interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Editorial

Covid-19 and the black population

Covid-19 e a população negra

Covid-19 y la población negra

Luís Eduardo Batista[a]
<lebatista@saude.sp.gov.br>

Adriana Proença[b]
<drikaproenca@gmail.com>

Alexandre da Silva[c]
<alexandre.geronto@gmail.com>

[a] Coordenadoria de Controle de Doenças, Secretaria de Estado da Saúde de São Paulo. Avenida Dr. Arnaldo, 351, 1º Andar. São Paulo, SP, Brasil. 01246-000.
[b] Grupo de Trabalho Racismo e Saúde, Associação Brasileira de Saúde Coletiva. São Paulo, SP, Brasil.
[c] Departamento de Saúde Coletiva, Faculdade de Medicina de Jundiaí. Jundiaí, SP, Brasil.

Deeply rooted in the structures of our society, racism affects our work, income, education, and employment conditions. Racism determines where we live and whether or not we have access to justice, properties, and healthcare rights. According to Silva[1], the quality of the support and assistance offered also reflect the way racism affects the healthcare system, and poses challenges to the public administration agenda. In addition to that, racism is related to poverty, sexism, ageism, and the many subjective realities of life. These elements can be individually more or less evident, but it also frequently happens that more than one of them are equally severe at the same time.

The shadows of racism have been made even wider by the effects of one of the most severe sanitary crises in the world, the coronavirus (Sars-CoV-2) global pandemic. According to Hallal[2], the society's structural inequalities have been a contributing factor to the high mortality rates of Brazilian populations living in conditions of more severe vulnerability, i.e., low-income, low-education people residing in subnormal urban agglomerates; indigenous people; and back people. According to Werneck[3] *et al.*:

Batista LE, Proença A, Silva A. Covid-19 and the black population. Interface (Botucatu). 2021; 25: e210470
https://doi.org/10.1590/interface.210470

> We cannot just go on telling people to simply wash their hands and maintain social distancing without acknowledging that they do not have access to a basic sanitation system and need to use public transportation that is packed to the ceiling. Structural inequalities cannot be explained by individual behaviors, and the pandemic only makes them more evident[3]. (p. 5)

The black population, who had long been living in socio-economic exclusion, without access to basic resources, having to struggle to survive through the worst economic conditions, poorest quality of life, and feeblest access healthcare, ended up being pushed even further away to the peripheral margin of society. In light of this scenario, we have no alternative other than to state that the Covid-19 pandemic is color-biased[4].

One of the first recorded deaths confirmed to be caused by Covid-19 was disclosed in March 2020: a 57-year-old woman who worked as a maid. More than one year later, the death of this woman still puts a face to thousands of other Brazilian men and women who have died without having the chance to avoid exposure to the virus by either working from home, for instance, or by having access to sufficient social-distancing resources, as required by the states and municipalities. Without access to a decent emergency relief fund, these people were (and still are) more exposed to contamination.

The excess mortality of the black population also results from a series of omissions and disarticulations by the government. The race/color issue was not taken into consideration when analyzing the Covid-19 epidemiologic situation. These data were only included in the analysis after joint efforts were made by the Race and Health Work Group of the Collective Health Brazilian Association (*GT Racismo e Saúde da Associação Brasileira de Saúde Coletiva, Abrasco*), the Black Coalition for Rights, and the Brazilian Society of Family and Community Medicine. Still, because public health authorities fail to track and monitor the actual numbers, this piece of information has not been duly included or considered in epidemiologic reports. Lack or incorrect race/color information in medical reports, which is essential data for decision-making, can be construed as the institutional racism's subjectivity and resistance to change knowingly insufficient practices in order to allow the black population to have access to a healthier life, with less diseases.

In addition to that, the terrible approach of the federal government in fighting the pandemic has left the Brazilian citizens adrift in the middle of a storm[5], especially those who need to use the Brazilian National Health System (SUS, *Sistema Único de Saúde*)–67% of which are black or non-white people. In the opposite direction of other countries around the globe, Brazil has failed to adopt emergency relief measures to mitigate the transmission of the virus. The consequences of such negligence have led to overcrowded public hospitals, lack of healthcare/hospital supplies, and shortage of oxygen tanks and ventilators, which ended up dragging us to the shameful second position in the rank of total deaths in the world, with more than 520 thousand lives lost to Covid-19[6] as of July 2021.

A significant part of these deaths could have been avoided, had the Federal Government's decisions been focused on human lives, rather than on economic and private interests, or had there been a structured public healthcare service in place, with increased capillarity to ensure high-quality primary healthcare provision, or on a deeper look, had the approach to the pandemic been adequate to meet the needs of

Brazilian men and women living in highly vulnerable conditions, most of whom are black. In short, living in the most impoverished areas, working the most underprivileged jobs, and receiving the least amount of social protection, the black population in Brazil continues to be neglected, unprotected, and even more vulnerable to death from Covid-19.

Is the coronavirus democratic?

When looking at how Covid-19 affects the black population, we have to acknowledge the restricted choice options they have. It is important to highlight that most of these people do not have the possibility of working from home (especially because of the type of work they perform), without losing their salaries, benefits, healthcare plan, and the staple foods basket. One must take into consideration where these people live: Are their houses ventilated enough? If they share a house with direct and extended family members, can they keep social distancing? Do they have access to basic sanitation system, electricity, internet connection? Are they able to come and go safely? Do they have any type of comorbidities and/or other health issues? All these realities make it paramount that, when coming up with strategies to fight the pandemic, we look at the various specificities of each population group.

Data provided by the Continuous National Household Sample Survey (PNAD, *Pesquisa Nacional por Amostra de Domicílios*)[7] show that black and non-white Brazilians working informal jobs total 47.3%. For white workers, this number drops to 34.6%, which shows how neglected the black population is. This reality has been made even more critical since March 2020, when the number of exasperated black Brazilians grew even more. There are approximately 17 million unemployed people, and 19 million hungry people, a significant part of which is comprised of black people.

When we look at the situation through the lens of the Covid-19 pandemic, the number of people who need hospital inpatient treatment and the number of deaths is a lot higher among the cleaning staff (62%); retirees (30%); housekeepers (6.5%); maids and cooks (6.5%); technicians and healthcare practitioners (0.3%); salespeople (0.3%); truck drivers (0.3%); delivery people (0.3%); production assistants (0.3%); other (0.3%)[7].

Housekeepers, maids, school cafeteria servers and cooks, teachers, nannies, sitters, bus drivers, and so many other workers whose jobs were vital to ensure the feasibility of social distancing, quarantining, and other Covid-19-safe measures to so many non-black and financially privileged people, were not included in the populations targeted for priority vaccination.

When it comes to the age groups affected by the pandemic, the black elders showed the highest numbers of confirmed cases and death by Covid-19, given that they may have all the issues and conditions scientifically related to the disease, such as comorbidities, old age, and dark skin. In spite of North American research previously indicating that the numbers of confirmed cases and death by Covid-19 were higher among the black elderly population, the Brazilian federal government closed, yet once again, their eyes to scientific information. The number of avoidable deaths among this group of people who have been historically excluded from public policies was, therefore, increased.

Brazilian public authorities have failed to take into consideration the several scientific pieces of evidence that were pointing out to more assertive ways to fight the pandemic and save more lives. Research carried out in May 2021 showed that the Covid-19 immunization campaign would have reached higher effectiveness in many municipalities, had the campaign considered the geographic criterion, in addition to the age criterion, i.e., had the people who live in areas where the death ratio by age group is higher been granted priority access to the vaccine[9]. Based on data disclosed by the Ministry of Health, and published on *Folha de São Paulo* newspaper, a LabCidade analysis clearly shows the difference in the number of deaths by Covid-19 and the number of vaccinated people between the rich and the poor neighborhoods in the city of São Paulo. This disparity happens exactly because the age criterion was the only one taken into account for the vaccination schedule. While 16% of the residents of areas such as Moema, Pinheiros, and Consolação had already been vaccinated based on the age criterion—and these areas were showing a mortality ratio of ten to twenty deaths per 10.000 inhabitants—, neighborhoods resided mostly by black people, such as Parelheiros, Cidade Tiradentes, and Jaraguá, had 4% to 8% of vaccinated people and an average of fifty deaths per 10,000 inhabitants[10].

The *quilombola* population (groups of people historically descending from black slaves), in turn, is still fighting for its right to have priority access to the vaccination schedule. In addition to the lack of updated data to support mapping of the *quilombola* population in Brazil, the government has been using the 2010 census information, coupled with the absurdity of requiring proof of residence in a *quilombola* community, to include these populations in the vaccination schedule.

Several studies have evidenced that the black population is more affected by chronic non-communicable diseases (NCD), when compared to the white population[1,5,11,12]. According to the authors, it is not possible to comprehend what it is that makes the black population more susceptible to developing chronic NCDs (and, consequently, more susceptible to Covid-19), if one fails to acknowledge racism as a risk factor. There is also another important factor that is not discussed enough: people with NCDs, such as high blood pressure, diabetes, and stroke, and their risk factors, such as smoking and not consuming enough vegetables and fruits, have not been able to seek healthcare and treatments due to the social distancing measures. Specialists worry that people with chronic diseases may not be able to access appropriate medical treatment, and, in this case, they would be even more vulnerable to Covid-19 as a result of their comorbidities. The same goes to those suffering from sickle cell disease, which happens in greater number among the black population. Even though people with chronic diseases have been included in the National Immunization Plan, this inclusion does not take racial aspects into consideration. Furthermore, there has been no tracking about whether or not the municipalities are really compliant with the Plan.

The influence of social determinants on the health-disease process is a milestone of the theoretical and methodological construction of the Latin-American Collective Health. This construction, however, seems to support analyses and management based solely on age, educational level, income, gender, and place of residence. Studies and management of health-related actions and policies need to expand their approach to cover the gender, social class, and race/color intersection as the construct of social determinants of health. It is paramount that we take into account not only the socio-economic conditions, but

also the impact of racism on the black, indigenous, and gypsy populations. Therefore, gender, social class, and race/color aspects are analytical categories that must be included as building blocks in the development of our studies, actions, policies, programs, and educational processes on collective health.

Historical inequities had been reported in epidemiologic data long before the Covid-19 pandemic. With actions and omissions in fighting the pandemic, the updated information about the virus and its consequences come to show that the health, well-being, and economic conditions of the black and indigenous populations have deteriorated even more. Racism is deeply rooted in Brazilian society, and we are all faced with the challenge of developing studies, educational courses, policies, programs, and actions to promote equity[13]. After all, as pointed out by Akerman and Pinheiro[14]:

> [...] we are not all on the same exact boat, as we sail towards the end of the world. Some of us are in transatlantic ships; others, in yachts, longboats, sail boats, schooners, kayaks, canoes, and rafts; and there are even those who are castaways, holding on to wooden logs in the middle of the storm.

Authors' contributions

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

Editor
Antonio Pithon Cyrino

Translator
Caroline Alberoni

Submitted on
07/26/21
Approved on
07/28/21

References

1. Silva A, Rosa TEC, Batista LE, Kalckmann S, Louvison MCP, Teixeira DSC, et al. Iniquidades raciais e envelhecimento: análise da coorte 2010 do Estudo Saúde, Bem-Estar e Envelhecimento (SABE). Rev Bras Epidemiol. 2018; 21 Suppl 2:e180004. Doi: https://doi.org/10.1590/1980-549720180004.supl.2
2. Hall PC. Comissão parlamentar de inquérito - Ações e omissões do Governo Federal no enfrentamento da Pandemia da Covid-19 no Brasil. Brasília: Senado Federal; 2021. p. 12.
3. Werneck GL, Bahia L, Moreira JPL, Scheffer M. Mortes evitáveis por Covid-19 no Brasil [Internet]. São Paulo; 2021 [citado 15 Jul 2021]. Disponível em: https://idec.org.br/sites/default/files/mortes_evitaveis_por_covid-19_no_brasil_para_internet_1.pdf
4. Santos MPA, Nery JS, Goes EF, Silva A, Santos ABS, Batista LE, et al. População negra e Covid-19: reflexões sobre racismo e saúde. Estud Av. 2020; 34(99):225-44. Doi: https://doi.org/10.1590/s0103-4014.2020.3499.014
5. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Departamento de Análise em Saúde e Vigilância de Doenças Não Transmissíveis. Vigitel Brasil 2018 População Negra: vigilância de fatores de risco e proteção para doenças crônicas por inquérito telefônico: estimativas sobre frequência e distribuição sociodemográfica de fatores de risco e proteção para doenças crônicas para a população negra nas capitais dos 26 estados brasileiros e no Distrito Federal em 2018 [Internet]. Brasília: Ministério da Saúde; 2019 [citado 8 Jul 2021]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/vigitel_brasil_2018_populacao_negra.pdf
6. Menezes RF, Soares A, Camargo IA. Panorama internacional sobre o enfrentamento à pandemia de covid-19 no ano de 2020. Humanidades Inovação [Internet]. 2021 [citado 8 Jul 2021]; 8(35):53-70. Disponível em: https://revista.unitins.br/index.php/humanidadeseinovacao/article/view/5342
7. Instituto Brasileiro de Geografia e Estatística (IBGE). Pesquisa Nacional por Amostra de Domicílios PNAD/Covid19 [Internet]. 2020 [citado 8 Jul 2021]. Disponível em: https://www.ibge.gov.br/estatisticas/sociais/saude/27946-divulgacao-semanalpnadcovid1.html?=&t=resultados
8. Barber S, Headen I, Branch B, Tabb L, Yadeta K. Covid-19 in context: racism, segregation, and racial inequities in Philadelphia [Internet]. Philadelphia: Drexel University; 2020 [citado 2 Nov 2020]. Disponível em: https://drexel.edu/uhc/resources/briefs/Covid-19 in Context/
9. Instituto Pólis. Raça e covid no Município de São Paulo [Internet]. São Paulo: Instituto Pólis; 2020 [citado 8 Jul 2021]. Disponível em: https://polis.org.br/estudos/raca-e-covid-no-msp/
10. Collucci C. Vacinação em SP não prioriza bairros com mais mortes por Covid-19. Folha de São Paulo [Internet]. 4 Jul 2021 [citado 8 Jul 2021]. Equilíbrio e Saúde. Disponível em: https://www1.folha.uol.com.br/equilibrioesaude/2021/07/vacinacao-em-sp-nao-prioriza-bairros-com-mais-mortes-por-covid-19.shtml
11. Malta DC, Moura L, Bernal RTI. Diferenciais dos fatores de risco de Doenças Crônicas não Transmissíveis na perspectiva de raça/cor. Cienc Saude Colet. 2015; 20(3):713-25. Doi: https://doi.org/10.1590/1413-81232015203.16182014
12. Barros MBA, Lima MG, Medina LPB, Szwarcwald CL, Malta DC. Social inequalities in health behaviors among Brazilian adults: National Health Survey, 2013. Int J Equity Health. 2016; 15(1):148. Doi: https://doi.org/10.1186/s12939-016-0439-0

13. Almeida-Filho N. Qualidade-equidade em saúde: novos desafios em um estado de mal-estar social. Interface (Botucatu). 2020; 24:e200171. Doi: https://doi.org/10.1590/Interface.200171

14. Akerman M, Pinheiro WR. Covid-19: Não estamos no mesmo barco [Internet]. 2020 [citado 8 Jul 2021]. Disponível em: https://diplomatique.org.br/covid-19-nao-estamos-no-mesmo-barco/