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**THE IMPORTANCE
OF RACIAL HEALTH
INFORMATION
IN COMBATING
INSTITUTIONAL RACISM**

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INTRODUCTION

The SUS (Unified Health System) guarantees access to health services for everyone, but racial inequalities persist and all health indicators such as rates of infant mortality and mortality rates from external causes — diabetes, high blood pressure and sickle cell disease — are higher in the black population; the number of prenatal exams is fewer for the black population. Bahia has the highest concentration of black residents in the country and the highest rates of sickle cell disease. Several studies carried out in other states in the country indicate that, despite advances in coverage of the race-color issue in health records, such as the mortality and live birth systems, morbidity records and access to services, coverage still needs to be expanded and the quality of racial information improved. Health workers need permanent training to guarantee access and an approach that guarantees racial equity in health, in accordance with the objectives of the National Health Policy for the Black Population.

This research combines coordination between health managers at the municipal level and the Institutional Racism Combat Program (PCRI) to expand the coverage and quality of the race-color issue in health records and the application of a questionnaire to a representative sample of health workers (both public and private sectors) in Camaçari, which includes data on family, working conditions, forms completion, knowledge of common diseases in the black population, opinion, attitudes and practices in relation to the most common diseases in the black population, including sickle cell anemia, and its receptivity to changing behaviors in order to increase access and the quality of approach to services for the black population. Six hundred and thirty-four questionnaires were administered on socio-demographic and family characteristics; work conditions;

completing the race-color question; knowledge and attitudes and practices regarding racism; and capabilities. Quantitative data is combined with qualitative analysis of the speeches and attitudes observed and recorded among employees during the application of the questionnaires in health services, which also included a dialogue and listening phase in the format of interviews. This way, the research adopts a mixed methodology.

INTRODUCTION AND CONTEXT ANALYSIS

In 2001, the Third World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance was held in Durban, South Africa, which resulted in a Declaration and Action Plan presenting a series of measures to combat racism in all sectors of social life including health. Following the time frame, we also highlight the creation, in 2003, of the Secretariat for Policies for the Promotion of Racial Equality (SEPPIR), the social movements that guided the health of the black population, especially the Black Movement and the Women's Movement, which began to have a dialogue differentiated from the government, enabling the incorporation of historical demands. According to the first Minister, Matilde Ribeiro (2003-2008), the demands received in the area of health, during this period, presented a well-structured content with the basis for the construction of a national policy, with the secretariat being responsible for promoting and monitoring developments with the Ministry of Health. This process culminated in the institution of the Comprehensive Health Policy for the Black Population, based on Ordinance No. 992, of May 13, 2009. (Santos, 2016).

In accordance with the National Policy for Health Information and Informatics (PNIIS), we can state that health information is a structuring element for universality,

completeness and social equity in health care. This represents a relevant instrument for developing social policies and planning actions and interventions.

With regard more specifically to the health of the black population, such information was indispensable for the formulation of the National Policy for Comprehensive Health of the Black Population. However, this data still does not present a completeness and dissemination that allows the analysis of the entire trajectory of the citizen in health services. The race-color issue is fundamental for collecting information on the health of the black population. Using these indicators, it is possible to visualize the situation, obstacles and progress of the PNSIPN with greater precision. In addition to paying attention to the quality of collection of this information by health professionals, the way in which this data is used and disseminated also needs to be evaluated.

The SUS IT Department — DATASUS — is institutionalized as the information technology body, linked to the Ministry of Health, with the responsibility for collecting, processing, analyzing and disseminating information in conjunction with municipal and state levels. However, some obstacles in the management of information technologies have hampered the performance of this department in fulfilling its functions and its operation and access are still restricted and need to be reorganized.

The criterion adopted by IBGE for information on “color or race” is collection through induced self-definition, that is, the interviewee is free to indicate their “color or race” among the five categories that are already widely accepted, as practically the entire population recognizes them and responds easily in censuses and surveys (OSÓRIO, 2003). The rate of refused or ignored responses to the “color or race” question is very low.

Only 0.7% of the population did not respond to their color in the 2000 census; In surveys throughout the 1990s, the lack of response was always less than 0.5% of the population.

To ensure good coverage and quality of racially-sensitive health information, it is important to recognize the importance of the self-declaration criterion and adequate completion of the race/color question by managers and workers in public and private health services, who must be trained to completely and correctly ask and record the color of SUS users at the time of data collection, following the IBGE criteria (DIAS, 2009; ARAÚJO, 2010).

The question of color or race/ethnicity is in the process of standardization in the SUS health information system, following the self-definition criteria and the categories used by IBGE: white, black, yellow, brown or indigenous.

This standardization of the race-color variable through self-declaration and the five fixed categories makes it possible to carry out precise estimates, studies and comparisons on racial inequalities in health at national, state and municipal levels and, consequently, contributes to the planning of actions to combat diseases that are more prevalent in the black population.

After the massive inclusion of Afro-Brazilians in universities through the system of social and racial quotas, affirmative policies were progressively implemented in public entrance examinations to hire professionals in municipal health services. At the time of the fieldwork for this research, several Afro-Brazilians had already not also been encountered — including doctors, dentists, social workers and technicians — as a result of affirmative policies, but also through the challenges faced during the growing participation of leaders and supporters of the black movement in anti-racist debates

in Brazilian society. As is the case of PCRI members. These workers and their colleagues reported several cases of racism experienced within the services in the professional-patient relationship. These reports are also analyzed in the article, demonstrating the way in which structural racism is reproduced both in institutional norms and in the micro-relationships established between employees and patients.

RESULTS ACHIEVED

The quantitative results were analyzed using descriptive quantitative techniques and show that 76% of workers are women, with an average age of 40 years, 83% declare themselves black, 42% are Catholic, 50% are married, 27% are childless, and 69% are responsible for families, earning an average of three thousand reais per month. 70% have statutory employment.

The results were analyzed for services with different levels of complexity in healthcare. Around 16% of workers do not know whether service forms contain a question about sickle cell disease, but this percentage is lower in the emergency services. Of the total, 65.7% say that the forms do not contain this question, with the highest percentage in the emergency services (87.4%), specialty services (79.3%) and basic units (61.7%). The Hospital has both the highest proportion of negative responses (56.2%) and the highest percentage of positive responses (25.6%).

Practically all workers have heard about sickle cell disease, and a third (34.1%) have already received training about the disease, with the highest proportions in basic units (45.9%), followed by the emergency services (29.9%) and the Hospital (29.7%), with specialty units having the lowest percentage of personnel trained in sickle cell disease — only 11.2%.

Regarding knowledge of the most common

diseases found in the black population, the Hospital presents the highest percentage (87.3%), followed by the emergency services, specialty and basic units.

Regarding the race-color issue, the vast majority of hospital and emergency service workers declare that they do not apply it (82.2% and 82.1%, respectively), followed by basic units (61.7%) and specialty centers (79.5%). In basic units, only 31.8% respond that it does not apply, with the highest proportion of employees always asking the patient's race/color (44.5%). Likewise, in basic units there is the highest proportion of those who never fill in the race-color question without asking the patient (49.3%). This is consistent with the level of complexity, as the basic units have fewer employees.

Regarding health workers' expectations regarding patients' difficulties when asked about their race-color, most of them consider that there would be no difficulties (29.6%), that only a minority would have difficulties (18.5%), or that half of them would (20%). A third of workers consider that many patients would have difficulty defining their race and color (18%) or that almost everyone would have difficulties (13.9%). The Hospital is the service where workers have more optimistic expectations regarding the patient not having difficulties in defining their race-color, and only 9.1% and 14.6% respectively consider that many or almost all patients would have this difficulty. The highest percentages of responses that demonstrate negative expectations are from specialty clinics, where 32.4% and 13% consider that many or almost all patients would have difficulties, followed by the emergency services and basic units.

On the other hand, expectations about patients' positive reactions are also more frequent in basic units (48.6%), followed by hospitals (39.9%), the emergency services (37.5%), and once again specialty clinics are

the ones where fewer expect naturalness in patients' reactions when asked about their race/color (33.5%).

Expectations about non-positive reactions are always more frequent in the emergency services, such as surprise (30.7%), distrust (32.4%), and questioning due to lack of understanding (37.3%). The Hospital is the second type of unit where these non-positive expectations occur (24%, 24.7%, 24.7%, respectively, for surprise, distrust and questioning). The expectation that the patient will feel uncomfortable is more frequent in specialty clinics (31.4%), followed by the emergency services (29%) and hospitals (23.4%).

Expectations of receiving more extreme negative reactions such as, for example, that the patient refuses to respond is more frequent in hospitals (19.7%), followed by specialty clinics (15%) and the emergency services (14.4%), while the expectation that the patient will react with irritation is most common in the emergency services (17.3%) and followed by hospitals (11%), being very infrequent in other units.

All of these negative expectations are much less frequent in basic health units, except the expectation that the patient will not understand and request clarification about the question about race – color (29.1%). This result coincides with the presence and proximity of PCRI representatives in the basic health units where they work and disseminate the program's anti-racist agenda.

The main discourses identified with racism in patient care included prejudice against young black men who are treated in emergencies, in particular those who have tattoos, as some professionals directly relate them to organized crime, and use this as an explanation to justify practicing neglect or even denying attention, both being a form of social punishment. However, situations are

also observed in which patients refuse the attention of black doctors and dentists, request to be seen by white professionals or explain to white technicians their doubts about the technical capacity of the black professionals who were assigned to care for them. When cross-referencing data by sex and age of health workers, it is observed that the group of younger black women who have recently been massively included in universities and as health professionals through inclusive policies use a more direct and less ambiguous discourse when denying institutional racism, and are more likely to oppose the implementation of inclusive measures for black people within health services, adhering more closely to priority rules according to the severity of the illness. By adhering strictly and uncritically to the rules exclusively related to the levels of urgency to provide care, they deny the need to also take into account social condition and racial disadvantage as relevant factors in care, as they ignore structural differences leading to a greater probability of living in poverty and greater difficulties in being absent from work or domestic child care, affording the costs of transportation and time to access health services, as well as the greater prevalence of chronic diseases such as diabetes, hypertension and heart problems observed in the black population, in addition to sickle cell anemia. The simple recognition of these inequalities and disadvantages is neither reflected in institutional regulations nor in the collective and individual practice of health professionals — including black professionals who were the object of inclusive policies in universities — but who do not recognize the need for special attention, or at least more empathy towards the population group to which they belong or belonged in the past. This result indicates the need to rethink care regulations, to reform curricula in the health area and training in services so

that employees are empathetic with social and racial inequalities and assume greater responsibility in their professional practice in order to correct social and racial injustices in patient attendance, or at least not reproduce them. This empathy and awareness is also necessary in the information and relationship with patients, as these same professionals often also suffer racial discrimination from patients, as they are perceived, due to their phenotype, as less qualified professionals. Explicit racism is evident in the case of patients who refuse to be treated by black professionals. In these cases, there is solidarity between some white professionals and their black colleagues. However, this solidarity and empathy is not always reproduced in the relationship between the professional and the patient. The results lead us to think of the term “cycle of ambiguity and revived racism”, related to the feeling that talking about race/ color would create a racist conflict, assuming in the first place its non-existence. The mask of Brazilian racism is based on the recognition of inequalities and injustices, but this recognition is immediately followed by resistance to asking about it and the refusal to correct it through affirmative policies. This circularity allows Brazilian society to use egalitarian discourse, accepting inequalities as something unfair, but normal. Universal and egalitarian declarations also deny any egalitarian action to correct injustices. attitudes and practices of healthcare personnel — from receptionists to nurses and doctors, at different levels and standards. Racism is also present in patients’ attitudes and practices when interacting with black workers in health services, as demonstrated in our qualitative approach. The results indicate a kind of “revived cycle of ambiguity”, related to the recognition that racial inequalities exist and are unfair, but must never be talked about in order to avoid racist conflict and white discrimination and, therefore, society can

continue to pretend that this does not exist and use it to deny the need for affirmative policies and a commitment to reducing racial inequalities and correcting injustices.

CONCLUSIONS

It is concluded that the team’s actions must focus on continuing meetings with managers to include the race-color issue in the forms and on training health workers to expand knowledge about the importance of racially-sensitive information.

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