Women in Primary Care: Reflections on Education and Race in the Social Determination of Mental Disorders

Mulheres na Atenção Primária: Reflexões Sobre Escolaridade e Raça na Determinação Social de Transtornos Mentais
Mujeres en la Atención Primaria: Reflexiones Sobre Escolaridad y Raza en la Determinación Social de los Trastornos Mentales

RESUMO
Objetivo: Analisar o perfil sociodemográfico de mulheres com diagnósticos psiquiátricos na atenção primária e associação com indicadores sociais. **Método:** Estudo epidemiológico transversal com dados secundários de 13.555 mulheres cadastradas em uma unidade básica de um município da região metropolitana de Curitiba-PR. **Resultado:** A prevalência de transtornos mentais foi de 14,10%: transtornos de humor (47,72%) e ansiosos (46,90%). Mulheres brancas apresentaram prevalência 20% maior (OR=1,20; IC95%: 1,05–1,36). Frequentar escola pública associou-se a risco duas vezes maior comparado à privada (OR=2,16; IC95%: 1,32–3,51). Analfabetismo aumentou o risco em 65% (OR=1,66; IC95%: 1,13–2,44). **Conclusão:** Os resultados evidenciam processos de determinação social do adoecimento mental feminino, que interseccionam raça, classe e escolaridade, indicando necessidade de políticas públicas intersetoriais e abordagem integral na atenção primária.
DESCRITORES: Transtornos Mentais; Mulheres; Determinantes Sociais da Saúde; Atenção Primária em Saúde

ABSTRACT
Objective: To analyze the sociodemographic profile of women with psychiatric diagnoses in primary care and its association with social indicators. **Method:** Cross-sectional epidemiological study using secondary data from 13,555 women registered at a basic health unit in a municipality of the metropolitan region of Curitiba, PR, Brazil. **Results:** The prevalence of mental disorders was 14.10%: mood disorders (47.72%) and anxiety disorders (46.90%). White women showed a 20% higher prevalence (OR = 1.20; 95% CI: 1.05–1.36). Attending public school was associated with a twofold higher risk compared with private school (OR = 2.16; 95% CI: 1.32–3.51). Illiteracy increased the risk by 65% (OR = 1.66; 95% CI: 1.13–2.44). **Conclusion:** The results highlight social determination processes of women's mental illness that intersect race, class and education, indicating the need for intersectoral public policies and an integral approach in primary care.
DESCRIPTORS: Mental Disorders; Women; Social Determinants of Health; Primary Health Care

RESÚMEN
Objetivo: Analizar el perfil sociodemográfico de mujeres con diagnósticos psiquiátricos en atención primaria y su asociación con indicadores sociales. **Método:** Estudio epidemiológico transversal con datos secundarios de 13.555 mujeres registradas en una unidad básica de salud de un municipio de la región metropolitana de Curitiba-PR, Brasil. **Resultados:** La prevalencia de trastornos mentales fue del 14,10%: trastornos del estado de ánimo (47,72%) y trastornos de ansiedad (46,90%). Las mujeres blancas presentaron una prevalencia 20% mayor (OR = 1,20; IC95%: 1,05–1,36). Haber asistido a escuela pública se asoció con un riesgo dos veces mayor en comparación con la privada (OR = 2,16; IC95%: 1,32–3,51). El analfabetismo aumentó el riesgo en un 65% (OR = 1,66; IC95%: 1,13–2,44). **Conclusión:** Los resultados evidencian procesos de determinación social del adoecimiento mental femenino que interseccionan raza, clase y escolaridad, indicando la necesidad de políticas públicas intersectoriales y un abordaje integral en la atención primaria.
DESCRIPTORES: Trastornos Mentales; Mujeres; Determinantes Sociales de la Salud; Atención Primaria en Salud

DOI: 10.36489/saudecoletiva.2025v16i102p18022-18037

RECEIVED: 10/05/2025 **APPROVED:** 10/21/2025

How to cite this article: Women in Primary Care: Reflections on Education and Race in the Social Determination of Mental Disorders. Saúde Coletiva (Brazilian Edition) [Internet]. 2025 [cited year month day];16(102):18022-18037. Available from: DOI: 10.36489/saudecoletiva.2025v16i102p18022-18037

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INTRODUCTION

Mental health is currently one of the areas with the highest demand in health services in Brazil, especially in primary health care (PHC), where more than half of users have some type of mental disorder [1,2][1] . It is estimated that between 20% and 25% of the population suffers from one of these disorders, with a huge impact on complaints of suffering in the SUS (Brazilian Unified Health System) today [3,4].

Basic health units (BHUs) play an essential role as the gateway to the SUS and in coordinating care in the Psychosocial Care Network (RAPS). However, there are barriers to the effective integration of mental health care into PHC, such as: limitations in the capacity of health teams to receive and diagnose patients, resulting in a significant portion of the population being underserved [5]; a shortage of care strategies appropriate to the epidemiological profile to be addressed; and exclusively or predominantly pharmacological approaches [6].

The distribution of mental disorders is uneven and heterogeneous among populations and regions, reflecting the weight of socioeconomic conditions and lifestyles of communities, classes, and their strata in the social production of diseases and their risks, according to their insertion in the social relations of production and reproduction of life. According to the perspective of critical epidemiology [7], reducing complex processes involving living conditions to the logic of risk factors ultimately denies the dialectical nature of mental health-illness phenomena and their complex links with the social totality, in which, in the case of women, gender inequalities, intersecting with race, represent *critical destructive processes* that are relevant and most overlooked in investigation[s] [8]. By being reduced to 'socially modifiable risk factors', they create the mistaken belief that focal actions or individual behavioral changes would alter structural determinants such as discrimination, violence, or even the capitalist economy—with its high levels of poverty and inequality—which affect huge population groups with "low socioeconomic status" [11], which is pointed to as the modifiable risk factor.

In psychiatric literature, there is consensus regarding the significant differences found in the prevalence of mental disorders between men and women, with women presenting significantly higher rates [11], higher levels of stress, a greater number of suicide attempts, and greater consumption of psychotropic drugs [12–14]. Studies also reveal that ethnic-racial identity, or manifestations of racism, also condition differences in prevalence: non-white individuals have a prevalence of mental disorders up to 1.85 times higher than white individuals [15], that is, quality of life and health are racialized and gendered.

In this study[s] , we seek to understand the sociodemographic profile

[1] Although there is a very important debate about the overdiagnosis of psychiatric disorders in the Brazilian population, which cannot be developed here, the growing number of people seeking basic healthcare services with complaints related to mental health problems and who are clinically diagnosed has been pointed out by several studies

[2] This corresponds to the analysis of part of the data from a more comprehensive study that brings together undergraduate and graduate researchers in Public Health at the Federal University of Paraná, entitled: "Mental Health and Psychological Suffering: A Study of Its Social Determinants Based on Individual Trajectories," approved by the Research Ethics Committee (opinion no. 6,688,267; CAAE: 70498423.9.0000.0102).

of women who, once registered and treated at a UBS in a given municipality in the metropolitan region of Curitiba-PR, are listed in the database as diagnosed with psychiatric disorders. The study is justified by the importance of strengthening the debate between the areas of public health policy and planning, mental health, and psychiatric medicine, based on critical contributions from the humanities and social sciences in analyses that elucidate the social determinants of epidemiological profiles.

METHOD

A cross-sectional epidemiological study was conducted using secondary data provided by the information management department of the Health Secretariat of the municipality surveyed, primarily produced in routine care by filling out registration forms and medical records for women over 18 years of age, up to August 2024. The researchers requested a wide range of information (previously verified as contained in the forms, and therefore, in theory, routinely filled out) deemed necessary[3] for the study of the epidemiological profile of the women in question, based on the parameters of social determination and critical epidemiology (8, 10). The analyses were performed in jamovi (v.2.3.28). The sample was described by n and %; bivariate associations were tested by Chi-Square (or Fisher, when applicable); crude Odds Ratios (OR) with 95% CI were estimated by univariate logistic regression.

RESULTS

After obtaining information from **18,258 registered females** and excluding children and adolescents, the analyses were performed on a total of 13,555 women, whose characteristics are shown in Table 1. Table 2 describes the percentages corresponding to the rate of collection or recording of information for each variable, some of which had very low recording rates, limiting their inclusion in the statistical analysis models.

Table 1. Sociodemographic characteristics of women registered at UBS in the Metropolitan Region of Curitiba, Paraná, Brazil, 2024 Source: Information System of the Municipal Health Secretariat; preparation: authors

Block	Variable / Category	n	% (of total)
Race/ethnicity (self-declared)	White	10564	77,93%
	Brown	2079	15,34%
	Black	383	2,83%
	Yellow	50	0,37%
	Indigenous	1	0,01%
	Not reported	478	3,53%
Psychiatric diagnoses	Women with ≥ 1 diagnosis	1911	14,10%
	Total diagnoses recorded	2674	—
	Mood disorders	1276	47,72%
	Anxiety disorders	1254	46,90%[4]
	Schizophrenia	121	4,53%[4]
	Psychoses	16	0,60%[4]
	Personality disorders	7	0,26%[4]
Education (aggregate)	Not reported	4974	36,69%
	Illiterate	134	0,99%
	Incomplete elementary education (1st–8th grade)	2272	16,76%
	Complete elementary education	741	5,47%
	Incomplete high school education	1131	8,34%
	High school completed	2853	21,05%
	Higher education (incomplete + complete)	706	5,21%
School attendance and type	Attended public school	8485	62,60%
	Attended private school	190	1,40%
	Never attended school	133	0,98%
	Not reported	4747	35,02%

[3] These included ethnic-racial distribution, educational level, place of school attendance, sexual orientation, gender identity, marital status, occupational status, whether or not they were mothers, and household composition, in addition to diagnoses attributed by physicians, based on the ICD and DSM, prescriptions and dispensing of psychotropic drugs, and records of medical care for self-harming behavior and suicide attempts. All registered men and their respective distribution of psychiatric diagnoses were also requested for comparison with women.

[4] Percentage referring to the total number of psychiatric diagnoses.

DOI: 10.36489/saudecoletiva.2025v16i102p18022-18037

Table 2. Sociodemographic categories with low completion rates in the UBS system in the metropolitan region of Curitiba, Paraná, Brazil, 2024. Source: Information System of the Municipal Health Secretariat; prepared by the authors.

Block	Variable/Category	n	% of total filled
Field completion	Marital status (filled in)	1526	1526
	Brazilian Classification of Occupations (CBO) (filled in)	9	9
	Labor market status (completed)	649	649
	Sexual orientation (completed)	290	290
	Gender identity (completed)	148	148

DISCUSSION

The ethnic-racial distribution of users of the UBS studied, based on self-reported data, follows a different trend compared to IBGE census data (2022) for the municipality [16]. There is an overrepresentation of the self-declared white population at the UBS (77.93%) in relation to its proportion in the municipality (62.42%), while the brown and black populations are underrepresented in the data provided. The brown population represents 15.34% of UBS users, contrasting with 32.13% in the municipal population, and the black population corresponds to 2.83% of users, versus 5.08% in the census. Thus, most of the people served whose data were requested/recorded self-identified as white, followed by brown and black, while yellow and indigenous people represented a much smaller portion.

Regarding the prevalence of psychiatric diagnoses among the women treated, 1,911 women (14.10%) were diagnosed with at least one mental disorder. Regarding the prevalence stratified by different psychiatric diagnoses, mood disorders and anxiety disorders represented the majority of psychiatric diagnoses. The same user may have received more than one diagnosis, either in a single visit or in different visits over time.

Data analysis revealed that white women had an approximately 20% higher prevalence of at least one psychiatric diagnosis compared to non-white women. This difference was statistically significant (OR = 1.20; 95% CI: 1.05–1.36; p < 0.01). This seems to diverge from most findings in the epidemiological literature. When analyzed stratifically by specific diagnostic categories (mood disorders, anxiety disorders, etc.), no statistically significant differences were observed between racial categories.

Regarding educational attainment, 36.70% of women did not have information about their educational level recorded, which limits more consistent analyses. Among the valid data, it is observed that most users of the unit have completed high school, followed by incomplete elementary school (5th to 8th grade). The proportion of women with higher education (complete and incomplete) represents only 5.21% of the registered female population. At the other extreme, there is a minimal contingent of illiterate users, a number lower than the municipal illiteracy rate, according to IBGE (2022) - (0.99% versus 2.83%). This discrepancy may be related to the high proportion of white women in the city, who, according to the literature, tend to have higher rates of access to and permanence in the educational system when compared to non-white women [17].

Regarding school attendance and type (public or private), only 0.98% of women reported never having attended school. Most women attended public schools (62.60%), while only 1.40% reported having studied in private schools. However, there is a high rate (35.02%) of women whose school attendance was not reported.

The higher attendance of women in the public education system converges with national data on the general population and also with the profile of the population using the SUS. With regard to overall school attendance, no significant association was identified between attending or not attending school as a social marker in relation to mental disorder diagnoses (OR = 1.25; 95% CI: 0.83–1.90; p = 0.29). The analysis revealed a relevant relationship between the type of school attendance and psychiatric diagnoses, in this case a higher prevalence of disorders among women who attended public schools compared to those who attended private schools.

Women who attended private schools had a significantly lower prevalence of at least one psychiatric diagnosis compared to those who studied in public schools, with a difference of more than double (OR = 2.16; 95% CI: 1.32–3.51; p < 0.01). Illiterate women had a 65% higher prevalence of psychiatric diagnosis compared to literate women or those with some level of education (OR = 1.66; 95% CI: 1.13–2.44; p = 0.01). Women who did not complete elementary school had a significantly higher probability of diagnosis than those who had completed elementary school (OR = 1.58; 95% CI: 1.41–1.76; p < 0.01).

Some reflections on the role of education in women's mental health, without conceiving it as a factor but rather as an indicator of living conditions and lifestyles, the results seem to point to the weight of adverse socioeconomic conditions on the lives of working women from lower so-

DOI: 10.36489/saudecoletiva.2025v16i102p18022-18037

cioeconomic strata who work in jobs that do not require a college degree (the vast majority). These conditions vary and are possibly mediated by the type of education (private or public) and, more specifically, by the different lifestyles between class strata: the stratum of women who attend public education and the stratum of those who attend private education (more accessible to middle-income strata). Types of education are considered mediating factors, as it is not possible to categorically affirm a direct, "mechanical" relationship between attending private education and finding specific protective resources for mental health in it, even though education research points to differences in quality between public and private networks. What converges with discussions in research in this area is that the process of schooling for more years, especially access to university level education, implies changes in sociability and economic-labor insertion, as well as scientific, sociocultural, and political appropriations that are potentially beneficial to integral human development. Access to better jobs and higher income levels, in the national capitalist system, converge towards a higher quality of life, including, for example, more leisure resources, support networks, and the guarantee of other social security rights and benefits that education tends to promote, thus reducing or alleviating the levels of stress generated by pressures and barriers to maintaining oneself and one's dependents (production and reproduction of life). Once the most serious and structural potential stressors that put survival, human dignity, quality of life, and health at risk are "under control" and mitigated, human development occurs with mental health being "better protected." Another equally important finding is that studies point to the condition of many women who are victims of violence in a capitalist-patriarchal society, which is one of the "risk factors" for mental disorders most evident in research. It is theorized that a higher level of education may represent, due to the relevance of the appropriations mentioned above and their cyclical beneficial effects, life trajectories that constitute a network of greater protection against violence and the suffering it implies, and a lower risk of developing psychiatric conditions [18]. Considering that violence, including that linked to greater exploitation and subordination in the labor market, affects black women and those with lower levels of education and income more, it is reasonable to think that the "low education" factor masks the overwhelming weight of violence on the lifestyles and psychological and health states of these women.

Along the same lines, we can reflect on the higher prevalence of mental disorders found in illiterate women, which is consistent with previous epidemiological studies [4]. Illiteracy predisposes women to more precarious lifestyles due to their subordination to more precarious working conditions, less autonomy, and lower income, thus increasing the economic insecurity of these women and their families, exposing them to acute, but also continuous, situations of stress in the struggle to reproduce their lives and those of their dependents. Illiteracy also hinders access to health information and education, as well as limiting cultural, political, and recreational opportunities, and impairs understanding of medical and health guidelines in general. Similarly, levels of education beyond elementary school completion would reduce the risk of developing disorders, since under the conditions described, there tend to be better opportunities in the labor market, more stable and less precarious contracts, access to social security benefits and rights, etc., which tends to guarantee this group of women a stable income and access to different resources and goods, leading to greater autonomy. They would thus be better supported and psychologically "strengthened" to face, without becoming ill, the critical destructive processes of *the knot of exploitation-racism-patriarchy* [19, 9].

Thus, the complex links between educational trajectory (sociologically conditioned to a large extent), psychological/intellectual development, and preservation versus deterioration of mental health must be understood, not as isolated factors of exposure to the outcome, but rather in the dialectical movement of the destructive and protective critical processes that flow into the social determination of illness (understood as biological and at the same time historical-social phenomena) in a broad, dynamic, interdependent, complex, and multidimensional way. For example, women who attend/attended private schools in Brazil are concentrated in greater numbers in the working class strata with better socioeconomic conditions, which may favor access to health services with greater promptness and quality, better quality of life, and more effective protection against the critical destructive processes that increase the risk among women of developing psychiatric disorders.

Latin American critical epidemiology, whose main exponent is Jaime Breilh, seeks to use *critical processes* to reveal the course of the social determination of disease, forcing an epistemological and political overcoming of traditional epidemiology which, according to critical authors, operates on an empiricist-functionalist, Cartesian, individualizing logic, in which a reductionist statistical approach devoid of social theory would associate diseases and risk factors, abstracting them from the totality of complex social processes that act in the production and reproduction of life and economic, social, and political formations [7-10].

DOI: 10.36489/saudecoletiva.2025v16i102p18022-18037

This framework also supports some possible analyses of racialized working women with lower levels of education and professional qualifications, whose findings in the present study indicated a higher prevalence of disorders in the group of white women, diverging from the most frequent findings in the epidemiological literature (a tendency toward a higher prevalence of mental disorders in non-white populations). Here, it is necessary to contribute other findings on the topic of access to mental health services and diagnoses and the manifestations of racism. The small but significant difference observed between white and non-white women in the findings of this study possibly reflects more the disparities between white and brown/black women in the search for, access to, and quality of health services (reception, evaluation, diagnosis, and treatment) than the feasibility of the hypothesis that the living conditions of white women specifically in the sample studied are worse, contrary to the trends. This is because racialized women, in addition to various social inequalities, often face barriers in accessing health services, including systematic underdiagnosis due to biases implicit in clinical practice, such as neglect of their experiences of pain and suffering, low confidence in the health system, and less regular visits, i.e., dynamics that manifest institutional racism [20]. In contrast, white women, who generally have greater access to medical services, may have their experiences of suffering more frequently accepted and "legitimized as such" when they are in psychological distress, evaluated, and therefore diagnosed as symptoms of psychiatric disorders. Although racialized women face more intense situations of violence in society, whether physical, psychological, or symbolic, which directly affect their mental health [21,22], this violence tends to be naturalized, invisible, and even legitimized, conceiving these forms of violence as "fatalities of life" or even mere consequences of their consciously or recklessly practiced "risky behaviors," thus blaming these women. Furthermore, studies show a tendency for racialized women to receive different diagnoses than white women, even when they report the same symptoms [23], demonstrating strong biases in psychiatric and health care practices in general.

Even while weaving this debate about racialized medical/health care and racism creating health inequalities, it is necessary to draw attention to another aspect in the analysis of the sociodemographic data of the users of the UBS surveyed, regarding the racial proportion of the population of the municipality in question. An overrepresentation of white women was identified in the studied territory, corresponding to 77.93% compared to 62.42% of white women in the total population of this municipality [16]. This fact can be explained by possible classification biases in self-declared race, as well as by flaws in the collection and recording of information, for example, by exclusively registering users in regular housing situations, making it difficult or impossible to register populations in areas of irregular occupation (which concentrate poorer populations where black and brown people are present in greater numbers) with the same speed, or because they are less likely to use services, as they are more subordinate in the labor market, prevented from taking time off, or because income cannot be obtained without working or due to employer coercion.

Finally, some limitations of the study should be clarified, even if largely beyond the control of the researchers, due to the high proportion of incomplete sociodemographic data, particularly in variables such as marital status and occupational status. This limits a more detailed outline of the epidemiological profile of mental health among women in the studied territory. It should also be considered that the data obtained in relation to race/ethnicity and education are self-reported in situations of care and registration, which may give rise to biases inherent to this. The absence of information on sexual orientation and gender identity suggests that these determinants are considered secondary or irrelevant in services, although they are fundamental for outlining the epidemiological profile of patients with psychiatric demands (in a broader sense, mental health demands) in primary care. The mistaken belief that it is irrelevant in primary care to verify and record information that enables profiling has systemic negative effects on the overall quality of care in the psychosocial care network (RAPS), of which basic units are integral parts with the functions of gateway, reception, and coordination of flows. These failures in the data collection process undermine the epidemiological characterization of the population served, prevent explanatory analyses of prevalence, and hinder the development or adjustment of comprehensive mental health care strategies that go beyond psychopharmacology and the structures of the SUS.

CONCLUSION

This study demonstrated that there is a significant disparity in the prevalence of mental disorders in women when stratified by race and education in Primary Care. These differences, when interpreted from a theoretical lens that seeks the social genesis of disease processes, must have their relevance recognized in order to guide care practices and formulate public policies with greater equity and more efficient in meeting social needs that impact quality of life and mental health. From the critical perspective

DOI: 10.36489/saudecoletiva.2025v16i102p18022-18037

adopted in this study, PHC should not only be guided by the identification of symptoms and assigning the corresponding diagnoses in order to prescribe certain drugs or referrals to specialists. But it should also be able, by knowing the social profile of populations and communities and of sick groups (survey of the epidemiological profile), to "force" and be involved in the adoption of public, institutional, and community and political mobilization measures that improve socially and historically constituted conditions and ways of life. By examining this data and analyzing it according to the assumptions of the inseparability of gender, race, and class relations and the impossibility of abstracting the historical and social processes that engender illness, SUS teams and managers can, in addition to providing care that is more attuned to psychosocial needs and therefore more humanized, give visibility in public management to the urgent need to advance the intersectorality of state action, with equity, for the promotion of well-being, labor and social protection, quality of life, and health, whether in the protection of dignity, guarantee of rights, or in the combative action against injustices, violations of rights, and structural inequalities imposed on large masses of workers in the current capitalist political-economic formation.

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DOI: 10.36489/saudecoletiva.2025v16i102p18022-18037