THE SILENCE OF WHITENESS IN CLINICAL AND FORMATIVE GUIDELINES OF PRIMARY HEALTH CARE

O SILÊNCIO DA BRANQUITUDE NAS DIRETRIZES CLÍNICAS E FORMATIVAS DA ATENÇÃO PRIMÁRIA À SAÚDE

EL SILENCIO DE LA BLANQUITUD EN LAS DIRECTRICES CLÍNICAS Y FORMATIVAS DE LA ATENCIÓN PRIMARIA DE SALUD

https://doi.org/10.56238/sevened2026.009-013

Anderson Martins da Rocha[1]

ABSTRACT

This article analyzes how racial debate, with a focus on whiteness, is presented -- or absent -- in the political, formative, and technical documents that guide the practice of Family and Community Medicine (FCM) in the municipality of Rio de Janeiro (MRJ). A qualitative documentary research was conducted of the following texts: the National Policy for Comprehensive Health of the Black Population (PNSIPN), the National Policy for Basic Care (PNAB), the Competency-Based Curriculum of the Brazilian Society of Family and Community Medicine (SBMFC), and technical protocols of the Municipal Health Secretariat of Rio de Janeiro (SMS-RJ). The results identify a critical disruption between equity policy (PNSIPN) and technical documents: while central-level policy recognizes racism as a health determinant, municipal guidelines and evidence-based formative curriculum operate under a logic of care universalism. Whiteness remains invisible and normative; both silence racism as a social determinant in clinical protocols. Finally, it is concluded that the absence of racial literacy in technical documents, in contrast with PNSIPN, perpetuates institutional racism and the narcissistic pact of whiteness in medical training and practice.

Keywords: Racism. Primary Health Care. Whiteness. Medical Education.

RESUMO

O presente artigo analisa como o debate racial, com foco na branquitude, apresenta-se – ou ausenta-se – nos documentos políticos, formativos e técnicos que guiam a prática da Medicina de Família e Comunidade (MFC) no município do Rio de Janeiro (MRJ). Realizou-se pesquisa documental qualitativa dos seguintes textos: a Política Nacional de Saúde Integral da População Negra (PNSIPN), a Política Nacional de Atenção Básica (PNAB), o Currículo Baseado em Competências da Sociedade Brasileira de Medicina de Família e Comunidade (SBMFC) e protocolos técnicos da Secretaria Municipal do RJ (SMS-RJ). Os resultados identificam uma disrupção crítica entre a política de equidade (PNSIPN) e os documentos técnicos: enquanto a política de nível central reconhece o racismo como determinante de saúde, os guias municipais e o currículo formativo baseado em evidência

[1] Master's degree of Public Health. Escola Nacional de Saúde Pública. Fiocruz.
E-mail: martins.drocha@gmail.com Orcid: https://orcid.org/0000-0002-7870-0010
Lattes: http://lattes.cnpq.br/5039990475656529

operam sob lógica de universalismo do cuidado. A branquitude mantém-se invisível e normativa; ambos silenciam o racismo como determinante social nos protocolos clínicos. Por fim, conclui-se que a ausência de letramento racial nos documentos técnicos, em contraponto com a PNSIPN, perpetua o racismo institucional e o pacto narcísico da branquitude na formação e prática médica.

Palavras-chave: Racismo. Atenção Primária à Saúde. Branquitude. Educação Médica.

RESUMEN
Este artículo analiza cómo el debate racial, con énfasis en la blanquitud, se presenta -- o se ausenta -- en los documentos políticos, formativos y técnicos que guían la práctica de la Medicina de Familia y Comunidad (MFC) en el municipio de Río de Janeiro (MRJ). Se realizó una investigación documental cualitativa de los siguientes textos: la Política Nacional de Salud Integral de la Población Negra (PNSIPN), la Política Nacional de Atención Básica (PNAB), el Currículo Basado en Competencias de la Sociedad Brasileña de Medicina de Familia y Comunidad (SBMFC) y protocolos técnicos de la Secretaría Municipal de Salud de Río de Janeiro (SMS-RJ). Los resultados identifican una disrupción crítica entre la política de equidad (PNSIPN) y los documentos técnicos: mientras que la política de nivel central reconoce el racismo como determinante de salud, las guías municipales y el currículo formativo basado en evidencia operan bajo una lógica de universalismo del cuidado. La blanquitud se mantiene invisible y normativa; ambas silencian el racismo como determinante social en los protocolos clínicos. Finalmente, se concluye que la ausencia de alfabetización racial en los documentos técnicos, en contraste con la PNSIPN, perpetúa el racismo institucional y el pacto narcisista de la blanquitud en la formación y práctica médica.

Palabras clave: Racismo. Atención Primaria de Salud. Blanquitud. Educación Médica.

1 INTRODUCTION

Racism as a system of power manifests itself at three levels: interpersonal, institutional, and structural (Almeida, 2020, p. 38). Although all forms are significant and impactful in the lives of black and white people, this article focuses on the last two, particularly in the structural dimension, where state institutions and macropolitical, economic and social modes of functioning operate in a normative and excluding way, based on race/color criteria, denying fundamental rights to the black population while privileging white people.

This tacit agreement is kept stable in the micropolitics of relations through what Bento (2022, p. 56) calls the "Narcissistic Pact of Whiteness". At the same time, Ramos (1995, p. 225) analyzes this phenomenon as the "Social Pathology of the White", showing how the white elite perpetuates inequalities through institutionalized structures that increase social inequality and that Carneiro (2023, p. 142) later reinterprets as devices of raciality.

In this context, Family and Community Medicine (FCM) has asserted itself through fundamental attributes of Primary Care: equity, integrality and universality in care (Giovanella, 2012; Starfield, 2002). Its differential lies in the attentive care and bond established with patients, as well as the live work in the field (Merhy, 2008). However, paradoxically, the practice has been guided by "universalizing" protocols, which operate as if the patient were deracialized. By being based on such protocols, without explicit race/color in its different levels of complexity, the question arises: does FCM effectively operationalize the comprehensive care it proposes, or does it reinforce institutionalized racism in the Family Clinics of the Municipality of Rio de Janeiro (SMS-RJ)?

The specific objective is to investigate the presence or absence of the debate on critical whiteness in the guiding documents of the FCM in Rio de Janeiro -- political, formative and technical -- analyzing how these guidelines treat -- or silence -- racialized care in clinical practice.

2 THEORETICAL FRAMEWORK

2.1 THE GAP BETWEEN POLICY, TEACHING, AND CLINICAL PRACTICE

The National Policy for the Integral Health of the Black Population (PNSIPN) represented a significant political milestone by giving visibility and appreciation to issues of ethnic-racial equity at the central level of the Unified Health System (SUS) (Brasil, 2009).

However, despite the quality and importance of this policy, its reverberation in daily clinical practice has been marginal. In the documents that guide and instrumentalize primary care in the city of Rio de Janeiro -- specifically in the protocols and guidelines of Family and Community Medicine (FCM) -- the policy remains almost as an "orphan" document in its three

versions (2009, 2011, 2017). This institutional mismatch reveals a fundamental tension between the political discourse of equity and the materiality of technical practices, where hegemonic biomedical rationality continues to produce silencing and structural erasures about racism.

2.2 THE CURRICULUM OF THE "DOCTOR WITHOUT COLOR": SUBSUMPTION AND UNIVERSALIZATION

The competency-based curriculum of the Brazilian Society of Family and Community Medicine (SBMFC) is a robust document built collectively in a herculean effort to contemplate various areas of knowledge in an equitable way (SBMFC, 2015). However, when addressing the theme of inequality, the document subsumes it within the generic notion of "cultural competence", without offering explicit or critical anti-racist guidelines. The result is the figure of the doctor as a universalized being, capable of interacting with "different cultures" in a superficial way, without his own racialized position being problematized.

This silencing of race fulfills the function of normalizing and exalting whiteness as an invisible norm, opening almost zero space for the debate on racial equity and anti-racism. The responsibility for addressing these issues is the responsibility of the individual sensitivity of local preceptors - mostly white men and women - perpetuating a logic of voluntarism that masks the absence of structured training. The white medical student is not questioned within the culture, since he represents the unnamed norm of the curriculum (Osorio Cock et al., 2023, p. 349435). "Culture" is attributed to the other, to the racialized patient, who often needs to have his culture "cured" or "domesticated" in order to approach the hegemonic biomedical model, configuring a true cultural expropriation with no return (Eugênio, 2019, p. 87).

2.3 THE BIOLOGIZATION OF RACE IN CLINICAL PROTOCOLS: FROM RACIAL SCIENTISM TO RACISM BY DENIAL, HISTORICAL ROOTS AND CONTEMPORARY PERSISTENCE

The racial scientism practiced at the beginning of the twentieth century operated as a biologizing movement that, through pseudoscientific explanations, justified eugenicist practices with the purposes of racial exclusion and population whitening as a government project (Josué, 2005, p. 380). Paradoxically, the contemporary clinical protocols adopted in the city of Rio de Janeiro do not differ significantly from this paradigm. The analysis of the Systemic Arterial Hypertension (SAH) and Prenatal Care guidelines reveals how normative whiteness operates under the cloak of technical neutrality.

3 METHODOLOGY

This study is an exploratory documentary analysis organized in three levels:

Political Level: PNSIPN and PNAB

Training Level: SBMFC Competency-Based Curriculum

Technical Level (Where life happens): SMS-RJ Quick Reference Guides -- Systemic Arterial Hypertension and Prenatal Care.

As a qualitative strategy, the documentary analysis was dedicated to the systematic examination of socially and institutionally produced documents, with the objective of understanding contexts, meanings, discourses and practices that cross a certain social phenomenon. According to Minayo (2021, p. 189), documents should be understood as social products loaded with intentionalities and inscribed in power relations, demanding a critical and contextualized reading.

For the analysis, systematic searches were carried out for the following documents:

Political Level: National Policy for the Integral Health of the Black Population (PNSIPN) and National Policy for Primary Care (PNAB), obtained from the Ministry of Health website and complemented by documents from the Institute of Applied Economic Research (IPEA).

Training Level: Competency-Based Curriculum of the Brazilian Society of Family and Community Medicine (SBMFC), consulted in the official version available on the SBMFC website.

Technical Level: Quick Reference Guides on Hypertension (2016) and Prenatal Care (2022) of the Municipal Health Department of Rio de Janeiro (SMS-RJ), consulted in their most recent versions on the website of the Undersecretariat for Health Promotion, Primary Care and Surveillance (SUBPAV-RJ).

The search for the key terms -- racism, whiteness, black population -- was combined with context analysis: it was verified whether these terms appeared in a strictly biological/genetic perspective or whether they contemplated sociopolitical dimensions related to racial inequities.

The analysis established a critical dialogue with: (i) authors consolidated in the Latin American racial debate: Lélia Gonzalez, Franz Fanon, Guerreiro Ramos, Sueli Carneiro, Rodney Williams, Silvio Almeida; (ii) seminal theorists in Primary Health Care Barbara Starfield, Ligia Giovanella. The texts were identified through a search in the SciELO and VHL databases.

4 RESULTS AND DISCUSSIONS

4.1 INSTITUTIONAL MISMATCH AND STRUCTURAL RACISM IN FAMILY AND COMMUNITY MEDICINE: BETWEEN PUBLIC POLICIES AND CLINICAL PRACTICES

4.1.1 Arterial Hypertension: Biological Determinism and Universalizing Treatment

The Quick Reference Guide: Systemic Arterial Hypertension of the SMS-RJ (SUBPAV, 2016, p. 45) epidemiologically recognizes the higher prevalence and severity of the disease in the black population, but does so through a strictly biomedical lens. The mention of race/color appears depoliticized, suggesting an intrinsic genetic or "racial" predisposition, disconnected from the social determinants that affect these bodies. By citing the black race only as a biological risk factor, the protocol operates what Gonzalez (1984, p. 234) calls "racism by denial": the institution admits the difference in numbers, but denies the racist structure that produces this difference.

The document is systematically silent about racism as a chronic psychosocial stressor – a determinant proven to be associated with persistent activation of the hypothalamic-pituitary-adrenal axis and, consequently, with blood pressure elevation. The erasure of whiteness lies in the presumption of universality of treatment. The protocol assumes a "universal patient" whose therapeutic adherence depends only on lifestyle changes and pharmacology, ignoring the impact of everyday racism on cardiovascular health. The guide was, therefore, designed for a subject whose existence is not crossed by this structural violence: the white subject.

Consequently, the technical guideline is not neutral; it is white-centered. It offers the family doctor tools to treat the physiological consequence -- high blood pressure -- but leaves him lacking the critical competence to address the root cause -- the ethical-political suffering of racism. By treating unequals as equals, it maintains inequities and does not prepare professionals for a powerful biopsychosocial approach, which considers the stress of minorities and the psychic suffering caused by racism in the black population, as denounced by Fanon (2008, p. 73).

4.2 PRENATAL CARE: DEPOLITICIZED RACIALIZATION AND EXCLUSIONARY UNIVERSALISM

This logic of biologization observed in Hypertension is repeated, even more dramatically, in maternal and child care. Racialization also manifests itself depoliticized in prenatal care. The Quick Reference Guide: Prenatal Care (SUBPAV, 2022, p. 28) exposes a flagrant contradiction. The document explicitly recognizes that maternal mortality is higher

among black, brown and low-educated women. However, when operationalizing care, the guide fails to convert this epidemiological data into anti-racist clinical conduct.

The official text warns that "professionals must be attentive, especially to black pregnant women who, in addition to presenting some biological peculiarities, are also affected by socioeconomic inequalities" (SUBPAV, 2022, p. 31). This passage is revealing. By using the term "biological quirks," the protocol flirts dangerously with genetic determinism, suggesting that the black body is intrinsically more pathological. It is ignored that the "peculiarity" is not biological, but political: it is racism that makes people sick, not melanin. The protocol admits race -- epidemiological data -- but denies racism -- socio-political data. This transforms the black pregnant person into a "body of biological risk", not a "subject of violated rights".

In addition, the protocol demonstrates what can be called selective blindness. It details risks such as smoking, maternal age, and previous illnesses, but is silent about obstetric and institutional racism. There is, for example, no recommendation for the doctor to investigate whether black pregnant women are suffering discrimination in the workplace or in the health service itself -- known psychosocial stress factors that directly impact outcomes such as premature birth and preeclampsia (Borret et al., 2020, p. 2255).

Whiteness is manifested here by absence. When the guide addresses "Obstetric Violence" or "Psychosocial Suffering", race disappears. The text once again speaks of a "universal woman", presumably white, whose pain is not crossed by the color of her skin. By not naming racism as a specific form of obstetric violence, the protocol leaves the black pregnant woman unprotected and the doctor de-instrumentalized to offer truly equitable care.

4.3 FROM ORPHAN POLITICS TO WHITE-CENTERED PRACTICE

The analysis reveals a systemic pattern of mismatch between racial equity policies and the materiality of clinical practice. The PNISPN remains orphaned in the technical documents that effectively guide primary care. The SBMFC curriculum, by universalizing the physician and subsuming raciality in cultural competence, avoids problematizing whiteness as a norm. Clinical protocols, in turn, by biologizing race and operating racism by denial, perpetuate inequities under the false premise of technical neutrality. The silence about whiteness in documents is not an oblivion; it is a technology of power devices (Carneiro, 2023, p. 167).

This cycle of silencing and structural erasure produces a clinical practice that, by trying to be "color-blind," ends up reproducing institutional racism. The non-naming of racism as a social determinant of health, the non-problematization of the racialized position of health

professionals, and the presumption of universality of treatment configure a system that treats unequals as equals, thus consolidating the inequalities it intends to combat. The effective transformation of clinical practice requires not only robust public policies, but also an epistemological reconfiguration of the technical instruments that operationalize health care. PHC will only be equitable when the Technical Protocols – and not only the policies – incorporate racism as a clinical variable and whiteness as a place of privilege to be deconstructed.

It is suggested to review the curricula and include questions about racial discrimination in the standard anamnesis of the SMS-RJ. As long as whiteness is the invisible norm of technical manuals, Family Medicine will continue to reproduce institutional violence, even under the discourse of "comprehensive care".

4.4 THE FORMATION OF THE UNIVERSAL SUBJECT: THE SILENCE ON WHITENESS IN THE COMPETENCY-BASED CURRICULUM

If clinical protocols fail to equip physicians to confront racism, the root of this lack of preparation can be traced back to training. The analysis of the Competency-Based Curriculum of the Brazilian Society of Family and Community Medicine (SBMFC) reveals a structuring epistemological gap (SBMFC, 2015, p. 78).

The document, inspired by Canadian models and focused on "Knowledge, Skills and Attitudes", adopts a stance of racial neutrality. When diversity is mentioned, it appears under the umbrella of "Cultural Competence" -- a concept that, while valid, is often limited to teaching the physician to "tolerate" or "respect" the culture of the Other. There is no explicit mention of the development of an "Anti-Racist Competence" or of Critical Racial Literacy.

Even more serious is the silence about the racial identity of the doctor himself. The curriculum does not challenge the resident to reflect on his own whiteness and the symbolic privileges he carries when wearing the lab coat. Thus, a professional is formed who sees himself as a neutral technician, devoid of race, working on racialized patients.

This omission reinforces the "Narcissistic Pact": whiteness protects itself by not naming itself. The resident learns, again, to treat black women's hypertension -- the biological data -- but does not learn to recognize how institutional racism -- the political data -- crosses the consultation. Without this critical training, Family Medicine runs the risk of training excellent disease technicians, but racial illiterates in the management of comprehensive care.

Table 1

Critical Analysis of the Racial Approach in the Guiding Documents of PHC Carioca

Document Title	Decree/Law	Document Summary
PNAB 2006	Ordinance No. 648/2006	It provides the definition of PHC, talks about its guiding and operational precepts, the role of each federative agent and the origin of its funding (BRASIL, 2007).
PNAB 2011	Ordinance No. 2,488/2011	This Ordinance, in accordance with the regulations in force of the SUS, establishes the structuring of the RAS as a strategy to provide comprehensive care directed to the health needs of the population (BRASIL, 2012a).
PNAB 2017	Ordinance No. 2,436/2017	It defends the confrontation of racial inequalities as a comprehensive social phenomenon and goal of policies to promote racial equality. It cites equity as the basis for promoting equality through the recognition of inequalities and strategic action to overcome them (BRASIL, 2017).
PNSIPN 1st ed.	Ordinance No. 992/2009	It defends the confrontation of racial inequalities as a comprehensive social phenomenon and a goal of policies to promote racial equality (BRASIL, 2009).
PNSIPN 2nd ed.	PNSIPN Policy 2nd ed./2013	This second publication includes the text of the policy and Ordinance No. 992, of May 13, 2009, providing guidance to managers and technicians in the implementation of this policy (BRASIL, 2012b).
PNSIPN 3rd ed.	PNSIPN Policy 3rd ed./2017	Recognition of racism, ethnic-racial inequalities and institutional racism as social determinants of health conditions, with a view to promoting equity in health (BRASIL, 2016).
Hypertension 2016	---	It reflects the position of the Undersecretary for Health Promotion, Primary Care and Surveillance (SUBPAV) and aims to guide clinical practice in PHC units in the city of Rio de Janeiro (SUBPAV, 2016).
Prenatal Care 2022	---	It represents the position of the technical area of the Municipal Health Department of Rio de Janeiro (SMS-Rio) and aims to guide the assistance to women and their families in the episode of prenatal, childbirth and postpartum care, with an emphasis on Primary Health Care (SUBPAV, 2022).
SBMFC 2015 Competency-Based Curriculum	---	Prepared during a workshop held in April 2014 and published in 2015, it had the participation of Canadian consultants associated with the University of Toronto, as well as Brazilian specialists working in the training of family and community physicians (SBMFC, 2015).

Source: Author.

5 CONCLUSION

The analysis of the guiding documents of Family and Community Medicine in Rio de Janeiro confirms the initial hypothesis of this study: there is structural silencing about

whiteness in the technical instruments that guide clinical practice. Specifically, a critical mismatch was identified between the national policy (PNSIPN), which recognizes racism as a determinant of health, and the local operational protocols (Hypertension guidelines, Prenatal Care and SBMFC Curriculum). While the former explicitly names racism, the latter operate under a logic of colorblind or biologizing universalism.

It is concluded that, although necessary, the insertion of the variable "race/color" in medical records and information systems is insufficient without concomitant epistemological reformulation of clinical guidelines. As long as the manuals treat race only as a genetic risk and not as a marker of social vulnerability produced by racism, we will continue to offer fragmented and inequitable care.

The study points to the urgency of three articulated movements in Rio de Janeiro and Brazilian PHC:

1. Epistemological Review of Clinical Protocols: Technical guidelines should incorporate racism as an explicit psychosocial risk factor, guiding physicians to investigate racial violence in anamnesis and to consider the stress of racism in the management of chronic and maternal diseases.
2. Anti-racism in Education: Residency programs must go beyond "Cultural Competence" and adopt "Anti-racist Competence", provoking the resident - especially the white one - to recognize their place of privilege and the normative whiteness that permeates their listening.
3. Structural Transversality of Equity: The health of the black population cannot be a separate chapter or an annex of policy; it should be the transversal axis that reorients the entire PHC clinic, given that the majority of the population using the SUS is black.

Breaking with the narcissistic pact of whiteness in health is not just a political or moral demand; It is a technical requirement for the qualification of care. Only when Family Medicine dares to see the color of those who serve – and the color of those who prescribe – will we be able to speak, in fact, of integrality and social justice in the SUS.

REFERENCES

Almeida, S. L. de. (2020). Racismo estrutural. Jandaíra.

Bento, M. A. S. (2022). O pacto da branquitude. Companhia das Letras.

Borret, R. H., et al. (2020). A sua consulta tem cor? Incorporando o debate racial na Medicina de Família e Comunidade: Um relato de experiência. Revista Brasileira de Medicina de Família e Comunidade, 15(42), Article 2255. https://rbmfc.org.br/rbmfc/article/view/2255

Brasil. Ministério da Saúde. (2007). Política nacional de atenção básica (3a ed.). (Série Pactos pela Saúde; v. 4).

Brasil. Ministério da Saúde. (2009). Política nacional de saúde integral da população negra. (Textos Básicos de Saúde).

Brasil. Ministério da Saúde. (2012a). Política nacional de atenção básica (1a ed.).

Brasil. Ministério da Saúde. (2012b). Política nacional de saúde integral da população negra: Uma política do SUS. (Textos Básicos de Saúde).

Brasil. Ministério da Saúde. (2016). Política nacional de saúde integral da população negra.

Brasil. Ministério da Saúde. (2017). Política nacional de atenção básica.

Carneiro, S. (2023). A construção do outro como não-ser como fundamento do ser.

Eugênio, R. W. (2019). Apropriação cultural. Sueli Carneiro; Pólen. (Feminismos Plurais).

Fanon, F. (2008). Pele negra, máscaras brancas (R. da Silveira, Trad.). EDUFBA.

Giovenella, L. (Org.). (2012). Políticas e sistema de saúde no Brasil (2a ed., rev. e ampl.). Editora Fiocruz; Centro Brasileiro de Estudos da Saúde.

Gonzalez, L. (1984). Racismo e saúde. ABCD: Revista Brasileira de Saúde da Comunidade, 3(4), 234–245.

Josué, L. (2005). Raça, genética & hipertensão: Nova genética ou velha eugenia? História, Ciências, Saúde – Manguinhos, 12, 371–393. https://www.scielo.br/j/hcsm/a/sLMdVpkVVRQVjhrbk4qRyZn/

Merhy, E. E. (2008). Saúde: A cartografia do trabalho vivo (8a ed.). Hucitec. (Coleção Saúde em Debate; n. 145).

Minayo, M. C. de S. (Org.). (2021). Pesquisa social: Teoria, método e criatividade (26a ed.). Vozes.

Osorio Cock, L. M., et al. (2023). Sobre el currículo oculto: Del buen médico, la jerarquía y el maltrato. Revista Facultad Nacional de Salud Pública, 41(3), 349435. https://revistas.udea.edu.co/index.php/fnsp/article/view/349435

Ramos, G. (1995). Introdução crítica à sociologia brasileira: A patologia social do branco brasileiro. In Introdução crítica à sociologia brasileira (pp. 215–242). UFRJ.

Secretaria Municipal de Saúde do Rio de Janeiro. (2016). Hipertensão: Manejo clínico em adultos. (Série F. Comunicação e Educação em Saúde).

Secretaria Municipal de Saúde do Rio de Janeiro. (2022). Guia rápido pré-natal: Atenção primária à saúde (3a ed.).

Sociedade Brasileira de Medicina de Família e Comunidade. (2015). Currículo baseado em competências para medicina de família e comunidade. http://www.sbmfc.org.br/media/Curriculo%20Baseado%20em%20Competencias(1).pdf

Starfield, B., et al. (2002). Atenção primária: Equilíbrio entre necessidades de saúde, serviços e tecnologia. UNESCO.