

## Should there be recommendations on the use of “race” in health publications? An emphatic “yes”, especially because of the implications for antiracist practices

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Recent decades have witnessed stunning growth, in Brazil and elsewhere in the world, in the number of publications in health that address ethnicity/race. A search in PubMed using the terms “race”, “ethnicity”, and “Brazil” yielded 1,294 results from 1990 to 2019. These 1,000 plus references are far from being distributed homogeneously over the last three decades. Seventy-five articles (5.8%) were published from 1990 to 1999, and 1,030 (79.6%) from 2010 to 2019. A search using the words “race” and “ethnicity” for the same period without limitation to one country yielded 135,027 references, likewise with a major increase over the years, in one of the most important indexes for health publications.

The race concept is widely analyzed in the social and human sciences and boasts an extremely complex trajectory in social history and science in the West. It is closely linked to oppressive regimes, hierarchy, and social and political exclusion, having supported colonialism for many centuries. Until a few decades ago, in the mid-20th century, race was considered a central analytical category for approaching the human species’ diversity from a biological perspective, but since then the biological interpretation of the concept has increasingly been criticized and is now no longer seen as scientifically valid. However, there are other “sides of the coin” in the race concept. While eroded from the scientific point of view, race in its various nuances is a social category with huge impact on daily life in human societies, clearly including the field of health. An important share of publications retrieved in databases such as PubMed, particularly in the field of public health, are thus related to analyses that employ race and associated categories in studies on health inequities.

In this context of a substantial and growing number of publications that address race and related concepts, journals with wide international circulation such as the *Journal of the American Medical Association* (JAMA) have published recommendations on the use of such categories in biomedical research <sup>1,2</sup>. The publication of such recommendations by JAMA was partly motivated by a controversial episode in early 2021: the podcast *Structural Racism for Doctors – What Is It?* and its widespread circulation in social networks, in which the two participants questioned the pertinence of the concept of structural racism to interpret the United States and health services in general. After widespread reaction by the American medical community and other professionals, activists, and societies worldwide, JAMA

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launched a series of initiatives such as publication of articles by Flanagin et al.<sup>1,2</sup> These and other measures constitute a response to the criticisms and a form of retraction; they aim to raise the scientific community's awareness of the need for redoubled (or tripled) caution in the use of a concept that is both central to the discussions on inequities and may be associated with interpretative errors and even stigmatization of research subjects. As indicated by Flanagin et al.<sup>1</sup> (p. 1049), "...terminology, usage, and word choice are critically important, especially when describing people and when discussing race and ethnicity". On this note, initiatives in this direction are not new<sup>3,4,5</sup>, which shows that the concept's uses in health research, often by researchers with little familiarity with critical perspectives in the social and human sciences literature, has raised concern in some scientific circles for several decades due to the potential implications for public policies.

In the case of the recent publications in JAMA, the recommendations range from the emphasis on methodological issues (on the need to specify how the ethnic-racial classification was performed) to considerations on the use of specific categories, avoiding stigmatizations<sup>1,2</sup>. The suggestions also include presenting the theoretical perspectives that underlie the use of the concept in specific research, calling attention to the risks of essentialized approaches, such as those explaining differences in health outcomes between ethnic-racial groups for reasons associated more with biological factors than historical and sociopolitical determinants. Even though perspectives on race and health have changed substantially in recent decades, with a massive shift of the arguments to the notion of social determinants of health, there are still approaches that attribute predominantly to biology the explanations for health inequalities between population groups. For example, the title of a recent article by Lujan & DiCarlo<sup>6</sup> defines the tone of the prevailing tension in the contentious debates on hypertension and race in the United States: *The 'African Gene' Theory: It Is Time to Stop Teaching and Promoting the Slavery Hypertension Hypothesis*.

Articles with recommendations on the use of race and related concepts in biomedical publications such as those recently appearing in JAMA certainly raise highly relevant questions. Meanwhile, regional and/or national contexts may involve particularities that are not contemplated in these more generic approaches. Brazil, for example, has a quite specific racial classification system. The system is based on a combination of color and race categories: white, black, yellow, brown, and indigenous<sup>7</sup>. Employed since the 1940s in population surveys by the Brazilian Institute of Geography and Statistics (while the "indigenous" category was only included in the 1991 population census), this classificatory system is widely used in current research and has also become predominant in the country's various health information systems. As a society, we Brazilians are so immersed in this system, activated in the widest range of social routines, that we are generally unaware that Brazil is one of the only countries in the world whose official classification system is based largely on the notion of color<sup>8</sup>.

The recent increase in public health research output on the ethnic-racial theme in Brazil is associated synergically with the influences of social movements, the growing interest in the topic in academia (influenced by international trends, among other factors), and the expansion of identity-based public policies, among many other reasons. Authors that have struggled against racism themselves have framed their works around the notion of social determinants of health, disease, and death to operationalize the discussion. Race, like gender, age, and class, has been widely employed as an analytical category and is present throughout the collective health field in biomedical, epidemiological, policy, planning, and

management studies <sup>3,9,10,11,12</sup>. For Batista et al. <sup>13</sup> (p. 1), “*racism structures our society profoundly and is related to conditions of work, income, employment, schooling, place of residence, and the possibility or impossibility of accessing rights to justice, goods, and health services*”. Ethnicity and race are thus central to analyses of Brazil’s abyssal inequities, and the theme has been enhanced through theoretical perspectives based on such concepts as structural racism and intersectionality. These are analytical keys that have accompanied the expansion of publications on race and health recently, both in Brazil and internationally.

This scenario raises the question of the pertinence of expanding and deepening the discussion on the use of race and associated concepts in collective health research in Brazil. Meanwhile, when establishing bridges with the current international debates, as exemplified by the articles in JAMA, it would be important to not only lend visibility to the recommendations for the Brazilian academic community but also to add questions that relate to the country’s own specificities.

There are analyses of the production in specific areas of collective health in Brazil suggesting that if recommendations on the use of race and associated concepts are disseminated more widely, there would potentially be greater “clarity” and visibility on a wide range of questions. In a study on the production in epidemiology based on recommendations proposed by Kaplan & Bennett <sup>5</sup>, whose arguments bear various similarities to those addressed by Flanagan et al. <sup>1,2</sup>, one of the findings was that approximately one-third of the studies analyzed did not explain the ethnic-racial classification method, and that fewer than half considered socioeconomic factors in the interpretation of ethnic-racial inequalities <sup>14</sup>.

As for Brazilian research output on ethnic-racial inequities in health, the visibility of which is characterized not only by the number of publications but also by related public policy proposals, various particularly relevant questions for the Brazilian context could be addressed in initiatives related to “recommendations”. One example is the tendency to group categories (such as the “black population”, based on the combination of “pretos” or blacks and “pardos” or browns). This perspective is commonly justified by the historical proximities and sociodemographic similarities of the specific categories, with evident marks of marginalization. Other authors contend that at the analytical level, this junction may attenuate profiles of inequality when compared to analyses based on the two disaggregated categories <sup>15</sup>. Would an important recommendation be to perform and present the analyses with different stratifications, both combining and explaining the results separately, according to the original categories? Another example that requires greater sensibility relates to the combination of numerical minorities (combining “yellow” and “indigenous” as “others”) in the description of the results of important Brazilian national studies <sup>16</sup>, as also observed in other publications. The central problem here is the grouping of ethnic-racial categories that are at the extremes of the socioeconomic spectrum, not to mention various other dimensions of social status, which has direct implications for identifying inequities. We conclude this brief list with a third example. Although timid, some publications have already suggested using genomic markers of ancestry to replace and/or complement the classification based on the subjects’ self-classification <sup>17</sup>. This is an extremely sensitive issue to say the least, since such a proposal ostensibly “returns” notions of belonging that are eminently historical and social to the biological plane <sup>18</sup>.

This editorial focuses particularly on the question of uses of race and associated concepts in biomedical publications. Nevertheless, we reiterate that such uses are central to public policy routine in health, as evidenced during the COVID-19 pandemic. The delay in

completing the race-color variable in COVID-19 case and death records, with high incompleteness rates, as well as discrepancies between estimates by social movements and official statistics, particularly impacted the black population and indigenous peoples in Brazil, in which the disease has spread more rampantly<sup>19,20</sup>. With significant public visibility, the controversies on recording color or race in the country's health information systems in recent years, featuring impacts on ethnic-racial groups, indicate the theme's importance in discussions of health equity, greatly transcending the universe of scientific publications<sup>20,21,22</sup>.

As if it were not challenging enough to expand the discussion on the use of race and associated categories in collective health in Brazil, such an approach must also be interscategorical, taking into consideration other identity-based categories such as gender, sexuality, and accessibility, among many others. This may initially appear to be a debate over "minutiae" in the inner workings of scientific publications, but in practice it is part of the foundations for the principles of democracy, equity, and social justice.

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All the authors participated in all stages of writing and revising the text.

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