



# “I actually never heard of it or participated in it”: the National Policy on Comprehensive Health of the Black Population in the perspective of health managers and professionals

“Na verdade eu nunca participei e nem ouvi falar sobre”: a Política Nacional de Saúde Integral da População Negra na perspectiva de gestores e profissionais da saúde


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## Abstract

This study analyzes how the National Policy on Comprehensive Health of the Black Population (PNSIPN) has been implemented in three municipalities in the state of Bahia, Brazil. This qualitative study is part of an ongoing action research, in which semi-structured interviews were performed with 27 professionals from family health, primary health care, and health district headquarters. Content analysis presented four categories: primary health care (PHC); Black health; health care in diversity; and PNSIPN. Health professionals showed a superficial understanding of PHC, despite recognizing it as a gateway. A specific health care for the Black population was considered irrelevant, on the grounds that everyone is equal. Diversity was linked to the LGBTQIA+ population and life cycles, but not to ethnicity or skin color. All municipalities lacked knowledge about the PNSIPN and the practical means to implement it in their daily work. Its absence in the services' planning and work processes shows an urgent need for permanent education in health so that managers and professional can appropriate the principle of equity.

**Keywords:** Health Care; Health Equity; Black Population; Public Policy.

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## Resumo

Este artigo analisa como a Política Nacional de Saúde Integral da População Negra (PNSIPN) tem sido implementada na atenção à saúde em três municípios do Estado da Bahia, Brasil. Trata-se de um estudo qualitativo que faz parte da primeira etapa de uma pesquisa-ação, na qual foram realizadas entrevistas semiestruturadas com 27 profissionais de unidades de Saúde da Família, Atenção Básica e Sede do Distrito Sanitário. Após análise de conteúdo, emergiram quatro categorias: Atenção Primária à Saúde (APS); Saúde da População Negra; Atenção à saúde na diversidade; e PNSIPN. Como resultado, os profissionais apresentaram entendimento superficial sobre a APS, apesar de a reconhecerem como porta de entrada. A relevância de uma atenção à saúde específica para a população negra foi desconsiderada, sob o argumento de que todos são iguais. A diversidade racial não foi reconhecida dentro do cotidiano, sendo o termo atrelado à diversidade LGBTQIA+ e aos ciclos de vida. O dado comum nos municípios foi o desconhecimento da PNSIPN e dos meios práticos para inseri-la no cotidiano do trabalho. A ausência da política para essa população no processo de planejamento e trabalho dos serviços revela a urgência da educação permanente em saúde para a apropriação do princípio de equidade pelas gestoras e profissionais.

**Palavras-Chave:** Atenção à Saúde; Equidade em Saúde; População Negra; Política Pública.

## Introduction

During the construction of Brazilian society, the establishment and reproduction of ethnic hierarchies subjected the Black population to disadvantages regarding access to services, rights, and opportunities. Ethnic inequalities are systematically updated as a consequence of racism, which, according to Almeida (2019, p. 32), “is a systemic form of discrimination based on ethnicity that manifests itself by conscious or unconscious practices that culminate in disadvantages or privileges for individuals, depending on the ethnic group to which they belong.”

Ethnic inequalities perpetrated within organizations are considered institutional racism, which is not limited to prejudice or interpersonal ethnic slurs, since it “acts diffusely in the daily functioning of institutions and organizations, which operate differently in the distribution of services, benefits, and advantages to different segments of the population from the ethnic point of view” (López, 2012, p. 127).

Current data on Black health reaffirm ethnic disparities and highlight the difficulty of health institutions in offering an equitable service. Except for genetic conditions, such as sickle cell anemia and glucose-6-phosphate dehydrogenase deficiency, other diseases considered more prevalent among the Black population are closely related to socioeconomic factors, life habits, and environmental conditions, such as systemic arterial hypertension and type 2 diabetes mellitus, which shows that racism is a social determinant of health (Varga and Cardoso, 2016). Moreover, from 2011 to 2019, 63% of maternal deaths occurred among Black women and 31% among white women, and the infant mortality rate is also higher among Black children (Brasil, 2021). Regarding mental health, from 2012 to 2016, the suicide rate among the Black population was 55.4% higher in comparison with other ethnic groups (Brasil, 2018).

Equity, which is one of the principles of the Brazilian Unified Health System (SUS), aims to guide health actions towards social justice, considering the differences and needs of different social groups, treating them unequally, according to the care required, in order to face health inequities (Barros and Sousa, 2016).

In line with the principle of equity, in 2006, the National Health Council (CNS) approved the National

Policy on Comprehensive Health of the Black Population (PNSIPN), by Ordinance No. 992/2009. Its objective is the “recognition of racism, ethnic inequalities, and institutional racism as social determinants of health conditions, aiming to promote equity in health” (Brasil, 2009).

The PNSIPN aims to ensure the realization of the right to health, in its aspects of health promotion, prevention, care, treatment, and recovery from communicable and non-communicable diseases and diseases, including those with higher prevalence among this segment of the population (Brasil, 2009). This policy is the result of the social participation mainly represented by Black movements fighting for the democratization of health.

Despite the efforts, the implementation of the PNSIPN faces challenges, such as: difficulty in institutionalizing the field of Black health in the academic and political environment; opposition to this field due to disagreement regarding the use of the concept of ethnicity, the lack of recognition of racism, and its influence on health in defense of the centrality of economic determination; difficulty in mainstreaming this policy in health actions; and the problem in establishing indicators to evaluate and monitor its actions (Faustino, 2017; Gomes, I. et al, 2017).

In Bahia, in 2007, the State Health Department created the *Comitê Técnico Estadual de Saúde da População Negra* (State Technical Committee on the Health of the Black Population), which became one of the main tools for the operationalization of PNSIPN in this state. In total, 80% of the population of Bahia is self-declared Black or mixed-race, and this state has an important number of traditional Black communities, remnants of the *quilombos*, with religions of African origin (Gomes, I. et al, 2017). However, information on the implementation process in its municipalities, which are privileged locus of political action, is little.

This study aimed to analyze how the PNSIPN has been implemented in SUS health care services from the perspective of managers and health professionals from three municipalities in Bahia.

## Methodology

This study is part of the action research “*Atenção à saúde na perspectiva da Política Nacional de Saúde*

*Integral da População Negra - PNSIPN*” and will present the results of its first stage. This qualitative exploratory study was performed by the *Núcleo de Estudos e Pesquisas em Gênero, Raça e Saúde* (NEGRAS - Center for Studies and Research in Gender, Ethnicity, and Health) and funded by the Fundação de Amparo à Pesquisa do Estado da Bahia (FAPESB), by the Research Program for SUS (PPSUS). Data were collected in 2019 in three municipalities in Bahia: Salvador (its capital), Santo Antônio de Jesus, and Cruz das Almas (in the Recôncavo Baiano). These municipalities were chosen due to the significant presence of Black people and because since 2007, they received state support for the operationalization of the PNSIPN in Bahia (Gomes, I. et al, 2017).

Initially, researchers contacted the health departments of each municipality. Later, for convenience, two health districts (the smallest territorial health management unit within the municipality) of each city were chosen. This study aimed to include regions with different socioeconomic characteristics.

Within each district, five family health units (Salvador: 2; Cruz das Almas: 2; Santo Antônio de Jesus: 1) and two primary health care units (Salvador: 1; Santo Antônio de Jesus: 1) were randomly selected. In Salvador, a district headquarter was also a research point for the interviews with managers. This study was performed this way because family health units provide continuous care by a multi-professional and interdisciplinary team while Basic Health Units (UBS) provide basic care actions and services (Brasil, 2017).

To reach the final number of interviews, the saturation method was used. In total, 27 interviews were performed with managers and higher and mid-level health professionals. Data collection was based on a semi-structured questionnaire with characterization questions (age, gender, and ethnicity/skin color) and guiding questions about Black health, population diversity, and the implementation of the PNSIPN in professional performance and health service planning. All interviews were recorded and later fully transcribed for analysis. Data were collected by members of the NEGRAS.

Answers were analyzed by the content analysis technique (Caregnato and Mutti, 2006). After analysis of the interviews, data were grouped into four categories, in relation to awareness, understanding, and effectiveness of the PNSIPN: primary health care (PHC); Black health; health care in diversity; and PNSIPN.

This study was approved by the Research Ethics Committees of the Escola de Nutrição da Universidade Federal da Bahia (UFBA) (proposing institution) and the Universidade Federal do Recôncavo da Bahia (UFRB) (co-participant) under no. 2,768,574 and no. 2,768,574, respectively. The statement of consent of the health departments was requested before contact with the selected health units. Health professionals who agreed to participate in this study were informed about its objective and signed an informed consent form before interviews. In order to preserve the identity of professionals, in speech coding, names of African countries were used.

## Results and discussion

Regarding ethnicity/skin color, of the 27 participants, 53.3% were self-declared mixed-race, 40% were Black, 3.3% were Asian, and 3.3% were white. Regarding gender, 90% were cis women and 10% were cis men.

Among nine managers, only one was a man. The age range of this group was of 29 to 51 years. The professional training of managers was diversified: administration, accounting sciences, physical therapy, dentistry, and nursing. Among 18 professionals, only two were men. The age range of this group was of 26 to 62 years. Higher level professionals were nurses, doctors, physical therapists, and dentists. Mid-level professionals were nursing technicians, work safety technicians, community health agents, and administrative assistants.

### Primary Health Care (PHC)

Working in the field of PHC requires fundamental knowledge for the exercise of health practice. The National Primary Care Policy (PNAB) (Brasil, 2017) includes a set of health actions at the individual, family, and collective levels that involve from health

promotion to palliative care, which are developed by integrated care practices. All these actions are essential for the implementation of the PNSIPN, since the PNAB provides for the adoption of strategies in primary care that help reduce inequities and inequalities of ethnicity/skin color, gender, sexual orientation, among others.

However, interviews showed a superficial understanding of PHC. Participants did not present more in-depth information about its main characteristics and possibilities of action, although they understood it as a basic form of care and a gateway to services of the health care network. Managers and higher level professionals associated PHC mainly with disease prevention and harm reduction, without differentiating health promotion, which has a range of activities.

*Primary care is the gateway, right, we need to try to work more with prevention to unburden hospitals; here we try to work with prevention, raise awareness among the population, avoid more serious damage... anyway, that's it, this part of prevention and health promotion. (Kenya; nurse/manager; ethnicity/skin color: mixed-race)*

Most mid-level professionals related this level of care to services of low complexity and preventive character, associating the quality of health care with the availability of vacancies for care.

*It's very precarious... especially for the poorest people... to get a vacancy... it's really very complicated... I see it day by day... that's it, the issue of making an appointment... sometimes the person comes and doesn't get a vacancy... they come back another day and don't get a vacancy. (Angola; administrative assistant; ethnicity/skin color: Black)*

Other mid-level professionals considered that PHC also represents a privileged space to welcome users and build the bond between services, professionals, and them. Thus, good communication and listening are powerful health care devices.

*Primary care, as I see, is the first place where a person goes, it is the first place, the first emergency*

*room that we have to go, the first place we go is the health center [...].* (Benin; administrative community health agent; ethnicity/skin color: Black)

For Camara, Belo, and Peres (2020), despite the progress made in the consolidation of the complex organizational structure of the SUS, numerous challenges affect its proper functioning. One of those is health education, even still traditionally reductionist, in which the concern with diagnosis and treatment of diseases prevails to the detriment of health promotion strategies that favor intersectoriality and social participation.

Considering that PHC is the core of the health system communication, such training does not provide the coordination of care, since it does not encourage the network performance, affecting the understanding of comprehensive care (Ribeiro and Cavalcanti, 2020). Moreover, among the different organizational spaces of the SUS, PHC is the one with the greatest training complexities, due to the centrality of the organization of care and health promotion (Camara, Belo, and Peres, 2020).

Amaral et al. (2021) showed that permanent education in health (PEH), the problematization and understanding of individual and collective attributions, and the purpose of the developed actions are central challenges for the work process in PHC. PEH can contribute to better efficiency of PHC and consequently enable way actions inherent to the PNSIPN in an emphatic and pragmatic by incorporating the issues of racism and Black health in the training of health professionals.

## **Black health**

Consolidating the issue of Black health within health sciences is a powerful strategy for this population to overcome barriers regarding both access to health and the guarantee of other rights. However, the reality of the daily life of PHC shows that the consolidation of this field still has gaps.

When asked about their understanding of Black health, the answers of managers and higher level professionals in the three municipalities of Bahia were similar and showed a superficial knowledge and little understanding of its relevance.

*To tell you the truth, I don't know. I tell you that I know almost nothing [...] I saw this theme of you, I found it super interesting and wanted to know more....* (Togo; dentist/manager; ethnicity/skin color: Asian).

Moreover, even admitting the existence of discrimination in society, they stated they did not see it in their daily service.

*[...] discrimination exists, unfortunately, right? This is already a case that is studied, it is already spoken, communicated to everyone, in relation to care being egalitarian, being equal; here, as I told you, I haven't seen, since I've been here, I'm going to complete one year yet, and I haven't really seen any difference in having discrimination.* (Cameroon; physical therapist/manager; ethnicity/skin color: mixed-race)

Studies have already shown the discrimination felt by Black users in health services, such as devaluation or mistrust of their complaint, verbal aggression, and disrespect from physicians or receptionists (Kalckmann et al, 2007). Cordeiro (2009) showed forms by which Black women with sickle cell anemia had already been discriminated against, such as the use of a discriminatory speech—“**Beware! It is sickle cell anemia! Put gloves!**”—the reinforcement of stereotypes when professionals say that they were addicted to medication, and negligence when they did not receive guidance on the disease. Although women demand better care, at times, the state of pain, the fact that they are alone, or the fear of suffering retaliation after complaint were obstacles in finding the direction of the service, which presents the naturalization process of the experienced oppression.

This intriguing scenario of denying racism is not an individual phenomenon, but a social phenomenon. The literature defines it as “racism without racists,” since “almost everyone agrees with the existence of ethnic inequalities, but it is almost impossible to see the existing racism in our society” (Figueiredo and Grosfoguel, 2009, p. 229). In this logic, racism is always somewhere else, among other people. This idea is based on the myth of ethnic democracy, which was disseminated in Brazil in the 19th century,

making the Brazilian population operate subjectively in three main dimensions: denying racism and discrimination, exempting white people, and blaming Black people (Hasenbalg, 1979).

However, the speech of a manager stands out for being in line with both the principle of equity of the SUS and assumptions of overcoming ethnic inequalities.

*In fact, Black health came with the objective of maintaining equity in public care, to bring the benefits that the whole population had and with it reduce racism and equal, I understand that is it [...] a vision of better care in the context of Black health.* (Egypt; nurse/manager; ethnicity/skin color: White)

On the other hand, the perception of mid-level professionals varied considerably and presented a much more critical and sensitive understanding of Black health. Thus, while some mid-level professionals immediately associated this population with pathologies, such as hypertension, diabetes, and sickle cell anemia, others recognized the breadth of the debate regarding the Black population, considering that the violence they suffer goes beyond the field of health and involves the political, economic, and social reality of the Brazilian Black population, who, in many cases, need to choose which basic needs to prioritize in order to survive.

*The Black population... I think it has very specific demands. When it comes to health, any other aspect... of a very specific demand... and we have to look from that bias. [...] in Salvador, which has the largest Black population outside Africa [...] because they are poor, because they are in community or in spaces with a smaller or almost no amount of sanitation, food ends up being due to income. Because you, to invest, for you to eat well, you need to have money... and most of the population that receives low wages is the Black population. So, you end up... or you pay for water, light... or you eat well [...] that's the reality... Then, it ends up developing problems that are very related to a poor diet and the lack of infrastructure in the neighborhoods....* (Ethiopia; work safety technician; ethnicity/skin color: Black)

The lack of recognition of the implications of racism on Black health and the importance of

basing the fight against it on the daily work can be understood as a historical erasure, crossing the dimensions of both the training of these professionals and PEH and making it difficult to fight against racism in health care practices.

According to Werneck (2016), racism is an ideological phenomenon that contributes to the violation of rights, favoring social inequities, especially in the field of health. Moreover, it is related to the entire life cycle of Black people, from their birth, their family, and individual trajectory to their conditions of life, housing, work, employment, income, and access to information, goods, and services. It is expressed in the quality of the care provided, the profiles and estimation of adult and infant mortality, and in avoidable suffering or early deaths. The unfavorable conditions faced by this population imply barriers to full and equitable access to health services.

This context explains why the inclusion of the issues of racism and Black health in the training of health professionals is a general guideline of the PNSIPN. The lack of knowledge about Black health in its breadth, beyond known diseases, has consequences in necessary referrals to perform differentiated actions according to their conditions and needs, thus, managers and health professionals need to incorporate these aspects in the practice of planning and acting in services so that the policy objectives are achieved.

## **Health care and diversity**

Diversity—often understood only as the difference between individuals regarding the expression of their singularities—also carries a political connotation, as differences can trigger inequalities and the manifest or not power (Sacristán, 2002). Thus, talking about diversity in health is also talking about access: for those who have their right guaranteed, but which is still denied. This is the case of the Black population, which is historically vulnerable.

In the SUS, diversity is directly linked to the principle of equality and equity, considering that, to live in an egalitarian society, recognizing diversities is necessary (Brasil, 2009). PHC activity implies building links with the diversities existing in the

communities. However, this study shows that these concepts are not well fixed among health professionals. The interviewed managers, for example, did not present in a practical and assertive way how to consider diversity in the planning and organization of the health service. When asking higher level professionals about diversity of ethnicity, gender, and sexual orientation, their answers were vague. Diversity was associated with differences in cycles and stages of life, as well as pregnancy.

*A lot of families ends up coming, people ends up coming a lot in families, the mother comes, then the son, sometimes a student from the federal college.* (Senegal; dentist; ethnicity/skin color: mixed-race)

On the other hand, mid-level professionals presented a discrepant view about the issue. Part of the participants presented a wider perception, mentioning ethnicity, gender, and religion as important aspects to be considered. However, others did not show an in-depth knowledge about the discussion, considering the difficulty in naming sexual diversity, the use of pejorative terms, such as “thing,” and the limited notion of the reality of the LGBTQIA+ population.

*Even in the rural area, I think so, there is little, but every day that passes it grows; you know that in the old days we did not see this kind of thing [...] I think discrimination [to LGBTQIA+ people] is greater here in the urban area.* (Namibia; community health agent; ethnicity/skin color: mixed-race)

The aforementioned speech is related to the fact that a greater number of people have been assuming their sexual orientation, and, thus, being more exposed to discrimination, especially in the urban area. The discussion on gender and sexuality, despite its current growth, is often scarce in the rural area. This is related to the repression of individuals regarding their identity and the reproduction of this repression against other individuals of this population, by criticisms and judgments on homosexuality (Ferreira, 2006). J. Gomes et al. (2017) state that the rural area has “a social control that, as a consequence, represses and excludes anyone who lives outside the conservative

standards of the place” and highlights that crimes of LGBTphobia in the field are usually not exposed in the media, which makes it even more difficult to visualize the problem.

Some mid-level professionals highlighted that the health unit hold lectures on diversity.

*We are always aware of this, we always have lectures on these subjects, we give a lecture in the waiting room, there is a traveling lecture that we do in the neighborhoods, we talk about it.* (Benin; community health agent; ethnicity/skin color: Black)

However, in a contradictory way, others do not consider diversity in care and do not identify the need for differentiation between individuals for a singular health care.

*No, here in the unit, no, everyone is treated equally [...] For me, they are the same; certain people have that thing, but for me there is nothing, I assist them easily, if they ask me something, I answer, informing some health stuff [...]* (Benin, community health agent; ethnicity/skin color: Black)

Regarding health care in diversity, the lack of knowledge about its concept and the difficulty of incorporating it into health practice show a scenario of reproduction of violence. Racism, sexism, and LGBTphobia cross the identities of individuals in the most diverse areas of life, including when seeking and receiving health care. Santana et al. (2021) state that several factors hinder the adherence and demand of the LGBTQIA+ community for health services, including discrimination, social stigma, and disrespect from health professionals. These elements were noticeable in the speech of some participants.

Although some health professionals reported the realization of courses on diversity, these discussions are not deepened or applied in daily practice, causing a generalized lack of knowledge, in which the concept of equality is idealized due to the misrepresentation of the notion of diversity. This diagnosis shows professional unpreparedness to include the demands of these groups in health plans and actions and reaffirms the need to include

the issue of fighting against gender and sexual orientation discrimination in intersection with Black health, according to the objective of the PNSIPN, in PEH activities of professionals.

### **National Policy on Comprehensive Health of the Black Population**

According to Faustino (2017), institutions have been showing greater resistance to the implementation of the PNSIPN to fight against institutional racism. Among impasses, the author points the lack of knowledge about the policy by managers and professionals at the three levels of SUS management.

In this study, most managers were unaware of the existence of the PNSIPN. Some of them stated that they had heard of it, but did not have an in-depth understanding. Most health professionals, in all municipalities, were unaware or had a superficial knowledge about the policy. In a study by Matos and Tourinho (2018), 75.65% of the interviewed health professionals knew that the policy exists, but only 16.52% had read it. This lack of knowledge directly implies its effective implementation and development.

*I've heard of it, but very superficially, I haven't delved into the subject yet. I even found it interesting when you guys got here, for me to appropriate more of it, because this is a policy a little... it is not unknown, it is known, but we do not delve into it too much, such as into others, right, not only for being about the Black population, but it is interesting [...]* (Rwanda, nurse/manager; ethnicity/skin color: mixed-race)

In the best-case scenario, both managers and professionals would have to be aware of the existing health policies. However, SUS health management has been facing challenges and weaknesses, such as the high work demand (Paiva et al., 2018) and the lack of investment in public health, especially after Constitutional Amendment No. 95/2016, which suspends investments in health for 20 years (Menezes, Moretti, and Reis, 2020).

The lack of knowledge about the PNSIPN is inserted in a context in which the debate

around universalization, focus, recognition, and distribution of rights remains tensioned, tending not to consider particularities. This implies resistance to recognize the role of racism in the determination of health, in the name of a universalization, which, for Faustino (2017), is abstract, in the face of significant ethnic inequalities in health. Rinehart (2013) observed this phenomenon in a study with Brazilian municipal managers, in which some of them denied the relevance of the PNSIPN, stating that it contradicts the principle of equality of the SUS.

Managers, besides neither knowing nor incorporating the objectives of the PNSIPN in the planning of actions in services, reproduced the idea that all users are equal. It shows indifference to the ethnic diversity of users, disregarding equity in services, making it impossible for them to have access to broad and integrated care and hindering the reduction of the effects of racism on their lives.

*Actually, there is no specific policy for that, you understand? [...] After all, we do not diversify by ethnicity, skin color, sex, and of course patients are treated regardless of anything [...]* (Togo; dentist/manager; ethnicity/skin color: Asian)

Several participants reproduced this discourse. They reported no need to prioritize ethnicity/skin color, since they do not see differences between the population that need the service. This perspective disregards that, by discrimination and violence, racism intensifies experiences of vulnerability and poverty among the Black population (Almeida, 2019).

*For me, there is no difference, for me, it would be for the population in need, you understand? I actually never heard of it or participated in it. For me, I know that it exists, after all, people are talking a lot about it, but in relation to unraveling the difference between the population in need and the Black one, I think it would be the same thing [...]* (Guinea; nurse; ethnicity/skin color: mixed-race)

Those who recognize the need to implement the PNSIPN pointed the difficulty in recognizing how to insert it in professional practice.



“How could I deal with it?,” Senegal questioned. In a study by Matos and Tourinho (2018), 85.22% of health professionals never had used the PNSIPN in any way in their professional practice. In the same study, 82.61% considered it important to achieve equity in the SUS. Batista, Monteiro, and Medeiros (2013) highlight the need for investments in the revival of learning about the PNSIPN in order to enable improvement and feedback. The policy already provides for it, due to its transversal character that encourages an articulation with the National Policy of Permanent Education in Health. A strategy of the PNSIPN is to develop actions to reduce the Black morbidity and mortality, considering the following issues: violence, incarceration, mental disorders, and diseases, such as STIs/HIV/AIDS, tuberculosis, sickle cell anemia, and leprosy (Brasil, 2009).

However, the formalization of the policy neither implemented the planned actions nor produced the expected results. After 10 years since its creation, 28% of Brazilian municipalities adhered the PNSIPN, mainly in Northern and Northeastern Brazil. In Bahia, about 40% of municipalities apply the policy, but less than 10% have monitoring committees and actions aimed at the Black population (IBGE, 2019).

I. Gomes et al. (2017), analyzing the implementation process of the PNSIPN in Bahia, stated that the cycle is not consolidated yet, thus, updating health indicators, specifically those disaggregated by ethnicity/skin color, and promoting the comparison between these health indicators in different regions and municipalities is extremely important, aiming to validate the effect and progress achieved in their implementation.

The difficulties to implement the PNSIPN gained specific features during the COVID-19 pandemic in Brazil. The reproduction of the idea that the virus and its disease affect everyone in the same way was one of the obstacles, disregarding the need for data on ethnicity/skin color in information systems and the most vulnerable conditions in terms of income, housing, and food security faced by the Black population (Malomalo, Vaz, and Medina-Naranjo, 2020). The urgency of the PNSIPN to fight against institutional

racism and guarantee the right to health becomes invisible by the idea of an ethnic democracy.

## Final considerations

The analysis of the PNSIPN from the perspective of managers and health professionals showed that, although this policy was an achievement of Black social movements and had a space in the State Health Department of Bahia (a Black-majority state), its implementation is an objective to be achieved in the municipalities studied and possibly in other municipalities of this state. The lack of knowledge about the PNSIPN and the practical means to implement health actions based on the established objectives, besides the difficulty in seeing the importance of considering ethnic diversity in care, is related to one of the faces of racism: the invisibilization of the health demands of the Black population.

The principle of equity of the SUS seems not to have been incorporated yet into the daily life of the interviewed health professionals or as a guide for managers to implement the established policies, which raises concern considering social inequality and ethnic disparity, showing the existence of a serious management problem.

For the implementation of the PNSIPN not only in Bahia but throughout Brazil, further research on the situation of the policy and its incorporation within health planning actions in a transversal way are essential, including evaluation and monitoring indicators disaggregated by ethnicity/skin color. Moreover, reinforcing narratives for the recognition of differences and their consequences for ethnic inequalities in health, along with the intensification of actions of permanent education in health, is necessary.

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### Authors' contribution

Silva, Berenguer, and Ricardo participated in the study conception and all stages of preparation of the manuscript. Lopes participated in the writing of the manuscript and the critical review. Santos, Bittencourt, and Santana participated in the coordination of the study and the critical review of the article. Sá participated in the critical review. All authors approved the final version of the article.

Received: 07/06/2022

Approved: 08/09/2022