Short Communication

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Victims of Inequalities: Health Situation of Black and Poor Women Confronting COVID-19

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Abstract

A woman dies every seven hours in Brazil victim of feminicide. Maternal mortality of black women due to COVID-19, the new coronavirus, is almost twice as high as that of white women. Studies were identified using large-circulation international journals found in two electronic databases: Scopus and Embase. This idea of the black and poor woman as disposable or unnecessary has an enormous race influency. In this context, the burden that the pandemic can cause to the country's health system may further expose the structural racism that goes through health care. Maternal mortality of black women due to COVID-19, the new coronavirus, is almost twice as high as that of white women. Thus, the concentration of efforts to approach COVID-19 in medical-centred care measures decontextualized, not only in relation to people's way of living and getting sick, but also, with other knowledge, also corroborate the high incidence and lethality rates of COVID-19.

Keywords: Reproductive health; Black women; COVID-19; Victims of inequalities

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The Covid-19 is pedagogical pandemic. However, the pedagogy is appalling: according to the World Health Organization, every month hundreds of thousands of women seek for health services to take care of incomplete abortions. In Argentina, it is estimated that there are 3.330 women in this situation; 1.522 in Chile; 7.778 in Colombia and 18.285 in Mexico. For each woman who is admitted at a hospital for an incomplete abortion, the same individual may use the services twice: first, for abortion care and second, for the risk of COVID-19 infection [1]. There is a global presumption that exist a house in which people- who have bodies, who have genders, class and race- can be in social distancing [2].

Agreeing with Deborah Diniz [3], we all need to be looked after. This role, in the overwhelming majority of cases, is played by women, and this task distribution is uneven. Diniz hopes a post-pandemic COVID-19 world in which feminist values could be part of our common vocabulary. When speaking about women, we regard those who walk for hours to get attention in reproductive health clinics to access contraceptive methods, because they do not want to become pregnant in the middle of a crisis; we are speaking about women helping other women to seek protection, away from their aggressor partners, at the same time that violence grows in times of social isolation. More than half of the Brazilian population is made up of women. Black, indigenous, white, in rural areas or in cities. Even with the government disregard, reality jumps into the eyes and shows faces and skin tones [4]. For Débora Diniz [5] poor women, who are mostly black, have no way to escape the contagion. Besides that, they will face unemployment, if not death, and an immersion in the risk of a very large contamination.

The restrictions imposed by the pandemic have increased the barriers to access clandestine abortion by poor women. The spaces of death- clandestine abortion ones- made some bodies bleed, while other individuals protect themselves from the pandemic far from the threat of the virus or criminal law [6]. Numbers are outrageous and they also distance people from the

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reality, since in statistics the stories of these women are covert. Every maternal death is preventable, if access to the health service were appropriate. But maternal deaths never present itself alone in a public health emergency [7]. The Brazilian rate is four dead women for every 100 thousand women, 74% higher than the world average. In addition, a woman dies every seven hours in Brazil victim of feminicide [8]. They are women who, if they challenge the rules of domestic reclusion and submit to the servitude of work, they may fall ill as caregivers of those who ignore their rights, their life or their name [9].

However, it is observed that violence against women also has intersectional relationships. Without a doubt, race and class are present factors in gender violence, since women who most need help are women with less financial resources and racialized women [10]. Contraceptives are still out of stock in Indonesia, Mozambique and many other countries. In Italy, abortion was cancelled. In addition to the increase in the frequency of sexual abuse, such factors also limit the sexual and reproductive autonomy of women and girls, which tends to harm their mental health and well-being [11].

By focusing on this particular group, we put under the microscope the most vulnerable layer, which is at the base of the social pyramid, in which poverty, violence, abandonment, underemployment and other day-to-day effects of structural racism are accentuated in the context of the pandemic, resulting in late arrival to health services and outcomes even more tragic for black women [12]. An outrageous example happened in India, where a 19-year-old woman, who had tested positive for COVID-19, was raped by the ambulance driver who took her to the hospital [13]. Thus, during pre-hospital and hospital care for COVID-19, women may end up experiencing episodes of extreme disrespect against their body's autonomy, due to the fragility and vulnerability imposed by the infection, as patients remain unconscious and, therefore, vulnerable to the most diverse violence. This just when they get specialized attention and access to ICUs.

It should be noted that this idea of the black and poor woman as disposable or unnecessary, has an enormous race influence. The aforementioned is because, the vision of the black and poor as "other people", allows to neglect these people from access to health policies, including them to actions that violate human rights. Black women constitute themselves as a portion of the population that dies the most, both for the violent actions, and for a virus called "democratic" in the application of technologies of death. It is clear that defective access to public policies is associated with racism [14]. In this context, the burden that the pandemic can cause to the country's health system may further expose the structural racism that goes through health care. In this scenario of racism, social inequality and underfunding of the Brazilian Public Healthcare System (Sistema Único de Saúde [SUS]), the COVID-19 pandemic finds a conductive environment to produce chaos to black bodies, considering that 80% of its users self-declare themselves as black. In this order of ideas, structural racism in health is revealed by an unequal division of access, by unequal treatment within the system and mainly by the invisibility of racial inequalities when planning health policies and actions15.

Maternal mortality of black women due to COVID-19, the new coronavirus, is almost twice as high as that of white women. This was one of the results of the study "disproportionate impact of COVID-19 among pregnant and postpartum women in Brazil through the structural lens of racism", originally published in the scientific Journal Clinical Infections Diseases, of the United States. The researchers analyzed data from 1,860 pregnant and postpartum women with complete information in the field race of the survey and compared the information of those classified as white or black, generating a total of 669. Black women had average ages similar to white women, but were hospitalized in worse conditions (higher prevalence of dyspnea, shortness of breath and low O_2 saturation), in addition to higher rates of admission to the Intensive Care Unit (ICU), mechanical ventilation and death [13-15].

Thus, the efforts to approach COVID-19 in medical-centred care measures are decontextualized, not only in relation to people's way of living and getting sick, but also, with other knowledge, also collaborate to the high incidence and lethality rates of COVID-19, positioning Brazil in a short time as the epicentre of the pandemic worldwide [11-13].

In this context, it is necessary to consider whether the principle of the autonomy of the black and the poor in ICUs is respected? But before that, is it necessary to reflect on whether this marginalized population is having access to the tertiary level of healthcare in the same way that whites do? To what extent should the autonomy of the patient be respected, whether black or white, when their lives depend on the decision, respect, human approach and clinical evidence of the practitioner?

The different impacts caused by the pandemic in Brazilian municipalities, especially those located in the Northern Region of Brazil, is a reflection of social vulnerabilities for population's health. There are towns in which people need to travel, on average, 240 kilometers to get to a hospital and have access to an ICU bed [8-11]. In the current scenario of countries with colonial history, such as Brazil and the United States, it is found that this fact is rapidly shifting to compose the increasing statistics of mostly black bodies killed by the pandemic [10,11]. The justification of death in the name of risks to the economy and security becomes the ethical foundation of this reality [15].

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