After all, who has to be studied: The coronavirus, Brazilians, or their administrators?

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Abstract
This article discusses one of the great governmental challenges of the last centuries—universalization of access to potable water and sanitation services (WSS)—in view of the geographical difficulties for the provision of services in certain regions, and differences in ability to pay for water and sanitation services. It is necessary to reinforce the various links between social and environmental conditions. A review of the literature finds that countries work differently on the approach to universal access to water and sanitation services (Marques, 2010), addressing the problem according to their laws with variable results in how these services are defined. In order to achieve the desired universalization of water and sanitation services in Brazil, in addition to the investment of significant amounts of money, coordinated administration is necessary to leverage these investments. In addition to this challenging scenario, the present moment is worrying! At the beginning of the 21st century, a new pandemic is causing deaths at an alarming rate. Most countries around the world are combating the new coronavirus that has disrupted economies, caused panic, and raised hypotheses about political hegemonies. On January 30, 2020, the World Health Organization (WHO) declared the outbreak of the disease caused by the new coronavirus (COVID-19) to be a Public Health Emergency of International Importance—the highest alert level of the Organization, as provided for in
Brazilians have to be studied, they fall into the sewer and nothing happens

The words spoken by the current president of Brazil, awaken to a reality that is often ignored, but affects most Brazilian state capitals. Simultaneously they generate a mixture of sensations, which migrate from repudiation to ignorance.

One of the great governmental challenges of the last centuries has been the attempt to guarantee the universalization of water and sanitation services (WSS) in view of the geographical difficulties for the provision of services in certain regions, in addition to the payment conditions of the population. It is necessary to reinforce the various links between social and environmental conditions, the trends and the social impacts of environmental policies, with the aim of valuing human life, environmental equity, employment, access to information, and to public participation in the decision making process (United Nation, 2017).

According to the literature, countries work differently on the approach to universal access to WSS (Marques, 2010). Most address the problem in their laws and vary in the way they are defined. In order to achieve the desired universalization of WSS in Brazil, in addition to significant amounts of money, coordinated administration is necessary to leverage these investments.

In the world context, since the second half of the twentieth century, urbanization occurred in an accelerated but uneven manner.

Brazil is a country that has a vast territorial dimension, with heterogeneous characteristics, both natural and socioeconomic in nature. Thus, the form and quality of access to water supply and treatment and sewage collection services are affected by these differentiations.

In Brazil, this process was mainly the result of late industrialization. It occurred in an intense and uneven manner in the regional dimensions. Brazil has five regions: North, Northeast, Midwest, Southeast, and South.

In the South and Southeast regions, whose urbanization and industrialization processes occurred in an intense and considerable manner, robust urban infrastructure networks were implemented. In contemporary times, this pioneering spirit justifies its better situation regarding access to drinking water supply and wastewater sanitation services.

Indeed, the North and Northeast regions have the worst rates both in terms of water supply and wastewater collection (and treatment).

The differences are so significant that the figures are astonishing. The difference is as much as ten times more between the Southeast and the North (SNIS, 2018).

In parallel with this scenario: This moment is worrying! A new pandemic is causing deaths at an alarming rate. Several countries are combating the new coronavirus that has disrupted economies, caused panic and raised hypotheses about political hegemonies. On January 30, 2020, the World...
Health Organization (WHO) declared the outbreak of the disease caused by the new coronavirus (COVID-19) to be a Public Health Emergency of International Importance – the highest alert level of the Organization, as provided for in the International Health Regulations. On March 11, 2020, WHO deemed COVID-19 a pandemic.

Developing countries like Brazil present greater weakness in the face of these circumstances due to the barriers present in their economic and social system, for example, the barriers directed at the health and well-being of the population. According to Harvey (2020), the circumstances in which a virus mutation occurs become life-threatening and these depend exclusively on human actions. The aforementioned author’s statement is consistent when we frame this pandemic in various world realities, and in the case of Brazil, this impact depends on the region it reaches due to the heterogeneity of socioeconomic conditions it presents.

The lack of WSS services explains most health problems of this nature, with the associated financial (treatment and hospitalization costs), social (sick days and weakness with individual and family implications), and economic (absenteeism for example) implications. That is, before the financial and technical intervention linked to infrastructure, it should proceed previously and with equal commitment to a correction/reinforcement of existing political and social systems in order to ensure greater efficiency in resources made available. In this sense, this article addresses a reflection on the importance of a coherent and legitimate positioning on the part of managers to face crises, especially when we relate the health aspects when advancing a pandemic, as in the case in question caused by the Coronavirus.

2 | BRAZIL IN FOCUS: THE EVOLUTION OF PUBLIC POLICIES IN THE WSS

Despite technological and political advances in the area of sanitation (Heller, 2009), Brazil is still incipient in meeting basic needs for part of its population. In the mid-1930s, an archaic policy with a large concentration of land and progress in the industrialization process predominated; with no reforms in scope, including reforms of land law. Brazil was moving toward changes in the urban structure, taking into account the ongoing industrialization process, episodes such as the rural exodus, and the consequent concentration of population in unplanned urban spaces. The author Maricato (2000) conceptualizes in “A tragédia urbana brasileira” [The Brazilian urban tragedy] that all of this is very firmly rooted in five centuries of the formation of Brazilian society. The consequence of exploitation and concentrated wealth, particularly in the south and southeast regions, are mainly represented by the city of São Paulo.

The national scenario during the initial period of the proclamation of the republic did not favor the leaders who defended the autonomy of states and municipalities. The society that lived in the cities endured misfortunes. One of these was the epidemics which were infesting the cities, mainly the well-known yellow fever. What is unusual in this context is that the situation began to reach the elite. Thus, there was a more systematic mobilization in order to demand federal intervention in public health matters, especially in states with limited technical and financial resources, and it became clear that self-sustainability was not feasible (Hochman, 1998). Faced with this scenario, local concern evolved to reach a national scale. According to Hochman (1998), only in 1999, faced with the calamitous situation regarding public health that plagued the country, the government created a new federal agency, the National Public Health Department, which was subordinate to the existing one, the Ministry of Justice and Internal Affairs. This agency represented the beginning of a new scenario in the constitution and expansion of the federal health authority.
Through this new body came the proposal of the states to sign voluntary agreements for the financing of federal sanitation and rural prevention actions in their respective territorial spaces. This partnership offered the states the possibility of facing their sanitary problems, through the benefits of the federal sanitary authority and varied resources, which would be all the more significant, the greater the transfer of their responsibilities in these sectors to the central power.

Through these forms of agreement, the federal government made it convenient for the states to obtain the necessary sanitary services, solving the enormous technical and financial difficulty which most of them experienced. This is how the epidemics and rural endemics that affected the population were combatted. From a general perspective, while benefiting the states with the implementation of services, the union relieved the states of much of the costs and responsibilities of implementing and administering those services.

In the period between 1920 and 1924, some states made agreements covering rural sanitation. By inserting some territories, like those belonging to rural areas in the federal health services, these agreements represented the beginning of the process of homogenization of health actions in the context of the national territory (Sousa and Costa, 2016). During this period, Brazil was going through a period of political instability. In the military coup of 1930, the constitution of 1891 was interrupted. However, conditions were favorable for the creation of the Ministry of Education and Public Health, which would become the institution responsible for the standards and execution of sanitation actions, in this case understood as water services and wastewater collection and treatment. In 1952, the ministry gained independence to act solely in the public health sector. Thus, the structure of operation of the sanitary services in the country was reformulated and centralized in the federal sphere (Hochman, 1998).

Although the 1934 constitution reaffirmed the competence of municipalities over services of local interest and, among them, basic sanitation, due to their fragile economic situation, this was not enough to achieve success. The vast majority of municipalities did not have the capacity to implement, or even operate, the necessary networks, requiring the intervention of the respective states or the union.

The federal government aimed to support housing and sanitation programs and policies. For this purpose, it created the SFS (Financial Sanitation System) in 1968, to be administered by the BNH (National Housing Bank), created in 1967. The basis of these resources was the FGTS (Service Time Guarantee Fund), established in 1966. The creation of these institutions represented a rupture with the existing model in the sanitation sector, supported by a decentralized policy and, therefore, conditioned local and once-off initiatives, mainly to the eventual acts of freedom by state and municipal governments (Albuquerque, 2011).

In 1967, the National Sanitation Policy was linked to the National Health Policy. In that period, the political context of Brazil was transitory. After all, a dictatorial policy which had the intention of being in force for two decades was on the rise. The “1964 coup” had a direct impact on the country's economy and infrastructure development. The political repression that was in force in Brazil compromised the capacity of political mobilization of the Ministry of Health regarding the delimitation of priorities in the sector and its articulation with regards to WSS actions. The polarization of public policies between states and municipalities restricts financial and political sustainability and weakens different sectors and functions, including WSS. In this context, the National Sanitation Plan (PLANASA) appears as an attempt to territorially standardize public policies aimed at the WSS sector. According to Parlatore (2000), it was only after the formulation of PLANASA in 1970 that the Brazilian government developed a national sanitation policy. In the political context of PLANASA in 1970, it was not possible for companies to turn to the government to correct market distortions. In an attempt to alleviate the situation, the government created the Water Supply and Sanitation Program for Low-Income Populations in Urban Zones in 1982. The objective was
to reach urban populations with reduced family incomes, the most vulnerable classes in terms of wastewater collection and treatment services. In the beginning, the union assumed the responsibility of financing the program only in the late 1980s (during the process of democratic transition of the Brazilian state).

This responsibility to finance the program only in the late 1980s (already during the democratic transition process of the Brazilian state) was attributed to the World Bank, states, municipalities, and Caixa Económica Federal, which received the name of PROSANEAR I (Mundial, 1992). Legitimately, there was an agglutination of the definitions of the infrastructures of sanitation and water supply, health, and environment, seeking to improve the quality of life of the poorest segment of the population (Lucena, 2006).

The evolution was not continuous, there were gaps in the evolutionary process of public policies aimed at the water and sanitation sector. After all, even with rises and falls, there was a growing process, a dichotomy declared between states and municipalities for the autonomy of services.

In general, state capitals and other municipalities reproduce administrative structures similar to those of the states. However, in smaller municipalities, the structure adheres to the minimum required by law. In addition, many city halls do not have technically qualified professionals in the sanitation and supply sector.

In 2007, after periods between ascension and decay, a new opportunity to make the process more continuous emerged. Initially, the national sanitation law No. 11.445 (Federal Law 11.445, of January 5, 2007) was drafted, which defined the national guidelines for basic sanitation, containing several guidelines including in the scope of regulation, and soon after investment programs were created by the administration to meet the basic needs of the population.

Federal Law No 11.445 / 2007 and its regulatory decree (Decree No 7.217 / 2010) establish the national guidelines for WSS in Brazil. Based on the principles of universalization, participation, and decentralization and the broader notion of sanitation, the new legislation seeks to treat the sector in a systemic manner and in conjunction with other policies, such as urban development, housing, and water resources.

Finally, the WSS in Brazil is characterized by the direct action of several entities from different spheres of government. The plurality of bodies with influence in this field is considered historically inclusive, as a factor that makes it difficult to direct the sector's policies (Paim, 2011). Therefore, the complex institutional environment of the sector offers innumerable barriers that contribute to the delay of the realization of actions, programs, and projects in the area, which represents a hindrance to universal access to services.

The barriers and discontinuities of public policies related to the WSS system gain even more prominence with the appearance of pandemics. In the case in question, the one related to the coronavirus. There are still thousands of Brazilians who are in fact in precarious and unhealthy conditions, which make it practically impossible for them to perform basic sanitary and hygienic care. The consequence of this scenario is that the population without access to WSS is even more vulnerable in the face of the pandemic outbreak.

3 | BRAZILIANS AND THEIR SEWERS

Brazil is facing the challenge of achieving sanitary sewerage network coverage. Amid advances and setbacks, this battle has been going on for more than half a century. According to the National WSS (PLANSAB, 2019), the national goal for 2023 is to increase from 79.9 25% to 84.8% the urban households served by a collection network or septic tank for excreta or wastewater; and to increase
wastewater treatment from 68.9% to 78.8%. However, greater volumes of investments are needed to universalize sanitary sewage services.

These values express a national reality. However, an analysis from an inter-territorial viewpoint reveals a relevant regional inequality.

According to Paiva and Souza (2018), hospitalizations and recurrent expenses for diseases transmitted to water and their conditions in Brazilian regions confirm the association between socioeconomic vulnerability and significant hospitalization rates and proportion of expenses. The North and Northeast regions have a low coverage installation of water and sewage services and consequently also concentrate a significant number of hospitalizations for waterborne diseases.

Despite the coronavirus being the main focus and current concern in 2020, Brazil has worrying cases of diseases that are linked to the absence of structural and structuring measures regarding water and sewage coverage. For example, dengue was also eliminated in 1955, but due to failures in the control coverage, it was reintroduced into Brazilian territory in 1976. In the period until April 13, 2019, 451,685 probable dengue cases were recorded in the country, an increase of 339.9% over the same period in the previous year, when 102,681 cases were registered (Ministry of Health, 2019). The presence of this disease is strongly associated with the quality of WSS. For example, an irregular water supply results in people having to store it in reservoirs, which often serve as breeding grounds for mosquitoes (IBGE, 2018).

The National Plan for Water and Sanitation – PLANSAB for 2014 and 2033 proposes the means to achieve this objective, including the role of stakeholder participation, as well as the necessary social instruments and grants (Pinto et al., 2015). According to PLANSAB (2019), federal investments made annually in sanitation, whose amount disbursed was of the order of R$ 10.0 billion in the average of the last 10 years (in values updated by the IGP-DI), keep an average – lower day in the next 5 years (subperiod 2019 to 2023), equal to R$ 9 billion, and rise to the level of R$ 19.2 billion in the average of the following 10 years (2024 to 2033).

There is an absence of investments. In addition, and most seriously, the lack of public commitment, due to the transformation of this scenario, is worrying. And as a direct consequence of this context, there is an absence of sanitation and water infrastructure—with adequate treatment—which effectively contributes to the perpetuation of diseases and epidemics, most of which have already been largely eradicated in much of the West.

Rationality in the direction of investments is essential in order to reduce or even prevent the spread of waterborne diseases. And in the current context of a pandemic, the consequences of the inefficiency of the WSS system can contribute to accelerating its spread of contagion, especially within the most marginalized population segment.

4 | AMID CHAOS – CORONAVIRUS

According to information from OPAS/WHO (2020), in December 2019, the Center for Disease Control and Prevention (CDC) in China pointed to the existence of an outbreak of respiratory disease in workers in a food market from Wuhan, capital of Hubei province.

Then, a new coronavirus, called SARS-CoV-2, was identified as the cause of the disease. The virus belongs to the Coronaviridae family and causes a respiratory disease called Covid-19. The disease spread rapidly in Hubei province and has since reached more than 100 countries on five continents. The WHO declared Covid-19 a pandemic on March 11, 2020. By March 27, 2020, 509,164 cases of COVID-19 (46,484 new cases compared to the previous day) and 23,335 deaths (2,501 new cases compared to the previous day) were recorded worldwide. In Brazil, the first positive test for COVID-19
took place on February 26, 2020, discovered in a São Paulo native who had recently visited Italy. Just 5 days after the first case was registered, another positive case was confirmed in the country and in just 11 days the sum of confirmed cases reached 25 people (Macedo et al., 2020). It is noteworthy that the Brazilian population is estimated at 211 million inhabitants (IBGE, 2020), of these 8% are men who fit the age profile of the disease, however, new cases of the disease are advancing rapidly in the country.

While Italy decreed national quarantine 10 days after the first positive cases, in Brazil quarantine was regulated by the Ministry of Health 16 days after the detection of the first case, when the number of confirmed cases already totaled more than 100. According to the COVID-19BR Observatory (2020), the current rate of multiplication of infected people given the containment measures (23/03) varies between 2.4 and 2.8 days. Following approximately the pattern of propagation in Italy and not decreasing even with the containment measures, Brazil already exceeds the quantity of Italy in comparison in its 23rd day with 1,128 confirmed cases as opposed to 17 Italians.

Brazil confirmed 3,147 cases and 98 deaths (58 in the state of São Paulo and 9 in the state of Rio de Janeiro) on the afternoon of March 27, 2020. The country’s Ministry of Health declared that there is community transmission from COVID-19 throughout the national territory. When a person in Brazil presents with respiratory symptoms—fever, cough, sore throat, or difficulty breathing—the doctor will prescribe isolation and issue the certificate to the patient and all people living in the same household (even if they have no symptoms) for 14 days, according to Ordinance No. 356 of March 11, 2020 (OPAS/WHO, 2020).

OPAS and WHO are providing technical support to Brazil and other countries in preparing for and responding to the COVID-19 outbreak. The protective measures are the same as those used to prevent respiratory diseases, such as: if a person has a fever, cough, and difficulty breathing, they should seek medical attention as soon as possible and share their travel history with the health professional; wash hands with soap and water or alcohol-based hand sanitizers; when coughing or sneezing, cover the mouth and nose with the inside of the elbow or with a handkerchief—then throw away the handkerchief and clean the hands.

According to the WHO, each person infected with the coronavirus can infect two more, while measles infects from 12 to 18 people. According to Zibechi (2020), bulletin 142 of the European Political Anticipation Laboratory (LEAP) states: The Chinese launched an emergency action plan of unprecedented magnitude, there were only 40 deaths in a population of 1.2 billion of people, noting that the flu, despite losing its prominence, still kills approximately 3,000 people in France every year. In 2019, the flu killed 40,000 people in the United States. Measles kills 100,000 people year after year and the influenza virus, commonly referred to as the flu, kills half a million worldwide. LEAP argues that we are facing a new crisis management model that is endorsed by the West. Italy almost immediately followed this path by isolating 10 villages with 50,000 inhabitants, when only 16 people had coronavirus.

More than 50 million cases of the new coronavirus have been recorded worldwide since the beginning of the pandemic in late 2019 until the month of November 2020. According to the Brazilian press consortium, Brazil has 162,305 deaths from coronaviruses confirmed until November 2020. These data are provided by the state health departments.

Ways to contain the advance of this pandemic urgently need to be studied. However, if the most favored classes are even more vulnerable when affected, along with the advance of coronavirus comes a “pack” of diseases that are already recurring in the poorest population.

5 | TWO SIDES OF THE SAME COIN

The coronavirus is real and threatening, but it is far from being a lone villain. In one respect, the President is right: Brazilians are strong. The scenario of the lack of treatment and inefficiency of the
sewerage network coverage are two sides of the same coin. Waterborne diseases continue to threaten. It is a “combo” of threats, resulting from the fragility of a short-sighted system and one which is more concerned with resolving party conflicts than with meeting the needs of a people who are calling for attention to their basic needs.

According to ONU/BR (2020), the year 2020 began with more cases of dengue than the previous year. Over 125,000 dengue cases have been recorded in 2020 to date, including 27 deaths (with a mortality rate of 0.021%). Also, according to OPAS’s epidemiological update, Bolivia, Honduras, Mexico, and Paraguay reported more cases of dengue in the first 4 weeks of 2020 than in the same period of 2019.

In this context of neglect and fragility, Brazil insists on going against the grain of what is being advocated worldwide by health authorities and still endorses campaigns to return to normal activities, minimizing the dangers that are facing the Brazilian population. The federal government did not consult the Ministry of Health about the “O Brasil não pode parar” [Brazil cannot stop] campaign, which cost 4.9 million reais – money that could be invested in the purchase of respirators, for example – and calls on Brazilians not to leave work during the coronavirus epidemic, contrary to the recommendation of experts and despite the restrictive measures adopted by states. This possibility should also include greater involvement and even accountability of the different stakeholders, among them, of course, the user communities themselves. However, it is relevant that this involvement is guided by the management entities. It is essential to articulate between the different entities, particularly when at the local scale. Mostly, the lack of articulation between the various actors that operate on a local scale is reflected in the existing failures. the combination between successive objectives set by supra-national entities (UN, OECD, Bank World, etc.) and the guidelines defined at national and regional level should systematically worked and operationalized through a system of governance that is open, transparent, and agile.

**6 | THE STRUGGLE IS CONSTANT, AND WILL IT END?**

Whether or not it has an end, we wish, more than ever, that we are here to answer this question. This Brazil is composed of strong Brazilians, yes. Not strong because they plunge into open sewers that run in the metropolises. But because they manage to survive the inequalities, the precariousness of public services, a corruption intrinsic to the political system, and a “steal, but get things done” culture. Brazilians are, above all, a multicultural people who seek to reinvent themselves and believe that change can bring new hope. It is a former colony that grew and prospered. In fact, the representatives’ choices reflect moments in history that need to be studied, indeed, need to be understood, as a moment of clamoring for change, justice, and encouragement. However, the big challenge is how to balance our choices so as not to make mistakes that can cost the Brazilian people very dearly.

Social isolation is the key to minimizing the impacts arising from the advance of the pandemic. However, the subliminal message of Brazilians and I suppose that from similar countries from a socio-economic point of view, is that social isolation has only gained another key role after all, it is present in the daily lives of a large part of the population. Brazilians considered “strong” are already living in social and economic isolation. Marginalized by the health system, competing not only for oxygen respirators but even for beds to make a simple suture; deprived of access to quality water, having to live with open sewers, and all the consequences arising from this reality.

The isolation accepted as an inherent process of an unequal society has now become a real necessity, and one which is now legitimized by administrators. Thus, it is confusing to understand and difficult to answer the question: who and what needs to be studied?
According to Macedo et al. (2020), infectious and contagious diseases that have been emerging for thousands of years include the bubonic plague, Eltor cholera, Spanish flu, and AIDS. In 1894, the third bubonic plague pandemic started in Hong Kong, reaching Brazil only 5 years later. However, it took only a few days for the first suspected cases of COVID-19 to arrive. This situation exposed the fact that there is indeed a globalization of the virus, which, in line with the idea of Harvey (1989), revolves around the compression of space and time, whereby the acceleration of global events is reflected in the way in which we feel the world is making distances shorter.

The recommendation is that developing nations similar to Brazil rethink the construction of public policies, especially the basic ones related to the universalization of water and sewerage services. This construction must be carried out taking into account the physical and social heterogeneities, especially when it comes to a country with continental dimensions such as Brazil. One single solution will never fit in a country with the dimensions and heterogeneity of Brazil. Unfortunately, more than social isolation, the specific reality of a country full of vulnerable areas with precarious conditions requires administrators who have compassion for marginal realities and the ability to create mechanisms so that the population realizes that while it may be isolated, the basic needs to at least eat and drink will be met.

The struggle is probably far from over.

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