

## Racial Discrimination in Access to Health: The Brazilian Experience

*Daniela Ikawa\* & Laura Mattar\*\**

### I. INTRODUCTION

The Brazilian version of race is quite different from the American version. In Brazil, blacks<sup>1</sup> account for almost half of the population, while they are only a little more than one tenth of the United States population. Racial discrimination in Brazil is based on phenotype and not on ancestry. De jure discrimination (although not de facto discrimination) has been banned in Brazil practically since the end of slavery in 1888.

However, even among these differences, we do find some similarities between the two social constructions of racism. Both societies have supported slavery; both have discriminated against blacks and other colored people; and both have attempted to avoid guilt and

---

\* Daniela Ikawa is a Brazilian lawyer with an L.L.M. from Columbia University (U.S.) and a Ph.D. from the University of São Paulo Law School—U.S.P. (Braz.). Her Ph.D. thesis on racially-based affirmative action was published in 2008 in Brazil. DANIELA IKAWA, AÇÕES AFIRMATIVAS EM UNIVERSIDADES (2008). Ikawa is a legal officer at the Public Interest Law Institute in New York, co-managing editor of the *Sur International Journal on Human Rights*, see [www.surjournal.org](http://www.surjournal.org), and a consultant for a project on black women's right to health, which is sponsored by Conectas Human Rights and Geledes in Brazil. Over the last eight years, Ikawa has created a human rights clinic, worked as the coordinator for a human rights fellowship program for Angola and Mozambique, and taught International Human Rights Law in Brazilian universities, graduate schools, and civil society organizations. Ikawa has published papers and organized books on racial equality, women's rights, rights of indigenous peoples, security and human rights, international criminal tribunals, the Inter-American System, and judicial discretion. Ikawa has recently collaborated on a report regarding racial discrimination in Latin America, requested by the UNHCHR.

\*\* Laura Davis Mattar is a Brazilian lawyer with an L.L.M. from Sussex University (U.K.). She is also a Ph.D. candidate at the Public Health School of the University of São Paulo (Braz.). Mattar coordinates the program on black women's right to health and the Human Rights Fellowship Program for Angola, Mozambique, Guinea-Bissau, and Cape Verde at Conectas Human Rights. Mattar wrote Part III, sections A1 and B2 of this Article, which discuss the description of the unified national health system and the two policies regarding the consideration of color in the provision of health services.

1. "Blacks" in this article encompass both blacks and browns, unless explicitly stated otherwise.

responsibility for past and existing forms of racial discrimination. To a certain extent, both countries have succeeded in doing so.

The choices to address current resistance against discrimination remedies from both government and civil society will depend on the way laws, ideologies, and social context frame race and racism in each country. Even if the different contexts in which race and racial discrimination were built makes comparative analysis difficult, studying the various equalitarian and anti-discrimination policies adopted in different societies may serve at least two goals: first, reveal new paths for fighting against racial discrimination, and second, underscore the ultimate artificial character of discrimination. As a result, analyzing the Brazilian experience may be a fruitful exercise for the American context.

This Article focuses on the Brazilian experience with regard to the way race was construed in that country, highlighting the preference for universalist policies and the main challenges for the adoption of group-based policies such as reparations for slavery or public policies specifically targeted at the Brazilian black population. This Article concludes that group-based policies should complement universalist policies, and that prospective policies should probably be taken as a priority over retrospective policies in countries that have long histories of unduly restricting the recognition of racism to the slavery period.

## II. THE BRAZILIAN VERSION OF RACIAL DISCRIMINATION<sup>2</sup>

The Brazilian version of racial discrimination is analyzed from three different perspectives: conceptual, political, and institutional.

### A. *The Conceptual Perspective*

A very strong source of continued de facto discrimination in Brazil is denial: denial of race and of racism. Denial is made possible by two subterfuges: first, a conceptual confusion involving the meaning of race, and second, a conceptual confusion between racism and racialism (or the belief that racism will be automatically overcome by an anti-racialist ideology).

As to the confusion about the meaning of race, two issues should be raised: first, race is still very often perceived in Brazil as a biological concept, and its existence is denied on that basis; and second, even when

---

2. This section is based on DANIELA IKAWA, *AÇÕES AFIRMATIVAS EM UNIVERSIDADES* (2008).

it is agreed that “race,” as a social construction, exists, its exact definition is quite controversial. Illustrative of the issue of existence, when the former Brazilian Supreme Court Justice Moreira Alves wrote his opinion in the habeas corpus petition 82424/RS (2003),<sup>3</sup> he denied the existence of racial discrimination against Jews by highlighting the non-existence of a biological Jewish race.<sup>4</sup>

The case cited to a habeas corpus petition filed on behalf of Siegfried Ellwanger, who had been found guilty of the crime of racial discrimination against Jews, after publishing and selling anti-Semitic books.<sup>5</sup> The Federal Anti-Racism Act, which criminalized racial discrimination, encompasses different forms of discrimination, such as discrimination based on race, color, religion, ethnicity, and national origin.<sup>6</sup> Even so, the then-Supreme Court Justice found it difficult to admit Jews were a race, socially defined by culture and religion, because races were, according to his view, “biological designations.”<sup>7</sup> The Supreme Court Justice’s argument is as follows: there cannot be race, as defined biologically, and therefore, there cannot be racism or a remedy against racism.

Understanding the social and artificial character of race is, however, essential to understanding a particular context of discrimination and to fighting against it. In the case of Brazilian blacks, race was constructed and socially defined by phenotype, and not by ancestry, as is the case in the United States. Remedies should, therefore, target beneficiaries predominantly by phenotype in Brazil, and not ancestry. This issue takes us to a second source of confusion, regarding the meaning of race.

---

3. S.T.F.-RS, HC 82424, Relator: Min. Moreira Alves, Relator do Acórdão: Min. Maurício Corrêa, 17.09.2003, 2144 S.T.F.J. 19.03.2004, 524 (Brazil). For more information on this case, see IKAWA, *supra* note 2, ch. 3. The crime of racial discrimination has no statute of limitations. C.F. art. 5, XLII (Braz.).

4. See S.T.F.-RS, HC 82424, Relator: Min. Moreira Alves, Relator do Acórdão: Min. Maurício Corrêa, 17.09.2003, 2144 S.T.F.J. 19.03.2004, 524, 541–42 (Brazil) (Then-Justice Moreira Alves cites rabbis Henry I. Sobel and Fred Foldvary (*Zionism and Race*), who deny that Jews are a race, for the proposition that races are biological or genetical categories). For more information on this case, see IKAWA, *supra* note 2, ch. 3.

5. S.T.F.-RS, HC 82424, Relator: Min. Moreira Alves, Relator do Acórdão: Min. Maurício Corrêa, 17.09.03, 2144 S.T.F.J. 19.03.2004, 524 (Brazil).

6. Federal law establishes that it is a crime to “practice, induce or incite discrimination based on race, color, ethnicity, religion or national origin.” Lei No. 7.716, de 5 de janeiro de 1989, Col. Leis Rep. Fed. Brasil, 181 (1): 10–11, jan./fev. 1989; Lei No. 9.459, de 13 de maio de 1997, Col. Leis Rep. Fed. Brasil, 189 (5): 2773–74, maio 1997. It also establishes that if any of those crimes are committed by the media or by publishers, the punishment should be aggravated. Lei No. 7.716.

7. See S.T.F.-RS, HC 82424, Relator: Min. Moreira Alves, 17.09.2003, 2144 S.T.F.J. 19.03.2004, 524 (Brazil) (“Não ha diferenças biológicas entre os seres humanos.”). For more information on this case, see IKAWA, *supra* note 2, at 101–06.

The second source of confusion, regarding the meaning of race, is related to the belief that there is no sufficiently objective way to define race in Brazil, where so much miscegenation has occurred. The issue of racial identification is complex, and we do not intend to exhaust it here.<sup>8</sup> It is relevant to say, however, that this problem is particularly raised in Brazil, in the comparison between race as defined in the United States, and race as defined in Brazil. Race, some would say, can only be precisely defined when legal segregation and lack of miscegenation have allowed one to establish rigid racial lines based on ancestry. In this vein, the American “one drop of blood” policy would be the only way objective enough to define race. Because Brazilians have not had legal segregation since the abolition of slavery, and because Brazilian society is highly miscegenated, one would not be able to identify particular races in Brazil.

This argument is, however, flawed, since it disregards the fact that race, as a social construction, will always vary from one society to the other, and will always carry complex definitions and complex processes of identification. In the United States, the Census Bureau started to collect information on color in 1850.<sup>9</sup> Since then, different classifications were adopted, including the consideration of “mullatos” from the 1850 census (when enumerators were instructed to classify a slave as black or “mullato”) to the 1930 census.<sup>10</sup> As of 1997, six racial categories are identified in the United States for census purposes: American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Asian, and White.<sup>11</sup> In Brazil, where race is based on phenotype and not on ancestry, identification will have to follow different patterns than the ones adopted in the United States. It does not mean, though, that identification will be impossible in Brazil. Reliable data on race started to be gathered in Brazil in 1872,<sup>12</sup> and it was suspended only between 1900 and 1930.<sup>13</sup> In the 1872 census, four terms were used: white, black, brown (*pardo*), and

---

8. See IKAWA, *supra* note 2, at 101–31.

9. Zaid A. Zaid, Note, *Continually Creating Races: The Census in the United States and Brazil*, 20 NAT'L BLACK L. J. 42, 45 (2006–2007).

10. *Id.* at 47, 55.

11. *Id.* at 52.

12. *Id.* at 57 (citing G. REGINALD DANIEL, RACE AND THE MULTIRACIALITY IN BRAZIL AND THE UNITED STATES: CONVERGING PATHS? 28 (2006)).

13. *Id.* at 58.

mestizo Indian (*caboclo*).<sup>14</sup> Today, the Brazilian census uses five categories: black, white, yellow, brown or *pardo*, and indigenous.<sup>15</sup>

Denial is not only based on the confusion about the meaning of race. It is also based on the belief that racism and racialism are the same thing. As a result, by denying the existence of race (anti-racialism), one would be able to overcome racism. In a society where exclusion based on race already exists, however, denying the idea of race will only serve to mask the existence of racism. In other words, it will only serve to shelter racism from any form of criticism. This sheltered form of racism is actually the prevalent form of racism in Brazil, and with time, it might also become the prevalent form of racism in the United States.

The myth of racial democracy was created in Brazil in the 1930s with Gilberto Freyre (1933), Sérgio Buarque de Holanda (1936), and Caio Prado, Jr. (1937).<sup>16</sup> Brazil invented then “a new tradition and a new origin,” thinking of itself not anymore as a “European” nation, but as a “mixed” nation. This new perception of nation was seen as a way to strengthen links among persons of different races.<sup>17</sup> However, it was not enough to end racial discrimination, and instead became a way to close one’s eyes to the existence of discrimination, and even to the existence of the other:<sup>18</sup> the other of a different race and holder of a restricted array of rights was purportedly categorized as equal. All were mixed and equal, but, in fact, some were more equal than others. By the 1950s, Brazil had acquired an (undeserved) international reputation for its racial democracy,<sup>19</sup> establishing for decades a kind of non-racialism that the United States would only face much later.<sup>20</sup>

---

14. *Id.* at 62 (citing MELISSA NOBLES, *SHADES OF CITIZENSHIP: RACE AND THE CENSUS IN MODERN POLITICS* 89 (2000)).

15. NOBLES, *supra* note 14, at 104 tbl.3.

16. See ANTONIO SÉRGIO ALFREDO GUIMARAES, *CLASSES, RAÇAS E DEMOCRACIA* 152–54, 117–18 (2002) (citing GILBERTO FREYRE, *O BRASIL EM FACE DAS ÁFRICAS NEGRAS E MISTIÇAS* (1962)). See also IKAWA, *supra* note 2, at 106–19.

17. See EDWARD TELLES, *RACISMO À BRASILEIRA: UMA NOVA PERSPECTIVA SOCIOLOGICA* 52 (Relume Dumará, 2003) (citing DONALD PIERSON, *NEGROES IN BRAZIL: A STUDY OF RACE CONTACT AT BAHIA* (1942)). It is also worth saying that a myth of racial democracy might have been a positive attempt to detach from an explicitly racist policy, such as the one that barred voluntary African immigration to Brazil from 1890 to 1907. See Zaid, *supra* note 9, at 63 (citing Edward E. Telles, *Ethnic Boundaries and Political Mobilization Among African Brazilians: Comparisons with the U.S. Case*, in *RACIAL POLITICS IN CONTEMPORARY BRAZIL* 82 (Michael Hanchard ed., 1999)).

18. IKAWA, *supra* note 2, at 108 (citing Antonio Sérgio Alfredo Guimarães, *Intelectuais Negros e Formas de Integração Nacional*, in *18 ESTUDOS AVANÇADOS* 271, 273 (2004)).

19. On Brazilian international reputation, see, e.g., *id.* (citing TELLES, *supra* note 17, at 50–52, 59, 325).

20. See *id.* (citing HOWARD WINANT, *THE WORLD IS A GHETTO: RACE AND DEMOCRACY SINCE WORLD WAR II* (2001)); see also TELLES, *supra* note 17, at 41, 97.

The persistence of the myth of racial democracy in Brazilian ideology is probably linked to an attempt to deny guilt, to deny the recognition of oneself as the perpetrator of something that is theoretically seen as a serious crime: racism is currently defined as a crime not subject to a statute of limitation.<sup>21</sup>

*B. The Political Perspective*

Brazil was the last country to abolish slavery in 1888, after supporting it for more than 300 years. Today, Brazil has the second largest black population in the world after Nigeria. While blacks were approximately 12% of the United States population in 2000,<sup>22</sup> they were 45.3% of the Brazilian population.<sup>23</sup> These numbers raise at least one issue: whether the fact that the racially discriminated group is a minority or a majority has an impact on the balance between universalist or group-based policies to be adopted; that is, between universalist policies on resource redistribution, on one side, and policies targeted on particular discriminated groups, on the other.

Universalist redistributive policies are expected to have a positive impact upon racially discriminated groups, as discrimination and poverty are often related. The case of racial discrimination in Brazil is not an exception. In 1999, 45.3% of the Brazilian population was black, but blacks were 64% of the poor and 69% of the absolute poor (indigents).<sup>24</sup> Whites were 54% of the Brazilian population, but only 36% of the poor and 31% of the absolute poor (indigents).<sup>25</sup> Still, 85% of the richest tenth of Brazilian society was white in 1999, and they held 87% of the income in this tenth.<sup>26</sup> If one divided Brazil into two countries, one all-black and the other all-white, the latter would be 2.5 times richer than the former.<sup>27</sup>

---

21. See *supra* notes 3 and 6 and accompanying text.

22. Black population both in 1999 and in 2000 was 12.8% of the total United States population. In 2000, 12.8% meant 35.47 million people. U.S. CENSUS BUREAU, RESIDENT POPULATION ESTIMATES OF THE UNITED STATES BY SEX, RACE, AND HISPANIC ORIGIN (Jan. 2, 2001), available at <http://www.census.gov/population/estimates/nation/intfile3-1.txt>.

23. According to the *Instituto Brasileiro de Geografia e Estatística*, black population was 5.4% and brown population (*parda*) was 39.9% of the Brazilian population in 1999 and 2000. RICARDO HENRIQUES, TEXTO PARA DISCUSSÃO NO 807: DESIGUALDADE RACIAL NO BRASIL: EVOLUÇÃO DAS CONDIÇÕES DE VIDA NA DÉCADA DE 90 4 (2001). See also IKAWA, *supra* note 2 (discussing Brazilian racial exclusion).

24. HENRIQUES, *supra* note 23, at 9.

25. *Id.*

26. *Id.* at 19.

27. IKAWA, *supra* note 2, at 119–31 (citing HENRIQUES, *supra* note 23, at 7, 12, 22, 23).

Indeed, with the transition from an authoritarian military regime to democracy in the 1980s, the black movement in Brazil pushed for the adoption of an important universalist policy in the field of health—a unified health system. This system was established by the 1988 Constitution and was made available to all, free of charge. As we will see later in this paper, the adoption of such a system was, however, not enough to overcome racial disparities in health. Targeted, group-based policies were needed. Nevertheless, Brazilian entrenched denial of race and racial discrimination would make the adoption of racially-based policies much more difficult than the adoption of universalist policies. The adoption of racially-based policies would require a political power that Brazilian blacks did not necessarily have in the 1980s and 1990s. Despite the fact that blacks are nearly the majority of the Brazilian population, blacks have been relegated for decades to the position of a silenced and fragmented majority, resulting in a political minority.<sup>28</sup>

Some numbers help to illustrate the exclusion of blacks in different social and political positions. In 1996, only one in ten Brazilian judges was black.<sup>29</sup> From the 1980s to 1994, in a group of more than two thousand representatives elected to the Brazilian Congress, there were only twenty-nine blacks.<sup>30</sup> According to Edward Telles, there were only eight blacks in a group of more than one thousand Brazilian diplomats in 1999<sup>31</sup>; only one black in a group of more than one hundred generals in 1996<sup>32</sup>; and only eight blacks in a group of six hundred Federal Prosecutors.<sup>33</sup> Blacks' limited political power does not, therefore, reflect their representation in Brazilian society. With little political power, blacks do not have the ability to be heard in the political arena as other numerical majorities would.

---

28. See, e.g., DAVID LUBAN, *LAWYERS AND JUSTICE: AN ETHICAL STUDY* 360–64 (1988) (discussing silent majorities).

29. IKAWA, *supra* note 2, at 19; see also TELLES, *supra* note 17, at 189 (citing the IBGE population census for 1996).

30. IKAWA, *supra* note 2, at 19; see also TELLES, *supra* note 17, at 189 (citing Ollie A. Johnson III, *Racial Representation and Brazilian Politics: Black Members of the National Congress, 1983–1999*, 40 J. INTERAMERICAN STUD. & WORLD AFF. 97 (1998)).

31. IKAWA, *supra* note 2, at 19; see also TELLES, *supra* note 17, at 189 (citing BLACK BRAZIL: CULTURE, IDENTITY, AND SOCIAL MOBILIZATION 105–42 (Larry Crook & Randal Johnson eds., 1999)).

32. IKAWA, *supra* note 2, at 19; see also TELLES, *supra* note 17, at 189 (citing Crook & Johnson, *supra* note 31, at 105–42).

33. IKAWA, *supra* note 2, at 19; see also TELLES, *supra* note 17, at 189 (Joaquim Barbosa Gomes provided Telles the estimates regarding Brazilian Federal Prosecutors.).

*C. The Institutional Perspective*

Although the Brazilian culture has long rejected racism as immoral (racial discrimination has been considered illegal since 1890,<sup>34</sup> only two years after the abolition of slavery), Brazilian racism has prevailed in implicit, but unfortunately pervasive forms.

Evidence of racism's pervasive character is still found in the exclusion of blacks from accessing services, including health services, on equal terms with whites. According to the 2000 Census, while Brazilian whites had a life expectancy at birth of 74 years, browns had a life expectancy of only 68.03 years, and blacks of only 67.64 years.<sup>35</sup> Mortality rates for those with blood or skin infections are at least 50% higher for blacks (excluding browns) than for whites and are almost 50% higher for blacks with digestive or respiratory diseases than for whites with the same diseases.<sup>36</sup> These racial discrepancies are accentuated in reproductive and sexual health. Mortality rates during pregnancy are two times higher for blacks (excluding browns) than for whites.<sup>37</sup> In a research study conducted on 9633 women (51.9% white, 29% brown, and 19% black) who had given birth between July 1999 and March 2000 in maternity hospitals in the city of Rio de Janeiro, 31.8% of black women and 28.8% of brown women against 18.5% of white women had to go to more than one hospital before being admitted.<sup>38</sup> In addition, more white women had access to anesthesia than black and brown women: 21.8% of black women and 16.4% of brown women did not have access to anesthesia.<sup>39</sup> It was also assessed that 43.7% of white

---

34. Claudia Travassos & David Williams, *The Concept and Measurement of Race and Their Relationship to Public Health: A Review Focused on Brazil and the United States*, 20 CAD. SAÚDE PÚBLICA 660, 667 (2004) (citing P. Fry, *Politics, Nationality, and the Meaning of "Race" in Brazil*, 129 DAEDALUS 83 (2000)).

35. Fernanda Lopes, *Experiências Desiguais ao Nascer, Viver, Adoecer e Morrer: Tópicos em Saúde da População Negra No Brasil*, in FUNASA, SAÚDE DA POPULAÇÃO NEGRA NO BRASIL: CONTRIBUIÇÕES PARA A PROMOÇÃO DA EQUIDADE 25 (2005) (citing INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTTÍSTICA, *Censo Demográfico 2000* (2001); M.J.P. Paixão et al., *Diferenciais de Esperança de Vida e de Anos de Vida Perdidos Segundo os Grupos de Raça/Cor e Sexo No Brasil e Grandes Regiões*). In the United States, the life expectancy of black men at birth was 68.6 years, while for white men life expectancy was 75.0 years. Black women had a life expectancy of 75.5 years; white women's life expectancy was 80.2 years. Elizabeth Arias et al., *Deaths: Final Data for 2001*, 52 NAT'L VITAL STAT. REP., Sept. 2003, at 6; see also Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 741–42 (2005) (noting the disparity in life expectancy at birth between whites and blacks).

36. Lopes, *supra* note 35, at 25.

37. *Id.*

38. Maria do Carmo Leal et al., *Desigualdades Raciais, Sociodemográficas e na Assistência ao Pré-natal e ao Parto, 1999–2001*, 39 REV SAÚDE PÚBLICA 100, 102–03 (2005).

39. *Id.* at 102–03.

women were assisted in private hospitals, while 89.5% of black women and 78.9% of brown (*parda*) women were assisted either in public hospitals or in hospitals linked to the Brazilian unified health system (SUS), indicating de facto segregation.<sup>40</sup> In 2000, 8.9% of black Brazilian women who gave birth in the Northern region of Brazil did not have access to prenatal consultations, while only 6.5% of white women did not have such access.<sup>41</sup> It means that black women had 36% less access to prenatal consultation than white women. In the Northeast region of Brazil, black women had 46% less access. The situation was similar in other regions in Brazil.<sup>42</sup> In 1999, in every 100,000, 11.39 black women and 4.92 white women died of AIDS in the state of São Paulo.<sup>43</sup> Even though it is not established by law, racial discrimination is still pervasive, reaching a structural, institutionalized form.

However, despite the evidence of deep racial inequalities, Brazilians' overall perception of racism is that of a non-structured phenomenon, concerning only isolated individual relationships where involved persons are conscious about race and racism. Brazilians' perception of racism is still based on the idea of individual guilt and individual responsibility.<sup>44</sup> In research conducted by Perseu Abramo Foundation and Rosa Luxemburg Stiftung Foundation, 49% of Brazilians believed that combating racial discrimination should be a responsibility of individuals and not of governments (only 36% agreed on governmental responsibility).<sup>45</sup> When people perceive racial discrimination as an individual problem,<sup>46</sup> they are often linking racial discrimination with instances where guilt can be individually (and punctually) assessed. In this sense, they often resist any quantitative measurement of racial exclusion as a basis for new equalitarian public policies and institutional reforms. In fact, numerical disparities can be the result of both direct and indirect discrimination,<sup>47</sup> and in the latter case, guilt is not easily

---

40. *Id.*

41. Lopes, *supra* note 35, at 18 (citing EMGP Cunha & AAE Jakobo, *Diferenciais Raciais nos Perfis e Estimativas de Mortalidade Infantil para o Brasil*).

42. *Id.*

43. Rubens de C.F. Adorno et al., *Quesito cor no Sistema de Informação em Saúde*, 18 ESTUDOS AVANÇADOS 119, 119 (2004) (citations omitted).

44. *See generally* IKAWA, *supra* note 2, at 106–19, 139–205 (discussing the ideas of guilt and unconscious racial discrimination).

45. RACISMO NO BRASIL: PERCEPÇÕES DA DISCRIMINAÇÃO E DO PRECONCEITO RACIAL DO SÉCULO XXI 158 tbl.46 (Gevanilda Santos e Maria Palmira da Silva organizadoras, 2005); *see also* IKAWA, *supra* note 2, at 117 (“A pesquisa consistiu em mais de 5.000 entrevistas, representativas da população brasileira com mais de 16 anos, realizada em 266 municípios e com aproximadamente 1,4% de margem de erro para o total da amostra.”).

46. IKAWA, *supra* note 2, at 117–18 (citing Santos & Silva, *supra* note 45, at 158 tbl.46).

47. Indirect discrimination is defined here as an apparently neutral norm or practice with a

identifiable. This is especially prejudicial in Brazil, where even instances of direct differential treatment are masked or not fully articulated.

Indeed, racial discrimination in Brazil has a strongly implicit character. A survey conducted by the Perseu Abramo Foundation and the Rosa Luxemburg Stiftung Foundation<sup>48</sup> says it all. More than 5000 people were interviewed, in 266 municipalities.<sup>49</sup> According to this research, while 96% of the Brazilian population denied being racist themselves, 89% of all Brazilians recognized that racism existed in the country (even if in an isolated manner, as mentioned above) and 74% expressed some degree of racial discrimination as they commented on statements such as: “a good black is a black with a white soul,” “when a black does not make a mistake entering a building, it does so exiting the building,” or “what would you do if you had a black boss?”<sup>50</sup> Besides, 81% of browns and 57% of blacks responded that they had never suffered any form of racial discrimination.<sup>51</sup> In sum, although Brazilians recognize that there is racial discrimination in their country, they deny being either the perpetrator or the victim. They deny guilt; they deny responsibility for racial discrimination; and they also try to flee from discrimination’s oppressive mantle by denying its existence.

Moreover, as Brazilians deny individual responsibility for racial discrimination (96% of the Brazilian population denied being racist themselves), discrimination can almost only be proved quantitatively: by comparing the numbers of black people with a certain disease receiving treatment “A” with the numbers of white people with the same disease receiving treatment “A”; or by comparing the percentage of deaths from the same disease for blacks and whites; and so forth. This is the case, even though 49% of Brazilians believe that combating racial discrimination should be a responsibility of isolated individuals,<sup>52</sup> not of the government or, let’s say, of the whole community.

---

discriminatory impact.

48. See generally Santos & Silva, *supra* note 45.

49. *Id.* at 130.

50. IKAWA, *supra* note 2, at 117 (citing Santos & Silva, *supra* note 45, at 145 tbl.27, 141 tbl.19, 148 tbl.30, 146–47 tbl.29).

51. *Id.* at 117 (citing Santos & Silva, *supra* note 45, at 151 tbl.35, 152 tbl.37).

52. See *supra* note 45 and accompanying text. Attempts to deny responsibility for racial discrimination and racial inequalities are not unfamiliar to Americans either. A good example is found in *Plessy v. Ferguson*, 163 U.S. 537 (1896), overruled by *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954), which for almost sixty years perpetuated a rule of “separate but equal.”

### III. RESPONSES OF THE BRAZILIAN GOVERNMENT AND ANALYSIS OF MISSING PIECES

In spite of the conceptual, political, and institutional barriers to the recognition of racial discrimination in Brazil, the Brazilian government gave a first universalist response to increase vulnerable groups' access to health in 1988, with the creation of a unified health system (*Sistema Único de Saúde*—SUS) accessible to all. This universalist response has not been enough to eliminate racial inequalities in access to health. As mentioned in previous sections, racial inequality is still the rule in Brazil.

Since 1990, some timid group-based initiatives have been proposed by the government in response to continued inequalities in access to health. In the following sections, this Article describes the unified health system and the first steps in adopting group-based policies in access to health.

#### A. *The Governmental Universalist Response to Racial Inequality in Access to Health*

##### 1. The Unified Health System

For the first time in Brazilian constitutional history, health was recognized in 1988 as a right belonging to all.<sup>53</sup> This was, in part, an achievement of the Brazilian black movement. Since 1988 Brazil has been governed by a Federal Constitution that specifically provides not only that health is a duty of the State, but also a right to which all are entitled.<sup>54</sup> Since the early 1980s the black movement has claimed further access to health, as well as policies to treat and prevent diseases that are prevalent among blacks. The participation of the black movement stood out during the work that preceded the drafting of the 1988 Federal Constitution, which eventually established a unified health system, the so-called SUS, or *Sistema Único de Saúde*. The SUS, which ensures full and free assistance to the whole population, is a set of actions and services within the health area provided by public federal, state, and local agencies and institutions.<sup>55</sup>

---

53. C.F., Art. 196 (Braz.). Brazilian constitutions of 1824 and 1891 did not mention health. Constitutions of 1934, 1937, 1946, 1967, and 1969 recognized the government's duty to provide health services. The 1988 Constitution recognizes the right to health in Article 196.

54. *See id.*

55. Lei No. 8.080, de 19 de setembro de 1990, Col. Leis. Rep. Fed. Brasil, 182(5): 2829–2907, setembro/outubro de 1990.

The SUS, according to Article seven of Law No. 8.080/1990, has universality, integrality, decentralization, and equity as its fundamental principles.<sup>56</sup> By universality it is understood that each and every Brazilian citizen must have access to the public health system; by integrality, that the supply of health services by the State must cover all illnesses, from basic care to the most advanced health practice. Decentralization is meant to be the participation of the different governmental spheres (federal, state, and local) in the provision of the health services, including by incorporating not only their own establishments but also those offering health assistance under an agreement with the government. The principle of equity indicates that the unequal must be treated unequally, in other words; providing the services to each according to his specific needs, considering that these may be, and quite frequently are, different. In this context, it is clear that the SUS, at least at the ideal level, is guided by the principle of material and not strictly formal equality.<sup>57</sup>

The SUS encompasses a series of governmental agencies fostering and ensuring health in Brazil,<sup>58</sup> the most important of them being within the federal scope, namely, the Ministry of Health. This is so because its function is “to ensure all the conditions to foster, protect and recover health, reducing illnesses, controlling endemic and parasitic diseases, improving health surveillance, and offering quality of life to the

---

56. Lei No. 8.080, de 19 de setembro de 1990, D.O.U. de 20.09.1990. (Brazil). Item VII of Article seven refers to equality as synonymous with equity. *Id.* According to Antônio Geraldo da Cunha and cited by Marcelo C. Pinheiro, Márcia F. Westphal, and Marco Akerman:

The word equity in its semantic aspect is quite close to equality, and may even be included as its synonym. The etymology of both shows the same forming element, “equ-,” from the Latin antepositive “aequus,” which may mean united, just, impartial or favorable. Whereas the word equity is a word formed in Latin itself, the word equality is introduced in the language of culture.

Marcelo C. Pinheiro et al., *Equidade em Saúde nos Relatórios das Conferências Nacionais de Saúde Pós-Constituição Federal Brasileira de 1988*, 21 CAD. SAÚDE PÚBLICA 449, 451 (2005) (citing ANTÔNIO GERALDO DA CUNHA, DICIONÁRIO ETIMOLÓGICO NOVA FRONTEIRA DA LÍNGUA PORTUGUESA 309 (2d ed. 1986)) (Author’s translation).

57. Moreover, the SUS, according to Article seven of Law No. 8.080/1990 must also be governed by the following principles: preserving the autonomy of people when protecting their physical and moral integrity; equality of health assistance, free of prejudices or privileges of any type; assisted people’s right to information about their health; disclosure of information with respect to the potential of the health services and their use by the patient; participation of the community in the local, state and federal health conferences and boards; and integration at the executive level of the health, environment, and basic sanitation actions. Lei No. 8.080, de 19 de setembro de 1990, D.O.U. de 20.09.1990. (Brazil); see also *Cartilha Direito à Saúde e Política Nacional de Saúde Integral da População Negra*, MULHER NEGRA: MANUAL DE REFERÊNCIA (Conectas Direitos Humanos, Geledés—Instituto da Mulher Negra, São Paulo) 2008, at 7.

58. C.F. Art. 197 (Braz.).

Brazilian citizens.”<sup>59</sup> At state and local levels, there are health secretaries in charge of the local and shared management of the SUS and respective services associated with it. They are also responsible for establishing the policies aimed at fostering access to health.<sup>60</sup> The SUS also encompasses the health conferences and boards where the communities participate. Such participation aims at ensuring social control over the public health policy. Community participation is provided in the Federal Constitution and is essential to improve the health system. It is at health conferences and board meetings that community representatives are able to influence strategies, make suggestions, and monitor official performance at federal, state, and local governmental levels. Health boards and conferences have been created so that the population, through its representatives, might discuss the health problems and decide what should be done in the area.<sup>61</sup>

## 2. Judicial Cases

The recognition of a right to health by the 1988 Constitution made it possible to claim this right judicially. Although judicial claims might have a political role in pressuring the executive and the legislative branches to implement existing legislation, they have not been necessarily used by and on behalf of the most disadvantaged. In the case of a social right, judicial claims might also ignore issues of distributive justice. Moreover, judicial claims have not yet encompassed the issue of racial discrimination in access to health. The main argument in claims for the right to health is related to the universalist character of this right in terms of economic disparities.

In a study conducted on judicial claims presented against the City of São Paulo Department of Health between January and December of 2005 for the acquisition of medications, the addresses of petitioners were compared with the map of social exclusion in the city of São Paulo.<sup>62</sup> The index of social exclusion varies from 1 to -1, where -1 indicates the maximum degree of exclusion. In 63% of cases, petitioners lived in

---

59. Responsibilities of the Ministry of Health, [http://portal.saude.gov.br/portal/saude/area.cfm?id\\_area=281](http://portal.saude.gov.br/portal/saude/area.cfm?id_area=281) (last visited Jan. 20, 2009) (Author’s translation).

60. Conectas Direitos Humanos, Geledés—Instituto da Mulher Negra, *supra* note 57, at 9.

61. Law No. 8.142/1990 regulates the participation of the community when managing the SUS. Lei No. 8.142, de 28 dezembro de 1990, D.O.U. de 31.12.1990. (Brazil).

62. The index of exclusion takes into account issues of autonomy, quality of life, human development, and equality. Fabiola Sulpino Vieira & Paola Zucchi, *Distorções Causadas Pelas Ações Judiciais à Política de Medicamentos No Brasil*, 41 REV SAÚDE PÚBLICA 214, 217–18 (2007).

areas with indices varying from 1 to -0.4.<sup>63</sup> Moreover, judicial decisions determined the provision of medications which are not in the national list of essential medications or which were prescribed by private doctors not linked to SUS.<sup>64</sup> In another study conducted on judicial claims presented against the State of São Paulo for the provision of medications between March and November of 2004, 67.7% of plaintiffs were represented by private lawyers.<sup>65</sup> The main arguments raised by the plaintiffs were risk to life or health (all cases), the prescribed medication was the only way to control the disease (all cases), and access to medications, as an element of the right to health, was a fundamental right (all cases). Moreover, more than 80% of plaintiffs alleged they did not have financial resources to acquire the medication.<sup>66</sup> In 90.3% of cases, judicial decisions favored the plaintiffs, based mainly on two reasons (more than 80% of cases): first, the right of all persons to health; and second, the need to have a specific medication provided free of charge.<sup>67</sup> In sum, cases of access to medications in São Paulo were heavily grounded on the universalist character of the right to health and the recognition of a principle of economic redistribution, even when the judicial branch and legal aid services were not advanced enough to actually reach the most disadvantaged. The main positive political result might have been, then, the strengthening of the right to health, by recognizing that the right to health is a justiciable right.

Although not yet explored, judicial claims could be an effective tool to fight racial discrimination in the access to health. As mentioned by Rodnei da Silva, a lawyer at Geledes, a Brazilian not-for-profit organization for the rights of black women, criminal claims of racial discrimination (grounded on Law No. 7716) have been consistently denied, as these claims are simply reclassified by judges as claims of “moral injury aggravated by a discriminatory intent,” a minor criminal offense subject to a six-month statute of limitations.<sup>68</sup> Claims involving a social right, however, might have a better reception among Brazilian judges, exactly for not implying a criminal offense. They will, notwithstanding, face the still widespread Brazilian resistance against the very ideas of race and racism.

---

63. *Id.* at 218–19.

64. *Id.* at 219.

65. Silvia Badim Marques & Sueli Gandolfi Dallari, *Garantia do Direito Social Assistência Farmacêutica No Estado de São Paulo*, 41 REV SAÚDE PÚBLICA 101, 103–04 (2007).

66. *Id.* at 104.

67. *Id.* at 105.

68. E-mail from Rodrei Jericó da Silva, Lawyer, Geledes, to Daniela Ikawa (Oct. 14, 2008, 08:52, Sao Paulo Time) (on file with author).

*B. The Government's Group-Based Responses to Racial Inequality: The Case of Education and the First Steps in the Access to Health*

Although the right to health is recognized by the 1988 Brazilian Constitution, its universal application is usually approached as a matter of economic redistribution. However, as indicated before, the establishment of a system of redistribution of health resources (the unified health system—SUS) has not been enough to overcome racial disparities on health. Differential treatment based on race is still being identified and mortality rates among blacks are still considerably higher than those among whites. There is a need to complement universalist policies with group-based policies or remedies, but the adoption of the latter will depend on the overcoming of conceptual, political, and institutional barriers (as mentioned in Part 2). So far, the major steps in this direction have been taken in the field of education.

1. The Case of Education<sup>69</sup> and a Few Notes on Reparations

The first strong racially-based policies adopted by the Brazilian government were affirmative action for blacks in universities. These policies helped open cracks in the mainstream ideology of racial democracy by opening a space for a broader discussion about race and racism that went beyond the black movement to reach the society in general. The first affirmative action program for blacks at universities was implemented by the State of Rio de Janeiro, by the enactment of three State laws: Law No. 3.524/2000, Law No. 3.708/2001, and Law No. 4.061/2003. Quotas for blacks were established for the 2003 entrance exam at the Rio de Janeiro State University: 50% of seats were reserved for students coming from public high schools and 40% for blacks. A claim of unconstitutionality was raised before the Brazilian Supreme Court. However, a fourth State law, Law No. 4.151/2003, replaced previous laws and established a new program before the claim of unconstitutionality was heard by the Supreme Court. According to the new program, 45% of seats should be reserved to the following groups: 20% for students coming from public high schools; 20% for blacks; and 5% for persons with disabilities.<sup>70</sup>

---

69. To learn more about Brazilian universities that have implemented affirmative action programs and for a proposal of affirmative action in higher education, see generally IKAWA, *supra* note 2.

70. FLAVIA PIOVESAN & DANIELA IKAWA, DIREITOS HUMANOS: FUNDAMENTO, PROTEÇÃO E IMPLEMENTAÇÃO—PERSPECTIVAS E DESAFIOS CONTEMPORÂNEOS (2006) (citing Barbieri Bertucci

After Rio de Janeiro State University, other public institutions adopted affirmative action programs for blacks: Bahia State University (40%),<sup>71</sup> University of Brasilia (20%),<sup>72</sup> and Federal University of Parana (20%).<sup>73</sup> According to a study published by Rio de Janeiro State University in 2008, fifty-one public institutions of higher education<sup>74</sup> currently offer affirmative action programs in Brazil. Among them, there are eighteen state universities and twenty-two Federal universities, which is more than half of state universities and forty-two percent of Federal universities. Programs for blacks have been created in thirty-three institutions. In forty-four, quotas were adopted.<sup>75</sup>

Affirmative action programs for blacks in Brazil often are perceived as reparations for past discrimination. However, in a country that for a century denied that racial discrimination was taking place, and that restricted the recognition of racial discrimination to instances of official discrimination that occurred almost only in times of slavery, the use of the argument of reparations for past discrimination is a tricky one. As explained by Jessé Souza, the psychological legacy of slavery is often more strongly weighed than its social legacy. Also, the argument of slavery is sometimes used to exempt current forms of discrimination from scrutiny. Florestan Fernandes identified in the 1970's two sources for racial inequalities: "internal slavery," or an internal feeling of inferiority that bars action, on one side, and color-based discrimination, an external result of slavery, on the other.<sup>76</sup> The main risk of focusing on slavery in Brazil is to over emphasize the former "source of inequality" in order to underscore the victim's own responsibility for existing racial

---

& José Guilherme Carneiro Queiroz, *Da Constitucionalidade das Cotas para Afrodescendentes em Universidades Brasileiras*).

71. IKAWA, *supra* note 2, at 196 (citing Luiz Francisco, *Bahia Reserva 40% das Vagas para Negros*, FOLHA ONLINE, July 22, 2002, <http://www1.folha.uol.com.br/folha/educacao/ult305u9961.shtml> (last visited Mar. 10, 2009)).

72. *See, e.g., id.* at 197 (citing Luciana Seabra et al., *Cotas: Uma Ação Afirmativa*, UNB NOTÍCIAS, June/July 2003, n.54, *passim*, [http://www.secom.unb.br/unbnoticias/un0603-p10\\_11\\_12-01.htm](http://www.secom.unb.br/unbnoticias/un0603-p10_11_12-01.htm) (last visited Mar. 10, 2009)).

73. *Id.* at 198 (citing Mari Tortato, *No PR, Negro Terá 20% das Vagas da Universidade Federal*, FOLHA ONLINE, May 8, 2004, <http://www1.folha.uol.com.br/folha/cotidiano/ult95u93958.shtml> (last visited Mar. 10, 2009)).

74. Among these institutions, there are universities (higher education institutions that comply with a certain degree of autonomy and research) and other centers and departments. Antônio Gois, *51% das Universidades Estaduais Adotam Ações Afirmativas*, FOLHA ONLINE, Aug. 1, 2008, <http://www1.folha.uol.com.br/folha/educacao/ult305u361070.shtml> (last visited Mar. 10, 2009).

75. *See id.* and accompanying text.

76. Jessé Souza, *(Não) Reconhecimento é Subcidadania, Ou o Que é "Ser Gente"?*, 59 LUA NOVA 51, 57 (2003) (citing 1 FLORESTAN FERNANDES, *A INTEGRAÇÃO DO NEGRO NA SOCIEDADE DE CLASSES* 92, 283, 316 (Atica ed. 1978)); *see also* IKAWA, *supra* note 2, at 116.

inequalities.<sup>77</sup> A second risk is to recognize racial discrimination only when it is legally supported by the State. In Brazil, such support was almost only explicitly given during slavery. As highlighted by Ubiratan Castro de Araujo, in the 1890s, just a few years after slavery had been abolished in Brazil, the physician Nina Rodrigues stated in his book, *Os africanos no Brasil*, that blacks should no longer be perceived as victims of slavery.<sup>78</sup> Those times had already passed. It was time to study blacks “scientifically” and to identify in their culture those characteristics that were dangerous to the public order.<sup>79</sup>

Although the Brazilian judicial branch has not yet addressed the issue of reparations for slavery, one decision of the Federal Regional Tribunal for the Fourth Circuit (*Tribunal Regional Federal da Quarta Região*) mentions the idea within the context of racially-based affirmative action in higher education: the issue in this case does not concern past discrimination; it is not a reparation or a vindication for the sufferings caused by slavery; injustice is still present: universities, the cradle for the elite, are inhabited by a white majority.<sup>80</sup>

In Brazil, it might not yet be the time to focus on slavery. It might still be more efficient to focus on present discrimination than on past discrimination, at least in these first steps taken after the recognition that racial discrimination exists in the country.

## 2. The First Group-Based Policies in Health

Affirmative action programs in education have opened the way for racially-based policies in other areas, such as health. Although a democratized Brazil initially focused on universalist health policies, with the creation of a unified health system, some group-based policies have been adopted, although not yet fully implemented. In 1995, a work group was established to support the black population, *Grupo de Trabalho Interministerial para Valorização da População Negra*,<sup>81</sup>

---

77. IKAWA, *supra* note 2, at 116 (citing Souza, *supra* note 76, at 57).

78. Ubiratan Castro de Araújo, Diretor do Centro de Estudos Afro-Orientais, Universidade Federal da Bahia, *Reparação Moral, Responsabilidade Pública e Direito à Igualdade do Cidadão Negro No Brasil*, Nov. 20, 2000. Dr. Castro de Araújo gave this presentation at the Conference *Racismo, Xenofobia, e Intolerância*, which took place at the Hotel Bahia Othon on Nov. 20, 2000. The conference was organized by IPRI—Instituto de Pesquisa de Relações Internacionais, Federal University of Bahia (Brazil).

79. IKAWA, *supra* note 2, at 116 (citing Souza, *supra* note 76, at 57).

80. R.T.R.F.-4, 2005.04.01.006358-2/PR, Relator: Des. Federal Luiz Carlos De Castro Lugon, 17.05.2005, R.T.R.F., 01/06/2005 (Brazil). In the decision, the Tribunal understood that universities could establish quotas, as quotas were constitutional measures to combat racial discrimination. *Id.*

81. SEPPIR & MINISTRY OF HEALTH, *Política Nacional de Saúde Integral da População*

which focused on various themes, health among them. In 2000 and 2003, the black movement participation in the 11th and 12th National Health Conferences was perceived as the cause for the movement's increased political participation in the SUS. Indeed, at those conferences, the movement approved proposals to include racial and gender equity standards in the Country's national health policy.<sup>82</sup> In 2001, during the Regional Intergovernmental Conference of the Americas, in Chile, and in the Third World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, in Durban, South Africa, the movement highlighted the existence of racial discrimination in Brazil, and forced the government to adopt specific racial policies.<sup>83</sup> In 2003, a special secretary was created to foster racial equality: the Secretaria Especial de Políticas de Promoção da Igualdade Racial ("SEPPPIR"),<sup>84</sup> and to assure that racially-based policies would be present in the governmental agenda within the federal sphere. In 2004, the Ministry of Health and the SEPPPIR established the Technical Health Committee of the Black Population,<sup>85</sup> aimed at fostering racial equality in the field of health. The Technical Committee has the following duties: first, to prepare proposals for joint intervention at the various levels and bodies of the SUS; second, to participate in initiatives related to the black population's right to health; and third, to assist in creating state and local committees representing the black population.<sup>86</sup>

Among the guidelines adopted by the Technical Health Committee of the Black Population for effectively fostering access to health is the reduction of morbidity and early death among the black population. This means, among other things, acknowledging the biological, psychological, and social impact of racism, discrimination, and prejudice in the constitution of the morbid-mortality profile and implementing a racial section in all the healthcare-related programs, projects, actions, and activities. With respect to the line of action concerning information, participation and social control, priority was given to adopting the "color query" (*quesito cor*), a query about racial identification, and monitoring

---

*Negra* (Feb. 2007) (Braz.) [hereinafter *SEPPPIR*], <http://bvsmms.saude.gov.br/bvs/publicacoes/politicapopnegra.pdf>, at 19 (Brazilian policy of full health to the black population).

82. *Id.* at 20.

83. *Id.* at 19.

84. The SEPPPIR was created by Lei No. 10.678, de 23 de maio de 2003, D.O.U. de 26.5.2003. (Brazil), available at [http://planalto.gov.br/ccivil\\_03/Leis/2003/L10.678.htm](http://planalto.gov.br/ccivil_03/Leis/2003/L10.678.htm).

85. The Committee was created by Administrative Ruling, Portaria No. 1678 (Aug. 13, 2004), available at <http://portal.saude.gov.br/portal/arquivos/pdf/GM-1678.pdf>.

86. *Id.* at Art. 1, Sections III, IV, and V (Aug. 13, 2004).

health information.<sup>87</sup> The Technical Committee has recently announced the national health policy for the black population, approved by the National Health Council in 2007. The policy is aimed at “fighting against racial discrimination and fostering racial equality in health services offered by SUS.”<sup>88</sup> The policy encompasses the following strategies, among others: “using the ‘color query’ (*quesito cor*) to produce epidemiological information so as to define priorities and make decisions; broadening and reinforcing social control; developing strategies [to] fight and prevent institutional racism [. . .]; [and], implementing affirmative action programs to achieve equity in the field of health.”<sup>89</sup>

An important step in the adoption of group-based policies is indeed the consideration of the “color query” (*quesito cor*) in health services and survey. Only the desegregation of data by race will ensure the information required to prepare and implement specific public health policies focused on the black population. While a national health policy for blacks has been launched by the federal government, some initiatives have also begun at state and local levels, with very timid results.

One example is the project adopted by the administration of the City of São Paulo. According to Bento, the process of adopting the “color query” (*quesito cor*) in the city administration of São Paulo began at the end of 1989, when Luiza Erundina/PT was elected. Erundina had a “government proposal more attentive to the social movements and to the underprivileged population.”<sup>90</sup> In the subsequent year, according to Oliveira, “the ‘color query’ (*quesito cor*) was the theme of the 1990 IBGE census campaign: ‘*Não deixe sua cor passar em branco,*’ or, roughly translating, do not [leave] your color blank, aimed at raising black people’s awareness of the need to answer the color query.”<sup>91</sup>

After intense mobilization of the black movement, on March 30, 1990, the then-City Secretary of Health, Eduardo Jorge, adopted

---

87. MINISTÉRIO DA SAÚDE, A SAÚDE DA POPULAÇÃO NEGRA E O SUS: AÇÕES AFIRMATIVAS PARA AVANÇAR NA EQUIDADE 23–29 (1st ed. 2005), available at [http://portal.saude.gov.br/portal/arquivos/pdf/caderno\\_spn.pdf](http://portal.saude.gov.br/portal/arquivos/pdf/caderno_spn.pdf).

88. *SEPPIR*, *supra* note 81, at 9 (Author’s translation).

89. *Id.* at 14 (Author’s translation).

90. CENTRO DE ESTUDOS DAS RELAÇÕES DE TRABALHO E DESIGUALDADES, PROCESSOS DE IMPLEMENTAÇÃO DO QUESITO COR NA SAÚDE 23 (forthcoming 2009) [hereinafter *CEERT*] (citing Maria Aparecida da Silva Bento, *A Implementação do Quesito cor na Área da Saúde*).

91. *Id.* at 39 (citing Edna Muniz de Souza et al., *Histórico da Implementação do Quesito cor: Um Relato de Experiências Exitosas de Parcerias Envolvendo Sociedade Civil Organizada, Governo e Agências Internacionais*, in FUNASA, SAÚDE DA POPULAÇÃO NEGRA NO BRASIL: CONTRIBUIÇÕES PARA A PROMOÇÃO DA EQUIDADE 438 (2005)); FÁTIMA OLIVEIRA, SAÚDE DA POPULAÇÃO Negra 215 (1st ed. 2002).

Administrative Ruling 696/90, formally introducing the “color query” (*quesito cor*) in the Information System of the City Health Secretary. In May of the same year, the seminar “Health Blackboard—Implementing the ‘Color Query’ (*Quesito Cor*) in the City Health System” was held. The seminar aimed at increasing awareness among health professionals and information about patients’ race.”<sup>92</sup> In this seminar, the represented institutions IBGE, Dieese, and Fundação Seade stated that:

the categories included in the IBGE (black, brown, white, yellow and indigenous) [were] the most frequently stated, even when patients responded to an open question. Accordingly, the participating institutions, experts and representatives defined that the methodology and categorization would be those defined by the IBGE. Another argument that influenced the decision was the fact that, if other categories were to be adopted, it would not be possible to make comparisons with the surveys carried out nationwide.<sup>93</sup>

According to Souza, on March 28, 1992, a working group was created by Administrative Ruling 492 with the objective of planning, implementing, supporting, and monitoring the activities set out in Administrative Ruling 696/90.<sup>94</sup> It was only then, in 1992, that the “color query,” in spite of much objection, was definitely adopted. However, in December 1992, during the seminar “It is black on white: winning over the silence conspiracy,” it was made public that the program had been discontinued.<sup>95</sup> As explained by Bento, “[the] truth is that the technical body [working group] was not effectively convinced of the significance of the query.”<sup>96</sup>

A more recent experience concerning the adoption of the “color query” (*quesito cor*) took place at the government of the State of São Paulo. The pilot project “Implementing the ‘Color Query’ (*Quesito Cor*) in the State Program of STD/AIDS” was carried out by the State of São Paulo<sup>97</sup> in association with the *Centro de Estudos das Relações de Trabalho e Desigualdades*—CEERT, the United Nations Development Program, and UNAIDS. The project proposed to “educate agents to implement, monitor and evaluate the process of collecting information

---

92. CEERT, *supra* note 90, at 23 (citing Bento, *supra* note 90) (Author’s translation).

93. *Id.* at 39 (citing Souza et al., *supra* note 91, at 438) (Author’s translation).

94. *Id.*

95. *Id.* at 30 (citing Bento, *supra* note 90).

96. Bento, *supra* note 90. See also Márcia Regina Giovanetti et al., *A Implantação do Quesito Cor/Raça nos Serviços de DST/Aids No Estado de São Paulo*, 16 SAÚDE SOC. SÃO PAULO 163, 164 (2007) (Author’s translation).

97. Giovanetti et al., *supra* note 96, at 165.

about race.”<sup>98</sup> More specifically, the project aimed at “increasing the awareness of health managers and professionals to the significance of collecting information about race, extending the collection of such information to STD/AIDS centers in the State of São Paulo; [and] improving the existing database.”<sup>99</sup>

Before beginning the pilot project, a survey was carried out among the STD/AIDS Centers of Reference and Training (*Serviços de Atendimento STD/AIDS*) in various cities of the State to evaluate the collection of information about race. According to Giovanetti et al.,

[O]f all the Centers [that answered the questionnaire], 15% had adopted the “color query” (*quesito cor*) in all the forms used, 48% in some of them, and 37% had not requested any information about race. At 37% of the institutions that had adopted the “color query,” the patients’ skin color was identified by health professionals and at 22% by the patients themselves; at the others, racial identification was carried sometimes by patients and sometimes by health professionals. Only 55% of the centers kept such data collection regularly.<sup>100</sup>

As it was clear that the health professionals and managers had to be trained to collect information about patients’ race, the project began by training forty-six health professionals at a *Centro de Referência e Treinamento/AIDS* and with a campaign to increase patients’ awareness of the interface between race and health.<sup>101</sup> Along this process of increasing awareness, two issues have been frequently raised: first, “the need to gather electronic data on patients’ race”; and second, the significance of the “color query” (*quesito cor*) as a “cornerstone to obtain information [that will] support the understanding of how to approach institutional racism, leading to more adequate and efficient health services.”<sup>102</sup> It was also assumed that it was essential to invest in continued training for all the professionals who have direct contact with patients and who are assigned the task of collecting information about patients’ race.<sup>103</sup>

The collection of information about race is not, however, constant

---

98. CEERT, *supra* note 90, at 43 (citing Gilza L. Silveira de Mello et al., *A Implantação do Quesito Cor/Raca/Etnia nos Serviços de Atendimento em DST-HIV-AIDS do Estado de São Paulo*) (Author’s translation).

99. Giovanetti et al., *supra* note 96, at 166 (Author’s translation).

100. *Id.*

101. CEERT, *supra* note 90, at 44 (citing Silveira de Mello, *supra* note 98).

102. Giovanetti et al., *supra* note 96, at 168 (Author’s translation).

103. CEERT, *supra* note 90, at 51–52 (citing Silveira de Mello, *supra* note 98).

and the “color query” (*quesito cor*) has not yet been included in all forms used by health institutions.<sup>104</sup>

#### IV. CONCLUSION

Brazil has fostered access to health among blacks by establishing a unified health system, guided by a principle of universality. Brazil has also innovated by recognizing the justiciability of the right to health. Such achievements have not, however, been sufficient to guarantee equal access to health for all. Group-based policies are needed, but they have only been timidly implemented in the field of health. Conceptual, political, and institutional barriers to the adoption of group-based policies have delayed the process. The myth of racial democracy is still prevalent in Brazil, and with it, the misunderstanding about what constitutes race, racism, and racialism. This misunderstanding has led to the denial of racism and to considerable resistance against any equalitarian policies specifically targeted at blacks. It remains to be seen if the first steps taken to address the vulnerabilities of discriminated groups will thrive in Brazil. There is certainly a long way ahead.

As to reparations for slavery, it is probably still best to focus on present rather than on past forms of racial discrimination. Prospective policies should still be taken as a priority over retrospective policies, for Brazil has a long history of unduly restricting the recognition that racism exists to periods where racial discrimination was established by the law, that is, to the slavery period. The sustainability of group-based policies targeted on blacks will depend on the recognition that racial discrimination is still a problem in the present and that it has evolved to adopt much more complex, implicit (and yet pervasive) forms than those initially established through slavery.

---

104. Bento, *supra* note 90; CEERT, *supra* note 90, at 29.