the four central factors for understanding how social processes and existing power dynamics shaped the impacts of the pandemic in the region, organized in two sections: in the first one, it is addressed both the structural elements and the disciplinary aspects; in the

second one, the discussion focus on the ideological aspects and how it reflects on the discrimination faced by "racialized, impoverished and sexualized" (Curiel, 2018) social groups.

The focus of this first section is the approach adopted in the pandemic response policies, which were mostly focused on containment and isolation. Primarily based on a security logic — security for some groups at the expense of others — such policies employ a punitive structure that reinforces existing power dynamics and the privileges of class, race, and gender, and diverge from a comprehensive approach to health as care and a human right.

The lack of a legal and political framework based on a comprehensive health approach, which would contribute to creating adequate conditions for COVID-19 prevention, is added to by the challenges faced by women, pregnant people[1], migrants, sex workers, and Indigenous populations in accessing healthcare services, especially sexual and reproductive health services, which will be addressed in the second section.

The overlapping dynamics of existing power relations with inequalities shaped by the social experiences of gender, race, ethnicity, class, and territory[2] require an intersectional approach for the creation and maintenance of public policies that ensure access to health in terms of availability, accessibility, acceptability, and quality.

THE REINFORCEMENT OF INEQUALITIES UNDER AN EXCEPTIONALITY APPROACH

One of the hallmarks of responses to international health emergencies has been a technocratic framework that claims the exceptionality of immediate threats to justify supposedly universal protection measures, based on authoritarian decisions that neglect existing knowledge in the territories and reinforce existing vulnerabilities,

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1- The term pregnant people is adopted as gender-inclusive language to refer to all people who can get pregnant, including women, trans men, non-binary and other gender-expansive people.

2- The term territory is used by Latin American' social movements, particularly of indigenous and traditional people, to counter hegemonic perspectives built on modern/colonial power, by opposing "the dichotomous vision between materiality and spirituality, nature and society" (Haesbaert, 2020). Territory refers to the integral relation established with the spaces where the community lives, including cultural, ecological, spiritual and other dimensions of life.

“rather than confronting the causes of the epidemics, rooted in the social determinants of health” (Duarte; Valença, 2021). Responses to health emergencies based on a security perspective dismiss the possibility of building integrated responses that consider existing inequalities, ignore ongoing territorial initiatives and reinforce the protection system for privileged groups.

The measures of social distancing and isolation were one of the most discussed and used mechanisms in the initial response to COVID-19. Different containment strategies included movement restrictions, curfews, mandatory quarantines, school closures, border control and the suspension of certain economic activities (Litewka & Heitman, 2020). In Peru, a state of national emergency was declared in March 2020, with mandatory social isolation, initially for 15 days, extended until July 30, due to continued increases in the number of COVID-19 cases. The quarantine included a curfew from 8pm to 5am, when people could only leave their homes to access food, medicine, health services and attend to other activities considered essential (Resurj & Vecinas Feministas, 2021). Despite being necessary in terms of containing the spread of the virus, isolation measures were not easily feasible for a significant part of the population, especially for those who depended on the informal economy.

In South America, informality is a very present reality, which largely translates into a lack of rights and social protection for working people. During the pandemic, the informality rate was around 40% in Argentina and Brazil and 53% in Ecuador. In Peru, this rate reached 70% (CEPAL, 2022). The health crisis caused by the COVID-19 pandemic also fostered an economic crisis that affected different social groups in unequal ways. While privileged groups spoke of “opportunities generated in the crisis”, the absolute majority of impoverished populations did not even have the option of isolating themselves or looking for alternative ways to carry out their work.

In Peru, as in Bolivia, around 85% of the population living in poverty have no access to the internet (CEPAL, 2020). According to the World Bank (2023), around 60% of Peruvian households lack one or more essential services, such as safe-drinking water, sanitation and electricity, which made it challenging to follow the COVID-19 protection recommendations. In Argentina, 45% of homes in urban areas have no access to sanitation and 16% have no access to safe-drinking water. In the state of Pernambuco, in the Northeast of Brazil, the outskirts of urban areas have historically struggled due to lack of basic infrastructure, including access to water. Some

neighborhoods have gone up to six weeks without water supply, while economically privileged locations tend not to suffer from these problems (Articulação Recife de Luta, 2020).

Resistance and Solidarity in Pernambuco, Brazil

While WHO (2020) was recommending hand washing as an effective tool to prevent COVID-19, the community-led initiative *Articulação Recife de Luta* launched a campaign to end, at least during the pandemic, the discriminatory policy in the state's water supply.

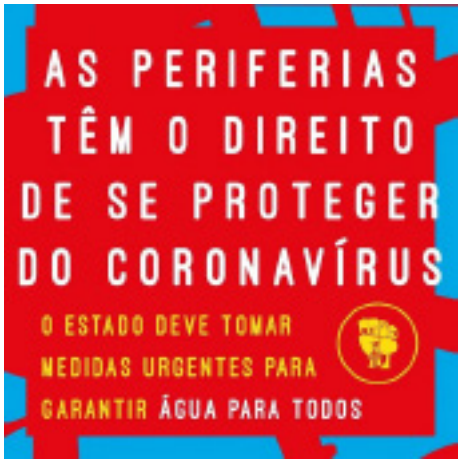

Figure 1: Campaign by Articulação Recife de Luta highlighting the need for urgent measures to guarantee access to water in underserved communities during the COVID-19 pandemic. The image emphasises that people from neglected communities have the right to protect themselves against the coronavirus and it calls for state action to guarantee water for all (Articulação Recife de Luta, 2020).

As a way of resisting the lack of effective multi-sectoral policies, solidarity networks led by affected communities and social movements played a central role in meeting emergency demands (*Santos et. al*, 2021). This is the case of the *Fórum de Mulheres de Pernambuco* (FMPE), in Brazil, which, based on the premise of solidarity as a feminist practice, has organised an important support network among its members.

Beyond promoting food security among people in situations of greater vulnerability, they acted as health advocates by disseminating accessible information about the pandemic that could be adapted to the realities of neglected populations. According to Heloína Paiva, member of the Pernambuco Women's Forum:

> We are allies on a daily basis, and our solidarity is also based on affection and political encounters. When we support each other as comrades, we support our families, or those who depend on us, or our communities and territories. And this is crucial to the network's existence and relevance. We also stimulate our collective action as FMPE. Acting as a network allows us to demand that the state fulfil its role, because we don't want to do what is its duty. We're providing short-term emergency support, but that's not our job, because otherwise we'd be acting on welfare. Our role is to engage in advocacy and political struggle (AFM, 2021).

Making use of social media, WhatsApp and community radio, FMPE solidarity network disseminated informative and educational content, produced with the aim of providing information that would help protect people in precarious situations while highlighting the problems related to the lack of democratisation in access to public services. This is the case of the "Economic Hygiene Manual: How to Prevent Covid-19 with Little Water and Little Money?" (Figure 2) (Fórum de Mulheres de Pernambuco, 2020), produced by the FMPE's health and communication working groups.

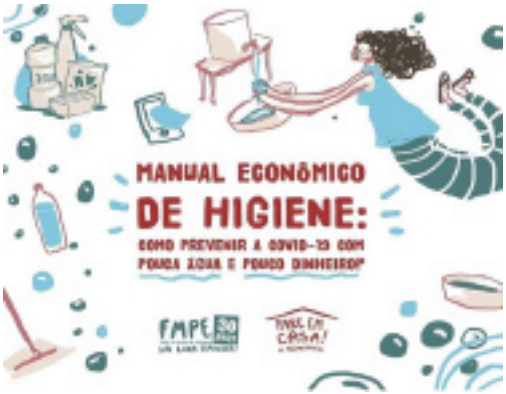

Figure 2: Figure 2: The image features a guide entitled "Economic Hygiene Manual: How to Prevent COVID-19 with Little Water and Little Money?", produced by FMPE, which points out affordable and sustainable hygiene practices during the COVID-19 pandemic. The guide emphasises the importance of staying at home whenever possible to reduce the spread of the virus (Fórum de Mulheres de Pernambuco, 2020).

Approaching the context experienced by different social groups is fundamental to understanding the barriers to compliance with the measures adopted in the context of the pandemic. In addition to these difficulties, there was also stigmatization of people who failed to comply with the imposed quarantine rules: “people who are not at home or show up breaking quarantine are labelled as irresponsible or selfish regardless of personal situations”. Stigma generated fear and delays or reluctance to consult health centers, which worsened the contagion (Resurj & Vecinas Feministas, 2021).

Policies aimed at promoting the right to health need to guarantee a welcoming approach that is sensitive to the reality experienced by people. However, what was observed in many countries in the region was the use of the context of the pandemic to “run the cattle through”[3] under sanitary justification, reinforcing abuses and punishments that function as mechanisms of control and reinforcing structural inequalities of class, gender, race, ethnicity and nationality. Instead of approaches of care, what we saw in the implementation of health quarantine policies were approaches of social repression and criminalization of groups that did not conform to the imposed norms, without considering their due adequacy.

During the first week of application of the health measure of compulsory social isolation in Peru, around 16,000 people were arrested for non-compliance with the measure. On a single day - March 24, 2020 - 2,451 people were arrested for this reason (Díaz, 2020). In April 2020, through a legislative decree, administrative sanctions were established for non-compliance with sanitary measures, which were monitored by the national police, and which could become criminal sanctions with a prison sentence of more than three years, according to the Peruvian Penal Code. Claudia Montalvo, a Peruvian woman who was violently and arbitrarily detained by the police, along with her girlfriend, María, in March 2020, said that “I’m afraid to go out, but it’s not because of the pandemic, it’s because of the violence” (Montalvo, 2020).

Many countries in the region have punitive mechanisms for crimes against public health in their penal codes and these mechanisms were activated and, in some cases, intensified during the pandemic. According to the analysis carried out

3- An expression used by a Brazilian minister during the pandemic to refer to the need to take advantage of the moment when attention was focused on the pandemic to approve policies and legislation with low popular support.

by the feminist alliance Realising Sexual and Reproductive Justice and Vecinas Feministas por la Justicia Sexual y Reproductiva en América Latina (Resurj & Vecinas Feministas, 2021), these measures are applied as a tool of social control, without a solid public health foundation, and based on high selectivity, both from the point of view of social class, but also based on elements of gender, race, ethnicity and nationality.

Far from being an exception, the case of Peru shows a reality that is replicated in many other countries in the region, where the police act quite differently depending on the area they are in and the population they interact with. This is evident in the dichotomy between violent interventions in cases of displacement in working class neighborhoods, and the high tolerance or even lack of enforcement in cases of agglomerations in economically privileged neighborhoods. Mónica Coronado, lesbian activist from Peru, highlights the abundance of cases of violent and disproportionate action from the police against women from working class neighborhoods and against trans women in Peru (Resurj & Vecinas Feministas, 2021).

The case of trans people in Peru is particularly striking, due to the institutional violence they were subjected to as a direct result of a state measure adopted with the aim of preventing new transmissions of the Covid-19 virus. By proposing a supposedly universal policy to "safeguard the lives of all Peruvians" (Quiñones, 2022, p.146), a new vulnerability factor was created for trans people, deepening the precariousness that existed before the pandemic. The sanitary measure established by the law adopted the logic of license-plate-based driving restrictions - which establishes alternate days for vehicles to circulate according to their license plate number - to propose a law on the circulation of people based on gender. In this way, it was established that women and men would be allowed to leave the house on alternate days, which resulted in the exposure of the trans community to acts of transphobia, especially on the part of the police. There were cases of multiple forms of violence, such as insults, abuse and humiliation, with direct impacts on the physical and mental integrity of trans women (Quiñones, 2022). According to trans Afro-Andean activist Gazela Cari - who had declared her opposition to the measure when it was announced - on the first day of the women-only circulation, more than 30 cases of discrimination by the police against trans women were recorded, despite public guidance from the Minister of the Interior regarding the need to respect gender identity when implementing the measure. For Cari, "this shows that talking is not enough. This is only the first step. Concrete and strict measures are needed to guarantee the rights and lives of trans people" (El Mostrador Braga, 2020).

The ‘pico y género’ law was repealed on April 11, 2020 (EP, 2020), due to its clear ineffectiveness, the growth of transmission cases in Peru, and the activism of the trans community. However, the maintenance of isolation measures, such as the curfew, lasted up to a year, a long period in which the control of movement included the review of personal documents, an especially vexatious situation for those people who do not have their legal right to self-perceived gender identity guaranteed by the state. In this sense, the effects of the measure adopted by the Peruvian government reinforces the need to guarantee the fundamental right of trans people to have their gender identity legally recognized and documented, since it constitutes a structural determinant of access to health care (Perez-Brumer & Silva-Santisteban, 2020).

By failing to recognize the concrete barriers faced by different social groups as a result of the intersections of the multiple inequalities to which they are subjected, many confinement measures adopted in response to COVID-19 transferred responsibility for the right to health to the individual. In this way, compliance with a universal standard was expected, without considering the structural dimensions that enable its realization.

The logic of exceptionality that justifies containment measures as a necessary reaction to the urgency of returning to ‘normal’ reflects a technocratic framework that does not question the status quo and its role in producing neglect and vulnerability. In the case of the COVID-19 pandemic, the unsustainability of the neoliberal model, based on the supposed efficiency of the market and individualism, was demonstrated by the impossibility of adopting prevention and care measures for marginalized population groups.

BARRIERS TO THE ACCESS TO HEALTHCARE SERVICES

The context of the COVID-19 pandemic imposed a series of challenges on health systems in South American countries, due to the exponential increase in demand for health services and the consequences of social isolation measures. The capacity of health services not directly related to COVID-19 was significantly impacted by the reallocation of resources and healthcare professionals to frontline work. According to the WHO (2020), previous experiences of international health emergencies had already demonstrated the need to guarantee the provision of essential health services, including reproductive health services, particularly those related to the prevention and care of pregnancy, childbirth and the puerperium, as well as the termination of pregnancy (Clacai, 2020).

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Despite the recognition by various international bodies of sexual and reproductive health services as essential health services, including a call from the Inter-American Commission on Human Rights for states to maintain their operation in the countries of the region, what was observed was a significant regression in the guarantee of the sexual and reproductive rights of girls and women. In the first months of the pandemic, UNFPA (2020) reported the reduction of access to sexual and reproductive health services, and the need to guarantee reproductive planning services, prevention and treatment of sexually transmitted infections and HIV, access to emergency contraception, services for voluntary and/or legal termination of pregnancy, clinical care for cases of sexual violence, and during pregnancy, childbirth and the postpartum period. One year later, the Inter-American Commission on Human Rights (OEA, 2021) expressed its concern about the initiatives and political decisions taken in the context of the COVID-19 pandemic, which created obstacles to the sexual and reproductive rights in the Americas, especially for women and girls in situations of vulnerability.

Between January and March 2021, 64% of Latin American and Caribbean countries experienced interruptions in reproductive planning and contraception services. Among the countries where these services were not interrupted, several reported a reduction in capacity of more than 50%. In Argentina, the number of contraceptive consultations fell from 77,795 in 2019 to 23,509 in 2020, and the distribution of long-acting reversible contraceptive methods went from 33,870 to 16,485 units in the same period. In Bolivia, Pap tests more than halved between 2019 and 2020, from 511,723 to 238,469. There were also significant reductions in sexual violence prevention and response services of around 50%, and in safe abortion and post-abortion care services of 33% (CEPAL & OPS, 2020).

According to the monitoring carried out by the regional platform Mira que te Miro (Malajovich & Re, 2023), South American countries had not adapted their sexual and reproductive health programs in the face of COVID-19, apart from occasional exceptions found in Chile and Bolivia, which created protocols for pregnant women during the pandemic, and minor adjustments made by Uruguay to the sexual and reproductive health care programs for young people. In this context of fragile health policies, the lack of an intersectional approach to adapting the rules and protocols for access to sexual and reproductive health services had led to a significant setback in the guarantee of historically established rights.

In some countries, such as Argentina, Colombia and Uruguay, abortion services were declared essential services during the pandemic. In other countries, such as Bolivia, Ecuador and Peru, abortion services were not included among the reproductive health services declared essential. In the case of Chile, reproductive health services were not recognized as essential during the pandemic, against WHO recommendations (Clacai, 2020).

Most countries maintained the same requirements for abortion, including, in the cases of Bolivia, Chile, Ecuador and Peru, the need for hospitalization in a second-level healthcare center, which goes against WHO recommendations (WHO, 2015). Few countries adopted measures to facilitate access to abortion services during the pandemic. In Argentina, progress was made in the use of telemedicine and the adoption of electronic prescriptions. In Colombia, previously approved strategies were implemented to guarantee the provision of abortions through telemedicine, but there is still a great disparity between private and public services. In both cases, even with the reach of telemedicine in terms of online consultations and prescriptions, logistics in terms of drug delivery and referral in cases where hospitalization was required was a challenging element given the context of a shortage of personal healthcare and mobility restrictions. Added to this was inequality in terms of access to technology and the internet, a barrier that exists mainly in rural areas (Michel *et al.*, 2022).

The lack of adequate information on how to access abortion services is a barrier that exists in different countries and mainly affects women in situations of greater vulnerability, such as indigenous and migrant women in the cases of Colombia, Ecuador and Peru. The need to seek information in more than one place before accessing the service was especially difficult in times of restricted mobility and risk of infection. Bolivia, Peru and Ecuador were the countries with the biggest drops in the rates of abortion services carried out in the public health system, reaching 86% in the case of Peru, which raised concerns about the increase in unsafe practices, complications and deaths, as well as the consequences of unwanted pregnancies. It's worth emphasizing that in Peru and Ecuador the availability of contraceptives was strongly affected by the "almost total shutdown of primary healthcare during the first semester of 2020" (Michel *et al.*, 2022, p.8), where the number of maternal deaths increased by 12% and 21% respectively.

In the Brazilian case, the Ministry of Health created new prerequisites for access to abortion during the pandemic, such as the need to prove registration with the

police in cases of abortion due to sexual violence, and the possibility of medical staff offering ultrasound to force pregnant people to see the fetus and listen to its heartbeat. The measure had strong repercussions in the media and a reaction from feminist movements, which led to its later cancellation. It is interesting to note that, despite the restrictive measures implemented by the Brazilian government, and the suspension of around 55% of the country's legal abortion services (Artigo19, 2022), there was an increase in the number of abortions performed, which reinforces the hypothesis that availability of information is a central dimension of access.

The context of multiple challenges to accessing sexual and reproductive health services is not new in South American countries. The difficulties brought about by the COVID-19 pandemic, in terms of restrictions on movement, economic precarity, and fear of contagion, added to existing barriers related to a lack of supplies and medical attention, as well as the ongoing ideological pressure on the services that exist to guarantee sexual and reproductive rights. These rights, which are fundamental, particularly for ensuring the human rights of women, pregnant individuals, LGBTQI+ people, young people, and sex workers, are under constant attack in patriarchal societies, where control over these bodies and lives is part of the structural matrix of power relations. Sônia Correa (2022) highlights that "in the countries where social actors and some governments were for a long time propagating speeches of praise and defense of the 'family', there was a clear resurgence of domestic and sexual violence".

GENDER-BASED VIOLENCE AGAINST WOMEN, CHILDREN AND LGBTQI+ PEOPLE

In July 2020 - when South America had been announced by the WHO as the new epicenter of the COVID-19 pandemic - a joint report published by CEPAL and PAHO (CEPAL & OPS, 2020) pointed out that women would be especially affected by the pandemic, due to their majority share of the informal economy and care work. They also warned that women would be particularly affected by the containment measures, which would leave them more exposed to situations of domestic violence.

It is well known that confinement in the domestic space led to an increase in violence against women, children and LGBTQI+ people, groups for whom the family environment has historically been violent. In Colombia, the number of calls to the hotline on gender-based violence increased by 127% in 2020 (Perez-Vincent & Carreras, 2022). In Chile, the Ministry of Women's Affairs reported a 70% increase in

calls to the hotline for advice on intrafamily violence (teleSUR, 2020). In the case of Peru, the increase was 48% (Agüero, 2020), and in Argentina 39% (CLADEM, 2021). Some studies suggest that the availability of a dedicated hotline to deal with cases of gender-based violence increased the chances of reporting it during the pandemic, as opposed to reporting it directly to the police (Perez-Vincent & Carreras, 2022).

In the case of Argentina, 98% of the people who reported cases of violence were women: 63% of them were aged between 15 and 44; 3% reported some kind of disability; and 2% were pregnant. Most cases were of domestic violence (90%), psychological violence (95%) and physical violence (67%). Around 13% of cases involved sexual violence and 14% involved the use of a firearm or sharp weapon. In 90% of the cases reported, the people accused were men, 44% were ex-partners and 39% current partners (Ministerio de Justicia de Argentina, 2020). In this scenario, the work of care networks and solidarity movements was fundamental in supporting women in situations of violence, but it also highlighted the need for greater coordination between national and state governments, which need to work together to implement existing guidelines effectively. In the province of Tucumán, feminist organizations carried out a successful campaign to get the state to adopt the National Law on Mandatory Gender Training, for all people who are part of the state government. Thus, in May 2020, the so-called Micaela Law was approved by 39 votes in favor and 8 against (CLADEM, 2021).

Different countries in South America adopted measures to guarantee women's access to services for reporting and monitoring cases of gender-based violence, whether in person, digitally or by telephone. In Paraguay, protocols were drawn up focusing on inter-institutional coordination for the rapid care and protection of women in situations of violence during the health emergency period, as well as for receiving women and their children in shelters. Ecuador drew up a protocol for the comprehensive care of victims of gender violence under the teleworking modality and adopted a protocol for communicating and caring for cases of gender and intrafamily violence during the Health Emergency, including the various services provided by different public institutions (Malajovich & Re, 2023). In Chile, a measure called Mascarilla 19 was adopted, which proposed that women use a keyword to report situations of violence and receive help in pharmacies. However, there is little data on the effectiveness of this type of measure, which seems to have more of a media effect than actually promoting protection and access to services for women in situations of violence (Albert, 2020; CLADEM, 2021).

Establishing services that respond to the vulnerabilities experienced by different social groups involves questioning socially established structures, such as the idea of the heteronormative family as a space for care and protection. During the pandemic, there was little progress in terms of the attention given in healthcare services to situations of sexual violence. In Argentina, Bolivia, Peru and Uruguay, there were initiatives to adapt existing protocols to the context of social isolation. However, in countries where there were no protocols for addressing cases of sexual violence in health services before the pandemic, no changes were identified in this context. In Argentina, communication campaigns were set up to publicize the hotlines, and in Uruguay, messages on gender-based violence were drawn up aimed especially at secondary school teachers and students (Malajovich & Re, 2023). In Brazil, the number of cases registered between 2019 and 2020 decreased significantly, which suggests an increase in underreporting, considering that in the country, only 6% of reports of violence against children and adolescents are made by children (Agência Câmara Notícias, 2022).

Just as it is necessary to confront hegemonic ideologies regarding family and gender relations to conceive health services that are accessible and appropriate for children, adolescents, young people, women, and others in situations of violence, it is essential to highlight the discriminatory practices directed against racialized populations. In the name of an exclusionary notion of citizenship, rights are denied based on nationality and documentation criteria, obstructing access to services and rendering diverse languages, cultural background, ways of life, and knowledge invisible.

Colombia's Ministry of Health reported a 40% increase in cases of gender-based violence against the Venezuelan population in the country between January and September 2020, compared to the same period in the previous year (PAHO, 2021). According to the Public Defender's Office (Defensoria del Pueblo de Colombia, 2021), throughout 2020 the states of Arauca, La Guajira, Norte de Santander, Putumayo and Santander recorded 1,617 cases of violence against women or people with diverse sexual orientations and gender identities in border areas. Of this total, 515 cases were against migrants or asylum seekers, who were more exposed to food insecurity, eviction for non-payment of rent, and cases of sexual violence.

THE RIGHT TO HEALTH OF MIGRANT AND REFUGEE POPULATIONS

According to the Economic Commission for Latin America and the Caribbean (CEPAL, 2022), there is very limited official data on the impact of the pandemic and

the policies adopted on migrant and refugee populations in the region. It is known, however, that they were strongly impacted by containment policies, which included the closing of borders. In South America, the situation of the more than five million Venezuelans who are migrants or refugees stands out. Of these, around two million were in Colombian territory during the pandemic, and 57% of them did not have the migratory documents required to access health services (NRC, 2021). In December 2020, the then President of Colombia, Iván Duque Márquez, announced in the media that Venezuelan migrants and refugees who were not regularized in the country would not have access to the COVID-19 vaccine (Radio Nacional de Colombia, 2020). This reinforced the denial of the right to health that undocumented Venezuelans were already subjected to in Colombia.

Once again, the national identification document appears as an important condition for access to healthcare. For indigenous Venezuelans from the Warao, Wayu and Motilón Barí peoples, the process of regularizing documentation in countries like Guyana and Brazil had been easier, because of the support of international and civil society organizations. In Colombia, although cross-border indigenous peoples are considered binational (Colombian and Venezuelan), they had encountered more difficulties in the process of legal recognition, due to the lack of an agreement between the countries (R4V, 2021).

Indigenous migrants and/or refugees from Venezuela reported intensified experiences of racism and xenophobia during the pandemic in their interactions with state institutions, including health services, “not only for being indigenous, but also for being indigenous Venezuelans” (R4V, 2021, p.40), in addition to their economic condition, physical appearance and the fact that they didn’t speak the same language.

Venezuelan refugees and migrants who are sex workers also reported experiences of discrimination by public institutions in South American countries. Even when they had the documents proving their refugee status, they were denied access to health services. More than the documentation itself, they saw stigma as one of the main barriers to accessing health, protection and justice services:

> I don’t feel that it is only because of the nationality (...) I feel it is because of our gender and the work we do. Even if they want to show an image of respect, it is pure image, they do not respect us as a population, nor as migrants, nor for our gender. (...) Not even in the hospitals we are given attention. If the clients hit

> us they do not provide us services and the police do not do anything, rather we are evicted, they run us around and do not let us ask for help. For them, we are 'thieves, insects' (R4V, 2021, p. 38).

During the pandemic, the multiple vulnerabilities in their work were reinforced by the need to meet clients in less safe spaces, the difficulty in protecting themselves against COVID-19, and the lack of access to sexual and reproductive health services, particularly related to the prevention of sexually transmitted infections. In addition, treatments for other pre-existing illnesses, including chronic diseases, were compromised due to the overburden of services capacity with COVID-19 cases.

The experience of Venezuelan migrant women who are sex workers is fundamental to understanding the limitations of existing health policies in terms of availability, accessibility, acceptability, and quality. Not only were they affected by the reduction of health care services during the pandemic (availability), but they also faced bureaucratic barriers because of the lack of documentation (accessibility), discrimination because of their social identification in terms of gender, nationality and the work they do (acceptability), and the lack of adequate services that respond to their needs (quality).

The limits of the health care services to respond to the diverse and unequal realities lived by marginalized populations during the pandemic highlighted the urgent need to reformulate health care systems, from an intersectional perspective of the right to health, which considers the determination of the health-disease-care process and adopts a comprehensive approach to the right to health.

LESSONS LEARNED AND RECOMMENDATIONS

Beyond a health crisis, the COVID-19 pandemic has proved to be a structural crisis, which demands "tensioning the continuous production of inequality, the circulation of power, and the production of relations of domination and neglect" (Di Giulio et al., 2023). At the same time that we need to understand how political norms and regulations operate to maintain and reinforce inequalities, we need to identify strategies that can reduce vulnerabilities and advance the right to health. Learning from the lived experiences of women, migrants, indigenous, sex workers, youth and LGBTQI+ people, regarding the barriers faced to their right to health during the pandemic, we share here some recommendations:

• *Investments in public health systems and services are crucial to strengthen the capacities to maintain continuity of health service delivery during times of sanitary crises*. It is essential to highlight the role of States as guarantors of the human right to health, both to reinforce their obligation to guarantee the necessary conditions of protection and collective care - as opposed to approaches that individualize responsibility - and to demand transparent, responsible and sustainable responses, "that go beyond biomedical and epidemiological aspects" (Ventura; Rached, 2023).

• *Promote multisectoral responses that safeguard the rights of people in vulnerable situations, in terms of both health sector responses and wider social policy responses.* Understanding the integrality of the right to health requires recognizing its interdependence with the various dimensions of social and political life, as well as its implications for human rights and democracy. Failure to recognize the social, political and economic dynamics in which health-disease-care processes are embedded leads to neglect of their structuring causes and the experiences lived by marginalized groups.

• *Strengthen national statistical systems, capable of providing timely, accurate and disaggregated data on the right to health*. The production of data at the national and local level is critical to identify inequalities in access to healthcare, to make decisions based on evidence at the national and local level, and to monitor the effects of the policies implemented. Evidence-based policymaking is an important strategy to build policies based on the lived realities in the territory, as well as to counter denialism and ultraconservative forces seeking to impose individual moral values in universal public policies. There is a need to improve the identification of cases, the referral systems for specialized services and the training of healthcare professionals. It is particularly worrying that there is limited information on strategies aimed at preventing and addressing sexual violence against children and adolescents.

• *Remove barriers impeding marginalized populations accessing healthcare and social protection services*, including, but not limited to: promoting legal recognition of gender identity of trans and gender-diverse people, and legal recognition and access to documents to migrant and refugee people, as a way of facilitating their access to healthcare services and social protection policies, and to prevent situations of institutional violence, particularly in times of sanitary crisis; ensuring public health information and communication is available and accessible, including for those with limited access to technology, in rural and remote areas, and establishing and/or

expanding helplines to inform about sexual and reproductive health services and for reporting gender-based violence.

• *Improve the mechanism of dialogue and consultation between government and civil society organisations at the national and the local level*, to advance the elaboration of adequate public policies and services. Top-down decisions and lack of transparency about information shared and the use of resources available during the COVID-19 pandemic were described as “a good example of the growing chasm between people and their governments” (Clark, Koonin, Barron, 2021). Community participation not only during health crises, but in a permanent and coordinated way is an essential part of strengthening health systems and building effective responses: “they know what knowledge and rumours are circulating; they can provide insight into stigma and structural barriers; and they are well placed to work with others from their communities to devise collective responses” (Marston et al, 2020). Health responses grounded on community engagement are crucial to guarantee solutions that take into account the lived realities of marginalized populations and do not reproduce previously established inequalities.

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Manuella Donato is a feminist researcher and activist from Pernambuco, in the Northeast of Brazil. For over fifteen years, she has dedicated her work to gender justice, sexual and reproductive health and rights, youth engagement and the HIV/Aids response, from a human rights perspective. She holds a PhD in sociology, master's degrees in political science and international relations, and a graduate specialization in gender, development and public policy.

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