Antiracist ethos and the collective oral health as a pathway for life

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Abstract This article proposes a reflection on the imperative of antiracism in collective oral health, which, as a science, field, core, and praxis, contributes significantly to the reconstruction of an ethos that considers equity and enables citizenship and democracy. As a paradigm, we assumed the concept of “Buccality” and the guidelines of the National Comprehensive Health Policy for the Black Population, emphasizing the defense of the right to health as a prerogative of the right to life and the combat against racism and all forms of discrimination systematically. As a critical exercise, we discussed the status quo of collective oral health. We pointed to adopting a racial pro-equity perspective as an intentional, political choice socially agreed upon with all of society for social justice. Finally, we propose recommendations for dismantling systemic racism in collective oral health.

Key words Black people, Oral Health, Systemic racism

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Introduction

In Brazil, the 1988 Constitution provides health to everyone indiscriminately as an inalienable, non-market, universal, comprehensive, and equitable right. Oral health is an indicator for all generations, a metric for quality of life and evaluating health systems, including the Unified Health System (Sistema Único de Saúde, SUS). In this sense, good oral health is an indicator of citizenship.

The report on the oral health condition of the population at a global level, published in November 2022 by the World Health Organization, reviewed the data on the oral health condition at a global level. It showed that oral diseases rank high in the causes of illness due to NCDs, affecting approximately half of the world’s population (45% or 3.5 billion people worldwide). Populations in situations of greater social vulnerability, such as racialized groups or minorities, are the most affected, and this is also observed in Brazil.

Black people are seen as different and, because this difference is problematic, they are left outside the power structures where the system is used to define everything, blocking spaces and narratives, conditions that evidence systemic racism. Furthermore, like a lethal virus, permanently reissued and with global coverage, in its institutional, interpersonal, and internalized multidimensionality, racism is characterized as another global public health issue, violates rights to health and life and makes democracy unfeasible. As a system, racism materializes by naturalized illness and normalized death, the lack of even fragility of effective public policies for racially marginalized populations over time, who are left to their own devices and blamed and stigmatized.

The denial of racism is camouflaged in the mistaken concept of racial democracy, the narcissistic pact of whiteness, and the production of oppression, neglect, and annihilation. It is directly related to preserved racial inequalities in oral health, reflected in the more significant accumulation of oral diseases in the Black population, such as tooth decay, periodontal disease, and tooth loss, and the persistent disregard for actions to implement public policies, including oral health, for this majority group in the Brazilian population.

The assumption of equity as a principle is imperative to reduce racial inequalities. It has already been stated by the National Comprehensive Health Policy for the Black Population proximately a decade and a half ago. Although it is not a new recommendation in Brazil, its implementation has not been effective, and this is fundamental to combat racism. The results of the 2019 National Health Survey exemplify this need by showing that if, on the one hand, Black men and women had a smaller number of dental appointments, on the other, the percentage of people aged 18 or over who lost 13 or more teeth in Brazil was higher in the Black population (i.e., both sexes of brown and Black people together). The situation is even more severe when considering only self-declared Black men and women since this population had more teeth lost than the other groups analyzed, even when they are minorities in the Brazilian North, Southeast, and South. In other words, besides being a minority and going to the dentist less frequently, the Black population had higher tooth losses than the Brazilian population as a whole.

Racial inequalities in oral health regarding tooth decay, tooth loss, pain, and the need for prostheses, to the detriment of the Black population (Black and brown) compared to white people, have already been reported in Brazil, with cumulative intersectional disadvantages when considering gender, generation, and territory intersections. One study showed a significant interaction between ethnicity and sex in tooth loss, with a disadvantage for Black women who had a 19% higher prevalence of tooth loss compared to white men (PR: 1.19; 95%CI: 1.05-1.34); 26% higher compared to white women (PR: 1.26; 95%CI: 1.13-1.42), and 14% higher compared to Black men (PR: 1.14; 95%CI: 1.02-1.27). On the other hand, the likelihood of never having been to the dentist is twice as high for the Black elderly population than for older white adults, and the probability of having oral health services in the last year is lower for Black older adults compared to older white adults. The need for a prosthesis or pain did not curb the difficulty in using the dental service for Black older adults. This setting is comparable to that of older adults of the traditional quilombola communities, particularly concerning high tooth loss frequency and the difficult access to dental services.

In a study that aimed to systematically review the association between social mobility throughout life and tooth loss among adults and older adults, the authors showed that downward social mobility had a stronger association with tooth loss than upward social mobility. The findings also showed that being persistently at lower social levels throughout life had the
most detrimental impact on tooth loss. However, downward and upward trajectories have also been associated with a greater likelihood of having tooth loss than persistently high social status, which means that socioeconomic disadvantage at any period of life leads to tooth loss, corroborating the accumulation hypothesis. However, we should underscore that the worst socioeconomic conditions have historically been experienced by racialized or minority groups, which is no different for the Black Brazilian population, reflecting structural racism. Failure to incorporate the perspective of ethnic-racial equity in studies, particularly in Brazil, does not contribute to a better understanding of socially determined phenomena for health outcomes and, therefore, hampers effective interventions to promote the improved health status of these populations.

Opting for tooth loss as a highlight to illustrate the deprivation of oral health among the Black population was not random and is grounded on its use as an indicator of quality of life. Tooth loss is used to calculate the indicator of years of life lost due to disability. Furthermore, tooth loss weighs heavily on the estimation of years of life lost due to disability when associated with other morbidity common to the Black population, such as sickle cell disease, stroke, cardiovascular disease, kidney disease, cancer, or metabolic diseases. Oral diseases associated with other diseases deteriorate the quality of life and reduce life expectancy. Keeping this setting of racial inequality in oral health is a way of anticipating death in the Black population.

The horizon of death embodied by Black genocide and the result of necropolitics is expressed in body objectification and disposal. It is yet another structural racism hallmark. Assuming such a concept and making an analogy to oral health, we can infer that such tooth loss, which is more frequent among the Black population, still implements, even today, a colonizing logic of successive and cumulative mutilations and, consequently, an induced slow death. We should add that the failure to make efforts to implement actions or strategies that promote "oral health rehabilitation" and, above all, expand access to oral health for the Black population confirms intentionality and violates rights. Furthermore, it is imperative to question a different care rationale for the same need in which racialized groups receive simpler, cheaper, or mutilating treatments. We should also be aware of how discriminatory treatment manifests in providing oral health care. Recent research conducted in Brazil showed that, dentistry students reported less confidence (more insecure/less prepared/more concerned about getting it right) for the same therapeutic proposal when treating white pediatric patients compared to Black ones. The highest level of self-confidence evidenced by dentistry students was for Black girls and shows how the subjectivity of racism materializes in racial discrimination. Increasing self-confidence is, intuitively or not, preconceiving simplification, devaluation, and objectification (unimportance) for those Black children bodies. This finding is not limited to dentistry regarding managing racially marginalized populations within the clinic.

In other words, the colonizer's logic of offering inferior treatment or treatment marked by more significant difficulties for specific population segments is reproduced. It is necessary to decolonize minds to produce oral health care since the consequences of racism are unquestionably harmful.

The "presumed" irrelevance of the theme of ethnic-racial relations is another form of systemic racism, observed in the systematic lack of this content in training curricula at different educational levels, in political-pedagogical projects, scientific or technological knowledge production spaces, management and care spaces, different discussion forums, meetings of societies and class representative associations. A "hallucinating" and "disturbing" silence needs to be interrupted by an anti-racist ethos for racial equity, impelling the change from this silenced status to the anti-racist ethos through collective voices for oral health such as possible pro-equity path, seeking citizenship and democracy, with attention to the specificities of the Brazilian reality, given the heterogeneous Black population and its connections with global populations and the world.

The hegemonic ethos in our country, that is, the sociocultural ethos intertwined with structural racism, introjected into all parts of society, infiltrating its values and counter-values at all levels, arises from the particularity of the Brazilian socio-historical reality resulting from four hundred years of slavery and how the dynamics occurred, which now brings this heritage to the construction and preservation of a social praxis. In this logic, the history of non-whites is traversed by the treble process of delegitimization as it almost completely removes the presence of epistemological contributions from other ethnic and cultural sources, leading to the invisibility and stereotyping of social groups once again. The advent of democratic republics acts similarly to past colo-
As clues to the anti-racist ethos, it is suggested to incorporate Law No. 11,645 of March 10, 2008, which amended Law No. 9,394 of December 20, 1996, modified by Law No. 10,639 of January 9, 2003, which establishes the guidelines and bases of national education, to include in the official curriculum of the education network, the mandatory theme “Afro-Brazilian and Indigenous History and Culture” in communion with the National Comprehensive Health Policy for the Black Population (PNSIPN) as de-silencing tools-resources. The PNSIPN points to six guidelines:

1) including the themes of racism and the health of the Black population in training and continuing education processes;

2) expanding and strengthening the participation of the Black social movement in bodies of social control of health policies;

3) promoting the recognition of widespread health knowledge and practices, including those preserved by African-based religions;

4) implementing monitoring and evaluating actions to combat racism and curb ethnic-racial inequalities in health in the different government spheres;

5) encouraging the production of scientific and technological knowledge in the health of the Black population;

6) developing information, communication, and education processes to deconstruct stigmas and prejudice, strengthening a positive Black identity to reduce vulnerabilities.

The status quo of Public Oral Health and confronting (or not) racism

Despite the worst oral health conditions of the Black population and their link with racism at various conceptual levels, the dominant interpretations of racial inequalities in the area are still based on biological conceptions of the division of humanity into genetically distinct races. These interpretations range from specific oral health problems to the use/access to health services and often blame Black populations for their worst conditions – whether due to biological aspects or culturally determined behaviors.
interpretations are invalid from a scientific viewpoint and ethically reprehensible. There is abundant scientific literature showing the non-existence of biological distinctions between racial groups, on the one hand, and on the other, the role of racism in the genesis of health inequalities. From an ethical perspective, if the ultimate reasons for racial inequalities in oral health are issues linked to biology or culturally determined behaviors, interventions on the problem are automatically limited and ineffective and preserve a general framework of racial inequalities in oral health.

Thus, racial inequalities in oral health must be analyzed in the context of racist societies, which adopt numerous strategies (e.g., symbolic/cultural, material, political, and social) to unfairly distribute power and resources under an arbitrary and hierarchical structure of the population into racial groups. We call these symbolic/cultural, material, political, and social processes systemic racism and are at the heart of racial inequalities in oral health. Conceiving racial inequalities in oral health from scientifically based and ethically positioned perspectives implies focusing on racism as its origin and implementing strategies, policies, and actions to combat it.

Discussing through the concept of health equity in the contemporary world of blatant socioeconomic-racial-geographical and environmental inequalities is urgent. Hence, radicalizing the adoption of ethnicity/skin color is an essential pro-equity social marker resulting from a political choice, from ethics (ethos) in search of social justice that permeates the production of scientific knowledge incorporating this social marker. The concept of buccality establishes as a reference for oral health its inseparability from the right to life and citizenship. Thus, collective (oral) health as a core and praxis must prioritize epidemiological studies that exceed merely measuring factors and consider their inseparable link with the social dimension since no epidemiology is non-social; likewise, evaluations of public policies and services must be based on solving detected problems to strengthen the Unified Health System and, consequently, benefits for most of society. Therefore, they need to be part of the State and Society discussion, increasingly requiring Social Sciences. To account for this complex relationship between the mouth and the world, Botazzo elaborates on the concept of buccality, where mouth-life articulates with generic social life or as part of the biopsychosocial nexus, resulting from subjectivities in which oral health derives from life opportunities, as a manifestation of the body as a whole and not isolated, compartmentalized, reduced to teeth/organs/body cavity, a subject in its entirety in its determinations, limits and possibilities, all of which are closely related to the fight for rights, equity, and democracy. This understanding is another analytical key to understanding and incorporating the anti-racist ethos into collective oral health.

We should remember the importance of health conferences to guide and incorporate regulations for the Unified Health System into their documents, assuming the premises listed for the effective achievement of citizenship and democracy. Like health, health equity must be understood as a state determined by multiple factors, and its measurement is made by comparing established parameters. The content on health equity is consolidated by explaining parameters that allow comparing social groups against given needs, with repercussions on health status. The construction of health equity takes on a political dimension when analyzing the acceptable scientific and moral standards that prevail in a given State. Equity is assumed to be an ethical value and can be considered the most political of virtues. No doubt, breaking the reproduction of health inequalities requires a very proactive stance from everyone based on an ethic of responsibility.

Demolishing barriers imposed by racism is an ethical choice in favor of life inherent to a new social pact, in which the fight against systemic racism is the (re)connecting link.

Practical notes for building an anti-racist ethos in collective oral health and confronting systemic racism

The advances in public policies for the oral health of Brazilians are recognized. The National Oral Health Policy within the Unified Health System is a concrete example. Incorporating the anti-racist perspective in its implementation and operationalization will reduce racial inequalities and include the Black population in the right to oral health (Chart 1). The case of oral health care for people with sickle cell disease is an example of how actions inherent to public policy for people's oral health need to incorporate the racial dimension. The adequate provision of dental services must address systemic racism as a producer of inequalities.

The following is proposed for a movement towards an anti-racist ethos in Dentistry:

1. Assume racial equity as a reference framework for any intervention;
2 - Incorporate the ethnic-racial perspective in education, research, and extension for collective oral health content in the light of buccality, explicitly considering the heterogeneous Black populations, their territories, geographic areas, habits, and local and ancestral customs and values;

3 - Include race/skin color/ethnicity as a proxy in all interventions to enable analysis and decision-making based on this social marker;

4 - Promote anti-racist governance;

5 - Promote the production of scientific knowledge, technologies, and innovation – organization, and production of new knowledge to clarify persistent doubts and support decision-making in oral health for the Black population in formal and, above all, non-formal spaces, providing opportunities for creative solutions produced by peripheral populations in holy African religion temples, villages, and on the streets, intersectionally;

6 - Qualify professionals to promote changes in the behavior of all professionals in the area through adequate formation and training to address the diversity of Brazilian society and the peculiarities of the health-disease-life process of the Black population;

7 - Communicate effectively with the population based on their daily lives, striving for representation, dialogue, dissemination of information and knowledge, emphasizing territories, healthy lifestyle habits, customs, and values to prevent diseases, potentialities, and susceptibilities in terms of oral health, to enable them to identify their vulnerabilities;

8 - Offer comprehensive, integrated, multidimensional, multidisciplinary, and territorialized health care in strategic and data-based fashion – including health promotion and education practices for the Black population in care routines and facilitating access at all levels of the health care system, including beliefs, customs, habits, values, and practices;

9 - Enable, defend, provide opportunities, and guarantee the occupation of positions or decision-making positions by social stakeholders with critical racial literacy and participate in agendas in defense of collective oral health in pro-racial equity mobilizations;

### Chart 1. Some practical notes for anti-racism in collective oral health.

<table>
<thead>
<tr>
<th>Actions or strategies</th>
<th>Black population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life cycles</strong></td>
<td>** Territories**</td>
</tr>
<tr>
<td>Children, Adolescents, Women/Men, Pregnant Adults, Older adults</td>
<td>Urban, Peri-urban, Rural, Peripheries, Assistance gaps</td>
</tr>
</tbody>
</table>

Include the racial dimension as a device for selection, analysis, monitoring, and evaluation of planned actions or strategies.

Ensure selection processes, training courses, qualification programs and decision-making spaces. Induce an agenda of studies, research, and training of human resources for and with racial literacy.

Adopt actions to repair the historical process of enslavement that act as access barrier.

Ratify the SUS as a privileged space for training and qualification in collective oral health and incorporate into the national curricular guidelines for graduation in Dentistry the National Curricular Guidelines for the Ethnic-Racial Relationships Education and the Teaching of Afro-Brazilian and African History and Culture as the population’s de facto guarantee of oral health as a right.

Source: Authors.
Finance or facilitate financing and provide sustainability to decolonizing actions and strategies that target previously silenced, made invisible, or disqualified narratives.

To be effective, such propositions must transcend the health domain and be articulated between other sectors, including human rights, racial equality, justice, housing, work, social assistance, food and nutrition, sports, culture, and education. For Higher Education, Resolution CNE/CES No. 3 of June 21, 2022, established the national curricular guidelines for the undergraduate course in Dentistry, with a proposal to contribute to the formation of a critical-reflexive, humanistic, and self-aware professional and society and include the racial perspective among the graduate's competencies. It is a strong ally for an anti-racist ethos when considering the ethnic-racial dimension in its implementation.

Most Black people are SUS clients. Thus, supervised internships in Dentistry at the SUS are another opportunity for this anti-racist ethos, given its intentionality, responsibilities, and objectives. Trad et al. propose breaking with the disciplinary format and focusing on practices in territories as the central axis of training, based on the questions: Which territories can provide significant learning? What do we take to the territory, and what do we intend to learn from it? How will we build knowledge with people instead of bringing information to people?

In Public Health, the stimulus in the teaching-learning process stems from sensitive and respectful listening to the Other, the critical and dialogical stance, and epistemological surveillance to foster interdisciplinary and interprofessional views among teachers and students that enhance the understanding of the health amid social, cultural, political and ideological processes. The challenge to be overcome and which also limits the teaching staff refers to the existence of racially illiterate university staff or even a low presence of Black teachers. Thus, a contribution to an anti-racist ethos in collective oral health is the Quota Policy adopted in Brazil as affirmative action to reduce such racial inequalities.

**A final practical note**

Agents working for collective oral health must pay attention to this call to catalyze this change by promoting a space for dialogue and articulation between researchers, health professionals, managers, social participation, educators, social movements, and society in general in search of equity, social justice, and democracy. To do this, in the face of any situation, look at the problem and analyze it carefully, especially the structures of decision-making – for “who, what, when, and where” –, policies – “how” it is written –, practices and norms – “how” it is not inscribed –, and values – “why”. Collective oral health is called upon to drive the antiracism ethos as an imperative.

Our reflection aimed to establish links between the anti-racist ethos and buccality, both as opportunities for collective oral health to confront the deep-seated dynamics of structural racism. Walsh made this invitation to us by indicating that it is necessary to explore the links between the “pedagogical” and the “decolonial”, realizing the inclusion of experiences defined in the path taken. We should consider initiatives based on solidarity and cooperation in the subversion favored by the community and disobedient practices. Therefore, any educational proposal will have to start from a sensitive listening (in the sense of reviewing its insufficiencies in terms of what we have been unable to denaturalize, including in the curricula) – something that is confronted, that denounces the also epistemic violence and can generate proposals for strategies that lead us to decolonize our bodies and discursive practices. Such an association is fundamental to the collective oral health we desire.
Collaborations

All authors collaborated equally in the elaboration of the manuscript.

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