Covid-19 and gender inequality in Mexico

The unequal impact of the pandemic on women’s healthcare

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Abstract

Healthcare systems and medical services all over the world have been facing a significant reliability crisis that has peaked in the past couple of decades from a series of criticisms regarding inequality. It is well-established that the inequality problem, especially in the Latin American region is an abiding and deep-routed phenomenon particularly in regards to gendered relationships, which has only recently been given the necessary attention.

Therefore, this study investigates the equality of healthcare access from a gendered perspective, as a result of gender inequality in Mexico. The foregoing issue shall be analysed by giving an overview of the pre-existing situation in Mexico and by examining the recent data from 2020 and 2021 resulting from the COVID-19 pandemic. In this context, gender inequality in the country will be analysed from a theoretical perspective, while statistical data will be used to examine the possible existence of a pattern and the societal influences on it in relation to healthcare.

In times like these, when the whole planet has been affected by a pandemic, the ongoing discrimination and inequalities regarding healthcare access have been brought to the surface. Many discussions have taken place regarding racial inequality in the sector and its effects on minorities such as black or immigrant communities globally. However, the focus given to the gender inequality in the health sector and how it has been affected by the pandemic is minimal. For this reason, this study introduces an innovative and relevant perspective to the current healthcare discussion in connection to gender inequality in Mexico.

Key words: gender inequality, healthcare access, Covid-19 pandemic, Mexico
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Chapter 1
1.1 Introduction

Medical care has long been recognized to be one of the most crucial universal human rights and is considered necessary in all societies that wish to lead lives with dignity and health. However, as with most human rights at some point throughout history, healthcare as a service provided by different groups and individuals, has in many instances depended on the disparities and inequalities reflected by the societies of these groups and individuals on the basis of race, gender, class and status. This study will focus mainly on how gender inequality and disparities based on it have come to play a role in the health sector in a country like Mexico and how this is reflected in times of a global pandemic like the current one caused by Covid-19.

It is important to begin by mentioning that the European Institute defines gender inequality as the “legal, social and cultural situation in which sex and/or gender determine different rights and dignity for women and men, which are reflected in their unequal access to or enjoyment of rights, as well as the assumption of stereotyped social and cultural roles” (EIGE 2021). It is also important to acknowledge the fact that as of May 2021, not one country in the world has yet achieved gender equality according to the Gini Index of Global Inequality (Gini index Data 2021). Even more, the World Economic Forum in its report “Closing the Gender Gap” predicted, prior to the Covid-19 pandemic crisis, that “at current rates of progress it will take 257 years to close the economic gender gap” (World Economic Forum 2021). Having said that, their report also suggests that “initial evidence is showing that the socio-economic implications of COVID-19 are impacting women disproportionately. Taking a gender lens in the immediate crisis response and recovery policies will be critical to advance economic gender parity” (World Economic Forum 2021).

Turning to the current global medical crisis, the Covid-19 outbreak of the coronavirus disease has started in late 2019 although it was only officially declared Public Health Emergency of International Concern by the World Health Organization on 30 January 2020, and later declared a pandemic on 11 March 2020 (WHO 2020). As of 15 April 2021, there have been more than 138 million cases confirmed worldwide, with more than 2.97 million deaths being attributed to COVID-19, making it one of the deadliest pandemics in history (WHO 2020). Looking more specifically into the Latin American continent, as of 13 May 2020, it was reported that Latin America and the Caribbean had reported over 400,000 cases of COVID-19 infection with, 23,091 deaths, while on 22 May 2020, due to the rapid increase of infections in Brazil, the WHO declared South America the epicenter of the pandemic. These
numbers in South and North America (excluding USA) have reached as of 26 May 2021, 33,605,651 confirmed cases and 1,041,882 deaths from COVID-19, although due to a shortage of testing and medical facilities, it is believed that the outbreak is far larger than the official numbers show (WHO 2020) (COVID Live Update 2021).

Such conditions in Latin America have shown to cause a general humanitarian crisis for the whole region, which finds its roots in many underlying issues such as “political instability, corruption, social unrest, fragile health systems, and perhaps most importantly, longstanding and pervasive inequality—in income, health care, and education—which has been woven into the social and economic fabric of the region”, that being precisely the main topic of focus for this study (The Lancet 2020). Therefore, the reasons why the Covid-19 pandemic has affected the Latin American region so deeply are numerous, as most of these countries share several common features of wide inequalities, one being the ineffective access to healthcare services, and health outcomes, making the region on of the most inequitable regions in the world as measured by the Gini Index (World Economic Forum 2021). These problems combined with the congregate settings cause favorable conditions for increased virus transmissions in the region, especially in megacities such as Mexico City with its rapid urbanization. In turn, this increases the already widespread poverty and inadequate living conditions, jobs and access to health services, while stretching even further the capacity of the region’s health systems, which suffer from low levels of investment in public health and high levels of corruption (CEPAL 2019) (García 2019) (Transparency 2019).

1.2 Problem and Justification

Multiple studies done in 2020 and 2021 have shown the effects of the Covid-19 pandemic on the access of healthcare non-related to the illness across the globe. In fact, an investigation done last year (Ahmed et al., 2020), discusses living and working conditions similar to those of low-income and informal workers of Latin American countries, showed a general reduction in access to healthcare services in Bangladesh, Kenya, Nigeria and Pakistan (Ahmed et al. 2020). This included different kinds of preventive services, as well as a general increase of the cost of healthcare meanwhile household incomes were reduced, resulting in many people having difficulty accessing healthcare facilities, either because of supply or costs, or simply because of the fear of being diagnosed with COVID-19 and being stigmatized and further economically affected, which in turn discouraged healthcare seeking (Ahmed et al. 2020).
Another similar research done in the US has reached similar conclusions regarding the effects of the pandemic on the access of healthcare non related to the illness, giving even different factors as the basis of their findings (Saba 2021). However, in both studies an intersectional factor that would include both Hispanic origin and a gender bias is missing, which proves the need for further studies and inclusion of all minorities within larger groups that may experience a bias in multiple forms due to the pandemic effects on healthcare and its access.

Overall, these studies suggest that similar finds could be observed in the Latin American region which has been widely affected by the pandemic resulting in different access barriers that may as well include increased cost of healthcare, reduced household income, increased challenges in physically reaching healthcare facilities and exacerbated reluctance of residents to seek healthcare due to fear of infection and stigmatisation. However, these challenges affect different groups and minorities differently and on multiple levels, and in this case in a region known for its gender inequality issues, the situation induced by the Covid-19 pandemic on the healthcare access of many countries, could be in the Latin American case affecting women more severely than men. For these reasons, it is necessary to fill this significant gap in the research done regarding the health sector during the current crisis by connecting the issues of gender inequality and healthcare access into a discussion of the ongoing global pandemic, which in this study shall focus on the Mexican case that provides a general insight into the Latin American region.

Mexico has been selected as the case study of this thesis because of the central role of several recent changes in the country within the field of gender equality development, having also undergone many changes and law enactments recently to promote the said development in multiple fields. However, their health system having gone through several transitions and reforms in the past decades has not been considered entirely beneficial in terms of gender equality, while the recent feminist movements against femicide prove that the inequality problem and its effects on women is still far from being solved. Overall, the country appears at a first glance as the perfect candidate for a research regarding gender inequality of the healthcare system, as it has taken numerous actions in developing this domain. In fact, according to the World Economic Forum Report of 2021 on the Global Gender Gap, Mexico has scored impressive numbers in closing the gender gap in “Health and Survival” reaching levels of 0,975 out of 1 (World Economic Forum 2021). However, at the same time, Mexico is facing several issues connected to the gender inequality discussion which generate questions regarding the new conditions imposed by the pandemic on the sector of healthcare and its gender bias for access.
1.3 Aim of the study

To enable this analysis, this study will look into three main dimensions of women’s access to healthcare and its quality that have been impacted by the Covid-19 pandemic. These will be: the collected data on the pandemic consequences for women’s healthcare in Mexico, the effects of rising violence and feminicides on women’s health, as well as the effects on women working as healthcare providers. The analysis will be enabled by using four intermediary factors regarding equity in health as explained by Gita Sen and Piroska Östlin (2009). By analyzing these three dimensions, this thesis will look for the inequity and inequality patterns in healthcare and its influences, while connecting the empirical data to the selected theories regarding gender inequality.

Hence, the research question that will lead this analysis is:

What patterns of gender inequality towards women are found in Mexico’s healthcare and how has the Covid-19 pandemic affected these patterns?

To answer to this main research question, this study will make use of the following sub questions:

Which are the most significant factors within women’s healthcare that have been affected by the Covid-19 pandemic?
How are these patterns of inequality being influenced by the realities of social norms and habits in Mexico?
To what extent do the theoretical discussions of gender inequality apply to Mexico and in what ways?

1.4 Disposition

This study will begin with the display of a short description of the methodological framework, which will be used in the analysis together with data selection, aspects of limitations and validity. Then, some contemporary outlooks on women’s healthcare during the Covid-19 pandemic follow, continuing with an overview of women’s healthcare in Mexico during this period of time and the literature review on the topic. This will be followed by an analysis divided into three parts; one focusing solely on the analysis of the data regarding the pandemic consequences in Mexico, the second displaying the pandemic effects on feminicide and violence and how these affect women’s healthcare, while the third part will give a brief view on the situation of women working as healthcare providers and how they have been affected by
the pandemic and its outcomes in Mexico. This division of the analysis aims to provide a general overview of the induced problems by the global pandemic on women’s healthcare and access to its services, while in a later stage allowing to analyze these outcomes with a connection to two gender inequality theories and the observed compatible patterns, adding this way a critical view to the debate on the phenomenon in the continent and its effects.

Chapter 2 – Methodology

2.1 Data selection and collection

To begin with, this research will function as a case study, as the one country of focus will be Mexico, while a qualitative research will be the main method for data usage and a secondary analysis will be applied for the investigation of this data. Regarding the process of gathering the information, data and material for this study, the objective was to use the most recent facts and figures available to investigate in what ways gender inequality of women’s access to healthcare in Mexico has been affected by the global pandemic of Covid-19. However, as the current global situation has it, a first-hand study of the issue by means of research, interviews and close-up observation determines these options as unattainable, since any form of travel and unnecessary meetings of people are strictly prohibited in most countries and across continents. Therefore, this study will resort mainly to a secondary analysis of data gathered by different researchers and larger databases on the results of the pandemic in Mexico, while investigating the possible connections between the finds and the gender inequality that exists in the area.

The prospects of secondary analysis according to Bryman hold numerous advantages including the benefit of using high quality data for a fraction of the cost, time and resources that it can require collecting it oneself, not to mention that large data sets can frequently “yield quite large nationally representative samples” which offers the opportunity for sizeable subgroups whose reanalysis may offer new interpretations (Bryman 2012: 312-313).

2.2 Limitations

As any research will have it, certain difficulties and obstacles arise, especially when the topic in discussion is centered on such recent events and changes as in this study. This section is dedicated for explaining the limitations of this thesis, regarding both the methodological approach, validity as well as the limitations posed to the researcher.

To being with, as with any research based on secondary analysis, it must be acknowledged that as the data analyzed and presented in the following sections is the product
of other original studies, there is a certain lack of familiarity with the specifics and details of the data and its complexity (Bryman 2012: 315-316). Also, as a secondary analysis will have it, a certain lack of control over the data’s precision might be present, which cannot be taken for granted knowing how recent these findings and data are, and that miscalculations and over- or underestimation of data are possible within the medical researches that are used in this study (Bryman 2012: 315-316). It must also be kept in mind that some of the studies and data analysis used may not meet all of the prospective needs of this secondary analysis, since the data itself may have not been collected on an aspect of a topic such as the current one if it was not of considerable interest at the time of the data collection (Bryman 2012: 316). On that note, it is also important to mention that according to Bryman (2012), when one chooses secondary analysis, it runs the risk of absence of key variable in his research, as the data subjected to his analysis was initially:

“…collected by others for their own purposes, it may be that one or more key variables may not be present…The inability to examine the significance or otherwise of a theoretically important variable can be frustrating and can arise when, for example, a theoretical approach that has emerged since the collection of the data suggests its importance” (Bryman 2012: 316).

2.2.1 Validity

With secondary analysis that connects different concepts and issues as this study attempts to, multiple questions of validity can arise. First, according to Bryman (2012) it is very important when analyzing a topic and finding a possible cause to keep in mind the internal validity question which is concerned with whether “a conclusion that incorporates a causal relationship between two or more variables holds water. If we suggest that x causes y, can we be sure that it is x that is responsible for variation in y and not something else that is producing an apparent causal relationship?” (Bryman 2012: 47). Specifically, a call is made to investigate “how confident can we be that the independent variable really is at least in part responsible for the variation that has been identified in the dependent variable?”, which in this case refers to investigating how can we know for sure that the potential rise of gender inequality in women’s healthcare access has been affected or caused by the conditions induced by the pandemic. Another important feature of validity is ecological validity which concerns the question of whether social scientific findings are applicable to people’s every day, natural social settings. According to Bryman:
“Cicourel (1982: 15) has put it: ‘Do our instruments capture the daily life conditions, opinions, values, attitudes, and knowledge base of those we study as expressed in their natural habitat?’ This criterion is concerned with the question of whether social research sometimes produces findings that may be technically valid but have little to do with what happens in people’s everyday lives.” (Bryman 2012: 48)

In this case ecological validity will question whether the finding of this research based on data from other studies will provide insights on women’s access to healthcare that are actually applicable and accurate to the daily conditions that women in Mexico experience on a daily basis, as well as to what extent are indeed these conditions that they experience a result of the global pandemic. These validity questions are to some extent left unanswered in a secondary analysis as the current one, since a different approach or a future research based perhaps on a combination of open interviews and first-hand observation of the situation would be required to determine the precise answers and make the conclusions set here valid and reliable, something that at the moment is not feasible for individual research due to the pandemic restrictions.

2.2.2 Limitations as a researcher

As it will be explained in the following section, the nature of a secondary analysis as the chosen method for investigation proclaims that any form of research will be subject to the existing studies and findings available to the researcher until the moment of publication. Therefore, it is important to acknowledge here that this study is written based on the current situation in Mexico as of May 2021, as the conditions of a global pandemic are not definite and consistent everlastingingly, while also being interpreted here from a cross-cultural perspective. However, as Chandra Talpade Mohanty (2003) explains in regards to her heavy critique on the prevailing Eurocentrism in development; cross-cultural research is not pointless or invalid. Still, every researcher should be aware of the historical heritage of a place and nation and avoid applying theories of universality and generalizations of the Global North to problems of the Global South (Mohanty 2003:107.). Therefore, the aim here is to carry this study out with as much awareness as possible and understanding that a researcher from the Global North needs to consider the limitations of knowledge, theoretical and practical, regarding several aspects of the Global South such as gender inequality. By embracing the fact that being from a different culture implies that gaining a full knowledge on such a topic is impossible without actually being the one experiencing it, one can accept the disadvantage of being in a situation requiring
to understand the context and perhaps point out solutions to local problems by conducting research, and in turn, approach the topic with as much consideration, understanding and skepticism as possible.

2.3 Theoretical and conceptual framework

2.3.1 Gender Inequality theories

Gender inequality has been a part of societies since the beginning of known history as the activities that women could participate in were limited by their less physical strength and their responsibility of bearing and raising children, leaving men to deliver the most important resources to the family. This in turn made males the powerful and dominant gender as they were the ones controlling these resources, whether that was food from hunting and fishing, or crops from farming or even an income from a job. However, in the past centuries several sociological theories have attempted to explain why different forms of gender inequality have persisted in contemporary and modern societies, where women and men officially have the same rights and responsibilities at providing for their families, forming personal careers and developing as individuals. Let us begin this analysis by defining once again the exact meaning of gender inequality as the “Social process by which people are treated differently and disadvantageously, under similar circumstances, on the basis of gender” according to the Oxford Dictionary (Kent 2006). In other words, this refers to people being subjected to different rights and opportunities from a social, political and economical point of view based on their gender and on socially constructed gender roles.

In this essay the topic of gender inequality will be approached from two theoretical perspectives that better explain its relation to healthcare access and the discriminations within the domain. Specifically, the first theory refers to Liberal Feminism which according to John Stuart Mill (1869) deals with explaining the gender inequalities in social and cultural attitudes that draw attention to many separate factors which contribute to inequalities between men and women, in places such as the workplace, educational institution and the media. The second theory that this study will use is Radical feminism, which according to Mill (1869) is based on the belief that inequalities such as domestic violence, rape and sexual harassment, which will be further discussed and connected to healthcare access below, are all parts of the systematic oppression of women as inevitable in all male dominated societies, whether that is capitalist, socialist or communist.

Having all this in mind, one can begin to analyze the different inequalities in healthcare and its access. It is important, however, to first differentiate between two concepts that are often
confused: health inequality and health inequity. Specifically, health inequality describes the observable differences in health outcomes between different population groups according to socioeconomic status, geographical area, gender, age, ethnic group and disability— which can in fact be measured and monitored easily (WHO 2013). Health inequity, on the other hand, describes the unjust differences in opportunity for different population groups which results in unequal access to health services, a concept considered more normative and harder to identify and monitor without studying personal experiences (WHO 2013). This study will attempt to investigate the current situation of women’s healthcare and access regarding both health inequity and health inequality and show to what extent they are influenced by the Covid-19 pandemic.

2.3.2 Gender Inequality in healthcare

Some of the most important factors that need to be considered when dealing with gender inequality and discrimination in health have been explained by Gita Sen and Piroska Östlin (2009) and will be used to further analyze the topic in the following section. Overall, their approach at examining the gendered structural determinants encounters four intermediary factors which will also be used for the analysis of this research in the analytical section:

“…(a) discriminatory values, norms, practices, and behaviors, in relation to health within households and communities; (b) differential exposures and vulnerabilities to disease, disability, and injuries; (c) biases in health systems; and (d) biased health research. These intermediary factors result in biased and inequitable health outcomes, which, in turn, can have serious economic and social consequences…” (Sen and Östlin 2009: 3).

Specifically, factors such as the aforementioned, according to Karina Batthyány and Sonia Corrêa (2007), tend to result in biased and inequitable health outcomes that in most cases restrict women’s healthcare just to maternal health and nutrition before and after births, leaving behind many other critical sexual and reproductive needs such as contraceptive assistance, HIV/AIDS, STD and cervical cancer screening, gender based violence or other relevant health demands specific to women as in the case of mental health and chronic diseases (Batthyány and Corrêa 2007). However, many implications from malfunctioning policies and programs arise from a gender perspective on health and poverty, first being the attention that is missing to women’s non-reproductive health needs, especially since poverty lays women in developing countries vulnerable to a range of health problems, of which many are not associated with reproductive
health, but are rather associated with poor women’s work and living conditions (Batthyány and Corrêa 2007). Another important factor of gender inequality in healthcare is determined by the lack of gender analysis in health which in turn requires the:

“analysis of sex disaggregated epidemiological data as well as the assessment of the characteristics of existing health system in terms of accessibility, finance and management, which implies the necessity of: (a) The opportunity to be in good health and not become ill or disabled, or die, due to preventable causes; (b) Access to health care according to need; (c) Financing of services according to payment capacity; (d) Division of responsibilities and power in the provision of health services and care” (Batthyány and Corrêa 2007).

All these factors are important and necessary for the achievement of equality and equity of the basic human right of access to health and medical care and the abolishment of discrimination and biases in the sector.

Chapter 3: Literature Review

3.1 Contemporary outlooks on healthcare during the Covid pandemic

It is an undeniable fact that the Covid-19 pandemic has caused deep consequences and regression on healthcare globally and has affected its access and effectiveness in unprecedented ways. More specifically, an investigation done last year (Ahmed et al. 2020) provides an overview of the observed problem in communities similar to the ones studied in this research. By engaging with 860 community leaders, residents, health workers and local authority representatives, the authors of this research investigated the effects of the pandemic on people that suffered from different illnesses perceived as common in all sites included “respiratory, gastric, waterborne and mosquitoborne illnesses and hypertension”. Also, the research investigated how various preventive, diagnostic and treatment services, “including well-used antenatal and immunisation programmes and some screening for hypertension, tuberculosis, HIV and vectorborne disease”, as well pharmacists and patent medicine vendors that acted as key providers of treatment and advice for minor illnesses were all affected by the pandemic (Ahmed et al. 2020).

The results found during the beginning of the COVID-19 pandemic were: “a reduction in access to healthcare services was reported in all sites, including preventive services”, while the actual cost of healthcare increased, meanwhile household incomes had been reduced and many residents even faced difficulty reaching healthcare facilities or were too afraid of being
diagnosed with COVID-19 which resulted in them being too discouraged to seek healthcare in times of need (Ahmed et al. 2020). Several actions taken such as provision of healthcare by phone, pharmacists and drug vendors extending credit and residents receiving philanthropic or government support were inconsistent, insufficient and inadequate (Ahmed et al. 2020). The authors explain that:

“To encourage healthcare seeking, clear communication is needed about what is available and whether infection control is in place (…) infection control measures and the importance of continuing to seek care for non-COVID-19 conditions, including pregnancy and long-term conditions… Policymakers and those planning healthcare services should ensure that the costs of accessing healthcare do not escalate and further deter healthcare usage, or unfairly disadvantage slum communities… Remote consulting to reduce face-to-face contact and provision of mental health and gender-based violence services should be considered” (Ahmed et al. 2020).

Another research on this topic was done by the Research and Development Survey (RANDS) which is an “ongoing series of surveys from probability-sampled commercial survey panels used for methodological research at the National Center for Health Statistics (NCHS)” (Saba 2021). RANDS surveys have provided some experimental estimates of “reduced access to healthcare for two rounds of RANDS during COVID-19 based on data collection”, for which the first occurred between June 9th, 2020 and July 6th, 2020 and the second round occurred between August 3rd, 2020 and August 20th, 2020 (Saba 2021). The aim of this research was to investigate the percentages of people that as a result of the coronavirus pandemic, may not get needed medical care due to cancelled appointments, cutbacks in transportation options, fear of going to the emergency room, or an “altruistic desire to not be a burden on the health care system”, among other reasons (Saba 2021). The research focused mainly on showing the percentages of U.S. adults that were unable to receive medical care (including urgent care, surgery, screening tests, ongoing treatment, regular check-ups, prescriptions, dental care, vision care and hearing care) because of the previously mentioned reasons (Saba 2021). Their data was organized based on different indicators of reduced access to care during the 2 preceding months of the research, those being race, age, Hispanic origin, sex, education, urbanization and chronic conditions (Saba 2021).

The sex factor, that is the factor of focus in the current study, of people that have experienced reduced access to health care due to the pandemic, show a significant gap between the two sexes, specifically of 34,9% for men and 42,3% for women in period 1, while during
the second period those numbers fell to 26.2% for men and 30% for women (Saba 2021). However, an intersectional factor that would include both Hispanic origin and a gender bias is missing, which further proves the need for further studies and inclusion of all minorities within studies of larger groups that may experience a bias in multiple forms especially in vulnerable countries that already suffer from gender inequality.

In fact, most researches from different countries and continents that have investigated the effects of the pandemic on healthcare and its availability and access during the past year, provide a general overview of the situation but lack gender segregated data and therefore the prospect of connecting any possible patterns to existing patterns of gender inequality within the country. One of the few exceptions of such studies is the “Global rapid gender analysis for Covid-19” conducted by CARE + IRC Global RGA for COVID-19, which according to their self-description seeks to “deepen the current gender analysis available by encompassing learning from global gender data available for the COVID-19 public health emergency” (CARE 2021). It is important to mention that the key points of their analysis that relate to healthcare of women and its access are still somehow general as they lack detailed numerical data. However, this is the case only because most countries have failed at providing gender segregated data for such studies- which is in fact one of their key observations. Nevertheless, this does not disqualify their research as their observations and findings are based on the realities of most of the fragile and “developing states” for which similar living conditions for women apply. In short, some of these points are: the available sex-disaggregated data is limited and incomplete although most facts point that men are at a slightly higher risk from the virus with regards to morbidity than women, and at 51%, men make up a slight majority of the infected, and yet women are affect by secondary consequences of the pandemic on multiple levels” and that is because “women perform 76.2% of the total hours of unpaid (and medically uncovered and uninsured) care work—more than three times as much as men” (CARE 2021).

During public health crises such as COVID-19, this labor will often involve taking care of sick family members, and in the case of school closures, looking after children, which in turn puts women at a higher risk of contracting the virus, not to mention that as 70% of workers in the health and social sector are women, they face even more increased risks (CARE 2021). On this note, the study adds that:

“Despite women constituting the majority of health and social care workers, a recent report showed that more than 70% of CEOs in global organizations active in health are male, and just 5% are women from low- and middle-income countries (not to mention that due to gender-related pay gaps,
on average women earn 28% less than their male colleagues in healthcare). These statistics demonstrate an extreme lack of women in leadership and decision-making positions, a disparity that negatively affects health outcomes for women and children worldwide” (CARE 2021).

The report continues by explaining the general lack of gender balance and gender lens in global COVID-19 decision-making since there is a critical gap of gender specialists who can influence the way such crises are dealt with. Even WHO’s framework of governance of outbreaks of infectious diseases does not require a gender specialist to be involved in decision-making task forces (CARE 2021). Regarding the access to healthcare, the study explains that:

“Maternal health is already a critical issue for women around the world. Unfortunately, redirecting resources to COVID-19 prevention and response efforts can make this issue even more dire. Worldwide, 61% of maternal deaths occur in fragile states, many of them affected by conflict and recurring natural disasters. Additionally, school closures often lead to increased sexual activity. With COVID-19 likely to increase barriers for accessing contraception, this can result in a spike in adolescent pregnancy, which will lead to school drop-outs that will disproportionately affect adolescent girls.” (CARE 2021).

Finally, some of their other key points are that “humanitarians should provide information about COVID-19 in ways that take into account differing literacy rates amongst women and men, and their different levels of access to mobile phones”, since the power within households also experiences a gender gap in many countries, meaning that “women’s health care is not determined solely by the provision of healthcare treatments, but also by whether women have free and safe access to such services” (CARE 2021). In fact, the COVID-19 pandemic has increased significantly the risk of all forms of gender-based violence (GBV), creating more demand and greater need for medical services for women, which in some cases may not have the required personnel or resources available due to redistribution for Covid-19 needs (CARE 2021). Lastly, the study explains that “women’s rights activists in China have reported that domestic violence cases have risen dramatically as people across much of the country have been quarantined, potentially with abusers, during the coronavirus outbreak” making it inevitable through their living situations to escape the captivity of violent environments (CARE 2021).

3.2 Literature Review: healthcare in Mexico
Generally speaking, evidence has shown that in many societies males have more access to healthcare than women, especially in countries where women’s status is lower and they are expected to follow the rules and permissions of the male household head, which in several cases control the family’s access to healthcare as in the case of many Mexican families (WHO 2007). Not only that, but women are also susceptible to more diseases and at higher risks either because of their roles as care providers and health providers, or just during their pregnancies when their immune system undergoes considerable change (WHO 2007). Additionally, studies have shown in connection to diseases that can be nosocomially spread, that women can face increased exposure during their pregnancy because of their higher contact than usual with health care settings, not to mention that some diseases have more severe complications for pregnant women especially since they are more prone to respiratory complications (WHO 2007). Such conditions in a combination with the emergency response to a virus outbreak like the current one, can also lead to a shortage of resources for sexual and reproductive health as services may be diverted to meet the needs of the pandemic, which according to studies contributes to rises in maternal and newborn mortality, increased unmet need for contraception and increased conductions of unsafe abortions and sexually transmitted infections (UNFPA 2020).

A UNFPA report on Covid-19 through gender lens explains how safe pregnancies and births depend on the sufficient numbers of skilled healthcare personnel, and specifically, midwives, as well as adequate facilities for providing essential and emergency quality care twenty-four hours a day, especially since “respiratory illnesses in pregnant women, particularly COVID-19 infections, must be treated with utmost priority due to increased risk of adverse outcomes” (UNFPA 2020). The report also emphasizes the need of infection control measures and proper segregation of suspected and confirmed cases from antenatal, neonatal and maternal units, as well as surveillance and response systems to be in place (UNFPA 2020).

However, to determine if these general facts apply to Latin America and to the consequences induced by the Covid-19 pandemic, the Mexican case will be studied more closely. It is important to mention here that although extended studies and research on the topic of gender discrimination in the responses to the Covid-19 pandemic or of treatment of unrelated illnesses to the virus that occur during this time is minimal, as most of the data in the majority of countries is not gender segregated, several organizations have addressed these issues and its importance in their reports.

To begin with, it is important to understand that Mexico’s health system has been undergoing major restructuring in the past 3 years, starting with the elimination of the 2003 health reform of Seguro Popular and returning to a centralized health system with “integrated
public financing and delivery and reduced private participation” that is founded on three main ethical principles: universality, free services and anti-corruption (Reich 2020). The clash of these changes with the rise of the Covid-19 pandemic has led to many shortages in health supplies and services and inadequate organizations and provision of care on a larger scale, which for many aforementioned reasons as well as other factors that are to be discussed below, are affecting women on multiple and deeper levels.

Specifically, in a journal of Medical Ethics Pauline Capdevielle, Amaranta Manrique de Lara and María de Jesús Medina Arellano emphasize how isolation and confinement at home are extremely concerning for women’s safety in Mexico as it leads to the serious problem of gender and domestic violence, that will be further analyzed below, which are significantly exacerbated during a pandemic due to stress, economic uncertainty and confinement which pulls women away from support (Journal of Medical Ethics 2021). Another consequence of confinement is that “it highlights the existing inequality, based on misogynistic stereotypes, in the distribution of unpaid labor (household chores and care)” (Journal of Medical Ethics 2021). This inequality is normalized to such an extent that the Mexican president, López Obrador, publicly stated that women at home would have no issue looking after the health of elders, affirming that men tend to be “more detached” (Journal of Medical Ethics 2021). Additionally, the report adds that as women make up most of the healthcare workforce and in other positions deemed essential (such as domestic workers, cleaning staff, cashiers at supermarkets and drugstores), they face increased exposure to contagion (Journal of Medical Ethics 2021). Furthermore, their health is also comprised by factors such as misinformation by social media in Mexico which have irresponsibly made inaccurate statements about the utility of some drugs like hydroxychloroquine leading to their panic-buying, without taking into consideration how such medication is essential to maintain the health and lives of thousands of women that are already at higher risks to develop chronic diseases such as rheumatoid arthritis and lupus (Journal of Medical Ethics 2021).

The journal also adds that in Mexico “no special protocols have been defined to tend to pregnant women, protecting them from COVID-19 while seeing to their usual needs before, during and after childbirth” which can lead to increased maternal mortality rates (Journal of Medical Ethics 2021). Also, the new Covid-19 measures and protocols don’t include anything about access to emergency services for victims of sexual violence, such as safe means to interrupt a pregnancy resulting from rape, which although being a controversial topic in Mexico for which laws vary by region, a federal norm ensures women’s right to abortion when they’ve suffered sexual assault (Journal of Medical Ethics 2021). However, the fact that the provision
of abortion services must be ensured in a timely manner, given that these procedures cannot be postponed and should be considered urgent combined with the occurrence of restrictions of health services such as the lack of resources and medical personnel, has led to an estimated downward trend of 25% for abortions during the pandemic (Observatorio Género y COVID-19 en México 2020).

On this note, a case study called “Mexico’s response to Covid-19” by the Institute of the Global Health Sciences explains in a small section regarding the gender lens of the pandemic in Mexico, how even though the president of the country and the health ministry have shown disregard for the reality reflected by some of the aforementioned facts and data, and has not officially proceeded with gender disregarded studies and statistics of the pandemic or regulations, civil society organizations have created programs and tools to face the pandemic from a gender perspective (UCSF 2021). Specifically, the National Network of Shelters served 48% more people in 2020 than in 2019, while the Center for Research and Gender Studies at the Autonomous National University (UNAM) has made available a repository with relevant academic literature, reports from international organizations, and infographics on gender violence during the pandemic (UNAM) (UCSF 2021).

Similarly, the Gender and COVID-19 Observatory in Mexico keeps track of government actions with regards to its human rights obligations and of the contributions of civil society for a more equal and gender oriented new normality. In fact, the Gender and Covid-19 Observatory makes sure to defend and stand by women of all groups and sectors by including all kinds of data and news on different issues such as the current situation on safe abortions; access to contraceptives; caretake; feminicides; agricultural journals; maternal mortality and obstetric violence; women with disabilities; women with HIV; homeless women; Indigenous women and Afro-Mexican; migrant women; women deprived of liberty; children and adolescents; LGBTIQA+ people; health workers; domestic workers; sex workers and women that live with family violence or as refugees (Observatorio Género y COVID-19 en México 2020). All these different sections are covered by this observatory by providing information on the situation before the pandemic, after the pandemic impacts, on the government’s response and the actions that are being taken for the specific group, while each group is being characterized by the current situation its facing as: insufficient actions or lack of measure implementation, omission or detrimental action or discussions without concrete actions (Observatorio Género y COVID-19 en México 2020).

Chapter 4 – Analysis
4.1 Overview of data on women’s current situation in Mexico

The analysis of this thesis begins by providing a general overview of the living conditions and situation in which many women that are coming from lower or poorer classes find themselves in Mexico. Specifically, a significant factor that needs to be addressed first when dealing with inequality in health and access to its services, is the ability of people to afford such services or to be covered by insurance. This leads directly to a short analysis of the current employment rate in Mexico, as well as to the job loss that has occurred in the past year and the percentage of medically insured people during this pandemic, all from a gendered perspective.

According to the International Labour Organization (2020), the total employment rate in Mexico during the first and second quarters of 2020 have fallen to 73.8% and 60.1% for men respectively, while for women those numbers are only 43.4% and 35.2% (International Labour Organization 2020: 7). Such numbers show a general decrease in employment, which as the research explains occurs in the whole continent with numbers that range in male employment decrease from 3 per cent to 34 per cent, while female employment decrease ranges from 7 per cent to 43 per cent (International Labour Organization 2020: 8). Although it is clear that the pandemic has led many people into unemployment in Latin America, the focus here is how these numbers in Mexico, as in many other countries in the region mentioned in the study, are significantly different for the two sexes. The report mentions that these trends “significantly exacerbate the employment gaps that existed prior to the pandemic” but explains that this difference between men and women in the results of job losses is due to women’s increased presence in “certain” economic sectors that were heavily affected by the crisis, the higher rate of informal employment which fell more sharply than total employment and the “increasing difficulties of reconciling paid work with family responsibilities in a context where education and care services have been profoundly altered by health measures for distancing and reducing people's mobility” (International Labour Organization 2020: 8). What this report fails to clarify is how all these reasons behind the gender differences observed are tied to the gender inequality experienced in the country and how this issue does not stop just at employment percentages but affects every aspect of these people’s lives.

In other words, loss of employment for many people also signifies loss of health insurance and coverage. In fact, according to the International Labour Organization’s report the number of people insured by the Mexican Social Security Institute dropped significantly since April 2020, and by June there were around 1 million fewer insured people than in March (International Labour Organization 2020: 15). The report adds “the 4.3 per cent year-on-year drop makes it the highest in the period under consideration, slightly higher than that observed
in the context of the international crisis of 2009” (International Labour Organization 2020: 15). The report also mentions that “according to the ILO (2020f), most of the formal jobs lost were permanent jobs, of which around 30 per cent were held by women” (International Labour Organization 2020:15). This already begins to show how women in Mexico are disproportionately economically affected by the pandemic and how their access to healthcare is reduced by loss of informal jobs and incomes, as well as loss of health insurances.

Furthermore, many scholars have pointed out that the attempts and laws build around gender in health insurance focus more on a predominant ideal of “equality” rather than “equity” issues and show an on-going failure to acknowledge the contribution of the care economy in the majority of health reform debates (MESA-LAGO 2008). In other words, this means that many countries, among them Mexico, focus on equality by the distribution of the same resources and opportunities to every individual across the population in health insurances, instead of focusing on equity and providing customized distribution of resources and opportunities across a population to ensure no subset of groups are at a particular disadvantage over others (American Medical Women's Association 2021). How this further applies to the Mexican case will be further shown in the following section.

On the note of health insurance, it is also important to keep in mind that the pandemic has coincided with major health reforms in Mexico to replace Seguro Popular with INSABI (Instituto de Salud para el Bienestar) (Garcia et al. 2020). Seguro Popular was the institute that provided health insurance for low-income groups and people from high or very high marginalization areas, although it is worth mentioning that even this institute has been criticized of having limited coverage of services, quality of the infrastructure and care, provision of medicines, and very long waiting times (Garcia et al. 2020). Nevertheless, this resulted in leaving major gaps in health services for the poor/marginalized groups and areas, since Seguro Popular was responsible for the Insurance of 42.2% of the population who lack of medical insurance as a job benefit (given that its beneficiaries do not have permanent job positions) (Garcia et al. 2020) (Martínez and Rodríguez-Brito 2020).

This chain of events caused by the pandemic and all the measures and consequences it induces in women’s lives, starting with loss of jobs for those that had any to begin with and loss of health insurance, results in the first structural determinant of the four factors of gender inequality in health as determined by Gita Sen and Piroska Östlin (2009): “discriminatory values, norms, practices, and behaviors, in relation to health within households and communities”. Particularly, the societal norms and discriminatory behaviors and values of these communities are the ones that place a significantly large number of women in positions of
informal jobs that are not covered medically or in conditional positions of “certain” economic sectors such as education, care, restaurant and hotel services, that are vulnerable and subject to change or complete termination in times of crisis such as the current. Such practices and customs expose these women to the risk of health insurance loss, unstable incomes that can assure adequate medical care in case of need and leave them and their health integrity dependent on the male figures in their lives.

4.1.1 Analysis of measures and actions taken by the government

Nonetheless, it must be acknowledged that the Mexican government as well as some Institutes and NGOs have taken several actions in their attempt to help and provide for the women that are facing different types of discrimination and inequality due to the pandemic. To begin with, several campaigns were organized that varied in scope, type and duration, but all had the goal to share information, educate and encourage people. Some initiatives even disseminated tools in order to promote co-responsibility within households (ECLAC and UN WOMEN 2021). For instance, the national campaign “Hombres en sana convivencia: en esta contingencia, cuidar hace la diferencia” (Men in healthy coexistence: in this contingency, caring makes the difference) in collaboration with UN Women and the dissemination of a guide and materials tried to encourage men to commitments for care (ECLAC and UN WOMEN 2021: 15).

Moreover, the Secretariat of Welfare in Mexico, in order to compensate for the suspension of care services for the elderly, promoted support networks such as tele-assistance channels for elderly women in order to monitor their emotional well-being and their health (ECLAC and UN WOMEN 2021: 13). Also, in their attempt to combat the rising percentages of gender-based violence, Mexico declared that shelters and care centers for women victims of violence and their children were considered essential activities and needed to continue to function during this emergency period (ECLAC and UN WOMEN 2021: 5). The Institute of Indigenous Peoples in Mexico has also produced radio material on violence, threats and sexual abuse against indigenous girls and women in almost 50 languages to be broadcasted by the Indigenous Cultural Radio Broadcasting System (Sistema de Radiodifusoras Culturales Indígenas) (ECLAC and UN WOMEN 2021: 6). Furthermore, different biosafety protocols and recommendations have been established to ensure the transfer, admission and stay of women that suffered violence and their dependents in temporary shelters or reception centers to protect their health and safety (ECLAC and UN WOMEN 2021: 9). Mexico is also one of the countries that defined that juridical services related to violence against women should maintain continuity
in their operations and although not all of them, some have remained open and still working (ECLAC and UN WOMEN 2021:10). In fact, Mexico has even created a Financial Support Program for micro-entrepreneurs, self-employed persons, service providers and paid domestic workers who are registered with the Mexican Social Security Institute called “Programa de Credito a la Palabra” and the Ministry of Health even recommended avoiding the attendance at the workplace with full pay for workers that belong to a risk group with priority given to pregnant or breastfeeding women on paid leave (ECLAC and UN WOMEN 2021: 16,22).

4.1.2 Analysis of the pandemic consequences for women’s healthcare

Diving deeper into the analysis of the consequences the pandemic has had on women’s healthcare and access to health in Mexico, the study will be examining the patterns of gender inequality that escalate because of the pandemic by means of the structural determinants of the four factors of gender inequality in health as determined by Gita Sen and Piroska Östlin (2009). These are “(a) discriminatory values, norms, practices, and behaviors, in relation to health within households and communities; (b) differential exposures and vulnerabilities to disease, disability, and injuries; (c) biases in health systems; and (d) biased health research”, all of which can result in inequitable and discriminatory health outcomes towards women (Sen and Östlin 2009). Therefore, the following section will be allowing us to answer the second and third sub-questions of this thesis, those being: which are the most significant factors within women’s healthcare that have been affected by the Covid-19 pandemic and how are these patterns of inequality being influenced by the realities of social norms and habits in Mexico?

Starting with the different discriminatory values, norms, practices, and behaviors in Mexico in relation to women’s health within households and communities, which in many cases is in fact the very reason behind women seeking medical attention or medications, one can find many aspects by which the pandemic has exacerbated gender inequality. First, due to the quarantine’s restrain measures and interruption of all kinds of services, the caregiving time demanded of women has increased multifold, exacerbating the already unequal division of labour in houses and impacting women’s physical and mental health. Specifically, time use surveys have already indicated that in Mexico, women dedicated 29 hours a week to caring for sick relatives, compared to 13 hours for men, while also receiving additional pressure due to the reduce amounts of resources and medication for the ill and elderly (CARE and UN Women 2020: 14). Furthermore, 15% of women in Mexico live in houses and communities with reduced infrastructure or space deficiencies, a percentage which increases to 45% for Indigenous (CARE and UN Women 2020: 31), which can in turn cause difficulty in access to health
services, pharmacies and proper medication. In fact, the UN Women report (CARE and UN Women 2020) explained that women’s “overrepresentation in informal settlements exacerbates their lack of access to the hygiene supply and measures needed to properly prevent COVID-19 infections” (CARE and UN Women 2020: 31).

Lack of access to essential infrastructure in informal settlements also restricts women from participating in decision making and income-generating activities and aggravates the resulting ‘time poverty’, further increasing their risks. For example, families who do not have running water at home must travel outside the home to collect water, use shared toilets, and gather sufficient quantities of items to service household hygiene needs” (CARE and UN Women 2020: 32). The report also explains how the pandemic affects women with current gender inequalities in access to and use of adequate and safe WASH services, since the burden of water collection falls disproportionately on women, with over half of households relying on women to use sources located off their close premises (CARE and UN Women 2020). These women not only spend between 5 to 12 more hours a week on unpaid domestic work, which in Mexico is indicated as 40% more of their time, but also run higher risks and exposure to the virus as their everyday living and obligations require them to disobey quarantine measures and restrictions in order to access the basic human need for clean water (CARE and UN Women 2020: 33). These factors, combined with the loss of jobs and loss of health insurance of women who are placed in positions that are subject to such losses during a crisis show precisely how different norms, values and different practices and behaviors within the Mexican society, discriminate against women and expose them to unequal tasks and obligations that in times of a pandemic are equivalent to higher risks of exposure to the virus or leave them uninsured in case of illness.

This realization introduces the second factor of gender inequality in health, being “differential exposures and vulnerabilities to disease, disability, and injuries” (Sen and Östlin 2009). As aforementioned, women risk higher exposure to the virus within their households and their communities, not to mention that in Mexico 79% of health workers are women (with the majority being in nursing and support positions, while men continue to make up the majority of medical staff) (CARE and UN Women 2020: 22). This means that the percentage of women exposed to the virus within hospitals or care services is much higher than men’s even if the majority of them are not actual medical personnel (CARE and UN Women 2020: 22). In fact, although global data suggests that those most affected and at risk by COVID-19 are reportedly men and people with chronic diseases and weak immune systems, Mexico is one of the few countries that shows a slightly higher number of confirmed Covid-19 cases in women than men,
specifically for ages between 20 and 60 the percentages by 2\textsuperscript{nd} May 2021 have been reported to be around 52\% to 48\% and 53\% to 47\% for women to men, further proving the higher exposure and vulnerability to the virus for women as per the aforementioned reasons (Data Visualization Charts 2021)(CARE and UN Women 2020: 22).

In connection to vulnerability, although there is not reliable evidence yet to identify significant risk to pregnant women, this has not been excluded by hospitals as this group is often vulnerable to infectious diseases due to a weaker immune system (CARE and UN Women 2020: 22). This is why according to the Mexico’s Observatory of Gender and Covid-19 obstetric services have been declared essential and prioritized, although public information from the Health Services of the states on which units continue to provide maternal and child care and especially for obstetrics emergencies are lacking (Observatorio Género y COVID-19 en México 2020). The observatory even goes on to explaining that as of July 20, 2020, the maternal mortality ratio had increased to 31.9 deaths per 100,000 estimated births in the country, representing a 19.2\% increase in the ratio compared to the same epidemiological week of the previous year prior to the pandemic, and explaining that the main cause of death is Covid-19 with 18.5\% confirmed deaths in pregnant women, suggesting indeed the increased vulnerability of this group to the pandemic (Observatorio Género y COVID-19 en México 2020). Also, it is almost an anticipated observation that pregnant women in Mexico as in any other country are at a higher risk of getting infected with the virus at their doctor appointments and during medical care for their pregnancies, especially due to the lack of proper prevention measures and protective equipment in many hospitals.

Similarly, sub-groups of women may face multiple levels of health discrimination as they belong to intersectional groups that receive the impacts of different types of inequality. In fact, women living with HIV/AIDS in the region, besides running the aforementioned risks and exposure, are also at significant risks as crises such as this pandemic often disrupt supply chains, leaving this population without critical medications such as antiretrovirals and supplies (CARE and UN Women 2020: 22). In Mexico, according to the Observatory (2020), structural problems coupled with hospital reconversion, shortages and the lack of affirmative measures for people with HIV in conditions of greater vulnerability, such as those with a detectable viral load, those who have less than 200 CD4 or pregnant women, have deepened the gaps that existed in access to services. Therefore, the prevention and detection of HIV and other sexually transmitted infections have remained in the hands of civil society organizations, while everyday people with new diagnoses are reported who face the lack of a plan defined by the federal and local
government in the context of a health emergency, leading to the next important factor of gender inequality regarding health, being gender biases in health systems.

The third factor of gender biases in health systems can refer to different kinds of biases, as for instance the laws and measures that acknowledge a possible gender discrimination and address it or the lack thereof, the insufficient measures and services that ensure the implementation of such measures, the omission or detrimental actions on the topic or the possibility of discussions without concrete actions. For example, the Mexican state in its actualization on 22 of July included the necessary attention that must be given to abortions when a woman’s life and health is in danger as an essential service of the whole country, although the measures taken for the implementation of this were according to the Observatory of Gender and Covid in Mexico, “insufficient or lacked implementation” (Observatorio Género y COVID-19 en México 2020). Therefore, since the provision of abortion services must be ensured in a timely manner, given that these procedures cannot be postponed and should be considered urgent, as well as restrictions of health services such as geographical barriers, restrictions of movement, delay in procedures because of lack of available health workers and doctors, and lack of medications such as misoprostol and mifepristone that are necessary for such procedures has led to an estimated downward trend of 25% for abortions (Observatorio Género y COVID-19 en México 2020). Such delays of an essential service for women has allegedly led in many cases in the country to unsafe abortions, of which the threats can be many and even put the woman’s life in danger, although a concrete number has not yet been published in studies.

Another important proof of lack of actions and measures by the Mexican State concerns the delivery of contraceptive methods by state health services. Specifically, the recent disappearance of Seguro Popular without the proper reference of beneficiaries, has left some people who were beneficiaries of this insurance without access to health services, including contraceptives (Observatorio Género y COVID-19 en México 2020). Similarly, the shortage of personnel to provide sexual and reproductive health services, which was already a problem far from being solved, has worsened during the past year leading to the delivery of contraceptives by state health services for only up to three or four months to active users, while the pandemic has officially surpassed one year since its declaration (Observatorio Género y COVID-19 en México 2020). Also, given the socioeconomic impacts and the health risks of contagion, women in Mexico fear visiting health services to access contraceptive methods. According to estimates from the National Population Council (CONAPO), confinement has increased the unmet need for contraception of women between 15 and 49 years of age and as a consequence there will be
more than 122,000 unplanned pregnancies compared to the estimated trend prior to the pandemic (Observatorio Género y COVID-19 en México 2020).

Additionally, as per the previous factor, many women that come from sub-groups face intersectional levels of inequality of health. The Observatory explains that in Mexico there is an absence of plans to meet the specific needs faced by people with disabilities in the face of the pandemic, which further highlights the unmet needs of the population with disabilities, as well as the lack of supports and services in the community (Observatorio Género y COVID-19 en México 2020). In the case of women and girls with disabilities, despite being 53% of the population with disabilities, there is a lack of specific care actions implemented by the State to prevent and combat the intersectional discrimination they face, as well as the lack of information, a fact that the Committee on the Rights of Persons with Disabilities had previously indicated with concern (Observatorio Género y COVID-19 en México 2020). In addition, these women are at greater risk of being victims of violence and abuse, which is compounded by the confinement derived from the pandemic. Similarly, in Mexico, 78.2% of the Indigenous population has no social security, which means that they have no protection against unemployment, illness or disability, meaning that women who are already experiencing previous forms of discrimination are also completely defenseless in the face of the Covid-19 virus (CARE and UN Women 2020: 19).

Finally, the final factor that discriminates against women within health is the biased health research or lack of research on important data that may affect women disproportionately. Specifically, the pandemic and confinement have increased the precariousness of street populations and the discrimination and violence against women that live and work in the street by the police and citizens (Observatorio Género y COVID-19 en México 2020). The shortages they face have been exacerbated by the loss of formal jobs, the closure of informal work spaces that impact their income, and food shortages, while the parks and squares that they usually visit or inhabit are cordoned off and the soup kitchens and institutions that previously offered them aid have closed, therefore limiting the options to rest or receive services (Observatorio Género y COVID-19 en México 2020). In fact, as Almudena Ocejo, Secretary of Inclusion and Social Welfare of the CDMX has pointed out, the situation is very difficult for people who live on the streets and require shelters, since they are saturated (Observatorio Género y COVID-19 en México 2020).

However, there is no official information available on the number of cases and the conditions in which those who could be infected with COVID-19 in this population are. Some media have reported alleged cases, but no authority has confirmed the veracity of the facts.
Women from the street population experience the pandemic in a complex way, since they do not have access to water, sanitary services are limited and they do not have the possibility of having sanitary towels or spaces to bathe (Observatorio Género y COVID-19 en México 2020). In addition, the care of children, as well as the sick or elderly, depends almost entirely on them. By not having nurseries, schools or recreational spaces, care tasks occupy twice their time, causing stress and anxiety in them and their families due to the uncertainty of when they will be able to resume their usual activities. They also face the constant risk of having their daughters and sons taken from them. In times of COVID-19, the operations of the System for the Integral Development of the Family of Mexico City (DIF) have increased with the aim of protecting the health of children and adolescents by taking them away from the streets during the pandemic, but more than often these operations lead to violent family separation (Observatorio Género y COVID-19 en México 2020). Similarly, the lack of updated data on other illnesses and conditions that affect women disproportionately such as lupus, UTIs, Alzheimer’s and others, as well as the lack of information about the accessible and safe services for these illnesses during the pandemic periods, show a certain disregard to health issues unrelated to Covid-19 that affect women. Nevertheless, it must be acknowledged that the Mexican government and its National Center of Gender Equality and Reproductive Health has addressed in its latest report some of the issues affecting women, even if not entirely inclusive of all groups and illnesses, such as cases of breast cancer, gender-based violence, maternal health during the pandemic, adolescent pregnancies during Covid-19 and sexual and reproductive health for people with disabilities during the pandemic (Secretaria de Salud 2020).

These four factors represent the most significant ways by which women’s healthcare has been affected by the Covid-19 pandemic, showing at the same time how the social norms and habits of households and the economic market in Mexico play their role in these conditions, therefore answering the first and second sub-questions of this thesis.

4.1.2 The pandemic effects on feminicide and violence and its connection to healthcare

As the pandemic exacerbates, existing gender inequalities and vulnerabilities, as well as the risks of abuse and violence within households increases, especially in a country like Mexico with a notable background in this issue. In fact, the past months have stunned the world as protests against feminicide, intimate partner violence and other forms of domestic violence and sexual exploitation and abuse have escalated in Mexico. Due to heightened tensions in the household caused by the confinement and the pandemic restrictions, Mexico’s Observatory of Gender and Covid reports that in two months of confinement for COVID-19, calls and messages
requesting support due to gender violence increased by more than 80%, while in the first month, more than 300 women, girls and adolescents who lived with their attacker were murdered (Observatorio Género y COVID-19 en México 2020).

Their report also adds that during March alone, the national emergency number 911 has received about 155 calls per hour for a situation of violence and as the months of the quarantine passed the requests for support received by the National Shelter Network (RNR) have increased up to 80% (Observatorio Género y COVID-19 en México 2020). Especially during the first months of the pandemic according to Maissa Hubert, the executive sub-director of Equis Justicia Para Las Mujeres, a Mexico City-based NGO, 11 women in total were killed each day compared to 10 per day at the start of 2020 (UCSF 2021). Also, in March 2020, the emergency call centers received 26,000 reports of violence against women, which was reported the highest ever in Mexico and the number of women leaving their homes to take shelter in the National Refuge Network quadrupled (UCSF 2021). The Institute of Global Health Sciences in its report regarding Mexico’s Response to Covd-19 explains that in 2020, calls to 911 lines related to “violence against women” increased by 73%, compared to 2019 (Secretaría de Seguridad), while the Mexico City government has released detailed information about phone calls made to a women’s emergency helpline “Línea Mujeres” showing that during May’s shutdown, calls increased by 97% relative to the same month in 2019 (Intersecta; EQUIS Justicia para las Mujeres. National Network of Shelters) (UCSF 2021).

What’s more important is how the issue was according to many NGOs and agency’s ignored by the Mexican State in the beginning of the pandemic, as for instance information generated by the RNR reveals that 19% of the women who requested support had already had an approach with government agencies, but had been ignored (Observatorio Género y COVID-19 en México 2020). Furthermore, newspapers have only reported in December last year President Lopez Obrador talking about gender-based violence, “having previously avoided using the word feminicide or acknowledge that women faced specific security concerns”, while in May 2020, the president said that 90% of domestic violence-related 911 calls were false, although his team failed to provide evidence to support this claim when requested to by different NGOs (Fair Observer 2021). Although Mexico in their attempt to combat these percentages has declared that shelters and care centers for women victims of violence and their children were considered “essential activities and needed to continue to function during this emergency period” such measures require securing financial resources, developing new modalities of care and specialized protocols that take into account the requirements of infection-prevention that need to be correctly implemented (ECLAC and UN WOMEN 2021: 5).
Having all these in mind, it is crucial to understand that during a global pandemic, life-saving care and support to gender based violence survivors (i.e. clinical management of rape and abuse or mental health and psycho-social support) are usually cut off in the health care response when health service providers are overburdened and preoccupied with handling the virus, in this case being Covid-19 cases. Therefore, systems must ensure the necessary health workers available for these services, that have the necessary skills and resources to deal with sensitive gender-based violence related cases, while ensuring that:

“Any disclosure of gender based violence be met with respect, sympathy and confidentiality and that services are provided with a survivor centered approach. It is also critical to update gender based violence referral pathways to reflect changes in available care facilities and inform key communities and service providers about those updated pathways” (UNFPA 2020).

4.1.4 Women as healthcare providers

Finally, the last part of this analysis will discuss the consequences of Covid-19 on a final dimension of gender inequality in health, that being women working as healthcare providers. Specifically, as aforementioned according to the Mexican Observatory of Gender and Covid, women as they are the first line of care for Covid-19 forming a percentage of 79% of healthcare in Mexico, are exposed to greater risks of contagion, physical and emotional tear and wear (Observatorio Género y COVID-19 en México 2020). However, due to the misinformation and fear of contagion of the virus that prevail in such times, medical personnel have been faced with unlimited discrimination and violence in public spaces as well as in their personal lives. In fact, as the Ministry of Interior (SEGOB) has reported, several serious attacks under different forms have occurred, including spraying nurses and doctors with chlorine, preventing them from using public transport or entering public places and using services, physical attacks and even death threats with firearms (Observatorio Género y COVID-19 en México 2020). According to SEGOB data, as of April 29, 47 attacks had been registered in 22 states against health professionals; 80% of them were against nursing personnel and 70% against women, which shows a differentiated impact of this violence against women in health workers (Observatorio Género y COVID-19 en México 2020). Moreover, some women, as health personnel have also faced a lack of sufficient medical supplies, the extension of their shifts due to a lack of medical workers and the lack of access to social security, rest days, vacations and other benefits of labor for being substitute workers (Observatorio Género y COVID-19 en México 2020). Furthermore, there have been incidents, such as in the case of María Elena Ponce, a mayor...
worker for 8 years at the Pediatric Hospital of Sinaloa and representative of the substitute workers, that have contracted the virus at work but have been denied any kind of medical supplies and support, such as a test or a hospital bed due to their lack of social security and therefore health insurance (Observatorio Género y COVID-19 en México 2020).

4.2 Gender inequality rise from Covid-19 – a critical analysis of the discourse results

Having analyzed the most significant factors within women’s healthcare that have been affected by the Covid-19 pandemic as well as how these patterns of inequality are being influenced by the realities of social norms and habits of Mexico, this study will continue by discussing these results from a theoretical perspective. As aforementioned, the two theories regarding gender inequality that will be used in this approach to healthcare access constitute of Liberal Feminism Theory and Radical Feminism Theory, therefore answering the third and final sub-question of this study: To what extent is the selected country characterized by the theoretical discussions of gender inequality and in what ways?

Starting with the theory of Liberal Feminism which refers mainly to gender inequalities in social and cultural attitudes which cause different factors to contribute to inequalities between men and women, in different places, such as healthcare (Mill 1869). Some theorists, as for instance Giddens (20001:692) define liberal theory as a “feminist theory that believes gender inequality is produced by reduced access for women and girls to civil right and allocation of social resources such as education and employment” (Giddens 2001). As observed from several definitions of this theory by different theorists, at its core, most versions agree on the existence of several types of disparities in society that are gender based. When analyzed in connection to healthcare and health access, by application this theory would suggest the existence of discrimination and disparities either caused indirectly by societal norms, practices and customs that affect women disproportionally, either by the provision or availability of unequal resources and opportunities for health between the two sexes.

In this case, based on the previously analyzed data, all four factors of possible health discrimination by Gita Sen and Piroska Östlin (2009) can be seen and interpreted from a Liberal Feminist point of view, as “discriminatory values, norms, practices, and behaviors, in relation to health within households and communities; differential exposures and vulnerabilities to disease, disability, and injuries; biases in health systems; and biased health research” and can all directly or indirectly, knowingly or not, cause inequitable and discriminatory health outcomes towards women that apply to this theoretic discussion. Specifically, previously analyzed data and facts showing lower employment and health insurance rates for women; more
women covering household tasks such as seeking and providing water or taking care of sick family members and risking contracting the virus on a daily basis because of tasks and practices that are considered as women’s responsibilities; the lack and disruption of supply chains of necessary medications or preventative measures for the reproductive needs of women; the lack of mandatory protective equipment for monthly visits or births in the maternal wings of hospitals, are all examples of gender based disparities within the Mexican society and health system that are compatible with the Liberal Feminist ideology on gender inequality. Furthermore, some tasks such as housekeeping and taking care of the ill or children are examples of what Liberal Feminists consider to be skills that are learnt and not innate, as men are capable of doing them even in the absence of women but chose not to in their presence, showing the effect of the sexist socialization and societal norms and stereotypes on most individuals, which in times of a pandemic are somewhat responsible for placing only women in higher risks of contracting the virus.

Looking at gender inequality from the perspective of violence, one can also identify in the Mexican society aspects of the theory of Radical Feminism, which perceives such kinds of systematic oppression of women as an inevitable product of male dominated societies (Mill 1869). In fact, domestic violence, which as analyzed in a previous section has reached new levels during the pandemic in Mexico, is one of the main concerns of Radical Feminists, according to which:

“Domestic violence against women by men is “caused” by the misuse of power and control within a context of male privilege. Male privilege operates on an individual and societal level to maintain a situation of male dominance, where men have power over women and children. Domestic violence by men against women can be seen as a consequence of the inequalities between men and women, rooted in patriarchal traditions that encourage men to believe they are entitled to power and control over their partners.” (Women’s Aid 2021)

Such demonstrations of violence are again linked directly to the roots of gender inequality between women and men that manifest more severely in times of confinement such as the ones imposed by the Covid-19 pandemic, when many women find themselves constantly “locked” in a house with their aggressor. In this case, a connection between this aspect of the gender inequality described in the Radical Feminist theory and the current escalating situation in Mexico can be easily identified.
Chapter 5 – Concluding discussion and future research

To conclude, this thesis has sought to answer what patterns of gender inequality towards women are found in Mexico’s healthcare and how has the Covid-19 pandemic contributed to and disinterred these patterns. This has been enabled by investigating the Mexican reality through recent data and facts that portray the most significant factors within women’s healthcare that have been affected by this global pandemic, as well as how these patterns of inequality are being influenced by the social norms, habits, stereotypes and customs of the Mexican society. By analyzing finding using the four factors of health discrimination by Gita Sen and Piroska Östlin (2009), compatible patterns were observed between the results of the analysis and the theories of Liberal Feminism and Radical Feminism regarding gender inequality. Additionally, some of the data analyzed have presented how these patterns of gender inequality have been aggravated and exacerbated due to the new conditions induced by the pandemic in both terms of health inequalities and health inequities.

In other words, the outlined analysis concluded that several patterns of gender inequality have been exacerbated by the Covid-19 pandemic affecting women’s healthcare and access in Mexico by aggravating the conditions of issues such as safe abortions, access to contraceptives, women as caretakers, feminicides, women living with HIV, homeless women, indigenous women, health workers and women that live with family violence among others. By analyzing such issues that affect women’s healthcare with information of the situation before the pandemic began, after the pandemic impacts and on the government’s response and the actions taken for each issue, several of these problems were noticed to be dealt with insufficient actions, lack of measure implementation, omission and detrimental actions and discussions in Mexico.

Conducting the analysis on the basis of the four factors of possible health discrimination, these being “discriminatory values, norms, practices, and behaviors, in relation to health within households and communities; differential exposures and vulnerabilities to disease, disability, and injuries; biases in health systems; and biased health research”, a compatible pattern is identified with the Liberal Feminist discussion, which provides a theoretical base for the gender inequality caused by the social norms and habits of the Mexican society (Sen and Östlin 2009). This was further consolidated by the data showing lower employment and health insurance rates for women; more women risking contracting the virus on a daily basis because of societal norms and practices that are considered as women’s responsibilities; the lack and disruption of supply chains of necessary medications or preventative measures for the reproductive needs of women and the lack of the necessary care for pregnant women and new mothers in the maternal wings of hospitals. Such findings portray the gender based disparities within the Mexican society and
health system that are compatible with the analyzed Liberal Feminist ideology on gender inequality. Similarly, the findings of domestic violence and feminicides exacerbated by the pandemic in the Mexican society, associate this type of gender inequality with the theory of Radical Feminism, which perceives such kinds of systematic oppression of women as an inevitable product of male dominated societies (Mill 1869). Additionally, Radical Feminism helps further understand the gender inequality within the discussion of gender based violence survivors and the treatment they receive during a global pandemic in the Mexican society, as in many other countries around the world. These include cut offs of services in the health care response when health service providers are overburdened and preoccupied with handling the Covid-19 cases and a general lack of the necessary health workers for these services that have the necessary skills and resources to deal with sensitive gender-based violence related cases. Overall, this study has answered the research question by identifying in what ways these patterns of gender inequality have been affected by the Covid-19 pandemic and reporting the different outcomes these patterns have had on women’s healthcare in Mexico, while also determining in what ways the social norms, practices and habits of the Mexican society influence said patterns.

The future evolution of research on this topic could involve an up close observation of the situation within communities and medical centers by means of interviews or questionnaires that can offer an insight on daily experiences of women within the health sector, while providing answers to some validity questions of these findings. Some interesting questions to pose here from this point of view and based on the outlined analysis would be “To what extent do Mexican women feel secure in terms of reaching to health centers during the Covid-19 pandemic and how accessible they find them on a daily basis?” and “To what extent do Mexican women feel represented, considered and included by health reforms, initiatives and measures during the pandemic?”. From a practical point of view one may even ask “How is the Mexican government’s responding to the reports and researches showing gender inequality in health access and what measures are being implemented- or not- during the pandemic on this topic?”. From a theoretical perspective of this research, after having connected the issue at hand with the gender inequality concept as portrayed by the Liberal and Radical Feminists, one may also ask “What course of action is needed according to the said theories for a possible improvement or solution of gender inequality in health and what barriers does it face?”. Such future research could help answer questions that may arise from this study, as well as providing an overview of real life experiences that may shed more light on gender inequality in health by contributing
with new and deeper dimensions of this relation between the two topics and perhaps offer new perspectives and form new questions.
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