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# Experiences for affirmative actions: strategies against ethnic-racial discrimination in medicine

*Vivências para ações afirmativas: estratégias ante as discriminações étnico-raciais na medicina*

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## ABSTRACT

**Introduction:** Slavery has left inequalities that still affect access to healthcare and education. In Medicine, affirmative actions have expanded access, yet challenges remain regarding the retention and legitimization of Black and Indigenous students in academic settings.

**Objective:** To understand, from a collaborative learning perspective, situations of racial and ethnic discrimination and strategies to confront racism in medical education.

**Method:** This qualitative study employed an ethnographic approach, utilizing participant observation and focus groups to gather insights into racial and ethnic discrimination and strategies to combat racism in Medicine. Three academic experiences were conducted, during which participants documented their experiences on index cards and proposed solutions, each session lasting approximately one hour. Thirty-three participants were involved, including 16 self-identified as Black or mixed-race and 2 Indigenous individuals from the Mundurucu and Borari ethnic groups. Data analysis followed collaborative learning theoretical frameworks, employing Minayo's thematic analysis technique. The study protocol was approved by the Research Ethics Committee under opinion number 5,736,372.

**Results:** The study revealed subtle forms of racism characterized by the normalization of discrimination and a logic of denial, expressed through microaggressions, identity denial, challenges in occupying and navigating medical spaces, and the perpetuation of stereotypical images of Black and Indigenous individuals. Conversely, it highlighted individual and collective strategies to combat racism, such as reporting incidents, promoting anti-racist dialogue, education on racial and ethnic relations, legal penalties, and raising awareness among the population about the experiences of being Black or Indigenous.

**Conclusion:** Racism continues to permeate university and healthcare environments, negatively impacting the experiences of Black and Indigenous students. Nevertheless, the study identifies pathways of resistance that underscore the importance of affirmative actions, racial consciousness, and transformative approaches in Medical Education. Integrating ethnic-racial discourse into health education is crucial for fostering inclusive and socially engaged learning environments.

**Keywords:** Racial discrimination; Social medicine; Equity; Medical education.

## RESUMO

**Introdução:** *A escravidão deixou desigualdades que ainda afetam o acesso à saúde e à educação. No curso de Medicina, ações afirmativas ampliaram o acesso, mas persistem desafios de permanência e legitimação dos estudantes negros e indígenas no meio acadêmico.*

**Objetivo:** *Este estudo teve como objetivo compreender, na perspectiva da aprendizagem colaborativa, situações de discriminação étnico-racial e estratégias de enfrentamento do racismo no ensino médico.*

**Método:** *Trata-se de um estudo qualitativo com abordagem etnográfica que utilizou a observação participante e o grupo focal para coletar informações sobre as situações de discriminação étnico-racial e as estratégias de enfretamento do racismo na medicina. Foram realizadas três vivências acadêmicas, nas quais os participantes registraram em papéis-cartões suas experiências e propuseram soluções, com duração aproximada de uma hora cada. Reuniram-se 33 participantes, sendo 16 autodeclarados pardos ou pretos e dois indígenas das etnias Mundurucu e Borari. A análise e interpretação dos relatos seguiram os pressupostos teóricos da aprendizagem colaborativa, utilizando a técnica de análise temática de Minayo. O protocolo do estudo foi aprovado pelo Comitê de Ética em Pesquisa com Seres Humanos: Parecer nº 5.736.372.*

**Resultado:** *Evidenciaram-se formas sutis de racismo, marcadas pela naturalização da discriminação e pela lógica da negação, manifestadas por meio de microagressões, negação de identidades, dificuldades de ocupação e circulação em espaços médicos, além da reprodução de imagens estereotipadas sobre pessoas negras e indígenas. Em contrapartida, destacaram-se estratégias individuais e coletivas de enfrentamento, como a denúncia e o estímulo ao diálogo antirracista, a educação para relações étnico raciais, a aplicação de punições legais e a conscientização da população sobre o significado de ser negro ou indígena.*

**Conclusão:** *O racismo ainda permeia o ambiente universitário e de saúde, impactando negativamente a vivência de estudantes negros e indígenas. Ao mesmo tempo, aponta caminhos de resistência que reafirmam a importância das ações afirmativas, da consciência racial e da transformação na educação médica. Conclui-se que é imprescindível integrar o debate étnico-racial na formação em saúde, a fim de promover uma educação inclusiva e socialmente comprometida.*

**Palavras-chave:** *Discriminação racial; Medicina social; Equidade; Educação médica.*

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## INTRODUCTION

An unprecedented study conducted in Brazil in 2025 revealed that the country has the greatest genetic diversity on the planet. According to the survey, 60% of the population has European ancestry, 27% African and 13% indigenous. The study identified DNA marks that reflect the violence of colonisation, such as the presence of genes from 90% of exterminated indigenous peoples and unique African genetic combinations formed only in Brazil. It was also found that 71% of the Y chromosome lineages are of European origin, while the mitochondrial lineages are mostly African (42%) or indigenous (35%), the result of sexual violence against indigenous and African women, genetic confirmation of something already condemned in the history books[1].

As a result, the enslavement of indigenous and African peoples played a fundamental role in the social, economic and cultural formation of Brazil, leaving a legacy of profound inequalities[2]. These marks are noticeable in the areas of education and health, with difficulties in access to services, limited use of diagnostic and therapeutic means, lower quality of care and worsening clinical outcomes. Not to mention the marginalisation of traditional knowledge and the persistence of structural racism in medical practice[3].

In the field of medicine, racism, a systematic form of discrimination, is manifested at different levels. Three concepts help elucidate its complexity: individualistic racism, which is understood as the result of personal attitudes, treated as "pathology" or "irrationality'; institutional racism, which is expressed in the policies, norms and practices of institutions; and structural racism, understood as a political and historical process that organises society and perpetuates inequalities. This latter form is the most comprehensive and explains how racial inequality is rooted in social structures, including health and education[4].

Racial discrimination, in turn, is the tangible manifestation of this racism. Materialised in the act that inferiorises or excludes someone on the basis of their race, ethnic origin, colour and/or condition that represents difference, with the aim of denying or restricting fundamental rights, opportunities and freedoms in various fields of life, including education and health[5]. In medical education, this discrimination is evident both in the profile of those who manage to enter and remain on the courses and in the practices and later relationships established in the professional routine, even if they were admitted to university by means of racial quotas.

Although the black population represents the majority in Brazil (55.5%)[6], their presence in medical courses in 2023 remained disproportionately low, representing only 29.2% of students. Indigenous peoples, on the other hand, account for only 0.40% of all enrolled students. In view of this, it can be seen that medical courses are still mostly made up of white people, both among students and teaching staff (77.4%)[7].

This structural inequality has been gradually tackled through affirmative action, which is a public and private policy that seeks to promote benefits, resources, opportunities and rights for historically discriminated groups. In higher education, these policies take the form of reserved places (quotas), grade bonuses, supplementary places, retention programmes and anti-racist experiences, among other initiatives [8]. Although these measures represent progress, they are still far from repairing the historical damage caused. And they continue to face persistent stigmas, especially in relation to the supposed inferiority of the education of quota students[9,10].

Nonetheless, the excellent performance of medical students at the Federal University of Fronteira Sul (UFFS), Passo Fundo campus (PF), in the 2023 National Academic Performance Exam (ENADE), achieving the fifth best results nationwide, reinforces the effectiveness of the national quota policy (Law No. 12.711/2012), especially considering that approximately 85% of these students were admitted through this quota system[11,12].

However, even with the increased access to university provided by these policies, measures to guarantee the retention of black and indigenous students remain scarce. Historically, the role of black and indigenous people in medicine has been that of objects of study rather than active subjects in this field. Accordingly, the presence of black and indigenous students in medical schools represents the occupation of a space that was not historically built to welcome them, meaning their path is marked by constant challenges, and their retention on it threatened[13,14].

Given this scenario, it is important to emphasise that discriminatory practices are routinely reproduced in medical institutions, and often silenced. The adoption of quota policies has allowed the entry of black and indigenous students, who sometimes occupy positions of "outsider within", because they produce different perspectives on the existing paradigms at the university, which can benefit the academic space as more inclusive and humane[15].

This study was therefore conducted by means of planned experiences in the UFFS Medicine course, on the PF campus, Rio Grande do Sul (RS) and at the Brazilian Congress of Medical Education (COBEM), in Fortaleza, Ceará, in 2023, with the aim of understanding, from the perspective of collaborative learning, situations of ethnic-racial discrimination and strategies for confronting racism in the medical teaching environment.

The activities sought to provide teaching staff and medical students with moments to reflect on these situations

in the teaching, research and community outreach setting, whether at the university, in practice settings, internships or in health services such as hospitals, Primary Health Units and outpatient clinics, with a view to promoting more equitable and respectful environments.

## METHOD

This is a qualitative study, based on ethnography and thematic analysis[16]. From this perspective, using participant observation with the field diary tool as the main resource, the research is inseparable from the ethnographic encounter between the researcher and the subjects, in a delimited and recognised space[17]. In this context, important ethical-methodological issues emerge, especially when dealing with sensitive topics such as ethnic-racial discrimination in the field of medicine.

As part of this study, an academic experience entitled "The effects of ethnic and racial discrimination in medicine" consisted of three face-to-face instances: two at UFFS, PF campus, and once at COBEM, in 2023. Participation required prior registration via an electronic form made available by the research team or on the congress website. Inclusion criteria included being a medical student or lecturer at the time of the workshops, aged ≥ 18, regardless of race/ethnicity, gender/sexuality and medical schools. This stage was fundamental for establishing consent to participate, organising information and proper planning of the activities.

The experiences were developed with the aim of promoting reflection with students and teachers on situations of ethnic and racial discrimination in medical institutions. To gather information, the focus group method was used as it supports the exploration of perceptions, beliefs and attitudes on the subject. The focus group, as a form of group interview, offers a platform for communication and interaction between the participants, allowing detailed information to be gathered on a specific topic defined by the researcher[18]. This structure promotes interaction, fostering the exchange of experiences, concepts and opinions among the participants, as well as reinforcing the central role of those involved insofar as they jointly dialogue and construct the results of the research[19].

Eight people took part in the first focus group, held at the UFFS PF/RS campus. Seven people took part in the second phase, including teachers, students, scholarship holders and volunteers from the outreach project: "Affirmative action and ethnic-racial issues: dialogues between universities, schools and the community", which was implemented in response to a demand from students on the Medicine course at UFFS, PF campus. At the third event, COBEM, 18 people took part, including doctors, nurses, public managers, students and teachers, totalling 33 participants in the three experiences, 16 of whom declared themselves to be brown or black, as well as two indigenous people from the Mundurucu and Borari ethnic groups.

The groups were moderated by one of the researchers, a scholarship holder from the extension project mentioned above, with previous experience in conducting focus groups and familiarity with the subject. The other researchers acted as external observers, speaking only a few times and trying to capture and record the participants' reactions in field diaries.

The activities lasted one hour. Materials such as index cards, pens and audio were also used. With this in mind, before the conversation began, the excerpt from the song "AmarElo" by the singer Emicida was played, the lyrics of which can be translated as follows: "Thinking that these ills define me is the worst crime of all. It is to give the trophy to our tormentor and make us disappear... lift that head up. Wipe those tears, won't you?"[20]. This song was used as a reference because it not only addresses the pain of racism, but, above all, tells stories of resistance, empowerment and the dreams of marginalised black and indigenous people in Brazil.

With this in mind, the focus group began with an invitation to the participants to write down an experience of racial/ethnic discrimination in the medical teaching environment, with 10 minutes allocated to this stage. Next, these written accounts were shuffled and shared, and another participant was assigned to write down a strategy for confronting or re-signifying this prejudice or (micro)violence that can be implemented in practice, with 10 minutes allocated to this next stage. Subsequently, the written accounts were shuffled again and read by another participant, so that everyone could be aware of the subtle forms of prejudice and violence suffered, raising their awareness and empowering them to be agents of change for anti-racist medicine, with 25 minutes set aside for debate[21]. After final last stage, the activity was brought to a close with thanks for participation in the experience.

The researchers involved in the study examined the contents of the participants' contributions, reinterpreting them in the light of the theoretical principles of collaborative learning[22,23,24]. To analyse the data, the accounts written on the index cards were transcribed in full and assessed using thematic analysis, as described by Minayo et al.[25] and Minayo[26]. This approach proposes a systematic analysis that includes: exhaustive reading of the material (pre-analysis); identification of units of meaning and coding of the information (exploration of the material); categorisation of the findings (treatment of the results); and, finally, interpretation guided by the research objectives. Based on this methodological approach, the emerging themes were

organised into analytical categories, making it possible to gain a deeper understanding of the meanings attributed by the participants.

This article complies with Resolution 466 of 12 December 2012 of the National Health Council, which provides for ethics in research involving human beings in Brazil. It represents a cross-section of a larger research project, institutionalised at the UFFS, PF campus, which began in 2022, entitled "Effects of racism on children's and young people's mental health", approved by the UFFS Human Research Ethics Committee, under opinion number 5.736.372[27].

## RESULTS AND DISCUSSION

Following these three experiences and analysis of the written accounts by the thirty-three participants, the following analytical categories were identified: situations of racism experienced and strategies for dealing with racism, which are consistent with the aim of the research.

The aspects discussed below relate to those most frequently mentioned by the research participants, whose statements will be presented together with the corresponding interpretations, connecting them to the theoretical principles of collaborative learning, as well as the reflections raised in the researchers from the thematic analysis.

### Situations of racism experienced

Racial identity among students is pervaded by historical and prejudiced ideologies, the result of the enslavement of black and indigenous peoples, which have moulded perceptions and experiences over time. These legacies manifest themselves in a significant and often painful way through the structural racism that still permeates educational and social institutions[4,3].

The discriminatory and exclusionary vision of whitening, based on the notion of white superiority, combined with the myth of racial democracy, which supports the false idea of harmonious coexistence in a mixed-race society, has historically contributed to the marginalisation and invisibilisation of black and indigenous identities[2,28]. Such conceptions have led to the denial of racial identity on the part of students and members of society, reflecting the internalisation of these stereotypes and the feeling of exclusion faced by many when trying to assert their cultural and ethnic heritage[29].

To this day, vestiges of the slave system still persist, reflected in the low presence of black and indigenous people in universities and the weakening of student permanence policies, which are essential for reducing dropouts and guaranteeing course completion[13]. From this perspective, it was only in 2012 that Brazil officially adopted the affirmative action policy, with the enactment of the Quotas Law (Law No. 12.711/2012), which reserves a percentage of places in Federal Higher Education Institutions (IFES) for low-income students, black, brown, indigenous, people with disabilities and those from public schools[30].

Although this law represents a significant step forward for the black and indigenous population in terms of access to higher education, a series of actions and incentives are still needed to achieve true racial equity in Brazil, considering the late implementation of compensatory policies[31].

In medical courses , studies show a marked contrast between student profiles. On the one hand, a privileged group, made up mostly of white, heterosexual, cisgender men with favourable socio-economic conditions. On the other, a systematically marginalised group of women belonging to racial/ethnic minorities, of low socio-economic class and/or belonging to the lesbian, gay, bisexual, transvestite, transgender, queer, intersex, asexual and other gender identities and sexual orientations (LGBTQIA+) community. This disparity reflects a historical intersectional power structure based on race, gender and social class, which still regulates access to medical spaces[32].

Furthermore, this discriminatory view, mentioned above, contributes to many black, brown and indigenous people facing difficulties in understanding and affirming their racial belonging and/or identity, especially in contexts such as the ethnic-racial hetero-identification committees adopted by universities[33]. In these cases, it is common to be unsure or confused when it comes to fitting in with the IBGE's official classification, which defines black and brown self-declared individuals as black[34].

A telling example of this complexity can be seen in a report on the enrolment process for the Unified Selection System (SISU):

> *I remember when, during the ENEM application process for Medicine, there was a field where you had to select your colour. At this point I was challenged by a colleague who told me that I didn't have the characteristics for my selected option. Afro-descendant.*

This questioning of self-declaration does not only happen on admission, but throughout the course, as if the student had to constantly affirm their racial belonging. Furthermore, in the context of medical practice, manifestations of racism occur both explicitly and subtly, often expressed through microaggressions, microinsults and/or microinvalidations[35].

These behaviours generate an environment marked by racial hostility, reinforce negative stereotypes and compromise the quality of the doctor-patient relationship[36], as well as affecting the psychological safety of health professionals and students in training[37]. An obvious example of racial

microaggression in medical institutions can be illustrated by the following story:

> *In an internship situation I heard racist remarks and phrases from both patients and doctors, even when it was gossip about someone who wasn't there. But last week, a very chatty patient caught my attention by talking about a black doctor, saying that despite being black, he was good.*

This type of comment carries an assumption of inferiority associated with skin colour, implying that a black person's competence would be an exception or a surprise. This constitutes a form of "benevolent racism"[38], which dehumanises the individual and reinforces structures of racial hierarchy. University environments, although they purport to be spaces for the production of knowledge, diversity and inclusion[39], still present numerous barriers to the full co-existence of black and indigenous people.

These spaces, marked by a historically Eurocentric logic, often disregard non-white knowledge, cultures and identities, hindering the belonging and well-being of students who break with this hegemony[13], such as what happened at a public university canteen:

> *I went for lunch at the university canteen and suffered an act of racism from a white employee. When I asked for eggs, because I didn't eat pork, she came looking for me and said that the eggs were for the "little black guy". When I confronted her, she justified herself by saying that she's not racist because her husband is black. However, I am indigenous to the Mundurucu ethnic group.*

This episode illustrates not only the naturalisation of racist expressions in the daily life of medical institutions, but also the recurrent attempt to deny racism through relational justifications, such as the allegation of emotional ties with racialised people. This form of denial is described by Bonilla-Silva (2006)[40] as part of "colour-blind racism" or disguised racism, which is manifested by a refusal to acknowledge discriminatory practices, even when they are evidently present[41].

Furthermore, the confusion between ethnic-racial identities reveals the persistence of stereotypes and the invisibilisation of indigenous peoples, who are often confused or homogenised under other racial categories, which reinforces the historical marginalisation and fossilisation of indigenous culture[42,43].

Systemic racism seriously damages the health and well-being of individuals, affecting even black[44] and indigenous[45]students, by making it difficult for them to seek and access appropriate and effective therapeutic care for their mental and physical conditions, whether through subtle or explicit discrimination[46], as exemplified by this student's account:

> *I was followed by a white security guard when I accompanied a black SUS user in the supermarket on a therapeutic counselling activity. She was treating her social phobia, but the racist action stopped her from leaving the house again the following week.*

This episode highlights how racism makes treatment and recovery difficult, causing psychological impacts and chronic stress, characterised as "Race-Based Traumatic Stress"[47], with depression being one of the most significant effects[48], which aggravates physical illnesses. These consequences are not just the result of individual attitudes, but reflect deep-rooted structural and systemic flaws.

In the context of the Unified Health System (SUS), medical racism manifests in various ways, such as diagnostic and therapeutic negligence, devaluing the complaints of black and indigenous patients, and the lack of specific content on the health of these populations in health training curricula. Added to this is the low representation of black and indigenous doctors, which contributes to the perpetuation of a Euro-centred biomedical model, distant from the ethnic-racial realities of Brazil and alien to the traditional knowledge and practices of these peoples, negatively impacting the quality of care offered[49,50].

In this research, the main reports of racism experienced were "subtle", characterised by the naturalisation of discrimination, by the logic of denial, and once racism is not explicit, it is difficult to confront. In addition, there is a lack of understanding of ethnic-racial hetero-identification, something that occurs with most of our population, as in the writing of the first situation described; then the confrontation of occupying and circulating in places and professions in the same way as a white person in the following cases, and finally, the need to deconstruct the stereotyped image of the indigenous person as someone who lives exclusively in villages.

## Strategies for tackling racism

Maintaining quota policies and retention programmes aimed at black and indigenous students has been essential to increasing access to public universities and promoting equity. By forging new forms of presence and identity at university, black and indigenous students have been occupying, reaffirming and self-demarcating this space as a territory in a constant process of being reclaimed. In the classroom, this movement materialises in the affirmation of their identities and the construction of dialogues with the knowledge, experiences and trajectories that come from their communities. The public university thus becomes a territory in dispute, demarcation and re-signification[51].

Despite the progress made, racism is still manifest in explicit and veiled ways in various spaces. Faced with this reality,

it is essential that we reflect on how to react to these situations and what our role is in the fight against racial discrimination. It is important to recognise that silencing and suffering in the face of discrimination can be linked to the weakness of student assistance, expressed in institutional support channels such as the ombudsman and psycho-pedagogical assistance. These provisions often address student demands in a fragmented way, ignoring central elements such as racism, which cuts across academic difficulties[52].

> *Nowadays, speaking out in these situations is not an easy task, as we fear repression or even violence. But we cannot accept these racist comments being perpetuated and we must try to call them out and express our opinion, engaging in dialogue and reinforcing our anti-racist stance.*

Practical training in health has weaknesses, with little approach to ethnic-racial issues, a lack of proposals for internships, and a lack of greater availability to encourage this debate. This devalues experience in understanding racialised health and compromises clinical practice in the face of structural racism. It is therefore urgent to restructure the curriculum, train the teaching staff and equip the institutional structure to break with the Eurocentric bias and promote genuine epistemic diversity[53,54,55].

Furthermore, the lack of an in-depth discussion on racism, whiteness and privilege in teaching-learning processes and health care results in deficiencies in the training of students, hides the inadequate preparation of educators and creates gaps in the care offered. A racialised approach to the processes of health and illness is essential to promote more complete training and a more equitable care practice[56].

Beyond individual attitudes, tackling racism also requires responsibility from institutions. Therefore:

> *Institutions need to select their employees in a way that protects people's integrity. There needs to be racial education and severe punishment for situations that the law doesn't cover (dismissal).*

In a society marked by stereotypes and prejudices, it is essential to promote educational activities that broaden understanding of racial and ethnic identity. Often, the perception of being black or indigenous is limited to physical characteristics, ignoring the wealth of experiences, cultures and histories that make up these identities[57]. Hence, it is essential:

> *To raise awareness among the population about what it means to be black and indigenous and how this is not limited to a certain facial feature, a curved hairline or a "very" dark skin tone, but rather to socio-cultural issues, self-perception and life experiences, as well as physiognomy. For example: round tables and talks in schools like the ones we've mentioned today.*

In terms of strategies for tackling racism, it is important to emphasise both collective and individual approaches. Some people choose to remain silent for fear of reprisals or violence, while others deny the problem or shirk their responsibility to act to combat racism. However, speaking out in these situations, although challenging, needs to be built strategically and collectively. We must confront racist comments, seeking dialogue and reinforcing our anti-racist stance, without allowing this type of discrimination to be perpetuated[58]. Finally, during the three research experiences, it was possible to promote exchanges and develop strategies to combat ethnic and racial discrimination, fulfilling the objectives of the Pedagogical Project of the Undergraduate Medicine Course[59].

This research highlighted the importance of comprehensive and humanised medical training, which encourages self-care and integrated care with other health actions and instances. Care was understood as a circular and complex process, emphasising the importance of strengthening the Transversal Themes – such as Inclusion, Education for Ethnic-Racial Relations, Afro-Brazilian and Indigenous History and Human Rights – throughout the students' training itinerary, from a transdisciplinary perspective.

In this regard, the results obtained can be useful for health managers, public policy makers, higher education institutions and researchers interested in the interface between health, education and racial inequalities, as well as subsidising health teachers and students in the construction of more inclusive and critical pedagogical practices. As for the areas of application, we would highlight medical schools, health services, equity councils and commissions at universities, as well as government bodies aimed at formulating policies to promote racial equality and equal access to health and education.

The limitations of this study include the participation of students and teachers selected for convenience and availability for the experiences, which compromises the possibility of generalising the results to large populations. In addition, the subjectivity of the process of interpreting the data by the researchers is recognised, as well as the risk of distortions in the results resulting from social factors that permeate the phenomenon being investigated. It is therefore necessary to carry out future studies with probabilistic analyses using scales of discrimination to verify the interrelations between racism and forms of access to health and education policies in this population of medical schools.

## CONCLUSIONS

The research reveals the persistence of structural racism within educational and health institutions, having a profound impact on the academic and emotional trajectory of the

black and indigenous students who took part in this study. Discrimination, which is often concealed and naturalised, manifests itself in everyday university and professional life, perpetuating stereotypes, erasing identities and compromising the right to stay and access health care with dignity and equity. However, we also highlight strategies of resistance and confrontation that, combined with affirmative policies, critical pedagogical practices and the strengthening of racial awareness, can transform the university into a more welcoming and inclusive space, with investment in permanent study, research and extension groups on the subject in medical schools, as a way of recognising and retracing history from a fairer perspective. In this scenario, it is imperative to restructure curricula, teaching staff and educational practices in the area of health to effectively integrate ethnic-racial debates, promoting a truly inclusive education that prepares professionals committed to equity and social justice.

## CONTRIBUTION OF THE AUTHORS

Jackson Menezes de Araújo was a scholarship holder in 2023 for the outreach project and a volunteer for the research described in this article. He also acted as a mediator in the research experiences and contributed to the writing of the manuscript. Renata dos Santos Rabello Bernardo, supervisor of the outreach project and coordinator of this research, contributed to the conception, design, critical review of the study and writing of the manuscript. Priscila Pavan Detoni, coordinator of the outreach programme, contributed to the conception, design, critical review of the study and writing of the manuscript.

## CONFLICT OF INTEREST

We declare no conflict of interest.

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## STATEMENT OF DATA AVAILABILITY

Research data is available in the body of the document.

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