

## Confronting racism in health services

Enfrentando o racismo nos serviços de saúde

Enfrentando el racismo en los servicios de salud

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The importance of the information race/color (color category) in evincing racial inequalities in health and in policy-making is the topic of this article.

We start with the assumption that race/color, social class, gender and generation and structuring forces in our society which interfere in health, disease and death outcomes <sup>1</sup> and that one strategy for facing these inequities is to advance equity-promoting policies within a systemic, universal policy.

In the 1970s and 1980s, the academic production, by establishing the relationship between social rights, citizenship and health, was anchored in the pillars of the social class concept in order to evince the relationship between population and health, morbimortality and its class, socioeconomic and cultural differences, established in time, space, individuals and populations <sup>2,3</sup>.

In the 1990s, reflections on the demography of inequalities emerged as a new object of study in the public health field. With this, categories of gender, homosexuality, heterosexuality, identities and health <sup>4</sup>, as well as the social construction of risk associated with socially constructed power relations and hierarchies <sup>5</sup>, also became a focus of investigation. But, if we are discussing socially-determined power relations and hierarchies, how were inequalities within inequalities configured? Were there differences in health outcomes among women from different social classes and races? What relation is there between gender, class, race/color and health?

To Saffioti <sup>6</sup> (p. 9), these elements make up a tight knot, an image used to simultaneously show “... the symbiosis between racism, sexism and social classes, and also leave open the possibility of tugging on one or another of the strands that compose it in order to carry out a more than accurate scrutiny”.

In the 1990s, leaders from the black movement, based on the theoretical assumptions of public health and on the indicators which show gender and race/color inequalities, began to question the relationship between racism and health, urging the public health administration to include the race/color category in the health information systems.

This inclusion first took place in São Paulo City (*Ordinance n. 696/90*<sup>7</sup>). In 1996, the color category was included in the Brazilian Ministry of Health's Mortality Information and Live-Births Information Systems (*Ordinance n. 3,947/98*<sup>8</sup>). The history of this implementation is described in Adorno et al. <sup>9</sup>.

The presence of the information on race/color, color category, in the mortality and live-births information systems made it possible to study differences in mortality and morbidity according to sex, age and race/color <sup>10,11,12,13</sup>. The resulting epidemiological data evince racial inequalities in the

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populations' life conditions and their impact on the morbimortality profile. The inclusion of the color category in studies on health service access and quality, carried out by Kalckmann et al.<sup>14</sup>, Leal et al.<sup>15</sup>, and Diniz et al.<sup>16</sup>, also show racial inequalities and their impact on health.

In order to respond to this reality, the Technical Committee on the Health of the Black Population was created by the Ministry of Health (*Ordinance n. 1,678/2004*<sup>17</sup>).

One of the Committee's main attributions was formulating a text about health care policy directed at the black population. On November 10th, 2006, the National Health Council approved the National Comprehensive Health Policy for the Black Population (PNSIPN, in Portuguese). In 2008, this policy was agreed to in the Tripartite Inter-Management Committee and it was published by the Ministry of Health in 2009 (*Ordinance n. 992/2009*<sup>18</sup>).

### Confronting racism in the health care services: implementing a policy

PNSIPN asserts the "*acknowledgement of racism, racial inequalities and institutional racism as a social determinant of health conditions*". Its goal is to "*promote the comprehensive health of the black population, prioritizing reducing ethnic/racial inequalities, combating racism and discrimination in health services and institutions*"<sup>18</sup>.

In 2014, in order to investigate the PNSIPN's implementation, we developed the research project *Evaluating the Implementation of the National Comprehensive Health Policy for the Black Population: Monitoring and Evaluation Indicators*.

The project was developed in three stages. In the first stage, we sent an electronic survey to health managers and social movement leaderships who work within the health field with the black population. This survey is composed of 52 questions divided into topics. Of these, 11 concern respondents' personal identification, three concern the characteristics of the answer site, 21 are objective questions on the experiences and problems faced during the policy's implementation, and 17 are open questions about what had been produced and accomplished in order to implement the PNSIPN and which indicators were being used to monitor it.

The second stage, *Indicators of Responses to Institutional Racism*, systematized the responses (between April and July 2016) based on the questionnaire's qualitative data. With this, we constructed a PNSIPN monitoring panel: sociodemographic, morbimortality and management indicators.

The third stage, *Validating the Indicators of Responses to Institutional Racism*, was carried out in two technical meetings with social movement representatives, state-level health managers, and representatives from PNSIPN, the National Council of Municipal Health Secretaries (CONASEMS, in Portuguese) and the National Council of Health Secretaries (CONASS, in Portuguese). In the first meeting, participants discussed the challenges and strategies for implementing PNSIPN and possible morbimortality indicators. In the second, participants discussed how potential sociodemographic, morbidity, mortality and management indicators may be used in monitoring and evaluating PNSIPN implementation.

Initial research results show that of the 27 Brazilian states, 7 State Health Secretaries responded to the survey. Out of the 5,561 Brazilian cities, only 31 responded/reported having implemented the policy (Figure 1).

According to respondents, PNSIPN works when health managers and technicians are committed, when there is an effective program coordination and when the social movement supports the administration.

Five states and 12 cities have a technical area or a technician responsible for developing actions to combat racism, that is, responsible for carrying out PNSIPN. The articulation between sectors and institutions is a facilitator in implementing the policy.

PNSIPN's implementation process took place under the Fernando Henrique Cardoso, Luiz Inácio Lula da Silva and Dilma Rousseff administrations. In that period, the social theme was put at the center of the national debate, enabling several social advancements in the consolidation of rights. The black movements, through dialoguing with the State, consolidated new demands, such as access to quality health and education policies and services which specifically meet their needs. In the case of PNSIPN, it is a policy under implementation, as our studies show.

**Figure 1**

Evaluation of the National Comprehensive Health Policy for the Black Population (PNSIPN, in Portuguese) implementation, Brazil, 2016.



However, in recent times, we have watched the advance of conservative forces – economically ultraliberal political forces anchored in conservative fundamentalism – which have attacked several social rights, especially those concerning the black and indigenous populations, women, and the lesbian, gay, bisexual and transgender communities.

The fundamentalist projects of power advance in the Legislative, Executive and Judiciary branches. In this scenario, we raise a few questions: what strategies should we develop in order to advance the implementation of policies that promote equity? What strategies should we develop in order to guarantee social rights? What coalitions should we establish in order to continue implementing policies for vulnerable populations?

Epidemiological data show racial asymmetry. This research project found clues as to how health managers who seek to confront racism in health services may act: (1) establishing a policy coordination (technical area/lead group); (2) including the policy within the management instruments and defining some PNSIPN monitoring and evaluation indicators. This is a great effort which health managers, health care professionals and the civil society need in order to promote and move towards the health system that the population deserves and needs.

The PNSIPN is only 10 years old. There is a lack of knowledge, both among the population and among health care professionals, regarding how racism impacts life, access to services and quality of care. The few health managers who are aware of this and take on the challenge to implement the policy do not know how to do it, but understand the impact, the difference that can be made in the black population's morbimortality profile by combating racism and discrimination in health services and institutions.

We still have a long way to go, but discontinuing or interrupting the PNSIPN will mean that the already-existing morbidity and mortality differences related to race/color will worsen. As a more evident example, we may say that people with sickle-cell disease will continue not to be assisted in basic care, the precocious death of black individuals due to preventable causes will persist, and the Brazilian society will suffer a huge loss from the social, economic and political points of view. This will be a setback in the democratization process in terms of reducing social inequalities.

In the current Brazilian context, in 2016, with all legislative proposals and government policies directed at cutting resources for social policies, the health budget cannot reduce what is already exiguous. The necessary organization of health managers, health care professionals and civil society in order to guarantee social rights must pay attention to racial inequities in the populations' health conditions and their impact on health profiles.

## Contributors

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