Intersectionality of gender, race, social vulnerability and barriers to healthcare access: a study on the lives of people with HIV/AIDS

Interseccionalidade de gênero, raça, vulnerabilidade social e barreiras de acesso em saúde: um estudo sobre a vida de pessoas com HIV/AIDS

Interseccionalidad de género, raza, vulnerabilidad social y barreras al acceso a la atención médica: un estudio sobre la vida de las personas con VIH/SIDA

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Abstract
The article aimed to analyze the barriers and access to health and the processes of intersectionality of gender, race and social vulnerability in the lives of people with HIV/AIDS. This is an exploratory qualitative study that used semi-structured interviews as a way of producing data for analysis. The study was carried out in a municipal specialized care service in a capital in the Northeast of Brazil, which is responsible for the care of people living with HIV/AIDS, people with other Sexually Transmitted Infections and Viral Hepatitis, the study sample was composed of users monitored by the service, through saturation of responses, totaling 12 participants. In the analysis, two thematic categories were constructed. In general, the paths taken by these users, mainly related to the ways of producing care in the city studied, are understood as cycles surrounded by barriers and tortuous paths that occur daily, which produce deleterious effects for comprehensive care, and have as an element structuring that interferes with care, the intersectionality of gender, race and social vulnerability. Therefore, it is necessary to discuss the possibility of building transformations in acting and thinking that are socially structured so that new forms of care production relations are structured in which there is no exploitation or subordination of living beings, considering singularities, and therefore, health needs.

Keywords: HIV. Intersectionality. Patient-Centered Care.

Resumo
O artigo teve como objetivo analisar as barreiras e o acesso à saúde e os processos de interseccionalidade de gênero, raça e vulnerabilidade social na vida das pessoas com HIV/Aids. Trata-se de um estudo qualitativo exploratório que utilizou entrevistas semiestruturadas como forma de produzir dados para análise. O estudo foi realizado em um serviço de atendimento especializado municipal em uma capital do Nordeste do Brasil, responsável pelo atendimento de portadores de HIV/Aids, portadores de outras Infecções Sexualmente Transmissíveis e Hepatites Virais, sendo a amostra do estudo composta por usuários monitorados pelo serviço, por meio de saturação de respostas, totalizando 12 participantes. Na análise, foram construídas duas categorias temáticas. Em geral, os caminhos tomados por esses usuários, principalmente relacionados às formas de produção de atendimento na cidade estudada, são entendidos como ciclos cercados por barreiras e caminhos tortuosos que ocorrem diariamente, que produzem efeitos deletérios para o cuidado integral, e têm como elemento estruturante que interfere com o cuidado, a interseccionalidade
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The first signs of Acquired Immunodeficiency Syndrome (AIDS), a clinical illness, occurred in 1981, when the first reports of pneumonia caused by Pneumocystis carinii,
currently known as Pneumocystis jirovecii, appeared. At that time, everything was still considered a mystery for science, therefore, AIDS and its causative virus, human immunodeficiency virus (HIV), belonging to the lentiviridae subfamily of human retroviruses, became the most lethal pandemic of the late 20th century, having a long incubation period until being identified as clinical manifestation of viral suppression (Rachid; Schechter, 2017; Brazil, 2019).

This virus attacks the immune system, which is responsible for protecting the body and combating external aggressions, reaching the lymphocytes, being able to modify the cell's DNA and generate new copies of it, after multiplication, it travels in search of other lymphocytes for dissemination of the infection, which makes the person living with HIV/AIDS susceptible to other infections, thus becoming part of the group of Sexually Transmitted Infections (STI) (Silva et al., 2020).

Most recent data show that in 2021, 38.4 million people in the world were living with HIV, 650 thousand people died from AIDS-related illnesses, 28.7 million people were accessing antiretroviral therapy, in addition to that, since the beginning of the HIV epidemic, 84.2 million people were infected with the virus, and 40.1 million of these people have died since the beginning of the pandemic. It is worth noting that 5.9 million people did not know they were living with HIV in 2021 (UNAIDS, 2021).

Given the impact of this disease, the discussion about becoming ill and the relationships between people living with AIDS, it is essential to include an expanded debate that covers the social, cultural, political and economic situation, in addition to the moral values rooted in society and the projects of life of each living being, always connecting with current laws and the updated legal situation of the country where the person lives, conditions of access to health services and other issues. Seeking to understand the vulnerability of individuals, populations and nations to epidemics touches all aspects of society. If AIDS is currently more likely to spread among women, young people, the poor and black people, that brings up the historical fragility of these groups, which manifests itself in the lack of political power and autonomy to assert themselves and protect themselves (Maia et al., 2019; UNAIDS, 2021).

Although, nowadays, it is an infection that is possible to control, the illness process caused by HIV carries with it a history of social and moral values, including religious issues. The feeling of sadness is the most representative theme within the diagnosis, and as it is a chronic disease, the condition can be interpreted as pain and sadness absorbed in everyday life. The diagnosis is presented as a reality that they live with and must accept and this
acceptance is inserted in the symbolic framework of the social group to which they belong. Understanding the aspects involved in the perception of health and the individual ability to deal with physical and social adversities can help in coping with the diagnosis (Pinto et al., 2020; Braga et al., 2016; Cardoso et al., 2023).

When presenting complex issues in relation to living with HIV, thinking about care networks is something consubstantial that can help in the production of care, whether family or institutional, experimenting with these lines of care can reveal vulnerable and challenging situations. Therefore, it is extremely important to look at the strengths and weaknesses of those networks, in order to provide better practices for coexistence with PLWHA, which can also provide emotional support and care tools to meet their real needs (Tonnera; Meirelles, 2015).

As a result, the paths taken by PLWHA in search of access and care are multiple and unique. Having an HIV/AIDS diagnosis at a certain point in life tends to change paths and tracks and makes crossroads more frequent. The truth is that in the face of personal and social disruptions, people seek strategies to cope with the diagnosis in favor of construction of their own paths (Ferreira; Silva, 2012; Ferreira; Favoreto, 2011; Cardoso et al., 2023).

In view of the above, this research aims to analyze the barriers and access to health and the processes of Intersectionality of gender, race and social vulnerability in the lives of people with HIV/AIDS.

**Methodology**

This is an exploratory qualitative study that used semi-structured interviews and field diaries as a way of generating data for analysis. As a philosophy, we sought to approach dialectics, which presents elements within its organizational structure that facilitate the construction of knowledge and assist in the learning process (Rosa et al., 2022).

The study was carried out in a municipal specialized care service in a capital city in the Northeast of Brazil, which is responsible for providing care to PLWHA, people with other Sexually Transmitted Infections (STDs) and Viral Hepatitis.

The study sample was made up of users monitored by the service and its quantity was defined by the saturation of responses, this being a validation process in research that addresses topics and the researchers' perception is fundamental to recognize when new information does not appear during the data production (Nascimento et al., 2018). Users
registered with the service, who were in adulthood, diagnosed with HIV, regardless of gender identity or sexual orientation, who received inadequate treatment or abandoned treatment, were invited to participate in the study. Human beings attending this health unit and having other illnesses unrelated to HIV/AIDS or associated with side effects of antiretroviral therapy were excluded from the study.

The qualitative research process does not allow for isolated points of view, it develops in a dynamic interaction constantly returning and forming. Therefore, a semi-structured interview was chosen to produce the data.

To begin the process, the Free and Informed Consent Form (TCLE) was published, emphasizing the guarantee of anonymity and the free choice to withdraw from the study at any time. A recorder was used during the interviews to guarantee the reliability of the evidence, but it was only used with the participant's authorization. To assess the effectiveness of the semi-structured interview, a script divided into four dimensions was followed.

The first dimension deals with the participant's general information and sociodemographic characteristics, then deals with the production of diagnosis and treatment; the third dimension seeks to discuss therapeutic paths; and finally, the obstacles, difficulties and confrontations in the illness process.

The interpretation of the data took place based on the conception of dialectics, which seeks in a dialogical way to produce results that confront each other. Among the characteristics of this philosophy, which includes phenomena, there is movement, historicity and transformation, so dialectics works with the conception that thought is a reflection of reality and human action in many circumstances (Leopardi et al., 2001).

The path to this production was followed according to Minayo (2014), which provides conditions for analysis through the construction of an analytical matrix with all the data produced. To carry out the analysis, it was important that it had a procedural design that went through three phases. The first of them was called pre-analysis, characterized by the general organization of the material, which consisted of the transcription of the interviews, followed by a floating and exhaustive reading of all the material so that the researched person could connect with the data produced.

Therefore, the phase of material exploration, coding and classification of data began, in this stage the process of building operations for coding and categorization was carried out, as well as the systematization of decisions taken in the first stage, which initially consisted of searching for meanings and in the materialization of subjective meanings organized by the
researcher in the material produced in the previous phase that needed to be classified into nuclei and, subsequently, in the construction of two empirical categories called Barrier and access to care for People with HIV/AIDS and Intersectionality of gender, race and vulnerability of people with HIV/AIDS. At this stage it is important to go beyond the statements and facts, it is essential to identify and problematize the explicit and implicit ideas in the text that can be addressed through questions we ask of the material we have, as well as the search for broader (sociocultural) meanings to what was said or expressed by the participant (Minayo, 2014).

Finally, the final analysis was characterized as the last stage, with the aim of processing the results obtained, with the strategy of finding inferences based on interpretation, in which the contents manifest in all the material collected were captured and analyzed.

Results and Discussion

3.1 Barriers and Access to Care for People with HIV/AIDS

There are several living conditions that can become barriers to access to healthcare, including issues that involve personal, social and economic demands, which increases the vulnerability of users of these services, which tends to facilitate or hinder access to healthcare facilities. Studies show that barriers to access to health care can have consequences for both the search for care and its continuity, such as the user interrupting treatment, abandoning or delaying the search for health care, worsening the condition of the patient. same, among other losses (Houghton, Bascolo; Del Riego, 2020; Franco; Lima; Giovanella, 2021; Sousa et al., 2014).

These barriers determine the factors corresponding to the guarantee and security of access to health services, and arise from geographic conditions, since the location of the services provided is related to the distance at which users of the system live, which can limit coverage of this access (Spedo; Pinto; Tanaka, 2010; Dubieux; Freese; Felisberto, 2013). Regarding economic aspects, social inequality imposed on modes of existence increases the complexity that involves access and consequently the quality of health services, which amplifies the obstacle to care, and as a consequence, can increase waiting time of users who find themselves vulnerable (Nunes et al., 2014).

It is important to understand that functional and communication barriers can also create
other obstacles to the comprehensive care offered in the health system. These barriers are related to the complexity of the system's inability to meet all the user's health needs (Souza; Souza; Merces, 2021). Therefore, communicational barriers prevent intersubjective constructions that enhance the meeting between users and health workers, therefore, a reception without connection can affect the construction of an early diagnosis, adequate treatment, and, consequently, the prognosis of the disease (Marques et al., 2020).

In view of the above, with regard to the geographic barrier, interviewees report that,

 [...] the location is a bit out of my way because I live in Brotas, Liberdade is kind of far away [...] (E4).

 [...] Yes, and I woke up early to be able to go to the health service (E5).

In the statements, it is evident that the location of the service where users receive care is far from their residence, which makes it difficult for them, and the distance makes it necessary to wake up very early to get to the service. Therefore, the ways in which access to health services are planned may have obstacles or not, due to the establishment of barriers that can cause interruptions in the continuity of care (Souza; Souza; Camelier; Camelier, 2017). Still in relation to the geographical barrier, it consists of the regional distribution of care units for part of the population, this happens because the distance between residence and the service, especially for those who are already physically weak, constitutes a strong barrier to access to care, whether due to the lack of personal transport, the lack of financial conditions for public transport or the lack of transport routes that cover health units (Oliveira; Brito; Oliveira, 2019).

Therefore, this availability of health care services is a factor that mediates the relationship between demand and user entry into the service, in addition to the fact that geographical barriers can be a complicating factor in monitoring the health status of people living with HIV/AIDS (Moraes et al., 2021).

Another underlying dimension that determines access to health services is related to economic barriers, therefore, thinking about health vulnerability requires understanding the social realities of the population to be analyzed. Given this, the interviews reveal that,

There are times when it's the day to pick up the medicine, and then I don't have money and I spend 2 days without getting the medicine or taking it because of transportation (E1).

It's very difficult without work, life for me is very difficult (E2).

The financial difficulty is in the community, the favela, far from my family, without friends and without being able to count on anyone, not even my aunt had access to this
information at that time I handled it all alone (E10).

It is observed that the financial condition makes the user uninterrupted treatment, which previously did not have the expected effect due to the lack of regular nutrition resulting from the economic condition in which they find themselves. It is also believed that the lack of employment and a stable economic condition makes daily life difficult, consequently affecting the moment when a positive diagnosis is discovered.

It is important to highlight that, when it comes to economic barriers, the structural condition built by colonialism and by a society produced through 350 years of slavery of the black population must be considered as a result of the production of inequalities, which reveals not only regional inequalities of territorial nature, but also inequalities that still exist in the ways of existence of these people. This factor can expose people in conditions of social, economic and cultural insertion in an unfavorable way with regard to the constitutive processes of the production of health care (Oliveira et al., 2019; Souza; Souza, 2020; Santos et al., 2021).

It is noted that economic and financial issues are predominant factors in the vulnerability of human beings, and in this case of people living with HIV/AIDS, since these factors increase the fragility of the affected person (Silva et al., 2020). Therefore, it is essential that economic conditions are observed as they can generate decisive impacts on the lives of people living with HIV/AIDS, since safe treatment involves several issues inherent to the implementation of care, such as good quality and adequate food, in addition to financial resources for transportation to the health service and expenses for extra medications that may be necessary.

In this sense, the economic issue can be considered as a vulnerability factor as a challenge to be faced in the process of caring for these living beings, because it covers not only personal resources, but also social resources and the availability of health services, therefore, of important preventive measures (Pereira et al., 2019; Soares et al., 2017).

Considering the functionality of services as a barrier, the design and effective implementation of health measures and services follow a reductionist logic, lacking ethical and political considerations for the lives of users, unable to cover the expected health needs (Souza; Souza; Merces, 2021). The interviewees’ statements revealed dissatisfaction with the attitude in communicating with professionals, who ignored the human complexities of vulnerability, sensitivity, doubt and uncertainty in the face of an HIV/AIDS diagnosis.

[…] well, the doctor who is kind of […], you know, I don't get assistance from him.
Because I go there and talk to him about the treatment and he doesn't even care. That's why when I arrived in 2020 I asked him to look at Kaposi's Sarcoma, which was still small, he […], oh no. Then, when I was admitted, they discovered that it was Kaposi's sarcoma and it had already settled in (E1).

 […] and then another doctor who works here also, treated me very badly and even asked to undergo treatment with another doctor, he said that he would no longer treat me and that I should choose another doctor and see another doctor, make an appointment with another one because he would no longer treat me. I was very sad, very bad, whether I wanted to or not that affects our mood, I kept thinking: “Wow, if I hadn't had this disease, in these conditions, I wouldn't have to go through this, I wouldn't have needed an infectious disease. to bring treatment” and I was very sad for 2, 3 days, but then it passed I didn’t keep. That in mind (E4).

The interviewees reported the rigidity and imposition of the medical professional, addressing the abandonment of their treatment, this situation leads to feelings of sadness and guilt for being HIV positive in relation to this situation, the lack of assistance and medical negligence was also what caused the non-adherence to early treatment of an opportunistic disease.

Therefore, guaranteeing access to comprehensive care and creating bonds between subjects and health professionals are influenced by several factors. Regarding communicational barriers, they prevent communication during the meeting and, therefore, a broad and comprehensive reception can negatively impact the patient's diagnosis, treatment and prognosis, since, in the health environment, verbal communication and not verbal is one of the main tools for effective care (Marques et al., 2020; Witski et al., 2019).

In relation to reception in the health care process for PLWHA, it should be noted that bonding and communication are the main starting points for a process of seeking and continuing this care. As a result of these issues, users point out that,

 […] We chat, you see it's such a nice place that we feel good, with a good treatment (E2).

 […] All this because accepting the treatment came from me, of course. But also from my family and the people I depend on to make this treatment happen in the best way possible, who are the people who work in this service (E3).

 […] and this part is very important because when I come to SEMAE, what I remember most is being welcomed, I was very well received, I was very well respected, even though my ego was talking nonsense, you all here respected me, the issue of resistance and such... so until
today this has not died, because it is a kind of universal love, this loving bond is love. Love is here! (E6).

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This bond is expressed in terms of humanization, responsibility and comprehensiveness of care, in which the relationship between user/patient involved is capable of creating a mutual approach. With this, the bond avoids taking the place of absolute knowledge about what is best for others, recognizing the need to take proactive measures to share health care between service and user in a symmetrical and singular way (Ferreira et al., 2019; Seixas et al., 2019).

Cota and Cruz (2021), in an interview with users of the health system, point out that the main barriers that interfere in the care of PLWHA are related to the lack of qualified professionals to apply the test, difficulty in accessing it, and the time required to perform the test. , fear of prejudice, fear of exposure, fear of the result, lack of information, stigma and shame. These barriers can be divided into organizational barriers and subjective or functional barriers, which means that the barriers overlap, resulting in vulnerability.

As with other health issues, the HIV/AIDS epidemic considers its identification, control and adaptation to incidence and spread linked to the identification of affected populations and their role in social structures, politics and the economy (Silva et al., 2020).

The bond and connection between service and user is of paramount importance in the path of diagnosis and adherence to treatment, offering equal access in order to humanize care, eliminating access barriers that interfere in this care process, achieving user satisfaction and encompassing their unique care process.

3.2 Intersectionality of gender, race and social vulnerability of people with HIV/AIDS

Intersectionality can be understood as a tool that can explain many coexisting forms of oppression, which makes intersectionality the most important sociological trend in analyzing social relations in complex societies. It is important to highlight that the origin of this terminology is directly linked to social conflicts and the theoretical development of black
women (Kyrillos, 2020; Hirata, 2014). Therefore, when talking about Intersectionality, it is important to highlight Kimberlé Crenshaw, who named this concept around the 1980s, and subsequently provided some of the most relevant theoretical postulates about this concept. Therefore, his proposal implements a vision of synthesis and convergence of multiple social markers of differences, especially gender and race, whose expression leads to the accumulation and dissemination of discrimination, exclusion and social inequality (Crenshaw, 1989).

Considering the issue of inequality and consequently social vulnerability, both are relevant factors in the characterization of HIV/AIDS cases (Amorim; Marques; Freitas, 2023). In view of this, interviewees point out that,

I was raised in the shelter until I was 18, then when I was 18 I had to leave but I asked to stay a little longer because I didn't have a job or a home yet. (E1).

 [...] What bothers me the most is this work thing, because I'm not working, then things are missing and they get even worse, that's why I combine one thing with another, I'm like: “hey, I already have these problems, It makes you want to give up everything”, I’ve even thought about throwing myself off the catwalk, because it’s painful, you look to the side and there’s nothing. (E2).

I just think about it more when I don't have things, because if you have children, it hurts! You've never been through this because you don't have children, but hunger is sad, seeing your children begging and not having what to eat (E2).

Taking into account the complexity of the statements, which in addition to living with positive serology, it is clear how arduous living in society in general is, and therefore, how this reality increases suffering, and when associated with processes that make humans vulnerable, they reconfigure perspectives on life, given the social inequalities that exist in everyday life.

In a unique way, depending on the process of vulnerability experienced, the discovery of HIV/AIDS infection can reflect on different behaviors and actions, however, it is always necessary to associate the sexuality of the infected person, especially through cultural factors that produce stigma and discrimination, as well as, conversely, having access to social and economic resources reshape the subjective dimension of living in society, somewhat distant from vulnerability (Costa; Almeida, 2021).

Congruent with issues of vulnerability, HIV/AIDS has become an example of how Institutions (families, churches, governments, schools and social movements) challenge their
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legitimacy, as well as in other social dynamics, reproduce hegemonic struggles linked to the opacity of reality. Within this context, the HIV/AIDS epidemic and gender and sexual violence are widespread social problems, with increasing rates of infection among the poorest populations, men who have sex with men (MSM) and women, especially those with low education, most often in informal and precarious work conditions, such as sex work. However, this vulnerability should not be related to risk groups, a stigmatized view popularized since the first cases of the infection (Cecccon; Meneghel, 2017; Rocha; Vieira; Lyra, 2013; Shannon et al., 2018; Silva et al., 2020).

In relation to barriers related to the strong presence of patriarchy built through social norms based on inequality, mainly gender, interviewees reveal that,

[...] I suffered prejudice, but, in the last 5 years, at most I no longer suffer, thank God! It's very bad to suffer prejudice, especially in relation to your family, the people in your home and family. (E4).

[...] At that time, the appearance of a gay person was a bomb that mobilized the whole city, you know, so I was a victim of prejudice at home, even from my own mother and father (E6).

[...] I'll never forget my father himself: He told me: “I'd rather see you crushed under my tractor than for you to grow up a queer”. Then I kept that forever. So much so that I haven't spoken to him since that sentence he said to me, understand? That was about 20 years ago. (E6).

[...] I didn't accept that about myself, because I didn't believe I was gay and everyone said: “you're gay”. I had a woman to disguise to society that I was a man, but I broke a nail, that's great (laughs). This is my way of coming out, but in the beginning, it was painful for me, it wasn't easy, today I speak openly and even joke about my situation (E9).

Speeches about family prejudice, feelings of guilt and the impossibility of personal experiences converge with ideas constructed by patriarchal traits disguised as misogyny and heteronormativity. These values remain rooted in patriarchal assumptions, particularly in the belief that others must submit to a situation that not only is it indisputable, but it also harbors veiled subordination and disrespect. From this perspective, it is clear that the family was and continues to be an institution that maintains patriarchal culture and a network of power that creates subjects and controls them. (Rissato et al., 2024; Barros; Coelho, 2021; Cecccon; Meneghel, 2017).

Going through this reality, one can see the framework of social inequality and its
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problems related to PLWHA. In this way, it is observed that Intersectionality supports the idea that the categories of race, class, gender and oppression interact and shape each other. In this sense, racism also translates as a producer of physical and symbolic barriers, being an institutionalized system that limits the conditions of human life based on issues of race, color and ethnicity (Goes, 2023). A concrete example of the translation of this racism is based on the temporal moment in which Africans were enslaved as commodities whose expiration date was based on perverse practices that created a state of submission where it was not possible to recognize one's own life, therefore, these elements were fundamental to the development of capitalism and its ability to dominate others (Souza et al., 2021).

Regarding racism and its layers formed by structures of oppression and vulnerabilities, interviewees highlight that,

[...] As you see, I'm dark. I was raised by my mother's family, understand?! who are blonde people, I was created the only dark one in this case. A blonde family and I suffered prejudice. We might see it as a light joke, but there are jokes that actually have an evil undertone, right?! [...] they called me burnt, dark, things like that, you know?! But like this… they joked as if it were a joke, but perhaps in reality there was a bit of prejudice. [...] he thought that black people were cursed because of old old stories he heard [...] he hated my father, he really did. He called it the burnt Jurema stump, rope smoke [...] (E6).

As a black body, LGBT, dissident of class, race, gender, the challenges are gigantic. Because people of class, of race, generally have a strong class position, the poverty of these bodies, black bodies, and the lack of education, which is what is even more aggravated in terms of access to information and therapies that both prevent and provide care and maintenance of the body already living with HIV (E10).

In view of the above, it is noted that the class dissident black body is restricted from access to knowledge, in addition to issues of race that have a strong presence at the limit of this access, consequently, being able to interfere in the search for care and maintenance of the body living with HIV. This related inequality is deeply rooted in the institutional racism that shapes society, crystallized through policies implemented at all levels of the country, therefore, this racial inequality exacerbates and exposes social inequality (Campos, 2018).

It is confirmed that the specific health vulnerability of the homo/bisexual, male and black population to HIV/AIDS. Therefore, PLHA experiences the intersection of oppression, due to social markers of sexual orientation, race/color, and commonly the social class they occupy. The factors presented become barriers to the exercise of the right to health and a
dignified life, since these markers of oppression intersect with other variables, which make them more susceptible to health problems, putting at risk the access and quality of care in the health system (Bezerra, 2022; Damião et al., 2022).

Therefore, the consequence of imposing these different barriers is the inability to provide comprehensive care. As a strategy, collaborative transversal education and expanding the knowledge of the healthcare team can facilitate access and reduce unnecessary referrals and repressed demands. Furthermore, the establishment of effective networks is encouraged through coordination between professionals at different levels of health care and the improvement of matrix support through specialist consultants. (Avelar, Malfitano et al., 2018).

**Final Considerations**

In general, the paths taken by PLWHA, mainly related to the ways of producing care in the city studied, are understood as cycles surrounded by barriers and tortuous paths that occur daily. Social structures create stigmas and prejudices that permeate services, resulting in violence and exclusion of these people, and consequently, given the intersection of gender, race, and social vulnerability, there is an overlap of conditions that negatively interfere in the production of care regarding the gaze of completeness.

Taken together, it is understood that it is necessary to return to a context of social organization, which makes the deconstruction of social markers of oppression related to class, race and gender that shape the social systems that permeate within other complex systems necessary and urgent. These ways of being in culture, subjectivity, institutions and other spaces of life are directly linked to the unequal distribution of power. Therefore, the expected transformation means a new social order that requires new forms of care production relations in which there is no exploitation or subordination of individuals, regardless of their uniqueness.

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