

Tensions between universality and equity in the access of racialised immigrants to the SUS in the metropolis of São Paulo during the COVID-19 pandemic

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Abstract

This article presents data from an engaged ethnography conducted on political movements of immigrants in the city of São Paulo between 2020 and 2023. I initially analyse the vaccination campaign against COVID-19 among immigrants living in the peripheries of São Paulo, seeking to demonstrate that undocumented status had a limited effect on difficulties in accessing the right to healthcare, highlighting that even immigrants who had documents – and who were, for all intents and purposes, legally Brazilian – were unable to get vaccinated. Thus, I argue that racialisation processes are more decisive than undocumented status in defining who is eligible to access to that which is considered universal. The second argumentative axis reflects on the guiding paradigms of Brazil's Unified Health System (SUS), and on the tensions observed in the discourses of certain actors involved in disputes in the field of healthcare, between the principles of universality and equity in the face of demands of certain specific health promotion actions for migrant populations. The paradigms of universality and equity are therefore considered mutually exclusive rather than complementary by these actors.

Key words: SUS, immigrants, universality, equity, racialisation.

Tensões entre universalidade e equidade no acesso de imigrantes racializados ao SUS na metrópole paulistana durante a pandemia de Covid-19

Resumo

Este artigo apresenta dados de uma etnografia engajada conduzida junto a movimentos políticos de imigrantes da cidade de São Paulo entre os anos de 2020 e 2023. Analiso, inicialmente, a campanha de vacinação contra a Covid-19 entre imigrantes moradores das periferias de São Paulo, procurando demonstrar que a indocumentação teve efeito limitado sobre as dificuldades de acesso ao direito à saúde, apontando que mesmo imigrantes que possuíam documentos - e que por vezes eram, para todos os efeitos, legalmente brasileiros - não conseguiam se vacinar. Assim, argumento que os processos de racialização são mais determinantes que a indocumentação para definição de quem será elegível para o acesso ao que é considerado universal. O segundo eixo argumentativo reflete sobre os paradigmas orientadores do Sistema Único de Saúde (SUS), e sobre as tensões, observadas nos discursos de determinados atores envolvidos nas disputas do campo da saúde, entre os princípios da universalidade e da equidade face às demandas de estruturação de determinadas ações de promoção de saúde específicas para as populações migrantes. Os paradigmas da universalidade e da equidade são, assim, considerados antes como mutuamente excludentes do que como complementares por tais atores.

Palavras-chave: SUS, imigrantes, universalidade, equidade, racialização.

Tensions between universality and equity in the access of racialised immigrants to the SUS in the metropolis of São Paulo during the COVID-19 pandemic¹

Alexandre Branco-Pereira

Introduction

(...) And so we continue. It is the time of crutches.
The time of the talking dead
and paralysed old women, nostalgic for dancing,
but there is still time to live and tell.
Certain stories have not been lost.²
Carlos Drummond de Andrade, *Nosso Tempo*, 1945

It was a sultry, rainy spring day in the city of São Paulo, and migrants from different national origins crowded together on chairs under a marquee in Guaianases, a neighbourhood in city's easternmost region. At the front, a line of migrant rights activists, including myself, directed them to different types of immigration regulation assistance services and to the team from the territory's *Unidade Básica de Saúde* (UBS) [Primary Healthcare Centre], which was performing vaccination against COVID-19 on site. 'Are you asking for a CPF³ to get vaccinated?' I was asked by a Bolivian woman who I was signing up to take her first dose of vaccine. 'No', I replied, since this was the first and only specific action to immunise immigrants in Brazil not requiring the presentation of Brazilian documents or documents within the period of validity. 'Then I'll get it', she replied.

1 This work was funded by a CAPES-DS grant (funding code 001) and by the Wenner-Gren Foundation (Grant no. 10496). It forms part of the project 'A Covid-19 no Brasil: análise e resposta aos impactos sociais da pandemia entre profissionais de saúde e população em isolamento' [COVID-19 in Brazil: analysis and response to the social impacts of the pandemic among health professionals and the population in isolation] (Agreement ref.: 0464/20 FINEP/UFGRS). The research is developed by the *Rede Covid-19 Humanidades MCTI* [MCTI COVID-19 Humanities Network] and forms part of a set of *Rede Vírus MCTI* [MCTI Virus Network] actions to combat the pandemic, financed by the *Ministério da Ciência, Tecnologia e Inovação* (MCTI) [Ministry of Science, Technology and Innovations]. The research has been developed in dialogue with researchers linked to the *Observatório Saúde e Migração* (OSM-UFSCar) [Health and Migration Observatory], the *Laboratório de Estudos Migratórios* (LEM-UFSCar) [Migration Studies Laboratory] and *PROMIGRAS - Migração e Saúde* (UNIFESP) [PROMIGRAS - Migration and Health]. I am grateful for the close dialogue with my colleagues from the *Rede de Cuidados em Saúde para Imigrantes e Refugiados* [Healthcare Network for Immigrants and Refugees], the *Frente Nacional pela Saúde de Migrantes* [National Front for Migrant Health], the *Associação de Mulheres Imigrantes Luz e Vida* [Light and Life Immigrant Women's Association] and the *Fórum Internacional Fontiê ki kwaze - Fronteiras Cruzadas* [Fontiê ki kwaze International Forum - Traversed Borders], without whom this work could not have been undertaken. I would also like to thank my partner, Juliana Maciel Machado, for the meticulous revisions made to this and other texts that compose the set of reflections that I have been developing, and to my son, Martin Maciel Pereira Machado Branco, for being so supportive from an early age.

2 From the poem 'Nosso Tempo' [Our Time] (1945). '(...) E continuamos. / É tempo de muletas. / Tempo de mortos faladores / e velhas paráliticas, nostálgicas de bailado. / mas ainda é tempo de viver e contar. / Certas histórias não se perderam.' Free translation by Philip Badiz.

3 A CPF number is an individual taxpayer registry attributed by the Brazilian Federal Revenue to Brazilians and migrants who pay taxes in Brazil. It is relatively easy to apply for and to be issued a CPF number, even though during the pandemic the application process, to be made exclusively online, got more difficult and intricate. Moreover, immigrants who got into the country after the closing of the borders were not allowed to apply for a CPF number or any other sort of regularisation, as we will see.

This episode occurred on 30 November, 2021, three months after the announcement made by the São Paulo municipal administration that 100% of the city's adult population had been administered at least one dose of the COVID-19 vaccine. On 25 November of the same year, the city also announced that all adults had completed their vaccination cycle, at the time consisting of two doses of vaccines produced by the laboratories AstraZeneca, Pfizer, Sinovac and Sputnik V (for some Brazilian states only), or a dose of the vaccine produced by the Janssen laboratory. However, this woman and 91 other immigrants who attended the series of three collective actions, mostly identified as Indigenous and Black, from Latin American and African countries, were administered the first dose of their vaccines only at this event, which further vaccinated 14 immigrants with their second dose and 1 with the third dose.

This article presents data from an engaged ethnography (Kirsch 2018; Ortner 2019) conducted with political movements of migrants and Brazilian allies in the city of São Paulo between 2020 and 2023. Between 2019 and 2022, I was part of the collegiate coordination of the *Rede de Cuidados em Saúde para Imigrantes e Refugiados* [Healthcare Network for Immigrants and Refugees], or simply the *Rede* [Network], a collective that at the time brought together more than 40 services and organisations that provide healthcare to immigrants in the city of São Paulo. As the pandemic situation worsened, I was invited to participate in several spaces to debate on possible emergency responses to the pandemic aimed specifically at migrant populations residing in the city. My growing political involvement with the demand for the development of equity actions within the *Sistema Único de Saúde* (SUS) [Unified Health System] and with the request for information on contagion and deaths of immigrants due to the disease presented me with abundant data on the impact of the pandemic on these populations in São Paulo, and in Brazil as a whole. Officially, I was more circumscribed by the fieldwork than I initiated it, figuring as a key articulator for the organisation of the events described here in collaboration with migrant political movements. Often acting as a mediator between such movements and state agents, I did not close ranks with my interlocutors exclusively for research purposes, but rather conducted research based on prior political and professional activities.

The article is based on two argumentative axes. The first is based on an analysis of the vaccination campaign against COVID-19. After describing how immigrants living in neighbourhoods in the easternmost region of the city of São Paulo were denied access to the vaccine, I seek to demonstrate that undocumented status has a limited effect on difficulties in accessing the right to healthcare, highlighting that even immigrants who had documents – and who were, for all intents and purposes, legally Brazilian – were unable to get vaccinated. Thus, I argue that the processes of racialisation, understood here as the processes through which any social difference is essentialised, naturalised and/or biologised, anchoring them in fixed types of otherness (Omi & Winant 1994; Vertovec 2011; Thomas & Clarke 2013), are more decisive than lack of documentation in defining who is eligible for access to what is considered universal.

The second argumentative axis reflects on the guiding paradigms of the SUS, and on the tensions between the principles of universality and equity frequently observed in the discourses of some actors in the face of demands for structuring certain specific health promotion actions for migrant populations. Even though they are complementary paradigms – it is only possible to guarantee the universality of the system through diligent observation of the inequities that constitute Brazilian society –, I seek to demonstrate that the existence of certain actions aimed at producing equity in the SUS are often qualified as creating privileges in a context of the scarcity of the right to healthcare. Thus, actions to mitigate the effects produced by these inequalities are classified as threats to equality – of rights and before the law – as is the case with other similar actions, such as affirmative actions. The paradigms of universality and equity are, therefore, considered by certain actors present in disputes specific to the health field as mutually exclusive rather than complementary. The first section is dedicated to a brief theoretical analysis of the tensions between universal, particular and equitable, and then I move on to discussions raised by the presentation of ethnographic data.

Of the universal and the particular, or of the equitable

The universal-particular dyad is a classic object of anthropology and social sciences. A by-product of the modern episteme, the idea of universality formed the basis of the epistemological construction efforts of anthropology by raising the category of humanity, of ‘universal’ scope, linear and relatively uniform development, and often averse to contextualisations. Even though ethnocentrism may be the most universal of human characteristics, as Lévi-Strauss (1966) affirmed, the articulation between the notion of humanity and the notion of universality presents itself as a diacritical trait of thought attributed to the macroblock that is commonly called ‘Western culture’ (Santos 1997). Modern notions of humanity and universality are associated through the attribution of universally shared basic characteristics that symmetrise everyone individually and collectively, supporting, among other things, the structuring of policies guaranteeing human rights – notoriously restrictive regarding what rights are guaranteed to which humans (Id. *Ibid.*).

As so-called critical studies and perspectivism demonstrate, access to the – universal – status of humanity that is worthy of rights no longer encompasses a myriad of subjects and creatures considered infra- or non-human. Feminist, anti-racist, decolonial studies and perspectivism have demonstrated that the failure to guarantee access to certain life possibilities for certain populations was closely linked to the greater or lesser consideration of those affected communities as equals – that is, as holders of rights with respect to state structures or certain relationships (Gonzalez 1984; Césaire 2004; Fanon 2008; Braidotti 2019; Kilomba 2019; Krenak 2020). The category ‘humanity’ is not only not universal – it is culturally specific –, but it is also an index of access to power (Braidotti 2019). Thus, access to the status of this universal humanity whose rights are ensured becomes a central political agenda, since the club of humanity is not open to everyone (Krenak 2020). Particular universalities are thus created, capable of simultaneously advocating the inclusion of all subjects and excluding certain groups incapable of fulfilling all the criteria of humanity stipulated by such situated perspectives.

If the representation of the universal-particular dyad in two diametrically opposed and exclusive poles is illusory, in addition to analytically and empirically unproductive precisely because it establishes distinctions between the two poles – that are often hybrid, fractal, use disparate scales and in which dividing lines are blurred and highly permeable (Santos 1997; Viveiros de Castro 2002) –, its presence is especially felt in the nebulous zones of epistemological and/or ontological interstice (Viveiros de Castro 2015). In the field of health, the dyad is often represented, on the one hand, by fields of knowledge that deal with structural, material and objective components of reality – universalisable components immune to contextualisation –, and on the other, by those that deal with symbolic and accessory superstructures, whose only universal property is variability – cultures, societies, meanings attributed to a structural external world⁴. Social scientists – and even psychologists and psychiatrists – are often faced with the task of having to repeatedly prove the relevance of socio-historical-cultural factors in health approaches (Carvalho et al., *in press*), and are often instrumentalised as devices to reduce resistance in communities that clinicians, public health professionals and epidemiologists want to access.

Later I discuss how this dyad is operationalised in disputes in the health field as mutually exclusive: ultimately, it is not possible for some actors in this field to conceptualise a universal healthcare system when the contexts are considered. On the one hand, from this perspective, considering the contexts creates segregation and exclusion and enormous potential for deepening racism and xenophobia, since it enables the creation of differentiated treatments for certain social groups. On the other hand, it creates privileges, because based on

⁴ In this second field, I also include extra-modern ontological and epistemological matrices, all reduced to imaginative fictions over an immanent, measurable world. It is no coincidence that neo-positivism and neo-enlightenment are found to be greatly strengthened following the COVID-19 pandemic.

the perspective of a scarcity of rights, in which a large portion of the population experiences severe difficulties regarding access, creating actions to reduce inequality for certain social groups produces greater inequality by privileging access for some to the detriment of other marginalised groups. Thus, equity actions – the equalisation of certain aspects of interventions, whether for public or individual healthcare, in order to reduce inequalities derived from differences of a diverse nature, establishing close and symmetrical dialogue with other knowledges and therapeutic systems – always have to be reduced to the minimum under the threat of compromising said universality, whether that of the system or of ‘evidence-based medicine’ and its object.

I now present an analysis of the ethnographic data, seeking to demonstrate that the vaccination campaign against COVID-19 in Brazil, specifically in the metropolitan region of São Paulo, also obeyed this logic.

‘Laws are not enough. (...)’⁵

In Brazil, 2021 began with the promise of an inclusive, comprehensive vaccination campaign: on 17 January, Mônica Calazans, a Black nurse who worked at Emílio Ribas Hospital, was immunised in the presence of the governor of São Paulo, João Doria, a few minutes after the approval of the emergency use of vaccines from the Sinovac (CoronaVac) and AstraZeneca (Covishield) laboratories by the *Agência Nacional de Vigilância Sanitária* (ANVISA) [Brazilian Health Surveillance Agency]. The choice of a Black woman was made to symbolise the inclusive nature of the upcoming vaccination campaign: Mônica was a resident of Itaquera, a low-income, easternmost district of São Paulo, and had worked as a nurse at two jobs since 1985. The event became a platform for political affirmation of the ‘triumph of life against denialism’, in the words of the governor of São Paulo, who sought the endorsement of the PSDB as a candidate for President of the Republic. A year later, Mônica was invited by João Doria to join his party. In 2022, the nurse was a candidate for federal representative and received 9,149 votes, not enough to be elected. João Doria was unable to gain the endorsement as presidential candidate, and left the PSDB in 2022.

What followed did not maintain continuity with the symbolic action in January. In February 2021, research already indicated that the adoption of age criteria to define priority groups, to the detriment of adopting territorial (and, consequently, racial) criteria in the city of São Paulo, meant privileging less vulnerable groups in terms of access to immunisations, directing vaccines to territories where there was no evidence of excess mortality and that had a greater concentration of white and high-income populations (Faustino et al. 2021). Between May and July, with vaccination data already relatively consolidated, data from LabCidade demonstrated that the Black populations in the peripheries of São Paulo were simultaneously those who died the most and were vaccinated more slowly, even when considering groups eligible for vaccination at the time (Marino et al. 2021; Mazza 2021; Ziegler 2021).

⁵ ‘As leis não bastam. (...)’ Excerpt from *Nosso Tempo* (1945) by Carlos Drummond de Andrade.

Figure 1. Distribution of the Black population in the city of São Paulo, according to the 2010 Census (self-declared Black or Brown). Map prepared by LabCidade (Marino et al. 2021).

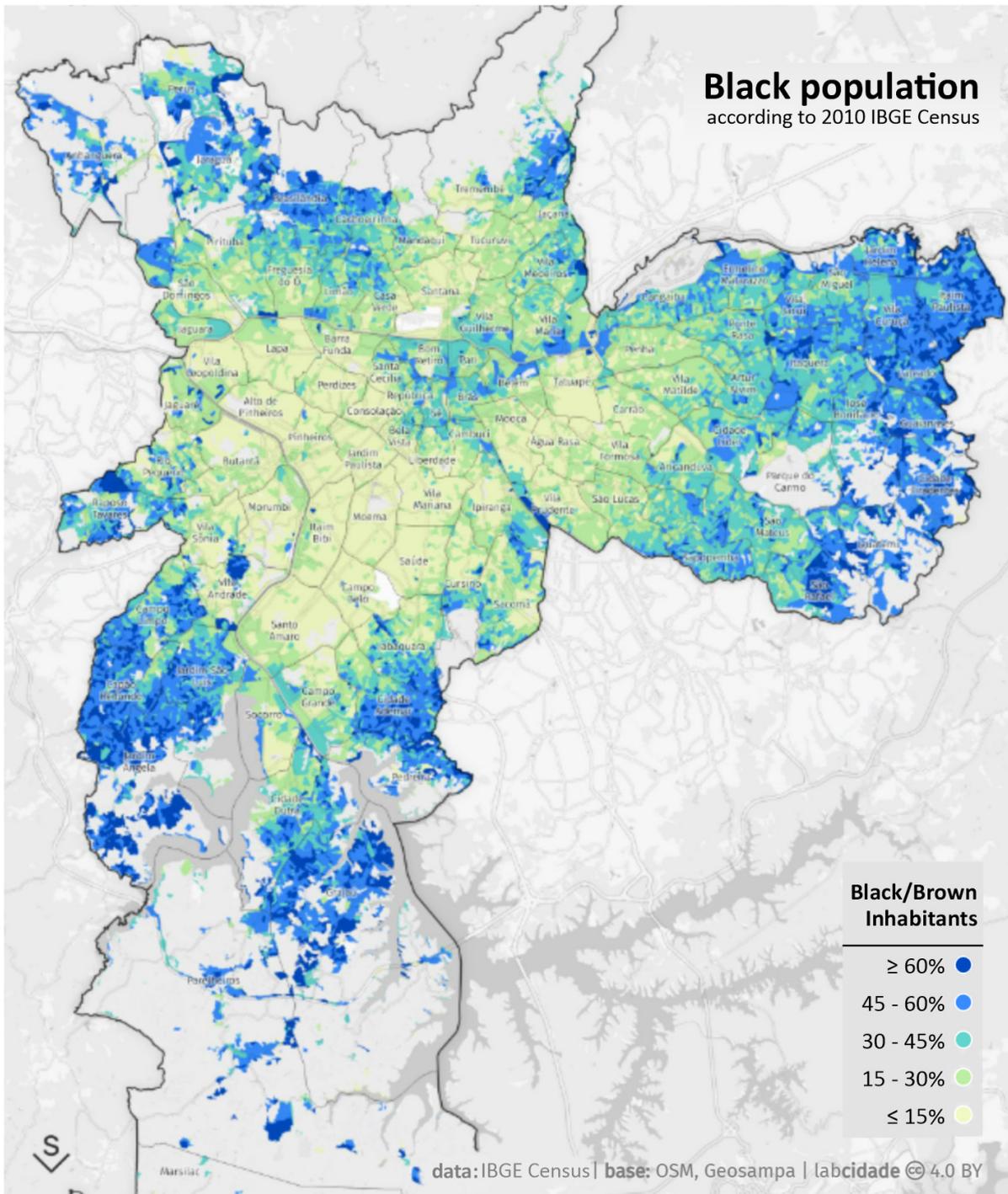


Figure 2.

Heat map representing the concentration of hospitalisations due to COVID-19 and severe acute respiratory syndrome (SARS) in the city of São Paulo between March 2020 and April 2021. Map prepared by LabCidade (Marino et al. 2021).

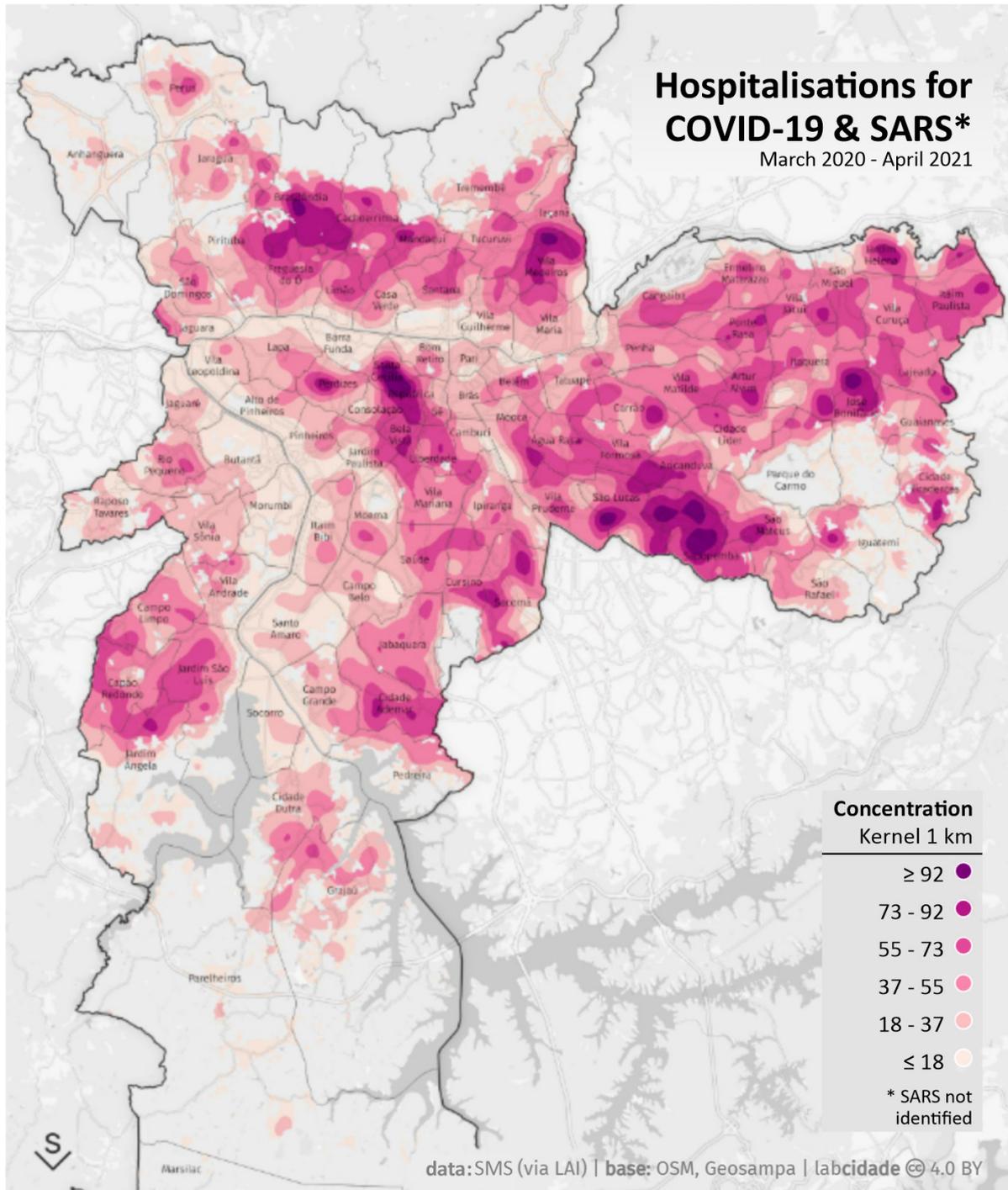


Image 3. Population vaccinated with one dose based on age criteria by 17 May 2021 in the city of São Paulo. Map prepared by LabCidade (Marino et al. 2021).

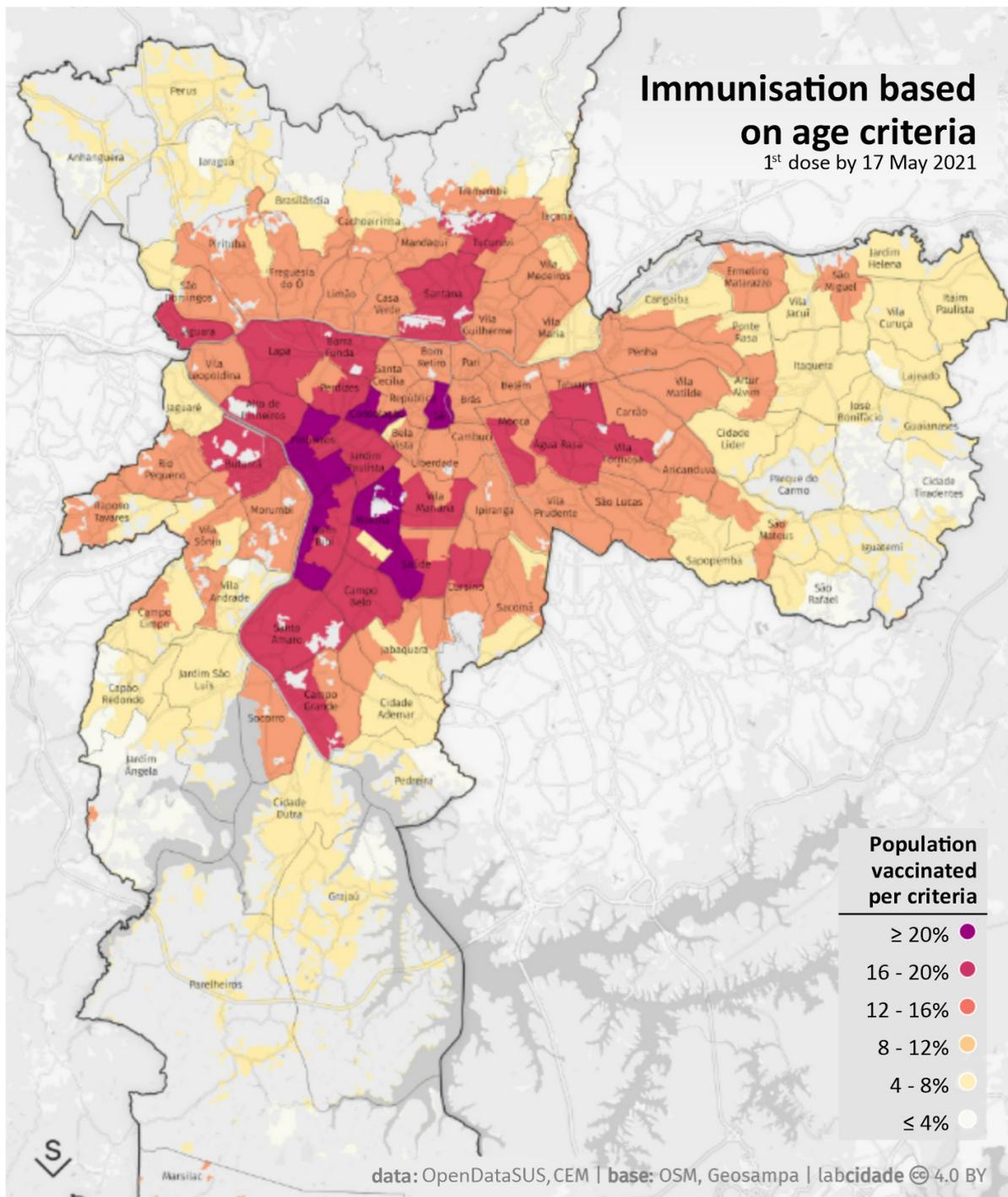
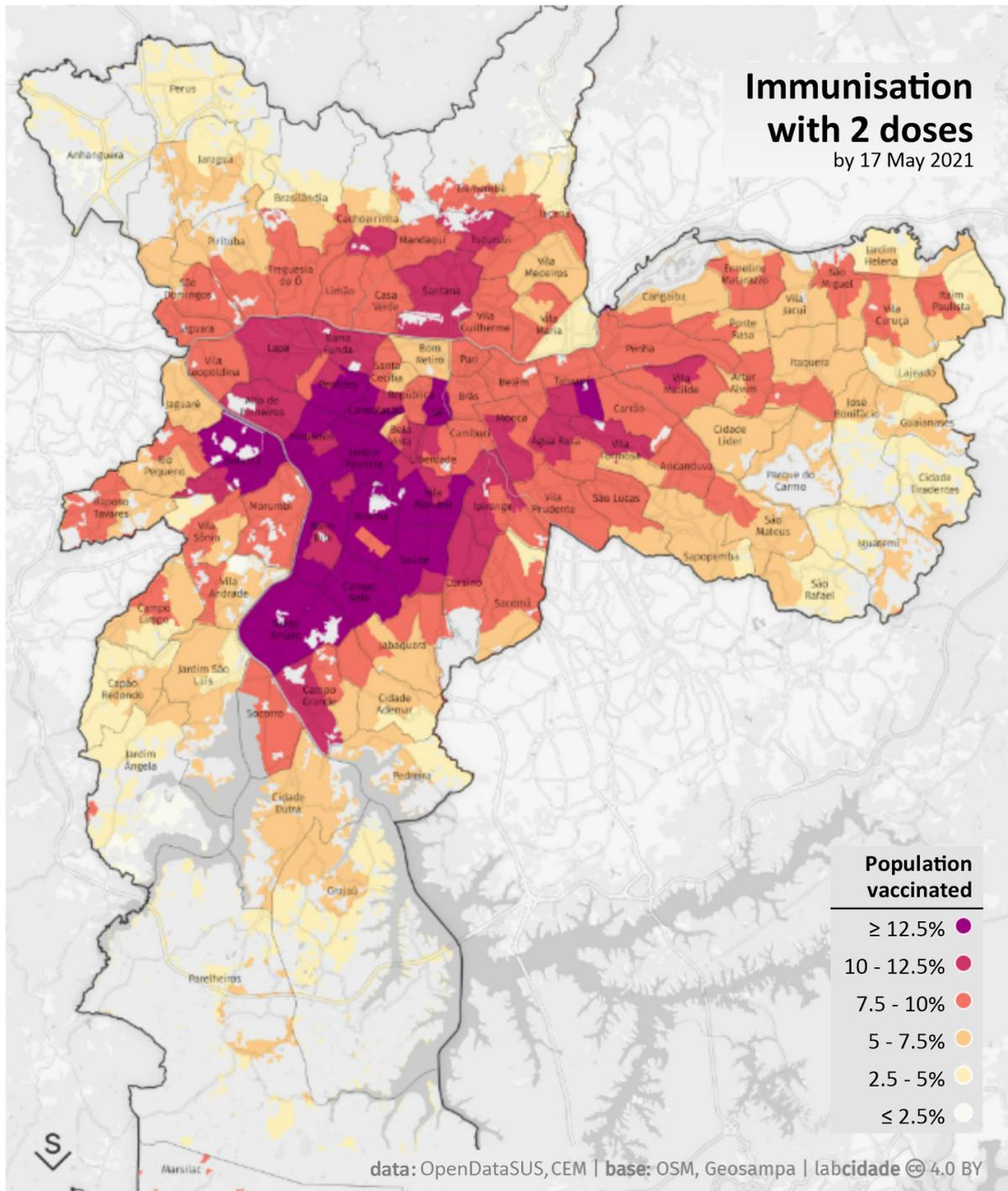


Figure 4. Distribution of the population immunised with two doses by 17 May 2021 in the city of São Paulo. Map prepared by LabCidade (Marino et al. 2021).



Since the onset of the campaign, the presentation of certain documents, such as a CPF and proof of residence, had been mandatory for vaccination in São Paulo and in most of the country. This document, and any other, is officially waived by several laws and other normative instruments: in the 5th article, the Federal Constitution affirms the equality of all before the law without distinction of any kind (Brasil 1988); Articles 1 and 7 of Law no. 8080/90 affirm universal access to the SUS at all levels of care, and section IV of Article 7 also affirms equal healthcare, without prejudice or privileges of any kind (Brasil 1990); Article 4 of Law no. 13.445/17 guarantees immigrants access to public health, social assistance and social security services without discrimination based on nationality and migratory status (Brasil 2017); Article 258 of Ministry of Health Ordinance no. 2.236/21 states that the identification of people will be waived when it is impossible to obtain data that guarantees their unique identification, like in cases of persons incapacitated for social and cultural reasons (Brasil 2021); Article 13 of Ministry of Health Ordinance no. 940/11 states that the non-existence or absence of a *Cartão Nacional de Saúde* (CNS) [National Health Card], lack of knowledge of a person's CNS number or the impossibility of registering or consulting the *Base Nacional de Dados dos Usuários das Ações e Serviços de Saúde* [National Database of Users of Health Actions and Services] (Brasil 2011) do not constitute impediments to the provision of requested care in any healthcare establishment.

On 28 May, 2021, the municipality of São Paulo began to require compulsory presentation of proof of residence to perform the first dose of vaccination within the municipal public healthcare network. The measure was adopted due to the progressive reduction in the age range of the population eligible for immunisation. Given the shortage of doses, it was necessary to channel vaccines to residents, preventing people from other cities from going to São Paulo to be immunised – violating equity, universality, and the structuring of the health system as nationally unified. Here I highlight an article on the subject published on the São Paulo City Council page, where it is stated that the city had been the only one – among how many or which towns or cities was not specified – until that moment that it had not made such a demand, ‘complying with all the rules of SUS’ (Monteiro 2021). The statement recognised, therefore, that the requirement was contrary to SUS regulations. The sole paragraph of Article 19 of the Law no. 13.714/18, for example, says:

Comprehensive healthcare, including the dispensing of medicines and products of interest to health, to families and individuals in situations of vulnerability or social and personal risk, under the terms of this law, will take place regardless of the presentation of documents proving domicile or registration in the Unified Health System (SUS), in line with the guidelines for articulating social and healthcare actions referred to in section XII of this article. (Brasil 2018)

However, cases of refusal of care and vaccination of immigrants in the municipality were not rare due to immigrants being unable to present documents, whether a CPF or proof of residence. In some cases, even with valid documents, immigrants were prevented from being vaccinated against COVID-19. In relation to the CPF, it must be said that Brazil experienced the establishment of a policy of producing undocumented status coupled with the coronavirus pandemic. Borders began to be closed following Ordinance no. 120/20, published on March 17, 2020, and the measure was re-issued in more than thirty other ordinances that followed it, with land borders remaining closed until December 2021. Thus, any immigrant who entered the country after this date did so via clandestine routes, and was formally prevented from regularising – that is, from requesting a CPF, opening a bank account, registering children born in Brazil, requesting a work permit, and, of course, from entering into formal rental contracts or any other type of consumer relationship that provided some proof of residence.

On 1 July, 2021, a meeting was held between the *Rede*, immigrant movements and the *Coordenadoria de Políticas para Migrantes e Promoção do Trabalho Decente* (CPMigTD) [Coordination of Policies for Migrants and Promotion of Decent Work] in the city of São Paulo. The meeting was intended to discuss the problems faced by immigrants living in São Paulo when getting vaccinated. The CPMigTD coordinator at the time stated that, despite the document requirements formalised in instructions released by the *Secretaria Municipal de Saúde* (SMS-SP) [Municipal Health Secretariat], no difficulties were being reported in vaccinating immigrants. He stated that he was aware that UBSs in the city centre were accepting handwritten declarations from occupation leaders as proof of residence, in the case of those immigrants who lived in occupations of housing movements, and that he would check with SMS-SP if there were complaints about denials of access to the vaccine registered with the municipality's SUS Ombudsman's Office. On July 7, the coordinator sent an email saying that SMS-SP had stated that there were no records of reports or complaints from immigrants regarding denial of access to vaccination at the SUS Ombudsman's Office.

Even though, as we saw above, the lack of documents alone was not be enough to bar access to vaccination against COVID-19 considering the laws that deal with the subject, or that there were no official records of denial of vaccines, which was enough for the authorities to ignore the problem, Yoselin⁶, a Bolivian woman who was pregnant at the time she became eligible for immunisation, could not get vaccinated. She was living at a friend's house as a favour, in the easternmost region of São Paulo, on the division with the city of Ferraz de Vasconcelos, and was not vaccinated against COVID-19 since she did not have proof of residence in her name. Yoselin was a member of the *Associação de Mulheres Imigrantes Luz e Vida* (AMILV) [Light and Life Immigrant Women's Association], a collective of Bolivian, Paraguayan, Venezuelan and Brazilian women who approached the *Rede* through the *Fórum Fontié ki Kwaze - Fronteiras Cruzadas* [Fontié ki Kwaze Forum – Traversed Borders] to denounce the denial of vaccination to immigrants in the peripheries of São Paulo. Yolanda, one of the leaders of AMILV, explains:

I had to really fight to get my SUS card. At the healthcare centre, they ask for a Brazilian document and proof of residence. There are people who have to go to the owner of the house to register, because there is nothing in their name. In Vila Yolanda II and Cidade Tiradentes, many women go, but they don't want to attend us. There are people who ask me: 'Do I need a document? A CPF?', and what can I say? There are people who don't know that they can get the SUS card without the RNM [National Migration Registry], they say 'but I don't have a CPF', so they can't get vaccinated. (Field record, 12 July, 2021)

Samuel is a naturalised Brazilian, but he was born in Haiti. Legally, he is a Brazilian citizen, and as such, he had documents from the country, but he was unable to transfer ownership of the house bills into his name for a property rented directly from the owner. Samuel also tried to get vaccinated at two different UBSs, one in Ferraz de Vasconcelos and the other in Guaianases, the latter in the city of São Paulo. He was unable to do so, and had to return to in-person work in August 2021 without being administered a single dose of vaccine, even though he was eligible.

Look, it was difficult. It was very difficult. I went to Ferraz, and they wouldn't let me [get vaccinated] there because I didn't have proof in my name. In Guaianases, it was the same thing. At the time my age started to get vaccinated, I was still working from home, teaching French and English online. But then the school said that we were going to go back to teaching at the school, so, right? Then I needed to be vaccinated. (Field record, 11 September, 2021)

6 The names of certain individuals and interlocutors were changed to protect the identity and privacy of those concerned.

Martin was a Venezuelan living in the Tiquatira neighbourhood, the East Zone of São Paulo. He came to the city after spending time in Roraima. When trying to get vaccinated for the first time, at the beginning of September, Martin presented the asylum request protocol, a Brazilian document, but was denied the vaccine: ‘the nurse looked at it and said only with a CPF, and that I also needed some proof of residence, electricity bill, water bill’, he says. Days later, now in possession of his CPF and an electricity bill in his parents’ name, he received a second denial, now claiming that to be vaccinated he needed a RNM [National Migration Registry] with a current expiration date.

The last two cases are especially emblematic as a means of highlighting that undocumented status in and of itself does not result in the denial of access to rights. Although exemption from the mandatory presentation of valid Brazilian documents is an important instrument for constructing equal access, something already provided for in law, this is systematically ignored by health teams and public managers. Even when racialised immigrants – some naturalised and legally Brazilian – residents from the peripheries of São Paulo or its metropolitan interstices – the nebulous borders between the conurbation of municipalities – had the requested documents, they were unable to get vaccinated, and no official records of such denials were produced. Universality imposed access rules based on the presentation of documents, but demanded it unequally from the population served, greatly impacting racialised subjects living in the peripheries – many of whom were Black and Indigenous immigrants.

‘(...) Lilies are not born from laws.’⁷

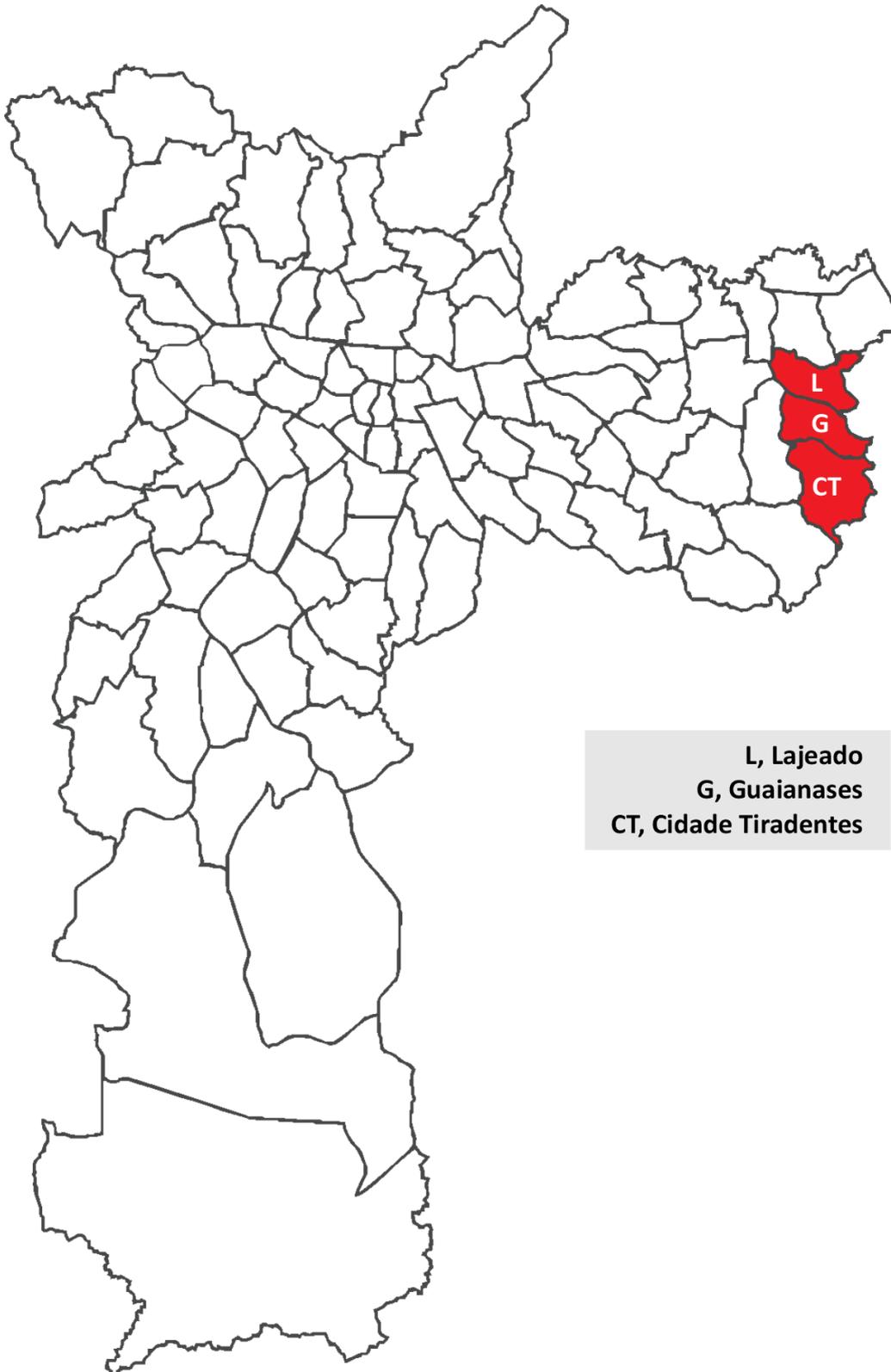
With the exception of Yolanda, all the immigrants whose statements were described above were vaccinated in the joint actions carried out by civil society. The events were held in the second half of 2021: the first joint action was on 11 September, the second on 30 October, and the third on 27 November. Coordinating the organisation was the responsibility of the *Rede*, as described above, in partnership with AMILV and the *Fontié ki Kwaze* Forum, a collective of Brazilian and immigrant researchers and activists on human and immigrant rights. Representing the *Rede*, I was responsible for liaising with the *Coordenação de Atenção Básica* [Primary Healthcare Coordination] of the SMS-SP to ensure a health team from the territory’s UBS⁸ was available to perform vaccinations against COVID-19 without requiring Brazilian documents or proof of residence, in addition to the creation of a SUS card for all those who were attended.

7 ‘(...) *Os lírios não nascem das leis.*’ Excerpt from the poem *Nosso Tempo* (1945) by Carlos Drummond de Andrade.

8 The Unified Health System (SUS) is territorialised, so districts and neighbourhoods are organised around a reference UBS. An UBS has the responsibility for primary care in a given territory, so if a vaccination action is to take place in that geographical and administrative region, a health team from that UBS must perform that action.

Figure 5.

Map of the municipality of São Paulo highlighting the three neighbourhoods where the collective actions took place: Lajeado, on 11 September; Cidade Tiradentes, on 30 October; and Guaianases, on 27 November. Prepared by the author.



The first event was held in the Lajeado neighbourhood, and in addition to the vaccination action, it included immigration regularisation services carried out by the *Defensoria Pública da União* [Federal Public Defender's Office] and ProMigra (an extension project of the Law School of São Paulo University), conversation circles on health, consular services from the Bolivian Consulate, and the *Restabelecimento de Laços Familiares da Cruz Vermelha* [Red Cross Restoring Family Links] service, responsible for locating and connecting family members who have lost contact due to the migration. Two hundred people were attended, including the administration of 38 doses of vaccine against COVID-19, corresponding to 19% of the total population attended.

Conversations with the *Coordenação de Atenção Básica* had begun on August 26, 2021. The coordinator determined that the manager of UBS Jardim Fanganiello [Fanganiello Garden UBS], reference for the territory where the joint action was to be held, had to align directly with the *Rede* concerning the details of the event. From the onset, the organisation of the task force established that the action needed to take place without demanding a CPF or proof of residence – nothing more than what is stated in the legal ordinances that govern attendance in the SUS. Initially, there was agreement, but on 9 September, two days before the joint action, the UBS manager communicated via WhatsApp message that proof of residence would be required as those vaccinated must be residents in the city of São Paulo. They then sent São Paulo City Hall Instruction no. 34, the most updated order dealing with vaccine prioritisation at the time. 'Just don't ask for proof for those who are bedridden', added the manager. I argued that this was one of the main reasons why immigrants were not getting vaccinated. A few minutes later, the *Supervisora Técnica de Saúde* [Technical Health Supervisor] for the Guaianases region, who coordinates the work of all health centres in the territory, called me and informed me that the vaccination action would be cancelled since the UBS was experiencing a lack of vaccine doses.

As a way to reduce animosity and ensure that the vaccination, which had already been announced, would take place, I went to the UBS with Yolanda, leader of the AMILV, to personally speak with the manager. Following our conversation, it was agreed that vaccination would take place without requiring documents, but only the first dose would be administered so as to prevent too many people from attending the event to get the vaccine, once they found out about the exemption for proof of residence.

The second joint action took place in the Cidade Tiradentes neighbourhood. The healthcare team present was linked to UBS *Nascer do Sol* [Sunrise UBS]. This time, 29 first and 6 second doses were administered, among a total of 180 visits, corresponding to 19.4% of those vaccinated. Approximately 83% of those who were vaccinated at this joint action were initiating their primary vaccination cycle, which took place more than two months after the São Paulo City Council's announcement that the entire vaccinable population at the time was already immunised with at least one dose.

Figure 6.

Bolivian Aymara immigrant receives his first dose of the vaccine against COVID-19 during the joint action in the district of Lajeado, 11 September, 2021.
Photo: André Vito of the Red Cross.



The third joint action took place in the neighbourhood of Guaianases, and provided 112 attendances. Thirteen days before, on 17 November, the government of the state of São Paulo had announced the application of booster doses for adults vaccinated at least five months previously, and so these were also made available. The health team from UBS Jardim Soares [Soares Garden UBS], the reference for the territory, vaccinated 24 people with their first dose, 8 with their second dose and 1 person with their third dose, representing 29.5% of the public present at the joint action – and once again, the majority of those vaccinated at this joint action were administered their first dose, and were therefore completely unprotected until the last two months of 2021.

In total, 106 people were vaccinated, corresponding to 21.5% of the total number of immigrants attended. Of these people, 91 (18.5% of the number of people attended and almost 86% of the vaccinated public) had not taken any dose of the vaccine until they were immunised in the joint actions. It is important to highlight again that the municipality had announced that its entire adult population had been vaccinated with at least one dose on 17 August, one month before the first joint action. The announcement that the entire adult population had completed the vaccination cycle occurred on 25 November, five days before the last joint action. The announcements, which considered the estimated population and cross-referenced this estimate with the number of doses applied, obviously ignored that the racialised immigrant population, with or without documents, was largely *forgotten and lived in continuous oblivion*.

Something never recognised as a real event cannot be erased or forgotten. Likewise, something that has never been recorded cannot be erased. Immigrants are not invisible, since invisibility is a trait attributed to the subject, and the act of imposing oblivion is situated elsewhere, external to immigrant populations. Initially, there is the imposition of a series of requirements designed to attest the real existence of a certain

experience – official records in mostly undisclosed reporting channels, for example –, subsequently allocating the remainder to the field of hallucinations – that is, a false experience that happened only within the minds of people not connected with the material reality of facts. Thus, when the experience leaves the present time, it cannot be remembered as something that already existed, since it was never registered or recognised, but rather hallucinated.

Considering the reflections by Gagnebin (2010) on the Brazilian military dictatorship to engender the notion of forced oblivion, when the state tortures, whether during the military dictatorship or in democratic times, it does not deny the existence of torture, it denies that the suffering imposed on the tortured is harmful, or something that must be avoided. Torture is not something to be erased, but its reasons are subject to dispute, and the state imposes oblivion on specific aspects of history as a way of extorting amnesty for its illegal actions. Thus, those tortured generally become communist terrorists, drug dealers, thieves, and criminals, deserving of that which is attributed to them. The pandemic engendered a similar mechanism: when there is a forgetfulness imposed by the lack of recognition and recording of immigrants' and other marginalised groups' experiences, it is acceptable to celebrate the deaths of unvaccinated people who are considered denialists, not as vulnerable people excluded from that which is considered universal.

Thus, the refusal of imposed forgetfulness, through the articulation of resistance movements, makes it possible to record the experiences of these people as a reality, not as an imagined political fact to be promptly disregarded. The involvement of public power under the terms that it defines for itself, guided by its laws, normative instruments and ordinances, results from an active effort against a structure capable of allocating uncomfortable perspectives of the world to power in the sphere of the hallucinatory (Branco-Pereira 2021). As Gagnebin states:

There seems to be a secret correspondence between the empty places, the holes of memory, these imposed blanks of the unspoken of the past, and the lawless places of the present, spaces of exclusion and exception, but located within the legitimate social locus, as if only the inclusion of the exception could guarantee the security of the social totality. The price of the silence imposed with respect to the past is not 'only' the pain of the survivors: it is also paid for by our resignation and impotence. (Gagnebin 2010, p. 186)

If silence concerning the dead of the past accustoms us to silence concerning the dead of today, it is necessary to move from resignation not only to indignation, but to effective resistance aimed at sabotaging the active mechanisms of erasure. Although these mechanisms can, at times, have retroactive action – as in the cases of extorted reconciliations promoted by dictatorships –, they unfold in the present moment and address populations to be forgotten in the present so that the echoes of their existence, suffering and demands do not resonate. However, their demands are not erased, given they were never registered to begin with. These mechanisms are multifaceted, acting, on the one hand, in a way to deny the recognition of existence to populations whom the state wishes to forget, and, on the other, in a way that once their existence is recognised, fails to meet their demands so that the recognition does not happen under the terms that the population itself wishes to be treated. The next topic aims to detail how the notion of universality of the health system sometimes becomes part of this mechanism of imposed forgetting.

Between universality and equity: brief remission, and disputes concerning the SUS

Another action organised during the pandemic was the *1ª Plenária Nacional sobre Saúde e Migração em Tempos de Covid-19* [I National Plenary on Health and Migration in Times of COVID-19]. With the purpose of being a space for listening and debate between immigrant populations, health professionals and managers, researchers and activists, the I National Plenary was articulated by civil society organisations as a form of combating

‘the systematic invisibilisation and silencing of immigrant populations residing in the country, particularly that portion that is undocumented or irregular’ (Plenária 2021). There were five regional stages, one for each region of the country, between June and July, followed by the national stage, held in August.

The process of organising the event began in January 2021 in conversations held between the *Comissão de Saúde da Central Única dos Trabalhadores* [National Trade Union Centre Health Commission], the *Rede* and the *Centro de Direitos Humanos e Cidadania do Imigrante* (CDHIC) [Centre for Human Rights and Immigrant Citizenship]. A series of preparatory and mobilisation meetings then followed with organisations, activists and academics aiming to engage actors from all parts of the country. Although the actions developed in the Plenary sessions are of interest to the central argument of this work as a fundamental strategy for making the demands for ensuring access to the SUS for immigrant populations visible, I will not describe them in detail here. The focus is on two illustrative episodes of the clash between the paradigms of universality and equity that underlie the Brazilian public health system, one of which occurred in the preparatory meetings, and the other in the Final Plenary of the South regional stage.

The first episode took place at the launch meeting of the Plenary organisation, held on 5 March, 2021. More than 30 organisations participated, and the first speech was by an epidemiologist who represented one of the social movements that made up the Organisation Committee.

I would like to bring up here the sum of my initial impressions. It is always necessary to consider the relationship between the needs of the national population and migrant populations, as we need to maintain the perspective of non-discrimination on the horizon. The Plenary is welcome, so long as it does not result in the creation of separate care services, nor in the creation of ***care privileges for migrants***, especially because this could result in difficulties in the forming of alliances, of turning a public that could be our allies into a hostile public. How big does the SUS have to be to serve everyone? Indeed, many people talk about equity, but what is constitutionally stipulated is that the SUS is egalitarian, not equitable. (Field record, 5 March, 2021; emphasis added)

It is important to emphasise that there is a difference between proposing specific health promotion strategies or a health policy for immigrant populations, as is the case with the homeless population, and proposing the creation of a health subsystem, as is the case with Brazilian Indigenous peoples. This proposition has already been rejected in Brazil by immigrant movements (Yujra 2020), particularly because the horizon of this type of positive discrimination tended towards ghettoisation, with health units and teams separated from those used by the general population, in addition to huge susceptibility to low funding and budget cuts.

Furthermore, it is essential to consider that the perspective of the scarce right, which advocates that the more people have a certain right guaranteed, the less right there is to access, cannot apply to the right to health, since guaranteeing the expansion of access to the SUS for immigrants ensures, in turn, an expansion of access to the public health system by Brazilians. One example might be exemption from the requirement for proof of residence, which would benefit the thousands of immigrants living in irregular occupations and residents under informal rental contracts, but would also expand the right of access to vaccines against COVID-19 to thousands of Brazilians living under very similar conditions – the case of Samuel, a naturalised Brazilian, is emblematic. Another example might be that of the Warao Indigenous people, from Venezuela, who during the Plenary claimed to be served by the Indigenous Healthcare Subsystem. This subsystem is exclusive to non-village Brazilian Indigenous people, and needs to guarantee healthcare in an intercultural manner, respecting traditional Indigenous knowledge. Ensuring that the Warao people can be served by this health subsystem would guarantee that thousands of Indigenous Brazilians living in cities also have access to it – and that they are, therefore, recognised as Indigenous by the Brazilian state even though they live in urban centres.

It is also important to understand the distinction made by the doctor between what is called equal access and equitable access to the SUS. The guarantee of ‘universal and equal access’ to the SUS, present in Article 196 of the Federal Constitution, presupposes formal isonomy between its users. In other words, everyone must be treated identically by the law, ‘leaving to the principle of equity that which, in legal theory, corresponds to the notion of equality in a material or substantial sense’ (Sarlet & Figueiredo 2014, p. 140). Thus, it is possible to understand that these are not mutually exclusive principles, but rather complementary, since regional, social, racial and other inequalities justify the adoption of positive discrimination in order to mitigate them.

In other words, universality should not be understood as the imposition of *identical* rules for access to the SUS by users, since certain vulnerable social groups are in a condition of inequality with regard to the ability to comply with these rules. Applying the idea of formal isonomy as a synonym for universality means, in reality, *amputating the system’s capacity to be universal*, since the guarantee of universal access necessarily involves privileging equitable access in a system that considers the inequalities that permeate the contexts that it forms a part of. There is no universality if we only apply the idea of formal isonomy, *since people have unequal capacities to comply with the access requirements*.

The other case occurred on 29 June, at the end of the Southern Regional Stage of the Plenary. All the activities were self-managed, and, at the end, the proponents of the activities were responsible for formulating three proposals to be discussed in the closing plenary. Two proposals raised a debate similar to that presented above: one, aimed at organising flows and protocols of service networks to and from migrants, inserting them into the existing networks of the SUS, the SUAS [Unified Social Care System] and other policies; and another proposed the production of a survey on the access of immigrants and refugees to social assistance and housing policies, specifying the nationality of the persons who access or try to access these policies, so as not to dilute them in the general data. An anthropologist, present at the event, took the floor after presenting the first proposal.

We have to think of health as a universal right, I will start from that principle. The problem is that healthcare for Brazilians is already difficult to access. I mean, we have a problem with access to healthcare in this country, right? So, we have to look for, and I’m trying to think together with you, mechanisms to facilitate access, **but not create privileges for the immigrant population**, if you know what I mean. (...) I mean mechanisms that facilitate access without it seeming that we are privileging [them] to the detriment of local populations who also have difficulty accessing and being welcomed by the health system. (Field record, 29 June, 2021; emphasis added)

The proposals were suspended, with participants initially agreeing to debate them again at the national stage of the event. However, after presenting the second proposal described above, the anthropologist restated his position.

I get very worried when we create mechanisms in relation to the migrant population, because it’s a very sensitive topic, right? We see the example of other countries that seek to avoid forms of stigmatisation of the migrant population, or even studies that identify issues related to health and illness among certain nationalities. (...) How can we create these mechanisms for the inclusion of migrants in services, or their access to services, that could lead migrants to a condition of equal access in relation to local populations, rather than proposing specific care protocols, in which I think we run the risk of exoticising or stigmatising this population even more. (...) Yes, look, I say this here, I think everyone here has the best of intentions, and wants to think about alternatives and policies that are more effective in caring for immigrants. What I’m saying here doesn’t go against this. There is a historical conditioning that precedes the discussion on health and migration, which is precisely the fact of identifying nationality as a study aim, or not, and determining cases or incidents of violence, or incidence of diseases related to people linked to the nationality of their country of origin. (...) We are suffering this now, right? Look at the pandemic, a Brazilian variant has been identified, we cannot, **Brazilian researchers** cannot enter France.

Look at that, right? We are living this, today. Right now, we are experiencing the identification of a possible Brazilian carrier of diseases so all Brazilians are prohibited from entering France due to the association of this variant with the body of Brazilians. (...) So, it worries me when, in a Plenary, we discuss issues of identifying nationality and associating the problem, whether it's disease... (Field record, 29 June, 2021; emphasis added)

It is important to emphasise the similarity with the position previously presented: the idea remains that addressing the inequalities in access for the migrant population would, in some way, create privileges for them in relation to Brazilians. The SUS, after all, is limited for everyone, Brazilians or immigrants, and facilitating access for the latter group – and, it must be said, this proposal is only being raised due to the identification of inequality of access in relation to national citizens, in particular to those who are wealthier and non-racialised –, would mean privileging them by not placing them on an equal footing with others. This formulation is only possible when it is considered that equal conditions exist prior to the debate on the guarantee of access that allows the establishment of what I previously called formal isonomy.

Furthermore, the anthropologist draws attention to the risks arising from identifying the nationalities of immigrants in health data, under penalty of intensifying stigmatisation, discrimination and racism. It must be said that this is a valid concern, and, indeed, the association between immigration and disease transmission is a phenomenon widely discussed in the literature on health and migration and, as the anthropologist highlighted, had even occurred during the pandemic. I will, however, divide the analysis into three parts in order to ensure a more comprehensive understanding.

First, it is crucial to scrutinise the idea that identifying the population served simultaneously attacks the principle of universality and institutes expressions of racism and discrimination. The argument that differentiation can violate the principle of universality is directly related to an assimilationist perspective that postulates that formal equality between persons in public matters necessarily derives from the flattening or suppression of the differences that constitute a given social group. Thus, the equality sought by the state could only come through the assimilation of difference and those who are different, guided by the construction of an archetype of citizen that should delimit said equality – speaking the language, having a certain skin colour or phenotype, sharing the same religious faith, having valid documents, and so on. In Brazil, this discourse is strongly informed by the idea of ‘one people, one language and one race for one nation’, which, among other issues, informs the rejection of the agendas of Black and Indigenous movements for identification and differentiation as a form of resisting colonial policies of extermination. Not by chance, the main exponent of Brazilian fascism today, Jair Bolsonaro, frequently uses this speech as a way of endorsing his fight against differentiations that, from this perspective, seek to divide the Brazilian people and territory, even serving to support the suspension of reparation policies for Indigenous and Black populations (Waltenberg 2020).

In health and healthcare contexts, the struggle of Brazilian Black movements for identification as a means of supporting, on the one hand, complaints concerning rights violations and violence committed in health and healthcare contexts, and, on the other, the construction of health promotion strategies specific to the reality of these populations, is well known. Thus, studies that indicate the use of less anaesthetic in the births of Black women (Leal et al. 2017), how Black women are less likely to undergo complete gynaecological and prenatal consultations (Miranda 2015), how Black men and women are touched less often in consultations and clinical examinations (Carneiro 2017), and, as previously mentioned, that Black people were over-represented in deaths from COVID-19, data that is available following intense mobilisation for the inclusion of the ‘race/ethnicity’ field in disease notification forms (Santos et al. 2020), are only possible by means of identification, which does not produce racism, rather it makes it visible.

The second part of the argument concerns the internal lack of differentiation of immigrant groups. It is not possible to identify inequities and respond to them by treating ‘immigrants’ as a monolithic, internally undifferentiated bloc. Proceeding in such a manner does not protect against discrimination, xenophobia and racism, on the contrary: such a stance is itself discriminatory, since it treats populations with languages, origins and cultures that are profoundly different from each other under the same heading. So, how is it possible to ‘identify the disadvantages’ relating to the migrant population’s access to the SUS without identifying them as non-nationals, and how do we develop strategies that guarantee that access will, in fact, be universal, treating different groups as if they were identical? Using practical examples, how is it possible to guarantee the presence of Lingala and Krèyol interpreters in healthcare services, or even the number of interpreters that should be made available in each territory without knowing how the territorialisation of the Angolan, Congolese and Haitian populations occurs? How can we produce informative materials concerning vaccination against COVID-19 in different languages without this data? Is it possible to hire immigrant *Agentes Comunitários de Saúde* (ACS) [Community Health Agents] without considering their countries of origin and the languages spoken? For example, would it not be a problematically racist stance when dealing with a Haitian community, if you hired a Cameroonian ACS and assumed they were all the same? What are the effects of this on the intensification of racism and xenophobia in health and healthcare contexts?

Finally, addressing the anthropologist’s discourse regarding the prohibition of circulation resulting from the health measures adopted due to the pandemic is essential. The ban on entry into France by any and all Brazilians due to the identification of a ‘Brazilian variant’ is, in fact, an expression of global, widespread, colonial racism and xenophobia, which found in the pandemic an opportunity to institutionalise the restriction on immigrant flows considered undesirable and the securitisation of borders. However, the shock is predicated on hidden suppositions: if before it was merely the indistinct mass of undocumented, irregular, illegal immigrants who were prohibited from circulating, now researchers cannot enter France. It is not just any Brazilian body whose forced immobility is of concern, but one whose class, race and gender are unaccustomed to being the targets of such measures. Failure to identify this Brazilian body could lead us to believe that they are all the same, and, as we know, they are not. For them to be so, it is essential to identify and recognise the differences, and then respond to the inequalities that are structured from these differentiation processes.

By way of conclusion: ‘Long live the SUS! Long live science!’

During much of the vaccination campaign against COVID-19, the slogans that make up the title of this section were widely used by those who opposed what was conventionally called the denial of state agents regarding measures to contain the pandemic and mitigate its devastating effects, including the then President of the Republic. The celebration of the SUS, and, in its wake, the scientific research that enabled the development of therapeutic intervention instruments capable of combating the virus, however, ignored the consideration of those left behind in an eminently multiple pandemic traversed by differences and inequalities of several orders. Rather than representing relief, in reality, the vaccination campaign demonstrated that once people felt safe enough, the safety of others no longer mattered as much (Gonsalves 2022).

In this article, I sought to argue that undocumented status has a limited effect on difficulties in accessing the right to healthcare, highlighting that even immigrants who had documents – and who were, for all intents and purposes, legally Brazilian – were unable to get vaccinated. Thus, racialisation processes, understood here as the processes through which any social difference is essentialised, naturalised and/or biologised, anchoring them in fixed types of otherness, are more determinant than undocumented status in defining who is eligible for universal access in the Brazilian context.

Furthermore, the tensions between the principles of universality and equity frequently observed in the discourses of Brazilians in the face of demands for structuring certain health promotion actions specific to migrant populations demonstrate how the notion of equity is often considered to create privileges in a context of scarcity of rights, threatening universality. Here, universality is simultaneously considered to be the existence of a common substrate that confers the status of humanity to all, and equality of treatment before the law and public services and affairs. Thus, any action that proposes to create differences in treatment is perceived as an attack on the very notion of equality on which this particular concept of universality is supported, even if they are actions in which the objective is to map and mitigate inequalities that constitute the contexts within which the SUS is inserted. Based on this perspective, the paradigms of universality and equity are considered mutually exclusive, rather than complementary.

I also sought to demonstrate how the forgetfulness imposed by the state is articulated through an erasure often disguised as principles tributary to universalism that advocates that equality, called here formal isonomy, must be absolute and unequalisable, even in the face of inequalities that make this horizon virtually unattainable. Thus, it is precisely through the defence of an unequalisable universality that the impossibility of accessing certain rights as universal is constructed. The systematic refusal of state agents and experts to map or debate the health system's capacity to respond to the presence of heterogeneity, and the inequalities of access derived from this refusal, constitute what I call erasure mechanisms, aimed at imposing forgetfulness and the obstruction of certain memories, or even the allocation of uncomfortable political facts in the field of hallucinations (Branco-Pereira 2021; Gonzalez 1984).

The SUS is and must be heterogeneous in order to respond to the multiple contexts in which it is inserted. Universality is not possible without equity due to the inability of certain groups to respond to the rules imposed for access. In this sense, the struggles of immigrant communities and Brazilian activists register the demand for equitable policies of access and guarantees of rights, and justify the political demands of these communities, bringing them from the intangible to the concrete arena of public policy formulation. The imposition of forgetfulness on the sufferings that motivate these political demands thus loses its immediate effectiveness, even though they are completely asymmetrical forces involved in these disputes. Moreover, if the price of imposed silence is also paid by resignation and impotence, the reverberations of the refusal to impose forgetfulness compose the very substance of our possibilities of life and existence. Otherwise, memory impeded will merely be a hallucination in the face of the official version.

Received: April 05, 2023

Accepted: September 19, 2023

Translated by: Philip Badiz

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