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# Racial inequalities and death on the horizon: COVID-19 and structural racism

## Desigualdades raciais e a morte como horizonte: considerações sobre a COVID-19 e o racismo estrutural

## Desigualdades raciales y la muerte como horizonte: consideraciones sobre la COVID-19 y el racismo estructural

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**Abstract**

*COVID-19 incidence and mortality in countries with heavy social inequalities differ in population terms. In countries like Brazil with colonial histories and traditions, the social markers of differences are heavily anchored in social and racial demarcation, and the political and social dynamics and processes based on structural racism act on this demarcation. The pandemic's actual profile in Brazil clashes with narratives according to which COVID-19 is a democratic pandemic, an argument aligned with the rhetoric of racial democracy that represents a powerful strategy aimed at maintaining the subaltern place of racialized populations such as indigenous peoples and blacks, as a product of modern coloniality. This essay focuses on the pandemic's profile in the Brazilian black population, in dialogue with decolonial contributions and critical readings of racism. The authors discuss government responses and COVID-19 indicators according to race/color, demonstrating the maintenance of historical storylines that continue to threaten black lives. The article also discusses the importance of local resistance movements, organized in the* favelas*, precarious urban spaces underserved by the State and occupied by black Brazilians.*

*COVID-19; Racism; Social Vulnerability*

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The intense global circulation of persons and merchandise was a determinant factor for COVID-19's pandemic situation. Having emerged initially in the Northern Hemisphere, in China, in a few months the disease reached Europe and then the United States, spreading quickly from there to the Global South. The virus was imported to Brazil by the middle and upper classes and initially helped forge a discourse (echoed by the media) that the disease would affect everyone, that the consequences would be felt equally, as a "democratic" disease. The only caveat was the differential mortality in certain population segments such as the elderly and persons with preexisting conditions [1]. In an equivocal appropriation of epidemiological knowledge, the political narratives and decisions produced an individualization of the issue, eliminating the illness's collective perspective. This focus not only played out in controversies, such as with social distancing, but also portrayed the problem as limited particularly to certain individuals. This raises an ethical and political issue [2], expressed not only in different guidelines depending on the place individuals occupy in the socioeconomic structure, as in young people and the workforce they represent in the generation of goods and services, as well as patient care protocols that set the priorities for access to intensive care, as in the case of the elderly and patients with comorbidities [3,4,5].

The second issue pertains to Brazil's societal process and the myth of racial democracy [6], which serves to disguise racial relations of subalternity, based on the idea of symmetric miscegenation, anchored in the notion of a society free of racism. Belief in the myth of racial democracy is sustained by ideas that marked contemporary Brazilian society, even though questioned and deconstructed by black movements' activism. The myth has been reupdated [7], delaying and hindering long-awaited progress in the discussion and implementation of affirmative policies and actions [7,8].

The idea that Brazilian society was built on harmonious conviviality in its racial plurality lends complexity to the process of production of a national identity, where the idealized ultimate outcome is represented by the white European reference, an ethnic unity that discursively operates the effacement of black identity from "miscegenated" subjects, but which does not necessarily imply altering their place in the social structure [9].

According to this narrative, except for the groups (cited above) at higher risk of COVID-19, other groups would purportedly be at the same risk level, eliminating the need for differential policies to deal with the pandemic. The initial measures took this direction, with social distancing facilitated by remote work and reinforcement of personal hygiene practices.

Yet the reality is quite different for Brazil's low-income working class, mostly black and living in vulnerable areas, the *favelas*. They are predominantly informal workers who lack the privilege to stay at home doing remote work; they commute on overcrowded public transportation; they have precarious access to basic sanitation; and they are on the front line, serving the public in the services sector, including healthcare. Race only became a concern on the agenda of some social and government agencies because of pressures, such as the position of a broad set of social actors (leaders of *favelas* and progressive political parties), members of the health field (researchers, health professionals, and administrators), part of the media, and essentially with the pandemic's progression in the already evident unequal epidemiological profile that has laid bare the social markers of inequalities, especially related to race.

We propose to focus the debate precisely on the world's racial division and its visible repercussions on the COVID-19 pandemic. Viewing the pandemic in light of racial inequalities requires considering not only the numbers they reveal, which are indeed important, but essentially the historically woven storyline that creates their structure, dynamics, and narrative practices.

## COVID-19 exposes the world's racial division

COVID-19 has sparked critical analyses in various fields, ranging from the biomedical perspective to geopolitical, social, subjective, and economic reflections, in order to present interpretations and proposals on the pandemic's effect on the world. Yet the attempted responses fail to keep pace with the infection's transmission. The experiences of death, illness, isolation, and restriction of persons' circulation, associated with epidemiological, social, and economic uncertainties, permeate daily lives in the Global North and South, especially in the latter. By analyzing such realities, we recognize the

heterogeneity in the ways of experiencing this pandemic, especially for subaltern peoples whose bodies are historically forged by the daily threat of death and by the suffering of the effects of inequalities, producing a veritable selective genocide [6].

Based on Achille Mbembe's decolonial perspective and conceptual contributions such as "*necropolitics*" [10] and the "*becoming-black of the world*" [11], endorsing the voices that denounce the racist, genocidal, and deadly nature of Western society's modern colonial project, we will address the racial geographic division evidenced by the trails of death and illness from COVID-19 in populations, especially the black population. COVID-19, with its pandemic global spread, not only exposes the inequalities, but reupdates the racially based colonial demarcations, foundational for the modern world, with the North/South demarcation as one of the main geographic and sociological anchors.

The decolonial perspective counters the naturalized notion of contemporary coloniality, as an expression of "*a global logic of dehumanization*" [12] (p. 36) which did not disappear with the end of colonialism. Mignolo [13] formulates the thesis that modernity entails a hidden side consisting of coloniality, propagating a Eurocentric narrative whose idea of "salvation" and "novelty" disguises the underlying expropriation, thus presenting itself to non-European territories. In the name of a civilizational project, modernity thus justifies practices of domination, exploitation, expropriation, and death. For Maldonado-Torres [12], the paradigm of war and violence against colonized subjects orients the modernity/coloniality project. The colonization project is one of the main pillars of modernity, now cloaked differently, responding to the project of coloniality to the extent that it preserves the elements for classification of the world, updating them dynamically [14]. Modernity's capitalist power, of a colonial order, is anchored in the "*imposition of racial/ethnic classification of the world population as the cornerstone of the above-mentioned power standard*" [15] (p. 84).

Since power's coloniality reveals the shaping of a power standard based on it the notion of race, the conditions are given for defining non-white others as "Indians", "blacks", and "mestizos" as new social identities, coupled with colonial relations of domination and exploitation established between Europeans and non-Europeans. The differentiation determines strata, places, and roles in the power structure, sustained by work systems of servitude and slavery. The race/forced labor dyad contributed to the emergence of a new structure of global production relations in the colonial period, founded on dehumanization of the "other" and not ceasing with the end of colonialism [12]. Coloniality propagates a Eurocentric narrative in the name of a "civilizational project" based on practices of domination, expropriation, and death. Unlike traditional colonialism, which ends with the political and administrative emancipation of the colonies or with the end of the exploitative forays, coloniality remains, founded on profound power relations, extending beyond the economic, political, and labor areas, permeating social relations and intersubjective constructions [15,16].

The Eurocentric perspective on knowledge, by conserving the idea of race as a social classification criterion, expropriates the original peoples and those from the African continent in their languages, histories, knowledge, and memory, reducing them to a uniform mass, worthless or virtually worthless as humans. Stripped of humanity, treated as things, treated as inferiors that have to be dominated and exploited, the "non-Europeans" lost their own names, history, memory, and language [11] and even carry in their bodies the open and bleeding wound of colonial trauma [17]. Racism as a process of reproduction of inequalities between peoples, forged from the body's attributes, predates the formulation of the notion of race, which then produces beings whose identity is encapsulated in being "black" or "Indian", as examples [18].

The racist logic is at the core of necropolitical practices, also operated in the context of the response to COVID-19, especially in peripheral territories where the poor black population mostly lives. The concept of necropolitics has been used to understand the relationship between the State and genocide of racialized populations. This perspective intersects with the Foucauldian concept of biopower, highlighting racism as a central element in the exercise of State power, legitimizing the right to let people die and/or to kill them in the name of sustaining certain forms of reproduction of other more legitimate lives [10]. "*The most original characteristic of this formation of terror is the concatenation between biopower, the state of exception, and the state of siege. Race is once again crucial to this chain*" [10] (p. 31): that is, other configurations of social existence in which populations suffer conditions that turn them into "*living dead*", in Mbembe's words [10] (p. 71).

The current scenario of countries with a colonial history, like Brazil and the United States, shifts quickly to the increase in the mostly black individuals killed by the epidemic. This "*superfluous humanity*" [10,19], with a predefined place and function in capitalism's functioning, has found its fate in mass graves dug daily, the result of this necropolitical order in which the power of death reigns over the right to life. "*The justification of death in the name of risks to the economy and security becomes the ethical basis for this reality*" [10] (p. 124). We thus ask: if we continue like this, will the "becoming-black of the world" [11] be the outcome on the horizon at the end of this pandemic? By mapping the dynamics of modern Western civilization, where the racial argument was at the root of massacres and crimes, Mbembe identifies in the 21st century, under the aegis of financial capital, the massive emergence of a surplus humankind, useless for the capitalist system – the emergence of men-things, men-machines, subject to capitalism's demands [11].

## Viewing the pandemic through the lens of inequalities

How can one justify the State's differentiated action in populations that are territorially and materially marginalized from the enjoyment of full civil rights, with health as an important pillar? In 1850, Rio de Janeiro was hit by a yellow fever outbreak, the disease that came to be known as the black vomit, a crucial episode for understanding the racial issue as political. Yellow fever mainly affected European immigrants who had been imported to replace slave labor, which in turn could not ascend to the status of salaried workers belonging to the formal structures in legal system and thus continued to be outcast. The assimilation of blacks by the labor market would have prevented shaping a "morally acceptable" working class [20].

Meanwhile, both the freed and enslaved blacks were relatively free of yellow fever when compared to other diseases such as smallpox and tuberculosis, which had been present in Brazil longer. Even so, yellow fever took an outstanding place on the public health agenda. According to Chalhoub [20], in the late 19th century, blacks were supposedly more resistant to diseases and more fit for heavy labor.

Today's racial inequalities are anchored in policies that have limited the black population's opportunities since abolition of slavery (1888). According to Hasenbalg [21], foreign immigration is the principal measure that explains the marginalization of blacks in Southeast Brazil and the distribution of non-whites in the regions of the country with limited educational and occupational activities. Hasenbalg also highlights that as Brazil moves away from the slavery period, the structural relations and racist principles of social selection and stratification gain more relevance for explaining the differentiated opportunities between whites and blacks, as well as for understanding the intragenerational and intergenerational transmission of racial inequalities [21].

Contextual specificities notwithstanding, racism in Brazil is not exclusive to the epoch and is refueled over the course of history. This allusion helps understand the present dynamics. Another significant example is tuberculosis. In the mid-1990s, the World Health Organization (WHO) reincluded tuberculosis on its agenda of priorities, due to the major increase in mortality as a result of co-infection with HIV, so that tuberculosis was considered a "reemerging" disease. The term is used to designate diseases that had been controlled or suppressed globally, but which have made a significant comeback. However, tuberculosis had never disappeared as a serious public health problem in several "peripheral" countries and in certain regions or even neighborhoods of "central" countries, such as those with concentrations of African-descendant populations in large U.S. cities, a phenomenon Farmer [22] calls "*tuberculosis's revenge*". The fact that tuberculosis is no longer seen as a health problem for the central populations of the world system [23] marginalizes the disease in terms of attention and resources, thus leading to a "*silencing of the tuberculosis situation as a social, economic, and health issue for the world's poor populations, with high incidence and death rates*" [24] (p. 2295).

The COVID-19 pandemic in Brazil shows that regions and populations are subjected to conditions of increased vulnerability to the risks of infection and death. We make these assumptions to analyze Brazil's national COVID-19 pandemic. Brazil ranks 79th in the United Nations human development index [25]. Recent years have witnessed an increase in inequality indicators, especially affecting the black population. In 2018, in Rio de Janeiro, 30.5% of African-descendants (black and brown) lived in *favelas*, compared to 14.3% of whites [26]. In terms of coverage of basic sanitation, blacks are more

likely to live in areas with inadequate infrastructure and exposure to disease vectors: 12.5% of blacks live in places without garbage collections, compared to 6% of whites; 17.9% of blacks lack access to running water supply, compared to 11.5% of whites; and 42.8% of the black population lacks adequate sewage disposal, compared to 26.5% of whites [26].

The inequality is evident, considering that 32.9% of black Brazilians live on USD 5.50 a day or less, and 8.8% live below the extreme poverty line, with USD 1.90 a day or less [26]. Overcrowding hinders compliance with the household distancing measures recommended in COVID-19. *Decree n. 10,329* of April 2020 exempts public services and essential activities, revoking, among others, the collection, treatment, and distribution of water and the collection and treatment of sewage and garbage [27], further aggravating the vulnerability of already precarious neighborhoods.

Brazil also displays unfavorable structural stratifications for the social inclusion of the black population in the labor market. Although blacks and browns represented 55.8% of the Brazilian population in 2018 [26], they are 64% of the unemployed and 66.1% of the underemployed [28], showing one of the contours of vulnerability in the guarantee of this population group's subsistence. Brazil is also experiencing a political and economic crisis with setbacks and repeal of labor rights. During the pandemic, the risk of infection for nurse attendants is 97.3%, due to direct handling of patients' bodies [29]. The use of personal protective equipment is crucial for the worker's protection, but the supply of personal protect equipment has been inadequate. There is also a shortage of healthcare workers, a problem aggravated by the high number of workers themselves on sick leave with COVID-19 [30]. Given the problem's severity, a Crisis Cabinet was created for daily monitoring of the COVID-19 pandemic's impact on nursing personnel [31].

Nursing is a mostly female and black professional class [32], working on frontline care of COVID-19 patients. As women, they also work a double workload. According to the Brazilian Institute of Geographic and Statistics (IBGE) [26], in 2019, 45% of the black population lived in households without washing machines, *"evidence that the black and brown population, especially women, bear a heavier load of household work"* (p. 6) [26]. The association between frontline care of COVID-19 patients, precarious housing, and overload of household work increases both the probability of infection at home and the illness itself.

Another aggravating factor involves individuals with chronic noncommunicable diseases and those over 60 years of age, considered a risk group, and who are not necessarily granted work leave [33]. In this sense, the pandemic's social impact on nursing as a professional class should be a priority on the healthcare management agenda.

## Concentration of COVID-19 in the *favelas* and racial demarcation

The first case of COVID-19 in Brazil was confirmed on February 26, 2020 [34], in São Paulo, and the epidemic was declared a public health emergency on February 3, 2020 [35].

The epidemic was initially concentrated in Southeast Brazil, in the cities of São Paulo and Rio de Janeiro. Due to insufficient control measures and the resulting increase in infections, the disease quickly spread to the rest of the country, with highly negative repercussions in terms of cases and deaths in the North and Northeast, which already experiences chronic infrastructure problems due to regional inequalities. Although the South and Central of Brazil were also hit, in April and May 2020, they were still not in such a critical situation as the other regions [36]. Since COVID-19 does not affect groups and places symmetrically and democratically, the pandemic shows its cruelest face in the outlying areas and *favelas*, which have the worst human development indices.

In the second half of May 2020, the states that ranked first in cases – São Paulo, Rio de Janeiro, Ceará, Amazonas, and Pará – also had regions and neighborhoods with case-fatality rates above the national average of 5.7% [36]. In São Paulo, the Brasilândia neighborhood, where more than 50% of the population is black [37] and with the second highest number of *favelas* [38], had reported 4,943 confirmed COVID-19 cases by late May 2020 and the majority of the deaths: 209 deaths among confirmed and suspected cases [39]. At the opposite extreme of the city, the higher-income central neighborhoods had the lowest infection and death rates. The blackest territories of the city also suffer from the unequal distribution of ICU (intensive care unit) beds, 60% of which are located in the wealthier city center [40].

Fortaleza, capital of the State of Ceará, had reported 21,389 cases and 2,120 deaths by late May 2020 [41]. The transmission dynamic, which began in the wealthy and tourist neighborhoods like Aldeota, Meireles, and Dionísio Torres, shifted during the same period to the more impoverished neighborhoods like Grande Pirambu and Barra do Ceará, contiguous to the coastline, evidencing the close relationship between mortality and precarious living conditions. Areas with extreme vulnerability and that rely on the public Brazilian Unified National Health System (SUS) are the most heavily affected by pandemic.

The need for access to the SUS in this context exposes the weakness of a system that is currently suffering dismantlement. In the months of April and May 2020, São Paulo, Rio de Janeiro, Ceará, Pernambuco, and Amazonas experienced a serious shortage of hospital beds [42]. In Manaus, in late May 2020, there were no more public hospital beds available, and the health system's collapse in the state of Amazonas was accompanied by 2,047 deaths, with the atrocious scene of patients alongside corpses in the hospitals [36]. Equally alarming was the indigenous population's plight: in the last week of May, Manaus had 92 officially confirmed cases and there was an increase in this number in the Upper Solimões River, where 351 cases were reported in the same period [43].

In the state capital of Rio de Janeiro, the first cases appeared in middle and upper-class neighborhoods, spreading quickly to the favelas. As of May 31, 2020, there were 260 deaths in the large *favelas*, especially Rocinha and Maré, with 55 and 48, respectively [44]. São Conrado, the wealthier neighborhood adjacent to the Rocinha *favela*, had only three deaths as of May 7, 2020 [45]. In the Baixada Fluminense, one of the poorest and most violent territories in the state, there was widespread news coverage in the latter half of April 2020 that containers were being used for temporary storage of corpses, as in Duque de Caxias, due to the increase in the number of deaths and problems with contagion in the cemeteries [46]. In this municipality, by late May 2020, there were 1,502 cases, surpassed by Nova Iguaçu with 1,770 [47].

Given the shortage of precise epidemiological data disaggregated for the *favelas* and the erratic state government agenda and insufficient response to COVID-19 in these neighborhoods, local collectives have launched their own initiatives, demonstrating the organizational power of local action in emergency situations. Given the lack of government action, these initiatives have included collecting and supplying food, personal hygiene items and cleaning materials; access to water; income generation; collective neighborhood cleanup work; and communication. The initiatives feature the Crisis Cabinet of the Alemão *Favela* Complex, with three movements: Voice of the Communities, Alemão Women in Action, and the Straight Talk Collective; the "COVID-19 in the *Favelas* Panel", which monitors and issues daily bulletins on the epidemic's statistics in some of the largest *favela* complexes in Rio de Janeiro; the Emergency Fund of the National Homeless Workers' Movement for homeless people affected by the coronavirus; the Corona on the Peripheries initiative, a partnership between *Favela em Pauta*, an initiative by grassroots journalists, and the Marielle Franco Institute, which register and support initiatives to fight the coronavirus in *favelas* and peripheral communities throughout Brazil [44]. The idea of "us-for-us" is basic to these initiatives, since their point of departure is action and resistance managed and created autonomously by the black and *favela*-dwelling population, anchored ancestrally in the African diaspora [48].

A sense of African diasporic world, produced with the collective consciousness amalgamated from a common history, was forged with the Middle Passage across the Atlantic of subjects whose bodies and lives were marked by exclusion and dehumanization. The key to re-humanization involves confronting the processes of expropriation of their humanity, reclaiming the sense of identity through the collective, and producing strategies of group resistance and care [48].

## The unequal distribution of deaths in international and national terms: what do the pandemic's numbers say about black lives?

Racial inequality, as an important social marker of differences, is made invisible in various aspects, with health as an important example. Health indicators according to race/color are not recorded satisfactorily, and the analyses are thus questionable. This is a longstanding demand by Brazil's black movements [49]. During Brazil's re-democratization, even with the emergence of studies unveiling

racial inequities in the country [50] and more recently with a set of affirmative action policies, the country has still not succeeded in fully guaranteeing the recording of the race/color item in various social and health indicators. The current context has been marked by serious underreporting of COVID-19 incidence and mortality rates. In order to reverse the persistence of discriminatory practices in dealing with COVID-19, a demand was raised to enforce Ministry of Health *Ruling n. 344 GM/MS*, of 2017, which provides for the mandatory completion of the race/color item during patient care in health services [51]. Although this item is part of the list of specific objectives in the Brazilian National Policy for Comprehensive Health of the Black Population (PNSIPN) of 2009 [52], the policy's enforcement remains insufficient.

As the result of a historical struggle by the black social movements for the democratization of health and promotion of racial equity, this policy stood out for its crosscutting actions and strategies, as well as the recognition of racism and ethnic and racial inequalities as part of the social determination of health. This policy was incorporated into a set of other government strategies to reduce morbidity and mortality indicators in this historically vulnerable population. The policy's wording includes comprehensive measures for patient care, promotion, and prevention of diseases, as well as participation in social control forums and training and education for healthcare workers. However, although the PNSIPN is proposed as a powerful instrument for limiting discriminatory acts and practices that produce and sustain health inequities, its enforcement has been persistently unsatisfactory. According to Werneck [53], explicit noncompliance and ignorance of the policy's provisions are factors leading to non-enforcement.

Health records are strategic and essential for understanding the morbidity and mortality conditions in populations and for decision-making by government policymakers. In the United States, a country with a colonial slaveholding history like Brazil, this information is more consistent in the official data, allowing to demonstrate the impact of racialized political and social dynamics on black lives. It is beyond the scope of this essay to discuss the topic, but different historical contexts marked by the binomial apartheid versus myth of racial democracy also involve different traces of political processes of sociability and subjectivation.

Blacks represent 29% of Chicago's overall population, but as of the first week of April 2020, they accounted for 70% of the COVID-19 deaths. During the same period, in the state of Michigan, blacks represent 14% of the population but 30% of the confirmed cases and 40% of the deaths [54]. The black population faces serious barriers to accessing health services and precarious housing and work conditions. As for testing, data from the second half of April 2020 are significant: low percentage of blacks tested (13.2%), but a high proportion of the deaths (38.1%) [55]. Black people are marginalized from health measures but are massively present in the number of deaths, demonstrating health policy's selectiveness.

Analyses such as those by Dorn et al. [56] also emphasize that the pandemic in the United States serves to confirm existing disparities. New York and other large cities have a strong African American and Hispanic presence, and the number of COVID-19 deaths in April 2020 was disproportionately high compared to the general population [56]. Elsewhere, as in Milwaukee, Wisconsin, three-fourths of the fatal COVID-19 victims were African Americans, also in April 2020. Preexisting racial inequalities produce the contours of health inequalities for blacks, Latinos, and other minorities, who bear a disproportionate weight of State inefficiency in an ultra-market-oriented government that fails to avoid COVID-19's spread [56].

The U.S. black population, compared to the white population, has worse health indicators: lower life expectancy at birth, higher proportion of persons living below the poverty line, higher infant mortality rates, and higher diabetes-related mortality rate, among others [57]. Structural racism has repercussions on the African American population's work market access and housing conditions. There is an evident racial segregation in U.S. territory, with neighborhoods in which the majority of the resident population is black. These neighborhoods suffer precarious living conditions, such as exposure to pollutants and toxins, besides limited opportunities for accessing quality schools and health services [57].

In terms of their colonially-based social fabric, the United States and Brazil are similar, yet they differ in various aspects, such as the black population's quantitative representativeness: 13% in the United States [58] and 57.8% in Brazil [26]. In addition, unlike the United States, Brazil has a universal

health system, premised on covering the entire population's health needs. However, Brazil also displays major disparities in social indicators, given the social and racial inequalities.

At the beginning of the COVID-19 epidemic in Brazil, the Ministry of Health organized a monitoring and evaluation system, systematically publishing *Epidemiological Bulletins* on the evolution of the disease, but which failed to include data disaggregated by race/color. After pressure from the black movements, spearheaded by the Luiz Gama Institute and the Office of the Federal Public Defender, the Federal Court in Rio de Janeiro ordered the mandatory recording and publication of COVID-19 data disaggregated by race/color [59]. The Ministry of Health began to publish these records in the *Epidemiological Bulletins* on April 11 [60]. However, there is a high percentage of missing information on race/color, which maintains the underreporting pattern and thus hinders analyses on racial disparities.

The Brazilian government has issued erratic and mismatched responses to the international guidelines led by the WHO and the evidence already systematized by countries that have been dealing with the pandemic longer. This lack of alignment plays out in various dimensions – absence of a Federal pact on the measures for containing transmission, such as social distancing (even lack of adherence to distancing by the Federal Government); absence of an effective social protection system for the more vulnerable populations; backing for controversial treatment measures with no consensus in Brazilian and international scientific societies; lack of prioritization of the testing strategy for individuals with respiratory symptoms and the more heavily exposed; low implementation of the expansion of supply of intensive care equipment and supplies; and insufficient supply of critical resources for treatment of the disease.

In addition, in just two and a half months since the pandemic's arrival in Brazil, the Health Minister was changed twice. Thus, the implementation of systematic publication of COVID-19 rates in Brazil, launched by the first Health Ministry's administration dealing with the pandemic, was discontinued, with a reduction in the periodicity of the *Epidemiological Bulletins*. These elements indicate questionable conduction of policies to deal with the health emergency, hindering the planning, monitoring, and control of COVID-19's spread.

The following analyses use data from the *Epidemiological Bulletins* (https://coronavirus.saude.gov.br/boletins-epidemiologicos, accessed on 30/May/2020) identified by Epidemiological Week (EW). When more than one bulletin is published in the same EW, the most recent bulletin from that week was considered.

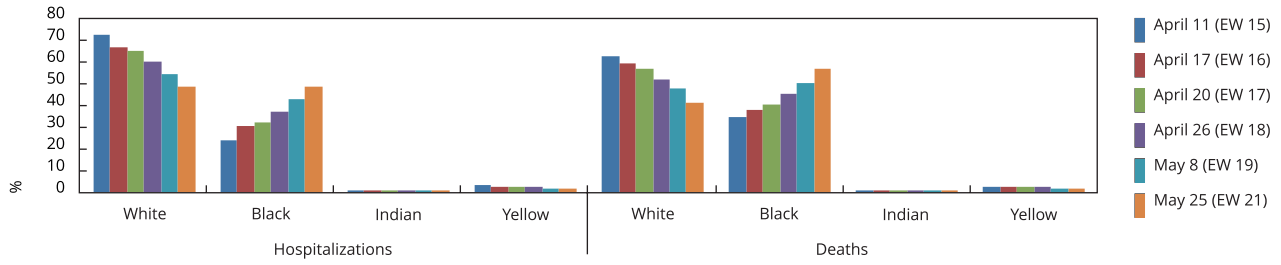
The information is disaggregated by race/color, and for the purposes of this study, we combined the categories "preto" (black) and "pardo" (brown) as the single category "negro" (black), as defined by the IBGE [26,61] and confirmed by the Institute of Applied Economic Research (IPEA) [62]. The proportions of COVID-19 hospitalizations and deaths were initially higher in whites than in blacks. However, over the course of the EWs, there was a reduction in the proportion of deaths and hospitalizations in whites (Figure 1), while they increased in the black population. In blacks, there is a low proportion of hospitalizations when compared to the proportion of deaths (Figure 1), signaling inequalities in access to health services and greater population vulnerability. Again, we call attention to the high rates of missing data on race/color in both hospitalizations and deaths, so the true difference may be even greater.

This highlights the magnitude of the drop in hospitalizations and deaths in whites and the increase in blacks in just a few weeks (Figure 2), underscoring the trend in racial inequalities and the maintenance of the racialized political and social conditions affecting black lives. In the EW 15, breakdown of hospitalizations was 73% whites versus 23.9% blacks. Subsequently, there was a downward trend in hospitalizations in whites and an upward trend in blacks, reaching 49% each in the EW 21, but with a slightly greater difference in blacks.

Meanwhile, the number of deaths in blacks exceeds that in whites, even though hospitalization does not follow this trend (Figure 3). This emphasizes the black population's difficulty in accessing health services, especially higher-complexity services such as intensive care beds, a critical resource in the current pandemic. The proportions of deaths between the first bulletin with stratification by race/color and the most recent bulletin shifted from 62.9% to 41% in whites, and from 34.3% to 57% in blacks. This trend can be expected to persist over the coming weeks, given COVID-19's heavy impact on peripheral neighborhoods, the *favelas*, where the black population is the majority [26]. According to

**Figure 1**

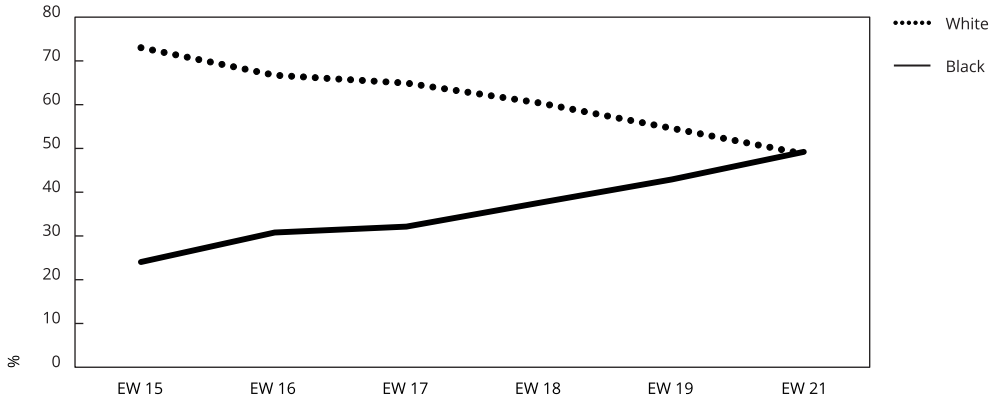
Severe acute respiratory illness hospitalizations and deaths according to race/color in Epidemiological Week (EW).




Source: Brazilian Ministry of Health. Epidemiological Bulletins (https://coronavirus.saude.gov.br/boletins-epidemiologicos, accessed on 30/May/2020).

**Figure 2**

Proportion of COVID-19 hospitalizations according to race/color, date of publication, and Epidemiological Week (EW).




Source: Brazilian Ministry of Health. Epidemiological Bulletins (https://coronavirus.saude.gov.br/boletins-epidemiologicos, accessed on 30/May/2020).

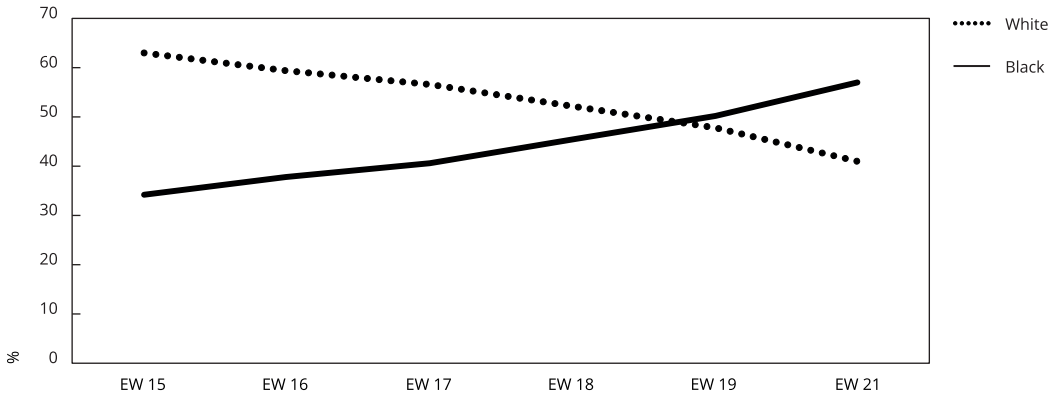
the COVID-19 in the *Favelas* Panel, until late May 2020, there were 266 deaths in a set of *favelas* in Rio de Janeiro, including Rocinha, Manguinhos, Maré, Jacaré, Alemão, Jacarezinho, and Cidade de Deus, among others [44].

Other studies have reached similar conclusions, corroborating the higher case-fatality in blacks and exposing a major difference in the odds of dying according to race/color: an illiterate black COVID-19 patient has 3.8 higher odds of dying compared to a white patient with a university degree [63].

This unequal behavior of the disease between the white and black populations, with an unfavorable trend in the latter, corroborates the analyses on racial inequalities in Brazil, resulting from the country's colonial background, which takes for granted the place destined to each person depending on their race, which is also a political construction. On the unsatisfactory quality of data disaggregated by race/color, the lack of recording of this information merits attention. Discussions on race

**Figure 3**

Proportion of COVID-19 deaths according to race/color, date of publication, and Epidemiological Week (EW).




Source: Brazilian Ministry of Health. Epidemiological Bulletins (https://coronavirus.saude.gov.br/boletins-epidemiologicos, accessed on 30/May/2020).

have concerned black women and men, since they have been racialized in the terms debated here. However, such discussions are not among the concerns of most non-blacks, who take both their own privilege and the subordination of black Brazilians for granted. The race issue matters for those who are racialized – black, indigenous, yellow, etc. – in a world where white is conceived as the universal standard. This represents an inversion, since racism is not situated and discussed at its origin, where it is actually produced, but at its consequence, that is, in racialized lives [64].

The failure to record this variable also reveals institutional racism, since it prevents Brazilians from seeing the true magnitude of the black population's exclusion. This observation relates to one of the dimensions of necropolitics: there are bodies whose morbidity and mortality profiles are not even recorded, since they are classified as disposable and superfluous [10]. Publicizing such data may lead to questioning the legitimacy of the racial democracy myth [6], a powerful argument at the service of erasing racism as a social trait, responsible for a certain social equilibrium that keeps black men and women in subalternity. Openly discussing the racialized political and social structures could open the way for a new understanding of this previously marked place, thus raising the question: who benefits from failure to expose the various faces of the black population's genocide?

It is important to question and resist, and debate on COVID-19's impact on the black population is already visible in some spaces: the media, scientific debates, and certain government agendas. The problem's visibility, pressured by black voices, mainly from the periphery, continues to be part of the antiracist struggle's banner, raised especially by the black people.

## Contributors

R. G. Oliveira formulated and designed the essay, wrote the manuscript, organized the editing, and critically revised the content. A. G. S. Gadelha made substantial contributions to writing and critically revising the manuscript. A. P. Cunha made substantial contributions to the data tabulation and analysis and writing the manuscript. C. G. Carpio, R. B. Oliveira and R. M. Corrêa made substantial contributions to writing the manuscript. All authors approved the final version of the article for publication

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## Resumo

*A incidência e mortalidade por COVID-19 em países com fortes desigualdades sociais se diferenciam em termos populacionais. Em países com histórico e tradição colonial como o Brasil, os marcadores sociais das diferenças têm profunda ancoragem na demarcação sociorracial, sobre a qual agem as dinâmicas e os processos político-sociais fundados no racismo estrutural. Contrapõe-se a narrativas que propõem uma leitura sobre ser esta uma pandemia democrática, cujo argumento se alinha à retórica da democracia racial que corresponde a uma potente estratégia de manutenção de lugar de populações racializadas, como indígenas e negros, uma produção da colonialidade moderna. Este ensaio debruça sobre o comportamento da pandemia em relação à população negra no Brasil, em diálogo com aportes decoloniais e de leituras críticas sobre o racismo. Discute-se respostas governamentais e indicadores da doença, segundo o quesito raça/cor, demonstrando a manutenção de tramas e enredos históricos que seguem vulnerabilizando e inviabilizando vidas negras. Aponta-se também para a importância de movimentos de resistência locais, operados a partir do lugar que esses sujeitos ocupam, os espaços urbanos precarizados por ação/omissão do Estado – as favelas.*


*COVID-19; Racismo; Vulnerabilidade Social*


## Resumen

*La incidencia y mortalidad por COVID-19 en países con fuertes desigualdades sociales se diferencian en términos poblacional. En países con historial y tradición colonial, como Brasil, los marcadores sociales de las diferencias están profundamente anclados en la demarcación sociorracial, sobre la que actúan las dinámicas y los procesos político-sociales fundamentados en el racismo estructural. Se contraponen las narraciones que proponen una lectura sobre esta pandemia democrática, cuyo argumento se alinea con la retórica de la democracia racial, que corresponde a una potente estrategia de mantenimiento del lugar de poblaciones racializadas, como indígenas y negros, producto del colonialismo moderno. Este ensayo se centra sobre el comportamiento de la pandemia respecto a la población negra en Brasil, en diálogo con aportes decoloniales y lecturas críticas sobre el racismo. Se discuten respuestas gubernamentales e indicadores de la enfermedad, según la categoría raza/color, demostrando el mantenimiento de entramados y enredos históricos que siguen vulnerabilizando e inviabilizando vidas negras. Se apunta también la importancia de movimientos de resistencia locales, operados a partir del lugar que estos individuos ocupan, espacios urbanos precarizados por acción/omisión del Estado: las* favelas*.*


*COVID-19; Racismo; Vulnerabilidad Social*

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