Revista ARACÊ
ISSN: 2358-2472

INTERSECTIONALITY AND BARRIERS IN BLACK MEN'S ACCESS TO HEALTH SERVICES: A SCOPING REVIEW

https://doi.org/10.56238/arev7n2-151

Submitted on: 01/12/2025 **Publication date:** 02/12/2025

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ABSTRACT

The history of Brazil, based on the structure of inequality, has assigned to certain segments of society a marginalized position in relation to public policies, exemplified by the black population. Objective: To search the scientific literature for the state of the art on evidence regarding black men's access to Brazilian health services. Method: Scoping Review Study, following the review method proposed by the Joanna Briggs Institute (JBI), whose guiding question was: What is the state of the art of evidence about the barriers in access to health faced by black men in Brazil? Searches were performed in the PubMed, LILACS, Scopus, CINAHL and Web of Science and Google Scholar databases. The search strategy was developed with the following terms in PubMed: ("Racism" OR Prejudice OR "SystemicRacism") AND ("Black People" OR "EthnicViolence" OR "Black or African American") AND ("Health Systems" OR "Unified Health System") AND (Brazil OR Brazilian), the same strategy was adapted to the other databases. Results: A total of 1654 studies were found, of which 543 were excluded that were duplicated, leaving 1111 studies. During the stage of reading titles and abstracts, 477 were excluded because they did not meet the inclusion criteria of this research, followed by 627 articles that did not meet the eligibility criteria, thus leaving 9 articles for analysis. Conclusion: With regard to the national reality, there are few studies on the population's perception of racism in health in the

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country, which are not reduced to a single social marker of difference, but several, which are intertwined and act in a complex way in the production of inequalities. It should be noted, however, that, in recent years, the theme of the relationship between color/race and health has gained visibility and is being incorporated by researchers in the field of public health.

Keywords: Racism. Prejudice. Systemic Racism. Black People. Ethnic Violence.

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ISSN: 2358-2472

INTRODUCTION

Despite 15 years since its enactment, the National Policy for the Integral Health of the Black Population (PNSIPN) still faces significant challenges for its effective implementation and consolidation as a public policy.[1] Although institutionally recognized, the policy remains below its importance in the context of the principles of the Unified Health System (SUS), especially with regard to equity in health.[1] These challenges acquire greater relevance in an intrinsically unequal society, marked by racist, heterosexist, and ableist structures, emphasizing the urgent need to strengthen collective struggles in defense of this policy.[2.3]

The PNSIPN was approved by the National Health Council, and was established by the Ministry of Health in 2009 through Ordinance GM/MS No. 992/2009.[2] This measure recognizes racism and ethnic-racial inequalities as social determinants of health conditions, aiming to promote equity in health.[4.5]

The black man, as a social being, unfortunately can suffer situations of racism throughout his life in society.[6] Law No. 7,716/1989 characterizes racism as a non-bailable and imprescriptible crime against a certain group or collectivity, carried out through verbal offense or acts such as refusing access to commercial establishments, social elevators, denying jobs, among others.[7] It is essential to differentiate between racism and racial injury, provided for in article 140, paragraph 3, of the Penal Code.8For Almeida (2015), the concept of racism is classified as individual, structural, and institutional. From the individualistic perspective, racism is considered a behavioral disorder of the individual, without fully recognizing its historical and real impacts on society. From an institutional perspective, the scope of analysis is broadened to consider the effects of segregation on institutions, which often favor specific racial groups over others. Structural racism manifests itself when institutions such as the judiciary, legislature, university rectories, public prosecutor's office, and company boards, predominantly occupied by white men, use rules and norms to hinder access for blacks and women. This exclusionary behavior creates a hegemonic pattern that affects other spheres of society. In short, structural racism perpetuates systemic inequalities and profoundly impacts people's lives.[9]

Injury is defined by the offense of one or more victims by the use of elements referring to race, color, religion, ethnicity or origin, where the penalty of imprisonment of one to three years and a fine is established, in addition to the penalty corresponding to violence, if committed. [8.10]

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The importance of presenting the concept of crimes that can affect the black population, in general, is based on the very need for citizens to know the legislation of their country and, along with it, their rights and duties so that they can appeal if damage is caused to them. [11.12]

BRIEF NOTE OF RACIAL INEQUALITY

When we turn our gaze to men, studies carried out by the IBGE bring the perception of how much more intense the vulnerability of the group is, and numerous causes can be cited, such as urban violence, schooling, income, access to basic sanitation and consumer goods, conditions that directly interfere in the individual's health condition.[1,5,7]

According to surveys conducted by the IBGE, the disparity in access to basic goods and services between different population groups, such as health, education, housing, work and income, is evident.[5.7] In the professional sphere, specifically in managerial positions, in 2019 blacks occupy 29.5% of the positions, while whites represent 69%.[1,2,5,7] In 2021 the condition of impoverishment, considering those who live below the poverty line receiving less than R$ 168 per capita per month, 9% are black, 11.4% are brown and 5% are white. Among those who receive less than R$ 486 per capita per month, the percentages are 34.5% for blacks, 38.4% for browns and 18.6% for whites.[2,5]

With regard to remuneration, there are disparities between ethnic-racial groups in both segments.[10] In addition to being deprived of social security, black men face a high rate of informality (44.5%), higher than that of whites/yellows (33.3%) in 2022. Despite a slight negative change in the informality rate among blacks/browns, it remains above the national average (39.4%).[2.5]

In 2022, the highest informality rates among blacks/browns are concentrated in the North and Northeast regions, highlighting, for example, Pará, where 6.3 out of 10 black and brown workers are in the informal sector. In contrast, the states in the southern region have the lowest rates of informality, with Santa Catarina (26%) and Paraná (33%).[11.12]

In the context of health, research on social inequalities by color or race in Brazil shows a notable discrepancy regarding the coverage of basic sanitation services according to color or race.[13.14] In 2018, a higher proportion of the black or brown population was found to live in households without garbage collection (12.5%, compared to 6.0% of the white population), without access to water supply through the general network (17.9%, compared to 11.5% of the white population) and without sanitary sewage through a

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collection or rainwater network (42.8%, compared to 26.5% of the white population).[16,17] These data imply conditions of vulnerability and greater exposure to disease vectors.

Initial data on the impacts of the COVID-19 pandemic on the black population showed a higher rate of hospitalizations and deaths from COVID-19 among whites compared to blacks.[17,18] However, over the Epidemiological Weeks (SE), there was a reduction in the proportion of deaths and hospitalizations among whites.[19] On the other hand, deaths and hospitalizations in the black population increased. These findings lead us to infer about the differentiation of access between the white and black population in relation to their health care.

In this regard, Cunha (2021) highlights the difficulties faced by the black population to access basic health services.[20] The situation has worsened, since Primary Health Care (PHC) has always been precarious, with minimal coverage of the Family Health Strategy (FHS) for this population and the sporadic presence of doctors in most communities.[21] It is known that a large part of the black population lives in the communities, where public health policies and comprehensive care do not really reach.[21,22]

Other factors highlight the considerable vulnerability of the population group of black men in society, including structural racism, violence and barriers to access, especially in the area of health.[17,21,22] The Social Determinants of Health (SDH) that are outlined by the National Commission on Social Determinants of Health (CNDSS) as social, economic, cultural, ethnic-racial, psychological, and behavioral elements that impact the occurrence of health problems and their risk factors in the population.[5,23] The WHO defines social determinants of health (SDH) as the social conditions in which people live and work.[24.25]

As established in the 2017 PNSIPN, men have higher mortality rates than women in the three main groups of causes of disease defined by the WHO (infectious and parasitic diseases, non-communicable diseases, and external causes). In the Brazilian context, deaths from external causes lead the statistics of deaths among black men, who face a 6.3 times higher risk of dying this way compared to women.[5.10]

With regard to morbidity caused by priority communicable diseases, tuberculosis emerges as a serious public health problem and is directly related to the condition of poverty. In 2022, the tuberculosis diagnosis rate among black individuals was 63.3%.[5,7,10] New cases of tuberculosis among black and brown people were predominantly observed in men aged between 20 and 49 years, representing 44.8% of these cases.[26.27]

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Most of the malaria cases recorded in the black population in 2022 were attributed to the species *P. vivax*, representing 86.86% of the average of the years studied.[28,29] This species is known to cause relatively milder symptoms compared to the *P. falciparum species*, which accounted for an average of 12.07% of cases over the years analyzed.[30] In addition, most cases occurred in males, representing an average of 63.06% in Brazil, especially in the North and Northeast regions.

In the case of HIV/AIDS, in 2021, 60.5% of deaths occurred among black individuals, of whom 46.5% were brown and 14.0% were black. Regarding deaths among blacks, the proportion of women is higher than that of men throughout the period analyzed. Among the deaths of browns, as of 2018, the proportion of men exceeds that of women.

In 2011, the proportion of acquired syphilis cases in individuals self-declared as black and brown was 50.2%, increasing to 59.0% in 2021. Notably, the proportion in brown people has been over 40% since 2016. As for cases of syphilis acquired in self-declared black people, the proportion of women is consistently higher than that of men throughout the period analyzed. On the other hand, among brown people, as of 2019, the proportion of men exceeds that of women.

Another disease that stands out among black men is Diabetes Mellitus (DM) type II. In Brazil, it is the fourth leading cause of death and the main cause of acquired blindness. Black men are more often affected by this disease, with a 9% higher incidence compared to white men.

High blood pressure is also a condition, which affects 10% to 20% of the adult population, directly or indirectly represents 12% to 14% of all deaths in Brazil. In general, hypertension is more prevalent among men and, in particular, tends to be more complex in black individuals.

Regarding cancer cases, the information obtained through the publication Estimate 2023 released by the National Cancer Institute (INCA), the most incident malignant tumor in Brazil is non-melanoma skin (31.3% of total cases), followed by female breast (10.5%), prostate (10.2%). In men, prostate cancer is predominant in all regions, totaling 72 thousand new cases estimated each year of the next three years, second only to non-melanoma skin cancer. In a study carried out at the Barretos Cancer Hospital, it was revealed that blacks die 18% more than whites when considering all types of cancer. For prostate cancer, blacks die 51% more than whites.

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Thinking beyond bodily health, but also mental health, suicide is a reality that also affects black men. According to information from the Ministry of Health, black men up to 29 years of age are up to 50% more likely to commit suicide.

It is observed that there are several problems regarding the health of black men, with this attitudeality directly influences the process of health, disease and death of these men. The term intersectionality was created by the black movement, which emphasizes those who are made invisible and excluded, and allows us to understand how gender, race, and class structures affect certain groups.[23,24] It is essential to understand that these characteristics are structural elements that not only determine and create situations of inequality, but also hierarchize the relations of power, exploitation and oppression, contributing to the perpetuation of subordination.[25]

She focuses on how racism, patriarchy, class oppression, and other discriminatory systems create fundamental inequalities that shape the positions of women, races, ethnicities, classes, and other people.[25,26] It helps us to better understand the inequalities and overlapping oppression and discrimination that exist in our society. It can be considered an important analytical tool for thinking about the social relations of race, sex and class, as well as the challenges for the effective implementation of public policies.[23]

The philosopher Baukje Prins (2006) reports that intersectionality is approached by two main strands among the theorists, which are established from different conceptions of power, agency and structure/system. These strands are characterized by a systemic/structural approach, which is based on studies originating in the United States and emphasizes the impacts of the system or structure on the formation of identities.[26, 27]

Intersectionality is a theoretical and methodological approach that recognizes that the discrimination faced by a person is more complex than the simple sum of its parts. It considers the multiple dimensions of identity (such as race, gender, social class) and seeks to understand how these intersections influence social inequalities. In addition, intersectionality proposes policy actions to combat these inequalities.[28.29]

Intersectionality recognizes that power relations related to race, class, and gender are not isolated or mutually exclusive. They intertwine and influence each other, shaping people's life experiences in complex and interconnected ways.[31]

Some theories are being used, such as the theory of social determination, of the health-disease process. It is a theory that reveals social determinants, including

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sociocultural, ethnic/racial, psychological, and behavioral issues that are directly associated with health problems in groups and populations.[32,33,34]

In this way, we understand the social abyss that the black population faces from the era of slaves from Africa to the present day.[35,36] It can be said that racism is a systematic form of discrimination that has race as its foundation, and that it manifests itself through conscious or unconscious practices that culminate in disadvantages or privileges for individuals.[37]

In "Black Skin, White Masks," Frantz Fanon argues that racism and colonialism are social constructs that shape our perception of the world and our experience of it. According to him, the notion of race only becomes relevant when internalized through language and cultural and social meanings that are also naturalized. In short, our racial identity is strongly influenced by the context in which we live.[38.39]

Michael Foucault (1992), in his work "Genealogía del Racismo", explores how racism was consolidated based on the scientific idea of the struggle between races, supported by evolutionary theory and the competition for survival. This process gave rise to a biological-social racism, which postulates the superiority of the white European race in physical, moral, intellectual and aesthetic terms. This supposed superiority conferred power over truths and norms, while other races were considered threats to biological heritage. In this context, racist discourses emerged that associated degeneration with certain groups.[40.41]

According to Foucault, one of the conditions that enabled the emergence of racism is related to the concept of biopower in the nineteenth century. Biopower refers to a set of practices and discourses that regulate bourgeois society, involving the accounting, classification and quantitative research of the human species. Governments have become increasingly concerned with "population," including variables such as birth, mortality, life expectancy, and disease incidence. [41.42]

The idea of race has been the subject of criticism, especially because its supposed existence has been used to justify harmful practices such as colonization, slavery, segregation, forced sterilization, persecution, and even the death of millions of people.[43,44] If we consider race/racism as an analytical category, we can identify various forms of exercise of oppressive power and deepen our understanding of society and the subjectivity it produces.[45]

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Discrimination is rooted in power relations, where certain groups hold advantages based on their race. These privileges manifest themselves in economic, political, and social spheres, perpetuating inequalities and widening differences.[45.46]

In this scenario, the objective of this study was to search the scientific literature for the state of the art on the evidence regarding the access of black men to Brazilian health services.

METHODS

This is a Scoping Review study, following the method proposed by the Joanna Briggs Institute (JBI).[39] The research protocol was registered in the Open Science Framework4015 of March 2024 (http://osf.io/qk8xu). The review was based on the guidelines of the international guide Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR). The guiding question was constructed using the Population, Concept, and Context (PCC) strategy for a scoping review, with the acronyms P= Black men; C= Barriers to access; C = Public and private health. The question was: "What is the state of the art of the evidence about the barriers to access to health faced by black men in Brazil?"

The search was carried out in the following databases: PubMed, LILACS, Scopus, CINAHL and Web of Science, and Google Scholar. MeSH terms were used, such as "Racism", "Vulnerable Populations", "Health Systems", to increase the sensitivity of the search. The strategy was adapted for each database. In addition, the search was expanded to gray literature with the objective of identifying guidelines, manuals, dissertations and theses, in the MedNar, CAPES, ProQuest, and Google Scholar databases.

The search strategy was developed with the following terms in PubMed: ("Racism" OR PrejudiceOR "SystemicRacism") AND ("Black People" OR "EthnicViolence" OR "Black or African American") AND ("Health Systems" OR "Unified Health System") AND (Brazil OR Brazilian), the same strategy was adapted to the other databases.

The references of the selected articles were checked to identify new studies not located in the previous searches, observing the previously established inclusion criteria and after collecting all references, duplicate articles were excluded, using the Rayyan® software.

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The inclusion criteria are: quantitative or qualitative primary studies, quasi-experimental studies, randomized clinical trials, cohort, case-control, cross-sectional, guidelines, manuals, dissertations, and theses addressing structural racism as a barrier to access to health services for black men in Brazil. Letters to the editor, opinion articles, and studies with children were excluded, as well as studies that were not conducted in Brazil. There was no limitation on language or year of publication due to the scarcity of studies on the subject.

The selection of studies was carried out by two reviewers based on titles and abstracts, followed by the full reading of the pre-selected articles. Divergences were resolved by consensus among the reviewers and there was no need for a third reviewer. The extracted data included, year of publication, study design, objective, and evidence (Chart 1). The quality assessment was conducted using the JBI Critical Appraisal Checklist for Studies Reporting Prevalence Data, classifying the articles as of low, moderate, or high methodological quality based on the score obtained on the checklist.

RESULTS

A total of 1654 studies were found, among which with the help of the Rayyan software, 543 were identified that were duplicated, leaving 1111 studies. During the stage of reading titles and abstracts, 477 were excluded because they did not meet the inclusion criteria of this research, during the screening, which are quantitative or qualitative primary studies, quasi-experimental studies, randomized clinical trials, cohort, case-control, cross-sectional, guidelines, manuals, dissertations and theses addressing structural racism as a barrier to access to health services for black men in Brazil. Thus, a search was carried out in the references of the selected articles and thus 2 more articles were integrated. A total of 627 articles that did not meet the eligibility criteria were excluded, thus leaving 9 articles for analysis of the studies described in (Figure 1).

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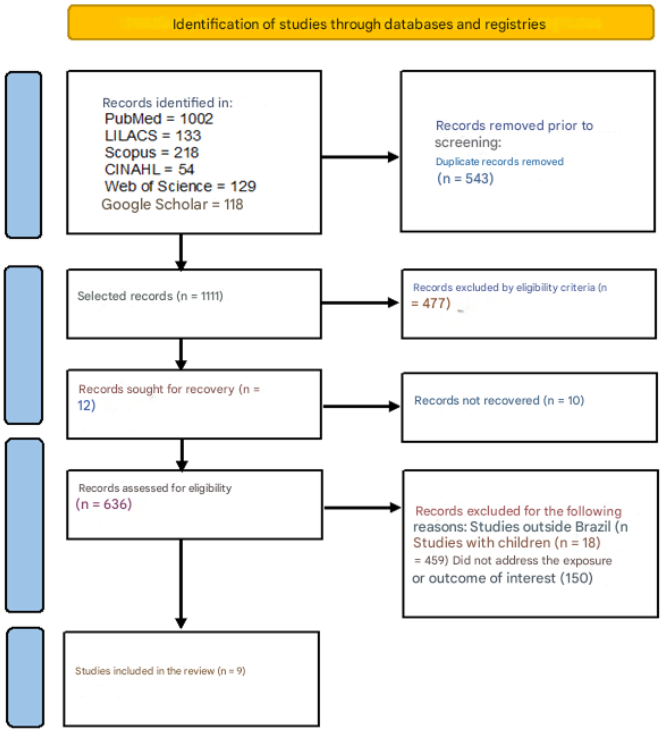
Figure 1 - Flowchart of the selection process of the articles in this research adapted from PRISMA. Rio de Janeiro, RJ, Brazil 2024 - Dates



Source: The authors, 2024

Chart 1 - Characteristics of the studies included in this review, according to title, year of publication, country, design, evidence, and methodological quality (N=09) Rio de Janeiro, RJ, Brazil, 2024.

Title	Year	Design/objective	Evidence from studies regarding black men's access to health services.	Methodological quality
Discrimination, Color/Race and Masculinity in the Health Sphere: contributions of social research	2011	Qualitative study / Reflect on the daily challenges of black people in the context of discrimination in the field of health.	- Analyses on the articulation of multiple systems of subordination, as well as a discussion on the tendency to naturalize inequalities in class society. - Territoriality serves as an explicit marker and helps subsume racial discrimination into a categorization of social position or status, indicating, once again, the combination of variables in the dynamics of discrimination.	High
Black men in times of COVID-19 pandemic	2021	Descriptive study / To analyze the dynamics that the COVID-19 pandemic may have	- High geographical density of the so-called subnormal settlements, which are usually composed of small	Low

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		changed in relation to the self-care of black men in Brazil through the survey from data from multiple surveys and epidemiological bulletins.	houses and many people, ends up making it difficult to comply with distancing recommendations. - Data on underreporting, difficulties with low-quality public transport, aggravations of poor health, poor basic sanitation, among other problems social issues, drastically affect the black Brazilian population.	
Race, Class and Income Inequality in Brazil: A Social Trajectory Analysis	2020	Descriptive study / To discuss the relationship between race, class and income in Brazil, with the main objective of studying the determinants of racial inequalities in Brazil.	Class and race act in sequential stages, always to the detriment of blacks. This is the case, in the first place, because their starting point is less advantageous than that of whites, given the smaller amount of economic and cultural resources of their family of origin. Secondly, the direct and indirect effects of this initial disadvantage are complemented by barriers conditioned by racial hierarchy, which are present in schooling, occupational allocation and, finally, at the time of wage setting, thus producing the inequalities observed between whites and blacks.	Low
Advances, barriers and debates on the Health of the Black Population. Black men's health: a theoretical reflection	2022	To present a theoretical reflection on socioeconomic, ideological and that influence the health of black men in Brazil.	The years of colonization and the westernization to which he was subjected, implanted in his subconscious the idea of not belonging to the human. In this way, assimilating this idea to the stereotype of virility, the black man tends to become even more vulnerable in a society that does not see him as worthy of care and assistance.	Moderate
The color and sex of hunger: analysis of food insecurity from the	2022	Cross-sectional study / To analyze household food	- The differential treatment of the black population, based on	High

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perspective of intersectionality		(in)security from the perspective of intersectionality	individual or institutional discrimination, harms, over time, all members of this group due to the lack of recognition, opportunities and material support. - Living in a situation of food insecurity signals not only material deprivation, but also ideological mechanisms that prohibit opportunities to improve the lives of the black population.	
Conceptions of health and the performance of the Black Movement in Brazil around a health policy	2022	Qualitative study / To analyze the conceptions and political action of the organizations of the Black Movement in the process of formulating the PNSIPN	Community assistance actions refer to a historical tradition of black movements since the beginning of the Republic, through mutual aid entities, professional associations of black workers (dockworkers, carpenters, etc.) and through the African-based religions themselves. What could be understood as "welfare actions", in the sense of charity, is an Afro-Brazilian heritage of autonomous organization of the black population, in the search for the resolution of their most immediate demands.	Moderate
The door is open, but noteveryonemayenter: racial inequities in healthcare access across three Brazilian surveys	2020	Qualitative study / To evaluate the impact of changes in the National Primary Care Policy on racial inequities in health	Racism, an all-encompassing social process underlying radicalized minorities' lower access to health services and lower quality of care, is evaluated here with its corresponding social marker: race.	Low
Access to Health Services and AssistanceOffered to the Afro-DescendantCommunities in Northern Brazil: A Qualitative Study	2021	Descriptive study / To evaluate access to health services and care offered to the remaining quilombo communities in the northern region of Tocantins, Brazil.	- The literature points out that SAH is one of the most incident and prevalent diseases among black men, responsible for a high number of deaths among men and women of this race. - Assistance offered to quilombolas in the north	Low

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			of Tocantins is fragmented, centered on the biomedical model, which is to treat only the disease	
Racial inequalities in mental health care use and mortality: a cross-sectional analysis of 1.2 million low-income individuals in Rio de Janeiro, Brazil 2010–2016	2023	Cohort Study/Investigating racial and socioeconomic inequalities in primary health care utilization, hospitalization, and mortality from mental health disorders in Rio de Janeiro, Brazil.	In low-income individuals in Rio de Janeiro, racial/color inequalities in mental health outcomes were large and not fully explainable by socioeconomic status. Black and brown Brazilians were consistently negatively affected, with lower PHC utilization and worse mental health outcomes.	High

Source: The authors, 2024

After analyzing the studies, it was possible to organize them into four categories: I – Users' access to the service; II – Limiting factors to adherence; III – Professional and institutional difficulty to work with diversity; and IV - Potential of the service to ensure access and adherence. The synthesis of these data and the analysis of the categories will be presented in the discussion

DISCUSSION

USERS' ACCESS TO THE SERVICE

Black men face obstacles in accessing health services, both public and private, due to structures that are considered bureaucratic, costly and inefficient.[9,14,43] This result corroborates the research by Almeida (2019)[46] In which he showed that black men's access to health services is a challenge, as well as their adherence to treatments, and involve obstacles ranging from structural issues, such as living conditions, nutrition, housing, financial power, and education are all linked to access to health care.[4,46]

This issue goes beyond geography and involves three aspects: economic, which includes health costs for the user; cultural, which includes standards and techniques adapted to the habits of the population; and functional, which concerns the adequacy and quality of the services offered to users of the health system.[4,5,46] In addition to the simple use of health services, accessibility includes the adaptation of health professionals and health technologies to the needs of patients.[20,21] It is essential to ensure that everyone has access to all levels of health care. However, establishing a Unified Health System, as

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provided for in the 1988 Constitution, faces several obstacles and difficulties such as: underfunding, lack of qualified professionals, management model.[33,34,47]

The study by Vasconcelos (2022)[6] showed that accessibility conditions are better understood in a multidimensional way, covering four dimensions: political, economic-social, technical, and organizational.[6] The political dimension involves the development of health awareness and social organization; the economic-social dimension refers to the organization of the service network, facilities and difficulties related to the search for health services; and the technical and organizational dimensions include characteristic aspects of the service, such as hours of service and quality of care.[6]

Other important aspects to be considered in the analysis of access to services include popular participation and social control, equity, coherence of services with the needs of the population, strategies, allocation of resources and autonomy.[6,8,11] This result is in line with recent research[4,5,7], in which the importance of the various forms of discrimination in the generation of social inequalities and in the health area was examined.

LIMITING FACTORS TO ADHERENCE

There is a latent deficiency in the health area, ranging from the infrastructure of services intended for the provision of basic care, through the scarcity of supplies and equipment, to the reduced number of professionals37,48. Buss (2007)[34] states that geographical barriers and the devaluation of traditional medicinal knowledge in a given region also contribute to this problem.

For Almeida (2019)[46] the discussion is much deeper, black men are stigmatized throughout life because of their color and because of all the risk factors to which they are exposed. Disparities are associated with social class and other social indicators, such as race/color, gender, sexual orientation, and generation.[46,49] These markers are linked to stigma and prejudice and directly affect access to public services.[32.50]

These studies indicate that different discriminatory manifestations can negatively impact the conditions and quality of life, thus affecting the health of both individuals and the community.[1,2,7]

We can assume that certain forms of stigma and prejudice can result in psychological damage, behavioral changes, leading to social exclusion, disabilities at work, obstacles in daily interactions and, in extreme cases, culminate in violence and death.[1,3,5,6] The severity and consequences of the most intense forms of discrimination are highlighted,

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considering their irreparable nature of denial of rights, representing an issue of concern with significant implications for health and well-being.[8.11]

In this challenging scenario, the promise of universal and free health care, most of the time, is little more than a formal commitment on the part of the authorities, often oblivious to the critical context of access to health services.[11,15] Considering that not all of them will be served, there is uncertainty about the experience of those who are able to use the service.[9,43,44] It is difficult to affirm that users will have their demands and expectations fully met, in this context, when we analyzed the limiting factors to adherence, it was noted that territorialization was considered as a geographic determinant (location, forms and access routes); technical (available services and professionals, operational capacity, profile and epidemiological dynamics); population and ethnic, with movable limits, to constantly adapt to the dynamics of these Factors.[20,21,45]

PROFESSIONAL AND INSTITUTIONAL DIFFICULTY IN WORKING WITH DIVERSITY

Experts3,4,6,42 agree that the reality of the black man in Brazil is characterized by an unwanted and often hostile condition. Both the State and social institutions seem to be aligned with the prevalence of the "death" of these men, either through policies that neglect their health, or through institutional indifference.[8,11,14] These elements are inserted in a project of power where centrality is occupied by whiteness43,44.

In the view of Monteiro (2011)[44], initiatives of this type reduce the demand of black users for health services, evidencing the presence of racism in these institutions. It is worth noting that racism, an all-encompassing social process underlying racialized minorities' lower access to health services and lower quality of care, is evaluated here with its social marker corresponding to race.[38,44,45]

For Separavich (2013)[38], institutional racism can manifest itself in various ways, including verbal abuse, such as blame, public humiliation, recrimination, and offenses directed at the patient, generating feelings of shame and exclusion. In addition, negligence on the part of health professionals is also considered a form of discrimination.

In addition, it is crucial to sensitize professionals to work in the face of diversity.[10] Adult mortality data reveal that mortality for blacks is twice as high as for whites in many diseases, indicating the persistence of significant inequalities in the health system.[10,49,51]

In the conception of Vasconcelos (2022)[6], the ineffectiveness of institutions and organizations lies in the professional and institutional difficulty in working with diversity, lack

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of professional services that respect diversity and are appropriate to people, considering their color, culture, racial or ethnic origin.[14] This problem is manifested through discriminatory norms, practices and behaviors that occur in the day-to-day work, resulting from racial prejudices, actions that involve discriminatory stereotypes, lack of attention and ignorance.[11,13,15] In many situations, institutional racism puts people belonging to racial or ethnic groups at a disadvantage in accessing benefits offered by the State and other institutions.[43,44] Black men face obstacles in accessing health services, both public and private, due to structures that are considered bureaucratic, expensive and inefficient.[9,14,43]

Barbosa (2018)[20] reiterates that black men are not granted good opportunities, due to their skin and subjected to racism. The black man becomes a slave to his appearance, where the color of his skin prevails before his individuality, personal characteristics, character, personality and complexity as a human being.[20,44] This discussion reveals the influence of stereotypes that precede and dehumanize the black man.[49.52]

POTENTIAL OF THE SERVICE TO ENSURE ACCESS AND ADHERENCE

Concomitantly in studies on the subject, the development of specific rights and public policies for these groups is also observed.[11,50] In addition to state action, civil society plays a fundamental role in the search for the recognition of identities related to race/color, gender, sexual orientation, generation, among others. Given the need for research and inclusion of themes pertinent to these groups in the political agenda by presenting Social markers of difference and debates on inequality.[34,46,51]

After the creation of the PNSIPN in 2009, expanding access, continuous evaluation and monitoring is still necessary to ensure the quality of access and adherence offered to this population.[38.45]

When analyzing the potential of the service to ensure access and adherence, recent legal changes can be noted, such as the creation of ministries dedicated to racial equality, indigenous peoples, human rights, citizenship and women that took place in 2023 by the current Federal Government, together with the establishment of the Advisory for Racial Equity in Health by the Ministry of Health, are initiatives that aim to address inequalities and promote diversity with an equity perspective.[49,51,53] However, the success of these actions requires substantial investments and the allocation of resources in the budget to effect structural changes in a society marked by historical disparities.[50.53]

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As for the opportunities and resources available, it is worth mentioning the Brazil Quilombola Program (PBQ), established by the Federal Government as a policy aimed at serving these communities through a series of integrated actions carried out by various government agencies.[43.54] For Miranda (2021)[54], among the projects and initiatives outlined to strengthen autonomous actions, the development of infrastructure, implementation of basic sanitation, installation of social equipment in communities, encouragement of productive inclusion, promotion of economic and social development, in addition to support for the control and social participation of quilombola representatives in various instances to ensure their rights and promote the full exercise of their rights of citizenship.[10.13]

In the view of Cesário (2018)[37], the definition of guidelines to promote the visibility and social inclusion of quilombola communities creates opportunities to reflect on the principle of equity, through the implementation of strategies that seek to reduce local social and health inequalities. Ethnic-racial issues related to accessibility to health services are rarely addressed.[9,20,44]

Another important factor recommended by the WHO is self-assessment in health, which is when the patient recognizes changes in their own body that may indicate a disease, and the black population in general has worse self-assessment.[55,56.] Specialists42,53 disagree, this is a risk because neoplasms are silent and by the time symptoms manifest, they may have already developed. Therefore, campaigns such as Blue November draw attention to specific exams, but much is questioned about a specific preventive approach aimed at the black population, considering that the risks are higher for this group.[7,15] Currently, there are no specific recommendations that modify, for example, the age for prostate cancer screening for black people, maintaining the age range of 50 years for all audiences.[6.11]

Prevention campaigns should also be directed to this group. In other words, black men need to be aware that physical exercise and weight control are effective preventive measures, especially if they have additional risk factors, such as smoking and first-degree family history, for example, Silva (2017) points out.[11] This may be because the black population is more vulnerable to these conditions.

CONCLUSION

The gap between the publications, 2011 to 2020, is noticeable, something that we can think about the invisibility of the black man in health. Studies indicate socio-historical

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neglect in relation to men's health, but there is little research that addresses the intersection between race, gender and health, especially in the context of black men. It should be noted, however, that, in recent years, the theme of the relationship between color/race and health has gained, in some way, a little more visibility.

With regard to the national reality, there are studies on the population's perception of racism in the country, but studies on the consequences of racial discrimination on health problems are still scarce.

Based on the experiences of these black men, it is clear that they share social disadvantages that are not limited to a single social marker that identifies difference; Instead, there are multiple social markers that connect and interact in complex ways to produce inequalities. Approaches that limit these inequalities to a single classificatory system, such as class, gender, race, or color, are considered inadequate to understand the various dimensions involved, including the political, economic, and resource issues at stake, which shape and impact people's social positions and experiences in society.

It is crucial to reflect on how caring and self-care behaviors, both at the individual and group levels, impact the preservation of the health of black men in the Brazilian scenario. This theme ranges from deficiencies in the formulation of public policies to the absence of approaches that contemplate male diversity, including guidelines for the promotion of the health of black men, including trans men.

In view of the above, it would be reasonable to argue that, in the current scenario, where government proposals and actions involve cuts in resources for social public policies, investments in the health area should not be further reduced. Thus, the joint effort of managers, workers and civil society to ensure rights becomes crucial, taking into account the racial ills present in people's daily lives and their impact on health conditions.

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