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Claudia Lyons Michaels April 2, 2021

Covid-19 in Greater Buenos Aires: A Review of Urban Inequality, Government Response, and the Legacy of Neoliberal Economic Reform during a Global Health Crisis

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Abstract

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Greater Buenos Aires, Argentina is a major Latin American city with significant inequality, and as the Covid-19 pandemic caused a major outbreak in the city, levels of inequality became magnified. This project studies the impact of the Covid-19 outbreak and government responses on inequality in Greater Buenos Aires between March and December of 2020. It employs a mixed-methods approach, examining data from government legislation, government datasets, the media, and interviews with local experts. Government responses to the Covid-19 pandemic included a lockdown and social assistance programs which yielded varying levels of success. It is found in this project that the outbreak peaked between May and June in the city's informal settlements and in August it peaked in the city at large. Implications of the outbreak included increased vulnerability in resource-poor areas and strain in the healthcare system. A historical framework is presented here to contextualize inequality in Greater Buenos Aires. Neoliberal economic policies implemented throughout the past forty years in Argentina have caused high levels of economic instability, exclusion, and poverty which shaped the landscape of inequality leading up to the pandemic and limited the current government's ability to respond. This project advocates renewed commitment to human rights and social justice as Greater Buenos Aires recovers from the pandemic.

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Chapter 1

Introduction

The Covid-19 pandemic afflicted nearly every major city of the globe in 2020, prompting varying degrees of government response and adverse health outcomes across countries. Argentina was no exception, with a major outbreak of Covid-19 emerging in its largest city, Greater Buenos Aires, in March of 2020. The Covid-19 outbreak in Greater Buenos Aires occurred within the context of significant pre-existing inequality which denied millions of people access to basic resources such as housing and water. Covid-19 poses a major threat to people who lack access to basic resources and who may be disproportionately affected by poor health and economic outcomes.

This project studies the impacts of the Covid-19 outbreak and subsequent government response on inequality in Greater Buenos Aires. The introduction begins by examining the scale of pre-existing urban inequality in Greater Buenos Aires and presenting the spatial distribution of inequality within the regional denominations of the city. It then introduces the Covid-19 virus and its global impact as of December of 2020, one year after it was first identified, noting that Argentina was among the most severely impacted countries in the Americas region. The results chapter combines government, newspaper, and interview data to understand responses to and impacts of the Covid-19 outbreak, paying particular attention to inequalities which emerged

or became amplified during the ten month period studied. Informal settlements and the healthcare system are major areas of focus. The analysis chapter presents a historical framework to explain the roots of inequality and exclusion. It argues that Argentina's past entanglements with neoliberal economic policy throughout the past forty years shaped the current government's ability to respond to the outbreak today and concludes by emphasizing areas of need following the pandemic.

1.1 Greater Buenos Aires and Argentina

Argentina is a country located in the southern part of South America sharing borders with Chile to the west, the Atlantic Ocean to the east, and several other countries to the north. By land area, it is the second largest country in Latin America after Brazil, one of its northern neighbors. Argentina has a population of nearly 45 million people, the majority of which live in urban areas. It is a majority Catholic country and the official language is Spanish. Argentina is referred to as a country of immigrants, with a large portion of its inhabitants tracing their roots to European migration in the late 19th and early 20th centuries. However, it is noted that while Argentina's identity politics emphasize European ancestry, minority ethnic and racial identities are often excluded from national discourse. Argentina has long-established Black and indigenous descended populations as well as more recent immigrants from Africa and other parts of South America.[1] In terms of its economy, Argentina is a middle-income country with a reported GDP of 449.7 billion USD in 2019, ranking it third in the region behind Brazil and Mexico.[2] It ranks 48th globally on the Human Development Index, which takes into account life expectancy, education, and per capita income.[3]

1. For more information about the construction of race and identity in Argentina, see Garguin, "'Los Argentinos Descendemos de los Barcos': The Racial Articulation of Middle Class Identity in Argentina (1920–1960)" and Adamovsky, "El color de la nación argentina: conflictos y negociaciones por la definición de un ethnos nacional, de la crisis al Bicentenario"

2. The World Bank, "GDP (current USD): Latin America and Caribbean."

3. United Nations Development Programme, "Human Development Indicators: Argentina."

Greater Buenos Aires is extremely important to Argentina. The city is located in the eastern part of the country with proximity to the Atlantic Ocean and Uruguay and lies on a large river called the Río de la Plata, which provides it access to Paraguay and Brazil as well. It was built in this location to serve as a port city and as a place of governance during Spanish colonization in the 16th century and it remains central to Argentina's export and import economies today.[4] Greater Buenos Aires is the port through which Argentina exports agricultural goods such as soy and wheat. It is also a major center of industrial production in the country for food processing, steel, and auto parts.[5] Greater Buenos Aires has remained the central place of governance in Argentina, as it houses the federal government, including the Palace of the Argentine National Congress, the *Casa Rosada* where the president works, and the Palace of Justice of the Argentine Nation. Greater Buenos Aires is the most populous city in the country with about 15 million residents, which account for approximately one third of the country's entire population. This distribution is largely attributable to urban migration and urbanization in the early 20th century as people from other parts of the country and from Europe came to Greater Buenos Aires. Today, Greater Buenos Aires serves as a major tourist destination in Latin America. It is often compared to European cities, and offers vibrant *Porteño* culture, wine and cuisine, and tango dancing and music. Wealth in Argentina is concentrated in Greater Buenos Aires compared to the rest of the country, yet the city itself remains quite unequal in terms of income, access to basic needs, and health outcomes. There is inequality between the two entities which comprise Greater Buenos Aires, which are the Autonomous City of Buenos Aires and a portion of the Province of Buenos Aires. There is also significant inequality within each of these entities.

The Autonomous City of Buenos Aires (*La Ciudad Autónoma de Buenos Aires*, or CABA, in Spanish) is the center of Greater Buenos Aires and is situated on the Río

4. Assadourian, Beato, and Chiaramonte, *Argentina: De la conquista a la independencia*.
5. Instituto Nacional de Estadística y Censos, "Argentine Foreign Trade Statistics."

de la Plata. It has a population of about 3 million people that live in fifteen *comunas*, as shown in Figure 1.1. The population is fairly evenly distributed between *comunas*, with Comuna 1 being the most populous with 255,405 residents according to a 2020 projection based on the 2010 census, and Comuna 2 being the least populous with 149,430 projected residents. Each *comuna* is further divided into one or more *barrios* which are listed in the key of Figure 1.1. There is significant inequality present in the Autonomous City of Buenos Aires which is most clearly identifiable between the northern and southern regions. Income in the Autonomous City of Buenos Aires is unevenly distributed, with the northernmost *comunas* being the wealthiest and the southernmost *comunas* having much lower incomes on average.[6] Beyond income, access to basic resources is not evenly distributed and is not available to all.

The Argentine census measures Unsatisfied Basic Needs (*Necesidades Básicas Insatisfechas*) which are assessed based on the presence of at least one of following five measurements: informal or unstable housing, lack of sanitary conditions or a bathroom, overcrowded conditions with more than three persons sharing a room, children between ages six and twelve not attending school, and employed family members supporting four or more people without having finished primary school (which in Argentina would mean discontinuing one's education at around the age of twelve or thirteen).[7] In the Autonomous City of Buenos Aires, these minimum thresholds of wellbeing were not met in 6.0 percent of homes and 7.0 percent of people in 2010. By contrast, the census counted 9.1 percent of homes and 12.5 percent of people in all of Argentina as not having their basic needs met, indicating worse outcomes in other parts of the country. In the Autonomous City of Buenos Aires, the most common unmet basic need was stable housing, which was absent in over 50,700 homes, followed by overcrowded conditions, which was found in over 17,500 homes. Comuna

6. Buenos Aires Ciudad, "Anuario Estadístico."

7. Dirección Nacional de Relaciones Económicas con las Provincias (DINREP), "Necesidades Básicas Insatisfechas (NBI): Información Censal del Año 2010."

1 had the highest prevalence of homes with unsatisfied basic needs, at 15.9 percent of all homes, followed by Comuna 4 at 12.7 percent, and Comunas 3 and 8 at 11.9 and 11.3 percent, respectively. All of these *comunas* are located in the southern region of the city. Comuna 12 had the lowest prevalence of homes with unsatisfied basic needs at 1.7 percent, indicating a significant contrast. Comunas 13, 11, and 2 also had low prevalences.[8] Given that the most recent census data available in Argentina is from 2010, the current extent of unsatisfied basic needs may be underrepresented by these statistics.

Homes that meet the definition of having unsatisfied basic needs often coincide with informal settlements. The Autonomous City of Buenos Aires has multiple informal settlements, which it refers to in Spanish as *villas miserias* (misery villages, if translated literally), *barrios vulnerables* (vulnerable neighborhoods) or *barrios populares* (popular neighborhoods). These are represented in Figure 1.1 by white areas. Among the largest informal settlements in the Autonomous City of Buenos Aires are Villa 31, Villa 1-11-14, and Villa 21-24. Estimated population sizes are as high as 40 thousand people in some informal settlements.[9] These areas have lower income levels, high levels of poverty, and more limited access to education. In addition to having unsatisfied basic needs as defined by the census, informal settlements do not have consistent access to official water or electricity networks, for reasons discussed in the analysis section. Sanitation is poor and leads to exposure to toxic materials and contamination of drinking water. This leads to further vulnerability and sickness. Infectious diseases such as Dengue and Tuberculosis are more common in the informal settlements. Additionally, infant mortality is higher and life expectancy at birth is lower in these areas compared to more privileged areas of the city. Nevertheless, informal settlements do exhibit high levels of community based support and self

8. See Appendix Table A.1, based on data from Dirección Nacional de Relaciones Económicas con las Provincias (DINREP), "Necesidades Básicas Insatisfechas (NBI): Información Censal del Año 2010"

9. Ministerio de Desarollo Social de la Nación (Registro Nacional de Barrios Populares).

reliance.[10]

Greater Buenos Aires also encompasses part of the Province of Buenos Aires. The Province of Buenos Aires is quite large in area and is divided into more than a hundred subdivisions called *partidos*. The *partidos* surrounding the Autonomous City of Buenos Aires make up the city's metropolitan area, or the *conurbano bonaerense*, an area which can be defined in a multitude of ways to include a larger or smaller area of land and population size. This project includes the 35 *partidos* listed by the president in official Covid-19 lockdown orders. The projected population of this area in 2020, based on the 2010 census, is 13.2 million people. La Matanza is by far the most populated *partido* with over 2.2 million residents. The next most populated *partido* is La Plata with over 700,000 people and the least populated *partido* is General Las Heras with less than 18,000 people. Figure 1.2 depicts Greater Buenos Aires, including the 35 *partidos* analyzed in this project and the Autonomous City of Buenos Aires as a reference point, labeled as "CABA". White areas depict informal settlements located in the geographical area shown.

Historically, the Province of Buenos Aires has not had as many resources as the Autonomous City of Buenos Aires has, and inequality in the *partidos* does not follow the same spatial stratification seen in the federal capital. The *partidos* just north of the Autonomous City of Buenos Aires have some of the lowest percentages of unsatisfied basic needs, as they lie adjacent to the wealthiest areas of the Autonomous City of Buenos Aires. For example, only 2.4 percent of households in Vicente Lopez and 3.7 percent of households in San Isidro have unsatisfied basic needs. By contrast, La Matanza, which borders some of the most resource-poor *comunas* of the Autonomous City of Buenos Aires, has a rate of 12.0 percent unsatisfied basic needs.[11] In the *partidos* farther away from the federal capital, wealth runs parallel to the

10. Jordán, Rehner, and Samaniego, *Latin America Megacities and Sustainability*.

11. See Appendix Table A.2, based on data from Dirección Nacional de Relaciones Económicas con las Provincias (DINREP), "Necesidades Básicas Insatisfechas (NBI): Información Censal del Año 2010"

location of transportation networks connecting to the Autonomous City of Buenos Aires. Inequality is much more spatially fragmented within certain areas, with poor and wealthy areas often located in close proximity with one another.[12] Quilmes, for example, holds significant wealth and poverty which average to a rate of 9.2 percent unsatisfied basic needs. As shown in white in Figure 1.2, Greater Buenos Aires contains many large and densely populated informal settlements across many *partidos*.

Governance of the Greater Buenos Aires region is divided between three entities. The most powerful of these three entities is the national government, which has been led by President Alberto Fernández since December of 2019. Fernández is a progressive leader who was elected to office following the presidency of Mauricio Macri, a conservative leader whose policies will be elaborated upon in the analysis chapter.[13] Fernández's vice present is Cristina Fernández de Kirchner, a progressive, *Peronist* politician who served as Argentina's president from 2007 to 2015.[14] The Autonomous City of Buenos Aires is led by Chief of Government Horacio Rodríguez Larreta, a conservative politician from the same party as former president Mauricio Macri. In fact, Larreta was preceded by Mauricio Macri, who held the Chief of Government office before being elected to the presidency. The Province of Buenos Aires is led by Governor Axel Kicillof, a progressive politician from the same party as President Fernández. Political polarization is a pressing issue in Argentina and has led to fragmentation and poor management of issues in Greater Buenos Aires, including poverty and inequality. Nevertheless, the current government officials promised unity

12. Pírez, "Buenos Aires: Fragmentation and privatization of the metropolitan city."

13. For more information about former president Macri and the election of President Fernández, see Mason-Deese, "A Changing Tide in Argentina?"

14. Progressive politics in Argentina are often linked to *Peronismo*, an ideology dating to the presidential terms of Juan Domingo Perón from 1946 to 1955 and from 1973 to 1974. Perón advocated for Argentina's economic independence through domestic markets and prioritized social welfare through income redistribution, salary raises for the working class, and investment in housing and education. His presidency displayed elements of authoritarianism, making him a somewhat controversial figure and supporters of Perón were targeted by the military dictatorship that succeeded his presidency in the 1970s. *Peronismo* remains central to understanding Argentine politics. See Novaro, *Historia de la Argentina Contemporánea de Perón a Kirchner*

during their campaigns for election in 2019.[15]

Healthcare provision in Greater Buenos Aires is managed by several entities, as Argentina's healthcare system consists of private and public sectors. The public sector of Argentina's healthcare system is universal and free at the point of care for all residents of the country. It is comprised of a network of hospitals and primary care facilities administered at national, provincial, and municipal levels. National and provincial hospitals offer specialized care and handle more complex health conditions, while primary care centers and clinics focus on prevalent health needs such as maternal care, immunizations, and infectious disease control. It is estimated that about one third of Argentina's population relies exclusively on the public sector of the healthcare system. While the public sector resembles a universal healthcare system, it has struggled with a lack of sufficient funding and excess fragmentation, problems which can affect responsiveness to a widespread outbreak. More than half of the population is covered by one of several social health insurance programs, called *obras sociales*. These include programs which provide coverage for government employees, retired and disabled people, and formal workers. Coverage is paid for by employer and employee contributions. Finally, a smaller subset of the population receives additional health coverage from private sector insurance, which is a voluntary system purchased through out of pocket payments. The social insurance and private insurance sectors use their own network of healthcare facilities, including hospitals, clinics, and private practices separate from those of the public sector. They employ their own workforce of healthcare providers, many of whom are also employed by the public sector. To some extent, the government oversees all three sectors of the healthcare system to ensure quality of care and provision of a minimum package of services.[16]

As with other forms of inequality in Greater Buenos Aires, the spatial distribution

15. *Página12*, "Horacio Rodríguez Larreta comenzó su segundo mandato."

16. Maceira, "Morfología del Sistema de Salud Argentino: Descentralización, Financiamiento y Gobernanza"; Penchaszadeh, Leone, and Rovere, "The Health System in Argentina: An Unequal Struggle Between Equity and the Market."

of public and private healthcare providers in Greater Buenos Aires is uneven. According to a primary care physician interviewed for this project, within the Autonomous City of Buenos Aires the public health sector's clinics are more heavily concentrated in the southern part of the city, where poverty and informality are more common. This claim is supported by a report published by the city government that shows more than twenty public health clinics, called *Centros de Salud y Acción Comunitaria* (CeSACS, or Health and Community Action Centers in English), located in the poorest area of the city encompassed by Comunas 9, 8, and 4. The wealthiest area, contained within Comunas 13, 14, and 2, have fewer than five of these clinics.[17] By contrast, the private sector operates most of its clinics and hospitals in the northern region of the city. The Province of Buenos Aires follows a similar pattern, with public clinics and hospitals more heavily concentrated in lower-income regions and private facilities in more wealthy areas. Historically, public hospital construction has not met the demands of population growth, contributing to this spatial distribution and gaps in coverage in some areas.[18] This is due largely to neoliberal policies and paradigms of public health which will be discussed further in the analysis chapter.

17. Buenos Aires Ciudad, "Anuario Estadístico."
18. Lloyd-Sherlock, "Policy, Distribution, and Poverty in Argentina Since Redemocratization."

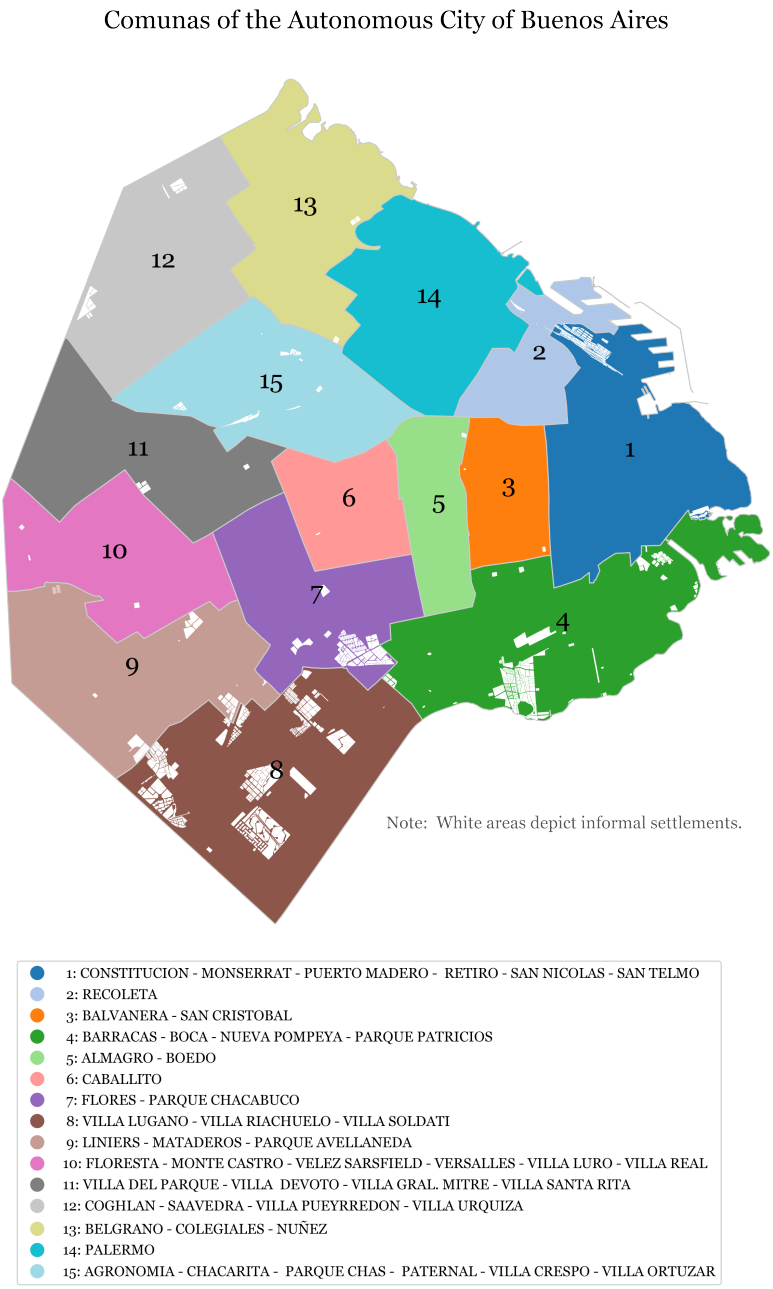

Figure 1.1: This map depicts the 15 *comunas* in the Autonomous City of Buenos Aires. The key indicates *barrios* contained within each *comuna*. White areas depict informal settlements. (Sources: Ministerio de Educación (Comunas); Ministerio de Desarrollo Humano y Hábitat (Barrios populares de la Ciudad Autonoma de Buenos Aires). Map created with: Van Rossum and Drake, *Python 3 Reference Manual*; Hunter, "Matplotlib: A 2D graphics environment"; Jordahl, "GeoPandas: Python tools for geographic data")

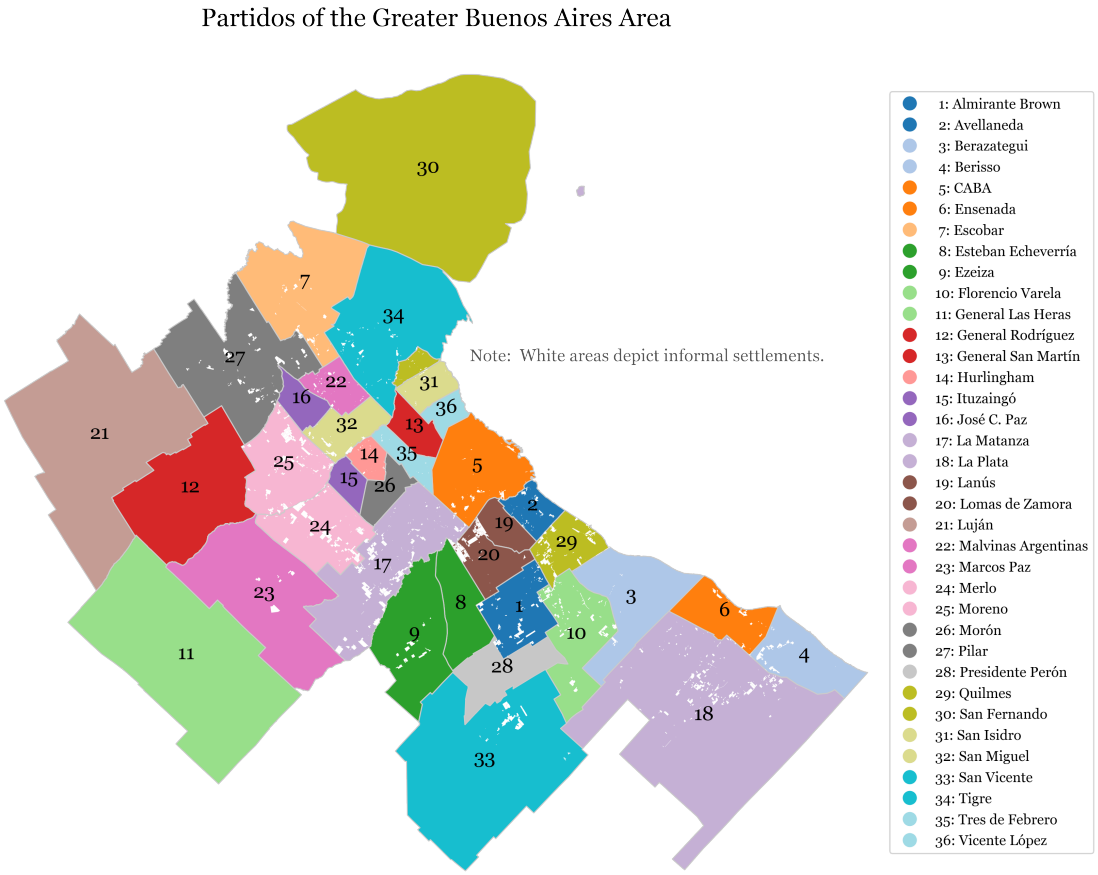

Figure 1.2: This map depicts the 35 *partidos* of the Province of Buenos Aires that combine with the Autonomous City of Buenos Aires (labelled as CABA, number 5, in this map) to make Greater Buenos Aires. White areas depict informal settlements. (Sources: Instituto Geográfico Nacional (Regiones y ciudades); Ministerio de Desarollo Social de la Nación (Registro Nacional de Barrios Populares). Map created with: Van Rossum and Drake, *Python 3 Reference Manual*; Hunter, "Matplotlib: A 2D graphics environment"; Jordahl, "GeoPandas: Python tools for geographic data")

1.2 Introduction to Covid-19

The novel coronavirus SARS-CoV-2 which gave rise to the Covid-19 pandemic in 2020 is a respiratory virus which emerged in late 2019. It is related to the viruses which caused the SARS (Severe Acute Respiratory Syndrome) outbreak in 2002 and the MERS (Middle East Respiratory Syndrome) outbreak in 2012, both of which initiated research into this family of viruses and sounded alarms warning of their potential threats to global health. The new Covid-19 virus causes symptoms such as fever, headache, cough, difficulty breathing, loss of taste or smell, nausea, and fatigue. Symptoms can vary in intensity and may appear between two and fourteen days following exposure to an infected person. The virus is spread through droplet transmission when an infected person coughs, sneezes, or talks. Droplets may be directly inhaled by another individual or could land on a surface which a healthy person touches before touching their mouth, nose, or eyes, although this second mode of transmission is less common. Evidence also suggests that Covid-19 can be spread in diarrhea, which is a common symptom in infected persons if sufficient hygiene and sanitation is lacking. The virus can cause life-threatening illness in people of all ages and more severe cases require ventilatory support. Old age and pre-existing conditions such as lung disorder indicate higher risk of experiencing severe symptoms or death. Many people who have been infected with Covid-19 do not display symptoms at all, marking them as asymptomatic carriers. There is also evidence of recovered persons becoming reinfected due to the presence of several strains of the virus circulating in certain areas.[19]

For the majority of the first year of the pandemic, there were no proven treatments for Covid-19 and various trials tested antimalarial drugs, antiviral drugs, and plasma transfusion. There were also no vaccines to prevent Covid-19 infection until the end of 2020, and even then these vaccines were not widely available. Personal

19. Keni et al., "COVID-19: Emergence, spread, possible treatments, and global burden."

hygiene practices such as hand washing as well as wearing masks or face coverings and practicing social distancing were recommended to prevent the spread of Covid-19. Contact tracing, testing, and quarantine were encouraged to minimize transmission amongst people suspected of coming into contact with the virus.[20]

The Covid-19 pandemic emerged as an outbreak in Wuhan, China in December of 2019 when cases of pneumonia began appearing. The outbreak was traced to a market in Wuhan, where it is suspected that the virus spread to humans through an animal carrying the virus, as occurred with earlier SARS, MERS, and Ebola epidemics. It quickly spread through the city of Wuhan and clusters of the virus soon appeared in other countries. On January 30th, the World Health Organization named Covid-19 a global emergency and on March 11th it declared Covid-19 a global pandemic. Italy and the rest of Europe, Iran, and the United States became major outbreak sites in the following months.[21] Covid-19 first appeared in Latin America on February 26th when a case was confirmed in São Paulo, Brazil. Soon after, other countries in the region began reporting cases, with cases emerging in Mexico on February 28th, Chile on March 3rd, and Peru on March 6th. These cases were imported from other parts of the world through major airports. Argentina's first case was confirmed on March 3rd when an Argentine man returned to the country following a trip to Italy, where there was a significant Covid-19 outbreak. Countries in the region took a range of measures to prevent the spread of Covid-19 including lockdowns and travel restrictions. Some countries were strict in their responses, whereas others such as Mexico and Brazil downplayed the risk of the pandemic. By summer of 2020, Latin America became the most heavily impacted region in the world in terms of cases of infection.[22]

As of the end of December 2020, one year after the emergence of Covid-19, the World Health Organization recorded a total of more than 79.2 million cases confirmed

20. Keni et al., "COVID-19: Emergence, spread, possible treatments, and global burden."
21. Keni et al.
22. World Health Organization (WHO Coronavirus Disease (COVID-19) Dashboard).

globally over the course of the year. It also recorded a total of more than 1.7 million confirmed deaths globally. The United States had the highest number of cases at over 18.5 million, followed by India with more than 10 million cases and Brazil with nearly 7.5 million cases. These countries also had the highest number of Covid-19 related deaths, with over 320,000 in the United States, over 140,000 in India, and over 190,000 in Brazil. Argentina reported over 1.5 million confirmed cases and over 42,000 deaths. Taking into account the population size of each of these countries, Argentina was more heavily impacted. Countries with larger populations, such as the United States and Brazil, often had the highest number of cases but the data failed to reflect the proportion of the population affected. Argentina's cumulative case count per 100 thousand people was over 3,400 in December of 2020, trailing only the United States, which had over 5,600 cumulative cases per 100 thousand people, and Panama, which had over 5,200 per 100 thousand people, within the Americas region. Argentina and all other countries mentioned here reported community transmission, meaning Covid-19 was present and constant amongst the general population and not limited to area clusters or sporadic cases. A large portion of Argentina's cases were concentrated in its largest city, Greater Buenos Aires.

It should be noted that reporting of Covid-19 has certain limitations. The World Health Organization publishes global data based on reports from national health ministries. Cases must fit the case definition for Covid-19 and when possible, must be confirmed rather than suspected. Nevertheless, case reporting is contingent on testing capacity and case tracking in different countries. Covid-19 data changes rapidly, as each day of the pandemic adds more confirmed cases and deaths.[23] While this project focuses only on the first ten months during which Covid-19 was present in Argentina, the pandemic is ongoing. See footnote for updated epidemiological data as of the

23. World Health Organization, "COVID-19 Weekly Epidemiological Update."

beginning of March 2021.[24]

Discourse surrounding the Covid-19 pandemic has labelled the virus as an equalizer, or something that has the potential to affect every person regardless of status. Phrases alluding to the fact that the virus is affecting the whole world and that everyone is experiencing a tough time have become common. However, this is a narrow view of the pandemic. As the virus spread throughout the world, it became abundantly clear that Covid-19 does not have the same impact on diverse groups of people. For example, a wave of anti-Asian racism has accompanied the Covid-19 pandemic since the outbreak originated in China.[25] In the United States, Black, Latino, and Native American people have been disproportionately affected by Covid-19 and experience higher case rates and death rates.[26] On the world stage, wealthy countries including the United States and Canada, as well as many European Union member nations, have had easier access to medical supplies, testing equipment, and treatments compared to poorer nations.[27] It is evident that Covid-19 is no great equalizer and it has in fact worsened inequality both between countries and within countries.

24. The World Health Organization has reported 113.5 million cases and 2.5 million deaths globally as of February 28th, 2021. Argentina remains one of the most heavily impacted countries in the Americas with 2.1 million total cases and nearly 52,000 deaths. This equates to 4,600 cases per 100 thousand people in Argentina, compared to 8,500 cases per 100 thousand in the United States and 4,900 cases per 100 thousand in Brazil. World Health Organization, "COVID-19 Weekly Epidemiological Update"

25. Gao and Liu, "Stand against anti-Asian racial discrimination during COVID-19: A call for action."

26. Webb Hooper, Nápoles, and Pérez-Stable, "COVID-19 and Racial/Ethnic Disparities."

27. Maffioli, "Consider inequality: Another consequence of the coronavirus epidemic."

Chapter 2

Structure and Methodology

The global Covid-19 outbreak made its first contact in Greater Buenos Aires in March of 2020. In the months that followed, the virus grew into a significant outbreak in the city. This study analyzes the responses to and the outcomes of the outbreak between the months of March and December 2020. Greater Buenos Aires is defined here as the Autonomous City of Buenos Aires, partitioned into 15 communes, and the surrounding metropolitan area located within 35 *partidos* of the neighboring Province of Buenos Aires. This definition corresponds with the area delineated in the legislative bulletins announcing lockdown orders released by the office of President Fernández during the outbreak. Three categories of data are employed in this project and due to travel restrictions during the pandemic, all data was collected virtually. The first category of data is information originating from the government, which includes legislation, reports, and datasets. The second category of data comes from major Argentine media outlets, and the third consists of a series of interviews conducted with local experts living and working in Greater Buenos Aires during the pandemic. The three categories of data combine to create a nuanced image of the Covid-19 outbreak in Greater Buenos Aires. In some cases the data is complementary and is able to confirm the veracity of certain claims. In other cases, triangulation occurs

as multiple sources of data contradict one another, revealing biases within sources or uncertainties in the outbreak response.

2.1 Government Data

Government legislative bulletins are used to describe the government response to the Covid-19 outbreak. These reports are accessible on the website of the office of the president and include the exact terms and effective dates of lockdown orders, lockdown extensions, private sector regulations, and public assistance programs. Particular focus is given to nationwide executive orders passed by President Fernández. Additional non-legislative reports from the press office of the government provide further analysis of the Covid-19 outbreak, including reports of testing and contact tracing procedures, collaboration between national and municipal government heads, and healthcare system capacity. Such reports often draw from quotes said in press conferences and briefings by members of the government including the president, the health minister, and the government heads of the Autonomous City of Buenos Aires and the Province of Buenos Aires. Non-legislative reports introduce some bias, as the government is rarely self-critical of its response to the outbreak. The inclusion of such forms of government data is skewed towards the national level in this project rather than the provincial or municipal levels, as Covid-19 response was dictated by the federal government for the majority of the time period evaluated.

A second type of government data is employed to describe quantitative outcomes of the outbreak. The websites of the federal government, the Autonomous City of Buenos Aires, and the National Institute of Statistics and Census (INDEC for its name in Spanish) publish datasets and spreadsheets with measures such as population, poverty level, and Covid-19 cases. This data was downloaded and processed using Python computer programming language, where it was filtered to show data from the

defined geographical region and ten month period being analyzed in this project.[1] Graphs were created using the MatPlotLib program to show the progression over time of Covid-19 cases in the Greater Buenos Aires region and within a subset of the city's informal settlements.[2] Maps were created using GeoPandas software and government shapefile data to mark the geographical distribution of the Covid-19 outbreak.[3] Formulas were created to standardize the data presented in these maps based on population size in order to create a greater level of comparability between the *comunas* and *partidos* that constitute Greater Buenos Aires. Covid-19 prevalence is shown as the number of cases per 1000 people, a measure calculated by dividing the total number of reported cases by the total current population as projected based on the 2010 census. Deaths are presented as a case fatality rate, calculated as the total number of deaths in a region divided by the total number of cases in the same region during the same period of time. Although the quantitative data presented in this paper represents official government data, it is susceptible to several forms of bias. Gaps in testing capacity and contact tracing can cause underreporting or bias across time and space. Areas with better testing capacity may appear to have more cases in comparison to areas with lower testing capacity. The progression of Covid-19 spread over time may experience a similar bias as testing capacity and contact tracing was expanded throughout the duration of the outbreak. Underreporting and reporting delays may also cause bias. This is a concern particularly within the private healthcare system, as the government has limited access to its information systems, thus slowing the official case reporting derived from the private sector.

1. Van Rossum and Drake, *Python 3 Reference Manual*.
2. Hunter, "Matplotlib: A 2D graphics environment."
3. Jordahl, "GeoPandas: Python tools for geographic data."

2.2 Media

Throughout the data collection period, newspaper articles were monitored to understand current events in Greater Buenos Aires as well as changing attitudes towards the Covid-19 outbreak response. Articles from Argentina's three largest print media sources, *Clarín*, *La Nación*, and *Página12*, were accessed through the outlets' online platforms and through the database *Factiva*, which archives publications from major global news sources. Each of these sources takes a political stance in current events. Their respective ideologies affect the kinds of stories they report as well as how they are interpreted. In this project, reporting from each outlet is compared to the other media outlets and to other sources of data.

Seventy-five years after its founding, *Clarín* has become the largest print media source in Argentina. It is owned by the *Grupo Clarín* media company, which oversees several newspaper publications, cable television networks, and radio programs. *Clarín* is a centrist newspaper which advocates for economic liberalism and often denounces more progressive or Peronist politics.[4] In recent years, its ideological tilt has shifted further to the right and it often disagrees with decisions made by current President Fernández. Its criticism of the Fernández administration could be linked to a conflict which arose between the media company and current Vice President Cristina Kirchner in 2009, during her own presidency, regarding antitrust laws and the media.[5]

La Nación is a competitor of *Clarín*. Since its establishment in 1870, it has remained grounded in its conservative views. Its opinion editorials often emphasize the value of individual freedoms, particularly within the business sector. It often opposes President Fernández's government and is explicitly anti-Peronist, yet it was also highly critical of conservative former President Macri's handling of the economy towards the end of his term. Its ideological orientation is well represented in an article

4. See the following article for a representation of the political stance occupied by *Clarín*: Montero, "El verdadero progresismo es liberal"

5. Repoll, "Política y medios de comunicación en Argentina: Kirchner, Clarín y la ley."

it published in late 2019 titled "The multiple faces of Alberto Fernández."[6]

Página12 is a widely circulated progressive newspaper in Argentina. It was founded in 1987 with a mission to support democracy and human rights.[7] Its articles are largely supportive of the Fernández government and critical of governance in the Autonomous City of Buenos Aires, which is led by conservative politician Horacio Rodríguez Larreta. Its ideological orientation is conveyed in articles such as "The Neoliberal Right Versus Progressivism."[8]

2.3 Interviews

Interviews were conducted to gain further perspective on the Covid-19 outbreak impact and response from people living and working in Greater Buenos Aires during the pandemic. Following approval from the Emory University Institutional Review Board, virtual interviews were scheduled with contacts established through a study abroad program which took place in early 2020. A total of four interviews were completed in October and November of 2020, each of which lasted about one hour on the online video conferencing platform *Zoom*. Each participant provided consent to be interviewed and in order to preserve confidentiality, the interviewees' names and employers will not be revealed. Instead, interviewees will be referred to by their first initial and their employment history will only be described in broad terms. The interviewees all work with issues of health and inequality in Greater Buenos Aires. Although they are experts in their respective fields, their views may not be generalizable to other experts in their fields due to personal biases or political views. In some cases interviewees shared information about vulnerable groups, including the urban poor and marginalized communities, with whom they have interacted in their work. Such information may not necessarily come directly from members of these

6. Di Marco, "Las múltiples caras de Alberto Fernández."
7. Tiffenberg, "Nuestra historia."
8. Enríquez-Ominami Gumucio, "La derecha neoliberal frente al progresismo."

groups. This project would be strengthened by further ethnographic field research, a task which was not possible due to travel constraints during the pandemic.

The first interview conducted for this project was with Ms. M, an environmental scientist, on October 21st, 2020. Ms. M holds a bachelor's degree in environmental science from a private university in Argentina. Throughout her career, she has worked with non-governmental organizations, municipal governments across Argentina, and multilateral organizations such as the World Bank, the United Nations, and the Inter-American Development Bank in projects relating to environmental conservation and sustainability, waste management and sanitation, and environmental impact assessment. She has experience working with sanitation issues in the informal settlements of Greater Buenos Aires, particularly in informal settlements adjacent to the highly polluted Matanza River.

The second interview was with a physician named Dr. P on October 24th. Dr. P practices family medicine in a public healthcare clinic located in the southern region of the Autonomous City of Buenos Aires and is working to complete his master's degree in epidemiology. The clinic where Dr. P works is located near the entrance of a large informal settlement, and the population it serves consists of first, second, and third generation migrants from Bolivia and other South American countries as well as migrants from Argentina's northern provinces. A large portion of the clinic's patients are low-income, live in informal housing which often lacks access to reliable electricity and water, and have limited access to education and formal employment. These inequities have implications for the health outcomes of the population, including its infant mortality rate and life expectancy at birth. Tuberculosis is particularly common at Dr. P's clinic. Prior to the pandemic, his clinic focused primarily on community-based preventative health. Typical services at the clinic included general medicine, family planning and sexual health care, pediatric care and immunizations, and communicable disease care. Beyond general medicine, the clinic offered dental

care and mental health care. Within the community, the clinic offered educational workshops and outreach programs addressing prevalent local health issues.

Two additional interviews were conducted with experts in the ongoing HIV/AIDS epidemic in Greater Buenos Aires. The first interview was with Ms. V, who holds a degree in psychology and works as a therapist and social researcher for a large HIV/AIDS-focused non-governmental organization in Greater Buenos Aires, on October 28th. Her organization provides a range of services including HIV prevention and education, therapy and support groups, legal services, and drug development and clinical trials. Ms. V works as a therapist primarily with transgender women and sex workers, demographics which account for a significant portion of Greater Buenos Aires's population of people living with HIV. A second interview was conducted with Mr. G on November 20th, who also holds a degree in psychology and who works primarily with another organization that does outreach to young people living with HIV. Mr. G works as a community organizer and support group facilitator for this organization and works most closely with men who have sex with men, and also with people born with HIV following mother to child transmission. He also works as a social researcher for Ms. V's organization.

Chapter 3

Results

3.1 The Initial Lockdown

Covid-19 began its spread across the globe in early 2020, and in the first days of March Argentina's federal and local governments acted quickly to respond to the onset of the pandemic. The initial federal response included travel restrictions, border closures, and the declaration of a national health emergency lasting one year. The Autonomous City of Buenos Aires and the Province of Buenos Aires prohibited large social gatherings and cancelled or postponed major sporting and cultural events.[1] On March 20th, President Fernández enacted a nationwide lockdown with strict stay-at-home orders, allowing movement only to buy essential needs such as food, medicine, and cleaning supplies. Schools closed or operated online, those who could worked from home, and essential workers were provided with travel permits to be on the streets. Security forces maintained the lockdown, issuing warnings and fines to those who violated orders.[2] The lockdown was intended to be a two week long preventative measure which would prevent Covid-19 from developing into an outbreak in Argentina. However, cases slowly continued to rise throughout the city

1. *La Nación*, "Coronavirus: Axel Kicillof dispondrá que no haya público en el fútbol y que no se realicen eventos masivos en la Provincia."

2. Decreto 297/2020.

despite the lockdown and the national government began extending the lockdown into the weeks and months that followed. During this time, cases also continued rising in other countries in the region such as Brazil and Chile.

The lockdown implemented by the government was particularly futile in Greater Buenos Aires's informal settlements, as social distancing was not feasible for these communities. Multiple articles published by *Página12* in May gave voice to residents of informal settlements in the Autonomous City of Buenos Aires and in Quilmes, a *partido* in the Province of Buenos Aires. According to these articles, social distancing was difficult because living spaces in informal settlements are much more crowded, with large families sharing only one or two rooms. In the event that a family member became sick with Covid-19, there was limited ability to prevent spread to other members of the household. People continued to work because without daily wages, they could not afford to pay bills or feed their families. Remote work was not an option for most. One resident of Villa 31, which is located in Comuna 1 in the Autonomous City of Buenos Aires, told *Página12*: "I held on all this time without leaving but my money's run out. Though I may be scared, if I don't work I won't be able to pay the rent, buy milk and food for my kids."[3] Another challenge was that access to water is unstable in many informal settlements. Many people rely on shared community pumps for water, which forced them to leave their residences more frequently during the lockdown and prohibited them from being able to wash their hands more often. The residents interviewed in the newspaper articles expressed that the government was slow to respond in the informal settlements and that fear was mounting due to rising cases and a continued lack of access to basic needs such as safe water.[4]

As it became clear that an outbreak was growing in Greater Buenos Aires with

3. Original Spanish: "Aguanté todo este tiempo sin salir pero se me acabó la plata. Aunque me de miedo, si no trabajo no voy a poder pagar el alquiler, comprar la leche y la comida para mis hijos." Bermejo, "Coronavirus: cómo se vive el miedo en la Villa 31"

4. Bermejo, "Coronavirus: cómo se vive el miedo en la Villa 31"; Micheletto, "Coronavirus: Cómo viven en Villa Itatí y Villa Azul el aislamiento y el operativo de detección."

a high concentration in informal settlements despite the lockdown, the government worked to strengthen testing and contact tracing capacity. These systems were implemented first in healthcare facilities and later in communities at large. In May, with the support and guidance of the World Health Organization, the Argentine government launched the initiative *Operativo Detectar*, which actively monitored and tested members of the population. Triage centers were built in areas where Covid-19 was actively spreading, particularly in informal settlements, and teams of volunteers from local organizations, the government, and medical schools traveled door to door to complete screening exams and administer rapid tests. Suspected cases were taken to isolation centers or emergency healthcare centers for further testing or treatment, depending on the severity of the case, and social support and housing accommodations were provided if needed. Following each new diagnosis, the team would identify any people with whom the case had had direct sustained contact and screen them for Covid-19.[5]

In the Autonomous City of Buenos Aires, *Operativo Detectar* was established in Villa 31 on May 5th, Villa 1-11-14 on May 11th, Villa 15 on May 23rd, and Villa 20 on May 26th.[6] Villa Azul and Villa Itatí, both located in Quilmes in the Province of Buenos Aires, began testing through *Operativo Detectar* on May 21st. Additional testing capacity was scaled up in other high risk areas throughout Greater Buenos Aires in the weeks and months that followed.[7] Case reporting from both the healthcare system and *Operativo Detectar* revealed the trajectory of the outbreak in the informal settlements of Greater Buenos Aires. Figure 3.1 shows the number of new confirmed cases reported each week in a subset of informal settlements in the Autonomous City of Buenos Aires. It includes data collected in Villa 31, Villa 1-11-14, Villa 21-24, Villa

5. Ministerio de Salud, "Dispositivo Estratégico de Testeo para Coronavirus en Territorio Argentino."

6. Gerencia Operativa de Epidemiología, "Boletín Epidemiológico Semanal."

7. Micheletto, "Coronavirus: Cómo viven en Villa Itatí y Villa Azul el aislamiento y el operativo de detección."

20, Carrillo, and Rodrigo Bueno. The figure indicates that new weekly cases peaked in May and June, which is noticeably earlier than peaks which occurred in the entire Greater Buenos Aires area, as shown in Figure 3.2 later in this chapter.

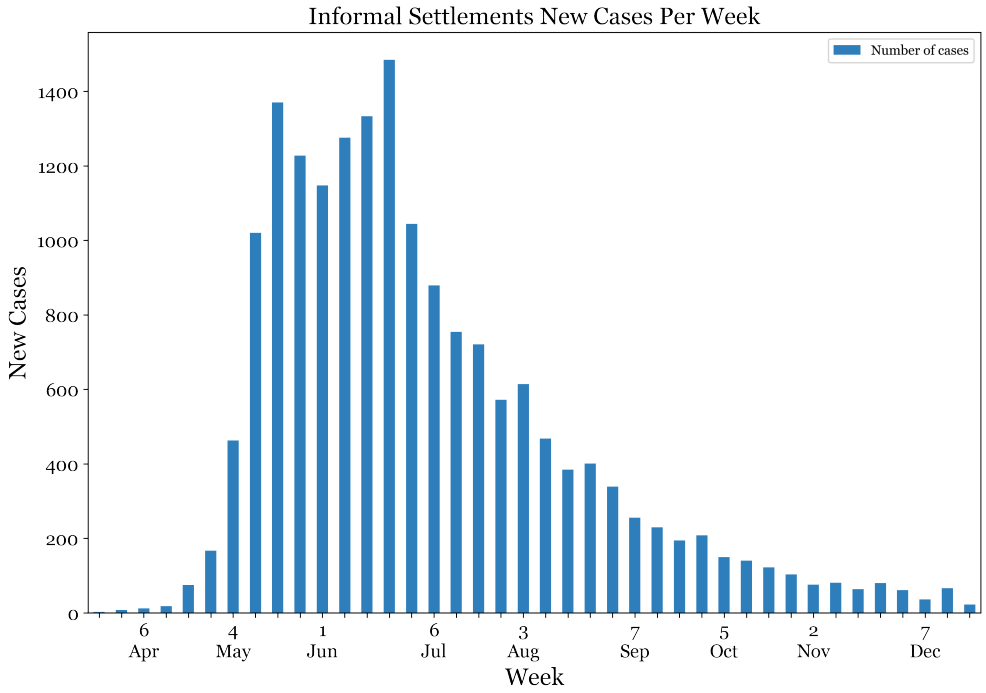

Figure 3.1: New confirmed cases of Covid-19 by week from March 1st to December 31st, 2020 in a subset of informal settlements in the Autonomous City of Buenos Aires: Villa 31, Villa 1-11-14, Villa 21-24, Villa 20, Villa 15, Carrillo, and Rodrigo Bueno. (Source: Ministerio de Salud (Reporte COVID-19). Graph created using: Van Rossum and Drake, *Python 3 Reference Manual*; Hunter, "Matplotlib: A 2D graphics environment")

While official case reporting from the healthcare system and from *Operativo Detectar* may contain inconsistencies due to delays in establishing testing capacity and outbreak monitoring, it is clear that the Covid-19 outbreak peaked earlier in the informal settlements than it did in the rest of the city. Dr. P confirmed in his interview that his primary health clinic, which serves a large informal settlement in the southern region of the Autonomous City of Buenos Aires, experienced peaks about two months prior to the rest of the city. From May to June, he said, his clinic treated dozens

of Covid-19 patients each day. For each patient they saw, they needed to perform contact tracing and follow-up care, which often included making arrangements for people who otherwise did not have the resources to self-isolate to stay in temporary accommodations, often at hotels which were converted to isolation facilities. They had to call ambulances two to three times a day for patients with severe cases to be transferred to the hospital and were frequently left to care for patients who should have been treated at hospitals but were routed to clinics instead in order to alleviate strain in hospitals. This included patients with non-Covid-19 health emergencies, some of whom required surgery. For a relatively small clinic, in this case with a staff of 40 people divided into two alternating shifts, responding to the outbreak each day was often overwhelming. On a personal level, working in healthcare was exhausting, as at the start of the pandemic healthcare workers were not allowed time off. Dr. P said he was lucky in that he was not transferred to an intensive care unit or hospital setting and instead continued working at the same clinic, but that wearing protective equipment for long hours and not being able to be in close contact with other people, as is customary in Latin American culture, was difficult.

The early outbreak in the informal settlements was largely attributable to a short-sided, strictly biomedical response to the emerging Covid-19 outbreak that gave little consideration to the social and economic factors preventing people from complying with lockdown orders. Mr. G compared such tactics to ones used in the context of HIV and AIDS. He explained that blame and fear mongering were used as control tactics to deter people from leaving their homes. Risky behaviors and lack of adherence to social distancing guidelines were antagonized. For example, he said that in the context of the HIV epidemic, sexual abstinence has been promoted as a method of prevention, despite that in many cases this is not a realistic solution, and as a result people are blamed for contracting HIV when they do not remain sexually abstinent. It is the same for Covid-19 when people are told to stay at home despite

their dependence on daily income or community water pumps. Such messaging causes stigmatization of people who contract Covid-19, instead of offering solutions to empower people to be as safe as possible during the pandemic. As Mr. G stated, "If we keep forcing a one-solution-fits-all approach, we are going to alienate those for whom that solution is not *their* solution. We have to be more creative and resourceful." In addition to improving messaging, the initial outbreak response needed more direct intervention to mitigate economic and social barriers to lockdown compliance. An article published in *Página12* in May heavily criticized the government of the Autonomous City of Buenos Aires for lagging in outbreak response. It noted in particular that a member of the city's government denied that there were breaks in the water network, despite part of Villa 31 having gone fifteen days without water at the time, which only exacerbated the vulnerability of this community during the outbreak.[8] The response in the informal settlements thus needed stronger acknowledgement of systems of inequality and more socially aware messaging and interventions to reduce the outbreak's impact.

For all of the shortcomings in the initial Covid-19 response, the outbreak in the informal settlements of Greater Buenos Aires began seeing declines in new cases per week in the beginning of July, as shown in Figure 3.1. There are a number of theories as to why this happened. One possibility is that case reporting methods changed and focus once channeled into informal settlements shifted. *Operativo Detectar* expanded to other parts of Greater Buenos Aires as cases began rising outside of the informal settlements. As a more generalized outbreak emerged, some reporting entities stopped distinguishing cases originating in informal settlements from cases in the city at large. This could indicate that the informal settlement outbreak was more sustained, but underreported. This hypothesis is not supported by anecdotal evidence from Dr. P's clinic. Dr. P explained that his clinic saw a noticeable decline in Covid-19

8. Pertot, "Coronavirus: todavía sin protocolo para las villas porteñas."

cases from the informal settlement it serves after a couple of months. Thus, factors such as herd immunity and outbreak responses could be responsible for the decline in cases. Herd immunity could have occurred if enough people in close proximity were exposed to the virus and developed immunity such that it slowed transmission. Outbreak responses such as Covid-19 testing efforts, quarantine accommodations, and financial assistance also could have aided the decline in cases by controlling spread and mitigating economic hardship. Still, Dr. P admitted that it is difficult to understand why the outbreak lifted in the informal settlements, as there are many factors at play.

3.2 The Peak of Covid-19

As cases spread in Greater Buenos Aires, especially in the informal settlements, the government established several financial support programs. On March 23rd, President Fernández announced the national Emergency Family Income (*Ingreso Familiar de Emergencia*, or IFE) which would benefit unemployed people or informal workers who submitted an application for a one time payment of 10,000 pesos (about 150 USD) starting in the month of April.[9] This program was extended several times later in the pandemic to distribute additional payments, ultimately sending payments to more than nine million families across Argentina.[10] On March 25th, a government decree prevented gas, power, water, phone, internet, and cable television providers from cutting services following nonpayment or delayed payment from qualifying users which included benefactors of certain welfare programs and small businesses. The companies, whose services were deemed essential, were obliged to provide a basic provision for the duration of the pandemic.[11] Another decree on March 29th banned evictions, extended leases, and froze rent rates for families, individuals, and small businesses

9. Decreto 310/2020.
10. *Clarín*, "Confirman el monto del bono para beneficiarios de Potenciar Trabajo: cuáles son todas las ayudas sociales sin IFE 4."
11. Decreto 311/2020.

who could no longer afford rent costs. An exception to the decree was made for landlords who themselves would be put at risk if they did not receive payments from tenants.[12] On April 4th, the Emergency Assistance to Work and Production (*Asistencia de Emergencia al Trabajo y la Producción*, or ATP) was established. It excused small businesses from paying into Social Security and helped cover worker salaries through December of 2020.[13] Throughout the pandemic, Argentina also continued and expanded existing programs that provide financial assistance to low-income families. These included the Food Card (*Tarjeta Alimentar*), which provides financial assistance for buying food, and the Universal Child Allowance (*Asignación Universal por Hijo*), which provides financial assistance to mothers and families with dependent children.

Such programs were intended to help people endure not only a spreading outbreak of Covid-19, but the hardship being under lockdown orders for first weeks and then months on end. The lockdown was extended multiple times after its initial introduction on March 20th, and phases were introduced which allowed some activities to resume. Initial phases maintained strict lockdown procedures, with one phase allowing for some industrial and agricultural production to resume and another permitting banks and libraries to operate. Early phases also eased restrictions on movement, allowing people to take outdoor walks near their places of residence.[14] For the first several months, the lockdown was mandated by the national government, although the president was in frequent communication with the leaders of the Autonomous City of Buenos Aires and the Province of Buenos Aires throughout the duration of the lockdown. President Fernández, Horacio Rodríguez Larreta, and Axel Kicillof held multiple press conferences together in order to present a unified front against the pandemic. Local governments were responsible for implementation and manage-

12. Decreto 320/2020.
13. Decreto 332/2020.
14. Decreto 576/2020.

ment of lockdowns at the municipal level, and as the outbreak continued tensions arose between local governments and the national government in how to continue the lockdown. In June, while still on lockdown, Horacio Rodríguez Larreta announced plans to allow more businesses to operate and for people to spend more time outside in the Autonomous City of Buenos Aires, citing concerns about the economy suffering during the lockdown. Meanwhile, Province of Buenos Aires Governor Axel Kicillof did not alter lockdown measures in the municipalities pertaining to Greater Buenos Aires, explaining that the outbreak was still not under control.[15] In August, President Fernández extended the lockdown in Greater Buenos Aires to September 20th, but with plans to allow more movement, including outdoor dining at restaurants.[16]

Around the month of June, cases in Greater Buenos Aires began rising more rapidly as cases in the informal settlements began their decline. This trend continued through July and the generalized outbreak experienced several peaks, first in early August and again in early September when more than 40,000 new cases were recorded in one week. This trend is represented by Figure 3.2, which visualizes the progression of new cases in the Autonomous City of Buenos Aires and the surrounding *partidos* in the Province of Buenos Aires, as reported by the national government. This trend may have emerged for a variety of reasons, with the first reason being that the government eased lockdown restrictions and that collaboration between the local and national government leaders became more tense. While President Fernández, Chief of Government Larreta, and Governor Kicillof had been emphasizing the same measures throughout the beginning of the pandemic, such as complying with the lockdown, debates about when and how to reopen the economy became more prominent and contentious. *La Nación* described this period in the lockdown as a point in which *la grieta*, or extreme polarization, returned as Larreta intended to distance himself

15. *Página12*, "Alberto Fernández anunció la nueva fase de la cuarentena"; *Página12*, "Coronavirus: la nueva etapa de la cuarentena que se inicia en CABA y el Conurbano."

16. *Clarín*, "La lucha contra la pandemia Coronavirus: la cuarentena sigue hasta el 20 de septiembre y se autorizan las reuniones en espacios abiertos."

from President Fernandez's politics to appease his more conservative base.[17] As more movement was allowed and businesses allowed to operate, it is possible that cases began spreading more easily. With more apparent tensions between leadership entities, safety precautions and health recommendations could have been undermined.

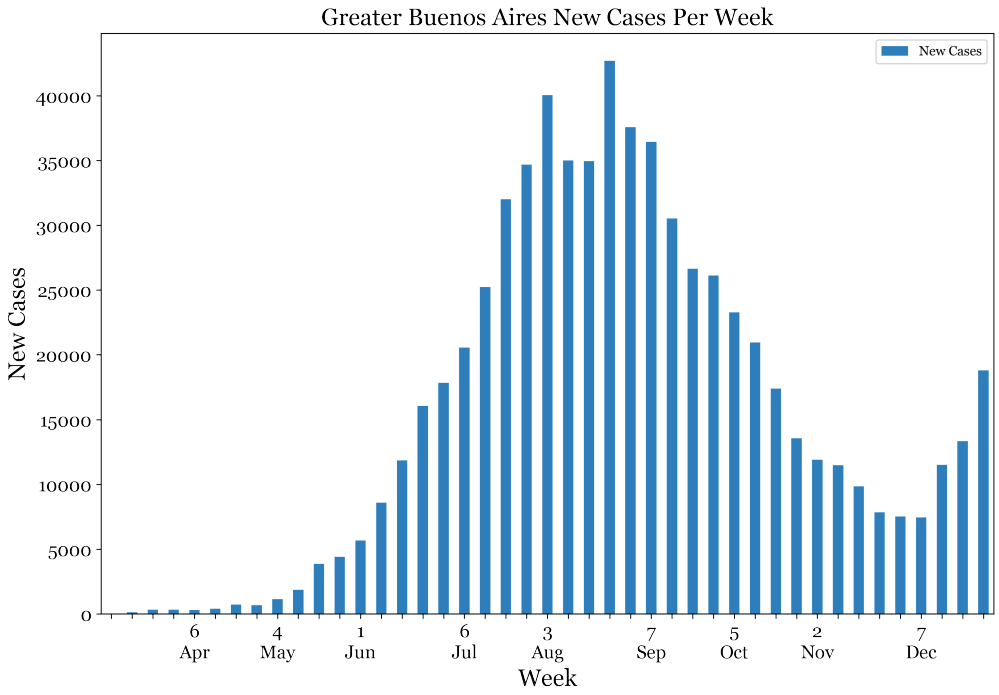

Figure 3.2: New confirmed cases of Covid-19 by week from March 1st to December 31st, 2020 in Greater Buenos Aires, which includes the entirety of the Autonomous City of Buenos Aires and 35 *partidos* of the Province of Buenos Aires. (Source: Dirección Nacional de Epidemiología y Análisis de Situación de Salud (Casos COVID-19); Ministerio de Salud (Casos COVID-19). Graph created using: Van Rossum and Drake, *Python 3 Reference Manual*; Hunter, "Matplotlib: A 2D graphics environment")

Political polarization and politicization of health recommendations amongst the general public developed during the trajectory of the Covid-19 pandemic and were often harmful to levels of compliance with health safety measures. This trend was noticeable around the world as disagreements about how to respond to the pandemic heightened. In Argentina, several anti-quarantine protests occurred, with de-

17. Liotti, "Entrampados otra vez en el juego imposible."

mands for individual rights intensifying in August. The protests were described as small but fierce, owing to relatively low attendance but intense messages against the government and the lockdown shouted at protest gatherings and posted on social media platforms.[18] Individualism and Covid-19 denialism were emphasized by the anti-quarantine movement and were supported by conservative politicians including former president Mauricio Macri, who vocally criticized both the Fernández administration and his former political ally Horacio Rodríguez Larreta for their handling of the lockdown.[19] The conspiracies spread by the anti-quarantine movement represent an extreme example of misinformation and political polarization during the Covid-19 outbreak, but as was noted by Dr. P during his interview, information dissemination was poorly handled by the media as well. Dr. P expressed that political polarization is also frequently reproduced in the media and explained that the media did little to promote health and safety, especially within outlets who are against the Fernández government such as *Clarín* and *La Nación*.

In addition to political polarization, Ms. M expressed that the quarantine was poorly contextualized in Argentina. The lockdown was strictly enforced by police and permission was required to go outside, especially early in the lockdown, which Ms. M noted felt reminiscent of a brutal period of military control during Argentina's dictatorship in the 1970s. She explained that people were worried about state surveillance and policing, especially in the informal settlements, although from her perspective there was no increase of state violence. Moreover, there was little acknowledgement of cultural or societal customs. For example, elderly people who relied on family members checking on them periodically lost their support systems. Cultural traditions such as kissing on the cheeks and sharing *mate* tea were no longer feasible, yet there was little acknowledgement of such consequences of the outbreak by official

18. *Clarín*, "En todo el país Marcha 1 de agosto: convocan a un banderazo en contra de la reforma judicial"; Molina, "Anticuarentena: Una marcha anti-todo con consignas furibundas."

19. Rosemberg, "Reapareció Macri con una fuerte defensa de "las libertades" y críticas al Gobierno"; Cafferata, "Macri empuja un discurso anticuarentena para arrinconar a Rodríguez Larreta."

sources. This lack of contextualization intensified as the lockdown continued, as the primary message vocalized by the government was that the lockdown would halt the outbreak's spread and then Greater Buenos Aires could return to normalcy. As the winter months, which in Argentina run from June to August, came to an end and temperatures outside became warmer, people were even more tempted to go outside and to congregate, according to Ms. M. This combination of factors, including warmer temperatures, lockdown fatigue, and poor contextualization of outbreak response, contributed to deteriorating compliance with guidelines to prevent the spread of Covid-19.

At the Covid-19 outbreak's peak in Greater Buenos Aires, during which tens of thousands of new cases were confirmed each week, the healthcare system was left with a huge responsibility to care for infected persons. Throughout the Covid-19 outbreak, in anticipation of the virus spreading, the government added resources and medical supplies to the healthcare system both to scale up capacity to contain the outbreak and to accommodate more patients accessing healthcare services. Early in the outbreak, added resources included personal protective equipment for healthcare workers and Covid-19 tests. As the outbreak continued, modular health units were constructed in high need areas and hospital beds and ventilators were purchased.[20] In addition to adding resources, the government established a relationship between the public and private sectors to increase healthcare system capacity across sectors. The government agreed to pay for people covered by the public sector to utilize private sector services for treatment in instances where the public sector was too overwhelmed to provide care to them.[21] According to Dr. P, this relationship was taken advantage of several times when public hospitals became oversaturated with cases. Across all healthcare facilities in Greater Buenos Aires, reports as early as June showed that

20. Ministerio de Salud de la Nación (Compras COVID-19).

21. Ministerio de Salud, "Acuerdo entre Nación y provincia de Buenos Aires para equipar clínicas privadas y financiar internaciones de pacientes COVID-19."

more than 50 percent of all intensive care beds were occupied, including beds occupied by patients with Covid-19 or non-Covid-19 related illnesses.[22]

The healthcare system was not only supported through government funding and redistribution of resources, but by non-governmental organizations. For example, Ms. V explained that the non-governmental organization for which she works, whose focus is primarily on HIV/AIDS research and interventions, shifted its activities to aid the healthcare system. Several infectious disease specialists from the organization were called to advise the national government in planning its response. The organization shifted some of its clinical resources which usually develop HIV/AIDS antiretroviral treatments and vaccines to conduct Covid-19 treatment and vaccine trials instead. The organization also targeted some of its educational materials towards Covid-19 prevention. Such task-shifting was influential in the response because it poured money, labor, and expertise into aspects of the response that were expensive for the government to bear alone.

3.3 The Landscape of Inequality

The worst of the Covid-19 outbreak in Greater Buenos Aires occurred in August and September. During that time, lockdown measures were tightened once again, although tension between political leaders about how to balance the lockdown and the reopening of economic activity resulted in uneven application of lockdown orders and response to the growing outbreak. As the number of new cases per week began declining, new guidelines to ease the lockdown were enacted. Greater Buenos Aires began its transition out of lockdown on November 9th, when President Fernández announced that the city would begin a social distancing protocol, which had previously been enacted in other parts of the country which were no longer experiencing high levels of community transmission. The name of this protocol, the Preventative and

22. *Página12*, "Coronavirus: la ocupación de camas llega al 54,1% en el AMBA."

Obligatory Social Distancing (DISPO, short for *Distanciamiento Social, Preventivo y Obligatorio*), was kept similar to the name of the original lockdown, the Preventative and Obligatory Social Isolation (ASPO or *Aislamiento Social, Preventivo y Obligatorio*) and emphasized many of the same messages about preserving health. However, it allowed for more cultural, social, and economic activities to take place as long as they followed certain public health guidelines. This protocol was extended into 2021 in Greater Buenos Aires.[23] Around this time, the government announced that the Emergency Family Income, which had paid three stipends of 10,000 pesos each to qualifying families who applied for the program, would be ending. In its place, the government initiated a program called Promote Work (*Potenciar Trabajo*) which intended to support low-income people between the ages of 18 and 29 struggling to find work and people who had lost their jobs during the pandemic. The program, which expanded upon an existing social salary program, paid recipients half the minimum wage to pursue employment in neighborhood improvement, recycling and environmental services, or manufacturing or food production, or to complete their education.[24]

By the end of December of 2020, one year after Covid-19 first emerged and ten months after it first arrived in Argentina, the Greater Buenos Aires area had a total of 666,668 confirmed cases and 23,811 deaths according to the Ministry of Health's official data. Within the Autonomous City of Buenos Aires's population of 3 million people, there were 175,974 confirmed cases and 5,719 deaths, indicating a rate of about 57 cases per 1000 people and a case fatality rate of 3.25 percent. Of the 12 million people living in the surrounding *partidos* in the Province of Buenos Aires, 492,579 cases and 18,694 deaths were confirmed, indicating a 3.80 percent case fatality rate. Of the confirmed cases across Greater Buenos Aires, 8,514 received intensive care treatment and 4,145 received breathing assistance from a ventilator. Less than half of the confirmed cases, equalling 312,429 people, originated from the private sector

23. Decreto 956/2020, Argentina Presidencia; Argentina Presidencia, "Decreto 1033/2020."
24. *Página12*, "Potenciar Trabajo en vez de IFE: cómo inscribirse."

of the healthcare system while the remaining cases, totalling 354,239 people, were covered only by public sector care.

Figure 3.3 shows the impact of the outbreak across the *comunas* of the Autonomous City of Buenos Aires using a choropleth map. It includes all new confirmed cases reported in the city between March 1st and December 31st, 2020. The dataset used included 4,450 confirmed new cases and 267 deaths which were not associated with any particular *comuna*. To compensate for this lack of data, portions of undesignated cases were assigned to a *comuna* based on its relative population size. Figure 3.3 shows that Comuna 4 in the southern region of the Autonomous City of Buenos Aires had the highest rate of Covid-19 cases per 1000 people. Comunas 3, 8, 7, and 1 also had relatively highe rates of cases compared to the rest of the city. Comuna 12 had the lowest rate of cases per 1000 people. This trend resembles the distribution of wealth in the Autonomous City of Buenos Aires, as the northern region is the wealthiest and the southern region has lower average incomes and higher rates of unsatisfied basic needs. This suggests that indicators of wealth and access to resources affected the spread of Covid-19 throughout the city, possibly due to differences in ability to follow social distancing and safety precautions, although further statistical analysis is needed to assess the significance of this finding.

Figure 3.4 elaborates upon the impact of the Covid-19 outbreak in the Autonomous City of Buenos Aires. This choropleth map, created using the same data present in Figure 3.3, shows the case fatality rate in each *comuna*. This measure was calculated as the total number of confirmed deaths in each *comuna* from March 1st to December 31st, 2020 divided by the total number of confirmed cases in the same area for the same period of time. Deaths and cases not associated with any *comuna* were scaled based on relative population and added to the counts in each *comuna*, as done with Figure 3.3. The case fatality rates reveal a different geographical pattern than that of the cases per 1000 people distribution. The *comuna* with the highest

case fatality rate was Comuna 10, followed by Comunas 11 and 2. The lowest case fatality rate was found in Comuna 8. This data does not support the theory that lower resource areas experience higher mortality from Covid-19. There are several explanations for this pattern. The first is that the response to the Covid-19 outbreak response focused heavily on low income areas, especially informal settlements. Efforts to test people and identify potential contacts could have detected a higher number of cases relative to northern areas and started monitoring and treatment earlier. In his interview, Dr. P explained that the northern region of the city is, on average, much older than the south. Since older people are more at risk of severe cases of Covid-19, this could also be an explanatory factor for this result. However, further statistical analysis is needed to fully understand case fatality distributions.

Figure 3.5 shows the impact of the outbreak across the wider city of Greater Buenos Aires using a choropleth map. The figure shows the Autonomous City of Buenos Aires and the 35 *partidos* of the Province of Buenos Aires that surround it. It includes all new confirmed cases reported in the city between March 1st and December 31st, 2020. Of the entire region shown, the Autonomous City of Buenos Aires had the highest rate of cases per 1000 people, and the areas of the Province of Buenos Aires immediately surrounding it had relatively high rates as well compared to *partidos* towards the periphery. This is most likely explained by high population density in the Autonomous City of Buenos Aires compared to the rest of the region, although with that logic La Matanza, which borders the city and has a population of over 2 million people, might be expected to have more cases per 1000 people. Another explanation could be that the Autonomous City of Buenos Aires did not maintain as strict of a lockdown as the Province did later in the outbreak, causing further cases to emerge.

Figure 3.6 maps the case fatality, or total Covid-19 related deaths divided by total cases, in Greater Buenos Aires for the same ten month period. There is a noticeable

difference between Figure 3.5 and Figure 3.6 when comparing the Autonomous City of Buenos Aires and the 35 *partidos* of the Province of Buenos Aires. The Autonomous City of Buenos Aires has a relatively low case fatality rate compared to the overall rate of cases. This could indicate that the Autonomous City of Buenos Aires has stronger healthcare systems or that people have better access to care. Across *partidos*, there are no strong correlations between levels of inequality and case fatality. This could have been an important factor in some places, but further investigation is needed to consider population density, testing capacity, healthcare access, age, and other variables.

As discussed previously, the healthcare system was redirected to adequately respond to the Covid-19 outbreak. The outbreak response thus detracted resources and energy from services directed towards other health needs. During his interview, Dr. P emphasized the changes in his own job requirements. Prior to the pandemic, his clinic focused primarily on community-based preventative health. Typical services at the clinic included general medicine, family planning and sexual health care, pediatric care and immunizations, and communicable disease care. Beyond general medicine, the clinic offered dental care and mental health care. Within the community, the clinic offered educational workshops and outreach programs addressing prevalent local health issues. The Covid-19 outbreak limited the clinic's ability to continue focusing on preventative care, and instead shifted its focus towards treating Covid-19 patients. Within the Covid-19 outbreak, its role was largely clinical and logistical. Diagnosing patients, treating patients, and performing contact tracing absorbed the clinic staff's time. The physician noted that this was true of his clinic and of the healthcare system as a whole. This shift in healthcare focus affected how people interacted with the healthcare system as well. According to Dr. P, the implementation of the lockdown caused many people to feel nervous to leave their home to visit the clinic for fear of violating lockdown guidelines. They also became nervous of

using healthcare services as the Covid-19 outbreak worsened for fear of contracting Covid-19. For example, he explained that his clinic saw a notable drop in patients continuing with tuberculosis treatment during the pandemic and a steep drop in new diagnoses of tuberculosis at the peak of the Covid-19 outbreak in their area. Following the outbreak's peak and the easing of lockdown measures, the clinic saw a large increase in new diagnoses of tuberculosis as well as complications in patients who had paused treatment.

This shift in resources affected the management of HIV and AIDS care in Greater Buenos Aires as well. According to Mr. G, testing capacity to diagnose new cases of HIV was drastically reduced. Mr. G also explained that strain on the healthcare system affected delivery of care for people living with HIV and AIDS. For people living with HIV and not currently in a treatment program, enrollment during the Covid-19 outbreak was not possible as hospitals stopped accepting new patients. Medication availability and distribution of antiretroviral treatment for people living with HIV or pre-exposure prophylaxis (PrEP) for those at risk of contracting HIV was interrupted. Whereas antiretroviral treatments were typically distributed to patients every month before the pandemic, the healthcare system announced plans to give three month supplies to avoid unnecessary trips to healthcare facilities during lockdown. However, Mr. G said that there were frequent shortages, insurance issues, or involuntary changes in treatment plans across all healthcare sectors. Ms. V corroborated this information, but did say that insurance issues surrounding the intervals of treatment distribution were resolved after two or three months. She also said that during the outbreak it became more difficult for patients to access blood tests at healthcare facilities to check their viral load and to monitor their diagnosis. Social issues amplified some of these problems. Mr. G said that involuntary disclosure of HIV status was forced upon many young people living with their parents or other roommates during the lockdown, as it was more difficult to pursue treatment discreetly and telehealth

appointments became more common. Economic hardship also affected many people living with HIV, putting them at risk of food insecurity and subsequent health issues, as the effectiveness of antiretroviral treatment is contingent on adequate dietary consumption. While HIV is not a major risk factor for severe Covid-19 infection, people with poor health or a weakened immune system following inconsistent adherence to antiretroviral treatment may be at increased risk of severe illness from Covid-19. Such increased barriers affecting people living with HIV, including variations in medication availability and access to medical appointments, most likely affected people with other chronic illnesses or health needs.

Throughout the Covid-19 outbreak and lockdown in Argentina, systems of community support remained quite strong and mitigated some of the hardships brought on by the outbreak. In some cases these support systems existed at an organizational level. Mr. G explained that support groups that had once been conducted in person transitioned to online spaces and often expanded. Such groups became more crucial as mental health deteriorated during the lockdown period. Ms V. added that not everyone had access to virtual spaces, including many low-income transgender women or sex workers who had limited access to internet and felt isolated. Her organization worked to conduct check-ins and to provide reading materials and games. Networks of people connected by these organizations managed donation drives which distributed furniture and food to people impacted financially by the lockdown, and as Ms. V noted, her organization saw increases in donations. Some people opened their doors to people experiencing homelessness due to the lockdown. Other services were initiated to deliver medications from the hospital to one's residence. The support systems that Mr. G and Ms. V described were not unique to their organizations. In her interview, Ms. M described community-led efforts in low-income communities and informal settlements. Food banks, soup kitchens, and donation drives became common. Community members often went grocery shopping or cooked meals for neighbors who

had poor health or were experiencing financial hardship. Similar initiatives occurred for elderly people. Ms. M described her own apartment building in which younger residents would frequently ask their older neighbors if they needed any food or groceries to be brought to them so that they would not need to leave their home. These acts of support initiated by organizations and community members were extremely impactful during the Covid-19 outbreak in terms of ensuring access to food, housing, and mental health support.

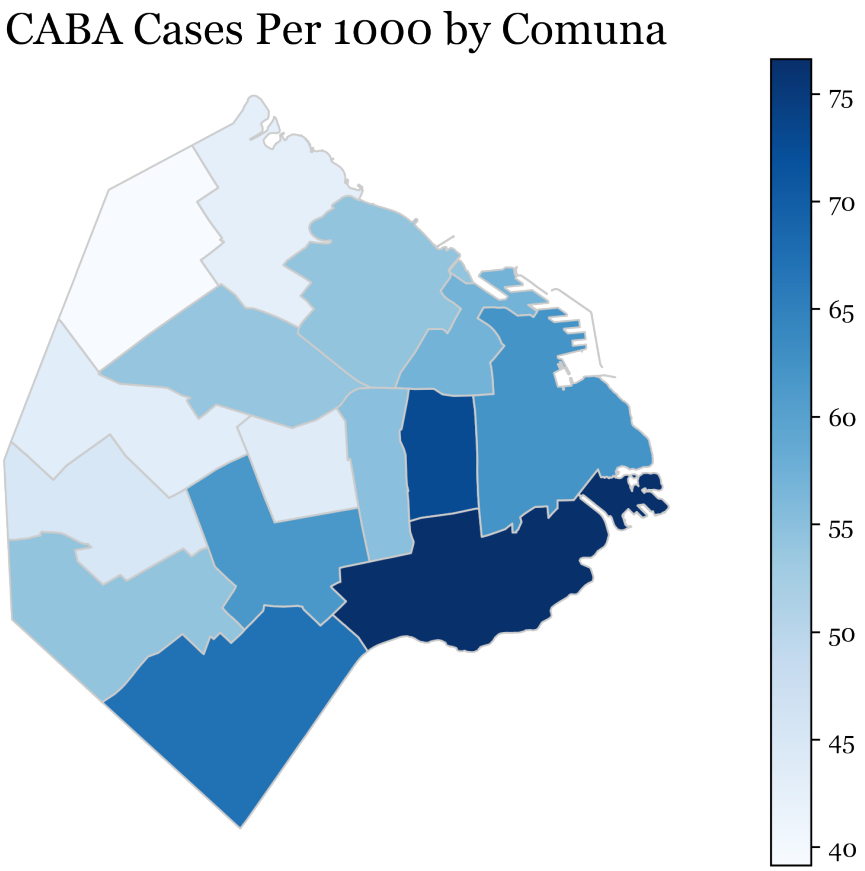

Figure 3.3: This choropleth map shows the number of confirmed Covid-19 cases per 1000 people in each *comuna* of the Autonomous City of Buenos Aires from March 1st to December 31st, 2020. (Source: Ministerio de Educación (Comunas); Ministerio de Salud (Casos COVID-19). Map created using: Van Rossum and Drake, *Python 3 Reference Manual*; Hunter, "Matplotlib: A 2D graphics environment"; Jordahl, "GeoPandas: Python tools for geographic data")

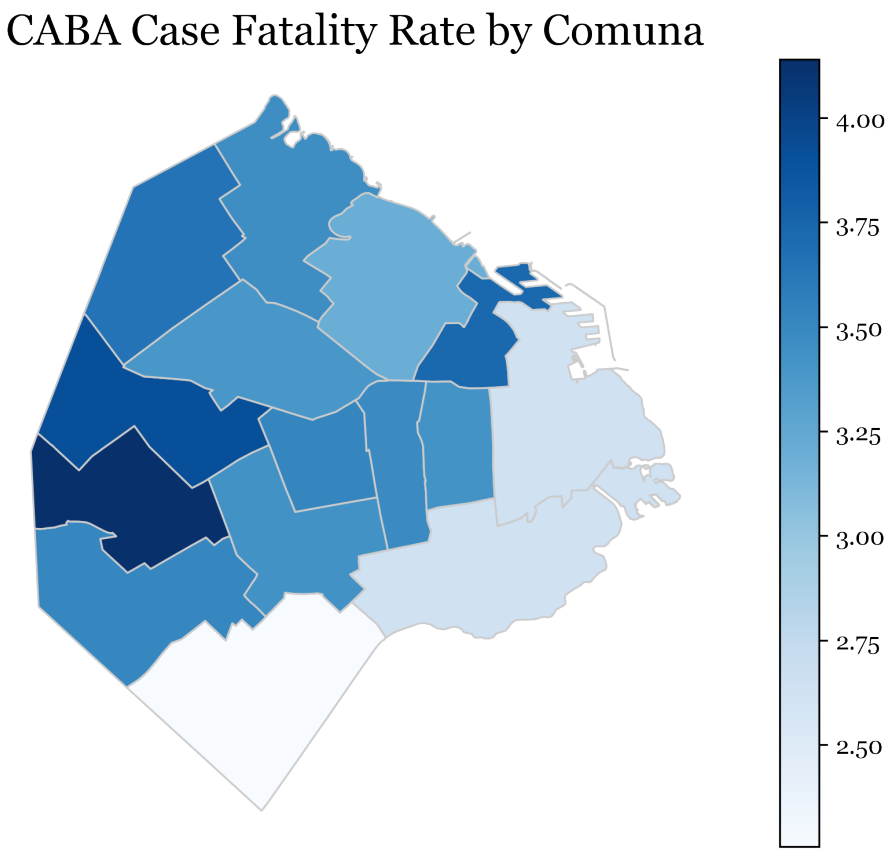

Figure 3.4: This choropleth map shows the case fatality rate, calculated as the total deaths divided by total cases, of Covid-19 in each *comuna* of the Autonomous City of Buenos Aires from March 1st to December 31st, 2020. (Source: Ministerio de Educación (Comunas); Ministerio de Salud (Casos COVID-19). Map created using: Van Rossum and Drake, *Python 3 Reference Manual*; Hunter, "Matplotlib: A 2D graphics environment"; Jordahl, "GeoPandas: Python tools for geographic data")

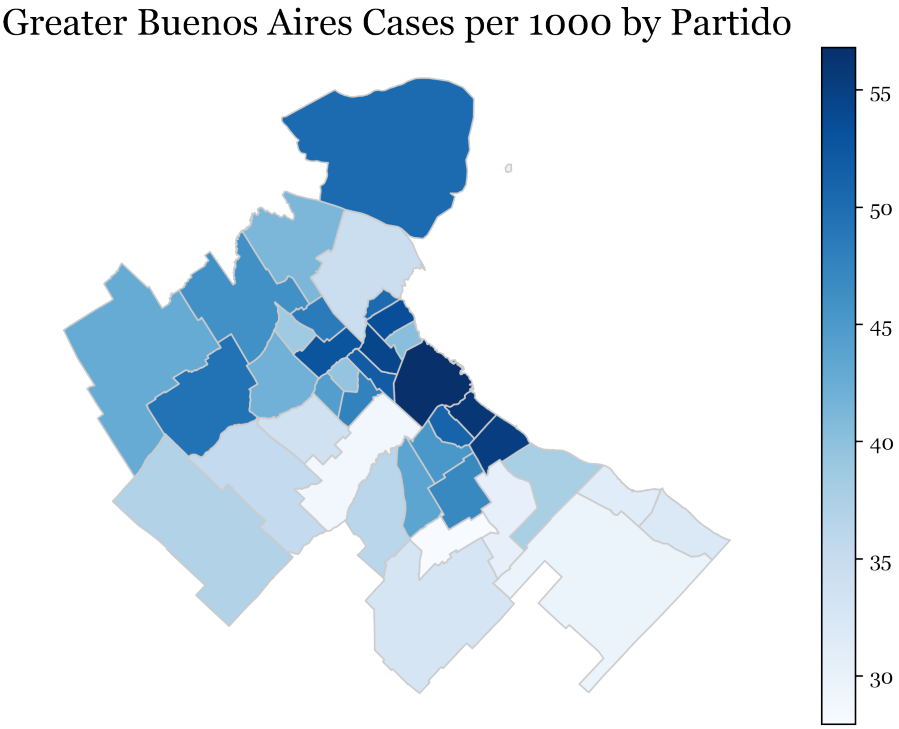

Figure 3.5: This choropleth map shows the total confirmed cases per 1000 people of Covid-19 in each *partido* of the Greater Buenos Aires area from March 1st to December 31st, 2020. The Autonomous City of Buenos Aires is included for reference. (Source: Instituto Geográfico Nacional (Regiones y ciudades); Dirección Nacional de Epidemiología y Análisis de Situación de Salud (Casos COVID-19); Ministerio de Salud (Casos COVID-19). Map created using: Van Rossum and Drake, *Python 3 Reference Manual*; Hunter, "Matplotlib: A 2D graphics environment"; Jordahl, "GeoPandas: Python tools for geographic data")

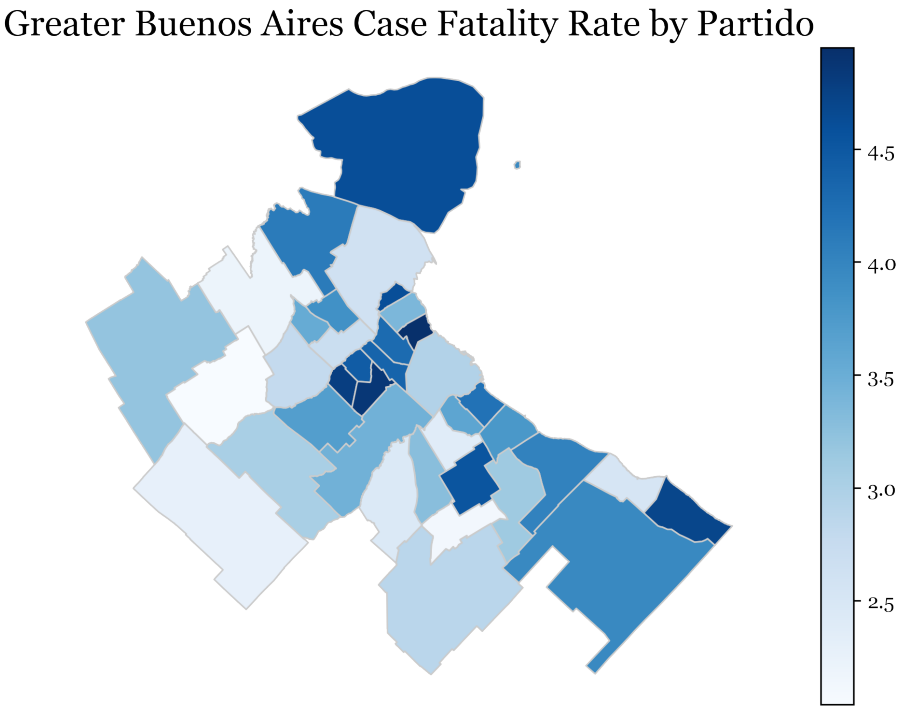

Figure 3.6: This choropleth map shows the case fatality rate, calculated as the total deaths divided by total cases, of Covid-19 in each *partido* of the Greater Buenos Aires area from March 1st to December 31st, 2020. The Autonomous City of Buenos Aires is included for reference. (Source: Instituto Geográfico Nacional (Regiones y ciudades); Dirección Nacional de Epidemiología y Análisis de Situación de Salud (Casos COVID-19); Ministerio de Salud (Casos COVID-19). Map created using: Van Rossum and Drake, *Python 3 Reference Manual*; Hunter, "Matplotlib: A 2D graphics environment"; Jordahl, "GeoPandas: Python tools for geographic data")

Chapter 4

Analysis

Greater Buenos Aires had some successful approaches to the pandemic and some misguided ones. For example, its government-mandated lockdown was implemented quickly and broadly but failed to consider the inability for some people to remain socially distanced. It successfully redirected its healthcare system to avoid exceeding hospital capacity during outbreak peaks, but discontinued many other healthcare services. It increased spending towards financial assistance programs, but was unable to meet the demands of people enduring severe economic hardship as a result of the pandemic. The government policies responding to the outbreak had clear effects on the outcomes of Covid-19, including the number of cases and the geographical distribution of cases. However, a more significant contributor to the city's outcomes was its preexisting urban inequality, much of which can be directly linked to failed neoliberal economic policies. Now, as Greater Buenos Aires recovers from the pandemic, it must reconcile the impacts these policies have had on the city's ability to respond to a major health crisis and it must commit to resolving systems of structural violence which have been ingrained in the city's fabric for decades.

Neoliberalism has been a reoccurring component of Latin American politics for over forty years. In that time, it has amassed several meanings and been promoted

by multiple political actors. The earliest form of neoliberalism can be defined as "a utopian ideology of individual realization through freedom from government constraints, and a practical strategy to halt and reverse the redistributive tendencies of Keynesian economics."[1] In economic development terms, this meant privatizing public services, deregulating economic activities, and reducing barriers to trade. Such policies were first implemented in Argentina by the military dictatorship of the late 1970s and early 1980s. Following the dissolution of the military dictatorship and the restoration of democracy, neoliberal economic policies continued under the presidencies of Raúl Alfonsín and Carlos Menem until the late 1990s. Following the economic crisis of 2001, Argentina entered a period of post-neoliberalism which lasted until the election of Mauricio Macri as president in 2015. The election of the current president, Alberto Fernández, in 2019 has initiated a new period of post-neoliberalism in Argentina. In this analysis, neoliberalism is defined narrowly to refer only to neoliberal economic policies. Used alone, the term neoliberalism now carries a wide range of vernacular meanings and connotations not discussed here.[2]

Neoliberal economic policies have been promoted for various reasons throughout Argentina's history. Two of the most commonly cited reasons for implementing these policies have been rising inflation and foreign indebtedness which would supposedly be remedied by economic growth produced by neoliberal policies. Argentina's encounters with neoliberal economic policies are not the sole doing of its former presidents, but of international organizations such as the International Monetary Fund and private foreign investors. In a critique of neoliberalism reforms, Tara Ruttenberg explains that several development organizations incorporated neoliberal economic policies intended to foster economic growth into their negotiations with Latin American countries. That is, upon accepting a loan from one of these organizations, national governments were compelled to follow the organization's structural readjustment recommendations

1. Hale, "Neoliberal Multiculturalism," 76.
2. Hale.

in order to meet the conditions of the loan agreements and loan repayment deadlines. Ruttenberg further explains that neoliberal economic policies contributed to increasing inequality, rising poverty and intensified reliance on raw exports from agricultural and industrial production.[3] They also contributed to rising inflation as the country struggled to pay interest on foreign debt. While social assistance programs have not been entirely nonexistent during periods of neoliberal economic policy, they have consisted of short-term and selective expenditures which have had little effect over time in substantially combating inequality.[4] Many of these conditions and policy precedents were prevalent in Argentina at the onset of the pandemic.

4.1 Poverty, Unemployment, and Informality

Neoliberal economic policies have been harmful to employment opportunities for the average worker. In investigating the effects of neoliberal economic policy on poverty in Argentina, Peter Lloyd-Sherlock found that the Argentine government in the 1980s responded to poor growth and increasing inflation by freezing and later reducing wages, an act which defied labor unions and hurt income levels and employment rates. Between 1982 and 1990, the informal employment sector grew from 20.4 percent to 24.7 percent of all urban employment. Also in the late 1980s, trade was liberalized such that export taxes were eliminated and import tariffs were reduced. This hurt domestic markets and further limited the government's ability to pay back its debt. A large trade deficit emerged as imports outpaced exports, and a large portion of the economy became controlled by foreign investors and private corporations. The weak domestic economy reduced employment opportunities, with unemployment reaching 18 percent in 1994. Underemployment and informal employment rose.[5] During this

3. Ruttenberg, "Post-Neoliberalism and Latin America: Beyond the IMF, World Bank, and WTO?."

4. Lloyd-Sherlock, "Policy, Distribution, and Poverty in Argentina Since Redemocratization."

5. Lloyd-Sherlock.

time, the Convertibility Plan (also called the Cavallo Plan, named for the Minister of Economy who advocated its implementation), was in place. It intended to balance increasing hyperinflation and indebtedness by pegging the Argentine peso to the United States currency such that one peso was equal in value to one US dollar. When this plan did not halt growing economic problems, it was abandoned and Argentina eventually defaulted on its debt before experiencing a massive economic crisis in 2001.[6]

Poverty and unemployment have contributed to a massive informal work sector in Argentina and Greater Buenos Aires. Ms. M explained this phenomenon in her interview, explaining that this was particularly true following the 2001 crisis. Many people work as *cartoneros*, which is one of the primary informal jobs in Greater Buenos Aires. *Cartoneros* are people, including women and children, who collect recyclable materials which other people have disposed of. They walk through the streets with large carts or bins in which they store cardboard (hence the name *cartonero*), glass, metal, and other materials to exchange for a small sum of money. For some people, this work is a primary source of income, and for others it an additional source of income that they combine with earnings from other forms of work. Ms. M discussed this form of work in the context of Covid-19, saying that the outbreak severely impacted *cartoneros*. Fortunately, progress has been made in formalizing the work of the *cartoneros* since 2001 and this allowed some people to continue working with work permits, although they were more limited geographically and found fewer materials to collect since fewer people were spending time outside their homes. Many *cartoneros* living in the *partidos* could no longer work in the Autonomous City of Buenos Aires as they once had before the lockdown. Furthermore, progress in the formalization of informal work has not been consistent, as recent years have seen declines in the number of registered informal workers compared to previous years, indicating that progress

6. Salvia, "The boom and crisis of the convertibility plan in Argentina."

has slowed.[7] And, as noted by Ms. V, not all informal workers have benefitted from legitimization by the government. Sex workers are excluded from formalization due to stigmatization of their work. During the outbreak, they continued to work in order to earn a living but faced increased criminalization for defying lockdown orders and were at high risk of becoming infected with Covid-19 due to the social nature of their work. In light of the Covid-19 outbreak, the Emergency Family Income was intended to support informal workers and was paid to a large number of people, but limited government funds prevented further financial assistance from being provided.

Lack of employment opportunity during the Covid-19 outbreak and lockdown will augment poverty and reliance on informal work following the pandemic. By the end of September of 2020, the unemployment rate, which considers the proportion of the population that is seeking work but not currently employed, rose to 13.8 percent in Greater Buenos Aires from 10 percent at the end of 2019.[8] Poverty, which is measured as an inability to afford basic needs including food, clothing, and transportation, rose to 41.6 percent or about 6.4 million people from 35.2 percent at the end of 2019. The rate of extreme poverty, which indicates an inability to afford sufficient food, rose to 11.7 percent or about 1.8 million people from 9.3 percent in December of 2019.[9] While these indicators have shown increased unemployment and poverty, spikes in these measures may not demonstrate failure on behalf of the government. Unemployment and poverty rose throughout former president Macri's term and could have risen much more drastically had the Fernández administration not prioritized welfare spending, albeit a finite amount, as part of the government response. Still, they indicate a significant area of need to be addressed as Argentina recovers from the Covid-19 pandemic. They seem to have been acknowledged by the government

7. Bermúdez, "El empleo informal es el único que crece en la Argentina hace cuatro años."

8. Instituto Nacional de Estadística y Censos, "Mercado de trabajo: Tasas e indicadores socioeconómicos."

9. Instituto Nacional de Estadística y Censos, "Incidencia de la pobreza y la indigencia en 31 aglomerados urbanos: Primer semestre de 2020."

as it works to create and protect jobs.

4.2 Informal Settlements

Neoliberal economic policy has shaped urban growth and the spatial distribution of inequality in Greater Buenos Aires. During the military dictatorship in the 1970s, privatization of urban development caused the northern part of the Autonomous City of Buenos Aires to become a place of expensive residential development and caused the price of land to rise significantly. The privatization of land and the opening of the economy to foreign developers continued into the 1980s, as gated residential communities and commercial centers were established both in the Autonomous City of Buenos Aires and in its surrounding metropolitan areas, typically following the layout of roads and transportation networks connecting to Escobar in the northern region of Greater Buenos Aires and La Plata in the southern region, for example.[10]

As indicators of poverty also increased in this period, a concurrent wave of development in the informal settlements occurred beginning in the 1970s. The informal settlements at that time were derived from temporary housing provided in previous decades for new migrants in the city. They originally acted as a transitional space as people found economic opportunity in the city and were able to better establish themselves, but the temporary housing spaces found themselves unable to accommodate increasingly large numbers of migrants. Thus, people began expanding into surrounding unoccupied land, often without central planning, formal building structures, or paved roads. The military dictatorship subsequently criminalized these emerging informal settlements, but with rising costs of land and severe growing lack of economic opportunity, people were left with nowhere else to go. This caused organized land invasions to occur in peripheral areas of the city where development corporations had not purchased land. Following the restoration of democracy in 1983, criminalization

10. Pírez, "Buenos Aires: Fragmentation and privatization of the metropolitan city."

of informal settlements ceased but continued economic crisis as a result of neoliberal economic policy caused informal settlements to continue expanding.[11] This growth has continued into the modern day, as the population of Greater Buenos Aires has remained fairly constant while the percent of the population residing in informal settlements has steadily increased.[12] While informal settlements are more concentrated in certain areas, such as in the southern part of the Autonomous City of Buenos Aires, the landscape of inequality has become increasingly fragmented, with informal settlements and high rise apartments or gated communities located within yards of each other.

Ms. M explained during her interview that many informal settlements were developed in areas where the land quality is not good. They were built on flood-prone lands or near landfills and polluted rivers. Lack of regulation of industrial activities has only worsened the situation as toxins and material waste from large factories and plants are often improperly disposed of. Due to lacking sanitation systems in the informal settlements, both industrial waste and sewage containing fecal matter cannot be properly managed, causing residents to come in contact with it either through skin contact or through contamination of drinking sources, which then leads to poorer health outcomes. In addition to lacking sanitation systems, informal settlements are not serviced by water and electricity providers. This is attributable to the privatization and decentralization of these services, such that private companies are no longer obliged to provide services in certain areas or to assure affordability to all consumers. Existing infrastructure is not frequently updated and many residents rely on informal and illegal connections to the main water and electric grids.[13] Ms. M noted that these connections are often constructed by community members using spare construction

11. VanGelder, "Tales of Deviance and Control: On Space, Rules, and Law in Squatter Settlements."

12. Goicoechea and Abba, "Geografías de la desigualdad en el nuevo milenio: los mapas sociales de la Buenos Aires metropolitana."

13. Pírez, "Buenos Aires: Fragmentation and privatization of the metropolitan city."

materials, and that construction work is a common type of employment for many people living in informal settlements.

As described in the results chapter, the informal settlements were among the first areas to experience large outbreaks of Covid-19. Given the infeasibility of following lockdown orders in informal settlements due to reliance on daily wages and community water pumps, for example, as well as crowded living conditions, these early outbreaks were predictable. However, there were criticisms that the government did not respond adequately to the needs of communities living in informal settlements. When the government did respond, it was primarily in the context of outbreak containment. The establishment of the *Operativo Detectar* testing and contact tracing program, modular health units, and the provision of quarantine accommodations for those who could not otherwise isolate themselves from other family or community members was central to the response. There was a strong emphasis on outbreak containment in low-resource areas, as they were the most at-risk of experiencing widespread outbreaks. This had tangible impacts in reducing the spread and severity of the outbreak, as evidenced by the decline in new cases in the informal settlements starting in late June and July and continuing through the end of 2020.

Nevertheless, there was noticeably less emphasis on prevention through government-sponsored food and income assistance programs which could have prevented spread earlier in the outbreak. As Ms. M stated, the Emergency Family Income which began in April was a start, but the amount paid was not enough to support an entire family for any extended period of time, especially with more limited employment opportunities during the pandemic. Again, this represents a lag in outbreak response that mirrors that seen in testing and contact tracing programs and which is attributable to overconfidence in the potential of the government lockdown to prevent an outbreak. During the outbreak, there were efforts to pave roads in some areas in order to increase accessibility to sections of the informal settlements. When some areas lost access to

water, the government sent trucks with giant barrels of water, although there was not enough to supply the entire community. Thus, it remains clear that a much more comprehensive approach to outbreak prevention and response was needed. Given that informal settlements face decades-long structural inequalities, and that Argentina had a limited amount of fiscal and technical resources at the start of the outbreak, perhaps the biomedical outbreak containment approach was the only solution available in a short amount of time and with a limited amount of resources.

As Argentina emerges from the Covid-19 pandemic, it must address the housing inequality problems created by neoliberal economic policies which caused privatization and lack of regulation of basic services, and subsequently, high levels of social exclusion and vulnerability. This includes infrastructure improvement to establish sanitation systems, paved roads, and permanent connections to water and electricity grids. It also includes improved regulation of service provision which guarantees basic access at an affordable price. Such changes must be comprehensive and structural in order to establish sustainable outcomes, which would include improved access to services, improved health outcomes, and improved ability to avoid future crises analogous to the Covid-19 pandemic. Ms. M also expressed concern about ongoing environmental exclusion caused by many industrial practices during her interview. She said that in an effort to preserve the economy, the government has been promoting the reopening of agricultural and industrial production without taking adequate measures to regulate activities that harm the environment. As seen in many informal settlements, lack of environmental protectionism disproportionately impacts poor people who reside in close proximity to such production and are more likely to come in contact with improperly managed waste and toxins, especially via water sources such as the Matanza River in Greater Buenos Aires. For this reason, protection of health and the environment should not be sacrificed for the sake of economic growth.

4.3 The Healthcare System

Neoliberal economic policies were influential in shaping the healthcare system in Argentina. The country's current healthcare system has evolved since its creation in the 1940s under the progressive government of Juan Domingo Perón. Initially, the healthcare system was dominated by a large, centralized public sector and by *obras sociales* established by union workers. A relatively small private sector expanded significantly throughout the 1980s, and by the 1990s the government's neoliberal economic policies called for widespread privatization of the healthcare sector. The private health sector began selling private insurance to wealthy individuals and contracting its services to the *obra social* and public sectors to generate profit. This has led to fragmentation and inequality in healthcare as resources were drained from the public sector healthcare system.[14] Most recently, neoliberal economic policies implemented by former president Macri downgraded the Ministry of Health to a secretariat and downsized its budget significantly, a move which President Fernández quickly reversed, according to Ms. V. Dr. P noted during his interview that neoliberal economic policies redefined the care that the public health system provides. Whereas the public system once delivered universal primary care, policies in the 1980s and 1990s emphasized selective primary care as a means of reducing spending. Rather than deliver comprehensive care to the entire population, selective primary care focused only on the most pressing needs, particularly amongst the poor. That said, the Argentine healthcare system does guarantee free access to all residents of the country. For all of its long wait times and inefficiencies, it is better equipped to provide universal coverage than some other countries including the United States.

In the early weeks of the pandemic, Greater Buenos Aires was a success story of a country in crisis following neoliberal economic mismanagement that was still able

14. Penchaszadeh, Leone, and Rovere, "The Health System in Argentina: An Unequal Struggle Between Equity and the Market"; Heredia et al., "The Right to Health: What Model for Latin America?"

to manage an infectious outbreak. Throughout April and May, the outbreak was much smaller than outbreaks in neighboring Brazil and Chile, although there were some concerns that Argentina was also severely lacking in testing capacity compared to these countries.[15] However, as the outbreak continued to expand, fragmentation and deregulation were a detriment to the response. There was little infrastructure to monitor outbreaks in place, and existing systems were uncoordinated. Case reporting mechanisms were lacking across the entire healthcare system. The private sector had its own information systems, but the government faced challenges in accessing this data in a timely fashion. As a result, the scale of the outbreak in real time was unknown or unclear, particularly towards the beginning of the outbreak.

Several months into the Covid-19 outbreak in Greater Buenos Aires, concerns about the capacity of the healthcare system to accommodate alarming rates of new cases were voiced. While investments were made in new supplies, including beds and ventilators, public health facilities were still unable to meet need. This was not so much due to high numbers of cases as it was related to longstanding deficits in public healthcare funding. For example, the Macri administration had halted the construction of a new hospital in La Matanza, a *partido* in the Province of Buenos Aires with a relatively large population and high percentage of people living with unsatisfied basic needs, in 2016 in order to reduce government spending. As the country faced a worsening Covid-19 outbreak, President Fernández called for the completion of the hospital, which began accepting patients in late July, and authorized funding for the construction of additional mobile health units and modular hospitals.[16] Still, capacity to make drastic changes to the healthcare system were limited by both time and budgetary constraints in the context of the Covid-19 outbreak, leading the government

15. Ruiz and Arambillet, "Coronavirus: la Argentina es uno de los países que menos testeos hacen en la región."

16. Ministerio de Obras Públicas, "El Hospital René Favaloro recibió al primer paciente con Covid-19"; Calderaro, "Coronavirus: Alberto Fernández terminó en cuatro meses un hospital que Mauricio Macri abandonó cuatro años."

to establish a partnership between the private and public sectors of the healthcare system. In the short term, this partnership was successful in preventing patients from being turned away at healthcare facilities which had reached capacity, which was the objective of the policy. However, in his interview Dr. P explained that this partnership was more predatory than collaborative. It did nothing to improve access to private health sector data or reduce inequalities between sectors and it funneled public healthcare funds into the private healthcare sector. Dr. P regarded this as a missed opportunity to rationalize the healthcare system and undo the harmful effects of neoliberal economic policy, saying that following the pandemic, "the healthcare system will remain fragmented, largely unregulated, and divided across socioeconomic status."

Additionally, as mentioned in the results chapter, the health system was entirely redirected to focus on the Covid-19 outbreak such that, according to Ms. V, some people began referring to the Ministry of Health as the "Ministry of Covid." This shift was in many ways needed, but it will also create a new host of health problems after the pandemic. Research projects, drug development, and public health campaigns all targeted Covid-19 at the expense of other health needs. Testing for tuberculosis, HIV, and other infectious diseases was halted. Follow up appointments for chronic health problems were difficult to schedule. The Covid-19 outbreak will have impacted the health outcomes of Greater Buenos Aires not only via infections of Covid-19, but via lack of attention and resources to combat other prominent population health needs. As the Covid-19 outbreak slows, increased focus towards other health issues will be necessary and will require sustained investments in the public healthcare sector.

4.4 The Way Forward

Structural violence is defined by Johan Galtung as violence which stems from an uneven distribution of resources and power, both between and within nations. It occurs when the actual state of poverty or sickness is less than the potential state of these conditions, or rather, when there is avoidable suffering in a society. Galtung provides the example that "if a person died from tuberculosis in the eighteenth century it would be hard to conceive of this as violence since it might have been quite unavoidable, but if he dies from it today, despite all the medical resources in the world, then violence is present".[17]

Neoliberal economic policies have acted as a form of structural violence in Greater Buenos Aires and Argentina. Since the 1970s, they have continued to reappear in various forms, and they have consistently failed to reduce poverty, inequality, and lack of access to basic needs. The preoccupation with neoliberal economic policies is not necessarily malicious in intent, but rather it is based on false assurance that such policies will reduce inflation and promote growth that, in the long run, improves wellbeing for all.[18] This false assurance has been amplified in cases where the implementation of neoliberal economic policy was accompanied by sizable loans from foreign investors. However, the Covid-19 pandemic has revealed the harmful impacts neoliberal economic policies have had on resource distribution, inequality, and vulnerability in Greater Buenos Aires. Structural violence as defined by Galtung was not readily apparent in the government response to the outbreak, since the government did make many attempts to reduce the impact of the outbreak on low-income communities and the health sector. Some responses were successful and others were well-intentioned, but ultimately misguided. Above all, the government was severely limited by institutional deficiencies and weaknesses and by lack of sufficient funds,

17. Galtung, "Violence, Peace, and Peace Research," 168.
18. Lloyd-Sherlock, "Policy, Distribution, and Poverty in Argentina Since Redemocratization."

as outlined in the above sections. The government was forced to employ selective responses to lessen the scope of the outbreak instead of comprehensive responses. In that sense, long entrenched systems of structural violence played a significant role in the Covid-19 outbreak in Greater Buenos Aires.

Dismantling long-established systems of structural violence in Greater Buenos Aires will be further complicated by the economic crisis which Argentina now faces as a result of the pandemic. While the lockdown was crucial for reducing the spread of Covid-19, it did hurt economic activity in the country. High levels of spending for medical responses and social welfare packages also drained Argentina's fiscal reserve and led to increased inflation. Growth decreased significantly, with the OECD projecting a nearly 13 percent drop in GDP compared to 2.6 and 2.1 percent drops in 2018 and 2019 respectively, although the GDP is expected to have an upward trend in the coming years.[19] This is necessary but not sufficient to undo structural violence by itself. As Amartya Sen writes,

> Growth of GNP or of individual incomes can, of course, be very important *means* to expanding the freedoms enjoyed by members of the society. But freedoms depend also on other determinants, such as social and economic arrangements (for example, facilities for education and health care) as well as political and civil rights (for example, the liberty to participate in public discussion and scrutiny).[20]

As such, it will remain crucial that despite economic downturn, continued spending towards social welfare is non-negotiable if systems of structural violence and poverty are to be overturned. Moreover, Argentina is still heavily indebted to foreign investors following loan agreements established by former president Macri. During the pandemic, Argentina delayed payments and was able to restructure its debt to have

19. Organisation for Economic Co-operation and Development, "Argentina."
20. Sen, *Development as Freedom*, 3.

later deadlines without increasing interest rates.[21] As seen in past entanglements with foreign debt and neoliberal economic policies recommended by foreign entities, Argentina will be pressured to practice fiscal austerity to repay debts. It should resist these pressures.

Argentina's response to the Covid-19 outbreak does leave room for optimism that reducing inequality will remain a priority. Health and wellbeing were central to the government response, despite critiques of narrow, selective approaches. President Fernández reiterated Argentina's human rights obligations in his executive orders, citing sections of international human rights documents defining the right to the highest attainable standards of health, housing, and food.[22] He made reference to the Universal Declaration of Human Rights and to the International Covenant on Economic, Social and Cultural Rights, both of which Argentina has signed, ratified, and granted constitutional status. These extensive acknowledgements of human rights are significant because Argentina has historically indicated support of human rights but failed to uphold both political rights, as seen under the rule of the military dictatorship, and social and economic rights throughout the past forty or more years. A renewed commitment to human rights, as indicated in the President's communications, would be beneficial to ongoing efforts to reduce inequality and offset temptations to pursue harmful strategies towards economic growth. While issues of human rights and social justice are amplified in the context of a global health crisis, enduring commitments to improving wellbeing are needed at all times.

This paper has presented the landscape of inequality in Greater Buenos Aires both before and during the Covid-19 pandemic. It has tracked the government's responses throughout the first ten months of the response, with data collection ending in December of 2020. It argued that outcomes of the Covid-19 outbreak, particularly

21. Ministerio de Economía, "Argentina y tres grupos de acreedores alcanzan acuerdo de reestructuración de deuda"; Lewkowicz, "Argentina inicia consultas formales con el FMI para acordar un nuevo programa."

22. Decreto 311/2020.

those related to urban inequality, are inextricably linked to the legacies of neoliberal economic policy and structural violence. In order to reduce inequality going forward, strengthened commitments to human rights and social justice are necessary to ensure recovery for all people. Further investigation is warranted as Argentina continues to confront the Covid-19 pandemic and as it seeks recovery following the pandemic. In the first days of January 2021, Argentina saw new and rapid rises in cases which subsequently peaked in mid-January. Following progress in vaccine development for Covid-19 around the world, Argentina was able to start vaccinating its people. However, it was discovered that the Minister of Health was allowing certain high profile business people and celebrities to access the vaccine before they were eligible, which launched an investigation and prompted his removal from the position.[23] Ongoing analysis of the Covid-19 outbreak and response are needed in Argentina to monitor continued tensions that may inhibit the reduction of inequality and to evaluate the broader impacts the outbreak has had. Accountability will become increasingly important as the world attempts a return to normalcy.

Focus in this paper is given primarily to wealth inequality and barriers to accessing basic needs and healthcare services. A broad overview of these topics is provided, yet deeper analysis is needed to understand the broader impact of the outbreak and response. More detailed investigation should be conducted, particularly in the informal settlements. Informal settlements are not a monolith, and particular attention should be given to each of the informal settlements within the Greater Buenos Aires area. Ongoing research is also needed to understand the impacts of increasing poverty and unemployment in the context of Covid-19. Health inequality also deserves further investigation. This paper mentioned the impacts that redirecting the healthcare system had on tuberculosis and HIV testing and treatment. Other prominent health needs, such as noncommunicable disease, Dengue outbreaks, and mental health should be

23. *Clarín*, "Allanaron el Ministerio de Salud por el escándalo del Vacunatorio VIP."

studied.

Many additional forms of inequality exist in Argentina and merit further investigation. These include rural versus urban inequalities, as Greater Buenos Aires is extremely powerful, both politically and economically, compared to the rest of Argentina. Other major cities in Argentina, such as Córdoba, Rosario, and Mendoza, should be researched. Less populated rural areas should also be studied, especially due to their lower levels of access to healthcare services compared to urban centers. Further research should examine racial and gender inequality in the context of the Covid-19 pandemic. As noted in the introduction, Argentina claims a European-descended identity which excludes racial and ethnic minorities. The impacts of Covid-19 among indigenous and African descended people and among migrants should be studied. Gender inequality and violence against women is a salient problem which in severe cases leads to *femicidio*, or the murder of a woman motivated solely on the basis of her gender. These murders can be committed by strangers or by close personal acquaintances. Such gender inequality should be studied in the context of Covid-19. While LGBTQ+ identities are briefly mentioned throughout this paper, further analysis is needed to understand effects of the Covid-19 pandemic on queer and transgender people, particularly with regards to healthcare and employment access and discrimination.

Addressing ongoing inequalities and systems of structural violence both during and after the Covid-19 pandemic will require the input of marginalized voices. The government will be responsible for implementing policy which reduces systems of structural violence and must value input from low-income communities, residents of informal settlements, racial and ethnic minorities, women, and LGBTQ+ people. Ethnographic research and community engagement will be crucial in identifying ongoing needs and in reconciling the legacy of harmful neoliberal economic policy.

Appendix A

Tables

Table A.1: Autonomous City of Buenos Aires Homes with Unsatisfied Basic Needs

Comuna	Total Homes	Percentage of Homes
Comuna 1	13,429	15.9
Comuna 2	1,497	2.0
Comuna 3	9,560	11.9
Comuna 4	9,678	12.7
Comuna 5	4,652	6.1
Comuna 6	1,656	2.2
Comuna 7	7,040	8.6
Comuna 8	6,582	11.3
Comuna 9	2,345	4.2
Comuna 10	2,149	3.5
Comuna 11	1,444	2.0
Comuna 12	1,335	1.7
Comuna 13	1,881	1.9
Comuna 14	2,423	2.4
Comuna 15	3,105	4.3
Total	68,776	6.0

Table A.2: Greater Buenos Aires Partidos Homes with Unsatisfied Basic Needs

Partido	Total Homes	Percentage of Homes
Almirante Brown	16,368	10.4
Avellaneda	6,508	5.8
Berazategui	9,664	10.4
Berisso	3,075	11.2
Ensenada	1,796	10.3
Escobar	6,962	11.6
Esteban Echeverría	9,208	10.7
Ezeiza	6,245	14.0
Florencia Varela	19,197	17.0
General Las Heras	319	6.9
General Rodríguez	3,469	13.9
General San Martín	8,942	6.7
Hurlingham	3,778	6.9
Ituzaingó	2,534	4.9
José C. Paz	8,641	12.0
La Matanza	58,053	12.0
La Plata	18,602	8.4
Lanús	7,426	5.0
Lomas de Zamora	16,834	8.9
Luján	1,977	6.1
Malvinas Argentinas	10,837	12.1
Marcos Paz	1,790	12.2
Merlo	16,969	11.5
Moreno	16,025	12.9
Morón	3,766	3.5
Pilar	10,776	13.0
Presidente Perón	4,098	19.1
Quilmes	16,310	9.2
San Fernando	4,239	8.6
San Isidro	3,555	3.7
San Miguel	6,592	8.2
San Vicente	2,646	15.5
Tigre	11,982	11.0
Tres de Febrero	4,877	4.3
Vicente López	2,414	2.4
Total	326,474	9.9

Table A.3: New Weekly Cases of Covid-19 in Informal Settlements and General Population of Greater Buenos Aires

Week	Informal Settlements	General Population
Mar 9, 2020	-	30
Mar 16, 2020	-	126
Mar 23, 2020	3	328
Mar 30, 2020	8	331
Apr 6, 2020	12	305
Apr 13, 2020	18	400
Apr 20, 2020	75	709
Apr 27, 2020	167	656
May 4, 2020	463	1,131
May 11, 2020	1,020	1,861
May 18, 2020	1,370	3,848
May 25, 2020	1,227	4,409
Jun 1, 2020	1,147	5,672
Jun 8, 2020	1,275	8,593
Jun 15, 2020	1,333	11,853
Jun 22, 2020	1,484	16,056
Jun 29, 2020	1,044	17,835
Jul 6, 2020	879	20,561
Jul 13, 2020	754	25,227
Jul 20, 2020	721	32,017
Jul 27, 2020	572	34,666
Aug 3, 2020	614	40,049
Aug 10, 2020	468	35,010
Aug 17, 2020	384	34,939
Aug 24, 2020	401	42,684
Aug 31, 2020	339	37,562
Sep 7, 2020	255	36,435
Sep 14, 2020	230	30,531
Sep 21, 2020	194	26,647
Sep 28, 2020	208	26,128
Oct 5, 2020	150	23,264
Oct 12, 2020	140	20,957
Oct 19, 2020	122	17,387
Oct 26, 2020	103	13,555
Nov 2, 2020	76	11,885
Nov 9, 2020	81	11,488
Nov 16, 2020	64	9,849
Nov 23, 2020	80	7,837
Nov 30, 2020	61	7,522
Dec 7, 2020	36	7,440
Dec 14, 2020	66	11,510
Dec 21, 2020	22	13,327
Dec 28, 2020	-	18,809

Table A.4: Covid-19 Data in the Autonomous City of Buenos Aires

Comuna	Population	Cases	Deaths	Cases/1000	Case Fatality
Comuna 1	256,405	15,963	420	62.26	2.63
Comuna 2	149,430	8,528	318	57.07	3.73
Comuna 3	193,276	14,058	481	72.74	3.42
Comuna 4	240,100	18,395	485	76.61	2.64
Comuna 5	187,518	10,309	359	54.98	3.48
Comuna 6	185,456	8,091	285	43.63	3.52
Comuna 7	241,861	14,913	511	61.66	3.43
Comuna 8	228,953	15,383	347	67.19	2.26
Comuna 9	171,264	9,302	327	54.31	3.52
Comuna 10	170,592	7,681	318	45.03	4.14
Comuna 11	190,076	8,246	323	43.38	3.92
Comuna 12	214,777	8,410	307	39.16	3.65
Comuna 13	236,358	10,061	348	42.57	3.46
Comuna 14	227,115	12,335	395	54.31	3.20
Comuna 15	182,465	9,849	334	53.98	3.39
Total	3,075,646	171,524	5,558	55.77	3.24

Table A.5: Covid-19 Data in the Partidos of the Province of Buenos Aires

Partido	Population	Cases	Deaths	Cases/1000	Case Fatality
Almirante Brown	597,969	23,777	1,009	39.76	4.24
Avellaneda	356,392	17,882	738	50.18	4.13
Berazategui	365,771	12,717	509	34.77	4.00
Berisso	96,701	2,978	135	30.80	4.53
Ensenada	61,783	1,870	54	30.27	2.89
Escobar	255,073	9,232	377	36.19	4.08
Esteban Echeverría	370,900	13,950	500	37.61	3.58
Ezeiza	219,031	7,469	214	34.10	2.87
Florencio Varela	517,082	15,515	538	30.00	3.47
General Las Heras	17,412	604	14	34.69	2.32
General Rodríguez	109,695	4,608	94	42.01	2.04
General San Martín	425,265	20,205	841	47.51	4.16
Hurlingham	193,583	6,881	291	35.55	4.23
Ituzaingó	180,914	6,831	330	37.76	4.83
José C. Paz	307,443	10,787	405	35.09	3.75
La Matanza	2,281,194	66,352	2,385	29.09	3.59
La Plata	713,947	21,303	829	29.84	3.89
Lanús	462,827	20,997	792	45.37	3.77
Lomas de Zamora	648,312	24,493	591	37.78	2.41
Luján	119,805	4,389	154	36.63	3.51
Malvinas Argentinas	359,953	14,828	574	41.19	3.87
Marcos Paz	66,466	2,259	77	33.99	3.41
Merlo	606,413	20,342	770	33.54	3.79
Moreno	541,691	19,796	631	36.54	3.19
Morón	318,632	13,044	632	40.94	4.85
Pilar	378,167	14,586	327	38.57	2.24
Presidente Perón	105,918	2,959	63	27.94	2.13
Quilmes	664,783	32,340	1,237	48.65	3.82
San Fernando	174,883	7,722	344	44.16	4.45
San Isidro	292,224	13,756	494	47.07	3.59
San Miguel	304,122	14,087	447	46.32	3.17
San Vicente	77,161	2,436	79	31.57	3.24
Tigre	462,998	15,562	478	33.61	3.07
Tres de Febrero	344,067	15,747	663	45.77	4.21
Vicente López	267,655	9,618	476	35.93	4.95
Total	13,266,232	491,922	18,092	37.08	3.68

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