The sociodemographic impacts of the COVID-19 pandemic in Latin America and the Caribbean

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Fourth session of the Regional Conference on Population and Development in Latin America and the Caribbean
Santiago, 28-30 June 2022

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Regional Conference on
Population and Development in
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Santiago, 28-30 June 2022

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This document was prepared by the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, in its capacity as technical secretariat of the Regional Conference on Population and Development in Latin America and the Caribbean, for the fourth session of the Conference (Santiago, 28–30 June 2022). The technical secretariat was assisted by the Division for Gender Affairs of ECLAC and received support and assistance from the United Nations Population Fund (UNFPA) in the preparation of the document.

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Support for the preparation of this document was also received from the twelfth tranche United Nations Development Account project "Harnessing the contribution of intra-region migration to socio-economic development in Latin American and Caribbean countries" and the "Social inequality and the future of workers in Latin America in the context of post-pandemic recovery" project, financed by the Ford Foundation.

United Nations publication
LC/CRPD.4/3
Distribution: G

Printed at United Nations, Santiago
S.22-00158

This publication should be cited as: Economic Commission for Latin America and the Caribbean (ECLAC), *The sociodemographic impacts of the COVID-19 pandemic in Latin America and the Caribbean* (LC/CRPD.4/3), Santiago, 2022.

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FOREWORD

Latin America and the Caribbean is characterized by a matrix of social inequality whose axes —such as socioeconomic stratum, gender, stage in the life cycle, ethnicity and race, territory, disability, and immigration status— create multiple, often concurrent, situations of exclusion and discrimination. The coronavirus disease (COVID-19) pandemic has exacerbated wide social gaps and it is no coincidence that Latin America and the Caribbean is one of the regions in which the health and socioeconomic impacts of the pandemic have been the most severe, which shows that the costs of inequality are unsustainable.

Added to this is the fact that while the economies of the region have yet to recover from the pandemic, they are already beginning to suffer the consequences of the war between the Russian Federation and Ukraine, reflected in slower growth and inflationary pressure; and the most vulnerable populations of the regions are the ones bearing the brunt of the resulting increase in food prices and the negative effects on the labour market.

In this challenging context, this document, prepared at the request of the Regional Conference on Population and Development in Latin America and the Caribbean, analyses the sociodemographic impacts of the pandemic and makes recommendations for recovery and reconstruction from the perspective of the Montevideo Consensus on Population and Development. The Montevideo Consensus, an intergovernmental agreement for follow-up and review of matters relating to population and development in the region, is considered one of the most progressive instruments of its kind in the world.

With a rights-based approach, it incorporates gender, generations, ethnicity, race, territory and the environment as key dimensions for the design of public policies aimed at fuller and fairer development for the whole population. It complements the 2030 Agenda for Sustainable Development by seeking to ensure that no girls, boys, adolescents and young people, older persons, women, migrants, indigenous peoples, Afro-descendants or persons with disabilities are left behind. It also makes a strong call for the fulfilment of sexual and reproductive rights and promotes universal access to sexual and reproductive health services.

The contents of this document encompass the impacts of the pandemic on the three components of population dynamics —mortality, fertility and migration— and we hope that it will help to guide the discussions at the fourth session of the Regional Conference on Population and Development in Latin America and the Caribbean.

The Regional Conference on Population and Development, a subsidiary body of the Economic Commission for Latin America and the Caribbean (ECLAC) supported by the United Nations Population Fund (UNFPA), is being reconvened four years after its last session precisely because of the situation caused by the pandemic. Despite the postponement of the session of the Regional Conference which was to be held in 2020, the Chair of the Conference, the Government of Peru, organized five virtual dialogues[1] between August and December 2020, with the support of the Presiding Officers, ECLAC and UNFPA, to analyse the sociodemographic situation in the countries of the region in the context of the COVID-19 crisis and its possible short-, medium- and long-term impacts on the most vulnerable population groups, in the light of the priority measures of the Montevideo Consensus on Population and Development and the Goals and targets of the 2030 Agenda for Sustainable Development.

The virtual dialogues, the outcomes of which form much of the basis of this document, focused on how the pandemic affected migrants, Afrodescendant populations, sexual and reproductive health, and persons with disabilities. Thanks to the collaboration of the ECLAC subregional headquarters for the Caribbean, they also addressed the sociodemographic impacts of the health crisis in that subregion. The dialogues provided an opportunity for reflection and sharing of experiences and lessons learned on the main difficulties and challenges faced by governments of the region in their efforts to protect the most vulnerable population groups from the effects of the health crisis and to implement the priority measures of the Montevideo Consensus. They were also an opportunity to share the initiatives and best practices implemented, and to promote mechanisms for

[1] See [online] https://www.cepal.org/es/publications/type/conferencia-regional-poblacion-desarrollo-america-latina-caribe/dialogos-virtuales-impactos-covid-19-la-perspectiva-poblacion-desarrollo.

cooperation between countries that can provide coordinated responses to the COVID-19 crisis. In addition to governments, representatives of civil society, academia and international agencies also participated actively in the virtual dialogues, which were attended by around 17,500 people.

At the fourth session of the Regional Conference on Population and Development in Latin America and the Caribbean, in line with the agreements adopted at the executive meeting of the Presiding Officers of the Regional Conference held in May 2021,[2] in addition to this document on the sociodemographic impacts of the pandemic in the region, a report on the progress of the activities of the working group on indicators for regional follow-up of the Montevideo Consensus on Population and Development will be presented. The secretariat will also present the website of the virtual platform to contribute to regional follow-up of the Montevideo Consensus, including a proposal for updating its content, and the Conference will consider a proposed timeline for the submission of national reports and of the regional report on the implementation of the Montevideo Consensus, in line with global cycle of review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development beyond 2014, and with the follow-up and review of the implementation of the 2030 Agenda for Sustainable Development.

We hope that the Conference, building on this document and other inputs, will contribute to the debate on a transformative recovery with equality in our region.

Mario Cimoli
Acting Executive Secretary
Economic Commission for Latin America
and the Caribbean (ECLAC)

[2] See the agreements of the executive meeting of the Presiding Officers of the Regional Conference on Population and Development in Latin America and the Caribbean, held virtually on 20 May 2021, [online] https://www.cepal.org/sites/default/files/events/files/21-00305_remp.2021_agreements.pdf.

INTRODUCTION

A. Summary of the analyses dealing with the socioeconomic impacts of the pandemic in Latin America and the Caribbean

B. Multiple risk factors: urbanization, density and metropolization, overcrowding, lack of access to basic services and structural weaknesses in the health-care sector

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In accordance with what was stipulated in the agreements of the executive meeting of the Presiding Officers of the Regional Conference on Population and Development in Latin America and the Caribbean,[1] this document analyses the sociodemographic impacts of the coronavirus disease (COVID-19) pandemic in the region and presents policy recommendations for a transformative recovery with equality, within the framework of the Montevideo Consensus on Population and Development.

The document consists of four thematic chapters following this introduction, which briefly reviews the socioeconomic impacts of the pandemic in the countries of Latin America and the Caribbean and summarizes the analyses that the Economic Commission for Latin America and the Caribbean (ECLAC) has produced on the subject since early 2020. Particular emphasis is laid on the contraction of economic activity and the subsequent (inadequate) recovery, the negative consequences for the labour market, the increase in poverty and inequality, the direct impacts on population health, education, women, indigenous peoples and Afrodescendants, and the repercussions for mobility and access to basic services. Certain risk factors associated with the rapid advance of the pandemic in most countries of the region are also addressed, such as high levels of urbanization and metropolization, overcrowding, and lack of access to basic services and prompt, high-quality health care. Some of these are also risk factors for infection and greater health impacts among the most vulnerable populations in the region.

Chapter I deals with the consequences of the health crisis for the three components of population dynamics in Latin America and the Caribbean: mortality, fertility and migration. Drawing on available data for the impact of the pandemic on life expectancy, the first section of the chapter focuses on analysing the behaviour of mortality in relation to the outbreak of COVID-19 in the region, looking at differences in mortality levels between countries and their relationship with national health, social and economic policies. The effects that the pandemic could have on fertility via different channels are then examined. Births, birth rates and fertility are expected to decline in 2020 and 2021, with subsequent developments more uncertain given the possibility of a recovery in fertility. Some conceptual debates about possible changes in reproductive preferences and intermediate variables that may result from the pandemic are touched on, with emphasis on access to contraceptive methods and the postponement and subsequent recovery of fertility, among other things. For countries with recent data, we attempt to estimate and compare births before and during the pandemic to obtain an initial approximation of its effect on birth rates and fertility. Lastly, the effects of the pandemic on both international and internal migration are analysed, with consideration given, among other factors, to the repercussions that sanitary measures and restrictions have had on population mobility across borders and within countries. In the case of international migration, we highlight the way the pandemic has aggravated economic and social difficulties and its effects on the most recent migratory flows in the region, such as those of Central American, Haitian and Venezuelan nationals. It is for these reasons that mobility statistics, which include refugees, are a necessary element to be considered in public policymaking. In addition, we note that natural phenomena, in some cases linked to climate change, are increasing in a number of subregions and making migration processes even more complex, with mixed flows in which many people have limited opportunities for regular migration. In the case of internal migration, we argue that the greater impact of this on urban and especially metropolitan areas may mean that these areas become less attractive to migrants, as well as registering higher mortality rates. We also hypothesize that some possible migration reconfigurations could be temporary and go into reverse after the crisis, while others could become permanent.

Chapter II analyses structural inequalities during the pandemic in the light of the priority measures of the Montevideo Consensus on Population and Development and the goals and targets of the 2030 Agenda for Sustainable Development with a view to ensuring the exercise of rights for all, and particularly those population groups that were already in a situation of particular vulnerability before the crisis and saw this exacerbated by the outbreak of the pandemic. The analysis of the situation of the different population groups is based mainly on three things: (i) the social inequality matrix, (ii) human rights (including collective rights, where applicable) and (iii) population processes, dynamics and transitions (such as ageing, urbanization and population mobility).

[1] See point 3 of the agreements [online] https://www.cepal.org/sites/default/files/events/files/21-00305_remp.2021_agreements.pdf.

The analysis also highlights the importance of having robust, responsive and resilient national statistical systems capable of providing timely and accurate data that can be used to monitor the effects of COVID-19 and design action plans, both nationally and locally. It highlights the need to uphold the commitments made in the Montevideo Consensus and the 2030 Agenda and redouble efforts to accelerate their implementation, including the strengthening of statistical systems to measure progress towards the goals and targets set.

The first section of chapter II examines the impacts of the health crisis on children, adolescents and young people, who may have suffered fewer direct health consequences but have been severely affected in other ways, such as by the loss of parents and protectors, unemployment and falling incomes in their families, disruption of their education and their connections with peers, loss of community ties, limitations on romantic relationships, reduced access to and disruption of sexual and reproductive health services, deteriorating mental health and the postponement of other health care and needs. This is followed by a review of the measures taken to promote and protect the rights of older people in the context of the pandemic and a brief survey of the sociodemographic vulnerabilities that particularly affect this population group, such as the differential effects of the disease by age. Other aspects that may increase the risks of infection, such as residential arrangements, intergenerational cohabitation, the degree of access to basic water and sanitation services and the risks of loss of autonomy and widening of the digital divide, are also discussed in greater depth.

The following section deals with the impacts of the pandemic on women and gender equality, with special emphasis on the physical autonomy of women and girls, violence against women (which the United Nations Secretary-General has identified as a veritable "shadow pandemic"), the crisis of care and the labour market, migration and the underrepresentation of women in political decision-making spheres, among other crucial aspects. The effects of the health crisis on migrants are then analysed, in the context of an increase in vulnerabilities throughout the migration cycle. In this framework, the section presents some illustrative data for the effects on migrants, who in many respects have been on the frontline of the pandemic in everything from health care to logistical support. It also reviews, as far as data permit, the access migrants have had to pandemic mitigation and indeed vaccination schemes.

The following section of the chapter focuses on the effects COVID-19 has had on indigenous peoples in the region. It highlights the historical exclusion and political and economic marginalization of the more than 800 indigenous peoples living there, exacerbated by the inadequacy of State responses to the crisis that have failed to take proper account of the collective rights of these peoples and have often been culturally inappropriate. It also identifies urgent challenges in the task of safeguarding and guaranteeing these peoples' rights. It then focuses on the situation of Afrodescendants vis-à-vis COVID-19 given the structural inequalities and racism that exist in the region, providing a diagnosis of the particular situation of these populations and the possible effects of the pandemic. Although the information is fragmentary, it reveals ethnic and racial divides in morbimortality and access to vaccines and provides an overview of the responses of States and organizations of Afrodescendants to the health crisis.

The section goes on to address the impact of the pandemic on persons with disabilities and their rights, with special emphasis on the sociodemographic situation of these persons and the socioterritorial inequalities that tend to increase the risk of infection, such as access to basic water and sanitation services, electricity, and information and communications technologies (ICTs).

Chapter III deals with the sociodemographic impacts of COVID-19 in the Caribbean, which merit a more extensive and focused analysis given the specificities and particularities of the subregion. Special emphasis is placed on the problems that have affected the Caribbean more strongly than or in a markedly different way to the Latin American countries, in relation either to specific population groups or, as in the case of the effects on mortality, to issues that present a quite differentiated pattern in the Caribbean subregion.

Lastly, chapter IV presents conclusions and recommendations for addressing the devastating social and economic consequences of the COVID-19 pandemic in the different population groups analysed, with a view to a transformative and equitable recovery within the framework of the priority actions of the Montevideo Consensus and the Goals and targets of the 2030 Agenda, so that no one is left behind.

A. Summary of the analyses dealing with the socioeconomic impacts of the pandemic in Latin America and the Caribbean

A number of ECLAC documents, many prepared in collaboration with other United Nations entities, have systematically and rigorously examined the socioeconomic effects of the pandemic in the region. The following is a synthesis of these analyses and those of other United Nations entities and academic institutions addressing aspects included in various priority actions of the Montevideo Consensus on Population and Development.

1. The health effects on the Latin American and Caribbean population have been among the world's worst

This statement is based on mortality data (ECLAC, 2021e and 2021f; ECLAC/PAHO, 2020 and 2021). Latin America and the Caribbean accounts for 8.4% of the world's population, but by 28 February 2022 it had already accounted for almost 66 million infections (15% of the global total) and 1.65 million deaths (28% of the global total) (WHO, 2022). Moreover, the inevitable focus of health-care activity on pandemic control has had a displacement effect on the care of non-COVID-19 conditions, with postponement or interruption of treatments and interventions such as surgery (other than emergency operations), non-communicable and chronic disease control, mental health care and sexual and reproductive health services and provision, among other things. The collateral effects of COVID-19 on population health have been massive and severe, but the more complex work of quantifying them is just beginning. The pandemic also exposed long-standing gaps and weaknesses in the region's health systems, whose segmentation, fragmentation and lack of funding made it difficult to provide the solid, coordinated and comprehensive response that the situation demanded, particularly at the start of the pandemic (ECLAC/PAHO, 2020 and 2021). For their part, health workers, most of whom are women, have been disproportionately affected both by COVID-19 infections, illness, complications and deaths and by an overload of work and stress that has had severe consequences for their physical and mental health.

2. Women and gender equality have been particularly affected

The fact that women have been most affected by the pandemic is due in particular to the significant decline in their labour force participation, the increased burden of unpaid domestic work and greater exposure to the risk of violence. This is because women are heavily overrepresented in the production sectors most affected by the pandemic (particularly services, such as commerce, tourism and personal services) and because lockdown measures have made domestic violence harder to avoid (ECLAC/UNFPA, 2020; ECLAC, 2021a and 2022b, p. 24). At the same time, school closures and teleworking have created a perfect storm for families with young and school-age children, as traditional household chores compete for time with work responsibilities and with parenting and educational support tasks. All this happened suddenly, without adequate preparation and often without the assistance that was available before the pandemic, whether in the form of family and community networks or, in the case of higher-income families, of paid domestic help. Because of the inertia of the patriarchal culture and the sexual division of labour, which unilaterally assigns women the main responsibility for domestic and child-rearing activities, this overlapping of tasks has meant an overwhelming and unfair increase in their workload, which is detrimental to their physical and mental health, their work projects, their personal space and their autonomy in general (ECLAC, 2021a). Furthermore, this overload and unequal distribution of domestic, child-rearing and care tasks led to a massive exodus of women from the labour market, resulting in a ten-year setback in labour participation in 2020 (ECLAC, 2021a). It also played a decisive role in widening gender gaps in the market for paid work, with female labour market participation and employment recovering more slowly in 2021 (ECLAC, 2022b, p. 204).

3. Poverty and extreme poverty have risen strongly

Both poverty and extreme poverty will rise to levels not seen for at least a decade. In 2021, the number of people living in extreme poverty is estimated to have reached 86 million (13.8% of the Latin American population), with 201 million living in poverty (32.1% of the population), a large rise on the figures for 2019 (70 million and 187 million, respectively). This increase was particularly sharp in 2020, the year the pandemic began, and could have been worse but for the emergency social protection measures taken to curb it. Without these measures, such as emergency income transfers, extreme poverty would have been about 1.8 percentage points higher in 2020 and poverty would have been 2.9 percentage points higher, on average, in seven countries analysed by ECLAC. The continuation, albeit partial, of these measures in 2021, together with the economic rebound of 2021, reversed part of this increase in poverty during 2021, but there is still uncertainty as to what the trend will be in 2022 (ECLAC, 2022a, 2022b and 2021c).

4. Social inequality has increased

The increase in social inequality was reflected in a Gini index that was 0.7% higher on average in the region in 2020 than in 2019. This regional increase did not occur in all the countries, and it might have been higher overall but for the economic support measures implemented by governments, targeting low- and middle-income groups. ECLAC calculations based on data from seven countries in the region indicate that the Gini coefficient would have increased by 4% between 2019 and 2020 had the emergency transfers not been implemented, whereas with the transfers the increase was only 1% (ECLAC, 2022b). Another aspect of this redistributive deterioration is the increase in the relative size of the low-income strata, especially in 2020, and downward mobility in the middle-income strata, which are not usually targeted by social protection policies and income transfer programmes (ECLAC, 2022b).

5. There was a record contraction in economic activity

The rebound in economic activity after this record contraction is no guarantee of sustained growth. In 2020, the contraction took the form of a 6.8% drop in GDP and a 7.7% drop in GDP per capita, the largest annual decline in the region's 120-year statistical history (ECLAC, 2021d). This sharp drop in regional output was due, first, to the collapse of world trade and the fall in international prices for the products that the region exports and, second, to the depression of domestic demand in the region's economies as a result of the extensive lockdown measures taken by the health authorities. The crisis was triggered by simultaneous and mutually reinforcing supply and demand shocks that had a number of major negative effects on the production structure, including the massive closure of businesses, particularly micro, small and medium-sized enterprises (MSMEs). The 2021 rebound is reflected in projected GDP growth of 6.2%, which will be insufficient, however, to restore output to its 2019 level (ECLAC, 2022b, p. 13), and whose future trajectory is subject to various uncertainties, such as those related to the vaccination process and the persistence of structural problems in the region's economies and societies.

6. The economic crisis had an immediate and devastating effect on the labour market

The impact of the economic crisis on the labour market was immediate and devastating (United Nations, 2020b), with all employment indicators deteriorating sharply. At the regional level, the unemployment rate is estimated to have increased by 3 percentage points between 2019 and 2020, from 6.8% to 9.8% (ECLAC, 2022b). This increase was smaller than might be expected given the magnitude of the contraction in activity, owing to a peculiarity of the current crisis: the massive shutdown of activities led to what was a likewise massive

expulsion of labour. In fact, the labour participation rate fell by 3 percentage points, from 65.1% to 62.1%, between 2019 and 2020 (ECLAC, 2022b), which reduced pressure on the labour market and contained the rise in unemployment. But this occurred in a rather perverse way: the reduction of the economically active population and the disappearance of the income generated by the workers who exited economic activity. The economic rebound of 2021 partially reversed this collapse, but the indicators are still worse than before the pandemic (ECLAC, 2022a).

7. A substantial fiscal effort has been made

The large fiscal effort made by the countries has been constrained by two major factors: the fall in public revenues due to the record downturn in economic activity, and the need for an extraordinary response to prevent even greater damage to the productive fabric and to directly support the huge number of individuals and families whose incomes were rapidly and drastically affected by the crisis. The government response included numerous measures, chief among them being direct transfers to individuals, families and businesses, subsidies for employment and basic services, and deferral of payments and remission of interest, fines and surcharges on arrears. Total tax revenues contracted by 0.5 percentage points of GDP at the regional level in 2020, a magnitude that varied between countries and over the year, however, being greatest in the second quarter (ECLAC, 2021c). Public spending reached record highs, driven by the public outlays resulting from fiscal plans worth an average of 4.6% of GDP regionwide in 2020. Real primary spending grew by more than 10% in a number of the countries and by 20% or more in four of them in 2020 (ECLAC, 2021c). Similarly, total central government spending in Latin America reached its highest level (24.7% of GDP in 2020 and an estimated 23.8% of GDP in 2021) since comprehensive fiscal data began to be published in 1950 (ECLAC, 2021c). This combination of falling tax revenues and rising public spending resulted, predictably, in a deterioration of the fiscal accounts, which showed large deficits. In fact, the average fiscal result in the region was -6.9% of GDP in 2020, with an estimate of -5.5% of GDP for 2021 (ECLAC, 2021d).

8. The pandemic quickly affected education

In 2020 alone, 32 countries closed their educational institutions, with more than 165 million students affected (ECLAC, 2021e). The situation continued for much of 2021 (UNESCO, 2021; Rodríguez, 2021), even though the decline in infections prior to the outbreaks of the delta and omicron variants allowed educational institutions to open in a number of places. While various means were found of allowing studies to continue remotely in most of the countries (via the Internet, television or radio), it is clear that none is able to abruptly replace face-to-face education. Given the stark digital divide between socioeconomic groups, combined with domestic circumstances that make teaching and learning at home difficult and challenging for many students, especially those from the most disadvantaged groups, these methods of delivery can widen learning inequalities. Physical attendance is integral to school life and interaction, which is a fundamental component of the school learning process. For a number of reasons, furthermore, the interruption of the school cycle particularly affected those students who were already disadvantaged before the pandemic, exacerbating existing inequalities. School closures also affect boys and girls differently. Because of the distribution of care roles in society, girls are at greater risk of being overburdened with domestic and care work that can interfere with the continuity of their education. They are also more vulnerable to situations of sexual and gender-based violence that may occur during lockdowns.

9. The housing outlook looks very challenging

This is due to a combination of supply and demand factors. On the supply side, the pandemic has affected the construction sector, both directly by halting construction work and indirectly through restrictions on movement and assembly. The public sector, a key principal or executor in the construction sector, has had to rethink its

priorities and reorient its budget to deal with the pandemic (ECLAC, 2022a). There have also been changes in the operating methods and outlook of the private sector, and the uncertainty affecting it is tending to inhibit construction and infrastructure investment projects. On the demand side, falling incomes and employment have significantly reduced people's ability to buy property and indeed to pay rent. This means a housing deficit owing to the postponement of residential projects (whether new housing or improvements to existing stock), the need to share accommodation with family or friends, poorer housing conditions and, in extreme cases, people becoming homeless and living on the streets or in shelters, all situations that to differing degrees constitute violations of the right to decent housing (UN-Habitat, 2021). Although programmes were put in place to alleviate this impact through income transfers and measures to curtail evictions (ECLAC, 2022e), these have been limited and the results uncertain. Data in this area seem particularly weak and fragmentary, and in some cases the pandemic could trigger behaviour, such as squatting, that counteracts certain of the adverse effects mentioned above.

10. Problems of access to some basic services have worsened

Worsening problems of access to some basic services such as water, gas, electricity, telephony and the Internet are the result of declining incomes reducing households' ability to pay and leaving them vulnerable to being cut off, which entails numerous risks, some of them life-threatening. Many countries have therefore implemented measures to prevent disconnections and to provide payment relief or subsidies for these services, including caps on price increases (UN-Habitat, 2021; ECLAC, 2022e).

11. The weaknesses of public transport have become apparent

The impact on public transport was mitigated by the abrupt reduction in mobility and consequent decrease in journeys, which had been a vector of contagion at the start of the pandemic. As countries opened up, it became clear that the region's public transport was not equipped to safeguard travellers' health in the context of a pandemic (Velasco, Rodrigues and Sobral, 2021; UN-Habitat, 2021).

12. During the pandemic, a range of public policy measures were deployed to protect the population, and new opportunities opened up

Among the emergency measures adopted in the countries to deal with the crisis, the most notable was the provision of direct public transfers in cash and kind to a large portion of the population that needed them (ECLAC, 2022b). Essential logistics networks also operated continuously, preventing the collapse in food supplies that was so much feared at the beginning. In cities, these networks were expanded significantly by home deliveries, leading to mass take-up of a form of commerce that was still in its infancy before the pandemic. Opportunities have included those associated with new forms of work and study and ways of carrying out other activities virtually that have proved effective, an appreciation among the population of the value of hygiene and self-protection measures, and recognition of the key role to be played by an integrated, inclusive and efficient health system and social protection systems. The strategy of free mass vaccination based on primary health-care systems has proven effective in many countries of the region and has set precedents for political prioritization, institutional and public-private coordination, nationwide efforts and delivery, and guaranteed access to health care in the future. Although these measures were adopted in different ways in different countries and their sustainability is not guaranteed, they should be noted so that they can be built upon and strengthened in the long term.

From this stark assessment, it can be argued that, as has been the case throughout history with other disasters (earthquakes, hurricanes, floods, economic crises), the COVID-19 pandemic ought to serve to

identify and address weaknesses and inadequacies in prevention, response and recovery. While some of these weaknesses and inadequacies are in the health sector and predate the pandemic, many other sectors also showed weaknesses and failed to respond adequately to the crisis. To address the pandemic and its effects, ECLAC has proposed a wide range of specific measures, as well as more general objectives with their respective action orientations, including the following:

(i) Achieve health-care self-sufficiency at the regional level by strengthening collaborative governance, joining forces for international negotiation, cooperating on production and sharing technical information among the countries of the region, which will serve both for the production of health-care inputs and for the mobilization of resources and the adoption of the kind of swift, coordinated and data-driven multidimensional measures needed to confront a global pandemic with regional manifestations (ECLAC/PAHO, 2021).

(ii) Build a new international financial architecture that, among other things, serves to mobilize resources in the event of other pandemics or major socioeconomic shocks (ECLAC, 2022c).

(iii) Establish a welfare State that is adapted to a new structure of risks, including pandemic risks, and generates certainty and protection for the entire population, expanding the horizon of rights and integrating and organizing new technological and digital tools and opportunities, both to prevent and to deal with and control the pandemic and its aftermath (ECLAC, 2022a, 2022b and 2022c).

B. Multiple risk factors: urbanization, density and metropolization, overcrowding, lack of access to basic services and structural weaknesses in the health-care sector

In 2020, 81% of the population of Latin America and the Caribbean was urban, according to national definitions of urban and rural residence, making this the most urbanized developing region in the world (United Nations, 2019). The region is also highly metropolized, with 35% of the population living in cities of 1 million inhabitants or more, and with five megacities of 10 million inhabitants or more (Buenos Aires, Mexico City, Lima, Rio de Janeiro and São Paulo) (ECLAC, 2021f). This constitutes an important risk factor, as COVID-19 is transmitted more rapidly in densely populated contexts, such as urban and metropolitan settings (United Nations, 2020c; OECD, 2020 and 2021; UN-Habitat, 2021). As of July 2020, more than 90% of reported COVID-19 cases worldwide were estimated to be in urban areas (United Nations, 2020c).

This pattern of overconcentration of infections and deaths from COVID-19 has been clearly observed in the region's metropolitan areas, although with some nuances, as it was very marked in some countries and less so in others (ECLAC, 2021f). However, the pervasive spread of the pandemic led to contagion in practically all territories, including rural areas and the territories of indigenous peoples.

The region's cities and metropolises present an accumulation of various types of deficits that constitute major risk factors for the spread of COVID-19, such as overcrowding, substandard and saturated public transport, lack of access to water and sanitation services and electricity, and the digital divide, which includes lack of access to the Internet, but also lack of knowledge about how to use the Internet, its platforms and its applications (this is common among older people, for example). The high level of residential segregation in Latin American cities means that these deficits are unevenly distributed within them (ECLAC, 2021f; ECLAC/PAHO, 2021). A particularly serious situation is observed in makeshift informal settlements, where overlapping disadvantages increase vulnerability to infection and disease (UN-Habitat, 2021).

The combination of a high level of urbanization and cumulative deficits has been influencing not only the magnitude and impact of the pandemic, but also its differential effects on population groups, with the low- and lower middle-income population being the most affected. Overcrowding, which especially affects

different population groups in vulnerable situations, is particularly closely linked to the spread of the pandemic, owing to the risk of contagion that sharing rooms entails and the difficulties this poses for compliance with quarantine and lockdown measures. The degree of overcrowding also varies greatly by socioeconomic level (ECLAC, 2021f; ECLAC/PAHO, 2020 and 2021). In 2020, 25.3% of urban households in the region lived in overcrowded conditions, according to the established threshold of more than two persons per bedroom, and the figure was 47.6% in the lowest-income quintile.[2]

Deficits in living conditions and services access that prevent an optimal response to the pandemic intersect with and reinforce the different axes of the social inequality matrix, generating greater vulnerability.

However, the urban and metropolitan focus of the pandemic should not cause rural areas and ancestral territories inhabited mainly by indigenous peoples to be neglected, as their sanitary and social conditions and their networks of infrastructure and basic and health services are weaker, while their medical infrastructure and capacity to respond to infections and serious cases is much more limited (ECLAC/PAHO, 2020; OECD, 2021). In the case of rural areas, it is therefore necessary to maintain prevention measures designed to stop the virus or new variants arriving or spreading, while at the same time establishing protocols and clear, effective logistics for the rapid in situ care of infected persons who are symptomatic or sick, especially when their condition is serious (including rapid transfers to hospitals).

In the case of the ethnic and racial aspect of the inequality matrix, it can be seen that socioeconomic exclusion and sociocultural and institutional discrimination, which includes the lack of truly intercultural and culturally appropriate health care, are compounded by patterns of location with clear disadvantages in terms of access to services, infrastructure and health care, which particularly disadvantages the 58 million members of indigenous peoples (ECLAC/FILAC) and 134 million Afrodescendants (ECLAC/UNFPA, 2020) in the region.

Long-standing weaknesses in the health-care sector have been a critical risk factor. Public spending on health in the region is well below the target of 6% of GDP recommended by the Pan American Health Organization (PAHO), and there are problems with resource allocation. Financing of the first level of care falls short of the recommended parameter of at least 30% of public health spending, and in the countries where this level is reached, the absolute amounts are extremely low. All this is detrimental to the efficiency and quality of the health system, and households face a high degree of financial vulnerability, which impoverishes them by forcing them to make large out-of-pocket payments when accessing the system (ECLAC, 2021f; ECLAC/PAHO, 2020 and 2021).

While remarkable efforts have been made in recent decades to strengthen health systems in the countries of the region, they remain weak, and their capacity to cope with the pandemic has been very uneven. Challenges range from lack of access to clean water and personal protective equipment to limited availability of ventilators or beds in intensive care units. The responses to these challenges are implemented through complex organizational systems that each country has developed on the basis of its historical trajectory, resources and priorities. In particular, there are problems of segmentation that have led to several subsystems existing within the same country, with dissimilar results in terms of equity (ECLAC, 2021f; ECLAC/PAHO, 2020 and 2021).

The various characteristics of health systems can help or hinder the advance of COVID-19. Likewise, once the disease has been contracted, the response of health services can be decisive in the prognosis of patients. However, the fact that developed countries with strong and extensive health systems have had high mortality rates from COVID-19 supports the notion that the fight against the pandemic is as much a matter of containment and mitigation outside the hospital setting —with actions at the primary level and in communities, with systems for testing, monitoring and proper isolation in case of contagion, and with a well-informed population practising self-care— as it is in hospitals, which must be prepared and have sufficient staff, equipment and supplies (ECLAC, 2021f; ECLAC/PAHO, 2020 and 2021).

[2] Data obtained by processing surveys available in the Household Survey Data Bank (BADEHOG), supplied by the Statistics Division of ECLAC. These are weighted data for countries with household surveys in 2020: Argentina, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico and Paraguay. The figures therefore differ from those presented in figure 3 of ECLAC (2021f), which were calculated on the basis of surveys from 2019 or earlier.

Another factor is access to vaccines, which must be treated as a global public good, in order to achieve timely, rapid and widespread vaccination against COVID-19 without discrimination of any kind and with as much transparency and information as possible for the population (ECLAC/PAHO, 2021; ECLAC, 2022b). As of September 2021, only 30% of the population had been fully vaccinated (ECLAC/PAHO, 2021). The situation later changed, and the public good approach, the efficient use of primary health-care systems and the willingness of the vast majority of the population to be vaccinated led to this percentage increasing significantly, putting the region at the global forefront of the vaccination process, albeit with disparities within and between countries (WHO, 2022). By late February 2022, the proportion of the population that was fully vaccinated globally had reached 55%, while in the region it exceeded 65%. While this achievement did not prevent record infections caused by the omicron variant, it does appear to have been crucial in moderating the impact in terms of severe morbidity and mortality.

What can be done about these risk factors? Here we will particularly discuss those related to cities, housing and mobility, since health-related factors have recently been addressed by ECLAC in the *Social Panorama of Latin America, 2021* (ECLAC, 2022b) and by ECLAC and the Pan American Health Organization (PAHO) in the *COVID-19 Report* (ECLAC/PAHO, 2021). Pursuing the New Urban Agenda[3] would make it possible to simultaneously address all the deficits in the region's large cities that were starkly exposed during the pandemic. This is a colossal challenge, because these are deficits that have built up over decades. Overcoming them requires adequate resources and public policies that take account of structural inequalities and also of inequalities in inclusion and participation. In particular, it is essential for significant resources to be provided to address the backlog of housing, transport and mobility needs (ECLAC, 2022c).

In the area of housing, the priority is to implement special programmes to address the situation of makeshift informal settlements and people living on the streets, with both having increased greatly during the pandemic. These are emergencies that require immediate action because of the breaches of basic rights and the numerous risks they entail. We must learn from experience, recognize the struggle for housing as legitimate and provide a response that satisfies both the right to housing and the right to the city, that is compatible with inclusive, sustainable and smart cities, and that averts property speculation at the expense of the needs of people and communities. This must be coupled with programmes to alleviate the quantitative deficit represented by the presence of secondary households in homes and to reduce overcrowding, which has caused so many problems during the pandemic.

At the same time, modernizing public transport fleets and equipping them to operate efficiently and safely, particularly in the event of new pandemics, is crucial and fully synergistic with the big push for sustainability proposed by ECLAC (2022d). This involves promoting more environmentally friendly energy sources for public transport, new sustainable forms of collective and individual mobility, including walking and cycling, and the growing mobility-saving options provided by teleworking.

[3] See [online] https://plataformaurbana.cepal.org/en/new-urban-agenda.

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CHAPTER

I

The impact of coronavirus disease (COVID-19) on demographic dynamics

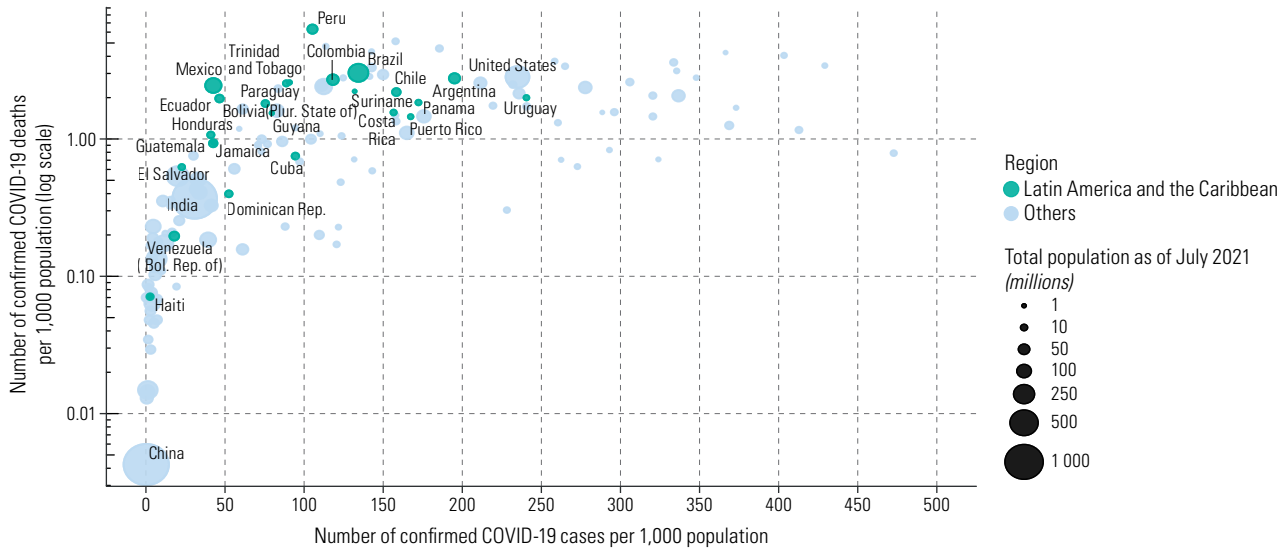
A. Mortality
B. Fertility, with special attention to sexual and reproductive health
C. International migration
D. Internal migration
Bibliography

A. Mortality

1. Mortality from COVID-19 in Latin America and the Caribbean

The first recorded cases of COVID-19 infection in Latin America and the Caribbean were notified in São Paulo, Brazil, in the last week of February 2020. As of 28 February 2022, almost two years after the pandemic was declared by the World Health Organization (WHO) (11 March 2020), a total of 1,653,822 COVID-19 deaths had been reported in Latin America and the Caribbean. These represent 27.8% of all COVID-19 deaths worldwide, even though the region is only home to 8.4% of the world's population (United Nations, 2019). In relative terms, the region has had 2.5 COVID-19 deaths per 1,000 inhabitants, with North America having slightly higher values (2.6), followed by Europe (2.3), Asia (0.29), Oceania (0.19) and Africa (0.18). Peru is the country with the world's largest number of reported COVID-19 deaths per 1,000 population (see figure I.1), at 6.3 deaths per 1,000 population, 2.5 times the regional average. It is followed in the region by Brazil (3.03 deaths per 1,000 population), Argentina (2.77), Colombia (2.7), Trinidad and Tobago (2.58), Paraguay (2.54) and Mexico (2.45). In absolute terms, Brazil has had the second-highest number of reported COVID-19 deaths in the world (648,913), after the United States (940,924) (WHO, 2022a).

Figure I.1
Number of confirmed coronavirus (COVID-19) deaths and cases in the world per 1,000 population, as of 28 February 2022



Source: Economic Commission for Latin and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), "WHO Coronavirus Disease (COVID-19) Dashboard", 2022 [online] https://covid19.who.int/ [accessed on 10 March 2022] for deaths and United Nations, *World Population Prospects 2019*, New York, 2019 [online] https://population.un.org/wpp/.
Note: Only countries with more than 500 reported COVID-19 deaths and more than 500,000 inhabitants are considered.

While reported COVID-19 deaths are a better indicator than the number of reported cases (Raftery and others, 2020), they may represent only a fraction of total COVID-19 deaths (Heuveline and Tzen, 2021; Peto, 2020). This is because there are significant differences between countries as regards access to testing and health services for diagnosing the disease, the completeness of death registers, the quality of data classification by cause of death, disease surveillance in emergency situations (ECLAC, 2021a) and the level of overload in health-care systems (Da Silva and Pena, 2021). Thus, the total (direct and indirect) impact of the pandemic on mortality may be even higher, with these figures representing only a floor for total COVID-19 deaths.[1]

[1] The direct effect of the pandemic on mortality means deaths directly related to COVID-19 infection, while the indirect effect refers to deaths with other causes but occurring because of the pandemic situation and breakdown in the health-care system (e.g., lack of beds in intensive care units could increase mortality from heart failure).

2. The new strains and the rise in mortality in 2021

New strains of the virus were detected as the pandemic progressed, and WHO had classified five variants of concern (Alpha, Beta, Gamma, Delta and Omicron) and two variants of interest (Lambda and Mu) as of 28 February 2022 (WHO, 2022b). Variants are considered critical if they are associated with one or more of the following changes to a degree that is significant for global public health: increased transmissibility relative to the original virus, increased virulence or a change in the clinical presentation of the disease, or a potential reduction in the effectiveness of treatments and vaccines or of public health and social measures.

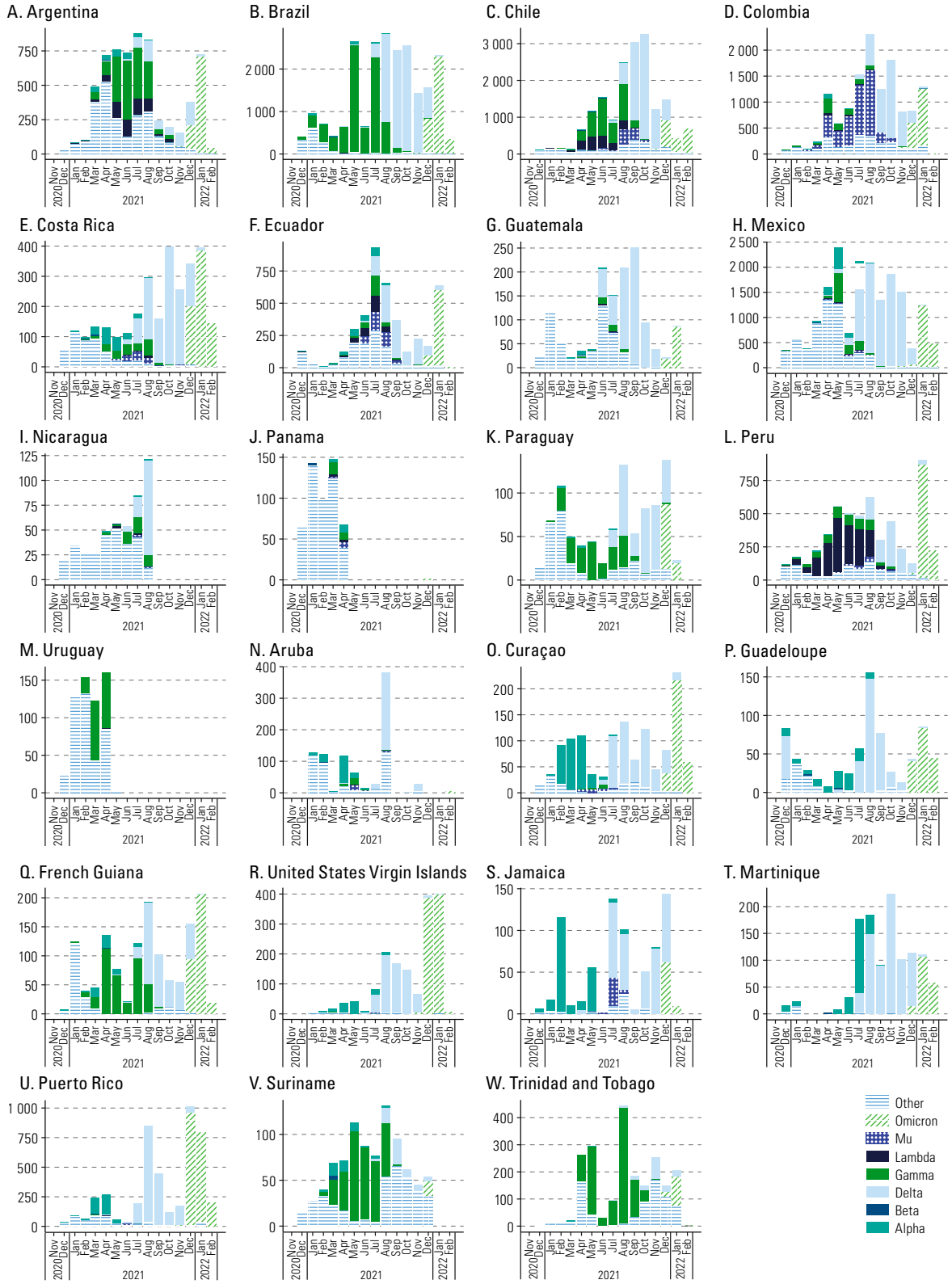
As of 15 March 2022, of a total of 48 countries and territories with identified samples in Latin America and the Caribbean, all had reported detecting some variant of concern: 42 had detected the Alpha variant, 17 the Beta, 39 the Gamma, 47 the Delta and 39 the Omicron (GISAID, 2022). Figure I.2 shows when each variant of concern and interest was first detected in the countries and how quickly it became the leading variant, as ascertained from genomic sampling. WHO has indicated that, given the evolutionary nature of the virus, there remains a risk that new strains will emerge.

During the first half of 2021, the new variants overwhelmed the region's health systems, whose structures were already weak, in some cases to the point of breakdown (Da Silva and Pena, 2021). The numbers of monthly COVID-19 deaths reported to WHO (2021) in those months were higher than in 2020 in some countries. Argentina, the Bolivarian Republic of Venezuela, Brazil, Colombia, Costa Rica, Cuba, Peru and Uruguay show a significant increase in reported COVID-19 deaths in 2021 compared with the previous year (see figure I.3), when there was less information available about treating and preventing the disease. Brazil, for example, reported a monthly peak of 32,512 COVID-19 deaths in July 2020, but in April 2021 the number of deaths was 2.6 times higher at 84,319. Colombia reported a peak of 9,610 COVID-19 deaths in August 2020, but in June 2021 there was a peak of 17,579 deaths, a 1.8-fold increase over the previous year. In Peru, a monthly peak of 18,064 deaths was observed in August 2020, while in 2021 the peak was 23,458, almost 30% higher.

In the second half of 2021, the number of deaths from COVID-19 declined sharply in some countries of the region (see figure I.3) despite the new variants detected, while in other countries there were significant increases (Bahamas, Belize, Cuba, El Salvador, Guatemala, Guyana, Jamaica and Trinidad and Tobago). When vaccination rates are analysed, it can be seen that the countries with the greatest reductions in reported COVID-19 deaths in the second half of the year are also the countries where the highest percentages of the population were fully vaccinated. In countries such as Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, Peru and Uruguay, with more than 70% of the total population vaccinated to date, the decrease in total COVID-19 deaths has been striking. On the other hand, countries such as Guatemala and Jamaica continue to have low vaccination rates, with less than 35% of the population fully vaccinated. In general, the distribution of and access to vaccines in Caribbean countries has been highly unequal, and the Economic Commission for Latin America and the Caribbean (ECLAC, 2022) has identified countries where there are major institutional and logistical obstacles to accelerating vaccination. In Haiti, in particular, less than 1% of the population is fully vaccinated.

Vaccination against COVID-19 is seen as a key tool for controlling both the health crisis and the economic and social crisis triggered by the pandemic. The slow speed of vaccination in the region, and the great inequality of the process between countries, could result in the pandemic being protracted yet further and new variants of the virus appearing, threatening the effectiveness of existing vaccines. At the request of the Community of Latin American and Caribbean States (CELAC), ECLAC (2021c) has developed a comprehensive health-care self-sufficiency plan focused on strengthening vaccine and medicine production and distribution capacity. This plan was unanimously approved at the sixth Summit of Heads of State and Government of CELAC, held in September 2021, with the objective of vaccinating at least 70% of the population of all the countries by mid-2022.

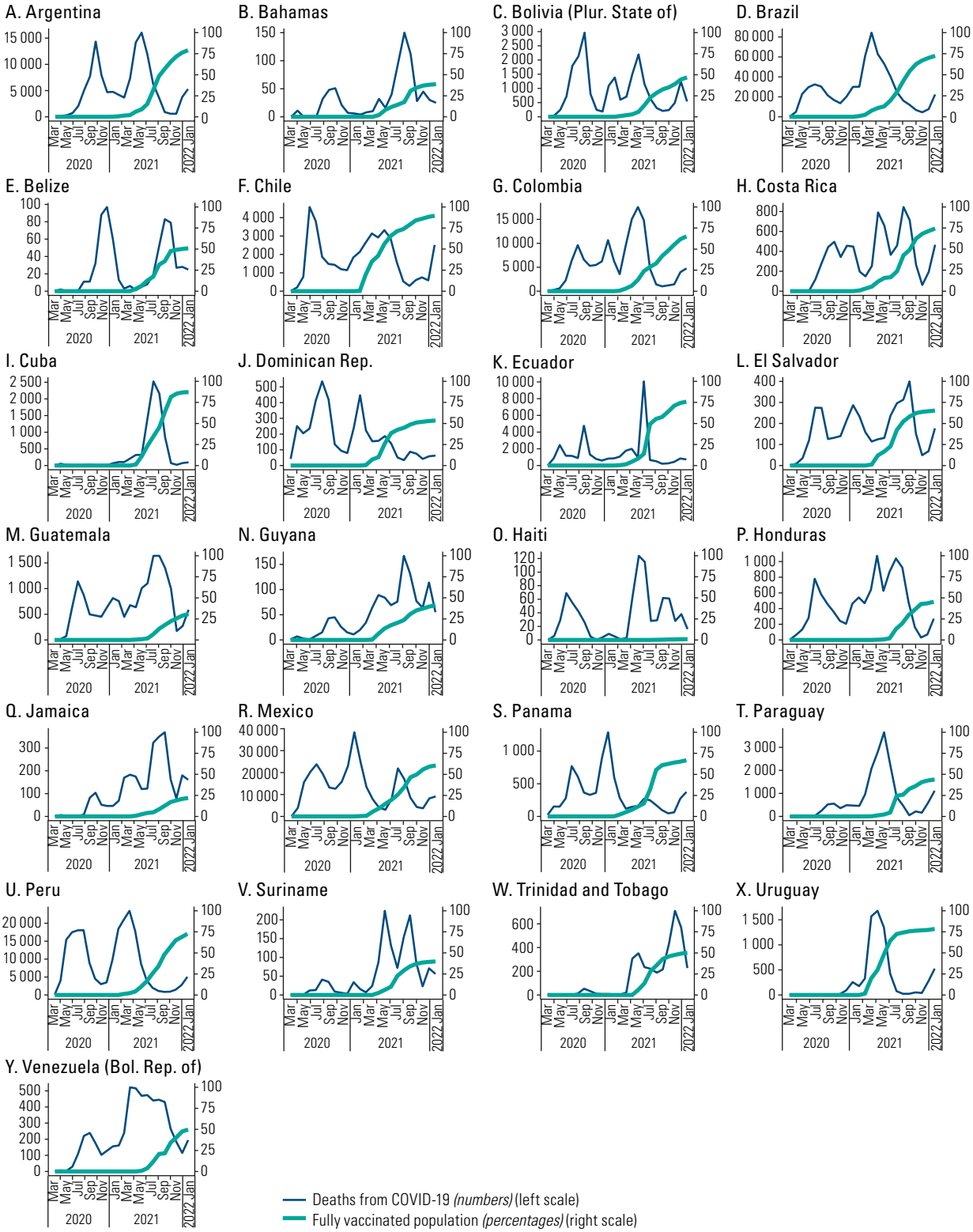
Figure I.2
Latin America and the Caribbean (23 countries): monthly distribution of COVID-19 variants, 1 November 2020 to 28 February 2022



Source: Economic Commission for Latin and the Caribbean (ECLAC), on the basis of Pan American Health Organization (PAHO), "COVID-19 Genomic Surveillance Regional Network", 2022 [online] https://www.paho.org/en/topics/influenza-and-other-respiratory-viruses/covid-19-genomic-surveillance-regional-network; PAHO, "Distribution of SARS-CoV-2 variants by subregion, Region of the Americas, 1 August, 2021 to 20 March, 2022", 2022 [online] https://ais.paho.org/phip/viz/SARS_CoV2_variants_regional.asp; and Global Initiative on Sharing All Influenza Data (GISAID), "Tracking of variants", 2022 [online] https://www.gisaid.org/hcov19-variants/ [accessed 10 March 2022].

Note: Only countries with more than 500 samples in the GISAID database as of 31 January 2022 are considered. The charts start in November 2020 because that was the date when the first critical variant was detected in the region.

Figure I.3
Latin America and the Caribbean (25 countries): reported COVID-19 deaths and fully vaccinated population, by month, up to 28 February 2022
(Numbers and percentages)

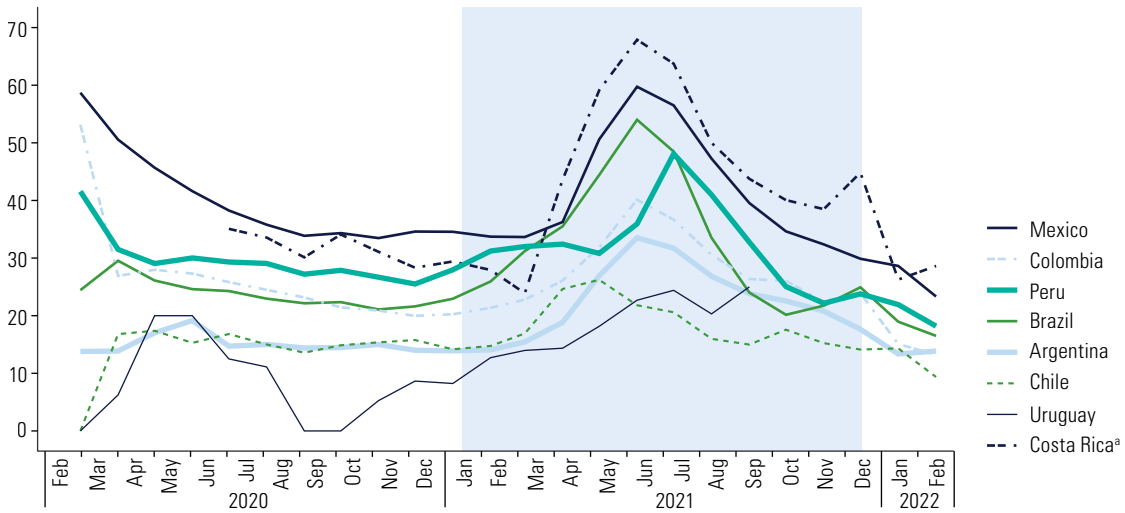


Source: Economic Commission for Latin and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), "WHO Coronavirus Disease (COVID-19) Dashboard", 2022 [online] https://covid19.who.int/ [accessed on 10 March 2022] and E. Mathieu and others, "A global database of COVID-19 vaccinations", *Nature Human Behaviour*, vol. 5, July 2021.

Note: Only countries with more than 500 COVID-19 deaths as of 28 February 2022 are considered.

The new variants of the virus and the consequent increase in the transmissibility and severity of infections in 2021 meant that people who were not initially at risk of death because they did not have comorbidities or existing chronic diseases (Hanlon and others, 2021; Nepomuceno and others, 2020) or belong to the age groups originally considered to be at risk (Meyerowitz-Katz and Merone, 2020) died during the new wave of the disease. When COVID-19 deaths are analysed by age group, all countries with information available by age show a marked increase in reported deaths among under-sixties, who presented lower proportions of reported COVID-19 deaths at the beginning of the pandemic (see figure I.4). This trend may have been due not only to the emergence of new variants, but also to the fact that older people were vaccinated earlier than younger people.

Figure I.4
Latin America (8 countries): reported COVID-19 deaths, persons aged 0 to 59, 1 March 2020 to 28 February 2022
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from the Ministry of Health of Argentina, the Ministry of Health of Brazil, the Ministry of Health of Chile, the National Institute of Health of Colombia, the Ministry of Health of Costa Rica, the Ministry of Public Health of Cuba, the Ministry of Health of Mexico, the Ministry of Health of Peru and the Interdisciplinary COVID 19 Data Analysis Group of Uruguay (GUIAD-COVID-19).
[a] The age groups are 0 to 64 years and 65 years and over.

In all the countries analysed except Mexico, there were more COVID-19 deaths among under-sixties in the first half of 2021 than in the whole of 2020. In Argentina, for example, there had been 86% more COVID-19 deaths at ages under 60 by 30 June 2021 than in all of 2020. The same is observed in Colombia and Costa Rica, where there were 85% and 81% more COVID-19 deaths, respectively, at ages under 60 as of June 2021 than in 2020. In Brazil, Cuba and Uruguay, values were twice as high as in 2020. These figures are troubling and show how urgent it is to increase genomic surveillance so that new variants of the virus can be forestalled (see box I.1) and to speed up vaccination at younger ages in the region's countries.

Box I.1
The importance of sequencing the COVID-19 virus genome and the challenges this involves in the region

The new waves of COVID-19 reported in 2021 increased mortality from the virus. Consequently, experts urged increased vaccination rates in developing countries (Cohen, 2021) and vaccination at younger ages. The likelihood of more variants emerging in the future has been pointed out and the difficulty of controlling the spread of these variants discussed (Kupferschmidt and Wadman, 2021). It has also been stressed that there are blind spots in the world when it comes to the genetic coding of COVID-19 virus samples and that most of the genomes in the international genome repository of the Global Initiative for Sharing All Influenza Data (GISAID, 2022) are from high-income countries (Wadman, 2021). Challenges for genetic sequencing of virus samples include the cost of a sequencer (approximately US$ 335,000), reliable transportation of samples in hard-to-reach areas, the need for refrigeration to transport samples, the high price of sequencing reagents and the training of local scientists (Wadman, 2021).

Box I.1 (concluded)

At the regional level, the Pan American Health Organization (PAHO) created the COVID-19 Genomic Surveillance Regional Network in 2020 (PAHO, 2022) to reinforce sequencing in laboratories and implement routine genomic surveillance, increasing the amount of sequencing data available in the region. This network plays an essential role in improving diagnostic protocols for the virus, generating information for vaccine development and identifying the patterns of evolution of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). As of 15 March 2022, only 32% of the 38 countries in the region had in-country sequencing capacity, 37% did external sequencing, i.e., sent genetic samples to one of the reference laboratories in the region, and the other third did not participate in the network, so that no information on their genetic sequencing was available. Sequencing reference laboratories in the region are located in Brazil, Chile, Mexico, Panama and Trinidad and Tobago. Greater genomic surveillance of the virus in the region and progress with vaccination are therefore considered necessary to prevent future waves of new variants. Exchanges of regional specialists in the subject are also important, and the Community of Latin American and Caribbean States (CELAC) has created the Network of Specialists in Infectious Agents and Emerging and Re-emerging Diseases, with the aim of carrying out research to avert contagion risks and combat diseases in the region.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of J. Cohen, "For WHO leader, a 'feeling that we're failing'", *Science*, vol. 372, No. 6549, 25 June 2021; Global Initiative on Sharing All Influenza Data (GISAID), "Tracking of variants", 2022 [online] https://www.gisaid.org/hcov19-variants/ [accessed on 10 March 2022]; K. Kupferschmidt and M. Wadman, "Delta variant triggers new phase in the pandemic", *Science*, vol. 372, No. 6549, 25 June 2021; Pan American Health Organization (OPS), "COVID-19 Genomic Surveillance Regional Network", 2022 [online] https://www.paho.org/en/topics/influenza-and-other-respiratory-viruses/covid-19-genomic-surveillance-regional-network; M. Wadman, "Blind spots thwart global coronavirus tracking", *Science*, vol. 372, No. 6544, 21 May 2021.

3. The impact of COVID-19 on life expectancy at birth: from steady increase to the current crisis

Until 2019, life expectancy increased steadily in most countries of Latin America and the Caribbean as a result of the unprecedented decline in specific mortality rates that began in the 1930s (Arriaga and Davis, 1969). Socioeconomic development translated into improvements in urban infrastructure, with the expansion of basic sanitation and access to safe drinking water, and enabled technologies to be imported and modern health-care methods to be adopted (Arriaga and Davis, 1969). Amidst all these transformations, life expectancy in the region increased from 51.4 years in 1950 to 75.2 years in 2019 (United Nations, 2019), a period of less than 70 years. By comparison, it took countries such as Sweden and the United Kingdom 90 years (1886–1976) and 83 years (1903–1986), respectively, to achieve this 25-year increase in life expectancy at birth (UC Berkeley/MPIDR, 2022).

The epidemiological transition observed since the 1930s in Latin America and the Caribbean has been marked by heterogeneous mortality and health trends.[2] It is characterized by different overlapping situations, as some population groups are already at a stage where chronic and degenerative diseases are a predominant factor in mortality and health, while for others this situation overlaps with a resurgence of infectious, parasitic and respiratory disease and high rates of infant mortality (Frenk and others, 1991). In the last 30 years, moreover, violence and external causes of mortality have had a major impact on the youth population, especially males. In some areas of Brazil and Mexico, for example, homicides and violence have limited the increase in life expectancy in the most vulnerable regions (Aburto and others, 2021; Canudas-Romo and Aburto, 2019; Canudas-Romo and others, 2017). In these and other countries of the region, violence is impeding convergence with the mortality regime of more developed countries (Alvarez, Aburto and Canudas-Romo, 2020). This context entails specific challenges in terms of strategies for health care and interventions by governments to deal with the social determinants of health, as different stages require different models of health and public security policies (Di Cesare, 2011), including consideration of the intersectionality of race or ethnicity, gender and age as determinants for mitigating violent mortality in Latin America and the Caribbean.

[2] The epidemiological transition theory described by Omran (1971) on the basis of historical mortality and health trends in the more developed countries refers to the transition from a context of high rates of infection and death from infectious diseases, especially in younger age groups, to a context of increased mortality from chronic and degenerative diseases and in older age groups.

The advent of the pandemic in 2020, in a regional context of severe socioeconomic and health inequalities and large differences between countries as regards health systems and response strategies, led to a shift in mortality trends in the region. ECLAC (2021a) estimated that, given the age distribution in the region's countries and the lethality of the virus before vaccination, the countries could lose 0.3 to 0.7 years of life expectancy at birth with an annual COVID-19 prevalence of 5% of the population. At 10% prevalence, the range of years of life expectancy lost would be 0.7 to 1.4. At 25% prevalence, 1.5 to 3.2 years would be lost, and at 50%, 2.8 to 6 years of life expectancy would be lost.

Some researchers have made country-level estimates. For Brazil, a loss of 1.3 years of life expectancy at birth is estimated (Castro and others, 2021), which implies a setback of at least 7 years of progress with this indicator, while for Chile a loss of 1.28 years for men and 0.85 years for women in 2020 compared to 2019 is projected (Aburto and others, 2022).

With the continuation of the pandemic in 2021, this scenario became even more troubling, as the economic and health consequences worsened for the most vulnerable populations with the greatest unmet basic needs (ECLAC, 2022). It is also important to highlight the impact on Afrodescendent and indigenous populations, in respect both of the monitoring and isolation of cases and of the distribution of vaccines and access to health services and treatment (ECLAC, 2021b; ECLAC and others, 2020). Various studies have shown that structural factors of inequality configure differentiated epidemiological and morbimortality profiles and that they have a significant impact on health conditions, over and above the effects of the complex interrelationships between social class, gender, ethnicity and territory and the way these operate through proximate variables. From this perspective, situations of greater socioeconomic vulnerability increase the risk of infection and death from COVID-19. Inequalities are related to people's ability to protect themselves from infection, a higher incidence of comorbidities associated with greater severity of the disease and potentially death (Wachtler and others, 2020), and differences in access to health services and timely high-quality treatment once a person falls ill.

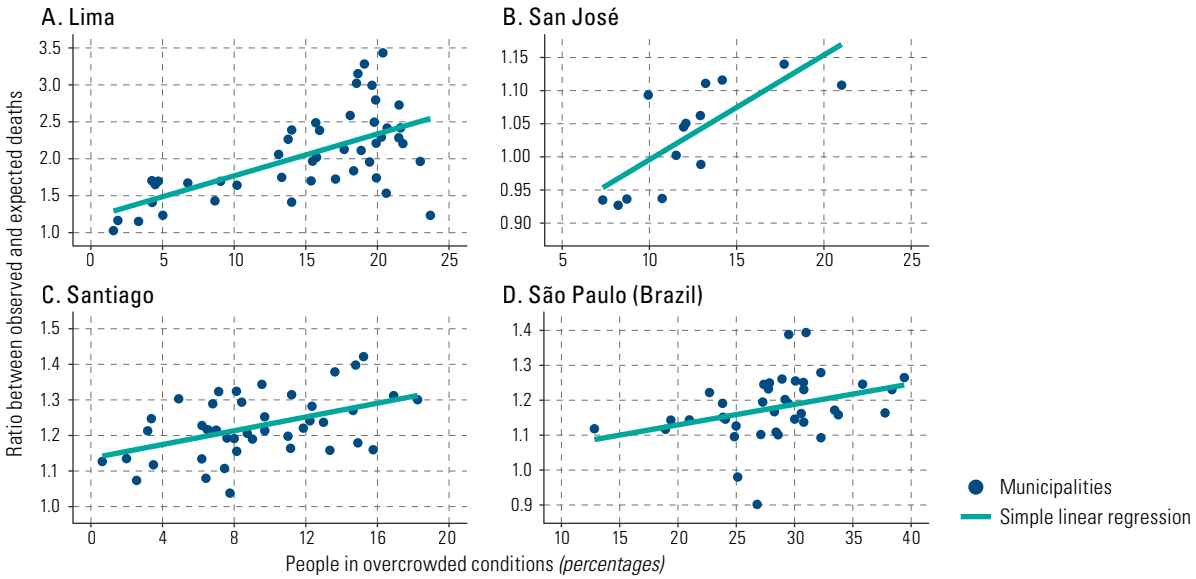
Risk factors associated with increased disease severity that are unevenly distributed in society include cardiovascular disease, lung conditions such as chronic bronchitis, liver disease, diabetes, cancer and immune system disorders (Wachtler and others, 2020). Smoking and obesity, two factors that are also more prevalent in socioeconomically vulnerable groups, are currently being discussed as possible additional risk factors for COVID-19 (Vardavas and Nikitara, 2020; Sattar, McInnes and McMurray, 2020). In the region, it has also been shown that there is a high correlation between socioeconomic vulnerability, COVID-19 severity and deaths and vaccination rates.[3]

The population size and greater local and international interconnectivity of densely populated urban centres make them more vulnerable to transmission and contagion of the virus (United Nations, 2020b). It has been shown that Latin America and the Caribbean has a high concentration of infections and deaths in its large cities (ECLAC, 2021b), which are characterized by a high level of residential segregation and inequalities with respect to major pandemic risk factors such as overcrowding, lack of access to water and sanitation, electricity and Internet services, informal employment and congested public transport (ECLAC, 2021b). The data presented in figure I.5 show that, in four cities of the region, municipalities with a higher percentage of people living in overcrowded conditions have had higher levels of excess mortality during the pandemic.

Barriers to access to health-care systems in the different countries are another major risk factor. Figure I.6 shows the relationship between excess deaths in the countries and the percentage of people who could not receive medical attention when needed at some point after the start of the pandemic on 15 March 2020. Ecuador and Peru are the countries with the highest proportions of excess deaths in 2020, as they had 50% more deaths than expected that year, and 48% and 42% of people, respectively, were unable to receive medical attention when needed. Conversely, Costa Rica had less than 10% excess deaths and the smallest percentage of households with unmet demand for medical attention.

[3] See Moralejo Bermudi and others (2021) and Werneck and others (2021) for Brazil; Bilal, Alfaro and Vives (2021), Mena and others (2021) and Canales (2020) for Chile; Macchia and others (2021) for Argentina; Vázquez-Rowe and Gandolfi (2020) and Taylor (2021) for Peru; Cifuentes and others (2021) for Colombia; Arceo-Gomez and others (2022) for Mexico; and ECLAC (2022) for Latin America.

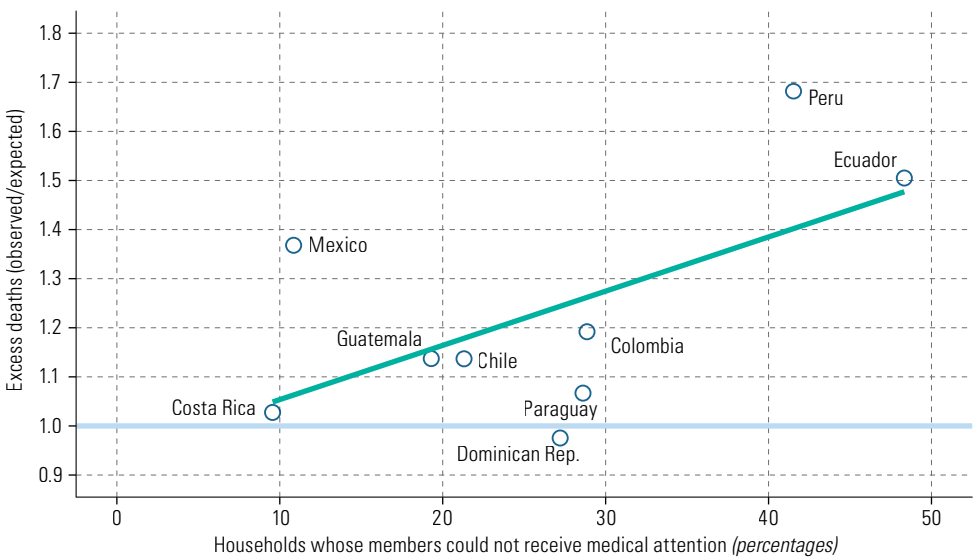
Figure I.5
Latin America (4 cities): relationship between excess mortality and level of crowding, 2020



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Ministry of Health of Brazil, Ministry of Health of Chile, Ministry of Health of Peru and National Bureau of Statistics of the Dominican Republic (numbers of deaths); Demographic Census 2010 of Brazil, Population and Housing Census 2012 of Chile, National Censuses 2017 of Peru and ninth National Population and Housing Census 2010 of the Dominican Republic (percentages of people living in overcrowded conditions).

Note: Although the information is from the latest census conducted in each country prior to 2020, it is assumed that the inequalities between municipalities observed at the time of the census have not changed significantly (even if the percentages of population with and without overcrowding have changed). People living in dwellings with 2.5 people per bedroom or 2 or more people and no bedrooms are considered to be living in overcrowded conditions.

Figure I.6
Latin America (9 countries): relationship between excess deaths and percentages of households whose members could not receive medical attention, 2020

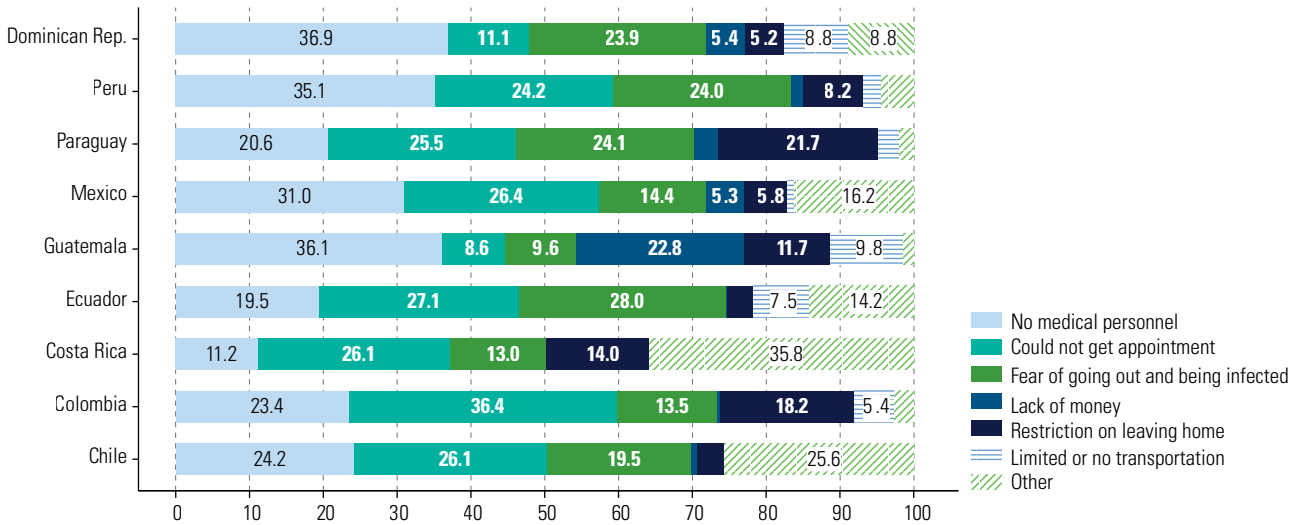


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from Ministry of Health of Chile, National Institute of Health of Colombia, Ministry of Health of Costa Rica, Ministry of Public Health of Cuba, Ministry of Health of Mexico, Ministry of Public Health and Social Welfare of Paraguay, Ministry of Health of Peru, Interdisciplinary COVID-19 Data Analysis Group of Uruguay (GUIAD-COVID-19) and National Bureau of Statistics of the Dominican Republic (for the number of deaths); and World Bank, "COVID-19 Household Monitoring Dashboard" [online] https://www.worldbank.org/en/data/interactive/2020/11/11/covid-19-high-frequency-monitoring-dashboard (for the proportion of households where members were unable to see a doctor).

Note: The World Bank surveys giving the proportion of households whose members sought medical attention were conducted on the following dates: from 20 May 2020 to 8 June 2020 in Chile, from 26 May 2020 to 4 June 2020 in Colombia, from 22 May 2020 to 5 June 2020 in Costa Rica, from 22 May 2020 to 3 June 2020 in the Dominican Republic, from 8 May 2020 to 23 May 2020 in Ecuador, from 26 May 2020 to 3 June 2020 in Guatemala, from 21 May 2020 to 11 June 2020 in Mexico, from 22 May 2020 to 1 June 2020 in Peru and from 24 May 2020 to 14 June 2020 in Paraguay.

The main reasons household members reported for not being able to receive medical attention were lack of availability of medical staff, lack of appointments and fear of infection. In Peru and Ecuador, the two countries with the highest excess mortality rates, more than 70% of households reported these three main reasons. In Colombia and Paraguay, 18% and 22%, respectively, cited restrictions on leaving home, and in Guatemala, 23% gave lack of money as a reason for not being able to receive medical attention. These findings highlight the need to improve the capacity and structure of basic health care in the region and the structural and circumstantial challenges posed by the pandemic.

Figure I.7
Latin America (9 countries): reasons for being unable to receive medical attention in 2020
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Bank, "COVID-19 Household Monitoring Dashboard" [online] https://www.worldbank.org/en/data/interactive/2020/11/11/covid-19-high-frequency-monitoring-dashboard.

Note: The World Bank surveys giving the proportion of households whose members sought medical attention were conducted on the following dates: from 20 May 2020 to 8 June 2020 in Chile, from 26 May 2020 to 4 June 2020 in Colombia, from 22 May 2020 to 5 June 2020 in Costa Rica, from 22 May 2020 to 3 June 2020 in the Dominican Republic, from 8 May 2020 to 23 May 2020 in Ecuador, from 26 May 2020 to 3 June 2020 in Guatemala, from 21 May 2020 to 11 June 2020 in Mexico, from 22 May 2020 to 1 June 2020 in Peru and from 24 May 2020 to 14 June 2020 in Paraguay.

4. In conclusion: there is an urgent need to adopt measures based on reliable, timely information

Although most countries in Latin America and the Caribbean report COVID-19 death figures to WHO (WHO, 2022a), data on total deaths (i.e., including all causes of death) for 2020 are not yet available for most of them.

Although the countries of Latin America and the Caribbean made great progress with their procedures for recording vital statistics while the mortality and epidemiological transitions were going on (Del Popolo and Bay, 2021), the pandemic has exposed the limitations that still persist in their vital statistics and health information systems. Many countries still do not have a continuous record of vital events, reflecting contexts of local political and economic instability (ECLAC, 2021a), and even in countries with well-structured systems, levels of completeness do not approach 100%. Only in Argentina, Brazil, Chile and Uruguay do vital statistics registration systems have levels of completeness above 90%. In addition, the classification of causes of death is still a challenge for the vital statistics systems of the countries, many of which have high levels of deaths from ill-defined causes, making health policies difficult to design (ECLAC, 2021a). Other challenges concern the disaggregation and analysis of health information by sex and by race or ethnicity, which could provide a better understanding of the size of health gaps in the countries. Gender and racial or ethnic inequalities should be taken into account as key social determinants of health.

B. Fertility, with special attention to sexual and reproductive health

The pandemic may affect fertility through many different mechanisms (United Nations, 2021a and 2021b; Sobotka and others 2021a; Berrington and others 2022) which, in general theoretical terms, can be said to operate through three main channels: (i) changes in "demand for children", either in the short term (births planned within a time horizon of 9 to 24 months) or in the long term (reproductive preferences or number of children desired by the end of the person's childbearing years); (ii) changes in reproductive capacity or the "supply of children"; and (iii) changes in intermediate variables, particularly sexual activity, marriage rates, access to contraception and abortion. Although these channels are autonomous to some degree, they are also interdependent, as is obvious in the case of the first and third channels, since one or more intermediate variables must be used to put changes in the demand for children into effect.

The pandemic is unlikely to change the supply of children, whose biological determinants do not seem to have been affected by COVID-19, at least so far. Conversely, it is highly likely to affect fertility preferences and intermediate variables. The pandemic and the resulting socioeconomic crisis will almost certainly reduce fertility intentions in the short term, as it is well established, both conceptually and empirically, that in modern societies uncertainty and deteriorating economic and social conditions tend to encourage the postponement or cancellation of reproductive projects (Luppi, Arpino and Rosina, 2020; Aassve and others 2021; Lee, 2021; Sobotka and others 2021a). According to most theories and research, however, the longer-term component of fertility preferences is more stable, at least at the cohort level, and thus more likely to withstand the impact of the pandemic. It may also be the case that fertility preferences are not changed by the pandemic. If so, the drop during the pandemic crisis period is largely due to desired children being postponed, and people will probably have these children later in order to achieve their fertility preferences. In comparative demographic history, there are a number of examples of fertility thus recovering after catastrophes such as wars, epidemics and economic crises (United Nations, 2021a; Sobotka and others 2021a; Aassve and others 2021).

At the same time, the pandemic has affected intermediate fertility variables, although the magnitude of the impact, and in some cases its direction, remain unclear, with different discussions having arisen around the subject (Ait Addi, Benksim and Cherkaoui, 2020; United Nations, 2021a and 2021b; Lehmiller and others 2021; Caruso, Rapisarda and Minona, 2020; Cito and others 2021; Coombe and others, 2021). Lockdown and social distancing measures have almost certainly affected sexual activity, but ambiguously, because while they reduce the sexual activity of non-cohabiting couples, they may increase that of cohabiting couples, making it difficult to draw a firm theoretical conclusion. The lack of reliable data makes it difficult to resolve this ambiguity empirically. Marriage rates, meanwhile, have historically fallen during economic crises for the same reason as fertility, and this time there is the additional factor of travel restrictions and administrative shutdowns, which may limit the formation of unions and marriages, including child marriages, although the informality of these unions, at least in the region, makes the trend more uncertain. On the other hand, the pandemic may also be temporarily inhibiting the break-up of unions and marriages. In any event, a postponement of unions can be expected, and with it a decrease in the sexual activity that is most likely to have a reproductive intent, namely that which occurs in unions (Castro Martín and others, 2011). Lastly, the greatest impact probably comes from the disruption of sexual and reproductive health services resulting from the pandemic, which could reduce access to contraception and safe abortion in countries where this is legal (see box I.2). In this case, the effect of the pandemic is to increase fertility, particularly unwanted fertility, in flagrant violation of the sexual and reproductive rights set out in the Montevideo Consensus on Population and Development.

Box I.2
Latin America and the Caribbean: the disruption of sexual and reproductive health services during the coronavirus disease (COVID-19) pandemic poses a threat to reproductive rights

The universal access to sexual and reproductive health and the fulfilment of reproductive rights posited in the 2030 Agenda for Sustainable Development and the Montevideo Consensus on Population and Development have been affected by the COVID-19 pandemic in a number of ways, including: (i) breakdowns in the contraceptive supply chain due, for example, to interruptions in the import chain or constraints on prompt distribution; (ii) restrictions on the operation of establishments offering these services due to the lockdown, social distancing and curfew measures implemented to combat the pandemic; (iii) health-care decisions to reallocate human and financial resources to containing the pandemic; (iv) reductions in supply due to staff shortages resulting from infections and to a lack of personal protective equipment providing protection against COVID-19 for the staff operating these services; and (v) reductions in demand due to people staying away from the establishments offering these services because of the risk of infection, to mobility restrictions preventing people from travelling to these establishments, and to loss of income where paid services are concerned.

Two lines of investigation have been deployed in relation to these interruptions in sexual and reproductive health services: first, quantification of the magnitude, scope and duration of disruptions and, second, estimation of the effects of these discontinuities on unmet demand for contraception, unwanted fertility, abortion and maternal and infant morbimortality.

Regarding the first line of investigation, according to the survey conducted by the World Health Organization (WHO, 2021) on the impact of COVID-19 on health services, 64% of countries in Latin America and the Caribbean reported interruptions in family planning and contraception services in the period January-March 2021, with several countries reporting severe disruption (a decline of 50% or more in supply). According to the same survey, there were also massive interruptions in sexual and intimate partner violence prevention and response services and in safe abortion and post-abortion care services (50% and 33%, respectively). The United Nations Children's Fund (UNICEF, 2021) has also conducted surveys on the subject whose results show disruption with a sharp decline in access to family planning services at the beginning of the pandemic (as of June 2020) and something of a recovery in 2021. Nonetheless, many countries still reported lower access to family planning services as of the third quarter of 2021 (see table 1).

Table 1
Latin America and the Caribbean: disruption to family planning and antenatal and postnatal care services, June 2020 and September-October 2021
(Numbers of countries and percentages)

Period of data	June 2020					September-October 2021					
Category	No change	Decline of less than 10%	Decline of 10% to 24%	Decline of 25% or over	Unknown	Increase	No change	Decline of less than 10%	Decline of 10% to 24%	Decline of 25% or over	Unknown
Family planning *(Number of countries)*	1	1	14	5	6	1	11	5	3	2	1
Family planning *(Percentages)*	3.7	3.7	51.9	18.5	22.2	4.3	47.8	21.7	13.0	8.7	4.3
Antenatal and postnatal care *(Number of countries)*	2	11	2	4	7	2	14	4	2	1	2
Antenatal and postnatal care *(Percentages)*	7.7	42.3	7.7	15.4	26.9	8.0	56.0	16.0	8.0	4.0	8.0

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of United Nations Children's Fund (UNICEF), "Tracking the situation of children during COVID-19 (Mar/Apr 2021)" [online] https://data.unicef.org/resources/rapid-situation-tracking-covid-19-socioeconomic-impacts-data-viz/.

Note: According to the United Nations Children's Fund (UNICEF), the first and fourth rounds of the survey (the two included in the table) were answered by 30 countries and 28 countries, respectively. However, the table totals are lower because countries did not respond to all questions. Percentages were calculated from actual responses. The questions asked in each round were as follows. Round 1: "What is the approximate current level of COVID-19 related disruption in existing child protection services nationally, including drop in coverage and service use?" Round 2: "As compared to this time last year, what is the approximate level of COVID-19 related change in coverage of child protection services nationally?"

Surveys of potential users of sexual and reproductive health services also show discontinuity and loss of access to such services. For example, the Guttmacher Survey of Reproductive Health Experience, conducted in the United States from 30 April to 6 May 2020, showed that 33% of women had to delay or cancel visiting a health care provider for sexual and reproductive health care services and that these interruptions were greatest among Hispanic women (45%) and those of African descent (38%) (Lindberg and others, 2020). The countries also report various indicators of service disruption. In Argentina, for example, the number of consultations for contraceptive devices fell from 77,795 in 2019

Box I.2 (concluded)

to 23,509 in 2020, and the distribution of long-acting reversible contraceptives fell from 33,870 to 16,485 units in the same period. In the Plurinational State of Bolivia, Pap smears fell from 511,723 in 2019 to 238,469 in 2020. In Chile, sexual and reproductive health check-ups, which had exceeded 2 million between 2014 and 2019, fell to 1.1 million in 2020, while in the Dominican Republic, family planning consultations fell from 200,481 to 112,449 between 2019 and 2020.

The academic sector, for example, through the ISLAC[a] project, and civil society in the region have also made efforts to monitor and report on these disruptions in order to hasten the recovery of service continuity and prevent such disruptions in the future. Table 2 provides a sample of one such effort, which gives a good idea of the scale of the disruptions in various dimensions of sexual and reproductive health care.

Table 2
Latin America (selected countries): illustrations of significant disruptions in five areas of sexual and reproductive health services, 2020–2021

Sexual and reproductive health and family planning counselling	Contraceptive methods	Human immunodeficiency virus (HIV) testing	Termination of pregnancy	Maternal mortality
In Peru, there was a reduction of at least 50% in family planning counselling in the first half of 2020 compared to the first half of 2019 (considering telehealth and outpatient care). Declines of more than 30% in sexual and reproductive health counselling generally are reported.	Sexual and reproductive health services were reduced by 43% in Argentina, 43% in Chile, 50% in Peru and 36% in the Plurinational State of Bolivia.	Colombia: HIV testing decreased by 20.3% and testing for other sexually transmitted infections by 36.0% between 2019 and 2020.	Chile, Ecuador, Peru, and Uruguay did not relax any requirements to facilitate terminations in cases of rape or life-threatening pregnancies. As a result, these countries recorded declines of up to 86% (Peru) in the number of procedures performed in 2020.	Between March and August 2020, there was an upward trend in maternal mortality indicators in the region compared to the previous year as a result of restrictions on reproductive health services during the pandemic.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Consorcio Latinoamericano contra el Aborto Inseguro (CLACAI), "La salud reproductiva es vital", 2020 [online] https://saludreproductivavital.info/.
Note: The national reports of the countries included in the "La salud sexual es vital" ("Sexual health is vital") project are for Argentina, Brazil, Chile, Colombia, Ecuador, El Salvador, Peru, the Plurinational State of Bolivia and Uruguay.

Regarding the second line of investigation, a recent systematization (United Nations, 2021) states that in April 2020 the United Nations Population Fund (UNFPA) projected that with "average" interruptions in health services for 6 months, some 26 million women in 114 low- and middle-income countries would be unable to use modern contraceptives, resulting in 7 million additional unintended pregnancies (UNFPA, 2021). The Guttmacher Institute presented a scenario of a 10% decline in the use of short- and long-acting reversible contraceptives in low- and middle-income countries due to COVID-19, which would result in 49 million additional women with an unmet need for modern contraception and 15 million additional unintended pregnancies over the course of the year in low- and middle-income countries (United Nations, 2021). Subsequently, UNFPA published an updated and much lower estimate of 12 million women experiencing interruptions in contraceptive use, resulting in 1.4 million unintended pregnancies during 2020 in 115 low- and middle-income countries (UNFPA, 2021). In the case of Latin America and the Caribbean, an August 2020 report (UNFPA, 2020) concluded that, considering the decline in procurement in the private sector and the shortages and reduced demand in the public sector caused by the pandemic in the area of sexual and reproductive health service provision, and assuming that the countries did not introduce corrective measures, 1.7 million unintended pregnancies, nearly 800,000 abortions and almost 3,000 maternal deaths were to be expected.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), *Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: January-March 2021. Interim report*, 22 April 2021 [online] https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS-continuity-survey-2021.1; United Nations Children's Fund (UNICEF), "Tracking the situation of children during COVID-19 (Mar/Apr 2021)", 2021 [online] https://data.unicef.org/resources/rapid-situation-tracking-covid-19-socioeconomic-impacts-data-viz/; United Nations, "A review of research related to the impact of the COVID-19 pandemic on fertility", *Background Note*, Population Division, 2021 [online] https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesa_pd_2021_egm_inf.7_background_note.pdf; United Nations Population Fund (UNFPA), "Impact of COVID-19 on family planning: What we know one year into the pandemic", *Technical Note*, 11 March 2021.
[a] See [online] https://www.islaccovid.org/.

There are several competing hypotheses regarding the net or final effect of the pandemic on fertility (Chamie, 2021; United Nations, 2021a and 2021b), and while the hypothesis of a short-term decline in fertility predominates among experts (Carballo and Corina, 2000; Esteve, Blanes and Domingo, 2021; Breton and others, 2021), this may well be transitory and soon reverse. There would also be no contradiction in overall fertility declining even as unwanted

fertility rose (Kumar, 2020; United Nations, 2021a and 2021b). Whatever the case may be, most of the participants in an expert meeting on the subject held by the Population Division of the Department of Economic and Social Affairs (DESA) argued that the pandemic would only have a short-term impact on fertility and that fertility would return to pre-pandemic levels between 2023 and 2025. Furthermore, almost all participants expected post-pandemic fertility trends to differ between high- and low-fertility countries and between regions (United Nations, 2021b).

This conclusion matters because future population growth depends not on a temporary and circumstantial fluctuation in fertility, but on the number of children that women ultimately have by the end of their childbearing lives (Carballo and Corina, 2020; Goldstein, 2020). However, even under conditions where reproductive preferences are maintained, it is highly unlikely that all births postponed because of the pandemic and associated economic crisis will be fully recovered, for reasons of both ability (when women desire to recover births but are no longer fertile) and opportunity (when women desire to recover births but are prevented from doing so by other contextual factors, such as the end of relationships, the appearance of other adverse factors or the emergence of alternative projects that are incompatible with reproduction). Moreover, all theories recognize that the immediate reproductive response to the pandemic and the subsequent economic crisis has been not only the postponement of births but also the cancellation of reproductive projects and thus a drop in final or cohort fertility, translating in some cases into unrealized fertility (i.e., people having fewer children than desired). This also affects the exercise of reproductive rights, as stated in the Montevideo Consensus on Population and Development, especially when people are permanently unable to achieve their desired fertility.

The data available in regions of the world with continuous, reliable statistical systems that rapidly disseminate indicators online show that fertility has been falling, in some cases very steeply, since November 2020, the month that marks the end of the nine-month waiting period for capturing births of children conceived during the pandemic (United Nations, 2021a; Sobotka and others, 2021a; Berrington and others, 2022; Aassve and others, 2021). Coupled with this has been a massive postponement or cancellation of births among young cohorts (Luppi, Arpino and Rosina, 2020). However, there also appears to be different behaviour in some countries, both developed and developing, which is more consistent with the hypothesis of the pandemic having an inconsequential effect on fertility because a rise follows the initial fall (Aassve and others, 2021; Sobotka and others, 2021a; Esteve, Blanes and Domingo, 2021), or even a fertility-increasing effect (Chamie, 2021). Table I.1 presents a representative sample of the general fertility trend in selected developed countries. It can be seen that a downward trend in total births and birth rates predominates between 2017 and 2020. While this is a continuing trend, the fall between 2019 and 2020 deepened in three of the four countries analysed, the exception being Japan, which was less affected by the pandemic. The most recent data, however, show that the three most affected countries (Germany, the Netherlands and Portugal) saw an increase in births in 2021, consistent with the small rebound in birth rates anticipated in the literature and already confirmed by some ongoing research (Sobotka and others, 2021b).

Table I.1
Four developed countries: birth rates, 2017–2020, and births, 2019–2021

Country	Birth rate						Births				
	2017	2018	2019	2020	Change 2017–2019 *(annualized percentages)*	Change 2019–2020 *(annualized percentages)*	2019	2020	2021	Change 2019–2020 *(annualized percentages)*	Change 2020–2021 *(annualized percentages)*
Germany[a]	9.5	9.5	9.4	9.3	-0.5	-1.1	718 099	712 428	727 590	-0.8	2.1
Japan[b]	7.46	7.26	6.85	6.68	-4.1	-2.5	722 870	704 002	674 324	-2.6	-4.2
Netherlands[c]	9.91	9.78	9.78	9.67	-0.7	-1.1	169 680	168 681	178 506	-0.6	5.8
Portugal[b]	8.37	8.45	8.43	8.21	0.4	-2.6	72 412	71 483	72 817	-1.3	1.9

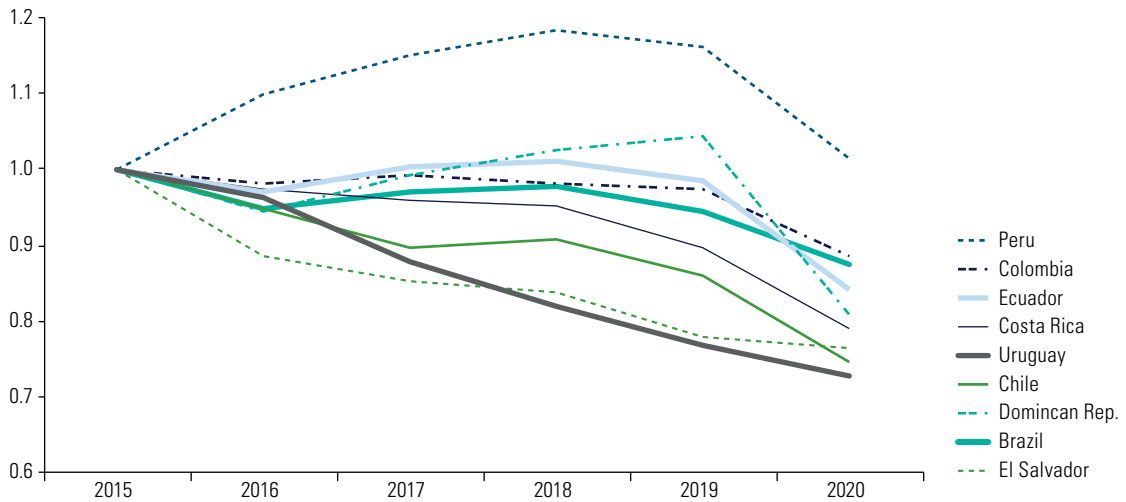
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Federal Statistical Office of Germany, "Births" [online] https://www.destatis.de/EN/Themes/Society-Environment/Population/Births/Tables/birth-deaths.html; Statistics Bureau of Japan, "Live births/Deaths" [online] https://dashboard.e-stat.go.jp/en/graph?screenCode=00020; Statistics Netherlands, "Population dynamics; month and year" [online] https://opendata.cbs.nl/statline/#/CBS/en/dataset/83474ENG/table?dl=4FDAA; and National Institute of Statistics of Portugal, "Main indicators" [online] https://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_princindic&menuBOUI=13707095&contexto=pi&selTab=tab0; for the number of births per month: United Nations, UNdata, "Live births by month of birth" [online] http://data.un.org/Data.aspx?d=POP&f=tableCode%3A55.

[a] Birth figures are for the period January-November.
[b] Birth figures are for the period January-October.
[c] Birth figures are for the full year.

In the case of Latin America and the Caribbean, virtually no country had rapidly available birth statistics, which has been a serious constraint on the empirical examination of the impact of the pandemic on births. However, nine Latin American countries have published 2020 data and some of them, such as Brazil, Chile and Peru, are already providing preliminary monthly birth data for 2021.

With regard to annual figures, figure I.8 presents the evolution of the total fertility rate for the period 2015–2020, showing an acceleration of the decline in this indicator between 2019 and 2020. These data clearly do not support the hypothesis of the pandemic increasing fertility in the short term, but rather suggest that the fertility-reducing effect has predominated. A similar conclusion can be drawn from table I.2, which presents official monthly birth data for three countries (Brazil, Chile and Peru) covering the months of January, February and March, from 2015 to 2021. All three countries show a marked drop in 2021, which again should be treated with caution.[4] These trends, besides being preliminary, are national and may not be representative of the experience of different social groups and territories within countries. However, empirical examination of subnational trends requires socially and territorially disaggregated birth information, which is even harder to come by and more problematic to assess because of the lack of reliable information on the denominators needed to calculate birth rates and fertility. Nevertheless, the persistence of the pandemic is a factor that is clearly impeding any large and sustained rebound in the birth rate.

Figure I.8
Latin America (9 countries): total fertility rate, 2015–2020
(Index: 2015 = 1)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Health Surveillance Secretariat of Brazil, "Painel de Monitoramento de Nascidos Vivos" [online] http://svs.aids.gov.br/dantps/centrais-de-conteudos/paineis-de-monitoramento/natalidade/nascidos-vivos/; Ministry of Health of Chile, "Hechos vitales desde el 2000" [online] https://public.tableau.com/app/profile/deis4231/viz/HechosVitalesdesdeel2000/NotaTcnica; National Administrative Department of Statistics (DANE) of Colombia, "Datos de nacimientos en Colombia" [online] https://www.dane.gov.co/index.php/estadisticas-por-tema/salud/nacimientos-y-defunciones/nacimientos; National Institute of Statistics and Census (INEC) of Costa Rica, "Nacimientos" [online] https://www.inec.cr/; National Institute of Statistics and Census (INEC) of Ecuador, "Nacidos Vivos y Defunciones Fetales" [online] https://www.ecuadorencifras.gob.ec/nacidos-vivos-y-defunciones-fetales/; Ministry of Health of El Salvador, "Estadísticas" [online] https://www.transparencia.gob.sv/institutions/minsal/documents/estadisticas?utf8=%E2%9C%93&q%5Bname_or_description_cont%5D=nacidos&q%5Byear_cont%5D=&q%5Bdocument_category_id_eq%5D=; Directorate General of the Civil Registry of Paraguay, "Informe Anual de Registros" [online] http://registrocivil.gov.py/valores_comparativo/; Ministry of Health of Peru, "Nacimiento según territorio / institución" [online] https://webapp.minsa.gob.pe/dwcnv/dwterritorio.aspx; National Statistical Office (ONE) of the Dominican Republic, "Subtema: Estadísticas Vitales" [online] https://www.one.gob.do/datos-y-estadisticas/temas/estadisticas-demograficas/estadisticas-vitales/; Ministry of Health of Uruguay, "Estadísticas Vitales: Nacimientos" [online] https://uins.msp.gub.uy/index.html; for the denominator, i.e., women of childbearing age (15–49 years): United Nations, *World Population Prospects 2019*, New York, 2019 [online] https://population.un.org/wpp/.

[4] Peru has already presented birth data for the whole of 2021, showing a slight increase over 2020, which supports the hypothesis of a rebound in fertility.

Table I.2
Brazil, Chile and Peru: monthly births, January to March, 2015–2021

Year	Brazil			Chile			Peru		
	January	February	March	January	February	March	January	February	March
2015	253 833	239 707	277 540	22 271	19 739	21 701	32 402	30 354	34 444
2016	246 388	241 133	267 249	20 197	19 094	21 495	38 690	37 996	39 695
2017	226 414	223 515	266 965	19 291	17 134	19 387	40 340	38 611	43 403
2018	248 735	230 349	264 342	18 978	17 236	19 005	41 902	39 760	44 521
2019	246 048	232 779	257 871	19 498	17 136	18 773	42 088	38 990	43 632
2020	230 660	219 669	246 833	18 151	16 050	17 287	42 125	40 514	41 191
2021	217 698	205 825	223 591	14 743	13 118	14 310	33 849	33 197	38 479
Change 2015–2019 *(annualized percentages)*	-0.8	-0.7	-1.8	-3.1	-3.3	-3.4	7.5	7.1	6.7
Change 2019–2020 *(percentages)*	-6.3	-5.6	-4.3	-6.9	-6.3	-7.9	0.1	3.9	-5.6
Change 2020–2021 *(percentages)*	-5.6	-6.3	-9.4	-18.8	-18.3	-17.2	-19.6	-18.1	-6.6

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Health Surveillance Secretariat of Brazil, "Painel de Monitoramento de Nascidos Vivos" [online] http://svs.aids.gov.br/dantps/centrais-de-conteudos/paineis-de-monitoramento/natalidade/nascidos-vivos/; Ministry of Health of Chile, "Hechos vitales desde el 2000" [online] https://public.tableau.com/app/profile/deis4231/viz/HechosVitalesdesdeel2000/NotaTcnica; Ministry of Health of Peru, "Nacimiento según territorio / institución" [online] https://webapp.minsa.gob.pe/dwcnv/dwterritorio.aspx.

Taken together, the data and analyses mentioned yield a number of applied conclusions. First, the abundant data on disruptions to sexual and reproductive health services caused by the pandemic, and the centrality of these services for the exercise of a wide range of rights, leave no doubt that these rights should be declared essential and formally included in the appropriate list in order to ensure access to them in all circumstances, even if this requires exceptional and selective formats based on health criteria. Some countries in Latin America and the Caribbean have already put this into practice (ECLAC/UNFPA, 2020), and the evaluation of their experiences may be useful for the rest of the region.

Secondly, given that some of the disruptions have been due to difficulties or fears affecting users of sexual and reproductive health services, it is necessary to implement measures to mitigate this unease in the future in the form both of safety protocols applied by staff in health centres and of self-protection standards and procedures required of the population using the centres. This should be supplemented by guidelines for special treatment of special cases, either because immediate care is essential (childbirth, emergency contraception, abortion, life-threatening situations, etc.) or because the risks of discrimination or exclusion are particularly high (lesbian, gay, bisexual, transgender and intersex (LGBTI) persons, adolescents, migrants, indigenous persons and Afrodescendants).

Thirdly, all the experience gained during the pandemic with the distribution of medicines to homes or safe pick-up points, telemedicine, virtual or telephone counselling, etc., should be used to optimize future care and prepare for possible disruptions.

As a fourth point, it is essential to improve the entire information network associated with birth registration and statistics on regular sexual and reproductive health care and services. The obligation to generate a continuous (specifically daily) flow of data on COVID-19-related infections, hospitalizations, vaccinations and deaths was a major challenge for the systems of health statistics of the region's countries. Despite shortcomings and underreporting of these data, which is a serious problem in several countries, their availability represented a significant institutional advance and a key input for identifying public health actions in the face of the pandemic. This was not true of fertility, since it was not part of the focus of the daily decisions taken to combat the pandemic. Nevertheless, some countries took advantage of the momentum around morbimortality data and started publishing monthly birth data almost in real time. Extending and strengthening this rapid production of vital statistics data would provide useful information for prompt analyses when policies need to be adopted urgently. Also, the regular flow of data on sexual and reproductive health provision and services can show how much action is needed and where in order to quickly and efficiently counteract disruptions or dramatic declines in access to sexual and reproductive health care.

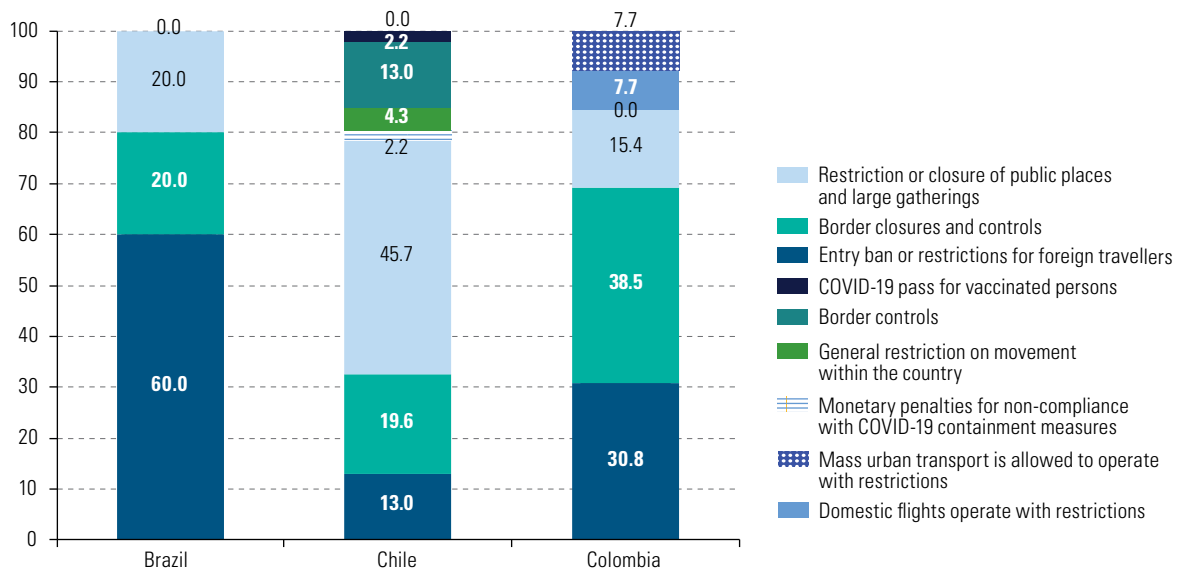
C. International migration

1. Border closures and restricted opening

Border closures have been one of the main measures adopted by governments in the region to prevent the entry of SARS-CoV-2 and its variants into their territory. Globally, at the beginning of the pandemic (April 2020), entry restrictions constituted 80% of all COVID-19-related measures (IOM, 2021c). This situation has been changing, and by early 2021 these measures accounted for only 25% of the total, given the significant increase in measures relating to authorized conditions for entry (IOM, 2021c). However, large differences between regions still persist: while Africa (except North Africa), North America and the Caribbean have virtually eliminated access restrictions, Europe, Asia, the Middle East and North Africa have maintained them at a level close to 50%. Latin America is in an intermediate situation, with restrictions of this type having decreased to levels of around 15% (IOM, 2021b).

There are also significant differences between countries in the region. Although during the first months of the pandemic, in 2020, the vast majority of governments decreed the closure of land, sea and river borders with their neighbours as one of the main health measures, there has been a gradual evolution towards opening, but with restrictions. As figure I.9 shows for Brazil, Chile and Colombia, governments have decreed different pandemic containment measures, such as closure (border closure and control) and conditional opening (restriction or prohibition of entry for foreign travellers).[5]

Figure I.9
Brazil, Chile and Colombia: mobility control and border closure measures, 2020 and 2021
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of COVID-19 Observatory in Latin America and the Caribbean [online] https://www.cepal.org/en/topics/covid-19.

Some countries in the region chose to implement prolonged border closures and various restrictions on the movement of people. Uruguay, for example, kept its borders strictly closed in 2020, complementing this with testing and quarantine measures to allow freedom of movement and assembly within the country (Ministry of Public Health, 2021). Argentina, Chile, Colombia, Ecuador and Peru have implemented sustained land border closures and military control of migratory flows, particularly of Venezuelans, by means of successive central government decrees. The situation is different in countries such as Brazil and Mexico, which still have tight restrictions on land border crossings but have kept their international air terminals open to keep the tourism industry going.

[5] Brazil reports 9 measures between February and July 2020, Colombia 11 between March and October 2020 and Chile 53 between March 2020 and January 2021.

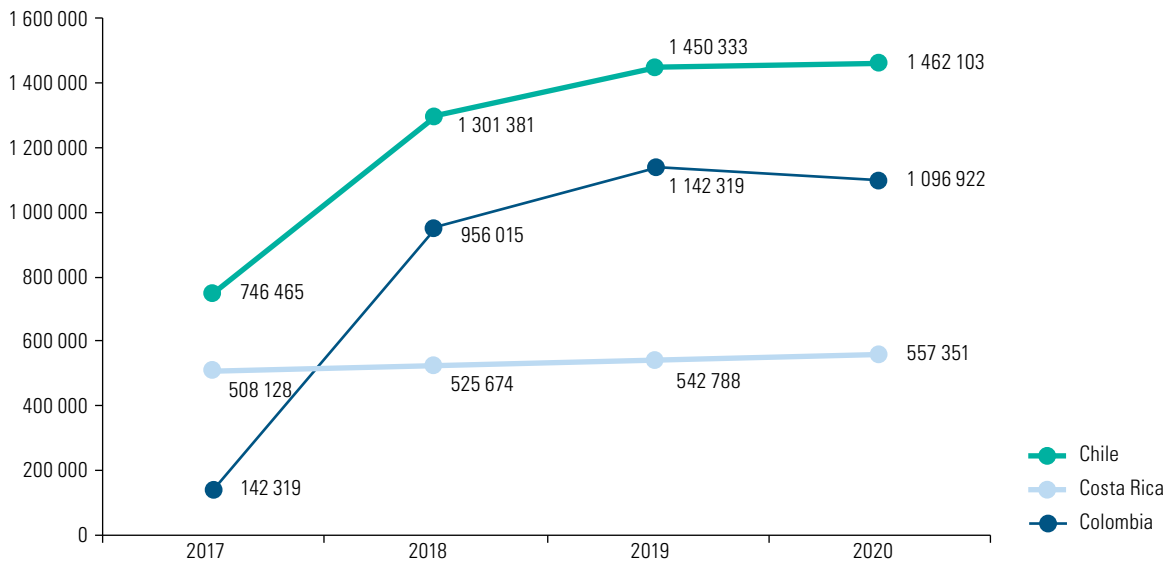
Since mid-2020, WHO has urged against border closures as an effective sanitary measure, given their unsustainability in the medium and long term (Adhanom Ghebreyesus, 2020). The recommendation has been to contain the spread of the virus through self-care measures, traceability and isolation of the infected, and, above all, increased vaccination rates. Other international organizations have called on countries to avoid border closures and guarantee the basic rights of refugees, asylum seekers and migrants (UNHCR/IOM, 2020). Similarly, humanitarian organizations and academics have raised reservations about the closure and militarization of borders as an anti-migration policy (Ikotun, Akhigbe and Okunade, 2021; Radil, Castan Pinos and Ptak, 2021).

2. Migration is continuing and becoming more complex

In the context of a persistent economic and health crisis in Latin America and the Caribbean, migration, both outward and intraregional, has not ceased despite the extended quarantines and land border closures decreed as health measures by the vast majority of countries, especially during the first phase of the pandemic, i.e., until early 2021.

As figure I.10 shows from the example of three Latin American countries (Chile, Colombia and Costa Rica), in 2020 the pandemic led to a slowdown in the migration growth that had been occurring since 2017, and even to a slight decrease in the number of migrants. However, current regional migration processes are characterized by rising complexity, accompanied by increasing irregularity and vulnerability, with, for example, an increase in mixed flows (combining mainly irregular migration, trafficking, smuggling and asylum seeking), the coupling of migrants and refugees, limited opportunities for regular migration and a growing pattern of relocation as migrants seek to change their host country in the region (IOM, 2021b).[6] Some fragmentary data also show the heterogeneity of migratory flows in the context of the pandemic, as some flows (such as those of Central Americans northward) have been maintained and others (generally return and regular mobility) have halted (IOM, 2021a).

Figure I.10
Chile, Colombia and Costa Rica: international migrant populations, 2017–2020

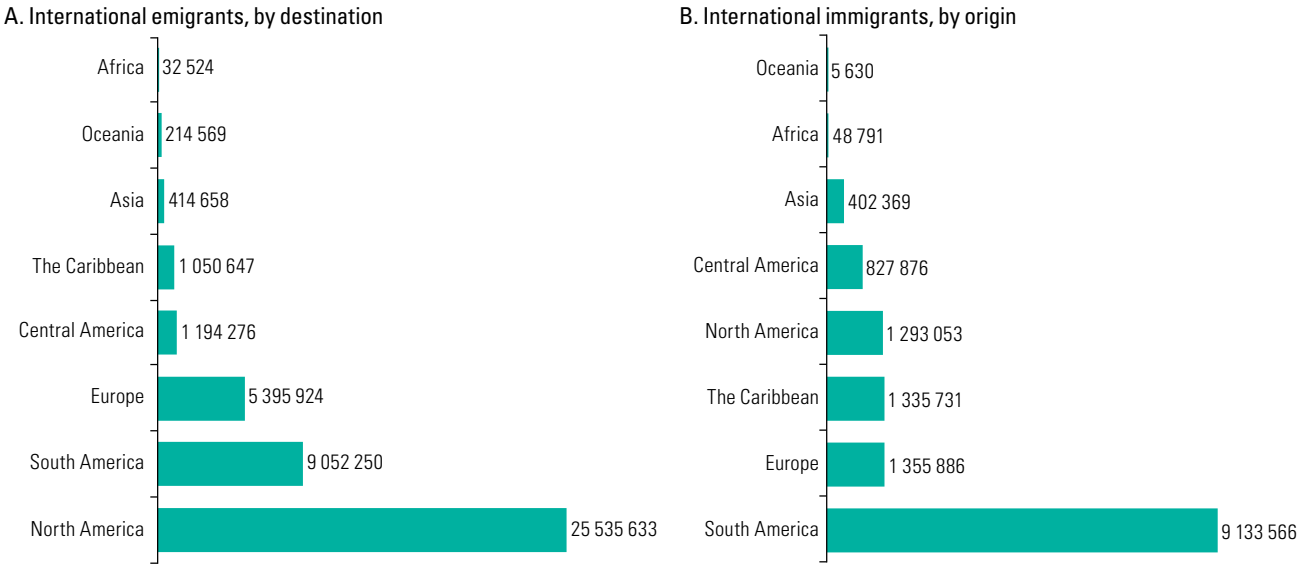


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from the National Institute of Statistics (INE), the Department of Foreign Affairs and Migration and the Investigatory Police of Chile; the National Administrative Department of Statistics (DANE) and the Ministry of Foreign Affairs of Colombia; and the Directorate-General for Migration and Foreign Nationals of Costa Rica.

[6] Data from the Jesuit Migrant Service (SJM, 2021) show a 70% decrease in migration inflows into Chile between 2019 and 2020, accompanied by a doubling of informal inflows into the country, which increased from 8,048 people in 2019 to 16,848 people in 2020.

The population of the region living in a country other than that of their birth in 2020 approached 43 million, the majority of whom, 25.5 million (59.5% of the total), resided in North America (the United States and Canada). There were 11.3 million emigrants in countries of the region itself (mainly in South America) (see figure I.11.A), equivalent to 26.3% of the total. The emigrant population represents 6.6% of the regional population, while immigrants represent less than 3%, although the data show the importance of intraregional migration, especially in South America (see figure I.11.B).

Figure I.11
Latin America and the Caribbean: international emigrants and immigrants, by destination and origin, 2020



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of United Nations, "International Migrant Stock 2020" [online] https://www.un.org/development/desa/pd/content/international-migrant-stock.

Along with an increase in intraregional migration over recent years, there is an emerging pattern of irregular, mixed migration in transit to the United States. These flows do not originate only in Central American countries, but are also driven by the departure of migrant populations, both regularized and unregularized, travelling with their children from South American countries to North America.[7] In particular, the International Organization for Migration (IOM, 2021a and 2021b) has warned about the increase in migration flows in the Darién Gap, one of the most dangerous migration routes in the world. According to IOM estimates, more than 125,000 people crossed there in 2021, 25% of whom were children. On a smaller but no less dangerous scale, an increase in irregular crossings at the Colchane border crossing on the Chilean-Bolivian altiplano has been accompanied by human losses, mainly of women, children and older persons (24 Horas, n.d.; SJM, 2021).

D. Internal migration

Some international studies (United Nations, 2020a; OECD, 2021; UN-Habitat, 2021; Martin and Bergmann, 2020), as well as others of national scope or dealing with specific cities (Fort, Espinoza and Á. Espinoza, 2021; González Leonardo and López Gay, 2021; Esteve, Blanes and Domingo, 2021; Tønnessen, 2021) and a number of press articles have suggested that the pandemic could have significant effects on population mobility and location.[8]

7 By way of example, 91,305 persons were registered as being in irregular transit through the Darién area between January and September 2021. Of these, two thirds were Haitian nationals, 7,757 were Chileans and 4,330 were Brazilians (these last being the children of Haitians born in Brazil and Chile) (IOM, 2021b).

8 See, for example, *Emol* (2021), De Abrantes, Greene and Trimano (2020) and Gordon (2022).

In the case of daily mobility or commuting between home and places of work or study, the main effect derives from the measures implemented to contain contagion. Lockdowns, curfews, restrictions on movement and travel, mandatory travel permits and the widespread shift towards teleworking in both the public and private sectors have a common goal: to reduce contact and mobility, and to prevent large gatherings. The pandemic has also affected commuting for work and study through other channels: (i) the interruption of travel for those infected, and in particular those who fall ill, which can sometimes be long-lasting; (ii) the fear of infection, which can inhibit travel, especially to places where there is congestion or a high risk of virus transmission, as well as travel on crowded transport; and (iii) the loss of jobs and income, which, together with the closure of educational establishments, halted daily commuting of all kinds (Martin and Bergmann, 2020).

With regard to internal migration, which involves movement to new places of residence and across geographical boundaries within a country, the effects of the pandemic have operated in a number of ways. The pandemic had a highly differentiated territorial impact and generated emerging push factors in the most affected areas (particularly large cities)[9] and pull factors in less affected areas (towns, villages and rural areas) (Martin and Bergmann, 2020; OECD, 2021; UN-Habitat, 2021; González Leonardo and López Gay, 2021; Borah, 2021). Push factors include the desire not only to avoid infection and disease, but also to flee the economic crisis, unemployment and the threat of hunger. To this must be added another centrifugal force: escape from the constraints, stress, confinement and tensions resulting from the restrictions imposed to control the pandemic, since in many countries these measures varied depending on the incidence of the pandemic at the subnational level. Thus, leaving big cities for rural areas, seaside resorts or small towns became an increasingly attractive option, facilitated by virtuality and distance work and education, especially for middle- and upper-income families.

However, the constraints on travel implemented to stem infections may also have had a dampening effect on internal migration, which creates some uncertainty about the effect of the pandemic on its magnitude. The question is whether the effect of infection containment measures has been wholly or partially offset by internal migration generated by the pandemic, particularly out-migration from the areas of highest initial infection (large cities). The general consensus is that the pandemic should also have reduced the strength of internal migration and restructured the balance of flows in favour of rural areas and smaller towns, to the detriment of large cities (Martin and Bergmann, 2020; Bernard and others, 2020; Dramani and others, 2021).

Between commuting to places of work or study and internal migration, there is a third type of mobility that may also have been affected by the pandemic. This is relocation or house moves due to loss of income, care needs and infection. There are conflicting forces at work here, because the pandemic may have prompted moves (e.g., people who have lost their jobs returning to the parental home to cope with the lack of income), but it may also have inhibited them (e.g., when the formation of unions or planned returns were prevented by the restrictions).

Whatever the case may be, these three types of mobility relate differently to demographic dynamics and therefore merit a differentiated treatment. Moreover, the data available on each of them vary significantly, which also influences the scope for analysis.

With regard to everyday mobility, the impact of the pandemic in the different phases of its epidemiological evolution and the measures taken to control it has been documented from a variety of sources, some traditional, such as records of arrivals and departures through air, sea and land transport terminals, and others more innovative, such as the use of ad hoc applications to track the location of mobile phones, the "seismic movement" generated by vehicle traffic, the monitoring of movements through social networks, and the use of cameras, toll systems or the number of daily trips (tickets purchased, card validations, etc., in public transport services) to count people and vehicles.[10] These sources have yielded fairly accurate estimates of the

[9] The case of New York, a metropolis that was very hard hit by the pandemic in its early days, is emblematic. Because the city has residency records, it was possible to quickly detect a significant increase in the net loss of residents, which more than tripled. In fact, this negative balance was up by 130 thousand people from March 2020 to June 2021 compared to pre-pandemic trends. While many departures were initially recorded as temporary, from mid-2020 most came to be recorded as permanent. Residents of affluent neighbourhoods were the most likely to leave the city. From July to November 2021, however, the city reversed this mass outflow and had a positive migrant balance, but only of around 6,000 people (Office of the New York City Comptroller, 2021).

[10] See, for example, Google (2022), Apple (2022), Institute for Data Science UDD (2021) and Ojeda and Ruiz (2021).

magnitude of the drop in daily mobility, although their reliability varies depending on the place and the source. However, most of this drop stems from pandemic control measures, which are dynamic and transitory, and whose impact may be limited to their period of application.

The subject raises many questions, but they can be divided into two main areas that merit specialized research in the future. Firstly, will work, study, shopping and so many other activities go back to being carried out in person to a degree similar to that seen before the pandemic? In this regard, it is reasonable to assume that telework will expand in the same way as digital modes of interaction for other purposes (leisure, study, commerce), and that the delivery of products and services through distribution and delivery platforms and companies will likewise grow, all of which implies a strategic reduction in mobility for work (Barrero, Bloom and Davis, 2021) and other activities (UN-Habitat, 2021; ECLAC/ILO, 2021; Atto, 2021). However, the scale of this reduction is currently unforeseeable. Secondly, will there be new inequalities in travel times and methods, and in travel comfort and safety? This is even less clear, but what is known is that telework is socioeconomically biased, both by occupation type and by the equipment required, and that lower-income and lower-skilled workers therefore find it more difficult to engage in. This inequality is compounded by the fact that shopping delivery platform workers are very unprotected and face high levels of overwork and occupational hazards, and basically lack a framework of protection and regulation (ECLAC/ILO, 2021).

With respect to housing moves and mobility, the available data are limited in quantity, quality and timeliness, largely because existing sources do not capture these things adequately, at least in Latin America and the Caribbean. Some of these moves may be part of demographic dynamics, e.g., residential mobility at the local level, where moves take place between municipalities in the same metropolitan area, or of traditional migration, in cases where the destination residence is some distance away. However, such housing moves do not necessarily involve an intention to change residence, as they can be reversed once the conditions that gave rise to them change. In any event, this is the type of mobility for which there is least in the way of theories and data and the least certainty about the effects of COVID-19 (González Leonardo and López Gay, 2021; Bernard and others, 2020).

Conversely, the internal migration generated by COVID-19, which falls squarely within demographic dynamics and is a central theme of chapter G of the Montevideo Consensus on Population and Development, requires special attention because it could be massive and thus produce significant and permanent effects on the location patterns of the population.

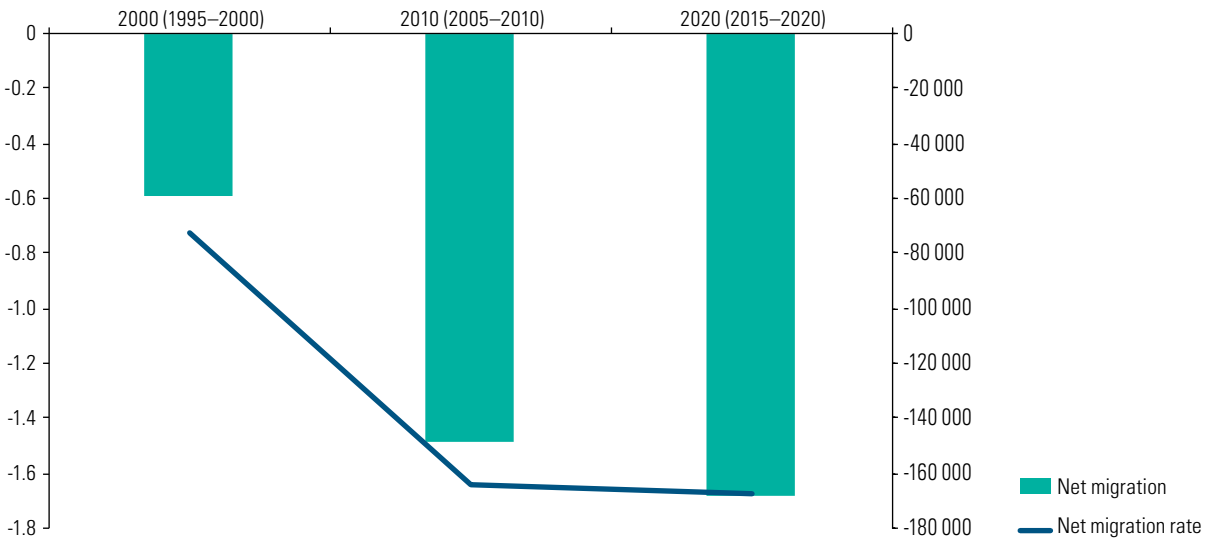
This being so, there are two key questions about internal migration and how it is affected by COVID-19. The first is how the magnitude and direction of this migration will change. The predominant response in the literature is that the pandemic will inhibit this migration, albeit it may spur certain specific movements, and that flows will be redirected from large cities to smaller towns, seaside resorts, villages and rural areas. In some cases this will be a move to a second home and in others a return to the place of birth (Bernard and others, 2020; OECD, 2021; González Leonardo and López Gay, 2021).

The second key question concerns the permanent or transitory nature of these movements, long-term changes in the residential preferences of individuals and families and the location decisions of economic agents, including the State. On this question, there is no single position and the data needed to settle the discussion, mainly from censuses, are not yet available. In fact, the only census available for the 2020s is that of Mexico, which was completed almost simultaneously with the outbreak of the pandemic in the country, so that it clearly did not capture the effect of the pandemic on internal migration. Nevertheless, this census provides at least one interesting piece of information for discussion: the metropolitan area of the Valley of Mexico continued to expel population, at a quickening pace in fact, following the indications to the contrary provided by the major intercensal survey of 2015. Thus, net emigration from large cities in the context of the pandemic cannot be mechanically attributed to the latter because this net emigration had already been dominant among the region's megacities since the beginning of the twenty-first century (Chávez Galindo and others, 2016; Rodríguez Vignoli, 2017) (see figure I.12).

According to Baumeister (2020), who analyses the situation in Central America, the combination of the decline in the commerce, restaurant and other sectors and restrictions on movement in large cities, coupled with the relative stability of agriculture and the lower incidence of COVID-19 and restrictive measures in rural

areas, could spur poor urban residents who migrated to other areas to return to their communities of origin. However, this could be complicated by the low wages and insecurity of employment in rural areas, the difficulty of securing food for self-consumption and the inability of rural families to support non-working members. Moreover, as cities open up, this return trend could be reversed and such movements could prove to have been temporary, without any long-term impact on the territorial distribution of the population.

Figure I.12
Metropolitan Area of the Valley of Mexico: net domestic migration and net migration rate annually per 1,000 population, censuses of 2000, 2010 and 2020



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the national population censuses.

A number of studies on the subject have dealt mainly with Peru, probably because of the severity with which COVID-19 affected the country and because it was one of the few countries that implemented programmes to help people return to their communities of origin and even tried to record this process in a statistical register.[11] These studies, all of whose results are preliminary, concentrate on the departure from Lima of recent migrants to the city who worked in insecure and informal jobs and whom the pandemic prompted to return to their areas of origin because of the delay in receiving assistance from both the State and other actors.[12] The main conclusion is that return was not only risky but did not result in smooth, rapid reintegration for most people. For the same reason, there are doubts about its sustainability, especially since the structural socioeconomic push forces in rural areas and villages have not gone away.

In Chile, a mobility monitoring system using big data (mostly from mobile phones) has identified a massive outflow of individuals and families from Santiago to several nearby regions during the period from March to December 2020.[13] These estimates have weaknesses, however, as they do not take account of inflows, which could offset outflows. Nor is it possible to know whether the movements constitute migration (with a change of residence) or are just seasonal.

In Colombia, an official report by the National Administrative Department of Statistics (DANE) used household surveys to establish that migration between municipalities grouped by size fell sharply between the 2019 survey (4,207,117 persons between 2014 and 2019) and the 2020 survey (3,588,989 persons between

11 See Boyd, Vásquez and Yancari (2021); Burneo and Castro (2020); Burneo and Trelles (2020); Delgado Pugley (2020); Lauda-Rodríguez and Pires Ramos (2021); Lázaro-Aquino (2021); Potesta Cortez and others (2021); Távara (2021); and Zolezzi Chocano (2020).

12 Using a simulation methodology based on Peru's 2017 census, Fort, Espinoza and Á. Espinoza (2021) estimate a return to rural areas from the main cities of around 250,000 people between March and November 2020.

13 "More than 380,000 people from the capital left it to live outside the Metropolitan Region. The regions of Valparaíso and O'Higgins appear to be the main destinations chosen to migrate to during the pandemic [...]" (Universidad del Desarrollo, 2021).

2015 and 2020), and that the slightly negative net migration balance of small (usually rural) municipalities in the 2019 survey gave way to a positive balance of 250,000 migrants in the 2020 survey, the counterpart of which was a rise in net emigration from the country's large cities (DANE, 2021).

Lastly, Cuba, the only country in the region with a residence register, reports a drastic drop in internal migration between provinces in 2020, in line with expectations. Conversely, and in contrast to Colombia and Chile, the attractiveness of the province of Havana has persisted during the pandemic, albeit to a lesser extent, with net internal migration flows of around 15,000 people a year between 2015 and 2019 being followed by a flow of around 8,000 people in 2020, the first year of the pandemic.

These fragmentary and partial figures aside, in most countries of the region a lack of reliable and up-to-date official data on internal migration prevents firm, data-driven conclusions from being drawn. Nevertheless, there will almost certainly be permanent effects, not only because of the damage caused by COVID-19 in cities, particularly metropolises, but also because of the massive growth of virtual activities allowing people to relocate from places where face-to-face activities were formerly concentrated. The scale of this transformation, however, remains totally uncertain.

Once the effects of the pandemic on the spatial distribution of population are clearer, actions could be implemented to capitalize on them, if they are deemed to contribute to the creation of more inclusive, sustainable and efficient societies. Any redistribution of population from large cities to medium-sized or smaller ones and rural areas could be beneficial in aggregate and individual terms, given the degree of primacy of large cities in most countries of the region and the huge deprivations they suffer from, and the way the demographic dividend is forfeited in the areas that lose population. However, all this will depend on the type of individuals and families that move, on goods and services access and productivity in the destination areas, and on how the increased per capita resources in the areas of origin are channelled and used. In the immediate term, at a minimum, there will need to be additional inclusive investments in accessibility, services and technology in destination areas, with further investment to close gaps and increase efficiency in areas of origin.

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CHAPTER

II

Structural inequalities and the protection of human rights during the pandemic: from the perspective of the Montevideo Consensus on Population and Development

Introduction

A. Children, adolescents and young people

B. Older persons

C. Women

D. Migrants

E. Indigenous peoples

F. Afrodescendent persons and communities

G. Persons with disability

Bibliography

Introduction

The rights- and equality-based approaches are the main pillars of the Montevideo Consensus on Population and Development. They are also central and essential components of the new development model proposal put forward by the Economic Commission for Latin America and the Caribbean (ECLAC), which is capable of boosting economic growth in an inclusive and sustainable manner (ECLAC, 2010).

The differentiated enjoyment —or deprivation— of rights is the most powerful expression of social inequality, particularly when it derives from factors that create privileges for some population groups and neglect or exclusion for others. The naturalization, crystallization and capillarity of these factors make them forces of structural discrimination that tend to reproduce over time, maintaining inequality and the model that creates it.

ECLAC showed clearly and early on that there is an economic pillar that builds and shapes social inequality in Latin America, comprising structural heterogeneity in the productive and labour sphere and the resulting differential access to assets, resources and income, which is reproduced through historical privileges and discrimination that continue to this day. This differential access limits the enjoyment of rights for large population groups, especially when the realization of rights depends on ability to pay.

Together with socioeconomic status, ECLAC has identified other structural axes of discrimination —such as gender, race and ethnicity, age, territory, disability, migration status, sexual orientation and gender identity— that tend to perpetuate social inequality and generate specific inequalities for certain population groups (ECLAC, 2016a). These axes of inequality intersect, reinforce one another and have knock-on effects throughout the life cycle, meaning that a comprehensive and diversified approach must be adopted in efforts and actions aimed at overcoming inequality. Identification of various axes of inequality also broadens the spectrum of egalitarian policies into issues that go beyond economic inequality. This variety of axes draws attention to population groups whose exercise of rights is limited.

The Montevideo Consensus can be considered a precursor to the social inequality matrix approach developed by ECLAC (2016a). The different chapters of the Montevideo Consensus focus on a set of population groups to which particular attention must be paid so that they can exercise their rights, owing to historical forms of discrimination, exclusion, stigmatization, subordination and a lack of protection. The Montevideo Consensus addresses areas relating to population in which the exercise of rights is limited: general and comprehensive well-being of all persons; development, including sex education and sexual and reproductive health according to the different ages of children, adolescents and young people; ageing and social protection of older persons; universal access to reproductive health; the exercise of sexual and reproductive rights for men and women of all sexual orientations and identities; women's autonomy and empowerment; international migration; location and mobility of the population; and ethnic identity and age-old racial and cultural discrimination.

It is therefore important to examine the impact of coronavirus disease (COVID-19) on population groups that require particular attention to guarantee the exercise of their rights in a wide variety of population and development issues, present in the chapters of the Montevideo Consensus and its priority measures and included in the ECLAC inequality matrix approach.

A. Children, adolescents and young people

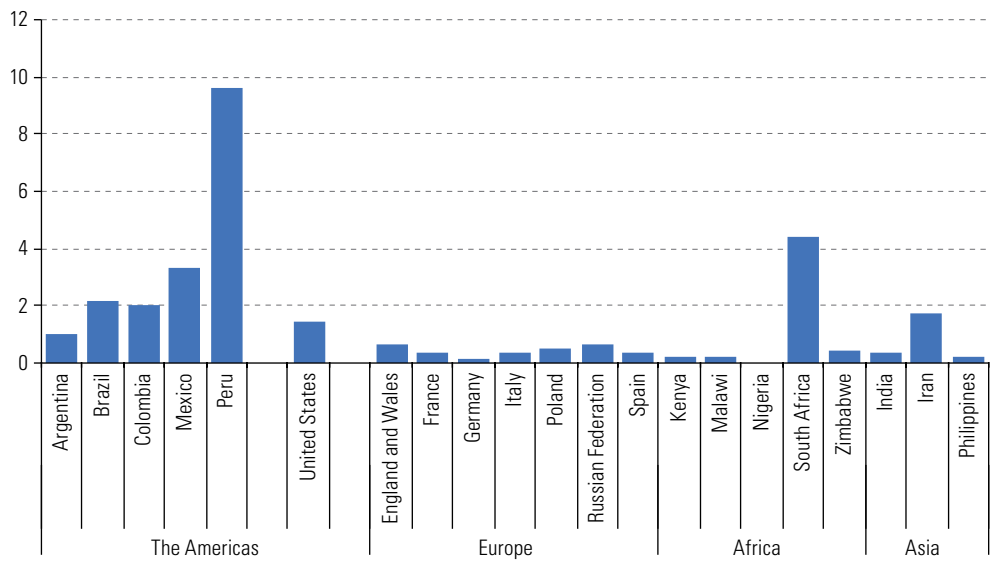
The pandemic has affected different dimensions of well-being and the exercise of the rights of children, adolescents and young people, as included in chapter B of the Montevideo Consensus on Population and Development. As regards health, although this is the least affected group in terms of mortality and serious disease, there have still been infections, sequelae and deaths from COVID-19, and associated syndromes are just beginning to be known, some of them serious, such as paediatric inflammatory multisystem syndrome (PIMS) (Committee/Working Group of Evidence-Based Pediatrics (AEPap/AEP), 2021).

Indirectly, the pandemic led to the postponement and suspension of regular health check-ups, limiting timely access to treatment and rehabilitation, as well as preventive actions and early detection of risk situations, increasing the incidence and severity of preventable or treatable pathologies. In addition, immunization coverage and newborn care services were drastically reduced (ECLAC/PAHO, 2020 and 2021; UNICEF, 2021a).

Feeding programmes have been disrupted, generating risks of setbacks in the fight against child undernutrition in some countries. In fact, 19 countries out of 32 consulted reported a decrease in the coverage of their school nutrition programmes, which seems to be resulting in an increase in malnutrition during the pandemic, both because of undernutrition and obesity (García, 2020 and 2021a). According to the World Food Programme (WFP, 2021), around 85 million children missed school meals during the early days of health restrictions —for weeks or months in some cases— until programmes were restructured.

Children's mental health, one of the aspects included in priority measure 7 of the Montevideo Consensus on Population and Development, has also been affected by different aspects of the pandemic including mandatory isolation and lockdowns, disruption of classes and school closures, and traumatic events, such as the loss of parents or caregivers (UNICEF, 2021c). Children may experience more acute stress when separated from one or both parents, including those who have been infected, those suspected of being infected, or those living in group homes. In this regard, children who have lost parents or caregivers to COVID-19 are in a particularly dramatic situation. In just five Latin American countries between March 2020 and April 2021, they amounted to 380,000, and more than 600,000 including those who have lost primary or secondary caregivers (Hillis and others, 2021). In fact, Latin America has the highest rates of orphanhood owing to COVID-19 in the world and Peru recorded the highest level, with almost 10 children per 1,000 (see figure II.1). The figure rises to 14.1 per 1,000 if including children who lost one or more primary or secondary caregivers. In fact, this extreme situation led the Government of Peru to create a special grant for these children and their families.[1]

Figure II.1
Selected countries: rate of orphanhood owing to coronavirus disease (COVID-19), 1 March 2020 to 30 April 2021
(Per 1,000 children)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of S. Hillis and others, "Global minimum estimates of children affected by COVID-19-associated orphanhood and deaths of caregivers: a modelling study", *The Lancet*, vol. 398, No. 10298, 2021.

[1] See "Asistencia Económica para Casos de Orfandad por la COVID-19" [online, available in Spanish only] https://www.gob.pe/institucion/inabif/campa%C3%B1as/5059-asistencia-economica-para-casos-de-orfandad-por-la-covid-19.

With regard to sexual and reproductive health —a central component of priority measure 12 of the Montevideo Consensus on Population and Development— reallocation of monetary and human resources to contain and respond to the health emergency left this dimension of health, and others, unattended. Disruptions were particularly severe in the case of adolescent sexual and reproductive health. These were caused by several factors: (i) difficulties in accessing contraceptives from private sources; (ii) shortages of contraceptives in public services; (iii) discontinuation of sexual and reproductive health services; and (iv) reluctance of users to attend medical appointments owing to the fear of infection. This resulted in forecasts of a marked increase in unmet demand and, therefore, an increase in adolescent pregnancy. The United Nations Population Fund (UNFPA), for example, estimated an increase from 61 to 65 live births per 1,000 adolescents aged 15–19 years at the regional level (ECLAC/UNFPA, 2020). An estimate for Mexico, focusing on unwanted or unplanned pregnancies, suggested increases of at least 10%, both for all women of reproductive age and for adolescents (Government of Mexico and others, n/d).

However, despite disruptions early in the pandemic, particularly in 2020, many countries were able to maintain or restore access to essential health services, including family planning services (UNFPA, 2021). For example, of the 29 countries that responded to the World Health Organization (WHO) monitoring survey on the disruption of essential services, 12 reported some type of disruption, with most countries reporting disruptions affecting 5%–25% of services (WHO, 2021). Among adolescents, the effect of restrictions on sexual activity and unions must also be considered, so a decline in the specific fertility rate is to be expected, and in the total fertility rate. In Chile, for example, preliminary data on births among adolescent mothers aged 10–19 years show a decrease of 2,201 births between 2019 and 2020, and a specific fertility rate among 15–19 year-olds that indicates a downward trend, reaching 15.3 per 1,000 in 2020 (D'Angelo, 2021). In Mexico, the drop in the number of births between 2019 and 2020 is very sharp and even more pronounced among adolescents.[2] However, this probable fall in total and adolescent fertility may be concomitant with a rise in the unwanted fraction of fertility.

Adding value to the international surveys on service disruption mentioned above, the countries of the region report specific data on problems and breakdowns in sexual and reproductive health services for adolescents. Monitoring data for 2020 from Argentina's National Plan to Prevent Unintended Adolescent Pregnancies (Plan ENIA) shows a 72% drop in the number of adolescents counselled in schools and health services (Ministry of Health/Ministry of Education/Ministry of Social Development, 2020b). Regarding contraception, data from the Argentine provinces show that in the first four months of 2020, placement of long-acting reversible contraception (LARC) was recorded in just 40% of facilities that are part of Plan ENIA and specifically in April, placements were performed in only 12.8% of facilities (Ministry of Health/Ministry of Education/Ministry of Social Development, 2020a). In Chile, birth control check-ups in adolescents declined by 77%, from 227,053 adolescents in 2019 to 52,005 in 2020 (D'Angelo, 2021). In 2019, comprehensive adolescent health-care coverage had reached 17%, but with the pandemic it dropped to 7% in 2020, returning to values recorded in 2012 (D'Angelo, 2021). In El Salvador, the number of adolescents who were active contraceptive users declined from 14,162 in 2019 to 8,666 in 2020 (Working Group on discrimination against women and girls, 2021).

According to the draft report on the second United Nations survey on Latin American and Caribbean youth within the context of the COVID-19 pandemic, by the Working Group on Youth of the Regional Collaborative Platform for Latin America and the Caribbean, which was answered by almost 47,000 adolescents and youth, a little more than half of the sample (53%) stated that during the pandemic they experienced changes in their access to health services. These changes mainly comprised interruption of routine care and procedures such as annual gynaecological check-ups and examinations (such as Pap smears), pregnancy check-ups, well-baby check-ups and vaccinations for babies and children, and psychological treatments, among others. Of the reported changes, 76% relate to these situations. About 12% relate to interrupted access to contraceptives, 7% to interrupted access to treatments for chronic diseases and 5% to interrupted hormone replacement therapies. With regard to the reasons, 43% of respondents stated it was impossible to attend health services or that they had deliberately chosen not to seek health services during the pandemic. In 28% of cases, respondents said that the required services were not being offered by health centres.

[2] See [online] https://www.inegi.org.mx/temas/natalidad/.

In education —a core component of priority measure 9 of the Montevideo Consensus on Population and Development— it is estimated that around 165 million students experienced total or partial interruption of their studies in 2020 (ECLAC/UNESCO, 2020), that 97% of students in the region have been deprived of their normal schooling (Seusan and Maradiegue, 2020) and that by the end of 2021, 60 million children and adolescents were still affected by total or partial school closures, averaging 162 school days without classes between March 2020 and early December 2021 (UNICEF, 2021c). Azevedo and others (2020) applied simulation models to estimate the impact of COVID-19 on years of education adjusted for quality of learning.[3] For Latin America and the Caribbean, the quality-adjusted number of years of education was 7.7 before the pandemic but they project a decrease to 7.4 in an optimistic scenario (the shortest school closure time), 7.1 in an intermediate scenario and 6.8 in the worst-case scenario. Other learning indicators show significant impacts, even in the "optimistic" scenarios. These include some basic indicators such as reading and writing: United Nations Educational, Scientific and Cultural Organization (UNESCO) has estimated that around 100 million children globally will not reach the expected level of fluency for their age because of the pandemic (UNESCO, 2021d).

A particularly harmful effect of the pandemic is the increase in educational inequality, which was already enormous in the region. This derives, on the one hand, from the better capacities of private schools to offer virtual classes, and, on the other hand, from these schools' better conditions for receiving students, who typically belong to more affluent population groups. In Chile, the Ministry of Education estimated learning loss in the best-case scenario in 2020 of 15% for the richest quintile and 50% for the poorest quintile (Centro de Estudios MINEDUC, 2020).

In addition to the repercussions for learning and its quality, it is estimated that there could be an increase in school dropout, particularly among adolescents and young people of low socioeconomic status, and adolescents and young people who are migrants, from indigenous communities, Afrodescendent and with disabilities, among other groups (Seusan and Maradiegue, 2020). Declines in school enrolment are also expected: UNESCO estimates indicate that 1.83% of students are at risk of dropping out in Latin America and the Caribbean, the second highest percentage worldwide (UNESCO, 2020). School dropout and lower enrolment are also triggered by loss of jobs in families, as this puts pressure on children and adolescents to drop out of school in order to reduce costs and also to join the labour market and thus contribute financially to households. Such work constitutes child labour, in direct conflict with target 8.7 of the Sustainable Development Goals (SDGs) (ECLAC/ILO, 2020a; García, 2020).

Distance learning solutions are less suitable for pre-primary-age children because their learning is more dependent on direct interaction with caregivers and peers through play and other activities (Seusan and Maradiegue, 2020; Centro de Estudios MINEDUC, 2021). School closures deprive this group not only of cognitive learning, but also of socioemotional development, and have long-term harmful effects because children who lag behind in beginning this level of education generally fall behind in the next educational levels (Nugroho and others, 2021). Despite the importance of early childhood education, from the perspective of Nugroho and others (2021), countries' mitigation measures and concern for learning losses prioritize other educational levels and not pre-primary.

Children and adolescents suffering abusive relationships are more likely to be exposed to violence with confinement to the home and school closures (Centro de Estudios MINEDUC, 2021). It is estimated that the pandemic may lead to an increase in domestic violence, and in particular gender-based violence; the connection with outbreaks has been well documented in previous occurrences of infectious diseases such as severe acute respiratory syndrome (SARS), Ebola and Zika virus disease (Seusan and Maradiegue, 2020). In fact, nearly 6 out of 10 adolescents and young people in the region believe that cases of gender-based violence have increased during the pandemic.[4] In that regard, school can act as a haven from possible physical, mental and emotional violations in the home (García, 2020), meaning that suspension of school activities could also lead to a reduction in investigation of such violations when children and adolescents —including those who

[3] See Filmer and others (2020) for more details on this indicator combining the number of years of study and learning.

[4] See UNFPA, "¿Cómo están afrontando las juventudes la pandemia de COVID-19? See [online, available in Spanish only] https://lac.unfpa.org/es/news/%C2%BFc%C3%B3mo-est%C3%A1n-afrontando-las-juventudes-la-pandemia-de-covid-19.

are lesbian, gay, bisexual, transgender or intersex (LGBTI)— are at home, where child abuse is more likely to go unreported (Centro de Estudios MINEDUC, 2021). Higher exposure to online media in lockdowns tends to lead to rises in digital violence and harassment. Furthermore, the return to face-to-face classes may be linked to episodes of violence as a result of missed opportunities for social interaction and tension accumulated during the pandemic, which schools should plan for and address through preventive adaptation and mitigation actions.

In direct relation to the notion of schools as spaces not only for training and learning but also for protection, development and socialization, there is consensus that the education system plays a very important role in protecting children's rights, particularly for those living in poverty and vulnerability, as schools perform protective and monitoring functions that go far beyond the scope of academic pursuits. Educational centres also provide opportunities for socialization, help to shield children from violence and support health care, among other factors that influence the well-being of children and adolescents and the protection of their rights. Prolonged lockdowns and the difficulty of maintaining contact with the education system through remote connections are an additional source of vulnerability and exposure to risks for this population. Any situation that undermines schools' ability to function is of concern to society at large and should be addressed when designing integrated social policies to counter the crisis and bolster a recovery. Thus, in the adverse situation of the pandemic, there is a greater need to invest in children, adolescents and young people to reduce the risk of there being a lost generation.

Schools are also the most important institutional support channel for caregiving tasks, which, because of the traditional sexual division of labour in Latin American and Caribbean societies, are primarily shouldered by women. The transfer of schooling to the home environment has therefore not only prevented many women from seeking paid employment but has also added to the unpaid caregiving and support tasks that they were already performing in the household (ECLAC/PAHO, 2021).

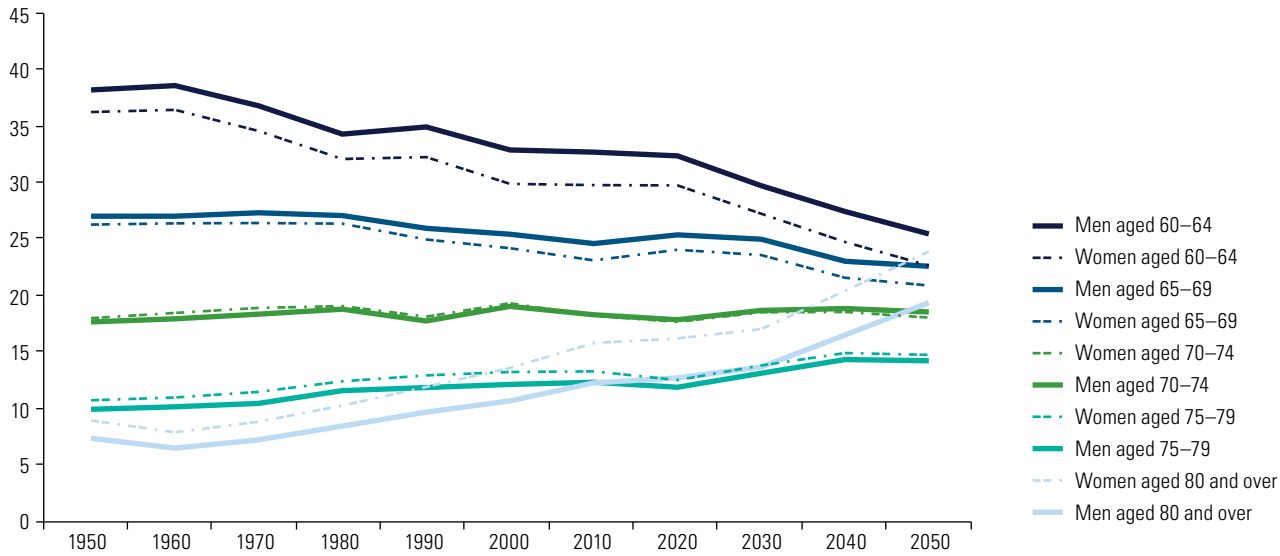
Lastly, based on a review of sexual and reproductive health and education, it is possible to argue that the pandemic may be having a significant impact on the coverage of both services, including comprehensive sexual education —the subject of priority measure 11 of the Montevideo Consensus for this age group— potentially having very harmful repercussions in the medium and long term for those affected. The decrease in access to comprehensive sexual education and quality sexual and reproductive health services could deepen pre-existing inequalities in the region, so it is crucial to ensure access to these areas that are key to the development of children and adolescents.

B. Older persons

In 2022, there will be approximately 665 million people living in Latin America and the Caribbean, of whom some 91 million (14%) will be aged over 60. This is a 75% increase compared to the number of elderly people in 1980. By 2030, this number is expected to have risen to 118 million (16.7% of the regional population) and by 2050 to 190 million (25%). By the end of the twenty-first century, it is expected to have reached 254 million people (United Nations, 2019b). Another important trend to be considered is ageing among older persons. The group of persons aged 80 and over, which currently represents 2.0% of the total regional population (roughly 13.5 million people), will grow particularly quickly and is projected to exceed 41 million people in the next 30 years (United Nations, 2019b) (see figure II.1).

This population ageing is the result of a sustained fall in mortality and fertility, as well as a significant increase in life expectancy, considered one of the main achievements of humanity in the twentieth century as a result of unprecedented global socioeconomic development over the last 50 years (see section A of chapter I). The fact that people are living longer, and older persons are increasing as a proportion of the total population is primarily society's achievement, the direct result of greater control over reproductive decisions and increased life expectancy in older age. It is essential to incorporate a demographic perspective into the identification of the population's needs, their link to development and the design of effective public programmes and policies. Within this framework, there is need for deeper reflection on old age in the region, analysing the policies formulated in Latin America and the Caribbean and the specificities of this age group when approaching comprehensive care measures for older persons.

Figure II.2
Latin America and the Caribbean: distribution of older persons by sex and age group, 1950–2050
(Percentages of the total number of older persons)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of United Nations, World Population Prospects 2019 [online database] https://population.un.org/wpp/Download/Standard/Population.

The population dynamics in the region and the characteristics of older persons are highly heterogeneous owing to each country being at a different stage of demographic and epidemiological changes. Although this results in notable disparities in the organization of individual lives, in all cases social inequality gives rise to differences in the quality of life of older persons (Redondo and others, 2020).

Since its emergence, COVID-19 has shown differentiated impacts on populations and a tendency to affect groups with sociodemographic vulnerabilities and disadvantages that translate into deteriorated health conditions. In countries and territories with high levels of poverty, weakened or fragmented health and social protection systems and higher levels of inequality, older persons have suffered more from the physical, psychological, economic and social repercussions of the pandemic (United Nations, 2020e).

According to the *Social Panorama of Latin America, 2021* (ECLAC, 2022a), the effects of the pandemic have highlighted and exacerbated the major structural gaps in the region, mainly levels of inequality, labour informality, lack of social protection, poverty and vulnerability. These problems weigh heavily on older persons, particularly women and those with disabilities (see box II.1), who have limited job opportunities and inadequate pensions and social protection. This, added to the epidemiological conditions of older persons, showed from the beginning differential effects of the pandemic with respect to other age groups and have highlighted the vulnerability in which a large part of this population lives, as well as resulting in greater demand for specialized and critical health care and caregiving. Older persons with pre-existing health problems have been delaying their treatment and have been exposed to enormous stress owing to the fear of infection. In addition, the impact on their mental health because of loneliness and isolation during lockdown is still unknown (Huenchuan, 2020).

The United Nations has noted since the mid-2020s that while all age groups are at risk for COVID-19, older persons and people with pre-existing chronic diseases are at higher risk of becoming seriously ill and dying (United Nations, 2020e). Figure II.3 shows the COVID-19 mortality rate by age group for six selected countries from Latin America, revealing that mortality increases with age in all of them from the age of 60 onward, Peru being the country with the highest rates.

Box II.1
Older persons with disabilities

Older persons with disabilities who also have comorbidities run a greater risk of having a severe case of COVID-19 if they become infected. The World Health Organization (WHO) has said that the main reason for this is that COVID-19 exacerbates "existing health conditions, particularly those related to respiratory function, immune system function, heart disease or diabetes" and that older persons with disabilities may encounter greater barriers to health-care access (WHO, 2020, p. 2).

An analysis of the most recent census results shows that the proportion of people aged 60 and over who had some type of disability ranged from 14% in Guatemala and Colombia to 35% in Peru. At 80 years of age and over, the prevalence of disability rises further, to around 30% in Guatemala and Colombia and 58% in Peru. In all countries this percentage is slightly higher for women than for men (see table).

Colombia, Guatemala and Peru: percentage of persons with disabilities, by age group and sex, according to the 2010 census round
(Percentages)

Country	Men			Women			Both sexes		
	60–79 years	80 years and over	60 years and over	60–79 years	80 years and over	60 years and over	60–79 years	80 years and over	60 years and over
Guatemala (2018)	10.0	30.8	13.0	10.9	31.6	14.0	10.5	31.2	13.5
Colombia (2018)	11.0	28.0	13.4	11.5	30.3	14.6	11.3	29.4	14.1
Peru (2017)	28.0	57.0	32.5	33.7	58.3	38.0	31.0	57.7	35.4

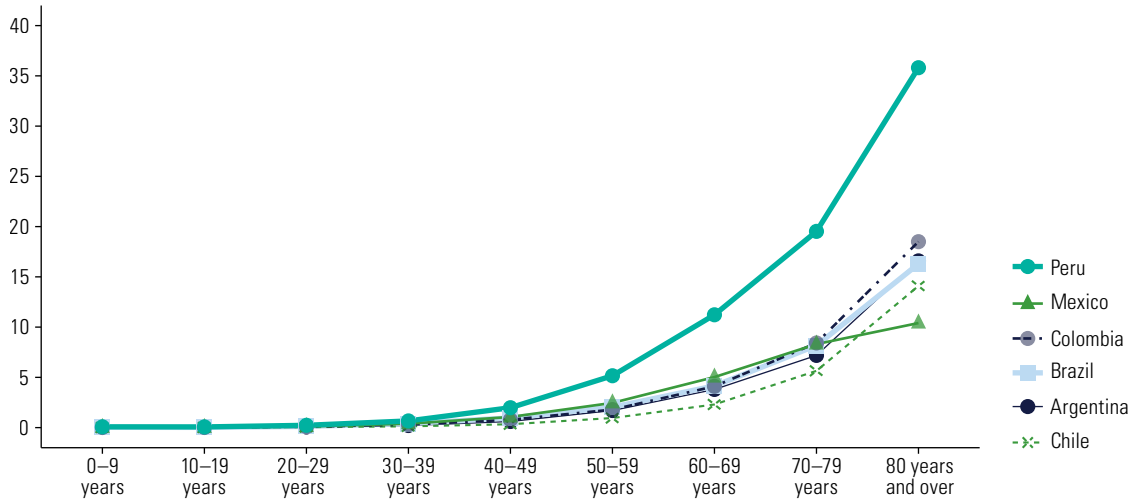
Source: Economic Commission for Latin America and the Caribbean (ECLAC), "Challenges for the protection of older persons and their rights during the COVID-19 pandemic", *COVID-19 Reports*, Santiago, 2020.

According to the Economic Commission for Latin America and the Caribbean (ECLAC), it can be inferred from the correlation between age and disability that many older persons who contracted or died from COVID-19 also had a disability of some kind. ECLAC also recognizes that disability represents a greater risk of infection as it makes it more difficult to protect against the virus. Visual and motor disabilities force greater contact with surfaces, which increases the risk of infection. In addition, information on prevention is not necessarily accessible to older persons with disabilities, and access to prevention, diagnosis and treatment mechanisms often does not depend on their decisions and possibilities, especially if they reside in long-term care facilities. These persons also face the stigmas of ageing and disability simultaneously.

The Joint Statement: Persons with Disabilities and COVID-19 urged States to continue to provide the necessary health services for persons with disabilities, older persons and persons with illnesses undergoing treatment. Therefore, it is necessary to establish mechanisms that guarantee the rights to life, non-discrimination, health and care. Dividing society between the weak and the strong would be an unfortunate path for humanity, whose interdependence is clearer than ever (Huenchuan, 2020).

Source: Economic Commission for Latin America and the Caribbean (ECLAC), "Challenges for the protection of older persons and their rights during the COVID-19 pandemic", *COVID-19 Reports*, Santiago, 2020; "Persons with disabilities and coronavirus disease (COVID-19) in Latin America and the Caribbean: status and guidelines", *COVID-19 Reports*, Santiago, 2020; S. Huenchuan, *El derecho a la vida y la salud de las personas mayores en el marco de la pandemia por COVID-19* (LC/MEX/TS.2020/9), Mexico City, ECLAC, 2020; Office of the United Nations High Commissioner for Human Rights (OHCHR), "Joint Statement: Persons with Disabilities and COVID-19 by the Chair of the United Nations Committee on the Rights of Persons with Disabilities, on behalf of the Committee on the Rights of Persons with Disabilities and the Special Envoy of the United Nations Secretary-General on Disability and Accessibility" [online] https://www.ohchr.org/en/statements/2020/04/joint-statement-persons-disabilities-and-covid-19-chair-united-nations-committee; and World Health Organization (WHO), *Disability considerations during the COVID-19 outbreak*, 2020 [online] https://www.who.int/docs/default-source/documents/disability/spanish-covid-19-disability-briefing.pdf?sfvrsn=30d726b1_2.

Figure II.3
Latin America (6 countries): mortality rate for coronavirus disease (COVID-19), by age groups, 1 March 2020–31 January 2022
(Number of accumulated deaths per 1,000 inhabitants)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data of Argentina: Ministry of Health, National Directorate of Epidemiology and Health Situation Analysis [online] http://datos.salud.gob.ar/dataset/covid-19-casos-registrados-en-la-republica-argentina/archivo/fd657d02-a33a-498b-a91b-2ef1a68b8d16; Brazil: Health Surveillance Secretariat, Ministry of Health, "SRAG 2021 e 2022 - Banco de Dados de Síndrome Respiratória Aguda Grave - incluindo dados da COVID-19" [online] https://opendatasus.saude.gov.br/dataset/srag-2021-e-2022; Chile: Ministry of Health, Health Statistics and Information Department [online] https://deis.minsal.cl/; Colombia: Ministry of Health and Social Protection [online] https://www.datos.gov.co/Salud-y-Protecci-n-Social/Casos-positivos-de-COVID-19-en-Colombia/gt2j-8ykr/data; Mexico: Dirección General de Epidemiología, Secretaría de Salud [online] https://www.gob.mx/salud/documentos/datos-abiertos-152127; and Peru: Ministry of Health (MINSA) [online] https://www.datosabiertos.gob.pe/dataset/fallecidos-por-covid-19-ministerio-de-salud-minsa.

The United Nations (2020e) also estimated that 66% of people aged over 70 had at least one pre-existing disease, which significantly increases the risk of serious complications and effects from COVID-19. This risk is higher when they are institutionalized —older persons living in long-term care institutions, prisons, shelters or psychiatric hospitals— and when they are unable to isolate because they live with others or because of their care responsibilities (CIM, 2020). Meanwhile, measures to control and mitigate the pandemic, especially those related to lockdowns, have increased situations of violence within households, putting older persons who are women, who have disabilities, are functionally dependent or who belong to the LGBTIQ+ community at greater risk of exclusion (Ramírez, Montes de Oca and Mendoza, 2021). The pandemic may also have caused irreparable cultural losses, as indigenous older persons, who are guardians and transmitters of culture, traditional knowledge, spirituality and indigenous languages, are at high risk of death because of their age and pre-existing medical pathologies,[5] requiring special attention owing to their heightened vulnerability to COVID-19.[6]

However, according to the *COVID-19 Report* entitled "The prolongation of the health crisis and its impact on health, the economy and social development", during the successive waves of the virus in the second year of the pandemic, there were rises in infections and deaths of people who did not belong those originally considered risk groups —based on either comorbidities or age— accompanied by a decline in deaths rates for the population aged 60 years and older. This may be linked to the start of vaccination programmes in the region, which prioritized older persons, providing them with greater protection in subsequent waves of the pandemic (ECLAC/PAHO, 2021).

Given that COVID-19 most severely affects older persons, their percentage in the total population is one of the key demographic factors to be considered, in terms of both the impacts of the pandemic

5 See A/75/185, para. 74 [online] https://digitallibrary.un.org/record/3879209?ln=en.
6 See A/HRC/48/54, para. 37 [online] https://documents-dds-ny.un.org/doc/UNDOC/GEN/G21/217/10/PDF/G2121710.pdf?OpenElement.

and States' policy responses and actions to mitigate those impacts. In this context, it is essential to put protection of older persons' rights at the centre of public policy responses and to incorporate the vision and commitments originating from the Montevideo Consensus on Population and Development (ECLAC, 2013b), which in chapter C "Ageing, social protection and socioeconomic challenges" includes 15 priority measures on ageing and social protection (priority measures 18 to 32), that are related to issues such as participation, social security, education, health, care, dignified death, work, violence, discrimination and savings, among others. Chapter C also affirms the need to eradicate the multiple forms of discrimination that affect older persons, including all forms of violence against older women and men, considering States' obligations with respect to ageing, with an intergenerational and human rights perspective.

The Montevideo Consensus also established the importance of access to basic services without discrimination of any kind to promote the development and well-being of all populations. However, older persons' access to basic services is in fact unequal and linked to place of residence, gender, income, disability, health conditions, ethnicity and other factors. During the pandemic, differential access to basic services such as water and sanitation, clean and safe energy services, and information and communications technology (ICT) has been a driver of inequality, increasing vulnerability to illness and death.

Despite the availability of water in the region, access to this basic service, which is essential for containment of COVID-19 infections, is either non-existent or intermittent in many locations. About 90% of older persons residing in urban areas have access to safe drinking water, while in rural areas this proportion is 64% (Huenchuan, 2018). The accessibility, availability and quality of drinking water vary from country to country. The most recent census and inter-census data for five countries show that the percentages of older persons living in households with inadequate access to water range from 4% of older persons in Chile to 16% in Guatemala (ECLAC, 2020i).

During the pandemic, older persons who live in areas where there is no water supply or it is limited to certain hours of the day or days of the week have found themselves in a situation of significant vulnerability, because access to water sometimes requires travel and support from other people and requires financial resources. For many, this difficulty accessing water makes it impossible to apply personal hygiene measures, such as handwashing and cleaning spaces, which are essential to contain the spread of the virus.

During the pandemic, older persons without access to clean and safe energy services were also exposed to greater risks from: (i) exposure to extreme temperatures; (ii) the use of polluting sources for cooking or heating homes, causing respiratory tract problems; and (iii) a lack of electricity that would allow access to inf ICT and thus access to information, medical services, education, and sources of essential goods and employment (Calvo and others, 2021).

Different levels of access to information and communications technology (ICT) have also become a factor in inequality. Sunkel and Ullman (2019), based on household survey data for eight countries in the region, report that older persons have less access to the Internet than other age groups. For example, Internet use among 15–29 year-olds was more than seven times higher than among older persons in El Salvador and Honduras, eight times higher in Mexico and almost nine times higher in Ecuador. Older people have had greater difficulties in achieving digital inclusion because, in addition to the inequalities they have accumulated throughout their lives, they are constantly confronted with negative and exclusionary narratives regarding technology. In Latin America, the age group of older persons is the most isolated from digital technology, reflecting a wide digital divide (Sunkel and Ullman, 2019).

The pandemic has shown how important it is to reduce the digital divide for older persons so that they can maintain their social ties, strengthen and expand their support networks, access medical care for therapeutic follow-up, and obtain accurate and timely information, in order to continue performing political, economic, educational and community activities, and thus maintain their quality of life. However, access to technology is meaningless if people do not feel able to use it. Access to and use of technology by older persons depends on numerous conditions and factors, such as gender, ethnicity, area of residence, schooling and age, all of which directly impact widening or narrowing of the technology gap. Older women who have performed domestic or care work throughout their life experience much wider digital divides. It is therefore necessary to rethink formal and non-formal education systems and to envision new ways of guaranteeing lifelong education.

It is paramount, then, to ensure that older persons have access to and are able to meaningfully participate in the digital world. Digital inclusion policies and programmes should start from recognition of the existence of structural and accumulated inequalities over the course of a person's lifetime that delineate environments of inequity in the spheres of access, use and ownership of ICTs (Alva de la Selva, 2015; Ferraro and Shippee, 2009), and take into consideration gender-sensitive mechanisms that are linked to the realities of care work (McCabe and others, 2021).

In addition to the Montevideo Consensus on Population and Development, consideration should be given to other international and regional instruments and agreements, such as the Madrid International Plan of Action on Ageing, 2002 (United Nations, 2003), the San José Charter on the Rights of Older Persons in Latin America and the Caribbean (ECLAC, 2012b), the 2030 Agenda for Sustainable Development (United Nations, 2015), the Inter-American Convention on Protecting the Human Rights of Older Persons (OAS, 2015), the Asunción Declaration "Building inclusive societies: ageing with dignity and rights" (ECLAC, 2017c) and the United Nations Decade of Healthy Ageing (2021-2030), which have focused their efforts on a paradigm shift that enables older persons in the region to be recognized as rights-holders, acknowledgement of their contributions to the development of their communities and countries, understanding of the various forms of ageing, and mechanisms to promote social protection and protection of rights that have a direct positive impact on their equitable development.

These agreements provide the region with guidelines for government public policy action that focuses on protection of human rights and improvements in living conditions, which until the pandemic had been reflected in several areas, such as rises in life expectancy in the countries (between 0.5 and 1.5 years over the last decade) (ECLAC, 2019e), improvements in health-care services, and increased pension coverage (public spending on pension systems in the region rose from 4.8% of GDP in 2000 to 5.5% in 2017) (Arenas de Mesa, 2020). As a result of the pandemic, central government social spending in the region increased as a percentage of GDP in 17 countries: spending on social protection climbed from 4.2% of GDP in 2019 to 5.9% in 2020 and health expenditure rose from 2.3% to 2.7% (ECLAC, 2022a).

Decent and adequate pensions, health care and social services are universal pillars of social protection systems (ECLAC, 2019b). The limitations of these systems were already evident in Latin America and the Caribbean before the pandemic and deepened as a result of the health crisis owing to: (i) high rates of informality and the resulting low contributory social protection; (ii) a lack of unemployment benefits in several countries of the region (unemployment insurance, individual unemployment savings accounts, severance payments or assistance for the unemployed); (iii) pressure from increased demand for sick leave benefits; and (iv) the need to expand non-contributory social protection and contributory pension programmes.

At the start of the pandemic, ECLAC (2020j) stated that pension systems in the region, which were already paying out very small amounts and were beset by financial problems, would also be hurt by the pandemic as their membership or contributions shrank, especially in countries that were most vulnerable to increases in unemployment and informal employment. The *Social Panorama of Latin America, 2021* (ECLAC, 2022a) stated that between 2010 and 2019 pension coverage expanded slightly from 45.5% to 46.8% of the economically active population (EAP), but that the pandemic caused a 2.1 percentage point decline in coverage, to 44.7% of EAP in 2020.

The *First regional report on the implementation of the Montevideo Consensus on Population and Development* (ECLAC, 2019b) noted that income security for older adults was an unresolved issue in all countries, despite the significant progress achieved. For example, between 2000 and 2017 the coverage of non-contributory pension systems in the region increased from 3.8% to 22.7% of those aged 65 and over (Arenas de Mesa, 2020). According to the ECLAC Non-contributory Social Protection Programmes Database-Latin America and the Caribbean, 24 countries in the region currently have a non-contributory old-age pension programme that is either universal or linked to certain selection criteria. ECLAC (2022a) estimates that, among older persons, receipt of pensions mitigated an increase of 34.9 percentage points in poverty and 22.9 in extreme poverty. It is therefore imperative to continue working on measures to increase pension coverage.

Because health systems in Latin America and the Caribbean are fragmented and weak, households in the region cover more than one third of health care payments out-of-pocket (34%), around 95 million people incur catastrophic health-care expenses and some 12 million become impoverished as a result (ECLAC/PAHO, 2020), which undoubtedly affects the older population as well. In response to the pandemic, the countries of Latin America

announced large fiscal packages of unprecedented scope, averaging 4.6% of GDP. The aim of these packages was to strengthen public health systems, support families and protect the production structure (ECLAC, 2022a). However, the financial, material and human resources of health systems have been concentrated on care and mitigation of COVID-19 and as a result, older persons have had difficulties in obtaining diagnoses, following up on treatments, accessing rehabilitation, and purchasing medication. In addition, older people with disabilities and chronic diseases may have even more difficulty accessing health care and thus become more marginalized (United Nations, 2020e), especially if they live in rural areas or belong to indigenous or Afrodescendent groups.

Care services have become an increasingly important part of discussions on the social protection and rights of older persons. As has been noted by ECLAC (2020c), the pandemic has provided more evidence than ever before of how important caregiving is in sustaining life, how nearly invisible this sector is in the region's economies and how overburdened women caregivers are. In inequality, access to these types of services involves intersections of multiple essential dimensions of development, such as human rights, social protection, gender and socioeconomic inequalities (Batthyány, 2010). In this regard, ensuring compliance with the right to care established by the Inter-American Convention on Protecting the Human Rights of Older Persons is fundamental for the development of older populations and women of all ages.

According to Casalí, Cetrángolo and Pino (2021), in most countries of the region older persons are cared for by family, less than 1% of those over 60 live in long-term care institutions and a smaller proportion are caregivers. The precariousness and inequitable distribution of both paid and unpaid care work makes older persons who require care vulnerable, as they may not receive adequate care or may be exposed to abuse or violence, either in at-home care or in long-term care institutions.

The discussion on social protection in the area of care with a rights-based perspective and focused on older persons should therefore encompass: (i) recognition of care work as a public good that enables the production and reproduction of societies (Gornick and Meyers, 2009); (ii) an end to the approach to care based on family members and as a consequence the full recognition of the interrelated role of the State, the market, the community and families in the social organization of care (Faur, 2014; Rico, 2011); (iii) identification of the specific requirements for strengthening each of the circuits of social organization of care: paid work (profession circuit), unpaid work (duty circuit) and mutual assistance (help circuit) (Araujo Guimarães, 2019; Araujo and Vieira, 2020); (iv) social reorganization of care, through a review of social protection systems (Rico and Robles, 2016); (v) strengthening of care infrastructure and all other infrastructure related to care (Pautassi, 2011; Pautassi and Zibecchi, 2013); and (vi) adequate and clearly earmarked budgets for installation of adequate infrastructure, rights-based training for caregivers and detailed follow-up from the national level to the local level.

In brief, the pandemic has exposed the effect of sociodemographic vulnerabilities and social inequalities and has also brought to light new problems such as age discrimination. In addition to the health problems caused by the disease, there have been drastic changes in interpersonal relationships owing to factors such as lockdowns that severely affected the psychological and emotional health of the population, particularly older persons, with effects that are likely to be long-lasting. With regard to health services and care, ECLAC has highlighted that within the countries this comprises a complex organization of medical service providers and the homes of the sick. As mentioned, families take charge of the health care of their members, reflecting a transfer of government responsibility for timely and quality public health to families and especially to women (ECLAC, 2020c).

The social protection of older persons and defence of their rights in relation to the pandemic must therefore be a priority, based on the right to life, to non-discrimination, to live with dignity in old age and to health (ECLAC, 2020j).

C. Women

During the pandemic, gender inequality has been reflected, as in previous crises, in more harmful socioeconomic consequences for women, whose economic, physical and decision-making autonomy have all been affected. This is connected to different structural and emergency-related factors.

For example, in Latin America and the Caribbean women's participation in the labour market is more precarious and informal, and they are more exposed to the risk of unemployment. In a context of lockdowns, school closures and a need for care, when household members have become infected with COVID-19 there have been significant increases in the burden of unpaid domestic work shouldered by women (ECLAC, 2020d).

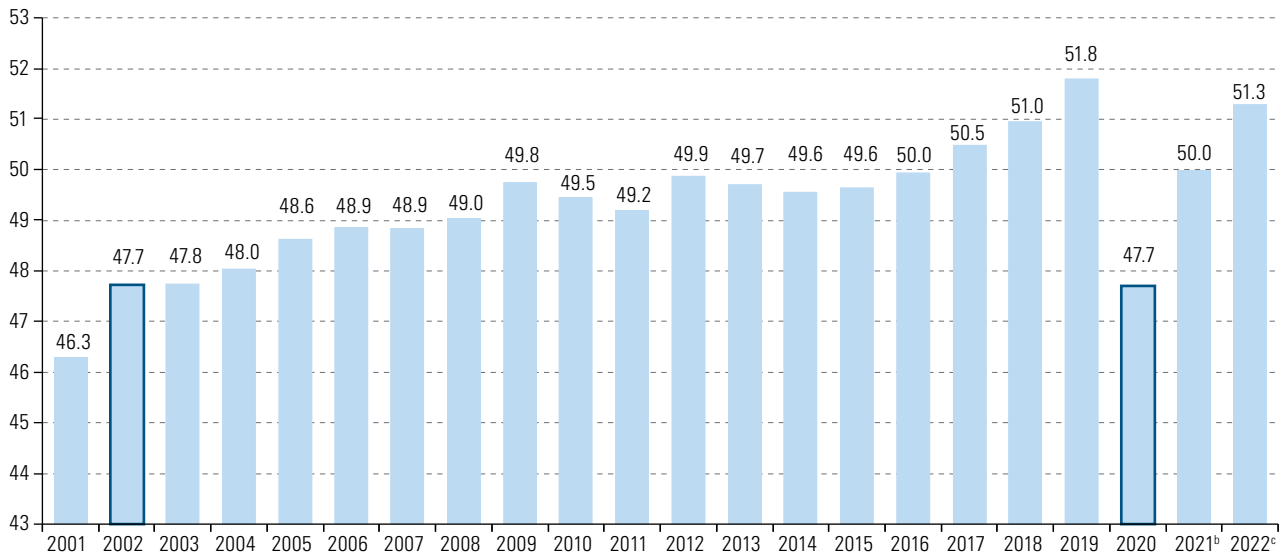
Women have also experienced the pandemic in different ways: accumulated disadvantages and intersectionality, indigenous or Afrodescendent origin, poverty, migration status, age and other characteristics have aggravated the effects on the labour market and on the performance of unpaid care and domestic work.

1. A historic reversal in women's economic autonomy

The pandemic has had a severe impact on employment, reflected in reductions in participation and employment rates and a larger rise in unemployment than in previous crises. In the second quarter of 2020, the region experienced the largest loss of working hours in the world, as a result of job losses and shorter working hours (ILO, 2020).

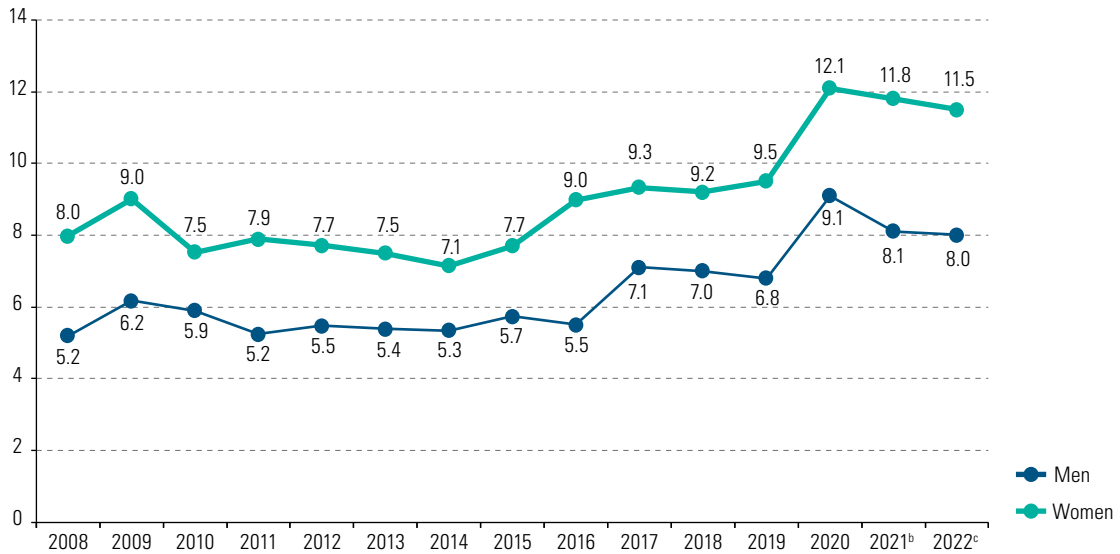
The crisis has affected women's employment to a greater extent than men's, following a sustained upward trend in women's labour force participation. The labour force participation rate for women has undergone an 18-year reversal because of the crisis, falling from 51.8% in 2019 to 47.7% in 2020, while for men it dropped from 75.5% to 70.8% over the same period. In 2022, women's participation rate is estimated to have climbed to 51.3%, close to the figure seen in 2018. This represents a return to the level seen four years previously, with half of women of working age out of the labour market (see figure II.4) (ECLAC, 2022a). In addition, women have higher unemployment rates than men, and despite the recovery since 2020 this gap has widened (see figure II.5).

Figure II.4
Latin America and the Caribbean (24 countries):[a] labour force participation rate for women, 2001–2022
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official figures from the countries and projections.
[a] Weighted averages for the following countries: Argentina, the Bahamas, Barbados, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Trinidad and Tobago and Uruguay. Figures for 2019 do not include data for the Bolivarian Republic of Venezuela.
[b] Estimated by ECLAC (2022b).
[c] ECLAC projection (2022b).

Figure II.5
Latin America and the Caribbean (24 countries):[a] unemployment rate, by sex, 2008–2022
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official figures from the countries and projections.
[a] Weighted averages for the following countries: Argentina, the Bahamas, Barbados, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Trinidad and Tobago and Uruguay. Figures for 2019 do not include data for the Bolivarian Republic of Venezuela.
[b] Estimated by ECLAC (2022b).
[c] ECLAC projection (2022b).

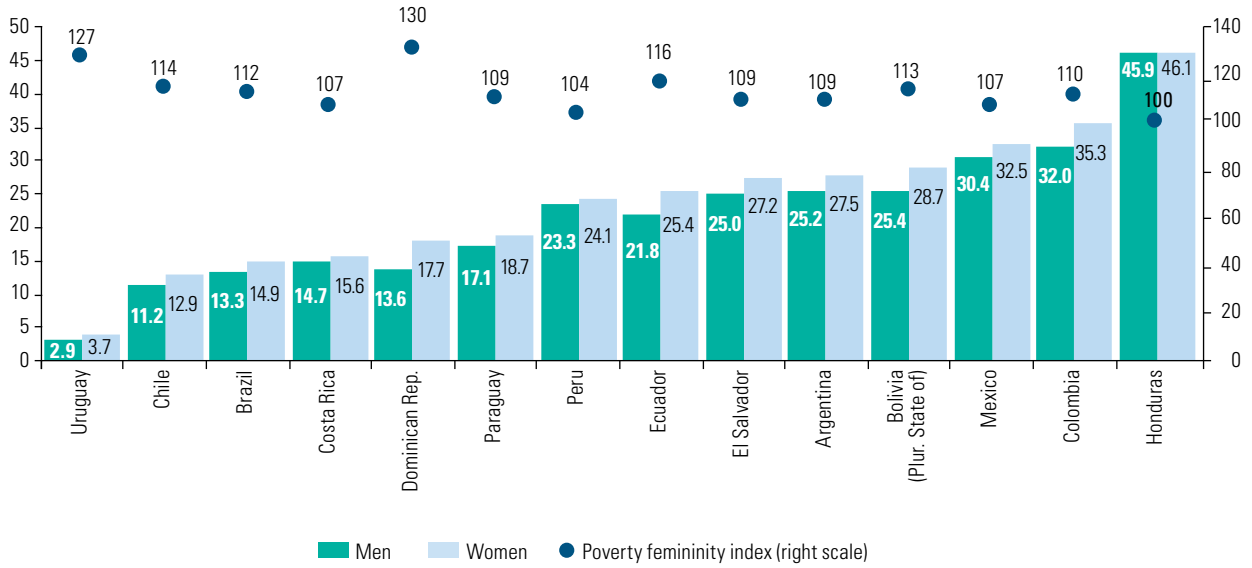
Women's labour force participation has been characterized by gender segregation both vertically (lower paying occupations) and horizontally (concentration in specific sectors and occupations), and a higher degree of informality. Most women work in traditionally underappreciated economic sectors and occupations, such as caregiving, which affects their wages and working conditions.

Gender inequalities intersect with ethnic and racial inequalities and are thus deepened. Indigenous and Afrodescendent women receive on average the lowest labour income, regardless of schooling levels or hours worked (ECLAC, 2020f and ECLAC/UNFPA, 2020). In addition, more than 85% of indigenous women in the labour force are in informal work, selling handicrafts or working in rural areas, putting them at risk of not receiving the financial assistance established by governments in response to the emergency.

ECLAC has estimated that the crisis has had a greater impact in highly feminized sectors such as commerce, manufacturing, tourism and paid domestic service. In 2019, sectors at high risk of production volume declines and employment losses as a result of measures taken to curb infections accounted for around 56.9% of women's employment and 40.6% of men's employment in Latin America; for the Caribbean, the figures were 54.3% for women's employment and 38.7% for men's. In addition, in 2021 some of the sectors most affected by the pandemic in terms of job losses, which have high female participation rates, showed signs of slower recoveries than sectors in which men are the majority. Consequently, women who have left the labour market are expected to remain in that situation for longer.

One of the main effects of the COVID-19 crisis has been a widespread increase in poverty, with women overrepresented. In all Latin American countries, women aged 25–59 have higher poverty rates than men (see figure II.6). Moreover, between 2019 and 2020, the proportion of women without their own income increased, resulting in an acute lack of autonomy (ECLAC, 2022a).

Figure II.6
Latin America (14 countries):[a] poverty rates by sex and poverty femininity index, people aged 20–59 years, around 2020
(Percentages and poverty femininity index values)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).
[a] Countries are ordered according to total poverty rates.
[b] The poverty femininity index is calculated as the ratio of the female poverty rate to the male poverty rate, multiplied by 100.

2. An unprecedented increase in the burden of unpaid domestic and care work

Before the pandemic, women in the region spent more than three times as much time on unpaid domestic work as men (ECLAC, 2021c).[7] This unfair social organization of care, with a burden that was already mostly shouldered by women before the pandemic, contributed to a deepening of inequalities during it.

The repercussions of COVID-19 significantly increased the burden of care work, both paid and unpaid, for several reasons. Households had to adapt to lockdowns, developing new routines and strategies to continue functioning daily, the first being preventive measures to avoid infection. The closure of educational establishments and care services for children and of most of those available to older persons, persons with disabilities and dependent persons, combined with enormous pressure on health systems, shifted the entire burden to the home. In the school environment, families were required not only to provide support for academic tasks, but also to develop skills for the use of digital platforms and to ensure that children and adolescents did not become totally disengaged from the education system despite the physical distancing.[8]

As a result, there was a huge and excessive burden of tasks that have historically been perceived and assumed to be women's responsibility, accompanied by an increase in the time required to perform them. This set of simultaneous tasks hampered the work performance of women with paid jobs, hindered women's attempts to join the labour market, and obstructed those who had lost their jobs and were attempting to find new work.

7 The contribution of domestic and care work was not as prominent in public discussions before the pandemic. However, estimates of the economic value of unpaid household work in Latin American and Caribbean countries put it at between 15.7% and 24.2% of GDP, with women contributing around 75% of this value (ECLAC, 2021c).

8 According to information collected by the United Nations Educational, Scientific and Cultural Organization (UNESCO), by mid-May 2020, more than 160 million students at all levels of education in Latin America and the Caribbean were not receiving face-to-face teaching (ECLAC/UNESCO, 2020).

The crisis showed that care work is not only distributed unequally, but is also a vector of inequality, which from the perspective of intersectionality is even more complex, as reflected by cases such as those of women with disabilities, indigenous or Afrodescendent women, older women or women living in rural areas.

There is a direct link between unpaid workloads and wage inequality, lower incomes, poorer educational outcomes, and physical and mental health stressors (United Nations, 2020i). In the context of the isolation, uncertainty and exhaustion created by the pandemic, ways of exerting emotional restraint were also needed in households to prevent further impacts on mental health. Thus, emphasis was placed on the need to integrate mental health into the COVID-19 response, to prevent an increase in linked cases of mental disorders, by integrating remote services such as telemedicine and helplines into the care toolkit; in some cases, this area was among the main objectives in countries' recoveries (PAHO, 2020).

3. Women on the front line of the pandemic response

Health and education services have been among the occupational sectors in most demand during the pandemic, as well as those linked to care in general, which have high female labour force participation rates. Added to all this are the family responsibilities of those who have work outside the home.

Women workers in the health sector have been among the most affected in terms of working conditions, owing to longer working hours, increased exposure to infection, higher demand because of staff shortages and overstretched health infrastructure, and fewer hours of care for their dependents. These factors, among others, created enormously taxing situations, given the need to respond to an unprecedented and prolonged crisis, resulting in extreme physical and mental exhaustion.

In the education sector, working conditions also changed significantly for women working as educators, who, despite keeping their jobs, generally moved en masse from face-to-face work to distance learning, without the training or right conditions to handle technological platforms and appropriate formats. This new demand led to longer working hours —as a result of new ways of planning and teaching classes— which, combined with unpaid domestic and care work, have deeply affected women, causing health problems linked to the tension and stress of teaching. The situation was even more difficult in educational establishments in communities where poverty increased and gender-based violence against women and girls continued.

According to a report by ECLAC and UNESCO (ECLAC/UNESCO, 2020) on the implementation of online distance learning since the beginning of the pandemic, 18 countries in the region used asynchronous formats, while just 4 offered live classes (Bahamas, Costa Rica, Ecuador and Panama). In addition, in 23 countries, educational programmes were broadcast on traditional media such as radio or television, which was a key innovative response for rural areas and isolated communities. In 2021, the process of returning to on-site classes began, in a growing effort to enable students to return to educational centres and re-join school communities.

Suspension of on-site activities at educational establishments also affected the jobs or income of those who provided indirect support for their operations and for the educational process, who were generally women —such as psychosocial support professionals, those in charge of extracurricular activities, food providers, and cleaning and health-care personnel linked to schools— who were not hired on a full-time basis, but temporarily, part-time or through outsourced services.

The paid domestic work sector has been one of the most affected by the pandemic. It is characterized by high levels of informality and low social security coverage, and is the weakest link in the care chain. Some 13 million people in Latin America and the Caribbean were engaged in paid domestic work in 2019, and 91.5% of them were women (ECLAC, 2021f).

According to estimates by the International Labour Organization (ILO, 2020c), at the beginning of June 2020, 69% of paid domestic workers in Latin America and the Caribbean were significantly affected by the lockdowns imposed by the pandemic, resulting in the loss of their jobs or a reduction in their working hours and income. That is the worst figure in the world and 20 percentage points above the global average (49%). Employment levels among female workers in the sector fell by 19.8% in the region between 2019 and 2020 (ECLAC, 2022a).

These job losses, which have affected the population as a whole, have had a greater impact on paid domestic workers, and it is likely that indigenous, Afrodescendent, older and migrant women are in a worse situation, especially if they have recently migrated or their migration status is irregular.

In 2020, just 25.5% of paid female domestic workers were affiliated or contributing to social security systems (ECLAC, 2022a). Informal work enabled irregularities such as termination of employment without compensation or imposed changes in agreed working conditions, schedules or tasks, while also exposing women workers to infection. Owing to their low salaries, many of these women do not have the capacity to save for contingencies, which makes them more vulnerable to labour abuses and leaves them with fewer alternatives for dealing with crises.

The situation of women in paid domestic labour, a sector that provides work to 8.3% of employed women in Latin America, illustrates many of the most complex problems women workers in the region face, and particularly those affecting older, indigenous, Afrodescendent and migrant women. Although some countries have made progress with formulation of regulations for the sector, 11.2% of paid domestic workers are living in poverty (ECLAC, 2022a). Many women head of households work in this type of occupation. According to the Regional Survey on the Impact of COVID-19 on Domestic Workers of the International Domestic Workers Federation (IDWF, 2021), 68% of workers support their families with their wages and in almost all cases (92%) this is the only household income (Valenzuela, Scuro and Vaca-Trigo, 2020).

In addition, in Latin America 51.6% of migrants are women and more than a third of them (35.3%) are engaged in paid domestic work (Valenzuela, Scuro and Vaca-Trigo, 2020). In the region there are several migration corridors of care workers towards Argentina, Chile and Costa Rica, as well as from Guatemala to the southern border of Mexico and from Haiti to the Dominican Republic. Panama and Brazil are also increasingly becoming destinations for women migrant paid domestic workers. Most of these female migrant workers come from neighbouring countries. Geographical proximity is an important factor in the decision to migrate, especially when migrants leave their family behind. However, in periods of tighter restrictions during the pandemic it was very difficult or impossible for migrants to return to their place of origin owing to border closures. They were also affected by increased difficulties in transferring money because of bank closures and depreciation of local currencies caused by the economic impact of the crisis. A specific problem that migrants have faced is not having a national identity document, which not only prevents them from entering formal work with social security, but in the pandemic has also hindered their integration, since it has prevented them from completing procedures online, leaving the home during lockdowns with the required permits, obtaining a current account or bank card, or contracting and paying for basic services and essential goods (Valenzuela, Scuro and Vaca-Trigo, 2020).

4. Effects of the pandemic on the physical autonomy of women and girls

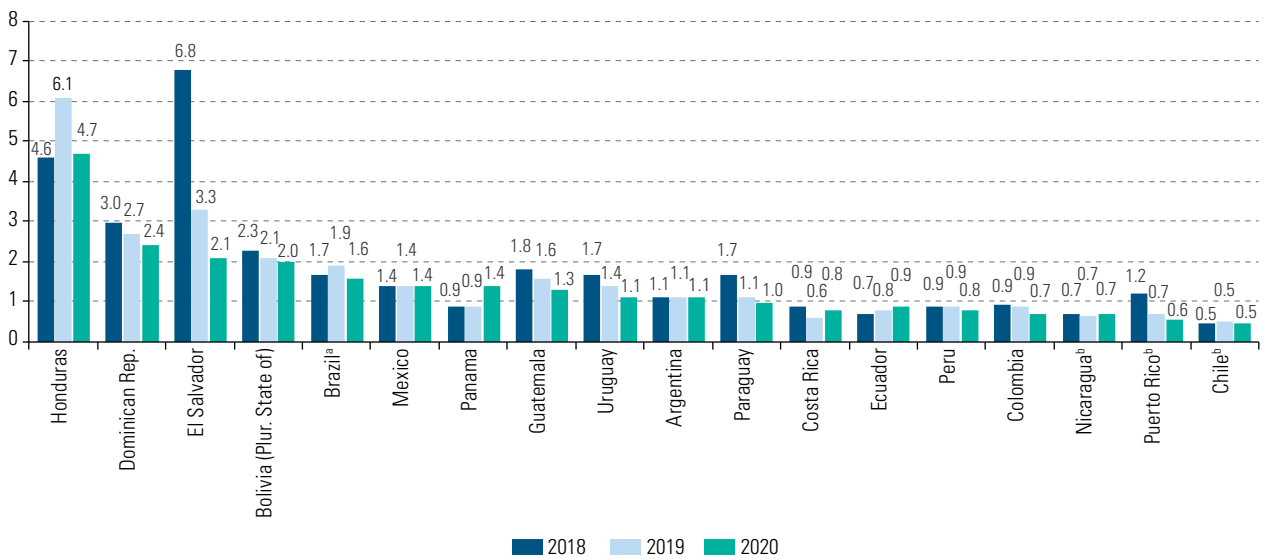
Gender-based violence has been described by the Secretary-General of the United Nations as a bona fide "shadow pandemic," because it affects at least one in three women (WHO, 2021). Government lockdown, physical distancing and movement restriction measures in response to the COVID-19 pandemic increased women's isolation from their support networks and have put up additional barriers to access to essential services (ECLAC, 2020l). Governments in several countries reported a significant rise in calls to helplines or other support services for women survivors of violence during the strictest lockdowns.[9] This, together with analysis of what happened in previous emergency situations and data on the prevalence of violence in intimate partner relationships or over the course of women's lives (WHO, 2021) led to a global alert on the risk of an increase in such violations of women's and girls' human rights. The governments of Latin America and the Caribbean responded to this alert through various strategies, as described in the ECLAC COVID-19 Observatory in Latin America and the Caribbean, which contains information on more than 106 measures taken to address violence against women in the pandemic.[10]

9 Information compiled by the Gender Equality Observatory for Latin America and the Caribbean.
10 See [online] https://www.cepal.org/en/topics/covid-19.

The public responses have been varied. Some countries (Argentina, Colombia, Dominican Republic, Honduras and Mexico) have classified all or part of the services to address violence against women as essential; in most cases, instructions were drafted or decrees were enacted to ensure continued operation of certain judicial services and automatically extend protection measures. Various mechanisms were also implemented to strengthen reporting channels, and awareness-raising campaigns were conducted through different media and channels. However, adaptation by public officials to operating services remotely has been very complex and limited in the justice sector, increasing the risk of the impunity traditionally associated with such crimes.

Taking the December 2021 figures, feminicides or femicides reported annually by countries to the ECLAC Gender Equality Observatory for Latin America and the Caribbean had not varied significantly over the preceding three years (see figure II.7). This reveals a persistent pattern that is resistant to decline in crises[11] and indicates that the different forms of violence are deeply rooted practices, conduct and behaviour, which are generally not rejected outright. Violence against indigenous and Afrodescendent women and girls is equally alarming, since in these cases gender-based violence is combined with violence owing to racism and discriminatory inter-ethnic relations, often aggravated by overexploitation of natural resources, internal armed conflicts or the persecution and criminalization of women defenders of indigenous peoples' and Afrodescendent communities' lives and territories. In addition, there is concern that women and girls who are survivors of violence frequently do not have access to psychosocial support services or assistance in reporting such events (ECLAC and others, 2020; ECLAC, 2020e).

Figure II.7
Latin America (18 countries and territories): feminicides or femicides, 2018–2020
(Rates per 100,000 women)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), Gender Equality Observatory for Latin America and the Caribbean [online] https://oigcepal.org/en.
[a] Brazil does not have a single register of feminicide cases. The National Justice Council only records new cases that enter the legal system.
[b] Nicaragua and Puerto Rico only report cases of femicide committed by a partner or ex-partner. Until 2020, Chile also reported only cases of intimate femicide; however, the country amended its legislation in 2020 and extended the definition of femicide to the generic crime of homicide of a woman because of her gender.

The pressing need to address the pandemic also caused widespread interruption of reproductive and non-reproductive sexual health services. In 2020, there was a decrease in the coverage of sexual and reproductive health services, expressed among other ways in a decline in the number of prenatal check-ups and births attended by qualified personnel in health centres, as well as a reduction in access to counselling and family planning services for various reasons. Pregnant women's fear of attending health facilities because they might be infected with the

[11] Sexual violence against women in public spaces, especially when they are alone, has continued during the crisis.

virus and, in some cases, the reassignment of health-care staff and infrastructure to patients with COVID-19 had resulted in a 40% decrease in pregnancy check-ups in 27 countries in the region by August 2020 (PAHO, 2020b). This led to warnings of possible complications during pregnancy, in childbirth and with regard to newborn health, and even an increase in maternal and neonatal mortality. Moreover, in a WHO survey, 40%–50% of countries reported partial or severe interruptions in family planning and contraceptive health care (PAHO, 2021b). In this regard, alarms were also raised that these limitations on care could have consequences for access to modern contraceptive methods and could increase unwanted pregnancies and teenage pregnancies, although there is still no information available from the countries on this subject. The inequalities in sexual and reproductive health that existed before the pandemic, which disadvantage women in the most deprived social groups such as indigenous peoples and Afrodescendent populations (see box II.2), are also likely to have deepened, especially considering the limited supply of culturally relevant services (ECLAC and others, 2020; ECLAC, 2020e).

Box II.2
The pandemic and women in Colombia: threefold cascading effects

A study by the United Nations Population Fund (UNFPA) in Colombia on the impact of the COVID-19 pandemic on sexual and reproductive health in that country provides an analysis based on a framework called the "triple cascade" (a concept proposed by civil society), which interlinks: (i) the direct effects of COVID-19 on sexual and reproductive health; (ii) the effects of the measures taken to contain the pandemic; and (iii) the effects of the socioeconomic crisis triggered by the pandemic.

The first cascading effect can be found by comparing sexual and reproductive health indicators for 2019 and 2020. Data from the National Public Health Monitoring System of the National Institute of Health of Colombia show a clear and significant rise in maternal mortality (the maternal mortality ratio climbed from 46.7 per 100,000 live births in 2019 to 65.5 in 2020), an increase in the rate of congenital syphilis (from 1.85 per 1,000 live births in 2019 to 2.85 in 2020), a sharp decline in provision of contraceptive counselling, advice and access, which in the most critical month of 2020 (April) reached 62.1% of the level seen in 2019, and a decrease of 2% in induced abortion care from 2019 to 2020.

The second cascading effect is reflected in the unequal effects on women, since some groups of women had the ways and means to deal with and mitigate the difficulties of the pandemic, while other groups did not. In that regard, the increase in the maternal mortality ratio in the 10–14 age group was 126.0%, three times higher than the national average. Among indigenous women, the downtrend in maternal mortality reversed sharply, with the maternal mortality ratio climbing by 23% to 230.7 per 100,000 live births in 2020. In the case of Afrodescendent women, the maternal mortality ratio rose by 40.3% in 2020 to 114.9 per 100,000 live births. The largest reductions in the provision of contraceptive services occurred among adolescents and in border departments of Colombia, such as Guainía, and island departments, such as San Andrés, Providencia and Santa Catalina. In terms of induced abortion, adolescents were once more the age group most affected by the decline in services.

Lastly, in keeping with the "triple cascade" concept, the effects of the pandemic on these indicators and their relationships with territorial socioeconomic indicators suggest that decreases in care and increases in maternal mortality and sexually transmitted infections tended to be more marked in municipalities with higher levels of multidimensional poverty.

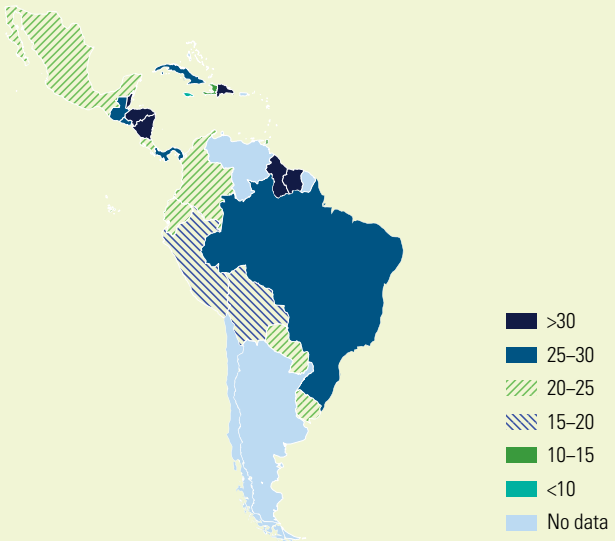
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of A. C. González Vélez and S. Valencia, "La salud sexual y reproductiva en tiempos de COVID: un estudio sobre sus efectos en Colombia. Estudio realizado por UNFPA Colombia", unpublished, 2022.

Child marriages and early unions are another factor that must be considered when analysing violations of young girls' and adolescent girls' rights and potential intensification of those violations during the COVID-19 pandemic. Recent studies have shown that child marriages and early unions expose young and adolescent girls to violence and an excessive caregiving burden at a time when their educational progress has not yet become consolidated (ECLAC, 2021a). Both of these situations became more widespread as a result of lockdowns. Prospects for personal development being limited to the domestic environment, together with dropout from education, limits girls' opportunities to interact with others and hampers development of physical and economic autonomy and integration into society, all of which worsened during the pandemic (see box II.3).

Box II.3
Child marriage and early unions, factors that deepen gender inequality in Latin America and the Caribbean

Child marriage is a widespread reality for young and adolescent girls in Latin America and the Caribbean: in 2020, 22.1% of women aged 20–24 had married or entered into an early union before the age of 18, while globally this percentage is 19.4%.[a] However, there are significant differences among countries in the region, as shown on the map.

Latin America and the Caribbean (24 countries): proportion of women aged 20–24 years who were married or in a union before age 18, latest year for which information is available
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Global SDG Indicators Database [online] https://agenda2030lac.org/estadisticas/regional-sdg-statistical-profiles-target-1.html?lang=en.
Note: The countries included are Barbados, Belize, Brazil, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Saint Lucia, Suriname, Trinidad and Tobago and Uruguay.

Being married or in union before the age of 18 increases the probability of becoming a mother at a very young age, just as being pregnant before the age of 18 increases the chances of young and adolescent girls entering into unions or getting married. In the region, most women who were married as children gave birth before the age of 18; 8 in 10 did so before the age of 20 (UNICEF, 2019).

For thousands of young and adolescent girls, pregnancy entails spending most of their time on care work, putting their education, labour income and development opportunities at risk (UNFPA, 2020; Working group of the Joint Inter-Agency Programme to End Child Marriage and Early Unions in Latin America and the Caribbean, 2021). The school attendance rates for adolescent girls who have had children are considerably lower than those for their peers who have not. For young and adolescent girls, limitations on exercise of sexual and reproductive rights therefore lead to a repetition of the sexual division of labour that results, at an early age, in socioeconomic precariousness, social isolation and restrictions on their comprehensive development.

Child, early and forced marriages and unions have been declared a harmful practice that violates young and adolescent girls' human rights. States have undertaken to eliminate such marriages and unions as part of the Sustainable Development Goals. In Latin America and the Caribbean, 11 countries and territories prohibit all marriages before the age of 18 (Antigua and Barbuda, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, Puerto Rico, and Trinidad and Tobago), as recommended by various human rights instruments; 13 countries and territories allow marriage from the age of 16 with adult authorization (Barbados, Bolivarian Republic of Venezuela, Brazil, Chile, Cayman Islands, Dominica, Jamaica, Nicaragua, Paraguay, Peru, Plurinational State of Bolivia, Turks and Caicos Islands and Uruguay), and 6 allow it before the age of 16 for qualified reasons (Anguilla, Argentina, Colombia, Cuba, Guyana and Saint Kitts and Nevis).[b]

Box II.3 (concluded)

However, to achieve SDG target 5.3 ("eliminate all harmful practices, such as child, early and forced marriage…"), countries must redouble their efforts in terms of public policies that, firstly, strengthen prevention of such marriages by guaranteeing universal access to quality non-sexist education and sexual and reproductive health services, as protective factors, and, secondly, advance programmes that support young and adolescent girls in unions or marriages so that they have the capacity to face gender inequalities.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Working Group of the Joint Inter-Agency Programme to End Child Marriage and Early Unions in Latin America and the Caribbean, "Los matrimonios y uniones infantiles, tempranos y forzados: prácticas nocivas profundizadoras de la desigualdad de género en América Latina y el Caribe", *Documentos de Proyectos* (LC/TS.2021/186), Santiago, CEPAL, 2021; United Nations Population Fund (UNFPA), *Socioeconomic consequences of adolescent pregnancy in six Latin American countries. Implementation of the MILENA methodology in Argentina, Colombia, Ecuador, Guatemala, Mexico and Paraguay*, Panama City, 2020; and United Nations Children's Fund (UNICEF), *A Profile of Child Marriage and Early Unions in Latin America and the Caribbean*, 2019 [online] https://www.unicef.org/lac/en/reports/profile-child-marriage-and-early-unions.

[a] UNICEF estimates for, proportion of women aged 20–24 years who were married or in a union and before age 18 (adapted from SDG indicator 5.3.1). See [online] https://unstats.un.org/sdgs/dataportal/database.

[b] See Gender Equality Observatory for Latin America and the Caribbean [online] https://oig.cepal.org/en/laws/9.

5. There is still a lack of women in political decision-making

Women represent 72.7% of those employed in the health sector in the region, and have been on the front line of the direct response to the pandemic (ECLAC, 2022a). However, public measures to address the pandemic have been established in decision-making bodies where they have a very limited presence. Indeed, in 2020 only 5 of the 20 health ministers in Latin America and 7 of the 22 in the Caribbean were women. In the same year, women made up no more than 23% of the members of the scientific councils that advised governments on how to deal with the crisis (ECLAC, 2020k). This low participation hampers incorporation of key gender issues into the response to the health crisis in the region.

The gaps in women's participation in decision-making spaces in management of the pandemic follow the same general pattern as those in leadership positions in public administration: according to data from the Inter-Parliamentary Union (IPU) and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women, 2020), in 2020 just 4 Latin American countries (Colombia, Costa Rica, Nicaragua and Peru) had 50% or more ministerial portfolios with women ministers; in 3 Latin American countries (Ecuador, El Salvador and Mexico) and two Caribbean countries (Grenada and Guyana), women were in charge of 35%–49.9% of ministries; in 12 Latin American countries (Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Cuba, Dominican Republic, Guatemala, Honduras, Panama, Paraguay, Plurinational State of Bolivia and Uruguay) and 10 in the Caribbean (Antigua and Barbuda, Bahamas, Barbados, Dominica, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago), women were in charge of under 35% of ministerial portfolios.

Furthermore, although the presence of women has increased in recent years, most representatives in legislatures are still men: in October 2021, women held an average of 33.6% of seats in national parliaments of the region (lower chamber or single chamber), according to data from the Inter-Parliamentary Union.[12]

D. Migrants

Among the diverse detrimental effects of the pandemic on the regional population, those on migration processes and migrant communities are among the most severe. Restrictions owing to border closures have increased vulnerability of travelling migrants. In addition, the living conditions of many of them have worsened due to overcrowding and informal labour. Simultaneously, migrants have performed front-line jobs that are vital for social reproduction.

[12] See [online] https://oig.cepal.org/en/indicators/legislative-power-percentage-women-national-legislative-body-0.

In the Montevideo Consensus on Population and Development, States agreed to implement measures to protect the rights of all migrants regardless of their migration status. As a set of measures, it predated the global initiatives that have flourished in recent years and is an instrument that can be used address the hostility and rejection surrounding migration in many countries (Mukumbang, 2021), especially in the context of restrictions on individual freedoms imposed by the pandemic (Araujo and Sarmiento, 2021).

From the perspective of the Montevideo Consensus, the call is for border sovereignty to be managed in accordance with human rights and international agreements that protect refugees, asylum seekers and migrants. Public health measures do not exempt States from fulfilling the principle of non-refoulement, or from prohibiting arbitrary detention and collective expulsions. Similarly, all border health measures must be non-discriminatory, necessary, proportional and subject to constant review. While it is understood that States have the right to return people to their countries of origin, in the context of the pandemic, special attention needs to be paid to the risk to which migrants are exposed upon returning to countries highly affected by the spread of the virus, with weak health systems, or where returnees place significant stress on health institutions (Ikotun Akhigbe and Okunade, 2021). A humanitarian alternative, in accordance with human rights and international treaties, is to welcome migration during the health crisis, providing health care and access to social assistance.

1. Differential impacts of the pandemic on the migrant population and a lack of information

From the point of view of policy diagnosis and formulation, there is little official information on the impact of the pandemic on migrants, on institutional support, health measures and direct social assistance to the migrant and refugee population, or on the effectiveness of public policy actions. Different governments in the region have made efforts to provide socioeconomic support to the population in response to the pandemic, but information on the impact of this assistance on the migrant population is still limited. Such is the case, for example, for direct cash transfers to individuals and families, which have been reported by different governments, although their reach within the migrant population is not known.[13]

Although official information is scarce, it is very likely that migrants have been among those most affected by the pandemic, not only those who are residents, but also those in transit, those whose status is irregular, asylum seekers, returnees, and even those who had planned to move from their countries of origin. For migrant individuals and families who have settled in destination areas, the more severe impact of the pandemic is related to four dimensions: (i) a higher level of poverty among recent migrants and refugees; (ii) housing conditions, in that they live in more precarious dwellings, with more limited connectivity to basic services (electricity, drinking water and sanitation), which are more overcrowded, increasing the risk of infection; (iii) employment in front-line jobs, which are more exposed and more precarious, especially in the case of migrant women, who suffer disproportionately from job losses;[14] and (iv) limited access to health care.

At the international level, various studies have shown that the migrant population is more vulnerable in crisis situations related to health status, owing to the social determinants of health (Espelt and others, 2016; Ramírez and Álvaez, 2013; Arellano and others, 2008) and the structural disadvantage factors that affect them. This appears to be the case for the COVID-19 pandemic. Studies conducted in countries with robust information systems and with disaggregation of official epidemiological statistics for the first wave of infection showed a significant difference between nationals and foreigners in terms of infections and deaths. In Europe, several studies have reported the highest level of infection among migrants from regions with lower levels of development. In Spain, exposure to infection was reported to be higher among people from sub-Saharan Africa and Latin America and the Caribbean (Guijarro and others, 2021), while Norway (Indseth and others, 2021) and Sweden (Hansson and others, 2020) reported significant numbers of deceased or infected people originating from Africa, Asia and South America. In the United States, the incidence of COVID-19 in African American and Latino populations has been disproportionately high with respect to their representation within the total population (Tirupathi and others, 2020).

[13] However, there are countries, such as Brazil, where the migrant population is recognized as rights-holders, which have provided them with assistance without discrimination with respect to their administrative status.

[14] See for example Fernández and others (2021), which concludes that in Brazil women and people without formal jobs had the highest rates of job losses during the pandemic.

In view of the international data on the repercussions of the pandemic for migrants, data is urgently required in the different countries of the region. Objective 1 of the Global Compact for Safe, Orderly and Regular Migration calls for countries to "collect and utilize accurate and disaggregated data" on the migrant population as a basis for evidence-based policies. Likewise, the Pan American Health Organization (WHO/PAHO, 2019) has drawn attention to the need to have health information on the migrant population throughout their journey, recording the treatments received and the compatibility of therapies applied to the same person in different countries. This state of affairs is not only restricted to the current health situation, and also affects chronic health conditions of migrants.[15]

The institutional barriers and administrative obstacles faced by migrants in their access to public health systems are well-known, and preliminary information suggests there is a lack of trust in the care received in the public system. Regarding access to public health, availability and affordability are territorial and economic factors that limit access (Cabieses, Bernales and McIntyre, 2017). Distrust relates to an individual and subjective view of health workers' capacities and their interest in a patient's wellbeing, which, in the case of irregular migrants, limits access to health systems. Subjective distrust (Cabieses, 2020; Zapata and Prieto Rosas, 2020) leads to scepticism regarding the quality of the services that a person will receive and suspicion that, when being attended, this situation or the information derived from it may put them at risk. This is especially pertinent in the case of irregular migrants, who may not seek diagnosis of symptoms for fear of being deported, punished or detained.

Given the social determinants of access to health care and barriers to it, overcrowded housing, and vulnerability resulting from segmented integration into the formal and informal labour markets in niches of commerce and services and in front-line activities, with little or no social protection, it can be assumed that the migrant population is more affected by infections, hospitalization and even death. However, two years into the pandemic there is no wide-reaching empirical information available in the region to support this assertion. Similarly, there are signs that the migrant population found fault with the health information provided and the social benefits available during the pandemic were insufficient (Cabieses, 2020; Zapata and Prieto Rosas, 2020). A report prepared by several civil society organizations in Mexico (FJDRL and others, 2020), highlights that detention and deprivation of liberty have severe physical and mental health consequences for migrants, who are held in holding centres and short-stay facilities and face a high risk of infection, without physical distancing measures, adequate hygiene, preventive practices or medical care.

Although the migrant population is vulnerable in terms of health, there is a paradox that despite being at greater risk of being affected by the pandemic, migrants face greater limitations on access to vaccination programmes (see table II.1).

Few countries have published official information on national vaccination coverage of migrants or refugees. However, there are press reports of partial vaccinations for foreigners in local administrative units. It is essential to continue to call for universal and free-of-charge vaccination processes at the national level, preventing the development of pockets without vaccination, as has been identified in other regions, and reducing the requirements that different local administrative units impose.

2. The need for State cooperation for safe, orderly and regular migration

Given that there are more than 40 million migrants in the region (ECLAC, 2019f), it is crucial to have effective mechanisms for safe, orderly and regular migration. Understanding this situation enables development of public policies, programmes and actions that ensure respect for migrants' human rights and progress toward migration that is protected in every sense.

[15] Medical records are private documents and are protected by law. Therefore, access to them and the information in them must be subject to protocols that prevent their use by administrations to control irregular migration.

Table II.1
Latin America and the Caribbean (24 countries): specific vaccination programmes for the migrant population and official calls for vaccination of migrant populations regardless of migration status, 2020–2021

Country	Vaccination programmes for the migrant population	Official calls for vaccination of the migrant population regardless of migration status
Antigua and Barbuda	-	-
Argentina	Yes	Yes
Belize	Yes	-
Bolivia (Plurinational State of)	Yes	-
Brazil	Yes	Yes
Chile	Yes	Yes
Colombia	Yes	Yes
Costa Rica	Yes	Yes
Ecuador	Yes	Yes
El Salvador	-	-
Grenada	-	-
Guatemala	-	-
Guyana	Yes	-
Mexico	Yes	Yes
Panama	Yes	Yes
Paraguay	Yes	-
Peru	Yes	Yes
Saint Kitts and Nevis	Yes	.
Saint Lucia	-	-
Saint Vincent and the Grenadines	-	-
Suriname	-	-
Trinidad and Tobago	-	-
Uruguay	Yes	-
Venezuela (Bolivarian Republic of)	-	-

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from the Office of the United Nations High Commissioner for Refugees (UNHCR), "Coronavirus: vaccination", ACNUR Brazil [online] https://help.unhcr.org/brazil/en/coronavirus-3/coronavirus-vaccination/; B. del Castillo, "Las trabas de los migrantes para acceder a la vacuna contra el COVID-19", *La Tercera*, 30 April 2021; V. Chávez, "México inicia vacunación contra COVID a migrantes que cruzan por el país", *El Financiero*, 20 September 2021 [online] https://www.elfinanciero.com.mx/nacional/2021/09/20/mexico-inicia-vacunacion-contra-covid-a-migrantes-que-cruzan-por-el-pais/; Inter-American Commission on Human Rights (IACHR), *Situation of human rights in Brazil*, Washington, D. C., 2021; ECLAC, *Preliminary Overview of the Economies of Latin America and the Caribbean, 2021* (LC/PUB.2022/1-P), Santiago, 2022; EFE, "Vacunas para migrantes indocumentados y otras claves de la COVID en América" [online] https://www.efe.com/efe/america/sociedad/vacunas-para-migrantes-indocumentados-y-otras-claves-de-la-covid-en-america/20000013-4648461; Buenos Aires provincial government, "La población extranjera podrá inscribirse en la campaña de vacunación bonaerense", 11 May 2021 [online] https://www.gba.gob.ar/jefatura/noticias/la_poblaci%C3%B3n_extranjera_podr%C3%A1_inscribirse_en_la_campa%C3%B1a_de_vacunaci%C3%B3n_bonaerense; Pan American Health Organization (PAHO), *Guidance Document on Migration and Health, 2019* [online] https://www.paho.org/en/file/52173/download?token=pSPuqrLo; SWI, "Costa Rica abre la vacunación contra COVID-19 a migrantes irregulares", SWI swissinfo.ch, 18 September 2021 [online] https://www.swissinfo.ch/spa/coronavirus-costa-rica_costa-rica-abre-la-vacunaci%C3%B3n-contra-covid-19-a-migrantes-irregulares/46958414.

The threats to which migrants are exposed have been widely and vigorously denounced, and in particular the most vulnerable, such as women, children and adolescents, sexual minorities and those belonging to indigenous and Afrodescendent peoples (ECLAC, 2020e). These threats include: (i) trafficking in persons and rejection of asylum seekers; (ii) criminalization of undocumented migration; (iii) administrative limitations on the exercise of rights; and (iv) partial or restricted inclusion in social protection systems, including health-care systems (Martínez Pizarro, 2020). In particular, in a context of heightened risks and vulnerability for the migrant population along migration routes owing to border closures, the region must comprehensively address: (i) rapidly changing and heterogenous migration patterns; (ii) increasingly complex and mixed flows along existing migration routes; and (iii) demand for international protection.

The Montevideo Consensus on Population and Development and the Global Compact for Safe, Orderly and Regular Migration focus on the need for joint and integrated action in the region to ensure respect for the human rights of migrants and to promote inclusion of these groups in destination countries (Martínez Pizarro, 2020). Among the objectives to ensure safe, orderly and regular migration, objective 11 of the Compact is to "manage

borders in an integrated, secure and coordinated manner" (United Nations, 2019, p. 6) and in the Montevideo Consensus, States agreed to "strengthen cooperation between countries of origin, transit and destination to address the causes and challenges of irregular migration, so as to generate safe, orderly, humane migration conditions through bilateral arrangements for labour force mobility and ensure protection of the human rights of migrants" (ECLAC, 2013b, p. 27).

E. Indigenous peoples in Latin America-Abya Yala

1. Indigenous peoples: the demographic background and its implications in the context of the pandemic

It is estimated that 17 countries of Latin America-Abya Yala are home to 57.7 million people belonging to one of more than 800 indigenous peoples in the region, representing around 9.5% of the total population (see table II.2).[16] Indigenous peoples' demographic profiles are heterogeneous: while in some countries they account for over 40% of the population (Guatemala and the Plurinational State of Bolivia), in others they represent under 5% (Argentina, Bolivarian Republic of Venezuela, Brazil, Colombia, Costa Rica, El Salvador, Paraguay and Uruguay). Moreover, countries differ in terms of the number of peoples within in their territorial jurisdictions. In this regard, Brazil, Colombia and Mexico are the most ethnically diverse (ECLAC, 2020f and 2014b). Indigenous peoples are at different stages of demographic transition, and there is great variability both among countries and among the peoples that inhabit them. The most recent censuses have shown that, despite still having younger population structures than the non-indigenous population, these populations are also beginning to experience ageing processes, as seen in Argentina, Chile, Costa Rica and Uruguay (ECLAC, 2020f).

In terms of gender composition, the 2010 census round showed rates of femininity rising with age among older persons, reflecting higher female survival in most countries in the region (Del Popolo, 2017). Recent censuses continue to show this pattern, as reflected in figure II.8. In the cases of Chile and Peru, a predominance of women is noticeable and systematically increases from the age of 60 onward, while in the rest of the countries it begins to increase after the age of 80. In Chile, among people aged 85 and over, there are 166 indigenous women for every 100 indigenous men, and in Peru this ratio is 148 to 100.

COVID-19 has caused more deaths among older persons and, in the case of indigenous peoples, may cause an irreversible cultural loss, since it is the older members who safeguard wisdom and collective memory, which must be transmitted for the cultural reproduction of the people. In addition, indigenous women act as healers and caregivers. Women have also had to face unequal access to opportunities throughout their lives, with a negative cumulative effect on their social, economic and psychological well-being, which in the case of indigenous women is amplified by their ethnicity.

Figure II.8 also shows an "atypical" female predominance in young persons and adults in Guatemala and Mexico, starting at 20 and 25 years of age, respectively. This behaviour may be related to the gender selectivity that characterizes international migration —in this case mainly male emigration— and to different mortality rates linked to violence and assassinations of territorial defenders (Del Popolo, 2017; ECLAC, 2020f). It is vital to examine demographic relations in the different territorial and cultural contexts of indigenous peoples, as these can have decisive impacts on the lives of indigenous women and their communities (Del Popolo, 2017).

[16] In this section a decision was made to include the name Abya Yala to refer to the Americas, given that indigenous peoples' organizations and establishments have adopted this name for the continent, based on the name given to it by the Guna people of Panama and Colombia before the arrival of Christopher Columbus and the Europeans. It is not an official name used by the United Nations. Literally, it means land in full maturity or land of lifeblood, noble land that welcomes all. Since the First Continental Meeting of Indigenous Peoples, held in Ecuador in 1990, the indigenous peoples of the region have progressively begun to adopt the name Abya Yala as part of formulation of a shared political project of epistemological decolonization, questioning the names of foreign origin given to their territories. The content of this section refers specifically to the indigenous peoples of Latin America.

Table II.2
Latin America (17 countries): population self-identifying as indigenous, according to the latest census and estimates to 2021
(Numbers of persons and percentages)

Country, census year	Census population	Indigenous population	Indigenous population *(percentages)*	Estimated indigenous population, 2021[a]
Argentina, 2010	40 117 096	955 032	2.4	1 094 540
Bolivia (Plurinational State of), 2012	10 059 856	4 176 647	41.5	4 910 670
Brazil, 2010	190 755 799	896 917	0.5	1 069 967
Chile, 2017	17 574 003	2 175 873	12.4	2 382 333
Colombia, 2018	43 309 477	1 905 617	4.4	2 255 697
Costa Rica, 2011	4 301 712	104 143	2.4	123 337
Ecuador, 2010	14 483 499	1 018 176	7.0	1 252 193
El Salvador, 2007	5 744 113	13 310	0.2	13 037
Guatemala, 2018	14 901 286	6 491 199	43.6	7 956 939
Honduras, 2013	8 303 771	646 244	7.8	784 913
Mexico, 2020[b]	126 014 024	24 455 845	19.4	25 280 302
Nicaragua, 2005	5 142 098	321 753	6.3	422 250
Panama, 2010	3 405 813	417 559	12.3	538 934
Paraguay, 2012	6 435 218	117 150	1.8	129 953
Peru 2017[c]	29 381 884	7 628 308	26.0	8 673 449
Uruguay 2011[d]	3 251 654	76 452	2.4	83 644
Venezuela (Bolivarian Republic of), 2011	27 227 930	724 592	2.7	775 034
Total	550 409 233	52 124 817	9.5	57 747 192

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special processing of census microdata. Mexico data: Instituto Nacional de Estadística y Geografía (INEGI), Censo de Población y Vivienda 2020 [online] https://www.inegi.org.mx/programas/ccpv/2020/#Tabulados; Paraguay data: Directorate General for Statistics, Surveys and Censuses (DGEEC), Pueblos indígenas en el Paraguay: resultados finales de población y viviendas 2012, Fernando de la Mora, 2014.

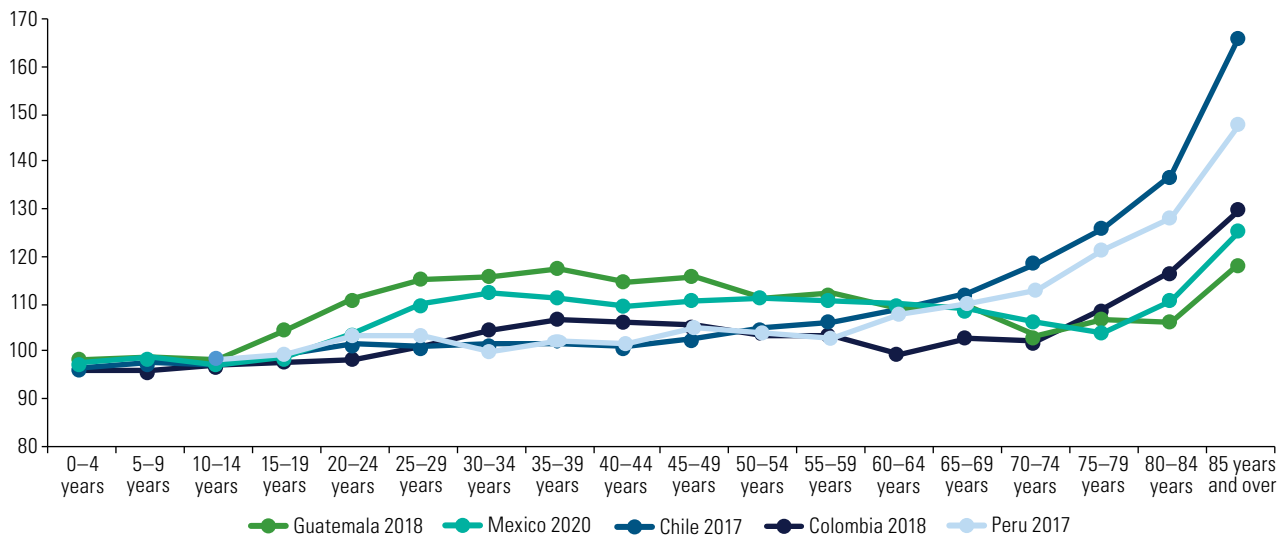
[a] The estimate for 2021 was obtained by applying the percentage of indigenous population from the last census to the total estimated population prepared by the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, Revision 2019.

[b] The indigenous self-identification question was put to the population aged 3 years and over. In the total shown, it is assumed that the proportion of indigenous population in the 0–2 years age group is the same as in the total for 3 years and over.

[c] The ethnicity question was put to the population aged 12 years and over. In the total shown, it is assumed that the proportion of indigenous population in the 0–11 years age group is the same as in the total for 12 years and over.

[d] Two questions on ethno-racial ancestry were included, one with multiple response categories, which yielded a total population of 159,319 indigenous people, and the other asking about "main" ancestry, which yielded the figures shown in the table.

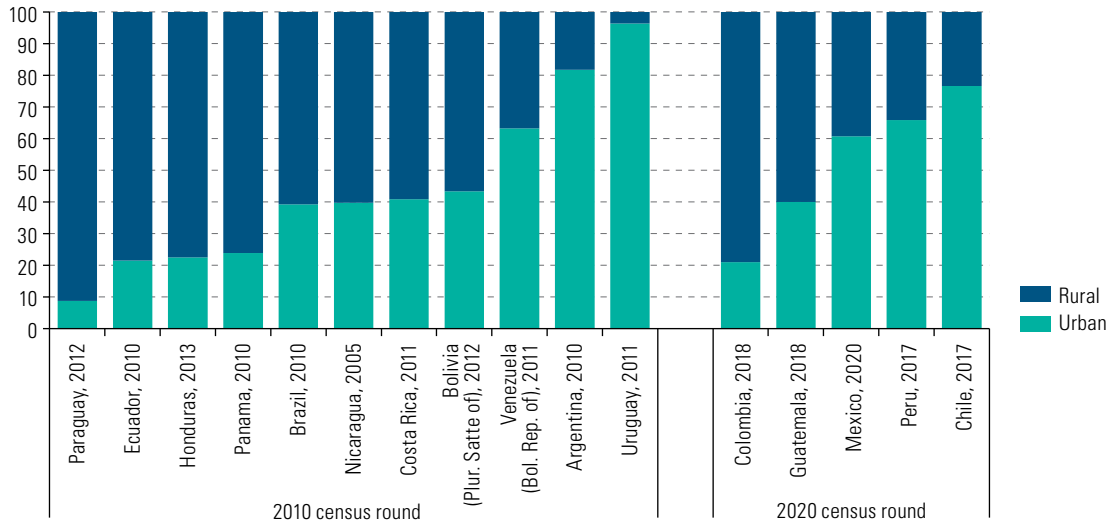
Figure II.8
Latin America (5 countries): femininity ratio of the indigenous population by age group, 2020 census round
(Number of women per 100 men)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special processing of census microdata.
Note: In the case of Mexico, indigenous self-identification was used from the age of 3 years and in the case of Peru, from the age of 12 years.

Although in most of the countries of Latin America-Abya Yala indigenous peoples still reside in rural areas, often linked to territories they have inhabited historically, migrations and urbanization have progressively changed this pattern, and it is now estimated that more than half of the region's indigenous population resides in cities (see figure II.9). Data from the 2010 census round showed that in 3 of 11 countries, most indigenous people lived in cities (Argentina, Bolivarian Republic of Venezuela and Uruguay); a similar situation was found in 3 of the 5 countries with more recent censuses (Chile, Mexico and Peru).

Figure II.9
Latin America (16 countries): relative distribution of the indigenous population by area of residence, latest available census
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special processing of census microdata. Mexico data: Instituto Nacional de Estadística y Geografía (INEGI), Censo de Población y Vivienda 2020 [online] https://www.inegi.org.mx/programas/ccpv/2020/#Tabulados.

Given the concentration of infections in large cities, the indigenous population residing there is exposed to high risks of infection, because of factors such as worse indicators of material habitability of homes than the non-indigenous population, as well as high rates of informal employment (ECLAC, 2020f and 2020g; ILO, 2020a). This widespread pattern of greater vulnerability of the indigenous population —considering key factors for the adoption of self-care measures such as access to water, sanitation and levels of overcrowding— is prevalent in the countries for which more recent information is available. In the cases of Colombia and Guatemala, vulnerability is greatest in towns and cities with the largest populations (over 100,000 inhabitants), where inter-ethnic gaps are also much more pronounced than in smaller settlements (see table II.3). However, the situation of urban indigenous populations has received little attention from the States in the context of the pandemic, and even less attention has been paid to their family dynamics and the differentiated impacts that could affect indigenous women, young people and older persons.

As the pandemic spread into rural areas, indigenous communities' access to markets and services was limited, heightening their vulnerability. Movement restrictions often made it impossible to sell products or access food, thus creating critical food insecurity in some cases. The standstill in the construction sector and the effective disappearance of tourism visits to those areas have severely affected indigenous economies and livelihoods (ECLAC, 2020g). In addition, during the pandemic, return migration to traditional territories has also been seen, putting even more pressure on living conditions at the local level (CIIR, 2021; Flecha, 2020; IWGIA/ILO, 2020).

Table II.3
Latin America (4 countries): index of housing vulnerability in indigenous and non-indigenous populations, by population size of municipality of residence, most recent available census

Country, census year	Housing vulnerability index	Population of the municipality of residence					Total
		<10 000	10 000–19 999	20 000–49 999	50 000–99 999	>99 999	
Chile, 2017	Indigenous	26.3	20.0	14.4	10.0	8.1	11.4
	Non-indigenous	13.4	10.0	8.0	6.1	5.8	6.6
	Relative difference	2.0	2.0	1.8	1.6	1.4	1.7
Colombia, 2018	Indigenous	52.7	49.1	47.9	51.3	62.0	52.5
	Non-indigenous	28.4	29.7	25.9	19.6	10.0	14.4
	Relative difference	1.9	1.7	1.9	2.6	6.2	3.6
Guatemala, 2018	Indigenous	44.1	43.6	52.6	60.8	59.0	56.2
	Non-indigenous	34.6	39.2	41.3	42.7	26.2	35.3
	Relative difference	1.3	1.1	1.3	1.4	2.3	1.6
Mexico, 2015	Indigenous	37.8	38.9	39.0	34.3	25.9	32.4
	Non-indigenous	27.4	26.7	27.2	24.9	17.4	20.0
	Relative difference	1.4	1.5	1.4	1.4	1.5	1.6

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special processing of census microdata.
Note: Housing vulnerability is measured as the weighted average of the percentage of the population that suffers deprivation in access to drinking water and sanitation, as well as domestic overcrowding.

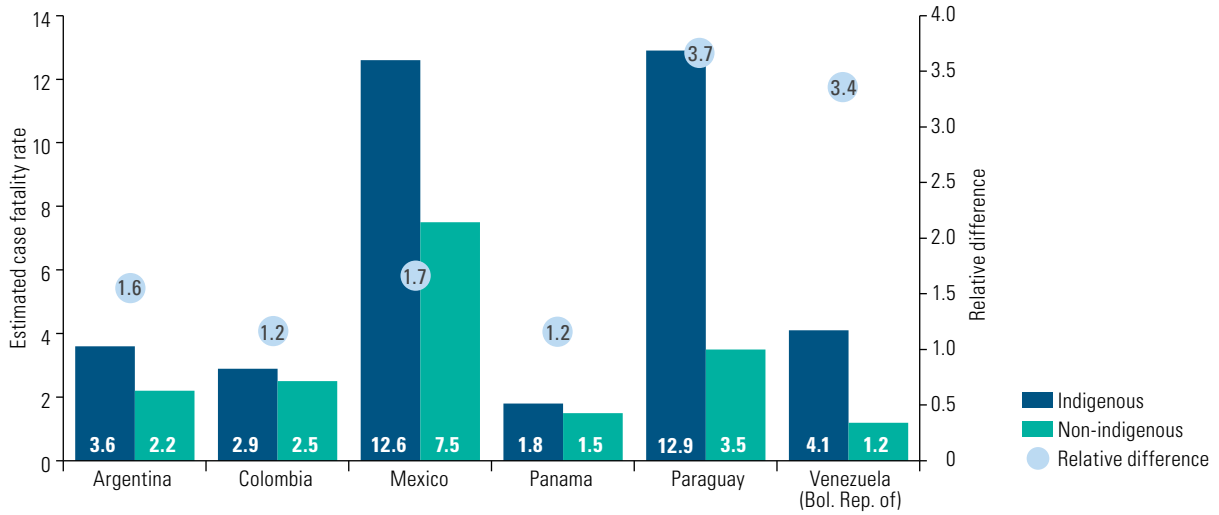
The demographic fragility of many indigenous peoples that was already reflected in census figures from Brazil, Colombia, Peru and the Plurinational State of Bolivia —showing various indigenous peoples with small population sizes (ECLAC, 2014b)— has most likely worsened during the pandemic, raising the number of peoples in danger of physical or cultural disappearance. In addition, there are around 200 indigenous peoples in voluntary isolation or initial contact, mainly in the Amazon and the Paraguayan Gran Chaco (IACHR, 2019), whose previous vulnerabilities have been amplified by a decline in public efforts to police their territories, exposing them to serious risks of infection owing to activities by illegal miners and loggers (ECLAC, 2020f; GTI-PIACI, 2020; Bello, 2021).

In the region, the traditional territories of 108 indigenous peoples cross national borders. Their rights, however, are not adequately protected in the countries of the region, despite the ILO Indigenous and Tribal Peoples Convention, 1989 (No. 169) requiring States to adopt appropriate measures to that effect. As a result, these peoples are left in a situation of particular vulnerability, reinforced by the pressure on the territories they inhabit exerted by regular and irregular armed actors and by the extractive industry. Added to this today are the effects of the pandemic, which, as several indigenous organizations have denounced, have not been taken into account sufficiently in government responses (COICA, 2020; Indigenous Technical Secretariat of the National Commission for Indigenous Territories, 2020; OCHA, 2020; ECLAC, 2020g).

2. The differential impact of the pandemic on indigenous peoples

The stalling of processes to include an ethnic approach in health records has become even more evident during the pandemic (ECLAC, 2020f and 2020g), as reflected in the lack of systematic information on the impact of COVID-19 on the region's indigenous peoples. Although 13 countries have included a variable on belonging to indigenous peoples in COVID-19 records (Argentina, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Ecuador, Guatemala, Mexico, Panama, Paraguay, Peru and the Plurinational State of Bolivia), most of them do not make this information available to the public through open data. However, PAHO has published reports on deaths and confirmed cases among indigenous peoples in these countries, which —combined with the daily reports published by the ministries of health of each country— give an initial idea of the differentiated impact of the pandemic on these peoples, at least in terms of case fatality rates. As shown in figure II.10, in six of the countries for which information was available, indigenous peoples are at the highest risk of dying from COVID-19.

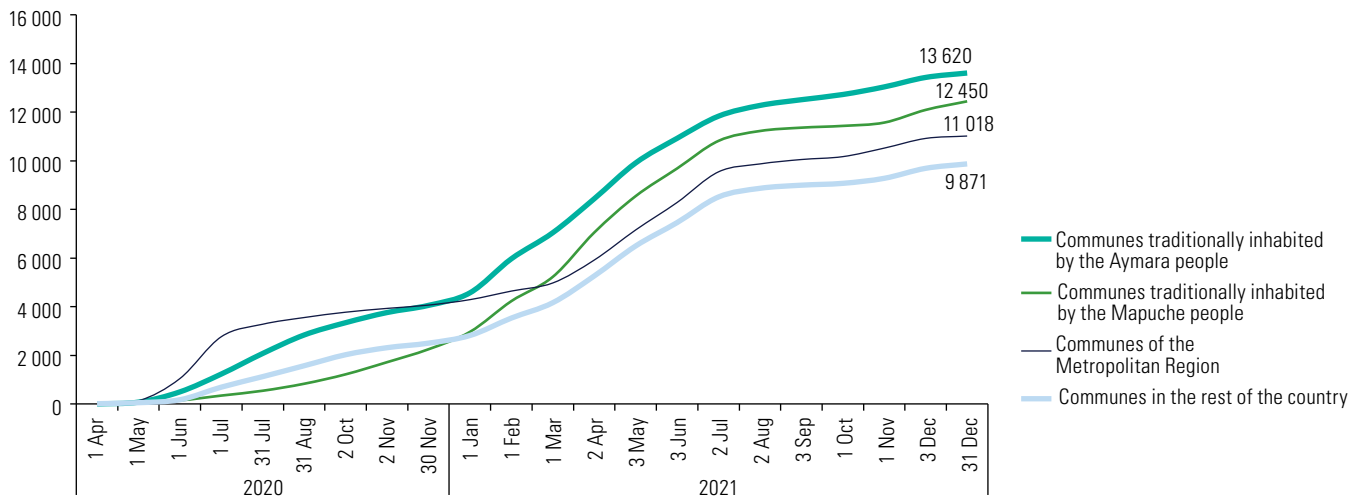
Figure II.10
Latin America (6 countries): estimated COVID-19 case fatality rate in indigenous and non-indigenous populations, as at 26 November 2021
(Per 100 cases and relative difference)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization/Pan American Health Organization (WHO/PAHO), "Epidemiological Update Coronavirus disease (COVID-19)", 2 December [online] https://www.paho.org/en/file/101857/download?token=VCW77APL and daily reports from the ministries of health of the respective countries.

It is also possible to estimate the pattern of infections at the municipal level, considering the proportion of indigenous population in them or where they overlap with traditional territories. In Chile, for example, in the early stages of the pandemic, the highest rates of infection were seen in communes with small relative indigenous population. This situation gradually changed, with the highest rates later found in municipalities with the largest relative indigenous populations. Similarly, in the early stages, the communes of the Metropolitan Region had the highest rates. However, as the virus spread, the communes in the traditional areas of settlement of the Aymara and Mapuche peoples became the most at risk (see figure II.11).

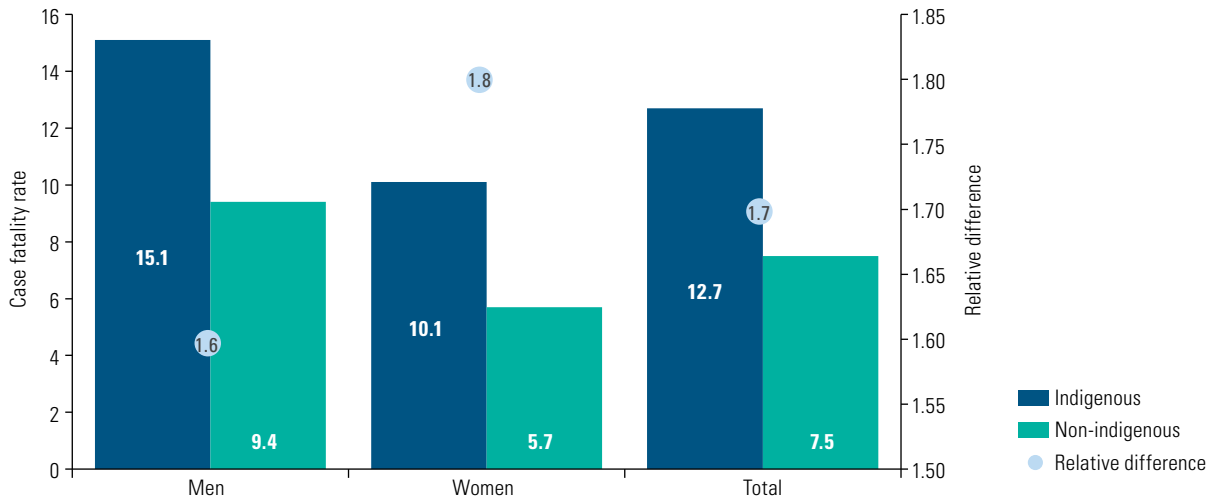
Figure II.11
Chile: rate of confirmed COVID-19 cases by large territorial areas, 1 April 2020 to 31 December 2021
(Per 100,000 inhabitants)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Ministry of Science, Technology, Knowledge and Innovation [online] https://github.com/MinCiencia/Datos-COVID19/blob/master/output/producto1/Covid-19.csv

In Mexico, which has open data disaggregated by ethnic group—together with Brazil, Colombia and Peru— the Ministry of Health periodically issues bulletins on the impact of the pandemic on indigenous peoples, based on self-identification. Although the bulletins systematically report a lower rate of infection among indigenous peoples, they also show a concentration of the risk of dying from this cause among them, with the highest case fatality rates among indigenous men, followed by indigenous women (see figure II.12).

Figure II.12
Mexico: COVID-19 case fatality rate in indigenous and non-indigenous populations, by sex, as at 20 December 2021
(Per 100 cases and relative difference)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), based on Secretaría de Salud "COVID-19 MÉXICO: Panorama en población que se reconoce como indígena", 20 December 2021 [online] https://www.gob.mx/cms/uploads/attachment/file/689653/panorama-covid19-poblacion-indigena-20-diciembre-2021.pdf, and "Informe Técnico Diario COVID-19 MÉXICO", 20 December 2021 [online] https://www.gob.mx/cms/uploads/attachment/file/688475/Comunicado_Tecnico_Diario_COVID-19_2021.12.20.pdf.

In addition, fatality rates for the indigenous population increase in tandem with the proportion of this population in federative states' demographic structures, as do ethnic inequalities: while fatality rate for the indigenous population is 8.5% in the federative states in which they account for 10% or less of the population, non-indigenous fatality rate is 6.3%. The figures are highest in states where indigenous peoples represent at least 30% of the population, with a fatality rate for these peoples of 16.4% and a non-indigenous rate of 7.5%.

Although this section has focused on the impact of COVID-19 on the indigenous population's morbidity and mortality, consideration should also be given to the pandemic's effects on other dimensions of their well-being and on rights violations, such as lack of access to comprehensive health services (including sexual and reproductive health care), structural discrimination and violence (on the basis of both gender and ethnicity), as well as other barriers to access to protection services, including social protection and care services, and access to justice, education and sources of decent work. Previous studies have found, for example, higher maternal mortality rates among indigenous women, which in the pandemic may have risen owing to overstretched health systems, isolation measures, and a decline in quality of consultations in reproductive health services (ECLAC, 2014b; Del Popolo, 2018; ECLAC, 2020g).

In the case of indigenous children, adolescents and young people, the digital divide —in the form of less access to the Internet at home than their non-indigenous peers— hinders continued education (ECLAC, 2020g). In the case of indigenous young and adolescent girls, even when they have been able to continue their education, their performance is hampered by the burden of domestic and care work they have shouldered during the pandemic. Indigenous boys, adolescent boys and young men may also face differentiated obstacles in this area, as they have to assume a more important role in the subsistence activities of traditional indigenous economies (ECLAC, 2020g). It is crucial to understand how the pandemic has deepened pre-existing inequalities to the detriment of indigenous peoples, using an intersectional approach to identify the specific needs of indigenous women and men, indigenous children and youth, and indigenous older adults in different territorial contexts.

3. Inclusion of indigenous peoples in national vaccination plans

Despite abundant data that confirms the greater vulnerability of indigenous peoples (ECLAC, 2020g; PAHO, 2021a; UNESCO, 2021b; FILAC/FIAY, 2021), their inclusion in national vaccination plans is still precarious. They are mentioned as a target population in 11 countries of the region (Argentina, the Bolivarian Republic of Venezuela, Brazil, Colombia, Ecuador, Guatemala, Mexico, Panama, Paraguay, Peru and the Plurinational State of Bolivia), but, in many cases, without specifying at which stage of the campaigns they will be included. Moreover, there are no specific strategies in place to make sure they have equitable access to vaccine (see table II.4).

Table II.4
Latin America (17 countries): inclusion of indigenous peoples as target population in national vaccination plans, October 2021 review

Country	Inclusion of indigenous peoples	Stage[a]		
		Early	Intermediate	Advanced
Argentina	X			
Bolivia (Plurinational State of)	X			
Brazil	X	X		
Chile	-			
Colombia	X	X	X	
Costa Rica	-			
Ecuador	X	X	X	
El Salvador	-			
Guatemala[b]	X	X		
Honduras	-			
Mexico	X			
Nicaragua	-			
Panama	X			X
Paraguay	X		X	
Peru	X		X	
Uruguay	-			
Venezuela (Bolivarian Republic of)	X		X	

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of national vaccination plans of the respective countries.
[a] The national plans set out vaccination stages in which priority was given to different population groups, with staggered coverage as access to the vaccine increased. Based on recommendations from the World Health Organization (WHO, 2020b), they considered three possible scenarios of vaccine availability: (i) first stage: very limited availability to cover 1%–10% of the national population; (ii) second stage: although availability is higher, it is still limited, and may cover 11%–20% of the total population of each country; and, (ii) third stage: vaccine availability is moderate, covering 21%–50% of the total population of each country.
[b] Only Maya therapists are prioritized.

The uneven progress of vaccination campaigns across countries and the sparse inclusion of indigenous peoples in national vaccination plans suggest that they have been left behind in this process. A report published by PAHO (2021b) shows that by 19 November 2021 an average of 52.3% of the population of the 17 countries analysed had received the full vaccination schedule, but with enormous inequalities among them. While in the four countries that account for more than 80% of the indigenous population of Latin America-Abya Yala the figures were lower (Guatemala 20.4%, Mexico 48.9%, Peru 50.6% and Plurinational State of Bolivia 34.0%), Chile and Uruguay, which account for just 5% of the indigenous population of the region, were among the countries with indigenous peoples reporting the greatest progress (82.5% and 77.5%, respectively).

Information on vaccination disaggregated by people of origin is scarce. For example, in Brazil, 85% of the indigenous population aged over 18 living in the coverage areas of the special indigenous health districts had received the full vaccination schedule by 25 December 2021, although with disparities among territories (Ministry of Health of Brazil, 2021b). Although this coverage is high, more than 30% of the country's indigenous population resides outside these districts, and their access to vaccination is unknown. In Chile, Guatemala and Peru, efforts have also been made to disaggregate this information, revealing extremely low coverage among indigenous peoples. This situation, however, seems to be linked not only to access barriers, but also to underreporting problems.

4. State responses to the health and economic impacts of the pandemic on indigenous peoples

State responses to mitigate the social and health impact of the pandemic on indigenous peoples have been weak and fragmented. In terms of health, based on information from the COVID-19 Observatory in Latin America and the Caribbean of ECLAC, 16 of the 17 countries of Latin America-Abya Yala with indigenous peoples have set specific standards or technical guidelines for dealing with the COVID-19 pandemic among those peoples (the exception being Uruguay).[17] Many of these guidelines were formulated after infections had already spread significantly into territories where indigenous peoples largely reside, or the neighbouring cities. In addition, there have been delays with respect to implementation deadlines and low coverage of State responses, mainly in traditional territories, as denounced by indigenous peoples' organizations.

One of the most widespread initiatives (13 countries) is production of audiovisual material in indigenous languages to ensure that those peoples have access to information about the disease. This is immensely important in countries and territories where those languages are widely spoken but has little impact on those where linguistic rights are most violated.[18] In addition, in many cases this material is not widely disseminated among the target indigenous communities (ECLAC, 2020g). Measures to guarantee access to food and biosafety inputs for the indigenous population have also been widespread and are reported in 11 of the countries analysed. However, indigenous organizations and human rights bodies have noted that their coverage has been limited and, in general, that they have not been adequately linked with indigenous leadership.

A critical weakness is access to information on the health impact of the pandemic on the indigenous population, as only four countries regularly report data broken down by ethnicity (Brazil, Colombia, Mexico and Peru). However, the data disseminated are general and do not effectively contribute to formulation and implementation of evidence-based responses, by citizens or the State. It is also problematic that governments do not disclose fiscal spending on pandemic containment and mitigation among indigenous peoples (ECLAC, 2020f).

Only two countries —Argentina and Costa Rica— have reported special economic measures for indigenous peoples. Argentina established a Critical and Direct Assistance Programme for Family, Peasant and Indigenous Agriculture (Ministry of Agriculture, Livestock and Fisheries of Argentina, 2020) and in Costa Rica, the National Production Council (CNP) established a mechanism through which its Institutional Supply Program (PAI) purchases bananas from indigenous producers of the Association for the Comprehensive Development of the Cabécar Indigenous Territory (ADITICA), a measure that is expected to be extended to other territories (Government of Costa Rica, 2021).

In the area of social policies, in Colombia, the non-contributory pension quotas of the Colombia Mayor programme for older persons were expanded to those residing in legally constituted indigenous reservations or communities (Ministry of Labour of Colombia, 2021). Likewise, to ensure continuity of education among indigenous peoples, in Mexico the Radio Strategy for Indigenous Communities and Peoples was implemented within the framework of the Aprende en Casa programme on learning in the home (Secretariat for Public Education of Mexico, 2021) and Ministry of People's Power for Education of the Bolivarian Republic of Venezuela (2020) established the Una Familia una Escuela pedagogical and protection plan, which establishes specific technical guidelines for indigenous peoples and communities.

5. Independent responses of indigenous peoples to the pandemic

In all the countries of the region, indigenous peoples have organized multiple collective actions to address the pandemic and States' weak responses to their specific needs. In the exercise of their right to self-determination, in most of the countries, many indigenous peoples decided to restrict or close access to the territories they inhabit as

[17] See COVID-19 Observatory in Latin America and the Caribbean, [online] https://www.cepal.org/en/topics/covid-19. Information updated as at 29 October 2021.

[18] The countries that have implemented actions to make information available in indigenous languages are: Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, Peru and Plurinational State of Bolivia.

one of the main measures to prevent transmission of the virus, especially in the case of groups that had adopted similar measures during previous epidemics. It is very likely that, without these measures, the health impact of COVID-19 among these peoples would have been much greater than it has been. Their effectiveness, however, depended on the degree of territorial control and robustness of each community's self-governance (ECLAC, 2020g).

Through strategies of reciprocity and inter-community cooperation, indigenous peoples have been able to somewhat alleviate the gaps in coverage of humanitarian assistance from governments. By resorting to traditional medicine, indigenous peoples have not only tried to remedy the lack of access to health care or to complement therapeutic resources offered by official health systems with their own, but have also strengthened community support networks and enhanced their cultural heritage in the medical field.

Ensuring access to information on means of viral transmission and measures to prevent infection, and later on the importance of vaccination, has been a central concern for indigenous organizations. Initiatives in this area have proliferated in the countries of the region, including information campaigns at the community level, the production of promotional and preventive material in indigenous languages, and action by indigenous communication networks and community radio stations (Huancollo, 2020; Cultural Survival, 2020; Estarque, 2020; Lado B, 2020; UNFPA, 2020a).

Moreover, indigenous peoples have shown themselves to be commendably technically adept at drawing attention to the impact of the pandemic on their populations and the territories they inhabit. Indigenous organizations in several countries continuously monitored the pandemic in 2020, combining official data with community reports. Good examples of this are the monitoring implemented by the National Coordinator for the Defence of Indigenous and Campesino Territories and Protected Areas (CONTIOCAP) in the Plurinational State of Bolivia, the platform for monitoring the impact of the pandemic on indigenous territories of the National Indigenous Organization of Colombia (ONIC), the periodic bulletins published by the Coordinating Body for the Indigenous Peoples' Organizations of the Amazon (COICA) and the Pan-Amazonian Ecclesiastical Network (REPAM), and the virtual platform of the Association of Indigenous Peoples of Brazil (APIB), which is still active.

6. Indigenous peoples' collective rights in the context of the pandemic: progress and tension

Following growing recognition of rights of indigenous peoples from the 1990s to the 2000s, many countries in the region are now in period of relapse in this area (ECLAC, 2020f; IACHR, 2021; IWGIA, 2021; ONIC, 2021). Fulfilment by the State of its duty to carry out consultations with indigenous peoples before taking any measure that could affect their rights is one of the most critical areas in this regard. Before the pandemic, these consultations were already in essence ineffective in safeguarding the collective rights of these peoples. Regulation of the consultations by States resulted in a restriction of rights in many cases, ignoring international standards and enabling legislative and administrative measures, public policies and investment projects to be imposed on the territories historically inhabited by indigenous peoples (ECLAC, 2020f). Restrictions to contain the spread of the virus aggravated the situation, because in the pandemic there were no longer safe health conditions to conduct the consultations and, when they were carried out, they did not fully meet applicable standards.

Although international organizations recommended States "refrain from introducing legislation and/or moving forward to carry out production and/or extractive projects in the territories of indigenous peoples during the period the pandemic may last, given the impossibility of conducting prior informed and free consent processes" (IACHR, 2020), some countries have pursued such measures, putting the collective rights of indigenous peoples at risk. Conversely, other countries have implemented initiatives that deepen recognition of those rights. This is the case of the General Law on Consultation of Indigenous and Afro-Mexican Peoples and Communities, the proposed constitutional reform in El Salvador, which expands protection of indigenous peoples, and the extension of the validity of the Law on Territorial Surveying of Indigenous Communities in Argentina. In Chile, one of the most significant events that guaranteed the political rights of indigenous peoples was the constitutional reform that reserved, for them, 17 of the 155 seats of the Constitutional Convention that is responsible for the constituent process begun after a crisis broke out in the country in late 2019.

In the pandemic, indigenous peoples continue to face tension arising from a lack of guarantees of their territorial rights. In most countries in the region, mining, hydrocarbon exploitation and agribusiness were quickly seen as essential in the context of the health crisis, meaning that extractivism was uninterrupted in indigenous territories, becoming a vector of infection and giving rise to multiple conflicts within those territories. In several countries, including Brazil, Ecuador, Mexico, Peru and Uruguay, the increase in illegal environmental destruction was accompanied by significant cuts in government control budgets (ECLAC, 2020g). A clear example of this is the increase in deforestation in the Amazon from 2019 to 2020. In the nine countries with Amazonian territories, approximately 2.3 million hectares of primary forest have been lost (MAAP, 2021), not only affecting the livelihoods of indigenous peoples, but also reducing the capacity to absorb greenhouse gases, while at the same time increasing the emission of these gases in the midst of a growing global climate crisis.

Violence against indigenous peoples and their criminalization, linked to territorial conflicts, has not stopped either (CIMI, 2021; ONIC, 2021; CLSS, 2021; OMCT/FIDH, 2021; HRW, 2021; Indigenous Technical Secretariat of the National Commission for Indigenous Territories, 2021; United Nations, 2020b). In recent years, various international bodies have warned about the rise in murders of defenders of the life and territories of indigenous peoples, as a deadly result of economic interests that conflict with their collective rights, environmental justice and sustainable development (IACHR, 2006, 2011, 2015 and 2017; United Nations, 2018 and 2019a; Global Witness, 2015, 2017 and 2020; ECLAC, 2020f). The situation has worsened in the pandemic: between January 2020 and October 2021, at least 236 of such crimes (mostly against men) were recorded, according to specialized agencies and indigenous peoples' organizations. Colombia remains the epicentre of these events, owing to the actions of paramilitary groups linked to drug trafficking and dissident guerrilla groups that continue to operate in the country, as a result of which indigenous peoples have been deprived of their territories or put at risk of being so (see figure II.13).

F. Afrodescendent persons and communities

The pandemic has had a differential impact on Afrodescendent persons and communities in Latin America, violating many of their rights and increasing inequality and the incidence of racism and discrimination.[19] These effects have differed from country to country, but few have collected disaggregated information that would enable more accurate measurement of this impact on the Afrodescendent population.

The Durban Declaration and Programme of Action, as recognized in the Montevideo Consensus on Population and Development, constitute a comprehensive human rights framework for the well-being and development of Afrodescendants and a basis for combating racism, racial discrimination and xenophobia. Victims of racism may, in addition, suffer the compounding effects of intersectional discrimination because of gender identity, sexual orientation, language, religion, social origin or other factors, which has consequences for their well-being.

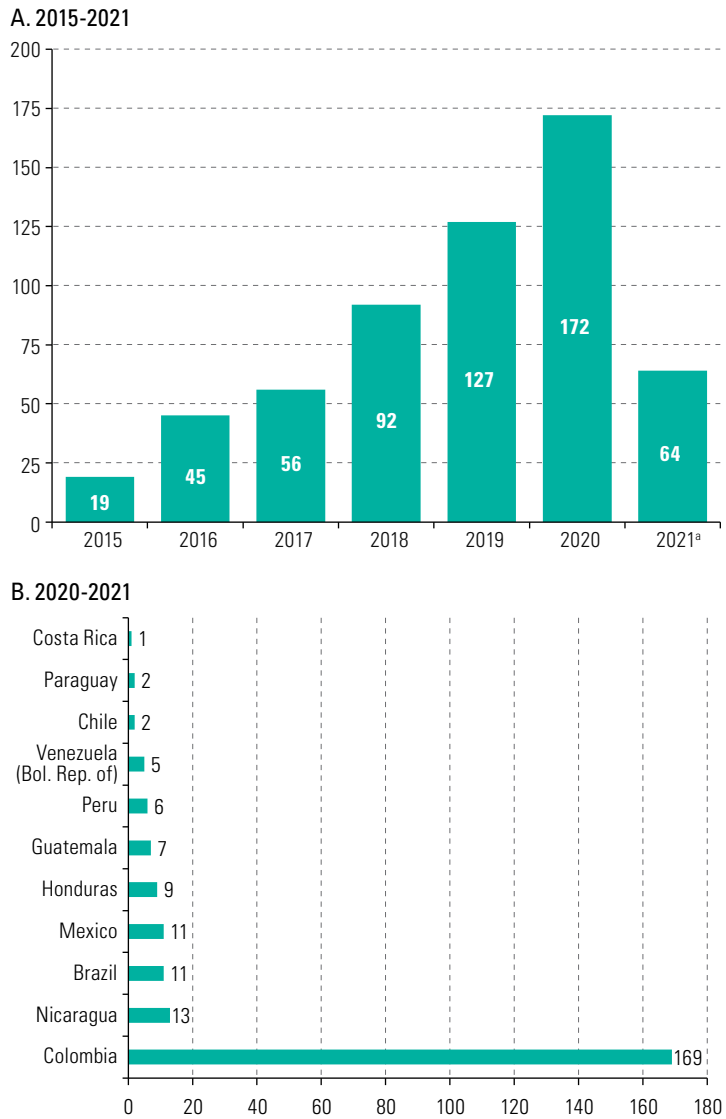
The Montevideo Consensus sets out a series of priority actions (92 to 98) whose implementation would contribute to improving the living conditions of Afrodescendent populations. These measures contribute to and are consistent with the programme of activities for the implementation of the International Decade for People of African Descent, which began in 2015 and will end in 2024, and with the General Assembly resolution adopted in August 2021 establishing the Permanent Forum of People of African Descent.[20] The Forum was established as a consultative mechanism for Afrodescendants and other relevant stakeholders, and a platform aimed at improving their quality of life and livelihoods, with a mandate to contribute to the full political, economic and social inclusion of people of African descent in the societies in which they live as equal citizens without discrimination of any kind and contribute to ensuring equal enjoyment of all human rights.[21]

[19] The United Nations has published several documents reporting allegations of increased racial discrimination since the beginning of the pandemic. See, for example, OHCHR (2020c) and United Nations (2020f).

[20] A/RES/69/16.

[21] A/RES/75/314.

Figure II.13
Latin America (11 countries): indigenous leaders and community members killed in the context of the lack of protection of indigenous peoples' territorial rights, 2015–2021
(Number of persons)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of reports from ombudsmen, international organizations, Amnesty International, indigenous organizations, communications and reports from the Inter-American Commission on Human Rights (IACHR).
[a] Data for 2021 cover the months up to October.

This section gives recent information on the distinct situation experienced by the Latin American Afrodescendent population during and before the pandemic, as regards inequalities in terms of infection, mortality and lethality, and access to vaccines. It also analyses the responses of States and the Afrodescendent population to the health crisis.

1. Population dynamics and vulnerability to the pandemic

(a) How many Afrodescendants are there and where do they live?

ECLAC estimates, on the basis of data from 2021, that the Afrodescendent population in Latin America amounts to 136 million people, or 21% of the total population. As shown in table II.5, there is great population heterogeneity among the countries of the region, in both absolute and relative terms. Brazil has the largest number of Afrodescendants (109 million, more than half of its total population). In terms of proportions, Haiti is the country with the highest percentage Afrodescendent population (95.5%, just over 11 million people). The second largest proportion of Afrodescendants is Cuba's (36%, more than 4 million people), followed by Colombia, Costa Rica, Ecuador, Panama and the Dominican Republic (7%–9% of the national total). In the other countries, such populations represent less than 5% of the totals.

Table II.5
Latin America (20 countries): Afrodescendent population, on the basis of most recent census and estimates as at 2021[a]
(Thousands of people and percentages)

Country and census year	Surveyed Afrodescendent population *(thousands)*	Proportion of Afrodescendent population *(percentages)*	Estimated total population in 2021 *(thousands)*	Estimated Afrodescendent population in 2021[a] *(thousands)*
Argentina, 2010	149.6	0.4	45 605.8	170.0
Bolivia (Plurinational State of), 2012	23.3	0.2	11 832.9	27.4
Brazil, 2010	97 171.6	50.9	213 993.4	109 008.9
Chile, 2017[b]	9.9	0.1	19 212.4	11.5
Colombia, 2018	3 023.0	6.8	51 265.8	3 509.1
Costa Rica, 2011	334.4	7.8	5 139.1	399.5
Cuba, 2012	4 006.9	35.9	11 317.5	4 060.8
Ecuador, 2010	1 041.6	7.2	17 888.5	1 286.4
El Salvador, 2007	7.4	0.1	6 518.5	8.4
Guatemala, 2018	47.2	0.3	18 249.9	58.4
Honduras, 2013	115.8	1.4	10 063.0	140.3
Mexico, 2020	2 576.2	2.0	130 262.2	2 663.1
Nicaragua, 2005	23.9	0.5	6 702.4	31.2
Panama, 2010	300.6	8.8	4 381.6	386.7
Paraguay, 2012	3.9	0.1	7 219.6	4.3
Peru, 2017[c]	1 049.9	3.6	33 359.4	1 192.0
Uruguay, 2011[d]	149.7	4.6	3 485.2	160.4
Venezuela (Bolivarian Republic of), 2011[e]	936.8	3.4	28 705.0	987.6
Estimates based on other sources				
Haiti[f]	---	95.5	11 541.7	11 022.3
Dominican Republic[g]	---	8.6	10 953.7	942.0
Total		21.0	647 697.5	136 070.5

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of population censuses; for Cuba: National Office of Statistics and Information (ONEI), *El color de la piel según el Censo de Población y Viviendas 2012*, Havana; for Mexico: "Censo de Población y Vivienda 2020" [online] https://www.inegi.org.mx/programas/ccpv/2020/#Tabulados; for Paraguay: Department of Statistics, Surveys and Censuses (DGEEC), *Atlas Demográfico del Paraguay, 2012* [online] https://www.dgeec.gov.py/Publicaciones/Biblioteca/atlas-demografico/Atlas%20Demografico%20del%20Paraguay,%202012.pdf.

[a] For the 2021 estimates, population figures from the *Demographic Observatory, 2020* (ECLAC, 2021d) were used and the percentages of Afrodescendants were applied according to the latest available census or source.

[b] Includes people who, in the question on which indigenous people they belonged to, specified in the "other" category that they were Afrodescendants.

[c] As the question was asked of the population aged 12 and over, to obtain a figure for the total Afrodescendent population, the Afrodescendent percentage of this age group was applied to the total population surveyed.

[d] The question on main ethnic origin was used, meaning that the figure in the table corresponds to people who replied that their main origin was "Afro or black". The question on recognition of origin with multiple response categories gives a total of 255,074 Afrodescendants, representing 7.8% of the national population.

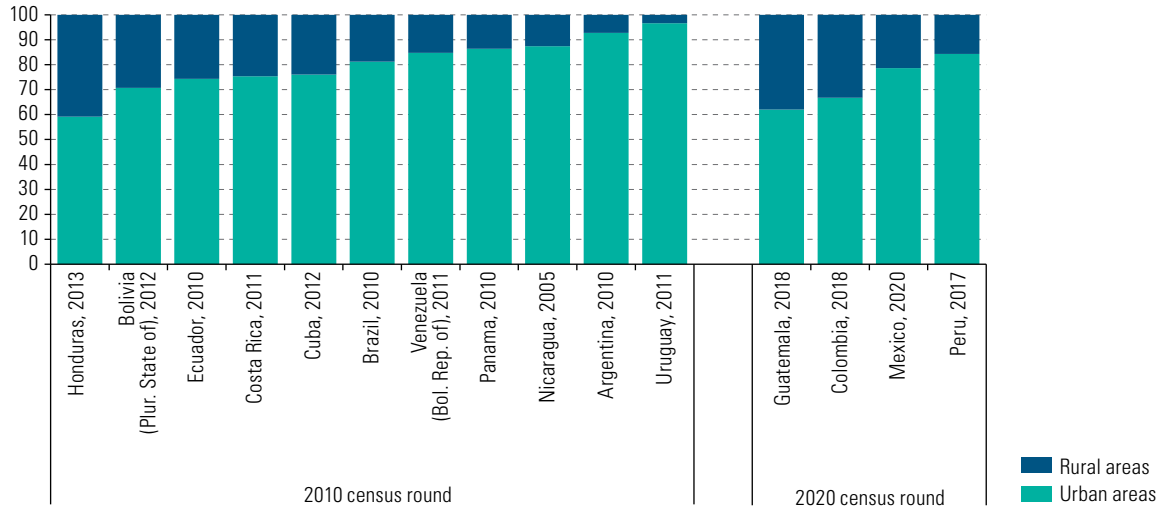
[e] The total Afrodescendent population was obtained by adding together the "black" and "Afrodescendent" categories and excluding the "brown" category.

[f] The percentage Afrodescendent population was calculated on the basis of the genetic study by Simms and others (2010, pp. 49–66).

[g] The percentage of the Afrodescendent population was based on the mother tongue of the head of household (Creole), included in the 2014 Multiple Indicator Cluster Survey (MICS) of the National Statistics Office (ONE).

Afrodescendent populations are distributed throughout most of the territory of each of the countries and are largely urban; in fact, in 12 of the 15 countries for which this information is available, the percentages living in urban areas exceed 70% (see figure II.14). In stylized terms, censuses have shown that the main areas of concentration of the Afrodescendent population —according to major administrative divisions— are those in which the main cities or large metropolises of each country are located (the exceptions being Colombia and Nicaragua), as well as settlements from the slavery era (ECLAC, 2017a). There are also smaller areas with a long-standing concentration of Afrodescendent communities,[22] which originally served as refuges for escaped slaves who had fled to remote areas, for example the quilombos in Brazil.[23]

Figure II.14
Latin America (15 countries): Afrodescendent population, by area of residence, latest available census
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of ECLAC/United Nations Population Fund (UNFPA), *Afrodescendientes y la matriz de la desigualdad social en América Latina: retos para la inclusión* (LC/PUB.2020/14), Santiago 2020 and special processing of census microdata of National Institute of Statistics and Geography (INEGI), "Censo de Población y Vivienda 2020" [online] https://www.inegi.org.mx/programas/ccpv/2020/#Tabulados.

In many countries, the areas in which Afrodescendent populations are concentrated are also the most disadvantaged and, in large cities, they are primarily marginal areas. These territorial distribution patterns add to risk factors for the Afrodescendent population, since several studies have shown a high correlation between socioeconomic vulnerability and COVID-19 severity and deaths, characterized by significant levels of residential segregation (ECLAC, 2022a and 2021c). This situation is even more critical in the case of Afrodescendent women, a greater proportion of whom live in poverty and extreme poverty. In addition, historical territorial asymmetries have had a differentiated impact on Afrodescendent populations in rural areas and in the territories in which they reside, meaning that States must pay special attention to recovery policies.

Although it is now possible to provide a demographic landscape of Afrodescendent populations in the region, mainly owing to the increasing inclusion of self-identification questions in twenty-first century censuses, in several countries these figures are open to question. That is why one of the challenges of the 2020 census round is to improve the quality of this information, including the self-identification question in the universal questionnaire to improve coverage, among other aspects (see more details in ECLAC/UNFPA, 2020).

22 These communities, also known as tradicionales, cimarronas, quilombolas, palenques or cumbes were meeting places of fraternal and solidary-based living and above all of resistance by members of the African diaspora (Nascimento, 1980, cited by De Souza, 2021).

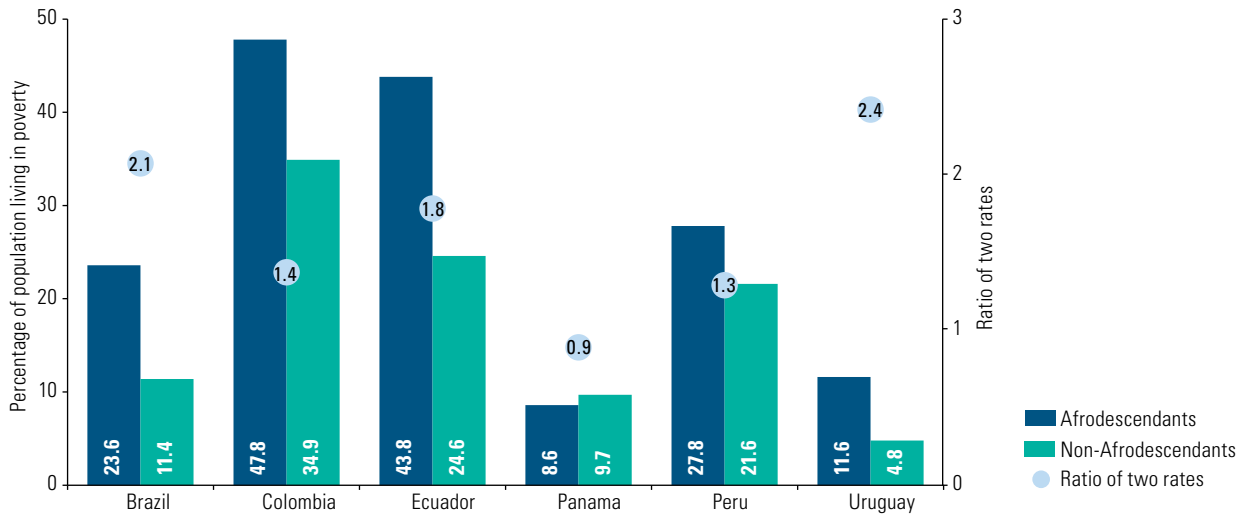
23 The existence of settlements that were considered to be ancestral led to Afrodescendent communities claiming territorial rights over them, and there is already favourable case law in this regard (ECLAC/UNFPA, 2020).

(b) Pre-existing and persistent vulnerabilities

ECLAC includes the Afrodescendent population among the groups that are most vulnerable to the pandemic (ECLAC, 2020d). Considering the social determinants of health and previous studies, the Afrodescendent population can be expected to be more affected by a pandemic, owing to ethnic and territorial inequalities, discrimination, structural racism and racial prejudice —which are exacerbated in this situation— and because of higher exposure to the disease, greater propensity to become infected and more limited access to health care.[24] Pre-existing inequalities and vulnerabilities include: overrepresentation of the Afrodescendent population in essential and informal labour sectors; Afrodescendants having lower incomes and suffering from socioeconomic disadvantages; and the greater vulnerability of Afrodescendent housing, located in poor neighbourhoods, where there is overcrowding and insufficient drinking water, sanitation and health services.

Poverty figures from six countries that included self-identification of Afrodescendants in their latest household surveys (Brazil, Colombia, Ecuador, Panama, Peru and Uruguay) show the persistence of these inequalities. Indeed, in 2020 the poverty levels of the Afrodescendent population were significantly higher than those of the non-Afrodescendent population[25] in all the countries except Panama. Colombia had the highest rate, with 47.8% of the Afrodescendent population living in poverty, compared to 34.9% of the non-Afrodescendent population. In the case of Uruguay, the country with the lowest overall poverty rate in the region, the percentage of the Afrodescendent population living in poverty (11.6%) was more than double the percentage of the non-Afrodescendent population (4.8%); in Brazil, the ratio between the poverty rate of the Afrodescendent population and the non-Afrodescendent population was around 2.0 and in Peru it was 1.3 (see figure II.15).

Figure II.15
Latin America (6 countries): population living in poverty, by ethnicity and race, 2020
(Percentages and ratios)



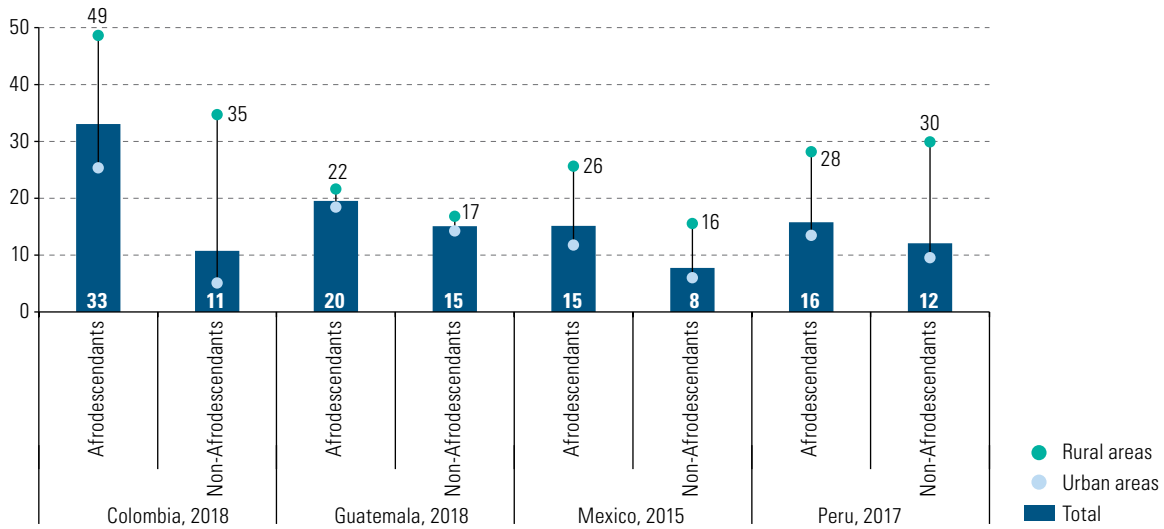
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys contained in CEPALSTAT [online] https://statistics.cepal.org/portal/cepalstat/index.html?lang=en.
Note: The non-Afrodescendent population does not include the population that self-identifies as indigenous, or cases where the ethnicity/race is unknown.

Living conditions are key in the event of a pandemic, both to mitigate the risk of infection and for care. Although living in adequate housing is an internationally recognized human right, which is included in the Montevideo Consensus among those rights that allow for the full empowerment and inclusion of people, a significant proportion of the population in the region does not enjoy this right. Likewise, the 2010 census round revealed existing ethnic and racial inequalities affecting Afrodescendent populations, in areas such as overcrowding

[24] In this regard, see for example the studies by Kumar and others (2012), Crouse Quinn and others (2011) and Blumenshine and others (2008), cited in ECLAC (2020f).
[25] Throughout section F, when reference is made to the non-Afrodescendent population, it does not include the population that self-identifies as indigenous or cases in which the ethnicity or race is unknown.

and access to drinking water and sanitation, while more recent censuses show that these inequalities persist (ECLAC/UNFPA, 2020). In Guatemala, for example, according to the 2018 census, around one third of the population lives in overcrowded conditions, and the proportion is slightly higher at 34% for Afrodescendants, compared to 30% for non-Afro-descendants. In Mexico, the 2015 inter-census survey revealed that 22% of the Afrodescendent population suffered from overcrowding, while for the non-Afrodescendent population the percentage was 16%. In relation to access to drinking water, in Colombia the percentage of Afrodescendent people without access in 2018 was three times that of non-Afrodescendants and in Mexico it was about double that of non-Afrodescendants. As regards the territorial dimension, 25% of Afrodescendants in urban areas of Colombia did not have access to drinking water, compared to 5% of non-Afrodescendants; in rural areas, these percentages were 49% and 35%, respectively (see figure II.16). Previous studies also found greater deprivation in access to electricity and Internet services affecting Afro-descendent peoples and communities, with specific consequences for the educational development of children and young people (ECLAC/UNFPA, 2020). In addition, poor infrastructure in many of the territories where they live limits their access to quality education and health care.

Figure II.16
Latin America (4 countries): population without access to drinking water, by ethnicity and race and area of residence, latest available census
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of ECLAC/United Nations Population Fund (UNFPA), *Afrodescendientes y la matriz de la desigualdad social en América Latina: retos para la inclusión* (LC/PUB.2020/14), Santiago, 2020.
Note: The non-Afrodescendent population does not include the population that self-identifies as indigenous, or cases where the ethnicity/race is unknown.

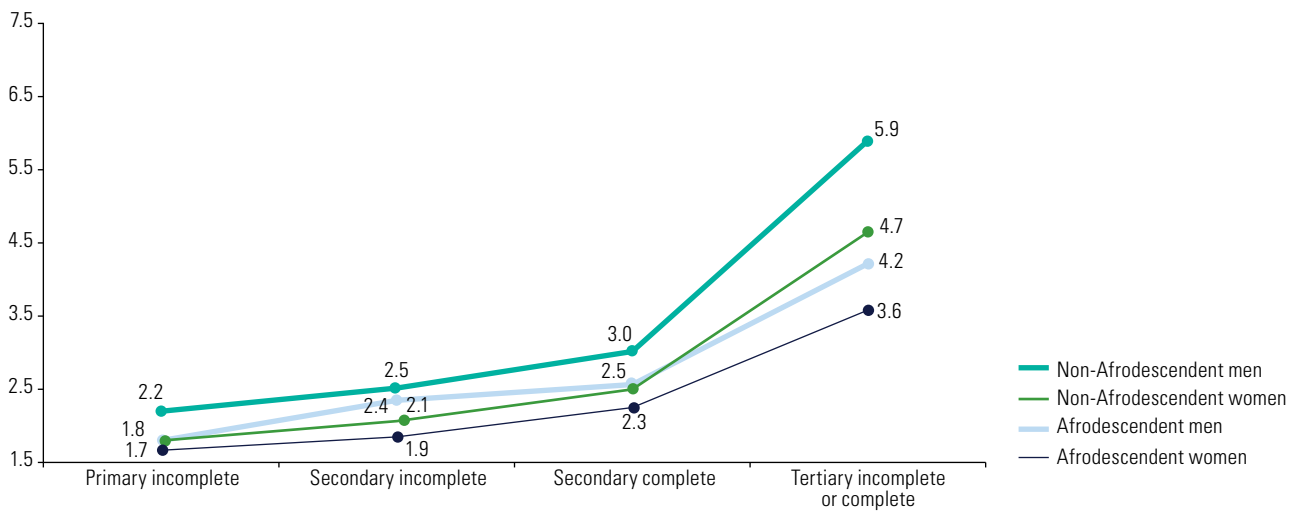
In terms of health, Afrodescendent populations also suffer high levels of inequality compared to non-Afrodescendent people, which has an impact on their living conditions and health, as studies on infant mortality have shown (ECLAC, 2017a and 2017b). Likewise, there are factors that make them more susceptible to disease, which increases the risk of morbidity and mortality. One example is obesity, which is a comorbidity for COVID-19, is closely related to malnutrition, and increasingly affects the most vulnerable groups. In Brazil, obesity is more prevalent among people with less schooling and among Afrodescendent women (Ferreira, Szwarcwald, and Damacena, 2019). With regard to adolescent sexual and reproductive health, the censuses showed that the percentage of adolescents aged 15–19 who had been mothers was higher among Afrodescendent adolescents in 10 countries of the region (Bolivarian Republic of Venezuela, Brazil, Colombia, Costa Rica, Ecuador, Guatemala, Mexico, Peru, Plurinational State of Bolivia and Uruguay). Among the countries with data from the 2010 census round, the range was from 14% of Afrodescendent adolescents who had been mothers in Brazil to 25% in Ecuador; for countries with more recent censuses, the range was 13%–15% (UNFPA/ECLAC, 2022). In view of the restrictions imposed by the pandemic on sexual and reproductive health care, particular attention should be paid to the possible differentiated harmful effects on Afrodescendent children, adolescents, youth and women, whose access to essential sexual and reproductive health services has been hampered.

In education, earlier studies from the initial stages of the pandemic also showed racial and ethnic gaps in terms of both access to and completion of secondary and tertiary or university education (ECLAC/UNFPA, 2020). Considering ethnic and racial inequalities in Internet access,[26] it can be assumed that during the pandemic many young Afrodescendants have seen their opportunities to continue studying severely compromised or have been forced to continue them under unfavourable learning conditions. For example, according to the United Nations Children's Fund (UNICEF, 2021a), in Brazil, difficulty accessing the Internet or connections that were too low-quality to follow online classes affected Afrodescendent students more: 42% of them faced such difficulties, compared around half this proportion (23%) of non-Afrodescendent students. In terms of devices, 48% of Afrodescendent students only had a mobile phone for remote activities, while among non-Afrodescendent students the percentage was 29%.

Lastly, in Latin America, the employment situation of many population groups is very unequal according to attributes such as ethnicity, race, gender or age, which contributes to exclusion, inequality and discrimination. For example, in Uruguay, the percentage of non-Afrodescendent self-employed workers who are affiliated with or contributing to pension systems (36%) is more than double the corresponding percentage of Afrodescendent workers (14%) (ECLAC, 2021c). Unemployment is proportionally higher among young people and Afrodescendent women (Del Popolo and Rangel, 2011; ECLAC, 2013c and 2016a; ECLAC/UNFPA, 2020). Indeed, in 2018 the unemployment rates of young Afrodescendent women were around double those of non-Afrodescendent youth in four countries (Brazil, Colombia, Panama and Uruguay) and around three and a half times higher in Ecuador[27] (ECLAC/UNFPA, 2020).

The intersection of gender, ethnicity and race shows that educational progress of Afrodescendent women is not reflected proportionally in the labour market (see figure II.17): in addition to the gender gaps related to the sexual division of labour and the greater responsibility assigned to women for unpaid caregiving, there are gaps caused by ethnic and racial discrimination. This intersectionality results in Afrodescendent women having the lowest employment rates and the lowest income levels compared to non-Afrodescendent women and men (ECLAC, 2016a, 2016b and 2017a; ECLAC/UNFPA, 2020).

Figure II.17
Latin America (weighted average of 6 countries): average hourly labour income of the employed population aged 15 and over, by ethnicity and race, sex and schooling, around 2019
(Multiples of a poverty line)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).
Note: The countries included are: Brazil, Colombia, Ecuador, Panama, Peru and Uruguay. The non-Afrodescendent population does not include the population that self-identifies as indigenous, or cases where the ethnicity or race is unknown.

[26] According to recent censuses, in Colombia in 2018 just 26% of the Afrodescendent population had Internet access in the home, compared to 47% of non-Afrodescendants; in Guatemala in 2018, 22% of Afrodescendants and 24% of non-Afrodescendants had Internet access, and in Peru in 2017 26% of Afrodescendants and 37% of non-Afrodescendants had such access (ECLAC/UNFPA, 2020).

[27] In the case of Ecuador, the data correspond to 2017.

2. The differentiated impact of the pandemic

Statistical invisibility resulting from a relative lack of data disaggregated by ethnic-racial status is yet another expression of discrimination and racism; and it makes it more difficult to uphold the rights of the most disadvantaged population groups. In the midst of the pandemic, the Secretary General of the United Nations stated that it was essential to collect disaggregated data to measure the effects of the pandemic on Afrodescendent populations, in order to adopt specific policies aimed at reducing the inequalities and structural discrimination that they endure (United Nations, 2020j). However, few countries took up this call, and the main constraints were insufficient coverage of health records and weak political will. In Peru, for example, the Government issued a decree approving guidelines for incorporating the ethnic variable in the records of public entities, with a view to obtaining disaggregated COVID-19 data. However, although this variable encompasses Afrodescendants in principle, they are excluded in practice. This is because the guidelines define their scope of obligatory application as geographic areas in which there are indigenous peoples.[28] Nonetheless, specific examples of the differentiated impact of the pandemic can be demonstrated.

(a) Disparities in employment

The pandemic had major effects on productive activities, which could prove to be irreversible (ECLAC, 2020h). The drop in female labour market participation, as women took on additional care responsibilities (ECLAC/ILO, 2020b), evidenced the importance of this type of work and highlighted women's dual burden. In Brazil, half of all women took on additional care work during the social isolation stage; of these, 80.6% were responsible for the care of family members; and 54% of them were Afrodescendants, who performed these tasks with less external support (Prates and others, 2021).

The occupations hit hardest by the COVID-19 pandemic were those that cannot be performed remotely. In Latin America in the first year of the pandemic (2020), it was estimated that only 21.3% of workers could telework from home (ECLAC/OEI, 2020). In Brazil, the proportion of employed non-Afrodescendants who were teleworking was double that of Afrodescendants (17.6% compared to 9%, respectively) (IBGE, 2020). Thus, a heavily impacted occupation was domestic employment,[29] in which Afrodescendent women are represented disproportionately. According to ILO, between the last quarter of 2019 and the second quarter of 2020 the number of domestic workers declined by half in Latin America and the Caribbean (in Peru, it decreased by 70%) (ILO, 2021). In Ecuador (in the provinces of Imbabura and Carchi), many female domestic workers started to cultivate and produce medicinal herbs (intended for self-consumption, sale or non-monetary exchanges) in order to avoid unemployment and as a way to prevent and cure COVID-19 (CONAMUNE, 2021).

Afrodescendent youth were already at a disadvantage before the pandemic, when around 20% of this population group in urban zones, and up to 40% in rural areas, were neither studying nor employed in the labour market (UNFPA/ECLAC, 2022). This indicator displays glaring gender and territorial inequalities which are undoubtedly reinforced by ethnic-racial inequalities; in nine out of 14 of the region's countries analysed, young Afrodescendent women in urban areas were the group most likely to be neither studying nor employed in the labour market (UNFPA/ECLAC, 2022).

In Brazil, unemployment among Afrodescendants climbed from 11.5% to 16.6% between May and November of 2020, while that of non-Afrodescendants rose from 9.2% to 11.6%. These figures represent increases of almost 2.8 million and 1.1 million unemployed people, respectively (Prates and others, 2021). In Colombia, the territorial concentration of unemployment was greatest in municipalities with a large presence of Afrodescendants (Quibdó, Riohacha and Valledupar) (iMMAP/USAID, 2021).[30] Similarly, the cities of Riohacha and Quibdó, which are among

[28] Supreme Decree No. 005-2020-MC of 29 May 2020, which approved guidelines for incorporating the ethnic variable in the administrative records of public entities, in the context of the health emergency declared because of COVID-19. See [online] www.gob.pe/institucion/cultura/normas-legales/633316-005-2020-mc.

[29] In 2019, there were about 13 million people in domestic employment in Latin America and the Caribbean, of whom 91.5% were women, many of them persons of African descent. In Brazil and Uruguay, more than 16% of employed Afrodescendent women were paid domestic workers, which is about twice the percentage of non-Afrodescendent women in the same situation. In the region, only 9.8% of these workers were legally covered by social security (ILO, 2021).

[30] In Quibdó, 87.5% of the population is Afrodescendent, while in Valledupar, 12.2% of people self-identify as Raizales, Negras, Palenqueras, Mulatas or Afro-Americans, a proportion that is replicated in Riohacha (iMMAP/USAID, 2021).

the seven Colombian cities reporting the steepest fall in female employment, saw this shrink by over 32% in the third quarter of 2020 relative to the year-earlier period (Isaza, 2021). In Uruguay, the economic sectors hit hardest by the pandemic, with a consequent increase in unemployment, included retail businesses, domestic service, construction and transportation. These employ 59% of men and 46% of Afrodescendent women (World Bank, 2020).

Lastly, the Afrodescendent population —especially its women— has been one of the groups to suffer most during the pandemic, also because of their overrepresentation in occupations that are classified as essential. Despite these occupations being so declared, no policies were put forward to assist their workers, especially those who were undocumented or did not have authorization from their employer to move about, and who therefore ran the risk of being detained during quarantines periods.[31]

(b) Inequalities in infection, mortality and case fatality rates

In Brazil, racial-ethnic inequalities in indicators of COVID-19 infection and mortality are attributed, partly, to life expectancy differences between non-Afrodescendent and Afrodescendent populations.[32] In the initial months of the pandemic, Afrodescendants displayed a 10% higher mortality rate than non-Afrodescendants; and they died sooner when hospitalized in intensive care units (after six days, compared to 7.9 days for non-Afrodescendants). This is explained by their health history and also by the fact that they tended to enter intensive care units (ICUs) a day and a half later than non-Afrodescendants (11 days after the first symptom, compared to 9.4 days for non-Afrodescendants) (Muniz and others, 2021). By 9 April 2020, Afrodescendants accounted for 45.2% of COVID-19 deaths recorded in Brazil, while only representing 37.4% of all hospitalizations (ECLAC/UNFPA, 2020).[33]

In Colombia, Afrodescendants were 21% more likely to be hospitalized, 88% more likely to enter an intensive care unit and 24% more likely to die from COVID-19 than their non-Afrodescendent peers (Sinisterra, 2021). Case fatality rates for the Afrodescendent population were similar to those of the country as a whole (2.5 per 100 infected). However, according to data from early 2022, these rates can reach 6.5% and 5.1% among Afrodescendants, in the departments of Amazonas and Antioquia, respectively; and case fatality rates exceeded 4.0% in several other departments, including Nariño, Cauca and Valle del Cauca, where a sizeable proportion of the Afro-Colombian population lives.[34]

In Costa Rica, as of 31 January 2022, the provinces with the largest numbers of COVID-19 cases were as follows, in descending order: San José, Alajuela, Heredia, Puntarenas, Cartago and Limón.[35] Coincidentally, San José is home to 30% of the Afro-Costa Rican population, Alajuela accounts for 16%, Limón 15% and Puntarenas 11% (ECLAC, 2017a). In other words, 72% of the country's total Afrodescendent population was located in four of the six provinces with the highest number of COVID-19 cases. Moreover, in general, 2020 figures show that urban municipalities with a higher proportion of Afrodescendants tend to have higher levels of excess mortality, (ECLAC, 2022b). However, the absence of epidemiological records with data disaggregated by gender and ethnic-racial status did not make it possible to determine the percentage of the Afrodescendants affected by the disease.

In many countries, Afrodescendent communities are located in places that are difficult to access. In the case of Brazil's Quilombola communities, which total 1,331,106 people, 301 deaths and 5,666 confirmed cases of COVID-19 had been reported as of 12 January 2022,[36] implying a case fatality rate of 5.3%. This is almost double the national rate, which was 2.8% as of 31 January 2022.[37] The fact that these communities have scant access to health policies, adequate housing, basic services and regularization of the ownership of their communal lands, forces some of their inhabitants to leave in search of work.[38] Moreover, at the onset

31 It is estimated that around 30% of domestic workers were fined or harassed for moving without authorization (ECLAC, 2020f).

32 In 2019, for example, more than 31.7% of adults of African descent who died were under the age of 69 (compared to about 20.0% for those of non-African descent) (Ministry of Health of Brazil, 2022).

33 Ministry of Health of Brazil, cited in ECLAC (2020d).

34 Information as of 17 January 2022, on the basis of Government of Colombia (2022).

35 See [online] https://www.ministeriodesalud.go.cr/index.php/vigilancia-de-la-salud/41-lineamientos-coronavirus/527-situacion-nacional-covid-19.

36 See National Coordination of Quilombo Communities (CONAQ), "Observatorio Covid-19 en Quilombos" [online] https://quilombosemCOVID-19.org/.

37 As of that date, a cumulative total of 22,196,442 cases of the disease and 627,138 deaths had been recorded. See [online] https://covid.saude.gov.br/.

38 Unfortunately, policies to promote and support these communities have been dismantled in recent years. For example, funds allocated for the titling of their land were cut by more than 97% between 2013 and 2018, which has resulted in a significant reduction in the titling process. In 2019, 56 property titles were issued and up to October 2020 just 21, compared to over 200 in 2018 (Gualberto, 2021).

of the pandemic, many infected people were left without medical guidance or medicines and fell back on traditional knowledge to treat COVID-19. Another problem was insufficient access to services such as Internet, electricity and cellular phones, which made it difficult to submit online applications to receive emergency cash transfers. In Ecuador, mining activities were considered essential during the pandemic; but the necessary security measures were not adopted to prevent or reduce contagion (ECLAC/UNFPA, 2020).

(c) Access to the vaccine

Although some countries have endeavoured to record the administration of COVID-19 vaccines by ethnic group, the information available is insufficient, which highlights the need to strengthen information systems. In the case of Colombia, for example, the Ministry of Health and Social Protection has undertaken various dialogue and consensus-building actions with Afrodescendent communities, given the importance of deploying the vaccination plan in the territories. It has also published some information on the progress of vaccination among ethnic groups, but not in a systematic and detailed manner.[39]

In Brazil, the Ministry of Health has put an interactive information system in place to monitor vaccination, which makes it possible to disaggregate data by ethnic-racial group. According to official figures, as of 21 March 2022, a total of 391,293,789 doses had been administered, of which 25.6% corresponded to the Afrodescendent population and 49.8% to non-Afrodescendants, while 24.8% did not report their ethnic-racial group. Although these data reflect the quality problems that exist in the register, the asymmetrical distribution of vaccinated persons whose ethnic-racial status is reported does not match the distribution of the national population. As Afrodescendants represent slightly over half (50.9% according to the data presented in table II.5), it can be inferred that access has been biased against Afrodescendants. When the figures are revised to include the booster doses, a similar pattern emerges: of the 63.5 million booster doses applied, 51.4% to were given non-Afrodescendants and 22.8% to Afrodescendants, while in 25.6% of cases ethnic-racial status is unknown. Although the latter percentage is higher, the figures for persons who declare their ethnic-racial status show that Afrodescendants also have less access to the complete vaccination plan.[40] On the other hand, since the priority groups in the vaccination process were not identified explicitly, some municipalities vaccinated doctors and nurses first, while others included nursing technicians and cleaning staff in their campaigns (Afrodescendants are a majority in the two latter categories). In the vaccination figures for physicians, three times as many non-Afrodescendants are vaccinated (67%) compared to Afrodescendants (22%) (Muniz and others, 2021). Another key factor affecting the vaccination of Afrodescendants has been the scarcity or total lack of information about the strategies of COVID-19 vaccination, prevention and care processes implemented in some Afrodescendent communities and in the territories in which they live. This underscores the need for urgent improvement of health-care models among these peoples and communities.

3. Responses to the pandemic

(a) Government responses

During the pandemic, many governments implemented policies prioritizing the groups considered most vulnerable to the health crisis; but very few implemented policies targeted on the Afrodescendent population. Initially, countries such as Colombia, Costa Rica, Ecuador, Mexico and Peru published recommendations on how best to address the pandemic among ethnic groups. In Colombia, the Government even stressed the need to guarantee self-determination and interculturality and to leave the communities themselves to control mobility, activities and isolation in their territories, according to their cosmovision, uses and customs (Ministry of Health of Colombia, 2020).

[39] For further details, see [online] https://www.minsalud.gov.co/Paginas/Asi-va-la-vacunacion-contra-el-covid-19-en-grupos-etnicos.aspx and [online] https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/PS/boletines-poblacionales-narp.pdf.

[40] If the distribution of the total number of persons vaccinated is calculated according to ethnic-racial status, 34.1% of the total number of doses administered correspond to Afrodescendants and 65.9% to non-Afrodescendants. This assumes that persons who do not enter ethnic-racial data are distributed in the same way as those who do. Following the same procedure for the booster doses, 30.8% of those vaccinated were Afrodescendent, and 69.2% were not. See [online] https://infoms.saude.gov.br/extensions/DEMAS_C19_Vacina_v2/DEMAS_C19_Vacina_v2.html.

The Government of Costa Rica recommended that emergency committees should consider sociocultural factors and ensure use of the conceptual framework of intersectionality. Guidelines were also published on COVID-19 prevention and care among Afrodescendants (Ministry of Health of Costa Rica, 2020). In Ecuador, the Government issued a protocol on relevance of intercultural factors in COVID-19 prevention and care among indigenous, Afrodescendent and Montubio peoples. This included interactions between agencies and sectors, and also among social actors in the territories (Government of Ecuador, 2020). In the case of Mexico, the government highlighted the need to adopt measures that took account of the cultural relevance, self-determination and autonomy of indigenous and Afro-Mexican peoples, as well as dialogue for decision-making. It identified vulnerable groups as a priority and prohibited the refusal of health care based on criteria such as migratory status or nationality, among others (ECLAC, 2021e; United Nations, 2020g). Lastly, in Peru, information material was prepared and prevention campaigns were deployed in the regions with the highest Afrodescendent concentrations, in coordination with their leaders (ECLAC, 2021e). A document was also published containing guidelines for the formation and operation of indigenous or Afrodescendent COVID-19 command centres, which were to include representatives of their organizations (Government of Peru, 2021).

In addition, countries such as Ecuador and Honduras prepared plans that included the provision of food and pedagogical support in response to school closures; the promotion of economic autonomy and participation in decision-making; and the revalorization of Afrodescendent culture and ancestral knowledge with support for economically and environmentally sustainable business models (United Nations, 2020c and 2020d). In the economic domain, Brazil adopted a special law to support Afrodescendent communities (Quilombolas).[41]

(b) Autonomous responses by the Afrodescendent population

The Afrodescendent population mobilized to face the pandemic through their organizations and communities, in many cases using their own resources, given the relative lack of government support. The practices developed were diverse, the most frequent including the provision of information on the disease and the distribution of food, hygiene articles and medicines.

An initial and important outcome of the mobilization of Afrodescendent people was the issuance of recommendations for dealing with the pandemic in a community-based manner and also highlighting the need for government work to be coordinated with the communities. Examples of this were seen in Brazil, Colombia, Honduras, Panama and Nicaragua. In Brazil, an active favelas movement was formed, which aimed to produce new information and also to collate information existing in dispersed form.[42] In Colombia, the National Conference of Afro-Colombian Organizations (CNOA) called for coordinated work with the territorial and national authorities, as well as the formation of community networks.[43] In Honduras, the Black Fraternal Organization of Honduras (OFRANEH) and the Community-based Ethnic Development Organization (ODECO), the country's two main Garifuna organizations, worked to disseminate information on prevention, care and impact. In Nicaragua, radio campaigns were broadcast in the native languages of the Afrodescendent population (ECLAC, 2021e; CNOA, 2020; Agudelo, 2021; Joseph, 2020).

Another very frequent action was the delivery of food, hygiene and medical supplies,[44] in addition to the provision of places in which to quarantine. Important examples can be found in Argentina, Brazil, Chile, Ecuador, Nicaragua, Panama, Peru and Uruguay,[45] where Afrodescendent organizations in some cases collaborated with government institutions in implementing these activities (ECLAC/UNFPA, 2020; Joseph, 2020).

41 See Law No. 14021 of 7 July 2020 [online] http://www.planalto.gov.br/ccivil_03/_Ato2019-2022/2020/Lei/L14021.htm.

42 This was done through a website (Wikifavelas), which gathered information on self-care and community care, contestable funds, news, and audiovisual material produced by the favelas themselves, as well as analyses and proposals for overcoming their problems. The website also requested support for promoting the favelas' own products and services; and it published accounts on the proceeds of fundraising campaigns and products received. See [online, Portuguese only] https://wikifavelas.com.br/index.php?title=Coronav%C3%ADrus_nas_favelas.

43 Mayors' offices (4), secretariats (15), grassroots organizations and community councils (20), educational institutions (15), universities (2 private and 1 public) and community libraries were all linked at the territorial level, implementing a comprehensive care programme in the areas of food, health, education, community and epidemiological intelligence with the objective of ending ethnic-racial gaps and generating capacities (Perini and Lara, 2021).

44 As face masks were not commercially available at the start of the pandemic, many communities in Brazil and elsewhere started to produce them. One project even brought together several civil society organizations and banks to produce and deliver masks to health institutions and vulnerable communities (ECLAC/UNFPA, 2020).

45 In Rivera (Uruguay), products were delivered to Afrodescendent families that had been previously identified by the organizations, and the model has been used to support local commerce.

Autonomous responses also included control of the territory and the use of their own health systems in the treatment of COVID-19 symptoms. As an example of the former, in Nicaragua, four indigenous and Afrodescendent communities of the Autonomous Region of the South Caribbean Coast, protected by Law No. 28 (Statute of Autonomy of the Regions of the Caribbean Coast of Nicaragua), decided to impose a quarantine and adopt the necessary prevention measures in their communities, including control of persons entering and leaving (Villena, 2021). In Brazil, the Paraisópolis favela[46] achieved better control of the pandemic than other vulnerable neighbourhoods in the city.[47] This was partly due to the fact that, as from their first case of infection and with a degree of control of the territory, they designed a plan in which each street had a person in charge of monitoring, orienting, distributing basic-commodity baskets and combating false information.[48]

In terms of the application of their own health systems, in Colombia, displaced Afrodescendent communities (which represent about 12% of all internally displaced persons in the country) drew on their ancestral knowledge and medicinal herbs. As these people resettled, they shared their knowledge of these plants. Although there is no conclusive scientific evidence that they are effective, they are a tool in the attempt to alleviate COVID-19 symptoms or prevent infections. Displaced communities emphasize the need to use ancestral medicine and demand its recognition by health services (Olaya, 2021). Similarly, in the Afro-Ecuadorian ancestral territories of Imbabura and Carchi, higher levels of female unemployment led many women to start cultivating medicinal herbs (CONAMUNE, 2021).

It is also important to note that, in the midst of the health crisis, Afrodescendent youth, especially tertiary education students, participated in volunteer work related to psychosocial support, food packing, document preparation, and cultural and entertainment activities, among others (Working Group on Youth of the Regional Collaboration Platform for Latin America and the Caribbean, 2021). Young people have also shown concern about the increase in youth unemployment in the Afrodescendants and the increase in the digital divide and domestic violence owing to the pandemic. To address problems such as these, they held virtual dialogues, emphasizing the importance of the struggle for equality (UNFPA, 2020b). In turn, the Secretary-General of the United Nations stressed the need to empower young Afrodescendants and ensure their participation in decision-making, especially in the crisis caused by the pandemic (United Nations, 2020j).

Mention should also be made of the use of violence by law enforcement agents and the militarization of certain territories during the pandemic.[49] In Brazil, for example, it was reported that police operations were conducted while basic food baskets were being distributed, often resulting in the death of young residents, the majority of whom were Afrodescendent (Pires, 2020). Between May and August 2020, there was a 36% increase in the number of people killed by police in favelas (United Nations, 2020f). In other cases, Afrodescendent organizations also reported excessive use of force against young Afrodescendants owing to isolation measures imposed because of the pandemic, and the existence of racial profiling in arrests and other actions targeting young, mostly Afrodescendent, people (UNFPA/ECLAC, 2022).

G. Persons with disability

In Latin America and the Caribbean, it has been estimated that there are about 70 million people living with some kind of disability (ECLAC, 2014a). They constitute one of society's most excluded groups and are among those most affected by the pandemic. Prior to the health, economic and social crisis caused by the COVID-19 pandemic, persons with disability were already less likely to participate in the community and to access health

[46] This favela, located in the city of São Paulo, has more than 70,000 inhabitants and a population density of 61,000 inhabitants/km2 (ECLAC/UNFPA, 2020).

[47] As of 18 May 2020, the COVID-19 mortality rate was 21.7 persons per 100,000 inhabitants, compared to the municipal average of 56.2 per 100,000 inhabitants (ECLAC/UNFPA, 2020). For further information on the strategy employed, see [online] https://outride.rs/es/favela-vs-covid-19/paraisopolis/.

[48] Ambulances, doctors, and nurses were hired, and 240 residents were trained to support the 60 bases created. These included firefighters, neighbourhood councils and two public schools that were transformed into isolation centres for the sick.

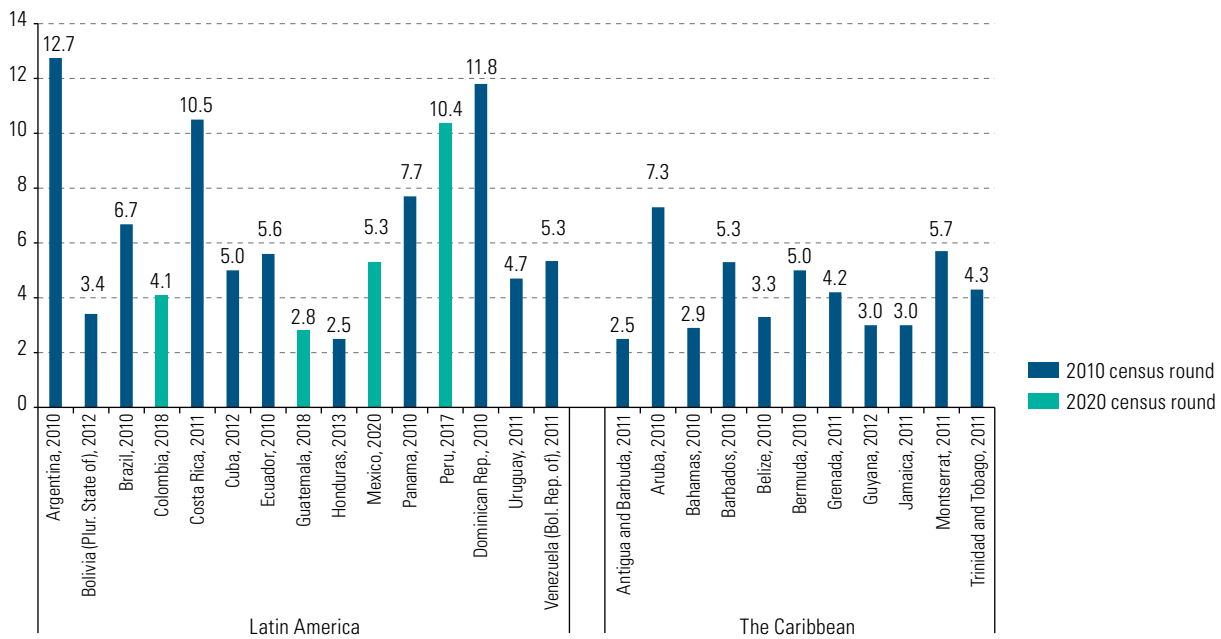
[49] The Office of the United Nations High Commissioner for Human Rights (OHCHR) has called for an end to impunity for human rights violations committed by law enforcement officials (United Nations, 2021b); while the Working Group of Experts on People of African Descent has noted that restrictions imposed during the pandemic have sometimes been used as a pretext for disproportionate enforcement and violence against people of African descent (United Nations, 2020f).

care, education and employment. Many of them live in poverty; and they are exposed to violence, neglect and abuse at higher rates than the rest of the population; they are also among the most marginalized groups in communities in crisis situations (ECLAC, 2021b and 2020a).

1. The sociodemographic situation of persons with disability in Latin America and the Caribbean prior to the pandemic

According to data from 26 of the region's countries and territories that conducted their censuses in the 2010 and 2020 rounds, about 6.5% of the Latin American and Caribbean population has some type of disability, which represents a significant group of the regional population. The highest percentages are found in four countries —Argentina, Costa Rica, the Dominican Republic and Peru— where the population with disability exceeds 10%; the lowest percentages are found in Antigua and Barbuda and Honduras (see figure II.18).[50] It is also necessary to investigate the sociodemographic characteristics of these people, since they face huge challenges in terms of gaining access to spaces and in opportunities for education, health and decent work, among other areas, especially in the crisis situation caused by the pandemic.

Figure II.18
Latin America and the Caribbean (26 countries and territories): proportion of persons with disability, 2010 and 2020 census rounds
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata from the respective countries processed with REDATAM and F. Jones and L. Serieux-Lubin, "Disability, human rights and public policy in the Caribbean: a situation analysis", *Studies and Perspectives series–ECLAC Subregional Headquarters for the Caribbean*, No. 64 (LC/CAR/TS.2017/12; LC/TS.2017/151), Santiago, ECLAC, January 2018.

[50] The percentages of persons with disabilities may be underestimated in some countries, since several of them did not include the internationally recommended questions in their censuses; in some cases, dichotomous answers were used or questions from different methodological approaches were combined. Caution is therefore needed when aggregating these census data at the regional level, because the methodological approaches used differ from one country to another; and degree disability is not considered in all cases. For further information on international recommendations on the inclusion of questions to measure disability in censuses, see ECLAC (2019a), Washington Group on Disability Statistics (2017) and CDC (2009).

(a) The importance of measurement: proportion of persons with disabilities, age and sex structure, and types of disability

Although the aggregate number of persons with disability in the region is known, this information is not fully up-to-date, since the censuses were conducted at different times, mainly in the 2010 decade, and they do not use the same approach when measuring disability. When the pandemic began in Latin America and the Caribbean, not all countries in the region had the most up-to-date information on the number of persons with disability, together with their sociodemographic and socioeconomic characteristics.

Information from four countries that have conducted censuses in recent years (Colombia, Guatemala, Mexico and Peru) shows that the proportion of persons with disability in urban and rural areas varies from country to country. Guatemala and Peru have a larger proportion of persons in urban zones than in rural areas, while the opposite is the case in Colombia and Mexico: the proportion of persons with disability is slightly higher in rural areas (see table II.6).

Table II.6
Latin America (4 countries): proportion of persons with disability, by area of residence, 2010 and 2020 census rounds
(Percentages)

	Colombia, 2018	Guatemala, 2018	Mexico, 2020	Peru, 2017
National total	4.1	2.8	5.3	10.4
Urban areas	3.8	3.0	5.2	10.7
Rural areas	4.9	2.5	6.4	8.8

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata from the respective countries processed with REDATAM.

The age structure of persons with disability tends to be older than that of persons without disability, since the proportion of persons with disability is higher in the middle and upper ages brackets (see table II.7) (ECLAC, 2021b). In addition, disability is more prevalent among women: the male-to-female ratio is systematically below 1, with 90 men for every 100 women (ECLAC, 2021b). This is more accentuated after the age of 60, mainly because "women's longer life expectancy would increase the chances of having a disability associated with a chronic disease or an accident in later stages of life (González and Stang, 2014, p. 83).

The fact that persons with disability tend to be older means that this population group has the comorbidities typical of older ages. These may or may not be related to the type of disability presented, but they result in more serious cases of COVID-19, since the virus exacerbates existing health problems and increases the probability of death among those over 60 years of age (WHO, 2020b; Meresman and Ullmann, 2020). Although systematic historical data in the region do not exist, there is information from Europe and the United States that reports higher mortality among persons with a disability, particularly in the case of mental and psychosocial disabilities (Ayoubkhani and Bosworth, 2021; Gleason and others, 2021).

In terms of types of disability, in the four countries under study, which held censuses between 2017 and 2020,[51] the largest proportion of the population with disability reports difficulty seeing, even if they use glasses (rates are between 24% in Colombia and 48% in Peru), while mobility limitations are the second most frequently mentioned (with rates ranging from 20% in Peru to 30% in Mexico). The third-ranked disability is difficulty hearing, even if using a hearing aid (rates range from 10% in Colombia to 15% in Guatemala). Persons with disabilities also report limitations in understanding or comprehension, ranging from 8% in Peru to 15% in Mexico, as well as limitations in performing self-care tasks,[52] ranging from 3% in Mexico to 8% in Guatemala.

There are significant gender differences in the type of limitations experienced. For example, difficulties seeing even when wearing glasses and difficulties moving and walking are more prevalent among women, while difficulty hearing is the most prevalent limitation among men, followed by difficulty moving and walking (ECLAC, 2021b). From the onset of the pandemic, WHO considered that persons with disabilities may be at greater risk of contracting COVID-19 owing to a variety of factors, which are more significant the higher the prevalence of some limitation (ECLAC, 2021b), for example, mental and psychosocial disability. Among persons with disabilities, some have underlying comorbidities or health disorders and maybe at greater risk of developing more severe cases of COVID-19 if they become infected. (WHO, 2020b).

51 With some nuances, the four countries (partially) follow the recommendations of the short set questions of the Washington Group on Disability Statistics.

52 This domain, which concerns self-care tasks, warrants consideration because it is a proxy for the number and proportion of people who need support to perform everyday activities and therefore require daily care (ECLAC, 2021b).

Table II.7
Latin America (4 countries): age structure of persons with and without disability and male-female ratio by age group, 2020 census round
(Percentages and value of the Male-female ratio)

	Colombia, 2018				Guatemala, 2018				Mexico, 2020				Peru, 2017			
	People with disabilities		People without disabilities		People with disabilities		People without disabilities		People with disabilities		People without disabilities		People with disabilities		People without disabilities	
	Percentage	Male-female ratio	Percentage	Male-female ratio	Percentage	Male-female ratio	Percentage	Male-female ratio	Percentage	Male-female ratio	Percentage	Male-female ratio	Percentage	Male-female ratio	Percentage	Male-female ratio
Under 18 years of age	10.6	124.9	28.5	104.3	14.6	114.0	34.7	101.4	14.2	134.6	31.5	102.2	14.3	102.7	33.3	103.0
18–29 years of age	9.5	116.1	21.3	98.6	12.4	109.2	25.5	92.2	8.7	112.9	20.2	96.5	10.4	81.5	21.1	97.2
30–59 years of age	34.0	86.6	38.4	90.7	29.2	89.4	31.9	86.8	30.0	91.8	38.1	90.9	34.7	63.0	37.0	98.3
60 years of age and older	45.9	74.9	11.9	82.7	43.9	83.5	7.9	90.7	47.0	76.2	10.2	88.7	40.5	77.1	8.6	98.2
Total	100.0	86.7	100.0	95.0	100.0	92.2	100.0	93.3	100.0	90.4	100.0	95.2	100.0	75.5	100.0	99.6

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata from the respective countries processed with REDATAM.

Contrary to the situation in some developed countries, the region does not have data on the number of infections and deaths disaggregated according to disability status, so the information available is limited.[53] When such information does exist, it is on specific situations resulting from the work of civil society organizations that engage with persons with disabilities. These organizations have also stressed the fact that, in the most complex moments, persons with disabilities have faced obstacles in accessing health care, medicines, outpatient care and rehabilitation, and also in accessing mental health care in accessible modalities (ECLAC, 2021b; Meresman and Ullmann, 2020). With respect to the difficulties in accessing essential health services that affect persons with disabilities, PAHO (2021b) noted that, during the pandemic in Latin America and the Caribbean, the interruption of access to health services for persons with disabilities attained a rate of 31%.

Since the pandemic began, and particularly as it intensified in some countries in the region, both the Committee on the Rights of Persons with Disabilities and the Special Envoy of the Secretary-General on Disability and Accessibility have issued various communications urging States to take all appropriate measures to ensure access to health services for persons with disabilities, and to provide them with the same range, quality, and level of care as provided to others. This includes mental health services, primarily because COVID-19 redefined many areas of care, generated fears, and exacerbated attitudinal and communication barriers.

Persons with disabilities who contract coronavirus disease are entitled to be treated with dignity, to make decisions with autonomy, to have their wishes and preferences respected, to have their free and informed consent sought, and to have the privacy of their personal data protected. This should be done especially taking account of Articles 10, 25 and 28 of the Convention on the Rights of Persons with Disabilities; the 2030 Agenda for Sustainable Development and its Sustainable Development Goals, in particular Goal 3, on health and well-being; and several priority actions of the Montevideo Consensus on Population and Development, in particular priority actions 26, 33 and 77, which refer to the promotion, protection and guarantee of health, sexual and reproductive rights, as well as the development and well-being of people in all territories, without any type of discrimination.

(b) Households and families that contain persons with disabilities: care and support facilities under increased pressure during the pandemic

Persons with disability are more likely to live in extended families rather than nuclear ones. This is because they need personal support and assistance in daily activities, and because the community, society and the State, view disability as a purely private matter, and do not provide the necessary support.

In all countries, the percentage of households that have at least one member with some type of disability far exceeds the proportion of people with disabilities. Considering the four countries with the most recent census data, from 2017 to 2020, it can be stated that in Peru one in every four households has one or more members with some type of disability; in Guatemala and Mexico around 15% of households have a person with a disability, while in Colombia the equivalent figure is one in every 10 households (ECLAC, 2021b). However, it is also noteworthy that about 10% of persons with disabilities live in single-person households (ECLAC, 2021b).

In the context of the health crisis and the lockdown measures that countries implemented to curb the transmission of the virus mainly in the first 12 months of the pandemic, persons with disabilities, particularly those living alone, were faced with situations in which their rights were violated (ECLAC, 2020a).[54] Access to essential goods and services to maintain their well-being was interrupted. This is especially critical in the case of health, rehabilitation and care services, but also in the case of medicines, assistive devices and special

[53] For example, a study in England showed that, among men, the risk of death from COVID-19 was 3.1 times higher for those with disabilities than those without; and for women, it was 3.5 times higher. In the case of persons with intellectual or psychosocial disabilities, both men and women, the risk of death from coronavirus disease was 3.7 times higher than for persons without such disabilities. The study also concluded that no single factor alone explains the considerably raised risk of death involving COVID-19 among disabled people, and place of residence, socio-economic and geographical circumstances, and pre-existing health conditions all play a part; an important part of the raised risk is because disabled people are disproportionately exposed to a range of generally disadvantageous circumstances compared with non-disabled people (Ayoubkhani and Bosworth, 2021).

[54] The study by González (2021) notes that the restrictions imposed in Uruguay during the emergency affected the procedure for applying for the Personal Assistance Programme benefit. This had negative consequences for people who had already begun the process and for new applicants. In Colombia, although numerous measures have been adopted by the national government to address the COVID-19 emergency, very few relate to the protection of persons with disabilities during the pandemic period (Camargo and López-Zamora, 2021).

foods, among other goods (ECLAC, 2020a). In addition, support relationships and the continuity of care were suspended at times, and support networks were weakened or truncated by full quarantines. In mid-2020, several countries in the region started to relax lockdown measures for the caregivers of persons with disabilities or for children and adolescents with autism spectrum disorder (ASD), to enable them to leave their homes during a specific time slot (Meresman and Ullmann, 2020). Although these restrictions have now been lifted in the region's countries, persons with disabilities must still maintain some restrictions for self-care reasons, in order to reduce the chance of becoming infected.

Women are the main caregivers, especially in households that include a person with a disability who requires daily support. This care is distributed between formal arrangements (educational and care centres, and paid domestic work, among others) and informal solutions (support from relatives and neighbours, among others). During the strictest lockdown periods, these arrangements were reduced or dispensed with, which put added pressure on female caregivers, since this work increased exponentially, with the burden falling mainly on women (ECLAC, 2020c).

In economic terms, households that have persons with disability face greater pressures. They incur higher expenses on health, rehabilitation, education, and purchase and maintenance of assistive devices, as well as on medicines and transport (ECLAC, 2020a). Moreover, meeting care needs may force a member of the household to abandon paid work; and, in general, it is women who withdraw from the labour market. This affects household incomes, which are already suffering the consequences of the economic crisis in the countries of the region; and it may aggravate poverty situations unless governments put support mechanisms in place to cover or subsidize the costs and needs of these households (ECLAC, 2020a).

(c) Socioterritorial inequalities that affect the risk of contagion

Several of the priority actions in Chapter G "Territorial inequality, spatial mobility and vulnerability" of the Montevideo Consensus on Population and Development call for the development and well-being of people to be promoted in all territories. Similarly, both priority action 77 of the Montevideo Consensus and article 28 of the Convention on the Rights of Persons with Disabilities address the issues of adequate standard of living and social protection. The Convention requires States to ensure essential basic services, which must be accessible to persons with disabilities on an equal basis with others.

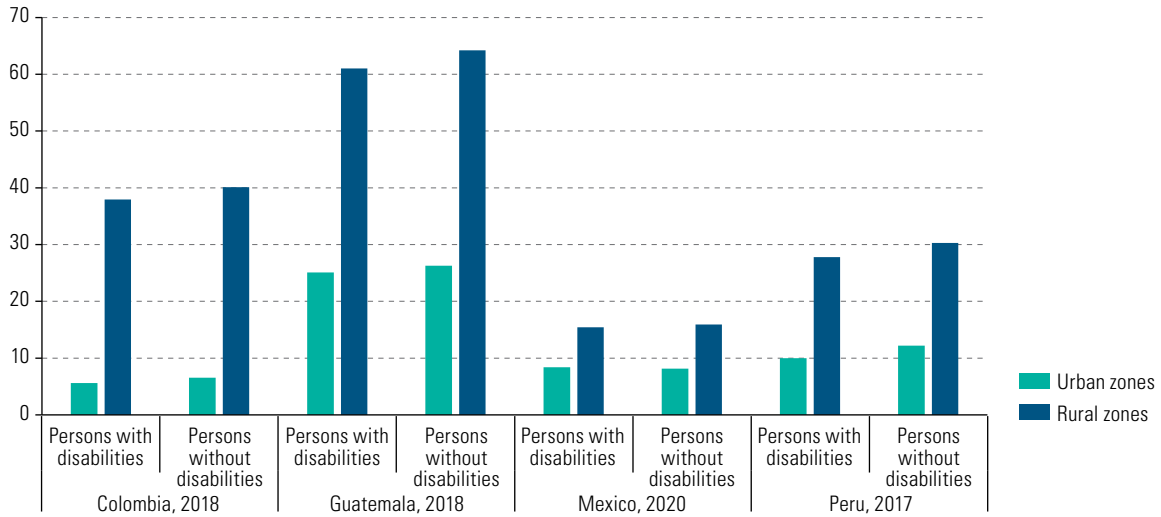
(i) Water and sanitation

In line with Sustainable Development Goal 6 (clean water and sanitation), the United Nations has stated that "availability and access to water, sanitation and hygiene (WASH) services is fundamental to fighting the virus and preserving the health and well-being of millions" (United Nations, 2020h). Accordingly, persons with disabilities should always have access to safe drinking water within their dwellings to comply with prevention measures; and the toilet or sink should not present physical access barriers.

Two regional reports issued prior to the pandemic noted that access to safe drinking water had improved in most countries; nonetheless, disparities between urban and rural areas persisted (ECLAC, 2019b and 2019c). In the four countries analysed, there are practically no differences in access between persons with and without disability. However, among persons with disability, those living in rural areas have less access to drinking water than their urban counterparts (see figure II.19).

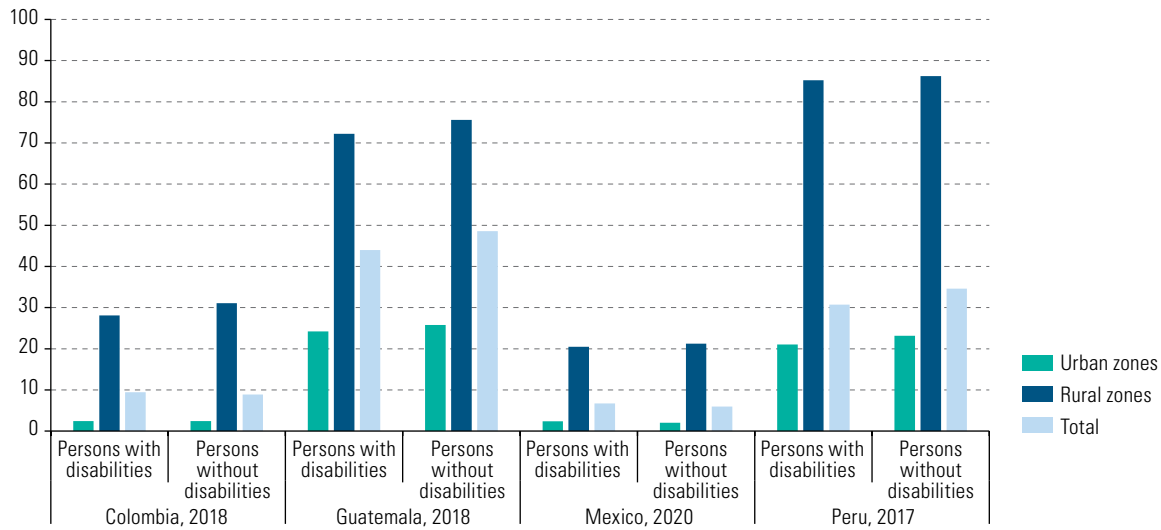
In terms of access to sanitation within the dwelling, the trends are similar in the four countries: there are practically no access disparities between persons with and without disabilities, although there are glaring differences between urban and rural areas (see figure II.20). Colombia and Mexico have the lowest proportions of the population without access to this service, at less than 10%. In Guatemala, the proportion rises to 48%, and in Peru it is around 33%.

Figure II.19
Latin America (4 countries): proportion of population without access to drinking water inside the dwelling, by disability status and area of residence, censuses of the 2020 round
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata from the respective countries processed with REDATAM.

Figure II.20
Latin America (4 countries): proportion of population without access to sanitation inside the dwelling, by disability status and area of residence, censuses of the 2020 round
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata from the respective countries processed with REDATAM.

(ii) Overcrowding

The degree of household overcrowding is another variable that completes the triad of sociodemographic factors that increase the probability that coronavirus will be transmitted and spread. In households that have persons with disabilities, overcrowding poses a particularly high barrier to implementing measures to prevent COVID-19 infection. It is not easy for people with disabilities to maintain physical distance, since in many cases they need others to support them. There are also times when, given their poverty, they have to share a room with several other members of the household. Moreover, at times of quarantine and mandatory lockdown, there are no spaces for privacy and moments of rest for those who provide support to persons with disabilities.

Data on overcrowding in households show that the proportion of households that are overcrowded is higher among persons with disabilities. In Guatemala, half of the households that contain persons with disabilities are overcrowded (51%); in Mexico and Peru, the percentage is around 20%, and in Colombia, 16%. Although overcrowding is greater in rural areas, the proportion of urban households containing persons with disabilities that are overcrowded is also high, especially in the context of the current health crisis (ECLAC, 2021b).

It is therefore particularly important for health agencies, and those responsible for adopting measures to halt the spread of COVID-19 in the region's countries, to consider the situation of overcrowding experienced by persons with disabilities.

(d) Access to and use of information and communications technologies

There is a divide between persons with and without disabilities in terms of their access to and use of ICTs. Table II.8 shows that in the three countries analysed, a larger proportion of persons without disabilities have access to the Internet, a computer or a mobile phone at home, compared to those with disabilities, and that the disparity is much greater in Mexico.

Table II.8
Guatemala, Mexico and Peru: proportion of population without access to the Internet, a computer or a mobile phone at home, by disability status, 2020 census round
(Percentages)

	Persons with disabilities			Persons without disabilities		
	Guatemala, 2018	Mexico, 2020	Peru, 2017	Guatemala, 2018	Mexico, 2020	Peru, 2017
No Internet access at home	85.0	55.1	70.4	83.8	44.4	69.5
No access to a computer at home	82.0	72.3	65.3	79.4	59.6	63.6
No mobile phone access at home	56.3	19.2	18.4	38.6	10.5	13.9

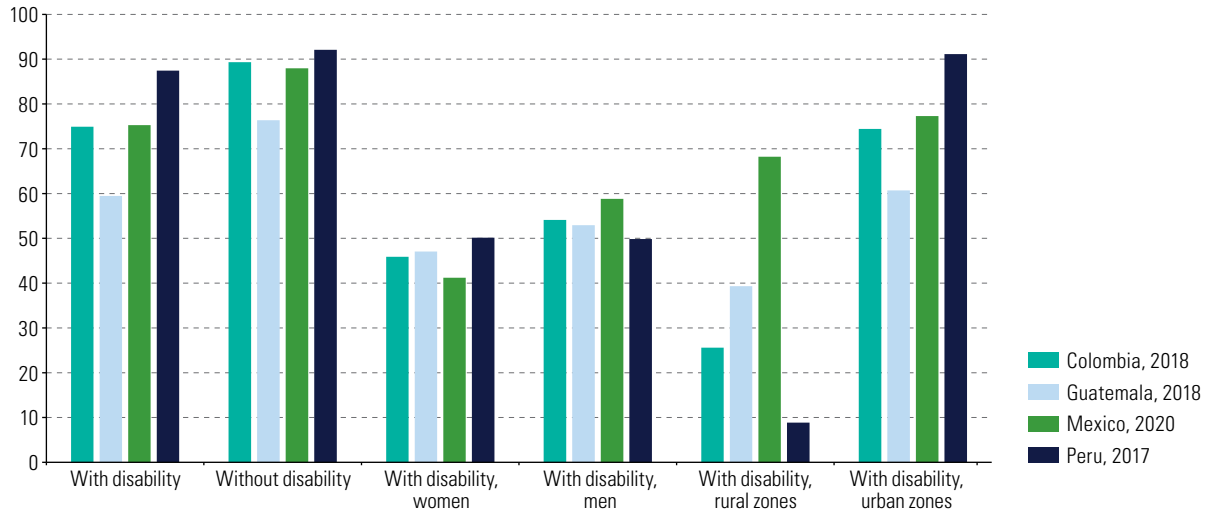
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata from the respective countries processed with REDATAM.

Persons with disabilities face specific barriers in their use of ICTs, depending on their type of disability. This means that the access percentages that have been reported do not reveal the real disparities that affect persons with disabilities when using these technologies (ECLAC, 2021b). Therefore, it is not enough to support access to ICTs only in economic terms; but applications should be created that allow for inclusive access to ICTs, taking diverse types of disability into account (ECLAC, 2021b).

(e) Level of education and school attendance

Prior to the pandemic, access to formal education among persons with disabilities was lower than that of persons without disabilities, as can be seen in the case of the four countries with census data from the 2020 round. The disparities between persons with and without disabilities range from 5 percentage points in Peru to 17 points in Guatemala. The gaps between rural and urban areas are particularly large (see figure II.21). Access to educational opportunities for boys and male adolescents with disabilities is very similar to that of girls and female adolescents with disabilities.

Figure II.21
Latin America (4 countries): proportion of children and adolescents attending school, by disability status, sex and area of residence, 2020 census round
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata from the respective countries processed with REDATAM.

After the onset of the pandemic, one of the first measures adopted in most countries was the suspension of face-to-face classes at all levels of education (ECLAC, 2021b). The document *Social Panorama of Latin America, 2021* states that, because of COVID-19, Latin America and the Caribbean is "one of the regions of the world with the longest interruption of face-to-face classes: on average, about 56 weeks of total or partial interruption" (ECLAC, 2022a, p. 122). It is estimated that around 167 million students were affected in the region (Meresman and Ullmann, 2020; ECLAC/UNESCO, 2020; ECLAC/UNICEF, 2021).

The countries of the region have initiated distance learning modalities in a variety of ways, using a range of formats and platforms (ECLAC/UNESCO, 2020). In general, suitable conditions for implementing online education in an expeditious manner for children and adolescents with disabilities did not exist (Meresman and Ullmann, 2020), since specific complex factors are present in the case of students in this situation. For example, they do not have the support of multidisciplinary teams to guide their school activities; and, at home, it is not easy to implement work routines, which are essential for good learning outcomes (ECLAC, 2020a).

Although there are no regional data on the number of children and adolescents with disabilities that were affected by school closures, census data from the four countries that have already conducted censuses in the 2020 round (Colombia, Guatemala, Mexico and Peru) clearly shows disparities in access to formal education, which were accentuated during the pandemic (Meresman and Ullmann, 2020; ECLAC, 2021b). Thus, it is highly likely that priority measure 9 of the Montevideo Consensus on Population and Development, "Invest in youth, through specific public policies and differentiated access, especially through the provision, without discrimination, of universal, free, public, secular, high-quality, intercultural education", has suffered significant setbacks with regard to children and adolescents with disabilities.

Given the barriers that students with disabilities may face in accessing online education, there may have been a risk of educational disengagement and dropout after the onset of the pandemic, particularly among the most vulnerable groups (ECLAC/UNESCO, 2020). In early 2022, most countries in the region have decided to resume face-to-face classes. In this context, it is important to monitor the return of students with disabilities, as they should not be prevented from returning owing to their being considered a risk group, or because of a lack of resources to support their reintegration.

(f) Labour inclusion

Prior to the crisis caused by the pandemic, data in the region showed that persons with disabilities experience higher unemployment rates and are more likely to be economically inactive than those without disabilities. If they are working, they are more likely to have low-paying, informal and unstable jobs with limited career prospects (ECLAC, 2019d and 2021b). The report titled *Persons with disabilities and coronavirus disease (COVID-19) in Latin America and the Caribbean: status and guidelines* (ECLAC, 2020a), states that persons with disabilities already had a weak position in the labour market and significant participation in the services sector and informal employment. Similarly, the report titled *Persons with disabilities and their rights in the COVID-19 pandemic: leaving no one behind* (ECLAC, 2021b) indicates that the proportion of persons with disabilities who work is small, and less than one third are engaged in a paid activity. In terms of occupational category, it is found that, regardless of age, persons with disabilities are mainly own-account workers and employees or unskilled workers. There are also differences between urban and rural areas, with a higher percentage of persons with disabilities working as employees or unskilled workers in urban areas, while in rural areas they are mostly own-account workers (ECLAC, 2021b).

Therefore, it is foreseeable that people with disabilities will be particularly affected by the adverse labour market scenario during the crisis and recovery period (ECLAC, 2020a). However, there are no systematic data on the loss of employment and income among persons with disabilities. As an example, however, sources mentioned by ILO point to a 39% loss of income among the population with disabilities in Paraguay (Meresman and Ullmann, 2020). In Ecuador, on the other hand, the monitoring of labour market inclusion conducted by the National Council for the Equality of Disabilities (CONADIS) shows that over 2,700 people with disabilities have lost their jobs as a result of the economic crisis in the initial months of the pandemic (Meresman and Ullmann, 2020).

This information, together with that provided by civil society organizations that engage with persons with disabilities shows that the problems of access to work, participation in economic activity and precarious employment among persons with disabilities, which were already considerable, have been accentuated during the COVID-19 crisis (ECLAC, 2021b).

2. Public policy actions implemented by governments in the light of the Montevideo Consensus and other international instruments

In different forums and in several regional documents on COVID-19 (Meresman and Ullmann, 2020; ECLAC, 2020a, 2021b and 2022a), it has been argued that persons with disabilities are not being considered fully in the strategies being implemented to respond to the pandemic in the different countries. In the current context, protection of the rights of persons with disabilities needs to be strengthened, particularly when there is a binding international instrument and other global and regional instruments that advocate this. The Convention on the Rights of Persons with Disabilities, the 2030 Agenda for Sustainable Development and the Montevideo Consensus on Population and Development place persons with disabilities at the centre and, therefore, call for them to be involved throughout the process of designing and implementing public policies, as well as in accountability. These instruments emphasize the need for States to take particular care of persons with disabilities in emergency situations.

(a) Actions in the health area

Article 11 of the Convention on the Rights of Persons with Disabilities provides that States Parties shall take "all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters" (United Nations, 2006). Governments must therefore ensure that all necessary measures are adopted to prevent persons with disabilities from contracting COVID-19; and, if they have already been infected, that they have prompt access to the health systems needed for their care.

In this context, both ECLAC (2022a and 2021b) and Meresman and Ullmann (2020) report that most countries implemented two basic accessibility measures. One was to ensure that relevant information, particularly that contained in official epidemiological reports, was provided in accessible formats, including the use of sign language interpreters and subtitling, or simplified versions with iconographic components. Essential information was thus made available to persons with disabilities and to their families, although the speed with which this was done varied across countries. The second refers to the fact that the information campaigns that provided on how to prevent COVID-19 transmission and promoted basic care measures, in nearly all cases used a variety of media (television, radio, Internet and written press), and modalities that are accessible to persons with certain disabilities (mainly sign language). Family health centres at the local level have distributed concise and clear information for persons with psychosocial disabilities. In addition, various social organizations in Colombia, Costa Rica, Ecuador, El Salvador, Mexico, Paraguay and Uruguay have implemented disability-specific precautionary measures; for example, they have produced face masks displaying a text to warn that the person has a disability, and have developed and disseminated materials designed especially for the population with disabilities, in accessible formats, containing instructions for the prevention, containment and mitigation of COVID-19.

Article 25 of the Convention on the Rights of Persons with Disabilities (which refers to the right to health), along with article 28 (on adequate standard of living and social protection), underscore the need for States to enhance measures and actions to ensure equal access to social protection programmes and to ensure that people can enjoy this right without discrimination on the basis of disability (United Nations, 2006). Goal 3 of the Sustainable Development Goals advocates similarly: "Ensure healthy lives and promote well-being for all at all ages". In this regard, the actions implemented by the countries in the health domain include, in the case of Argentina, Chile, Colombia, Costa Rica, Ecuador, Mexico, Panama and Uruguay, sign language interpretation services to provide support to those who needed this to ensure the continuity of basic services, needed to clarify doubts, or were seeking information on available services and access modalities (ECLAC, 2021b; Meresman and Ullmann, 2020).[55] Support persons have been exempted from travel and physical distancing restrictions, to allow them to assist persons with disabilities (ECLAC, 2021b). Community support networks have been created, and volunteers have been recruited to support persons with disabilities and help the elderly in their shopping for food and other products. Civil society has undertaken support initiatives to provide alternative care and attention to persons with disabilities who needed this to maintain their daily activities, in Argentina, Colombia, Cuba, Ecuador and Uruguay, among other countries (ECLAC, 2021b; Meresman and Ullmann, 2020). In addition, several countries in the region implemented partial or gradual exception mechanisms for people with disabilities and their families. For example, Argentina, Chile, Costa Rica, Ecuador, Panama and Uruguay implemented measures to relax restrictions and thus allow the providers of support to persons with disabilities to continue performing their tasks. During prolonged periods of confinement and quarantine, families with children subject to ASD and other psychosocial disabilities were allowed to take short walks and participate in other outdoor activities, to promote the well-being of individuals who are often extremely dependent on their daily routines (ECLAC, 2021b; Meresman and Ullmann, 2020).

Persons with disabilities have been among the priority groups included in the initial stages of the COVID-19 vaccination process in most countries (ECLAC, 2022a). It remains essential to ensure that vaccination plans are implemented on an inclusive basis, that differences are taken into consideration, and that protocols adjusted to the population with disabilities are designed (ECLAC, 2022a). Participation by persons with disabilities should be guaranteed throughout the vaccination process and in decision-making, to avoid situations of discrimination or exclusion. The accessibility of information on vaccination and preventive campaigns needs to be guaranteed, taking account of the diverse types of disability, as well as the adaptation and reasonable adjustments needed to make vaccination centres accessible (ECLAC, 2022a). Lastly, progress should be made in statistical records and monitoring of the vaccines, disaggregated by disability, so that both the acceptance and the coverage of the vaccination process of this population will be known in the future (ECLAC, 2022a).

[55] Although sign language is highlighted as the main accessibility measure, it should be remembered that accessibility also has other dimensions, such as measures to improve visual formats and tactile information. Consideration must also be given to content, which should provide synthetic information with key concepts highlighted and distinguished.

(b) Social protection actions

Social protection measures need to consider article 28 of the Convention on the Rights of Persons with Disabilities, which deals with adequate standard of living and social protection; as well as priority actions 1 and 77 of the Montevideo Consensus on Population and Development and Sustainable Development Goal 1 (end poverty), particularly target 1.3, which refers to the implementation of appropriate social protection systems and measures for all. Meresman and Ullmann (2020) note that many of the region's countries announced emergency cash transfers. However, it was impossible to gauge the extent to which the population with disabilities had been effectively considered. Nor were adaptations and adjustments systematically observed that would enable this population to obtain information on the benefits in question.

Cash transfers were made in Argentina, the Bahamas, Barbados, Brazil, Chile, Colombia, Ecuador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia, Saint Kitts and Nevis and Suriname. These were implemented through increases, advances and extensions of pre-existing benefits, and through vouchers, food coupons, hygiene products and items for other extraordinary expenses. In some cases, they were provided once only, while in others they were delivered repeatedly for several months. The measures were accompanied by actions to ensure that the population with disabilities had access to consultations and information through WhatsApp messages and Internet (ECLAC, 2022a; Meresman and Ullmann, 2020; Knox-Vydmanov, Cote and Wodsak, 2021). Goods of basic necessity (food, medicines and hygiene items) were also delivered to persons with disabilities in Chile, Costa Rica, Guatemala and Uruguay, through cooperation campaigns in conjunction with private firms that joined the emergency response (Meresman and Ullmann, 2020).

(c) Employment actions

Article 27 of the Convention on the Rights of Persons with Disabilities addresses the issue of work and employment and recognizes "the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and a work environment that is open, inclusive and accessible to persons with disabilities" (United Nations, 2006). States must therefore create conditions for working persons with disabilities to be able to continue their activities with the maximum safeguards. In 2020 and 2021, a number of countries implemented measures in response to the critical situation faced by the population owing to the loss of employment sources and the suspension of economic activities. However, these measures did not always include people with disabilities. Meresman and Ullmann (2020) note that Argentina, Ecuador and Mexico have sought to include the population with disabilities in the responses implemented and to make the available tools accessible, so as not to worsen their situation. In these countries the measures were aimed at incorporating workers with disabilities by providing monthly financial assistance to subsidize their wage, issuing guidelines to enable people with disabilities to continue teleworking, and encouraging companies and institutions to implement teleworking as a modality for people with disabilities. Workers with disabilities were included in the measures adopted for all workers should they become unemployed, maintaining access to health care, social security savings, family allowance and access to intermediation services and job training.

(d) Education actions

Article 24 of the Convention on the Rights of Persons with Disabilities, which addresses education, requires States Parties to "ensure an inclusive education system at all levels" and asserts that one of the reasons for this is to enable "persons with disabilities to participate effectively in a free society" (United Nations, 2006, p. 14). Sustainable Development Goal 4 (quality education), "Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all", sets various targets in which persons with disabilities are considered and highlights access to inclusive school physical spaces and the development of educational materials for all. In this regard, it is important to make sure that students with disabilities are not left behind or excluded from education systems owing to the pandemic, since this could jeopardize hard-won gains in inclusive and comprehensive education. Directly related to the aforementioned is priority measure 9 of the

Montevideo Consensus, which refers to the need to "Invest in youth, through specific public policies and differentiated access, especially through the provision, without discrimination, of universal, free, public, secular, high-quality, intercultural education."

Ever since the onset of the pandemic, international recommendations have promoted the continuity of the educational link, emphasizing the need to ensure that the most susceptible children and adolescents do not disengage from education and to exhaust all possible options to encourage them to continue learning (ECLAC/UNESCO, 2020). This is even more important for students with disabilities, where it is necessary to reduce the barriers they may encounter, as far as possible, trying to assess, on a case-by-case basis, the need for support to provide continuity in their studies and make the necessary adaptations. It is especially important that these students do not lose connection with their formal educational environments, so that they are not excluded because of a lack of technical support and reasonable adjustments (ECLAC/UNESCO, 2020). Another challenge also arises in the medium and long terms: to prevent students with disabilities being left confined to their homes and receiving distance education only, in order to simplify accessibility. The greatest wealth of inclusive educational places are the relationships that are generated among all students, and the links between them, their teachers and the educational community: this not only improves the condition of the student with disabilities, but also enriches relationships for all. Measures and actions to be implemented in the short and medium terms should act to protect and guarantee children's rights, as well as the rights of children with disabilities and the social protection of families that include children with disabilities (ECLAC, 2021b).

The reasonable adjustments implemented in some countries have included participation in distance education programmes by sign language interpreters, often through teleconsultations. Although it is impossible to quantify their availability or assess the number of consultations made, these are important and relatively frequent practices. In Argentina, Belize, Colombia, Brazil, Mexico, Guatemala, Peru and the Plurinational State of Bolivia, teacher training actions were undertaken in relation to students with disabilities (Meresman and Ullmann, 2020). In Argentina, Chile, Costa Rica, Cuba, Ecuador, El Salvador, Mexico and Peru, television and radio were also deployed as distance education tools, integrating accessible modalities and in some cases making curricular adaptations to their pedagogic proposals.

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CHAPTER

III

The sociodemographic impacts of COVID-19 in the Caribbean

A. Older persons and those with noncommunicable diseases (NCDs)
B. Children, adolescents and youth
C. Women
Bibliography

The Caribbean has been affected by many of the same health, social and economic repercussions of the coronavirus disease (COVID-19) pandemic as Latin America: there have been waves of cases and deaths; reduced business activity and travel; periods of school closure; and restrictions on social interaction. This section of the document addresses selected sociodemographic impacts on the Caribbean, focusing on those which have affected the subregion either more strongly or in a notably distinct way, when compared to the situation in Latin America.

The incidence of COVID-19 and related mortality have followed a rather different pattern in the Caribbean. In the first year of the pandemic, while Latin America was one of the world's most heavily affected regions, the number of cases per capita and death rates in the Caribbean generally remained lower, closer to the global average. During this period, the measures taken by Caribbean governments, including border controls —with the ensuing drop-off in tourism and other travel— controlled the spread of the virus.

During 2021, however, the incidence of COVID-19 and deaths caused by the disease started to increase in the Caribbean and, in August of that year, infection rates overtook those in Latin America. For most of the rest of the year, case and mortality rates were much higher in the Caribbean than in Latin America (and well above global averages). During this latter part of the year, COVID-19 caused around 4–7 deaths per day per million inhabitants in the Caribbean (similar to the rates in North America during this period). In Latin America, meanwhile, by December 2021, daily deaths had fallen to a low of less than 1 daily death per million inhabitants.

From the end of 2021 to January 2022, the wave of Omicron variant cases rapidly drove up incidence across the world to previously unseen levels. In the Caribbean, cases greatly outstripped the September 2021 high of around 320 per day per million inhabitants, reaching 1,000 in mid-January 2022, compared to a rate during the Omicron wave of 700 in Latin America and a global average of around 430. This wave of infections kept mortality rates high in the Caribbean through January and most of February 2022. However, with the peak in cases passing relatively quickly, the mortality rate then fell below 2 by early March 2022, in both the Caribbean and Latin America (see figure III.1A).

Figure III.1
Selected regions and countries: COVID-19 deaths and vaccination rates, 1 March 2020–10 March 2022

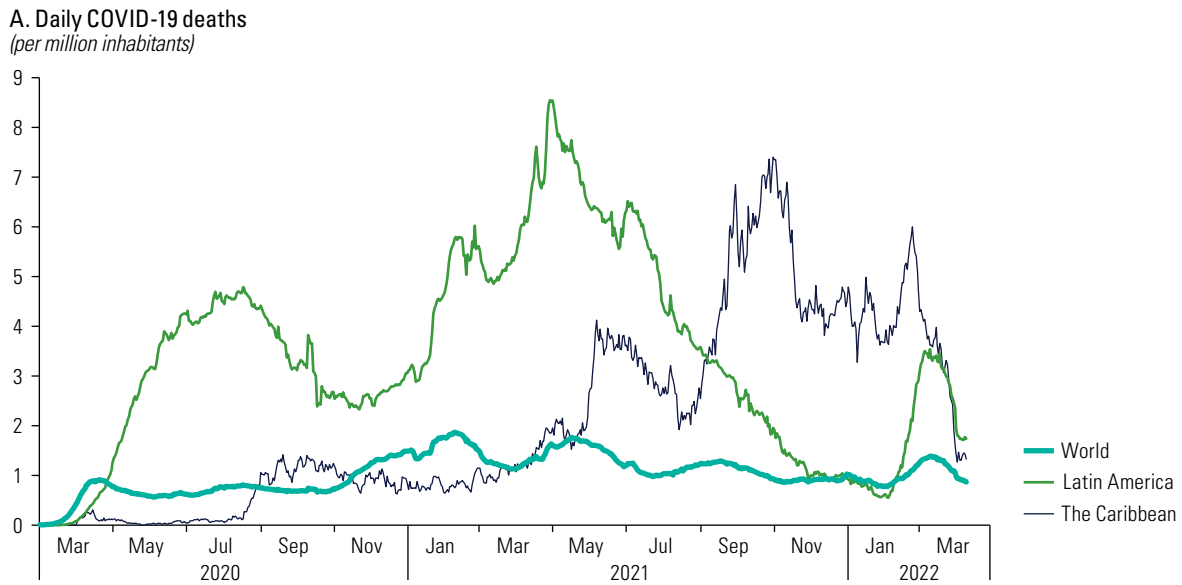
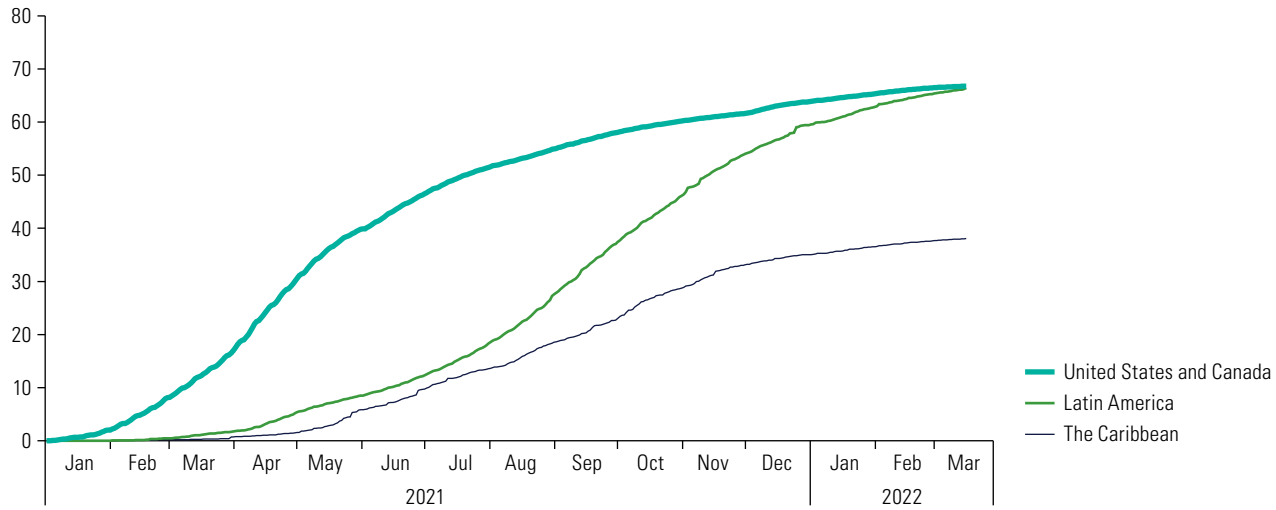


Figure III.1 (concluded)

B. Population fully vaccinated
(percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of H. Ritchie and others, "Coronavirus Pandemic (COVID-19)", 2020 [online] https://ourworldindata.org/coronavirus and data from Johns Hopkins University.

Note: Daily estimates of COVID-19 deaths for the Caribbean (A) are based on data for 21 Caribbean countries and territories (Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Curaçao, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago and the Turks and Caicos Islands), while the daily estimate of the percentage of the population fully vaccinated (complete schedules per 100 people) (B) is based on data from 22 countries (the 21 countries mentioned above plus Sint Maarten).

There is considerable variation from country to country in the number of deaths caused by COVID-19. The Caribbean countries and territories with the highest death tolls have been Trinidad and Tobago, Martinique, Guadeloupe, Suriname and the British Virgin Islands, all with more than 200 deaths per 100,000 inhabitants (see figure III.2A). The territories with the lowest number of deaths have been Dominica, Saint Kitts and Nevis, Anguilla, Montserrat and the Cayman Islands, all with fewer than 90 deaths per 100,000 inhabitants.[1]

The vaccine rollout has been slower in the Caribbean compared with Latin America and North America. The overall vaccination rate in the Caribbean is 38% compared with 66% in Latin America, 67% in the United States and Canada and 57% globally (see figure III.1B).[2] Among Caribbean countries, vaccination rates range from 92% in the Cayman Islands to 22% in Jamaica (see figure III.2B). The low level of vaccination has contributed to the relatively high number of deaths in the subregion since September 2021. The mortality rate in the Caribbean, for example, was similar to that in the United States and Canada in the latter part of 2021, even though COVID-19 case rates were significantly higher in North America.

During the first half of 2021, both Caribbean and Latin American countries encountered difficulties obtaining COVID-19 vaccines in sufficient quantities. The region is heavily dependent on imports of both medicines and the raw materials required for the development of health technologies, and high-income countries hoarded the relatively scarce supply of vaccines (ECLAC/PAHO, 2021). In a competitive scramble for a finite supply, it was particularly difficult for small island developing States to secure vaccine doses. Some overseas territories were able to roll out their vaccination programmes more rapidly, having sourced vaccine supplies with the help of the Netherlands, the United Kingdom or the United States.

In the second half of 2021, it became more apparent that vaccine hesitancy was undermining efforts to inoculate the population. When governments considered or, in some cases, implemented vaccine mandates (compulsory vaccination for certain groups of workers, such as health-care workers) this provoked protests, most notably in Guadeloupe, Martinique and Saint Vincent and the Grenadines. There have been repeated

1 As at 21 March 2022.
2 As at 10 March 2022.

instances of Caribbean countries obtaining vaccine supplies but then being unable to use them in full owing to the unwillingness of a significant minority of the population to present themselves for vaccination. When this has occurred, vaccine doses have been donated between Caribbean countries to try and minimize wastage. During 2021, Trinidad and Tobago, for example, received vaccine donations from Barbados, Bermuda, Grenada and Saint Vincent and the Grenadines, while it donated to Bahamas, Dominica, Grenada and Saint Kitts and Nevis. Despite these efforts, between August and October 2021, tens of thousands of doses expired before they could be administered (United Nations, 2021a).

Figure III.2
The Caribbean (26 countries and territories): COVID-19 deaths and vaccination rates, to 21 March 2022

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), "WHO Coronavirus Disease (COVID-19) Dashboard" [online] https://covid19.who.int/ and Pan American Health Organization (PAHO), "COVID-19 Vaccination in the Americas" [online] https://ais.paho.org/imm/IM_DosisAdmin-Vacunacion.asp [accessed on 22 March 2022].

To better understand the reasons for vaccine hesitancy, a study was conducted during October and November 2021 (CADRES/USAID/UNICEF, 2021). The results confirmed that an estimated 38% of the population across the six Caribbean countries surveyed was choosing to remain unvaccinated. Survey respondents provided various reasons for not getting vaccinated, including concerns about safety, possible long-term side effects, lack of trust in the government or medical authorities, or pre-existing medical conditions. Only 17% of those who had chosen not to get vaccinated made this decision after consulting a doctor. Notably, many of those who had chosen not to get vaccinated were in favour of the continued use of restrictions to manage the pandemic, so vaccine sceptics are not necessarily dismissive of the threat posed by the virus. This does at least provide some common ground and a starting point for engaging with those who have not yet been persuaded to get vaccinated. The Pan American Health Organization (PAHO) also conducted a survey on COVID-19 vaccine hesitancy among Caribbean health workers in 14 countries. It found that 23% of health workers were "vaccine-hesitant"[3] while 4% stated an intention to refuse a COVID-19 vaccine altogether (PAHO, 2021a).[4]

Public health officials need to be aware of public attitudes to vaccination including anti-vaccination messages on social media and respond with communication strategies to address the trust deficit. There is evidence from some developed countries that vaccine hesitancy has declined during the pandemic (ONS, 2021; Melbourne Institute, 2021), presumably because people can clearly see the protection that vaccination provides against COVID-19, which shows that anti-vaccination attitudes are not immutable.

A. Older persons and those with noncommunicable diseases (NCDs)

As COVID-19 spread during the first months of 2020, it quickly became clear that older persons and persons with NCDs were at significantly greater risk of severe illness and death. For those contracting the virus, underlying health conditions, together with age, are major determinants of both severity of illness and mortality. The population is slightly older in the Caribbean, with 10.5% aged over 65, than in Latin America, with 8.9% (United Nations, 2019). The subregion also has a relatively high disease burden attributable to NCDs, which is 17% higher in the Caribbean than in Latin America (after standardizing for age).[5] The differential is most notable for cardiovascular diseases, diabetes and kidney diseases, and to a lesser extent neoplasms (see figure III.3).

There is overwhelming evidence that, once they are infected by the virus, patients with certain chronic illnesses —such as diabetes, hypertension (and other cardiovascular diseases) and respiratory, renal or hepatic conditions— have a much higher likelihood of worse clinical outcomes (developing a more severe form of the disease or dying) than an average patient (Nikoloski and others, 2021). NCD risk factors such as obesity, tobacco and alcohol consumption, and physical inactivity are also linked to worse outcomes for COVID-19 patients (WHO/UNPD, 2020; Bello, 2021). Obesity in particular is strongly linked to severe COVID-19 illness and mortality; one study found that with a body mass index of greater than 35 the odds of severe illness were seven times higher (Simonnet and others, 2020). Tobacco smoking, meanwhile, directly increases vulnerability to respiratory infectious diseases (WHO/UNPD, 2020).

It has been argued that the links between COVID-19 and NCDs are so strong that instead of being thought of as a pandemic, COVID-19 is better understood as a "synergistic epidemic" or "syndemic" (Horton, 2020). A syndemic refers to a set of linked health conditions, interacting synergistically, with both biological and social interactions, which are important for prognosis, treatment, and health policy (Singer and others, 2017).

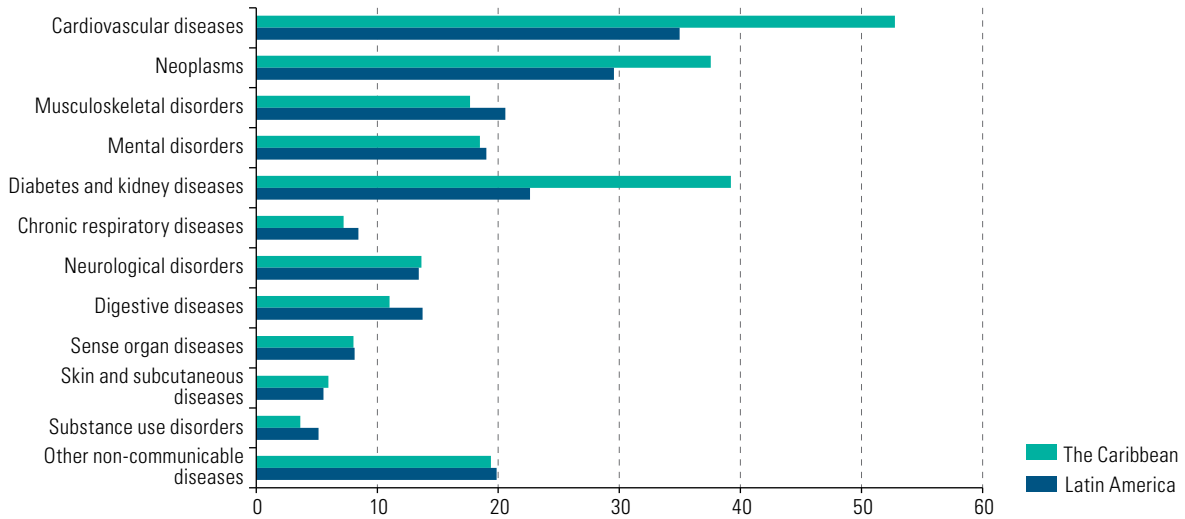
[3] Agreement with the statement "If a COVID-19 vaccine becomes available, I intend to get it as soon as possible" was used as a proxy for vaccine acceptance. Those who disagreed or strongly disagreed with this statement were considered to be COVID-19 vaccine-hesitant.

[4] Vaccine hesitancy is commonly linked to lack of trust in governments and is fed by misinformation on social media. Opinion surveys indicate that trust in public institutions has declined in recent decades while trust in all news sources, including scientific authorities, seems to be at an all-time low (United Nations, 2021b). Studies have shown that there is a relationship between the activity of anti-vaccination campaigners (few of whom are medically trained) and public doubts about vaccine safety (Lloyd Wilson and Wiysonge, 2020; Hernandez and others, 2021).

[5] Measured using disability-adjusted life years (DALYs), a widely used measure of the burden of disease. DALYs are calculated as the sum of years of life lost (YLL) and years lived with a disability condition (YLD) and therefore one DALY can be thought of as one lost year of healthy life. The measure is age-standardized.

COVID-19 is interacting with a range NCDs, together with socioeconomic inequalities, which lead to different levels of susceptibility to the virus. The syndemic lens emphasizes the need to address not just COVID-19, but also underlying NCDs and socioeconomic factors.

Figure III.3
Latin America and the Caribbean: disability-adjusted life years, by type of noncommunicable disease and subregion, 2019
(Age-standardized rate per 1,000 inhabitants)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from T. Vos and others, *Global Burden of Disease Study 2019, The Lancet*, vol. 396, October 2020.

Recent studies by ECLAC (Abdulkadri and others, 2021) and the Healthy Caribbean Coalition (HCC, 2021) have underscored the need for a renewed effort to reduce the burden of NCDs. The ECLAC report indicated that the Caribbean was not on track to achieve Sustainable Development Goal target 3.4 to "reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" by 2030. HCC, meanwhile, called for a transformative new NCD agenda and recommended building on existing interventions and programmes which are focused on life course prevention and universal health care, together with more participatory engagement of civil society and improved information and communication systems.

Like their counterparts in Latin America, Caribbean public health systems were ill-equipped to respond to the COVID-19 crisis (ECLAC, 2021 and 2022a). Public health systems are underfunded, and public spending on health has fallen below the regionally agreed threshold of 6% of GDP in most Caribbean countries. This underfunding prevents public health systems from providing comprehensive primary and secondary care for the entire population while tertiary care is further complicated by the challenges involved in treating rare and complex conditions across small island populations. These constraints have affected the public health response to the pandemic. In Saint Lucia, hospitals reported staff and oxygen shortages as COVID-19 hospitalizations increased during 2021; similar shortages of clinical supplies impeded health-service delivery in Dominica, Grenada and Saint Vincent and the Grenadines (PAHO, 2021b).

The low level of public spending on health goes hand in hand with high out-of-pocket expenses in the countries of the region, which is a major source of structural inequality in access to health services and therefore health outcomes (ECLAC/PAHO, 2021). The need to incur out-of-pocket expenses for health-care treatment and medication increases the risk of impoverishment, especially for people in vulnerable situations who, on average, are in poorer health and so more in need of health care.

Furthermore, health systems are diverting resources to address the pandemic, which inevitably has consequences for prevention, care, and treatment services for other conditions, including NCDs. Delayed diagnosis and treatment lead to worse clinical outcomes while reduced incomes also act as a disincentive for patients to present themselves

for treatment. Managing the pandemic to minimize its health impacts therefore means not only being concerned about illness and death which is directly attributable to COVID-19, but also ensuring that the focus on the pandemic does not lead to any increase in morbidity and mortality owing to other conditions going undetected or untreated.

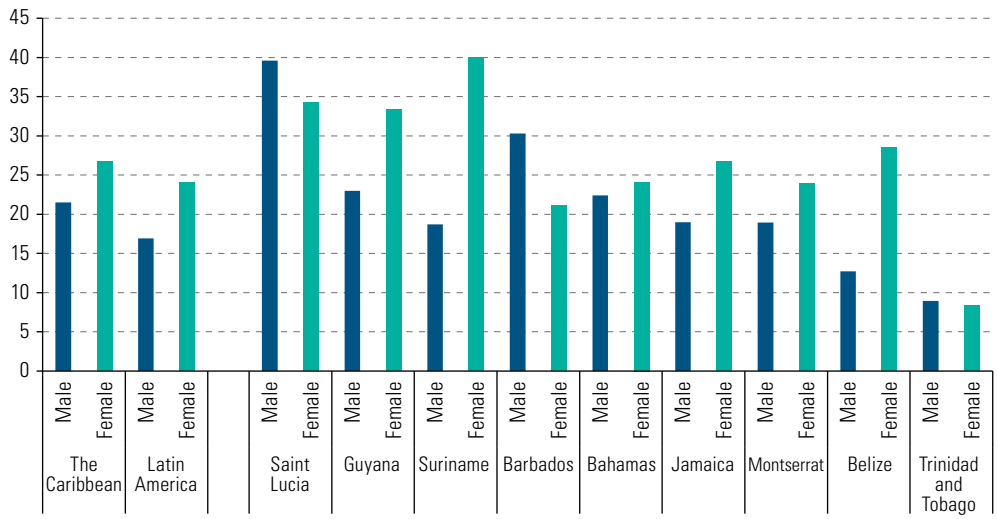
With severe pressure on underresourced public health-care services, older persons could face difficulties in accessing treatment, either for COVID-19 or other conditions, as well as age discrimination. For those who reside in long-term care facilities, such as nursing homes, infection prevention and control standards are a matter of life and death. While the health of older persons depends on polices which restrict movement and social contact, the damaging impact of isolation and loneliness upon their health and well-being cannot be ignored, and should be mitigated wherever possible, for example through technology. In the longer term, the structural weaknesses exposed by the COVID-19 pandemic must be addressed through the universalization of health services, social protection and the strengthening of legal frameworks for the protection of the human rights of older persons. The COVID-19 pandemic should serve as a wake-up call to refocus on NCD prevention and treatment to reduce the population's vulnerability to infectious disease and improve long-term health and well-being.

B. Children, adolescents and youth

The social and economic disruption caused by the pandemic has had a detrimental impact on young people. Based on data from United Nations Children's Fund (UNICEF), in February 2022, schools were fully closed in 7 out of 17 Caribbean countries, partially closed in 6 countries and fully open in 4 (UNICEF, 2022). Most Caribbean schools were closed during the early months of the pandemic. Since September 2020, schools have reopened and then closed again (either partially or fully) whenever deemed necessary to control waves of infections.

Youth transitions, from education or training to work, partnership and parenthood are being undermined by disruption to education systems and other support networks, and a lack of decent work opportunities. These disruptions in turn prejudice human capital development, mental health and well-being. Even before the pandemic, youth unemployment was high in many Caribbean countries, at around 25% since 2010 (Jones, Camarinhas and Gény, 2019). This is high by international standards and about three times the adult rate. Youth unemployment is particularly high in Guyana, Saint Lucia and Suriname (see figure III.4).

Figure III.4
Latin America (17 countries) and the Caribbean (9 countries): estimated youth unemployment rates (15–24 years) by sex, 2016–2021
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of International Labour Organization (ILO), ILOSTAT [online database] https://ilostat.ilo.org/.

Note: The estimates for the Caribbean are simple averages of the 9 countries shown in the figure, while for Latin America they are simple averages for 17 countries (Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, Peru, Paraguay, Plurinational State of Bolivia, and Uruguay).

The unemployment rate is highest among 15–19 year-olds. Most of this age group are in some form of education or training (neither employed nor unemployed), but the high unemployment rate among those young people who are in the labour market is a further reason for encouraging members of this age group, boys in particular, to continue their education. The unemployment rate among 20–24 year-olds is also high, albeit not as high as the rate among 15–19 year-olds. Overall, there are more unemployed 20–24 year-olds than 15–19 year-olds (because those in the older of these two age groups are much more likely to be labour market participants). A study of Organisation of Eastern Caribbean States (OECS) countries, for example, found an average unemployment rate of 40% among 15–19 year-olds and 22% among 20–24 year-olds (OECS Commission/UNICEF, 2021). The same study also showed that, among all persons aged 15–24, including those who are not labour market participants, an average of 14% were unemployed, but that if the broader category of not in employment, education or training (NEET) was used (which does not depend on whether someone is seeking work), then 22% of 15–24 year-olds fell into this category.

The onset of the COVID-19 pandemic has made it even more difficult for young people seeking to enter the workforce. Caribbean economies were severely impacted, even more so than those in Latin America, primarily owing to their dependence on the tourism sector, which saw widespread loss of jobs and livelihoods. Amidst the economic downturn, employers are less likely to take on new staff and young people looking for employment face an acute shortage of decent work opportunities.

Labour force surveys conducted since the beginning of the pandemic have shown how youth unemployment increased after its onset in March 2020. Based on national estimates, youth unemployment in Jamaica increased from 20.2% in July 2019 to 30.4% in July 2020 (although it had declined to 23.9% by July 2021); in Belize the rate increased from 21.4% in September 2019 to 23.0% in September 2020; while in Saint Lucia, after declining from 41.0% to 31.6% between 2015 and 2019, the rate then increased to 34.4% in the second quarter of 2020 and to 42.0% in the second quarter of 2021.[6]

High youth unemployment and a lack of decent work make it difficult for young people to become fully independent, leaving many dependent on relatives for an extended period. Employment opportunities for Caribbean youth are mostly found in low-skill jobs. The social and economic costs of this are high: alienation, exclusion, migration, deprivation and a high incidence of crime. To support young people in finding pathways through the pandemic, measures must be adopted to improve the quality of learning and training (whether in-person or remote), to provide decent work opportunities for young people, and to protect mental health and well-being.

The pandemic is also affecting young people's access to sexual and reproductive health services. Caribbean countries tend to have relatively high rates of unmet need for contraception.[7] Based on estimates and projections for 2019, the Caribbean countries with the highest rates are Guyana and Suriname with unmet need[8] of 26.1% and 23.4%, respectively, compared to an average of 9.7% for the Latin America and Caribbean region (United Nations, 2020). Unmet need is particularly high among the young, owing to societal and legal barriers preventing them from accessing services, such as the requirement for parental consent. In Guyana and Suriname, for those aged 15–19 unmet need is around 60% compared to rates of around 20% for those aged 35–39 (BoS/Ministry of Public Health/UNICEF, 2015; Ministry of Social Affairs and Public Housing, 2019).

Delivery of sexual and reproductive health services is being affected by the pressures that the pandemic is placing on already overstretched health-care systems, undermining progress towards ending unmet need for family planning services by 2030. Weaknesses have been exposed in reproductive health commodity supply chains and logistics management information systems, contributing to low availability and often stock-outs of modern contraceptives (UNFPA, 2021a). UNFPA estimated that across 13 Caribbean countries, this disruption to supply chains equated to the loss of 89,121 couple-years of protection;[9] 75,830 unintended pregnancies; 11,898 abortions; 45 maternal deaths and 595 neonatal deaths between November 2020 to July 2021 (UNFPA, 2021b).

6 National estimates calculated using different age groups (Jamaica, 15–24; Belize, 14–24; and Saint Lucia, 15–29). For further information see: Statistical Institute of Jamaica (2021 and 2022); Statistical Institute of Belize (2020); and Central Statistical Office of Saint Lucia (2020 and 2021).

7 See for example ECLAC (2022b) or UNFPA (2010).

8 Unmet need for family planning (the proportion of married or in-union women aged 15–49 who want to stop or delay childbearing but are not using any method of contraception), model-based estimates.

9 The estimated protection provided by family planning methods during a one-year period.

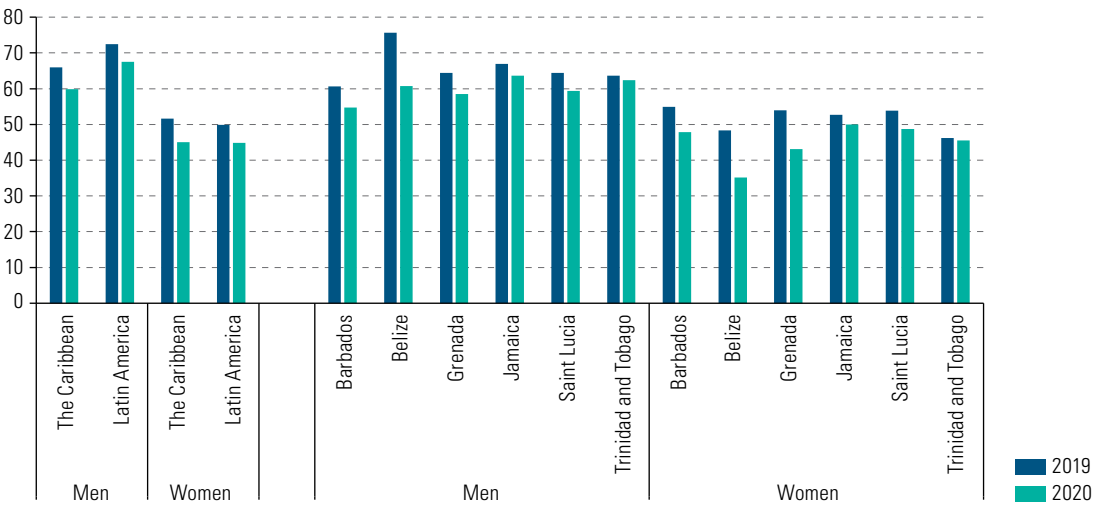
Providers have sought to adapt services and outreach programmes to the COVID-19 context. They have put in place procedures to make in-person interactions as safe as possible for service users and providers while making greater use of remote consultations, counselling and health education sessions. Measures such as these to maintain continuity of sexual and reproductive health services, together with a renewed focus on longstanding barriers, are essential to the achievement of universal access by 2030.

C. Women

The pandemic has disproportionately impacted Caribbean women. Their incomes have been adversely affected, they have faced an increased burden of unpaid care work and have been at increased risk of intimate partner violence.

Female employment in the Caribbean has tended to be concentrated in particular sectors, for example tourism (hotels and restaurants) and retail or personal services (Padmore, 2021), which have been significantly affected by the collapse of tourism and COVID-19 restrictions. Workers were laid off or had their hours reduced and informal workers dependent on the tourist trade also lost their livelihoods. Between 2019 and 2020, the average employment rate across six Caribbean countries fell by 6 percentage points for men and 7 percentage points for women (figure III.5). This compares to average falls of 5 percentage points for both men and women in Latin America. Alongside this reduction in employment, there were increases in both unemployment and inactivity. In a survey of almost 14,000 households across six Caribbean countries, carried out by the Inter-American Development Bank (IDB) in July 2020, it was found that among low-, middle- and high-income households, it was low-income households that were the most likely to be affected by loss of employment and high-income households the least likely (Arteaga Garavito, Beuermann and Giles Álvarez, 2020). In the same survey, more than 70% of households reported reduced income in the preceding week (Arteaga Garavito, Beuermann and Giles Álvarez, 2020).

Figure III.5
Latin America (17 countries) and the Caribbean (6 countries): employment rate by sex, 2019–2020
(Percentages)



Source: Economic Commission for Latin America and the Caribbean/International Labour Organization (ECLAC/ILO), "Policies to protect labour relations and hiring subsidies amid the COVID-19 pandemic", *Employment Situation in Latin America and the Caribbean*, No. 25 (LC/TS.2021/163), Santiago, 2021.

Note: The estimates for the Caribbean are simple averages of the 6 countries shown in the figure, while for Latin America they are simple averages for 17 countries (Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Honduras, Mexico, Nicaragua, Panama, Paraguay, Plurinational State of Bolivia, Peru and Uruguay).

During 2020, governments sought to provide emergency assistance through stimulus packages which included support to businesses to help them retain workers, temporary unemployment benefits, expansion of public assistance programmes, and relief on loan repayments and utility bills. Labour market and social protection responses continued on a significant scale in 2021, albeit with some COVID-19 emergency measures either dropped or integrated into pre-existing programmes (and not necessarily presented as part of a "COVID-19 response") (ILO, 2021). These measures enabled many, albeit not all, businesses and households to keep afloat. Women working in the informal sector have been more likely to lose income than those in formal employment. Then, having lost income, informal sector workers only have recourse to public assistance programmes, which offer a much less secure safety net compared to contributory social security, providing a subsistence income at best.

Stay-at-home measures, school closures and lockdown restrictions have seen marked increases in unpaid care work, with much of the burden borne by women. Based on an analysis of data from six Caribbean countries, twice as many women compared to men reported increases in cleaning, cooking and home-schooling children. Almost twice as many women compared to men reported increases in entertaining children (Padmore, 2021).

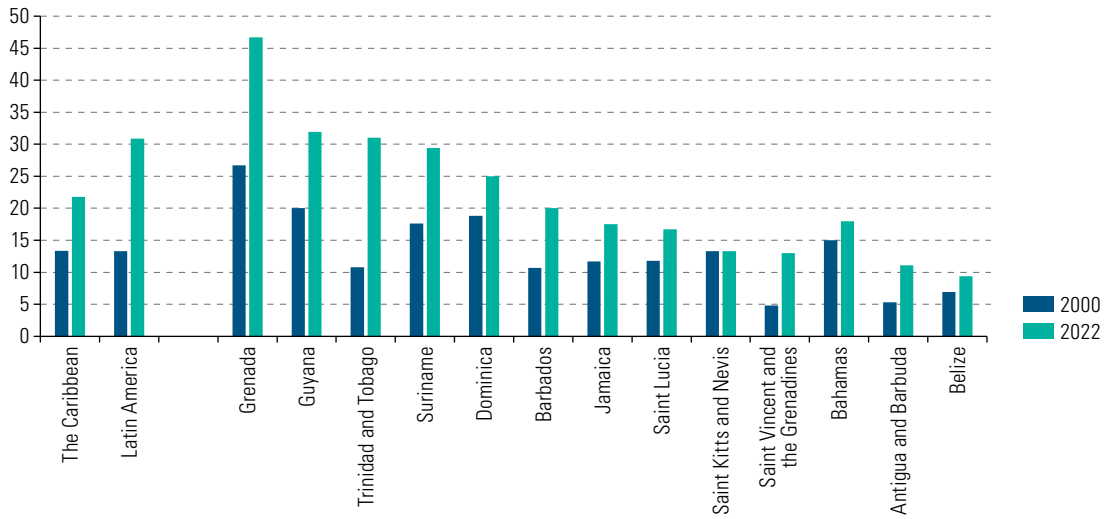
The restrictions on movement and hardships associated with the pandemic have led to increases in intimate partner violence while simultaneously limiting victims' access to support services and networks. Prior to the pandemic, five Caribbean States had conducted surveys to measure the prevalence of violence against women.[10] Prevalence rates for intimate partner violence[11] were highest in Guyana at 38% (lifetime) and 11% (last 12 months) with rates close to 30% (lifetime) and 6% (last 12 months) in Grenada, Jamaica, Suriname and Trinidad and Tobago. These are similar to the prevalence rates seen in Latin America. After the pandemic began, many police services and domestic violence hotlines saw increases in the number of reported cases of violence, including intimate partner violence.

Pregnant women are one of the groups most vulnerable to COVID-19, owing to changes in their immune system which can put them at risk of severe disease (PAHO, 2022). These risks are accentuated by disruption to prenatal care and low levels of vaccine take-up, and together these factors are leading to an increase in the number of maternal deaths. Trinidad and Tobago, for example, saw five maternal deaths linked to COVID-19 in 2021 (Loop News, 2022), which represents a significant increase on recent levels of maternal mortality. A recent PAHO study found that one in three pregnant women with COVID-19 who required critical care did not access it in time, and many were already experiencing life-threatening symptoms when admitted to hospital (PAHO, 2022).

To address these and other issues, women need to be equally represented in decision-making in response to the COVID-19 pandemic and in public policy-making in general. The United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) analysed the gender makeup of the primary committee responsible for each country's national COVID-19 response and found that women were generally in a minority, in some cases a small minority: in Barbados, 3 out of 8 committee members were women; in Jamaica 6 out of 27; in Saint Lucia 20 out of 44; and in Trinidad and Tobago 3 out of 22 (Padmore, 2021). Progress towards gender equality in political decision-making has been somewhat slower in the Caribbean compared to Latin America. In 2000, the average proportion of female parliamentarians in the Caribbean was the same as in Latin America (13%). However, by 2022, the average proportion of parliamentary seats[12] occupied by women in Latin America had increased to 31% while in the Caribbean the percentage had only increased to 22% (see figure III.6). Targeted measures such as time-bound goals and quotas are needed to address women's underrepresentation in government.

[10] The Women's Health (or Women's Health and Life Experiences) Surveys for Jamaica (2016), Grenada (2018), Guyana (2018), Suriname (2018) and Trinidad and Tobago (2017).
[11] Percentage of ever-partnered women aged 15–64 experiencing physical and/or sexual violence.
[12] In lower chambers and unicameral parliaments.

Figure III.6
Latin America (19 countries) and the Caribbean (13 countries): female parliamentarians, 2000 and 2022
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from the Inter-Parliamentary Union (IPU).
Note: The estimates for the Caribbean are simple averages of the 13 countries shown in the figure, while for Latin America they are simple averages for 19 countries (Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Plurinational State of Bolivia, Peru and Uruguay).

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CHAPTER

IV

Conclusions and recommendations for action in light of the priority measures of the Montevideo Consensus on Population and Development

A. The pandemic's impact on information sources
B. Children, adolescents and young people
C. Older persons
D. Women
E. Migrants
F. Indigenous peoples
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Bibliography

The COVID-19 pandemic has had a devastating impact on the region's different population groups. This chapter puts forward a number of conclusions and recommendations for action, with a view to supporting recovery and social and economic transformation in light of the priority measures of the Montevideo Consensus on Population and Development.

The pandemic has exacerbated the structural problems that had been afflicting the countries of Latin America and the Caribbean; and the crisis has affected the most vulnerable population groups disproportionately, although its scope is still being analysed and evaluated. It is also widely recognized that the crisis is no longer confined to the health domain, but extends with unusual severity to other dimensions, including the social and economic spheres, exacerbating the risks and disadvantages already being faced by these groups.

In this context, the Montevideo Consensus on Population and Development —along with the 2030 Agenda for Sustainable Development— is a strategically important tool for steering national and regional endeavours to overcome the ravages of the health crisis and its effects on achieving sustainable development in the Latin America and Caribbean region. In particular, protecting the rights and promoting the well-being of individuals, families and communities must be placed at the centre of the public policy response, incorporating the vision and commitments emanating from the Montevideo Consensus and the 2030 Agenda, among other regional and global multilateral instruments.

The recommendations presented below have their foundation and common denominator in the human rights approach, with a gender and intercultural perspective that stems from the Montevideo Consensus.[1] They recognize the intersectional nature of the impacts of the pandemic, which are aggravated in different population groups according to socioeconomic level, age, territory of residence, gender, ethnic and racial origin, sexual orientation, migratory status, disability and social origin, among other dimensions.[2]

It is therefore essential that States do their utmost to safeguard and strengthen the rights of all people in the post-pandemic reconstruction scenario; and that they address and respond to the various, and often overlapping, situations of disadvantage and vulnerability that undermine people's health, well-being and quality of life.

A. The pandemic's impact on information sources

Priority measures 102, 103 and 104 of the Montevideo Consensus refer to the improvement of data sources, particularly population censuses, administrative records and specialized surveys; the development of information systems with an intersectional approach; and inter-agency coordination for producing improving statistics. Information is a key tool for designing evidence-based public policies and, at the same time, for measuring progress and setbacks in the population's living conditions and in the exercise of rights, especially the right to health.

The pandemic has undoubtedly underscored the important role of official statistics in monitoring the progress of the disease and its varied impacts, including the increase in mortality; as well as in monitoring containment measures, especially vaccination, and for guiding mitigation measures in various social and economic spheres. Despite being so necessary, most statistical operations were suspended initially, owing to the health emergency; and then a series of innovations were introduced that made it possible to continue the tasks of information production, albeit with disparities between countries and specific features related to the different data sources.

Ever since the onset of the pandemic, the United Nations system, along with other multilateral agencies, has been monitoring the effects of the crisis on statistical production. This has involved identifying the

1 In priority measure 2 of the Montevideo Consensus, the countries of the region agreed to "Apply a human rights approach with a gender and intercultural perspective in addressing population and development issues, and step up efforts to recognize, promote and uphold relevant goals in order to eliminate inequalities and foster social inclusion". See [online] https://repositorio.cepal.org/bitstream/handle/11362/21860/S20131039_en.pdf?sequence=15&isAllowed=y.

2 In priority measure 50 of the Montevideo Consensus, the countries of the region agreed to "Fulfil the commitment to promote and ensure gender mainstreaming and its intersection with perspectives on race, ethnicity, age, social class and disability status in all public policies, especially in economic and cultural policies, and coordination between branches of government and social stakeholders, including organizations of young, Afro-descendent or indigenous women, to ensure gender equality".

difficulties that national statistical institutes have had to face and are still facing; but also the opportunities that are emerging through technological and methodological progress, even though the challenges in the region remain significant.[3]

Another issue that became clear was the importance of having timely and quality health sector data. In general, health information systems, and vital statistics systems in particular, suffered from the effects of the crisis. This led to time lags in records and in the production of timely and sufficiently disaggregated figures, especially in the case of racial-ethnic variables. The severity of this lag is associated with the conditions of infrastructure and human and financial resources prior to the pandemic, an area in which digitalization (that is, the transformation from analog to digital processes) remains one of the main challenges. Few countries in the region have robust health information systems that are accessible through open data and offer possibilities for various territorial and social disaggregations of morbidity and mortality, in particular of infections and deaths due to COVID-19. However, the region's countries have made significant efforts to generate daily data on infections, hospitalizations and deaths; and the urgent need to report these cases has hastened the implementation of technological, methodological and inter-agency coordination enhancements. These are expected to be used to strengthen the vital and health statistics that are essential for following up on several priority measures of the Montevideo Consensus.[4]

Following the suspension period, the national statistical institutes started to conduct household surveys by telephone or Internet, in order to continue producing statistics on employment, poverty and other socioeconomic indicators. The figures have thus revealed increases in poverty and extreme poverty, the rise in unemployment, huge setbacks in terms of female labour market participation, and widening disparities in access to education. However, owing to changes in data capture methods, alterations in sample compositions and the fact that data were collected in a crisis context (which may affect comparability with previous figures), there are certain biases in the information that require detailed evaluations and possible adjustments.[5] In addition, it is necessary to analyse changes that could be adopted more permanently (such as the use of mixed interview methods, for example face-to-face and telephone) and their inherent challenges (such as ensuring data quality irrespective of the interview method).

Population and housing censuses of the 2020 round were well under way when the pandemic broke out; and, apart from three countries that had conducted their censuses earlier (Peru in 2017 and Colombia and Guatemala in 2018), delays in the census were widespread. Only Mexico and Aruba managed to conduct their census in 2020, and four countries or territories did so in 2021 (Barbados, the Bolivarian Republic of Venezuela, the Cayman Islands and Dominica).[6] Although preparatory activities generally continued, they were severely hampered by the health crisis. A variety of problems arose, including financial difficulties and the impossibility of undertaking processes that necessarily require fieldwork (such as updating cartographic data or conducting pilot tests and experimental censuses). Some countries postponed their censuses, initially to 2021 and eventually to 2022 or 2023; others still do not even have dates confirmed. Nonetheless, 22 countries or territories in Latin America and the Caribbean are expected to hold their censuses in 2022 (Anguilla, Antigua and Barbuda, Argentina, Bahamas, Belize, Brazil, Costa Rica, Curaçao, the Dominican Republic, Ecuador, Grenada, Guyana, Jamaica, Montserrat, Panama, Paraguay, the Plurinational State of Bolivia, Saint Lucia, Saint Kitts and Nevis, Suriname, Trinidad and Tobago, and the Turks and Caicos Islands); and the remaining five countries plan to conduct theirs in 2023 (Chile, Cuba, Honduras, Saint Vincent and the Grenadines, and Uruguay). In some cases, these dates should be treated with caution because further postponements are still possible.

In this context, the countries have introduced several methodological and technological changes, such as moving from de facto to de jure censuses (Argentina, Chile, Ecuador and Panama); and most of them have

3 In conjunction with the World Bank and in coordination with the five regional commissions, the United Nations Statistics Division conducted a survey of national statistical offices to monitor the pandemic worldwide in May, July and December 2020. The results can be consulted [online] at https://covid-19-response.unstatshub.org/posts/survey-of-national-statistical-offices-during-covid-19/. ECLAC also carried out series of virtual activities with national statistical institutes to complement monitoring in the region's countries; for further information, see [online] https://rtc-cea.cepal.org/ and [online] https://www.cepal.org/es/temas/censos-poblacion-vivienda/impactos-covid-19-censos-poblacion-vivienda.

4 For information on the effects of the pandemic on vital statistics systems see [online] https://unstats.un.org/unsd/demographic-social/meetings/2020/webinar-crvs-Latin/ for the Latin American countries, and [online] at https://unstats.un.org/unsd/demographic-social/meetings/2020/webinar-crvs-caricom/ for the Caribbean countries.

5 In March 2022, ECLAC held a seminar on how the pandemic has affected household surveys (see [online] https://www.cepal.org/fr/node/55727).

6 In the case of the Bolivarian Republic of Venezuela, an Internet-based self-enumeration of the population residing in the country began in 2021; and there are plans to undertake a complete field survey as soon as health conditions permit.

opted for mobile capture devices (MCDs) as the main data collection method, in combination with others such as self-enumeration through an electronic or virtual census and telephone censuses. While the use of MCDs offers great potential to improve census quality, their implementation presupposes the availability of suitable infrastructure and human resources, and a large amount of testing. These new alternatives pose a range of challenges that national statistical institutes will have to face, including modernization of the census production process and changes in the way it is managed. This in turn generates greater demands in terms of public budgets and both human and technical resources. The main challenges, therefore, include securing an adequate and timely budget appropriation; and the need to prevent censuses from being subject to tight schedules that do not ensure the time needed, from the technical standpoint, to ensure quality and compliance with international standards. Given their universal nature, censuses are clearly crucial for identifying priorities and allocating resources in health and economic and social recovery policies, among many other uses for which there are no other data sources.

In short, as advocated in target 17.18 of the 2030 Agenda for Sustainable Development, the availability of quality data, disaggregated according to socioeconomic level, age, sex, ethnic-racial status, territory, migratory status, disability status or other relevant factors, is essential for following up on the Montevideo Consensus and for steering public policies. It is therefore urgent to redouble efforts and invest in strengthening statistical production, particularly in the successful implementation of population and housing censuses, which are essential for promoting sustainable development with equality, since issues that the figures reveal can be addressed and improved.

B. Children, adolescents and young people

Children, adolescents and young people in Latin America and the Caribbean display significant vulnerabilities and suffer higher poverty rates than other age groups. During the pandemic, they have endured multiple inequalities and have been one of the population groups hit hardest in socioeconomic terms. Accordingly, the Economic Commission for Latin America and the Caribbean (ECLAC, 2022) and other agencies of the United Nations system (UNICEF, 2020) have called for decisive action to prevent a generation being lost owing to the pandemic. In order to realize the rights, meet the needs and respond to the demands of children, adolescents and young people, this should be focused on the following minimum set of pillars: (i) closing the digital divide, which accentuates educational and learning inequalities; (ii) guaranteeing universal access to education, health services —with emphasis on sexual and reproductive health— nutrition and vaccination; (iii) providing cross-cutting and equal protection of mental health; (iv) preventing abuse, gender-based violence and neglect and providing safeguards against them; (v) promoting access to basic services and a safe, clean and friendly environment; (vi) overcoming poverty; and (vii) providing special care in situations of conflict, disaster and displacement.

One of the most dramatic impacts of the pandemic has been the orphaning of thousands of children and adolescents in the region —a situation that calls for urgent measures to ensure that no child is left alone. These should include some type of material contribution —cash or in-kind transfers to families or care providers— and guaranteed access to health care, education and other social services, as well as professional support in the mental health area.

It is also crucial to avoid a repetition of widespread interruptions in access to sexual and reproductive health care for adolescents and young people. In this population group, such interruptions are more likely to involve unwanted pregnancies and cause a radical deterioration in life projects, with diminished opportunities across the board. It should be considered essential to maintain sexual and reproductive health care, to enable adolescents and young people to exercise their sexual and reproductive rights.

It is also imperative to implement national mental health programmes targeted on children, adolescents and young people, who suffered the greatest deprivations in terms of loss of contact, socialization and exchange with peers during the pandemic. Similarly, reclaiming the school as a space for face-to-face coexistence and enriching exchange may be crucial for coping with the mental health crisis.

Nonetheless, this recovery does not come automatically with a return to face-to-face classes. It will also require the application of self-care protocols and due protection against possible contagion and the implementation of conversation and support initiatives to share experiences and bolster mental health. It will also be necessary to take steps to promote a welcoming, harmonious and respectful environment, which was already a major challenge in many educational establishments before the pandemic. On the other hand, all the progress made in e-learning should certainly not be wasted, because there are many ways in which it can complement face-to-face education, even though the latter remains essential.

C. Older persons

The pandemic has affected older persons disproportionately; and, its impact has been differentiated, according to sociodemographic vulnerabilities, disability status and difficulties in accessing basic services. This has underscored the need for universal social protection systems in respect of pensions, health and care services.

The consequences of the pandemic for older persons once again place human rights at the centre of the policies of the region's governments. In particular, chapter C of the Montevideo Consensus on Population and Development is particularly relevant, since it addresses the link between ageing, social protection and socioeconomic challenges. In this context, it is necessary to:

- Focus on strengthening social protection by pursuing universal health services, placing special emphasis on medical care, rehabilitation services, the distribution of medicines and primary health care. Incomes must be protected through an expansion of contributory and non-contributory pension coverage and the creation of comprehensive care services that allow for a revalorization, redistribution and social reorganization of care. The emphasis here should be on making care less dependent on family members, increasing infrastructure and training, and the promotion of legislation that decouples the right to care from a person's labour market status.
- Promote the inclusion of ageing on public and government agendas, by harmonizing laws, based on the Inter-American Convention on the Protection of the Human Rights of Older Persons; the strengthening of institutions responsible for the coordination of national policies on ageing, and inclusion of the various stakeholders, such as civil society organizations and the academic and private enterprise sectors, in the design of strategies to protect the human rights of older persons.
- Make sure older persons have access to basic services, which had been a neglected issue in the discussion on development, but has regained importance during the pandemic. Access to basic utilities such as water and sanitation, along with clean and safe energy services, and information and communication technologies (ICTs) has contributed to protection against the possibility of illness and death.
- Strengthen mechanisms for collecting sociodemographic data disaggregated by age, sex, ethnicity, morbidity and disability, and thus obtain information that will make it possible to design evidence-based policies, programmes and actions that take into account the different realities of old age and ageing modalities in the region.

All of the above should be based on an intersectional approach that reveals the realities of the different ways in which old age is experienced in the region. In particular, in view of the pandemic, it is vitally important to emphasize collective responsibility for guaranteeing full access to social protection for older women, persons with different gender identities, older persons with disabilities, the elderly, those who are members of indigenous and Afrodescendent populations, those who require long-term care and those who are more vulnerable or these or other reasons. It is also necessary to address the structural causes that, unfortunately, are leaving so many older persons behind in this crisis.

D. Women

For women, the pandemic caused an unprecedented setback in their economic autonomy, manifested in increases in both time and income poverty and in the excess burden of care work. In addition, the unjust distribution of power between men and women persists. As ECLAC has pointed out, the signs of a recovery in activity show that the region's production structure is based on a sexual division of paid and unpaid work that reproduces historical patterns of inequality that are deepened by ethnic-racial, poverty and migratory conditions. The effects of the crisis are compounded by weak access to social protection and high levels of labour informality, particularly among women, who are more likely to be in informal work in more precarious sectors and receive lower pay. It is therefore essential to design and implement recovery measures in the different sectors, backed by transformative actions that promote women's economic autonomy and protect their rights.

The impact of the pandemic in the social and economic spheres, beyond its strictly health-related aspects, has revealed the central importance of care for society; and it has deepened the debate on the unfair social distribution of these responsibilities. The tangible reality of the overloading of care tasks on women during the crisis crystalized the urgent need to shift towards co-responsibility. This refers both to the need to distribute care work between men and women in the private domain, and to its distribution between the State, the market, households and the community, considering its relevance in the public sphere (as indicated in priority measure 61 of the Montevideo Consensus). It is therefore necessary to move towards universal policies and services as part of comprehensive care systems (priority measure 53) and towards the recognition of care as a right for persons who require it throughout the life cycle. It is also necessary to recognize the rights of care providers, whether paid or unpaid. The development of the care society not only has positive effects for the persons directly involved, but also contributes to an increase in women's participation in the labour market, the redistribution of income and time, and economic growth, among other benefits.

Although the vast majority of individuals tasked with implementing pandemic response measures are women, their participation in decisions on public policy design remains meagre. Women were on the front line of defence, but not on the front line of decision making. This lack of equal participation hinders the application of a gender approach and the allocation of resources to address the situations of discrimination, invisibility and poor care that affect women and girls. For this reason, priority measure 48 of the Montevideo Consensus, which refers to "fulfilling the commitment to increase and enhance opportunities for the equal participation of women in adopting and implementing policies in all spheres of public authority and in high level decision-making," is particularly urgent.

During the most severe phase of the crisis, diagnostic and decision-making processes were hampered by a lack of timely disaggregated figures with which to analyse the impact of the pandemic with an intersectional approach, and to reveal the diversity of the situations affecting different groups of women. Strengthening the permanent capacities of statistical systems (in accordance with priority measure 62 of the Montevideo Consensus), as well as linking them to decision-making processes and monitoring the effects of the measures adopted, is important for responding with better diagnostic assessments and more effective decisions, both at times of crisis and in normal situations. Achieving statistical visibility for indigenous, Afrodescendent, migrant and other women, including those with disability, is a first step towards responding adequately to the diversity of women throughout the life cycle, and addressing the specific barriers they face in exercising their rights.

Specific problems that afflicted women before the crisis, such as gender-based violence and unequal access to sexual and reproductive health services, were aggravated further, generating situations of risk and greater vulnerability, especially among the most neglected groups who faced greater obstacles to exercising their rights. The sudden interruption of contraception and family planning, or pregnancy check-ups and other services, or difficulties accessing them, can have serious consequences for women's health and lives, and increase the risk of unwanted pregnancies, morbidity and maternal mortality.

In addition, despite the efforts made by countries to implement awareness campaigns and provide different ways to access services, supported by the initiatives of civil society organizations, the persistence of gender-based violence shows that this extreme manifestation of discrimination and denial of women's rights is deeply entrenched in our societies.

The construction of a new normality, in which the lessons learned during this difficult stage are applied, must consider new partnerships and strategies, and implement multisectoral responses to women's needs. These include addressing gender violence, which is a minimum and indispensable requirement for leaving no one behind.

E. Migrants

Given the imperative of equal treatment, the process of including migrants and refugees in public policies for emergency response and recovery is a huge challenge. The objectives of the Global Compact for Safe, Orderly and Regular Migration, in conjunction with the Goals of the 2030 Agenda for Sustainable Development and the priority measures of the Montevideo Consensus, provide States with guidelines for including these population groups in their societies and economies, and for promoting the human dignity and well-being of migrants in their processes of departure, entry, stay and return.

The pandemic has had disproportionate effects on migrants, especially in cases where factors that multiply vulnerabilities overlap, such as migrant women or unaccompanied migrant children. In the employment domain, there is tension in the situation of the migrant population: while many migrants have lost their jobs or have seen them become precarious, they have also become indispensable in the front-line occupations responding to the pandemic. Migrants are employed in essential activities such as: (i) seasonal agricultural work; (ii) food supply chains; (iii) cleaning tasks; (iv) online service platforms; (v) care services; and (vi) health services. In particular, migrants increasingly work in online service platforms, yet national legislation still fails to formalize this type of work. As a result, the workers in question maintain high levels of informality. In the medical professions, several of the region's countries issued official decrees allowing medical professionals to practice even if they had not yet validated their degrees, as a way of easing the pressure imposed on health services by the pandemic.

Job losses and dwindling incomes have had a major impact on the migrant population, as exemplified by paid female domestic workers. Nonetheless, migrants are not unequivocally included in government social protection and employment support measures (Carella, Frean and Velasco, 2021). The post-pandemic recovery should follow a dual path: first, to incorporate migrants into the country's health and social services, both decisively and unconditionally; second, to recognize, encourage and increase their contribution to national economic development. Both the Montevideo Consensus and the Global Compact for Safe, Orderly and Regular Migration urge States to redouble their efforts to regularize migratory flows and guarantee migrants' access to social services that ensure basic health coverage and appropriate housing conditions, together with opportunities for children and adolescents to continue attending school.[7] In this context, the COVID-19 vaccination process must be made universal and cost-free nationwide, by eliminating the requirements that different local administrative units impose.

In terms of inclusion, migrants must be recognized explicitly in national responses to the COVID-19 crisis, in terms of both containment and recovery. Similarly, bilateral cooperation is needed between the countries of origin and destination, in terms of social welfare and the recognition of skills (Carella, Frean and Velasco, 2021). All of the above should be done through dialogue between the different stakeholders, including migrant organizations, employers' associations, the government and civil society organizations. The latter are a fundamental pillar for achieving the full socioeconomic integration of migrants and refugees in the destination communities.

In the current complex migratory scenario, it is therefore imperative to save lives in border areas, combat human trafficking and restrict the use of detention as an administrative measure. It is crucial to strengthen international partnerships and coordination among States to promote safe, orderly and documented migration, bringing national migration control policies into line with international agreements, based on respect for the human rights of migrants. During the pandemic, examples of good practice have included the exceptions made to border closures for workers in agricultural activities that are considered essential, and the possibility of humanitarian transit for migrants and asylum-seekers. These experiences reveal a spirit of respect for the rights of migrants and asylum-seekers.

[7] Mention should also be made of the global compact on refugees, which aims to implement the principles of burden- and responsibility-sharing to better protect and assist refugees and support host countries and communities. As in the case of the compact on migration, this global compact is based on relevant international human rights instruments, international humanitarian law and other international instruments on the subject.

Actions that need to be carried out jointly, pursuant to international agreements, include the following: (i) an increase in funds channelled to the communities that receive migrants and refugees and the organizations that work directly with them; (ii) consideration of measures other than the detention of migrants and refugees; and (iii) the temporary interruption of deportations, as a way to prevent the spread of the virus (Brito, 2020). The potential role of civil society organizations also warrants consideration, especially when the militarization of borders has become a de facto form of migration management (Brumat and Finn, 2021; SJM, 2021).

F. Indigenous peoples

The social and health crisis triggered by the pandemic has exacerbated the structural problems that were already affecting the region. Its effects on the most neglected groups and those whose rights are least protected, including indigenous peoples, cannot yet be fully assessed. Nonetheless, the region clearly needs to redouble its efforts to make up for the lack of progress and delay in including indigenous peoples in sustainable development; and the priority measures agreed upon by the States in the Montevideo Consensus can be an important tool for this purpose. The commitment to respect and implement the provisions of the United Nations Declaration on the Rights of Indigenous Peoples, as well as those of the Indigenous and Tribal Peoples Convention, 1989 (No. 169) of the International Labour Organization (ILO), with particular emphasis on the territorial and political rights of these peoples (priority measure 85), is more important than ever. In this context, it is necessary to:

- Evaluate existing regulatory frameworks in conjunction with the indigenous peoples, identifying the disparities between them and the standards established in the aforementioned international instruments, as well as in the jurisprudence of the Inter-American human rights system. Then —when appropriate— introduce the necessary reforms to close the gaps. States must guarantee the biosecurity measures needed in these processes of consultation with indigenous peoples and their participation.
- Strengthen —or create, in countries that do not have them— permanent and institutionalized mechanisms enabling indigenous peoples to participate and be represented in the State agencies that are leading the response to the pandemic, in both its health and its socioeconomic dimensions. Economic and social recovery measures also need to be defined, drawing on the main lessons learned from the autonomous measures that indigenous peoples have implemented during the emergency.
- Evaluate the degree to which the rights of indigenous peoples have been upheld during the pandemic; identify and define mechanisms to restore rights that have been violated, and put measures and mechanisms in place to make sure this is not repeated.
- Provide specific budget appropriations to address the health, social and economic dimensions of the pandemic and its effects, considering both demographic factors and the vulnerability of each of the indigenous peoples present within national jurisdictions.
- Ensure that governments do not issue regulations or adopt administrative measure that could affect the rights of indigenous peoples, until adequate biosecurity conditions are guaranteed for holding prior consultations to obtain the free, prior and informed consent of the peoples affected.

Priority measure 86 of the Montevideo Consensus, which calls for the special demographic dynamic of indigenous peoples to be taken into account in public policy design, is of great relevance in the design, implementation and evaluation of economic recovery strategies. To ensure indigenous peoples are duly included in these processes, it is necessary to:

- Conduct rapid assessments of the socioeconomic impact of the pandemic on indigenous peoples, from a gender and generational perspective, in both urban and rural areas. This should take account of the pandemic's differential effects in traditional contexts and in large cities, and the scope and coverage of the measures adopted by States during this period.

- On this basis, work with the indigenous peoples' representative organizations to implement special reactivation measures that are relevant and in keeping with the different sociodemographic realities, and which are consensual and sustainable, and guarantee rights.

During the pandemic, the weak protection of the right to health of indigenous peoples and the weakness of State institutions in responding to their needs in this area have become more salient than ever. Governments therefore need to increase and upgrade their efforts to guarantee these people's right to health (priority measure 87), including the following measures, among others:[8]

- Strengthening of the public health care network in indigenous territories, including the authorization of new health-care facilities, expansion of technical teams and the provision of equipment. This should be done in harmony with the healing systems of indigenous peoples, guaranteeing their autonomy and cultural integrity.
- Implementation of public policies and programmes that emphasize funded interventions to reduce maternal morbidity and mortality, with a special focus on indigenous peoples and in accordance with their rights standards.
- Adoption of legislative and administrative measures for the recognition and effective protection of indigenous peoples' health systems and practices. These should include sui generis mechanisms of collective intellectual and industrial property, to protect indigenous knowledge, technologies and therapeutic resources and safeguard them from potential misappropriation by non-indigenous third parties.
- Participatory design of effective and culturally relevant strategies to guarantee access to vaccination programmes for the most neglected indigenous peoples.
- Establishment of agreements between countries to guarantee access to culturally relevant health services for trans-border indigenous peoples.

Lack of protection for the territorial rights of indigenous peoples remains a critical issue in most of the region's countries; and the situation has worsened during the pandemic. In order to fulfil the commitments made by governments in this area (priority measure 88), it is necessary to:

- Reactivate the mechanisms for the demarcation, titling and regulation of indigenous lands that were suspended during the pandemic, adopting administrative and legislative measures, as necessary, to make it possible to implement them effectively.
- Generate legislative and administrative conditions to ensure that all investment projects, both public and private, that are promoted in indigenous territories have the free, prior and informed consent of the indigenous peoples in question —regardless of the legal status of the lands in question.
- Adopt measures, including legislation, to guarantee the right of indigenous peoples to participate in the benefits generated by these projects.
- Stop criminalizing persons who defend the lives and territories of indigenous peoples, by adopting measures, including legislation, to protect their work and guarantee their access to justice and uphold the right to due process. This should include the establishment of criminal defence facilities for indigenous peoples, the training of court personnel, and the hiring of translators.

Lastly, the availability of disaggregated information on indigenous peoples remains a challenge in the region. Although countries have taken steps to comply with priority measure 90, on the need to guarantee indigenous peoples' right to information, progress has been made mainly in the population and housing censuses. There is still much to be done to ensure that national statistical systems as a whole provide timely and quality information that responds to the needs of the peoples themselves. It is therefore necessary to redouble efforts, based on the standards and recommendations currently in force, including the following:

[8] These measures emphasize the collective rights of indigenous peoples, following the spirit of Chapter H of the Montevideo Consensus. As stated in Article 44 of the United Nations Declaration on the Rights of Indigenous Peoples, rights must be guaranteed to indigenous men and women equally.

- Strengthen processes for including indigenous self-identification in the various data sources, especially in health registries, through participatory mechanisms involving the indigenous peoples. This should take advantage of the actions undertaken and the experience gained by indigenous organizations in monitoring the pandemic.
- Generate up-to-date knowledge on the living conditions of indigenous peoples, especially the impact of the pandemic on health, including sexual and reproductive health, and on other socioeconomic dimensions, taking account of ethnic, gender, generational and territorial inequalities.
- Generate accessible and inclusive information that helps to guarantee timely access to comprehensive and high-quality public health services, of universal coverage and intercultural relevance.
- Strengthen health information systems to provide information, disaggregated by ethnic-racial status, on access to modern contraceptive methods, ante-natal check-ups, quality childbirth and postpartum care, maternal and neonatal deaths, and interventions to prevent unintended pregnancies and sexually transmitted infections, including HIV/AIDS. The aim is to generate conclusive information for the design, implementation and monitoring of policies to guarantee the sexual and reproductive rights of indigenous peoples.
- Design and implement information systems that respond to the needs of indigenous peoples, considering their collective rights. In particular, make progress with methodological developments and measurement of the indicators agreed upon by the countries of the region for following up the Montevideo Consensus, in terms of chapter H, on indigenous peoples.
- Strengthen national capacities to harness and analyse information on indigenous peoples, obtained both from government institutions and from indigenous organizations and other relevant actors.

G. People of African descent and their communities

Afrodescendent people in Latin America live in a more vulnerable situation than their peers who are neither Afrodescendent nor indigenous. After the onset of the pandemic, levels of inequality increased, and Afrodescendants suffered higher rates of infection and mortality than other population groups, according to the sparse disaggregated information that is available. In this scenario, it is crucial to speed up implementation of the Montevideo Consensus on Population and Development, in particular the priority measures of chapter I. A set of recommendations in various areas is presented below.

Right to equality and non-discrimination:

- Promote the implementation of international laws on the rights of populations and peoples of African descent; restructure national institutions and policies, valorizing their contributions and protecting their rights, with a view to eliminating racism and the structural disparities that restrict full exercise of the human rights of Afrodescendent peoples and communities. This should take into account mechanisms and instruments that serve as important roadmaps, such as the International Decade for People of African Descent, the United Nations Permanent Forum of People of African Descent and the 2030 Agenda for Sustainable Development.
- Implement policies, plans and programmes, including affirmative actions, with an intercultural, gender and intersectional approach, to eradicate the multiple forms of discrimination endured by Afrodescendent women, boys, girls, adolescents and youth.

Disaggregated data and information:

- Make the Afrodescendent population visible in official statistics, including those related to the pandemic, by improving data collection aligned with international and regional recommendations in this area, and enhancing access to the data and its accessibility. This includes guaranteeing participation by

Afrodescendent communities in all stages of the statistical process (from design and production to analysis, evaluation and dissemination); and disaggregating information by ethnic-racial status, gender, age, territory and other relevant factors, in order to "leave no one behind".

- Create a mechanism for compiling and systemizing sociodemographic indicators for following up implementation of the Montevideo Consensus on Population and Development. This aims to improve understanding of the living conditions of Afrodescendants and realization of their rights, thus strengthening mechanisms for monitoring national public policies implemented in follow-up to regional commitments and international agreements.

Participation:

- Promote and guarantee the active and effective participation and representation of people of African descent, particularly women, and their organizations in all public spaces (parliaments, labour unions and State institutions, among others), as well as in private firms.
- Strengthen the various national and regional coordination mechanisms that are permanently linked to the Regional Conference on Population and Development in Latin America and the Caribbean, and ensure that they adopt a participatory intercultural approach.
- Ensure effective implementation of the Montevideo Consensus on Population and Development, including affirmative actions to hasten the fulfilment of commitments made by the States in relation to Afrodescendent populations.
- Ensure that Afrodescendent communities and peoples have relevant information about their rights, by improving cultural accessibility and including information in their first language, where appropriate.

Overcoming poverty:

- Guarantee a basic minimum income for the Afrodescendants living in situations of poverty and vulnerability, particularly Afrodescendent women.
- Make sure that the economic and social measures put in place as part of the response to the COVID-19 pandemic address the needs of the Afrodescendent population.

Education and digital divide:

- Increase access to free, quality education (including comprehensive education on sexuality) for the Afrodescendent population. Special attention should be paid to the completion of secondary education, training, entry into higher education and the provision of tools for online learning, with free Internet access and provision of digital devices.
- Implement specific measures to mitigate the difficulties faced by Afrodescendent households and communities in accessing technological services.

Employment:

- Encourage labour market participation by Afrodescendent populations through quality jobs and in positions of greater responsibility and prestige, specially targeting young people who are neither studying nor in the labour market. These include young mothers and those who work informally, such as own-account, seasonal and domestic workers, in order to guarantee their social protection and their right to a dignified old age.

Health:

- Guarantee the Afrodescendent population timely access to public, comprehensive and quality health services, of universal coverage, that are culturally relevant and provide accessible and inclusive information.
- Ensure access to modern contraceptive methods, ante-natal check-ups, and quality care during childbirth and puerperium to prevent maternal and neonatal deaths; avoid unintended pregnancies, particularly among adolescents, and prevent sexually transmitted infections, including HIV/AIDS. To this end, policies and programmes need to be evidence-based; and it is also essential to produce relevant information for follow-up.

- Generate up-to-date knowledge to understand the functioning of the Afrodescendent communities' health services, systems and practices, in both urban and rural areas where these populations have a major presence, in order to design and improve intercultural and quality care models.

Vaccination:

- Provide equal and timely access to vaccines; and, in the vaccination process, take account of ethnic-racial relevance, geographical specifics and persons who perform essential jobs in the health sector, even if they are undocumented migrants.
- Make sure that health centres and hospitals located in areas with large Afrodescendent populations have the health services, medicines and infrastructure needed to provide adequate care during the pandemic.

H. Persons with disabilities

The countries of the region have little information on persons with disabilities, which, in the current context, makes it impossible to estimate the real impact of the pandemic on this population group. It is therefore essential to strengthen the collection and systemization of data on persons with disabilities in national statistical systems. There should be robust instruments for data collection and dissemination that ensure disaggregation at the national and subnational levels by disability status, age, sex, and cause of death. The data should be collected using internationally recognized methods. It is also important to have information showing how many persons with disabilities are accessing the pandemic mitigation measures being implemented in the areas of health, education, social protection and employment. This will make it possible to judge whether they are being included in all phases of the response and recovery process.

The pandemic has crystalized the importance of strengthening universal actions, guaranteeing visibility and non-discrimination of the population with disabilities, and adopting an inclusive and cross-cutting approach in all policies and actions in response to the crisis. These measures have been advocated in the Convention on the Rights of Persons with Disabilities, the 2030 Agenda for Sustainable Development and the Montevideo Consensus on Population and Development. The public policy actions in question must be adapted and fine-tuned to protect the principle of non-discrimination on the basis of disability. The most specific recommendations to emerge from this analysis are as follows:

- Health information and communications should be developed and disseminated in accessible modes, media and formats; and persons with disabilities and their organizations should be actively involved in designing a rights-based response to the pandemic that is inclusive of persons with disabilities in all their diversity.
- In terms of social protection measures, it is essential to guarantee the income and consumption of households that contain persons with disabilities, by providing financial assistance for the individuals in question when their income is insufficient. It is also necessary to ensure that children, adolescents and young people with disabilities have access to basic services, housing, adequate food and education.
- Make sure that persons with disabilities have access to support services, enabling them to lead safe, healthy and independent lives. In cases where individuals give up formal employment to devote all their time to supporting a relative with a disability, financial assistance programmes should be implemented and maintained to cover the lack of income.
- In the workplace, all necessary protective measures, specific arrangements, and accessible environments should be put in place to guarantee the safety of persons with disabilities who continue to work during the pandemic. Where necessary, employers should give persons with disabilities priority to work from home, at their request; and they should take steps to make working from home feasible —for example, by providing accessible computers.
- In terms of education, universal measures (curricular adaptations and inclusive design of online education platforms and proposals) must be matched by resources to support persons with disabilities. To this end, Internet access and equipment should be provided in homes, particularly for children and

adolescents with disabilities; and software that is accessible to persons with disabilities should also be made available, including through the provision of assistive devices and the implementation of reasonable adjustments. Teachers need guidance, training and support to provide inclusive education through distance learning; and accessible materials tailored to the needs of children and young learners with disabilities should be designed to support such learning.

- Persons with disabilities are entitled to participate fully and effectively in the decisions that affect their lives. An inclusive response must be ensured by putting into practice the slogan "Nothing about us without us," which was coined by the initiators of the Convention on the Rights of Persons with Disabilities. Persons with disabilities and their organizations should be consulted and involved actively at all stages of the response, from planning and design to implementation and monitoring. This will help achieve immediate inclusion, enable all COVID-19-related actions to benefit persons with disabilities, and contribute to longer-term development and recovery.

I. Emerging priorities in the Caribbean

The diagnostic assessment of the pandemic's impacts on Caribbean countries reveals features that are specific to this subregion. These call for specific recommendations on possible courses of action to promote recovery and social and economic transformation in the light of the Montevideo Consensus on Population and Development.

Achieving high levels of vaccination will be crucial to enable the full reopening of schools, to attract tourists back to the Caribbean and for economic recovery more generally. With vaccination rates in many Caribbean countries currently falling below the regional and global averages, there is an urgent need to scale-up vaccination programmes and coverage. Supply, storage and distribution networks all require further strengthening while vaccination campaigns must be designed to target hard-to-reach groups and those in remote areas. This includes tackling the fear, mistrust and misinformation deterring many from being vaccinated. The recently published report of a vaccine hesitancy survey (CADRES/USAID/UNICEF, 2021) provides invaluable data on attitudes to COVID-19 vaccines and provides policymakers and health officials with national data to inform the design of vaccination campaigns.

The health crisis has highlighted the need to overhaul the region's health systems and to address their structural weaknesses, including their underfunding, which is manifested in low per capita levels of health expenditure, shortages of human resources, high out-of-pocket costs and inequality in access to services and health outcomes. The interaction between COVID-19 and non-communicable diseases (NCDs) makes clear that reducing the prevalence of NCDs is just as important as tackling the pandemic itself. There are a range of options for tackling NCD risk factors and unhealthy lifestyles but dedicated taxes, for example taxes on sugar-sweetened drinks, are a particularly appealing and underutilized policy option because they provide an additional source of funding while disincentivising the unhealthy behaviours which cause so many NCDs.

Lastly, COVID-19 has also highlighted two major deficiencies in both Caribbean and Latin American social protection systems: the existence of large, uninsured, informal sector workforces who have no protection against loss of income; and the absence of unemployment benefits, even for insured workers, in most countries. It was in precisely these two areas that governments had to implement emergency measures as part of their COVID-19 responses. Developing permanent systems of unemployment insurance and minimum income protection for all are crucial steps towards the universalization of post-COVID-19 social protection systems.

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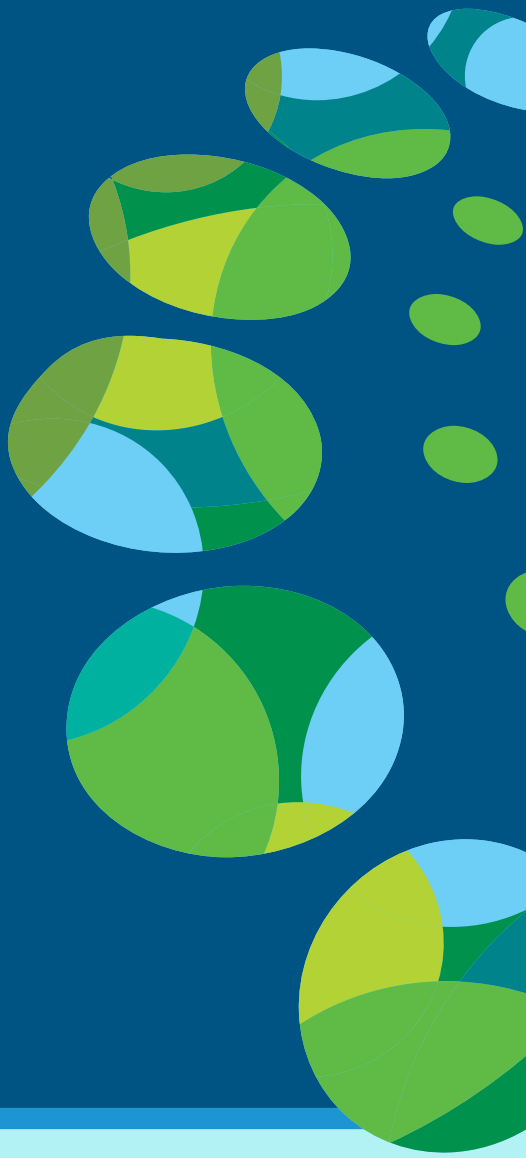
The coronavirus disease (COVID-19) pandemic has had a profound and multidimensional impact on the population. Latin America and the Caribbean, characterized by high levels of inequality, labour informality and vulnerability, is one of the regions hardest hit by the health, economic and social impacts of the pandemic.

This document analyses the effects of the pandemic on population dynamics and on the sociodemographic processes outlined in the Montevideo Consensus on Population and Development, such as ageing, gender equality and women's autonomy, the exercise of sexual and reproductive rights, territorial inequalities and mobility. It also assesses how the pandemic has affected the different population groups identified as targets of the priority measures of the Consensus owing to the exclusion, discrimination and vulnerability they have historically experienced, and the fulfilment of the rights of which they are holders.

This document was prepared pursuant to the request of the Presiding Officers of the Regional Conference on Population and Development of Latin America and the Caribbean, with a view to systematizing and analysing the sociodemographic impacts of the pandemic in the region, and includes policy recommendations for a sustainable recovery with equality in the framework of the Montevideo Consensus on Population and Development.



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