

Gender and racial inequalities in the perceptions of women at a health center*

Desigualdades de gênero e de raça na percepção de mulheres de um centro de saúde

Desigualdades de género y raciales en la percepción de mujeres de un centro de salud

Virgínia Aparecida de Faria Sousa^I ,
Ivonete Teresinha Schülter Buss Heidemann^I , Michelle Kuntz Durand^I ,
Francis Solange Vieira Tourinho^I , Camila Trindade Coelho^I ,
Denise Antunes de Azambuja Zocche^{II} , Ana Karoliny Machado^I 

^I Universidade Federal de Santa Catarina, Florianópolis, Santa Catarina, Brazil

^{II} Universidade do Estado de Santa Catarina - UDESC, Chapecó, Santa Catarina, Brazil

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Abstract

Objective: To understand the perceptions of women working at a health center regarding gender and racial inequalities. **Method:** A qualitative action-research study conducted with 10 women at a health center in the capital of Santa Catarina. Data were collected and analyzed through dialogue within a Freirean Culture Circle, following these stages: thematic investigation; coding and decoding; and critical unveiling. **Results:** Gender and machismo (male chauvinism) emerged as central themes, impacting social relations and women’s daily lives. We identified that women – particularly Black, mixed-race, and Indigenous women – experience gender and racial inequality, despite available policies aimed at this population segment. **Conclusion:** Collective effort is essential for the participants to be recognized as rights-bearing subjects and to achieve an egalitarian society, emphasizing men’s participation in breaking the cycle of oppression, violence, and superiority upheld by machismo.

Descriptors: Gender Studies; Gender and Health; Racism; Equity; Women

Resumo

Objetivo: compreender a percepção de mulheres que atuam em um centro de saúde acerca das desigualdades de gênero e raça. **Método:** pesquisa qualitativa do tipo pesquisa-ação, realizada com 10 mulheres em um Centro de Saúde da capital catarinense. Os dados foram coletados e analisados a partir do diálogo no Círculo de Cultura Freireano, nas etapas: investigação temática; codificação e decodificação; e, desvelamento crítico. **Resultados:** o gênero e o machismo foram revisados como temas centrais, repercutindo nas relações sociais e no cotidiano feminino. Constatou-se que mulheres, especialmente, as negras, pardas e indígenas, vivenciam o processo

de desigualdade de gênero e de raça, mesmo com políticas voltadas para esse segmento da população. **Conclusão:** para que as participantes sejam reconhecidas como sujeitos de direito e alcancem uma sociedade igualitária é fundamental o empenho coletivo, com ênfase na participação dos homens para a quebra do ciclo de opressão, violência e superioridade defendido pelo machismo.

Descritores: Estudos de Gênero; Saúde de Gênero; Racismo; Equidade; Mulheres

Resumen

Objetivo: Comprender las percepciones de mujeres que trabajan en un centro de salud sobre las desigualdades de género y raciales. **Método:** Estudio cualitativo de investigación-acción realizado con 10 mujeres en un centro de salud de la capital de Santa Catarina. Los datos se recopilaron y analizaron mediante el diálogo en un Círculo de Cultura freireano, siguiendo estas etapas: investigación temática; codificación y decodificación; y develamiento crítico. **Resultados:** El género y el machismo surgieron como temas centrales, influyendo en las relaciones sociales y en la vida cotidiana de las mujeres. Se identificó que las mujeres – particularmente las negras, mestizas e indígenas – experimentan desigualdad de género y racial, a pesar de las políticas existentes dirigidas a este segmento de la población. **Conclusión:** Es fundamental el esfuerzo colectivo para que las mujeres sean reconocidas como sujetos de derechos y para lograr una sociedad igualitaria, destacando la participación de los hombres en la ruptura del ciclo de opresión, violencia y superioridad que sostiene el machismo.

Descriptores: Estudios de Género; Género y Salud; Racismo; Equidad; Mujeres

Introduction

Women face multifaceted challenges, exacerbated by the intersection of gender, race, and social inequalities. Machismo, deeply rooted in the structure of society, perpetuates gender disparities that affect their lives. This ideology, which attributes superiority to men and subordinates women, manifests itself in different forms, ranging from harassment and violence to workplace discrimination.¹

Shaped by its history of slavery, Brazilian society is characterized by profound social inequality and labor exploitation, leading Black women to face specific forms of oppression and exclusion, such as racial prejudice.²

Racism manifests itself in individual, structural, and institutional spheres. It is reflected in forms of oppression that affect access to health care, constituting a significant social determinant of health.³

In addition, Black, Brown, and Indigenous women experience a double burden of prejudice, facing both racism and sexism, which results in specific barriers and poorer health outcomes.⁴ These intersectional forms of oppression reveal that gender, race, and class produce inequalities that manifest as health inequities and as forms of violence against women, affecting both access to and the quality of health care.⁵

Gender inequality refers to the distribution of power, resources, and opportunities between men and women. It is evident in several areas, including work, education, politics, and culture.¹

Brazilian feminist movements have a long history, and today political organizations also mobilize in the digital sphere, addressing issues such as child marriage, reproductive rights, and femicide.⁶

However, the impact of these forms of oppression is not homogeneous across the female population. The relevance of this study lies in the impact of overlapping gender, race, and class inequalities on the health and safety of Brazilian Black women, a population group with the highest rates of social vulnerability and femicidal violence in the country.

This context directly resonates with the reality of other Latin American countries, such as Colombia and Peru, where racial and gender disparities structure similar dynamics of exclusion and invisibility affecting Afro-descendant women.

Thus, incorporating the concerns raised by social movements and critically examining these forms of violence through the lens of health promotion frameworks can strengthen care strategies and the ongoing effort to address inequities within the Unified Health System (SUS).⁷

In its diversity, the feminist movement seeks to combat these forms of oppression and build a more egalitarian society. Black feminism emerged from the need to address the specific forms of subjugation experienced by Black women, which were often overlooked by traditional feminist agendas, coordinating race and gender in the struggle for emancipation and recognition of their needs.⁸

Against this backdrop, it is evident that racism and gender inequalities significantly affect women's lives, especially those of Black, Brown, and Indigenous women. Thus, understanding the perceptions of female professionals working at a

health center regarding forms of gender- and race-based subjugation is vital to reveal how differences and oppression manifest daily and interfere with the quality of life.

In addition, it is essential to support health workers in addressing racism and gender diversity and in implementing actions to promote social justice and inclusion. Accordingly, this study aims to understand the perceptions of women working at a health center regarding gender and racial inequalities.

Methods

This qualitative participatory action research study was based on Paulo Freire's Research Itinerary, which comprises three interdependent stages developed through Culture Circles: 1) Thematic investigation; 2) Coding and decoding; and 3) Critical unveiling. The Culture Circle is a space for exchanging knowledge and ways of knowing aimed at transforming the social environment.⁹ The writing of this article follows the *Consolidated Criteria for Reporting Qualitative Research*.¹⁰

In the Culture Circles proposed by Paulo Freire, participants teach and learn from one another through their experiences and reflections.¹⁰ Dialogical moments of Thematic Investigation, Coding and Decoding, and Critical Unveiling occurred during the activity.

The study was conducted at a Health Center (HC) located in a municipality in southern Brazil, selected by the Municipal Health Secretariat because it serves the territory with the largest Black population in the region.

Initially, the Culture Circles were planned to be conducted with Black female users receiving care at the facility. However, because of a curfew imposed due to local violence, the schedule was reorganized and the study population was changed to female workers from the HC itself. Participants were recruited through direct verbal invitations in their respective work sectors.

Ten women who worked at the HC participated in the study. The inclusion criteria were being a woman, regardless of skin color; working at the Health Center; and agreeing to participate in the meeting. The exclusion criteria were being on vacation, medical leave, or any other type of leave during data collection, as well as being unable to participate fully in the entire scheduled activity because of service demands. Data

were collected in the second half of 2024 through a Culture Circle lasting a total of two hours, held in the Health Center auditorium.

The study objectives and the methodology to be adopted were initially presented on the day the Culture Circle was held. This was followed by an introductory activity and completion of socioeconomic information. Subsequently, the initial phase of the study, known as thematic investigation, occurred. Participants were divided into three subgroups, in which they were encouraged to engage in dialogue and record the generative themes on kraft paper in response to the following prompting questions:

“What do you understand by the empowerment of White, Brown, Black, and Indigenous women and health?” “What facilitates the empowerment of White, Brown, Black, and Indigenous women in health?” “What makes the empowerment of White, Brown, Black, and Indigenous women in health difficult?”

The prompting questions initiated the activity and stimulated dialogue, and the participants shared reflections on their experienced reality and the proposed topic.¹¹ At this stage, the participants divided into groups to consider the questions, reflect on their own reality, and then share it with the group. As they shared their reflections, similar words emerged; these were written on cards and subsequently grouped to facilitate collective visualization.

In the second stage, called coding and decoding, the themes that emerged were discussed in the larger group and organized into two categories: Gender and Machismo; and Gender and Racial Inequalities. The mediators engaged in dialogue with the participants, encouraging them to consider their reality and reflect on these themes.

The themes identified during the coding and decoding stages were explored in greater depth during critical unveiling – the final stage of Paulo Freire’s Research Itinerary. At this stage, through dialogue and the continuous action-reflection-action process, the participants and mediators critically analyzed their lived reality, envisioning new possibilities for reflection and pathways toward the social, political, and cultural transformation of the context addressed.¹¹⁻¹²

During the Culture Circle the discussions, with the participants' consent, the dialogues were audio-recorded and the main impressions were documented in a field notebook, constituting the material that was subsequently transcribed verbatim for detailed analysis.

Data were analyzed simultaneously with the development of the Culture Circle, in constant alignment with Freirean principles.¹³ This analytical and participatory process was conducted interactively between the women and the research facilitators, without the use of *software* to support qualitative analysis and with priority given to the collective construction of knowledge and the sharing of emerging proposals.

Notably, the study complied with the requirements governing Brazilian human research.¹⁴ The participants signed an Informed Consent Form, ethical safeguards were observed, and anonymity was ensured. To preserve the confidentiality and privacy of the data collected, all participants were identified using the names of prominent Black Brazilian women who have been important to Brazilian society, such as Ivone Lara, Marielle Franco, Maria Soldado, Carolina Maria de Jesus, Clementina de Jesus, Antonieta de Barros, Martinha, Elza Soares, and Glória Maria. The Human Research Ethics Committee approved the study, in compliance with Resolutions N°466/12 and N°510/2016 of the Brazilian National Health Council, under Approval Opinion N°6.856.056 and Certificate of Presentation for Ethical Appraisal N°79654924.3.0000.0121, dated May 29, 2024.

Results

Ten women who worked at a health center in a municipality in southern Brazil participated in the Culture Circle. The center was located in the area with the largest number of Black residents assigned to its catchment population.

The participants were between 46 and 66 years of age whose educational attainment ranged from elementary education to incomplete higher education. Four identified seven women self-identified as Black (four Black and three mixed-race), one as an Indigenous woman, and two as White women.

The Health Center is located in an area of socioeconomic vulnerability. Notably, an attempt was made to hold the previously scheduled Culture Circle; however, it was postponed because the local criminal faction operating in the area had ordered that groups not gather due to ongoing violence.

The themes resulting from the Culture Circle, which emerged from the participants' statements, reflections, and dialogues, were presented as follows: Gender and Machismo; and Gender and Racial Inequalities. Each theme was illustrated with examples drawn from the participants' reflections, highlighting their perceptions and experiences.

Gender and Machismo

Through critical unveiling, the participants experienced a process of action and reflection in which dialogue enabled them to relate the topic to their own lives and connect it with their family histories and ancestral experiences. Machismo is structurally embedded in the formation of Brazilian society and continues to reverberate to this day. It acts as a barrier to women's advancement within society, as illustrated by the participants' statements below:

[...] Society is still sexist today; women are expected to be submissive. [...] (Maria Soldado).

[...] Women couldn't wear long trousers at first. [...] (Martinha).

[...] Nowadays, I have the right to go to the market and pay the bills; in the past, men handled all of that. [...] (Glória Maria).

The participants' reflections reveal a society that has evolved following multiple feminist mobilization waves; however, the rights achieved still do not fully encompass the realities and arbitrary conditions to which women remain exposed, as illustrated by the following excerpts:

[...] It is closely related to the issue of gender, because men earn more than women. [...] (Marielle).

[...] My father's salary – she was the one who took charge of organizing the house [...] (Martinha).

[...] My mother never worked outside the home. [...] (Ivone).

[...] Generally, the one leading the way isn't the feminine – it's the masculine. [...] (Maria Soldado).

The dialogues highlighted changes in social norms and practices related to women's behavior and roles in society, shifting from a restrictive model governing how women should act and participate in community and domestic life toward greater autonomy and freedom of movement. However, the burden of childcare and household responsibilities persists, reflecting the continued influence of cultural machismo.

Persistent machista social practices are evident in participants' accounts of women's overload and the disproportionate distribution of professional and domestic responsibilities, whereby women ultimately assume a double workload, including unpaid household labor.

[...] Women didn't work; it was just the home and the children, and they relied on their husbands' money. [...] (Carolina Maria).

[...] They didn't work outside the home, but worked hard at home. [...] (Antonieta).

[...] My mother worked, but she was the one who organized the whole house. [...] (Martinha).

It is also noteworthy that, although social norms and values have evolved over the years, granting women greater "freedom," their time has been increasingly consumed by paid work. In addition to their employment, women remain primarily responsible for household chores and for caring for children and older adults, even when they work full-time.

Gender and Racial Inequalities

Inequalities and racism perpetuate women's exclusion across multiple sectors of society and hinder women's empowerment. The participants' reflections provide

examples of situations experienced during their mothers' generation that continue to persist to the present day:

[...] Social and racial inequalities in general pose a challenge. [...] (Carolina Maria).

[...] Generally, men earn more than women. [...] (Elza).

[...] Participation in affairs, power, and equality [...] (Maria Soldado).

[...] Difficulty in having autonomy and an awareness of power [...]. (Glória Maria)

[...] As for difficulties, I think it's discrimination based on skin color and prejudice in general. [...] (Clementina).

The participants identified discrimination as a barrier to autonomy and freedom, along with limited financial resources and a lack of voice in society.

[...] If I don't stand up for myself, who will? (Glória Maria).

[...] Women began fighting for space and rights; they were tired and set out to claim their rights. [...] (Ivone).

[...] But there are still men today who just want to be in charge. [...] (Marielle).

[...] My mother is 70 years old and is going to the market today; she doesn't stay at home like she used to – she goes out and buys her own things. [...] (Glória).

Regarding the recognition and protection of women's rights, the participants' reflections indicated that skin color is a factor that restricts the full right to be and to exist. They emphasized that the struggle for women's rights, particularly those of Black and Indigenous women, is ongoing, whether regarding rights achieved through political action or to skin color-based discrimination, and these experiences still shape and guide these women's daily lives.

[...] Because I don't think it's the color of your skin that defines you, but rather your ability. [...] (Martinha).

The participants' statements reflect Black women's perceptions of their own rights vis-à-vis their skin color, while also revealing doubts about whether they are able to fully exercise those rights, as expressed in the following reflections:

[...] For example, Black people and Persons with Disabilities (PwD) do not have the same access to public service examinations as others. [...] (Elza).

[...] I don't use the priority line at the supermarket; I don't take advantage of it. It's my right, but in my opinion, I'd be lowering myself. [...] (Martinha).

Society, as currently structured, leads the population to believe that everyone has equal opportunities and that achieving one's goals requires nothing more than effort; in reality, however, vulnerable groups, such as Black women, face limited access and inclusion.

Regarding Black women, while issues of gender inequality and racism are widely discussed, little progress has actually been made in these areas. Mere willpower or a desire for inclusion does not suffice; society as a whole must unite to combat these inequities, even though public policies exist to guarantee these rights.

Discussion

The analysis of the dialogues that emerged from the Culture Circle revealed that machismo and gender and racial inequalities continue to operate as central structures of oppression in the daily lives of the Health Center workers, affecting mental health, work overload, and limitations on the full exercise of citizenship. The action-reflection-action process enabled by the Freirean itinerary allowed the participants to critically unveil the historical and cultural roots that sustain the asymmetry of power between men and women.

The participants' perceptions of wage disparities between men and women and the predominance of men in leadership positions reinforce the social construction of gender as a marker of asymmetric power. When the workers state that "those in charge are men" or recall that historically "women were not allowed to wear trousers", this reflects a critical unveiling of structural machismo.¹⁵

Machismo refers to a set of beliefs, behaviors, and practices that perpetuate gender inequality by placing men in a position of superiority over women. It manifests in different ways, ranging from apparently subtle expressions, such as jokes, teasing, and popular sayings, to explicit practices of discrimination and violence.¹⁵ Machismo and gender are, therefore, interconnected concepts that shape social relations and sustain unequal power structures. These findings are consistent with the literature in showing that the sexual division of labor constrains women's time and generates emotional overload, directly affecting the mental health of health care workers.³

By revealing the burden resulting from the double workday and unpaid household care, the Health Center workers exemplify the "traffic intersection" metaphor. At the intersection of gender, race, and class, these women are simultaneously affected by machismo, which assigns domestic work to them, and by economic hardship, which compels them to engage in paid employment, placing an additional burden on their physical and mental health.¹⁶

In Brazil, during the colonial period, there was a persistent and aggressive attempt to erase Indigenous peoples, with Black and Indigenous women subjected to various forms of abuse and violence in the service of colonization and racial whitening.¹

This historical legacy is reflected in the trajectory of the feminist movement in the country itself: while the earliest abolitionist and emancipatory agendas were led by White women and did not include discussions of race and gender, Black women, who were already subjected to forced labor, struggled to be recognized as women.¹

As a legacy of this structural exclusion, Black and Indigenous women currently remain exposed to the highest discrimination rates and the most adverse health outcomes, including the highest rates of premature mortality, obstetric violence, and mental illness. These data confirm that the gender-race intersection operates as a central social determinant that undermines living conditions and access to health care among this population group.³

In the Brazilian political and institutional landscape, women remain underrepresented in decision-making spaces and leadership positions that enable social advancement. Despite historical advances, such as the appointment of an Indigenous woman as a minister, women still earn lower wages and have limited voice, which

affects their autonomy and freedom of expression. Within this context of transition, Black women have made a decisive contribution to ensuring that the feminist movement becomes genuinely more inclusive and incorporates the antiracist struggle alongside demands for gender equality.⁸

Gender inequalities and machismo affect women worldwide and manifest in multiple forms, ranging from discrimination in the labor market to physical and sexual violence. In response to this context of structural oppression, collective feminist movements organize to challenge power asymmetries, advocating for the protection of fundamental rights, socioeconomic equity, and the elimination of all forms of discrimination against women.

In 2009, the National Policy for the Comprehensive Health of the Black Population was established as a result of advances in social participation and oversight in discussions on racism and health.¹⁷ However, its full implementation requires greater adherence by states and municipalities to prevent health inequities within the Unified Health System (SUS). Eliminating the forms of oppression experienced by women therefore requires the engagement of society as a whole in combating racism and the gender asymmetries present in everyday life.

Contemporary expressions of gender inequality include wage disparities for performing the same work; moral and sexual harassment experienced by women; their limited representation in public office and leadership positions; as well as gender stereotypes and the objectification of women's bodies, all of which contribute to upholding women's social subordination.

The bodies of Black, Brown, and Indigenous women largely occupy a fantasized place in society and in the male imagination. This is evident, for example, during Carnival, when these women may gain visibility because of their bodies and performance, yet they are poorly compensated and are consumed primarily for male pleasure during this period of the year.¹⁸

These sociocultural constructions reinforce stigmatizing stereotypes of Black women, such as the servile woman, the "loud and confrontational" woman, or the hypersexualized woman, whose body is subjected to objectification. However, both nationally and internationally, intellectuals and artists such as Angela Davis, Grada

Kilomba, Sueli Carneiro, Djamila Ribeiro, Elza Soares, and Larissa Luz have contributed to bringing these issues into public debate, denouncing the oppression experienced by Black women and broadening the struggle for equality and social justice.

The participants' narratives resonate with the pain and resilience portrayed in Brazilian popular music, as in the lyrics of *Mulher do Fim do Mundo*, by Elza Soares – which depict the silencing and surrender of “Black skin,” “voice”, and “opinion” in the public arena – and in the song *A Carne* (performed by Larissa Luz), which highlights how “Black flesh is the cheapest meat on the market”, relegated primarily to underemployment and spaces of vulnerability. This intertwining of insurgent art and the workers' accounts reveals that racial and gender inequities are not theoretical abstractions, but concrete markers that affect women's health, subjectivity, and everyday lives within the SUS.

The lyrics sung by Elza Soares and Larissa Luz encapsulate experiences of pain, inequality, and exclusion that reflect the realities lived by Brazilian Black women. This exclusion is rooted in colonial and patriarchal processes and has continued to place Black women in subordinate and marginalized positions, resulting in a double burden of oppression based on gender and race, as Black women continue to occupy subordinate and marginalized social positions that subject them to oppression on both grounds.⁴ In this context, machismo operates symbiotically with structural racism, intensifying invisibility, wage disparities, the Sexual Division of Labor, and the objectification of Black women's bodies.

Several gains have been achieved since the emergence of women's emancipation movements, including the right to vote, the attainment of civil autonomy, and freedom from the legal guardianship of fathers and husbands. However, these advances stand in contrast to a harsh epidemiological and social reality: a sexual assault is recorded every eleven minutes, and women continue to experience sexual violence in Brazil.¹⁹ Women's freedom remains constantly threatened by machismo: women are harassed on public transportation, on the streets, and in the workplace, and the rights they have achieved are not permanent. Historical gains are repeatedly brought back into debate and questioned in spaces of power occupied predominantly by men – one example is the right to abortion in circumstances already provided for by law.

Although Brazil defines itself as a secular state, religious institutions that are increasingly present in the political arena have sought to restrict women's access to their rights, using faith as an instrument of manipulation. Fundamentalist discourses instrumentalize religious dogmas to reinforce traditional gender roles, associating men with the role of provider and relegating women to a subordinated position. This sociocultural construction emerged in the Culture Circle dialogues: although the participants indicated that such normative patterns were stricter in the past – “that was how things were back then” – they recognized that asserting themselves as women and as rights-bearing subjects in society remains an ongoing struggle.

Study limitations include the constraints imposed by territorial violence and organized crime in the community where the Health Center is located. The control exercised by the local criminal faction prevented staging the Culture Circle with users of the Health Center and restricted the amount of time available for the health workers' participation, requiring the activities to be concluded at the time they had established.

Conclusion

This study provided an understanding of Health Center workers' perceptions of gender and racial inequalities, revealing that machismo and structural racism continue to operate as central axes of oppression in these women's daily lives. The burden imposed by the double workday, limited autonomy, and subjective and social barriers to the full exercise of citizenship persist despite historical transformations and advances in feminist agendas, indicating that skin color and gender continue to determine positions of greater vulnerability within Primary Health Care and the territory.

The reflections emerging from the Culture Circle demonstrate that overcoming these inequities requires dismantling the myth of racial democracy and recognizing racism and machismo as social determinants of health. The persistent conservative discourses and weak institutional adherence to guidelines such as the National Policy for the Comprehensive Health of the Black Population continue to keep access to and quality of care below the actual needs of Black, Brown, and Indigenous women. Thus,

safeguarding fundamental rights, safety, and women's integrity requires constant political vigilance and societal engagement in the antiracist struggle and in preventing the erosion of rights.

For nursing praxis and health practices within the SUS, the findings reinforce the urgent need to consolidate stable spaces for continuing education and qualified listening, grounded in Paulo Freire's Research Itinerary, thereby promoting the empowerment of both female workers and users. Managers, health professionals, and social movements should coordinate intersectoral actions aimed at gender and racial equity, transforming routine health services into safe and emancipatory environments that are genuinely committed to health promotion and social justice.

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Authorship contribution

1 – Virgínia Aparecida de Faria Sousa

Nurse, Master – virginia.faria.sousa@gmail.com

Research conception and/or development and/or manuscript writing; Review and approval of the final version

2 – Ivonete Teresinha Schülter Buss Heidemann

Corresponding author

Nurse, Doctor – ivonete.heidemann@ufsc.br

Research conception and/or development and/or manuscript writing; Review and approval of the final version

3 – Michelle Kuntz Durand

Nurse, Doctor – michakd@hotmail.com

Review and approval of the final version

4 – Francis Solange Vieira Tourinho

Nurse, Doctor – francis.tourinho@ufsc.br

Review and approval of the final version

5 – Camila Trindade Coelho

Nurse, Master – trielho_camilla@hotmail.com

Review and approval of the final version

6 – Denise Antunes de Azambuja Zocche

Nurse, Doctor – denise.zocche@udesc.br

Review and approval of the final version

7 – Ana Karoliny Machado

Nursing undergraduate – anakaroliny@gmail.com

Review and approval of the final version

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