

Racism as a social determinant of health and its mechanisms of action in Brazil: a scoping review

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Abstract *The myth of racial democracy has contributed to the invisibility of racism as a determinant of social and health inequalities in Brazil. Despite the influence of racism on illness and mortality, there are still few studies that address it as a social determinant of health, and it is often treated as a secondary factor. This study conducted a scoping review to identify racism theories that explain its effects on the health of the Brazilian population. Four theories that position racism as a social determinant were identified: structural, institutional, vicarious, and anti-Black racism. These theories operate through historical, social, and symbolic processes that structure inequalities in interpersonal and institutional relationships. The findings show that racism negatively impacts the health of the Black population and reinforce the need for scientific production and formulation of public policies that address racial inequities, promote equity, and ensure human rights in the field of health.*

Key words Racism, Racial discrimination, Social determinants of health, Health of the black population, Brazil

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Introduction

The State, through the policies it establishes over time, plays a fundamental role in shaping social relations and identities, including, significantly, racial identities. For many years, Brazil upheld the myth of racial democracy, which delayed the recognition of racism as a social determinant and, consequently, the development of public policies that considered this dimension^{1,2}.

In 1950, UNESCO funded extensive research to understand the dynamics between different races in Brazil from economic, social, cultural, and psychological perspectives. The results indicated that applicable laws against racism were created without clearly acknowledging the issue. Additionally, the research found that Black people experienced poorer housing and working conditions, greater exposure to daily violence, and that racial inequalities were evident in several aspects of Brazilian society³.

However, there was a delay in recognizing racism as a determining factor in social inequalities in Brazil. Only in the late 1990s, driven by the long history of mobilization of the Black social movement, the then-President Fernando Henrique Cardoso officially acknowledged the existence of racism in Brazil and instituted affirmative action policies as part of the public agenda. This recognition was also driven by preparations for the World Conference on Racism, held in Durban, South Africa, in 2001, which led to a national reflection on racial inequalities¹.

In the field of health, even before formal recognition by the State, the historical construction dating back to the colonial period consolidated racism as an important determinant of health inequalities. This problem is complex due to its dynamic nature, which persists and adapts over time, influencing multiple mechanisms, policies, and practices, impacting the health of the population^{4,5}.

The dynamics of racism in health, reflected in its social construct, can be traced back to the development of health measures that presupposed a hierarchy of superiority and inferiority between whites and Blacks. These measures were accompanied by the construction of institutions, norms, and practices that, while not exclusively, were often based on, or even guided by, race⁶. This process influenced the production of knowledge, establishing race as a biological event, instead of recognizing it as a social category⁷. This conception justified, within the scope of education and medical practice, that Black individuals were biologically distinct

from others and, therefore, could be subjected to differentiated and lower quality treatments^{8,9}.

Discriminatory practices can influence access to health services, with white individuals reportedly having more efficient access, affecting health outcomes among the Black population. Current evidence suggests that health professionals sometimes favor white patients, impacting the care received by Black patients¹⁰⁻¹². In other words, institutional structures in health-care, including norms and rules, may contribute to more effective access for whites and create barriers for Black individuals, limiting or delaying access to comparable resources¹²⁻¹⁴.

Racial and ethnic health disparities are identified globally^{15,16}. In Brazil, even with the efforts of public policies, these disparities persist^{5,10,11,17}. Given this, linking studies in the field of health to theories of racism is necessary so that we can delve deeper into our understanding of the mechanisms by which racism and discrimination affect the lives of so-called minority groups^{4,7,15,16}. In this sense, it is necessary to consider health as a bodily manifestation of the social conditions of existence of subjects¹⁸, with racism as a determining element, as well as an analytical tool that defines how systems, patterns, and outcomes vary across population groups^{4,19}.

Historically, policymaking and resource allocation in healthcare have not considered race as a central determinant. Even so, the unequal distribution of services and resources across territories reveals discriminatory effects^{20,21}. In Brazil, Black and low-income populations predominantly live in urban suburbs, where there is a greater availability of primary care, which in principle would facilitate access for these groups.

Given the health inequalities influenced by race, it is essential to delve deeper into the concepts that shape the relationships between individuals and health production in order to understand how different theories of racism explain their effect on health outcomes. Furthermore, the conceptual definition itself is an essentially political and historical practice, so that its representation is not necessarily a reflection of ideological advances, but rather an expression of changes in social relations²².

Thus, in this study, theoretical racism currents are the mechanisms by which racism influences health outcomes. Starting from the concept of "theory", defined by Kerlinger in 1964²³, which considers it as the explanation for natural situations, whose scope encompass-

es the description, prediction, and control of events. From the perspective of racism theories, the predictive function informs the theory's potential to predict the conditions under which racism influences health.

When racism theories are established or identified, they become elements for health to be understood as a product of economic-ethical-political care that considers population plurality and social markers of difference, preventing the neutrality with which health is addressed, by disregarding race in its reaffirmation of social and political property, from continuing to reproduce inequalities and render subjects invisible²². Understanding the concepts of the social determinants of health avoids superficial approaches and promotes more sustainable and transformative health justice²⁴. In this context, this study aimed to identify racism theories that explain its effect on the health of the Brazilian population.

Methods

We conducted a scoping review to map research and identify knowledge gaps regarding the following question: What theories explain the effect of racism on the health of the Brazilian population? The Population, Concept, and Context strategy was applied, where population refers to the Brazilian population, concept refers to the relationship between racism and health conditions, and context refers to race. This review used the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews guidelines²⁵, and its report was registered in the Open Science Framework (DOI 10.17605/OSF.IO/BEZF8).

The review included studies on racism theories and their effects on health that described health outcomes included in the International Classification of Diseases and/or their risk factors, in the Brazilian population, without restriction of age, gender, or publication date, considering articles published up to January 2025. The term "racism" adopted in this review aimed to understand the differences in health outcomes between racially distinct groups, classified as Black (Black and brown), Indigenous, white, and Asian, as defined by the Brazilian Institute of Geography and Statistics.

Review articles, meta-analyses, and meta-syntheses were not included, but their references were tracked to check for any publications not found in the search. Experimental studies,

conferences, forums, abstracts, editorials, reports, commentaries, research protocols, theses, and dissertations were also excluded.

The databases used for the search were: Medical Literature Analysis and Retrieval System Online (MEDLINE) via Public and Medical Literature (PubMed), because it contains millions of articles and is one of the most accessed in the world; Virtual Health Library (BVS), due to its focus on studies from Latin America and the Caribbean; Web of Science, for allowing the simultaneous exploration of several databases; and Scopus, for providing varied academic information, broadening the scope of the research area. The search was conducted from December 2024 to January 2025. The descriptors were extracted from the Health Sciences Descriptors (DeCS) and the terms from the Medical Subject Headings (MeSH). We performed data management using Zotero and Microsoft Excel 2010 software.

The search strategy used (Chart 1) was designed to retrieve studies that contained at least one of the terms from each concept (racism, racial discrimination, racism theories, health, and Brazil). It was not restricted to the title and abstract fields, but conducted in full text, in order to broaden the sensitivity of the search and identify studies whose relevant content was not necessarily available in the metadata.

The evidence was selected independently and sequentially. The first step consisted of evaluating the title, followed by evaluating the abstract. Once components that corroborated the guiding question were identified, the article was considered potentially relevant for the review. In the second stage, we performed a complete reading of the study and decided on its inclusion or not. The synthesis of the results is organized based on the health context (mortality, morbidity, access, public policies), life cycles (birth, childhood, adolescence, adulthood, aging), gender, theoretical framework of racism, and the impact of racism on health.

Results

We identified 3,210 studies in the databases, of which 1,201 were duplicates. After reading the titles and abstracts, we excluded 1,891 studies for not meeting the eligibility criteria, including 85 review studies whose references were analyzed but did not return any studies. A full reading of 118 studies ensued, and we excluded 91 because they addressed racial inequalities in ac-

Chart 1. Search strategy, databases, and references retrieved.

Databases	Search strategy	References retrieved
BVS*	(Racismo OR Racism OR Racisme OR "Desigualdade Racial em Saúde" OR "Discriminação Racial" OR "Preconceito Racial" OR "Fatores Raciais" OR "Race Factors" OR "Factores Raciales" OR "Facteurs raciaux" OR "População Negra" OR "Black People" OR "Población Negra" OR "Racial Discrimination" OR "Racial Prejudice") AND ("Saúde das Minorias Étnicas" OR "Health of Ethnic Minorities" OR "Salud de las Minorías Étnicas" OR "Santé des Minorités Ethniques" OR "Saúde da População Negra" OR "Etnia e Saúde" OR "Raça e Saúde" OR "Saúde da População Negra" OR "Saúde Étnica" OR "Diagnóstico da Situação de Saúde em Grupos Específicos" OR "Diagnosis of Health Situation in Specific Groups" OR "Diagnóstico de la Situación de Salud en Grupos Específicos" OR "Diagnostic des Situations de Santé dans des Groupes Spécifiques" OR Saúde OR Health OR Salud OR Santé OR "Ethnic Health" OR "Ethnicity and Health" OR "Race and Health") AND (Brasil OR Brazil OR Brasil OR Brésil)	1473
PUBMED** SCOPUS WEB OF SCIENCE	(Racism OR "Race Factors" OR "Black People" OR "Racial Discrimination" OR "Racial Prejudice") AND ("Health of Ethnic Minorities" OR "Diagnosis of Health Situation in Specific Groups" OR Health OR "Ethnic Health" OR "Ethnicity and Health" OR "Race and Health") AND (Brasil OR Brazil)	1750

* BVS: Virtual Health Library; ** PubMed: Public and Medical Literature.

Source: Authors.

cess to health services, morbidity, mortality, and policies without considering the mechanisms by which racism operates to produce inequalities.

In the end, 27 studies were included as they met the eligibility criteria (Figure 1). The time-frame of the studies was from 2007 to 2025. Seventeen (63%) were published in the last five years (2021 to 2025), 21 (78%) evaluated theories explaining the effect of racism on the health of the Brazilian adult population, 13 (48%) evaluated exclusively women, and only one evaluated elderly individuals and the birth period. Methodologically, 17 (63%) used a quantitative approach and 7 (26%) a qualitative approach; the others were divided between historical overview, documentary basis, and descriptive and exploratory methods.

Four theories were identified as being used to explain the effect of racism on health: structural racism, present in 16 studies²⁶⁻⁴², institutional racism, described in 15 studies^{26,27,30,37,41,43-52}, anti-Black racism, in two^{37,53}, and vicarious racism, in one²⁸. The total number of studies compared to the theories is higher because some research worked with more than one theory. Chart 2 presents a summary of the studies included in this review.

Discussion

We identified 27 articles that engage with four theories that seek to explain the effect of racism on health in Brazil, namely: structural racism²⁶⁻⁴², institutional racism^{26,27,30,37,41,43-52}, anti-Black racism^{37,53} and vicarious racism²⁸ (Figure 2). In the period covered by this review (2007 to 2025), we observed that 23 out of 27 (85.19%) articles considered were published from January 2020 to January 2025. This shows that the use of theories that explain racism as a social determinant of health is recent in Brazilian health research.

The number of studies included indicates that the topic has not yet been extensively investigated. Many studies have addressed race as a negative marker for health outcomes, as Black individuals are at a disadvantage regarding the occurrence of diseases and health problems, and in timely access to health services.

However, few studies advance the analysis of racism as a social determinant of health, and even fewer elucidate how it operates. Furthermore, it is necessary to consider that although the search strategy was broad and conducted in full text, it may have excluded studies that exclusively used terms such as "ethnicity/skin color"

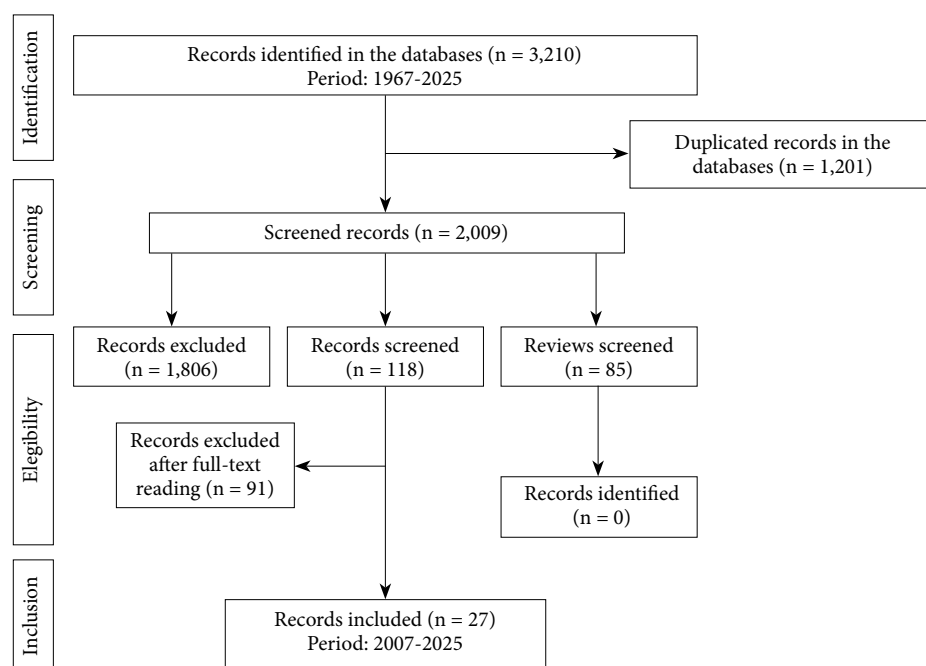


Figure 1. Flowchart of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) for the scoping review process..

Source: Authors.

or generic sociodemographic markers, without explicitly defining the concept of racism.

Institutional racism dates back to 1967, when American researchers Hamilton and Kwane⁵⁴ described discriminatory acts as not being exclusive to certain individuals. It manifests itself more broadly and collectively, where the entire white community acts against the Black community. It cannot be reduced to a behavioral perspective. It is supported by how rules are formulated by institutions and how social standards are established, and this applies to the practices, rules, and structures of institutions.

Even in contexts where it is harder to identify individuals who commit discriminatory acts, this does not mean that institutional racism is any less severe or harmful. Its impact is profound and affects a large number of people^{54,55}. Formally, it can be understood as the “collective failure of an organization to provide appropriate and professional service to people because of their color, culture, or ethnic origin”⁵⁴. It has a hierarchical, subordinate character⁵⁶ and can be identified in “processes, attitudes, and behaviors that result in discrimination stemming from

unintentional bias, ignorance, negligence, and racist stereotyping, which cause disadvantages to individuals from ethnic minorities”^{54,55,57}.

The impact of institutional racism on health is evident in access to services, as shown by Dórea and Borges (2021)²⁶, who report that Black individuals had late access to cancer diagnosis. Notably, it is also noticeable throughout the disease, with greater difficulty in accessing specialized treatment⁴³ and greater exposure to risk factors that can only be controlled through the implementation of interinstitutional policies that seek to overcome discriminatory practices related to exposure to disease-causing agents⁴⁵. Furthermore, Black people have a higher risk of mortality, as evidenced by Santos, Guimarães, and Araújo (2007)⁴⁷, who indicate that adult Black women (20-59 years old) are more likely to die from external causes and preventable diseases, such as diabetes and hypertension, than white women.

In Brazil, although the geographical distribution of PHC services is concentrated in areas with a predominance of Black residents¹⁴, the availability of services, per se, does not guaran-

Chart 2. Studies included in the review by health context, racial theory, and impact of racism on health, 2007 to 2025.

Author, publication year	Study design	Study objective	Health context (morbidity, mortality, access, and policy)	Life cycle	Gender	Racial theory	Impact of racism on health
Dórea, A.M.; Borges, S.A.C. 2021 ²⁶	Qualitative research	How racism situations reverberate in psychological practice, impacting professional listening and demanding a stance at the clinical-political interface.	Pediatric oncology (Morbidity; Access)	Childhood	Male Female	Structural racism Institutional racism	Delays in the diagnosis and treatment of central nervous system cancer, culminating in sequelae such as vision loss and extensive neurological damage.
Azevedo, U.C.; Gomes, D.D.O. 2023 ⁴³	Case study with documentary and field research, using a qualitative approach	To analyze the social determinants of health (SDH)* that affect the lives of Black women undergoing biopsychosocial care at the Alcohol and Other Drugs Psychosocial Care Center.	Biopsychosocial (Morbidity; Access)	Adult	Female	Institutional racism	Difficulties in obtaining specialized treatment due to poor infrastructure and lack of services.
Mota, C.S. <i>et al.</i> , 2024 ²⁷	Historical trajectory	To define the historical trajectory up to the present day of the implementation of health policies aimed at people with sickle cell disease.	Sickle cell disease (Morbidity; Access)	No limit	Male Female	Structural racism Institutional racism	Failure to prioritize the formulation of public health policies, neglecting the disease and impacting survival and quality of life.
Catoia, C.C.; Severi F.C.; Firmino, I.F.C. 2020 ⁴⁴	Case analysis with a qualitative approach	This analysis examines the Alyne Pimentel v. Brazil case, judged by CEDAW**, aiming to highlight its main legal contributions to the issue of gender-based violence against women. It delves into the legal understanding of the effects of racial discrimination on gender-based violence and the reproductive health of Black, poor, and marginalized women.	Maternal death (Mortality; Access)	Adult	Female	Institutional racism	Poor quality of treatment and lack of prenatal care are both considered decisive factors in preventable maternal death.
Santana, K.S.O. <i>et al.</i> , 2020 ⁴⁵	Cross-sectional quantitative approach	To present an overview of the spatiotemporal distribution of confirmed cases of microcephaly associated with CZS*** and its intersection with vulnerabilities to which Black women are subject.	Congenital Zika Syndrome (Morbidity)	Childhood	Male Female	Institutional racism	Development of CZS***, due to greater exposure to arboviruses from living in areas with poor infrastructure.

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tee either access or the quality of the necessary healthcare. Part of this reality is attributed to

discrimination experienced within health institutions^{13,58}, which limit access, either by pro-

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Author, publication year	Study design	Study objective	Health context (morbidity, mortality, access, and policy)	Life cycle	Gender	Racial theory	Impact of racism on health
Góes, E.F., Ferreira, A.J.F., Ramos, D.O. 2023 ⁵³	Cross-sectional quantitative approach	To analyze racial inequalities in lethality and likelihood of death from Severe Acute Respiratory Syndrome among diagnosed COVID-19 cases in pregnant and postpartum women.	Maternal death (Mortality; Access)	Adult	Female	Anti-Black racism	Higher mortality rates among Black and brown women and a higher likelihood of death associated with COVID-19 among brown women.
Fattore, G.L. <i>et al.</i> , 2022 ²⁸	Cross-sectional, population-based quantitative approach	To assess the effect of maternal racial discrimination on the prevalence of asthma symptoms in their children, including potential moderating effects of family social support and maternal mental health.	Asthma (Morbidity)	Childhood	Male Female	Vicious racism Structural racism	Children whose mothers reported racial discrimination were more likely to have asthma symptoms.
Góes, E.F. <i>et al.</i> , 2020 ⁴⁶	Cross-sectional, population-based quantitative approach	To identify factors associated with institutional barriers to accessing health services for women who have had abortions due to ethnicity/skin color.	Abortion (Morbidity; Access)	Adult	Female	Institutional racism	Black women experienced more spontaneous abortions and at more advanced stages (≥ 13 weeks) and were more affected by barriers to accessing hospital admission for abortion completion. Black women were the majority with fair, severe, or very severe health conditions.
Siqueira, J.S., Fernandes, R.C.P. 2021 ²⁹	Cross-sectional quantitative approach	To analyze the association between ethnicity/skin color and two work outcomes to which workers are subjected: psychosocial and physical demands.	Occupational Disease (Morbidity)	Adult	Unrestricted	Structural racism	Black workers are subjected to higher psychosocial and physical demands at work. They are more exposed to heavy physical labor and stressful situations, with greater time constraints and less autonomy in performing tasks.

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professionals who neglect the demand and/or do not offer humanized care, or by users who do not seek the service because they have already suffered racism within the institution or know

of people who have experienced it, which are barriers to the full exercise of health as a right⁵⁸.

The theory that stands out most in this study is that of structural racism. The discus-

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Author, publication year	Study design	Study objective	Health context (morbidity, mortality, access, and policy)	Life cycle	Gender	Racial theory	Impact of racism on health
Santos, S.M., Guimarães, M.J.B., Araújo, T.V.B. 2007 ⁴⁷	Cross-sectional quantitative approach	To characterize the mortality of Black and white adult women residing in Recife, between 2001 and 2003, describing and analyzing racial inequalities in the risk of death.	Deaths of young women - 20 to 59 years old (Mortality)	Adult	Female	Institutional racism	Higher mortality rates are observed in Black adult women, who are 1.7 times more likely to die than white women. The main causes include homicides, traffic accidents, ischemic heart disease, cerebrovascular diseases, hypertension, diabetes, and tuberculosis.
Fanton, M. <i>et al.</i> , 2024 ³⁰	Cross-sectional, population-based quantitative approach	To analyze the direct and indirect associations between the experience of racial discrimination and dietary patterns, obesity, and abdominal obesity.	Obesity; abdominal obesity (Morbidity)	Adult	Male Female	Structural racism Institutional racism	Obesity and abdominal obesity are associated with higher levels of self-reported experiences of racial discrimination, and these associations are independent of healthy or unhealthy dietary patterns among Brazilian adults.
Taquette, S.R., Meirelles, Z.V. 2013 ⁴⁸	Qualitative research	To examine the racial discrimination experienced by Black teenage girls living in favelas in Rio de Janeiro and its possible influence on the process of vulnerability to HIV****/AIDS*****.	STI*****/AIDS***** (Morbidity; Access)	Adolescent	Female	Institutional racism	Impossibility of adequate treatment of STIs*****, acquisition of prevention supplies, and guidance on STI/AIDS prevention*****
Dominigues, P.M.L. <i>et al.</i> , 2013 ⁴⁹	Exploratory-descriptive, with a qualitative approach	To understand how women perceive racial discrimination in reproductive health care practices.	Reproductive health (Access)	Adult	Female	Institutional racism	Superficial care provided by health professionals and longer waiting times to be seen.
Cajazeiro, J.M.D., Cardoso, A.M., Nobre, A.A. 2024 ³¹	Ecological spatiotemporal approach with a quantitative approach.	To investigate the association between the proportion of vulnerable population (Black, mixed-race, and Indigenous people) and mortality from severe acute respiratory infection (SARI)***** resulting from COVID-19.	COVID-19 (Mortality)	No limit	Male Female	Structural racism	COVID-19 mortality rates increase 12% and 9%, respectively, for every 10% increase in the proportions of vulnerable populations or brown populations.

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Chart 2. Studies included in the review by health context, racial theory, and impact of racism on health, 2007 to 2025.

Author, publication year	Study design	Study objective	Health context (morbidity, mortality, access, and policy)	Life cycle	Gender	Racial theory	Impact of racism on health
Moura, R.F. <i>et al.</i> , 2023 ³²	Cross-sectional quantitative approach	To identify the determining factors of disparities in social conditions and health among non-institutionalized older adults in São Paulo from the perspective of self-reported skin color.	Self-assessed health; Arterial hypertension (Morbidity)	Ageing	Male Female	Structural racism	The prevalence of self-assessed health (fair, poor, and very poor) and hypertension was higher among brown (45.5%) and Black individuals (47.2%).
Pereira, S., Schraiber, L.B., d'Oliveira, A.F.P.L. 2025 ³³	Qualitative research with exploratory approach	To understand whether there are differences between the experiences of Black and white women in accessing and receiving support from the multi-agency network of specialized services in São Paulo, after initiating criminal proceedings against their partners for domestic violence under the Maria da Penha Law.	Domestic violence (Access)	Adult	Female	Structural racism	Black women reported experiencing more episodes of institutional violence, through attitudes of blaming providers and doubts about the veracity of their statements. Their journeys were interrupted, either by policymakers directly denying them access, or by rude and objectifying treatment that kept them away from services. In healthcare settings, they were exposed to embarrassment from the hospital staff upon entering the emergency room; lack of anesthesia during procedures; and poorly performed reconstructive surgeries for the aftereffects of violence, resulting in the need for further surgical repairs.
Silva, J.C. <i>et al.</i> , 2023 ³⁴	Cross-sectional quantitative approach	To analyze the effect of intersectionality on patients' access to COVID-19 diagnostic tests during the SARI outbreak*****.	Access to COVID-19 diagnosis (Access)	Adult	Male Female	Structural racism	Black women and men had less access to diagnostic testing than white individuals, even when controlling for markers of clinical severity and variables related to access.

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Author, publication year	Study design	Study objective	Health context (morbidity, mortality, access, and policy)	Life cycle	Gender	Racial theory	Impact of racism on health
Santos Ferreira, R.B. <i>et al.</i> , 2020 ⁵⁰	Descriptive with a qualitative approach	To understand the implications of institutional racism in the therapeutic journey of patients with chronic kidney disease in their search for diagnosis and treatment.	Chronic Kidney Failure (Access)	Adult	Male Female	Institutional racism	Conservative treatment was offered only to white people; Black people were referred directly to renal replacement therapy. Access to early diagnosis also only occurred for white people, and 81.8% of Black people were referred to nephrology services after deteriorated symptoms and hospitalization, compared to 41.7% of white people.
Silva, A.R., Scorzafave, L.G.D.S. 2024 ³⁵	Cross-sectional quantitative approach	To understand whether the COVID-19 pandemic has exacerbated disparities in breast cancer screening among women of different races and ethnicities.	Breast cancer (Access)	Adult	Female	Structural racism	Screening rates for Black, brown, and Indigenous women are lower than for white and Asian women throughout the period. The COVID-19 pandemic narrowed the gap between women due to the sharp drop in screening mammograms for white and Asian women in the first year of the pandemic.

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sion about this theory emerged in the late 1990s with American researcher Bonilla-Silva⁵⁹. He described it as a normative part of society, as a system that separates and hierarchizes people, from birth, based on skin color, conferring overlapping power, benefits, and rights⁵⁹. In this context, racism is a social situation, not a private behavior of individuals. Over time, the theory has been refined to differentiate it from institutional racism, which would be unable to express all the complexity inherent in the multilevel and multidimensional relationships established in society that produce racism^{19,60,61}.
Currently, structural racism is understood as the “all the ways in which societies promote

racial discrimination by mutually reinforcing unequal systems, sharpening discriminatory beliefs, values and distribution of resources”^{16,62-64}. In the case of groups racially described as minorities (or marginalized), these structures, such as laws, norms, and social practices, have been shaped in such a way as to ensure that these groups face inequalities and discrimination continuously and systematically. Oppression is part of a historical and social system sustained by ideologies that justify inequalities based on supposed racial superiority and individual choices, ignoring the historical denial of access to development and the influence of white supremacy in policymaking⁶³.

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Author, publication year	Study design	Study objective	Health context (morbidity, mortality, access, and policy)	Life cycle	Gender	Racial theory	Impact of racism on health
Paixão, E.S. <i>et al</i> 2023 ⁴²	Cross-sectional, population-based quantitative approach	To estimate the burden of maternal and congenital syphilis attributed to ethnic-racial inequalities in Brazil.	Congenital syphilis; Maternal syphilis (Morbidity; Access)	Adult Birth	Female	Structural racism	Black women were more likely to have been inadequately treated or not treated for maternal syphilis, more likely to have been diagnosed during or after childbirth, and their partners were less likely to have been treated for syphilis than their white counterparts. The attributable fractions, defined as the proportion of risk among an exposed group attributable to exposure for congenital syphilis increased substantially among live births of brown and Black women.
Ferreira, R.B.S. <i>et al.</i> , 2022 ⁵¹	Ecological, based on documentation and description	To analyze, from an intersectional perspective, the influence of ethnicity/skin color on the morbidity and mortality of pregnant women due to Covid-19 in Brazil.	COVID-19; maternal morbimortality (Mortality; Morbidity)	Adult	Female	Institutional racism	Black pregnant women have a higher risk of death than white pregnant women due to a more severe situation of vulnerability, with higher rates of death than hospitalizations for severe acute respiratory infection (SARI)*****.
Araujo, E.M. <i>et al.</i> , 2020 ³⁷	Descriptive and exploratory	To describe the experience of Brazil and the United States of America regarding morbidity and mortality data from Covid-19 according to race/color/ethnicity.	Morbimortality from COVID-19 (Mortality; Morbidity)	Not informed	Male Female	Structural racism Institutional racism Anti-Black racism	The impact of the virus was greater on the Black population, with higher morbimortality rates. Notably, even when hospitalizations predominated in the white population, a higher incidence of death was observed in the Black population. However, disaggregated data were obscured and of low quality, limiting more robust analyses with an ethnic-racial perspective.

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Author, publication year	Study design	Study objective	Health context (morbidity, mortality, access, and policy)	Life cycle	Gender	Racial theory	Impact of racism on health
Faerstein, E. <i>et al.</i> , 2014 ³⁸	Prospective cohort with a quantitative approach	To report possible combined effects of African ancestry/perceived racial discrimination and socioeconomic disadvantage on the risk of hypertension in Brazil.	Arterial hypertension (Morbidity)	Adult	Male Female	Social racism (structural)	Black individuals who experienced racism had a 2.1 times higher prevalence of hypertension than white individuals.
Camelo, L.V. <i>et al.</i> , 2022 ³⁹	Cross-sectional cohort, population-based quantitative approach	To investigate the combined effect of ethnicity/skin color and racial discrimination on pulse wave velocity and carotid intima-media thickness in the Brazilian context.	Subclinical markers of CVD*****	Adult	Male Female	Structural racism	Black and brown individuals had higher average pulse wave velocity and carotid intima-media thickness, and a greater likelihood of these being higher than white individuals. These differences were even greater among those experiencing racial discrimination.
Camelo, L.V. <i>et al.</i> , 2022 ⁴⁰	Cross-sectional cohort, population-based quantitative approach	To investigate the association between racism and self-assessed health, and to verify to what extent intergenerational social mobility mediates this association.	Self-assessed health status (Morbidity)	Adult	Male Female	Structural racism	Black and brown individuals were respectively 115% and 82% more likely to report their health as poor than white individuals, regardless of potential confounding factors.
Góes, E.F. <i>et al.</i> , 2023 ⁴¹	Population-based longitudinal cohort with a quantitative approach	To investigate racial inequalities in breast and cervical cancer mortality and whether education and family conditions interact with race/ethnicity.	Breast cancer; cervical cancer (Mortality)	Adult	Female	Structural racism Institutional racism	Black and brown individuals were respectively 115% and 82% more likely to report their health as poor than white individuals, regardless of potential confounding factors.
Góes, E.F. <i>et al.</i> , 2020 ⁵²	Cross-sectional cohort with quantitative approach	To identify the individual barriers that women face in seeking initial post-abortion care under unsafe conditions, adopting a racial perspective.	Abortion (Access)	Adult	Female	Institutional racism	Among Black women, a higher percentage reported individual barriers faced when seeking initial care (32% vs. 28% among brown women and 20.3% among white women).

* SDH: social determinants of health; ** CEDAW: United Nations Committee on the Elimination of Discrimination against Women; *** CZS: Congenital Zika Syndrome; **** HIV: Human Immunodeficiency Virus; ***** AIDS: Acquired Immunodeficiency Syndrome; ***** STI: Sexually Transmitted Infections; ***** SARI: Severe Acute Respiratory Syndrome; ***** CVD: cardiovascular disease.

Source: Authors.

From a health perspective, structural racism is an analytical tool that allows us to understand how social relations impact health outcomes. In the study by Paixão et al. (2023)⁴², the investigation on maternal and congenital syphilis showed that 95% [CI: 34.9-36.1] and 41% (95%CI: 40.5-42.1) of cases, respectively, could be avoided if all women had the same baseline risk as white women. The study also revealed that Black women were more likely to be treated inadequately or not at all, more likely to be diagnosed late, and their partners were less likely to receive adequate treatment. Syphilis infection is linked to structural markers of oppression, such as race and socioeconomic disadvantage, exposing marginalized populations to the unequal distribution of resources and opportunities, including access to medical care, screening, and contact tracing for sexually transmitted infections⁶⁵.

Just as health outcomes are impacted by structural racism, so too is individuals' perception of their health status. According to Camelo et al. (2022)⁴⁰, Black individuals are more likely to self-assess their health as poor compared to white individuals. This perception is even worse among Black individuals [(OR) 2.15; 95%CI: 1.9-2.4] than among brown individuals (OR 1.82; 95%CI: 1.6-2.0). The negative assessment among Black individuals is mediated by intergenerational socioeconomic conditions, characterized by social disadvantages and fewer opportunities for upward mobility.

In this sense, Moura et al. (2023)³² pointed out that self-assessed health as fair, poor, and very poor was more prevalent among Black older adults exposed to worse socioeconomic and health conditions. The same was observed for hypertension³², and by the research of Camelo et al. (2022)³⁹, where Black people showed a higher average of subclinical markers for Cardiovascular Diseases compared to white people, and those who suffered from racial discrimination had even higher values. The relationship between poor self-assessed health and structural racism can be mediated by eco-social theory, where individuals biologically incorporate exposures resulting from their living social context^{62,66}.

The impact of structural racism on health outcomes reinforces the need to analyze it not only at a single point in time but throughout life, considering the cumulative effect of racism's dynamics.⁶¹ The mechanism by which structural racism operates in health begins at the social level. The individual is exposed to discrimina-

tion and restricted or lack of access to resources, which continues to the psychological level, with the emergence of chronic stress, anxiety, and depression, among other psychological disorders. Prolonged exposure to these experiences influences biological processes, with illnesses resulting from biopsychosocial responses to socially experienced racism. Ultimately, this can generate cellular and epigenetic changes that will be felt throughout life and across generations^{62,66,67}.

To address the complex relationship between structural racism and health outcomes, health research should consider, besides more than one point in time, intersectional and sequential factors that culminate in adverse health outcomes. These guidelines were proposed by North American authors^{19,66}, but still find little adherence in Brazil. Part of the national research remains restricted to the use of race as a variable and its association with socioeconomic determinants, without incorporating an intersectional perspective. Furthermore, these studies often adopt limited timeframes, disregarding the fact that experiencing racism throughout life accumulates multiple disadvantages, not only for health but for several social dimensions.

The anti-Black racism theory was evidenced in only two studies^{37,53}. It understands the existence of structural and institutional racism and their potential to be eliminated or combated through structural and institutional arrangements that consider the disadvantage to which Black individuals are subjected. However, anti-Black racism is defined from the perspective of humanity, understanding that, to be human, one cannot be Black, since these two conditions do not coexist in the existence of a subject. This definition was presented in 1952 by the Martinican philosopher and psychiatrist Frantz Fanon⁶⁸. In his first book, he describes how the denial of humanity to Black people prevents them from being recognized as subjects, thus disregarding their identity, rights, and needs⁶⁸.

Recently, based on Fanon's narrative, Cameroonian philosopher and political scientist Achille Mbembe reinforced the theory of dehumanization through an analogy with the behavior of a virus, which "phagocytizes bodies and lives as reserves of raw material, which cannot be dispensed with, but are consumed, discarded and destroyed, usually without apparent reason"⁶⁹. This practice is the hardest to combat, since the human interaction of denying the existence of the subject is immune to political and administrative adjustments and individual efforts^{68,70}.

The lack of data disaggregated by ethnicity/skin color is a way of making the subject invisible. This fact was reported in the research by Araújo *et al.* (2020)³⁷, which sought to show the relationship between Brazil and the United States with COVID-19 morbidity and mortality data, by race/skin color/ethnicity. In Brazil, the availability of disaggregated data through the Epidemiological Bulletin (BE) of the Ministry of Health began late (15th epidemiological week; BE-9), with only data on hospitalizations due to Severe Acute Respiratory Syndrome (SARS). Disaggregated data on COVID-19 deaths were also released starting with BE-10; disaggregated data on SARS were made available only in BE-11, and data on hospitalizations for SARS due to COVID-19 were only shown in BE-13. The lack of disaggregation and the low quality of the data limit the development of more robust analyses with racial bias and the identification of the real health condition of the Black population.

The invisibility of subjects is also manifested in how health care is offered to Black people. According to Góes *et al.* (2023)⁵³, lethality and the chance of death from SARS associated with diagnosed cases of COVID-19 in pregnant and postpartum women were higher among Black women, who also accumulate more risk factors for negative maternal outcomes (diabetes, obesity, chronic cardiovascular disease, and asthma). Despite these findings, pregnant Black women were the least likely to be admitted to the ICU. This factor denotes how the subject is dehumanized, because even with more risk factors, Black women were not the majority in receiving comprehensive care.

Anti-Black racism continues to be refined in practice by the colorblind theory developed within the context of the Civil Rights Movement of the 1960s in the United States. This theory posits that skin color does not matter⁷¹. Thus, there is no need for specific policy proposals or programs to address what “cannot be seen or what someone refuses to see or acknowledge even when it is seen”^{72,73}. In healthcare, neglecting specific conditions, such as clinical markers of severity and the lack of disaggregated data, promotes racial erasure and prevents the full exercise of the principle of equity. This fact culminates in inadequate access to healthcare, disrespect for differences, and neglect of individual needs^{72,74}.

The least identified racism theory was vicarious racism²⁸. This theory is understood as indirect exposure to racism, where the other is exposed through the constructed environment, by witnessing, hearing, or observing the

experiences of prejudice and discrimination of relatives, close friends, or strangers. These experiences occur in how Black people are portrayed in social media, in the perception of racial injustices, such as in cases of police violence and racially discriminatory comments made by elected officials, or in everyday settings, among other ways^{75,76}. This experience is described as more prevalent than direct racism, because the constructed environment provides more opportunities to witness, hear, and observe racist actions than individual experience⁷⁷.

The vicarious racism theory was developed from Barnes's (1954)⁷⁸ “linked lives” theory, which proposes that events affecting one individual also affect others. This theory was incorporated into the field of health by researchers Krieger (2000)⁷⁹ and Berkman *et al.* (2000)⁸⁰, and into the analysis of racism as a social determinant of health by researcher Harrell (2000)⁷⁵, who discussed the importance of studies addressing the interpersonal effects of racism. Since then, some studies focusing particularly on child health, including birth, have addressed the topic. The focus on child health stems from the understanding that exposure to racism makes this group vulnerable, compromising their development^{28,67,76,81}. In addition, other studies seek to measure the impact of this theoretical current on the mental health of young people and adults⁸²⁻⁸⁴.

In this review, only one reported study aimed to identify the effect of racial discrimination experienced by the mother on the prevalence of asthma symptoms in her children.²⁸ The findings showed that children whose mothers were exposed to racism were more symptomatic than those whose mothers did not report exposure. This finding is supported by the fact that children's health is multifactorial and interconnected with the environmental systems and relationships with which they interact⁷⁶.

The mechanism by which vicarious racism affects the health of Black people is similar to that of structural racism, which begins at the social level and continues through to the biopsychosocial response^{76,85,86}. Some research explains this relationship through neuroscience models, where racism directed at other people causes physiological arousal, which involves the activation of the hypothalamic-pituitary-adrenal axis with subsequent release of cortisol, a systemic hormone that mediates the stress response and has several effects on the body, including metabolic changes, the immune system, and behavioral changes. Concomitantly,

the stress caused by racism activates the sympathetic-adrenal-medullary axis, which can modify cardiovascular function by increasing heart rate, blood pressure, and vasoconstriction^{83,85,86}. Experiencing these changes chronically can lead to these systems' dysfunction and trigger metabolic, cardiovascular, immunological, and mental illnesses⁸⁷.

This review identified how racism, as a social determinant of health, has been addressed in research in Brazil. Its findings reinforce the importance of using theories as a mechanism to identify the source of racism, so that control or elimination measures, and consequently the suppression of its deleterious effects on the health of the Black population, can be effective.

The studies listed in this work corroborate the theory that racial democracy is a myth in Brazil. This fallacy is evident from data's invisibility to access to healthcare services, which occurs late for Black people, especially regarding access to specialized care. Furthermore, the type of care provided does not depend exclusively on the availability of services in the territory, but on the quality of care provided and how the user perceives the service. In this sense, self-assessed health is also impacted by racism, as is the risk of developing and dying from preventable diseases. Racism acts socially, producing biological effects and weakening individuals. It prevents them from enjoying health in its broadest sense, which goes beyond the lack of disease. Furthermore, racism is an evil whose effect on health is felt not only by those who experience it directly but also by those in their social circle.

Despite the extensive discussion and important findings regarding racism's mechanisms, some omissions are noteworthy in this

review. We did not identify any studies that assessed the effect of specific policies, whether health-related or not, on the health of the Black population. If the discussion about structural and institutional racism is, in part, grounded in the historical, social, and political construction and the understanding of white supremacy in the creation and application of policies, it is necessary to understand how the State, through its order, has contributed to or not to the expansion of racism as a social determinant of health. Furthermore, we could not identify studies on the effect of environmental racism on the health of the Brazilian population; this theory is gaining ground in parallel with the expanded discussion about climate change and its effects on environmental disasters.

This review did not intend to exhaust all information on how racism theories explain the impact on people's health, but rather to broaden the discussion about the need to produce health studies with a perspective that does not view race merely as an explanatory or additive factor interacting with outcomes. We should consider its potential as an analytical tool for understanding the social effects of exposure to discrimination grounded in ethnicity/skin color on health, as well as how these discriminations are produced, so that a political and social reshaping is possible, through which Black people can find ways to restore the human dignity that encompasses the individual. This dignity has been denied from the colonial period, through the abolition of slavery, and extending to the present day, imposing on this large segment of the Brazilian population the adverse effects of experiencing inhumane, inequitable, and disintegrated social structures.

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ACO Costa: article conception, literature review, article design and writing. LL Jardim: article writing and critical revision. R Paes-Sousa: article conception, article writing and critical revision. All authors read and approved the final version.

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The data sources adopted in the research are indicated in the article's body.

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