Vulnerabilities mediating the Healthcare encounter: by an intersectional agency

Ana Cláudia Barbosa (https://orcid.org/0000-0003-0046-7455) [1]
Simone Santos Oliveira (http://orcid.org/0000-0002-1477-749X) [2]
Roberta Gondim de Oliveira (https://orcid.org/0000-0001-8408-6427) [3]

Abstract *This essay elucidates the Healthcare and Intersectionality notions to prompt reflections on the interaction between healthcare professionals and individuals referred to as Nanás: elderly, poor, and Black women who represent a historically marginalized profile throughout Brazilian history. By delving into the arguments about the concept of Intersectionality and the multifaceted Care dimensions, it becomes apparent that there is a pressing need to broaden the perspective on women who access healthcare services, as they are inherently shaped by their life experiences. Moreover, it is imperative to acknowledge how the intersecting factors inherent in their profiles can influence the approach taken by those providing Care, which underscores the essentiality of an intersectional agency on the part of the agents involved in this encounter, namely the Nanás and healthcare workers, to effectively uphold the principles of comprehensiveness and equity within the Unified Health System (SUS).*

Key words *Health vulnerability, Healthcare, Intersectionality, Social determinants of health*

[1] Instituto Federal de Educação, Ciência e Tecnologia do Rio de Janeiro (IFRJ). R. Buenos Aires 256, Centro. 20070-021 Rio de Janeiro RJ Brasil. ana.barbosa@ifrj.edu.br
[2] Centro de Estudos da Saúde do Trabalhador e Ecologia Humana, Fundação Oswaldo Cruz (Fiocruz). Rio de Janeiro RJ Brasil.
[3] Escola Nacional de Saúde Pública Sergio Arouca, Fiocruz. Rio de Janeiro RJ Brasil.

Introduction

Racism and race are structural aspects of social relationships in Brazil, representing class hierarchies and gender relationships. This fact is anchored in our history as a colonized and slave-owning society built under the sign of the enslavement of African and Indigenous people, with their consequent subordination in our setting, which helps us to understand the disparities pointed out in health indicators, enhanced by the COVID-19 pandemic[1].

The pandemic context was characterized as a complex, diverse, and non-monolithic experience, sickening and fatal for these populations due to their historical life and health conditions, highlighting our social vulnerabilities, how social markers of difference (such as gender, race, generation, and class intersections) intervene conjecturally or contextually for better or worse health outcomes and the need to reflect on the care offered when the goal is equity in Health.

This theoretical essay analyzes an argument involving intersectionality and healthcare. When the social markers of difference intersect, and we have a Black/elderly/poor/woman in search of care, we need to reflect on how these people have met with health workers, as they are agents who awaken, through their intersections, specific triggers in care providers. Following the Unified Health System (SUS) precepts, care must consider the principles of equity, comprehensiveness, and humanization. However, depending on who is being cared for, will these tools be used more or less? How do health workers (the other agent in the care relationship) weave the care work micro-politics regarding intersectional characteristics? How is the profile of being a Black/elderly/poor/woman activates and is activated by care experiences? From now on, this woman will be called Naná to personalize this agent and avoid exhaustive repetition of terms about her race/age/class/gender, which derives from the nickname of the maternal grandmother and most significant ancestor of one of the authors.

We bring up the Social Determination of Health (SDH) as part of this discussion, where the debate arises, and definitions are disputed fields, which is why it is necessary to consider the limits of the terms. Minayo[2] (p.1-2) states that if "everything historically constructed can be deconstructed by human action", then SDH would be something transient, as opposed to a "reification of social structures". Therefore, she believes it is contradictory to call "determined" something

"changeable". The author states that accepting Social Determination (SD) implies "disdaining [the] creativity, [the] autonomy, and [the] power of each person or society to react"[2] (p.9).

However, people who are vulnerable due to different oppressive structures would have less autonomy, agency, and reaction. Breilh[3] (p.1) argues that the SDH has a "counter-hegemonic toolbox" that could serve as an interpretative model for observing a complex and uncertain reality where people and groups move around with relative autonomy.

In their critical commentary on research addressing the issue of SDH, Nedel and Bastos[4] point out that the idea that health, illness, and death conditions are determined by the social life reproduction conditions has been disseminated since the Hippocratic texts. However, the understanding that health has a SD and the advance of biomedical knowledge have been insufficient to rid societies of morally unjustifiable inequalities or to guarantee the idea of change and social justice as an imperative for improving living conditions. The non-linear logic that there is an overdetermination, that is, elements that are both cause and consequence "of the social reproduction of health-illness processes", which Almeida-Filho[5] (p.2) tells us about, can dialogue with the paradigm of intersectionality, a theme that we bring to the centrality of care.

Healthcare has interfaces with structural and institutional racism because we still live under the myth of racial democracy, which, through socio-racial grammar, enforced the idea that we live in cordiality between the races. "Human bodies are not homogeneous everywhere; they are variants of countless dynamics, especially historical, social, environmental, and political ones"[6] (p.30).

Considering this heterogeneity, we have taken a definition of agency from the philosopher Molefi Asante[7] (p.94), who defines it as "the capacity to dispose of the psychological and cultural resources necessary for the advancement of human freedom"; an agent "is a human being capable of acting independently according to their interests". The author then goes on to discuss the obliteration of those of African descent in a system of white supremacy: they experience a *disenchantment* when they are discarded as protagonists, even with the end of their bodies' enslavement, which is particularly true of Black people in the diaspora, such as in Brazil, whose ideal norm is whiteness, thus banning issues such as racism/race from the Brazilian social structure.

In an analysis of Bourdieu's work, Thiry-Cherques[8] emphasizes that establishing structures, representations, and practices is continuous, thus denying their determinism, as is individual conduct. Social agents construct social reality, but social events are not the product of individual actions. There is a "historicized structure that imposes itself on thoughts and actions"[8] (p.30), and we, the agents, are the "product of profound structures"[8] (p.34), each with their vision of the world and with agency to build, preserve, or transform it.

Narratives about sexism, classism, ageism, racism, and anti-Blackness point to inequalities in the possibility of self-care/healthcare. Breilh[9] says Latin America has three elements to be considered for a critical theory of health, and the assumption is that it will not be possible to develop progressive content unless all three are simultaneously transformed: addressing health as a complex object, a methodological concept, and a field of action. Therefore, it is not enough to establish the multicausal principle, transform probabilistic risks in isolation, or act on the "determining" factors of illness. We should focus on the structural processes determining illness and its historical and social contexts and identify its connections and associations without fragmenting the social structure into/between factors[9].

We need research and a critical praxis that transcends denunciation to promote health and social justice. A critical practice presupposes a rejection and an attempt to correct or reorient actions that generate social injustice. It is "how ideas are used in specific historical and social contexts"[10] (p.87).

Intersectionality seeks to investigate how power relationships influence social relationships since society is marked by diversity, and diversity, in turn, by the individual experiences of everyday life. Intersectionality, as an analytical tool, will consider several constructs that shape each other and interrelate but do not manifest themselves in relationships as distinct and excluding entities. It is a tool for understanding and explaining "the complex nature of the world, people, and human experiences"[10] (p.16).

According to Henning[11], although in vogue in academic productions, there is no cohesion or consensus on the term, which can be seen "as a theory, method, approach, paradigm, concept, heuristic concern, 'social analysis lens', the basis for analytical work, and analytical metaphor" (p.102). Given these possibilities, he uses the term "intersectional agency" to consider the spaces of action that occur under this sign, in theory and practice, in response to structural settings of inequality, mainly fostered by structural racism.

Thus, intersectionality will be used in this work as a lens on the gender/race/class triad added to age, elucidating "what emerges regarding the production of meanings about diseases and people whose bodies are historically traversed by layers of oppression"[6] since it is a concept applicable to localized and contingent analyses, contextualized historically and culturally[11].

Intersectionality(ies)

Collins and Bilge[10] consider that we should look at the possibilities intersectionality can provide for our understanding of reality instead of asking ourselves what it is, stressing the importance of the concept in actions that seek social justice. Considering neoliberal politics and the widespread far-right populism, we can talk about escalating social injustice, aggravated in the post-pandemic period.

In using intersectionality as an analytical tool, the authors[10] draw attention to how social movements have privileged one category of analysis and action while discarding others. They cite the Brazilian Black Movement, which discarded the gender issue, and the Brazilian Feminist Movement, which discarded the racial issue. As a practical example of intersectionality, they bring up the Brazilian Black Women's Movement (MMNB), where Lélia González and Sueli Carneiro pioneered the contemporary understanding of intersectionality in a country that refused to recognize racial categories. Under the myth of racial democracy and by eliminating any language that referred to Blackness and the racial inequalities that afflicted the population of African descent, as there were no Blacks, there was also no official record of disparities in education, employment, health, or any other space. Thus, the advancement of the discussion of Brazilian Black feminism is related to a specific social context since ethnicity/skin color have always been a determining factor in the placement in the world of work, health care, and the acquisition of other social goods[10].

The challenge of Being

We will highlight some of the challenges in the construction of being a *Naná*, which is built under the sign of multiple oppressions. In *The Second Sex*, Beauvoir[12] asks herself how being a

woman has affected our lives (p.25). What possibilities have we been offered, and which have we been denied? Extending this thought to old age, poverty, and Blackness/racism, an intersectional aspect translates into fewer concrete opportunities given to these agents. What place does society reserve for elderly Black women in a white patriarchal system, where they face stereotypes created by the ruling class? This author tells us that women were born on the "wrong side"; which side were Black women born on?

The *Dossiê Criola* [13] shows that, in Brazil, maternal mortality is 65.9% (Black women) to 30.1% (white women). Data on obstetric violence shows that between Black and white women, the former are less likely to receive analgesia (pharmacological or otherwise) to control pain and are more likely to undergo the now obsolete Kristeller Maneuver (pressure on the upper part of the uterus). Cases of rape occur at a ratio of 57.3% (Black women) to 34.9% (white women), and deaths from abortion, 45.2% (Black women) to 17.8% (white women).

Racism and its derivatives, such as the construction of the idea of race, have led to the construction of an Other[14]. Being the Other implies being the Other of those who hold the power to pronounce this Other: the "Absolute Subject"[12]. The Other is the one on whom racial overexploitation is imposed, the peoples of the slams, such as those who were subjugated in the Americas, the non-human, hierarchized, and socially classified as a kind of sub-people[14] (p.233). Grada Kilomba says Black women have "a double Otherness because we are the antithesis of both whiteness and masculinity"[15] (p.164).

Some capitalist democracies make these "Others" invisible, ignoring the pain and suffering imposed by white supremacy, yearning for a past where stories other than those of coloniality were not yet told, subjugating an entire community in the name of white male patriarchal cisheteronormativity. This profile of who is the model human being arose in the colonial process, the marks of which are still visible since white supremacy is an affirmative action of many centuries – see the Brazilian legal framework that excluded Black and Indigenous people from citizenship.

It is necessary to consider the subordinate role of women in our society, which their Blackness enhances; the racial division of labor that gives the black population a predominantly lower income and occupation than non-Black people; and the augmented oppressions when aging and the consequent ageism come.

Carla Akotirene[16] gives an example of the difficulties faced by Black, poor women who grow old after a life dedicated to manual labor. The market rejects them because of their old age, and class labels them as employees, not employers: "For Black women, there is no time to stop working [...] Old age is how race is lived"[16] (p.27). We can ask: what is the value of a body seen as beneficial for heavy, manual labor when this possibility becomes non-existent? Is there another type of "femicide", racialized, engendered in old age, characterized by abandonment, neglect, and experienced more intensely in the presence of other oppressions?

Although aging is an inexorable biological fact, its existence is a cultural event that is difficult to ignore, given the number of older adults in much of the world; however, the marginalization and loneliness experienced by some of them depends on the situation and illness is related to SD, how older adults eat, take care of themselves, have sufficient retirement pensions in the face of chronic illnesses that prevent them from working: "...this degradation is not naturally linked to senescence"[17] (p.339). In this context, poor health, indigence, and loneliness acquire the character of a triple chain of factors that lead older adults into isolation and asylums[17] because of their diminished capacity.

Linking the concept of the Other to that of production in capitalist societies, we recall that, in this respect, older adults appear as the Other of young people, to whom greater importance is given since they are the ones who will "lead" the world, consuming and producing goods and wealth. In the most impoverished families, with precarious work for adults, seniors sometimes have their earnings (pensions) as part (or all) of the household income, leading to an intergenerational exchange of benefits: income x care.

Thus, with the reflections by Beauvoir[12,17], we can think about intersectionality based on some assumptions that involve gender and age and class and race. Poverty, Blackness, being a woman and old represent places in the world; places where one does NOT belong to the classes with practically guaranteed access to goods, essential services and fundamental rights, such as health, decent work, and housing; one does NOT belong to the world of whites, who have always been guaranteed privileges; one does NOT belong to the patriarchal-masculine-dominant world; one is NOT young, enjoying the benefits of different kinds guaranteed to them. As Souza *et al.*[18] state, they represent "the most subordinate and exploited fringe of our society" (p.424).

Because of these intersections, growing old becomes a unique collective experience. There is intersectionality and overlapping of oppressions in the experience of aging because if there is no single right way to be a woman, there is no single right way to grow old either. Even with the discourse that we are a "gray-haired country", aging is still discussed more from a geriatric (pathological aging or senility) than a gerontological viewpoint: Being an Older Adult. We see silence about the sexuality of older adults, domestic violence committed against them, and in health, the scarce resources are rarely directed at this segment of the population.

Studies carried out in the context of the COVID-19 pandemic provide information on ageism because if aging in "normality" is already a complex, dynamic, and heterogeneous event, prejudice also circulates in this setting, either increasing or decreasing. Silva et al.[19] point to the specificity of ageism in Brazil since older adults are more susceptible to the impacts brought about by significant changes in the social body in countries with a significantly aging population and significant social inequalities, as was the case when the pandemic was declared. Besides immunosenescence, a biological characteristic that made them more prone to infections and, therefore, to the most severe forms of COVID-19, social distancing as a way of preventing the spread of the virus removed them from their already restricted circle of social interaction and belonging and led them to develop emotional loneliness, increased vulnerability to depression, and a greater risk of death. They point out that the pandemic has reinforced a current idea of homogenization of what it means to grow old, which occurs implicitly or explicitly at a structural and individual level and neglects the internal differences between older people, attributing similar attributes – and often stereotypes – to people based on their chronological age[19].

We would add to this analysis of aging the need to consider *gender* since women achieve greater longevity than men; the need to consider *class*, since poorer people have fewer and more complex possibilities for self-care, early diagnosis, and access to health services; the need to consider *ethnicity/skin color*, due to the structural and institutional racism that excludes and segregates, which guides clinical decision-making, albeit subliminally, judging by the epidemiological data. These three attributes, taken together, already indicate a different way of aging compared to their peers in opposite conditions. It is necessary to consider ageism beyond the analyses that

place prejudice against older people in the field of age difference and senescence because some elements that make up this Being precede their aging process and help define ways of being born, living, and dying.

Healthcare

The work of caring, as a reflexive act, is the object of study in Brazilian Collective Health, where we have a theoretical and propositional production on Care (with a capital letter because, in this conception, it is a proper noun, somewhat removed from the idea of *treating*, *curing*, or *controlling*), but without finding discussions that point to intersectional aspects. We reflected on how healthcare is an inventive and complex process for the health worker and the one being cared for and is regulated by these agents. These care aspects go in the opposite direction to the idea of care hetero-determined and regulated by the high yield of capitalist production.

Even so, readings on the theme of Care, in all its nuances, are directed towards a single body without considering the specificities and wholeness of the person, as is the case with *Naná*. Some policies struggle to reverberate equity and comprehensiveness, such as the National Policy for the Comprehensive Health of the Black Population (PNSIPN), which is hardly called upon to dialogue with others, revealing a social dynamic and translating social values.

Regarding work and action in health, Merhy[20] proposes the micro-political analysis of living work in action as a political methodological plan. While offering a toolbox for thinking about the tensions and challenges of this action, he emphasizes the need to (re)invent health as a public good at the service of individual and collective life. This professional's technological valise will include technologies that will build the necessary daily bonds between workers and users, intervening effectively in their individual and collective needs and lives.

In proposing that we think about representations of living, Merhy et al.[21] bring us a fascinating image: they call us to pay attention to the seven billion beings who live on Earth without one being absolutely the same as another, thus forming seven billion singularities, albeit with many similarities. There is also the detail that even these unique beings, as they live their lives, will be unique vis-à-vis themselves because the details of this living and the conformations in the territory of their existence change all the time, so

unique is also several. Therefore, care production cannot lead to a "prescriptive, predictable, and standardizing" healthcare model. If there is a desire to provide care, repetition is not desirable, or one should at least try to produce a difference in the repetition and production of the act of caring.

From Campos[22], we highlight the idea of the Subject's Clinic to think of a shift from the centrality of the disease to the subjects with a disease, who are concrete, with their unique biography, their body, their dynamics, and yes, a disease. Their humanity includes pain, the risk of dying, and suffering. Therefore, to consider subjects as a whole, we should consider their concrete existence in their existential and social dimensions, with the illness being just *one* of the components of this existence, which can disturb and transform but rarely liquidate the other dimensions, which is not to ignore the illness but to understand the necessary expansion of the object of work of the Subject's Clinic to that of a Subject/Body traversed by a history. Campos[22] recognizes the idealism in assuming a clinical rationality not crossed by the SD, politics, and economics from which the concrete subject emerges. This agent, *Naná*, is a concrete subject.

Care as a value is affirmed as ethical and political, an intrinsically human activity. Zoboli[23] will say that "the ethics of care moves the caring professional and goes out to meet the other to establish a bond and create ties of trust" (p.63). She considers care a comprehensive action, a respectful and receptive service, observing the biological and social fragility of the other, and building health as a citizenship project. It is a relational activity of perceiving and responding to health needs. This ethic of care presupposes a contextual approach and attention to singularities and diversities. It includes emotion and affectivity and has an attitude of accountability. It reminds us that *action and omission are equally choices*, and to be responsible is to answer for what you have done or failed to do in the meeting of care.

The idea that these encounters can be conflictual conjures the idea of recognition and identity, as put forward by Ayres *et al.*[24]: to think of identity policies arising from the concrete experiences of the agents' lives implies recognizing them, which is not always the case. An intersectional agency must be preceded by an intersectional lens, which can be called Care when, in the act of assistance, it is broadened, made more flexible, humanized, and turns to the "existential meaning of the experience of physical or mental illness"[25] (p.22), which is unique to those who experience it.

Health cannot be conceived as a *situation or something* complete[25], as this makes the idea of gaining and permanently searching for that horizon where health is impossible. However, the horizons that move do not do so at the same speed, and those that are reached are not reached at the same speed, depending on one's place in the world and where and how one walks.

The author brings up the idea of building a *happiness project*, understanding that human happiness is a singular experience but that some values make up these experiences that occur in the collective field to the point where they can be inserted and enhanced through political proposals that include the State as their proposer – such as the PNSIPN, which is also because many of these values can only be lived in common, collectively, interacting with others[25]. The obstacles to building this project are also in common life, and racism is one of these hurdles, so a collective response to this issue is also necessary.

For health professionals, it is of fundamental importance to reflect on who is in front of them in the Care encounter. Building an identity between the caregiver and the person cared for is fundamental to establishing the bond necessary for effective care between these agents. However, as this construction occurs within the social structure, we should underscore that with our history of inequalities, thinking about identity construction in which both sides take on equal roles in the professional-user relationship, living a dialogical encounter, it´s still not plausible.

In the author's words, "The professional who appears before a client is loaded with meanings", and when an interaction is established, it is "resumed" and not "initiated"[25], with all the previously conceived ideas about the social role of each agent because we are not "establishing a dialogue"[26]; we live immersed in a dialogue that precedes the therapeutic encounter, and we should consider "the universe of resistance that both opposes and brings us closer to this other"[26] (p.28).

From this perspective, from an intersectional standpoint, we should reflect that if we could name just one thing that opposes and distances, what would it be? A centuries-old structure governs this country. This structure has racialized, objectified, inferiorized, and excluded people who carry a non-place in the color of their skin. If you were born a woman, lived your life cycles in poverty and through resistance, grew old in these conditions, you will be a body at a disadvantage in the face of biomedical power, in the face of the possibilities of projecting yourself as a

human being, since you are systematically dehumanized. How can you project *happiness* if your main project is to survive, make your loved ones survive in the diaspora context, or be free to live, without the pain and nausea that traverse us daily in personal or collective experiences?

Rita Borret *et al.*[27] use the term "*anti-racist healthcare*", which is one of the gaps in the proposition of comprehensive care for the profile of the *Nanás* in the Care aspects mentioned above. Mapping work in the act, without racializing and observing gender and class issues in the light technologies, does not consider the act of caring in full nor guarantees the light-hard and hard ones for this public. We should look at this Subject's intersubjective elements for a Subject's Clinic to achieve its comprehensiveness. If Care is indeed a value, racism/sexism/classism/ethnicism influence on health-disease processes cannot be silenced or unrecognized.

An intersectional agency permeating Healthcare

Besides understanding the living conditions and health of the Black population, within the proposed gender/race/class/age selection, we should reflect on the need to contextualize these multi-causations that bring so many disadvantages. From a historical viewpoint – including healthcare – we need to find out who the actual producers of morbimortality are because these people are not in a "social *vacuum*"[4]. It is not enough to replicate knowledge about intersectionality and denounce it because even excessive denunciation, if uncritical, can naturalize the social fact as inherent to that society; we need to propose actions and public policies that reduce these inequalities and reverse this situation. Between a sterile denunciation and a potential proposal stands a political choice[4] between the will and the ability to act on the social structure.

Lugones[28] points out that oppression has historically been accompanied by concrete and lived resistance. The idea of resisting is to reject their subjectification and highlight their subjectivity in an infra-political process of liberation by contesting coloniality. Henning[11] affirms it means making use of our identity marks to question the structure and deconstruct inequalities, which implies, for example, that white people racialize themselves and recognize their privileges.

Inside or outside institutionalized militancy, seeking not to become calcified in pain, Black women resist and *re-exist*. Cestari[29] underlines

the daily political militancy of each Black woman, showing her insubordination every time the colonial trauma is reenacted and updated, ready to confront it when, for example, they see their children killed by the State, when their home is invaded by water, or when one of their own, or indeed them, is inflicted with suffering and pain in the health services.

This militancy makes Black women leading figures in the discourse about themselves and their community, moving away from the homogenization that comes from the stereotypes of a post-colonial expropriation imagination about gender-race-class. It moves her away from objectification and the condition of "objects without agency/body without mind", challenging the "social division of enunciation" (p.31) by promoting a dialogue that often clashes with historically and epistemologically imposed limits[29]. The dubious exercise of thinking of *Naná* in this place of self-enunciation, in a health service, in the meeting of two in the clinics, it already makes us postulate for an intersectional agency.

Let us take Grada Kilomba's narrative[15] in a doctor's office as an example: She – a 13-year-old Black girl – goes from patient to domestic worker under the eyes of the doctor – a white man: "*During our vacation trip, would you like to cook, wash, and clean for my family?*". The child became the servant; the doctor became the *master*. This colonial fantasy, possible in the doctor's mind, occurs due to a preserved, genderized racism, which is why we understand that the act of caring needs to be dialogically transformed since it is acted upon by intersectionality.

Adding to what Akotirene[16] said – "It is the Black woman who is at the heart of the concept of intersectionality" (p.24) – and Angela Davis[30] – "When the Black woman moves, the whole structure of society moves with her" (p.1) – we like to imagine that intersectional agency[11], as Henning proposes, will occur between the main actors in the care relationship: the Nanás as agents of their care based on the intersectionalities that make them up; and health professionals, as agents of care based on a comprehensive approach that recognizes the intersectionalities that traverse the Nanás, their agency, and that does not subjugate or infantilize them; actions particularly common to women and older adults[18].

In this way, after the COVID-19 pandemic, and in the face of the necessary reorientation of knowledge and practices in health services, we should reflect on Care that cannot be done without critical references from this field, whi-

ch refute medicalizing practices hegemonically constituted by institutional racism and which were born in a "Europe that is understood as a rule, norm, and parameter for the definition and production of the meaning of what can be considered human"[6] (p.31), practices, which, because they take place in *collective contexts of* inequality, must not only recognize the impact of the SD but also enable "emancipatory health care"[6] (p.185).

We emphasize that the context is collective because there are many *Nanás*. From 2012 to 2021, the Continuous PNAD[31] shows an increase in the Brazilian population who self-declare as Black: 56.1%. In the same period, the number of people aged 60 or over grew: from 11.3% in 2012, they will represent 14.7% of the population in 2021 in all the country's Principal Regions, with a predominance of women in this age group, given the "mortality differentials between the sexes", indicating a feminization of old age[31] (p.4). Regarding extreme poverty, although the breakdown of the data by sex does not show significant differences (51.1% for women, 48.9% for men), when the breakdown is by ethnicity/skin color, "Black people accounted for more than 70% of the poor and extremely poor"[31] (p.66). Among Black women, 11.6% lived in extreme poverty and 39% in poverty. In contrast, for white men, these percentages were 4.7% (extreme poverty) and 18.1% (poverty)[32] (p.67).

By understanding the vulnerable place occupied by Nanás in a racist social structure, heal-

th professionals can and should make conscious choices to dismantle these inequalities, at least in the field of care. This is about using the power of action inferred to these professionals to exercise their activity, which is found in interpersonal relationships with the Nanás, pushing them away or bringing them closer together. The professionals' capacity for agency, shaped by all the complex interactions of the structure, positively affects the health experience of the Nanás when they recognize their social trajectory and address the intersections of their identities in the context of Care, in the search for Comprehensiveness.

Thus, we need both agencies in this encounter between *Nanás* and health professionals. An agency with an intersectional verve, which does not reduce the experience of being a *Naná* "to a single primary axis of inequality"[11]; that the lens of care is perfected, evaluating each social marker as potentially affected and altered by the others. We emphasize the need for care that perceives, stimulates, and understands this identity and its subjectivities so that she is no longer a "patient", "merely subordinate, submitted, made invisible, silenced, and disempowered subjects"[11]. There is a potential to use these intersectional identity marks to strain this care, create relationships, question the hegemonic model, and deconstruct social differentiations and inequalities, primarily in health and in the SUS.

Contributions

AC Barbosa: conceptualization; research; drafting the original manuscript; drafting – review and editing. SS Oliveira: drafting – review and editing. RG Oliveira: drafting – review and editing.

References

1. Santos MPA, Nery JS, Goes EF, Silva A, Santos ABS, Batista LE, Araújo EM. População negra e covid-19: reflexões sobre racismo e saúde. *Estud Av* 2020; 34(99):225-244.

2. Minayo MCS. Determinação social, não! Por quê? *Cad Saude Publica* 2021; 37(12):e00010721.

3. Breilh J. La categoría determinación social como herramienta emancipadora: los pecados de la "experticia", a propósito del sesgo epistemológico de Minayo. *Cad Saude Publica* 2021; 37(12):e00237621.

4. Nedel FB, Bastos JL. Para onde seguir com a pesquisa em determinantes sociais da saúde? *Rev Saude Publica* 2020; 54:15.

5. Almeida-Filho N. Mais além da determinação social: sobredeterminação, sim! *Cad Saude Publica* 2021; 37(12):e00237521.

6. Oliveira RG. *Vidas em exclusão e a reinvenção do Cuidado*. Rio de Janeiro: Ed. Fiocruz; 2021.

7. Asante MK. Afrocentricidade: Notas sobre uma posição disciplinar. In: Nascimento EL, organizadora. *Afrocentricidade: uma abordagem epistemológica inovadora*. São Paulo: Selo Negro; 2009. p. 93-110.

8. Thiry-Cherques HR. Pierre Bourdieu: a teoria na prática. *RAP Rio de Janeiro* 2006; 40(1):27-55.

9. Breilh J. Una perspectiva emancipadora de la investigación y acción, basada en la determinación social de la salud. In: Asociación Latinoamericana de Medicina Social. *Taller Latinoamericano sobre Determinantes Sociales de la Salud: documento para la discusión*. México, D.F.: ALAMES; 2008.

10. Collins PH, Bilge S. *Interseccionalidade*. Trad.: Rane Souza. São Paulo: Boitempo; 2021.

11. Henning CE. Interseccionalidade e pensamento feminista: as contribuições históricas e os debates contemporâneos acerca do entrelaçamento de marcadores sociais da diferença. *Mediacoes* 2015; 20(2):97-128.

12. Beauvoir S. *O Segundo Sexo – vol. I e II*. Trad.: Sérgio Milliet. 5ª ed. Rio de Janeiro: Nova Fronteira; 2019.

13. Dossiê Criola. *Mulheres Negras e Justiça Reprodutiva* [Internet]. Rio de Janeiro; 2021 [acessado 2023 abr 27]. Disponível em: https://assets-dossies-ipg-v2.nyc3.digitaloceanspaces.com/sites/3/2021/10/Dossie-CriolaJusticaReprodutiva_compressed-1.pdf.

14. Brambilla BB, Rocha RVS, Oliveira WLG, Cordeiro RC. A branquidade e a (des)racialização do estado brasileiro e suas desigualdades. In: Cordeiro RC, Oliveira WLG, Vicentini F, organizadores. *Saúde da população negra e indígena*. Cruz das Almas: EDUFRB; 2020. p. 231-254.

15. Kilomba G. *Memórias da Plantação: episódios de racismo cotidiano*. Trad.: Jess Oliveira. Rio de Janeiro: Editora Cobogó; 2019. [Edição em e-book].

16. Akotirene C. *Interseccionalidade*. São Paulo: Selo Sueli Carneiro, Ed. Pólen; 2019.

17. Beauvoir S. *A Velhice*. Trad.: Maria Helena F. Martins. 4ª impr. Rio de Janeiro: Nova Fronteira; 1990.

18. Souza MF, Mariano SA, Ferreira LP. Tecendo fios entre interseccionalidade, agência e capacidades na teoria sociológica. *Civitas* 2021; 21(3):423-433.

19. Silva MF, Silva DSM, Bacurau AGM, Francisco PMSB, Assumpção D, Neri AL, Borim FSA. Ageism against older adults in the context of the covid-19 pandemic: an integrative review. *Rev Saude Publica* 2021; 55:4.

20. Merhy EE. *O cuidado é um acontecimento e não um ato. Trabalho, produção do cuidado e subjetividade em saúde: textos reunidos*. São Paulo: Hucitec; 2013.

21. Merhy E, Feuerwerker L, Cerqueira P. Da repetição a diferença: construindo sentidos com o outro no mundo do cuidado. In: Franco TB, Ramos VC. *Semiótica, Afecção e Cuidado em Saúde*. São Paulo: Hucitec; 2010. p. 60-75.

22. Campos GWS. A Clínica do Sujeito: por uma clínica reformulada e ampliada. In: Campos GWS. *Saúde Paidéia*. São Paulo: Hucitec; 2003.

23. Zoboli E. Cuidado: práxis responsável de uma cidadania moral. In: Pinheiro R, Mattos RA, organizadores. *Razões públicas para a integralidade em saúde: o cuidado como valor*. Rio de Janeiro: IMS/UERJ, CEPESC, ABRASCO; 2007. p. 113-126.

24. Ayres JRCM, Castellanos MEP, Baptista TWF. Entrevista com José Ricardo Ayres. *Saude Soc* 2018; 27(1):51-60.

25. Ayres JRCM. O cuidado, os modos de ser (do) humano e as práticas de saúde. *Saude Soc* 2004; 13(3):16-29.

26. Ayres JRCM. Sujeito, intersubjetividade e práticas de saúde. *Cien Saude Colet* 2001; 6(1):63-72.

27. Borret RH, Araujo DHS, Belford OS, Oliveira DOPS, Vieira RC, Teixeira DS. Reflexões para uma prática em saúde antirracista. *Rev Bras Educ Med* 2020; 44 (Supl.1):e0148.

28. Lugones M. Rumo a um feminismo descolonial. *Estud Fem* 2014; 22(3):935-952.

29. Cestari MJ. *Vozes-mulheres negras ou feministas e antirracistas graças às Yabás* [tese]. Campinas: Universidade Estadual de Campinas; 2015.

30. Silva B. *A mulher negra e o futuro do país* [Internet]. Portal Geledés/O Globo; 2022 [acessado 2023 abr 24]. Disponível em: https://www.geledes.org.br/a-mulher-negra-e-o-futuro-do-pais/.

31. Instituto Brasileiro de Geografia e Estatística (IBGE). *PNAD Contínua. Pesquisa Nacional por Amostra de Domicílios Contínua. Características gerais dos moradores 2020-2021* [Internet]. 2022 [acessado 2023 abr 24]. Disponível em: https://biblioteca.ibge.gov.br/visualizacao/livros/liv101957_informativo.pdf.

32. Instituto Brasileiro de Geografia e Estatística (IBGE). *Síntese de indicadores sociais: uma análise das condições de vida da população brasileira. Coordenação de População e Indicadores Sociais* [Internet]. Rio de Janeiro: IBGE; 2022 [acessado 2023 abr 24]. Disponível em: https://biblioteca.ibge.gov.br/visualizacao/livros/liv101979.pdf.