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Everyday Narratives on Race and Health in Brazil

In 2006, Brazil approved a groundbreaking policy aimed at reducing significant racial health inequalities among its citizens. Like health disparities programs in the United States, Brazil's policy is based on the assumptions that racial identity and racism are important health determinants, and that citizens who identify as "black" suffer disproportionately from a number of health problems. How do these assumptions compare to Brazilian citizens' conceptions of racial identity and health inequalities? To address this question, I present ethnographic data from two years of fieldwork in Brazilian public clinics and low-income neighborhoods. I show that a majority of research participants made no connection between race and better or worse health. Of those who perceived health inequalities by race, most believed that white Brazilians had more health problems than black or brown Brazilians. Finally, I consider the implications of these ethnographic findings for Brazil's health disparities campaign. [race, health, Brazil]

One night in mid-2009, my friends Mário and Angela gave me a lift to the subway station after a visit to their home in the middle-class São Paulo neighborhood of Liberdade.¹ Both white *paulistanos* in their twenties, Mário and Angela held stable jobs: Mário was a financial consultant at one of São Paulo's many multinational firms, and Angela was a social worker for the city's public health department. As we drove through the narrow streets festooned with red lamps, passing an expanse of tall residential buildings and Japanese eateries, Mário casually asked how my fieldwork was going. When I mentioned a recent seminar I had attended about Brazil's new health policy targeting black citizens, the following conversation ensued:

Mário: But why should there be a health policy for Blacks? That sounds like racism.

Angela: No, we had to take a workshop about that at work. Blacks have specific health issues because they are more—genetically they have issues, like they are born with sickle cell anemia because it's a disease of the black race, and they also suffer more from lots of other health problems. Like having diabetes and hypertension that are more complicated [than in Whites].

Mário: Ah, yes. In that case, it makes sense—if they have specific genetic issues, like, for instance, the way Blacks are better at sports.

During the years I spent in Brazil, I grew accustomed to hearing comments like these from Brazilian friends of various ethnic and socioeconomic backgrounds. Mário, like many Brazilians, felt that race-conscious health policies were divisive and even racist—unless they

addressed Blacks' supposedly natural differences (which he seemed to view as a two-sided coin that could confer both health-related vulnerabilities and superior athletic prowess).²

Meanwhile, Angela had learned at her clinic that black patients had worse overall health than Whites, although she could not articulate exactly why that was the case.³ Like Mário, she seemed to find a genetic explanation most plausible. After all, she had learned that sickle cell anemia was a genetically heritable disease with a high prevalence in people of African descent. From there, she applied the genetic model to other health problems from which she had learned Blacks suffered disproportionately, such as hypertension and diabetes.

This anecdote illustrates the extent to which the idea of race-conscious health care remains a strange concept to many Brazilians. As an outsider from the United States, where minority health initiatives blend relatively seamlessly into the fabric of racialized "common sense," I was acutely aware of Brazilians' discomfort with the idea. For many Brazilians, the practice of making any racial distinctions among citizens—even with the goal of combating inequality—smacks of racism. For a small but growing group of Brazilian activists, policymakers, and researchers, however, the failure to address race-based inequalities constitutes racism by neglect.

According to recent epidemiological studies, there is little question that significant health disparities exist among racialized groups in Brazil. These studies have only begun to appear in the last few years because prior to 1996 the Brazilian public health system did not collect patients' race data. Now, public clinics and hospitals are supposed to record patients' self-declared race utilizing Brazilian census categories. As of Brazil's 2010 Census (IBGE 2010), 48% of the population identified as white (*branca*), 43% as brown (*parda*), 8% as black (*preta*), 1% as Asian (*amarela*), and less than 1% as indigenous (*indígena*).

Within health policy and biomedical research, the *parda* and *preta* categories are increasingly collapsed into a single category called *negra* (black) to demonstrate major differences in health indicators between white and nonwhite (black/brown) individuals.⁴ This practice is endorsed by social demographers such as Lovell and Wood (1998) and N. Silva (1988), who argue that similarities between pretos' and pardos' life chances (i.e., educational attainment, income, life expectancy) justify consolidating the two categories within statistical analyses (N. Silva 1985; Wood and Carvalho 1988).

When it comes to health data, however, the consolidation approach sometimes obscures internal variations between pretos' and pardos' epidemiological profiles (Pagano 2011; Travassos and Williams 2004). Several recent epidemiological studies suggest that pardos' mortality rates from a variety of causes are either similar to those of Whites or are intermediate between those of Blacks and Whites (Cardoso et al. 2005; Chor and Lima 2005; Fonseca et al. 2007; Lessa et al. 2006; Lotufo et al. 2007). In most cases, pretos' morbidity and mortality rates are bleaker than those of pardos.

Regardless of categorical ambiguity, Brazilian researchers have found that black Brazilians (pretos and pardos) die disproportionately from HIV/AIDS, homicide, alcoholism and mental illness, stroke, diabetes, and tuberculosis (E. M. Araújo et al. 2009; Batista 2005; Batista et al. 2004; S. M. Santos et al. 2007). As of 2001, black women's (pretas) maternal mortality rates were seven times those of Whites (Chor and Lima 2005). Black Brazilians' (pretos and pardos) life expectancy was 5.3 years less than that of Whites in 2000 (Cunha 2008). This scenario represents a serious public health problem for Brazil, especially given that over half of the Brazilian population now identifies as *parda* or *preta* (IBGE 2010).

As in the United States, Brazilian epidemiologists have not yet reached a consensus about the etiology of these disparities. Are they caused principally by widespread socioeconomic inequality? Racial discrimination in health care? Genetic or lifestyle characteristics? At first glance, socioeconomic status would seem to be the most likely cause, based on the unrelenting correlation between skin color and life chances in Brazil (Lovell and Wood 1998). Blacks represent nearly three-fourths of the poorest 10% of Brazilians. Meanwhile, Whites account for nearly 83% of the richest 1% (IBGE 2009).

Many Brazilian epidemiological studies attribute health disparities to poverty, arguing that residing in poorly served areas interferes with health care access and treatment adherence (e.g., Batista 2005; Nyarko et al. 2013). Others, however, show that racial health disparities persist even after controlling for SES (e.g., Barata et al. 2007). Still others deploy racialist hypotheses, making the assumption that medically significant genetic differences exist a priori between Blacks and Whites (e.g., Jaime et al. 2006; Ribeiro et al. 2009; Vale et al. 2003).

In this article, I present ethnographic findings from two years of fieldwork among patients in Brazilian public clinics and low-income neighborhoods.⁵ I begin with a discussion of racial identity discourses and recent health policy developments focused on race-based health disparities in Brazil. Next, I present data from semi-structured interviews on race and health conducted with public health patients in two Brazilian cities, São Luís and São Paulo. In the final sections, I discuss the implications of incongruence between popular perceptions and official discourses on race and health for Brazil's attempts to reduce health disparities among racialized groups of citizens. Throughout, I focus primarily on discourses related to the European/African heritage spectrum, rather than those related to indigenous, Asian, and other populations. This choice reflects the article's central task, which is to evaluate the degree of similarity between everyday narratives and official discourses regarding the health status of negros and brancos.

Racial Identity in Brazil

The dynamics of racial identity in Brazil are famously complex. As Telles (2004) observes, Brazilians utilize at least three kinds of racial identity models: the traditional/popular model, the census model, and the bipolar (black–white) model popularized by “black movement” (*movimento negro*) activists.⁶ The traditional/popular model features a wide spectrum of terms to describe skin color and physical features. In addition to branco and preto, it includes many intermediate color terms such as *moreno*, *mestiço*, and *sarará* (descriptors of mixed-race features and/or brown skin color). In fact, when the Brazilian Census Bureau included an open-response color question on the 1976 national household survey, respondents supplied a total of 136 different color terms (Nobles 2000).

As described above, the Brazilian census utilizes only four color/race terms (branca, parda, preta, amarela) and one “ethnic” descriptor, indígena (indigenous). Parda refers to either brown or a grayish color, while amarela (literally, “yellow”) denotes Asian ethnicity. The census model is used for official documents such as birth certificates.

The bipolar model propagated by Brazil's black movement utilizes the terms branco and negro, where negro encompasses those with any degree of (visible) African ancestry—including pardos. This model dispenses altogether with intermediate terms between black and white and focuses primarily on the negro/branco dichotomy, with less emphasis on indigenous and Asian categories due to its political orientation.

Brazilians utilize these models in a selective fashion, activating different modes of racial classification depending on situation and context (Harris 1970; Maggie 1994). For example, an individual with dark skin and African features might identify as *preto* or *negro* in bureaucratic spaces, but his family and neighbors might refer to him as *moreno*; his romantic partner might call him *nego*; and his soccer buddies might call him *negão* (Sansone 1996).⁷

That is, Brazilians have traditionally constructed racial identity as a malleable, rather than essential, quality. A striking example of this is *branqueamento*, or “whitening.” As a social practice, whitening refers to Brazilians’ tendency to identify with the lightest racial category permitted by their skin color. Socioeconomic status also plays an important role in social whitening. There is a popular saying in Brazil that “money whitens” (*o dinheiro embranquece*), meaning that higher SES may enable an individual to identify with a lighter race category than someone of similar appearance but lower SES. Some scholars, however, argue that despite the apparent malleability of racial identity in Brazil, Brazilians share a tacit understanding of a color line that divides Whites from non-Whites. An example of this is *boa aparência* (good appearance), an infamous code for European features and light skin color once ubiquitous in employment ads (Damasceno 2000).

Despite the premium placed on whiteness within Brazil’s aesthetic hierarchy, Brazilians still tend to identify strongly with a discourse of mixed-race national identity, called *mestiçagem* or *morenidade* (Pinho 2009; D. Silva 1998). This discourse is often accompanied by the assertion that racial discrimination cannot logically exist in Brazil because of the high degree of racial mixture throughout the population

The negation of racism based on a discourse of pervasive miscegenation is a classic theme from late-19th century Brazilian abolitionist discourse and from Brazilian intellectual production during the first half of the 20th century (Pinho 2009; Skidmore 1993). The most famous example is Gilberto Freyre’s seminal work, *Casa Grande e Senzala (The Masters and the Slaves)* (1963), in which he recounted the forging of the authentic *mestiço* Brazilian subject through free intermingling between indigenous peoples, Portuguese colonizers, and enslaved Africans during Brazil’s colonial period. Freyre depicted Brazilian society as a “racial democracy,” in which its three constitutive races received equal opportunity and treatment.

Freyre’s work both expressed and reinforced a dominant discourse of Brazilian non-racism that reached well beyond the realm of intellectual production. His ideas influenced not only Brazilians’ everyday concepts of race and racism, but also government policies around race (Skidmore 1993). An example is the decision of Brazil’s military government (1964–1985) to remove the color question from the 1970 census on the grounds of irrelevance. Skidmore (1993) and Nobles (2000) interpret this episode as a sign of the government’s reluctance to highlight racial inequalities in the country. The change did not last long, however, as the color question was reinstated on the 1980 census and has been included ever since.

Race in Brazilian Public Policy

In the last few decades, the ideology of racial democracy has been dealt serious blows by factors such as the state’s endorsement of the need for race-based affirmative action policies in education, employment, and health care.⁸ This change resulted partly from increasing pressure by the international community for Brazil to address glaring race-based inequalities in public policy (Pagano 2006; Telles 2004). Brazilian civil society organizations, particularly those that compose Brazil’s *movimento negro* (black movement), were also instrumental in Brazil’s

decision to pass affirmative action programs for the “black population” (*população negra*) beginning in 2001.

Black movement activists first pressured the state to address racial health disparities on a national level at the 1986 National Health Conference. The conference is a participatory planning forum that convenes a National Health Council of citizens and public health officials every few years to make health policy decisions. The 1986 conference report recommended increased public funding for the study of illnesses believed to affect certain “racial-ethnic groups” in a disproportionate manner (Oliveira 2002).

Despite activists’ efforts, however, there were no significant national policy developments concerning black Brazilians’ health until 1995, when President Fernando Henrique Cardoso convened a task force to discuss various issues affecting black Brazilians disproportionately. Although the task force concluded that specific health programs for Blacks were unnecessary, its members endorsed the creation of a national sickle cell anemia program. The 1996 founding of the Sickle Cell Anemia Program marked the first time Brazil’s Health Ministry had instituted a program targeting an illness associated with the black population (Fry 2005; Oliveira 2004).

The next major milestone came in 2001 following the United Nations’ World Conference on Racism in Durban, South Africa. In response to conference resolutions for increased attention to health inequalities suffered by communities of African origin, Brazil began to craft partnerships with the Pan-American Health Organization (PAHO), the United Nations Development Program, and the British Department for International Development. This transnational collaboration resulted in financial and ideological support for the creation of a Special Secretariat for the Promotion of Racial Equality (SEPPIR) in Brazil. In 2004, SEPPIR, PAHO, and a task force of black movement activists, researchers, and health professionals began to formulate the National Health Policy for the Black Population (*Política Nacional de Saúde Integral da População Negra*). In 2006, the National Health Council formally approved the policy. Since then, several Brazilian states and cities have followed suit and implemented their own versions of the policy at the local level.

To date, the National Health Policy for the Black Population and its state- and local-level versions have been enacted in three main ways. First, public health care providers are now required to record patients’ self-declared race data. Second, many public health employees now receive periodic training on issues such as black patients’ health concerns and racial discrimination within health care. Third, the state has begun to incentivize scientific research on health problems that affect Blacks disproportionately. The net effect of these measures has been to initiate a paradigm shift in the way health inequalities are conceptualized in Brazil. Increasingly, race and racism are taking center stage in research, debates, and policymaking around health disparities.

The Health Ministry’s new discourses on racial health disparities have not gone unchallenged. In fact, they are vociferously debated by a group of scientists and researchers who argue that the new policy racializes medicine and promotes unnecessary racial division while ignoring socioeconomic determinants of health inequalities (e.g., Fry 2004; Laguardia 2005; Maggie 2007; Maio and Monteiro 2005; Pena 2005). Government officials have also challenged race-specific health measures. In 2010, the Brazilian senate approved the Racial Equality Statute (*Estatuto da Igualdade Racial*) but eliminated provisions for black health programs based on a lack of conclusive genetic evidence for diseases considered more prevalent in Blacks.⁹

How do the ideas about race and health presented in the new health measures compare to Brazilian citizens' ideas about race and health "on the ground," so to speak? This was one of the questions guiding my field research from 2007 to 2009 in the Brazilian cities of São Luís do Maranhão and São Paulo. During that time, I also interviewed black health activists, researchers, health care providers, and public health administrators involved in crafting the national policy. I will present their side of the story in forthcoming articles; here I focus on the viewpoints of patients.

Methods

Between September 2007 and August 2009, I conducted participant observation, semi-structured interviews, and brief structured interviews in São Luís and São Paulo, Brazil. Participant observation took place in public clinics and hospitals, patients' homes, and during meetings and seminars in which black health activists, health care providers, and health care administrators discussed strategies for improving the black population's health indicators in Brazil. I present findings from brief structured interviews with 160 patients. Table 1 shows the demographic characteristics of the 160 patients who participated in the brief structured interview.

Table 1. Interviewee Characteristics

		City		
		São Paulo	São Luís	Combined Sample
Sex	Male	11.9%	22.6%	18.1%
	Female	88.1%	77.4%	81.9%
Age	18–29	25.8%	16.1%	20.1%
	30–45	19.7%	29.0%	25.2%
	46–64	39.4%	34.4%	36.5%
	65–90	15.2%	20.4%	18.2%
Education	None	16.4%	10.8%	13.1%
	Elementary	43.3%	33.3%	37.5%
	Middle	16.4%	12.9%	14.4%
	High	22.4%	35.5%	30.0%
	Some College	1.5%	7.5%	5.0%
Color/Race (self-declared)	Branca	25.4%	14.0%	18.8%
	Negra/Preta	14.9%	18.3%	16.9%
	Morena	33%	54%	45%
	Parda	19%	5%	11%
	Other	1.5%	3.2%	2.5%

Each brief structured interview lasted between 20 minutes and one hour, and all were conducted in Portuguese with patients in public clinics and low-income neighborhoods served by Brazil's universal health care system. I interviewed public health patients—who tend to live in

lower-income areas—rather than wealthier Brazilians with access to private health care to capture the views of the citizens most directly affected by the introduction of race-conscious public health measures.

In São Paulo, I recruited interviewees by accompanying community health workers on their weekly neighborhood visits to elderly people, pregnant women, and those with infectious diseases (e.g., tuberculosis, hepatitis, Hansen’s disease) or other serious health problems that kept them housebound. At each house, I obtained consent and conducted the interview with any adult family member who answered the door. Many of these visits stretched into longer conversations inside homes, with additional family members and neighbors drifting in and out and contributing to the discussion.

I conducted most of the São Paulo interviews in Cidade Satélite, a town located in the western periphery of Greater São Paulo.¹⁰ A handful of the São Paulo interviews also took place at a neighborhood association in Campo Santo, a working-class neighborhood on the southern periphery of the city. In São Luís, I interviewed clinic patients waiting to be seen in the low-income neighborhood of Lourenço. Interviews took place on several different days of the week and in specialty as well as internal medicine departments.

Field Sites

São Luís is the capital of Brazil’s most impoverished state, Maranhão, located in the northeast region of the country. São Paulo is the capital of considerably wealthier São Paulo State in the southeast region. I selected these cities not only for their socioeconomic contrast, but also for their diversity in population ethnicity. Figure 1 shows the distribution of self-declared pretos and pardos throughout Brazil. Progressively darker shading indicates increased concentrations of pretos and pardos in certain areas. I have added arrows pointing to São Luís and São Paulo. The map clearly shows regional differences; generally speaking, the north and northeast regions have higher concentrations of black and brown residents while the south, southeast, and central-west regions have lower concentrations. As of the 2010 census, the city of São Paulo had twice as many white (61% in São Paulo versus 29% in São Luís) and half as many black residents (pretos) as São Luís (6.5% in São Paulo versus 13% in São Luís). Pardos are the majority group in São Luís at 56%, while in São Paulo they account for a modest third of the population.¹¹

Patients’ Narratives on Race and Health

I now turn to a discussion of patient interview findings from São Paulo and São Luís. As Table 1 shows, most interviewees in the combined sample were women (81.9%). According to the community health workers I accompanied, this was because clinic directors authorized me to conduct interviews during weekdays when many men were out working or looking for work. The largest percentage of respondents (36.5%) fell between 46 and 64 years of age. A little over half of the respondents had an elementary school education or less, which was not surprising given that they were drawn from resource-poor areas.

On the race/color question, 45% of interviewees chose morena, while 11% chose parda (brown). Together, individuals selecting these “intermediate” terms accounted for 56% of the total sample, as compared to 43% of Brazilians who chose the category parda on the 2010 Brazilian Census.¹² This is likely because my questionnaire used an open race/color question (see Appendix). Harris et al. (1993) also found that allowing survey respondents in Brazil to select

morena as opposed to parda increased the proportion of respondents selecting “mixed-race” categories; this is because morena reflects Brazilians’ popular race terminology, whereas parda is a census term rarely used in everyday life (see also Travassos et al. 2011).

When I asked interviewees to identify their “color or race” (the phrasing used by Brazilian census takers), more often than not they would laugh self-consciously, glance at the skin on their forearms, and ask me what I thought. When I encouraged them to respond, they would often pose their response as a question, such as, “I don’t know, morena?” Only about 17% of respondents in the combined sample self-identified as “negro/a” or “preto/a”—two individuals used the term “preto/a,” whereas all of the others preferred “negro/a.” In all, individuals produced the following terms to describe their own skin colors or racial identities: morena, branca, preta, parda, negra, *clara* (light), morena clara, *escura* (dark), *mulato/a*, *branqueela* (really white), *índio* (Indian), *afro-descendente* (Afro-descendent), *misturada* (mixed), and amarela. Most interviewees did not articulate a bipolar model of race like the one utilized in affirmative action policies.

Table 2 provides a breakdown of interviewees’ self-identified race or color by city. As expected given the differences in population ethnicity between the two cities, a higher number of respondents in São Paulo self-identified as white. The “other” category indicates indigenous or Asian responses; a higher number of interviewees self-identifying as indigenous in São Luís was responsible for the more than doubled percentage of other responses in comparison to the São Paulo sample.

After collecting demographic information, I asked interviewees about their utilization of health care services and whether they had noticed any differential or unequal treatment of patients at the nearby public clinic (*posto de saúde*). Forty-one percent of the combined sample (66/160) responded in the affirmative; of these, only three respondents attributed the differential treatment to patients’ race or color. The most common reasons given for patients receiving unequal treatment included “poor” appearance (e.g., wearing worn clothing), being rude to clinic staff, and having a friend or relative working at the clinic (and thus receiving *better* treatment such as getting appointments sooner than others).¹³

Next, I asked interviewees whether they thought there were any health differences between people with lighter skin and people with darker skin. It is important to note that I use the terms “black” and “white” in this discussion for the sake of simplicity; many interviewees did not frame their responses in these terms. Some used negro and branco; others preferred claros and escuros (“lights” and “darks”) or morenos and claros. To avoid imposing North American race terminology (i.e., black or white) during interviews, I framed this question using each respondent’s own preferred color terminology, which I had elicited earlier in the interview (see Appendix).

Overall, 43.8% of the sample affirmed the existence of health-related differences between lighter- and darker-skinned people (Table 2). Notably, of the respondents who affirmed the existence of health inequalities by race, 92% (62/70) stated that Whites (or people with lighter skin) actually have worse health than Blacks (or people with darker skin).

In general, two patterns were observed. First, respondents in São Luís were more likely than those in São Paulo to perceive health-related differences by skin color. Second, across the sample, older interviewees were more likely than younger interviewees to perceive health-related differences according to race/color. No other respondent characteristics (i.e., gender, self-declared race/color, education) demonstrated a correlation with beliefs regarding racial health

disparities. The reason for the regional pattern is unclear. The age-related difference could indicate a cross-generational decline in beliefs about the existence of biological races, with younger Brazilians more often conceptualizing race as a social construct.

Whenever interviewees affirmed that there were health differences between lighter- and darker-skinned people, I asked them to elaborate on their answers. This was an open-ended question; I made no reference to physical differences or social inequalities by race. Interviewees responded that Blacks age more slowly, have a lower prevalence than Whites of diseases ranging from skin cancer to leprosy to AIDS, and generally enjoy better overall health than Whites. Their responses often involved the trope of blood. Here are some examples of this type of response:

Whites (brancos) suffer more; blacks (negros) are stronger. White people are weaker in terms of their blood and cardiovascular health. This comes from their nature.

—64-year-old homemaker, 4 years of school, self-identified as branca

Blacks (negros) are stronger than us and have better health than ours. Their blood is more powerful and their skin is firmer.

—66-year-old homemaker, 0 years of school, self-identified as clara (light-skinned)

Blacks (negros) have stronger antibodies and hemoglobin. The [black] race is stronger, although this also depends on diet. Blacks have more capacity to heal. My mother survived a cardiac arrhythmia. If she were white, she would no longer be alive.

—43-year-old unemployed woman, 12 years of school, self-identified as morena

Other respondents asserted Blacks' superior tolerance for pain, illness, and childbirth:

Blacks (negros) are stronger than whites (brancos). I am diabetic, but I don't feel the symptoms that other diabetics have. I also have high blood pressure, but it's controlled with medication.

—74-year-old homemaker, 11 years of school, self-identified as negra

People of color (a cor morena) are stronger than white people (a cor branca). If a moreno complains, it means he is already very ill.

—71-year-old retired woman, 0 years of school, self-identified as morena

Whites (brancos) get sick more often, people of color (a cor negra) are hardier. White women (brancas) who have had one child look like they've had ten, while black women (negras) with four or five children look as if they haven't had any.

—48-year-old college-educated housewife, self-identified as morena

When I asked this group of respondents why they thought Blacks were more resilient (*resistentes*) than Whites, several answered that Blacks' ancestors were slaves and therefore had to be strong and healthy to perform hard labor. They implied that these traits had been passed down genetically to their descendants in a Lamarckian fashion.

In contrast, only 5% of respondents stated that Blacks have worse health than Whites (Table 2). The majority of these responses, like those that affirmed the opposite, relied on the trope of blood; the theme of Blacks having "stronger" or "thicker" blood was particularly salient.

Table 2. Beliefs Regarding the Relationship of Race/Color to Health Status.

Response	Total %	São Paulo	São Luís
“Lighter-skinned people have worse health”	38.8%	29.9%	45.2%
“Darker-skinned people have worse health”	5.0%	4.5%	5.4%
“No difference”	56.2%	65.7%	49.5%

According to one 50-year-old negra homemaker with six years of formal schooling: “Blacks have thicker blood. They have more diabetes, cholesterol, and heart attacks. They suffer more.”

Similar responses came from Carol and Maria, two middle-aged black women who identified as negra and Maria’s elderly father-in-law, who identified as branco. Carol commented, “the black race (*a raça negra*) has more health problems ... it’s in the blood.” When I asked what kinds of illnesses Blacks experience disproportionately, Carol responded, “strokes and sickle cell anemia.” Maria added, “Arthritis and osteoporosis are more prevalent in [people of] our color.” When I asked why Blacks would suffer more strokes, she replied, “Their blood is stronger. It clogs their veins.” Her father-in-law and Carol voiced their agreement. In addition to blood-related illnesses, some respondents also commented that Blacks suffer more from skin diseases such as vitiligo.

Of those who claimed that Blacks have worse health, only a few attributed the disparity to socioeconomic factors. For example, a 41-year-old branca female shopkeeper observed, “Blacks do not have good living conditions. When they do not have a clean living environment, their social milieu produces more illness ... especially due to [poor] diet.” Two other respondents noted that Blacks have less time to seek treatment for health problems because they work so much and that they have fewer financial resources to seek “quality” (i.e., private) health care.

Overall, essentialist explanations predominated in interviewees’ theories of the association between race and health status—among the 44% who affirmed that such an association existed. This finding may seem surprising given the affirmations of many scholars (e.g., D. Silva 1998; Skidmore 1993) that Brazilians do not believe in separate races or fixed racial identity, but rather in one Brazilian race with many different colors (*cores*). Indeed, this discourse informs most areas of social life in Brazil. Consequently, Brazilians tend to feel more comfortable speaking in terms of color (*cor*) than in terms of race (*raça*) (Sheriff 2001).

On an explicit level, interviewees in my study reiterated this cultural norm. Although many interviewees used the term “raça” in their responses, most either could not define it or rejected the concept outright when I elicited their definitions. A common response was, “Races are for dogs. There is only one human race.”¹⁴ Nevertheless, when asked about race/color and health, over 40% of interviewees described a direct relationship between the two that they frequently attributed to differential qualities of the blood between Blacks and Whites or “darks” and “lights.” That is, in the context of our discussions about health and biology, these respondents articulated a biologized model of race—not just color—although they were no more likely than other respondents to explicitly endorse the concept of race.

It is important to note a few limitations of the study. First, it is possible that these same interviewees would articulate altogether different concepts of racial identity in other situations and contexts. It is also important to consider how my own appearance (light-skinned, North American) and the interview context itself may have shaped responses (see Bastos et al. 2009).

By asking people whether they perceived any relationship between race and health, I created an artificial and potentially awkward social situation that undoubtedly influenced their formulations of the topic in some way—indeed, this is the case in most, if not all, interview contexts.

Admittedly, my sample lacks statistical power due to its size and lack of randomization. However, if these findings reflect even roughly the attitudes of Brazilians who access the public health system, then patients' beliefs about racial health disparities (or lack thereof) could present a significant obstacle to their acceptance of policy measures to address special health concerns for black Brazilians. At the time of my research, most patient interviewees were aware that public clinics had begun to ask them to identify their race on intake, but they did not know why (and even that was done on a haphazard basis). Many found this practice off-putting, and some expressed fears that their race data could somehow be used to discriminate against them in the future (see Pagano 2011).

There are three findings of interest in this article. First, more than half of my sample denied any relationship between racial identity and health status. Second, nearly half the interviewees spoke of significant health-related differences between people of different races or colors. Third, the vast majority of interviewees formulated the relationship between race and health in ways that contradict the Health Ministry's newly adopted dominant discourse on black citizens' health vulnerabilities.

Discussion

Thus far, I have tried to give an idea of the sharp contrast between Brazilians' everyday narratives on race and health, on the one hand, and the Brazilian government's now-dominant discourse on health inequalities between negros and brancos, on the other. Given the existence of epidemiological data demonstrating significantly worse health indicators among black (and brown) Brazilians versus white Brazilians, why did so many interviewees deny the existence of health inequalities by race, or even affirm that pardos and pretos were healthier than brancos?

Similar to a recent study of racial identity narratives among Brazilian sickle-cell anemia patients (Calvo-González and Rocha 2010), my findings show that Brazilians may alternate between naturalizing race as a genetic entity with attendant health implications, and insisting that only color gradations—not race—exist in Brazil due to pervasive miscegenation. In both studies, interview questions about the link between racial identity and health/illness evoked themes of ancestry and heredity, which many Brazilians associate with the foundational story of the three constitutive races of Brazil (DaMatta 1981; R. Santos et al. 2009). Although the Brazilian nationalist text is based on the idea of mixture between the Portuguese, Africans, and indigenous peoples (D. Silva 1998), that text presupposes the historical existence of distinct peoples or races that came together to form the amalgam of the Brazilian subject. Indeed, many of my interviewees' responses referenced a primordial era of nation-building in which the blood of each group trickled into the veins of their racially mixed descendants (see also Calvo-González 2011:92).

The idea that Blacks are physically stronger than Whites is a deeply ingrained cultural theme based on two related suppositions: First, that enslaved Africans who survived to produce offspring in Brazil possessed superior physical constitutions; and second, that their physical strength somehow passed through the bloodline to future generations of offspring (as several interviewees explained). This kind of narrative is not unique to Brazil, but rather is found throughout the Americas (e.g., Restrepo 2007). The stereotype of Blacks as more physically

resistant to pain and suffering, for example, is echoed in other countries that participated in the Atlantic slave trade (e.g., Washington 2006). A related stereotype portrays Blacks as natural athletes (St. Louis 2003), as Mário suggested on the occasion described at the beginning of this article. In general, the image of Blacks as healthier is related, in my view, to the historical Western association of Africans and their descendants with physicality, sensuality, and nature, as opposed to intellect, reason, and culture (see Eze 1997; Gould 1996).

I am not arguing that Brazilians today invariably subscribe to discourses of racial democracy or associate blackness with physicality—in fact, these ideas have been widely discredited—but rather that some of the themes recorded decades ago by Freyre and others have persisted within the collective Brazilian race imagination (if we can speak of such a thing) and are continually reproduced in Brazilians’ cultural habitus around race, even as they are openly questioned (see also Sansone 1996). But how does this process occur?

Bourdieu’s theory of social reproduction through *habitus* (Bourdieu 1977) provides a plausible explanatory model both for the durability of certain racial ideologies within Brazilian culture and for the apparent contradiction between statistical accounts of health disparities in Brazil versus popular perceptions of them.¹⁵ According to Bourdieu, individuals continually and unconsciously adjust their thoughts and actions to comply with the unstated collective norms of their social environment. I want to call attention to two aspects of Bourdieu’s theory in particular: First, social actors learn to expect only what the social field teaches them is possible; second, individuals are incited by the social order to misrecognize systems of inequality as natural or attributable to other causes.¹⁶ The working-class Brazilians I interviewed did not misrecognize their socioeconomically subjugated position in society; on the contrary, most were adamant that health inequalities lie between rich versus poor citizens, but not black versus white citizens. Rather, if recent epidemiological studies are reliable (and many of them claim to have controlled for socioeconomic status), then interviewees may have misrecognized the additional health costs of being nonwhite in Brazil (see N. Silva 1985).

These ideas are useful in trying to understand how race can become a “blind spot” in a culture that values color blindness and racial harmony. Of course, habitus only goes so far in explaining the social reproduction of dominant cultural discourses, since competing discourses are constantly created, circulated, and adopted. This process occurs unevenly, however, across a population divided by vast differences in education, income, and access to information.

Another possible explanation for the mismatch between interviewees’ responses and Brazilian public health discourse is that racial health disparities may simply look different on the ground. Statistical data provide a macro-level picture of observable trends that can vary widely over a country as diverse as Brazil. Until recently, statistics demonstrating health inequalities by color/race were not available; they still are not publicized widely, beyond the occasional newspaper article.¹⁷ Furthermore, my findings are based on each interviewee’s personal experiences and observations; these might look quite different if the same study were conducted in another state, city, or neighborhood. More research is needed to construct a more complete picture of Brazilians’ perceptions concerning racial identity and health status.

Conclusion

Brazil’s new race-conscious health measures are part of a new biopolitical paradigm in which the Brazilian state formalizes citizens’ racial and ethnic differences to address inequalities among them. As Brazil increasingly adopts global discourses on racial categorization and racial health

disparities, it also deploys a new mode of biopolitics that seeks to track black Brazilians and, according to official discourse, maximize their health. The moment of race tracking during the medical encounter becomes a site for altered rituals of interpellation between state and subject (Althusser 1971). In the process, the state concedes that Blacks have been categorically excluded from equitable health care and proposes to redress their exclusion through an ideological makeover of the public health system, its employees, and their practices. However, reports of patients' resistance to having their race data recorded (Pagano 2011), and of health care providers' reluctance to ask patients their race (Araújo et al. 2010), indicate that the new paradigm has not yet taken hold.

I have argued in this article that Brazil's new health measures for black citizens embed discourses related to health equity that fail to resonate with many Brazilian citizens' ideas about race and health. The result is a disjuncture between policy and practice that complicates the Brazilian state's efforts to reduce health inequalities among its citizens. This does not mean that the state should take no political action to combat health inequalities between people from different racialized groups. On the contrary, I believe that discrimination based on social categories of race can dramatically affect populations' health and that measures to address the root causes of health disparities are indispensable. In the case of Brazil, such measures are warranted as epidemiological research continues to show a significant and troubling association between darker skin color and worse health—even if the real picture of health disparities does not fall neatly into black/white categories.

Health disparities interventions in Brazil would perhaps reach more citizens if they utilized more familiar categories of racial identity. Then again, maybe they would not. As long as most Brazilians continue to identify poverty (not race) as the primary determinant of poor health, and resist the idea that "Blacks" have worse health than "Whites," Brazilian black health activists will face an uphill battle in convincing policymakers, providers, and patients to think otherwise. Brazil's Health Ministry would need to undertake a long-term, nationwide public education campaign to accomplish such a feat. Until then, the task of addressing racial health disparities in Brazil remains far from black and white.

APPENDIX

QUESTIONNAIRE: PUBLIC HEALTH PATIENTS

A. Demographics and Health Care

1. Sex: M F

2. How old are you? _____

3. Are you currently working? Y N

(If yes) What is your occupation? _____

4. What is the highest grade level you have completed? _____

5. What is your race or color? _____

6. What is your religion (if you have one)? _____

7. How many times per year do you visit your local public clinic? _____

8. Please tell me about your experiences with the public health services here in your neighborhood. How have you been received and treated by them?

9. Do you think all patients at your local public clinic are treated equally? (If no): Why or on what basis are they treated differently?

B. Race/Color and Racism

10. What does “race” mean to you?
11. What are the colors or races of the human species? Please list them for me.
12. Do you think people of different colors have equal living conditions? (If no) Please tell me more. Why are their living conditions unequal? Where do you see this inequality happening?
13. Do you think blacks (here, use interviewee’s own term from #10) suffer more or more often from certain illnesses than whites (idem), or vice-versa, or do they suffer from the same illnesses in equal measure? (If interviewee says there is a difference) Who suffers more/less from which illnesses? Why do you think this difference exists?
14. Would you like to add anything?

Notes

1. All research participants’ names have been changed to protect confidentiality
2. Throughout this article, I assume that biological human races do not exist. Rather, I use race to signify a shifting social construct that can nevertheless impact health due to social stratification and exclusion. To not compromise readability, I have avoided placing the word race in quotes within the body of the text.
3. It is difficult to choose appropriate terminology when discussing racial identity in any context; this difficulty is compounded when writing in English about Brazil’s famously complex system of racial classification. My use of “black” and “white” in this article is not meant to superimpose U.S. racialization norms, but is necessary due to the lack of a more precise analytical lexicon in English.
4. Due to the recent focus in health policy on black health issues (*saúde da população negra*), health indicators for Asian and indigenous populations are often deemphasized in papers addressing this topic. There is, however, a substantial amount of research on indigenous Brazilians’ health indicators (e.g., Coimbra and Santos 2000; Langdon 2004).
5. My fieldwork also included participant observation in health administration offices and social movement meetings, as well as interviews with social movement activists, health care providers and administrators, and biomedical researchers. Due to space limits, I cannot include data from those interviews here. They will be the focus of future articles.
6. I use the term “movimento negro” in accordance with academic literature and Brazilians’ common use of the term to denote a set of political and cultural organizations generally dedicated to the empowerment of black Brazilians and the valorization of black identity in Brazil.
7. Nego is an affectionate, diminutive version of negro, while negão is an augmentative form.
8. Analysts and policymakers in Brazil often refer to race-conscious health policy as a non-quota-based form of “affirmative action” in health care (e.g., Maio et al. 2010).
9. “Senadores aprovam Estatuto da Igualdade Racial, mas retiram cotas.” <http://correiobrasiliense.com.br> (accessed June 18, 2010).
10. From this point on, place names have been changed to protect the communities that participated in my study.
11. Source: www.ibge.gov.br/cidadesat (accessed October 20, 2011).
12. Source: www.ibge.gov.br (accessed October 18, 2011). Race categories are stated in the feminine gender on the Brazilian census since they correspond to the question, “Qual é sua raça ou cor?” (What is your race or color?), where both raça and cor are feminine substantives.

13. In their study of Brazilians' perceptions of discrimination in health care, Travassos et al. (2011) found that lack of money and social class were the most commonly cited reasons for unequal treatment.
14. In Portuguese, *raça* can have various meanings, including a dog's breed.
15. Twine (1998:67) also applies Bourdieu's theory of social reproduction (in particular, *doxa*) to explain the simultaneous maintenance and denial of structural racism in Brazil.
16. See Scheper-Hughes (1992:Chap. 5) for an insightful discussion of misrecognition of hunger and oppression among poverty-stricken Brazilians.
17. See, for example, *Folha de São Paulo*, June 26, 2009. Negros fumantes têm cinco vezes mais risco de câncer. <http://www1.folha.uol.com.br/folha/equilibrio/noticias/ult263u586716.shtml> (accessed December 16, 2010).

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Figure 1. Distribution of Race/Color (Pretos and Pardos), 2000.

