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Structural Inequalities: Obstacles to Promoting Collective Health

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Editorial

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Editorial

Health, illness and care are socially determined, varying according to times, places and cultures, so that the organization of actions, health services and social support networks needs to be planned and managed according to the needs of the population in a given territory [1]. In Brazil, the right to health, reflected in the creation of the Unified Health System (SUS) by the Federal Constitution of 1988, encounters obstacles to its universalization in rural areas, as structural inequalities have relegated the less privileged populations to more precarious.

The Declaration of Alma-Ata, adopted in September 1978, conceives the promotion and protection of people's health as a unique condition for improving quality of life [2]. In this conception, the broad right to health is linked to the exercise of citizenship, including access to land, drinking water, housing, work, education, the environment and a way of life free from physical and psychological violence [3]. Only in this context can a fully healthy human being be conceived.

Citizenship can therefore be understood as an institutionalized form of affiliation, constituting an expression of full and formal belonging, and encompasses a range of exchanges that weave ties between the individual and the state. Thus, it is the perception of belonging to a state, legitimized by the public recognition of these ties, which confers the identity of citizen [4]. For the authors, citizenship can also be an institutional instrument through which states include or exclude individuals. Beyond a concept linked only to the idea of national identity, citizenship is linked to the praxis with which citizens exercise their civil and political rights, and is not just a passive criterion of belonging; it is also a social practice. Citizenship comprises popular conquest, with aspirations and efforts to democratize power relations and access to symbolic and material goods [5].

The public health perspective is based on thinking and acting in favor of the health of the community, so that among the Social Determinants of Health (SDH), which include the socioeconomic, cultural and environmental conditions of a society, basic sanitation acts as a direct strategy for health promotion and disease prevention [6]. In this way, the association between water supply and sanitation (or lack of sanitation conditions) with health and the influence on specific indicators (such as diarrhea), or on broader measures of health (such as infant mortality or life expectancy), as well as the transmission of diseases arising from the inadequate disposal of solid waste.

Article 2 of Brazil's Sanitation Law (Law No. 11445 of January 5, 2007) states that public basic sanitation services will be provided based on the fundamental principle of universal access, with the adoption of methods, techniques and processes that take into account local and regional peculiarities. This national law considers basic sanitation to be an integrated set of water supply, sewage disposal, urban cleaning (drainage) and solid waste management, which must be carried out in ways that are appropriate for public health and environmental protection.

The basic sanitation services offered to Brazil's rural population, which include sanitary sewage systems, water supply and garbage disposal (solid waste), have poor coverage. Only 33.5% of rural households are connected to the water distribution network, while the majority of this population draws water from fountains and wells (protected or not), directly from watercourses without any treatment or from other alternative sources, which are generally unhealthy [7]. In addition, 54.1% of rural households have poor sanitation and 25.3% do not have adequate sewage treatment or disposal systems, which is generally dumped

into rudimentary pits, ditches or directly onto the ground or into streams, rivers and ponds. With regard to solid waste management, 55% of Brazil's rural population is totally unserved by this type of service. Access to health care is also unequal, as is the number of health professionals working in rural areas, with only 23% [8].

This set of structural inequalities reinforces the vulnerability of rural populations. Vulnerability can be understood as the lack of capacity to prevent, act and resist the effects of a crisis. It is a dynamic process, the result of an unequal social, cultural, political and economic relationship and can manifest itself between individuals and between different cultural groups [9].

Recent research carried out at the Federal University of Viçosa (Brazil) [10] highlights that the black rural population has more inadequate sanitation conditions, confirming the view that the black population is more likely to live in households with worse housing conditions than the white population [11]. A vicious circle has been established: prejudice reinforces poverty, keeping black and brown people in unsuitable conditions for competition. In addition,,the Continuous National Household Sample Survey (PNAD) states that 45.3% of the black population lives without at least one basic sanitation service, compared to 27.9% of the white population. The aspect of sewage collection, according to the 2018 National Sanitation Information System (SNIS), indicates that 38.85% of blacks (44.8% of browns and 32.9% of blacks) are without this service, while whites are 26.5%. The percentage of the black population without regular access to water is an average of 29% (32.1% of browns and 25.9% of blacks) compared to 18.6% of the white population.

Other studies also point to significant inequalities resulting from the direct and indirect influences of ethnic-racial belonging in various areas, including access to basic services and morbidity and mortality profiles. Thus, when analyzing the indigenous category, studies generally indicate that this segment of the population has less satisfactory indicators of health. Every year, thousands of hospitalizations and deaths are recorded in Brazil due to causes related to the absence or inefficiency of sanitation services in households. Among indigenous children, various studies conducted in specific contexts (ethnic groups and/or indigenous lands) point to a high prevalence of diarrheal infections, which account for around half of the causes of hospital admissions and up to 60% of deaths in children under one year of age.

Brazil, like many developing countries, still has a long way to go in terms of universalization and equity in the provision of basic sanitation services to ensure better health indices for marginalized populations. It can be seen that increasing access to basic sanitation is related to reducing the inequalities of gender, race and class that have been present historically and culturally in Brazil for centuries.

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