Revista Brasileira em Promoção da Saúde
e-ISSN:1806-1230
Original Article
DOI: 10.5020/18061230.2019.9764

PREVALENCE AND FACTORS ASSOCIATED WITH RACIAL DISCRIMINATION PERCEIVED IN BRAZIL'S HEALTH SERVICES

Prevalência e fatores associados à discriminação racial percebida nos serviços de saúde do Brasil

Prevalencia y factores asociados con la discriminación racial percibida en los servicios de salud de Brasil

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ABSTRACT

Objective: *To analyze the prevalence of race/color discrimination practiced by healthcare providers in Brazil and its associated factors.* **Methods:** *Cross-sectional study based on data from the 2013 National Health Survey (PNS). The dependent variable was elaborated from the answer to question X25 - Have you ever felt discriminated against or treated worse than other people in the health service? The independent variables used in the study were: region of residence in the country, domicile situation, skin color, sex, age group, living with spouse, occupation, education, social class criterion in Brazil, smoking, alcoholism, presence of multimorbidity, self-rated health and use of a private medical or dental health plan. These factors were analyzed through the Prevalence Ratios (PR), with Poisson Regression multivariate analysis (95% CI), using the Wald test for robust estimation.* **Results:** *The prevalence of race/color discrimination was 1.45%% (n = 6055), associated with being black (PR 3.74 95% CI 2.89-4.85), aged 25-39 years (PR 1.89 95% CI 1.21-2.55), being a smoker (PR 1.55 95% CI 1.17-2.09), having four morbidities (PR 2.54 95% CI 1.62-3 99), evaluate their health as poor or very poor (PR 1.76 95% CI 1.25-2.48), be a public health service user (PR 1.33 95% CI 1.02-1.73), and reside in the urban area of the country (PR 1.48 95% CI 1.10-1.98).* **Conclusion:** *It was possible to identify that the discrimination by race/color practiced by healthcare providers in Brazil has low prevalence, which may be related to the cultural, social and legal constructions and sanctions involved in this phenomenon.*

Descriptors: Racism; Health Services; Socioeconomic Factors; Prejudice; Brazil.

RESUMO

Objetivo: *Analisar a prevalência da discriminação por raça/cor praticada por prestadores de cuidados em serviços de saúde no Brasil e seus fatores associados.* ***Métodos:*** *Estudo transversal realizado a partir dos dados da Pesquisa Nacional de Saúde (PNS) de 2013, com variável dependente elaborada a partir da resposta à questão X25: O(A) Sr(a) já se sentiu discriminado*

Received on: *07/30/2019*
Accepted on: *11/18/2019*

(a) ou tratado(a) pior do que as outras pessoas no serviço de saúde? As variáveis independentes foram: região de moradia no país, situação de domicílio, raça/cor, sexo, faixa etária, vive com cônjuge, ocupação, escolaridade, critério de classe social no Brasil, tabagismo, alcoolismo, presença de multimorbidade, autoavaliação de saúde e uso de plano privado de saúde médico ou odontológico. Esses fatores foram analisados através das razões de prevalência (RP), com análise multivariada pela regressão de Poisson (IC95%), com teste de Wald para estimação robusta. ***Resultados:*** *A prevalência da discriminação por raça/cor foi de 1,45% (n=6055), associada a ser negro (RP 3,74 IC95% 2,89-4,85), ter idade entre 25-39 anos (RP 1,89 IC95% 1,21-2,55), ser fumante (RP 1,55 IC95% 1,17-2,09), possuir quatro morbidades (RP 2,54 IC95% 1,62-3,99), avaliar a própria saúde como ruim ou muito ruim (RP 1,76 IC95% 1,25-2,48), ser usuário do serviço público de saúde (RP 1,33 IC95% 1,02-1,73) e residir na zona urbana do país (RP 1,48 IC95% 1,10-1,98).* ***Conclusão:*** *A discriminação por raça/cor praticada por prestadores de cuidados de saúde no Brasil apresenta baixa prevalência, o que pode estar relacionado às construções e sanções culturais, sociais e legais envolvidas nesse fenômeno.*

Descritores: *Racismo; Serviços de Saúde; Fatores Socioeconômicos; Preconceito; Brasil.*

RESUMEN

Objetivo: *Analizar la prevalencia de la discriminación de raza/color practicada por los prestadores de cuidados de servicios de salud de Brasil y sus factores asociados.* ***Métodos:*** *Estudio transversal realizado a partir de los datos de la Investigación Nacional de Salud (INS) de 2013 con la variable dependiente elaborada a partir de la respuesta de la pregunta X25: Usted ya se sintió discriminado(a) o tratado(a) peor que las otras personas en el servicio de salud? Las variables independientes fueron: la región de vivienda en el país, la situación del hogar, la raza/color, el sexo, la franja de edad, si vive con pareja, la ocupación, la escolaridad, el criterio de clase social en Brasil, el tabaquismo, el alcoholismo, la presencia de multimorbidad, la auto evaluación de la salud y el uso de seguro privado de salud médico o de salud bucal. Eses factores han sido analizados a través de las razones prevalencia (RP), el análisis multivariado por la regresión de Poisson (IC95%), la prueba de Wald para estimación robusta.* ***Resultados:*** *La prevalencia de la discriminación de raza/color ha sido del 1,45% (n=6055) asociada con el hecho de tener el color negro (RP 3,74 IC95% 2,89-4,85), tener la edad entre 25-39 años (RP 1,89 IC95% 1,21-2,55), ser fumador (RP 1,55 IC95% 1,17-2,09), tener cuatro morbidades (RP 2,54 IC95% 1,62-3,99), evaluar la propia salud como mala o muy mala (RP 1,76 IC95% 1,25-2,48), ser usuario del servicio público de salud (RP 1,33 IC95% 1,02-1,73) y vivir en la zona urbana del país (RP 1,48 IC95% 1,10-1,98).* ***Conclusión:*** *La discriminación de raza/color practicada por los prestadores de cuidados de salud de Brasil presenta baja prevalencia lo que puede estar relacionado con las construcciones y sanciones culturales, sociales y legales de ese fenómeno.*

Descriptores: *Racismo; Servicios de Salud; Factores Socioeconómicos; Prejuicio; Brasil.*

INTRODUCTION

Racism presents itself as an ideology of social inferiority used to justify the derogatory treatment granted to members of racial and ethnic groups, and which contributes to the aggravation and maintenance of disadvantages of power, resources or opportunities between these groups[1,2].

This phenomenon can materialize in three dimensions: through internalized prejudices, stereotypes and negative feelings linked to the racial or ethnic characteristics of a group; by the interpersonal manifestation of discriminatory behaviors and practices, which exclude and lower these groups, granting them attributes of lesser value or considering them worthless to the detriment of the characteristics of others; and, as a structural component, legitimized and practiced by organizations, policies, and standards, through unfair, discriminatory, negligent treatment, with a disadvantage in accessing benefits and delay in implementing actions and policies that favor its victims[1-4].

According to the last population census conducted in Brazil, more than 50% of the country's population is composed of black and brown individuals. However, this population group has worse health indicators[5,6].

In the field of public health, race/color discrimination practiced by health care providers has been internationally studied, as it is considered to generate and/or enhance health problems, precarious self-rated health, and losses in the quality of care of health services and the level of satisfaction and trust in health services by ethnic groups[7-12].

Furthermore, equitable and universal health care are prerogatives announced by milestones in the creation and regulation of the Brazilian Unified Health System (*Sistema Ùnico de Saúde - SUS*). Even with the existence of this robust legal framework, disparities in health between racial groups are identified, which indicates the failure to implement the principles defended by the Federal Constitution of Brazil[13].

However, disparities in the living and health conditions of the Brazilian black population are recognized to be influenced by structural racism[13]. In the Brazilian society, this structuring took place throughout the slavery period,

passing through abolition, as the segregation of the population into two races (white and black) managed to maintain itself even at a time when racism became an non-bailable crime[14].

The crime of racial discrimination has still been frequent in Brazil. The Public Ministry of Labor of Mato Grosso do Sul released a balance sheet for the past five years and, during this period, 896 complaints were received for discrimination based on origin, race, color, or ethnicity. In 2014, there were 157 reports, and this number grew by about 30.5% until 2018, reaching the mark of 205 complaints[15].

To ratify the country's commitment to tackling it, the National Policy for the Comprehensive Health of the Black Population (PNSIPN) presents itself as a strategy to combat inequalities in the SUS, intending to improve access and health status for this population, as it comprises that comprehensive care, free from racial discrimination, is indispensable for reducing health disparities arising from race/color[16].

Considering the complexity of racial relations existing in Brazil, the importance of the item "color/race" in the elaboration of racism and the practice of discrimination in the country, it is relevant to recognize this social inequity, to identify the characteristics associated with this phenomenon, allowing reflections about its effects, as well as the elaboration of intervention strategies, with managers and health care providers, to face it. Thus, the objective of the present study was to analyze the prevalence of race/color discrimination practiced by healthcare providers in Brazil and its associated factors.

METHODS

This is a cross-sectional study that used data from the National Health Survey (*Pesquisa Nacional de Saúde - PNS*) in Brazil, developed by the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística -IBGE*) with the Ministry of Health in 2013. The survey is a nationwide home-based inquiry that characterized the health situation, lifestyles, surveillance of chronic diseases, risk factors, and access to and use of health services by the Brazilian population, enabling ways to get to know the profile of the population in these matters[17]. The analysis of the data used in the present research was carried out in October 2018.

The population surveyed in the PNS comprised residents of private households in the country and in adulthood (≥18 years of age), excluding those located in special census sectors (barracks, military bases, accommodation, camps, boats, penitentiaries, penal colonies, prisons, jails, nursing homes, orphanages, convents, and hospitals). Conglomerate sampling was carried out in three stages, with weights assigned to each sample unit. In the first stage, the census sectors were selected (territorial unit for collecting census operations, defined by the IBGE), forming the primary sampling units (PSUs); in the second, households were selected and, in the third, adult residents. In all stages, subsamples were selected by simple random sampling (SRS)[17].

The size defined for the sample was 81,357 households, considering one individual per household. At the end of the collection, 60,202 households were interviewed, resulting in a response rate of 86%[6,17].

The PNS questionnaire was divided into modules, which include characteristics of the household, all residents, and the adult resident selected in the study, totaling 743 questions. The interviewers were trained to conduct the interview and to use handheld computers, in which the collected data were inserted[18].

The present study analyzed PNS questions regarding discrimination in health services, present in the "Module X" of the questionnaire, which contains 24 questions about medical care, access to care, and assessment of care received in the health service[18].

For the construction of the dependent variable called "discrimination by race/color practiced by health care providers in Brazil", the following questionnaire question was used: "X25 - Have you ever felt discriminated against or treated worse than other people in the health service, by any doctor or other health professional, for any of these reasons?" The question contemplated as alternatives the answers "yes" or "no" for ten reasons of discrimination, ordered from "a" to "j", they are: a) lack of money, b) social class, c) race/color, d) type of occupation, e) type of illness, f) sexual preference, g) religion/belief, h) sex, i) age and j) others(19). To identify discrimination by race/color, the indicator was calculated from the answers "yes" to "item c", corresponding to discrimination by race/color (18). Of the 60,202 individuals interviewed in the PNS, 6,055 claimed to have suffered discrimination by "race/color".

In this study, the independent variables were used: region of residence in the country (Midwest, South, Southeast, North, Northeast), home situation (rural or urban area), race/color (blacks - blacks and browns; and non-blacks - white, yellow and indigenous), sex (male or female), age group (18-20, 30-39, 40-59, 60 or more), live with spouse (yes

or no), occupation (busy, unemployed), education (no education, elementary school, high school, higher education or more), criteria of social class in Brazil (A and B, C, and D and E), use of tobacco and its derivatives (smoker, ex-smoker, never smoked), use of alcoholic beverages (excessive use, moderate use, never drank), presence of multimorbidity (none, two, three, four or more multimorbidities), self-rated health (very good/good, regular, bad/very bad), and use of a private medical or dental health plan (yes or no).

For statistical analysis, we used the analysis of the prevalence of discrimination by race/color practiced by health care providers about the socio-economic characteristics and health conditions of the population studied. Subsequently, a bivariate analysis was performed to obtain the prevalence ratios (PR) with the respective 95% confidence intervals (95% CI) and p-values ($p<0.05$). For variables with statistical significance in the bivariate analysis (p-value <0.2), multivariate analysis was performed using Poisson regression, with Wald's test for robust estimation, since, from this analysis, it is a greater sensitivity of the data is possible, considering the sample weights resulting from the design of the complex PNS sample. For statistical analysis, the program Stata, version 14, was used through the command complex sample.

The PNS project was approved by the National Research Ethics Commission, on July 8, 2013, under number 10853812.7.0000.0008.

The present study uses secondary PNS data available on official websites of the Ministry of Health of Brazil, therefore, being exempted from appreciation in a research ethics committee, following Resolution No. 466⁄2012 of the National Council of Health.

RESULTS

Table I shows the general prevalence of discrimination by color/race practiced by health care providers in Brazil, according to the population's socioeconomic and health characteristics. This type of discrimination was identified in 1.45% (n = 6055; 95% CI 1.29-1.62) in the population studied, with greater propensity to be discriminated the residents of urban areas (1.48%), with the highest prevalence in the North of the country (2.12%), followed by the Midwest (1.92%) and Northeast (1.6%).

The descriptive analysis confirms that they reported in greater proportion having suffered discrimination by race/color practiced by health care providers: black people (black and brown) (2.29%; 95% CI 2.02-2.59), having between 25-39 years (1.82%; 95% CI 1.56-2.12), without education (1.69%; 95% CI 1.24-2.31), smokers (2.29%; 95% CI 1, 81-2.90), who drink excessively (1.78%; 95% CI 1.26-2.50), who rate their health as poor / very bad (2.80%; 95% CI 2.17-3, 62), who have four morbidities (2.64%; 95% CI 1.76-3.94) and who do not have a private medical or dental health plan (1.65%; 95% CI 1.46-1.88). (Table I).

Table II presents the results of the bivariate analysis of the relationship between race/color discrimination practiced by health care providers in Brazil and socioeconomic and health factors.

There is a statistically significant association between greater discrimination by race/color and living in the North (RP 1.66; 95% CI 1.17-1.35) and the Midwest region (RP 1.50; 95% CI 1.07- 2.11), having black skin (PR 4.06; 95% CI 3.15-5.22), being between 25-39 years old (PR 2.17; 95% CI 1.56-3.01), being a smoker (PR 1.80; 95% CI 1.37-2.36), not having a private medical or dental health plan (PR 1.72; 95% CI 1.33-2.22), having four morbidities (PR 2.17; 95% CI 1.56-3.01) and self-rated health as bad / very bad (PR 2.45; 95% CI 1.54-3.28).

The statistically significant variables (p-value <0.2) in the bivariate analysis underwent a multivariate analysis, and the results are shown in Table III.

In this last analysis, the factors that were associated with the studied outcome were: being black (PR 3.74; 95% CI 2.89-4.85), being between 25-39 years old (PR 1.89; 95% CI 1, 21-2.55), smoker (PR 1.55; 95% CI 1.17-2.09), who has four morbidities (PR 2.54; 95% CI 1.62-3.99), who self- rated their health as bad / very bad (PR 1.76; 95% CI 1.25-2.48), who is an exclusive user of the public health service (RP 1.33; 95% CI 1.02-1.73) and who resides in urban areas of the country (PR 1.48; 95% CI 1.10-1.98).

Table I - Prevalence (%) of discrimination by race / color practiced by health care providers, according to the independent variables of the National Health Survey, 2013.

Variables	P (%)	IC (95%)	
		LI	LS
Racial discrimination	1.45	1.29	1.62
Region			
Midwest	1.92	1.46	2.51
South	1.09	0.79	1.50
Southeast	1.28	1.04	1.56
North	2.12	1.60	2.81
Northeast	1.60	1.31	1.95
Home situation			
Urban	1.48	1.31	1.67
Rural	1.22	0.95	1.57
Color / race			
Black	2.29	2.02	2.59
Non black	0.56	0.45	0.70
Sex			
Female	1.55	1.35	1.78
Male	1.32	1.13	1.55
Age			
18-24	0.95	0.70	1.29
25-39	1.82	1.56	2.12
40-59	1.65	1.38	1.97
60 ou +	0.84	0.62	1.14
Live swith spouse			
No	1.40	1.19	1.64
Yes	1.47	1.27	1.71
Ocupation			
Working	1.43	1.26	1.63
Not working	1.47	1.23	1.75
Education			
No schooling	1.69	1.24	2.31
Elementary School	1.58	1.34	1.86
High school	1.49	1.24	1.77
Higher education or more	1	0.79	1.28
Economy class criteria			
A and B	1.33	1.06	1.67
C	1.44	1.20	1.73
D and E	1.53	1.30	1.79
Smoking			
Never smoked	1.28	1.11	1.46
Smoker	2.29	1.81	2.90
Ex smoker	1.39	1.08	1.79
Use of alcohol			
Do not drink	1.48	1.30	1.69
Moderate	1.15	0.86	1.56
Excessive	1.78	1.26	2.50
Multimorbidities			
No morbidity	1.21	1.07	1.37
Two morbidities	2.25	1.74	2.91

Three morbidities	1.69	1.19	2.41
Four morbidities	2.64	1.76	3.94
Health self-assessment			
Very good	1.14	0.99	1.32
Regular	1.88	1.56	2.25
Bad / very bad	2.80	2.17	3.62
Private, medical or dental health plan			
Yes	0.96	0.77	1.20
No	1.65	1.46	1.88

P: Prevalence; CI: Confidence interval; LS: upper limit; LI: lower limit

Table II - Bivariate analysis of factors related to discrimination by race / color practiced by health care providers, according to the independent variables of the National Health Survey, 2013.

Variables	RP	IC (95%)		p-valor
		LI	LS	
Region				
Midwest	1			
South	1.5	1.07	2.11	**<0.001**
Southeast	0.85	0.59	1.25	
North	1.66	1.17	2.35	
Northeast	1.25	0.95	1.66	
Home situation				
Urban	1			**0.178**
Rural	1.21	0.92	1.6	
Color / race				
Black	1			**<0.001**
Non black	4.06	3.15	5.22	
Sex				
Female	1			**0.110**
Male	1.17	0.97	1.42	
Age				
18-24	1			
25-39	1.14	0.74	1.74	**<0.001**
40-59	2.17	1.56	3.01	
60 over	1.97	1.39	2.79	
Lives with spouse				
No	1			0.610
Yes	1.06	0.86	1.3	
Ocupation				
Working	1			0.820
Not working	1.02	0.83	1.26	
Education				
No schooling	1			
Elementary School	0.93	0.66	1.31	**0.010**
High school	0.88	0.63	1.22	
Higher education or more	0.59	0.4	0.88	
Economy class criteria				
A e B	1			0.610
C	1.08	0.81	1.44	
D e E	1.15	0.87	1.51	
Smoking				
Never smoked	1			**<0.001**
Smoker	1.80	1.37	2.36	
Ex smoker	1.09	0.83	1.44	

Use of alcohol				
Do not drink	1			**0.14**
Moderate	0.77	0.56	1.06	
Excessive	1.20	0.83	1.73	
Multimorbidities				
No morbidity	1			
Two morbidities	1.86	1.43	2.42	**<0.001**
Three morbidities	1.40	0.97	2.01	
Four morbidities	2.18	1.43	3.32	
Health self-assessment				
Very good	1			**<0.001**
Regular	1.64	1.32	2.04	
Bad / very bad	2.45	1.84	3.28	
Private, medical or dental health plan				
Yes	1			**<0.001**
No	1.72	1.33	2.22	

PR: Prevalence ratio; CI: Confidence interval; LS: upper limit; LI: lower limit; p value: probability of significance

Table III - Multivariate model using Poisson Regression with adjusted Prevalence Ratios (RPaj) of the variables associated with discrimination by race / color practiced by healthcare providers. National Health Survey, 2013.

Variables	RPaj	IC (95%)		p-value
		LI	LS	
Home situation				
Rural	1			**<0.010**
Urban	1.48	1.1	1.98	
Color / race				
Black	1			**<0.001**
Non black	3.74	2.89	4.85	
Sex				
Female	1			0.30
Male	1.11	0.91	1.35	
Age				
18-25	1			
25-39	1.81	1.29	2.55	**<0.001**
40-59	1.31	0.89	1.94	
60-over	0.59	0.35	0.98	
Smoking				
Never smoked	1			**<0.010**
Smoker	1.57	1.17	2.09	
Ex smoker	1.04	1.41	0.77	
Multimorbidities				
No morbidity	1			
Two morbidities	1.97	1.49	2.59	**<0.001**
Three morbidities	1.63	1.11	2.38	
Four morbidities	2.54	1.62	3.99	
Health self-assessment				
Very good	1			**<0.010**
Regular	1.32	1.06	1.64	
Bad / very bad	1.76	1.25	2.48	
Private, medical or dental health plan				
Yes	1			**0.04**
No	1.33	1.02	1.73	

RPaj: adjusted prevalence ratio; CI: Confidence interval; LS: upper limit; LI: lower limit; P-value: probability of significance

DISCUSSION

The study of the prevalence and factors associated with racial discrimination practiced by health care providers in Brazil allowed to observe a low prevalence pattern (1.45%) when compared to those observed in American studies.

One study[19] points out that the discrimination by race/color practiced by health care providers had a general prevalence of 10.38%, whereas, for the black population, this prevalence was 25.41%. Besides, another study[20] identified that 4.7% of people were victims of discrimination in health services and that this value corresponded to 9.7% among blacks.

Multiple social and historical events can contribute to minimizing both the practice and the perception of race/color discrimination among Brazilians when compared to the United States of America (USA). In Brazil, after the end of slavery, an alleged "racial democracy" became evident, which includes the idea of equality among its citizens, regardless of race/color, masking the perception and practice of the phenomenon[5]. Besides, the miscegenation process, evident in the Brazilian reality, did not proceed in the same way in the USA, where it was accompanied by intense racial segregation, which resulted in a deep sense of ethnic identity of its black population and expanded its perception of the phenomenon of racial discrimination[19,20].

Furthermore, reflections on racial discrimination have already taken place since the end of the 19th century in the North American context, allowing the population to understand and perceive the phenomenon; whereas, in Brazil, debates about discrimination experienced by the black population are recent and still scarce, making this practice more and more subtle, veiled and, at times, shrouded in ambiguity, making it difficult for victims to perceive and exempting their perpetrators from social and criminal sanctions[21].

In health care spaces, racial discrimination can materialize by the professional behavior through looks and silence during care, as well as through ignorance and unpreparedness about the health conditions peculiar to the black population, impairing the assessment and approach of your health-disease process[22].

The low prevalence of perceived discrimination in health services found in the current study can be explained by the fact that blacks who make up traditional communities tend to seek African religions for the first health care visits [23,24], reducing their contact with professionals in health units, reducing the possibility of the occurrence of the act of discrimination[22].

The black Brazilian population living in urban areas may represent the biggest victims of race/color discrimination practiced by health professionals. In urban spaces, blacks mostly occupy the peripheries, places with precarious goods and services, with exposure to situations of vulnerability and which are often linked to stigmas of violence, delinquency and disintegration These characteristics can generate a prejudiced, hostile and discriminatory attitude on the part of health workers in the face of certain negatively stigmatized social groups, such as the black population[23-26].

When analyzing the variable smoking, it was possible to observe that people who smoke suffer more discrimination when compared to those who do not smoke or ex-smokers. Therefore, the social stigma attached to tobacco and smokers, evidenced by the emergence and consolidation of anti-smoking laws, generates marginalization of users of this product due to the greater knowledge of the ills caused by it or, also, by the increased perception of discrimination by the smokers themselves[27].

The present study also identified a greater proportion of those who reported having suffered discrimination by race/color among individuals who rated their health as poor / very bad. The precariousness of the service offered, as a result of this type of discrimination, can be a determining factor for the emergence or potentiation of health problems or inappropriate lifestyle habits[7,9,11,12,28].

Evidence in the literature indicates that, even though they are victims of race/color discrimination, people with more fragile health do not give up looking for health services, because their situation searches for these spaces indispensable, making the event studied an experience particularly harmful[12,29]. Besides, race/color discrimination by health care providers can contribute to reducing user satisfaction with professionals and the health service, which can cause non-adherence to treatments, directly impacting the effectiveness of health care[12].

Another finding reveals that using the public service is related to greater discrimination by race/color in health services when compared to people who have a private health plan[10]. In Brazil, data from the Institute of Applied Economic Research point out that, in 2008, 67% of the population served by SUS was black and that the income range of its users was between a quarter and a half of the minimum wage. Considering that the black population constitutes the majority of SUS users and that racial discrimination is more prevalent among public service users, the findings of this study reflect a worrying fragility of this system, which reinforces the institutional racism that already exists in the Brazilian panorama[30].

Thus, the relevance of these data is highlighted for the accomplishment of objectives already agreed by SUS through the National Health Promotion Policy, revised in 2014, such as the adoption of social and health practices centered on equity, participation and social control, seeking to reduce systematic, unjust and avoidable inequalities concerning differences, including ethnic and racial differences. Therefore, the evidence from the present study allows us to detect a rupture in the principles of the Brazilian health system and points to the need to expand discussions on equitable treatment of vulnerable groups in this space.

Discrimination by race/color, as a subjective phenomenon, presupposes a difficult measurement and capture, so it is a complex topic to be debated in quantitative research. Besides, the memory bias, the constraint caused by the questioning and the extensive PNS questionnaire can reduce or increase the number of positive or negative responses to this question, configuring the limitations of the present study.

On the other hand, the limited number of studies with quantitative and association design from the perspective of race/color discrimination in health services in the Brazilian territory reinforces the relevant contribution of these results to the expansion of the debate.

CONCLUSION

It was possible to identify that race/color discrimination practiced by health care providers in Brazil has a low prevalence, which may be related to the cultural, social and legal constructions and sanctions involved in this phenomenon.

The studied event happens diffusely in all regions of Brazil, especially affects the black population, regardless of gender, and people with vulnerability in their health condition, with multiple morbidities, smokers, with poor / very bad health self-rated and that exclusively uses SUS.

CONFLICTS OF INTEREST

The authors have declared that there are no conflicts of interest.

CONTRIBUITIONS

Marianny Nayara Paiva Dantas and **Isabelle Ribeiro Barbosa** contributed to the preparation and design of the study; the acquisition, analysis and interpretation of data; and the writing and / or revision of the manuscript. **Kezauyn Miranda Aiquoc**, **Emelynne Gabrielly de Oliveira Santos** and **Nayre Beatriz Martiniano de Medeiros** contributed to the acquisition, analysis and interpretation of data; and the writing and / or revision of the manuscript. **Mercês de Fátima dos Santos Silva** contributed to the acquisition, analysis and interpretation of data. **Dyego Leandro Bezerra de Souza** contributed to the preparation and design of the study and to the acquisition, analysis and interpretation of data.

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How to cite: Dantas MNP, Aiquoc KM, Santos EGO, Silva MFS, Souza DLB, Medeiros NBM, et al. Prevalence and factors associated with perceived racial discrimination in health services in Brazil. Rev Bras Promoç Saúde. 2019;32:9764