

Leny Alves Bomfim Trad¹

Marcelo Eduardo Pfeiffer
Castellanos¹

Maria Clara da Silva
Guimarães^{II}

Accessibility to primary health care by black families in a poor neighborhood of Salvador, Northeastern Brazil

ABSTRACT

OBJECTIVE: To analyse the accessibility of primary health care for black families from a poor neighbourhood.

METHODS: Ethnographic study with an interpretative anthropological approach, carried out with 18 families selected from a poor neighbourhood of Salvador, Northeastern Brazil, over a period of two years. Criteria for inclusion included being resident in the neighbourhood and classifying themselves as black. The analysis was based on interpretative anthropology and encompassed the following categories: ethnic and racial self-reference; experience of discrimination from public services; perception of accessibility to primary health care and barriers to accessibility.

RESULTS AND DISCUSSION: We identified the following aspects: a) ethnic and racial identity and health: the users' perception that organizational barriers and barriers to access are due to the wider social context which produces "first class" and "second class" citizens, rather than due to institutional racism; b) the accessibility of the Brazilian National Health System (Sistema Único de Saúde, SUS): difficult access, delays in being seen, lack of commitment on the part of health professionals, no management action taken to manage or improve these situations; c) accessibility of primary health care; overall vision of the context of the SUS and support in the interviewees descriptions of access to primary health care.

CONCLUSIONS: There are economic, organizational and cultural barriers to access which come between the service provided and effective care for the needs of the population of this study.

DESCRIPTORS: Ethnicity and Health. African Continental Ancestry Group. Health Services Accessibility. Primary Health Care. Equity in Access. Qualitative Research.

¹ Departamento de Saúde Coletiva I. Instituto de Saúde Coletiva – Universidade Federal da Bahia. Salvador, BA, Brasil

^{II} Programa de Pós-Graduação em Saúde Coletiva. Instituto de Saúde Coletiva. Universidade Federal da Bahia. Salvador, BA, Brasil

Correspondence:

Leny Alves Bomfim Trad
Instituto de Saúde Coletiva
Rua Basílio da Gama, s/n. 1 andar – Canela
40110-040 Salvador, BA, Brasil

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INTRODUÇÃO

Access to, and the accessibility of, health care services is attracting more and more attention from researchers in the area of public health, at the same time as they are proving to be a challenge to the organisation of today's Brazilian Unified Health Care System (SUS – Sistema Único de Saúde).⁸ Different uses and definitions are identified in the operationalization of these concepts.²⁷ Access covers the availability of health services from the point of view of what is provided. Accessibility deals with the practicalities of being able to use the services on offer.

Travassos & Martins²⁷ consider that

“accessibility (...) is more than the mere availability of resources at a specific time and place. It refers to characteristics of the health services and resources which facilitate or limit their use by their potential users”.

The term encompasses socio-economic, geographical, cultural and political dimensions of the social and health care context, which may be expressed as barriers to meeting (actual and/or potential) users' health care needs.²⁷ Accessibility can be measured by the ration between the resistance represented by these barriers and the users' efforts to overcome them (health care utilisation).⁹

The guarantee of universal access to the SUS depends upon identifying barriers related to the characteristics and needs of the population. Their heterogeneity, inevitably, refers to another basic principal of the SUS: equality, which may be defined as

“the absence of systematic and potentially remediable differences in one or more aspects of health in population groups or sub groups defined socially, economically, demographically or geographically” (Frenk⁹).

Equality in access to health care represents one of the greatest and most complex challenges faced by many countries today, requiring specific study and public policy initiatives.²⁸ Among the challenges facing research into the area is that of creating categories capable of capturing the process of producing and reproducing the “disadvantageous totalities in the exposure of certain individuals and populations to threats to their health and the construction of responses to defend them” (Ayres³).

Economic and ethno-racial barriers stand out among the elements which indicate the production of inequalities and contribute to the vulnerability of different social groups. Social class and ethnicity are important factors in the process of social stigmatisation. Parker & Aggleton¹⁹ argue that this process is related to wider structures of discrimination, expressed in certain frameworks of relationships between culture, power

and difference (specific to each social environment). The emphasis on analysing relationships between the context of interaction and wider social structures is defined in recent theoretical reflections on the processes of stigmatisation.^{14,22}

Brazilian studies have identified conditions of vulnerability, including problems in accessing health care services, related to the processes of racial stigmatisation. These processes arise from, at the same time as they affect, the living conditions and state of health of certain groups, as in the example of the black population.^{4,7,15}

The black population in Brazil is in a situation of epidemiological and social vulnerability which includes difficulty in accessing health care services.^{16,18} Epidemiological studies using race as a factor when analysing mortality rates in men⁵ and evaluating access to pre-natal and childbirth care¹³ found disadvantage to the black population, followed by the mixed one, when compared with the white population.

The double social disadvantage (low economic and symbolic capital) of this population, fruit of a historically complex process, emerges among other aspects of this situation, which is also applicable to the indigenous population of Brazil.

This study aims at analysing the accessibility of SUS primary health care for black families in a poor neighbourhood. We considered the challenges and limits arising from the imprecision of categories such as “black” or “of African descent” in Brazil, as well as the controversial nature of analyses which seek to associate racial traits and health indicators.^{10,12} The complexity inherent to analysing relationships between inequality and ethnicity (and the social conflicts associated with this phenomenon) is recognised in other fields.²⁰

METHODS

This ethnographic study is part of a wider piece of research,^a focussing on the therapeutic itineraries of black families and the social and health care support networks available. The study was carried out using 18 families in the Boca do Rio neighbourhood, located on the main urban waterfront of Salvador, BA, over a period of two years. The fact that the research group had been carrying studies out in this area since 2005 was decisive in selecting this neighbourhood.

It is an area of great contrast, in which long-standing urban intrusions, occupying the majority of the neighbourhood and concentrating large population contingent into the available space, border on luxury

^a “Therapeutic Itineraries of Families of African Descent in a poor neighbourhood in Salvador, Bahia”.

condominiums. This is in contrast to the profile of poor neighbourhoods on the outskirts of the city, which are distant from the affluent areas. On the other hand, it follows the trends for neighbourhoods of this type: the population is predominantly black.

The health care services in the neighbourhood are not sufficient and are not evenly distributed throughout the territory. In the area with the highest population and the lowest spending power, there are two public health units (Primary Care and Psychosocial Care Centre). There is an emergency care unit, located further away, on the border with another neighbourhood. There is a small number of private services (clinics, dentists etc.) and non-governmental and community institutions.

Over the course of two years, we carried out participant observations (based around the social and health care support networks in the neighbourhood) and semi-structured interviews with key informants. In this article, we will focus on data from case studies of 18 families, generated from interviews with family members.

The criteria for inclusion were the following: 1) being resident in the neighbourhood; 2) classifying themselves as black, although we admitted hybrid classification (classifying a minority of family members as light brown skinned or – in one case, white); 3) being dependant on the SUS. The number of families was defined based on the saturation principle.

The term “of African descent”, adopted by the researchers, produced reactions of unfamiliarity and/or incomprehension during the investigative stage. We attempted to identify the terms/expressions which the group in question used to refer to their own racial identity or colour.

The sample (family members) had the following socio-demographic profile: mothers, aged 29 to 50; low level of education and doing casual work for low pay. As regards the families’ main health problems, there was repeated reference to high blood pressure, diabetes, childhood viral diseases and injuries linked to violence in the neighbourhood.

We conducted, on average, two interviews per family, totalling 42 interviews, also bearing the saturation principle in mind. The interviews were carried out by pairs of interviewers, lasted on average 1hr 10min and were recorded (with permission granted beforehand) and later transcribed.

This article brings together the results for the following categories: ethno-racial identity, health problems, relationship with the health care services in the neighbourhood (especially aspects associated with access/ accessibility), perception and/or experiences of racism or discrimination from the services.

Guided by interpretative anthropology, the analysis focussed on the inter-relationships between the social experience and context obtained from the interviews (main source) and our own observations. We identified the feelings the subjects attributed to their experiences and their links with specific aspects of the socio-cultural context (proximal and distal).

The project was approved by the Committee of Ethical Research of the Instituto de Saúde Coletiva, Universidade Federal da Bahia (process n° 024-09; 2009). All of the participants signed consent forms as recommended in Conselho Nacional de Saúde Resolution n° 196/96.

RESULTS AND DISCUSSION

Black was expressed in many different ways (*nego(a)*, *negro(a)*, *negão(ona)*, *negrinho(a)*). It is noteworthy that “*moreno/a*” (dark skinned) and its permutations (e.g. “*moreninho/a*”) appeared relatively frequently. In the production “*racismo à brasileira – racism in Brazil*”, the term “*moreno*” may be considered more positive than “*negro*”, and more specific than “*pardo*” (brown/mixed race).¹¹

Racial prejudice was seen as inseparable from class prejudice in the subjects’ perception of discrimination and racism in health services. Although the population of the city of Salvador is predominantly black, an obvious overlap between race and social class can be seen when analysing indicators of social and epidemiological vulnerability.^{2,16}

Class is more important than colour as the most determinative aspect of discrimination. These statements demonstrate that the main source of humiliation suffered in the health services was from being in position of “needy”:

“Not because of colour. They often humiliate anybody who turns up there in need” (Celeste).

Many of our interviewees stated the fact that the SUS deals principally with the “poor” directly affects the quality of the services provided, the infrastructure, conditions of access etc. This was the most striking reference to the relationship between social class and discrimination in services (health inequality).

For those who attributed their experiences of discrimination to being poor, they felt that being black would increase the chances of being discriminated against. As one of our interviewees explained, the assumption that black people are poor and have low levels of education is a driving factor in the social stigmatisation of this group.

“For being black? No. I think I already felt discriminated against for being poor. Because others look at

you like that. Sometimes the two things come together. People discriminate against blacks thinking that blacks are poor. If you don't have education, you don't have culture, you don't have anything" (Flávia).

Analysing the relationship between characteristics which cause discrimination and stigmatization can show the impact of these processes on the lives of those affected to the extent that they affect access to resources and social positions.^{6,14}

There was one concrete example of discrimination or racism in the public health service reported.

"The doctor touched her like this [makes gesture of two fingers barely touching the skin], she didn't even touch the child (...) as if the children made her sick, even though she (the child) had had a bath, lovely and clean. It's just like that, just like that, because she's dark skinned" (Clarissa).

This story suggests that racial discrimination can be felt in subtle (even ambiguous) gestures, further emphasised, later, by words which reflect and explains such a gesture. The use of the term "dark skinned" to refer to her daughter, who is black, corroborates Guimarães' observations.¹¹

The processes of discrimination in the health care services, the material and symbolic repercussions of which are significant, should be recognised as central elements when considering the effectiveness and equality of the SUS. However, this is not the stated aim of this research.²⁶ The fact that, in this study, we did not find significant records of discrimination in the health services does not invalidate the argument in defence of greater investment into investigation on the subject.

As we delved deeper into the discussion of their day to day relationship with the health services, above all with primary health care, there was less and less emphasis on references to ethno-racial elements. The poverty of the population affected by the problems reported emerged as the factor which explained the authorities' "disregard" towards it.

The informants' impressions and experiences comprise a corollary of complaints about services similar to those of studies that evaluated primary care in other municipalities in Bahia or the Northeast (covering areas in which the populations were predominantly mixed race or white).²³⁻²⁵

The subjects' perceptions of primary health care repeated stereotypes associated with this type of health care: little use of technology, not feeling the problem was resolved, offering mainly palliative actions, performed by unskilled practitioners and characterized by simplicity/lack of treatment resources – a vision which is accompanied by demand for the creation and expansion of outpatient specialties in the primary care network.

"At the health centre, they just give you a tablet (...) and first aid... they don't give any treatment (...) they just give you something for the pain, or an anti-inflammatory, antibiotic (...) they don't have anything more specific" (Clara).

"It's mainly oral health (...) the centre can help you if you need a tooth out, a filling or a clean" (Roberta).

Upon analysing potential barriers or obstacles between service and user, we found aspects referring to organisational deficiencies or dissatisfaction with the organisational logic.⁹ These limitations were also associated with the users' behaviour, such as scheduling appointments for the same procedure in different units.

Long waiting times, both at the unit itself, and for appointments, were shown to be the main causes of dissatisfaction in the families we interviewed:

"You never get seen at the right time (Roberta); dentist.... a year" (Clara); "gynaecologist, two months from now" (Jussara).

The limited hours available for medical or dental appointments, confirmed by observations, was another subject of complaint. Some of those we interviewed resented the lack of action taken by those in power ("the mayor", the minister") in checking that the professionals fulfilled their timetable obligations.

Dealing with people from other neighbourhoods or towns was highlighted as aggravating this problem:

"People come from as far as the countryside (...) when our turn arrives, we end up not seeing the doctor" (Clara).

Being resident in the catchment area, therefore, is recognised as being a legitimate criterion in defining access to local services. It was precisely this criterion, deemed to be strategic in organising services, which explains the decision to have local residents enrol in family health programmes.

The criterion for prioritizing risk groups was contentious for some respondents, who argued in favour of the "first come first served" as a fair criterion for managing care.

"Only the elderly have priority, and the disabled. Sometimes it makes you mad, you turn up at two am to get an appointment. Then, when it's seven o'clock (...) twenty old people turn up. They have to have their priority, they have to see a doctor. Sometimes they get all the appointments and we go home without having seen a doctor" (Flávia).

The preferential treatment given to the elderly stands out. Considering the demographic tendency of this age group to expand, health care managers should pay

special attention to this information. Although preferential treatment is a legal requirement and may be considered fair, it is almost always called into question. Research carried out in family health units found the users to be resistant to adopting criteria for priority in the distribution of appointments.^{24,25}

Certain regulations for the health care services were considered rigid and seen as “bureaucracy.” This emphasises, once again, the stand-off between the logic of supply, defined by the services, and users’ expectations, which refer to diverse needs.^{1,28}

The role of personal contact, which means users depend on knowing someone in the service in order to guarantee an appointment, was another point of contention. Whereas, for some, this was the only way of minimising difficulties accessing the service, others viewed it as favouritism:

“Friends and relatives have priority, they get pushed in at the front. If they push in front of me I make a big fuss” (Flávia).

Some of our interviewees reported making appointments in different units to try and reduce the wait for an appointment. This behaviour contributes to deficits in the organisation of the services. Seeking help from the private sector was mentioned as an alternative when it was not possible to wait to be seen at the public centre.

One of the interviewees lamented no longer having private health insurance as a consequence of losing their job:

“When I was working (...) I went private, obviously. I had private health insurance” (Mariana).

There is a tendency to idealise the organisation and quality of health care services in the private sector.

Racial and socio-economic inequality are accentuated in the private sector. Private health insurance, in Brazil, is firmly concentrated in the hands of those with higher incomes, white and highly educated.²¹ Paradoxically, this panorama favours the perception, especially among those who do not have private health care, that the quality of care is better than that provided in the public sector.⁸

High staff turnover among the health care professionals was another criticism. There was dissatisfaction associated with this fact, principally when it implied losing a professional who had been well regarded:

“Sometimes, there is a good paediatrician in the centre, you get used to taking the kids there. Soon enough though, where have they gone?” (Celeste).

Stability of the care team was highlighted as a factor which favoured the welcoming impression of the

service and inspired confidence in the professionals. Moreover, the fact of being recognised (“remembered”) by the health care professionals was valued by the families, reiterating the findings of previous studies.^{24,25}

“The people there are a blessing, apart from the receptionist. If I don’t go, they (...) ask about each other and the other people there for treatment. “Why didn’t Clara come today?” (Clara).

Difference in the health care professionals’ attitudes were attributed to personal (temperament, upbringing), and cultural characteristics or, to a lesser degree to dissatisfaction with the working conditions (being overworked, lower salaries etc.):

“There are some who are polite, who are prepared to work there. And there are others who are bad tempered” (Roberta).

We observed a paradoxical situation as regards religious affiliation. Religion featured as an option in the therapeutic itineraries of the families. On the other hand, religious affiliation and/or following its respective precepts was, in some cases, an obstacle with the relation to health care services (SUS or non-governmental organisations). Religious intolerance and prejudice when faced with the beliefs of others emerged. One of the interviewees explained why she did not seek help in a health centre run by a local Spiritist institution in the following terms:

“I don’t use [that service] because I’m a Jehovah’s witness. The brothers (...) don’t forbid it (...) if I read my bible, I know it’s forbidden (...) to fraternise with spiritists (...) They must take the children there to, I don’t know, hypnotise them, or whatever, like in their treatments” (Mariana).

Some community health workers (CHW) who are evangelists refuse to visit homes in the neighbourhood where *candomblé* takes place (there are 13 registered in Boca do Rio), which concerned the local management.

One of the interviewees (“mãe de santo” – who leads the *candomblé* pointed out the historic role of *candomblé* which the blacks took for their own and how it defended their cultural values, which, for her, contributes to the prejudice against the *povo de santo*, who practise it. Race and religion, when put together, produce discrimination.

The question of ethnicity or race was rarely mentioned with regards to accessing the health care services. In addition to the aspect mentioned above, “disregard” or negligence towards sickle cell disease, recognised as prevalent amongst blacks in the municipality of Salvador, was also mentioned.

CONCLUSIONS

The subjects associated manifestations of stigma and social discrimination (observed or experienced) more with being poor than with skin colour. There was a prevailing view that the processes of social discrimination in Brazil, which are also expressed in health care, are part of a wider social context which produces “first class” and “second class” citizens. Thus, a complex arrangement between economic and symbolic capital is created.

On the other hand, some of our interviewees found that the combination of “being black and poor” was an element which made the relationship with the health care services more difficult. The lack of strategies which

allows us to compare the perceptions of blacks and non-blacks in the same area – which could offer clues as to the influence of skin colour on the results – may be noted as a limitation of this study.

Studies which allow one to give a specific weighting to ethno-racial and social class markers when accessing health care services, as well as in the event of discrimination occurring in this context, should be undertaken. It would be useful if such research covered different regions of the country, with different ethno-racial profiles and compared conditions and accessibility of health care among population groups with diverse characteristics in terms of skin colour and social class.

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