


# Coronavirus in Brazil: the march of folly


## Coronavírus no Brasil: a marcha da insensatez

### Adilson Soares<sup>a</sup>

 <https://orcid.org/0000-0001-5414-9634>

E-mail: [asoares@saude.sp.gov.br](mailto:asoares@saude.sp.gov.br)

### Ricardo Fernandes de Menezes<sup>b</sup>

 <https://orcid.org/0000-0003-2433-3566>

E-mail: [rfdmenezes@uol.com.br](mailto:rfdmenezes@uol.com.br)

<sup>a</sup>Health Secretariat of the State of São Paulo, São Paulo, SP, Brazil.

<sup>b</sup>Health Secretariat of the State of São Paulo, São Paulo, SP, Brazil.

## Abstract

The circulation of the new coronavirus is a health event in the dimensions of the Dantesque phenomenon that constituted the Spanish Flu, but aggravated by the fact that we live in an interconnected world. The choice of this object of study was imposed due to the worldwide concern with the covid-19, and the perception that there are persistent questions and insufficient analyses that explain the intrinsic relationship between the health-disease process and the political, economic and social dimensions associated with it. We defend that the foolish and uncoordinated confrontation of the epidemic in Brazil would have affected the number of cases and deaths. This is an exploratory study, supported by the theoretical framework of critical hermeneutics, developed based on the analysis of documents and data, which aims at analyzing the epidemiological profile of Covid-19 and to discuss economic, social policies and sanitary measures adopted in Brazil in the face of the pandemic situation. We concluded that the political, economic, social and sanitary folly in the application of public policies combined with the lack of coordination of the federal government of Brazil in confronting the covid-19 pandemic reflected in the exponential increase in the number of cases and deaths, especially among the poorest and most vulnerable populations.

**Keywords:** Covid-19; Coronavirus; Pandemics; Public Health; Public Policy.

## Correspondence

Adilson Soares

Rua Voluntários da Pátria, 2041, ap. 403. São Paulo, SP, Brazil.

CEP 02011-500.

## Resumo

A circulação do novo coronavírus é um acontecimento sanitário nas dimensões do fenômeno dantesco que se constituiu a Gripe Espanhola, porém, agravado pela globalização. A escolha deste objeto de estudo se impôs em função da preocupação mundial com a covid-19, e pela percepção de que há indagações persistentes e insuficiência de análises que explicitem a intrínseca relação entre o processo saúde-doença e as dimensões políticas, econômicas e sociais a ele associados. A tese defendida é de que o enfrentamento insensato e descoordinado da epidemia no Brasil traria reflexos no número de casos e óbitos. Trata-se de estudo exploratório, apoiado no referencial teórico da hermenêutica crítica, desenvolvido com base na análise de documentos e dados, que tem como objetivo analisar o perfil epidemiológico da covid-19 e, a partir desta análise, discutir as políticas econômicas, sociais e sanitárias adotadas no Brasil diante do quadro pandêmico. Conclui-se que a insensatez política, econômica, social e sanitária na aplicação de políticas públicas, bem como a descoordenação do governo federal do Brasil no enfrentamento da pandemia da covid-19 trouxe como reflexo o aumento exponencial do número de casos e de óbitos pela doença, principalmente em populações mais pobres e vulneráveis.

**Palavras-chave:** Covid-19; Coronavírus; Pandemia; Saúde Coletiva; Políticas Públicas.

## Introduction

The world followed the onset of the new coronavirus epidemic, and the news from Wuhan, Hubei province, China, became of concern to public health officials and governments after confirmation of the first case on December 31, 2019. On January 5, 44 cases were confirmed and, two weeks later, the disease affected 2,798 people, of which 2,761 (98.7%) were in China (Brasil, 2020a). It was a health event that referred us to its dimensions to the Dantesque phenomenon that constituted the Spanish Flu in the 1918-1919 biennium. However, globalization aggravated it, leading the United Nations (UN) to affirm: no country can solve this problem alone and - we emphasize - no part of our society can be disregarded if we are to effectively face this global challenge (Bachelet; Grandi, 2020).

In Brazil, the news of the circulation of the new coronavirus had manifested itself for some time. The rumors about cases occurred already at the beginning of January 2020, with reports of 7,063 rumors, all of them discarded. On January 22, 2020, the Public Health Emergency Operations Center was activated for the new coronavirus, and the concern about the disease turned on the alert when 10 cases were notified, one in Minas Gerais being considered suspected that, after investigation, was discarded (Brasil, 2020a).

The world started to worry about the new coronavirus contamination capacity and destructive power, and the World Health Organization (WHO) declared a Public Health Emergency of International Concern (PHEIC) on January 30, 2020. On March 11 of the same year, WHO decreed pandemic status for the new coronavirus (Sars-Cov-2). In Brazil, the Ministry of Health (MS) declared a state of emergency in public health on February 3, 2020. On March 20, the country recognized a state of public calamity due to the situation caused by Sars-Cov-2. On April 9, the Ministry of Health forced the registration of hospitalizations for covid-19 in all health establishments in the country.

The proximity of the carnival in February, due to the lack of evidence of the circulation of the virus in the country, led the authorities to

maintain the event and to recommend primary hygiene care to the population, and how to avoid close contact with people returning from the most vulnerable areas affected (Cimini *et al.*, 2020). During this period, the first covid-19 disease case was confirmed in Brazil, in São Paulo: in a 61-year-old man with a history of travel to Italy, notified to the health authority on February 26, 2020. On March 12, the first Brazilian fatal victim of the covid-19 was confirmed on the east side of the capital of the state of São Paulo.

Thus, choosing the epidemiological profile of covid-19 as an object of study is necessary due to the following: the worldwide concern with this public health emergency, the perception that there are many questions about the subject, and insufficient analyses that explain the intrinsic relationship between the health-disease process and the associated political, economic, and social dimensions. The advocated thesis is that the foolish and uncoordinated confrontation of the Sars-Cov-2 epidemic in Brazil would impact the number of cases and deaths.

This is an exploratory study (Gil, 2008), developed based on documents and analysis of data obtained from primary and secondary sources, websites, technical and public domain documents (Spink, 2000). The study is based on the theoretical framework and the assumptions of critical hermeneutics. They allow us to search for an understanding of the texts' argumentative nuclei where "there is no hidden intention to look behind the text, but a world to be manifested before it" (Ricoeur, 1990, p. 138), and that "in written form, everything transmitted is simultaneously there for any present" (Gadamer, 1997, p. 568).

In carrying out the study, the epidemic situation in the first half of 2020 is analyzed in the world, Brazil, the state of São Paulo, and the municipality of São Paulo. For this study, the most developed and least developed districts of the municipality of São Paulo were paired, selected by the Human Development Index (HDI), and electing the 15 most developed and the 15 least developed among the 96 districts of the municipality to verify the number of deaths, cases, and the lethality profile.

Therefore, the research aims to analyze the epidemiological profile of covid-19 in the

countries where this disease manifested itself more appropriately and, from this analysis, discuss the economic, social, and health policies adopted in Brazil in the face of the pandemic situation. In the country, we are interested in understanding the disease profile, the responses adopted by the central government to the epidemic, and their consequences.

The study begins by exposing the epidemiological profile of covid-19 and examining the responses that affected countries have given to the disease. We did this to locate Brazil in this context. Then, the (un)wisdom of adopting policies to face the pandemic is discussed. In this chapter, we highlight the political, economic, social, and health aspects to reveal the coordination, or not, of the process by the federal government and its consequences. Finally, the disease is analyzed in the municipality of São Paulo, exposing the inequities in the municipality's territory, resulting from historical, social construction, revealing the consequences of central incoordination to mitigate the effects of the disease.

## The epidemiological profile of covid-19 and the global response

The prompt response that is given by the authorities set up to face emergencies in public health, such as the epidemic whose etiologic agent is Sars-Cov-2, is a condition for its outcome. A limitation to the prompt response is the limited knowledge about the virus and the disease, its speed of transmission, and lethality (Barreto *et al.*, 2020).

In December 2019, a clinical picture of pneumonia of unknown etiology had been detected and reported to the WHO in the aforementioned 11-million inhabitant city of Wuhan, China. The causative agent of pneumonia was isolated on January 7, 2020. A new type of coronavirus was identified, whose genetic sequence was shared by China on January 12, 2020, so that other countries could develop diagnostic tests. WHO would later receive information pointing out that the outbreak was associated with exposures in a seafood market in Wuhan, sent by the National Health Commission of China, on January 11 and 12, 2020 (Brasil, 2020b).

In January, while health authorities were taking measures to protect the population with the knowledge then available, researchers scrutinized scientific knowledge about the virus to support effective interventions in the health reality. In facing the health emergency starting this month (Brasil, 2020c), three experiences stood out: China, South Korea, and Vietnam, with central axes recommended by WHO, which guided interventions developed in the national States affected by Sars-Cov-2 in subsequent months.

China, the initial epicenter of the epidemic, shortly after the burst in the number of cases, adopted a nationally coordinated policy involving local authorities and communities, which altered the epidemiological characteristics of the ongoing outbreak with the following measures:

1. recommendations for prevention practices and contact precautions that have proven effective, as the awareness of the population has made more people protect themselves and seek care;
2. lockdown, which started on March 23 and ended on April 8, 2020, in Wuhan and other cities in Hubei province, implying: closure of the city's borders; travel restrictions and withhold of the circulation of automobiles and public transport; restrictions on the movement of people - only allowed to leave the house to buy food and medicines; institution of distance classes and closing of schools and universities; cessation of the operation of public facilities and non-essential activities; and cancellation of public events;
3. isolation of suspected cases;
4. application of diagnostic tests to confirm infections by Sars-Cov-2 (Barifouse, 2020);
5. provision of healthcare;
6. development of a mobile phone application to track contacts from confirmed Covid-19 cases.

A research published in Science magazine and carried out by scientists from China, the United Kingdom, and the United States of America, from January 24 to February 8, 2020, in 375 Chinese cities, demonstrated that social isolation is fundamental. Amid the pandemic, many infected

people have mild symptoms or are asymptomatic, who, when moving within a country, account mainly for transmitting the Sars-Cov-2 virus (Barifouse, 2020).

From the first case of covid-19 confirmed on January 20, 2020, South Korea coordinated national policy based on prevention practices and contact precautions. A mandatory two-week quarantine was required from those who came into contact with a confirmed case of the disease. Diagnostic testing was prioritized, making tests available in hundreds of locations in the country, thus enabling to locate outbreaks and contaminated individuals and track the history of their movement and their contacts. This strategy allows public places or specific residential units to be isolated without blocking an entire region. The country has also developed a mobile application to monitor quarantined people and used information technology to locate people confirmed for covid-19 (Rocha, 2020).

Vietnam, which borders China, from the first confirmed case of covid-19, on January 23, 2020, acted quickly by immediately isolating itself. The country adopted collective recommendations and introduced the mandatory use of masks, strict social distancing, and an emphasis on diagnostic testing and contact tracking. Prioritization was granted to public awareness campaigns, involving artists and technological resources, based on four levels of health intervention: 1) patient with confirmed covid-19 (level 1: isolation and treatment in a hospital); 2) contacts close to level 1 (level 2: isolation in structures set up by the government); 3) contacts close to level 2 (level 3: self-isolation at home); and 4) lockdown of the neighborhood, village, or city where the patient with covid-19 lives (level 4).

The country also developed a mobile application enabling people to update their health status and used social networks and local newspapers to search for people who had been in contact with a patient affected by covid-19. In April 2020, Vietnam established a total blockade of the country for 22 days (COMO, 2020).

On July 7, 2020, in China, South Korea, and Vietnam, respectively, there were 85,345

(6.1 per 100 thousand inhabitants), 11,541 (22.29 per 100 thousand inhabitants), and 328 (0.34 per 100 thousand inhabitants) confirmed cases, and 4,648 (0.3 per 100 thousand inhabitants), 272

(0.52 per 100 thousand inhabitants), and zero (0 per 100 thousand inhabitants) deaths. The importance of interventions by these countries can be seen from the comparison with the global indicators in Table 1.

**Table 1 – Covid-19: comparison between deaths, cases, lethality, and diagnostic tests in selected countries with the highest number of deaths**

Countries	Total Deaths	Deaths per 100 thousand inhab.	Total cases	Cases per 100 thousand inhab.	Lethality	Covid tests per 1 million inhab.
United States	129,643	39.3	2,877,238	872.9	4.5%	117,211
Brazil	64,867	30.7	1,603,055	758.0	4.0%	20,304
United Kingdom	44,236	66.6	285,772	430.1	15.5%	158,741
Italy	34,869	57.9	241,819	401.4	14.4%	94,338
Mexico	30,639	24.2	256,848	202.9	11.9%	4,972
France	29,831	44.5	159,568	237.9	18.7%	21,212
Spain	28,388	60.3	251,789	534.6	11.3%	122,652
India	20,160	1.5	719,665	52.8	2.8%	7,398
Iran	11,731	14.1	243,051	291.4	4.8%	21,983
Peru	10,589	33.0	302,718	942.1	3.5%	55,227
Russia	10,494	7.2	694,230	473.1	1.5%	147,584
Belgium	9,774	84.8	62,058	538.5	15.7%	113,287
Germany	9,024	10.9	196,944	236.9	4.6%	70,099
Canada	8,684	22.8	105,536	277.6	8.2%	80,009
Chile	6,384	33.4	298,557	1562.5	2.1%	63,305
Netherlands	6,119	35.0	50,602	289.8	12.1%	35,970
Sweden	5,433	52.6	73,061	706.7	7.4%	51,503
Turkey	5,241	6.3	206,844	248.7	2.5%	-
Pakistan	4,839	2.2	234,509	106.2	2.1%	6,541
Ecuador	4,821	27.6	62,380	356.9	7.7%	9,536
China	4,648	0.3	85,345	6.1	5.4%	62,814
<b>Total - Selected countries</b>	<b>480,414</b>	<b>10.8</b>	<b>9,011,589</b>	<b>203.1</b>	<b>5.3%</b>	<b>19,384</b>
<b>Total - Selected countries (excluding China and India)</b>	<b>455,606</b>	<b>27.2</b>	<b>8,206,579</b>	<b>490.8</b>	<b>5.6%</b>	<b>53,948</b>
<b>Total - World</b>	<b>535,759</b>	<b>7.0</b>	<b>11,500,302</b>	<b>150.1</b>	<b>4.7%</b>	<b>23,000</b>
<b>Total - World (excluding China and India)</b>	<b>510,951</b>	<b>10.4</b>	<b>10,695,292</b>	<b>218.3</b>	<b>4.8%</b>	<b>24,226</b>

Source: Source: WHO (2020b) and Worldometers (2020).

Note 1: Data for 07/07/2020.

The spread of Sars-Cov-2 continued, confirming cases in practically all parts of Asia, Africa, Oceania, Europe, and America. Virus characteristics (high transmissibility and intense organic impairment in seriously ill patients), manifestation or not of symptoms of the disease, and the absence of specific pharmacological resources (drugs and or vaccines) led to a consolidated combination of categories of State intervention in the health reality in the first quarter of 2020:

1. awareness of the population about prevention practices and contact precautions and seek for clinical care in the presence of symptoms;
2. immediate isolation of people with a suspected clinical picture of covid-19, performance of diagnostic testing and tracking confirmed patient contacts to provide isolation and testing;
3. notification to the public authorities of suspected and confirmed cases of covid-19;
4. social isolation;
5. availability of diagnostic testing in healthcare services to detect Sars-Cov-2 infection in people with symptoms;
6. healthcare assurance: organization of the healthcare service network, including general admission and intensive care services.

In this context, social isolation takes on a core role in tackling the covid-19 pandemic. The countries that adopted it were successful in controlling the pandemic (Okell et al., 2020). However, heads of state in some countries were opposed to its concretization.

## The epidemiological profile of covid-19 and the Brazilian response: (un)wiseness

When the first case of a patient with covid-19 was confirmed in Brazil, the world followed how several countries faced the health emergency resulting from the spread of Sars-Cov-2, paying attention to the successful experiences previously mentioned and, from the February-March period to the drama experienced by Italy, which revealed that the way the

government organizes and responds politically to the crisis is a crucial factor in explaining the magnitude of the epidemic in each context. The main lessons of the Italian case were the need for: (1) orchestrated governance throughout the national territory; (2) operationalization, in due time, of measures to contain transmission and complementary actions to social distancing to strengthen them; (3) expansion of the fight against covid-19 (strengthening of basic actions, health surveillance, hospital infrastructure, human resources, access to inputs); (4) comprehensive and concomitant mitigation measures (Cimini *et al.*, 2020).

In February-March 2020, given that the covid-19 epidemic was progressing, Brazil had the opportunity to take initiatives both in the domestic and foreign production markets to obtain more significant quantities of personal protective equipment (PPE), diagnostic tests, and pulmonary respirators sufficient for the SUS Network. Such measures were required as the centers producing these products were not yet overloaded. There was also the possibility of proposing to the companies installed in Brazil to convert their industrial plants to produce PPE and pulmonary respirators.

The federal government had insufficiently mobilized in this direction, 41 days after the WHO issued the Public Health Emergency of International Concern. Covid-19-related morbidity and mortality place Brazil as the second in the absolute numbers of cases and deaths (1,603,055 and 64,867, respectively), according to Table 1. Also, due to the pandemic's economic and social reflexes, the central government must act in proposing and implementing policies, articulating federated entities, economic agents, and society.

A study by the Universidade Federal de Minas Gerais on the first quadrimester of 2020 analyzed the positive and sensible initiatives referred to previously adopted by the federal government, alongside the decree by the Federal Senate of the state of public calamity, and other initiatives to tackle the pandemic (laws, Provisional Measures, and other instruments). It concluded that, despite the scope of the measures, they lacked articulation since many were recommendations with slight effectiveness (Cimini *et al.*, 2020); others represented folly.

## Political folly

Divergences in the conduct of health policy for tackling Sars-Cov-2 between the head of the executive branch and the Minister of Health stood out as a chapter of political folly amid the covid-19 pandemic. Social isolation was at the center of the discussions, and contrary signals came from the central command of the federal government.

Following the World Health Organization guidance, the Minister of Health advocated social isolation to the population and guided the federated entities to implement their policies in this direction. However, since the decree of a public health emergency, the President of the Republic conferred no seriousness to the epidemic nor importance to social isolation, on the contrary. Neoliberal ideology assumptions, such as the maintenance of economic activity - above all and everyone - guided the government and the population on the lack of need for social isolation. Such attitude was the object of critical appreciation by The Lancet magazine (Editorial, 2020) and “demonstrates the contradictions of neoliberalism, which requires circulation even when it is proven to promote the illness and death of a significant percentage of the population” (Nunes, 2020).

Political folly extended with the replacement of the Minister of Health in the middle of a pandemic escalation in Brazil. A new minister was appointed, who remained in office for 28 days and left because of diverging from the Republic's presidency in health policy, so he did not have time to implement any policy. Currently (17/07/2020), the position has been occupied temporarily, for more than two months since the last incumbent minister left, by an army general who is not a healthcare professional. He is advised by more than two dozen military personnel when the country lives with an ascending curve of cases and deaths and occupies the second world position in the incidence of covid-19.

Instead of nationally coordinating the effort to tackle Sars-Cov-2's spread, since mid-March 2020,

the President of the Republic has been attacking guidelines from the Ministry of Health, governors, and mayors. He has been sowing confusion and clouding the understanding of a portion of the population that, through the media, learns daily about the covid-19 pandemic's seriousness.

## Economic folly

Amid signs of contraction in the global economy caused by the pandemic, major countries (G20), adopting an anti-cyclical policy, injected nine trillion dollars into the world economy, 89% of the total (Battersby; Lam; Ture, 2020). In the last three years, the Brazilian economy has been the subject of a restrictive policy with a growth of around 1% of the Gross Domestic Product (GDP), which should see a decline of 9.1% of GDP in 2020 (IMF, 2020).

Despite the economic team's austerity discourse and the implementation of a policy to reduce public spending, economic measures aimed at mitigating the challenges imposed by the covid-19 pandemic were adopted. These measures were implemented with little agility, mainly issuing the Constitutional Amendment 106/2020, which instituted an extraordinary fiscal, financial, and contracting regime to face the pandemic with financing mainly through the issuance of government bonds. This measure aims to increase and speed up the public spending outside the ordinary administrative and fiscal regulation, separating from the General Budget of the Union (OGU) expenses for the prompt confrontation of the pandemic.

Table 2 shows that, until July 7, 2020, resources of R\$ 505.8 billion reais had been allocated in the extraordinary 2020 budget of the federal government, through the edition of 26 Provisional Measures (MP), to carry out actions to face Sars-Cov-2. After 154 (one hundred and fifty-four) days of decreeing a Public Health Emergency of National Concern (03/02/2020) due to the pandemic, the government federal government had executed R\$ 215.9 billion reais, corresponding to 42.7% of the authorized amount.

**Table 2 – Analysis of the execution of the Extraordinary Budget of the Federal Government to face Sars-Cov-2**

Values in millions of reais

Provisional Measure	Short Description of the Budget	Planned Expenses (Authorized)		Executed Expenses (Paid)	
		Value	%	Value	%
	Emergency aid for vulnerable people	254,240.00	50.27%	121,790.00	47.90%
937/2020	Emergency aid for vulnerable people	98,200.00			
956/2020	Emergency aid for vulnerable people	25,720.00			
970/2020	Emergency aid for vulnerable people	28,720.00			
988/2020	Emergency aid for vulnerable people	101,600.00			
	Emergency benefit to Maintain Employment and Income	51,640.00	10.21%	15,150.00	29.34%
935/2020	Emergency benefit to Maintain Employment and Income	51,640.00			
	Public health emergency tackling - ESPII	44,523.55	8.80%	14,540.00	32.66%
921/2020	Public health emergency tackling - ESPII	11.29			
924/2020	Public health emergency tackling - ESPII	5,099.80			
929/2020	Public health emergency tackling - ESPII	382.00			
940/2020	Public health emergency tackling - ESPII	9,444.37			
941/2020	Public health emergency tackling - ESPII	2,113.79			
942/2020	Public health emergency tackling - ESPII	639.03			
947/2020	Public health emergency tackling - ESPII	2,600.00			
953/2020	Public health emergency tackling - ESPII	2,550.00			
957/2020	Public health emergency tackling - ESPII	500.00			
962/2020	Public health emergency tackling - ESPII	418.80			
965/2020	Public health emergency tackling - ESPII	408.87			
967/2020	Public health emergency tackling - ESPII	5,566.38			
969/2020	Public health emergency tackling - ESPII	10,000.00			
976/2020	Public health emergency tackling - ESPII	4,489.22			
985/2020	Public health emergency tackling - ESPII	300.00			
	Payroll financing	34,000.00	6.72%	17,000.00	50.00%
943/2020	Payroll financing	34,000.00			
	Assistance for federated entities - FPE and FPM drop	16,000.00	3.16%	9,860.00	61.63%
939/2020	Assistance for federated entities - FPE and FPM drop	16,000.00			

continues...



**Table 2 – Continuation**

Provisional Measure	Short Description of the Budget	Planned Expenses (Authorized)		Executed Expenses (Paid)	
		Value	%	Value	%
	Assistance for federated entities - Tackling Covid-19	60,189.49	11.90%	15,040.00	24.99%
978/2020	Assistance for federated entities - Tackling Covid-19	60,189.49			
	Support for micro and small businesses	15,900.00	3.14%	5,000.00	31.45%
972/2020	Support for micro and small businesses	15,900.00			
	Support for small and medium-sized companies	20,000.00	3.95%	15,900.00	79.50%
977/2020	Support for small and medium-sized companies	20,000.00			
	Financing of national tourist infrastructure	5,000.00	0.99%	388.47	7.77%
963/2020	Financing of national tourist infrastructure	5,000.00			
	Transfer to poor families – Bolsa Família	3,037.60	0.60%	369.29	12.16%
929/2020	Transfer to poor families – Bolsa Família	3,037.60			
	Electricity tariff exemption for low-income consumers	900.00	0.18%	900.00	100.00%
949/2020	Electricity tariff exemption for low-income consumers	900.00			
	Hiring healthcare professionals - CTD (Salaries)	320.11	0.06%	27.40	8.56%
970/2020	Hiring healthcare professionals - CTD (Salaries)	320.11			
	Hiring healthcare professionals - CTD (Charges)	18.15	0.00%	0.74	4.08%
970/2021	Hiring healthcare professionals - CTD (Charges)	18.15			
<b>Total expenses for tackling Sars-Cov-2</b>		<b>505,768.90</b>	<b>100.00%</b>	<b>215,965.90</b>	<b>42.70%</b>

Source: National Congress (2020) and Federal Senate (2020).

Note: Provisional measures, authorized expenditure, and execution data for 07/07/2020

In the execution of less than half of the available resources, what stands out is as follows: the use of less than a third of the resources to support micro and small businesses (31.45%) and the low executions for hiring and paying salaries to healthcare professionals working in locations affected by the pandemic (8.56%), support for tourism infrastructure (7.77%), expansion of the number of families in the Bolsa Família Program (12.16%), maintenance of business activities and jobs and workers' income (29.34%), support for federated entities to face the pandemic (24.99%), confrontation of the ESPII to be applied by various

ministries, including the Ministry of Health (32,66%), financial assistance to federated entities to offset the negative nominal variation of funds transferred to the State Participation Fund (FPE) and Municipal Participation Fund (FPM) (61.63%), granting of a credit line for small and medium-sized companies (79.5%), and emergency social protection assistance (47.9%).

Despite the importance of measures of this nature, adopted recently, they are insufficient. They should be accompanied by measures that allow the issuance of paper money on a large scale to tackle the central problem of Brazil today. This is

the liquidity crisis and the need for recovery of purchasing power (Bolle et al., 2020), which is in sharp decline due to the unfavorable indicators of the labor market.

The resistance of the economic team in the monetary financing (Bastos; Belluzzo, 2020) of public expenditure - issuing of paper money - to face the economic and social crisis caused by the covid-19 pandemic constitutes an economic folly. This folly is characterized insofar the predicted increase in the poverty rate in Brazil to 7% of the population, compared to 4.4% in the last three years (The World Bank, 2020).

### **Social folly**

In the countries that adopted the lockdown, a measure proposed by the World Health Organization as adequate to face Sars-Cov-2, there was a substantial reduction in aggregate demand because there was economic paralysis, an increase in the unemployment rate, and a drop in the income of workers and families. This movement caused governments in developed countries to activate social security mechanisms, providing resources to workers, families, and companies to have no economic and social collapse.

In Brazil, the federal government instituted monthly emergency aid to the most impoverished population. The amount of R\$ 600.00 was paid to compensate for the economic crisis, unemployment, drop in the income of workers and families. There was a great difficulty of implementation due to the administrative/bureaucratic disarticulation role of the federal government and the level of poverty in the country, generating queues and crowding people in front of the official benefit payment bank branches.

Given the socioeconomic profile of the Brazilian population, which is characterized by inequities in income, education, housing, consumption, and work, the fact that the central government did not assume the direction of the policy to confront Sars-Cov-2, articulating with the other federated entities, made the situation of workers and families dramatic. Without income and considering that at least 50% of Brazilian homes are irregular or illegal (Tonucci Filho; Patrício; Bastos, 2020),

the population has difficulty respecting the guidelines of social isolation. The situation is aggravated by the disarticulation and dubious signs of government leaders concerning isolation, markedly at the federal level. Thus, there is a change in the profile of cases and mortality due to covid-19 towards the country's most disadvantaged regions, particularly the peripheral and local areas with irregular housing in large cities and countryside.

A study of the Solidary Research Network (Pandemia, 2020) with community leaders points to the possibility of an increase in the number of cases and deaths due to covid-19, due to misinformation, increased unemployment and drop in income, difficulties in respecting isolation social and access to health services, as well as the increase in hunger with impacts on the levels of violence, theft, and looting.

### **Sanitary folly**

The Brazilian National Health System (SUS) legal and regulatory framework requires that health policy be conducted in a tripartite manner by the federated entities and implemented jointly. Faced with the misalignment at the central level and the epidemic's speed, subnational governments started adopting a policy according to their capacity in each way and schedule. In this context, an additional element emerged, the judicialization of health, which, on the one hand, contributed to guarantee constitutional rights, welcoming individual, collective, and Public prosecutors' demands for access to goods, health services, and lockdown. On the other, it dismantled the planning when determining the obligation to do by the executive branch.

The measures proposed by WHO in the strategic plan for preparing and responding to covid-19 and loosening of social isolation (WHO, 2020a) have not yet found adequate conditions in Brazil. With the increased number of cases and deaths, the transmission of the virus is far from being controlled. Studies carried out weekly by the Centre for Global Infectious Disease Analysis, which analyze the number of deaths in countries with active transmission of covid-19, maintain a projected expansion in the number of deaths to Brazil (Imperial College Covid-19, 2020).

In this scenario, conducting diagnostic tests to monitor the epidemic, control transmission, and reduce deaths (Imperial College Covid-19, 2020) is central. Underreporting is considered to occur in the country due to several factors, such as the non-registration of cases outside healthcare environments, deaths due to causes resulting from Sars-Cov-2 not counted as Covid-19, and, mainly, due to failure to carry out tests to detect Sars-Cov-2 in people who have mild symptoms. Also, it is possible to mention the insufficient tracking of the contacts of diagnosed patients. These factors bring uncertainties about the actual number of cases, deaths, and lethality, hampering the implementation of public policies.

Research centers in Brazil have published studies pointing to the underreporting of cases of covid-19. The first nationwide survey, with sampling and testing, developed by the Universidade Federal de Pelotas (UFPel), Evolution of the Prevalence of Infection by covid-19 in Brazil: Population-Based Study - Epicovid19-BR, stands out. The official results reveal general contamination of 3.8% of the Brazilian population, the disease forming an epidemiologic 'mosaic' in the country, and an estimated six times more infected cases than the official numbers (Comunello, 2020). According to the dean of UFPel and research coordinator Pedro Hallal: "Today, we are the country in which covid-19 expands more rapidly worldwide" (Boehm, 2020).

Health surveillance measures, such as the isolation of infected individuals and the screening of people in contact with them in due time, depend on the performance of tests. However, in Brazil, only 20,304 tests are performed per million inhabitants (Table 1), with the country appearing in position 106 of a list from 217 countries. This fact is directly related to the inability to carry out the number of tests essential to adopting effective health surveillance measures to face the epidemic. Thus, the country deals 'in the dark' trying to tackle the exponential number of appearing cases.

The absence of univocal national coordination in the confrontation of Sars-Cov-2 in Brazil was a determining factor for the under-involvement of the SUS structure - surveillance units, primary care, specialized outpatient, and hospital care. SUS, endowed with capillarity in national territory, is fundamental

to guarantee universality, health integration, and the articulation of assistance services at the levels of care. Despite the historical underfunding, deepened by Constitutional Amendment No. 95/2016, SUS has already consolidated strategies within the scope of primary care for monitoring risk groups (Cimini et al., 2020). SUS is recognized as coordinator of healthcare and organizer of the care network and can reinforce preventive, health-promoting, and protective actions in local communities.

Also, due to the absence of single national coordination in the confrontation of Sars-Cov-2, solidly articulated with the federated entities, there was the non-involvement and incorporation of living social forces and community leaders. As they know the local territories, being crucial elements in the population's engagement in measures of social isolation, the non-involvement constituted a sanitary-epidemiological folly.

Between March 13 and 21, 2020, social distancing measures were adopted in municipalities in practically all states, with São Paulo decreeing social isolation as of March 24, 2020. There was a conjunction of attributes of the most populous and economically prominent federated region of the country that, at the same time, constituted the epicenter of the epidemic. On the one hand, it led state leaders to adopt a procedure that proved to be decisive in combating Sars-Cov-2 social isolation. On the other hand, it brought an under-involvement of SUS structure, the non-incorporation of community leaders in the process, and neglect in acquiring diagnostic tests for the entire SUS Network.

The Brazilian performance in the confrontation of Sars-Cov-2 did not observe the successful experiences, dramas, and responses that some countries gave to the crisis. According to Barbara Tuchman:

"If men could learn from History, what lessons it could teach us!" lamented Samuel Coleridge. "But passion blinds our eyes, and the light that experience gives us is that of a lantern at the stern, which only illuminates, the waves that we leave behind." The image is beautiful, but its message is misleading - because the light in the waves that we have already passed could make us able to infer the nature of the waves ahead. (Tuchman, 1989, p. 389)

## The epidemiological profile of covid-19 in the city of São Paulo: exposing inequities in the territory

Preliminarily, it is worth mentioning that the municipality of São Paulo has no updated free access database on cases and deaths by covid-19, by administrative district. The data were made available upon request supported by the law on access to information and as of 02/06/2020. The data show that the municipality of São Paulo has 38.8 deaths

per 100 thousand inhabitants, 608.0 cases per 100 inhabitants, and lethality of 6.4%. Following the death/case/lethality order, these numbers are 123.0%, 136.0% above the state of São Paulo's average and 5.9% below, respectively; 162.2%, 131.5%, and 14.3% above the Brazilian average, respectively; 66.5%, 86.7% above the average of countries with the highest mortality, and 7.2% below, respectively; and 424.3%, 403.7%, and 6.7% above the world average, respectively (Table 3).

**Table 3 – Cases, deaths, and lethality by Covid-19 in the municipality of São Paulo and most and least developed districts of the municipality compared to the state of São Paulo, Brazil, selected countries with the highest number of deaths and the world**

Data	Cases per 100 thousand inhab.	Deaths per 100 thousand inhab.	Lethality
<b>Municipality of São Paulo (A)</b>	608.0	38.8	6.4
% A/D variation	136.0	123.0	-5.9
% A/E variation	131.5	162.2	14.3
% A/F variation	86.7	66.5	-7.2
% A/G variation	403.7	424.3	6.7
<b>15 Most developed districts in the municipality of São Paulo (B)</b>	855.3	43.2	5.1
% B/D variation	232.0	148.3	-25.0
% B/E variation	225.7	191.9	-8.9
% B/F variation	162.7	85.4	-26.1
% B/G variation	608.6	483.8	-15.0
<b>15 Least developed districts in the municipality of São Paulo (C)</b>	432.9	31.8	7.3
% C/D variation	68.1	82.8	7.4
% C/E variation	64.9	114.9	30.4
% C/F variation	33.0	36.5	5.8
% C/G variation	258.7	329.7	21.7
<b>State of São Paulo (D)</b>	257.6	17.4	6.8
<b>Brazil (E)</b>	262.6	14.8	5.6
<b>Selected countries (F)</b>	325.6	23.3	6.9
<b>World (G)</b>	120.7	7.4	6.0

Source: WHO (2020b) e PMSp (2020)

Note 1: Data for countries, municipality of São Paulo, and districts of the municipality for 02/06/2020.

Note 2: Line (F) of selected countries with the highest number of deaths on 02/06/2020: United States of America, United Kingdom, Italy, Brazil, France, Spain, Mexico, Belgium, Germany, Iran, Canada, Netherlands, India, Russia, China, Turkey, Peru, Sweden, Ecuador, Switzerland, Ireland.

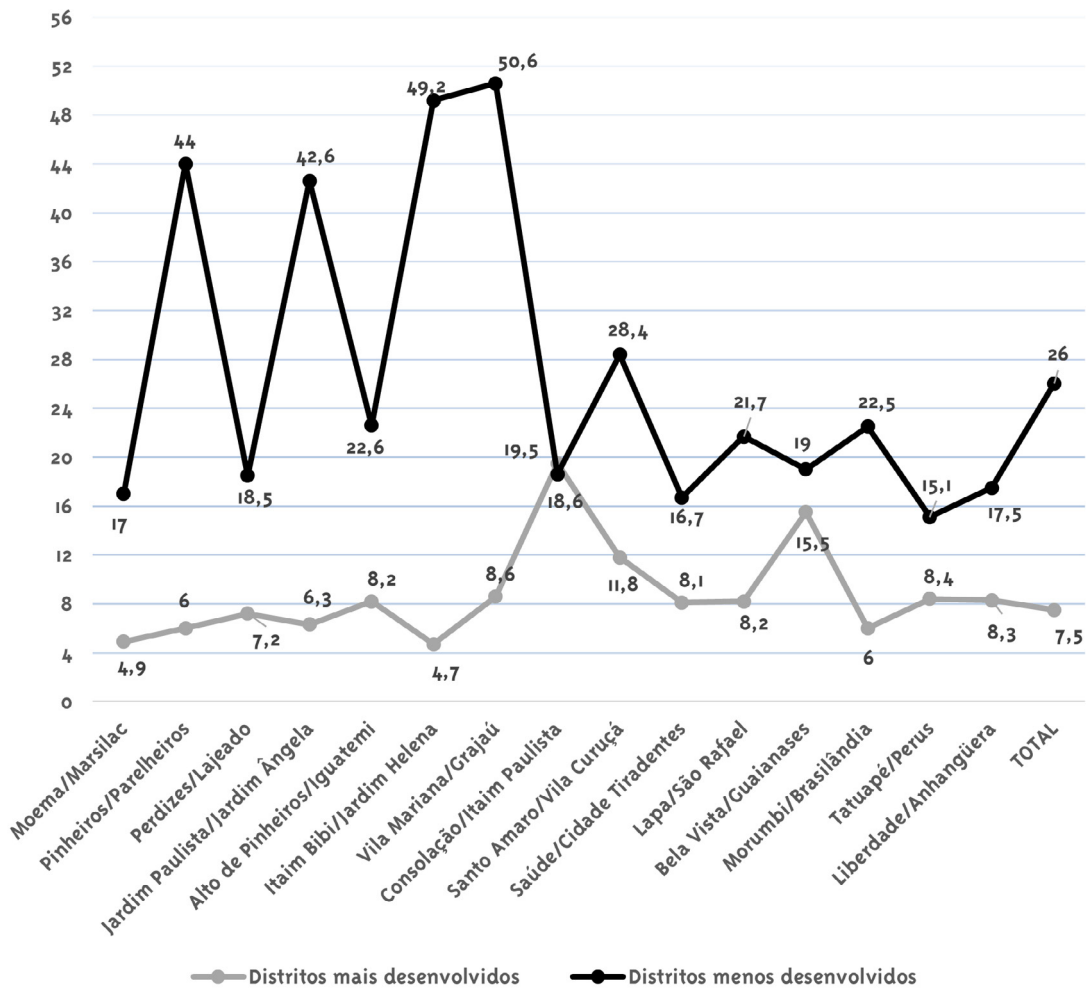
The 15 most developed districts in the city of São Paulo had, on average, 43.2 deaths per 100 thousand inhabitants, 855.3 cases per 100 thousand inhabitants, and lethality of 5.1%. Compared to the state of São Paulo, Brazil, selected countries, and the world average, the percentage variation is, respectively: 148.3, 232.0, and -25.0; 191.9, 225.7, and -8.9; 85.4, 162.7, and -26.1; 483.8, 608.6, and -15.0 (Table 3).

The 15 least developed districts in the city of São Paulo had, on average per 100 thousand inhabitants, 31.8 deaths, 432.9 cases, and 7.3% lethality. Compared to the state of São Paulo, Brazil, selected countries, and the world average,

the percentage variation is, respectively: 82.8, 68.1, and 7.4; 114.9, 64.9, and 30.4; 36.5, 33.0, and 5.8; 329.7, 258.7, and 21.7. Lethality in the 15 least developed districts (7.3%) is higher than in the 15 most developed districts (5.1%) and above the municipality average (6.4%) (Table 3).

Analyzing the evolution of confirmed cases of covid-19 in the municipality of São Paulo from 31/03/2020 to 02/06/2020 and pairing the most developed districts with the least developed (Figure 1), an increase 18.5 times higher in the number of cases in the least developed districts is noted compared to most developed districts.

**Figure 1 – Number of times for the growth of confirmed cases of Covid 19 in the city of São Paulo in the period from 03/30/2020 to 06/02/2020 -Pairing of 15 most developed and 15 least developed districts**



Source: Own elaboration based on PMSP (2020)

Distritos mais desenvolvidos = Most developed districts; Distritos menos desenvolvidos = Least developed districts.

In pairing the number of cases between the most developed district, Moema, with the least developed, Marsilac, there is a 12.1-fold difference; between the second most developed district, Pinheiros, and the second least developed, Parelheiros, there is a difference of 38 times; Perdizes to Lajeado, 11.3 times; Jardim Paulista to Jardim Ângela, 36.3 times; Alto de Pinheiros to Iguatemi, 14.6 times; Itaim Bibi to Jardim Helena, 44.5 times; Vila Mariana to Grajaú, 42 times; Consolação to Itaim Paulista, an almost identical case increase; Santo Amaro to Vila Curuçá, 18.6 times; Saúde to Cidade Tiradentes, 8.6 times; Lapa to São Rafael, 13.5 times; Bela Vista to Guaianazes, 3.5 times; Morumbi to Brasilândia, 16.5 times; Tatuapé to Perus, 6.7 times; Liberdade to Anhanguera, 9.2 times (Figure 1).

The average increase observed in the 15 most developed districts and in the 15 least developed districts (7.5 times and 26 times respectively), despite affecting all age groups, genders, races/ colors, exposes the inequity of the health-disease process as a historical, social construction (Singer; Campos; Oliveira, 1981) in the territory of the municipality of São Paulo.

## Final Considerations

Had there been national political coordination and political, economic, social, and health sensibility when facing Covid-19, a more comprehensive economic and social protection would quickly have reached the fragile and vulnerable social sectors. Alongside this, agile and unbureaucratic measures aimed at maintaining companies, especially micro, small and medium ones, conditioned to the preservation of jobs, would have been adopted. As a result, it would have been possible to essentially stop non-essential activities in the country, encourage people's commitment to social distancing, and demand, as did the overwhelming majority of countries, effective compliance by the population with strict social isolation.

The Brazilian government, translating the neoliberal positioning of the dominant classes and their allies, did not treat the covid-19 pandemic, and its expression in Brazil, as an object of priority

combat. On the contrary, there was not - and still is not - political coordination of the confrontation of covid-19 as a national emergency. Therefore, each federated entity adopts the policy that it deems most appropriate. This is the worst-case scenario in a country with an extensive territorial area, whose regions are heterogeneous from the economic, social, demographic, and health infrastructure points of view.

Illustrative of what we have just stated is as follows: after 154 days of issuing the Public Health Emergency of National Concern, the federal government has implemented less than half of the global resources available to face the pandemic, less than a third of the resources available for both ministries, including the Ministry of Health, to support micro and small businesses, and less than ten percent of the resources available for hiring and paying salaries for healthcare professionals to work in locations affected by the pandemic.

In January and February 2020, the federal government had time to prepare the country. In that bimester, there was an advance in the confrontation of the epidemic by health authorities worldwide, which already pointed to the urgency of speeding up internal measures, which were early and sufficient, in the following sense:

1. involve SUS teams in confronting Sars-Cov-2, with an emphasis on collective and individual dimension actions, in that order;
2. plan and acquire PPEs for SUS workers;
3. create conditions internally for producing sufficient diagnostic tests for use in SUS;
4. check the international producer market foreseeing the need to purchase PPEs, pulmonary respirators, and diagnostic tests, as well as stimulating the internal conversion of industrial plants for the production of these items;

Social isolation is a core tool in the fight against the spread of Sars-Cov-2, having proved to be vital in countries that maintain low mortality rates or overcome Dantesque health conditions and stabilize their mortality rates. Inspired by these practical experiences, we must pursue social isolation, whenever necessary, to combine

federal participation with decisive action by local authorities and communities.

In Brazil, social isolation was adopted independently by states, the Federal District, and municipalities. Therefore, there was no previous definition of national criteria, which would have enabled these federated entities to adopt more restrictive measures gradually according to an increasing number of cases and deaths.

Although governors and mayors adopted social isolation early, the alienation of the federal government caused us to lose this tactical-operational advantage in the process of tackling covid-19. In other words, we lost this advantage due to the following: we did not have the coordination that would help supply states, the Federal District, and municipalities with diagnostic tests; to collaborate more closely with the organization of SUS networks, in short, to help in the discussion of criteria for the resumption of functioning and social interaction.

Brazilian law makes it possible to request ICU beds from the private sector for the treatment of covid-19. However, due to little progress in its regularization, there is an urgent need to discipline the use of private beds by the public sector, agreeing on it with the Tripartite Inter-manager Committee (CIT) and in the Bipartite Inter-manager Committees (CIB) in the Federation States.

There was no consensus on the central role of primary care and health surveillance in tracking contacts of patients with covid-19. The rapid disease expansion to the popular neighborhoods of Brazilian cities has required SUS teams to solve a concrete problem: how to isolate patients positive for Sars-Cov-2, no severe symptoms, whose effective isolation is impossible due to social conditions alien to the patients' willingness? We believe that, under the coordination of SUS technical teams, municipalities and states could organize and standardize a new health environment designed to isolate these patients.

From the confirmation of the first covid-19 case in São Paulo, there was a greater targeting of confirmed cases to the periphery and places of irregular housing in the city as the days passed. It was not inevitable that this would occur as we are sure that no part of our population can be disregarded if we want to face this global challenge. However, we are not unaware of the social inequalities in Brazilian society.

In this sense, there is an urgent need to ensure that the State's economic and social protection reaches fragile population sectors and that active solidarity with these numerous human beings is cultivated. Consequently, the measures in charge of collective health - the fruit of our health tradition - can take place in a more fertile ground for the defense of people's lives as the center of action of health teams, thus minimizing suffering, anguish, and pain of the Brazilian population.

The unavailability of information on cases and deaths by Sars-Cov-2, by the administrative district in the municipality of São Paulo in databases, and the delay in its dissemination, may represent a study limitation and compromise the results of national and international research. Also, they may influence the planning and management of actions to face the pandemic.

One of this work's initial assumptions was that the application of neoliberal policies by governments emerging in recent times, particularly in Brazil, in the face of the pandemic caused by Sars-Cov-2 would reveal political, economic, social, and sanitary folly with all its nefarious reflexes and the social and human life costs. This was confirmed and evidenced that folly and lack of coordination of the federal government in tackling the covid-19 pandemic generated an exponential increase in the number of cases and deaths due to this disease, mainly in poorer and more vulnerable populations.

Given the above, more investigations are considered essential to be conducted, expanding and updating the scope of this study as a contribution to the discussion and guidance of public policies in Brazil.

## References

- BACHELET, M.; GRANDI, F. Pandemia de coronavírus é um teste de nossos sistemas, valores e humanidade. *Saúde Amanhã*, Rio de Janeiro, 19 mar. 2020. Disponível em: <https://bit.ly/3wwGnUV>. Acesso em: 17 maio 2020.
- BARIFOUSE, R. Coronavírus: lentidão inicial em diagnósticos facilitou disseminação de vírus na China, diz estudo. *BBC News Brasil*, São Paulo, 19 mar. 2020. Disponível em: <https://bbc.in/3dGoJFz>. Acesso em: 15 maio 2020.
- BARRETO, M. L. et al. O que é urgente e necessário para subsidiar as políticas de enfrentamento da pandemia de COVID-19 no Brasil? *Revista Brasileira de Epidemiologia*, Rio de Janeiro, v. 23, e200032, 2020. DOI: 10.1590/1980-549720200032
- BASTOS, P. P. Z.; BELLUZZO, L. G. M. Financiamento monetário é arma orçamentária em “guerra” contra a covid-19. *Carta Capital*, São Paulo, 12 abr. 2020. Disponível em: <https://bit.ly/3rTEcap>. Acesso em: 12 abr. 2020.
- BATTERSBY B.; LAM W. R.; TURE, E. Rastreado o suporte fiscal global de US\$ 9 trilhões para combater o COVID-19. *IMFBlog*, Washington, DC, 20 maio 2020. Disponível em: <https://bit.ly/3cXQIkX>. Acesso em: 23 maio 2020.
- BOEHM, C. Proporção da população com anticorpos do novo coronavírus aumenta 53%. *Agência Brasil*, São Paulo, 12 jun. 2020. Disponível em: <https://bit.ly/321cduB>. Acesso em: 13 jun. 2020.
- BOLLE, M. et al. Emitindo moeda, o Estado cria poder de compra que antes não existia. *Folha de São Paulo*, São Paulo, 20 abr. 2020. Disponível em: <https://bit.ly/3fRX6Mb>. Acesso em: 5 maio 2020.
- BRASIL. *Boletim epidemiológico 01: infecção humana pelo novo coronavírus (2019-nCoV)*. Brasília, DF: Ministério da Saúde, 2020a.
- BRASIL. *Boletim epidemiológico 04: novo coronavírus (2019-nCoV)*. Brasília, DF: Ministério da Saúde, 2020b.
- BRASIL. OMS declara emergência de saúde pública internacional para novo coronavírus. *Governo do Brasil*, Brasília, DF, 30 jan. 2020. Disponível em: <https://bit.ly/3wyaJWW>. Acesso em: 7 maio 2020c.
- CIMINI, F. et al. *Nota Técnica: Análise das primeiras respostas políticas do Governo Brasileiro para o enfrentamento da COVID-19 disponíveis no Repositório Global Polimap*. Belo Horizonte: Centro de Desenvolvimento e Planejamento Regional da UFMG, 2020. Disponível em: <https://bit.ly/2OzOb7a>. Acesso em: 29 jun. 2020.
- COMO o Vietnã conseguiu vencer o coronavírus, apesar do sistema de saúde precário. *BBC News Brasil*, São Paulo, 9 maio 2020. Disponível em: <https://bbc.in/3t3UChG>. Acesso em: 23 maio 2020.
- COMUNELLO, P. Lockdown rigoroso de 15 dias no Brasil inteiro, defende reitor da UFPel. *Jornal do Comércio*, Porto Alegre, 27 jun. 2020. Disponível em: <https://bit.ly/3tov2u3>. Acesso em: 7 abr. 2020.
- CONGRESSO NACIONAL. Medidas provisórias. Disponível em: <https://www.congressonacional.leg.br/materias/medidas-provisorias>. Acesso em: 8 jul. 2020.
- EDITORIAL. COVID-19 in Brazil: “So what?”. *The Lancet*, London, v. 395, n. 10.235. p. 1461-1520, 2020. DOI: 10.1016/S0140-6736(20)31095-3
- GADAMER, H. G. *Verdade e método: traços fundamentais de uma hermenêutica filosófica*. Petrópolis: Vozes, 1997.
- GIL, A. C. *Métodos e técnicas de pesquisa social*. São Paulo: Atlas, 2008.
- GRASSLY, N. C. et al. *Report 16: role of testing in Covid-19 control*. London: Imperial College London, 2020. DOI: 10.25561/78439
- IMF. *A crisis like no other, an uncertain recovery*. Washington, DC: International Monetary Fund, 2020.
- IMPERIAL COLLEGE COVID-19. Short-term forecasts of Covid-19 deaths in multiple countries. *Imperial College London*, London, 2020. Disponível em: <https://bit.ly/3wA4KRq>. Acesso em: jun. 2020.
- NUNES J. A pandemia de COVID-19: securitização, crise neoliberal e a vulnerabilização global. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 36, n. 4, e00063120, 2020.



OKELL, L. C. et al. Have deaths from COVID-19 in Europe plateaued due to herd immunity? *The Lancet*, London, v. 395, n. 10.241, p. 1.883, e1110-e1111. DOI: 10.1016/s0140-6736(20)31357-x

PANDEMIA e suas consequências estimulam violência e desesperança em comunidades carentes. *Jornal da USP*, São Paulo, 26 maio 2020. Disponível em: <https://bit.ly/2PATbh9>. Acesso em: 11 jun. 2020.

PREFEITURA DO MUNICÍPIO DE SÃO PAULO - PMSP. Secretaria Municipal de Saúde. Covid-19. Boletim semanal. Disponível em: [https://www.prefeitura.sp.gov.br/cidade/secretarias/upload/saude/PMSP\\_SMS\\_COVID19\\_Boletim%20Semanal\\_20200417\\_atualizado.pdf](https://www.prefeitura.sp.gov.br/cidade/secretarias/upload/saude/PMSP_SMS_COVID19_Boletim%20Semanal_20200417_atualizado.pdf). Acesso em: 8 jul. 2020.

RICOUER, P. *Interpretação e ideologias*. Rio de Janeiro: F. Alves, 1990.

ROCHA, C. Coronavírus: as ações da Coreia do Sul e as lições para o Brasil. *Nexo*, São Paulo, 13 mar. 2020. Disponível em: <https://bit.ly/3rYV7Ir>. Acesso em: 22 maio 2020.

SENADO FEDERAL. Siga Brasil painéis. Disponível em: <http://www9.senado.gov.br/QvAJAZZfc/opendoc.htm?document=senado%2Fsigabrazilpainelcidadao.qvw&host=QVS%40www9&anonymous=true&Sheet=shOrcamentoVisaoGeral>. Acesso em: 8 jul. 2020.

SINGER, P.; CAMPOS, O.; OLIVEIRA, . M. *Prevenir e curar: o controle social através dos*

serviços de saúde. Rio de Janeiro: Forense-Universitária, 1981.

SPINK, P. Análise de documentos de domínio público. In: SPINK, M. J. (Org.). *Práticas discursivas e produção de sentidos no cotidiano: aproximações teóricas e metodológicas*. São Paulo: Cortez, 2000.

THE WORLD BANK. *Semiannual Report of the Latin America and Caribbean Region: the economy in the time of covid-19*. Washington, DC: The World Bank, 2020.

TONUCCI FILHO, J. B. M.; PATRÍCIO, P. A.; BASTOS, C. *Nota Técnica: desafios e propostas para enfrentamento da Covid-19 nas periferias urbanas: análise das condições habitacionais e sanitárias dos domicílios urbanos no Brasil e na Região Metropolitana de Belo Horizonte*. Belo Horizonte: Centro de Desenvolvimento e Planejamento Regional da UFMG, 2020.

TUCHMAN, B.W. *A marcha da insensatez: de Tróia ao Vietnã*. 3. ed. Rio de Janeiro: José Olympio, 1989.

WHO. *Covid-19 Strategy Update*. Geneva: World Health Organization, 2020a.

WHO. *Coronavirus (Covid-19) Dashboard*. Geneva: World Health Organization, 2020b. Disponível em: <https://covid19.who.int/>. Acesso em: 8 jul. 2020.

WORLDOMETERS. *Coronavirus*. Disponível em: [worldometers.info/coronavirus/](http://worldometers.info/coronavirus/). Acesso em: 8 jul. 2020.

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### Authors' contributions

Soares and Menezes developed all steps of the study, contributing to the elaboration of the text, critical review of the content, and approval of the final version of the manuscript.

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