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STRUCTURAL RACISM IN HEALTH CARE FOR BLACK IMMIGRANTS DURING THE COVID-19 PANDEMIC IN BRAZIL

ABSTRACT

Introduction: The black population in Brazil was the most severely affected by the COVID-19 pandemic, both in terms of incidence and the lethality of the disease. Structural racism presents significant barriers to access to healthcare services for the black immigrant population. There is a lack of information regarding how structural racism impacted access, welcoming, and healthcare practices for black immigrants during the COVID-19 pandemic. **Goals and Methods:** This study aimed to identify how healthcare professionals received and provided care to black immigrants who sought healthcare during the COVID-19 pandemic. It employed qualitative exploratory and descriptive research, utilizing the conceptual framework of structural racism. Data was collected between October 2020 and January 2021 through semi-structured interviews with a script created by the researchers. Twenty-one professionals from the multidisciplinary health team in ten Primary Health Care Units in a southern Brazilian city participated. The statements were audio-recorded, transcribed, and subjected to content analysis with the support of MaxQDA software®. **Results:** Two empirical categories emerged from the analysis: structural racism concealed in the discourse of health professionals; and structural racism as a social determinant and its impact on the health of the black immigrant population. **Final Considerations:** The study highlighted that racial and social issues exacerbate the health condition of the black immigrant population. Thus, health professionals need awareness regarding how structural racism determines access to healthcare for the black immigrant population. Therefore, the promotion of training focused on recognizing the impact of structural racism on the health of this population is an essential step in countering the trivialization of the topic and promoting anti-racist actions.

Keywords
COVID-19; Immigrants; Black people; Access to Health Services; Structural Racism.

1. Introduction

The exploitation and enslavement of the black population throughout history have remnants and consequences today, especially in the perpetuation of historical mortality patterns that are often veiled in society. However, the COVID-19 pandemic has exposed data highlighting social, socio-economic, and structural disparities.

An American study calculated the transmission rate of COVID-19, considering any monetary compensation paid to the African-American descendants of enslaved people in Louisiana, United States. This study pointed out that if this payment had been implemented before the pandemic event, its effects on the health of the black population would have been different, including a lower mortality rate, probably due to the opportunities to reduce some factors, such as: better housing conditions; less exposure to risk situations; access to the use of preventive measures. The same study showed a COVID-19 mortality rate up to seven times higher in the black population compared to the white population, considering that the inadequate payment of compensation had an impact on this rate (Richardson et al., 2021).

In Brazil, during the COVID-19 pandemic, a survey identified the profile of patients admitted to the Intensive Care Unit (ICU). It showed that 71.10% of patients were black and that 77.36% of them faced a higher probability of death compared to white patients (França et al., 2021). According to Almeida (2021), race is a determining factor of vulnerability in our society since the state is built on policies of exclusion and the identification of bodies that are useful and those that are discarded.

Another example of these exclusionary policies, often adopted by several countries, was the failure to identify on the notification form the nationality of the population that became infected with the virus or died from COVID-19. The literature has shown this to be the case in countries with large immigrant populations, such as Canada (Choi et al., 2020), the United States (Richardson et al., 2021) and Brazil (Souza et al., 2020). When it occurred, the expression used for this identification focused on the terms white or black race without considering the specific vulnerabilities related to the immigrant's condition.

Regarding the importance of identifying race in health care records, it should be noted that many chronic diseases are more prevalent in black and brown people than in white people, including Diabetes Mellitus (DM) and Hypertension (HA). These diseases, combined with other factors, have become risks for the worsening of COVID-19 during the pandemic. From this perspective, it is not appropriate to establish a care policy without knowledge of the social determinants of health. Without this knowledge, it is impossible to plan comprehensive care and guarantee the principle of comprehensive health care. Furthermore, disregarding these determinants creates a risk for vulnerable populations, including the black immigrant population (Santos et al., 2020).

In Brazil, access to health services is guaranteed to everyone by the legislation and policies of the Unified Health System (SUS), from primary care services to hospitals.

However, the black immigrant population faces barriers such as xenophobia and racism (Moraes, Araújo & Camargo, 2023) built with historical reflection and appropriated by the culture of their people. It is up to health professionals to identify the vulnerabilities and social determinants that lead individuals to seek health services, using the principles of the SUS, as these indicate that care should be provided in a universal, comprehensive, and equitable manner.

Equity is a principle that must be worked on to promote critical reflection. Social problematization must be built daily among team members, especially among Primary Health Care nurses (PHC). The practice of discussions tends to instigate reflections and the best ways to build unequal care for the unequal. Public policies have been drawn up with this intention, including the National Policy for the Comprehensive Health of the Black Population, which suggests welcoming as an access strategy. However, its applicability depends not only on its existence as a protocol but also on professionals who are aware of its recognition and are interested in breaking paradigms (Maisa et al., 2021).

Considering the context previously discussed, we established this study's research question: How does the perception of health professionals influence the management of actions carried out in PHC for black immigrants during the COVID-19 pandemic? This research aimed to identify how health professionals welcomed and attended to black immigrants who sought health care during the COVID-19 pandemic.

2. Methodology

Exploratory and descriptive qualitative study. This research was based on the theoretical perspective of structural racism, which seeks to understand how aspects of race and racism impact social construction. Considering this theoretical perspective, the aim is to understand how the historical processes of slavery and colonialism still reverberate in social sectors and how they can have an impact on the health of the black population. It is necessary to understand that racism is essentially structural, serving as an organizing element of society's economic and political logic. The maintenance of this structure is configured as a normative expression that underpins inequalities, permeating adjustments to practices of exclusion and violence (Almeida, 2021).

Data was collected between October 2020 and January 2021 through semi-structured interviews using a script developed by the researchers. Twenty-one professionals from the multi-professional health team of ten Basic Health Units (UBS) in a municipality in southern Brazil took part. These professionals were recruited by contacting the managers of each selected BHU, and from there, the available professionals were approached. The scenarios were defined based on a previous survey by the researchers on which territories received the most black immigrants in the municipality under investigation.

The interviewees were identified according to their work category: three community agents (AC 01, AC 02, AC 03), two nursing assistants (AE 01, AE 02), two oral health assistants/technicians (AS 01, AS 02), three nursing technicians (TE 01, TE 02, TE 03), two dentists (DE 01, DE 02), five nurses (EN 01, EN 02, EN 03, EN 04, EN 05), and four doctors (ME 01, ME 02, ME 03, ME 04).

The inclusion criteria were defined as professionals working in PHC in the UBS of the municipality of Curitiba, serving the black immigrant population. The exclusion criteria were professionals on vacation or leave during the data collection period. The testimonies were audio-recorded and fully transcribed.

For the analysis, we adopted Content Analysis. This technique aims to identify the main points of meaning present in the research and is composed of the steps: 1) pré-analysis; 2)

exploration of the material, categorization or coding; 3) processing of results, inferences, and interpretation. This type of analysis is intrinsically linked to the topic in question, giving rise to units of meaning of varying length, according to the rule for cutting out meaning in line with the specific interests of the analysis (BARDIN, 2016).

MaxQDA software® supported data analysis. This software was chosen because it lends credibility to the research approach. We explored the empirical material with MaxQDA® support in the first coding cycle. In the second coding cycle, we refined the codes and added new codes. The integration of the analysis process took place through the Question-Themes-Theories (QTT) resource, which made the empirical categories emerge.

The interviews were carried out after approval by the ethics committee and complied with Resolution 466/2012 of the National Health Council of Brazil. In 2020, the research was approved by the Research Ethics Committee of the Health Sciences Sector of the Federal University of Paraná (UFPR), under number 4.216.553, and by the Municipal Health Department (SMS), under number 4.251.498.

3. Results

The professional category with the most extended service period in the current Basic Health Unit (BHU) was community agent, with an average of 17 years and five months, followed by a dentist, with an average of 14 years and nine months. The category with the shortest service period was doctor, with six years and one month, followed by nurse, with six years and five months.

It should be noted that although the research took place during the COVID-19 pandemic, PHC services were organized so that rapid testing and referral of the population to hospital services could be carried out. However, elective care was temporarily withheld due to the disease's high transmissibility, and the first vaccine dose had not yet been administered to the population. Even with this reorganization of PHC, it was possible to identify in the interviewees' reports other health demands presented by black immigrant users before the pandemic.

After organizing the categories with the support of the MAXQDA software® and based on the typology of content analysis, two empirical categories were highlighted: veiled structural racism in the discourse of health professionals and structural racism as a social determinant and its impact on the health of the black immigrant population.

3.1 Veiled structural racism in the discourse of health professionals

In this category, the statements highlighted the health care provided to black immigrants during the COVID-19 pandemic. In this category, no speeches were identified that pointed to a racist discourse. Still, aspects were identified that denote the existence of veiled racism in the participants' speeches, for example, when professionals classified the care provided as normal, with the term *normal* being used to signal that there is no discrimination against black immigrants and that the care provided is the same for all service users.

> "Look, they get normal care, regardless of whether they are immigrants, but they have rights to the SUS, to equal care at the unit." [AU3]
>
> "No... As far as I know, all types of races come. There's no discrimination or anything." [AC 02]

In addition, the racism that guides certain practices was perceived when the professionals seemed to feel the need to reinforce that the principle of equality underpins their professional actions and that what guides the issues of care and reception is the demand that exists in the service.

> "We didn't see them as blacks or immigrants. They're people, you know? It's difficult for us to talk like this because we treat them the same as everyone else. I treat them the same as everyone else. It doesn't matter to me if they're white, black, or yellow; there's not much like that. We have those who are always here" [EN 01].
>
> "Oh, like any other patient, it's not any different to the others because the demand, you depend on the demand; if the patient needs something better, in some situations that need guidance, the unit is always providing the service. There's usually social assistance, a nurse, and the whole team helping everyone."[ME 03]

Other statements revealed that during the reception of black immigrants, some professionals were positively surprised by the fact that these immigrants had good hygiene, thus breaking a pejorative stereotype about the black race.

> "[...] this is an exciting thing that they are cautious with their health, they look for, same as everyone else, it doesn't matter to me if they're white, black, they bring their children, sometimes the babies come all dressed up like this, they ... the mothers are cautious, and we provide a service as we do for everyone..." [...] They... they come very clean, very well dressed, very well looked after, we notice that they take a lot of care, they... some of them already speak Portuguese very well, so..." [DE 01]

> '[...] I found that the dentition compared to ours in Brazil, in the interior of Paraná itself or the interior of Brazil as a whole, is much better, it's much better. They take more care! That's right. More care, in terms of personal hygiene and everything, the Haitians are perfect, you know? The Venezuelans, too. [AS 01]

3.2 Structural racism as a social determinant and its impact on the health of the black immigrant population

Through the second category that emerged, it was possible to identify that the structural racism faced by black immigrants determines the main health needs that this population manifests when using PHC services in the scenario investigated. These needs are expressed in the demands for dental consultations, women's health consultations, especially gynecology and prenatal consultations, and pediatric consultations. In addition, the health problems prevalent in this population are related to their way of life and social organization and refer to respiratory diseases, sexually transmitted infections (STIs), severe arterial hypertension (SAH), diabetes mellitus (DM), and obesity. It was noteworthy that the professionals perceive that the social vulnerability that characterizes the group of black immigrants living in the municipality investigated is a determining factor in the expression of their health conditions and access to resolving these problems.

> "Oh, they bring a lot of sexually transmitted diseases, something like that... they have many problems, women especially have a lot of gynecological complaints, you know gynecological, you know?" [AE 01]

> "...they put on much weight like that? Then sometimes they get hypertension, we've picked up some people with diabetes, a device is provided, we monitor them, they come, they have their BP (Blood Pressure) checked...everything." [EN 01]

Despite these perceived needs, access to health services by the black immigrant population is often hampered and impacted by barriers, such as ignorance of the right to health.

For the professionals, the primary access is through women who come directly to the unit for prenatal care, as shown below:

> "Yeah, we had a pregnant patient, right? Who had a toothache..." [AS 01]
>
> "The most common cases that appear here are either respiratory symptoms or pregnant Haitians; it would be more gynecology and pediatrics" [EN 02].
>
> "[...], but she had HIV, and she discovered it during pregnancy ..." [ME 02]
>
> "[...] to the unit, I think it was because of the prenatal care" [DE 02]
>
> "...what I know is that they come a lot by direct search, so people know that there's a prenatal service and since they're already pregnant, they end up coming, right" [ME 02].

When black immigrants access the service, the professionals explain that they are guaranteed health rights because they are on Brazilian soil. The dissemination of this information is often responsible for increasing the direct search for health services by other members of the immigrant group.

> "There's even a case of a family who are all diabetics and who are being treated as adults, children, and pre-teens. So, the approach is the same: they have the same rights as Brazilians; they go for consultations, monitoring, and everything. They continue to be monitored with routine consultations and everything else." [TE 03]
>
> "I had one who came, a Haitian couple, who came from Haiti, and they arrived here with difficulties that they had... they arrived without a job, so they came here to be taken care of. They arrived without a job, without anything, so they came here to be looked after..." [AC 01]

4. Discussion

When discussing the issue of the reception and care of the black immigrant population in PHC services from the perspective of structural racism, it is imperative to recognize that the impacts of the years of colonization continue to feed the machinery of social exclusion daily, segregating spaces of belonging based purely on the identification of the black body. Individuals are constantly identified by the bodies they inhabit, as is the case with the differentiation between female and male bodies and between white and black bodies.

In this way, bodies carry with them marks that are discernible through the historical processes that have shaped behavior in the realm of the social subjective.

The normalization of "equals" was presented in the interviewees' discourse. Although it carries a sense of equity in health care, it makes identity and the historicity of the representation of the black body invisible. This common practice in society's discourse is proof of the direct relationship between the ability of institutions to assimilate or normalize the influence of structural racism on all individuals, as discussed by Almeida (2020). Within this context, bodily identities are not uniform and carry significant classification marks. Therefore, the discourse that suggests universality in equal care, as expressed by the participants, suggests a perspective that neglects the existence of the black body. However, identifying a person as black will always remain present, bringing with it all its symbolic charge (Alves-Brito et al., 2020).

It is noteworthy that the racial issue is still not adequately recognized in various health and social sectors, which impacts on not having it as a social determinant and, consequently, on topics related to health in a nation like Brazil, with a history in which it was the last country to abolish slavery almost five centuries ago.

Racial injustice, because of the process of slavery and sometimes manifested through exclusion, leads to a social disparity of inequality, creating a fallacious perspective of homogenization that prevents society from realizing the persistence of racism. The ruling class in Brazil, although numerically inferior, has established norms and standards that naturalize and sometimes color the historical process, promoting a consensus on the nature of domination and other forms of racial supremacy (Almeida, 2020).

Regarding the comments that praised the hygiene of black immigrants, Kilomba (2020) says that the construction of the social imaginary of black people is directed towards places of racial isolation, segregated in conditions that are not only social but also spatial, as marginal places within the territories of the city, as places recognized as vulnerable. The aesthetics of these territories are seen as dirty, so the identification that this population maintains adequate hygiene standards is something to be admired.

A study conducted by the American Heart Association and presented by Churchwell (2020) identifies that, from the conditions resulting from the social organization of structural racism, the black population is exposed to various events such as childhood trauma, discrimination, health disparities, and inequities, prejudice, racial trauma, social determinants of health and economic position. These elements contribute to the onset of heart disease. Therefore, when discussing what health professionals can help to provide for their population, the impact of the social life of the black body within a society that produces racism always cannot be ignored.

The research highlights that black immigrant women seek out health services for prenatal care and, in the process, discover associated or existing pathologies that are naturally screened out in this condition.

It is worth noting that access barriers can have an impact on many women starting prenatal care late, and although black immigrant women seek out health services more than black immigrant men, the approach and care provided by professionals can have an impact on their decline and, consequently, on the maternal and child health of this population. Although Brazil already has policies to guarantee rights and access, there is still a structural and cultural barrier to overcome (Vieira et al., 2022).

Dias et al. (2023) points out that inequalities in access to health services, associated with socioeconomic barriers, result in significant disparities in the detection, treatment, and prevention of Sexually Transmitted Infections (STIs). The stigma related to STIs compels as food within racial stereotypes, leading to difficult access to information and health services. In contrast, racial discrimination in health systems compromises the quality of care.

Barriers can be overcome differently, but responsibility for action is shared. Everyone's individual, cultural, and specific values, and in this research, the focus on black immigrants, are barriers linked to history yet to be broken and not always mediated by professionals prepared to do so. It is necessary to implement sectoral and intersectoral actions linked to policies as support tools for understanding and establishing person-based care (Tafner et al., 2023).

The methodological limitation of this study is that the setting investigated was chosen because it is home to significant communities of black immigrants in the municipality participating in the study. Although, this may have brought the participants closer to issues related to structural racism. However, this limitation does not detract from the novelty of this research since it is an approach that has yet to be investigated in the context of the COVID-19 pandemic around the world. It also sheds light on a veiled practice that can compromise the reception and care of this population in PHC services. Throughout this study, it is relevant to note that no conflicts of interest or substantial disagreements were identified between the researchers.

5. Final considerations

The existence of structural racism in society, with its naturalized inference, impacts the provision of health services to the black immigrant population since the absence of this debate in professional training and society reflects discriminatory practices.

The homogenizing approach of equality in health care, while seeking equity, often makes the identity and history of the black population invisible, which determines the health and disease process of this population. This situation highlights the need to recognize and combat structural racism. The impacts on the health of the black immigrant population go beyond the physical aspects; they are perceived in the social segments, for example, in the spatial segregation they face in the city they live in and the psychological ones resulting from traumatic events of discrimination. These findings point to the importance of considering the social dimension of the existence of structural racism as a determinant of the health of the black immigrant population.

Intersectoral movements and actions are needed to promote efficient, effective, and individual-centered care, especially for black immigrants.

The study highlights the importance of recognizing racism as part of the social structure and seeking to overcome it with anti-racist practices. Historical inequalities persist, highlighting the need for anti-racist policies and education to promote fair and equal coexistence between black and white populations to build a more equitable future.

This research underscores the critical role of health rights knowledge among the population. For the participants, the absence of this knowledge significantly hampers their access to services and the quality of care they receive from professionals.

It is noteworthy that the use of the MaxQDA® software presented a rapid separation of information during data processing, which allowed the researcher more time for analysis. Scientific rigor also generated the promotion of quality knowledge and social impact and required qualitative research.

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