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"The same way as there are black and white dogs": an analysis of the intersections between race and health

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Abstract *This paper reflects on the Family Health Strategy (ESF) workers' understanding of racial relationships and health intersections. We conducted semi-structured interviews with ESF teams' professionals in the State of Pernambuco, Brazil, whose data were analyzed in light of the discussions that focused on the racial theme. The results point to discrepancies between different health models in the daily routine, race/skin color invisibility in training and professional work, and whiteness as a structuring element of race relationships. The study reaffirms the need for Public Health to focus on the intersection between the issue of race/skin color and healthcare relationships and invest in the training of professionals regarding race discussions.*

Key words *Racism, Whiteness, Health, Primary Care Service, Equity*

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Introduction

This work aims to contribute to producing anti-racist knowledge in public health through a study on the understanding of the Family Health teams (eSF) professionals about the intersections between race and healthcare for the enrolled population.

Race is understood here as a divided and circumscribed social construction from the field of relationships, historical and social differences, and, in Brazil, emphasizing the phenotype, ethnic-racial relationships are translated into preserving the historical racial hierarchy[1].

Racialization is the belief that individuals have aspects socially expected as a race characteristic[2]. Racism is systemic discrimination found in dealings between individuals, which expands to the spheres of politics, economics, and everyday relationships[3].

Racism determines how public and private stakeholders address minority groups, reproducing the social ideology that legitimizes a position of perennial subordination of these minorities, responsible for creating cultural and material status inequalities, with repercussions on access to social rights[4].

Almeida[3] highlights that power is addressed as a central element of relationships in racism. Power is held by the groups that exercise control over a society's political and economic organization, whose maintenance is conditioned to the dominant group's ability to institutionalize its interests.

In this setting, Schucman[5] discusses whiteness, pointing out that racial miscegenation in Brazil provides unequal mediations in establishing subjectivities, permeating the entire socialization of individuals. Thus, whiteness is conceptualized as an identity experienced by white subjects as an inherited essence, conferring powers, privileges, and intrinsic aptitudes; that is, a naturalized racialization to such an extent that they do not perceive themselves as racialized[5].

The racial repercussions are questioned from these discussions, particularly how health professionals, mostly considered white, perceive the effects of racism on health. Professionals are knowingly not critical of racial issues and their health implications, reflecting institutional racism and denial of the racialized aspect of professional-professional and professional-client relationships[6]. The literature points to the close relationship between race and health inequalities[7] and racism as barriers to accessing health services and policies[8,9].

The inclusion of the race/skin color item in information systems, the Indigenous Health Care subsystem within the SUS, the establishment of the National Policy for Indigenous Health Care and the National Policy for Comprehensive Health for the Black Population (PNSIPN) are milestones of the recognition of ethnic-racial inequalities as a social determinant of health[10]. However, such legislative efforts still face implementation and consolidation challenges, with significant, persistent differences in the health indicators of these populations against the white population[11,12].

Thus, the present article aims to communicate the results of a conducted research whose central question is, "How do Family Health Units' professionals understand the intersections between race and healthcare, and how does this understanding affect the offer of care to the population assigned to the territory?". The primary author is a white woman, psychologist, and Family Health resident. At the same time, the co-author is a Black woman, a psychologist working in Primary Health Care (PHC), and both are from the working class.

Methodological aspects

This exploratory and descriptive study was conducted in a northeastern municipality that assumed the implementation of PNSIPN[13] in 2006. The municipality is divided into districts, and each one is subdivided into micro areas.

Professionals with a higher education required to integrate the eSF and oral health teams, white and non-white, were interviewed, three from each professional category: Nursing, Medicine, and Dentistry. The professionals were listed from the contact with the micro areas' managers, who invited the teams and highlighted professionals. These categories were chosen considering their place of power in the eSF, the representation of these relationships in the teams' dynamics[14], and contact with clients.

Respondents were, on average, 37 years old, primarily women, 11 years working in the SUS, seven years in PHC, and eight had undergone additional training in Collective Health.

The authors' perceptions of the race/skin color of the professionals were considered, as the understanding of racial issues in Brazil permeates the collective belief in miscegenation[15]. Moreover, the race-based socialization of individuals can interfere with understanding the theme. Five of the respondents self-declared as white, and one self-declared brown, as identified by the re-

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searchers. A divergence was identified between the self-declaration and the perception of the researchers regarding the others. Notably, none of the respondents self-declared or were identified by the authors as black.

The authors conducted a pilot interview and later held semi-structured interviews with the professionals, with a roadmap that addressed sociodemographic information and triggered questions on the racial topic. The field diary was used as a collection instrument to record the researchers' information and perceptions.

One of the researchers conducted the interviews, which were filmed and transcribed. Then, the transcripts were watched and read by the researchers. The study complied with the necessary ethical aspects, with approval by the ethics committee and the use of the Informed Consent Form. After systematic analyses, the meaning cores in the data found for categorization were identified and discussed in meetings, and subcategories and thematic categories were defined based on the Content Analysis technique[16].

The categories were organized and are presented from the following discussions: a) The different health care models in the daily lives of professionals; b) The invisibility of race/skin color in education and professional work; and c) Whiteness as an element of racial relationships in PHC.

Results and discussions

The different healthcare models in the daily lives of professionals

Professionals spoke about using health devices by clients, suggesting that the importance of PHC was conditioned to the fact that they could not afford healthcare in the private network. SUS role was reduced to providing care services at different care levels, leaving room for understanding a focused policy, contrary to one of universalization, an important aspect to pay attention to when geared to policies aimed at vulnerable populations, as highlighted by Faustino[17] when discussing the Black population policy.

Regarding health, SUS, and network devices, the professionals portrayed the experience and the assertions in the theoretical contents underlying the training of public health workers without necessarily being interconnected. An example was the frequent mention of the principle of equity and the difficulty in showing how it is operationalized in everyday life.

We highlight excerpts from experiences using the word "privilege" for situations that could be examples of equity, as observed in the statement of professional 2 when recalling working with the Indigenous population:

[...] it was easier when care was delivered outside the municipality. When they [Indigenous clients] came here, a car brought them, and they stayed in an inn, right? There they stayed in this inn, then returned... [laughs]. It had its privileges, you know? (Professional 2).

The concept needs a proper definition in the theoretical field, corroborating its abstract location in the discussions, resulting in its challenging operationalization[18]. Despite this, the concept has often been understood as an essential strategy for social justice, requiring State intervention in redistributing resources and eradicating avoidable disadvantages, which transcend the individual's control and harm health[18].

Health was understood as the lack of disease, and race was conceived as a determinant of health if it were directly linked to the body. Similarly, care strategies were significantly linked to the disease:

We must discuss equity and other issues in the politically correct discourse. However, in practice, we cannot do it daily [...]. We receive and give access to clinical treatment without considering these particularities (Professional 1)

Regarding the importance of PHC for healthcare, professionals began to use the first person to refer to PHC, emphasizing their work and locating the client as a recipient of their knowledge and care, suggesting that they play a leading role in the care relationship.

This aspect was also found regarding health education activities that, although signaled as aimed at the prevention of diseases and illnesses, expanded health concept beyond the lack of disease, and awareness of shared responsibility and role of clients in care, also included complaints about the level of education of clients, associating it with their resistance to moving away from the doctor-centered healthcare model:

As much as I try to make my knowledge accessible to them, whether in language, in bonding, it is not accessible, you know? I bump into the lack of education and instruction [...] they don't understand what health I try to do. Health for them is having access to an appointment and a pill (Professional 8).

This last data makes us think that, at first, the client is pointed out as not knowing, which leads to the welfare-like healthcare model. As for

transmitting health knowledge, the theoretical dimension predominates in the discourse, disconnected from practice.

Professionals must be aware that clients have apparently apprehended the healthcare model communicated to them in the daily routine of the services. They need help to absorb the guidelines given in health education activities because these are configured in a discourse disconnected from reality. Discussing education as a liberating practice, hooks[19] dialogues with Paulo Freire and points out that the split between theory and practice denies the construction of critical awareness and feeds hierarchization, elitism, and domination policies.

Souza and Jacobina[20] point out that the hygienist model influences health education, with vertical knowledge transmission, considering the people who receive it incapable of greater understanding, thus disregarding widespread knowledge and hindering the shared and co-responsible care construction.

This obstacle dialogues with the persistent presence of the welfare-medical care model in professional training and work, weakening the system in the face of complex transformations in the different environments in which people live, arising from poor urbanization and socio-spatial segregation[21].

Some data diverged from the hegemonic conceptions, which emerged exceptionally in a respondent's statement with experience in social movements, pointing out that the approximation of equitable action is possibly conditioned to the professionals' sensitivity and commitment.

The invisibility of race/skin color in education and professional work

Hesitations, defensive behaviors, and difficulties in understanding the questions were noticed when the racial theme came up directly in the interview, and explanations were frequently requested.

At that point, definitions of race were closely linked to physical features (skin color and phenotypic traits) and self-identification. In this regard, there were suggestive considerations that individuals who do not identify with the social perspective about their body vis-à-vis race harbored self-prejudice. The professionals' interpretation can be associated with reproducing the racist social imposition that keeps the individual to the race dimension.

Recognizing that racism exists in the shape of discriminatory acts among individuals was identified in the foreground; even so, in reality, far removed from the respondents, who had a defensive posture as if to distance themselves from the racist status and then reinforce the idea of equality among people.

Notably, the statements addressed Black population racism, making other non-white people invisible, although some professionals mentioned having experience in healthcare with the Indigenous population. The race belief appeared reduced to physical traits and the denial that the racialized body social reading can produce inequalities:

What changes is the amount of melanin, which will not interfere with anything in humans. Just as there are white dogs and black dogs, what's the problem? [...] right, all dogs? It's all people to me (Professional 3).

I learned that there is no such thing as a patient being white, Black, almond-eyed. There is no such thing as being yellow. There is no such thing. I was trained to treat people. So, the skin color...is not relevant (Professional 4).

The insistence on equality between people was accompanied by specific comments about miscegenation in Brazil, pointing to racial harmony among the Brazilian people.

Regarding the territory and client profile, professionals identified geographic aspects, epidemiological data, age group, gender, and data related to social vulnerability, such as occupations, income, and type of housing. However, the presentation of the research theme was indicated at the onset of each interview, the professionals did not bring any race/skin color data. Professionals who reported working in indigenous health care did not show that they had broadened their understanding of racial issues and their repercussions on health.

The information that most assisted clients were Black emerged when race was directly addressed in the interview roadmap. At this point, the answers reinforced the definition of race linked to the Black person and perceived from a perspective of physical illness, strengthening the belief that racial differences are limited to biological features and denying racism's social repercussions.

These data make us reflect on PHC territorialization and the influence of the work process distribution directed to the care of priority groups that make up the lens through which professionals see the territory. Thus, if professionals do not identify race as an integral element of clients' profiles, the work process does not include equitable care strategies.

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In this sense, we observed that, concerning racial repercussions on health, some professionals denied any relationship between race and health. Others presented the social class factor as a condition for distributing resources and access to social rights and, consequently, effects on health.

Finally, the respondents signaled areas for improvement in how the discussion about racial issues is presented in institutionalized training processes, whether in graduation or professional practice.

Some mentioned approaching the theme from the student movement and, after joining the SUS, taking UNA-SUS courses offered for voluntary access by professionals; and because racial discussions were more present at the broader social level:

Not even at the university. I just started to understand this issue a little, to have contact with this theme in the residency's student movement [...]. I started to have this approach in the indigenous area. Then, I started to study the issue of ethnicity and everything else more (Professional 7).

I got in touch more because things evolved rather than what the SUS actually paved the way regarding this theme, you know? [...] the SUS makes it a little easier when you are sensitive to it. I think this path should not only be based on people's sensitivity. However, this needs to be more institutionalized (Professional 9).

The training addressed the Black population's clinical specificities and completing the race/skin color item on forms. Interestingly, the professionals associated these last actions with the care of this population while suggesting that the racial issue is a broader issue than health:

Look at SUS. I already had access to lectures talking about diseases associated with race. For example, sickle cell anemia. However, not approaching the topic exclusively, without being associated with health (Professional 1).

We observe that actions aimed at the Black population are generally unlinked from racism as a component of the health setting. Thus, the peculiarities of racial relationships in daily work are sidelined and not considered in the composition of care strategies.

The discussion about white fragility is provoked in this category, which consists of defensive behaviors that range from showing disinterest in the subject to disproportionate reactions when discussing race, reflecting how white socialization occurs in environments with racial comfort; that is, without racial relationships being debated, decreasing in the ability to address the racial stress that the approach to the subject can cause[22].

Concerning the predominance of professionals in defining race from physical traits and self-identification, the scope and repercussions of the official Brazilian classification are reflected, referring to appearance and not ancestry. This classification dates back to colonial Brazil and remains until today, as shown by the IBGE censuses[23].

Still, on this point, Schucman[5] portrays the difficulty of black people in defining themselves racially with adjectives that move away from the spectrum of colors associated with human skin, contrasting with how white people define themselves racially in Brazil, with a greater plurality of adjectives, using terms such as "Latin" or "human", pointing to the imposition suffered by people who are part of non-white groups in hierarchically racialized societies, reducing them to a mere race.

Regarding the ambivalent dynamics of professionals in simultaneously recognizing the existence of racism, reducing it to the individual/relational dimension, and moving away from the status of racist, attention is paid to the Brazilian-style racism features, which highlights the prejudice of having prejudice[1].

Moreover, the racial democracy myth, a founding element of the Brazilian identity, which originates in the romanticizing race miscegenation in the slave-owning colonial period and the whitening policy adopted by the State, consists in believing in the existence of equality between whites and Black people, configuring itself as an ideological weapon that hinders advances in the racial debate, and consequently preserves the racist structure[24].

As for the invisibility of the perception of race/color in the territory/client profile, we recall the inputs of Santos and Rigotto[21] regarding territorialization, which, although consisting of the search for delimiting service work areas, recognizing the environment, population, and existing social dynamics, and establishing horizontal relationships with other adjacent services, depending on how this process occurs, may have reduced its analytical and descriptive power on countless aspects of people's lives.

Despite the prerogatives of the eSF being directed to comprehensive healthcare with care strategies that address the real needs of clients in the territory, these need to be operationalized and perceived by workers and clients homogeneously, evidencing challenges and contradic-

tions. In practice, the prescription of planned programmatic activities is inflexible, hindering the perception of the environment-territory, distancing itself from the actual living conditions of the population, contributing to the fact that some health needs are not included in the list of programmatic actions of the health teams[21].

Despite not being cited by professionals, we should note that, despite the difficulties[17], some initiatives to sensitize professionals on the reality of racism as a social determinant of health based on the PNSIPN are in place. However, the reach and effectiveness of the policy need to rely on the shared commitment between managers and technicians, social movement, intersectoral articulation, and social advances in the consolidation of rights[11].

Thus, policy actions will be insufficient to achieve comprehensive health care for the Black population or bring racial awareness to professionals, expanding racial understanding, if they are not composing a set of anti-racist actions that consider the broader social setting.

Whiteness as an element of racial relationships in PHC

Within PHC, regarding the whiteness dynamics, lies how clients are responsible for the most varied factors, from living conditions in the territory to racism-related distress.

The description of living conditions was accompanied by an attempt to explain them for reasons other than racism, with the client often identified as someone who, due to lack of interest or information, did not have access to formal education, and correcting this factor would be enough to change the living conditions:

Black people may not have the same access because they don't receive the same guidance, right? About the importance of education and information in people's lives (Professional 1).

Professional 8 statement summarizes the data found about the dynamics of whiteness in the professional-client relationship:

It reflects the slavery that we lived. The Black race still suffers. Black people are not born with a silver spoon in their mouth. They have to fight a lot more to get things, right? Few succeed, but most are resigned to living in their reality because too many things drag them down. For example, back then, when with that thing with the governor, boys were going to do an exchange program abroad, I had a boy who would do it. She wouldn't let him go because he was the one who helped at home with his younger sister. Can you believe that? Then you see, right, everything drags people down. Ignorance drags people down. People with another level of understanding would have a different attitude (Professional 8).

The professional suggests that aspects such as poverty and unequal distribution of resources can be explained as a "reflection of slavery" and that the continuity of this reality is grounded in most Black people's ignorance. There are no critical reflections on the households' social context or any reference to current exclusion mechanisms that preserve the client's social marginalization: only accountability, which at first is individual, but expands to the entire race.

Black people's accountability and white people's unaccountability are two sides of the same discussion and underlie the setting that seeks to reduce the problem of racism to a consequence of the past. Also, the accountability of Black individuals about the aspects that victimize them configures racial comfort of whiteness[25].

The professional describes black female clients as ignorant, suggesting that this is their intrinsic trait, without complementing that, as someone experiencing a different social dynamic, she may also be unaware of the peculiarities of the clients' reality and, thus, projects her ignorance on the black body, aligned with the white social work that concentrates the positive aspects in the white group, and shifts to the black group the negative features that she does not recognize in herself.

Still, she identifies with the white researcher, a frequent situation in other interviews, asking a rhetorical question as if she naturally shared his reading of the given example: "*Can you believe that?*"; and ends his statement by saying that: "*people with another level of understanding would have a different attitude*". In this context, she identifies with this second group of people. She again does not bring critical considerations, placing herself at the opposite pole to that of ignorance, where she sets the client, reducing the possibility of acting differently, being hypothetically in a similar situation, just because she has "*another level of understanding*".

Here, the scene of racism is installed: the professional who speaks openly about her racist perceptions; the researcher, a white professional identified as an ally in her reading of the given example; and finally, the client, the Black person who receives the racist reading of the white perspective. We should point out that the statement does not mention the white race.

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Kilomba[26] calls this scene a triangular constellation, essential for the white consensus, and is found in everyday racism. Each subject plays a pre-established role without needing individuals to be physically present. A Black person occupies the place of the object of racist aggression, a white subject performs racism, and a third element simultaneously assists and validates the act.

Regarding the justification for the Black people's living conditions, relating them to the slavery period, Schucman[25] identifies that this is a common argument presented by white people. However, such an argument is not maintained in the discourse, and other explanations are added, expanding the interracial gaps to include moral, psychological, and intellectual traits.

As for the social situation assigned by the professional to the client and herself, we recall the belief that, within racial groups, "better" attitudes are naturally associated with whites, and "the belief in a moral and intellectual superiority of whites is directly related to a contrast they make vis-à-vis blacks"[25](p.91).

We highlight the essentialist identification that falls on Blacks and imprisons them in racialized images, denying them the right to subjectivity[24]. Black subjects are perceived as a person, body, race, and history (descendants of enslaved people). Thus, their existence is conditioned to this triplicity, locating them socially as race representatives subjected to constant white verification[24].

Besides the discussion is the conception of culture transformed into a fixed and stable notion of biological race[25]. The intercultural hierarchy supports a racialized discourse without referring to race or skin color so that whites are considered more civilized and cultured, a civilizing and universal horizon[27], and not whites as having inherent inferior traits, evidencing a shift from a biological racist language to a cultural one[25]. The white-colonizer and black-colonized concept is internalized[28].

The word "resigned" stands out in the professional 8's statement. Resignation is defined as submitting to another person's desire, and synonyms are "conformed" and "submissive"[29]. This perception of the Black person conforming to their subaltern location refers to the sanitized slavery history, with the denial of victimization, resistance, and black struggle, and the white narrative embellished by the discovery, contributing to a self-representation in which white privilege and the need to fix it is non-existent[30].

The professional makes a hypothetical suggestion about the client's different reaction to the same situation she experiences; here, we identify the lack of reflection on several existing factors and "another level of understanding", such as financial resources and social devices that operate as a family support network.

Woody Doane *apud* Mills[30] points to an ideology of racial color blindness, which consists of the white people's difficulty in recognizing the structure of privileges that permeates their daily lives and the perception of the structure of opportunities as open and available to all and institutions as impartial; promoting a mistaken interpretation that social inequalities are justified by cultural characteristics, motivation and values of subordinated groups, fostering their blaming for their disadvantageous position.

Another critical point in this analysis is the professionals' reaction to the clients' discourse exposing racist situations. Let us look at the statement excerpt from Professional 2:

I assisted a mother who was with her daughter; she's mixed race, right? and her baby is really white. She cried so much here because she said she couldn't stand people looking at her and asking, sometimes people she didn't even know, whether she was the girl's babysitter. They didn't see her as a mother, right? I talked a lot with her and said, "Look, [laughs] you are lovely! (She's charming, you know? She is a very pretty mixed-race girl). You don't have to worry about that, with people's prejudice, because people can really be talking out of spite, right? However, sometimes it's you being prejudiced against yourself" [...] I realize it started with her, you know? This prejudice. She had with the color because the girl was different from her (Professional 2).

The report refers to the colonial period, in which the relationship between whites and Black people was limited to exploiting the workforce, and enslaved Black women cared for white children. The child's non-recognition as her daughter brings the colonial scene to the fore, re-enacting it, rejecting new configurations for interracial relationships, and producing the distress the client complains about.

The professional-client bond nature in the territory may explain this user's choice to expose her distress to Professional 2. However, we do not observe a movement of validating the client's distress; on the contrary, there is a suggestion that her reaction is disproportionate to what happened since, according to the professional's perception, the content of the complaint does not address racist violence but self-prejudice.

Interpreting a racism episode as self-prejudice stems from the widespread misunderstand-

ing that racism is a personal/moral issue and not a social event[26], or even from the whiteness viewpoint[15], the white person's analysis of the Black person about what racism is.

The professional's discourse denies the construction of subjectivity traversed by the racialization process[27], naturalizes racism[31], and is articulated with the construction of the place of black women in Brazilian society and its damaging effects, as discussed by Lélia Gonzalez[31]: "Being black and a woman in Brazil, we repeat, is to be the object of triple discrimination, since the stereotypes generated by racism and sexism place her at the highest oppression level"(p.58).

We observe a weakness in the eSF professional training to address racism, leading to Blacks' revictimization in the health spaces in the territory.

Conclusion

The study indicates that the professionals who make up the eSF hardly perceive the effect of racism. The difficulty is traversed by health-related hegemonic conceptions, which feed exclusionary behaviors, built from an understanding of superiority in the professional-client relationship and intrinsically related to the aspects discussed in the presented categories.

Furthermore, the self-perception of professionals and their relationship with clients was firmly crossed by whiteness. It materialized by the lack of racial awareness and denial of racism as a social issue with direct repercussions on health and access to services. The dynamics of the racial relationships presented here, built from power structures that involve racism, contributed to client victimization and hindered the construction of equitable care strategies.

The primary limitation of the present study is the non-inclusion of other eSF professionals. We suggest expanding the interviews and deepening them from other methodological perspectives. Finally, we see an urgent need to train professionals to expand and consolidate a concept of health that transcends the focus on disease and considers race as essential when thinking about care relationships in health, valuing the comprehensive healthcare model with equitable and democratic care strategies, combating institutional racism and the revictimization of the non-white population within PHC.

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Collaborations

T Lima was responsible for conducting and transcribing the interviews. Both authors participated in the conception and design of the study, analysis, and interpretation of data, and drafting and critical review of the article.

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