DOI: 10.1590/1413-81232020259.14052020

Covid-19 Pandemic: reflecting vulnerabilities in the light of gender, race and class

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Abstract *This study aims to reflect the impact of COVID 19, considering gender, race, and class markers. This is an exploratory study, with an emphasis on the analysis of selected publications, based on a systematized search on official websites, and on the PubCovid-19 platform that includes papers published on COVID-19, which are indexed in PubMed and EMBASE. This work was based on these documents and built with reflections from the authors from the perspectives of social markers related to gender, race, and class, which contribute to the prognosis of the disease. The reflection carried out from the analyzed literature revealed that the markers of gender, class, and race emerge as a vulnerable condition to the exposure of COVID-19 in the most diverse world scenarios. This context reveals the historical need to implement strategies to improve the lives of this population, not only during the pandemic but also after their passing. Therefore, it is necessary to adopt socioeconomic policies with a more significant impact on the lives of these people and with greater coverage, expanding access to better health, education, housing, and income.*

Key words *COVID-19, Pandemic, Race and health, Gender, Social class*

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Introduction

COVID-19 has spread rapidly worldwide since its emergence. Its expansion has had economic, social, and health impacts, especially when the social markers of race, class, and gender are mainstreamed, conditions that make several population groups vulnerable. Thus, there is a need for discussion about these markers in order to understand and overcome the countless challenges that permeate this scenario.

The repercussions in the economic and health areas were the first to be noticed with the advent of COVID-19. A deficit of US$ 1 trillion in the world economy during 2020 is expected due to health expenditure and support to households[1]. Moreover, the advent of the pandemic had an overwhelming impact on the lives of people who were already in a situation of social vulnerability due to informal work, poor housing conditions, and difficulty in accessing health services[2].

The context of these audiences relates the convergence of social markers that act distinctly, making them vulnerable in their individualities. Furthermore, the disease caused by the new Coronavirus, SARS-COV-2, COVID-19, has, for the most part, mild symptoms. However, it can develop severe conditions in specific groups, such as street populations. This public was already in a situation of vulnerability before the pandemic. However, the situation deteriorated with the disease, as it was interrelated with the biological and social fields. Thus, one can observe that factors contributing to the rapid spread of SARS-COV-2 are linked not only to the pathogenic features of the virus but also to social determinants.

In the face of these situations, people have been affected, especially those with lower income and in unfavorable social conditions, which signals a reflection on the markers that generate social inequalities. Considering this scenario and the Brazilian reality concerning inequalities, this study aims to reflect the impacts of COVID-19, considering markers of gender, race, and class.

Methods

This is an exploratory study, with emphasis on the analysis of publications written and disseminated by institutional bodies of the public health network and scientific productions referring to the COVID-19 pandemic. The work was based on the referred documents and built with reflections from the authors from the perspectives of social markers related to gender, race, and class, which contribute to the prognosis of the disease.

The reflection is inherent in the researcher since knowledge depends on it to be built. This statement is corroborated by Pierre Bourdieu[3], who highlights the importance of reflexivity in research practice when he affirms that this posture represents not only thinking, but acting on the subject and the individuals studied. Thus, reflection is an essential method in rethinking and reorganizing care in the face of the current pandemic context and the need for constant construction of knowledge that supports the practice and serves as a basis for looking at vulnerable audiences.

The documents used were selected from a systematized search on official websites and on the PubCovid-19 platform, which contains papers published on COVID-19 that are indexed in PubMed and EMBASE. The newly created platform was created to compile publications related to the theme since knowledge about COVID-19 has been published at an increasing speed. It contains papers organized by thematic areas to facilitate access and guide researchers.

The inclusion criteria were papers addressing COVID-19 and with an interface with gender, race, and class, including the street population. The unavailability of the free, full-text papers was considered as an exclusion criterion. Data was collected in April 2020 and was associated with an instrument that allowed gathering the following data: name of the authors, year of publication, language, and identification of the social marker selection.

Completing this instrument gave rise to the tables below that summarize the findings (Chart 1 and Chart 2). The studies were thoroughly read and analyzed to find the elements for discussing the impacts of gender, race, and class markers on COVID-19 infection.

Discussion

Given the exponential growth of COVID-19, it is essential to reflect on the vulnerability of specific groups in hard times. Although the SARS-COV-2 virus is not selectively contagious, its impacts will be felt differently depending on race, class, and gender. Such markers affect people in different areas of their lives beyond health due to socially produced inequalities.

In Brazil, the first cases were associated with the more affluent classes, due to internation-

Chart 1. Distribution of the selected documents as per the search on official websites.

Nº	Title	Authors and year of publication
1	Prevenção ao COVID-19 no âmbito das equipes de Consultório na Rua[4]	Primary Health Care Secretariat (SAPS) 2020
2	NOTA TÉCNICA Nº 04/2020 GVIMS/GGTES/ ANVISA[5]	Primary Health Care Secretariat (SAPS) 2020
3	Risco dos bairros de Salvador ao espalhamento do COVID-19 decorrente da circulação de pessoas e condições socioeconômicas[6]	Federal University of Bahia (UFBA) - Geo Group Combating COVID-19 BA 2020
4	Protocolo de Tratamento do Novo Coronavírus (2019-nCoV).[7]	Ministry of Health 2020
5	Saúde da população em Situação de rua; um direito humano[8]	Strategic and Participative Management Secretariat 2014
6	Desigualdades Sociais por Cor ou Raça no Brasil.[9]	Brazilian Institute of Geography and Statistics (IBGE) 2018
7	Política Nacional para a População em Situação de Rua.[10]	Decree nº 7.053, of December 23, 2009.

Chart 2. Distribution of selected papers as per the search on PubCovid-19 platform.

Nº	Title	Autores e ano de publicação
1	The Brazilian slums hiring their own doctors to fight covid-19[11]	Authors and year of publication
2	The vulnerability of low-and middle-income countries facing the COVID-19 pandemic: The case of Haiti.[12]	Cénat JM 2020
3	Covid-19 is an opportunity for gender equality within the workplace and at home[13]	Wenham C et al. 2020
4	COVID-19: Vulnerability and the power of privilege in a pandemic.[14]	Smith JA, Judd J 2020
5	If the world fails to protect the economy, COVID-19 will damage health not just now but also in the future[15]	McKee M, Stuckler D 2020
6	Laster Pirtle, Whitney N. Racial Capitalism: A Fundamental Cause of Novel Coronavirus (COVID-19)[16]	Pirtle WNL 2020
7	Efforts escalate to protect homeless people from COVID-19 in UK.[17]	Kirby T 2020
8	Racism and discrimination in COVID-19 responses.[18]	Devakumar D et al. 2020
9	COVID-19 precautions: easier said than done when patients are homeless19	Wood LJ et al. 2020

al travel, which became infected and later returned to the country. The Ministry of Health[20] affirms that the first case of an infected Brazilian was notified on February 26, 2020, a patient who had recently returned from a trip to Italy. In the suburbs, the reports were of housekeepers, application drivers, food deliverers who were in contact with those who traveled, became infected and carried the infection to their homes. Thus, low-income people living in the outskirts of Salvador have also been exposed to the disease because they worked in the most affluent places in the city, where the highest percentage of people infected with SARS-VOC-2[6] has been identified.

It should be noted that people are infected equally. However, preventive measures and the possibility of deteriorating signs and symptoms vary. Regarding the class, the low level of education associated with extreme poverty directly affects non-compliance with public health instruc-

tions. This situation is challenging worldwide and has been pointed out mainly in emerging countries. In Haiti, with a population of 11 million inhabitants, less than 30 ICU beds, and the unavailability of protective equipment for service providers, the lack of resources is relevant in the absence of preventive measures, causing a severe health crisis[12].

Given this scenario, the adverse effect on health produces an economic decline for individuals and households, since disease control requires strategies such as social distancing and quarantine. Such measures apply with impacts on low-income populations with low access to health care and need to choose between staying at home and going hungry or taking the risks of non-compliance with isolation to support themselves and their families[15].

Concerning the field of work, besides those who cannot meet restrictive measures because they depend economically on these earnings to survive, others perform essential activities and, thus, are exposed[6]. An example of this audience are men with high disease incidence rates, which may be related to the provision of their homes. The gender impact of the COVID-19 outbreak is hardly discussed, and we observe a neutral position in public policies as if men and women were infected and affected equally.

In Brazil, class selections are also linked to race, since as per data released by the Brazilian Institute of Geography and Statistics in 2018 through the survey "Social Inequalities by Skin Color or Ethnicity in Brazil", 75% of people living in extreme poverty self-declared as black or brown[9]. National social inequities organize their societies in ways that make them extremely vulnerable. Thus, the socio-economically disadvantaged are represented by racial and ethnic minorities working in casual jobs and lacking the necessary financial resources for self-isolation. In contrast, an increasingly small and select elite shows the power of privilege in a pandemic, where the most vulnerable will be the most affected[14,15,18].

Again, dealing with race as a social marker, racial capitalism is a fundamental cause of health inequities. A study carried out in Detroit, the USA, where only 14% of its population is black, showed that 40% of mortality by COVID-19 are of blacks[16], which may be related to the high rates of comorbidities in this population, and makes them vulnerable to the deterioration of COVID-19. A report with data from Italy showed an association between severe illness and diabetes, a common situation in the black population of South Asia, according to the research[18]. Thus, race and its mainstreaming aspects are elements that make COVID-19 vulnerable.

These differences are evidence of structural racism that makes it difficult for black men and women to access tests to detect the virus to the treatment of the infection, facilitated by power, money, and prestige that can alleviate the consequences of the disease. A study reveals that Detroit is among the top 20 cities in the United States with the highest number of homeless people, and most of these people are black[16]. Homelessness, poorest and black people are more vulnerable to the consequences of COVID-19.

Living on the street exposes people to countless sickening situations, and is more latent in the pandemic. The difficult access to health services and prejudice translate into even more significant impacts. When patients come to the emergency departments and hospitals with COVID-19 symptoms, their complaints can be minimized, which confirms the difficulty in maintaining health. This population is often socially excluded, which ends up restricting a range of human rights. This invisibility is perceived in public policies, since the National Policy for the Homeless Population was enacted only in 2009 through Decree N° 7.053, of December 23, 2009. People living on the streets meet the following requirements: being in extreme poverty, having broken or weakened family ties, not having regular conventional housing, and using public streets or degraded areas to shelter or support themselves[10].

A large team is working across the UK at breakneck speed to deploy systems to protect homeless people from the potentially devastating effects caused by COVID-19. This group generally has a much higher prevalence of chronic conditions such as lung disease, diabetes, and cardiovascular diseases compared to people of the same age living in accommodations[17,19]. They share tight accommodations, in agglomerations, and are therefore vulnerable to high rates of infection and severe symptoms[17]. How do they compress social distancing and live in a place without shelter? Isn't washing your hands with soap and water a privilege if there is no water to drink and bathe? As much as the recommendation is not to share personal items, the least essential thing during hunger and cold is to know where that wasted food or donated clothes came from.

In Brazil, the municipality of Salvador, through Technical Note N° 04/2020, provided guidance on how to facilitate the access of peo-

Ciência & Saúde Coletiva, 25(9):431-3436, 2020

ple on the street to health care in the face of the COVID-19 pandemic. This standard guides the reception, case definition, reporting, diagnosis, clinical management, follow-up in the Reception or Home Unit, Street Clinic actions, and prevention and control measures[5].

If social distancing is required, the team that received this patient is responsible for identifying a possible home in which he/she can rest. It must also obtain a telephone contact and address to ensure treatment/care continuity. If there is no home, it is necessary to contact the Social Approach service to regulate the case concerning housing assistance[4].

This vulnerable and marginalized population is the result of a social event, where homes are streets, bridges, or hostels. However, this is not the only challenge experienced by these people, as they still live without access to essential health services. Urgent strategies should be established around the world to increase access to health for this population.

Final considerations

The reflection based on the analyzed literature revealed that the markers of gender, class, and race are a condition vulnerable to the exposure of COVID-19 in the most diverse world scenarios. This context reveals the historical need to implement strategies to improve the lives of this population, not only during the pandemic but also after their passing. Therefore, it is necessary to adopt socioeconomic policies with a more significant impact on the lives of these people and with broader coverage, expanding access to better health, education, housing, and income conditions.

Collaborations

FM Estrela, CFS Soares, MA Cruz, AF Silva and JRL Santos contributed to the conception and project, writing of the paper and final approval of the version to be published. TMO Moreira, AB Lima and MG Silva contributed to the conception and project, critical review of the paper, and the final approval of the version to be published.

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Article submitted 01/05/2020
Approved 14/05/2020
Final version submitted 16/05/2020