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The intersectionality of health (in)security: Healthcare, disposable workers, and exposure within Brazil's pandemic politics

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Abstract

Brazil has suffered severe consequences from the Covid-19 pandemic, currently ranking second globally in terms of total fatalities, with more than 682,000 lives lost. This article critically outlines how a 'health security' framework overlooks processes of intersectionality and the varying impacts of the virus on different segments of society, or what we term *health insecurity*. We organize our analysis around three aspects of the pandemic that have become salient in Brazilian society, namely *access to healthcare*, *disposable workers*, and *exposure to the virus*, and delineate the intersectional impact of gendered inequality, neoliberal ideologies, and racial hierarchies within these three themes. Our methodology employs media and scholarly interpretations of Covid-19, and other secondary empirical and statistical data, to outline the virus's impacts on differently positioned bodies throughout Brazilian society. Our main findings reveal that during the pandemic, women's labor and health concerns have been undervalued, exploitative working conditions have been exacerbated, and Afro-Brazilians have been put in situations of higher exposure to the virus in both public and private spaces. This article underscores the need to better examine how public health, systems of oppression and exclusion, and (in)security overlap with each other.

Keywords

Biopolitics, Brazil, Covid-19, health security, insecurity, intersectionality

Introduction

Between March and June 2021, Brazil's Covid-19 infection rate was consistently above 60,000 new cases per day, and its mortality rate was upwards of 1600 individuals per day (*New York Times*, 2021; Senado, 2021). These trends are alarming because the South American state came to rank third, globally, in total number of cases during June 2021, only behind the United States and India;

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and second in total deaths with more than 682,000 fatalities, only behind the USA, even though it is the world's sixth most populous country (BBC, 2021). Furthermore, the virus's speedy and deadly advance has placed great strain on both the country's public *Sistema Único de Saúde* (Unified Health System, or SUS) and private healthcare systems. However, as these figures exemplify, most social debates and media accounts have centered the Brazilian state or entire population as the appropriate referent object of study, overlooking the nuanced and varying impacts the Covid-19 pandemic has had at the micro or individual level.

The article addresses that oversight by employing an *intersectionality*-based approach to explore how pathogenic outbreaks and health emergencies are not gender, class, and/or race-neutral – meaning they do not impact every *body* in a similar or equal manner (Wenham, 2021: 4). Instead, these social categories of difference and marginalization have had nuanced sociopolitical, economic, *and* health implications for different segments and subgroups of Brazil's population during the pandemic. In the following sections, we organize our analysis around three aspects of the pandemic that have become salient in Brazilian society, namely, which individuals receive *access to healthcare*, become *disposable workers*, and are likelier to face *exposure to the virus*. Our intersectionality-based approach then leads us to shift our attention from the customary scholarly emphasis on health *security*, and instead ascertain how it is interrelated to health *insecurity*, as manifested throughout Brazil's experience with Covid-19.

We understand *health insecurity* as the threat to human life caused simultaneously by: 1) biologically contagious pathogens and illnesses; and 2) asymmetrical and conflicting power relations (such as inequality related to class, race, and/or gender differences), which disproportionately distributes protection/care and risk/anxiety among individual bodies and social groups. Stated differently, if we conceptualize health security as 'a complex set of practices through which global life is to be protected from epidemic and pandemic threats and the anxieties they generate' (Ingram, 2008: 81), then health insecurity is also a product of these 'practices', which we read as thoroughly gendered, classist, and racialized in how they impact individual bodies. In effect, our central claim here is that (health) insecurity should not be viewed as the opposite or other side of (health) security; rather the two are *co-constituted processes* that depend on each other to operate politically.

As scholars, policymakers, and social commentators make sense of Brazil's experience with the global health pandemic, some preliminary analyses place the blame on the country's far-right President Jair Bolsonaro (Hunter and Power, 2019; Ortega and Orsini, 2020; Pevehouse, 2020; Senado, 2021; Smith, 2020), others understand it as symptomatic of the country's long history of racism (Dos Santos et al., 2020), and others frame it as one of many plagues the country faces, 'along with economic stagnation, political polarization, environmental crisis' (*Economist*, 2021: 2; Stewart et al., 2021). The contribution here is to elucidate that the growing technocratic and technology-based approaches to health securitization (see Bengtsson, Borg and Rhinard, 2019; Roberts and Elbe, 2017; Voelkner, 2011) miss multiple political dimensions of how security/insecurity is produced or enacted, and which, in turn, renders many health securitization initiatives ineffective (at best) or detrimental (at worst). Our principal findings exemplify how public health discourses, socially and historically constituted systems of oppression and exclusion, and (in)security overlap with each other, fostering mixed levels of vulnerability for various segments of Brazil's population.

Methods and data triangulation

Our case study of Brazil was conducted in sequential research steps, employing a *triangulation technique* to develop and support our theoretical claims. Firstly, we selected and read several Brazilian (*Folha de São Paulo*, *O Globo*, *UOL*, etc.) and international (*New York Times*, *Economist*,

Washington Post, etc.) media articles that highlighted how gender, race/ethnicity, and inequality/neoliberalism modulated the spread of Covid-19 in Brazil. Secondly, based on the main themes identified in newspaper coverage (i.e. vulnerability of healthcare workers, differing levels of access to healthcare/equipment, varying forms of violence and mortality from the pandemic, etc.), we narrowed our scope, and performed an in-depth search in scientific databases for material related to these themes (Web of Science, Scopus, SciELO). This then led us to a third stage of tracking academic publications from the medical/public health fields about Brazil's Covid-19 response in both domestic (*Ciência & Saúde Coletiva*, *Saúde em Debate*, *Cadernos de Pesquisa*) and international (*The Lancet Global Health*, *International Journal of Gynecology & Obstetrics*, *Global Public Health*) peer-reviewed journals. Fourthly, we analyzed documents and public reports from Brazilian civil society organizations and government agencies, such as the Institute of Applied Economic Research (IPEA), National Agency of Supplementary Health (ANS), Oswaldo Cruz Foundation (Fiocruz), among others, searching for quantitative indicators of intersectionality-based processes. Finally, we observed the live proceedings and analyzed the final report of the Covid-19 Parliamentary Commission of Inquiry (*Comissão Parlamentar de Inquérito*, CPI), which conducted hearings on Brazil's response to the pandemic via a select Federal Senate Committee (Senado, 2021).

From these sources, we performed *data triangulation*, or a process where a 'series of data are gathered from different sources, at different times, in various situations, and sometimes by many researchers', to 'acquire a new vision of the phenomenon examined or aspects of it', by combining elements of discourse analysis and process tracing (Balzacq, 2014: 377–378). Thus, below we include the myriad sources described here and their findings as *secondary data*, each of which individually utilized contrasting methods – opinion surveys, statistical analysis, interviews, fieldwork, etc. – and collectively facilitate our interpretivist analysis (Yanow and Schwartz-Shea, 2006) of emerging themes vis-à-vis Covid-19's impact in Brazil. This correlates with what Ayoub, Wallace, and Zepeda-Millán describe as a *convergent triangulation design* whereby 'qualitative and quantitative data are collected and analyzed separately, and then compared to assess whether the findings contradict or confirm each other' (2014: 68). We are aware of the limits of our claims, given that our sources are secondary in nature, and we did not engage in any direct interviews or conduct our own survey. However, both authors are fluent in Portuguese and English, and possess training in qualitative and quantitative analysis (allowing for direct engagement and interpretation of sources) and lived in Brazil at various times between 2020 and 2022 (allowing for personal interaction and experience with Covid-19 dynamics in Brazil).

Reconceptualizing health (in)security via intersectionality

The field of global health security studies (henceforth health security) challenges mainstream conceptualization of security by decentering the role of the state as the referent object of security. It is part of the larger academic debate over the 'deepening' and 'broadening' of security studies in the post-Cold War era (Buzan, 1997; Walt, 1991). Health security scholars underscore human populations as organic entities capable of pathological infection, transmission, and death, and consequently as suitable referent objects of security (Elbe, 2006, 2008, 2011; Nunes, 2013, 2014; Peoples and Vaughan-Williams, 2015, Ch. 8). The state as an object, protected from intrusion via strong borders, military arsenals, radar defenses, and so forth (Elbe 2009), is reframed as an object that can be debilitated by the introduction of a new pathogen or micro-organism, requiring a renewed focus on the 'global politics of medicine' (Howell, 2014). Most notoriously, the HIV/AIDS epidemic during the 1990s and early 2000s was increasingly viewed as a possible national security threat (Elbe, 2005, 2009), requiring *securitization*, or the use of military planning, techniques, and

strategies, oftentimes done via executive-level fiat and without extensive legislative or democratic deliberation (Buzan, Wæver and De Wilde, 1998).

However, health security approaches replace the state (which is a collective object/entity) with a population (also conceptualized as a collective object/entity), thereby bracketing how health policy outcomes can impact individuals in unequal and/or interconnected ways. As Stefan Elbe argues, 'health security debates begin gradually to redefine security as something that is – in part – a medical problem' (2011: 849), thereby legitimizing the inclusion of public health experts in the production of security policy and moves to provide security via pharmacological interventions, without thorough reflection on the possible spillover effects of this inclusion. The growing securitization of public health dilemmas has produced, as stated above, 'a complex set of practices through which global life is to be protected', but which despite its potential for global cooperation and coordination, 'is hardly immune from power relations' (Ingram, 2008: 81).

Health security, and its critiques of mainstream security, have been heavily influenced by the Foucauldian concepts of governmentality and biopolitics and the role they play in: 1) creating subjects to be medicalized; 2) structuring the patient–doctor relationship; and 3) positioning the modern medical professional as a harbinger of knowledge/truth. Governmentality, or the art of governance, entails systems of power and quotidian administrative gestures that result in the functioning of a modern polity, contra the pre-modern notion of ubiquitous sovereign control over the ruled (Elbe, 2009: 9–12). Or, as Foucault defined it in his seminal essay 'Governmentality',

> the ensemble formed by the *institutions*, *procedures*, *analyses*, and *reflections*, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge *political economy*, and as its essential technical means *apparatuses of security*. (2001: 219–220, emphases added)

Biopolitics is a form of governmentality aimed to control populations, and conducted through various techniques such as demographic studies/censuses, vaccination campaigns, institutionalization of modern hospitals, medical record-keeping, and so forth (Foucault, 1984, 2003). Disease control and prevention efforts rely on biopolitics, and the surveillance of populations around the world, to provide health security, raising questions about the ethics surrounding habitual monitoring, data extraction, forced medicalization, and quarantining (Youde, 2010). Equally important, Foucauldian governmentality and biopolitics have been criticized for stemming from a Eurocentric conceptualization of 'the subject', and for lacking a critical reflection on how these processes impact variously positioned bodies, depending on gender, race, class, etc. (Ettlinger, 2011; Howell and Richter-Montpetit, 2019; Richter-Montpetit, 2014; Taylor and Vintges, 2004). The modern medical profession also has a problematic history of abusing Black women, Indigenous peoples, racial minorities, and Global South peoples, by using them as medical test subjects without their knowledge or consent (Washington, 2006).

Biopolitics has been further problematized by various scholars, who argue that it is not inherently conducive to processes that simply foster life *or* death, but rather is crucial for political control over life, death, and everything in between, posing wide-ranging effects for marginalized groups around the world (Agamben, 1998; Aradau and Tazzioli, 2020; Mbembe, 2003; Richter-Montpetit, 2014; Youde, 2010). This is a troubling realization, because health security approaches that employ notions of biopolitics over a population, as a means to reduce pathological insecurity, then have this oversight baked into them. Or as Jessica Kirk argues, health security efforts always fall short because health threats are future-oriented and uncertain, thereby producing perpetual risk, vulnerability, and an inability to ever reach 'total' security (2020: 267–269). This line of reasoning can be amplified with other recent arguments that take issue with how security studies and

securitization theory, for instance, attempt to analyze society in an alleged effort to prevent violence, without addressing how the racialized and gendered foundations of these very theories may in fact contribute to differing degrees of (in)security around the globe (Howell and Richter-Montpetit, 2020).

Moreover, health security has tended to view the body as primarily a living biological organism with the potential for contagion/illness (Mitchell, 2014), and has subsequently inserted it into security studies as one of many possible referent objects with the potential to be securitized (Elbe, 2006; McInnes and Rushton, 2010). This move is symptomatic of how international relations (IR) in general (and security studies in particular) overlook the role of the human body as a location of securitization outcomes, violent practices, and attempts at gender fixation (Wilcox, 2015). Stated differently, the securitization of health transforms practices of care into 'sites for the global dissemination of a biopolitical economy of power that first emerged in 18th-century Europe around the government of "life"' (Elbe 2005: 404), and is aimed at human bodies via universalizing and homogenizing tendencies. The body, however, is more than a biological entity composed of cells, organs, DNA, bacteria, etc., or as Wilcox writes,

> as objects of security studies, the people who are protected from violence or are killed are understood as *only* bodies: they are ahistorical, biopolitical aggregations whose individual members breathe, suffer, and die. In both cases, the politics and sociality of bodies are erased. (2015: 2)

Both mainstream security and health security studies – even though the latter attempts to be more critical of its concepts and objects – have privileged a 'scientific', or presumably more 'objective', understanding of the body within practices of security. This oversight is troubling because during the Covid-19 pandemic, most responses (border closures, mandatory testing, quarantines, and mask mandates) were crafted at the state level, but implemented at the level of individual bodies. This points to an unresolved nuance within health security, whereby the state is displaced in favor of a population as the referent object of security without addressing that, 'the security of the state is not necessarily synonymous with that of the people who live within its physical boundaries' (Bilgin, 2003: 208). In effect, this oversight misses the role of biopolitics and health insecurity in delineating not only who lives and who dies from Covid-19 and other health threats, but also *how* individuals live and die (Puar, 2007: xii). Or, as João Nunes contends, studies of the health–security nexus via governmentality consistently miss how different bodies have different positions of power within society, thereby constituting some as secure and others as inherently insecure within global relations of domination that 'emerge from different combinations between the subjective, intersubjective, and structural levels' (2014: 948).

In Brazil, specifically, public health and health security have been deeply politicized processes since well before the Covid-19 pandemic (Wenham and Farias, 2019). Employing the 2015 response to the Zika epidemic as a case study, Nunes argues that neoliberalism has created an 'everyday political economy of health' in Brazil, whereby health security imperatives are in tension with neoliberal objectives, leading to increased risk for those unable to afford private healthcare or those who are part of socially marginalized groups (2020a). Another example of healthcare politicization in Brazil is the government's *Mais Médicos* ('More Doctors') program, a 2013 initiative that attempted to reduce public health disparities between wealthier/poorer municipalities by employing thousands of Cuban and other foreign doctors in the country's public health system (Pérez and Da Silva, 2019). *Mais Médicos* sparked an outcry from Brazil's medical professional class and conservative elites who viewed the immigrant doctors as an attack on their ability to effectively command domestic biopolitics, resulting in the harassment of these foreign healthcare

professionals and instances of racism, with many being labelled 'slaves' during public protests (Pérez, 2020).

Understanding the fight against Zika and *Mais Médicos* as a precursor to the polemical struggle we have seen over public health initiatives during the current global health pandemic, as well as the role of race, class, and/or gender in this process, underscores the need to examine the pandemic via intersectionality. This analytical approach was popularized by Kimberlé Crenshaw's work which called on researchers to reconsider the 'single-axis framework' analyses that prioritize the effect of either race *or* gender (1989: 139; see also Hancock, 2016). Instead, Crenshaw's approach draws attention to the 'multidimensionality of Black women's experiences'(1989: 139), both in everyday life and in the production of social science research, thereby pointing to connections between gender/sex, class, race, *and/or* sexuality. An intersectionality-based framework also better parses out hierarchy and the politics of difference vis-à-vis how power is constituted within the 'public' and 'private' sociopolitical spheres (Okin, 1998). Moreover, intersectionality allows us to comprehend varying political outcomes, as well as how identity regiments intra and intergroup conflict by better 'mapping the margins' (Crenshaw, 1991; Enloe, 2014) of social tensions.

Conversely, intersectionality has been challenged by other scholars, who argue that it conceptualizes variation in social conditions as fixed and given, following a stable ontological understanding of identities such as 'Black', 'women', etc. (Puar, 2007; cited in Day, 2016: 123). This, in turn, produces an emphasis on material and structural forms of inequality that overlook ideational and emotional forms of oppression *and* resistance (Day, 2016: 123–124). Contra intersectionality, Jasbir Puar and Keri Day employ the Deleuzian concept of 'assemblage' to highlight overlapping forms of oppression as 'patchwork, heterogeneity, fluidity, and temporary configurations' (Day, 2016: 123). In other words, a Black woman's oppression is not an ontologically predetermined phenomenon or causal mechanism; instead her oppression is dependent on time and space and on how the gendered/racial systems of oppression *operate and morph in each given context* she traverses throughout the day. We do not, however, view intersectionality and assemblage-based understandings of social oppression and exclusion as irreconcilable. Instead, we acknowledge the need to unpack and comprehend *both* material/structural *and* ideational/agentic manifestations of these processes, and how intersectional inequalities become stronger, weaker, or imperceptible depending on the geographic and temporal context in which a given 'body' circulates. The following sections are an attempt to parse out these various but nonetheless overlapping and interrelated forms of oppression and how they produce varying degrees of health (in)security.

Inequality in access to healthcare

We highlight three points with regards to disparate access to healthcare in Brazil during the Covid-19 pandemic and how it demonstrates the intersectional nuance of gender, class, and racial dynamics during public health emergencies: women's health (specifically that of pregnant *and/or* Afro-descendent women) has suffered unique and negative effects because of the pandemic; women's labor contributions to fighting the pandemic have been undervalued even as their health is put in jeopardy; and a masculinist discourse driven by President Bolsonaro has contributed to the spread of the virus by discouraging preventive healthcare measures. Specifically, although the pandemic has impacted every individual's life and healthcare, it poses distinctly pernicious side effects for women. Acute Respiratory Distress Syndrome, a side effect of Covid-19 that is particularly harmful to expectant mothers, has been reported in 978 pregnant and postpartum women in Brazil, leading to 124 fatalities or a 12.4% mortality rate, which is 3.4 times higher than the Covid-19 related death rate amongst mothers reported in other countries (Freitas-Jesus et al., 2020; Takemoto et al., 2020). This is because in Brazil, 'the data seem to reflect that obstetric patients

may face barriers to access ventilators and intensive care' (Takemoto et al., 2020: 156). In other words, the pandemic impacts women's health *as women*, because the ability of some women to conceive and carry children creates unique health concerns, which are amplified by pre-existing social inequities in gendered access to healthcare.

Race, in addition to gender, has also created challenges and divergent outcomes for Brazilian women during the Covid-19 pandemic. Between February and June 2020, 71 Black and mixed-raced (*Pardo*) pregnant women died from complications relating to Covid-19, compared to 23 White expectant mothers, reflecting a threefold difference in mortality between these two racial groupings (Takemoto et al., 2020: 155; see also De Araújo et al., 2020: 195). Another study finds Black and White women had a similar mean age when it came to mortality rates; nonetheless, 'Black women [in Brazil] were hospitalized in worse conditions (higher prevalence of dyspnea and lower O_2 saturation) and had higher rates of intensive care unit admission, mechanical ventilation, and death' (Santos et al., 2021: 2068). Thus, coronavirus has put *all* Brazilian women in an increased state of risk due to the complications it can produce, yet it has placed Black and mixed-race Brazilian women in an even more precarious state when seeking healthcare, due to pre-existing cleavages in access to adequate care based on class and race differences.

Moreover, patients in Brazil are not the only ones experiencing varying outcomes as a result of the interaction between health (in)security and social markers of difference. For example, throughout 2020,

> 442,285 cases of Covid-19 were confirmed among health professionals. About 148,000 of these infections occurred among nursing assistants and technicians (33.5% of the total). More than 67,000 nurses were contaminated (15.2%), and 48,000 positive diagnoses among physicians were registered (11%). (Sudré, 2021: 1)

This means the *lower* one ranks in the medical profession hierarchy of physicians, nurses, nursing assistants, and technicians, the *higher* one's social and economic vulnerability and probability of being infected by Covid-19 while at work. These discrepancies are alarming because lower-ranked care-centered labor positions have historically been feminized as 'women's work'. Moreover, as of 2020, men represented 53.4% of all physicians in Brazil, while women represented 46.6% (Scheffer, 2020: 41), and some scholars have found evidence of gendered salary disparities in Brazil, whereby male physicians receive on average R$9,877.58 per month, while female physicians receive on average R$7,483.72 per month (Madalozzo and Artes, 2017: 210). To add another layer of nuance, Madalozzo and Artes (2017: 210) find 82% of male and 81% of female physicians in Brazil are White.

We can interpret these data points collectively to signal that physicians throughout Brazil are predominantly White and male, and receive salaries disproportionally higher than nursing professionals, assistants, and technicians, the latter tending to be disproportionately female professionals, even as they all contribute to fighting the pandemic and attempt to enact health security. Stated differently, even before the pandemic, the patriarchal structure of Brazilian society influenced who became doctors and who became nurses, and legacies of racism simultaneously predetermined a greater opportunity for White Brazilians to become doctors than either Black men or women. Secondly, these data imply that even within the medical professional class, which per a Foucauldian understanding of biopolitics is supposed to be a powerful social group due to their ability to diagnose and treat the human body (Rosenberg, 2002), we nevertheless see income and power disparities that reflect grander social problems.

The undervaluation of women's labor and their contributions to healthcare are not, however, simply limited to income gaps as the pandemic has laid bare; rather, Covid-19 responses in Brazil

and around the world have relied extensively on women's 'resilience' in times of crisis for their success and continuity, despite resource constraints (Moreyra, 2020). For instance, of Brazil's over 286,000 Community Health Workers, who work in the public health system and are also predominantly female (Krieger et al., 2021: 2), only about 9% reported receiving personal protective equipment (PPE) (Lotta et al., 2021: 365). Female healthcare professionals in Brazil have been placed in positions of extreme and multifaceted insecurity during the Covid-19 pandemic while grappling with 'fear of coronavirus infection, concerns with their children and other family members, and illness and death of coworkers and themselves' (Bitencourt and Andrade, 2021: 1013; see also Cotrin et al., 2020). This is as well as the countless lower-income and marginalized women for whom Covid-19 came to mean additional labor tasks within the home and/or workplace such as supervising children's virtual schoolwork, cleaning common areas and surfaces, disinfecting groceries and other purchases, etc. Or, as the Brazilian Senate investigation into the impacts of the pandemic final report states,

> It is important to emphasize, finally, that Covid-19, in addition to the deaths it causes directly, also impacts the lives of women due to the increase in domestic and family violence; through the aggravated suffering of mental stress, due to the accumulation of tasks, especially those related to caring for the sick and children; due to the closure of schools and daycare centers; lapses in the functioning of public services for pregnant and postpartum women; and also by the interruption of services related to contraceptive care. (Senado, 2021: 653, translation ours)

The underlying point here is that an overlooked but central aspect of health security moves and policies is their reliance on women's underpaid and undervalued labor (see also Ackerly, 2000; Enloe 2014), as well as insecurity, as health security initiatives seek to treat, care, and provide for the medicalized masses.

Moreover, further exacerbating this overreliance and exploitation of women's roles within Western medical processes, during the pandemic President Jair Bolsonaro has engaged in a series of toxic masculinity performances to discourage individuals from seeking or demanding adequate healthcare access and preparedness. As examples, we can cite Bolsonaro's refusal to wear a mask in public, asking his opponents to attend large gatherings in direct disobedience of public health ordinances, and minimizing the virus as a '*gripezinha'*, or 'little flu', stating that due to his personal history as an 'athlete' the disease would probably not impact him severely (Lima Neto, 2021; UOL, 2021). These actions can be read, as Agius et al. (2020) argue, as signs of feelings of insecurity during crises, which men attempt to downplay via displays of toxic masculinity and references to gendered nationalist motifs in efforts to ontologically reassure themselves. The president further accused others of 'hysteria' in their response to the pandemic, which is a loaded term with a gendered history of framing women in a manner that produces social exclusion (see Howell, 2011: 39–44). In effect, the president and his right-wing sympathizers attempted to gender the pandemic response and frame the following of public health guidelines or the seeking of healthcare as signs of cowardice and lack of virility.

Bolsonaro's approach to Covid-19 demands that individuals place themselves in heightened circumstances of insecurity to prove their masculinity, which runs contrary to the notion of the state within international relations as the alleged provider of security. As a result of Bolsonaro's unwillingness to securitize Covid-19 as a public health emergency, and instead choosing to ignore it and securitize individual masculinity, countless lives have been harmed and others lost as the president framed preventive care measures as effeminate. Moreover, Bolsonaro's 'distraction' tactics divert attention away from discrepancies between who received care and who did not, due to different gender, racial, and/or class identities. Health security, in theory, has an underlying rationality that

presupposes the subject/individual as wanting and deserving health and its accompanying reassurances, but this conceptualization misses the pernicious outcomes that occur when health concerns come into conflict with patriarchal, racialized, and classist imperatives that devalue some individual's safety and spur others to recklessness.

Disposable workers and precarity of labor

The individual versus collective tension in health securitization efforts is also present when we examine the role of inequality in the production of disposable workers and precarious labor conditions under Covid-19 in Brazil. More concretely, Bolsonaro and his allies have continuously attempted to paint their actions as consistent with neoliberal practices that view the individual as a self-contained entity completely responsible for their own success or failure, decenter the role of the state in resource provision, and position the free market as the ultimate path towards prosperity (see Brown, 2015; Foucault, 2008). However, an individual-based understanding of decisionmaking is in direct tension and opposition to the collective or population-level initiatives that health security measures envision to be effective. Said differently, neoliberalism, with its emphasis on individuals, makes it increasingly difficult for health security strategies to manage and overcome sanitary collective action problems (Nunes, 2020b), as the pandemic has exemplified across numerous sociopolitical settings. This section details these incongruencies within Brazil, and how neoliberalism has impacted different segments of the labor force during the pandemic by positioning proletarianized workers at higher levels of risk in order to maintain the profit-maximizing logic of free markets.

Throughout the pandemic, Bolsonaro has espoused the rationale that shutdowns and quarantines are bad for the economy because they increase unemployment rates. Therefore, he has argued that reopening businesses and commercial centers is 'best' even if it means many will perish from Covid-19 (UOL, 2021). This line of reasoning is consistent with neoliberalism's internal logic that envisions a truncated role for the state in providing aid or welfare for workers, instead placing the burden on individuals to acquire income via the labor market. Put differently, workers were expected to leave their homes to generate labor, revenue, wealth, and economic security for themselves, their bosses, and the Gross Domestic Product, while potentially exposing themselves to an illness that could temporarily or permanently leave them unable to make a living. These nuances speak to the idea of 'insecurity and the everyday' (Autesserre, 2014), or how quotidian events and practices can place individuals in positions of insecurity, even as the nation-state is safe and securitized from outside invasion, and are illustrative of how security/insecurity are co-constituted within contemporary 'risk societies' (Bilgin, 2003: 217). In effect, the individual is habitually caught within various apparatuses that attempt to deliver one form of security, but which simultaneously spur forms of insecurity.

According to various studies, White Brazilians were less likely than Afro-Brazilians to be unemployed or underemployed during the pandemic, and more likely to have the means to afford private healthcare plans/hospitals (Baqui et al., 2020; IPEA, 2008). Furthermore, in May 2021, the unemployment rate amongst Brazilian women reached 17.9%, the highest rate ever recorded in the country, whereas the unemployment rate among men was 12.2% (Silveira and Alvarenga, 2021). From these figures we see racial and gendered disparities in whose economic survival and participation was more severely jeopardized during the pandemic. Baqui et al. (2020) find also that Brazilians hospitalized in private hospitals were less likely to die from Covid-19 than those hospitalized in public hospitals. And as of March 2021, only 24.7 million Brazilians had a private healthcare plan, representing a little more than 10% of the population (ANS, 2021), while another study estimates that about 60%–70% of the population depends exclusively on SUS for care (Viacava et al., 2018). Although related to the dynamics of healthcare access presented in the previous section,

these statistics also delineate a connection between income levels (or social class), race, and gender, and how one is subsequently positioned *because of* one's location on the labor/income hierarchy to suffer from the virus, if at all.

Neoliberalism, then, is where health security encounters a 'limit' because it cannot overcome the collective action problem posed by the spread of the virus, as certain bodies are positioned to bear its worst consequences due to their social disposability (Amar, 2009). In practice, 'biopolitics [. . .] *requires* a "negative" biopolitics, that is, the abandonment of some lives and/or deliberate targeting and killing of some in order to strengthen the health of others and the polity' (Wilcox, 2021: 1111, emphasis in original). Covid-19 has demonstrated how the 'essential worker' or 'frontline worker' narrative loses its surface-level patina of respectability when we realize that the infection of nurses, grocery store clerks, bus drivers, and delivery workers, among others, is essential for the maintenance of neoliberal hierarchies during times of crises. Additionally, these hierarchies determine who has the privilege to stay at home and work remotely, and whose social position demands they leave the home and risk their health to 'save' the economy. During the height of the pandemic, for example, images of crowded city buses in Rio de Janeiro and São Paulo, with dozens of working-class passengers packed together in settings where social distancing was utterly unfeasible, began to go viral on social media, illustrating the difference in pandemic lifestyle between those with the income and job security to work from home and those who were marginalized as disposable workers (De Góis et al. 2021).

Another example of heightened insecurity and downward social mobility for Brazilian workers during the pandemic is the online delivery app sector. This market is primarily composed of three transnational corporations in Brazil – iFood, Rappi, and Uber Eats – which employ individuals using city bikes, personal bikes, rental vehicles, or private vehicles to deliver food, medications, etc. According to the BBC, 'numbers [. . .] indicate a [trend towards] lower payment, longer hours, and of migration of qualified professionals from other types of jobs [to app delivery jobs] during the pandemic', with approximately 42,000 Brazilians with a higher education degree declaring their current occupation as 'delivery of goods' (BBC, 2020). Moreover, 57.7% of the BBC survey respondents stated that they had not received any support, such as PPE equipment, from the companies to reduce the risk of infection while on the job (BBC, 2020). And 15.7% of these types of workers reported, in another similar study, feeling some Covid-19 symptom(s), such as fever, cough, or difficulty breathing, during May 2020, but most did not stop working (Manzano and Krein, 2020: 7).

These statistical findings collectively point to how Brazilian workers have been squeezed during the pandemic to produce labor in deteriorated conditions, due to the absence of sufficient state assistance or workplace safety oversight. This is the same state that should, theoretically, provide 'security', both of national borders in the traditional sense, and from pathogenic debilitation in the health security sense. However, neoliberal ideologies have positioned these workers as 'independent employees' with the 'freedom' to choose where they work, absolving these transnational corporations of workplace safety standards and responsibility for injuries, car crashes, etc., or even the need to provide PPE. Examining the experiences of Brazil's most vulnerable workers during the pandemic highlights how Booth's (1991) 'security as emancipation', notion can be complicated and derailed in settings where neoliberalism coincides with health (in)security, leading instead to the political domination of working-class subjects (Nunes, 2014).

Delivery app workers are not alone, however, as numerous other educated professionals in Brazil have been pushed by the pandemic into the informal sector selling homemade goods, such as desserts and meals, artwork, clothing, and other precarious forms of employment without benefits or stability. Despite pandemic narratives of 'We are all in this together', as Nunes explains, Covid-19 'demonstrates neoliberalism's contradictions, demanding circulation even when such

circulation provenly promotes the sickness and death of a significant contingent of the population' (2020b: 2–3), as well as their amplified precarity. In summary, delivery app workers, workers who rely on public transport, and countless other proletarianized individuals have endured some the worst ramifications of the 'negative biopolitics' that result from neoliberalism's interaction with pandemic politics in Latin America, altering their way of life, perhaps holistically, for the worse.

Exposure in the private and public spheres

In her study of Black female domestic workers in Brazil during the Covid-19 pandemic, Juliana Teixeira (2020) asks: 'How can they isolate if domestic work stems from racism?' This question is in regard to the racialized history of domestic labor in Brazil which evolved as a replacement for service in the master's house, or *casa-grande*, and was purposefully constituted around close and intimate interactions between employee and employer (Fernandes, 2021 [1964]). For Teixeira, domestic labor creates a particular form of violence and necropolitics for Black female workers during Covid-19 because they cannot achieve a state of security, or social distancing, during their working hours (2020). Or as Angela Davis argues, slavery was for many Black women a 'domestic institution', whereby their labor came to be associated (even post-emancipation) with domestic servitude, intimate contact with White households, and constant supervision while working (1983: 95–96). In other words, domestic labor fosters a private form of insecurity during the pandemic because it requires habitual contact with White families who were more likely to have recently returned from trips to Europe in early 2020, the route by which the virus was spreading into Brazil.

As a case in point, the first person to die from Covid-19 in the state of Rio de Janeiro was a 63-year-old female domestic worker who caught the virus from her employer, an upper-class White female judge who had returned from vacation in Italy to her home in the wealthy neighborhood of Leblon (Corrêa and Fontes, 2020; G1, 2020). Although the exact identity of the domestic worker was never revealed by authorities, to protect her family from discrimination, most domestic workers in Brazil are women of color, and this domestic worker turned to the country's public health system for treatment in the early days of the pandemic when testing was still very rare. Concomitantly, her White employer had the option of private medical attention to treat her illness and was able to survive. Social distancing, the tediousness of online meetings, and masking can be read as economic and class privileges that not everyone could afford during the height of the pandemic; and in a security and social context such as Brazil's, they also became forms of White privilege (Guerra, 2021).

Black domestic workers are not the only group within Brazil to have felt a racialized form of exposure to the virus during the pandemic. Lotta et al. find in their survey that 84.2% of Black healthcare professionals reported a feeling of fear in the workplace, as opposed to 69.7% of White male healthcare professionals (2021: 15). Conversely, White male and female healthcare workers reported higher rates than their Black male and female colleagues across all indicators of access to PPE supplies, specific training for treating Covid-19 cases, continuous testing, and overall preparedness to face the pandemic (Cotrin et al., 2020; Lotta et al., 2021: 26). Baqui et al. (2020) conclude, after examining mortality rates across the entire country, that race in Brazil is the second most important predictor of Covid-19-related fatalities, second only to age (see also Ribeiro et al., 2020). These findings collectively signal an unequal and racialized distribution of exposure and mortality from the virus that state policies of health security have been unable, or unwilling, to address. Likewise, they are in line with the claim that the 'global politics of medicine' complicates notions of 'securitization' (Howell, 2014), because healthcare inequality and violence – more so than security – have been historically ingrained as the expected or likely outcome of certain sociopolitical structures. Or to quote the final report of the Brazilian Senate investigation on the

government's Covid-19 response, 'this Commission emphasizes that Brazil's Black population was the one that died the most because of the mismanagement of the pandemic. Thus, the government's indifference, disguised as neutrality and isonomy, materialized once again the damage caused by structural racism' (Senado, 2021: 658; translation ours).

Covid-19 has also impacted various political economies in Brazil in myriad ways due to the underlying racialization of space throughout society. For example, ongoing surveys of small and local businesses throughout the country have found specific negative repercussions of the pandemic for Black entrepreneurs and their businesses:

> In Brazil, the proportion of Black entrepreneurs affected by economic downturns (circulation restrictions, temporary interruptions, quarantine, lockdown, etc.) was higher [. . .]. 70% of Black entrepreneurs said they were harmed by quarantines or lockdown, against 60% in the case of White entrepreneurs [. . .]. This increased impact on Black entrepreneurs occurred because their presence is greater in the peripheries of large cities, where Covid-19 was more intense, and because the proportion of businesses that can only operate in person is greater (De Abreu et al., 2021: 68–69, translation ours).

This data highlights the incongruencies of health security approaches when applied to a Global South setting where biopolitical applications of preventative measures do not impact all communities equally due to centuries of uneven development, government omission, and policy exclusion. The imbalanced distribution of exposure to the virus between White versus Black bodies in Brazil, in effect, rendered certain neighborhoods inherently more dangerous for walking around, going to work, or keeping a small business afloat (see Martins-Filho et al., 2020). We also highlight the study's finding that these Black-owned businesses are more likely to *have* to operate in person. This finding indicates an asymmetrical and racialized access to e-commerce and digital technologies that can increase distance between bodies, and which have been employed in many countries as a biopolitical substitute for close and in-person commercial encounters.

Nevertheless, in this context of racialized exposure and harm from the virus, we can further gauge impacts of how gender, class, and race transversally interact with each other. For example, expanding on our previous example of delivery app workers, another recent survey of 298 of these workers across 29 Brazilian cities found that

> among respondents, almost all (94.6%) identified as male. As for color or race, 39.9% identified themselves as White; 44% as Brown; 14.8% as Black; and 1% as Indigenous [. . .]. Therefore, the dominant profile of the interviewed delivery workers is men who recognize themselves as White or Brown (83.9%), with ages between 25 and 44 years (78.2%) [. . .]. Comparing the distribution by working time ranges, it was found that more than 57% of respondents reported working above nine hours per day (Abílio et al., 2020: 6–7, translation ours).

Thus, on the one hand, as detailed above, many Black women in Brazil must confront health insecurity in the *private sphere*, as domestic work entails perpetually close encounters with individuals from outside their own home, whose activities and level of risky behavior they do not necessarily have the power to curtail or influence. This erases the traditional sense of 'safety' that is attributed to the private/home and to labor within these spaces in patriarchal Western societies (Okin, 1998).[1] Conversely, many Black and mixed-race men in Brazil must confront health insecurity in the *public sphere*, due to the gendered construction of employment, working via delivery apps, or as waiters, doormen, bus drivers, etc., but even these forms of labor still entail some contact with families not their own. Finally, these Black working-class Brazilians then meet in their own homes and in their social milieu throughout the peripheries of Brazil's largest cities, collectively creating the conditions for heightened exposure to the virus in spaces where access to healthcare is severely truncated, as detailed earlier.

Much of the social and media commentary surrounding Covid-19 has centered individual responsibility for 'social distancing' as a highly effective manner for stopping the spread of the virus. This overlooks the fact that for countless racially marginalized individuals, their employment essentially involves bodily contact with White and wealthier 'others' as a means for economic survival, and the relations of power that structure these encounters are often beyond their control. As Shinko explains, 'COVID-19 has exposed how our bodily proximity, our physical interactions within our families, in our communities, and across the world, poses a threat to our survival. And when this is layered over long-standing racial and ethnic prejudice', she goes on to add, 'we need to be attentive to why *COVID-19 infects some bodies and not others and why some are more exposed than others* across a spectrum of unequally distributed precarities' (Shinko 2021: 1120–1121, emphasis added). In other words, Covid-19 has exemplified how state-sanctioned economic, public health, and security policies, *and lack thereof*, across the entirety of Brazil's sociopolitical geographies reinforce racism as the 'production and exploitation of group-differentiated vulnerability to premature death' (Wilson Gilmore, 2007: 247). This partially explains why the murder of George Floyd in the United States, in the midst of the pandemic, resonated so profoundly with activists in Brazil, and led to numerous protests with chants of '*Vidas Pretas Importam*' (Black Lives Matter) and '*Aqui é Minneapolis*' (Minneapolis is here). Risking one's health during a global health pandemic to protest social inequality is indicative of the deep connections between these seemingly separate social policy spheres, and how the multifaceted nature of (in)security impacts numerous aspects of both public and private life for Afro-Brazilian men and women, even though oftentimes in divergent manners.

Conclusion

This article has detailed how *security* and *insecurity* are co-constituted via daily experiences in Brazil, such as commuting to work, working in another person's home, or pursuing a career as a nursing assistant. Although these forms of (in)security have always existed and been stronger for some groups than others, the pandemic has made them more visible and accentuated for all. Our case study of Brazil's experience with Covid-19 highlights the difficulty of securitizing health, and in providing health security in contexts where structural violence is more the norm than the exception. Moreover, we have limited our discussion here to how gender, race, and neoliberalism complicate our conceptualizations of biopolitics and public health governmentality within the interrelated themes of *access to healthcare*, *disposable workers*, and *exposure to the virus*, but one could certainly add sexuality, ablism, and other variables to this process.

The implications of our findings are crucially important for the field of international relations as the world continues to face ever-growing challenges to the nation-state model and notions of security due to the movement of viruses and bodies across borders. As the Zika virus, Covid-19, and most recently, Monkeypox, all illustrate, the introduction of public health menaces automatically draws up social categories of exclusion and marginalization to make sense of the public health emergency; targets specific bodies for surveillance, diagnosis, and medicalization; and has various and unpredictable consequences for other social realms, such as political economy. This realization highlights the shortcomings, as outlined in the preceding sections, in the technical/administrative construction of pathogenic threats to bodies/polities as 'unruly' parts of nature that can be controlled via 'proper' science, data, and public health governmentality (Voelkner, 2011), while missing the difficult political questions of social exclusion and oppression that predetermine who suffers more from microbes, viruses, and illness.

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Note

1. Anthropologist Roberto DaMatta (1997) conceptualizes this dichotomy in Brazilian society specifically as between '*casa'*, or home, and '*rua'*, or street.

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