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WHO GETS TO ACCESS HEALTHCARE?

LESSONS FROM THE PANDEMIC ON ACCESS TO HEALTH IN MEXICO AND CENTRAL AMERICA FROM A FEMINIST INTERSECTIONAL PERSPECTIVE

Natalia Marsicovetere Fanjul

FEMINISTS
FOR A PEOPLE'S
VACCINE

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INTRODUCTION

The first case of COVID-19 in Mexico was detected on February 27, 2020, followed by the first case in Central America on March 6, 2020, in Costa Rica. By mid-March 2020 all of Mexico and Central America had implemented emergency prevention and attention protocols for COVID-19. The COVID-19 pandemic exacerbated pre-existing issues in public healthcare, highlighting inequality, unaffordability and the exclusion of certain populations based on neoliberal and anti-gender government models.

This paper looks at how social, political and commercial determinants of health worsened the pandemic's effects on marginalized communitiesas well as lessons learned and the demands of these communities for more equitable and inclusive healthcare. These findings are based on a combination of desk research and interviews with activists from the region. The main limitation of the study is the lack of public data available from governments, especially regarding the impact of COVID-19 on marginalized communities in Mexico and Central America.

THE DETERMINANTS OF HEALTH IN THE CONTEXT OF COVID-19

To understand the structural causes of public health issues and to design effective policies to address them, three main frameworks have been proposed in international public health: social determinants of health (SDoH)[1], the commercial determinants of health (CDoH)[2] and political determinants of health (PDoH)[3]. While these frameworks have limitations, analyzing healthcare access through these determinants pinpoints systemic and structural causes of the collapse of healthcare systems during the pandemic.

1. SOCIAL DETERMINANTS OF HEALTH (SDOH)

The SDoH framework, proposed in 2008 through a commission in the World Health Organization, analyzes how different types of education, healthcare, work,

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1- Marmot et al., "Closing the Gap in a Generation."

2- Gilmore et al., "Defining and Conceptualising the Commercial Determinants of Health."

3- Dawes and Williams, *The Political Determinants of Health.*

living situations, access to goods and services are key factors in a person's health outcomes.[4] In the context of the pandemic, it was found that in general there was a correlation between low income and higher COVID-19 infection incidence, which was observed in the Latin America region. It was also observed that women were more likely to be infected with COVID-19, possibly due to women usually being socially assigned the role of caretakers and thus at higher risk of infection.[5]

Although the SDoH framework has the important merit of challenging reductionist behavioral and biological frameworks of public health, it has been criticized by scholars and health practitioners in Latin America for not taking into account the sociopolitical processes that give way to health disparities.[6,7] Additionally, this framework has been criticized for focusing on marginalized populations as "passive victims of inequality and, thus, carriers of risk" and does not factor in the agency that people have of using various resources, such as community and social resources, to address health.[8] For this reason, the commercial and political determinants of health have been proposed as complementary frameworks, particularly for complex sociopolitical contexts like Latin America.

2. COMMERCIAL DETERMINANTS OF HEALTH (CDOH)

More recently, adding on to the SDoH analysis, the CDoH framework has also been proposed considering the "factors that influence health which stem from the profit motive".[9] This refers to how commercial entities engage in practices, policies and norms that prioritize their capitalistic profit over the protection of health, environment and social cohesion.[10] The CDoH are also connected to the legacies of colonization and slavery, in which people of the global South who have been historically dispossessed of land face structural inequities in health.[11] In Mexico and Central America, this group primarily comprises indigenous people living in rural areas, who are a large part of the informal workforce.

4- Marmot et al., "Closing the Gap in a Generation."
5- Antoñanzas Serrano et al., "Los Determinantes Sociales de La Salud y Su Influencia En La Incidencia de La COVID-19. Una Revisión Narrativa."
6- Borde and Hernández, "Revisiting the Social Determinants of Health Agenda from the Global South."
7- Harvey, Piñones-Rivera, and Holmes, "Thinking with and Against the Social Determinants of Health."
8- Frank et al., "The Social Determinants of Health."
9- West and Marteau, "Commentary on Caswell (2013): The commercial determinants of Health"
10- Gilmore et al., "Defining and Conceptualising the Commercial Determinants of Health."
11- United Nations, "Report by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Racism and the Right to Health."

This framework provides a critical view of how commercial actors have gotten involved in decision-making processes and capture functions of the state, shaping public policy to serve their interests.[12] In the context of the pandemic, the CDoH played a crucial role in the spread and management of COVID-19. There is evidence on how these affected the procurement of PPE, rapid antigen tests, the availability and rollout of vaccines (particularly in the Global South), as well as public health regulations due to lobbying of commercial actors to maintain profit.[13]

3. POLITICAL DETERMINANTS OF HEALTH (PDOH)

There are power-dynamics in both SDoH and CDoH and implicit within them power imbalances that constitute the PDoH that underly them. Hence, PDoH are not separate or distinct from the SDoH and CDoH; but a catalyzing factor of both[14] The PDoH are defined as "involving the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities."[15]

The COVID-19 pandemic shed light on the impacts of the PDoH on public health outcomes around the world. These impacts include corruption as health is one of the sectors most prone to corruption. This is heightened during emergencies like COVID-19 in which regular procurement and transparency regulations are lifted to prioritize crisis response.[16] In such emergencies, exceptions are made in procurement protocols, public spending controls[17], which leave important gaps and loopholes from which those in positions of power can benefit. COVID-19 became a tool for political coercion as well. For instance, there is evidence on how COVID-19 public policy, including vaccine rollout and data collection, were manipulated to influence electoral outcomes in countries around the world.[18,19]

12- Lee and Crosbie, "Understanding Structure and Agency as Commercial Determinants of Health Comment on 'How Neoliberalism Is Shaping the Supply of Unhealthy Commodities and What This Means for NCD Prevention.'"
13- Freeman et al., "Illustrating the Impact of Commercial Determinants of Health on the Global COVID-19 Pandemic."
14- Dawes and Williams, *The Political Determinants of Health*.
15- Dawes, Amador, and Dunlap, "The Political Determinants of Health: A Global Panacea for Health Inequities."
16- Wilson Center, "COVID-19 and Latin America's Epidemic of Corruption."
17- Wilson Center.
18- Público, "Este fue el rastro de corrupción y mentiras que dejó el COVID-19 en Centroamérica."
19- Arija Prieto et al., "Political Determinants of COVID-19 Restrictions and Vaccine Rollouts."

PDoH also include how political bipartisanship impacted access to health of specific populations. In Mexico and Central America, the rise of authoritarian populist democracies and anti-gender ideology[20] heavily influenced public policy in healthcare, particularly for women and LGBTI people, as well as general sexual and reproductive care access. This led to inequality in healthcare access for these populations, which was made worse by the further deprioritization of related health services.

4. AN INTEGRATED FRAMEWORK

Proponents of an integrated framework that combines the SDoH, CDoH and PDoH highlight a multisectoral and multidisciplinary approach for health equity.[21] In the context of the COVID-19 pandemic, this integrated framework of health determinants encompasses and combines several factors and entities - the root causes of unequal access to health, corruption, and the roles of international corporations, local and national governments and anti-rights movements.

THE NEOLIBERAL STATE: THE RIGHT TO HEALTH FOR THE "RIGHT" WORKERS AND IDENTITIES

The public healthcare systems in Mexico and Central America are shaped by neoliberal paradigms, characterized by weakened public health, privatized healthcare, austerity measures, intellectual property rights, and the influence of private corporations in policies and public health procurement.[22] This neoliberal model is a significant CDoH. It often comes hand in hand with other PDoH, such as autocratic governments that promote anti-gender ideologies[23], leading to the erosion of sexual and reproductive health, women's rights and the rights of LGBTI people.

This state model dictates who is included or excluded, and expendable; it excludes those it exploits through informal work and those it deems expendable through anti-

20- DAWN Feminist, "Feminists for People's Vaccine - Issue Paper #1."
21- Freudenberg, "Integrating Social, Political and Commercial Determinants of Health Frameworks to Advance Public Health in the Twenty-First Century."
22- DAWN Feminist, "Feminists for People's Vaccine - Issue Paper #1."
23- DAWN Feminist.

gender ideology.[24] Those marginalized by State recognition are primarily left out of public healthcare, wellness support, and public policies. This was evident during the pandemic, in which legal recognition became a crucial factor in accessing healthcare and government aid for unemployment.

A. INFORMAL ECONOMY AND SEX WORKERS' RIGHT TO HEALTHCARE

An important CDoH is how informal economy workers are underpaid, overworked and deprived of basic worker rights, like social security, as this allows for the increased profit and benefit of corporations and those in positions of power. Workers in the informal economy include domestic workers, farmers, sex workers, small scale traders, transport and delivery drivers, sweatshop workers, and other blue-collar workers in jobs that are not officially recognized by the State. Although these workers were often considered "essential" during the pandemic, they were unable to access social security, government aid and other forms of worker protections.

This, in combination with PDoHs like anti-rights and anti-gender ideologies in the State, left informal economy workers in industries like sex work without government aid or access to social insurance healthcare during the pandemic. The lack of recognition of sex work gave healthcare providers excuses to discriminate against sex workers, using COVID-19 as an excuse to refuse health care services. Furthermore, sexual health clinics were shutdown, depriving them of access to crucial care, including lubricants, condoms, and HIV testing[25]. As a result of this, only 34% of sex workers in Latin America had access to healthcare during 2020.[26]

By early 2021, 54.8% of sex workers in Central America had experienced a reduction of income; 40% from a reduction in their work hours and 30% from a reduction in the number of clients.[27] In 2020 Costa Rica launched Plan Proteger[28], a government programme of assistance for people who had lost their livelihood due to COVID-19, which provided a 3-month unemployment stipend. Sex workers were unable to

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24- Travaglia and Robertson, "The Necropolitics of COVID-19."
25- Mulabi, Interview with Mulabi.
26- Alpízar Lobo, Rivers-Moore, and Hardy
27- Alpízar Lobo, Rivers-Moore, and Hardy
28- Ministerio de Planificación Nacional y Política Económica, "Evaluación de Impacto Del Bono Proteger Determinó La Efectividad Del Programa | Ministerio de Planificación Nacional y Política Económica."

access this or any other form of government aid during COVID-19 despite the brutal impact of the pandemic on their livelihoods. The lack of legal recognition fostered stigma and invisibility in health policies, and the neoliberal healthcare model and anti-gender ideologies as PDoHs further marginalized them.

B. TRANS PEOPLE CAUGHT IN LEGAL IDENTITY LIMBO

Trans people throughout the region have been advocating for their legal gender recognition for decades and have warned of the huge impact this has on their access to health, employment, education and housing. Despite this, trans people were not considered in COVID-19 prevention and attention protocols, a result of PDoH such as anti-gender lobbying in the region which has purposefully marginalized gender diverse identities from state recognition.

For instance, Panama issued restrictions on civilian mobility from April 1, 2020, using biological sex as an identity on their legal/national documents. Men and women had designated days of the week for venturing out of home. This mobility restriction trapped trans people, who found it challenging to leave home. When they ventured out according to their identity document, they were questioned and detained for mismatch between their gender identity and the sex marker. Conversely, when they went out according to their gender identity, they were questioned and detained by the police for the mismatch with the sex markers on their identity document as well. Additionally, they could be refused service at any time at grocery stores, pharmacies, and other basic services and necessities.[29]

C. IMMIGRANTS AT THE STATE'S MARGINS

A case study[30] with migrants in transit in Honduras found that COVID-19 policies did not address immigrant populations and their specific health conditions. Migrants suffer from respiratory ailments making them particularly prone to COVID-19 infection. Yet, they were not part of any vaccination plan or COVID-19 attention protocol. In Central America, only those with valid national identification could access COVID-19 vaccination during the height of the pandemic., and thus

29- González, Interview with Panama Trans Rights Activist.
30- Fondo Social de Deuda Externa y Desarrollo de Honduras, "Estudio de Caso Dos: COVID-19 En La Población Migrante, Departamento de Choluteca."

immigrants were unable to get vaccinated in transit. This put them at higher risk of COVID-19 related complications, while being unable to access public healthcare in transit.

Additionally, a survey found that for immigrants living with HIV the main reason for lack of treatment addition is being ineligible for social security.[31] According to the 2019 General HIV-AIDS Law, only foreigners who are documented through regular, humanitarian or refugee visas and those with a valid form of national identification are eligible to receive HIV treatment in Costa Rica. During the pandemic, migrants' wait times to register at the health services through these visas increased significantly, thereby excluding them from social security during this critical time.[32]

SEXUAL AND REPRODUCTIVE HEALTH AS "NON-ESSENTIAL SERVICES" DURING THE COVID-19 EMERGENCY

In 2020, public health resources were redirected to cover the COVID-19 emergency, resulting in the reduction or complete halting of "non-essential" health services. Services deemed "non-essential" by those in power included pregnancy care, abortion services, sexually transmitted infection screenings, HIV detection and attention clinics, among other crucial integral health services for women, girls and LGBTI people. These emergency policies lacked an intersectional approach and disproportionately impacted indigenous people, people of African descent, and people living in rural areas. This is not a coincidence but a result of PDoH and CDoH; as previously mentioned, the rise of anti-gender ideology in the region, combined with colonial legacies of exploitation of racialized identities, ensured that these populations remained marginalized from public health responses before, during and after the COVID-19 pandemic.

The overwhelmed capacity of the public health systems during COVID-19 was not unexpected. Prior to 2020, CDoHs had already impacted public health systems: these

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31- Sánchez, Longhi, and Pacheco, "Situación de las personas LGBTI y que viven con VIH en Costa Rica durante la crisis de COVID-19."
32- Sánchez, Longhi, and Pacheco.

were already struggling under austerity measures[33], privatization initiatives[34], and insufficient coverage in rural areas[35], leading to insufficient, poor-quality healthcare access for most of the population. The pandemic further broke down an already precarious public health system[36], and the shutdown of "nonessential services" severely impacted those at the system's margins.

1. MATERNAL AND NEWBORN HEALTH

The COVID-19 prevention and attention policies heightened existing barriers for maternal and newborn health. These policies reduced access to pre- and post-natal clinical checkups, emergency obstetrician attention and preventative treatments[37], especially in remote or rural areas. One in three pregnant people who required intensive care were not able to access it during the first 2 years of the pandemic in Latin America.[38] Furthermore, 93% of maternal deaths associated with COVID-19 in the region occurred among indigenous and Afro-descendant women[39], due to these women being marginalized from healthcare services prior and during the pandemic.

In an analysis of maternal deaths associated with COVID-19 in the region[40] 99.7% of death cases occurred seven days after delivery and in 70.5% of cases the cause of death was acute respiratory failure associated with severe infection. Preterm delivery was the most common perinatal complication, and stillbirth was observed in 25% of cases. On top of reduced health services, people were unable to reach clinics and hospitals within crucial timing due to lockdown and mobility restrictions imposed by police or soldiers.[41]

In El Salvador, all non-emergency gynecological and obstetrical services, prenatal checkups, ultrasound and lab testing in public clinics were suspended,[42] resulting in

33- Redacción, "Gasto Público En Salud: Recursos En México Cayeron 3.4% En 2023."
34- Editorial, "Protestas en Honduras en contra del gobierno."
35- Ávila et al., "Guatemala: Analisis Del Sistema de Salud 2015."
36- Hurtado, "Médicos En Nicaragua Alertan de 'Colapso' En El Sistema de Salud y Convocan a Cuarentena."
37- Ministerio de Salud Pública y Asistencia Social, "Situación de Mortalidad Materna En Guatemala Años 2020 y 2021."
38- Maza-Arnedo et al., "Maternal Mortality Linked to COVID-19 in Latin America: Results from a Multi-Country Collaborative Database of 447 Deaths."
39- de Mucio and Gordillo-Tobar, "Challenges of Reducing Maternal Mortality."
40- Maza-Arnedo et al.
41- Vílchez, "Guatemala: Mujeres Embarazadas En La Última Línea de Atención Durante La Pandemia."
42- Herrera et al., "El Impacto de La Pandemia En La Mortalidad Materna de El Salvador, Guatemala, Honduras y México."

a lack of detection and attention to comorbidity risks. As a result, there was a 37% increase in maternal deaths from 2020 to 2021, and 71% of indirect maternal deaths were attributed to COVID-19 comorbidities.[43] During 2020, 6.85% of pregnant people also died in Honduras due to a combination of the reduction in health services for maternal health and comorbidities with COVID-19.[44] These findings demonstrate that delays in receiving adequate care before birth due to the shutdown of "non-essential" pregnancy care services and lockdown policies resulted in a significant increase in maternal mortality rates.

2. ACCESSING ABORTION

When the pandemic started in 2020 in Mexico, abortion was only decriminalized and permitted under certain circumstances in Mexico City and Oaxaca. Abortion access in these states was already unequal and insufficient, as it was still part of an ongoing battle in which anti-gender ideology pushed back against wider coverage, and the gaps in abortion services were further widened when the COVID-19 crisis began. Abortion services were considered a "non-essential service" and were not provided due to the COVID-19 prevention and attention policies in place. Additionally, lockdown policies influenced the capacity to reach these services. It made transportation to hospitals and clinics difficult, while also locking pregnant people in with partners or family members who could force them to continue the pregnancy.[45] By May 2020, at the height of the pandemic, only 13 hospitals were carrying out abortion services in Mexico City[46], a city of a population of 126 million in that year.

IPAS Central America and Mexico[47] reported that abortions should have been considered an essential health service during the pandemic in Mexico, especially since they are able to be carried out in ambulatory clinics with low risks of COVID-19 contagion. The time-sensitive nature of pregnancy interruption also requires quick and efficient services to reduce risks to the wellbeing of pregnant people and their

43- ORMUSA, "Análisis Del Alza de Mortalidad Materna En El Salvador."
44- Herrera et al., "El Impacto de La Pandemia En La Mortalidad Materna de El Salvador, Guatemala, Honduras y México."
45- Observatorio de Igualdad de Género, "Los riesgos de la pandemia de COVID-19 para el ejercicio de los derechos sexuales y reproductivos de las mujeres."
46- Navarrete and Yañez, "El Aborto Legal Cae 42% En La CDMX Durante La Pandemia Por COVID-19."
47- Ipas México, "ABORTO SEGURO."

families. According to IPAS, deprioritizing abortion services also represented an opportunity for anti-gender groups to continue advocating for the criminalization of abortion by framing it as "a luxury instead of a necessity"[48].

3. COVID-19 LOCKDOWN AND GIRL/ADOLESCENT PREGNANCY

COVID-19 policies also increased situations of violence against women and girls. According to organizations responding to gender-based violence in El Salvador, half of their users before the pandemic reported being victims of sexual abuse within their households.[49] This meant that COVID-19 lockdown policies forced these women and girls to be locked in with their aggressors.

In El Salvador, at the height of the lockdown during the pandemic, from April to June 2020 there was a 79% increase in pregnancies among girls from 10 to 14 years of age[50] and an increase of 71% of pregnancies in adolescents from 15 to 19 years of age.[51] As high as these statistics are, civil society sources[52] considered that there was underreporting due to families avoiding registration of girl and adolescent pregnancies in hospitals or clinics. The shutdown of pregnancy-related care as a "non-essential service" allowed families to hide girls and teenage pregnancies with the help of lockdown policies, and avoid sexual abuse prosecution.[53]

4. HIV DETECTION AND CARE

Programs for HIV were greatly impacted by the pandemic, with clinics shutting down to prioritize COVID-19 responses. According to a report of public spending for HIV in Guatemala, during 2020 there was a significant reduction of budget execution in laboratory testing, particularly monitor tests for people living with HIV.[54] It is estimated that there were 4,000 less diagnostics in the first half of 2020 compared to the first half of 2019 in eight countries from Latin America and the Caribbean,

48- Palomino, "La Pandemia Obstaculiza Aún Más El Aborto Seguro En América Latina."
49- Gavarrete, "Los Embarazos En Adolescentes Están Aumentando Durante El Confinamiento En El Salvador."
50- Girón, "Embarazos en niñas de 10 a 14 años aumentan 79.16% en tres meses, según MINSAL."
51- Gavarrete, "Los Embarazos En Adolescentes Están Aumentando Durante El Confinamiento En El Salvador."
52- Rodríguez et al., "1 Informe Anual 2021 Derechos Sexuales y Derechos Reproductivos En El Salvador."
53- Hernández, "Las madres adolescentes del confinamiento en El Salvador."
54- ONUSIDA, "Medición del Gasto en Sida -MEGAS-2019 y 2020 Flujos de Financiamiento y Gasto de la respuesta al VIH en Guatemala."

including Guatemala and Honduras[55]. In Mexico, there were 59% less HIV detections in 2020 compared to 2019[56]. These numbers mean that a large number of people living with HIV (PLHIV) were undiagnosed, with a risk of spreading the virus, and remained outside the ambit of life-saving treatments.

The lack of HIV care coverage, prior and during the pandemic, also impacted indigenous people disproportionately. In some regions in Central America, HIV rates in indigenous communities are six times higher than in non-indigenous populations.[59] Public health services for HIV attention are primarily centralized in cities and inaccessible for indigenous populations.[58] Due to COVID-19 lockdown policies, traveling to the few clinics that remained open during the pandemic became impossible for those living in rural areas, impacting the detection of HIV and continuation of treatment for PLHIV. Despite these issues, PLHIV were not included in COVID-19 policies, and the policies in place worsened their already precarious health access.

5. MENSTRUAL CARE DURING THE PANDEMIC

Access to menstrual care in Mexico and Central America is difficult due to SDoH related issues, including lack of water and sanitation facilities, particularly in rural areas. For instance, in Guatemala, more than 40% of homes do not have direct access to water in their houses and 44% do not have toilets, and thus rely on facilities at their schools or workplaces for managing their menstruation. With the COVID-19 lockdown policies, people lost access to water and sanitation facilities outside their homes. Additionally, low income people are unable to afford menstrual products for menstruation management, and this was made worse with the economic impact of the pandemic.[60,61]

55- Organización Panamericana de Salud, “Los casos nuevos de infección por el VIH aumentaron más del 20% en
56- García and Rodríguez, “El impacto de la COVID-19 en la detección del VIH: a propósito del Día Mundial del Sida 2021#.”
57- Ponce, Muñoz, and Stival, “Pueblos Indígenas, VIH y Políticas Públicas En Latinoamérica.”
58- Ponce, Muñoz, and Stival.
59- Gomez, Interview with Guatemala Menstruante.
60- Gomez.
61- Carriazo, Loboguerrero, and Villavieja, “La lucha contra la pobreza menstrual: un vistazo a América Latina.”

Additionally, during the pandemic, care related to menstruation and bleeding was also considered “non-essential”. Some common bleeding episodes, besides monthly menstruation, include abortions (both spontaneous and induced), the postpartum period, endometriosis, some forms of cancers, and infections (such as HPV).[62] Additionally, it was found that 1 in 10 people had experienced significant changes in their menstruation after COVID-19 infection, usually heavier flow and stronger menstrual cramps[63], which made bleeding management increasingly difficult.

PHARMACEUTICALS AS A PANDEMIC LUXURY

As mentioned in Section 1, the CDoHs are catalyzed by the power dynamics of PDoHs. Thus, it is crucial to address how public sector complicity in enriching pharmaceutical companies led to the increased cost of key medications and vaccines, reduced individual economic access and shortage of crucial pharmaceuticals during the pandemic, transforming these into “luxury” items reserved for the Global North, for the rich, and for those in positions of power.

The COVID-19 pandemic exacerbated the influence of commercial determinants of health (CDoH) on access to pharmaceuticals in which corporations, with the backing of neoliberal states, prioritized profit by exploiting private property rights at the expense of public health. The economic fallout from COVID-19 further complicated access to medications, disproportionately affecting women, people living with HIV, LGBTI people, and indigenous communities, particularly when COVID-19 responses had de-prioritised public health services for these populations, or when these populations had legal and administrative barriers to accessing healthcare.
The following are some of the crucial pharmaceuticals that became increasingly difficult to access during the pandemic in Mexico and Central America, due to the combination of CDoH and PDoH.

A. THE COVID-19 VACCINE

The COVID-19 vaccine is a prime example of the interplay of PDoHs and CDoHs, which led to a critical COVID-19 vaccine scarcity in the region. The COVID-19 vaccine scarcity was primarily due to corruption in central governments of the region in

62- Carriazo, Loboguerrero, and Villavieja.
63- Rodríguez, Interview with Menstruación Digna México.

procurement and distribution processes,[64] combined with international intellectual property rights agreements that left countries in the Global South with insufficient amounts of vaccine units to cover their entire populations.

COVID-19 vaccines in countries like Guatemala, the country with the lowest vaccination rate in the region by 2022, thus became a luxury item; they were extremely difficult to obtain through public healthcare and those who could afford it traveled to the United States of America to be vaccinated there instead.[65] Here, the slow vaccine purchase and rollout was due to corruption in the national vaccine procurement and distribution processes. At the time this paper was written, Guatemalan government officials were still under investigation for irregular procurement processes in vaccine purchases.[66] Additionally, the lack of infrastructure and adequate plans to effectively distribute the scarce amount of vaccines in the country led to 7.8 million vaccines expiring before being administered in 2021.[67]

Vaccine scarcity throughout the region particularly impacted indigenous peoples and people of African descent, and those living in rural areas in Mexico and Central America[68]. In Guatemala, by 2022, only 37% of the general population had received a complete initial vaccination in accordance with protocol. However, less than 30% of the total indigenous Maya population and less than 10% of the total indigenous Xinka population had had a complete vaccination in line with protocol at the time[69], even though indigenous populations make up approximately half of the country's total population. In El Salvador, rural women were unable to access vaccination centers due to lack of public transport. Austerity measures by the central government in El Salvador impacted municipalities' budgets, reducing the infrastructure in rural areas for accessing health and vaccination centers.[70]

64- Público, "Este fue el rastro de corrupción y mentiras que dejó el COVID-19 en Centroamérica."
65- Based on the personal lived experiences of the author based in Guatemala during the pandemic.
66- Delcid, "Gobierno de Guatemala Denuncia a Exministra de Salud Por Supuestas Irregularidades En La Compra de Vacunas Sputnik."
67- Maldonado, "El gobierno dejó vencer 7.8 millones de vacunas por un valor estimado de Q505 millones"
68- United Nations Human Rights Office of the High Commisioner, "Global North States' Persistent Refusal to Waive COVID-19 Vaccine Intellectual Property Rights Violated Non-Discrimination Guarantee, UN Committee Warns."
69- Delcid, "Gobierno de Guatemala Denuncia a Exministra de Salud Por Supuestas Irregularidades En La Compra de Vacunas Sputnik."
70- Oxfam en Centroamérica, "Barreras y Acceso a Vacunación Covid-19 para Mujeres Rurales en El Salvador."

B. CONTRACEPTION AND FAMILY PLANNING

Unfortunately, the COVID-19 vaccine was not the only key pharmaceutical that became inaccessible during the pandemic. The combination of loss of income with lack of public health access to certain health services due to the PDoH discussed in Sections 2 and and 3 led to reduced capacity to access contraception and family planning services. According to UNFPA, the increase of 1% in poverty rates across the Latin America region during the pandemic accurately predicted a drop of 2% in the growth of contraceptive sales.[71] Costa Rica found that due to economic insecurity, women's capacity to purchase contraceptives in the private sector in 2020 was set back to even lower levels than 2015.[72] At the same time, contraceptive distribution through public programs was considered a "non-essential" health service, leaving low-income people, particularly in rural areas, with no access to family planning. For instance, in Guatemala, a clinic that provided contraceptives in rural Quiché, was shut down permanently because of the pandemic. This clinic used to have 14 to 17 users daily in 2019.[73]

In 2020, the unmet demand for contraception increased by 72% in Mexico.[74] The highest unmet teenagers and young women from 15 to 24 years of age, meaning that the loss of access to contraceptives particularly impacted youth.[75] In the overall region, it is estimated that due to the economic barriers set in place by the pandemic, by 2021 the rates of met demands for contraception were set back approximately 9 years.[76]

Considering the shutdown of pregnancy and abortion care as "non-essential services" as discussed in Section 2, not being able to access contraceptives put people at high risk of unwanted pregnancies and related health complications, and thus the impact of lack of access to contraceptives was extremely detrimental.

71- Fondo de Población de las Naciones, "El Impacto de COVID-19 En El Acceso a Los Anticonceptivos En América Latina y El Caribe."
72- Durán, "El impacto del COVID-19 en los logros alcanzados en anticoncepción y en la prevención y atención de la violencia basada en género en Costa Rica."
73- Morales Rodas, "Pandemia Dificulta Acceso a Planificación Familiar y Causará Embarazos No Deseados."
74- Digital and Torres, "Planificación familiar."
75- Argüello Avendaño and Gómez Guillén, "Acceso a servicios de planificación familiar durante la pandemia por COVID-19 en adolescentes embarazadas en México."
76- Fondo de Población de las Naciones, "El Impacto de COVID-19 En El Acceso a Los Anticonceptivos En América Latina y El Caribe."

C. ANTIRETROVIRALS AND HIV MEDICATIONS

Life-saving medications like antiretrovirals for people living with HIV also became a luxury during the pandemic due to the combination of CDoH and PDoH. PLHIV currently rely on public medication distribution due to the high cost of these medicines resulting from the protection of intellectual property rights. However, at the beginning of the pandemic, WHO[77] had warned of a probable antiretroviral drug shortage due to supply-chain issues and increased production cost.[78] Consequently, PAHO[79] strongly reiterated that all HIV programs should provide at least 3 to 6 months' supply at a time to users of both pre-exposure prophylaxis and antiretroviral treatment. However, a survey in April 2020 by UNAIDS found that 5 out of 10 PLHIV in Latin America were having difficulty accessing medication, with 49% of people reporting only having 1 month supply left by the time they had responded to the survey.

Without antiretroviral treatment, PLHIV were at heightened risk of contracting COVID-19 and of having COVID-19 related complications.[80] This meant that for people, particularly indigenous people, rural people and immigrants, who have limited access to HIV care and treatment, COVID-19 became particularly risky. Activists had been demanding for years prior to COVID-19 that at least a 3-month supply stock policy be set in place for antiretrovirals. These demands had not been met due to the historical deprioritization of HIV care and stigma, an important PDoH.

Countries like Panama[81] and Costa Rica changed their antiretroviral stock policies during the pandemic to comply with PAHO's suggestions, but found logistical issues with procurement processes[82] and medication delivery in rural areas, with

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77- UN News, "Countries Urged to Act over Potential HIV Drug Shortages, within next Two Months."
78- UNAIDS, "The Impact of the COVID-19 Response on the Supply Chain, Availability and Cost of Generic Antiretroviral Medicines for HIV in Low- and Middle-Income Countries."
79- Grupo Regional de Patrocinadores del ONUSIDA para América Latina y el Caribe, "Enfermedad Por Coronavirus (COVID-19) y VIH: Asuntos y Acciones."
80- Organización Panamericana de Salud, "Preguntas y respuestas sobre COVID-19, VIH y uso de antirretrovirales - OPS/OMS."
81- *Lanzamiento de Los Resultados Da La III Encuesta Sobre El Impacto de COVID-19 En Poblaciones Clave de América Latina y El Caribe.*
82- Mulabi, Interview with Mulabi.

resulting delays that affected continuity of treatment for PLHIV.[83] Furthermore, in other countries in the region like Nicaragua, there was no COVID-19 policy inclusive of PLHIV at all, which led to a shortage of Ritnavir and Tenofovir in hospitals and clinics during the pandemic.[84]

D. HORMONE REPLACEMENT THERAPY (HRT)

Economic and political factors also played a role in making hormone replacement therapy inaccessible for the trans and gender-diverse population in Mexico and Central America during COVID-19. In Central America, due to anti-gender ideologies and discriminatory practices in health policies, there were no policies to guarantee trans people's right to gender affirming care, and thus accessing hormone replacement therapy during the pandemic became even more difficult.[85]

In Panama, medications are distributed through licenses that must be renewed regularly, and due to COVID-19 the administrative processes of license renewal were halted. This led to a shortage in HRT, particularly the more affordable brands of testosterone that trans men use, as opposed to other available brands which cost around $120[86] a vial for a 3-month dose, due to intellectual property rights. In the region, a large majority of trans people work in the informal sector, and thus losing their livelihoods during lockdown made HRT completely unaffordable. In Guatemala, a large number of users of Trans-Formación's health clinic reportedly interrupted their HRT for up to 8 months during the pandemic for economic reasons.[87] Additionally, a study found that 81% of trans people in Costa Rica did not have any access to HRT during the pandemic.[88]

83- Fallas, "Vivir con VIH en tiempos de COVID-19."
84- Castillo Vado, "Nicaragua: pacientes de VIH temen por sus vidas ante la falta de medidas en plena pandemia."
85- The World Professional Association for Transgender Health, "7th Version Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People."
86- González, Interview with Panama Trans Rights Activist.
87- Carranza, Interview with Trans-Formación.
88- Sánchez, Longhi, and Pacheco, "Situación de las personas LGBTI y que viven con VIH en Costa Rica durante la crisis de COVID-19."

COMMUNITY SOLIDARITY: COLLECTIVE CARE IN ABSENCE OF THE STATE

As mentioned in the first section of this study, traditional health frameworks often overlook the capacity of communities to address health through collective care and through their own cultural practices.[89] The Latin American social medicine tradition emphasizes the importance of civil society and community action on SDoH.[90] Similarly, the CDoH and PDoH frameworks propose civil society as key in mobilizing action and developing strategies for health equity. These also recognize the historical role social movements have played in regulating public healthcare[91], and how they continue to do so today.

This was evident during the pandemic, when communities created solutions to manage their health when the State failed. They found ways to provide mutual economic support, advocate for better health policies, and to uphold human rights for all. This was crucial in the response to the health crisis, and their experiences offer insights for health policies beyond COVID-19. The following are some examples of collective care initiatives during the pandemic in Mexico and Central America.

A. COLLECTIVE ACTION FOR CHANGE

During COVID-19 lockdown in Latin America, menstrual activists who typically worked locally, created national and regional solidarity networks.[92] Online activism and organizing played a key role in the elimination of tax on menstrual products in Mexico, as the COVID-19 lockdown galvanized activists nationwide to connect and lobby with public officials. These led to huge strides being made to pass this policy change in 2022.[93]

In Panama, trans rights activists documented human rights violations related to COVID-19 policies and successfully advocated for their declaration as unconstitutional in June 2021. This set an important precedent for trans rights in the

89- Frank et al., “The Social Determinants of Health.”
90- Solar and Irwin, “Social Determinants, Political Contexts and Civil Society Action.”
91- Friel et al., “Commercial Determinants of Health: Future Directions.”
92- Interview with Adriana Gomez from Guatemala Menstruante
93- Rodríguez, Interview with Menstruación Digna México.

country.[94] Their advocacy efforts also contributed to the Inter American Commission of Human Rights' release of a resolution on the pandemic and the human rights of trans and gender diverse people[95].

B. THE PARTERAS/COMADRONAS AND THEIR KEY ROLE IN RURAL HEALTH ACCESS

Midwives or *parteras/comadronas* are essential providers of sexual, reproductive, maternal and newborn health care, particularly in rural areas. Often, indigenous and rural women find *parteras/comadronas* more trustworthy and reliable than institutionalized healthcare providers, particularly due to their cultural relevance.[96,97] Institutionalized healthcare is rarely available in rural areas in the region, and thus cultural health practices are crucial for these communities.

With hospitals shutting down and mobility restrictions in place due to COVID-19 policies, pregnant people increasingly sought midwives for primary pregnancy and childbirth care. In Honduras, some midwives even reported that they delivered 800% more births from March 2020 onwards compared to previous years.[98] Midwives, during the pandemic and beyond, were crucial in reducing maternal and newborn deaths in regions like Latin America[99], particularly when institutionalized pregnancy care was deemed a "non-essential service" in COVID-19 policies.

A. CIVIL SOCIETY ABORTION PROVIDERS

As previously mentioned, in the few states where abortion was legal by 2020 in Mexico, it was considered a non-essential service and deprioritized from public health care during the pandemic. The shortage of medical personnel and the restructuring of public health services to focus on COVID-19 resulted in the postponement or cancellation of abortion appointments in Mexico City.

94- Gracia, "Inconstitucionales restricciones de movilidad basada en sexo, día y cédula."
95- Comisión Interamericana de Derechos Humanos, "La CIDH llama al Estado de Panamá a garantizar los derechos humanos de las personas trans y de género diverso en el contexto de las medidas de restricción parcial de la movilidad durante la pandemia del COVID-19."
96- "La CIDH llama al Estado de Panamá a garantizar los derechos humanos de las personas trans y de género diverso en el contexto de las medidas de restricción parcial de la movilidad durante la pandemia del COVID-19."
97- Regadas, "Parteras Indígenas: La Clave Contra La Mortalidad Materna En Honduras."
98- Monzón, "Nacer En Tiempos Del Covid-19 Con Partera y Sin Registro."
99- de Bernis et al., *State of the World's Midwifery Report 2021*.

Consequently, in-clinic abortions were reduced by over 30% in 2020 compared to the year prior.[100,101] This forced people who needed abortions to turn to non-institutional alternatives. During 2020, the civil society organizations which "clandestinely" distributed misoprostol throughout the country and provided virtual guidance on administration, saw a monthly increase of 500% users.[102] Such initiatives by activists and grassroots organizations are fundamental to ensuring sexual and reproductive health when government policies fail to guarantee the right to healthcare, particularly during emergencies like COVID-19.

B. MUTUAL AID AND SOLIDARITY WITHIN COMMUNITIES

In response to discriminatory COVID-19 protocols in Panama, a trans solidarity network was formed. The network linked volunteers to trans people in need to help them with grocery runs, getting medications, bringing food baskets to remote rural locations, among other necessities. It also created a list of professionals who offered services to support the trans community, including mental health practitioners who helped create an online support group.[103] Similarly in Guatemala, the trans health clinic of Trans-Formación began providing health consultations online, significantly increasing their user base, including individuals from remote areas of the country as well as from other Central American and Caribbean countries.[104]

During the pandemic, sex workers also turned to mutual aid systems to support themselves during the loss of livelihood. Organizations like La Sala organized fundraisers to provide food and basic necessities for other sex workers in need.[105] These mutual aid solutions were common throughout Latin America and the Caribbean, especially during 2020 and 2021, distributing not only food baskets but also information on COVID-19 prevention and personal protection equipment such as alcohol gel, facemasks, and condoms.[106] This was a crucial response to the shutdown of health clinics and the exclusion from health services due to the lack of State recognition of their work.

100- Observatorio de Igualdad de Género y COVID-19, "Aborto Seguro."
101- Gobierno de México, "Egresos Hospitalarios."
102- *México, Pandemia y Abortos Clandestinos.*
103- González, Interview with Panama Trans Rights Activist.
104- Carranza, Interview with Trans-Formación.
105- Cerdas Díaz, "El Distanciamiento Social."
106- Alpízar Lobo, Rivers-Moore, and Hardy, "Sex Work, COVID-19 and Mutual Aid in Latin America and the Caribbean."

RECOMMENDATIONS TOWARDS HEALTH EQUITY

As highlighted throughout this study, achieving health equity requires restructuring the power imbalances that prioritize neoliberal interests over the right to health for all. Civil society organizations, communities, and activists play a crucial role in holding public institutions accountable, outlining pathways for improved health policies, and creating public healthcare solutions that embrace the diverse needs of people at the state's margins.

Based on the lessons learned during the pandemic regarding access to healthcare for women and girls, indigenous and rural communities, people of African descent, PLHIV, LGBTI individuals, and informal workers, the following recommendations are proposed for achieving health equity in the context of Mexico and Central America:

1. TACKLING CORRUPTION IN CENTRAL GOVERNMENTS

Implementing transparency mechanisms, auditing procurement processes and ensuring accountability in the allocation and use of public funds are essential for strengthening healthcare systems and public health institutions. Without these mechanisms, health programs will remain of insufficient coverage and quality, and continue to exclude populations at the heart of inequalities. Civil society plays a fundamental role in monitoring government spending and advocating for adequate public program execution and should be made a part of appropriate insititutional mechanisms that hold the government to account.

2. INVESTMENT IN PUBLIC HEALTHCARE

Governments should increase budgets and public spending on healthcare at all levels. Healthcare systems need adequate resources for routine and emergency care that meet the intersecting needs of diverse populations. Public healthcare should not deprioritize essential health services during crises; this requires the allocation of more resources to public health programs and institutions.

3. UNIVERSAL HEALTH COVERAGE

Healthcare coverage should not be contingent on employment, nationality, immigration status, gender identity or any other sociopolitical or economic

condition. Healthcare must be recognized as a basic human right, accessible at preventive, curative and rehabilitative levels. A universal healthcare coverage program should also be of high quality with differentiated care and consideration disabilities, diverse socioeconomic backgrounds, gender identities, and cultural and religious diversity.

4. EXPANDING HEALTH INFRASTRUCTURE TO RURAL AREAS

It is imperative that healthcare be decentralized from urban centers and expanded to include rural areas throughout the region. It should work alongside community-led initiatives, be culturally relevant, and ensure diverse language inclusion. The healthcare expansion also needs to include infrastructure for accessing healthcare, including efficient and affordable public transport, disability access and safe roads.

5. SUPPORT CIVIL SOCIETY AND COMMUNITY HEALTH INITIATIVES

Grassroots and community-led health initiatives should be strengthened and funded to address local health needs through culturally pertinent solutions. These initiatives must be considered a crucial aspect of public health programs and health institutions should work alongside these initiatives to effectively meet local communities' needs.

6. LIMITING CORPORATE/PRIVATE POWER AND INFLUENCE

Regulations should be implemented to limit the influence of corporations and profitable industries on public health policies. Clear guidelines based on the human right to healthcare should regulate the economic relationships between private and public institutions, especially regarding healthcare, to prioritize public welfare over profit. This includes regulating the lobby of pharmaceutical companies, intellectual property rights, and procurement agreements. Particularly, regulations on intellectual property rights on key pharmaceuticals during pandemics or health crisis should be reformulated.

7. ELIMINATION OF ANTI-GENDER POLICIES IN HEALTHCARE

Laws and policies that are discriminatory on gender identity, sexual orientation or sexual and reproductive choices should be repealed. Policies that are inclusive of sexual and reproductive rights, LGBTI rights and PLHIV rights must be promoted in their place.

8. RECOGNITION OF SEXUAL AND REPRODUCTIVE HEALTHCARE AS ESSENTIAL

Sexual and reproductive health on all of its levels should be recognized as an essential health service. Adequate emergency responses should include strategies for the continuous provision of sexual and reproductive health, and health budget allocations should ensure coverage in both urban and rural areas.

9. DATA COLLECTION

Public health programs should have data collection plans that disaggregate information to include diverse populations such as those with disabilities, diverse sexual orientation, gender identities and occupations. This data should inform inclusive public health policies.

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BIOGRAPHY

Natalia Marsicovetere is a queer activist and researcher in Guatemala, with regional expertise in Latin America. As an M.Sc. in Social and Cultural Psychology, she has conducted research for thematic studies in cooperation with UN agencies and for advocacy reports for civil society organisations. Her research has primarily focused on LGBTI rights violations, multistructural gender-based violence, and gender in public policy. She collaborated with Guatemala Menstruante in research on women and gender-diverse people’s access to menstrual health in Latin America. Currently, she is part of the global research team for ILGA World and Global Philanthropy Project’s LGBTI Pathways, a community informed research project.

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