Conceptualization and uses of Ethnicity and Race Categories in the Health Analysis for Afro-Colombian Population

Conceptualización y usos de las categorías etnia y raza en el análisis de salud para población afrocolombiana

Conceptualização e usos das categorias etnia e raça na análise de saúde para a população afro-colombiana

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Abstract

Objective: The objective of the study was to analyze the conceptualization and use (from the health sector) of the ethnicity and race variables for this population in Colombia. Methodology: This is a qualitative-type study. The corpus consisted of the section "2.3. Intercultural strategic framework with black, Afro-Colombian, Raizal and Palenquera communities" from chapter 8 of the Colombian Ten-Year Public Health Plan 2022-2031 and a text in a medical journal. Points of view and arguments were analyzed from the selected documents. Results: The study found that, for the Afro population in the health sector, there are at least four uses and conceptualizations of their ethnicity and race: one considers this as a social determinant, another as a biological gradient, while the other two may be complementary, when considering the third, the Afro ethnic group as a political, legal fact, which favors a differential approach in health; and the last one, as a culture with African ancestral traces Conclusion: As soon as the ethnicity and race of Afro-descendants is considered as a biological gradient, individual and biological interventions will be strengthened. If, on the contrary, a social determinant is assumed, the focus will be placed on aspects that improve their quality of life, the affirmation of their ancestry in health or the political fact. In addition, without acknowledging the historical and current conditions of exclusion of this population, it will not be possible to understand and influence their health situation.

Keywords: Afro-descendant, black communities, ethnicity, race, health

Resumen

Objetivo: El propósito del estudio fue analizar la conceptualización y el uso que se hace, desde el sector de la salud, de las categorías etnia y raza para esta población en Colombia. Metodología: Estudio de tipo cualitativo. El corpus estuvo constituido por el apartado “2.3. Marco estratégico intercultural con las comunidades negras, afrocolombianas, raizales y palenqueras” del capítulo 8 del Plan Decenal de Salud Pública 2022-2031 de Colombia y un texto en una revista médica. De los documentos seleccionados se analizaron puntos de vista y argumentos. Resultados: El estudio encontró que para la población afro en el sector salud hay, por lo menos, cuatro usos y conceptualizaciones de su etnia y raza: una considera esta como un determinante social, otra como un gradiente biológico, mientras los otros dos pueden ser complementarios, al considerar, la tercera, a la etnia afro como un hecho político, legal, que favorece un enfoque diferencial en salud; y la última, como una cultura con huella ancestral africana Conclusión: En cuanto se considere la etnia y raza de los afrodescendientes como un gradiente biológico, se fortalecerán intervenciones individuales y biológicas; si, por el contrario, se asume un determinante social, se hará énfasis en aspectos que mejoren su calidad de vida, la afirmación de su ancestralidad en salud o el hecho político. Además, sin que se reconozcan las condiciones históricas y actuales de exclusión de esta población, no se podrá comprender e incidir en su situación de salud.

Palabras clave: afrodescendiente, comunidades negras, etnia, raza, salud.

Resumo

Objetivo: O propósito do estudo foi analisar a conceptualização e o uso que se faz, desde o setor da saúde, das categorias etnia e raça para essa população na Colômbia. Metodologia: Estudo de tipo qualitativo. O corpus constituiu-se pelo parágrafo “2.3. Quadro estratégico intercultural com as comunidades negras, afro-colombianas, raizales e palenqueras” do capítulo 8 do Plano Decenal de Saúde Pública 2022-2031 da Colômbia e um texto em uma revista médica. Nos documentos selecionados foram analisados pontos de vista e argumentos. Resultados: O estudo encontrou que para a população afro no setor saúde há, pelo menos, quatro usos e conceptualizações de sua etnia e raça: um deles a considera como um determinante social; outro como um gradiente biológico; já os outros dois podem ser complementários, pois o terceiro considera a etnia afro como um fato político, legal, que favorece um enfoque diferencial em saúde; e, o último, como uma cultura com uma impronta ancestral africana. Conclusão: Sempre que a etnia e a raça dos afrodescendentes se considerem um gradiente biológico, serão fortalecidas intervenções individuais e biológicas; pelo contrário, se é compreendida como determinante social, haverá atenção especial em aspectos que melhorem sua qualidade de vida, a afirmação de sua ancestralidade em saúde ou o fato político. Além disso, sem o reconhecimento das condições históricas e atuais de exclusão dessa população, sua situação de saúde não poderá ser compreendida nem modificada.

Palavras-chave: afrodescendente, comunidades negras, etnia, raça, saúd

Introduction

In Colombia, ethnic and cultural diversity is recognized and protected in the Political Constitution of 1991, article 7. For black communities, Legislation 70 of 1993 defines them as “the group of families of Afro-Colombian descent with their own culture, share a history and have their own traditions and customs within the countryside-town relationship, which reveal and preserve awareness and identity that distinguish them from other ethnic groups” [1].

For this text, *ethnicity* refers to “people who share a cultural heritage. The members of an ethnicity have common ancestors, speak the same language, and have the same religion, and due to all this, have their own or specific social identity” [2, p. 300], while *race* refers to “a category of individuals who share certain hereditary traits that the members of the society consider socially significant or relevant. People can be classified into racial groups, based on physical characteristics, like skin color, facial traits, type of hair, or body shape” [2, p. 299]. Due to the foregoing, *race* and *ethnicity* are not the same and are social categories, inasmuch as “many people continue to classify each other in racial terms and assigning themselves, according to their race, or a place

or another in the social stratification system" [2, p. 299] (this last quote also applies to ethnicity).

In Legislation 70 of 1993, the only legal classification to differentiate the Afro-descendant population in the country is that of "black communities". Nevertheless, the Ministry of the Interior and Justice distinguishes three categories from ethnicity:

- *Afro-Colombians:* it is used to claim or highlight the African ancestry of the population. In recent years, use of this ethnonym has become widespread according to the level of awareness or the political location or historical conception of the person who uses it. In turn, it has emerged as an integrative category of the different ethnic expressions of Colombian Afro-descendance. [3].
- *Palenqueros:* corresponds to groups of black people and families (*cimarrones*) who escaped slavery and spontaneously created group awareness; they founded towns located in places of difficult access, called "*palenques*", where they built an independence project that allowed them to live autonomously, outside the slave society [3].
- *Raizales:* natives of San Andrés, Providencia and Santa Catalina. They are people from west-central Africa and Jamaica, who "were brought to work on the tobacco and cotton plantations […] the native *raizal* community characterized principally by the use of the Creole language, resulting from English and African Ewe, Ibo, Mandinga, and perhaps other languages" in identification process [3].

The Afro-Colombian population is estimated in 4,671,160 people, according to the " 2018 Quality-of-life. Ethnic groups. Technical information Survey (QETS)". In it, the multidimensional poverty index is 11 points above the national average, with lower coverage of basic sanitation and health services, which confirms the importance of a differential approach for this population [4].

Diverse studies conducted in Latin America, including Colombia, demonstrate that important inequalities of the black communities in the situation and access to health services, in contrast with the general population, derive from prevalent political-social structures [5-8].

Given the aforementioned, the Colombian state, from the ethnic differential approach in health, seeks to improve health conditions for Afro-descendants and ethnic peoples overall; however, to achieve this purpose, it is necessary to have conceptual and operational clarity of the *ethnicity and race* categories used, and of the implications derived from this categorization in the health system. The aim of this study was to analyze the conceptualization and use made, from the health sector, of the ethnicity and race categories for the Afro-descendant population in Colombia.

Methodology

A qualitative study was conducted. The corpus was constituted by two documents, section "2.3. Intercultural strategic framework with the black, Afro-Colombian, *Raizales*, and *Palenquero* communities", from chapter 8 of the Colombia's Ten-Year Public Health Plan 2022-2031 (PDSP) [9], which is a normative and reference document for actors of the health system, and a text from medical sciences denominated "Reflections on the Origin of Afro-descendants and Cases of Dengue in Colombia", a letter to the editor of the journal *Colombia Médica*, in 2017, about the article "Afro-Colombian Ethnicity, Paradoxical Protective Factor against Dengue" (journal in the maximum A1 category for the Publindex System) [10], where researchers from the Colombian National Health Institute (NHI) and the article's researchers discuss about the research results.

This study is based on the premise that in the conceptualizations and uses of the ethnicity and race categories for the Afro population in the health sector in Colombia there are at least four variants that are not mutually exclusive: the first considers Afro ethnicity and the black race as a biological gradient and risk or protective factor for certain health conditions; another assumes the Afro ethnicity as a social determinant that stratifies and explains the health outcomes of this population; the third one emphasizes on their ethnicity and traces of the African ancestral legacy; and the last refers to subjects enjoying legal and political recognition since the 1991 Constitution.

From the documents selected, the work analyzed the points of view and arguments that relate the categories and the use assigned to the ethnicity or race of Afro-Colombians, to validate the premise.

The study took into consideration the ethical requisites established in Resolution 8430 of 1993 by the Colombian Ministry of Health, specifically in article 11, which defines research free of risk [11].

Results

The following presents the results of the analysis of the texts stated for each.

As indicated, the first text is section "2.3. Intercultural strategic framework with the black, Afro-Colombian, *Raizales*, and *Palenquero* communities", from chapter 8 of the PDSP.

Within this framework, three points of view are presented about the *Afro-Colombian* category: the first accounts for its ethnic category and this argument highlights the statements:

1. Black communities are defined as the group of families of Afro-Colombian descent who have their own

culture, share a history, and have their own traditions and customs within the populated field relationship, which reveal and preserve identity awareness that distinguish them from other ethnic groups (Congress of Colombia, 1993) [9, p. 198].
2. The guarantee of "enjoying life" for black, Afro-Colombian, Raizales, and Palenquero communities (Quiceno, 2016) means caring for life, territories and development in perspective of biocentrism because various forms and practices are combined in terms of their personal well-being, health, physical strength, and relief from suffering in their daily lives in the family, community and social environments in which they spend their lives, through ritualistic, productive, and political practices [9, p. 198].
3. Traditional Afro-Colombian medicine is a complex system that ranges from prevention and diagnosis practices to curative practices. It covers their own conceptions about health and disease, knowledge about plants and animals with healing properties, techniques for healing and childbirth care, and numerous "secret" practices to cure snake bites, stop hemorrhages or "close the body" to avoid curses and diseases, for which healers use the preparation of "cured bottles" [9, p. 207].

The second point of view accounts for the *Afro* category as a structural determinant of health and the following statements are highlighted:

1. In this sense, a series of historical, social, economic and even political circumstances exist that affect the epidemiological situations and conditions of people and of communities or sectors of population. Thus, said circumstances can become causes of inequities, inequalities and gaps in health […] among the Social Determinants of Health, there are some of structural nature that affect population sectors and which are related with income, education, gender, race, and ethnic pertinence [9, p. 215].
2. […] based on census microdata from eight Latin American countries that collect information on ethnic-racial self-identification in their 2010 round censuses, ECLAC [Economic Commission for Latin America and the Caribbean] estimated that child mortality is higher in the Afro-descendant population in comparison with those not Afro-descendant, with Colombia being the country with the highest proportion of deaths of Afro-descendant children and that registering the greatest gap with the population not Afro-descendent [9, p. 205].
3. Racial discrimination still permeates health systems and hinders quality care for black, Afro-Colombian, Raizales, and Palenquero communities [sic]; in the territories there is no equipment or staff to treat the health of these communities; health centers are normally far from the territories, and there are no access roads or transportation to get to them quickly and/or urgently. [...] (interview knowing woman 2) [9, p. 205].

The third point of view alludes to the political nature of the *Afro* category and is argued with the following statements:

1. It is a right of tribal peoples established by the ILO [International Labor Organization] Convention 169 to participate effectively in decisions that affect them and decide their own priorities regarding processes of economic, social, and cultural development. This Convention and the constitutional principles establish that the organizations and institutions representing the black, Afro-Colombian, Raizales, and Palenquero communities [sic] can develop their objectives for political, organizational, administrative and institutional incidence through the practice of dialogue with the government […] [9, p. 201].
2. The foundations of the preferential treatment that the State must provide to black, Afro-Colombian, Raizales, and Palenquero communities to protect their differentiated ethnic identity must be sought in the different constitutional postulates that proclaim Colombia as a participatory and pluralist Social State of Law that recognizes its ethnic and cultural diversity and the equality and dignity of its entire culture, in human rights treaties incorporated into the internal order with a hierarchy of constitutional norms, like the ILO Convention 169, and in other international instruments that, without having that normative force, operate as a criterion to interpret the content and scope of the fundamental rights recognized for ethnic minorities [9, p. 208].

The second text analyzed was that issued from the medical sciences, "Reflections on the Origin of Afro-descendants and Cases of Dengue in Colombia", a letter to the editor of the journal *Colombia Médica*. Herein, the work reviews the letter from a team of NIH researchers and professionals who make a dissertation of an article published in the aforementioned journal, which concludes that "the Afro-Colombian population had a significantly lower risk of contracting dengue and its complications compared with non-Afro Colombians" and, then, reviews the response to the letter by the article's authors [10].

The document has two postures: the first is defended by the team of NIH researchers, which states that it cannot be concluded that Afros have a lower risk of suffering from dengue and its complications, and it is argued with the following statements:

1. Although characteristics specific to Afro-descendants exist that can give them lower susceptibility to the serious manifestations of dengue, it is known that the pathogenesis of this disease is multifactorial in nature, influenced by variables, like envi-

ronmental factors [...], age [...], gender [...], among others [10, p. 98].

2. A dichotomous classification as Afro-Colombian or not Afro-Colombian can generate measurement errors, considering that patients with an Afro background (mulatto, zambo, mestizo, among others) may be classified as not Afro-Colombian; however, they might have genetic conditions from their ancestors and, thus, vulnerability to possible complications of infectious events of external origin. It is possible that of the 402/431 of severe cases of dengue with complications in not Afro-Colombians reported by the authors, several of these may have genetic elements and traits of Afro-Colombian population, which would cause a measurement error so it was necessary to perform genetic and biological measurements that were not considered [10, p. 98].
3. Several of the statements in the article may be the subject of xenophobic and exclusionary assessments towards Afro-Colombian populations, as perceived when the authors conclude that in zones or neighborhoods with high Afro-Colombian population there is higher incidence of dengue in the population not Afro-Colombian. Here, the authors did not indicate data or measurements of this condition to identify if effectively Afro-descendant individuals were infected in the evaluation site and if they did or did not develop the disease [...] [10, p. 98].
4. [...] the NIH report notified that the principal departments in order of magnitude where there were cases due to classic dengue and severe dengue were Tolima, Valle, Santander, Norte de Santander, and Cundinamarca; all of these, except for Valle, have low population with black race [10, p. 98].
5. Although the authors stated that there is no risk of a possible ecological fallacy, clearly the vast majority of conclusions were obtained with analysis of data or records at population level that exceed the conclusions at individual level [10, p. 98].

Posture 2, which states that dengue is less severe in Afros, is defended by the article's authors, in their response to the editor, with the following arguments:

1. [...] we recognize great difficulty to establish the Afro-descendant category to each of the individuals. Some proposals to classify ethnicity in Latin American populations based on genetic and biological tests have shown much miscegenation that makes classification difficult. The method of self-recognition [*sic*] of ethnicity is imperfect, as we noted in our study methodology, but valid for the scientific community at this moment, until other efficient, more reliable and robust methods are proposed [10, p. 99].
2. We differ with the correspondents of the letter in considering any element of the investigation xenophobic. The study design considered any risk of discrimination because it was considered to directly affect the result and the principle of equity was protected in the selection and evaluation of the variables [*sic*]. Significant results were verified by adjusted models that, in some cases, refuted the original findings (cumulative incidence by age and ethnic origin). Our interpretations of the results also warn of a silent phase of epidemic spread in communes with higher Afro-Colombian population that may require sanitation adjustments to modify the figures of cases of dengue and severe dengue [10, p. 99].

In this text, in spite of the postures found to argue about the risk of dengue in Afro-Colombian individuals, both discuss – from a single point of view about this category – and it is the biological nature, which is assigned to the Afro-Colombian ethnicity, and is equated to a risk gradient that increases or diminishes the probabilities of a disease. In addition, the ethnicity and race categories are used as similar.

Figure 1 represents the conceptualization and uses of the ethnicity and race categories in the health analysis for Afro-Colombian population from the texts reviewed.

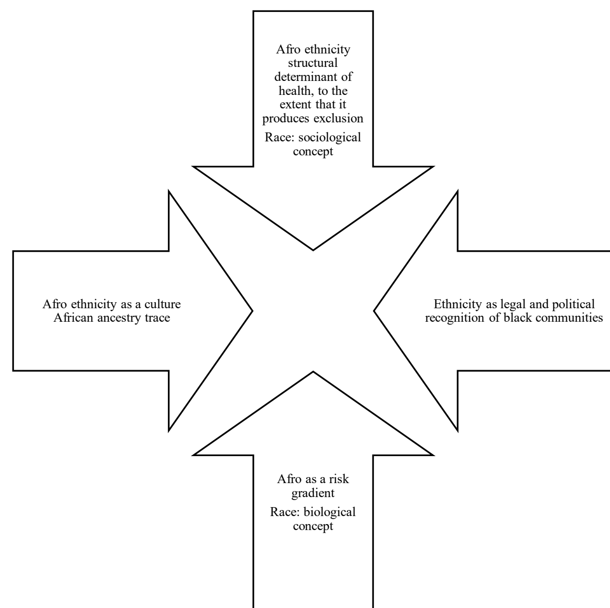

Figure 1. Conceptualization and uses of the ethnicity and race categories in the health analysis for Afro-Colombian population from the texts reviewed.

Source: elaborated by the author.

Discussion

The analysis of the conceptualization and use of the ethnicity and race categories, conducted from the health sector for the Afro-descendant population in Colombia, found that from the PDSP statements are presented that

approve ethnicity as a health determinant, as a cultural construction and as a political fact from the 1991 Colombian Political Constitution, which dictates: "Article 7. The State recognizes and protects the ethnic and cultural diversity of the Colombian nation". These statements, as well as the integrated approach to the subjects of law, both individual and collective that conceptually frame the pdsp, "express the constitutional, legal and regulatory developments that have consolidated the recognition and protection of the ethnic cultural diversity in the country" [9, p. 183].

Regarding the recognition of the country's rich ethnic diversity and multiculturalism, Castillo [12] and Olaza and Cabrera [13] show the decisive contribution of ethnic peoples and their political struggle to reinvent ethnic identity, in the last two decades, in some Latin American countries.

Castillo explains that "the new place occupied by indigenous people and Afro-descendants in Colombia, after the nca [National Constituent Assembly], has implied a process of remanufacturing and construction of ethnic identity within the context of a shift from a policy based on class identity to another based on cultural identity. The political use of the difference has shown great strategic and 'performative' capacity" [12, p. 10]. Likewise, the author states that "From the imaginary of the mestizo nation arises the notion that equality of rights is incompatible with safeguarding identity". On the contrary, in the diverse nation, blacks and Indians – as differential identities – must be linked to the national construction project, which implies a more fluid relationship with the State, with all the consequences this has" [12, p. 472].

In the same sense, the article by Camargo shows that the definition as ethnicity for black communities has great political relevance, inasmuch as it facilitates their access to new ways of organizing and turns them into interlocutors of the State [14, p. 2].

With respect to the position that addresses ethnicity as a social determinant that directly affects the burden of morbidity and mortality, it should be noted that in 2005 the World Health Organization formed the Commission on Social Determinants of Health (csdh), a network that studies social causes, their impact on health, the inequalities produced and how to mitigate them. In this commission, ethnicity appears as a structural determinant of health.

The csdh affirms that "the most important determinants are those that give rise to a stratification within a society (*structural* determinants), like the distribution of income, discrimination (for example, due to gender, class, ethnicity, disability, or sexual orientation), and the political and governance structures that reinforce inequalities in the economic power rather than reduce them". It also indicates that "discrepancies attributable to these mechanisms configure the state of health and health results of each individual, through its impact on intermediate determinants, such as living conditions, psychosocial circumstances, behavioral or biological factors and the health system itself" [15, p. 2].

This approach by the csdh is contrary to the predominantly medical approach consolidated with industrial development in western countries and which emphasizes that the origin of disease is in some biological dysfunction within the individual, therefore, the main center of attention must be the body of the sick individual. Criticisms of this strictly medical health model reject the excessive emphasis on biological aspects and describe other factors that can cause difficulties to adapt to a changing social context [2, p. 622].

From the point of view that positions Afro as an ethnicity, it must be taken into account that Smith "establishes six characteristics of the ethnic community: a collective name, a myth of common descent, a shared history, a distinctive culture, an association with a specific territory, and a sense of solidarity" (1986, cited in [12, p. 74]).

In this aspect, identity studies in social sciences differentiate the constructivist and essentialist perspectives. While the first denies the existence of unique and unalterable identities, for the second there is some essential intrinsic content in every identity. The constructivist position is that evidenced in the pdsp text, where the Afro identity is an identity constructed socially, in the different contexts, subject to relations of power and determined by a particular history, experiences, institutions, and discursive formations [12, p. 6].

Finally, in the letter published in the medical journal, ethnicity and race are assumed as similar and are taken as gradients or a biological variable of risk that increases or diminishes the probabilities of a disease. Here it should be noted that the article by Parodis and Bolis [16], which refers to the evolution of the *ethnicity/race* concept and its impact on the formulation of policies for equity, asserts that

Although the debate about the existence of differences of biological nature among human beings is far from over, the Report of the Consultation Meeting on the World Conference against Racism, Racial Discrimination, Xenophobia and Related Forms of Intolerance, held in Bellagio, Italy, from 24 to 28 January of 2000, states that "the vast majority of experts on the matter coincides in that, from the scientific and anthropological perspective, the concept that human beings can be divided and classified definitely into distinct 'races' lacks foundation. There is only one race: the human race" (6). Hence, the notion of race is not a biological entity and must be understood in light of the history and of the social relations [16, p. 406].

Studies, like that by Mosquera, reveal that important weaknesses are found in the use of the ethnicity and race

categories in this health sector. In addition, it indicates that few investigations exist that analyze how these impact upon the health of the populations, asserting that:

Confusion exists in using these notions: *race, ethnicity* and other denominations derived, like *ethnic group,* used interchangeably; even united as nomination: *race/ethnicity.* Thereby, the biological dimension (genetic variation, phenotype) and the social dimension (population groups that share territory, customs, traditions, ancestors, group pertinence, form of identity) are in indistinct manner, as if they had the same meaning [17, pp. 122-123].

And the author adds that "This limitation can be a result of the complexity and lack of consensus that still persists to conceptualize the notions of race and ethnicity within the Colombian context, where ethnic-racial studies in health are quite recent and great racial and ethnic heterogeneity prevails" [17, p. 124].

As in this study, ours also found approaches of ethnicity and race as a biological category, a social construction, and as part of the sociodemographic variables.

Although the analysis presented here has the limitation of not including a broader sample of texts that use the ethnicity and race categories for Afro-Colombians in the health sector environment, hence, that found is not conclusive; the findings allow getting closer to the way these concepts and variables are understood and addressed by the sector currently.

Afro-descendants, more than other ethnicities, are affected by racialization; they are classified, reiteratively, from phenotypic traits, principally through their skin color, and the approach to them from stigmatization and racism persists, which is why the differential approach in health should also be aimed at diminishing racism in this sector.

León Díaz conceives *ethnic-racial differential approach* "as the implementation of specific actions that result in correcting situations of discrimination and inequality and in promoting differences of black, Afro-Colombian, *Raizales* and *Palenqueros* peoples" [18, pp. 51-52].

Holds that: "despite the relevance of the norms, principles, and the indicatives in the existing legislation on the rights of individuals, groups, communities and black, Afro-Colombian, *Raizales* and *Palenqueros* peoples, legislation is insufficient without specific measures that address and minimize the complex situation of vulnerability of this population in Colombia" [18, p. 44].

And adds that "the intention of proposing the EDE [ethnic differential approach] seems to respond to the State's perspective and its bureaucracy to substantiate pluri-ethnicity and multiculturalism values of the Colombian nation focused, specially, on the aspect of *cultural belonging*, declared in the 1991 Political Constitution" [18, p. 59].

Conclusion

This research sought to draw attention so that from the health sector, in the multiple scenarios attended, public policies are investigated or generated with Afro people, communities, and populations, the construction and use of the ethnicity and race categories is reviewed. It seeks to discourage their use as a biological gradient and, on the contrary, strengthen the concept and use of these categories as a structural social determinant of health, to emphasize on aspects that improve the quality of life of these people and communities, investments in basic sanitation, food and nutritional sovereignty, the dialogue of knowledge, guaranteeing health services, employment, housing, education, among others.

We consider that recognizing ancestry in health or political fact, with the implementation of affirmative measures, is fundamental, but if the historical conditions and current conditions of exclusion of these communities are not recognized, it will not be sufficient to understand and influence their health situation.

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The author is responsible for the opinions expressed in the article.

Declaration of contributions by authors

The author conceived and designed the study and performed the analyses and data interpretation; besides, approving the final version of the manuscript submitted,

and can respond for issues related with the precision or integrity of any part of the work.

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