Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.3
DOI: 10.1590/1413-81232024293.06732023EN

Antiracist ethos and the collective oral health as a pathway for life

Marcia Pereira Alves dos Santos (https://orcid.org/0000-0003-0349-8521) [1]
João Luiz Bastos (https://orcid.org/0000-0002-1816-0745) [2]

Abstract *This article proposes a reflection on the imperative of antiracism in collective oral health, which, as a science, field, core, and praxis, contributes significantly to the reconstruction of an ethos that considers equity and enables citizenship and democracy. As a paradigm, we assumed the concept of "Buccality" and the guidelines of the National Comprehensive Health Policy for the Black Population, emphasizing the defense of the right to health as a prerogative of the right to life and the combat against racism and all forms of discrimination systematically. As a critical exercise, we discussed the status quo of collective oral health. We pointed to adopting a racial pro-equity perspective as an intentional, political choice socially agreed upon with all of society for social justice. Finally, we propose recommendations for dismantling systemic racism in collective oral health.*

Key words *Black people, Oral Health, Systemic racism*

[1] Faculdade de Odontologia, Universidade Federal do Rio de Janeiro. R. Prof. Rodolpho Paulo Rocco 325, Ilha da Cidade Universitária. 21941-913 Rio de Janeiro RJ Brasil. dramarciaalves@ufrj.br
[2] Faculty of Health Sciences, Simon Fraser University. Burnaby BC Canada.

Introduction

In Brazil, the 1988 Constitution provides health to everyone indiscriminately as an inalienable, non-market, universal, comprehensive, and equitable right[1]. Oral health is an indicator for all generations, a metric for quality of life[2] and evaluating health systems[3,4], including the Unified Health System (*Sistema Único de Saúde*, SUS)[5]. In this sense, good oral health is an indicator of citizenship[1].

The report on the oral health condition of the population at a global level, published in November 2022 by the World Health Organization[6], reviewed the data on the oral health condition at a global level. It showed that oral diseases rank high in the causes of illness due to NCDs, affecting approximately half of the world's population (45% or 3.5 billion people worldwide)[7]. Populations in situations of greater social vulnerability, such as racialized groups or minorities, are the most affected, and this is also observed in Brazil[8].

Black people are seen as different[9] and, because this difference is problematic, they are left outside the power structures where the system is used to define everything, blocking spaces and narratives[9], conditions that evidence systemic racism[9]. Furthermore, like a lethal virus, permanently reissued and with global coverage[10], in its institutional, interpersonal, and internalized[11,12] multidimensionality, racism is characterized as another global public health issue[13,14], violates rights to health and life and makes democracy unfeasible[15]. As a system, racism materializes by naturalized illness and normalized death, the lack of even fragility of effective public policies for racially marginalized populations over time[10-17] who are left to their own devices and blamed and stigmatized.

The denial of racism is camouflaged in the mistaken concept of racial democracy, the narcissistic pact of whiteness, and the production of oppression, neglect, and annihilation[9,13-15]. It is directly related to preserved racial inequalities in oral health[8], reflected in the more significant accumulation of oral diseases in the Black population, such as tooth decay, periodontal disease, and tooth loss[8], and the insistent disregard for actions to implement public policies, including oral health, for this majority group[12] in the Brazilian population[16,17].

The assumption of equity as a principle is imperative to reduce racial inequalities[18]. It has already been stated by the National Comprehensive Health Policy for the Black Population approximately a decade and a half ago[19]. Although it is not a new recommendation in Brazil[19], its implementation has not been effective, and this is fundamental to combat racism. The results of the 2019 National Health Survey[20] exemplify this need by showing that if, on the one hand, Black men and women had a smaller number of dental appointments, on the other, the percentage of people aged 18 or over who lost 13 or more teeth in Brazil was higher in the Black population (i.e., both sexes of brown and Black people together)[20]. The situation is even more severe when considering only self-declared Black men and women since this population had more teeth lost than the other groups analyzed, even when they are minorities in the Brazilian North, Southeast, and South. In other words, besides being a minority and going to the dentist less frequently, the Black population had higher tooth losses than the Brazilian population as a whole[20].

Racial inequalities in oral health regarding tooth decay, tooth loss, pain, and the need for prostheses, to the detriment of the Black population (Black and brown) compared to white people, have already been reported in Brazil[21], with cumulative intersectional disadvantages when considering gender, generation, and territory intersections. One study[22] showed a significant interaction between ethnicity and sex in tooth loss, with a disadvantage for Black women who had a 19% higher prevalence of tooth loss compared to white men (PR: 1.19; 95%CI: 1.05-1.34); 26% higher compared to white women (PR: 1.26; 95%CI: 1.13-1.42), and 14% higher compared to Black men (PR: 1.14; 95%CI: 1.02-1.27)[22]. On the other hand, the likelihood of never having been to the dentist is twice as high for the Black elderly population than for older white adults, and the probability of having used oral health services in the last year is lower for Black older adults compared to older white adults[23]. The need for a prosthesis or pain did not curb the difficulty in using the dental service for Black older adults[23]. This setting is comparable to that of older adults of the traditional *quilombola* communities, particularly concerning high tooth loss frequency and the difficult access to dental services[24].

In a study[25] that aimed to systematically review the association between social mobility throughout life and tooth loss among adults and older adults, the authors showed that downward social mobility had a stronger association with tooth loss than upward social mobility. The findings also showed that being persistently at lower social levels throughout life had the

most detrimental impact on tooth loss. However, downward and upward trajectories have also been associated with a greater likelihood of having tooth loss than persistently high social status, which means that socioeconomic disadvantage at any period of life leads to tooth loss, corroborating the accumulation hypothesis[25]. However, we should underscore that the worst socioeconomic conditions have historically been experienced by racialized or minority groups[7], which is no different for the Black Brazilian population[17], reflecting structural racism. Failure to incorporate the perspective of ethnic-racial equity in studies, particularly in Brazil, does not contribute to a better understanding of socially determined phenomena for health outcomes[26] and, therefore, hampers effective interventions to promote the improved health status of these populations.

Opting for tooth loss as a highlight to illustrate the deprivation of oral health among the Black population was not random and is grounded on its use as an indicator of quality of life[27]. Tooth loss is used to calculate the indicator of years of life lost due to disability[27]. Furthermore, tooth loss weighs heavily on the estimation of years of life lost due to disability when associated with other morbidities common to the Black population, such as sickle cell disease, stroke, cardiovascular disease, kidney disease, cancer, or metabolic diseases. Oral diseases associated with other diseases deteriorate the quality of life and reduce life expectancy[27]. Keeping this setting of racial inequality in oral health is a way of anticipating death in the Black population.

The horizon of death embodied by Black genocide and the result of necropolitics is expressed in body objectification and disposal[28]. It is yet another structural racism hallmark. Assuming such a concept and making an analogy to oral health, we can infer that such tooth loss, which is more frequent among the Black population, still implements, even today, a colonizing logic of successive and cumulative mutilations and, consequently, an induced slow death. We should add that the failure to make efforts to implement actions or strategies that promote "oral health rehabilitation" and, above all, expand access to oral health for the Black population confirms intentionality and violates rights. Furthermore, it is imperative to question a different care rationale for the same need in which racialized groups receive simpler, cheaper, or mutilating treatments[29]. We should also be aware of how discriminatory treatment manifests in providing oral health care. Recent research conducted in Brazil[30] showed that, dentistry students reported less confidence (more insecure/less prepared/more concerned about getting it right) for the same therapeutic proposal when treating white pediatric patients compared to Black ones. The highest level of self-confidence evidenced by dentistry students was for Black girls and shows how the subjectivity of racism materializes in racial discrimination. Increasing self-confidence is, intuitively or not, preconceiving simplification, devaluation, and objectification (unimportance) for those Black children bodies. This finding is not limited to dentistry regarding managing racially marginalized populations within the clinic[31-33]. In other words, the colonizer's logic of offering inferior treatment or treatment marked by more significant difficulties for specific population segments is reproduced. It is necessary to decolonize minds[32] to produce oral health care since the consequences of racism are unquestionably harmful.

The "presumed" irrelevance of the theme of ethnic-racial relations is another form of systemic racism, observed in the systematic lack of this content in training curricula at different educational levels, in political-pedagogical projects, scientific or technological knowledge production spaces, management and care spaces, different discussion forums, meetings of societies and class representative associations[34,35]. A "hallucinating" and "disturbing" silence needs to be interrupted by an anti-racist ethos[36-38] for racial equity[18], impelling the change from this silenced status to the anti-racist ethos through collective voices for oral health such as possible pro-equity path, seeking citizenship and democracy, with attention to the specificities of the Brazilian reality, given the heterogeneous Black population and its connections with global populations and the world.

The hegemonic *ethos* in our country, that is, the sociocultural *ethos* intertwined with structural racism, introjected into all parts of society, infiltrating its values and counter-values at all levels, arises from the particularity of the Brazilian socio-historical reality resulting from four hundred years of slavery and how the dynamics occurred, which now brings this heritage to the construction and preservation of a social praxis[39]. In this logic, the history of non-whites is traversed by the treble process of delegitimization as it almost completely removes the presence of epistemological contributions from other ethnic and cultural sources, leading to the invisibility and stereotyping of social groups once again[32]. The advent of democratic republics acts similarly to past colo-

nialism since it is historically impossible to consider for these inferior groups all their demands in democratic action. On the contrary, exercising hegemonic power occurs through the right of veto as an expression of hatred. It is directly antagonistic to a (loving) human relationship, which should lead to the relationships between people and their counterparts[40]. Establishing a coherent social praxis requires imperatively (re)recognizing that the ties inherent in and resulting from enslavement by the forms of agency of subjectivities and a way of being and leading conducts underlies the subjectivization and constitution of social subjects that reify the current *ethos*[32,39-41].

The anti-racist *ethos* is a civilized way of resisting and opposing the hegemonic ethos (status quo) and the incivility of Brazilian policies by proposing to break with the coloniality that still plagues us[41]. In practice, it means questioning the current asymmetries of power and knowledge coloniality: recognizing and strengthening what one's own is, assuming one's thinking, experimenting with inversions, and questioning identities and colonial differences. This insurgency allows self-decolonization or implies new social conditions of power, knowledge, and being[41]. In other words, it is the awareness of the evils caused by oppression. Kostuczenko *et al.*[42] argues that Freire and Fanon propose the unveiling of this oppressive reality through a community praxis in which cooperation and participation are the driving axes for developing an anti-racist education enshrined in curricular decolonization through the denunciation of racism concomitantly with the announcement of pedagogical and political practices embodied in commandments in favor of the enjoyment of a full life for all human beings, lived out of compassion and solidarity with the entire community of life. They translate into possible teaching-learning experiences grounded on what is our own[43] whether in academic spaces, but above all, outside; in territories, African religion temples, the streets, prisons, quilombos, that is, the mobilizer is what emanates from popular education[32,41-43]. As long we are imprisoned by outdated theories or by habits of rigid practices, we will not truly transform reality and propose equity in our daily lives, highlighting the need for theory and practice to go hand in hand so that a liberating action can be produced in societies historically marked by inequalities[44]. An anti-racist *ethos* as a brand differentiates itself, therefore, by establishing a practical link with theoretical devices, considering the latter not as theorizations removed from reality but as transformative technologies; and, secondly, by its ability to link and unlink with other post-emancipation movements and ideas. In this sense, the anti-racist ethos is flexible and open to dialogue from a place of critical and practical enunciation and, above all, functionally as a technology of and for social transformation.

As clues to the anti-racist *ethos*, it is suggested to incorporate Law No. 11,645 of March 10, 2008, which amended Law No. 9,394 of December 20, 1996, modified by Law No. 10,639 of January 9, 2003, which establishes the guidelines and bases of national education, to include in the official curriculum of the education network, the mandatory theme "Afro-Brazilian and Indigenous History and Culture"[45] in communion with the National Comprehensive Health Policy for the Black Population (PNSIPN)[19] as de-silencing tools-resources. The PNSIPN[19] points to six guidelines:

1) including the themes of racism and the health of the Black population in training and continuing education processes;

2) expanding and strengthening the participation of the Black social movement in bodies of social control of health policies;

3) promoting the recognition of widespread health knowledge and practices, including those preserved by African-based religions;

4) implementing monitoring and evaluating actions to combat racism and curb ethnic-racial inequalities in health in the different government spheres;

5) encouraging the production of scientific and technological knowledge in the health of the Black population;

6) developing information, communication, and education processes to deconstruct stigmas and prejudice, strengthening a positive Black identity to reduce vulnerabilities.

The status quo of Public Oral Health and confronting (or not) racism

Despite the worst oral health conditions of the Black population and their link with racism at various conceptual levels, the dominant interpretations of racial inequalities in the area are still based on biological conceptions of the division of humanity into genetically distinct races[31-37]. These interpretations range from specific oral health problems to the use/access to health services and often blame Black populations for their worst conditions – whether due to biological aspects or culturally determined behaviors[31-37]. Such inter-

pretations are invalid from a scientific viewpoint and ethically reprehensible[31-37]. There is abundant scientific literature showing the non-existence of biological distinctions between racial groups, on the one hand, and on the other, the role of racism in the genesis of health inequalities[14,31-37]. From an ethical perspective, if the ultimate reasons for racial inequalities in oral health are issues linked to biology or culturally determined behaviors, interventions on the problem are automatically limited and ineffective and preserve a general framework of racial inequalities in oral health.

Thus, racial inequalities in oral health must be analyzed in the context of racist societies, which adopt numerous strategies (e.g., symbolic/cultural, material, political, and social) to unfairly distribute power and resources under an arbitrary and hierarchical structure of the population into racial groups. We call these symbolic/cultural, material, political, and social processes systemic racism and are at the heart of racial inequalities in oral health. Conceiving racial inequalities in oral health from scientifically based and ethically positioned perspectives implies focusing on racism as its origin and implementing strategies, policies, and actions to combat it[15,18,29,30-35,45,46].

Discussing through the concept of health equity in the contemporary world of blatant socioeconomic-racial-geographical and environmental inequalities is urgent[17]. Hence, radicalizing the adoption of ethnicity/skin color is an essential pro-equity social marker resulting from a political choice, from ethics (*ethos*) in search of social justice that permeates the production of scientific knowledge incorporating this social marker[26]. The concept of buccality[47] establishes as a reference for oral health its inseparability from the right to life and citizenship. Thus, collective (oral) health as a core and praxis must prioritize epidemiological studies that exceed merely measuring factors and consider their inseparable link with the social dimension since no epidemiology is non-social; likewise, evaluations of public policies and services must be based on solving detected problems to strengthen the Unified Health System and, consequently, benefits for most of society. Therefore, they need to be part of the State and Society discussion, increasingly requiring Social Sciences[48]. To account for this complex relationship between the mouth and the world, Botazzo[47] elaborates on the concept of buccality, where mouth-life articulates with generic social life or as part of the biopsychosocial nexus, resulting from subjectivities in which oral health derives from life opportunities, as a manifestation of the body as a whole and not isolated, compartmentalized, reduced to teeth/organs/body cavity, a subject in its entirety in its determinations, limits and possibilities, all of which are closely related to the fight for rights, equity, and democracy. This understanding is another analytical key to understanding and incorporating the anti-racist ethos into collective oral health.

We should remember the importance of health conferences to guide and incorporate regulations for the Unified Health System into their documents, assuming the premises listed for the effective achievement of citizenship and democracy. Like health, health equity must be understood as a state determined by multiple factors, and its measurement is made by comparing established parameters. The content on health equity is consolidated by explaining parameters that allow comparing social groups against given needs, with repercussions on health status. The construction of health equity takes on a political dimension when analyzing the acceptable scientific and moral standards that prevail in a given State. Equity is assumed to be an ethical value and can be considered the most political of virtues[49]. No doubt, breaking the reproduction of health inequalities requires a very proactive stance from everyone based on an ethic of responsibility[32]. Demolishing barriers imposed by racism is an ethical choice in favor of life inherent to a new social pact, in which the fight against systemic racism is the (re)connecting link[50].

Practical notes for building an anti-racist ethos in collective oral health and confronting systemic racism

The advances in public policies for the oral health of Brazilians are recognized. The National Oral Health Policy within the Unified Health System is a concrete example[51]. Incorporating the anti-racist perspective in its implementation and operationalization will reduce racial inequalities and include the Black population in the right to oral health (Chart 1). The case of oral health care for people with sickle cell disease is an example of how actions inherent to public policy for people's oral health need to incorporate the racial dimension[52]. The adequate provision of dental services must address systemic racism as a producer of inequalities[53-55].

The following is proposed for a movement towards an anti-racist *ethos* in Dentistry:

1 - Assume racial equity as a reference framework for any intervention;

2 - Incorporate the ethnic-racial perspective in education, research, and extension for collective oral health content in the light of buccality[47], explicitly considering the heterogeneous Black populations, their territories, geographic areas, habits, and local and ancestral customs and values;

3 - Include race/skin color/ethnicity as a proxy in all interventions to enable analysis and decision-making based on this social marker;

4 - Promote anti-racist governance;

5 - Promote the production of scientific knowledge, technologies, and innovation – organization, and production of new knowledge to clarify persistent doubts and support decision-making in oral health for the Black population in formal and, above all, non-formal spaces, providing opportunities for creative solutions produced by peripheral populations in holy African religion temples, villages, and on the streets, intersectionally;

6 - Qualify professionals to promote changes in the behavior of all professionals in the area through adequate formation and training to address the diversity of Brazilian society and the peculiarities of the health-disease-life process of the Black population;

7 - Communicate effectively with the population based on their daily lives, striving for representation, dialogue, dissemination of information and knowledge, emphasizing territories, healthy lifestyle habits, customs, and values to prevent diseases, potentialities, and susceptibilities in terms of oral health, to enable them to identify their vulnerabilities;

8 - Offer comprehensive, integrated, multidimensional, multidisciplinary, and territorialized health care in strategic and data-based fashion – including health promotion and education practices for the Black population in care routines and facilitating access at all levels of the health care system, including beliefs, customs, habits, values, and practices;

9 - Enable, defend, provide opportunities, and guarantee the occupation of positions or decision-making positions by social stakeholders with critical racial literacy[56] and participate in agendas in defense of collective oral health in pro-racial equity mobilizations;

Chart 1. Some practical notes for anti-racism in collective oral health.

Actions or strategies	**Black population**				
	Life cycles	**Territories**	**Income**	**Access to health**	**Different needs**
Plan strategic actions for oral health in science, field, core, and praxis	Children Adolescents Women/Men Pregnant Adults Older adults	Urban Peri-urban Rural Peripheries Assistance gaps	Education Employability Informality Social programs	Basic sanitation Foods Access to services, inputs and health systems	Quilombola, riverside communities and other traditional communities Homeless population People deprived of liberty LGBTQIA+ Immigrants and refugees People with diseases more prevalent in the Black population
Include the racial dimension as a device for selection, analysis, monitoring, and evaluation of planned actions or strategies.					
Ensure selection processes, training courses, qualification programs and decision-making spaces. Induce an agenda of studies, research, and training of human resources for and with racial literacy.					
Adopt actions to repair the historical process of enslavement that act as access barrier.					
Ratify the SUS as a privileged space for training and qualification in collective oral health and incorporate into the national curricular guidelines for graduation in Dentistry the National Curricular Guidelines for the Ethnic-Racial Relationships Education and the Teaching of Afro-Brazilian and African History and Culture as the population's de facto guarantee of oral health as a right.					

Source: Authors.

10 - Finance or facilitate financing and provide sustainability to decolonizing actions and strategies that target previously silenced, made invisible, or disqualified narratives.

To be effective, such propositions must transcend the health domain and be articulated between other sectors, including human rights, racial equality, justice, housing, work, social assistance, food and nutrition, sports, culture, and education. For Higher Education, Resolution CNE/CES No. 3 of June 21, 2022, established the national curricular guidelines for the undergraduate course in Dentistry[57], with a proposal to contribute to the formation of a critical-reflective, humanistic, and self-aware professional and society and include the racial perspective among the graduate's competencies[57]. It is a strong ally for an anti-racist ethos when considering the ethnic-racial dimension in its implementation[57].

Most Black people are SUS clients. Thus, supervised internships in Dentistry at the SUS are another opportunity for this anti-racist ethos, given its intentionality, responsibilities, and objectives[58]. Trad *et al.*[59] propose breaking with the disciplinary format and focusing on practices in territories as the central axis of training, based on the questions: Which territories can provide significant learning? What do we take to the territory, and what do we intend to learn from it? How will we build knowledge with people instead of bringing information to people?

In Public Health, the stimulus in the teaching-learning process stems from sensitive and respectful listening to the Other, the critical and dialogical stance, and epistemological surveillance to foster interdisciplinary and interprofessional views among teachers and students that enhance the understanding of the health amid social, cultural, political and ideological processes[59]. The challenge to be overcome and which also limits the teaching staff refers to the existence of racially illiterate university staff or even a low presence of Black teachers. Thus, a contribution to an anti-racist *ethos* in collective oral health is the Quota Policy adopted in Brazil as affirmative action to reduce such racial inequalities.

A final practical note

Agents working for collective oral health must pay attention to this call to catalyze this change by promoting a space for dialogue and articulation between researchers, health professionals, managers, social participation, educators, social movements, and society in general in search of equity, social justice, and democracy. To do this, in the face of any situation[31], look at the problem and analyze it carefully, especially the structures of decision-making – for "who, what, when, and where" –, policies – "how" it is written –, practices and norms – "how" it is not inscribed –, and values – "why". Collective oral health is called upon to drive the antiracism *ethos* as an imperative.

Our reflection aimed to establish links between the anti-racist ethos and buccality, both as opportunities for collective oral health to confront the deep-seated dynamics of structural racism. Walsh[41] made this invitation to us by indicating that it is necessary to explore the links between the "pedagogical" and the "decolonial", realizing the inclusion of experiences defined in the path taken. We should consider initiatives based on solidarity and cooperation in the subversion favored by the community and disobedient practices. Therefore, any educational proposal will have to start from a sensitive listening (in the sense of reviewing its insufficiencies in terms of what we have been unable to denaturalize, including in the curricula) – something that is confronted, that denounces the also epistemic violence and can generate proposals for strategies that lead us to decolonize our bodies and discursive practices. Such an association is fundamental to the collective oral health we desire.

Collaborations

All authors collaborated equally in the elaboration of the manuscript.

References

1. Brasil. Constituição da República Federativa do Brasil de 1988. *Diário Oficial da União* 1988; 5 out.
2. Peres MA, Macpherson LMD, Weyant RJ, Daly B, Venturelli R, Mathur MR, Listl S, Celeste RK, Guarnizo-Herreño CC, Kearns C, Benzian H, Allison P, Watt RG. Oral diseases: a global public health challenge. *Lancet* 2019; 394(10194):249-260.
3. Watt RG, Daly B, Allison P, Macpherson LMD, Venturelli R, Listl S, Weyant RJ, Mathur MR, Guarnizo-Herreño CC, Celeste RK, Peres MA, Kearns C, Benzian H. Ending the neglect of global oral health: time for radical action. *Lancet* 2019; 394(10194):261-272.
4. Wang TT, Mathur MR, Schmidt H. Universal health coverage, oral health, equity and personal responsibility. *Bull World Health Organ* 2020; 98(10):719-721.
5. Pucca GA, Gabriel Jr M, Araujo ME, Almeida FCS. Ten Years of a National Oral Health Policy in Brazil. *J Dent Res* 2015; 94(10):1333-1337.
6. Word Health Organization (WHO). *Non-communicable diseases WHO team. Global oral health status report: towards universal health coverage for oral health by 2030* [Internet]. 2022 [cited 2023 maio 1]. p. 8. Available from: https://www.who.int/teams/non-communicable-diseases//global-status-report-on-oral-health-2022.
7. Word Health Organization (WHO). *Non-communicable diseases WHO team. Global oral health status report: towards universal health coverage for oral health by 2030* [Internet]. 2022 [cited 2023 maio 1]. p. 15. Disponível em: https://www.who.int/teams/non-communicable-diseases//global-status-report-on-oral-health-2022.
8. Fagundes MLB, Bastos LF, Amaral Júnior OLD, Menegazzo GR, Cunha ARD, Stein C, Iser BPM. Desigualdades socioeconômicas no uso de serviços odontológicos no Brasil: uma análise da Pesquisa Nacional de Saúde de 2019. *Rev Bras Epidemiol* 2021; 24:e210004.
9. Kilomba G. *Desobediências poéticas*. Curadoria Jochen Volz e Valéria Piccoli. São Paulo: Pinacoteca de São Paulo; 2019.
10. Paim P. Sobre 20 de novembro: com racismo, não há democracia [Internet]. *Nexo Jornal, Coluna Tribuna*; 2020 [acessado 2023 jan 7]. Disponível em: https://www.nexojornal.com.br/colunistas/tribuna/2020/Sobre-20-de-novembro-com-racismo-n%C3%A3o-h%C3%A1-democracia.
11. Jones CP. Confronting institutionalized racism. *Phylon* 2003; 50(1-2):7-22.
12. Werneck J. Racismo institucional e saúde da população negra. *Saude Soc* 2016; 25(3):535-549.
13. Ford CL. *CDC Director Declares Racism a Public Health Issue - My Initial Reflections* [Internet]. Center for the Study of Racism, Social Justice & Health; 2021 [cited 2023 jan 07]. Available from: https://www.racialhealthequity.org/blog/2021/4/9/cdc-director-declares-racisma-public-health-issue-my-initial-reflections.
14. Eschner K. *Racism is undeniably a public health issue* [Internet]. Popular Science; 2020. [cited 2023 ago 9]. Available from: https://www.popsci.com/story/health/racism-public-health/.

15. Coalizão Negra por Direitos. *Manifesto: "Enquanto houver RACISMO, não haverá DEMOCRACIA"* [Internet]. Geledés; 2020 [acessado 2023 jan 7]. Disponível em: https://www.geledes.org.br/manifesto-enquanto-houver-racismo-nao-haverademocracia/.
16. Instituto Brasileiro de Geografia e Estatística (IBGE). *Pesquisa Nacional por Amostra de Domicílios Contínua (PNAD)* [Internet]. Rio de Janeiro: IBGE; 2023 [acessado 2023 ago 7]. Disponível em: https://www.ibge.gov.br/estatisticas/sociais/populacao/17270-pnad-continua.html?=&t=notas-tecnicas.
17. Instituto Brasileiro de Geografia e Estatística (IBGE). *Desigualdades sociais por cor ou raça no Brasil. Estudos e Pesquisas. Informação Demográfica e Socioeconômica*. 2ª ed. Rio de Janeiro: IBGE; 2022.
18. Welch VA, Petkovic J, Jull J, Hartling L, Klassen T, Kristjansson E, Pardo JP, Petticrew M, Stott DJ, Thomson D, Ueffing E, Williams K, Young C, Tugwell P. Chapter 16. Equity and specific populations. In: Higgins J, Thomas J, Chandler J, Cumpston M, Li T, Page M, Welch V, editors. *Cochrane Handbook for Systematic Reviews of Interventions*. 2nd ed. Hoboken: John Wiley & Sons; 2019. p. 435-449.
19. Brasil. Ministério da Saúde (MS). Portaria nº 992, de 13 de Maio de 2009. Institui a Política Nacional de Saúde Integral da População Negra. *Diário Oficial da União* 2009; 14 maio.
20. Instituto Brasileiro de Geografia e Estatística (IBGE). *Pesquisa nacional de saúde 2019: percepção do estado de saúde, estilos de vida, doenças crônicas e saúde bucal: Brasil e grandes regiões*. Rio de Janeiro: IBGE; 2020.
21. Guiotoku SK, Moysés ST, Moysés SJ, França BHS, Bisinelli JC. Iniquidades raciais em saúde bucal no Brasil. *Rev Panam Salud Publica* 2012; 31(2):135-141.
22. Terra e Souza LH, Diaz-Quijano FA, Barros MBA, Lima MG. Race (blackwhite) and sex inequalities in tooth loss: A population-based study. *PLoS One* 2022; 17(10):e0276103.
23. Souza EHAD, Oliveira PAPD, Paegle AC, Goes PSAD. Raça e o uso dos serviços de saúde bucal por idosos. *Cien Saude Colet* 2012; 17(8):2063-2070.
24. Miranda LDP, Oliveira TL, Queiroz PDSF, Oliveira PSD, Fagundes LS, Rodrigues Neto JF. Saúde bucal e acesso aos serviços odontológicos em idosos quilombolas: um estudo de base populacional. *Rev Bras Geriatr Gerontol* 2020; 23(2):e200146.
25. Celeste RK, Darin-Mattsson A, Lennartsson C, Listl S, Peres MA, Fritzell MA. Social Mobility and Tooth Loss: A Systematic Review and Meta-analysis. *J Dent Res* 2022; 101(2):143-150.
26. Santos RV, Bastos JL, Kaingang JD, Batista LE. Cabem recomendações para usos de "raça" nas publicações em saúde? Um enfático "sim", inclusive pelas implicações para as práticas antirracistas. *Cad Saude Publica* 2022; 38(3):00021922.
27. GBD 2019 Diseases and Injuries Collaborators. Global burden of 369 diseases and injuries in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet* 2020; 396(10258):1204-1222.
28. Mbembe A, Corcoran S. *Necropolitics*. Durham: Duke University Press; 2019.
29. Chrisini LA, Noronha, TG, Santos-Junior RB, Sampaio KH, Faria-E-Silva AL, Corrêa MB. Does the skin color of patients influence the treatment decision -making of dentists? A randomized questionnaire-based study. *Clin Oral Investig* 2019; 23(3):1023-1030.
30. Lamenha-Lins RM, Paiva SM, Prado IM, Assis Vieira AC, Pithon MM, Maia LC, Serra-Negra JM. Facial Type, Sex and Skin Color of Pediatric Patients Are Associated with Dental Students' Empathy and Self-Confidence During Dental Care. *J Dent Child (Chic)* 2022; 89(2):75-82.
31. Jones CP. In National Academies of Sciences, Engineering, and Medicine; Policy and Global Affairs; Health and Medicine Division; Roundtable on Black Men and Black Women in Science, Engineering, and Medicine. In: Alexander M, Jones CP, Marrett CB, Bright C, Gamble VN, Hammonds EM, Laurencin CT, editors. *COVID-19 and the Present and Future of Black Communities: The Role of Black Physicians, Engineers, and Scientists: Proceedings of a Workshop*. Washington, D.C.: National Academies Press; 2021
32. Fanon F. *Os condenados da terra*. São Paulo: Companhia das Letras; 2022.
33. Sevalho GD, Santos JV. Frantz Fanon, descolonização e o saber em saúde mental: contribuições para a saúde coletiva brasileira. *Cien Saude Colet* 2022; 27(3):937-946.
34. Gomes NL. Relações étnico-raciais, educação e descolonização dos currículos. *Curriculo Fronteiras* 2012; 12(1):98-109.
35. Santos Júnior MB, Correa MAC. Reflexões imagéticas: entre modelo educacional e práticas antirracistas. *BOCA* 2022; 9(27):98-114.
36. Flanagin A, Frey T, Christiansen SL. AMA Manual of Style Committee. Updated Guidance on the Reporting of Race and Ethnicity in Medical and Science Journals. *JAMA* 2021; 326(7):621-627.
37. Jamieson LM. Racism and oral health inequities; an introduction. *Community Dental Health* 2021; 131:38.
38. Jamieson L, Peres MA, Guarnizo-Herreño CC, Bastos JL. Racism and oral health inequities: An overview. *EClinicalMedicine* 2021; 34:100827.
39. Moura C. Escravismo, colonialismo, imperialismo e racismo. *Afro Asia* 1983; 14:124-137.
40. Estrada MM. Cap. 92. Frente al odio el amor: del imperio de la diferencia a un ethos decolonial. In: Olivero Guidobono S, Martínez González AJ, coordinadores. *Identidades, segregación, vulnerabilidad. Hacia la construcción de sociedades inclusivas? Un reto pluridisciplinar*. Madrid: Dykinson; 2021. p. 1843-1859.
41. Walsh C, organizador. *Pedagogías Decoloniales: prácticas insurgentes de resistir, (re)existir y (re)vivir*. 1ª ed. Equador: Abya Yala; 2013.
42. Kostuczenko K, Figueiredo DG, Figueiredo JW. Contribuições de franz fanon e Paulo Freire para a emersão de uma educação antirracista. *Rev Inter Ação* 2021; 46(ed. esp.):930-945.
43. Freire P. *Pedagogia do Oprimido*. 84ª ed. Rio de Janeiro: Paz e Terra; 2019.
44. hooks b. *Ensinando a transgredir: a educação como prática da liberdade*. São Paulo: Martins Fontes; 2013.

45. Brasil. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. Lei nº 11.645, de 10 de março de 2008. Altera a Lei nº 9.394, de 20 de dezembro de 1996, modificada pela Lei nº 10.639, de 9 de janeiro de 2003, que estabelece as diretrizes e bases da educação nacional, para incluir no currículo oficial da rede de ensino a obrigatoriedade da temática "História e Cultura Afro-Brasileira e Indígena". *Diário Oficial da União*; 2008.
46. Brasil. Presidência da República. Casa Civil. Lei nº 12.288, de 20 de julho de 2010. Institui o Estatuto da Igualdade Racial; altera as Leis nos 7.716, de 5 de janeiro de 1989, 9.029, de 13 de abril de 1995, 7.347, de 24 de julho de 1985, e 10.778, de 24 de novembro de 2003. *Diário Oficial da União*; 2010.
47. Botazzo C. Sobre a bucalidade: notas para a pesquisa e contribuição ao debate. *Cien Saude Colet* 2006; 11(1):7-17.
48. Ferreira EF, Ferreira RC, Botazzo C, Gomes VE, Rodrigues LG, Vargas AMD. A ciência da saúde coletiva por escrito: contribuição para estudos em saúde bucal coletiva. *Cien Saude Colet* 2020; 25(12):4875-4886.
49. Pinheiro MC, Westphal MF, Akerman M. Eqüidade em saúde nos relatórios das conferências nacionais de saúde pós-Constituição Federal brasileira de 1988. *Cad Saude Publica* 2005; 21(2):449-458.
50. Grupo Temático Racismo e Saúde. *Documento de planejamento* [Internet]. Rio de Janeiro: Abrasco; 2018 [acessado 2023 jan 7]. Disponível em: https://www.abrasco.org.br/site/wp-content/uploads/2019/02/Planejamento-01-2018.pdf.
51. Brasil. Ministério da Saúde (MS). Lei nº 14.572, de 8 de maio de 2023. Institui a Política Nacional de Saúde Bucal no âmbito do Sistema Único de Saúde (SUS) e altera a Lei nº 8.080, de 19 de setembro de 1990, para incluir a saúde bucal no campo de atuação do SUS. *Diário Oficial da União*; 2023.
52. Santos MPA, Limia R, Masterson DT, Dias KHC. Sickle Cell Disease Literature. *JADA* 2021; 152(4):256-257.
53. Power-Hays A, McGann PT. When actions speak louder than words - racism and sickle cell disease. *N Engl J Med* 2020; 383(20):1902-1903.
54. Bulgin D, Tanabe P, Jenerette C. Stigma of sickle cell disease: A systematic review. *Issues Ment Health Nurs* 2018; 39(8):675-686.
55. Royal CDM, Babyak M, Shah N, Srivatsa S, Stewart KA, Tanabe P, Wonkam A, Asnani M. Sickle cell disease is a global prototype for integrative research and healthcare. *Adv Genet (Hoboken)* 2021; 2(1):e10037.
56. Pereira AL, Lacerda SSP. Letramento racial crítico: uma narrativa autobiográfica. *Travessias* 2019; 13(3):90-106.
57. Brasil. Ministério da Educação (MEC). Conselho Nacional de Educação. Câmara de Educação Superior. Resolução nº 3, de 21 de junho de 2021. Institui as Diretrizes Curriculares Nacionais do curso de graduação em Odontologia e dá outras providências. *Diário Oficial da União* 2021; 22 jun.
58. Noro L, Narvai PC. Estágio curricular supervisionado: o Sistema Único de Saúde no centro do processo. *Rev ABENO* 2021; 21(1):1744.
59. Trad LAB, Mota CS, López YAA. O ensino das ciências sociais e humanas na graduação em saúde coletiva: entre desafios e oportunidades de transgressões. *Saude Soc* 2019; 28(2):11-24.

Article submitted 14/08/2023
Approved 15/12/2023
Final version submitted 17/12/2023

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva