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Gender bias in Brazil's response to covid-19: evaluating the reception of WHO/PAHO recommendations

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ABSTRACT

Here, we present a comprehensive analysis investigating the potential gender bias in global and Brazilian responses to the covid-19 pandemic. Our primary objective was to evaluate the extent to which the World Health Organization (WHO) and the Pan American Health Organization (PAHO) considered the needs and perspectives of women in their key recommendations. Additionally, we aimed to determine the level of adherence of the Brazilian public authorities to these recommendations. Drawing upon insights from feminist literature on Global Health, we have identified relevant topics and intersectional considerations that inform our analysis of the recommendations provided by international organisations (IOs) and subsequent public policies. By employing content analysis techniques, we describe the recommendations issued by WHO/PAHO throughout 2020, along with an examination of the actions taken by the Brazilian executive branch. In the later stages of our research, we prioritised the triangulation of various documents and information complemented by semi-structured interviews. This approach enabled us to select pertinent evidence that effectively addressed our central question regarding gender bias.

KEYWORDS

covid-19, gender inequality, global health, intersectionality, World Health Organization, Pan-American Health Organization

RESUMO

O artigo investiga um possível viés de gênero nas respostas globais e brasileiras à pandemia de covid-19. Seu principal objetivo foi avaliar em que medida a Organização Mundial da Saúde (OMS) e a Organização Pan-Americana da Saúde (OPAS) levaram em conta as necessidades e perspectivas das mulheres em suas principais recomendações. Além disso, buscamos determinar o nível de adesão das autoridades públicas brasileiras a essas recomendações. Com base em insights da literatura feminista sobre Saúde Global, identificamos tópicos relevantes e considerações interseccionais que informam nossa análise das recomendações fornecidas por organizações internacionais (OIs) e políticas públicas subsequentes. Ao empregar técnicas de análise de conteúdo, descrevemos as recomendações emitidas pela OMS/OPAS ao longo de 2020, juntamente com um exame das ações tomadas pelo poder executivo brasileiro. Nas etapas posteriores da pesquisa, priorizamos a triangulação de vários documentos e informações, complementados por entrevistas semiestruturadas. Essa abordagem permitiu selecionar evidências que permitem responder nossa questão central sobre a existência de um viés de gênero.

PALAVRAS-CHAVE

covid-19, desigualdade de gênero, saúde global, interseccionalidade, Organização Mundial da Saúde, Organização Panamericana da Saúde

1. Introduction

This paper presents some of the results of an investigation aimed at identifying whether there was a gender bias in the international response to the covid-19 pandemic. We focus on the World Health Organization (WHO) and Pan American Health Organization (PAHO) recommendations for 2020. The specific case study is Brazil, as we seek to observe how gender-related issues appear in these organizations' advice and their impact on Brazilian authorities.

Until July 2020, only 2% of the articles mentioning covid-19 covered issues related to race/ethnicity, gender, or intersectionality[1]. At the same time, 56% of the publications that addressed sexual and reproductive rights emphasized pregnancy and delivery of babies, but not contraception and abortion. Domestic violence is another theme that the authors considered overlooked.

In recent epidemics, authors in feminist literature have been exposing agents on global health failure to address gender-related issues in emergencies. Among these authors, the concept of "tyranny of the urgent" has gained popularity to debate how the focus on biological dynamics during emergencies usually leads to the neglect of structural factors and their consequences on vulnerable groups[2].

The dynamics of health governance based on biological indicators often produce a masculinist bias in combating health emergencies, particularly because women are socially responsible for caring services. Gender is a significant factor in the social division of labour, so care may also be unpaid and invisible work that benefits some individuals and institutions monetarily; public investment in social security policies and infrastructure tends to reduce this care burden, and the opposite is also true[3]. Therefore, neglecting care burden consequences affects both women's capacity to invest in themselves, and the sustainability of the health system, creating harmful effects at both the individual and collective levels.

In an article presenting a case study of the Social Enterprise Network for Development (SEND) Sierra Leone, during the Ebola outbreak, Julia Smith poses some questions that can be useful in detecting whether there is a gender bias in public policies during health emergencies: "Do policies consider the differing roles and experiences of men, women, and other social groups? Do they aim to maintain the status quo or promote gender transformation? (...) Do policies recognize how gender norms impact the healthcare roles men and women fulfil during an outbreak? Do they support or exploit unpaid care work?" (p. 358)[4].

In this study, we aim to answer these questions by adopting a framework of main themes regarding women rights and the concept of intersectionality. Studies based on an intersectional approach seek to reflect about inequalities, such as racism, misogyny, classicism, and ableism[5]. These forms of oppression are not analysed separately but as dynamic axes of subordination that interact collectively and in individuals' lives. Therefore, each government policy affects these dynamics, even if authorities do not reflect on their consequences.

Next, we introduce the literature used to interpret the data by discussing experiences from recent epidemics, such as Ebola (2014), Zika (2016) and covid-19 (2020-2021). We argue that the international system, divided into sovereign states, allows governments to prioritize courses of action aligned with the authorities' ideological bias. Often, this results in favouring the free-market agenda to the detriment of vulnerable groups' necessities, especially women. Even if the activities that these groups perform in precarious jobs are considered "essential".

1.1. Epidemics history: the economy must go on and women as "shock absorbers"

Since the beginning of health diplomacy around the 16th century, sovereign states have prioritized international trade during outbreaks[6]. Nowadays, the neoliberalism is part of a deep core of beliefs in Global Health, resulting in "individualization of risk and responsibility for health" (p. 163)[7]. Therefore, the current international system favours governments that focus on maintaining trade and goods circulation.

Establishing the economy as a priority for sovereign states during the pandemic demonstrates how Foucault's concept of biopower works. This power is characterized by the ability to define who can live or die, and by controlling the conditions of life and death. This power is not only expressed by the monopoly on the legal use of force, but also by the management of the material conditions of existence[8]. It includes controlling access to "public health, basic sanitation, transport and supply networks, and public safety" (p. 70) so that the absence of these services would be a way of letting oneself die. Racism is one of the main tools in defining who should live or die, having its root in colonial power and creating another form to exercise biopower through necropolitics, the celebrated concept developed by Achille Mbembe[9].

Thus, when sovereign states refuse or neglect advice aimed at protecting human rights, these states use their biopower to define who should live or die. Economic maintenance requires human sacrifice, both from those who will die from neglect and from those who will keep the machine running at the expense of their quality of life and protection. Vulnerable groups tend

to play the role of being left to die, especially women, black and indigenous people, people with disabilities, and the lower classes.

The feminist literature on Global Health indicates that ignoring outbreak effects on gender is a global trend, expressed in the tendency to reduce women to their reproductive roles. Women's unpaid work as caregivers may be invisible, but their performance is crucial for maintaining the health system as a whole[10]. Thus, in times of crisis, women act as "shock absorbers," engaging in functions of care and well-being when the state, employer, or individual can no longer or refuse to pay for these services.

Immediate health problems and the tendency to focus on women in their reproductive roles resulted in health programs that do not address the marginalization of these women; there is a disconnection between international public health advice and experiences of structural gender inequality[2]. Therefore, authorities should consider the social determinants of health in the early stages of an epidemic. Women may be in the risk group but do not participate in the decision-making process at all levels of national and international responses.

Global health agents failed to assess the unequal impact of emergencies on women, by focusing too much on a securitizing and masculine emergency vocabulary and prioritizing a biological approach of "prevention, detection, and response" (p. 2) [11]. Meanwhile, women are at the forefront not only because of their role in their family and community, but also as professionals in the health system. Consequently, they are in a strategic position to participate in the planning of surveillance and prevention policies.

During the Zika epidemic in Brazil, some authors criticized the government strategy to focus on the vector, the mosquito *Aedes aegypti*, instead of previous structural issues[12]. The news and the government used pictures of children and their families to create a sense of risk around the epidemic, often represented in the maternal figure with a baby in her arms. The epidemic's cause was the long-lasting Brazilian enemy, the mosquito, even if congenital Zika syndrome mainly affected women from specific profiles considering the places they live, their social class, and race. The majority of reported cases were from lower-class families in Northeast Brazil (p.1)[13].

In Brazil, meanwhile, colonial history has created a social context in which black women are usually the most affected by the neglect of structural problems and responsibility to care. It is closely related to tools of social control and stereotypes that classify black women as

naturally abnegated and submissive. Regarding black women, gender and race interact to reinforce stereotypes of servitude[14].

These stereotypes contribute to normalizing racism, sexism, and poverty, so that social injustices seem inevitable and part of everyday life [15],[16]. In the United States, this mechanism is expressed in the *mammy* figure, while in Brazil it appears as the Black Mother (Mãe Preta) role, both of which contribute to reinforcing the notion of selfless care and submission.

We could also mention Hill Collins work on the *mother depending on the State*, a controlling image used to judge single mothers as lazy for raising their children receiving social benefits. In Brazil, a similar case occurs with female beneficiaries from social programs such as Bolsa Família (an income distribution program) and BPC (an income program granted to the elderly and people with disabilities), both of which benefit families affected by the Zika epidemic. This mindset persisted during the covid-19 pandemic in discussions on the state's role in guaranteeing social security for vulnerable people.

A study on the growing poverty in some Latin American countries during the covid-19 pandemic demonstrated that the pandemic's economic impact hit members of the middle class, black, brown, and indigenous people the hardest[17]. Despite this, several countries in the region prioritized the economy instead of strengthening their health systems[18]. Brazil is one of the examples, a choice justified by conservative and neoliberal ideals of individual responsibility for health issues, using notions of nationalism allied to the idea of sovereignty and toxic masculinity.

This neglect of public health, even in the face of pandemic effects on more vulnerable groups, demonstrates that some lives are worth more than others in Brazil. Brazilian society delimits racial roles very precisely: whites have access to goods, services, and leisure, while blacks and browns have precarious subsistence conditions, often in slums or outskirts, without health, education, or security services. Lélia Gonzales affirms that racism is part of a Brazilian cultural neurosis, and the intersection between gender roles and racism produces violence against black women in a particular way. Women were "overrepresented in in the economy most affected sectors during the pandemic, including informal and precarious work", while "in Brazil, black people are 40% more likely to die from covid-19 than white people" (p. 9-10)[19]. Unpaid care work is one of the main factors that explains the precariousness of these women's living conditions.

Next, we discuss the methods used in this study. Before that, some considerations: we understand that there is some focus on the experience of cis women, which occurs partly because of the authors' research expertise and partly because of the documents themselves. This is the first important observation: most treat gender discussions through a binarist lens, some by explaining that it is helpful from a biological-epidemiological point of view[20], others by assuming that some themes are only of interest to cis-women. This issue should be addressed in future studies.

1.2. Research methods

In this study, we used qualitative content analysis techniques to analyse the data, first by searching for evidence in public databases with predetermined descriptors within a period limit[21]. The selection process included several documents, such as reports, press releases, interviews, news, norms, ordinances, laws, decrees, and provisional measures. Subsequently, we establish a framework with analytical categories to classify the information contained in these documents. In the last stages, the feminist literature on Global Health and the interviews helped us interpret the data.

The descriptors used to search in PAHO and WHO digital libraries were: “covid-19”; “Coronavirus,” also “covid-19+gender”, and “covid-19+women”[2]. We set the year 2020 as a time limit to concentrate on the first recommendations and efforts, considering that urgency should not justify postponing dealing with gender-related issues. At this stage, there was enough information to set an analytical framework, including themes with the greatest impact on women during the pandemic. We formulated this framework using feminist literature on Global Health, by guidance of Clare Wenham[22],[23],[24]. The final categories to discuss the impact of the pandemic on women are as follows:

Themes with impact on women	**Intersectionality related topics**
Closures of schools and kindergartens Financial support or tax relief Informational campaigns Political participation Domestic violence Sexual and Reproductive Rights	Race/ethnicity Disability Local of residency Religion Sexual Orientation Socioeconomic status Gender identity

[2] PAHO digital library website: https://iris.paho.org/
WHO digital library website: https://apps.who.int/iris/

Workplaces closure (schools, kindergartens, beauty salons, services in general) Women's Health Health professionals Care for the vulnerable (children, elderly, unpaid care)	

When collecting documents related to the Brazilian government, we used two databases: the Oxford covid-19 Government Response Tracker (OxCGRT) and the Rights in the Pandemic Project from the Centre for Studies and Research on Sanitary Law (CEPEDISA from the Public Health Faculty at USP). In the CEPEDISA database, we selected documents classified by researchers as policies that affected women. In both databases, we selected evidence related to the themes in the main framework. We focused on documents that cited gender-related issues during the pandemic. Finally, we read 65 documents from PAHO, 22 from WHO, and 58 related to the Brazilian response.

2. Results

At the beginning of the pandemic, despite President Jair Bolsonaro's opposition, state governments took the initiative to establish social distancing and support policies, many of which used the WHO emergency declaration to justify it[25]. Governors decreed the closure of several establishments with public contact, such as schools, cinemas, gyms, malls, parks, and businesses, while only essential services were allowed, such as security, health, transport, and inspection[26].

The divergence between President Bolsonaro and state governments regarding what policies should be adopted to respond to the pandemic resulted in a lawsuit in the Federal Supreme Court (STF)[27]. The STF determined that the president could only establish benefits and actions of national interest, but it was up to the mayors and governors to define local regulations. From then on, Bolsonaro blamed governors and the STF for the pandemic's consequences, attacking isolation measures. Bolsonaro used to say that he was doing that in the name of a metaphorical family man who should have the right to bring food to his family.

Bolsonaro eventually adopted a denialist stance, recommending chloroquine as a miracle solution to treat and preventing covid-19. Several experts with experience in fighting viral infections criticized his stance. Meanwhile, Bolsonaro advocated a type of "herd immunity" strategy, in which everyone should catch the virus to develop antibodies, even if the "weakest" die[28].

On several occasions, Bolsonaro and representatives of his government attacked WHO's credibility, even claiming that Brazil was a sovereign state and therefore owed no explanations to the organization[29]. However, the government allowed PAHO and WHO representatives to circulate in the health ministry building and used to refer to the organizations in various standards and guides published during the period. Several times, the preamble of decrees, laws, and ordinances cited the WHO's declaration of emergency.

WHO reports that it has produced dozens of documents throughout the pandemic, always aiming to collect and analyse research data and guide Member States[30]. According to the organization, they used several platforms to disseminate its content, such as publishing it online and distributing it on networks. However, WHO claims that only 40% of confirmed cases of covid-19 in the world had been reported directly to the organization disaggregated by age and sex until May 2020[31].

WHO experts have evaluated several factors that cause setbacks during the pandemic and reduced access to health services, such as the unexpected volume of patients in health facilities, social isolation, and overload of professionals. However, in addition to these factors, they understand that other issues should be considered, such as insufficient human and financial investment, lack of adequate information, and the advancement of fundamentalist sectors opposed to secularism and inclusion policies[20].

In a report on the response to the pandemic, PAHO also understood that gender dimensions have not received due attention[20]. Some countries already have the institutional capacity to consider gender and introduce policies in that sense. However, countries with more conservatively biased governments focused more on epidemiological criteria and emergency measures (p. 37). Accordingly, the organization understands that gender received attention in issues that generated greater visibility, such as domestic violence, but lacked visibility in other areas.

The WHO and PAHO assessment of the progress of conservative groups aligns with feminist literature on Global Health. There is a relationship between Christian conservatism and neoliberalism in Latin America, evident in the antagonistic reaction to recent advances in human rights[32]. Bolsonaro and his supporters primarily targeted sexual and reproductive rights. Around 2011, when Bolsonaro was only a deputy, he made a campaign against what he used to call a "kit-gay" – some informational materials regarding sexuality the government would distribute in schools.

Bolsonaro and his allies mobilized against LGBT+ and gender agendas that they call "gender ideology," striving to eliminate any mention of policies to protect these groups. This position has been reflected in the Brazilian foreign policy, which not only barred dialogue with feminist movements, but also carried out an equipping of bodies responsible for the formulation of foreign policy by ultraconservative groups and sectors opposed to the rights of women, the LGBTQI+ population and the debate on sexual orientation and gender identity[33]. The business class endorsed this posture because they saw Bolsonaro as an opportunity to place the economist Paulo Guedes in the Ministry of Economy, who advocates for neoliberal reforms, such as reducing public expenditure, reviewing labour rights, and advancing the privatization of public services. This relationship of mutual support between conservatism and neoliberalism intersects in the defence of "family values" since placing all responsibility under the families contributes to exempting the state from the austerity agenda that reduces social benefits[32]. We evaluate the consequences of this in the following sections.

2.1. Women as "shock absorbers" on covid-19 pandemic

2.1.1. Responsibility to care

Concerning care, both WHO[31] and PAHO[34] consider the extra workload women would have during the pandemic and its possible consequences. Both mention that the states should meet some needs, such as addressing the reduction in access to income[34]; providing financial support and training for health professionals[35]; incorporating the community into planning care policies[35]; preventing substance abuse by caregivers[36]; psychosocial support to families and caregivers[35]; transportation services to guarantee access to vaccines[20]; establishment of support networks[35]; involving men in family responsibilities[37]; facilitating access to food outside of schools, support for students and teachers in online classes, and preventing online violence[38].

The evidence evaluated in this sample demonstrates that the Brazilian government's recommendations are limited to protocols with some few exceptions. Brazilian authorities acknowledge how the pandemic affects more vulnerable groups, such as women, black and indigenous peoples, and people with disabilities, among others. However, the Brazilian response focused on disseminating information about existing public services.

Public authorities recommended that public officials and families adopt sanitary protocols, social isolation, and community solidarity measures. There is some financial support for purchasing equipment, but the authorities have focused on proposing procedures for maintaining school life and food distribution. Women's responsibility for care is acknowledged

but only as a group at risk. We did not find any evidence of an invitation to participate in government care planning.

In April, the Ministry of Health released the National Contingency Plan for the Care of the Institutionalised Elderly Person in the covid-19 Pandemic, in which they recognised that most deaths came from the elderly[39]. In the same month, the Secretariat of Primary Health Care released another technical statement concerning care in Long-Term Institutions for the Elderly (ILPI)[40]. Both technical guides aiming to inform how to adopt sanitary protocols at this kind of institution.

In April, the Ministry of Health and PAHO jointly launched a campaign to promote mental health in the context of the covid-19 pandemic[41]. PAHO disclosed videos to specific target audiences, such as health professionals, caregivers of the elderly and children, and the general population. Following the same pattern, the Ministry of Health released an animated short video and comic book to guide children about the pandemic[42]. In addition, the Ministry of Women, Family, and Human Rights created a website with guidance on covid-19 for people with rare conditions, disabilities, and their caregivers[43].

Also in April, the Ministry of Health released the National Contingency Plan for the Care of Institutionalized Elderly Persons in the covid-19 Pandemic[39]. In this document, the ministry established some objectives and lines of action for the protection of the elderly, including early identification of cases, active search for sick people through Primary Health Care (PHC), promotion of appropriate isolation measures, preclinical care over the SUS telephone number, and distribution of PPE equipment following ANVISA and WHO guidelines.

In July 2020, the National Secretariat for Social Assistance of the Ministry of Citizenship, made a series of technical recommendations for maintaining social assistance services during the pandemic[44]. This ordinance mentions priority groups, such as low-income families, women with a history of domestic violence, homeless people, the elderly, and people with disabilities.

In September, the federal government published a guide with health protocols to prevent infection by covid-19 in schools reopening. The secretary also provides resources for purchasing equipment and hygiene products such as face masks[45]. Among these recommendations, they suggest that schools create different shifts to stagger the entry and exit

of students. They also recommended contacting the families of students with comorbidities to assess their return.

In the same month, the National Fund for the Development of Education published a guide with recommendations for implementing a national school meal plan when returning to classes[46]. The document is a partnership between the Ministry of Health, the National Health Surveillance Agency (ANVISA), and the Pan American Health Organization (PAHO), among other health institutions. These recommendations include sanitary protocols to reduce transmission throughout food distribution and feeding time.

2.1.2. Access to the job market and income losses

Isolation in Brazil began in March 2020, service shopping centres were closed by local determination throughout the country, and only essential businesses remained open, such as supermarkets, bakeries, pharmacies, and hospitals. In some states, the police could intervene in large gatherings and fine open establishments[47].

Since the beginning of the pandemic, WHO and PAHO have recommended financial support measures for women affected by the closures and reduced access to the informal labour market. The recommendations involved programs to reduce debt with banks, pay rent, income redistribution policies, and paid leave[34]. They also recommend direct compensation for informal workers, discouragement of mass layoffs, subsidies for purchasing food, support for the unemployed, access to mental health services, redressing unpaid work, and reducing the wage gap between men and[38] women[20].

WHO and PAHO advocate that governments should economically empower vulnerable women, including direct compensation for formal and informal workers, especially health professionals and housekeepers[34]. PAHO required particular attention to informal communities and settlements, where most families are low-income and headed by women, not to mention migrants, indigenous, and black people[38].

In April 2020, the Presidency of the Republic of Brazil adopted a provisional measure No. 936, establishing the Emergency Program for the Maintenance of Employment and Income[48]. The objective was to preserve employment and income and reduce the social impact of the pandemic. The plan included emergency benefits, working hours, wage reduction, and temporary suspension of employment contracts. The government would pay the aid monthly, but the employees had to reduce their working hours and salaries proportionally. There was an

option to temporarily suspend the employment contract when requested. The program was eventually extended to December 2020[49].

In April 2020, the president sanctioned Law No. 13.982, establishing rules for granting the Benefit of Continuous Provision (BPC), an aid created to help the elderly and people with disabilities[50]. Under the same law, the president established the Emergency Aid, which would grant BRL 600.00 for three months to workers who were unemployed, small entrepreneurs, or informal workers and did not receive any social aid (except for the Bolsa Família program), inside the personal income limit. The Emergency Aid was extended twice, first in June 2020, for two instalments of BRL 600 (resulting in five instalments in total), and then in September 2020, for four instalments of BRL 300 reais[51].

The Emergency aid was one of the main support measures for low-income people affected by the pandemic, as inequality and poverty rates reached a historically low level and restrained a drop in GDP in 2020[52]. To some degree, the policy considered inequalities in the effects of the pandemic on women by offering double monetary assistance to single parents, teenage mothers, and favouring women when in line in the family to receive aid.

The Emergency Program for the Maintenance of Employment and Income also represented some level of care towards the loss of income by the population. One of its principles was to guarantee employment for the same period applied in the program, which benefited pregnant women. Simultaneously, the government expanded access to the BPC, a historical demand from families and caregivers of people with disabilities. People in more vulnerable situations were also considered in the decision to allow states to use the National Social Assistance Fund, focusing on female victims of domestic violence, minority ethnic groups, People with Disabilities, and people who lives in the street[53].

However, the adopted policies did not consider alternatives for tax relief, except for reducing electricity tariffs[54]. They also failed to address the historical inequalities that women face in the labour market, such as lower wages and informality. These policies reflected little or nothing on the consequences of making women responsible for care, such as increased spending on supplies, food and medicine; mental health; access to education, and other forms of personal development. In particular, these policies did not consider racial intersections in reducing access to income during the pandemic, although they have some merit in mitigating their effects.

It is worth mentioning that Congress implemented emergency aid despite Bolsonaro wanting a modest version of the program and opposing extending the benefit[55]. In addition, the Ministry of Women, Family, and Human Rights, commanded by Damares Alves, spent only 5.4% of the budget to protect women in 2020, the year of the pandemic[56]. In an interview, the president of the Brazilian Union of Women (UBM), Vanja Santos, alerted us to the National Health Council's complaint about the inappropriate use of resources by the government, which culminated in the Repassa Já! (Transfer the Federal Funds now!) movement[57].

An economic downturn was possible after Emergency Aid, so expanding income distribution policies was necessary to avoid setbacks in the battle against gender and racial inequalities. It was also necessary creating credit policies for micro and small companies headed by women and fostering digital transition[58].

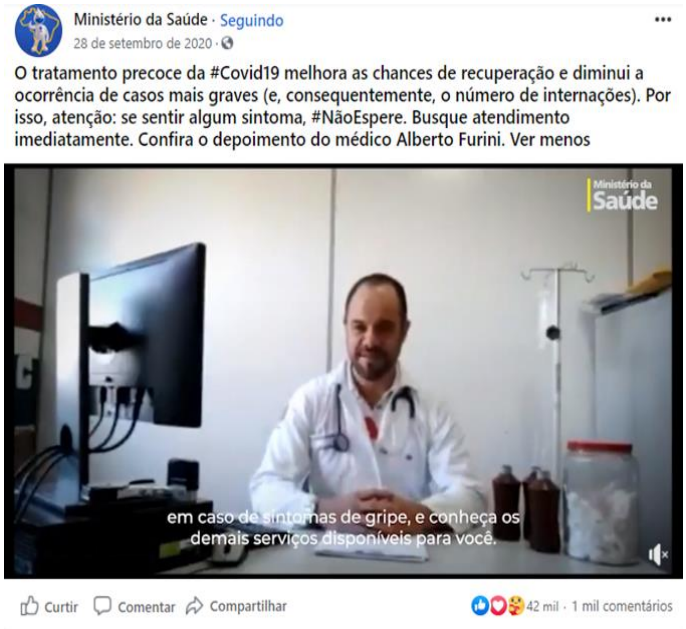
As for the Emergency Employment and Income Maintenance Program, evidence shows that the program scope was not as broad as expected. An estimated 59% of small companies had to stop their activities during the pandemic, while 15% of the companies surveyed did not know or had never heard of the programme[59]. The pandemic hit the ventures of black people the hardest – while the activities of white men fell by around 4% in the second quarter of 2020, black people establishments dropped 13%, and specifically establishments from black women fell 16%[60].

2.1.3. Informational campaigns

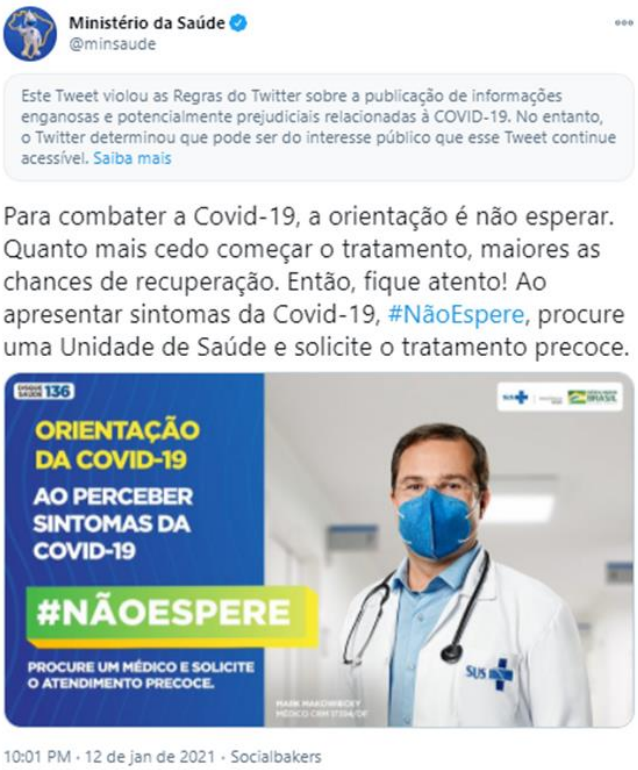
PAHO recommended using information campaigns to guide the population on adequate protection measures, such as social isolation and the adoption of health protocols, also to help with the anxiety around the disease[61]. The organization requested attention to cultural differences and the needs of different groups, such as pregnant women, the elderly, children, indigenous peoples, afro-descendants, and other ethnic groups[62]. They also recommended offering channels through which the public could contact health services and participate in actions to combat pandemics[63].

In this regard, we argue that the measures adopted by the Brazilian government were insufficient. In March 2020, the Ministry of Health disclosed media materials to help spread information regarding the coronavirus to be used online, on the radio, and on TV[64]. In addition, the Ministry of Health launched an application for cell phones called "Coronavirus-SUS," aiming to raise public awareness about the infection, including how to identify symptoms, prevent protocols, and indicate nearby health units[65].

However, some campaigns carried out by the Ministry of Health were mediated on social networks to spread false information about the pandemic, including recommending treatments without proven effectiveness. As shown in the examples below:



Caption: Publication made by the Ministry of Health profile on Facebook, on September 28, 2020, about the "early treatment".



Caption: Publication made by the Ministry of Health profile on Twitter, on January 12, 2021, about the "early treatment".

There is also evidence that the federal government contributed to anti-vaccine groups[66] by discrediting vaccines in a political dispute with China[67]. Pregnant women were one of the groups targeted by the anti-vaccine movement. Pregnant women deaths have increased significantly during the pandemic, reaching 40% by 2021[68]. The prospect of developing thrombosis due to the vaccine was one of the biggest fears pregnant women faced during that time[69].

2.1.4. Health professionals

PAHO and WHO point out that most health professionals are women, which has several implications regarding gender discrimination, including lower wages and overloaded work dynamics[70]. Therefore, they recommended efforts to provide support and training for these professionals, including collecting epidemiological data, guaranteeing labour rights, inclusion in the decision-making process at high levels, and distributing equipment with other essential resources[31], [20]. In Brazil, although the government stated that it prioritized health professionals, we did not identify broad-ranging national policies to support the category or any measure that considered gender inequality among these professionals.

In April 2020, the Ministry of Citizenship published Ordinance No. 366, which established sanitary protocols to prevent the contamination of social workers responsible for the Happy Child/Early Childhood Program[71]. In the same month, the Secretariat of Primary Health Care released guidelines regarding Community Agents (ACs) during the pandemic, including the importance of social distancing, mask use, and hygiene protocols[72].

In July, the president sanctioned Law No. 14,023, which determined measures to preserve the health of essential professionals and control the spread of the virus while maintaining public order[73]. The government also promised to distribute materials and personal protective equipment (PPE) recommended by the ANVISA agency to health professionals. Finally, health professionals should be a priority in testing and treatment.

2.1.5. Political participation

WHO and PAHO advocated for including women in response preparedness, similar to other vulnerable groups, such as afro-descendants, indigenous peoples, people with disabilities, and LGBT+[70], [34]. To this end, they suggest some solutions, such as remote contact and meetings

with community leaders and social movements[62]. These dialogues should consider cultural differences in the conception of life and death, and sometimes adapt to the local language. They were concerned with including women community leaders who have proven to be crucial for the resilience of some communities during the pandemic[37].

Unfortunately, we did not find any measures taken in this regard by the federal government. In an interview, Vanja Santos warned us that the federal government removed several spaces for participation, including councils and forums. In addition, during the covid-19 CPI, epidemiologist Pedro Hallal denounced government representatives censored data on the effects of the pandemic on black and indigenous people[74]. The data showed that indigenous people were five times more likely to die and black people were twice as likely to die than white people. This information was part of the Epi-covid-19 report, a partnership between the Ministry of Health and Federal University of Pelotas (UFPel). However, the federal government cancelled this partnership.

The data indicate that black communities called *quilombolas* were four times more likely to die than white people living in urban centres[75]. However, community leaders denounced the government for neglecting to disclose reliable data and the distribution of vaccines in quilombolas communities[76]. Some communities had to make legal demands to be heard, such as the National Coordination for the Articulation of Rural Black Quilombola Communities (Conaq), which filed a lawsuit in the Supreme Court requesting the government to favour quilombolas in the vaccination. The same occurred with quilombola communities in the state of Alagoas, which filed lawsuits complaining about the bureaucracy required to vaccinate[77].

Finally, the Attorney General's Office (PGR) urged the Federal Supreme Court (STF) to define a healthcare plan for quilombola communities setting a deadline[77]. In April 2021, the Ministry of Women, Family, and Human Rights published the Plan to Combat the covid-19 Pandemic among Traditional Peoples and Communities, including quilombolas and indigenous peoples[78].

2.2. Pandemic impact on women's health

2.2.1. Domestic violence

PAHO and WHO recommended that services to combat domestic violence should be considered essential during an emergency because of the risks caused by the stress of isolation, aggravated in cases of substance abuse[31],[35],[37],[63]. Public services, especially health professionals,

should be instructed to recognize signs of violence in people who seek help[70]. Protection mechanisms could be innovative and incorporate technology and ways to call for help outside police stations, such as pharmacies and supermarket signs, or even involve schools and the community in surveillance and support[34],[38].

We believe that measures to combat gender violence during the pandemic were insufficient. The list of essential services included domestic violence support and innovative legal mechanisms to expand protective protocols[79]. However, the guidelines for public institutes were largely protocol-based and did not consider broad communication campaigns, professional training, or community involvement. According to the Brazilian Public Security Forum, as requested by the World Bank, the number of femicides in Brazil increased by 22.2% in 12 Brazilian states between March and April 2020[80].

2.2.2. Sexual and reproductive rights

The PAHO and WHO recommendations encompass several themes related to sexual and reproductive rights. First, they stated that services aimed at guaranteeing these rights are essential during a pandemic, including access to resources for reproductive planning, prevention of STIs, and pregnancy termination in cases already permitted by law [81],[82],[83]. They mention how the emergency period imposes a series of dangers for people who suffer from gender discrimination, such as reduced access to contraceptives, vulnerability to sexual violence, and reduced access to guidance and abortion services[34],[37].

The same concerns pregnant women, who should have access to prenatal care and humanized deliveries, considering caesarean sections should only happen with medical advice and in case of need[84],[85],[83]. In addition, WHO has released a guide on breastfeeding, stating that breastfeeding is a priority and recommending that women receive psychosocial and practical breastfeeding support, even if they or their babies have confirmed covid-19 infection[86].

Both WHO and PAHO recommended that these services should be guaranteed, even if remotely, including psychosocial support; campaigns to reduce teenage pregnancy; means to return social life and autonomy regarding their life[87]. PAHO also guided states regarding the risk of death of pregnant women during childbirth due to haemorrhage. They signed an agreement with the National Association of Private Hospitals (ANAHP)[88].

In Brazil, however, we identified that support policies for sexual and reproductive rights were insufficient and mostly protocols. Government members and federal entities published several guides and ordinances proposing measures aligned with the WHO and PAHO

recommendations; however, there was little or no material support to implement them. Even in these guidelines, the recommendations mentioned mainly pregnant women and new-borns to the detriment of other topics.

The Brazilian government considered the implementation of telemedicine under Ordinance No. 467 in March 2020[89]. In April 2020[90], the Secretariat of Primary Health Care released a technical memo on the risks of covid-19 in pregnant women, recommending caution because of the recorded mortality rates. In April 2020, the Secretariat for Primary Health Care published another technical memo with recommendations for deliveries during the pandemic[91].

In June 2020, the Coordination of Women's Health of the Ministry of Health published Technical Memo No. 16/2020, written in collaboration with PAHO[92]. In the memo, ministry technicians mention the emergency declared by the WHO and the meeting promoted by the organization to warn countries about the risks of the pandemic, especially among the most vulnerable groups subjected to social inequalities. Among these groups, there are considerations low-income women and their difficulties in accessing health services.

The memo mentioned that WHO considered access to sexual and reproductive services a priority to reduce unwanted pregnancies and violence against women. Governments should guarantee the distribution of contraceptive methods, a service that is precarious in low-income and middle-income countries. The secretariat was also alert to the increase in maternal morbidity and mortality rates, and the interruption of health services focused on women's health.

The Ministry of Health technicians made some recommendations on what should be considered essential and uninterrupted services:

> sexual violence care services; access to emergency contraception; the right of adolescents and women to sexual and reproductive rights, including safe abortion in cases provided by law; prevention and treatment of sexually transmitted infections, including diagnosis and treatment for HIV/AIDS; and, above all, admit contraception as an essential need (author's translation).

Finally, they list concrete actions that the government should take, such as training professionals to deal with cases of violence, monitoring the stock of contraceptive drugs, campaigns on sexual education and assistance services, and the use of telemedicine.

The progressive tone of the memo did not please the top echelon of the Ministry of Health. A few days later, The Ministry of Health, Pazuello, cancelled the memo and fired two coordinators: one from the Women's Health Department and the other from Men's Health[93]. Bolsonaro called the memo "apocryphal" on social networks, because "it claims the legalisation

of abortion". The Secretariat of Primary Health Care released a memo stating that the technical guidelines of memo No. 16/2020 lacked legitimacy once it did not go through the internal deliberation process.

The CoVida Network (Rede CoVida, 2020) denounces that the technical memos published by the Brazilian government began to reduce assistance to women to the pregnancy cycle (p. 12)[94]. Only in July 2020 did the president sanctioned the law 14.028, in which the prescription of medical or dental drugs for continuous use started to last as long as social distancing was necessary, including contraceptive medicine[95]. In June 2020, the National Health Council (CNS) published a memo condemning the Ministry of Health's attitude towards Memo No. 16/2020 because of the setback it represented for the National Policy for Integral Attention to Women's Health[96]. The National Human Rights Council (CNDH) published a similar memo on June 16, 2020[97].

Meanwhile, the Ministry of Women, Family, and Human Rights, commanded by Damares Alves, focused on further increasing restrictions for women in accessing sexual and reproductive health, even articulating themselves in international far-right networks[98]. Regarding the right to information, the Ministry of Health only addressed women to recommend postponing pregnancies, supposedly because of the severity of the P1 variant in pregnant women[99].

Access to hospitals that performed abortion procedures was reduced or stopped during some periods. In a survey carried out by the NGO Artigo 19, AzMina magazine, and Portal Gênero e Número, they contacted 76 hospitals that used to offer abortion services, and only 55% of them maintained the service during the pandemic[100]. The authors of the CoVida Network (Rede CoVida, 2020) reported that the Brazilian government did not mention the topic after the controversy surrounding Technical Memo No. 16/2020.

However, in the first months of the pandemic, low and middle-income countries recorded higher maternal death rates than other European and Asian countries[101]. Women with comorbidities were at greater risk, and the literature indicates that black women were even more affected.

In addition, in an interview[102], Daphne Rattner mentions the change in the Pregnant Woman's Handbook, made in 2022 in Ordinance 715, April 4, 2022[103]. In the ordinance published, the government announced that the former Stork Network would be replaced by the Maternal and Child Care Network (RAMI), bringing about changes in the care approach,

especially concerning the composition of the care team. From then on, the work of obstetricians would become a priority to the detriment of other health professionals, such as obstetric nurses, which meant taking part of pregnant women's autonomy.

In August, in Memo No. 15, The Secretariat of Primary Care published a guide on breastfeeding in the context of transmission of flu-like illness. The secretariat reaffirmed that there was no evidence of covid-19 transmission via breastfeeding, which is why they corroborated the WHO guidance to maintain contact between mother and child, especially during the first hour of life. In November 2020[104], the then-Minister of Health, Eduardo Pazuello, instituted an ordinance to establish a financial incentive for states and municipalities to acquire equipment for health establishments that assisted pregnant women and new-borns.

In March 2021, the Ministry of Health published a memo with guidelines for what the government called "early drug treatment" for patients diagnosed with covid-19[105]. In the preamble, the ministry made several considerations about the state of scientific knowledge regarding the effects of covid-19 on pregnant women. However, several studies have already pointed out that pregnant women do not have a higher risk of miscarriage due to covid-19, and that the clinical characteristics of this group were similar to those of non-pregnant women. They claim that: "low doses of chloroquine are used for the prophylaxis of malaria in pregnancy" (p. 4)[105]. They continued to argue that there are no contraindications for the use of hydroxychloroquine during pregnancy.

2.2.3. Women's health

On this topic, WHO and PAHO have made several recommendations concerning the possible gender bias in the care of women during the pandemic. To deal with this, they suggested supporting and training health professionals, especially nurses[70]; attention to situations that affect women's autonomy in decisions about their well-being[31]; gender considerations in vaccination campaigns[106]; collecting disaggregated data by sex[37]; psychosocial support, and maintaining other campaigns to combat conditions that particularly affect women[107].

Once again, the federal government's response to this issue was incipient, focusing mainly on the dissemination of care protocols. On the one hand, they inform about the symptoms and protocols to prevent the spread of the virus in health services and recommend the maintenance of urgent consultations and treatments. On the other hand, there are no specific

programs for the most vulnerable groups, support policies and training for health professionals, or attention to possible biases in care, among others.

In April 2020, the Ministry of Health released a technical memo regarding remote medical appointments that focused on women's health during the pandemic[108]. In this memo, they stated that the Primary Health Care/Family Health Strategy (APS) should be the users' first contact with the SUS, and during the pandemic, these services would be crucial for the early identification of cases of infection by covid-19.

2.3. Interviews: social movements, experts and PAHO staff

We interviewed specialists about gender issues in health to discuss their perceptions of gender biases during the pandemic. Vanja Santos is the president of the Brazilian Union of Women (UBM) and a member of the National Health Council (CNS). Vanja assessed that the required social distancing during the pandemic reduced the possibility of social movements to make demands on the street, so the federal government took the opportunity to attack women's rights. Among the setbacks that affect women's lives, the interviewee highlighted the changes in the pregnant woman's booklet and the policy of access to contraceptive methods and abortion. She argues that the government made decisions without extensive discussion with social movements. In fact, public authorities choose to favour conservative groups.

We also interviewed Estela Aquino, a retired professor from the Federal University of Bahia, who is also the vice president of the Brazilian Collective Health Association (ABRASCO) and a member of the executive coordination CoVida Network – Science, Information and Solidarity, a scientific collaboration project on the covid-19 pandemic. Estela understands that there are some contradictions in the performance of international organizations. On the one hand, they are influenced by biomedical literature that tends to naturalize the difference between the sexes. On the other hand, organizations such as WHO and PAHO, together with feminist women's movements, warned about the risks of the pandemic on gender issues.

The third interviewee was Daphne Rattner, professor at the University of Brasília and president of the Network for the Humanization of Childbirth and Birth-ReHuNa, and a member of the board of the International MotherBaby Childbirth Organization. Rattner recognizes that she has not participated in many PAHO initiatives recently and even considers it prudent to deal separately with PAHO and WHO. Based on her observations during the pandemic, she understood that PAHO depends on the collaboration of the Ministry of Health, which is why

they try not to alienate the government. Thus, when the government moved away from issues related to sexual and reproductive rights, the organization would not have stood out in promoting the agenda.

Finally, we interviewed a PAHO official from the Washington Office, who requested anonymity in his responses. In his day-to-day work, he observed several situations in which women assumed leadership roles in health emergencies, in local communities, and inside the agency. Therefore, he understands that PAHO has transparent positions on gender, ethnic minorities, and people with disabilities, among other human rights issues.

In this way, the organization would take all possible measures to deal with gender equality during health emergencies, which also occurred during the covid pandemic. He is unaware of any situation in which the organization has deliberately avoided dealing with gender-related issues, but clarifies that they do not impose any position, considering that their counterpart is usually the national Ministry of Health.

3. Conclusion

In this paper, we argue that an international system divided into sovereign states allows governments to prioritize authorities' ideological bias instead of the interests of vulnerable groups. Therefore, neglect in health emergencies does not occur only due to low material capacity but also due to government priorities.

In 2020, a marketing and neoliberal agenda competed for dominance in the Brazilian health sector by advocating austerity policies and the privatization of public services. The consequences of reducing public expenditure mostly affected women socially responsible for care, as demonstrated by the Zika epidemic. Feminist literature on Global Health adverts how unpaid care work is essential for maintaining the economy and health systems. However, women's capabilities have limitations as recent health emergencies have been highlighting.

Feminist literature has used the concept of tyranny of the urgent to demonstrate how responses to health emergencies tend to overlook gender bias in health by focusing only on epidemiological aspects. However, we are not sure that concept explains the Brazilian neglect towards gender issues. In Brazil, the priority was to maintain the economic system to the detriment of human life as a whole, a strategy that could only be possible in a country already embedded in a necropolitical culture.

The context for Bolsonaro’s rise results from years of practice by economic sectors interested in fiscal austerity in collusion with conservative groups opposing progressive

policies. Therefore, we argue that Brazil had the human and material capacity to meet the various challenges posed by the pandemic, including those related to gender, but the government choose not to do it. It is evident from the documents that there were officials in the government, mainly the Ministry of Health, who knew what to do. However, these officials were hounded and silenced.

The evidence demonstrates that even officials who stayed in the government lacked the moral and material support to implement appropriate policies. President Bolsonaro's friends gradually dominated all the key positions in the ministries to promote a conservative agenda. Social participation occurred mainly through judicial demands and congressional pressure, including vaccination and emergency assistance.

On the other hand, WHO and PAHO were aligned in their reports and guides to the debates proposed in the feminist literature on global health, even using terms such as the tyranny of urgent, community participation, and gender bias. In addition, we identified situations in which government officials used their material to attribute technical legitimacy to the policies adopted.

However, WHO and PAHO influence was limited, as Bolsonaro publicly attacked WHO several times on social media and public statements. Simultaneously, Health Ministers claimed that Brazil, as a sovereign state, should not be accountable to external entities. Pazuello goes so far as to mention: “PAHO employees are always there, circulating the ministry buildings”, putting them in a very accessory position. Meanwhile, representatives of feminist movements acknowledge that WHO and PAHO were present in public debates, but they have difficulty pointing out their contributions to defining the Brazilian response.

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