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Thematic Dossier
HEALTH OF THE BLACK POPULATION: COUNTER-HEGEMONIC PRACTICES AND REFLECTIONS

EXPRESSIONS OF INSTITUTIONAL RACISM IN PRIMARY HEALTH CARE IN THE MUNICIPALITY OF ARACAJU: AN EXPERIENCE REPORT

EXPRESSÕES DO RACISMO INSTITUCIONAL NA ATENÇÃO BÁSICA DE SAÚDE NO MUNICÍPIO DE ARACAJU: UM RELATO DE EXPERIÊNCIA

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Abstract
Introduction: this article discusses our professional experiences in Primary Health Care in Aracaju and addresses some expressions of institutional racism at this level of care. **Objective**: to problematize some institutional codes that make it difficult to focus on health care for the black population, in flagrant non-compliance with the National Policy for Comprehensive Health of the Black Population (PNSIPN). **Method**: we are anchored in participant observation, document analysis and literature review situated between the boundaries of historical-dialectical materialism and decoloniality to address the reflections punctuated here. We divided the report, for organizational purposes, into three axes that portray racist experiences in a Basic Health Unit in the capital of Sergipe: 1) Denial of title with pecuniary progression to health professionals formally certified with PNSIPN update; 2) Non-compliance with the race-color item in the registration of users who use the SUS and; 3) Preservation of symbols with slave and colonial connotations. **Conclusion**: the inaccuracy of race/color records, the disinvestment in continuing education for health professionals and the maintenance of symbols with slavery connotations show lack of knowledge or apathy in the effective implementation of PNSIPN.

Keywords: PNSIPN; SUS; Institutional Racism; Basic Attention.

Resumo
Introdução: este artigo discorre sobre as nossas experiências profissionais na Atenção Básica de Saúde de Aracaju e aborda algumas expressões do racismo institucional nesse nível de atenção. **Objetivo**: problematizar alguns códigos institucionais que dificultam a focalização da assistência à saúde da população negra, em flagrante inobservância à Política Nacional de Saúde Integral da População Negra (PNSIPN). **Método**: ancoramo-nos na observação participante, na análise documental e na revisão de literatura situada entre as fronteiras do materialismo histórico-dialético e da decolonialidade para abordar as reflexões aqui pontuadas. Dividimos o relato, para fins

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organizativos, em três eixos que retratam experiências racistas em uma Unidade Básica de Saúde da capital sergipana: 1) Indeferimento de titulação com progressão pecuniária a profissionais de saúde formalmente certificados com atualização da PNSIPN; 2) Inobservância do quesito raça-cor no cadastro dos usuários que utilizam o SUS e; 3) Preservação de simbologia com conotações escravocrata e colonialista. **Conclusão**: a imprecisão dos registros raça/cor, o desinvestimento em educação continuada para os profissionais de saúde e a manutenção de símbolos com conotações escravocratas evidenciam o desconhecimento ou apatia na efetiva implantação PNSIPN.

Palavras-chaves: PNSIPN; SUS; Racismo Institucional; Atenção Básica.

INTRODUCTION

Before delving into the proposed issue, it should be noted that we renounce the alleged neutrality imposed by Western canons for the production of knowledge validated in the academy, leaving us to enunciate as subjects located in Coloniality/Modernity (C/M)[1]. We are two cissexual women, self-declared brown, which in some circumstances places our black racial identity in a condition of suspicion/strangeness within our own community[2], despite the presence of some black traits. Our bodies coexist and face the overlapping and inseparable oppressions of racism and patriarchy[3], in addition to being researchers and workers in the smallest state of the Federation (Sergipe), located in the Brazilian Northeast.

We have been working in Primary Health Care in Aracaju for almost two decades and we are in a cumulative effort to decolonize our respective training and professional experiences. We endorse the broad definition of decoloniality, which does not restrict it to Latin authors of the decolonial turn, but also includes subaltern knowledge, notably Afro-diasporic and Amerindian, as well as the forms of resistance and re-existence of these segments[4].

We understand that “the colonization process goes beyond the economic and political spheres, deeply penetrating the existence of colonized peoples, even after 'colonialism' itself has exhausted itself in their territories”[5] (p.3). we have rights and duties that, when respected, grant us the title of citizens. However, on a daily basis, these guarantees are obliterated and their materializations converted into conquests, often threatened by prejudice and social injustice, which is the reality of the Brazilian black community.

Even today, when slavery succumbs and the State enshrines equal rights on a formal level, the idea of race is metamorphosed and starts to serve the interests of the beneficiary heirs of colonization. In this context, the theory of whitening and the idyllic racial democracy provided the construction of social markers of privileges, hierarchies, places and distinct social roles, which make it difficult to reaffirm identity and socioeconomics, where "the more distant from a European model of -being and exist -if there is, the greater the exclusion and lack of opportunities[6](p.25)". With this, "[...] in Brazil the myth of racial democracy blocked for many years the national debate on affirmative action policies and at the same time the myth of cultural syncretism or national mestizo culture[7](p.11)", thus delaying the national debate that would lead to the implementation of multiculturalism in the Brazilian educational system.

Indeed, for Marx, some nation-states, such as the Brazilian one, was the way in which white supremacy was sustained, above all because black identity was, to a certain extent, belatedly organized and recognized[8]. As a result of this, even today, interracial relations in Brazil are coated with a measured tolerance that proves to be perverse, as the real intention to humiliate, subjugate, demean is not always explicit. So that "[...] racial prejudice against blacks is violent and at the same time subtle, it exists latent and often comes to the surface among ourselves; the presence, the confrontation with the other bothers us too. Brazilian racial democracy may exist, but in relation to black people it does not exist"[9] (p.94).

In this way, we perceive that government actions are crucial points to make the inclusion process viable, repair historical injustices, reaffirm ethnic identity and claim equal opportunity and respect for cultural values in favor of building an effectively democratic society. Finally, it is up to the State to provide public policies capable of compensating the original peoples for the continuous and successive erasures in several dimensions. was published in the Official Gazette of the Union, through Ordinance 992 of May 13 of the Ministry of Health (MS). As a result of the protagonism of black feminism in the struggle for reproductive justice intersected with the respective living conditions of these women, the PNSIPN was converted into a Law by the Statute of Racial Equality (Law 12.288/10) and meant the inaugural milestone in the Ministry of Health of the recognition of the persistence of denial of the institutional racism in instances of the SUS.

Racism is not born directly in institutions, but these act as a transmission belt and "are hegemonized by certain racial groups that use institutional mechanisms to impose their political and economic interests"[10](p. 40). In the field of health, institutional racism has been defined as:

> The failure of institutions and organizations to provide a professional and adequate service to people because of their color, culture, racial or ethnic origin. It manifests itself in discriminatory norms, practices and behaviors adopted in everyday work, which are the result of racial prejudice, an attitude that combines racist stereotypes, lack of attention and ignorance. In any case, institutional racism always places people from discriminated racial or ethnic groups at a disadvantage in accessing benefits generated by the State and other institutions and organizations"[11] (p. 22).

Thus, these colonizing mechanisms support institutions and organizations anchored by Anglo-Saxon and/or North American matrices with inadequate or insufficient offers of actions and services in view of the real health needs of the population, due to their color/phenotype, culture and /or ethnic-racial origin. Conduct of this nature places the black population at a disadvantage in terms of access to rights and health care managed by the State. And, therefore, the consequences of racism appear in the late statistics on inequities and in the disastrous therapeutic outcomes with a growing number of preventable deaths, which are not even registered to serve as scientific evidence, in order to guide future political decisions that aim to minimize the vulnerability of this population[12].

To face these inequalities, the advances of the PNSIPN are fundamentally linked to three factors: the commitment of managers, the social movement and health workers[13]. It is, therefore, in the chameleonic bulge of institutional racism and in the "permanently colonial nature of the State"[14](p. 16), now operated by the MS, now by the Municipal Health Secretariat (SMS) and with repercussions in Primary Care, that we begin to thematize our experiences as health professionals committed to another cosmovision. Reflecting on some of these practices is the purpose of this article.

REPORT

The present study reports our professional experiences in a Basic Health Unit (UBS), curiously called (and for reasons still unknown) Dona Sinhazinha, located in the noblest and, therefore, whitened area of Aracaju. We worked together for five years on it. The records that supported this article were anchored in participant observation, document analysis and literature review located between the boundaries of historical-dialectical materialism and decoloniality, whose reflections led to problematize the slow operationalization of the PNSIPN. Part of this essay is part of ongoing research that investigates the health advantages of whiteness that access the SUS through Primary Care. And, in line with the National Primary Care Policy (PNAB/2017), the terms Primary Care (AB) and Primary Health Care (PHC) were used interchangeably.

- Brief considerations on Primary Care in Aracaju

Aracaju is located in the Northeast region of Brazil, has 672,614 inhabitants, which corresponds to about 28% of the entire Sergipe population, with a municipal HDI of 0.770[15]. It comprises 40 districts, 04 districts, 08 health regions, 45 UBS, with 141 Family Health teams (eSF) and 63 Oral Health teams (eSB), totaling 67.33% coverage of the Family Health Strategy, according to the 2018 Quarterly Management Report. Absorbs ¼ of the state's demand; consequently, most health professionals are concentrated in the capital and metropolitan region[16]. In general, PC is the main gateway to the SUS and, according to the Pan American Health Organization (PAHO), it can meet 80% to 90% of the population's health needs, characterized by:

> Set of individual, family and collective health actions involving promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance, developed through integrated care practices and qualified management, carried out with a team multidisciplinary and aimed at the population in a defined territory, over which the teams assume health responsibility[16] (Online).

The PNAB also envisaged the adoption of strategies that allow minimizing inequalities/inequities, in order to avoid social exclusion of groups that may suffer stigmatization or discrimination, in a way that impacts autonomy and health status[17]. However, as previously discussed, Brazilian-style racism does not appear with a lighted sign, quite the contrary, its great hallmark is denial. Therefore, the plethora of legislation that prevents its occurrence, although indisputably important, may prove insufficient, given that colonial metrics are hidden in the regulations themselves or in the eyes of those who interpret them, as in the examples below.

- Refusal of title with pecuniary progression to health professionals formally certified with PNSIPN update

The first guideline of the PNSIPN is the inclusion of the topics Racism and Health of the Black Population in the processes of training and permanent education of health workers. Indeed, this measure is central to the decolonization of the knowledge that organizes health practices and services, as

> Professional training, research, circulation texts, magazines that are received, the places where postgraduate courses are held, the evaluation and recognition systems of its professors, all point to the systematic reproduction of a vision of world from the hegemonic perspective of the North[18] (p. 43).

At SMS, progression by title is provided for in Complementary Law 61/2003, which provides for the Plan for Positions, Careers and Salaries (PCCV). In short, the process happens as follows: the professional takes the course, usually through the Open University of SUS (UNASUS), formalizes the application accompanied by a copy of the certificate and some personal documents, all in a virtualized way. Subsequently, the request is forwarded to the immediate superior, who is responsible for correlating the acquired content with the professional's attributions (depending on the relationships, this situation can be discussed directly between the manager and the server).

Once this information has been collected and in a virtual form, the dossier is sent for analysis by a technical team, created especially for this purpose. This team has no direct interaction with the server and is responsible for assessing the legal requirements (minimum time of effective exercise, suitability of the certifying institution and recognition by the Ministry of Education, including access to passwords to verify attendance and average approval of the candidate, spacing between the presentation of one title and another, corresponding percentages, prerequisites according to the position, discarding simultaneous titles, etc.). After all this, an opinion is issued, granting or rejecting the claim.

In cases of rejection, the server has ten working days to appeal. In the case of the PNSIPN, the cases that we were aware of, the standard rejection is accompanied by the following argument: “the course taken does not fit the hypothesis of relationship with the area of performance and with the occupational content provided for in Art. 26”. Depending on the server's argumentative capacity, the situation can be reversed and a favorable outcome aired.

Without investing in continuing education and actively acting against recognition of the training of professionals who take the PNSIPN as a possible response to health inequalities, the SMS continues privileging colonized content that not only marked out the curricula of universities, but also serves as a stimulus for the revitalization of institutional norms that guide the scope of practices of the collective of professionals that statistically have favored the assistance of whiteness. it is how institutional expedients guided by European epistemes have harmed health professionals who have a look based on historical reparation and who walk in the opposite direction, to what they have learned and reproduced automatically.

However, the central aspect of the discussion is how institutional expedients guided by European epistemes have harmed health professionals who have a look based on historical reparation and who walk in the opposite direction, to what they learned and reproduced automatically. The denial of continuing education focused along these lines invalidates the race-color issue as a social determinant of the health-disease binomial in health care for the 71% of Brazilians who depend exclusively on the SUS[19], of which 80% declare themselves to be black[20]. This redoubles the commitment to an equitable, emancipatory and effectively anti-racist Health Policy. But it also goes through

the need to investigate, expose and confront the place of symbolic and material privilege within the SUS, occupied by whites[21], who remain closed in their own whiteness[22], whether as managers, professionals or even users of the System, not bothering to re-signify the old colonial practices that historically oppress and cover up the dignity of the other.

Reinforcing this perception, in the recent context of the Covid-19 pandemic, Folha de São Paulo denounced on 03/22/2021[23], that the white population received almost twice as much vaccines against COVID-19 in relation to blacks, as they constitute the majority among priority groups: the elderly and health workers. This situation is connected to the concept of necropolitics[24], through which the State holds sovereignty to save lives, kill or let it die. Another example of institutional racism, even from healthcare professionals, was the hostility suffered by Cuban medical immigrants in 2013, in which they were "received" by their peers with curses of monkeys, slaves and other pejorative terms[25], a situation that restores the urgency of advance in the implementation of the PNSIPN.

Finally, it is necessary to understand the importance of continuing education aimed at deconstructing colonial practices, because only then will affirmative policies that minimize social inequalities in health, such as the PNSIPN, effectively be inserted in care, which in fact it has not been happening routinely in our assistance servisse.

- Non-compliance with the race-color item in the registration of users who use the SUS

PREVINE BRASIL was instituted by Ordinance nº 2979 of 11/12/2019, being effectively implemented in 2020, with the objective of qualifying PC indicators based on a new financing model, aiming at increasing people's access to the services offered and the link between population and staff. According to this Program, user enrollment is carried out through "the citizen's registration and can be done by CPF or the National Health Card (CNS) **by all members of the health team**"[26](Online) (emphasis added).

In Aracaju, since 2018, the Health Care Network has been fully computerized and the collected clinical/administrative information is stored and can be migrated to the national database (DATASUS), through the E-Gestor-AB platform. Personal data with the race-color variables, standardized by Ordinance nº 344/2017 of the MS[27], following the same epidermal matrix adopted by the IBGE, are filled in almost exclusively by Community Health Agents (ACS) or receptionists, with these two categories being the ones that most orbit around the theme of race.

The aforementioned Ordinance warns that

> Art. 1 The collection of the color item and filling in the field called race/color will be **mandatory** for professionals working in health services, in order to **respect the criterion of self-declaration of the health user**, within the standards used by the Brazilian Institute of Geography and Statistics (IBGE) and who appear in the forms of the health information systems as white, black, yellow, brown or indigenous. BR
>
> Single paragraph. **In cases where there is no responsible person**, the health professionals who provide the care will fill in the field called race/color. BR
>
> Art. 3 **It is incumbent upon the spheres of management of the Unified Health System (SUS): I - to encourage and qualify the use of institutional means or existing management tools** related to the monitoring and evaluation of the implementation of the National Policy for the Comprehensive Health of the Black Population (PNSIPN) (Online - emphasis added).

Therefore, our experience confirms the existence of silent institutional codes, possibly unreachable by the lenses that connive with the maintenance (conscious or not) of colonial practices and that directly contradict the Ordinance, creating an intermittent and bureaucratizing cycle of sanitary inequities. Ignoring racial divisions as one of the determining elements of the health-disease binomial and, consequently, of the production of statistical data that subsidize the formulation of public policies, has proved to be effective precisely because it produces the opposite effect: the accumulation of a colonial legacy bequeathed to the whiteness always expressed in better Social Determinants of Health (SDH). Here, it is worth pointing out the need to face the challenge of racialization of SUS users, considering that,

> Whiteness, like other identities in power, remain nameless. It is an absent center, an identity that is placed at the center of everything, but such centrality is not recognized as relevant, because it is presented as a synonym of human. In general, white people do not see themselves as white, but as people. Whiteness is felt as the human condition. However, it is precisely this equation that ensures that whiteness remains an identity that marks others, remaining unmarked. And believe me, there is no more privileged position than just being the norm and normality[28] (p. 17).

We are not advocating that, if registered by other professionals, especially those with university training, the legislation would be strictly obeyed. Perhaps the resistance was even greater, considering the veiled phenomenon of the narcissistic pact of whiteness21 and a graduation, in general, sheltered in the Eurocentric Enlightenment shadow. What we are trying to highlight is that: 1) the existence of the "S/I" item is an automatic invitation to disregard the data and a bait for its inaccuracy as a subsidy for the elaboration of health policies; 2) There is an urgent need for continuing education on the importance of race-color for all health professionals, including those who have precarious/outsourced/non-stable contracts and who are more subject to turnover and discontinuity of actions; 3) the breaking of this convenient conspiracy of silence will not happen without provoking driving forces, demanding the need for involvement of social movements with negotiations or tensions with the highest deliberative instance that is the Municipal Health Council.

- Preservation of symbology with slave and colonialist connotations

Institutional racism represents the collective failure of an organization to provide a professional and adequate service to people with certain group markers of color, culture, ethnic or regional origin, extrapolating interpersonal relationships. It may be present, in a more or less veiled way, in opinions, allusions and references, which promote or reinforce inequalities of disadvantaged people and ethnic minorities[29]. It should be noted that the institutional baptism of a UBS by Dona Sinhazinha, where one of the most expensive square meters in the capital is concentrated, is an explicit allusion to manorial relations typical of colonialism and slavery. It is a kind of monument that survives time, without any type of contestation, to demarcate the power of some racial groups to the detriment of others that gravitate around them as homeless users.

In this regard, we are faced with two distinct experiences: a) the discomfort generated by the possible presence of some black, barefoot, dirty bodies in the Health Unit. This scene of estrangement sometimes happens at the aforementioned UBS, in the form of imperial gazes, especially from users and white workers, translating into messages that inhibit access and permanence. However, the aggression described in this episode continued when, disregarding the priority or the clinical risk identified by the health professional, another user of the service complained, demanding "care" in the disinfection of equipment and facilities, demonstrating a certain private appropriation of a public good. In effect, where there is white there is a fence, the idea of demarcating everything came from the "man of merchandise"[30]; b) The last two workshops carried out by the Consultório na Rua (CnR) and the Harm Reduction Program (PRD) in which the health care of people living on the streets was thematized, discussed, filed, generated flowcharts, however, there were no no interweaving with the racial debate. In one of the cases, a group dynamic was carried out with a large exhibition of photos of homeless people (all black) contrasting with the phenotype of the professionals (mostly white), aligning (perhaps unconsciously) the facts with the Princess Isabel syndrome, that is, of the white saviors. The historical context and the comfort of whiteness did not pass unscathed only because our cosmovision no longer blindly subscribes to these expedientes, which cries out to be inscribed with other shades and textures.

CONCLUSION

At the "gateway" of the SUS in Aracaju, the management of affirmative action focused on the black population is still, in principle, a blank page, which cries out to be inscribed with other shades and textures. It is imperative to lift the blanket that covers this social fabric, where the inequalities of health-disease distribution are stored, disguised in institutional norms. Decoding them with new interpretive keys requires the reaffirmation and defense of those that Fanon called the condemned of the earth[31], for inhabiting a sterile and arid zone of non-being[22].

In addition to deficiencies in data collection, disinvestment in continuing education for professionals and maintenance of slavery symbols, SMS managers have demonstrated a profound lack of knowledge of the PNSIPN or apathetic behavior that largely cooperate with the complete emptying of the Policy. Walking in this direction, we run the risk of characterizing the PNSIPN much more as a negative action than an effectively affirmative action. It is exactly its opposite that seems to be in vogue, as the colonial heritage and the health advantages bequeathed by whiteness seem to be being reinforced without interdiction or fuss, imposing the investigation and dissemination of situations such as those problematized here.

Finally, it is necessary to encourage political mobilization for the abolition of racist institutional conduct, enabling the implementation of compensatory actions that restore human dignity not as an attribute of the few, but as a right of all. Deconstructing the colonial mentality that organizes and structures our country is an urgent need.

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