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# Reflections on comprehensive care in the ethnic-racial context: an integrating review

Pedro Henrique Melo Alves (https://orcid.org/0000-0003-2262-0561) [1]
Claudia Daniele Barros Leite-Salgueiro (https://orcid.org/0000-0002-8384-4254) [1]
Ana Carla Silva Alexandre (https://orcid.org/0000-0002-5754-1778) [1]
Gislene Farias de Oliveira (https://orcid.org/0000-0001-5373-2326) [2]

**Abstract** *The objective of this article is to identify in the scientific literature affirmative care actions for the black population. This is an integrative review of the literature carried out in April 2017 at the Virtual Health Library (BVS), using LILACS (Latin American and Caribbean Literature in Health Sciences) and the Nursing Database (BDENF). Ten papers explored and shown in synoptic tables were used and analyzed through an instrument after taking into account the inclusion and exclusion criteria. Nine affirmative actions were listed to promote healthcare for the black population following the study of the papers. It is necessary, in both care and training spaces, to question the main demands against the context in which the black population is inserted, as well as the affirmative care actions for the black population to implement the principles of universality and integrality in health services to their full extent.*

**Key words** *Black population, Collective Health, Comprehensive Care, Care*

[1] Departamento de Enfermagem, Instituto Federal de Educação Ciência e Tecnologia de Pernambuco. BR 232 Km 208 s/n, Campus Pesqueira. 55200-000 Pesqueira PE Brasil. alvespedro113@gmail.com
[2] Universidade Federal do Cariri. Juazeiro do Norte CE Brasil.

## Introduction

The meanings pointed out for the term "care" are polysemous and diverse and emerge as a challenge within collective health. However, this term is related to the act of gathering, which in turn is a meeting of knowledge, technologies, cultures, affections, where it works in the nuances of collective health, as a moment of exchange between professionals, services and health teams with those who need/seek care[1], valuing horizontality, breaking the hierarchical barrier in the professional-user dyad.

The act of caring is essential to human beings, since it is related to zeal, proper treatment, empathy, solicitude, characterizing, thus, the act by which someone "transcends itself", ridding of its social and individual ties to focus on the concern with another person. In this perspective, the art of caring is born and is the essence of doing in nursing, to scientifically support the practice. Thus, at the end of the twentieth century, the first nursing theories based on the holistic view of the human being[2] are published.

In the period preceding the establishment of the Unified Health System (SUS) in Brazil in 1988, care was promptly replaced by treatment, due to the health commodification process, culminating in the carelessness and dehumanization of care, and is supported by private groups, where the scientific and economic interest is more important than the social interest, where the disease is more important than the sick body, since the money and prestige obtained by the medical services had no obligations and debts with human suffering[3].

Integrality carries within itself the essence of care, both between services and professionals, based on the integration of knowledge between the multidisciplinary team and the professional's view vis-à-vis the users, considering them as biopsychosocial beings, taking into account the strong influence of the social, economic and cultural context in the process of becoming ill[4].

However, integrality is an incipient practice in collective health, since the ideology that permeates the operationalization of the SUS is strongly linked to the biomedical, curativist paradigm, where care was replaced by treatment, building a barrier between those involved, expressing the assistance in an inhumane, mechanized way, mainly focusing the pathology and not the human being as a social being[4,5].

Thus, in order to break with the biomedical paradigm, the National Humanization Policy is established and values care through qualified listening and the reception of health demands for people seeking the service, recognizing users as biopsychosocial beings. It is worth emphasizing that other social factors contribute to the effectiveness of the doctrinal principles governing the SUS, since in many services, color/ethnicity and belief/religiosity are limiting factors in health care, and are expressed by discriminatory acts or race-related insults, causing much psychosocial and structural harm in the black population[6].

Besides being the Latin American country with a more significant number of black people outside the African continent, represented by about 54% of the Brazilian population, Brazil was one of the countries that most enjoyed the black slave labor and maintained it in force the most. While recognizing the contributions of the African population to the economic and social construction of the country, through economic, social and statistical data, Brazil can be considered as a racist nation[7], since, above all, wealth, schooling, housing, consumer power and access to services of citizens self-declared as whites, negroes – blacks and browns – and indigenous people hold different social spaces, reflecting significantly on social indicators. Undoubtedly, people of black and indigenous origin have the worst schooling indicators, hold the worst jobs and have less access to social and health goods and services[8].

Faced with capital expansion, domination strategies were established on the African continent, making the trafficking of the black population of several locations of Africa one of the quick-profit activities, a profit generated through violent acts, considered even a kidnapping, since the enslaved are deprived of their identity, lands, families, beliefs and traditions, their real home, and even their own body's power. Many witnessed the deaths of their families and friends during their trip to the "New World" since the subhuman conditions in which they were brought to Brazil facilitated a high death toll of this "commodity"[8,9].

In the midst of the institutionalized organization of the enslaving process, both the black population and the indigenous population organized themselves differently to resist the white colonial system through the quilombos in defense of freedom. It is worth noting that abolition was not a gift from Princess Isabel since the struggle of the black people and their resistance liberated much of the African people from the bonds of slavery through escapes and wearing of the slavery system[8].

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The abolition of slaves did not end with racism-based violence, because being free did not ensure the recapture of dignity for the black population, and a cluster of people wandered in search of true "freedom". Thus, the strengthening of the black movement takes place, participating in several revolutions in the post-abolitionist period. The struggles of the black movement were pressed during the 1964 coup, reactivating in the 1970s with the creation of the Unified Black Movement (MNU), where the struggle for equality and universal citizenship was strengthened, breaking with the racist culture that reverberates to this day in all institutional spheres. In the 1980s, the Black Women's Movement appeared in the space of militancy, fighting for feminine empowerment, in the struggle of the "*terreiros*"[10]. Nowadays, the black movement has been taking on a new outfit since it includes women, lesbians, gays, bisexuals, transgender (LGBT), people from the "*terreiros*" and other representatives.

Currently, institutional racism and the discriminatory process suffered by black people influence education and health indicators. According to Werneck[11], racism is an ideological phenomenon, characterized as a factor of violation of rights, where it contributes to social inequities, especially in the field of health. Racism is related to black people's whole life cycle, from birth, as well as his family and individual course, up to the life, housing, work, employment, income and access to information and goods and services conditions. Racism becomes visible in the quality of care and assistance provided by the service, in the profiles and estimates of adult and child mortality, avoidable suffering or early death.

In Brazil, the risk of a black or brown child dying before the age of five due to infectious and parasitic causes is 60% higher compared to a white child. Also, the risk of death due to malnutrition is about 90% more likely among black and brown than white children. The risk of a black person dying from an external cause is 56% more likely than that of a white person; taking into account a black man, the risk is 70% more likely than that of a white man. Overall, the risk of death from homicides was higher in black and brown populations, regardless of gender. Moreover, pregnant black women die more from maternal causes, such as hypertensive gestation syndromes[6].

One of the ways of overcoming this problem in health and the myth of racial democracy (characterized by the harmonious relationship between ethnic-racial groups "fruit of the relationship of the Portuguese colonizers with the people they dominate") is with the implementation of policies to correct racial inequalities, that is, affirmative actions, as a strategy to overcome racism and build a real democracy[10].

Nevertheless, on November 20, 2007, the National Policy for the Comprehensive Health of the Black Population (PNSIPN) was published, whose main feature is the recognition of racism, ethnic-racial inequalities and institutional racism as social determinants, aiming to promote equity in health, as well as improve the health indicators of the Brazilian black population[6], through affirmative action.

Affirmative actions are reparatory or preventive actions that aim to correct discriminatory actions perpetrated against a socially discriminated group, reducing social inequities, breaking with the idea of institutional racism. The PNSIPN is one of the guiding instruments for affirmative health actions, focusing on the black population[10].

Thus, this integrative review study shows affirmative actions for the promotion of black population care from an ethnic-racial perspective, as well as the implementation of the PNSIPN within collective health.

## Methods

This is an integrative literature review, which is characterized as a broad methodological approach to reviews, where integration occurs between experimental and non-experimental studies for a complete understanding of the phenomenon analyzed. It also combines data from the theoretical and empirical literature and incorporates a wide range of purposes, namely, definition of concepts, theory and evidence review, and analysis of methodological issues of a particular topic[12].

The following steps were followed: definition of the guiding question of the study, establishment of inclusion and exclusion criteria, definition of the information to be removed from the selected studies, analysis and interpretation of the studies underlying the sample, synthesis of results and presentation of the review[12].

The guiding question was: "What affirmative actions have been taken to promote the care of the black population, since the implementation of the National Policy for the Comprehensive Health of the Black Population (PNSIPN)?". The

papers were collected in April 2017, through the Virtual Health Library (BVS), LILACS (Latin American and Caribbean Literature in Health Sciences) databases and the Nursing Database (BDENF), from the Portuguese language descriptors extracted from the Descriptors in Health Sciences (DeCS), namely, "*Saúde Pública*", "*População Negra*", "*Atenção Integral*" and "*Cuidado*".

The databases were chosen due to the number of indexed health-related papers, and also because they are based on primary studies, as well as for indexing papers on nursing-related topics. The descriptors were adjusted differently to expand the search for studies. We considered terminological variations and synonyms. All were used to carry out a sensitized search using the Boolean operators AND for the simultaneous occurrence of subjects.

The following inclusion criteria were established: studies from 2007 (Year of publication of the PNSIPN) to 2017, papers in Portuguese, with full text available and that addressed the development of affirmative actions to promote healthcare for the black population. Exclusion criteria were papers repeated in more than one database, incomplete papers, theses, dissertations, book chapters, news and studies not addressing the chosen topic.

Initially, the search was conducted by cross-linking two descriptors, "*População* Negra" and "*Saúde Pública*", using the Boolean connective "AND". The search returned a total of 378 studies. Shortly after reading titles and abstracts to verify which ones were adequate to the inclusion and exclusion criteria, we selected eight studies to compose the results of this paper. Later, the three descriptors were cross-linked using the Boolean connective "AND" between "*População* Negra" "AND" "Cuidado" and "OR" between "*Cuidado*" and "*Atenção Integral*", returning 479 published studies, which were narrowed down to two papers after the application of inclusion and exclusion criteria and reading the abstract, totaling a sample of ten papers.

Subsequently, tables were cataloged, adapted from URSI (2005) and Souza et al.[12]. The search strategy allowed the identification of studies that were included in the review is shown in Chart 1 and includes the following aspects: title, authors of the studies, year of publication, Brazilian region of the study, type of study, publication area, level of evidence and the listing of the affirmative actions found in the studies.

## Results and discussion

Ten papers that met the proposed objectives were selected from the established inclusion and exclusion criteria, by paper code (CD), paper title, author(s), the region where the research was conducted (RR) and year of publication (YP).

Concerning the years of publication, there is a growing trend regarding the number of publications, since two studies were produced between 2011 and 2012. Two surveys were conducted in 2013, and a significant increase between the years 2015 and 2016 produced six scientific works. The scientific research was strengthened after the implementation of the PNSIPN in 2007, covering the health of the black population, supporting the professional practice regarding the implementation of care actions with black people, significantly increasing research in this area.

One of the hypotheses to be raised is that the field of research with the black population is continuously growing, which may be related to the quota system of universities that enabled the black population, specifically black youth, to attend university and have the opportunity to produce its people's science for its people, thus ensuing the strengthening of the discussion about blackness in the university sphere, with the leadership of the black youth holding these spaces.

Chart 2 shows the authors' training area, as well as the type of publication or training area (TP/AF), type of research (TR) and, finally, the level of scientific evidence (LSE).

The professional area that had a significant number of publications on black population care was psychology, with six studies of the sample, medicine and education, representing one publication each. On the other hand, the nursing area showed a sample with two publications, representing, thus, a reduced interest in the production covered in this study.

Another variable considered was the level of scientific evidence, which aims to strengthen the process of Evidence-Based Practice, using evidence classification systems characterized hierarchically, based on the methodological approach adopted[11]: Level 1: Evidence from the meta-analysis of multiple controlled and randomized clinical trials; Level 2: Evidence obtained from individual experimental studies; Level 3: Evidence from quasi-experimental studies; Level 4: Evidence from (non-experimental) descriptive studies or with a qualitative approach; Level 5:

**Chart 1.** Articles selected after inclusion and exclusion criteria.

| CD | Title | Authors | RR | YP |
|---|---|---|---|---|
| A1 | Política Nacional de Saúde Integral da População Negra: implementação, conhecimento e aspectos socioeconômicos sob a perspectiva desse segmento populacional. | Chehuen Neto et al.[22] | Southeast | 2015 |
| A2 | Axé, práticas corporais e Aids nas religiões africanistas do Recife, Brasil | Rios et al.[20] | Northeast | 2013 |
| A3 | Racismo institucional e saúde da população negra | Werneck[11] | Southeast | 2016 |
| A4 | Abordagem psicossocial e saúde de mulheres negras: vulnerabilidades, direitos e resiliência. | Prestes e Paiva[15] | Southeast | 2016 |
| A5 | Jovens, negras e estudantes: aspectos da vulnerabilidade em São Luís do Maranhão. | Jesus e Monteiro[16] | Northeast | 2016 |
| A6 | Humanização na atenção à saúde e as desigualdades raciais: uma proposta de intervenção | Batista et al.[17] | Southeast | 2016 |
| A7 | Procura por cuidados de saúde: questões de gênero e raça entre colaboradores negros de uma universidade. | Bispo et al.[18] | Northeast | 2015 |
| A8 | Saúde da população negra: A religiosidade afro-brasileira e a saúde pública | Lages[9] | Midwest | 2012 |
| A9 | Iniquidades raciais e saúde: o ciclo da política de saúde da população negra | Batista et al.[8] | Southeast | 2013 |
| A10 | Apoio social como possibilidade de sobrevivência: percepção de cuidadores familiares em uma comunidade remanescente de quilombos | Silveira et al.[21] | Southeast | 2011 |

**Chart 2.** Distribution of items raised by area of publication, type of research and level of scientific evidence.

| CA | TP/AF | TR | LSE |
|---|---|---|---|
| A1 | Medical Publication | Quantitative approach | Level 04 |
| A2 | Other: psychology | Qualitative approach | Level 04 |
| A3 | Other: psychology | Other | Level 06 |
| A4 | Other: psychology | Other | Level 06 |
| A5 | Other: educational | Qualitative-quantitative approach | Level 04 |
| A6 | Nursing publication | Qualitative approach | Level 04 |
| A7 | Nursing publication | Qualitative approach | Level 04 |
| A8 | Other: psychology | Qualitative approach | Level 04 |
| A9 | Other: psychology | Other | Level 06 |
| A10 | Other: psychology | Qualitative approach | Level 04 |

Evidence from case or experience reports; Level 6: Evidence based on expert opinions[11].

This sample showed that about seven papers of the sample fit the Level of evidence 4, which is very relevant since it provides the black population with the possibility of speaking and listening by the team of interviewers and the general reading population. It represents a vivid expression, mainly because black people have been silenced for a long time, which required the opening of spaces to listen to them and to produce science, and also to benefit them through this process. It endorses one of the agendas which the black movement fights for, which is the right of argument and voice in both political and scientific spaces.

The construction of affirmative actions to combat and overcome institutional racism is

proposed for the various institutional spaces. In this study, nine affirmative actions were listed by reading the papers as shown in Chart 3.

Racism acts in three realms (Internalized, Interpersonal, Institutional), producing effects on individuals and groups (not only of its victims), generating thoughts, feelings, personal and interpersonal behaviors, exerting strong influences in the face of institutional processes and policies, thus naturalizing the iniquities produced by racism, often acting subtly[13,14].

In this perspective, among the affirmative actions listed in this study, good practices in the professional and academic scope appear in four of the studies. Academic settings exert a strong influence on the process of citizen formation, but as an active ideological apparatus, they end up, sometimes, neglecting the languages of diversity and positive discrimination, thus giving rise to racism. Faced with its complex and broad performance, racism is considered as a system, since its structures, policies, practices and norms can define opportunities and values for people and populations from their appearance[10].

The professional training environments are essential for the development of affirmative actions, from the strengthening of intersectoral partnerships between health and education, culminating in the assurance of the fundamental rights of human beings, discussing racism and its influence in the health promotion process, strengthening in this context the PNSIPN[15].

There is a need to include a holistic approach to the health of the black population in the curricula of health courses so that professionals do not reproduce in their practice the racial hierarchy deeply rooted in society. Besides advocating for changes in the academic curricular matrices, in his study, Batista et al.[16] affirm that information should reach the professionals already trained, especially those working at the gateways of the SUS, in the PHC facilities, through permanent education, by sensitizing them to adopt, in their care, skin color indicators to support the planning of actions and services aimed at the black community[16]. An example of this is that the skin color variable is used in maternity wards, focusing mainly on humanization for black women, since about 90% of black pregnant women die from preventable causes in maternity wards[8].

The oppression exerted by white men and women and black men on black women sometimes results in traumatic conflicts. Wounds caused by racism and sexism weaken their emotional state[17].

The second affirmative action was the activities aimed at strengthening access to health services and actions, especially for black women, where the service would establish strategies to break with institutional racism, as well as the chauvinism involved in this process. It is essential to provide spaces for discussions on the health of black women reaching out to health professionals, in order to support the diagnosis of institu-

**Chart 3.** Affirmative actions to promote care for the black population.

| N° | Affirmative actions/percentage | CA |
|---|---|---|
| 01 | Good practices in the professional and academic context. | A4; A5; A6; A9 |
| 02 | Establishing measures to facilitate the approach and access of the population to the service, especially for black women. | A3; A4; A5; A7 |
| 03 | Eliminating Institutional Racism (IR), which permeates the SUS at all levels of management. | A3; A4; A9 |
| 04 | Recognizing the ancestry of the spaces of the African matrix religion as community equipment in the Healthcare Network. | A2; A8; A9 |
| 05 | Strengthening black population research. | A1; A3 |
| 06 | Training with civil society, service users and Black Movement leaders. | A6; A7 |
| 07 | Family attachment and involvement both in the care process and in the development of resilience, based on the past generation. | A4; A10 |
| 08 | Access to traditional, practical or ritual therapies for psychic reorganization and the potential to love and establish a bond, also promoting ancestral and generational reception | A4 |
| 09 | Strengthening of the health education process regarding the pathologies that most affect the black population as per the PNSIPN. | A9 |

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tional racism based on discussions of conceptual frameworks, analysis of social indicators, identification of how racism focuses on inequalities and in assessing levels of social protection/neglect of black women[17]. Thus, it is necessary to hold on to resources to advocate for and maintain their integrity, where with available resources, it is possible to overcome problems and, thus, activate capacities such as transformation, creativity, hope and resilience[14,17].

The process of training and qualifying civil society, consisting of service users and leaders of the black movement[16], can be accessed, ensuring participation and social control of health, which returned two of the papers surveyed. The development of technologies that can involve and hold society accountable as a whole for their health has sensitized the population to the needs of preventive and health promotion actions[18].

Institutional Racism (IR) encompasses the individual axis, acting structurally, and is also termed systemic racism, as it occurs at organizational levels, in policies, practices and norms, resulting in unequal treatments and outcomes, producing a racial hierarchy, contributing to the suffering and neglect of the black population, especially in the area of health. In Table 3, it can be seen how the third affirmative action, namely, the elimination of IR, impregnates the SUS at all levels of management, and emerged, in turn, in about three of the studies.

The process of implementing the skin color variable in the information systems of the SUS directs the planning of health actions and services, covering the black population[8]. It is essential to increase the participation of managers and professionals in the actions and policies of eliminating institutional racism and racial disparities in health[11], and can be implemented through training and workshops with professionals at all management levels[14].

Batista et al.[17] used in their approaches allusive materials such as books, audiovisual devices, booklets, covering the process of humanization in the maternity, with a positive feedback from the professionals involved in the intervention, implementing the skin color variable in the Hospital Admission Authorization (HAA) in the state of São Paulo.

The analysis of data of this study also indicates that the Brazilian process of colonization and migration contributed to religious plurality in the country. Nowadays, it is possible to perceive the potential of the African matrix religions' spaces as community equipment in the Healthcare Network. These spaces are potential places of information and education in health because they mostly integrate the black population[19]. The recognition of this affirmative action acts not only in the fight against cultural prejudice but also in the inclusion of such religious manifestations in the debates about health with the community, mobilizing the participation and social control of health.

It was possible to perceive this process in the study by Rios et al.[20], where, in the face of the AIDS epidemic in the state of Pernambuco, it was noticed that HIV (Human Immunodeficiency Virus) was being transmitted in the coexistence within the *terreiro*, through the rituals (removing or adapting). So the head religious healers, jointly with the health service, thought about strategies to cope with and combat HIV/AIDS within African matrix religious *terreiros*, guiding both the community in which the *terreiros* were inserted and the initiated religious healers-to-be, recognizing them as community equipment.

Traditional practices have a strong influence among the black population in situations where the subject is not a follower of some of the African matrix religions, but they are practices that are handed down from generation to generation, such as teas, for example, and is an affirmative action in one of the presented studies. Another affirmative action in the care process with the black population is the participation of the family in the care process, since it can be considered a permanent social institution and a source of potential support and care, since all inspiration from black figures corroborated the development of resistance from shared meanings in black cultural manifestation in the intra-family environment through the appreciation and recognition of their ancestral roots[17]. One should take into account the importance of the black family in the home care process and how the health team acts to restructure the family by sensitizing it towards co-responsibility of care[21].

Another affirmative action found in one of the present studies evaluated was the process of health education with the population, covering the most frequent diseases in the black population that are (a) genetically determined; (b) acquired under unfavorable conditions; (c) of aggravated development or with a difficult treatment[6], requiring a specific professional approach. In the study by Batista et al.[8], this specific glance at the health demands of the black population enabled the elaboration of the State Policy for the Care of People with Sickle Cell Disease in the

State of São Paulo, strengthening the articulation of the other devices in the health care network. The health education process with the black population is extremely relevant and health services are crucial and should bring information to this population, ensuring health promotion and prevention within the SUS.

Finally, the research with the black population is shown in two (A1[22]; A3[17]) of the analyzed studies and is an essential factor to promote a situational diagnosis on the health demands of the population in question, supporting the care promotion practices in a holistic and humanized way.

## Final considerations

Given the above, the incentive for research with the black population must be strengthened in the academic field, mainly in the North and Northeast, which have a more significant number of blacks, allowing the population to study itself and benefit its population through science. As an area that operates under the light of care, it is of great relevance to sensitize both the student body and faculty staff of the nursing courses and health sciences, encouraging research, covering the black population, improving, through science, the strategies of care that can be adopted in the face of the health demands of black people.

The affirmative actions carried out since the implementation of the PNSIPN shown in the papers, namely, (1) Good practices in the professional, academic and school context; (2) Integration of black women to improve access to health services; (3) Elimination of Institutional Racism (IR); (4) The recognition of ancestry and the spaces of African matrix religion as community equipment in the Healthcare Network; (5) Strengthening research with the Black Population; (6) Training with the follow-up of society on the fight against IR; (7) Family adherence and involvement both in the care process and in the development of resilience, where the past generation is shown as a mirror; (8) Access to traditional, practical or ritual therapies for the psychic reorganization and the potential for love and bonding, also promoting ancestral and generational acceptance; (9) Strengthening the health education process about the pathologies that most affect the black population as per the PNSIPN are of great relevance, since they provide a broad analysis of the experience of the black population, where the State should build strategies in the face of the provision of support for the implementation of these affirmative actions, since it will enable the full operationalization of the PNSIPN.

Many of the affirmative actions listed in this study can be put into practice from the awareness of health professionals since academia shows a weakness regarding the discussion about the influence of racism. Therefore, they should seek information, breaking the barrier of prejudice, fighting against racism and all forms of discrimination, respecting the human being in its fullness, thus promoting holistic care, strengthening integrality as a doctrinal principle of the SUS.

## Collaborations

PHM Alves proposed the theme of the integrative review, raised the articles, built the methodology, as well as the results and discussion of the article, also contributing to the final considerations. CDB Leite-Salgueiro helped significantly in the process of guiding the writing, in the process of constructing the methodology of the article, as well as the discussion and final considerations. ACS Alexandre and GF Oliveira participated in the final review of this study, with significant contributions.

## References


1. Cruz MCC. *O conceito de cuidado à saúde* [dissertação]. Salvador: Universidade Federal da Bahia; 2009.
2. Vale EG, Pagliuca LMF. Construção do conceito cuidado em enfermagem contribuição para o ensino de graduação. *Rev Bras Enferm* 2011; 63(1):106-113.
3. Martins PH. *Contra a desumanização da medicina: crítica sociológica das práticas médicas modernas*. Rio de Janeiro: Editora Vozes; 2003.
4. Pereira TTSO, Barros MNS, Augusto MCNA. O Cuidado em Saúde: o Paradigma Biopsicossocial e a Subjetividade em Foco. *Mental* 2011; 9(17):523-526.
5. Aguiar ZN. *SUS: Sistema Único de Saúde – antecedentes, percurso, perspectivas e desafios*. São Paulo: Martinari; 2011.
6. Brasil. Ministério da Saúde (MS). *Política Nacional de Saúde Integral a População Negra*. Brasília: MS; 2007.
7. Freitas MDS. Refletir sobre a história do negro no brasil: uma resposta ao racismo. In: *Anais do II Congresso de Educação*. Goiás: Universidade Estadual de Goiás/ Unidade Universitária de Iporá; 2011.
8. Batista LE, Monteiro RB, Medeiros RA. Iniquidades raciais e saúde: o ciclo da política de saúde da população negra. *Saude Debate* 2013; 37(99):681-690.
9. Lages SRC. Saúde da população negra: A religiosidade afro-brasileira e a saúde pública. *Rev Argumento* 2012; 30(69):401-410.
10. Gomes NL. O movimento negro no Brasil: ausências, emergências e a produção dos saberes. *Política Soc* 2011; 10(18):133-154.
11. Werneck J. Racismo Institucional e Saúde da População Negra. *Saude Soc* 2016; 25(3):535-549.
12. Souza MT, Silva MD, Carvalho R. Revisão integrativa: o que é e como fazer. *einstein* 2010; 8(1 Pt. 1):102-106.
13. Brasil. Estudo aponta a distribuição da população por cor ou raça. 2013. Disponível em: www.brasil.gov.br/cidadania-e-justiça/2013/11/estudo-aponta-distribuição-da-populção-por-cor-ou-raca
14. Jones CP. Confronting institutionalized racism. *Phylon* 2002; 50(1):7-22.
15. Jesus MLG, Monteiro RB. Jovens, negras e estudantes: aspectos da vulnerabilidade em São Luís do Maranhão. *Saude Soc* 2016; 25(3):652-663.
16. Batista LE, Rattner D, Kalckmann S, Oliveira MCG. Humanização na atenção à saúde e as desigualdades raciais: uma proposta de intervenção. *Saude Soc* 2016; 25(3):689-702.
17. CRS, Paiva VSF. Abordagem psicossocial e saúde de mulheres negras: vulnerabilidades, direitos e resiliência. *Saude Soc* 2016; 25(3):673-688.
18. Bispo A, Dias AB, Pereira A. Procura por cuidado de saúde: questão de gênero e raça entre colaboradores negros de uma universidade. *Rev Peq Cuid Fund Oline* 2015; 7(1):1856-1866.
19. Rezende EG, Concone MHVB. Espiritualidade e religião no processo saúde-doença. In Silva EA, organizador. *Sociologia aplicada à enfermagem*. São Paulo: Manole; 2012. p. 70-107.
20. Rios LF, Oliveira C, Garcia J, Parker R. Axé, práticas corporais e Aids nas religiões africanistas do Recife, Brasil. *Cien Saude Colet* 2013; 18(12):3653-3662.

21. Silveira CL, Budó MLD, Ressel LB, Oliveira SG, Simon BS. Apoio social como possibilidade de sobrevivência: percepção de cuidadores familiares em uma comunidade remanescente de quilombos. *Cien Cuid Saude* 2011; 10(3):585-592.
22. Chehuen Neto JA, Fonseca GM, Brum IV, Santos JLCT, Rodrigues TCGF, Paulino KR, Ferreira RE. Política Nacional de Saúde Integral da População Negra: implementação, conhecimento e aspectos socioeconômicos sob a perspectiva desse segmento populacional: implementação, conhecimento e aspectos socioeconômicos sob a perspectiva desse segmento populacional. *Cien Saude Colet* 2015; 20(6):1909-1916.

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