Reflections on the collection of the issue of race/color in the Basic Care (SUS) in the south of Brazil

Reflexões sobre a coleta do quesito raça/cor na Atenção Básica (SUS) no Sul do Brasil

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Abstract

This article analyzes the form and effects of collecting information on race/color in the research "Racism, knowledge-power relations and psychological suffering". The research was carried out in a partnership between the Federal Universities of Rio Grande do Sul and Pelotas and the Municipal Health Departments of Porto Alegre and Pelotas, focused on the Basic Care of the Unified Health System (SUS). This is a research developed in conjunction with health professionals. The theoretical-methodological framework is based on social psychology and research-intervention. In total, 580 users were interviewed, and 11 focus groups were held with users and health professionals. The results show that 53% of the interviewed users declared themselves as black, corroborating other studies that demonstrate that SUS' users are mostly black. In the analysis of the focus groups, we identified three main aspects: (1) there is a difficulty in asking/ answering the racial self-declaration; (2) racism is expressed in the collection of information on race/ color; (3) health professionals find it difficult to recognize the usefulness of the race/color item for health practices. Thus, it is necessary to strengthen continuous education practices on the relation between racism and health.

Keywords: Racism; African Continental Ancestry Group; Primary Health Care.

Resumo

Este artigo analisa a forma e os efeitos da coleta do quesito raça/cor na pesquisa "Racismo, relações de saber-poder e sofrimento psíquico". A pesquisa foi realizada em uma parceria entre as Universidades Federais do Rio Grande do Sul e de Pelotas e as Secretarias Municipais de Saúde de Porto Alegre e de Pelotas, com foco na Atenção Básica do Sistema Único de Saúde (SUS). Trata-se de uma pesquisa elaborada em conjunto com profissionais da rede. O referencial teórico-metodológico se sustenta na psicologia social e na pesquisa-intervenção. Foram entrevistados(as) 580 usuários(as) e realizados 11 grupos focais com usuários(as) e profissionais da saúde. Os resultados apontam que 53% dos(as) usuários(as) entrevistados(as) se autodeclararam negros(as), corroborando outros estudos que demonstram que os(as) usuários(as) do SUS são majoritariamente negros(as). Na análise dos grupos focais, identificamos três aspectos principais: (1) existe a dificuldade em perguntar/responder a autodeclaração racial; (2) o racismo se expressa na coleta do quesito raça/cor; (3) os(as) profissionais de saúde têm dificuldade em reconhecer a utilidade do quesito raça/cor. Assim, é preciso fortalecer as práticas de educação continuada sobre as relações entre racismo e saúde.

Palavras-chave: Raça/Cor; Racismo; Atenção Básica.

Introduction

The issue of race/color in health is a central theme for confronting racism, as it is based on the racial disaggregation of epidemiological information that one can visualize and analyze inequities in health. Therefore, this issue is present in the regulations of public policies, public health and health service practices. Within the scope of scientific production in health sciences, the theme still needs to be incorporated. Even in the field of care practices in the Basic Care of the Unified Health System (SUS), this effective incorporation has not taken place either (Sacramento; Nascimento, 2011), which can be observed in the National Comprehensive Health Policy for the Black Population (PNSIPN), which has encountered difficulties in its implementation.

A recent study shows that only from 2008 onwards there was a greater publication of Brazilian articles on this topic (Kabad; Bastos; Santos, 2012). This increase in research is related to the recent historical period of achievements of the black movement, driven by the III World Conference against Racism, in Durban, South Africa, in 2001. Even with the increase in academic research and the continuity of racial inequities in statistical analyzes disaggregated by race/color, the findings continue to be read and interpreted as if they were a mere accident in the trajectory of black people (Werneck, 2016).

In Porto Alegre, the highest rates of maternal mortality, external causes, accidents and violence are reserved for the black population (Porto Alegre, 2018). Thus, we intend to contribute to the theme of race/color, reaffirming its importance in the fight against racism as a social determination in health. This article is the result of the research "Racism, knowledge relations and psychological suffering" (CNPQ 2015-2018), which was carried out in a partnership between the Universidade Federal do Rio Grande do Sul, the Universidade Federal de Pelotas and the Municipal Health Departments of Porto Alegre and of Pelotas. Along this path of exchanges and experiences with SUS health professionals, we followed the change in the municipal, state and federal

governments. We experienced, collectively, the difficulties of continuing the research, as changes in management imposed new negotiations and authorizations. In addition, we witness the uncertainties, sadness and anguish of health professionals, as the perspective of Basic Care was being changed to that of Primary Care, impacting on care practices and on the work itself.

The shift in perspective from the principles of SUS (Basic Care) to a more epidemiological model, with a North American aspect (Primary Care) produces a disengagement from the principles of equity and integrality of the Health Reform in Latin America (Giovanella; Franco; Almeida, 2020). In addition, Basic Care proposes the work of prevention and health promotion through a set of individual, collective and family health actions (Brasil, 2018). In this perspective, the Family Health Strategy, with its activities in the territories and strengthening ties with the community, increased the promotion of care strategies for the black population.

In September 2019, the Municipal Institute of Family Health Strategy (IMESF) of Porto Alegre, a public foundation under private law responsible for Basic Care, was extinguished (Hamerski, 2018). This occurrence was the result of a long legal dispute over the legitimacy for implementing the public health policy, which resulted in the resignation of many professionals and actions disarticulation of Basic Care and Community Health Agents (CMS, 2020). The consequences have not yet been measured, but they certainly affect the black population, mostly users of the SUS, to a greater extent. It was in this context of losses that the university-health services collective constructed and worked for the elaboration of this article.

It is worth noting that the state capital was a pioneer in the implementation of the PNSIPN guidelines, starting in 2012 the Curso de Promotor@s da Saúde da População Negra[1] (Health Promoters Course for the Black Population). As a permanent education action, the course seeks to prepare health workers and the community to face institutional racism in SUS through practices that promote the expansion of health services access for the black population (Soares et al., 2018).

In a dialogue with Public Health, we believe it is essential to include race/color in the understanding of health-disease processes, understanding that there are social determinations in health that act throughout the life cycle of people (Garbois; Sodré; Dalbello-Araujo, 2017). Since 2005, the World Health Organization has recognized the multifactorial dynamics of social, economic, political, gender/sexuality, race/ethnicity, disabilities, among many others, that need to be considered in health care. However, academic qualification in health areas continues to favor a biomedical training, based on the concept of universal subject, with a focus on biological aspects (Amoretti, 2005).

In this way, race relations are still made invisible by those who wear white coats. In denying the inequalities in the knowledge-power relations between white and black people, university-educated health professionals, mostly white people, believe they do not condone racism, as they consciously claim not to differentiate users. The statement "I treat everyone the same" is an affirmation gathered numerous times in our field diaries, as well as in the work experiences of these authors.

Despite what has been stated, this belief in equal treatment and care for users is a fallacy in many respects. Interpersonal relationships are never neutral, as we are constituted in a subjectivity production crossed by countless knowledge-power relations and different affects, which will be activated in the professional-user encounter. Aligned to this, the myth of racial democracy (Guimarães, 2006) still sustains the production of supposedly neutral and universal scientific knowledge, producing negligence and invisibility of racism as a social determination in health.

The very concept of racism is not something that is discussed in academic qualification (Santana et al., 2019) and racism is often understood as an explicit and individual discriminatory act, restricted

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1 Since Portuguese is not a gender-neutral language, the use of the @ symbol in the course title was chosen by the SMS racial equity management to clarify its alignment with an inclusive and anti-sexist language.

to the field of morality. We oppose to this idea the definition of racism in its symbolic and material dimension of instituted racial relations. Racism understood as a social structure that historically constituted a profound inequality in the distribution of material and symbolic resources in favor of white people (Moore, 2007). In the specific case of this article, the focus is on the way it presents itself in Brazilian society.

Since our objective is to discuss the health of the black population, we will not address the ethnicity category here, which refers to issues of origin, place/territory/country/tribe, language, customs, food and beliefs. Race and ethnicity are different concepts, but not completely separate. In this sense, when we refer to race, we are explicitly talking about colonialism and relations of domination (Rios; González-Zambrano, 2014).

In the research, we used the black category in its dimension of political identity, constructed as an affirmation by the black movement in resistance to the processes of domination (Gomes, 2011). It is worth remembering that, for the Brazilian Institute of Geography and Statistics (IBGE), self-declarations such as black and brown, together, make up the black population.

The inclusion of race/color in academic qualification is in line with national legislation (Law 10.639/2003; CNE/CP Resolution 1/2004, Law 11.645/2008). Therefore, it is necessary that health qualifications take responsibility for the study of health indicators while analyzing racial inequities and their effects on health.

According to Jurema Werneck (2016), in the field of health, biomedical training, the whiteness of health researchers, the myth of racial democracy, among other factors that hinder anti-racist practices, still prevail. The concept of "whiteness" is inscribed in studies of racial relations, pointing to the place of privilege that white people benefit from in societies (Bento, 2017).

Although Rio Grande do Sul is one of the states with the lowest percentage of black population, with 16.13% (PESQUISA, 2019), in our sample, we found that 53% of SUS' Basic Care users declare themselves as black, data that corroborates other studies on the population characteristics that uses

this service (Guibu et al., 2017). In this context, the objective of this article is to analyze the form and effects of collecting information on race/color in the research "Racism, knowledge-power relations and psychological suffering", carried out in SUS' Basic Care.

Method

It was an intervention-research (Rocha, 2006), designed and elaborated in conjunction with the service network to produce quantitative and qualitative information, in the cities of Porto Alegre and Pelotas. Intervention-research problematizes how change processes can be triggered by the encounter of knowledge from academia with the community. From the ethical point of view of research with human beings, this study was approved by Consolidated Opinion No. CAAE 44949315.3.3001.5338.

In Porto Alegre, we have the support of the Racial Equity Management of the municipality's Municipal Health Department. In Pelotas there were no specific actions for the black population, but there was a partner who helped carrying out the research. The field work took place in SUS' Basic Care. A total of 580 users were interviewed and 11 focus groups were held, with users and multidisciplinary health professionals (community health agents, nurses, nursing technicians, health surveillance professionals, doctors, dentists).

Individual interviews relied on the application of a single instrument, which contained: sociodemographic data, general health data and the Explicit Discrimination Scale (EDE – Escala de Discriminação Explícita, Bastos et al., 2012). Racial and gender/sexuality self-declaration items were asked at the end of the questionnaire, as they are social markers (Brah, 2006) that, due to being strongly crossed by power relations, triggered important affects and reflections.

The EDE consists of 18 situations of discriminatory treatment, such as being treated with contempt when trying to date someone, being unfairly evaluated in activities at work or internship and being excluded or left out by a group of friends from school/college. In each of the situations,

the respondent is asked to indicate the frequency of occurrence of the discriminatory treatment described and the reason(s) for the discriminatory treatment chosen from a list of 17 suggestions (e.g., socioeconomic status, race, age, gender and others). The average interview time with black users was around 50-60 minutes compared to 20-30 minutes with white people.

The research's target population was all users of the Health Units in the cities of Porto Alegre-RS and Pelotas-RS. Both cities have percentages around 20% of the general population self-declared as black, that is, black or brown (PESQUISA, 2019). Both cities were divided into eight and six Health Regions, respectively. The Health Units are distributed according to the Human Development Index, that is, there is more health equipment in peripheral and with greater vulnerability regions.

The sample calculation considered a proportion of the population of 0.5, to be estimated, with a confidence level of 95% and a margin of error of 0.042. We obtained a minimum size sample of 545 people. The software Winpepi version 11.37 was used in the calculation. In Porto Alegre, we covered all Health Regions, reaching 76 of the 142 Health Units (HU). In Pelotas, we did not cover all the Health Regions due to lack of resources. We reached 21 of the 51 HU in Pelotas. In the capital, the groups took place in three health regions: the south/periphery; the east/northeast/periphery and the central area. In Pelotas, the groups took place in three urban regions and in a rural area of the city.

To carry out the approach, the interviewers were trained to inform the user of the risks and benefits of the research and the items contained in the Informed Consent Form (ICF), as well how to collect the participant's signature on the respective term. The application of the questionnaire lasted between 20 and 60 minutes.

The collections took place in the waiting rooms of the Health Units. The criteria for inclusion in the research were being over 18 years old and not having mental disorders or visible changes in mental status. The user was invited to participate in a survey on "discrimination and health"; if accepted, the consent form was read, the interviewee's signature was collected, and the face-to-face questionnaire was started. If the user did not accept, another person was invited, until the goal established by the sample calculation of six interviews per HU was met. The orientation for the interviewers was to approach people of different profiles (ages, genders, races). The research teams were interracial. Studies show that race relations can interfere in the answers when the colors of the interviewed and researcher are different (Bastos et al., 2009).

Thus, we constructed an introductory text before the question about racial self-declaration. **Chart 1** shows how the race/color item was used in this research.

Chart 1

RACE/COLOR ASPECT
Finally, we would like to talk to you about the importance of some information on public policy forms. For Brazilian society, in order to face the harm caused to the health of the black population, as well as the inequalities and discrimination rates that affect this population, it is essential to make people's racial and ethnic self-declaration visible. Therefore, we want to know how you self-declare in this regard. In your opinion, what is your race or color? ( ) White ( ) Black ( ) Brown ( ) Yellow ( ) Indigenous

Note: Information taken from the questionnaire applied to the interviewees, prepared by the authors. The bibliographic reference is hidden by the confidentiality of the article's authorship.

Focus groups were used due to their power to provide exchange of collective experiences and discussions, which are difficult to emerge in individual interviews (Trad, 2009). These groups took place in the selected Health Units, with a single meeting, due to the difficulty of releasing the professionals aiming for their participation, as well as the difficulty in organizing the participation of the users. In Porto Alegre, the conduct of the focus groups was mediated by a researcher, and, in Pelotas, the mediation was carried out by two researchers. On average, the groups lasted one hour, with an average participation of nine

people. Discourse Analysis was used because of its power to analyze language as a system, in which the constructed meanings are socio-historically inscribed in knowledge-power relations (Damico, 2006). In the analysis, we selected the focus group wordings in which the race/color theme emerged. Afterwards, we identify the main aspects of the debate, which will be discussed in the results.

The NVIVO 12 tool was used to organize and analyze the focus groups. The names of the people who participated in the groups were replaced by the names of white and black intellectuals. The identification of health professional or user and city was made. Health regions were omitted to preserve the confidentiality of participants.

Results and discussion

As already stated, 580 users responded to the questionnaire, with 53% self-declared black, only 1.8% self-declared indigenous and 0.4% yellow. Thus, indigenous and yellow self-declarations were excluded, and we analyzed only white and black populations. The majority (79.8%) were women and the personal income of 83.6% was a maximum of 2 minimum wages (Silveira et al., 2018).

As previously reported, studies show that the national profile of Basic Care users is mostly black (Guibu et al., 2017). This is a situation resulting from the profound economic inequality to which the black population has been relegated. Racism has articulated race/color with social class in such a way that poverty remains concentrated in people of color, whether black or indigenous. Thus, with less material and economic resources, these populations live in the most vulnerable places in urban centers. As equity is one of the basic principles of SUS, public health management has distributed a greater number of health units in the most vulnerable territories, which have a higher concentration of black population.

Associated to this, the result found of 53% of black Basic Care users in the capital and Pelotas reflects the increase in self-declaration of the black population, which may be an effect of public policies and black social movements (Alves; Jesus; Diaz, 2017). In Porto Alegre, there

was a strong performance of more than 600 Health Promoters of the Black Population, which develop several actions to promote the health of this group in Basic Care, from conversation circles, lectures, fairs and celebrations during the Black Awareness Week (Soares et. al, 2018). At the same time, the new generation of the black movement has had a strong role in the dissemination of black content. The power of social media and the increased insertion of black students through racial quotas in universities produced significant changes in the production of knowledge and in the construction of black identities. We often witness the pride of self-declaring as black on the part of the interviewees, especially the younger ones. In one of the focus groups, we found the following report from a health professional:

> *When I finished the course (Health Promoters for the Black Population), I went to study race/color in a family. The family was a black family. But, a girl, she was black with straight hair, and the grandmother explained her point of view, then the girl responded saying: "No, I consider myself black", her grandmother said: "No, no, you're not black, you are white". I kept looking. She said: "No, grandma, I'm black".* (Patrícia, 57 years old, black, health professional from Porto Alegre).

This speech points to the complexity of racial relations in Brazil, as the whitening processes and interracial relations produced a "mixed race" nation that makes the recognition of black identity difficult. Currently, the term "colorism" has been used to reflect on the color prejudice that persists in our society and more violently harms dark-skinned black people (Francisco, 2018).

Despite the achievements of the black movement and public policies for racial equity, the race/color information collection is still a sensitive issue. The questionnaire used was long and the response time varied, mainly due to the race/color of the person interviewed. The questions began with socio-demographic data, went through health issues and, finally, reached the situations of experienced discrimination. White people responded more quickly to the questionnaire, while black people

took longer, as they reported more experiences of discrimination and racism.

It should be noted that the EDE was initially built to make the specifics of "Brazilian racism" visible, however, it opens the possibility for the person to identify many variables in the experienced discrimination, from issues of class, gender, disability, etc. Thus, many white users of SUS identified situations of discrimination due to the condition of poverty. The black population interviewed, on the other hand, always identified race as one of the main causes of discrimination, followed by class issues. The frequency of discrimination situations was higher among black people than among white people (Silveira et al., 2018).

During interviews, it was common for black people to tell their stories of racial discrimination, causing the interviews to lengthen. We read the introduction of the race/color information collection, explaining to the person what this information means for public policy. Certainly, the interview experience mobilized memories of racism suffered and allied to this, a large part of the interviewers was black, which allowed for identification and complicity at the time of collection. Our team, especially black students, often left the field with concerns and feelings of sadness, as they witnessed the dimension of racism in the lives of users of SUS and recognized themselves in the same situations.

The focus groups in the two cities showed differences in relation to race/color, with greater visibility in the city of Porto Alegre. We understand that the absence of actions related to the PNSIPN in Pelotas minimized its importance in the groups. We identified three main aspects about race/color in the analysis of the focus groups: (1) that there is difficulty in asking/answering the racial self-declaration; (2) that racism expresses itself in the whitening process of the population in relation to the race/color item; (3) that health professionals find it difficult to recognize the usefulness of the race/color item.

The first aspect that emerged was the difficulty in the process of asking about race/color, both for the questioner and the answerer.

So... So much for the patient, who also when they get there, when they ask: – "What's your color?" – "Put whatever you want". They have that difficulty of saying "But it's self-declared". – "What do you think I am? Can't you see?". Then, that violence comes, and sometimes it comes from the employees themselves, as well as from the user as well. Sometimes, you are also embarrassed, and you do not ask, even because of the aggression they portray. – "What color do you think I am? Can't you see? Why are you asking this?". (Carolina, 42 years old, black, health professional from Porto Alegre)

The expressions "Can't you see? Put whatever you want" were recurrent in the speeches in the groups. This speech illustrates the difficulty we have to explain racial classifications. On the one hand, we have the training of health professionals, mostly, in the biomedical model, in which the social determinations of health are minimized. On the other hand, Brazilian racism produced dehumanization and exclusion of the black population in all spheres of society. The myth of racial democracy is a mark of the uniqueness of our racist history, in which the silence about race and color supports the discourse that "we are all equal".

We found in the group discussions with the professionals that the discomfort on asking about race/color is evident when the person questioned is black. In the case of the white user, the conflict does not appear. Feelings of violence, aggression, fear and shame surface when issues that evoke racism emerge. Questioning about race/color turns into a conflict with black people, as it explains a hierarchy between whites and blacks. Saying the black race/color prevents it from being silenced.

We have profound inequities in our lives, in our society, which emerge in language (Fanon, 2008). In group discussions, expressions such as "*negrinha*" (little black girl) and "*moreninha*" (little brown girl) appear, explaining the supposed superiority of the "white/adult" in relation to the "black/child". The use of the diminutive to infantilize the black person has been the object of analysis on the impacts of racism on the subjectivity production.

When the person wants to say that black woman, they will say "that little black girl" or "that little brown girl". Then it ends with the person's blackness, because if you call yourself "brown/tanned girl" I say, but is she white or black? But you are not black. And I ask, what do you mean? There is a person who is darker. And then there is that perception that we see a lot. (Jurema, 55 years old, black, health professional from Pelotas)

The person is afraid to say why they think they will offend the black person. (Neusa, 38 years old, black, health professional from Pelotas)

Cuti[2] (2017) analyzes the fear that white society has of using the word black, because, when pronouncing it, all the perversity of our slaveholding past and the abandonment of the black population emerges. Recognizing racial inequities is destabilizing for the denial of racism and the ideology of meritocracy that constitutes us as a society. As previously mentioned, the process of whitening and miscegenation in Brazil has produced a rupture in the identities of the black population. Unlike the legal racial segregation in the USA, where skin tone did not differentiate the black population from each other, in Brazil, the further away from black skin, the greater the probability of acceptance in society. This author points out the issue of the psychological suffering that the denial of racial identity produces in the black population.

The second aspect that we highlight is that racism is expressed in the whitening process of the population when asking about race/color. Brazil promoted a public policy on European immigration with the aim of whitening the Brazilian population (Schwarcz, 1994). Parallel to this, the discourses of valuing European culture, of the phenotypic traits of white people as a synonym for beauty and humanity, produced feelings of inferiority and dehumanization in the black population. One of the expressions of this process appeared in the professionals' reports on situations in which race/color was asked, in which there is a disagreement between the user's self-declaration and the professional's perception.

But it has that function, when we get to the family, we have a record, we have the question "What color the person is?". I often see that the person is black, but the person does not self-declare as black… I have already asked people their color and they say to me: – "I am the color you are seeing". I am seeing one thing, but they think another. You ask a person with lighter skin tone, the whole family is black, but they think they are white, then you have to put what the person thinks… (Angela, 42 years old, black, health professional from Pelotas)

The lack of reflection on the whitening phenomenon generates yet another racial violence, as it pushes whitening to the individual level, as if it were just a problem in the user's self-image. This situation could be used as information to be worked on from the perspective of comprehensiveness in health. What effects does this whitening have on the black population? What is the psychological cost of this whitening? Which actors and actresses in the community can be called upon to act in the strengthening of black identities?

Another element present in the moments when questioning race/color is the violence of whitening by the workers who ask.

Nowadays, I think, they do not even put it like that, when you go to a place: – "What color are you?". Then you put the color you want. I thought it was cool! If I want to put that I am white, I am white! […] No… But then I put my color on! But the person today, for example, the person chooses. It is already said like this: – "You put the color you want there, it is you who decide the color that your son is, which color you think your son is". Then I looked at the woman at the notary office, when I went to register my little one… When I had my two older ones it was not like that […]. – "Is it you who is saying that he is black? So, you put black, but actually he is not

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black". I said "No, he's black". (Virginia, 39 years old, black, health professional from Porto Alegre)

In this tension-filled speech, at first, the user is happy with the possibility of answering "whatever she wants", thus being able to assume responsibility for her own identity. When registering her child, however, there is an attempt by the attendant to deny the child's color. The mother is obliged to impose herself in order to guarantee the correct registration of her own child. The professional's manifestation of expressing the desire for whitening the child is noteworthy, inscribed in the whitening ideal in the Brazilian State. The excerpt above addresses a family with interracial traits, in which one of the children has a slightly lighter skin than the siblings, having been classified as white by the professional. However, the mother recognizes that he does not cease to be black, as well as the rest of his family, in this way, this mother guaranteed the registration of the child as black. This is an interesting case for thinking about the right of self-declaration. If it were not guaranteed, perhaps the child would have been registered in another way.

The third point that emerged is that health professionals find it difficult to recognize the usefulness of asking race/color. What is this information for? Will it be used for effective actions for the population?

In the professional groups in Porto Alegre, this question about the usefulness of asking race/color appeared in two dimensions. The first one, recognizing that before the course on Health Promoters for the Black Population, started in 2012, they had no knowledge of the meaning of asking a person's race/color. It was an information collected only out of obligation, when it was collected.

[...] *we went through a lot of work in relation to this because the patients arrived furious: - "Can't you see what color I am?". - "Yes, we need to know to write it down". - "Why do you want to know this for?". Look, I confess, I said like this: - "I do not know. I'm just asking because it's in the questionnaire".* (Lélia, 35 years old, black, health professional from Porto Alegre)

On the other hand, currently, they are aware of the importance in Porto Alegre, however, they do not perceive any feedback from the management on the work of collecting information on race/color. These professionals recognize a flaw, as adequate information is not produced for the service to be performed by the professionals, nor is information passed on to users. Analyzes disaggregated by race/color have not been produced to guide public policies for the black population, according to the interviewees.

How many black men do we attend, how many white women? We do not have the information, even to see if we are managing to achieve it. (Simone, 55 years old, black, health professional from Porto Alegre)

You fill it and there is no feedback (regarding asking about race/color), we would like to have a feedback from the responsible body, that a black woman has this, has that... Why not? We have no feedback for anything, to tell you the truth. (Edith, 60 years old, white, health professional from Porto Alegre)

If these actions were carried out, the interviewees believe that the information would have a meaning in health practices and filling in the medical record data could be better performed, in addition, it would raise the awareness of a greater number of health professionals. In the city of Pelotas, training on the PNSIPN and the questioning of race/color is still incipient.

Final remarks

The route taken so far reinforces the importance of qualifying the information collection of race/color, producing epidemiological data disaggregated by race/color. This theoretical-political stance contributes to confronting racism as a social determination in health, as it provides visibility to racial inequities. In this way, strategies for health promotion, prevention and health care for the black population can be outlined based on health indicators. In the qualification field, it

is essential that curriculum addresses the issue of racism in health, encouraging reflections on professional practices to confront it. In Basic Care, it would be important to plan actions and goals to improve racial inequities in health indicators, for example, with monitoring and indication of the participation of black users in different health promotion groups. In addition, it would be important to disseminate the Health Promoters Course for the Black Population (or similar activity) to other regions of Brazil, with the incorporation of promoters in the areas of management and monitoring of black population's health in their regions. We believe it is important to strengthen the continuous education practices for health professionals about the black population as a way of confronting racism in health.

To conclude, we note that the field of this research, the SUS' Basic Care, is inserted in a confrontational environment, with an exponential increase in the demand for health services and a reduction of investments of all kinds (financial and structural) (Hamerski, 2018). This reality can make it impossible to collect appropriate information on race/color. This production and reproduction of racial inequalities imply high subjective and social costs for the black population, requiring the incorporation of debate in academic qualification in the area of health and a stimulus to scientific production. It is noteworthy that the Primary Care proposal, combined with the dismantling of the IMESF and the privatization of the contracting of human resources, dismantles all the work invested in permanent education with the Health Promoters of the Black Population and other professionals who were in the process of qualification related to the theme of black population health.

The results of this research will continue to be analyzed and published in order to contribute to the fight against racism and its deleterious effects on the black population.

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