

Ways and detours in guarantee of health for the black population and the confrontation of racism in Brazil

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Abstract *Institutional racism is prevalent in the health services in Brazil and is based on concrete power relations that subjugate, dominate and exclude blacks from having adequate access to health care and health institutions. This critical essay analyzes the importance of expanding the debate, and the production of knowledge about the health of the black population (HBP), focusing on two points: the role of the National Policy for the Integral Health of the Black Population (PNSIPN) and the importance of including the skin color item in the health information systems; and the need for a process of permanent training of professionals, including contents related to the understanding of racism as an element of the social determination of health/disease and their effects. To demonstrate how structural and institutional racism have affected the black population, we bring also examples of the quilombola populations in the context of the Covid-19 pandemic in the country since 2020. It is concluded that the promotion of care, the reduction of inequities and the quality of health care need to undergo changes in several dimensions, such as the strengthening of the SUS, the daily fight against structural and institutional racism, among others.*

Key words *Health of the black population, Institutional racism, Public health policies, Quilombola communities, COVID-19*

Introduction

This article, written as a critical essay, aims to discuss the importance of expanding the debate and the production of knowledge about the need to guarantee health for the black population (HBP) and the ways to confront racism in Brazil, considering the intersectoral perspective. Therefore, the following question is asked: “Is the field of Public Health attentive to this issue as a priority element in its production of knowledge and teaching actions?”

The Federal Constitution of 1988 establishes health as a right of all people, and that the government must implement public policies, guaranteeing universal access to health care programs¹. The Brazilian Unified Health System (SUS, *Sistema Único de Saúde*), therefore, seeks to implement this right through actions of health promotion, protection and recovery of individuals based on the principles of Universality, Equity, and Integrality of care.

In Brazil, the construction of the right to health and the creation of SUS were surrounded by political disputes over corporate projects². As this clash, in reality, still remains, SUS has not been able to guarantee the adequate coverage for health and illness needs of the population, especially the black population and the traditional communities, such as native peoples and *quilombolas*.

Since 2017, the different economic crises and the political direction taken by the federal administration have resulted in a great throwback in relation to social policies, especially those related to health, social assistance and security, which comprise the Brazilian Social Security system. These policies have suffered greatly due to neoliberal economic measures, the repeated fiscal adjustments, and the implementation of the Constitutional Amendment n. 95/2016, which has led to a continuous process of reduction of the budget aimed at funding health care actions and programs³. This continuing socioeconomic imbalance and the evident racial inequality derive from historical and, above all, ethnic-racial elements that are deeply ingrained into the Brazilian nation, resulting in distinctive disadvantages and privileges among the racialized groups⁴.

As we are part of a structurally racist society, health institutions are also organized around this same structure, expressing dissimilarities in health care, inequities in access to services, differences in care for diseases prevalent among the black people – sickle cell anemia, diabetes mel-

litus and arterial hypertension - insufficient disclosure of official data, and lack of research on HBP in high-impact scientific journals, among others^{5,6}.

The perspective of the social determination of health (SDH) helps to understand that inequities in health are intrinsically related to political, economic, social, cultural and racial inequalities, since these dimensions have an impact on the ways of being born, living, working, aging, getting sick and dying as well as in the conditions of access to health care services⁷. In this sense, markers such as social class, gender and race/ethnicity influence the access of people and groups to goods and opportunities in Brazilian society.

This demonstrates that racism is a part of the social determination of health, affecting the black population in all stages of life^{6,8}. In the analysis of the interrelationships between the social determination of race/skin color, class and gender markers, the concept of intersectorality is vital as it has the potential to improve population health research by bringing greater validity and attention to the heterogeneity of the effects regarding the causal processes that produce inequalities and inequities⁹, given the fact that the biological factors used to explain differences in people's health status, in general, do not fully elucidate the differences in the way diseases affect the individuals. Therefore, an intersectoral analysis identifies that social, economic, cultural, environmental and political factors, and therefore collective factors, are essential to explain why some individuals and/or groups are subject to a greater risk of illness and death than others.

When using the intersectoral analysis to demonstrate the racial dimension of health inequalities, it is possible to observe discrepancies in the difference of profile between race/skin color and gender for different outcomes of the health-disease-death process, such as maternal mortality^{10,11}; lethal and intentional violent crimes for black men (CVLIs, *crimes violentos letais e intencionais para homens negros*)¹², childhood deaths¹³, domestic violence and femicide of black women¹⁴, COVID-19⁸, morbidities for risk behavioral disorders¹⁵, ill-defined and external causes¹⁶, quality of life and life expectancy¹⁷, late diagnosis of malignant neoplasms¹⁸, oral hygiene indicators, and self-perception of oral health as good or very good¹⁹.

Considering this situation, it is necessary that the intersectorality between different biopsychosocial markers be considered in scientific research, in extension projects, in the training of

professionals and in the organization of health institutions, as well as in the creation and implementation of public policies, in health actions and funding.

Therefore, it is a challenge and an essential role for collective health to identify the relationships that exist in the process of social determination of health – of a social, economic, political, cultural, environmental nature, and the intersections among them – that directly impact the HBP. This reveals that the relationship of determination is not a simple direct cause and effect equation, and that racism is one of the bases of social inequalities in Brazil.

Based on the above mentioned, we focus on two analytical points: i) the role of the National Policy for the Integral Health of the Black Population (PNSIPN, *Nacional de Saúde Integral da População Negra*) and the importance of including the skin color item in health information systems; and ii) the need for permanent and continuous training of health professionals, so that they are taught to understand racism as one of the elements of the social determination of health and its intersections and effects on the black population. To demonstrate in practice how structural racism, in its institutional development, has affected this population, we bring as an example the case of *quilombola* populations and the context of the COVID-19 pandemic from the year 2020 on.

The National Policy for the Comprehensive Health of the Black Population (PNSIPN) and the importance of the skin color item

Although the legislation does not allow discrimination among the Brazilian population to access health care services, as universality of care is one of its principles, structural racism historically compromises the principle of health equity, which seeks to correct unfair and historically created inequalities. In Brazil, the legal guarantee of universal and equitable access to health actions and services has not been fully guaranteed to the black, *quilombola* and indigenous populations, since these have been especially subject to social and racial inequities in health^{3,8,20}.

Considering the diversity of the Brazilian population, and the importance of including the specific needs of these historically excluded segments, as well as to guarantee equity in SUS, with the struggle and mobilization of social movements, the government elaborated some specific policies such as the National Policy for Health

Care of Indigenous Peoples (*Política Nacional de Atenção à Saúde dos Povos Indígenas*), the National Policy for the Integral Health of Rural, Forest and Water Populations (*Política Nacional de Saúde Integral das Populações do Campo, da Floresta e das Águas*), and the National Policy for the Integral Health of the Black Population.

The Ordinance n. 992, of May 13th, 2009, established the PNSIPN²¹, which is supported precisely on the acknowledgement by the Brazilian State of the presence of institutional racism in the health services, and the importance of creating strategies to fight racism, aiming to correct health inequities and guarantee universal access to health services for the black population.

The PNSIPN has historical importance, being an instrument that allows the inclusion of the racial topic in the implementation of health policies, recognizing racism as part of the determination of the health-disease process, outlining a commitment by the government to face racial inequalities, both in the management and organization of services, as well as in health care practices. The policy recognizes institutional racism as an element that organizes health inequities and the need for providing adequate access for blacks to health services²¹.

However, studies indicate that the PNSIPN has not been appropriately implemented due to factors such as lack of knowledge of the health professionals about it; the non-recognition of the importance of affirmative actions in SUS²²; the reduced adherence of municipalities to the policy²³; the little recognition of institutional racism by professionals and managers²⁴, and the lack of indicators disaggregated by race/skin color for monitoring and evaluating actions^{20,25}. In this sense, the need to include skin color in monitoring systems is a fundamental issue when discussing institutional racism in the health area. Several studies have highlighted the importance of the skin color variable in the health care forms in SUS, and in the information systems. According to Batista, Monteiro and Medeiros (2013, p. 687) “Qualified information about skin color in SUS information systems would allow the monitoring and follow-up of the PNSIPN”. Thus, the absence of a racial information in the data collection instruments and information systems, prevents the identification of the health problems and the specific needs related to the black population, as well as the monitoring by SUS of the racial dimension, a crucial action to make racial inequalities visible, as well as to improve the services offered in the health system.

Despite the insufficiency of the inclusion of the skin color item, the few systems which allow the disaggregation of the variable show that the racial dimension greatly influences the situations of health, illness and death of the Brazilian population, and the differentiation regarding access to health services. When analyzing the context of the Covid-19 pandemic, for instance, some studies point out that the absence of notification of this variable, as well as the insufficient filling out of the item in the information systems have led to subnotification and underreporting, preventing the true measurement of racial inequities in health during the pandemic^{26,27}.

Therefore, improving data and providing greater transparency to information systems, as well as reducing underreporting, will allow a realistic analysis of the racial dimension of the health information as well as information crossings from an intersectoral perspective. The generation of disaggregated indicators by race/skin color, gender, class, among other social markers, constitutes a fundamental strategy to guarantee the monitoring and evaluation of social policies, and the confrontation of inequalities and institutional racism⁶.

The production of knowledge about the health of the black population and the continuing education of health professionals

Public management has the role of building actions and services that support SUS and develop policies of permanent education to prepare professionals to work in the recognition of racism and in the transformation of work processes, aiming to improve health care and equity, considering the diversity and specific health needs of the Brazilian population.

The field of health, strictly speaking, has a technician and biologicist formative perspective, characterized by its centrality in the disease and not in the individual and its social interaction. It is a fragmented pedagogical model, expository and centered on the teacher, disregarding the necessary competences and skills that guarantee a process of humanization of care.

To deal with interpersonal racism, in addition to institutional racism, both which permeate the practice of health professionals and institutions, it is necessary to align the PNSIPN with the National Policy of Permanent Education in Health (PNEPS, *Política Nacional de Educação Permanente em Saúde*), since both presuppose a

historical review of the process of idealization of the so-called racial democracy^{28,29}.

A qualitative research on the representations of policies aimed at fighting racial discrimination in the health sector, carried out with professionals working in this field in 76 health units of the public system in the municipality of Camaçari, state of Bahia, Brazil, disclosed the lack of knowledge of the PNSIPN by the majority of the participants. The results point to the constructed idealization that policies for specific populations promote racism and discrimination, and that the National Humanization Policy (PNH, *Política Nacional de Humanização*) itself would be enough to guarantee racial equality, without the need to “label policies”^{30,31}.

However, it should be noted that the PNH does not bring in its text an adequate discussion of the impact of racism on the black population's life and of possible ways of confronting racism in the health services. Only in the General Guidelines, in item 5, it indicates that the implementation in the different levels of care must sensitize the health teams in relation to the issue of prejudice (sexual, racial, religious, and others) at the time of reception and referrals, which is not enough to address the entire problem involving the impacts of structural racism in Brazilian society.

The survey also reflects on the filling out of the skin color item in the information systems. For most professionals who participated in the research, the skin color of the user should not be asked, because it would imply differentiating people, promoting racism, being misunderstood, delaying the service, or even because it is not part of their responsibilities. It is evident the need for permanent and continuous training of these professionals to discuss the historical processes of the Brazilian society formation, having structural racism as a founding element of the socioeconomic inequalities, the processes of social determination of disease and the health inequities³¹.

Another study carried out in public higher education institutions (HEIs) in four Brazilian states analyzed the Political-Pedagogical Projects (PPP) of undergraduate courses in health and related areas. The result showed that the inclusion of ethnic-racial topics in curricular components is incipient or non-existent, even in those courses that had their projects updated after 2009, when the PNSIPN came into effect. The health for the black population has occupied a secondary place in the training, almost always appearing as an elective subject or as a sub-topic of some curricular component³².

It is clear, therefore, that the training in the health, and related areas, offered by the HEIs has not effectively contributed to the reduction of racial inequities in health, or even to the provision of dialogical and humanized services to establish comprehensive care and attention adequate for the black population, and that it has not contributed to the implementation of the PNSIPN³³.

In addition to a legal and structural (re)ordering that the PNSIPN demands from health institutions, it also prioritizes the permanent and continuing education of professionals. The topic of racism and HBP must appear in the pedagogical projects of the training courses for health workers, aiming to encourage the production of scientific and technological knowledge, as well as to develop processes of information, communication and education in health, strengthening the identity and culture of the black population and helping to reduce social vulnerability²¹. Therefore, the HEIs, through the PPPs of undergraduate and postgraduate courses in health and related areas, must adapt to the demands presented in the PNSIPN, expanding the discussion on health inequities that directly affect the living conditions of the black population.

When conceiving the conjunction between the PNEPS and the PNSIPN as a pedagogical instrument, it becomes evident that an expanded, interdisciplinary and humanizing training aimed at meeting the specific health needs of the black population would be able to focus on the dimensions that prioritize modifying the stigmatizing perceptions about such policies, the racist social representations, and the strengthening of comprehensive and equitable care²⁸.

Therefore, since 2001, when the document “National Policy for the Health of the Black Population: a question of equity” (*Política Nacional de Saúde da População Negra: uma questão de equidade*) was launched – document created at the Interagency Seminar on Health of the Black Population, held in Brasília/DF, and afterwards debated at the 12th National Health Conference (CNS, *Conferência Nacional de Saúde*), in 2003 – it was decided that pedagogical actions relevant to the ethnic-racial issue for the training of health professionals should prioritize four work axes^{31,34}. These axes constitute the “quadrilateral of permanent health education”, and permeate the following elements: management, social participation and control, teaching and learning, and in-service education for health care³⁵.

Nevertheless, one cannot fail to consider the advances that the social movements have

attained such as the affirmative action policies for the reservation of vacancies and permanence policies implemented in HEIs and other public institutions. Also, the creation of the Racism and Health Thematic Group (GT) of the Brazilian Association of Collective Health (ABRASCO, *Associação Brasileira de Saúde Coletiva*) brings to the political and scientific arenas the importance of studying, debating and analyzing the health conditions of the black population based on the impacts caused by everyday racism³⁶, institutional, structural and interpersonal racism^{4,6}, environmental racism³⁷ and recreational racism³⁸, just to name a few. More recently, we ought to celebrate the implementation of the first Professional Master’s Degree Program in Health of the Black and Indigenous Population, at Universidade Federal do Recôncavo da Bahia (UFRB), which aims to train, qualify and expand the existence of researchers at the graduate level, form specialists in interrelationships in the field of health, public policies, health of the black and indigenous populations, as well as the production of knowledge in this field of studies.

Therefore, institutional racism, operating in the educational and health spheres, works as an instrument with which the government consolidates the project of supremacy of a certain racial group that subjugates others. This is one of the faces of the death policy, or *necropower*³⁹, which prevents the establishment of a specific, comprehensive, and humanized care for those who are not seen as persons and citizens, resulting in illness, injuries and deaths of Brazilian blacks and indigenous peoples.

Quilombola populations in times of COVID-19: structural racism as part of the Social Determination of Disease

In the context of public health, although ethnic-racial disparities have been known for decades, they have worsened during the COVID-19 pandemic and have particularly affected the most vulnerable populations, such as indigenous peoples and the *quilombolas*^{27,40}. At the end of the first half of 2020, Brazil became the second country in number of COVID-19 cases worldwide, behind only of the United States and, in March 2022, it surpassed 600,000 deaths from COVID-19.

Proportionally, blacks and indigenous peoples are the groups most affected by the pandemic in Brazil^{8,40,41}. In the case of the rural black communities, there are at least 5,972 *quilombola* localities, but only 709 have been officially recog-

nized. In the North region, 873 were identified, 516 of which in the state of Pará alone, one of the largest concentrations in the country. However, it is not known exactly how many *quilombola* communities exist, as these, for the first time, would be included in the 2020 Census, which was transferred to 2022 due to the pandemic.

Pará was one of the states hit the hardest by the pandemic. The number of cases in *quilombola* communities, riverside and indigenous populations grew rapidly, especially in 2021⁴¹. The great distances, difficulties in access, the chronic lack of health infrastructure in the *quilombos* and smaller municipalities⁴², and the absence of government policies for the Brazilian rural populations, are elements that contributed to the worsening of the situation experienced by these groups during the pandemic. It was only after intense mobilization by the organized civil society, especially through the proposition of the Action Against the Violation of Constitutional Fundamental Rights (ADPF, *Ação de Descumprimento de Preceito Fundamental*) number 742, in August 2020, that the *quilombolas* started having more visibility and their demands for priority protection and vaccination started to be considered^{40,43}.

The state of Pará is an emblematic example of the national situation of the rural black populations during the pandemic, as it is the state with the largest number of officially declared *quilombola* areas, comprising more than 6,000 families in 64 municipalities, and concentrates one-third of deaths due to SARS-CoV-2 in *quilombolas* in the country. Up to the first half of October 2021, according to the State Coordination of Associations of the Remaining Communities of *Quilombos* of Pará (*Coordenação Estadual das Associações das Comunidades Remanescentes de Quilombos do Pará*) (Malungu) and the *Sacaca* Nucleus of the Universidade Federal do Oeste do Pará (UFO-PA), which have been monitoring the communities through personal contacts with local leaders, there were 2,633 confirmed cases of COVID-19, and 97 deaths in several regions of the state.

Although it was a demand of ADPF n. 742, which was accepted by the Federal Supreme Court (STF, *Supremo Tribunal Federal*) and although there was a plan established by the Ministry of Health, there has never been adequate or sufficient testing for this population. Therefore, the number of unreported cases and, potentially, of deaths, across Brazil is incalculable. Estimates done by Orellana et. al. (2020)⁴⁴ in several state capitals indicate that there is high under-notification of cases and deaths by COVID-19 in the

Brazilian population in general. As the registration in the health systems of traditional communities, including *quilombolas* and indigenous peoples, was only implemented after the Technical Note CGIAE/DASNT/SVS/MS n. 215, in 2021, it is impossible to know exactly how many victims of the pandemic there were among traditional populations.

In Brazil, data from the Center of Operations and Intelligence in Health (NOIS, *Núcleo de Operações e Inteligência em Saúde*) of the Pontifícia Universidade Católica do Rio de Janeiro (PUCRJ), according to information available in the databases of the Ministry of Health (MS), 54.8% of black people hospitalized with Covid-19 died, while the case fatality rate among white people in the same period was 37.9%⁴⁵. And in the state of São Paulo, for example, the urban black population was 60% more likely to die from COVID-19 than the white population²⁰.

The underreporting of skin color and traditional community origin in the official systems, associated with repeated “blackouts” of the Ministry of Health databanks (caused by hackers, according to official sources) meant that many *quilombolas* across Brazil did not enter the records of vaccination or death from COVID-19.

According to the National Coordination of Articulation of Rural Black *Quilombola* Communities (CONAQ, *Coordenação Nacional de Articulação das Comunidades Negras Rurais Quilombolas*), in January 12, 2022, there were 5,666 confirmed cases and 301 deaths of *quilombolas* in Brazil. CONAQ and the Socio-Environmental Institute (ISA) also point out that, until June 2020, the estimated lethality rate among *quilombolas* was 11.62. However, in Pará, the estimated mortality in *quilombolas* in the same period was 153/100,000 inhabitants, three times that of the state (56/100,000) and almost five times that of Brazil (28/100,000)⁴⁶. Most of the infected and dead *quilombolas* were the elderly, who represent the social memory and history of the communities. The data show the impact caused by the lack of adequate means to face the pandemic among these vulnerable groups^{8,42}.

Unlike indigenous communities, which have their own support and funding legislation (albeit poorly implemented) through the indigenous health subsystem, in the case of *quilombola* groups there is no provision of regulation or budget for their demands by the government, which makes it even more difficult to mobilize resources to meet needs in emergency times, hence the importance of ADPF n. 742⁴³.

As an alternative to the absence of adequate public policies, most traditional rural communities chose self-isolation, setting up sanitary barriers with volunteers, seeking to keep strangers out of their territory, and following quarantine rules for those who had to go out to get food, medication or taking relatives to hospitals⁴⁰.

The historical lack of health services in the territories, such as regular medical follow-up and dispensing of medication, already promoted people's fragility, particularly those in the risk groups for SARS-CoV-2. By having to seek health services in urban areas, the *quilombolas* increased their chances of dying from COVID-19. Sanitary barriers also faced legal resistance, as many areas are not officially demarcated, and during the pandemic there have been cases of invasion and increase in conflicts in some areas that wish to maintain their isolation and autonomy⁴².

The livelihood of *quilombola* communities depends mainly on agriculture, extractivism and fishing. Unable to go out to sell their products, many communities also suffered from increased food and nutrition insecurity, and had to ask for support from NGOs, *quilombola* associations, researchers, activists and students in the capital, to purchase basic food baskets and hygiene kits to be distributed among disadvantaged families⁴⁷. Due to the lack of official initiatives, it was up to local associations and national organizations to articulate most actions and mobilizations aimed at rural black populations, often performing the role of the government.

From the south to the north of the country, Afro-descendants have a rich history of struggles for the preservation of the environment, their culture, as well as vast traditional knowledge. However, historically they suffer the weight of structural racism⁴. They experience a context of vulnerability that worsens the situation of *quilombolas* in the face of unexpected new problems, such as the COVID-19 pandemic, characterizing a syndemic scenario, from which these groups will take decades to recover.

The National Plan for Racial Equality, the Statute of Racial Equality⁴⁸, the PNSIPN²¹, among others, recognize that institutional racism exists, has serious impacts on people's lives and health, and needs to be urgently overcome in the country. Unfortunately, for most rural black communities, these represent just the dead letter of the Law, since they practically do not appear in the PPPs for the training of health professionals, most of them are not implemented by municipalities or states, and are practically ignored by man-

agers, who consider that "everyone is treated the same" under their jurisdiction, even in the face of visible and profound inequality in health.

Final considerations

Considering the aforementioned facts, it becomes evident that the structuring normative model of Brazilian society naturalizes racial inequalities and promotes their invisibility by centralizing the debate on social class when discussing social inequalities. It is necessary to mention that there is a process of dehumanization of the black population that precedes discriminatory practices, constituting, therefore, the stigmatized stereotypes that underlie racial prejudice. For this reason, in response to the initial question, we affirm that the scientific perspective and the pedagogical processes of Public Health training must contemplate intersectorality and, above all, the dimensions of race/ethnicity, class and gender. These must be based on political criticality, built on analytical equality, given that the matrix of oppression transforms political identities in subordinate identities.

The racist stereotypes built around black and indigenous populations, since the colonization process, are symbolic instruments that allow the material accomplishment of power, which has historically subjugated black and indigenous bodies through the scientific racism. In this context, the purpose of institutional racism would be to regulate, order, control, coerce, and restrict the movement of the black and indigenous populations in society, an instrument of biopower.

Therefore, we perceive that the manifestation of institutional racism in health is processed, mainly, through the non-implementation, lack of knowledge and even denial of the importance of the PNSIPN; the lack of adequate training and education of health workers; the absence of social indicators in the information systems and/or neglect in filling out the skin color item in the forms; the lack of adequate promotion of specialized, professional or technical services; by the invisibility of diseases that are prevalent in the black population; by the non-recognition of the existence of racist practices and underfunding for the health and education sectors.

In addition to the difference in morbidity and mortality between whites and blacks, the way *quilombolas* and indigenous people were treated during the worst period of infections and deaths by COVID-19 evidenced the systemic mecha-

nism of structural racism, in line with the privatist neoliberal policies, and the weakening of the institutions, which lead to unequal access to health, increase in mortality, as well as the con-

struction of barriers to social control, and also showed the ways and detours faced by society in the search for the elimination of racism and the guarantee of health care for the black population.

Collaborations

DA Santos: conception and design of the article, writing and critical review of all versions of the manuscript. LL Pereira: writing and critical review of all versions of the manuscript. Standardized the references according to the norms of the Journal. HP Silva, APN Nunes and JO Soares: writing and critical review.

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