Mapping the expressions and impacts of racism on health in Brazil: a scoping review

Priscila de Morais Sato,[a,*] Fernanda Lopes,[b] Sonora English,[c] Silvana Oliveira da Silva,[d] James Berson Lalane,[e] Thilagawathi Abi Deivanayagam,[c] Rute Ramos da Silva Costa,[f] Elizângela Baré,[g] Indira Ramos Gomes,[h] and Delan Devakumar[c]

[a]School of Nutrition, Federal University of Bahia, Salvador, Bahia, Brazil
[b]Independent Researcher, Sao Paulo, Brazil
[c]Institute for Global Health, University College London, London, United Kingdom
[d]Institute of Collective Health, Federal University of Bahia, Salvador, Bahia, Brazil
[e]Faculty of Medicine, Sao Paulo University, Sao Paulo, Brazil
[f]Institute of Food and Nutrition, Federal University of Rio de Janeiro, Macae, Brazil
[g]Faculty of Public Health, University of Sao Paulo, Sao Paulo, Brazil
[h]Ministry of Health, Brasilia, Brazil

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Summary

We conducted a scoping review to examine how racism affects the health of minoritized populations in Brazil. A comprehensive search was carried out, and identified articles underwent independent double screening. The 145 included studies consistently highlighted structural health inequities, with White advantage functioning as a protective factor. Institutional racism restricts healthcare access and availability, exacerbating minoritized populations' vulnerability to violence and disease through discrimination and substandard care. Spatial segregation further exposes minoritized populations to harmful environmental conditions and limited infrastructure, while traditional and migrant communities experience marginalization, social isolation, increased disease exposure, and poorer livelihoods. Interpersonal racism negatively impacts mental and physical health across the lifespan, with gender and socioeconomic conditions intersecting and shaping these experiences. The study provides critical insights for practice, policy, and research by demonstrating how racism at multiple levels shapes health inequities in Brazil and by emphasizing the need for human rights-centred, redistributive interventions that promote justice, equity, and inclusive care for minoritized populations.

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Introduction

Brazil is a racially diverse country where health inequities are driven by entrenched and structural racism that has persisted since the country's formation.[1] Brazil has approximately 203.1 million people, with 55.5% identifying as Brown or Black, 43.5% as White, 0.8% as Indigenous, and 0.4% as Asian. The small proportion of self-identified Indigenous People reflects the violation of their rights and a history of genocide against several ethnic groups.[2] While representing a numerical majority at 112.7 million,[2] Black and Brown populations continue to face significant restrictions on their civil rights. In 2022 the average per capita household income of the White population was nearly twice that of the Black and Brown populations.[3] Regarding housing conditions, in 2019, 27.8% of White individuals living in their own households lacked a sewage collection or a rainwater harvesting system, compared to 45.9% and 36.0% of Brown and Black individuals, respectively. Similar inequalities were observed in terms of access to the water supply network and garbage collection.[4]

Racism is an organized system that maintains a racial hierarchy by embedding power and privilege within social, legal, economic, and ideological structures. The Lancet Series on Racism, Xenophobia, Discrimination, and Health presented a conceptual model to understand how racism manifests across the different levels: structural, institutional, spatial, community, and individual. Structural racism refers to systems that entrench inequities, while institutional racism stems from discriminatory policies and practices that sustain unequal opportunities.[5] At the spatial

*Corresponding author. Rua Basilio da Gama, s/n, Canela, Salvador, Bahia, Brazil.
E-mail address: pri.sato@gmail.com (P.d.M. Sato).
Disclose: This summary is available in Portuguese in the Supplementary Material.

level, racism appears as environmental injustice, with minoritized groups more exposed to hazards and fewer health-promoting resources.[6] Communities, rooted in commonality such as identity or shared interests or visions, can be targets of discrimination while also building resilience through belonging and mutual support. At the individual level, racism takes the form of interpersonal discrimination and internalized stereotypes that reinforce marginalization.[5]

In the Series, a scoping review highlighted that racism diminishes both the systemic quality of care and the quality of life for minoritised patients and healthcare professionals, while also identifying periods of increased vulnerability to the harmful effects of discrimination, such as the critical transition from adolescence to adulthood.[7] However, global reviews tend to underrepresent Brazilian studies due to language barriers, limited inclusion of regional databases, and the dominance of research from high-income countries; limiting the understanding of how racism operates in Brazil. National reviews on racism and health have focused on specific (a) groups and experiences (e.g. Indigenous,[8] migrants[9] and Black women[10]) (b) specific health outcomes (e.g. mental health[11]) or (c) health courses (e.g. medical education[12]). However, no reviews have yet analysed the experiences of multiple minoritized groups in Brazil or analysed how racism operates across several levels.

Within the contexts of racism, the minoritization refers to the process through which certain groups are systematically marginalized, excluded, or oppressed due to their racial or ethnic characteristics. This process leads to these groups being rendered "minorities" in terms of access to resources, opportunities, or power within society. The term highlights how these groups are not necessarily minorities by number but are actively made to occupy a marginalized position.[13] While minorization can result from various intersecting factors, such as gender, disability, race, and social status, this article specifically uses the term "minoritized" to refer to individuals who are marginalized due to racism, unless otherwise specified. In this paper, we review the scientific literature on how racism across different levels of society affects the health of minoritized groups and peoples in Brazil.

Methods

Overview

We conducted a scoping review following the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR), guided by the research question "What does the scientific literature show about racism and minoritized peoples' health in Brazil?".

Search strategy and selection criteria

Searches were conducted at Embase, MEDLINE, PsychINFO, Web of Science, Scopus, and Virtual Health Library (*Biblioteca Virtual de Saúde–BVS*), and included articles from inception to June 17, 2025, with no language restrictions.

The search strategy was developed by the team and refined with the support of an experienced librarian, who tested keywords from a comprehensive list across multiple databases and finalized a relevant set of search terms. We followed the PCC (population, concept, and context) framework, combining terms referring to: (1) minoritized populations (social discrimination, racism, prejudice, minority groups, disaster victims), (2) health outcomes and healthcare (mental health, health, disease, healthcare, health policy, food (in)security, and (3) the study setting (Brazil). We searched for papers' titles, abstracts and keywords. Search strategies for each database are presented in the Appendix (p. 2).

We included original quantitative, qualitative, and mixed-method studies conducted in Brazil that examined racism—defined as discrimination based on ethnicity, Indigeneity, migratory status, race, religion, or skin colour—in relation to health, or health inequities across racial groups. Health was broadly defined to include risks, conditions, healthcare access and quality, and professional training. Articles were excluded if they were not original research, lacked methodological description, or did not assess race through self-identification or, when self-report was not possible (e.g. in cases of birth or death), through a report from a close family member or friend. This reflects the consensus in national and global research that race and colour are socially constructed categories best captured through self-identification.

The final search results, with 3659 articles, were exported into Rayyan and duplicates were removed (n = 1644).

Selection of sources of evidence

Articles were first screened based on titles and abstracts. Those included (n = 321) were then screened based on their full text. The screening process was conducted by seven researchers (PdMS, SSdO, RRdSC, JBL, SE, TAD, IRG). All articles were independently double screened, with disagreements solved by discussion or by consulting a third researcher. After full text screening, 145 articles were included. Quality and risk of bias assessment were not conducted, as these steps are not typically undertaken in scoping reviews, which aim to provide a comprehensive overview of the existing body of literature, regardless of quality or potential biases. A PRISMA flow diagram with the steps of screening and inclusion are presented in Fig. 1.

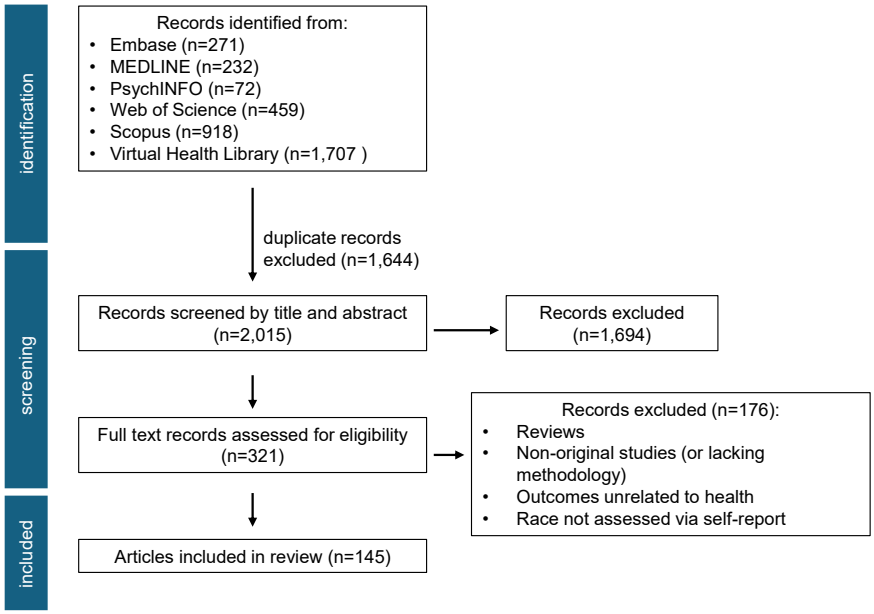

Fig. 1: **PRISMA flow diagram**. This figure presents the steps of screening, with the respective number of articles included and excluded at each step.

Data description

We extracted data from all included articles on health outcomes and racial discrimination experiences. Given the heterogeneity in design, population, and methods across the included studies; a narrative synthesis was undertaken. Findings were organized thematically according to the level at which racism was expressed to capture patterns and variations,[5] rather than to assess the magnitude or direction of effects. Definitions for all levels, as well as criteria for including and excluding papers in each of them are presented in the Appendix (pp. 3–4). Levels' descriptions follow the stages of the life course, except for the institutional level, which is presented following the "availability, accessibility, acceptability framework".[14]

Results

The literature shows the health impacts of racism across all levels of society in Brazil and across the life course (Fig. 2). Health inequalities exist at the structural level, reflecting macro-level mechanisms and hierarchical power that sustain racial inequity. These inequalities are reinforced by healthcare and health education institutions that restrict access to quality care for minoritized populations. Racism in various systems shapes health determinants, limiting access to care and increasing vulnerability to violence and disease in marginalized settings. Additionally, minoritized communities face the intersection of race and other identities, leading to poorer living conditions that undermine their health. The beliefs sustaining racism manifest as racial discrimination (direct and vicarious) during interpersonal interactions, contributing to poorer health outcomes. We present each level below, with further evidence synthesized as an extensive results summary table in the Appendix (pp. 5–39). Panels are utilised to demonstrate the histories and pathways through which racism leads to measurable differences in health outcomes.

Structural: health inequities across racial groups

Studies addressing structural racism (n = 39) unveil the health effects of separation, hierarchical power and the legacy of colonialism on contemporary structures of governance and political dynamics. These studies show racial health inequities at the population level across the lifespan, where minoritized groups are disadvantaged, and White advantage is protective.

Studies on preconception and perinatal health show greater maternal mortality,[15] number of hospitalizations and deaths of pregnant women during COVID-19,[16,17] preterm birth rate, and risk of low birth weight[18] for minoritized people compared to White people. Studies of child and adolescent health reveal worse oral health,[19] development,[20] child growth[21] and nutritional status[22] among Indigenous, Black and Brown children compared to White children. Afro-Brazilian children have a lower life expectancy,[23] and children from Indigenous (1.98; 95% CI 1.92–2.06), Black (1.39, 95% CI 1.36–1.41), and Brown (1.19, 95% CI 1.18–1.20) mothers have a higher risk of mortality compared to White counterparts.[24]

During adolescence, studies reveal the impacts of discrimination and racial violence in the form of

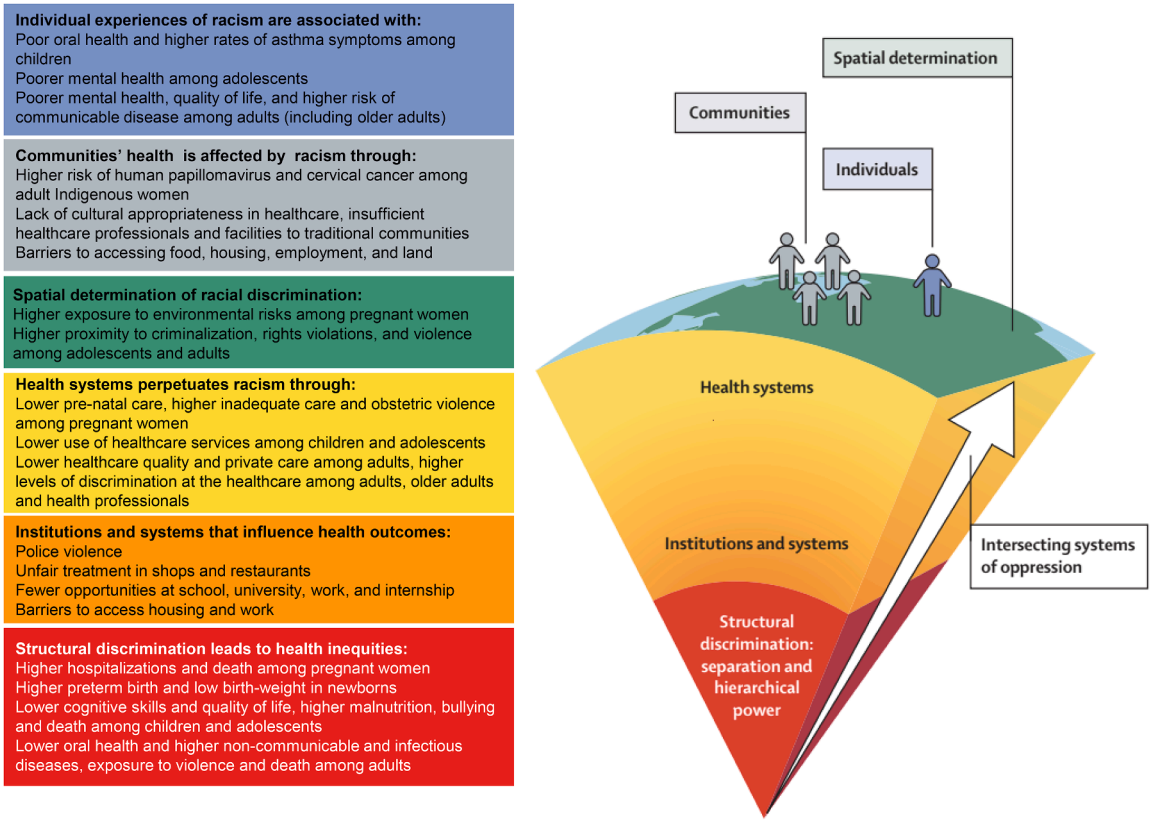

***Fig. 2:* Main consequences of racism at each level of society on minoritized populations' health**. Adapted from the Lancet Series *on Racism, Xenophobia, and Discrimination*, this figure illustrates how racism, as manifested at multiple levels of the conceptual model, affects the health of minoritized populations. Original article DOI: 10.1016/S0140-6736 (22)02484-9.

physical violence, forced sexual intercourse, and racial bullying.[25,26] Studies on adult and elderly health reveal higher prevalence of chronic, non-communicable diseases among minoritized people, including tuberculosis and mental health disorders,[27,28] untreated depression,[29] anxiety,[30] overweight and obesity,[31,32] physical violence[33] and poor oral health.[34] Higher mortality rates are also found associated with physical violence,[35] cervical cancer,[36,37] breast cancer,[37] Covid-19 infection,[38,39] and suicide.[40] Blacks and Brown elderly people have worse self-rated health[41–43] and racial differences in the cognitive domain (1.80, 95% CI 1.42–2.28, and 1.41, 95% CI 1.21–1.65) compared to those with White skin colour.[44]

Institutional: racism within institutions, including the health system

Studies pertaining to institutional racism and health concentrate on the impacts of racism on the health system (n = 56), showing that racism undermines the right to health for minoritized people across all four healthcare-related essential elements of the right to health; availability, accessibility, acceptability, and quality.[45]

Availability

Availability refers to the sufficient supply of health facilities and workers to serve the populations' health needs.[45,46] Studies highlight that neighbourhoods in the periphery of cities, urban areas, and remote territories often lack basic infrastructure including health centres and professionals. As Black and Brown people disproportionately live in these areas, inequitable healthcare availability limits their access to healthcare, including essential prenatal care.[47]

Accessibility

Healthcare is less accessible for minoritized people than for their White counterparts. In the perinatal period, Black women are more likely to have insufficient prenatal consults (1.6; 95% CI 1.4–1.9); lack of affiliation with maternity services (1.2; 95% CI 1.1–1.4); and absence of a companion (OR = 1.7; 95% CI 1.4–2.0) compared to White women.[48] When seeking abortion care, Black women are more than twice and Brown women more than 1.5 times more likely to report fear of mistreatment as a barrier to accessing care compared to White women,[48] and both Black and Brown women are more likely than

their White counterparts to lack money for transportation to a healthcare facility.[49] Barriers to access of healthcare by traditional communities include geographical distance and inadequate service organization, inadequate, dehumanized, and ineffective assistance.[50,51]

Analyses of nationally representative surveys show that, in adolescence, adulthood, and older adulthood, Black and Brown people are consistently more likely to report difficulty accessing health services[52] and oral healthcare compared to their White counterparts.[53] In the case of chronic renal failure, Black people lack access to diagnosis during outpatient care, follow-up care and conservative treatment.[54]

Acceptability

Experiencing discrimination can lead to disrespectful care being delivered to the patient and future avoidance of healthcare.[55] In a national survey of 60,202 individuals, more than 10% reported experiencing discrimination due to race or colour, and Black and Brown people are consistently more likely to experience discrimination in healthcare than their White counterparts.[56] This discrimination can manifest in more insidious ways, such as medical professionals assigning less autonomy to Black patients and disproportionately attributing treatment failures to them compared with White patients.[54]

Quality of care

Within perinatal healthcare, minoritized women are more likely to receive inadequate care across a range of indicators,[48] less likely to receive an anaesthetic during painful interventions,[48] and face greater institutional barriers within healthcare upon access.[57] The negative role of racism in the quality of perinatal care that women receive in Brazil has also been explored in qualitative research, with women linking their experiences of negligence, abuse, and poor treatment to racism.[58] Similar trends exist in healthcare for adults and older adults, with both doctors[59] and patients[53] highlighting that quality of care is worse for minoritized patients compared to White patients. These inequities in quality of care result from both discriminatory practices such as preferential treatment for White patients,[47] and lack of training and awareness amongst health professionals.[60]

Other institutions and systems: medical education

Racism is embedded in health education in Brazil. Black and Brown medical and dental students report experiencing interpersonal racism, such as racist jokes, silencing, and disbelief in their abilities, and institutional racism, including lack of support and institutional barriers.[61–63] In face of the complex forms in which racism manifests in the health systems, Panel 1 presents barriers and perspectives to promote health equity and the right to health in the Unified Health System (*Sistema Único de Saúde*–SUS).

Spatial: racism in spaces and environments

Studies included in this level (n = 5) evidence that minoritized populations are more exposed to harmful environmental conditions compared to non-minoritized groups. For example, there is a higher proportion of Black pregnant women in areas where Zika virus is common.[69] Additionally, discrimination interacts with different institutional norms shaped by location. Three studies explored racism embedded in police actions in major Brazilian cities, underscoring the exposure of young Black adult males to criminalization, rights violations, and fatal police violence.[70–72] Despite facing heightened health risks and violence, Black families encounter numerous geospatial barriers in accessing primary healthcare in their communities such as long distances or closure of services because of local violence.[72,73]

Community: experiences of racism and health in traditional communities and migrants

Studies included in this level (n = 16) present the experiences of communities with marginalization, social isolation, increased disease exposure, and risk of death. Among traditional communities, studies report cultural inadequacy,[51,74] disrespect for traditional diets, prohibition of traditional health care and non-recognition of traditional diseases in healthcare.[75] In the context of COVID-19, artisanal fishers,[76] Quilombolas,[77] and Indigenous communities[78] reported psychological suffering and dehumanization. Panel 2 illustrates how the health disparities faced by traditional populations in Brazil are rooted in colonialism, reinforcing patterns of exclusion and inequity.

Among migrant populations, perceived prejudice affects multiple spheres of daily life, including employment, housing, and interactions with police.[79] Migrants navigate multiple health systems, combining formal care with self-care, traditional remedies, and support from social networks, often in response to inequitable experiences.[80] Venezuelan migrants, for example, face briefer, less interactive care than Brazilians, reflecting discriminatory professional attitudes despite the SUS's universal mandate.[81] For Black refugees, racialization and prejudice further shape health access and social positioning, illustrating the intersection of race and migration in shaping health inequities.[74] Panel 3 examines how racism, shaped by enduring historical racial hierarchies, affects migrants' health in Brazil by influencing their experiences and access to healthcare.

Individual: experiences of discrimination and health consequences

The studies at the individual level addressed interpersonal racism and its health impacts (n = 29). Regarding childhood, the studies indicated the effects of racial discrimination on health outcomes in Black and Brown children, such as the worsening of quality of oral

***Panel 1*: The realization of the Human Right to Health through the Unified Health System: Challenges and perspectives**

Since its implementation in the Federal Constitution of 1988, the *Sistema Único de Saúde* (SUS) represents a milestone in Brazilian public health, ensuring comprehensive, universal, and free access to the entire population of Brazil. According to the principles and guidelines of the SUS, actions must have efficacy and problem-solving capacity proven by scientific evidence for all people (universality), at all levels of complexity (integrity), with particular attention to those who have the most needs and who are on the margins of power (equity). To this end, the system must be organized to respect local dynamics and autonomy (decentralization) and incorporate participation of the community (social participation).[64] This panel reflects on how racial discussions are integrated into the SUS and the challenges faced in addressing racial health inequities within this framework.

In the SUS, the PNSIPN is a guideline established to ensure that people with disabilities receive adequate and integrated healthcare services. The Black social movement, particularly led by Black women, has been crucial in placing Black health on the political agenda. Key issues include sexual and reproductive rights, maternal mortality, STIs/AIDS prevention, mental health, healthcare quality for sickle cell patients, worsened health conditions due to racism (e.g. diabetes and hypertension), respect for Afro-Brazilian religious traditions, and the elimination of racial discrimination in healthcare.[65] The health of the Black population has been part of the public management agenda for over 30 years, beginning with the Interministerial Working Group for the Valorisation of the Black Population in 1995, the Special Secretariat for Policies for Racial Equality in 2003, and the Technical Committee for Black Health in 2004. These initiatives led to seminars and meetings that resulted in the PNSIPN, approved by the National Health Council in 2006 and regulated by ministerial ordinance in 2009. However, 15 years later, only about 1% of municipalities have implemented it.[66] Challenges include recognizing the health impacts of racism, disseminating the PNSIPN, and ensuring financial resources, human resource training, and accountability.

The reluctance of institutions to acknowledge various forms of racism directly affects the care provided to Black users. For example, data collection on race and colour is often inconsistent, hindering evidence-based decision-making and the evaluation of health policies for the Black population across regions.[67] Additionally, while national health authorities highlight the fight against racism in the SUS as a strategic priority, no specific goals or indicators have been established to measure the effectiveness and impact of policies and programs for diverse populations.[68]

Promoting equity in resource distribution, considering racial, migratory, territorial, and geopolitical factors, is essential for mitigating racial health disparities. National authorities must establish criteria for allocating financial resources to promote racial equity in health. Conditional transfers tied to specific goals and result evaluations foster transparent and accountable management, encouraging continuous improvements in health services and the quality of life for populations affected by racism. By implementing policies to combat racism, the country recognizes health as a strategic investment rather than merely a cost to minimize.

Intersectoral collaboration among academia, civil society, and public and private sectors is essential for promoting innovative and inclusive policy solutions that comprehensively address the roots of racism in health. Anti-racist health management practices that align with principles of transparency, responsiveness, and accountability aimed at promoting racial equity are still scarce in Brazil. A health system can only be equitable if it centres all people. This necessitates a profound change in the structure and power dynamics within the health system, fostering diverse frameworks that reflect the realities and needs of the community, ensuring that no-one is left behind.

health,[87] as well as emerging evidence on the impact of vicarious racial discrimination (i.e. maternal experience of racism) on child health, such as increased risk of asthma symptoms.[88]

In studies that addressed adolescence, mental health stood out as a dimension affected by the ways in which racism, when interacting with sociodemographic and socioeconomic determinants, impacts the individual health-disease-care processes of Brazilian youth.[88–90] The association between the perception of racial discrimination and depression, low self-esteem,[91] and worse oral health[87] were highlighted, as well as the repercussions of socioeconomic, gender and ethnic-racial inequalities, as factors that impact the experience of Black adolescents in health services and increase their susceptibility to HIV/AIDS.[90]

Most of the publications covered adulthood (n = 21), nine of which also discussed older people.[92–94] They showed how interpersonal racial discrimination impacts the health of Black and Brown adults and elderly individuals, resulting in poor health outcomes,[93] such as higher prevalence or likelihood of developing obesity[95] and chronic non-communicable diseases, including mental health conditions,[92,96] and systemic arterial hypertension (SAH),[97] compared to White individuals.

Racial inequities were linked to gender, and socioeconomic factors throughout different life stages.[90,96] Reports of discrimination were notably higher among Black women, particularly those with low socioeconomic status.[96] Compared to White men, Black women experienced significantly differential treatment, such as unjust treatment in establishments (56.5% versus 16.8%) and being perceived as less intelligent (52.6% versus 14.1%). Black men with low socioeconomic status faced greater discrimination from law enforcement and security personnel.[98] Black transgender women often encounter rights violations in healthcare, increasing their vulnerability at individual, social, and programmatic levels.[99]

Among the literature reviewed, the importance of self-organized collectives is highlighted for strengthening self-esteem, fostering a sense of belonging, and developing strategies to confront racism and other forms of oppression.[97,99]

Panel 2: Indigenous Health and Racism

This panel was written by Elizângela Baré, an Indigenous woman and researcher.

Writing about racism and Indigenous health is to rise from the ashes left by colonization, a period defined by the relentless pursuit of wealth, power, and domination, whose consequences continue to resonate in the lives of Indigenous Peoples.

From the Indigenous perspective, racism is a legacy of colonization, in which the invaders bring with them from the moment they arrive, their forms of organization and their thirst for power. Because Indigenous Peoples have experienced decades of greed and domination over our bodies, minds, and territories, our Indigenous knowledge—preserved by more than five centuries of struggles and ancestral protection—is not valued as part of health.

Indigenous health in Brazil is organized by the Secretariat of Indigenous Health (*Secretaria de Saúde Indígena–SESAI*), which is responsible for coordinating and executing the National Policy for Health Care for Indigenous Peoples and the entire management process of the Indigenous Health Care Subsystem in the Unified Health System (*Sistema Único de Saúde–SUS*). This formal healthcare system, structured in the Western model, prioritizes treatment within clinics and hospitals—often confined to four walls—by professionally trained individuals. In doing so, it relegates traditional knowledge, with its languages, myths, blessings, and songs, to the margins.

For my people, who are the *Baré*, women's knowledge related to women's health are an important part of the Indigenous health system. In the first menstruation, our oldest and wisest elders share with us their wisdom, knowledge and techniques. This is called *Kariamã*, also known as "Ritual of the New Girl". The *Kariamã* is the moment of learning through orality, referenced by the "myth of Amaro": the primordial woman who was in the creation of humanity, leaving knowledge to her daughters, granddaughters and great-granddaughters in this contemporary world. The myth of Amaro is part of the cosmology of the *Baré* and reaffirms the *Baré* Indigenous Knowledge and the Traditional Medicine. When women become pregnant, leaves and roots are used in treatments to ensure that the pregnancy is healthy, and when the child is born, care is redoubled for the woman and the baby, with the use of teas, decoctions, *xincanta resins*, and *maiwa mira* (bark of the *manjuba tree*).

But Indigenous health in Brazil also results from the organization of the Brazilian State, which means that Indigenous Peoples must fight for the recognition and fulfillment of their rights by the State. As a result, we have waged several struggles for public policies. For this reason, today we have several Indigenous fronts fighting for the demarcation of lands, for policies in Indigenous school education with an emphasis on the appreciation of Indigenous languages, and for the safeguarding of culture through myths, songs, rivers, mountains, lakes and forests.

Environmental racism leads us to new formats of adaptation, making us navigate on paths that aim to destroy our existence, such as those traced by climate change: furies of nature that human beings cause but cannot control, leaving the planet vulnerable not only for the Indigenous populations but for all of humanity. For us, Indigenous Peoples, without the land we have no health. Without rivers, lakes and streams, we have no health. For us, our body is interconnected with nature, and nature, being part of our bodies, often reveals itself through it. That is why we have healing within nature. The Indigenous medicines are in these territories composed of living (human and non-human) bodies. The Medicinal Plants are a living pharmacy that is found in the rivers, seas, forests, and gardens.

Environmental racism has been experienced by Indigenous Peoples in Brazil since the invasion of Indigenous territories, which excluded our existences from the places of origin, imposing perspectives of experiences that are not appropriate for us and creating social organizations in which we are excluded and that are not compatible with our realities. The so-called "development" brought by colonization keeps us away from living where we fish, plant, and build gardens. Indigenous life cycles are interrupted by roads, expansion of cities, highways, hydroelectric dams, deforestation, agribusiness and illegal mining, which cause changes in the traditional way of life, leaving our peoples vulnerable to the ways of life that enterprises bring with their arrival. They aim at profit, power and wealth, not life, leaving the bodies of Indigenous Peoples on the margins.

Approach to measuring racism

Across the studies, qualitative information mainly referred to episodes of racial discrimination and coping strategies, while quantitative data focused on racial differences in health outcomes or on single dimensions of interpersonal discrimination, and multi-level or structural indicators were rarely incorporated. Interpersonal racial discrimination was measured by validated questionnaires or by direct questions about whether the person felt discriminated against. Only the Experiences of Discrimination Scale[100] investigated discrimination strictly related to race, while four other scales questioned about feeling discriminated, with a follow-up question about reasons for it (which included race/ethnicity) and frequency of occurrence. The most commonly used scale was the Major Experiences of Discrimination Scale,[101] and only the Explicit Discrimination Scale[98] was developed in Brazil. At the institutional level, in addition to interpersonal discrimination in the health system or by health professionals, racial discrimination was approached through health professionals and students' responses to hypothetical clinical scenarios, and perceptions about the patients' autonomy and responsibility for treatment failure. However, measurement remains inconsistent across studies.

Limitations and contributions of the literature

Despite the growing body of literature on racism, few studies in this review articulated a clear theoretical or analytical approach to understanding it, often treating it as a background variable rather than a central mechanism shaping health outcomes. The predominance of cross-sectional and quantitative designs constrains understanding of the longitudinal and cumulative effects of racism across the life course, narrowing the

Panel 3: Migration, Health and Racism

Migration is a longstanding phenomenon that has shaped societies, influencing cultures, economies, and social structures. In contemporary contexts, especially in countries like Brazil, migration remains a subject of intense debate, particularly when connected to the complex issue of racism. This panel aims to explore the intersection between migration and racism, with a specific focus on Haitian migrants in Brazil, highlighting how historical legacies of colonialism and racial hierarchies shape their experiences today.

After World War II, Brazil saw an influx of immigrants from various countries. However, in the 1960s and 1970s, international immigration slowed, while domestic migration grew. In the 2010s, international migration reemerged as a significant political issue, fuelled by the global migration crisis. Haitian migration became a key aspect of contemporary human mobility, spurred by natural disasters, economic decline, and political instability in Haiti. Between 2010 and 2018, the Federal Police recorded 116,625 Haitian entries into Brazil, with 73.78% occurring between 2015 and 2017. Most migrants were male, with the largest age group between 20 and 44 years old. During this period, the Ministry of Labor registered 48,116 Haitian workers in Brazil, 42.15% of whom had completed high school.[82] Between January 2023 and July 2024, Brazil granted 11,200 humanitarian visas, with Haiti being the second-largest beneficiary. A total of 4149 visas were issued to Haitians, following Afghanistan, which received 6179 visas.[83]

Structural barriers, such as labour market discrimination, force Haitian migrants into precarious, low-paying jobs with little job security or benefits, exacerbating economic instability and poor living conditions.[82] These conditions increase the risk of respiratory diseases, infections, and other physical and mental health issues. The intersection of racism, systemic discrimination, and exclusionary policies also prevents full participation in poverty alleviation programs, perpetuating cycles of poverty and social inequality.[84] A key issue is the mental health impact: the stress of navigating hostile systems, compounded by discrimination and xenophobia, leads to high levels of anxiety, depression, and PTSD.

Racism not only heightens vulnerability to diseases through poor living conditions but also limits healthcare access due to language barriers, cultural mismatches, restricted service hours, delays, and the cost or lack of medications, worsening existing inequalities.[85] This lack of access to healthcare, combined with the lack of education, perpetuates generational disparities. Children of Haitian migrants often face linguistic and cultural barriers that hinder their academic success, leaving many behind and limiting their future opportunities.[86] Without access to formal education, vocational training, or legal support, Haitian migrants are often trapped in informal labour markets marked by low wages and exploitation.

Undocumented migrants face heightened exclusion due to fear of deportation. Even when legally entitled to healthcare and assistance, Haitian migrants often avoid seeking help to protect their immigration status.[86] This fear extends to reporting crimes, such as workplace violations or domestic violence, due to the risk of family separation. Many remain trapped in cycles of abuse and poverty, unable to access the support they need. The lack of inclusive policies isolates them further, excluding them from public spaces and community programs, deepening their alienation.[82] This isolation weakens community bonds, hindering organizing and advocacy, and exacerbates social inequalities, limiting civic and political participation.[84]

From a public health perspective, the marginalization of Haitian migrants not only threatens their individual well-being but also poses risks to the broader community. Efforts to dismantle systemic barriers must prioritize equitable access to education, healthcare, and social services, enabling Haitian migrants to fully participate in society. Culturally sensitive outreach, multilingual resources, and community-based initiatives can bridge the gap between migrants and essential services. Strengthening legal protections and creating pathways to regularization can reduce the fear of deportation, empowering Haitian migrants to seek the support they need. Ultimately, addressing their lack of access to basic services requires a holistic approach grounded in human rights, equity, and social justice.

By investing in inclusive policies and fostering mutual respect and understanding, societies can break the cycle of exclusion and unlock the full potential of migrant communities. This benefits not only Haitian migrants but also strengthens the social fabric and resilience of the broader community, contributing to a more just and equitable future for all. While the challenges are significant, migration can serve as a catalyst for change, challenging racial norms and promoting diversity. Haitian migrants bring resilience, cultural richness, and a strong advocacy for racial justice, all of which contribute to reshaping Brazilian society. Through their activism and broader migrant rights movements, they emphasize the urgent need to address the interconnected issues of race, migration, and social inequality.

conceptualization of racism to individual experiences rather than structural processes. Moreover, existing research disproportionately focuses on heterosexual, cisgender Brazilian adults, with limited attention to youth, older adults, LGBTQIA + populations, traditional communities, and migrants, constraining understanding of how racism intersects with social markers across the life course. Nevertheless, the existing literature makes important contributions to advancing racial health equity, highlighting the urgency of developing robust, multi-level measures of racism and implementing a justice-oriented perspective that recognizes health disparities as manifestations of historical and structural inequities.

Discussion

This review illustrates the ways in which racism leads to poor health at all levels of Brazilian society, with processes at each level reinforcing and amplifying inequities at others. At the structural level, health inequities across the life course unveil the effects that separation and hierarchical power have on minoritized groups, including through historical experiences of colonialism and social and economic inequalities.[5] These structural forces influence institutional practices in health (such as the shortage of health units and professionals, limited access to quality care, and professional bias) as well as in other sectors, including housing, labour, and public security, in marginalized

areas and communities. At the interpersonal level, racism manifests through stigma, discrimination, and differential treatment, compounding the effects of structural and institutional inequalities. Together, these mechanisms sustain a two-way relationship between socioeconomic and health status, in which poorer physical and mental health among minoritized populations creates additional barriers to learning and work, further reinforcing social and income inequalities.

Studies in this review show that minoritized groups in Brazil face greater health risks across all stages of the life course, consistent with international findings on racism's impact on health.[7] Black and Brown Brazilians face higher rates of maternal mortality, preterm birth, and low birth weight. Children are affected by direct and vicarious racism, while adolescents and adults experience greater exposure to physical violence and poorer mental health. Among older adults, racism is associated with lower cognitive function and overall perceived health. Among traditional populations and migrant groups, studies report combining formal care with self-care and traditional remedies in response to inequitable treatment. Importantly, Brazil's unique race/colour categories and significant regional heterogeneity underscore the need for tailored measures and subgroup-specific analyses; findings from global reviews may not be directly comparable unless these variations are considered.

In contrast to international findings, unaffordable healthcare was not identified as a major barrier. This difference likely reflects Brazil's public health system, which provides broad, universal, access to care. Nonetheless, persistent racial inequities in the quality and accessibility of services suggest that racism operates through mechanisms other than cost, such as discrimination in service provision, geographic exclusion, and differential treatment within health institutions. Additionally, the data architecture of the SUS, while providing comprehensive population coverage, shows incomplete racial classification, limiting the ability to monitor racial health inequities over time.[102]

In terms of healthcare acceptability, our results evidenced how interpersonal racism compromises respectful care, while responsibility for failures in health treatments are forced onto minoritized individuals.[55] Blaming the patient for treatment failures has been shown to have negative psychological impacts and lead to deterioration of trust, being particularly unfair and stigmatizing in a context in which minoritized people are more likely to receive worse quality of care. National and international evidence show that negative experiences with the health service affect access to healthcare by causing minoritized people to avoid healthcare.[7]

Combating institutional racism cannot rely solely on individual practices, as the racism embedded in institutional structures encourages the reproduction of individual practices that maintain the *status quo*, while disarming individual initiatives that contest established practices. Therefore, institutions must clearly define operational dimensions to guide program development, implementation, and evaluation processes, ensuring that goods and services are available, accessible, acceptable, and of high quality.

To ensure inclusive scientific knowledge production, informed political decisions, and equitable health practices in a nation rich in racial and ethnic diversity, it is imperative to involve a wide array of social actors. The overwhelming majority of White medical students in Brazil highlights the systemic exclusion of Black individuals from positions of higher social status and financial reward.[103] This disparity, that starts much earlier in life and is perpetuated throughout education, not only maintains inequalities but also epistemic injustice.

Epistemic injustice encompasses the ways in which racism and discrimination influence the creation and validation of knowledge, favouring individuals positioned at the apex of established power structures. This unequal distribution of weight and credibility perpetuates disparities in access to knowledge and resources, leaving marginalized communities grappling to articulate their lived realities and experiences.[5] Health-related educational institutions further perpetuate epistemic injustice by neglecting to integrate the objectives of the National Policy for the Integral Health of the Black Population (PNSIPN) into their curricula.[104] This omission reinforces the notion of a "universal user," failing to address the specific healthcare needs and experiences of marginalized communities, particularly those of Black and Brown individuals. The limited representation of community-level articles in our review highlights the exclusion of traditional communities, reflecting inherent racism and ethnocentrism. Although we primarily focused on racial inequities among traditional populations, our results also highlight migration as another structural determinant, acknowledging that different migrant groups experience minoritization and the impacts of colonialism in varied ways, with some facing greater injustices than others.

Results from the individual level show the constant interpersonal discrimination to which minoritized people are exposed throughout their lives and the necessity of understanding health inequities in an intersectional framework, with racism operating with other systems of oppression, such as sexism, classism, and transphobia.[26,98] We highlight the urgent need for new epistemologies in the study of racism and health, ones that extend beyond the knowledge systems rooted in White, cisgender experiences and spaces, particularly in addressing racial inequities in healthcare from early life. This involves challenging the entrenched

assumption that health standards and provisions designed for the White, cisgender population should serve as the universal benchmark.

Based on the review's findings, several actions are suggested to strengthen Brazil's health system and clinical practice in addressing racism as a determinant of health. Monitoring racism's impact on health requires combining individual, institutional, and structural measures. Health systems should establish real-time analytic tools and equity dashboards to track disparities, guide resource allocation, and evaluate anti-racist policies. Clinicians and public health professionals should receive training on structural competency and racial equity, ensuring that care practices recognize and mitigate racial bias, following standardized protocols to reduce racial disparities in care. Policymakers must support workforce diversity through affirmative action initiatives, enforce anti-racism laws, embed Afro-Brazilian and Indigenous histories in health education, and treat police violence, labour inequities, and environmental injustice as public health issues. Investments should be directed toward underserved areas to ensure equitable access to quality care, and public communication strategies must actively combat racial stereotypes. Strengthening democratic governance, community participation, and research infrastructure is essential to sustain progress and ensure accountability in racial health equity. Although these recommendations are rooted in the Brazilian context, they remain highly relevant to other settings, offering transferable strategies to advance racial equity in health systems worldwide.

When interpreting our results, it is important to recognize that the described ways in which racism affects the health of minoritized people are shaped by the studies' designs and methodologies. Most articles lacked a clear definition or conceptual framework for approaching racism. Theory-driven studies are essential to capture the complexity of racism's impact on health and variables beyond health outcomes and interpersonal discrimination. Additionally, measures of racism were predominantly interpersonal and cross-sectional, with few capturing structural and policy-level mechanisms or the interlocking and cumulative effects of racism over the life course. These gaps highlight the need for a coordinated research agenda capable of shifting the field from association-mapping to mechanism-testing. Researchers should apply strong theoretical basis for anti-racism research, such as the Critical Race Theory, to examine systemic inequities and the health impacts of structural racism, ensuring that studies centre on the lived experiences of racialized populations, involve community partnerships, and use disaggregated data and innovative models that reflect the complexity of the problem. Integrating multi-level exposure measures and structural indicators such as residential segregation, labor market stratification, and differentiated policing could enable clearer identification of how racism produces and sustains health inequities. Employing longitudinal or quasi-experimental designs would strengthen causal inference and reveal how racism accumulates over the life course. Consistent use of validated instruments and transparent reporting of subgroup analyses, particularly along Brazil's colour continuum and regional gradients, would improve comparability and enable stronger policy translation.

This study has limitations. Our findings are based on literature published in academic journals, which may perpetuate epistemic racism by shaping whose knowledge is produced and disseminated. The absence of evidence on certain forms of racism affecting health outcomes does not mean they lack impact. Because racism is not always explicitly named or conceptualized, some relevant studies may have been overlooked, and research examining aspects of structural racism without direct empirical health data may have been excluded. Nevertheless, this review makes important contributions by synthesizing existing evidence and highlighting key gaps, offering a foundation for theory-driven, innovative approaches to address health inequities.

Conclusion

Racism ingrained in Brazilian society manifests in various forms of injustice, contributing to lower life expectancy among Black, Brown, and Indigenous children, poorer health behaviours and mental health among adolescents, and higher prevalence of non-communicable chronic and neglected diseases among adults. In this scoping review, few studies focused on older adults, despite their chronic exposure to racism throughout life. Perinatal and maternal health have primarily been investigated at the institutional level. Access to healthcare is notably worse in urban peripheries and remote areas where minoritized populations reside. To address racism in healthcare, it is essential to place the promotion of health, disease prevention, and the treatment of minoritized groups at the forefront. Health policies must be rooted in principles of justice, dignity, and equity to safeguard both collective well-being and individual rights. Implementing real-time equity monitoring, expanding anti-racist clinical training, enforcing protective policies, and directing investments to underserved regions are concrete actions that can help Brazil address the racial health inequities identified in this review. Advancing this agenda also requires strengthening research through theory-driven designs, understanding of the subjectivities and collective experiences of marginalized groups, multi-level measures, and disaggregated data to capture the structural mechanisms through which racism shapes health. We underscore the urgent need for

research that transcends colonialist epistemic standards, embracing subjectivities and collective experiences within a human right-centred approach to health.

Contributors

DD, PdMS and FL conceived and designed the review. PdMS ran the searches and undertook the initial screening process. Further screening and data extraction was conducted by PdMS, JBL, RRdSC, SE, SOdS, TAD and IRG. PdMS, SE and SOdS summarised the data in a comprehensive results summary table. PdMS designed the figures, and led the collaborative structuring, writing, and editing of the manuscript. The sections on the levels of society in which racism affected health were written by SOdS, SE, PdMS, IRG and RRdCS. EB wrote panel 1, FL, SOdS and PdMS wrote panel 2, and JBL wrote panel 3. All authors edited and critically revised the draft.

Declaration of interests

DD is director of the Race & Health collective within UCL. FL is one of the funders of the Brazilian Association of Collective Health (ABRASCO) Racism and Health Working Group. SOdS received honoraria from Faculdade VP and from Colóquio Ânima Plurais. RRSC disclosed consulting fees from FIAN Brasil and Instituto Ibirapitanga, as well as Payment or honoraria from Desiderata. All other authors declare no competing interests.

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Appendix A. Supplementary data

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References

1 Gonzalez L, Hasenbalg CA. *Lugar de negro*. Rio de Janeiro: Zahar; 2022.
2 Sá EB, Santos YL, Silva TD. *Edição Censo Demográfico 2022. Ministério da Igualdade Racial. (Informe MIR - Monitoramento e avaliação, n° 3)*. Brasília: DF; 2024. https://www.gov.br/igualdaderacial/pt-br/composicao/secretaria-de-gestao-do-sistema-nacional-de-promocao-da-igualdade-racial/diretoria-de-avaliacao-monitoramento-e-gestao-da-informacao/informativos/Informe-edicao-censo-demogrfico2022.pdf.
3 IBGE, Coordenação de População e Indicadores Sociais. *Síntese de indicadores sociais: uma análise das condições de vida da população brasileira: 2023*. Rio de Janeiro: IBGE; 2023.
4 IBGE, Instituto Brasileiro de Geografia e Estatística. Desigualdades Sociais por Cor ou Raça no Brasil. https://www.ibge.gov.br/estatisticas/sociais/populacao/25844-desigualdades-sociais-por-cor-ou-raca.html. Accessed January 14, 2025.
5 Devakumar D, Selvarajah S, Abubakar I, et al. Racism, xenophobia, discrimination, and the determination of health. *Lancet*. 2022;400(10368):2097–2108. https://doi.org/10.1016/S0140-6736(22)01972-9.
6 Deivanayagam TA, English S, Hickel J, et al. Envisioning environmental equity: climate change, health, and racial justice. *Lancet*. 2023;402(10395):64–78. https://doi.org/10.1016/S0140-6736(23)00919-4.
7 Selvarajah S, Corona SM, Deivanayagam TA, et al. Racism, xenophobia, and discrimination: mapping pathways to health outcomes. *Lancet*. 2022;400(10368):2109–2124. https://doi.org/10.1016/S0140-6736(22)02484-9.
8 Silva KKR, Lima MEO, Silva PD. Racism and Indigenous peoples in Brazil: a scoping review. *Psicol Teor Prat*. 2024;26(1):ePTPSP15944. https://doi.org/10.5935/1980-6906/eptpsp15944.en.
9 Sampaio ML, Almeida ACGD, Silveira C, Matsue RY, Martin D. Repercussões sociossanitárias da pandemia por Covid-19 para imigrantes e refugiados no Brasil: uma revisão narrativa da literatura. *REMHU*. 2023;31(68):219–239. https://doi.org/10.1590/1980-85852503880006814.
10 Oliveira BMC, Kubiak F. Vista do Racismo institucional e a saúde da mulher negra: uma análise da produção científica brasileira. *Saúde Debate*. 2019;43(122):939–948. https://doi.org/10.1590/0103-1104201912222.
11 Santiago GHDP, Gaudenzi P. Uma análise dos estudos brasileiros, do campo da Saúde Coletiva, sobre racismo e sofrimento psíquico. *Physis*. 2023;33:e33071. https://doi.org/10.1590/S0103-733120 2333071.
12 Fredrich VCR, Santos HLPCD, Rocha TDP, Sanches LDC. Percepção de racismo vivenciado por estudantes negros em cursos de Medicina no Brasil: uma revisão integrativa da literatura. *Interface*. 2022;26:e210677. https://doi.org/10.1590/interface.210677.
13 Selvarajah S, Deivanayagam TA, Lasco G, et al. Categorisation and minoritisation. *BMJ Glob Health*. 2020;5(12):e004508. https://doi.org/10.1136/bmjgh-2020-004508.
14 Montel L, Ssenyonga N, Coleman MP, Allemani C. How should implementation of the human right to health be assessed? A scoping review of the public health literature from 2000 to 2021. *Int J Equity Health*. 2022;21(1):139. https://doi.org/10.1186/s12939-022-01742-0.
15 Alves LGR, Guimarães RM. Race inequalities in maternal mortality in the city of Rio de Janeiro, Brazil: 2010-2019. *Rev Assoc Med Bras*. 2021;67(1):120–124. https://doi.org/10.1590/1806-9282.67.01.20200633.
16 Ferreira RBS, Camargo CLD, Sousa ARD, Whitaker MCO. Morbimortalidade de gestantes pela COVID-19 e os atravessamentos da raça/cor: uma análise interseccional. *Online Braz J Nurs*. 2022;21(Suppl 2):e20226553. https://doi.org/10.17665/1676-4285.2022.6553.
17 Dantas-Silva A, Surita FG, Souza R, et al. Brazilian black women are at higher risk for COVID-19 complications: an analysis of REBRACO, a national cohort. *Rev Bras Ginecol Obstet*. 2023;45(5):253–260. https://doi.org/10.1055/s-0043-1770133.
18 Fonseca JM, Silva AAM, Rocha PRH, et al. Racial inequality in perinatal outcomes in two Brazilian birth cohorts. *Braz J Med Biol Res*. 2021;54(1):e10120. https://doi.org/10.1590/1414-431X202010120.
19 Emmanuelli B, Kucner ÂA, Ostapiuck M, Tomazoni F, Agostini BA, Ardenghi TM. Racial differences in oral health-related quality of life: a multilevel analysis in Brazilian children. *Braz Dent J*. 2015;26(6):689–694. https://doi.org/10.1590/0103-6440201300478.
20 Wehby GL, Trujillo AJ. Differences in early cognitive and receptive-expressive neurodevelopment by ancestry and underlying pathways in Brazil and Argentina. *Infant Behav Dev*. 2017;46:100–114. https://doi.org/10.1016/j.infbeh.2016.12.001.
21 Burgard S. Does race matter? Children's height in Brazil and South Africa. *Demography*. 2002;39(4):763–790. https://doi.org/10.2307/3180830.
22 Silva HBM, Ribeiro-Silva RDC, Silva JFM, et al. Ethnoracial disparities in childhood growth trajectories in Brazil: a longitudinal nationwide study of four million children. *BMC Pediatr*. 2024;24(1):103. https://doi.org/10.1186/s12887-024-04550-3.
23 Wood CH, Carvalho JAM, Horta CJG. The color of child mortality in Brazil, 1950-2000: social progress and persistent racial inequality. *Lat Am Res Rev*. 2010;45(2):114–139. https://doi.org/10.1017/S0023879100009377.
24 Rebouças P, Goes E, Pescarini J, et al. Ethnoracial inequalities and child mortality in Brazil: a nationwide longitudinal study of 19 million newborn babies. *Lancet Glob Health*. 2022;10(10):e1453–e1462. https://doi.org/10.1016/S2214-109X(22)00333-3.
25 Menezes AAS, Ramos DO, Sanchez ZM, Miskolci R. Racial-based bullying and substance use: a Brazilian national cross-sectional survey among students. *J Racial Ethn Health Disparities*. 2023;10(3):1441–1454. https://doi.org/10.1007/s40615-022-01330-6.
26 Ramos DO, Goes EF, Ferreira AJF. Intersection of race and gender in self-reports of violent experiences and polyvictimization by young girls in Brazil. *J Racial Ethn Health Disparities*. 2022;9(4):1506–1516. https://doi.org/10.1007/s40615-021-01089-2.
27 Batista LE. Masculinidade, raça/cor e saúde. *Cien Saude Colet*. 2005;10(1):71–80. https://doi.org/10.1590/S1413-81232005000100013.
28 Medeiros S, Coelho R, Millett C, et al. Racial inequalities in mental healthcare use and mortality: a cross-sectional analysis of 1.2 million low-income individuals in Rio de Janeiro, Brazil 2010-2016.

BMJ Glob Health. 2023;8(12):e013327. https://doi.org/10.1136/bmjgh-2023-013327.
29 Mrejen M, Hone T, Rocha R. Socioeconomic and racial/ethnic inequalities in depression prevalence and the treatment gap in Brazil: a decomposition analysis. *SSM Popul Health*. 2022;20:101266. https://doi.org/10.1016/j.ssmph.2022.101266.
30 Alckmin-Carvalho F, Torre RD, Teixeira I, et al. Perceived homonegativity and psychological distress in gay men in Brazil: does skin color matter? *Healthcare (Basel)*. 2025;13(9):1030. https://doi.org/10.3390/healthcare13091030.
31 Pinheiro TDLF, Silva LDD, Santos CM, Oliveira GMD, Borba DP, Abbade EB. Associação entre etnia e sobrepeso/obesidade populacional no Brasil. *Med (Ribeirão)*. 2023;56(1):e-198948. https://doi.org/10.11606/issn.2176-7262.rmrp.2023.198948.
32 Araujo TA, Silva TGV, Jesus ACS, et al. Race inequality and undernutrition in older Brazilian adults. *Estud Interdiscip Envelhec*. 2024;29. https://doi.org/10.22456/2316-2171.133739.
33 Oliveira GCMD, Martins AC, Pazini DDS, Paula EEPD, Nunes LC, Freitas EDD. Typification and factors associated with violence among the homeless in a municipality of Minas Gerais, Brazil. *Ciência Saúde Coletiva*. 2023;28(6):1607–1617. https://doi.org/10.1590/1413-81232023286.13582022.
34 Celeste RK, Gonçalves LG, Faerstein E, Bastos JL. The role of potential mediators in racial inequalities in tooth loss: the pró-saúde study. *Community Dent Oral Epidemiol*. 2013;41(6):509–516. https://doi.org/10.1111/cdoe.12051.
35 Santos SMD, Guimarães MJB, Araújo TVBD. Desigualdades raciais na mortalidade de mulheres adultas no Recife, 2001 a 2003. *Saúde Soc*. 2007;16(2):87–102. https://doi.org/10.1590/S0104-12902007000200009.
36 de Melo AC, da Silva JL, Dos Santos ALS, Thuler LCS. Population-based trends in cervical cancer incidence and mortality in Brazil: focusing on black and Indigenous population disparities. *J Racial Ethn Health Disparities*. 2024;11(1):255–263. https://doi.org/10.1007/s40615-023-01516-6.
37 Góes EF, Guimarães JMN, Almeida MDCC, et al. The intersection of race/ethnicity and socioeconomic status: inequalities in breast and cervical cancer mortality in 20,665,005 adult women from the 100 million Brazilian cohort. *Ethn Health*. 2024;29(1):46–61. https://doi.org/10.1080/13557858.2023.2245183.
38 Silva ACRD, Lemos ACDS. 'Race and health': black female healthcare providers in the COVID-19 pandemic. *Saúde Soc*. 2024;33(3):e240356pt. https://doi.org/10.1590/S0104-12902024040356en.
39 Cardoso FS, Gomes DCK, Silva ASD. Racial inequality in health care of adults hospitalized with COVID-19. *Cad Saude Publica*. 2023;39(10). https://doi.org/10.1590/0102-311XEN215222.
40 Araujo JAP, Fialho É, Oliveira Alves FJ, et al. Suicide among Indigenous peoples in Brazil from 2000 to 2020: a descriptive study. *Lancet Reg Health Am*. 2023;26(100591):100591. https://doi.org/10.1016/j.lana.2023.100591.
41 Silva AD, Rosa TEDC, Batista LE, et al. Iniquidades raciais e envelhecimento:análise da coorte 2010 do Estudo Saúde,Bem-Estar e Envelhecimento (SABE). *Rev Bras Epidemiol*. 2019;21(Suppl 02):e180004. https://doi.org/10.1590/1980-549720180004.
42 Soares BQ, Rabelo DF, Cruz SS. Mulheres na meia idade e velhice: condições de vida e saúde mental por raça/cor no contexto brasileiro. *Interam J Psychol*. 2024;58(3):e1999. https://doi.org/10.30849/ripijp.v58i3.1999.
43 Moura RF, Cesar CLG, Goldbaum M, Okamura MN, Antunes JLF. Factors associated with inequalities in social conditions in the health of elderly white, brown and black people in the city of São Paulo, Brazil. *Ciência Saúde Coletiva*. 2023;28(3):897–907. https://doi.org/10.1590/1413-81232023283.08582022.
44 Plácido J, Marinho V, Ferreira JV, Teixeira IA, Costa EC, Deslandes AC. Association among race/color, gender, and intrinsic capacity: results from the ELSI-Brazil study. *Rev Saude Publica*. 2023;57:29. https://doi.org/10.11606/s1518-8787.2023057004548.
45 UN, Committee on Economic, Social, Cultural Rights. The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights). https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf; 2000. Accessed August 31, 2025.
46 Jesus TS, Landry MD, Dussault G, Fronteira I. Human resources for health (and rehabilitation): six rehab-workforce challenges for the century. *Hum Resour Health*. 2017;15(1):8. https://doi.org/10.1186/s12960-017-0182-7.
47 Hogan VK, de Araujo EM, Caldwell KL, Gonzalez-Nahm SN, Black KZ. 'We black women have to kill a lion everyday': an intersectional analysis of racism and social determinants of health in Brazil. *Soc Sci Med*. 2018;199:96–105. https://doi.org/10.1016/j.socscimed.2017.07.008.
48 Leal MDC, Gama SGND, Pereira APE, Pacheco VE, Carmo CND, Santos RV. A cor da dor: iniquidades raciais na atenção pré-natal e ao parto no Brasil. *Cad Saude Publica*. 2017;33(suppl 1). https://doi.org/10.1590/0102-311X00078816.
49 Goes EF, Menezes GMS, Almeida MDCC, et al. Vulnerabilidade racial e barreiras individuais de mulheres em busca do primeiro atendimento pós-aborto. *Cad Saude Publica*. 2020;36(suppl 1). https://doi.org/10.1590/0102-311X00189618.
50 Pereira LL, Santos LMP. Programa Mais Médicos e Atenção à Saúde em uma comunidade quilombola no Pará. *Argum*. 2018;10(2):203–219. https://doi.org/10.18315/argumentum.v10i2.18737.
51 Feitosa MDO, Gomes MEA, Fontoura IG, et al. Access to health services and assistance offered to the Afro-descendant communities in northern Brazil: a qualitative study. *Int J Environ Res Public Health*. 2021;18(2):368. https://doi.org/10.3390/ijerph18020368.
52 Constante HM, Marinho GL, Bastos JL. The door is open, but not everyone may enter: racial inequities in healthcare access across three Brazilian surveys. *Ciência Saúde Coletiva*. 2021;26(9):3981–3990. https://doi.org/10.1590/1413-81232021269.47412020.
53 Souza LHT, Santiago SM, de Azevedo Barros MB, Lima MG. Racial inequalities in oral health: a population-based study. *Race Soc Probl*. 2021;13(2):122–130. https://doi.org/10.1007/s12552-020-09299-9.
54 Ferreira RBS, de Camargo CL, Barbosa MIS, Servo MLS, Oliveira MMC, Leal JAL. Implications of institutional racism in the therapeutic itinerary of people with chronic renal failure. *Invest Educ Enfermería*. 2020;38(2). https://doi.org/10.17533/udea.iee.v38n2e09.
55 Candido LC, Finkler M, Bastos JL, Freitas SFTDE. Conflitos com o paciente, cor/raça e concepções de estudantes de Odontologia: uma análise com graduandos no Sul do Brasil. *Physis*. 2019;29(4). https://doi.org/10.1590/S0103-73312019290410.
56 Dantas MNP, Aiquoc KM, Santos EGO, et al. Prevalência e fatores associados à discriminação racial percebida nos serviços de saúde do Brasil. *Rev Bras em Promoção Saúde*. 2019;32:1–11. https://doi.org/10.5020/18061230.2019.9764.
57 Goes EF, Menezes GMS, Almeida MDCC, et al. Barriers in accessing care for consequence of unsafe abortion by Black women: evidence of institutional racism in Brazil. *J Racial Ethn Health Disparities*. 2021;8(6):1385–1394. https://doi.org/10.1007/s40615-020-00900-w.
58 Williamson KE. The iatrogenesis of obstetric racism in Brazil: beyond the body, beyond the clinic. *Anthropol Med*. 2021;28(2):172–187. https://doi.org/10.1080/13648470.2021.1932416.
59 Lages SRC, Silva A, Silva D, Damas JM, de Jesus MA. O preconceito racial como determinante social da saúde - a invisibilidade da anemia falciforme. *Rev Interinst Psicol*. 2017;10(1):109–122. https://doi.org/10.1080/13648470.2021.1932416.
60 Damasceno MG, Zanello V. Psicoterapia, raça e racismo no contexto brasileiro: experiências e percepções de mulheres negras. *Psicol Estud*. 2019;24. https://doi.org/10.4025/psicolestud.v24i0.42738.
61 Valério ACDO, Bezerra WC, Santos VSD, Leite Junior JD, Farias MN, Santos SMBD. Racismo e participação social na universidade: experiências de estudantes negras em cursos de saúde. *Cad Bras Ter Ocup*. 2021;29:e3007. https://doi.org/10.1590/2526-8910.ctoAO2278.
62 Fredrich VCR, Coelho ICM, Sanches LDC. Desvelando o racismo na escola médica: experiência e enfrentamento do racismo pelos estudantes negros na graduação em Medicina. *Trab Educ Saúde*. 2022;20:e00421184. https://doi.org/10.1590/1981-7746-ojs421.
63 Lopes-Silva J, Paiva SM, Oliveira PAD, Bendo CB. Explicit discrimination among Brazilian dental students: a multicenter study. *J Dent Educ*. 2024;88(11):1467–1475. https://doi.org/10.1002/jdd.13634.
64 Lopes F. Justiça reprodutiva: um caminho para justiça social e equidade racial e de gênero. *Organicom*. 2022;19(40):216–227. https://doi.org/10.11606/issn.2238-2593.organicom.2022.205773.

65 Araújo MVRD, Teixeira CFDS. Concepções de saúde e atuação do Movimento Negro no Brasil em torno de uma política de saúde. *Saúde Soc.* 2022;31(4):e220246pt. https://doi.org/10.1590/S0104-12902022220246pt.

66 Silva SOD, Berenguer AAS, Ricardo TMDS, et al. 'I actually never heard of it or participated in it': the National Policy on Comprehensive Health of the Black Population in the perspective of health managers and professionals. *Saúde Soc.* 2022;31(4):e210969pt. https://doi.org/10.1590/S0104-12902022210969en.

67 Faustino DM. A universalização dos direitos e a promoção da equidade: o caso da saúde da população negra. *Cien Saude Colet.* 2017;22(12):3831–3840. https://doi.org/10.1590/1413-812320172212.25292017.

68 Imprensa Nacional. Portaria GM/MS N° 2.198, de 6 de dezembro de 2023. https://www.in.gov.br/web/dou/-/portaria-gm/ms-n-2.198-de-6-de-dezembro-de-2023-528577869. Accessed January 26, 2025.

69 Santana KDSO, D'Oliveira Júnior A, Bittencourt LJ, et al. Analysis of the socio-environmental vulnerability of black and Caucasian pregnant women in Salvador, Bahia, Brazil to the occurrence of microcephaly associated with the congenital syndrome of Zika virus. *Geospat Health.* 2020;15(1). https://doi.org/10.4081/gh.2020.795.

70 Ryngelblum M, Peres MFT. Social segregation and lethal police violence in the city of São Paulo, Brazil (2014-2015). *Cien Saude Colet.* 2021;26(9):4275–4286. https://doi.org/10.1590/1413-812320212691.25002020.

71 Costa ACDO, Faria Júnior JGD, Oliveira GLD, Ramos DDO, Paes-Sousa R. Material deprivation, racial inequalities and mortality from female breast, prostate, and cervical neoplasm in the Brazilian adult population: an ecological study. *Cien Saude Colet.* 2025;30(1):e02212024. https://doi.org/10.1590/1413-81232025301.02212024.

72 Tramontano L, Nascimento MAFD. 'Crias da Maré': homens jovens, desigualdades sociais e saúde em tempos de pandemia de Covid-19. *Interface.* 2025;29(suppl 1):e240341. https://doi.org/10.1590/interface.240341.

73 Trad LAB, Castellanos MEP, Guimarães MCDS. Accessibility to primary health care by black families in a poor neighborhood of Salvador, Northeastern Brazil. *Rev Saude Publica.* 2012;46(6):1007–1013. https://doi.org/10.1590/S0034-89102012000600010.

74 Pereira AB. Refuge in Brazil: an ethnographic approach. *Antipoda.* 2021;(43):197–214. https://doi.org/10.7440/antipoda43.2021.09.

75 Pontes A, Garnelo L, Rego S. Reflection on moral issues in the relation between Indigenous people and health services. *Rev Bioét.* 2014;22(2):337–346. https://doi.org/10.1590/1983-80422014222015.

76 Félix-Silva AV, Gomes CBS, Severo AKDS, Amorim AKDMA. Implicações psicossociais da covid-19 em comunidades tradicionais pesqueiras: a luta das mulheres pescadoras artesanais do Brasil. *Interface.* 2025;29:e240519. https://doi.org/10.1590/interface.240519.

77 Madureira KG, Barsaglini R. The Mata Cavalo/Brazil quilombo and the COVID-19 syndemic: racism and the right to (r)exist in question. *Cien Saude Colet.* 2024;29(3):e08322023. https://doi.org/10.1590/1413-81232024293.08322023EN.

78 da Silva LL, Nascimento PE, Araújo OCG, Pereira TMG. The articulation of the Indigenous Peoples of Brazil in facing the Covid-19 pandemic. *Front Sociol.* 2021;6:611336. https://doi.org/10.3389/fsoc.2021.611336.

79 Weber JLA, Brunnet AE, Lobo NDS, Cargnelutti ES, Pizzinato A. Imigração Haitiana no Rio Grande do Sul: Aspectos Psicossociais, Aculturação, Preconceito e Qualidade de Vida. *Psico USF.* 2019;24(1):173–185. https://doi.org/10.1590/1413-82712019240114.

80 Haydu M, Viodres Inoue S, Silveira C, Martin D. Therapeutic itineraries of Congolese refugees in the city of São Paulo. *Glob Public Health.* 2020;15(6):840–851. https://doi.org/10.1080/17441692.2020.1714071.

81 Barbosa LDA, Sales AFG, Cavalcante Neto AS, Oliveira MADC. Migrantes venezuelanos e direito à saúde: percepções de técnicos de enfermagem de um hospital geral. *Physis.* 2024;34:e34036. https://doi.org/10.1590/S0103-7331202434036pt.

82 Lalane JB. *Migração e saúde: perfil de saúde dos migrantes haitianos no Brasil 2010/2018. Master of sciences thesis.* University of São Paulo; 2021. https://doi.org/10.11606/d.5.2021.tde-27102021-144240. Accessed January 21, 2025.

83 Secretaria de Comunicação Social. Em 19 meses, Brasil concede mais de 11 mil vistos de acolhida humanitária a migrantes. https://www.gov.br/secom/pt-br/assuntos/noticias/2024/09/em-19-meses-brasil-concede-mais-de-11-mil-vistos-de-acolhida-humanitaria-a-migrantes; 2024.

84 David JB, Rizzotto MLF, Gouvêa LAVND. Modos de vida e trabalho de imigrantes haitianos no Oeste do Paraná/Brasil. *Rev Esc Enferm USP.* 2023;57(spe):e20230030. https://doi.org/10.1590/1980-220X-REEUSP-2023-0030en.

85 Araújo TN, Pessalacia JDR, Balderrama P, Ribeiro AA, dos Santos FR. Atenção à saúde de imigrantes haitianos em diferentes países na atualidade: revisão integrativa de literatura. *Rev Electron Comun Inf Inov Saude.* 2021;15(1). https://doi.org/10.29397/reciis.v15i1.2082.

86 Joseph H. Cor e dinâmicas raciais nas migrações internacionais no Brasil: configurações de desigualdades e horizontes de possibilidades. In: de Oliveira SF, Lemos SLCT, eds. *OBMIGRA 10 anos: Pesquisas, dados e contribuições para políticas públicas.* Brasília: OBMIGRA; 2023.

87 Noronha TG, Knorst JK, Godois LDS, Emmanuelli B, Ardenghi TM, Tomazoni F. Sense of coherence moderates the relationship between perceived racial discrimination and oral health-related quality of life in schoolchildren. *J Dent.* 2023;131(104432):104432. https://doi.org/10.1016/j.jdent.2023.104432.

88 Fattore GL, Amorim LD, Dos Santos LM, Dos Santos DN, Barreto ML. Asthmatic symptoms in children and adolescents: the role of maternal experiences of racial discrimination. *J Racial Ethn Health Disparities.* 2022;9(3):938–945. https://doi.org/10.1007/s40615-021-01032-5.

89 Santana V, Almeida-Filho N, Roberts R, Cooper SP. Skin colour, perception of racism and depression among adolescents in urban Brazil. *Child Adolesc Ment Health.* 2007;12(3):125–131. https://doi.org/10.1111/j.1475-3588.2007.00447.x.

90 Taquette SR, Meirelles ZV. Discriminação racial e vulnerabilidade às DST/Aids: um estudo com adolescentes negras. *Physis.* 2013;23(1):129–142. https://doi.org/10.1590/S0103-73312013000100008.

91 Reis TS, Nóbrega MDPSS, Pillon SC, Teixeira JAM, Soares RAQ, Oliveira E. Sofrimento psíquico dos adolescentes da periferia de São Paulo, Brasil. *New Trends Qualitative Res.* 2024;20(4):e1098. https://doi.org/10.36367/ntqr.20.4.2024.e1098.

92 Pavão ALB, Ploubidis GB, Werneck G, Campos MR. Racial discrimination and health in Brazil: evidence from a population-based survey. *Ethn Dis.* 2012;22(3):353–359.

93 Camelo LV, Machado AV, Chor D, et al. Racial discrimination is associated with greater arterial stiffness and carotid intima-media thickness: the ELSA-Brasil study. *Ann Epidemiol.* 2022;72:40–47. https://doi.org/10.1016/j.annepidem.2022.03.009.

94 Camelo LV, Giatti L, Ladeira RM, et al. Racial disparities in renal function: the role of racial discrimination. The Brazilian Longitudinal Study of Adult Health (ELSA-Brasil). *J Epidemiol Community Health.* 2018;72(11):1027–1032. https://doi.org/10.1136/jech-2018-210665.

95 Fanton M, Rodrigues YE, Schuch I, Cunha CML, Pattussi MP, Canuto R. Direct and indirect associations of experience of racial discrimination, dietary patterns and obesity in adults from southern Brazil. *Public Health Nutr.* 2024;27(1):e60. https://doi.org/10.1017/S1368980024000338.

96 Santos VCD, Dias AB. Os Efeitos do Racismo na Saúde Mental das Militantes Negras do MMNDS. *Psicol Ciênc Prof.* 2022;42:e235483. https://doi.org/10.1590/1982-3703003235483.

97 Nishida W, Kupek E, Zanelatto C, Bastos JL. Mobilidade educacional intergeracional, discriminação e hipertensão arterial em adultos do Sul do Brasil. *Cad Saude Publica.* 2020;36(5):e00026419. https://doi.org/10.1590/0102-311X00026419.

98 Bernardo FR, Bastos JL, Moretti-Pires RO. A dança dos números: aferindo experiências de discriminação em grupos multiplamente marginalizados. *Cad Saude Publica.* 2018;34(11):e00167117. https://doi.org/10.1590/0102-311X00167117.

99 Siqueira GC, Marcolino AM, Santos AO. Mulheres transexuais e travestis negras: vulnerabilidade, preconceito e discriminação.

Debates Sociol. 2021;(53):43–57. https://doi.org/10.18800/debatesensociologia.202101.003.
100 Fattore GL, Teles CA, Santos DND, Santos LM, Reichenheim ME, Barreto ML. Validade de constructo da escala Experiences of Discrimination em uma população brasileira. *Cad Saude Publica*. 2016;32(4):e00102415. https://doi.org/10.1590/0102-311X00102415.
101 Williams DR, Gonzalez HM, Williams S, Mohammed SA, Moomal H, Stein DJ. Perceived discrimination, race and health in South Africa. *Soc Sci Med*. 2008;67(3):441–452. https://doi.org/10.1016/j.socscimed.2008.03.021.
102 Cataife G, Courtemanche C. Income-based disparities in health care utilisation under universal health coverage in Brazil, 2002-2003. *Glob Public Health*. 2014;9(4):394–410. https://doi.org/10.1080/17441692.2014.891631.
103 Souza PGAD, Pôrto ACCDA, Souza AD, Silva Júnior AGD, Borges FT. Perfil Socioeconômico e Racial de Estudantes de Medicina em uma Universidade Pública do Rio de Janeiro. *Rev Bras Educ Méd*. 2020;44(3):e090. https://doi.org/10.1590/1981-5271v44.3-20190111.
104 Scheffer M. *Demografia Médica no Brasil 2023*. São Paulo: FMUSP; 2023.