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Cultural competence, intersectionality, and equity in health

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Abstract

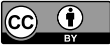
Objective
This study aimed to analyze the approach to cultural competence and equity in health from an intersectional perspective, investigating the extent to which scientific production problematizes health disparities in relation to social markers of difference understood as interrelated axes of subordination that cut across the subjective experiences of professionals and users, as well as work processes in the field of health.

Method
An integrative literature review was conducted based on the following guiding questions: how is cultural competence understood and does it point to an intercultural and dialogical perspective of health work; what perspectives emerge regarding the relationships between social markers of difference, the health-disease process, and the production of culturally sensitive, congruent, and competent care.

Results
The selected studies highlight that the intersections between social markers of difference and the cultural dimension of health-disease processes are poorly addressed in the training of health professionals. On the other hand, critical studies confer on cultural competence the role of an analytical device for health practices, leading to an intersectional perspective of the social determination of health-disease-care processes.

Conclusion
In general, there is a gap in the scientific literature on the relationships between cultural competence, intersectionality, and inequalities, which contributes to the low visibility of the relationship between the absence of cultural competence and unsatisfactory results in terms of effectiveness, access, resolution, and, consequently, health equity.

Keywords: Cultural competence; Culturally competent care; Healthcare disparities; Health equity; Intersectional framework.



In the field of Collective Health, equity is a principle based on recognizing the needs and vulnerabilities of each group or population, whose specific demands require differentiated responses from services and workers (Oliveira et al., 2020). In this context, cultural competence in health — understood as the ability of healthcare workers and systems to recognize cultural diversity and act with cultural sensitivity — represents a decisive element for the provision of comprehensive and equitable care, ensuring social justice (M. R. Müller et al., 2023).

The ongoing pursuit for comprehensiveness, equity, and social justice — considered the ethical and democratic horizon of the *Sistema Único de Saúde* (SUS, Brazilian Unified Health System) — leads to the acknowledgment of the limitations of policies that are grounded in the notion of a universal subject. It also entails positioning culture as a constitutive element of the health-disease-care process. According to C. P. Müller et al. (2007, p. 861), culture is understood as "a complex set of influences referring to what people believe and how they live". Thus, culture encompasses knowledge, values, beliefs, worldviews, practices, and shared meanings — elements that are constantly evolving yet may endure across generations, marking differences among groups, societies, and peoples.

Currently, there is an intensification of exchanges between groups and individuals from different cultures at a global level and the organization of complex and multicultural societies, which poses significant challenges for healthcare systems. Consequently, in recent decades, international organizations such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO) have sought to implement global actions to foster intercultural encounters and dialogues to ensure access to quality healthcare and promote health equity. However, this requires the development of skills, training technologies, care strategies, and, more broadly, cultural competence.

This term is used in the health context to refer to the ability of organizations, systems, and workers to operate effectively in intercultural situations, providing care that acknowledges individuals' uniqueness and sociocultural context. Beyond the mere acquisition of knowledge and linguistic or communication skills, M. R. Müller et al. (2023, p. 3) argue that:

> Culturally sensitive health care practices are related to the ability to recognize cultural diversity and to understand that diversity shapes the process of seeking care. Although all individuals share basic needs, there are significant differences in how people address these needs. It is essential not only to recognize different patterns of seeking assistance but also to consider the ways in which health is communicated, defined, and evaluated, as well as the support networks involved.

For this reason, in contemporary multicultural and multiethnic societies, the cultural competence approach has become a turning point in the field of collective health, aimed at combating the significant health disparities that disproportionately affect minority, ethnic, and racial groups, migrants, women, older adults, people with disabilities, LGBTQIAPN+ persons, Indigenous populations, and people experiencing homelessness (Brach & Fraserirector, 2000; Damasceno & Silva, 2018; Gouveia et al., 2019; Santos et al., 2020; Zambrana et al., 2004).

In Brazil, health disparities are directly associated with social differences and inequalities among individuals and groups, manifesting in morbidity and mortality rates, life expectancy, and differing levels of exposure to health- and disease-related risk factors. These disparities are also evident in barriers to accessing services, the quality of care provided, the unequal distribution of healthcare teams and resources across regions and territories, and the presence of discriminatory, racist, and violent practices in various healthcare settings (Amaral et al., 2021; Castro-Nunes & Ribeiro, 2023; Dantas et al., 2020; Mendonça et al., 2021; Passarelli-Araujo, 2023; Polidoro et al., 2023).

Thus, understanding the multiple factors associated with health inequalities is critical to the formulation and implementation of equitable public policies. However, there is an emerging incorporation of an intersectional perspective in understanding these interrelations, including in the collection of data and the production of national statistics that intersect social markers of difference. It is understood that "an intersectionality analysis reveals these relationships and allows for a differentiated understanding of how health inequities are structured and perceived" (Venkatachalam et al., 2020, p. 109). An intersectional lens is crucial for monitoring equity, as it aids in identifying patterns and needs, enables a better understanding of the specific characteristics of a population, and facilitates more accurate analyses of health situations (Organização Pan-Americana de Saúde, 2020).

This article aims to address cultural competence and health equity through an intersectional lens. In this regard, it may contribute to deepening analyses of health disparities by proposing to examine these asymmetries in relation to social markers of difference and their intersections, viewing them as interrelated axes of subordination present in the subjective experiences of professionals and users, as well as in healthcare work processes. Based on an integrative literature review, the following aspects were analyzed: 1) how cultural competence is conceptualized and whether it points to an intercultural and dialogical perspective in healthcare work; 2) what perspectives emerge regarding the relationships between social markers of difference, the health-disease process, and the production of culturally sensitive, congruent, and competent care, which may allow for insights into potential effects on health equity.

Method

This study is an integrative literature review on cultural competence, intersectionality, and health equity, conducted following the research steps outlined below: a) formulation of guiding questions; b) literature search or sampling; c) data collection; d) study categorization; e) study assessment; and f) interpretation and discussion of the results (Souza et al., 2010).

The search included articles indexed in the Periódicos database of the *Coordenação de Aperfeicoamento de Pessoal de Nível Superior* (CAPES, Brazilian Federal Agency for Support and Evaluation of Graduate Education) and was concluded on July 12, 2023. The following keywords were used, drawn from the Health Sciences Descriptors (DeCS): "Cultural Competency" AND "Intersectional Framework"; "Cultural Competency" AND "Culturally Competent Care"; "Cultural Competency" AND "Social Determination of Health"; "Cultural Competency" AND "Social Determinants of Health"; "Cultural Competency" AND "Anthropology Medical"; "Cultural Competency" AND "Racism"; "Cultural Competency" AND "Health Status Disparities"; "Cultural Competency" AND "Healthcare Disparities"; "Cultural Competency" AND "Health Inequities"; "Cultural Competency" AND "Cultural Diversity"; "Cultural Competency" AND "Ethnopsychology"; "Cultural Competency" AND "Cross-Cultural Comparison".

As well as their variations in the Portuguese language: "Competência cultural" AND "Enquadramento Interseccional"; "Competência cultural" AND "Assistência à Saúde Culturalmente Competente"; "Competência cultural" AND "Determinação Social da Saúde"; "Competência cultural" AND "Determinantes Sociais da Saúde"; "Competência cultural" AND "Antropologia Médica"; "Competência cultural" AND "Racismo"; "Competência cultural" AND "Disparidades nos Níveis de Saúde"; "Competência cultural" AND "Disparidades em Assistência à Saúde"; "Competência cultural" AND "Iniquidades em Saúde"; "Competência cultural" AND Diversidade cultural; "Competência

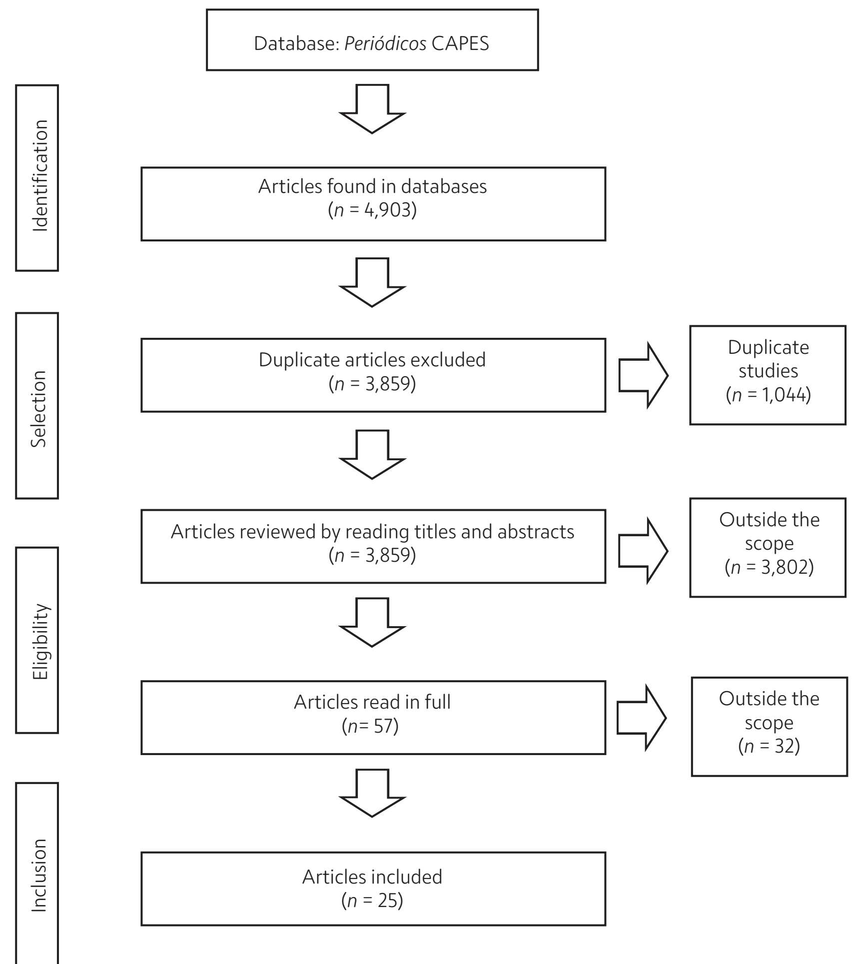
cultural" AND "Etnopsicologia"; "Competência cultural" AND "Comparação Transcultural". And in Spanish: "Competencia cultural" AND "Marco interseccional"; "Competencia cultural" AND "Asistencia Sanitaria Culturalmente Competente"; "Competencia cultural" AND "Determinación Social de la Salud"; "Competencia cultural" AND "Determinantes Sociales de la Salud"; "Competencia cultural" AND "Antropología Médica"; "Competencia cultural" AND "Racismo"; "Competencia cultural" AND "Disparidades en Atención de Salud"; "Competencia cultural" AND "Inequidades en Salud"; "Competencia cultural" AND "Diversidad Cultural"; "Competencia cultural" AND "Etnopsicología"; "Competencia cultural" AND "Comparación Transcultural".

The following inclusion criteria were applied: (a) theoretical and empirical scientific articles; (b) written in Portuguese, English, or Spanish; (c) no publication time restriction; and (d) addressing topics related to cultural competence in health, health disparity, equity, intersectionality, minority groups, and social markers of difference. Theses, systematic reviews, monographs, undergraduate dissertations, and other articles that did not align with the discussion focus were excluded.

The selected articles were exported to Zotero, duplicates were removed, and titles and abstracts were reviewed to determine if they met the proposed inclusion criteria. A total of 4,903 studies were identified in the databases. Of these, 1,044 were duplicates, and 3,834 were outside the scope as they did not meet the inclusion criteria. They were all excluded. The final sample consisted of 25 studies. All phases are detailed in Figure 1.

Figure 1

Flowchart of the identification, selection, eligibility and inclusion phases of the literature review



In the first stage of the analysis process, descriptive categories were created based on the year of publication, journal name, field of knowledge, country where the research was conducted, type of study (theoretical or empirical), theoretical framework, and methodological design. Next, an effort was made to determine how the selected articles addressed the research questions.

Results

The selected articles (*n* = 25) comprise theoretical (*n* = 14) and empirical (*n* = 11) studies, of which five are qualitative studies, and six utilized mixed methods. The target audiences include healthcare professionals (physicians, nurses, psychologists), healthcare service users, and medical students. No cutoff time frame was established for the material search; the publications date back to the year 2000 and span various journals. Regarding the areas of knowledge of the journals indexed in Qualis *Periódicos*/CAPES, the main fields are Nursing (*n* = 7); Medicine (*n* = 7); Collective Health (*n* = 6); Psychology (*n* = 4); and Sociology (*n* = 1). Concerning the countries where the studies were conducted, the distribution is as follows: United States (*n* = 18); Brazil (*n* = 2); Portugal (*n* = 1); Canada (*n* = 1); Spain (*n* = 1); Chile (*n* = 1); and Netherlands (*n* = 1).

As shown in Table 1, most studies were conducted in the United States, a country with notable disparities in healthcare and medical assistance. Minority groups in this country are more likely to lack health insurance, face barriers to care, and experience worse health outcomes in terms of preventable and treatable diseases, differences in access, care quality, and health metrics, including life expectancy and infant mortality (Brach & Fraserirector, 2000; Cuevas et al., 2017; Drevdahl et al., 2008; Jackson & Gracia, 2014; Kersey-Matusiak, 2012).

In this context, studies such as that by Jackson and Gracia (2014) highlight that actions based on the perspective of Social Determinants of Health (SDOH) have become critically important for improving healthcare and addressing health disparities. These studies acknowledge the significant impact of social, economic, cultural, ethnic/racial, psychological, and behavioral factors on the occurrence of health problems, whether positively or negatively. Kersey-Matusiak (2012) points out that "these inequalities may stem from differences in care-seeking behaviors, cultural beliefs, health practices, language barriers, trust levels in healthcare providers, geographic access to care, insurance status, or ability to pay for services" (p. 5).

Cuevas et al. (2017), in their analysis of health disparities in the care of African American, Latinos/Latin-Americans, and European patients in U.S. primary care, found that patients across all groups desired physicians who were attentive and sensitive to their needs, who acknowledged their racial/ethnic background and refrained from discriminatory or prejudiced practices. Schilder et al. (2001), while examining care-seeking and adherence among HIV-positive men from three minorities (gay men, bisexual men, and transgender individuals) in a Canadian healthcare service, suggest that awareness of sexual identity and the various values, beliefs, and cultural customs related to sexual minorities improves care-seeking behavior, access, and treatment adherence. Finally, Ida (2007), reflecting on the recovery of diverse populations with mental health issues in the U.S., emphasizes that cultural competence mitigates the impacts of social, cultural, linguistic, and geographic factors, as well as the isolation caused by cultural and linguistic barriers, stigma, and shame associated with mental illness.

Table 1
Selected studies

1 of 2

Author (year)	Title	Journal	Field of Knowledge	Country	Study Type	Theoretical Framework	Methodology
Brach & Fraserirector (2000)	Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model	Medical Care Research and Review	Medicine	USA	Theoretical Article	Public/Collective Health	Conceptual Analysis
Schilder et al. (2001)	Being dealt with as a whole person. Care seeking and adherence: the benefits of culturally competent care	Social Science & Medicine (1982)	Collective Health	Canada	Empirical	Public/Collective Health	Quantitative & Qualitative
Ida (2007)	Cultural Competency and Recovery within Diverse Populations	Psychiatric Rehabilitation Jornal	Collective Health	USA	Theoretical Article	Public/Collective Health and Mental Health	Conceptual Analysis
Drevdahl (2008)	Of goldfish tanks and moonlight tricks: Can cultural competency ameliorate health disparities?	Advances in Nursing Science	Nursing	USA	Theoretical Article	Public/Collective Health	Conceptual Analysis
Powell Sears (2012)	Improving cultural competence education: the utility of an intersectional framework	Medical Education	Medicine	USA	Theoretical Article	Public/Collective Health and Intersectionality	Conceptual Analysis
Kersey-Matusiak (2012)	Competent Care: Are we there yet?	Nursing (Jenkintown, Pa)	Nursing	USA	Theoretical Article	Public/Collective Health	Conceptual Analysis
Jackson & Gracia (2014)	Addressing Health and Health-Care Disparities: The Role of a Diverse Workforce and the Social Determinants of Health	Public Health Reports (1974)	Medicine	USA	Theoretical Article	Public/Collective Health and Social Determinants of Health	Conceptual Analysis
Plaza (2014)	Diversidad cultural o desigualdad social? Una aproximación crítica a la competencia cultural en la salud a partir de las necesidades sentidas por mujeres en contextos de diversidad, injusticia social y austeridad	Configurações	Sociology	Portugal	Empirical	Public/Collective Health and Social Determinants of Health	Quantitative & Qualitative
Case (2015)	White Practitioners in Therapeutic Allyance: An intersectional privilege awareness training model	Women & Therapy	Psychology	USA	Theoretical Article	Public/Collective Health and Intersectionality	Conceptual Analysis
Onyeabor (2016)	Addressing Health Disparities at the Intersection of Disability, Race, and Ethnicity: The Need for Culturally and Linguistically Appropriate Training for Healthcare Professionals	Journal of Racial and Ethnic Health Disparities	Collective Health	USA	Empirical	Public/Collective Health and Intersectionality	Quantitative & Qualitative
Freshman (2016)	Cultural Competency - Best Intentions are not good enough	Diversity and Equality in Health and Care	Collective Health	USA	Theoretical Article	Public/Collective Health	Conceptual Analysis
Lima et al. (2016)	*Atuação de enfermeiros sobre práticas de cuidados afrodescendentes e indígenas*	Revista Brasileira de Enfermagem	Nursing	Brazil	Empirical	Public/Collective Health and Health Care	Qualitative
Muntinga et al. (2016)	Toward diversity-responsive medical education: taking an intersectionality-based approach to a curriculum evaluation	Advances in Health Sciences Education: Theory and Practice	Medicine	Netherlands	Empirical	Public/Collective Health and Intersectionality	Quantitative & Qualitative
Estevan & Ruíz (2017)	*La aplicación del modelo de competencia cultural en la experiencia del cuidado en profesionales de Enfermería de Atención Primaria*	Atención Primaria	Nursing	Spain	Empirical	Public/Collective Health, Primary Care, and Health Care	Qualitative
Cuevas et al. (2017)	What is the key to culturally competent care: Reducing bias or cultural tailoring?	Psychology & Health	Psychology	USA	Empirical	Public/Collective Health, Primary Care, and Patient-centered care	Qualitative

Table 1
Selected studies

2 of 2

Author (year)	Title	Journal	Field of Knowledge	Country	Study Type	Theoretical Framework	Methodology
Wesp et al. (2018)	An Emancipatory Approach to Cultural Competency: The Application of Critical Race, Postcolonial, and Intersectionality Theories	Advances in Nursing Science	Nursing	USA	Theoretical Article	Social and health sciences; Transcultural nursing; and Critical race, postcolonial feminist, and intersectionality theories	Conceptual Analysis
Pérez et al. (2018)	*Competencia cultural: La necesidad de ir más allá de las diferencias raciales y étnicas*	Atención Primaria	Nursing	Chile	Empirical	Public/Collective Health and Primary Care	Qualitative
Polster (2018)	Confronting barriers to improve healthcare literacy and cultural competency in disparate populations	Nursing (Jenkintown, Pa.)	Nursing	USA	Theoretical Article	Public/Collective Health, Transcultural Nursing, and Health Literacy	Conceptual Analysis
Freitas Júnior et al. (2018)	*Incorporando a Competência Cultural para Atenção à Saúde Materna em População Quilombola na Educação das Profissões da Saúde*	Revista Brasileira de Educação Médica	Collective Health	Brazil	Empirical	Public/Collective Health, Primary Care, and Health Care	Qualitative
Kivlighan et al. (2019)	Examining Therapist Effects in Relation to Clients' Race-Ethnicity and Gender: An Intersectionality Approach	Journal of Counseling Psychology	Psychology	USA	Empirical	Public/Collective Health and Intersectionality	Quantitative & Qualitative
Al'Uqdah et al. (2019)	African American Muslims: Intersectionality and Cultural Competence	Counseling and Values	Psychology	USA	Theoretical Article	Public/Collective Health and Intersectionality	Conceptual Analysis
Bi et al. (2020)	Teaching Intersectionality of Sexual Orientation, Gender Identity, and Race/Ethnicity in a Health Disparities Course	MedEdPORTAL	Medicine	USA	Empirical	Public/Collective Health and Intersectionality	Quantitative & Qualitative
Lekas et al. (2020)	Rethinking Cultural Competence: Shifting to Cultural Humility	Health Services Insights	Collective Health	USA	Theoretical Article	Collective/Public Health and Intersectionality	Conceptual Analysis
Nguyen (2020)	Update on Medical Education, Insurance Coverage, and Health Care Policy for Lesbian, Gay, Bisexual, Transgender, Questioning, Intersexual, and Asexual Patients	Dermatologic Clinics	Medicine	USA	Theoretical Article	Public/Collective Health and Intersectionality	Conceptual Analysis
Namer & Wandschneider (2021)	Skills building seminar: How to integrate social identities in public health education – an intersectional approach	European Journal of Public Health	Medicine	USA	Theoretical Article	Public/Collective Health and Intersectionality	Conceptual Analysis

In these scenarios, cultural competence is prioritized to provide care for individuals from diverse cultural, social, and linguistic backgrounds. This includes training the healthcare workforce, integrating intercultural education into health training, and implementing interventions aimed at reducing racial/ethnic health disparities (Brach & Fraserirector, 2000; Cuevas et al., 2017; Jackson & Gracia, 2014; Kersey-Matusiak, 2012). The provision of culturally competent care is believed to contribute to improved healthcare services, greater treatment adherence, and enhanced recognition of the values, beliefs, attitudes, and health needs of individuals and groups, considering their culture, race/ethnicity, gender, disability, sexual orientation, immigration status, socioeconomic status, and religion.

In all studies, cultural competence is associated with the knowledge, attitudes, and skills necessary to effectively address cultural differences, improve the quality of care provided to racial/ethnic minority groups, reduce communication barriers for individuals with limited English proficiency or low literacy, support the diversity of values and beliefs within the population, and increase cultural awareness in healthcare service delivery (Brach & Fraserirector, 2000; Drevdahl et al., 2008; Jackson & Gracia, 2014; Kersey-Matusiak, 2012). The acquisition of cultural competence is regarded as a continuous process, requiring ongoing self-assessment, skill development, and knowledge acquisition regarding culturally diverse groups, alongside motivation, purpose, and goals to achieve cultural competence (Kersey-Matusiak, 2012). Consequently, U.S. governmental agencies, academic institutions, and private organizations have invested in offering guidelines, educational resources, and information to facilitate the acquisition and application of cultural competence skills for the benefit of patients and the communities they serve (Drevdahl et al., 2008; Jackson & Gracia, 2014; Kersey-Matusiak, 2012).

Some authors highlight the limitations of studies on cultural competence. Kersey-Matusiak (2012), for instance, cautions about the variety of cultural competence models and/or cultural assessment tools. The author emphasizes the lack of a universally accepted definition of cultural competence and the absence of evidence supporting the use of a single model. Drevdahl et al. (2008) argue that cultural competence extends beyond language access or interpreter support. According to Drevdahl (2008, p.19), this restriction reinforces relevant critiques of the concept, stating: "In general, these critiques note that cultural competency overgeneralizes, reinforces stereotypes, treats culture as something static, and is devoid of historical context".

Corroborating these positions, Brach and Fraserirector (2000) emphasize that culture should not be limited to aspects of race and ethnicity or focus on specific racial and ethnic minority groups. They warn that much of the literature on cultural competence discusses the importance of cultural awareness, knowledge, attitudes, and skills, but does not describe how a healthcare system becomes culturally competent, with the discussion often restricted to patient-physician communication. They highlight that, although a wide range of cultural competence techniques have been identified, such as interpreter services, recruitment policies, training, coordination with traditional healers, use of community health agents, inclusion of family/community members, and immersion in another culture, healthcare systems have limited evidence on which techniques are most successful and under what circumstances.

Plaza (2014) points out that the promotion of culturally competent practices alone has not transformed the conditions that generate inequality in access to healthcare in contexts of diversity associated with migration, and that health disparities are associated with social and economic inequalities, social stratification, power asymmetries, and deficiencies in the public health system. Lekas et al. (2020), while recognizing the importance of providing cultural competence training

to healthcare professionals to reduce health disparities and improve the quality of care offered, note that such training is often designed to expose funders/providers to some results, risking the stereotyping, stigmatization, and fostering of racist and oppressive attitudes and behaviors.

In this regard, Drevdahl et al. (2008) observe that, in most studies, cultural competence is oversimplified, under-theorized, and does not address how workers confront the "nearly insurmountable task of overcoming the formidable mechanisms of power that keep structural disparities at play and in place" (p. 14). They argue that addressing such issues requires entering a far more complex and challenging terrain – one that cannot be resolved through technical guidelines or checklists – and instead calls for "new theories and methods that explore and understand cultural differences and critically examine the dominant culture" (p. 22). This is particularly important because many of the "models developed to address cultural difference are often created by dominant and privileged individuals, operating from predominantly white and hegemonic perspectives" (p. 21).

Due to this, some studies, such as those by Muntinga et al. (2016), Nguyen (2020), and Onyeabor (2016), focus on the challenges of training and qualifying healthcare workers and faculty members, considering social markers of difference in the provision of culturally competent care. Namer and Wandschneider (2021) discuss the need to incorporate intersectionality into public health curricula in the U.S. and Europe to enable students to identify mechanisms of privilege and oppression related to social identities. They emphasize the importance of providing transformative methodologies and teaching strategies for faculty so that classrooms become spaces for critical self-reflection on the intersectionalities that affect individuals and social groups. Powell Sears (2012) indicates that teaching cultural competence in medical schools in the U.S. has little impact on physicians' behaviors and/or health outcomes for racial and ethnic minorities. Programs tend to teach specific cultural knowledge, despite the vast heterogeneity within racial and ethnic groups, often relying on simplistic and homogenizing cultural prescriptions. The author argues that education for cultural competence must go beyond cultural essentialism and should enable healthcare professionals to critically analyze their own beliefs, values, and social statuses regarding race, ethnicity, gender, social class, and sexuality, which intersect in their personal and professional life histories.

Pérez et al. (2018) state that the cultural competence approach should consider a broad and inclusive concept of culture that encompasses the entire population. According to these authors, healthcare professionals' training should focus on developing specific competencies, such as cultural sensitivity, non-discrimination, and self-awareness, which can be integrated into the early stages of professional education. Polster (2018) outlines guidelines that can enhance health literacy among patients, families, and healthcare team members, such as cross-cultural communication, a multicultural workforce, and intercultural leadership. Estevan and Ruíz (2017) emphasize the importance of promoting the training of professionals in designing programs and protocols specific to the social group served and in conducting research with socially vulnerable groups.

Freshman (2016) argues that the appreciation and value of diversity should be institutionalized in policy, processes, and organizational culture. The author presents three recommendations for learning and practicing cultural competence: promoting cultural awareness, sensitivity, and realignment of values; understanding and respecting the social/cultural environment of the patient population, their personal resources, and traditional healing methods; and developing and maintaining systems that reinforce culturally competent behaviors and practices across the entire team.

In a similar vein, Wesp et al. (2018) assert that current approaches to cultural competence do not adequately equip healthcare professionals to address the inequalities that persist among

marginalized communities and minority groups. This inadequacy stems, in part, from neglecting to analyze the power dynamics of dominant ideologies, thereby heightening the likelihood of healthcare professionals (re)producing stereotypes and perpetuating discrimination. The authors advocate for an emancipatory approach to cultural competence, guided by critical race theories, postcolonial feminisms, and intersectionality, organized around three pillars: 1) recognizing the diversity of values, practices, and traditions of each individual or group; 2) providing education and training in culturally competent care through an intersectional lens, acknowledging markers such as race, ethnicity, religion, sexuality, gender identity, and country of origin, as well as the dominant ideologies and power dynamics present in society and the workplace; 3) engaging in critical reflection on one's own culture and beliefs to understand power relations, prejudice, and dominant ideologies — including racism, whiteness, patriarchy, and heteronormativity, etc. — prevalent in both society and professional practices.

Kivlighan et al. (2019) highlight the limited research on how the intersections of healthcare professionals' race, ethnicity, and gender influence the provision of culturally competent care. Case (2015) points to a lack of awareness among professionals regarding unconscious stereotypes, systemic racism, white privilege, and white racial identity, which interfere with clinical management, therapeutic alliances, the reproduction of prejudices and assumptions, and even the enhancement of cultural competence. In this challenging context, certain experiences stand out, such as the study by Bi et al. (2020), which reported the impact of an innovative module addressing the intersectionality of sexual orientation, gender identity, and race/ethnicity within the mandatory curriculum of the Pritzker School of Medicine (USA). Through lectures and videos that highlight the intersections of social markers of difference in individuals' life stories — such as a non-gender-conforming Latina lesbian, an older African American gay man, an African American transgender woman with chronic health conditions, a Latina transgender woman, and an Asian American transgender man who survived intimate partner violence — medical students were able to identify barriers to care and confront their own biases regarding the patients they serve.

Using intersectional theory, Al'Uqdah et al. (2019) guide psychologists, psychiatrists, and therapists in improving their cultural competence when providing care to African American Muslims residing in the United States. To achieve this, they recommend increasing knowledge and understanding of the values, habits, rituals, and practices of this population, as well as their perspectives on Muslims in general. They also highlight the importance of recognizing how racism and Islamophobia influence their behaviors, thoughts, feelings, and relationships, resulting in prejudice and discrimination. Freitas Júnior et al. (2018), through an action-research aimed at implementing an interprofessional prenatal care service for *quilombola* women in Rio Grande do Norte, identify the establishment of (a)effective bonds between users and the healthcare team and the ability to reflect with an emphasis on intercultural dialogue as the primary needs for culturally competent behavior in *quilombola* maternal healthcare. They also report that the opportunity for medical students to learn about the health conditions of the *quilombola* population and experience interprofessional work proved to be an effective strategy for enhancing the development of cultural competencies during medical training. Similarly, Lima et al. (2016), when analyzing the practices of nurses in the *Estratégia Saúde da Família* (ESF, Family Health Strategy) in a region of northeastern Brazil regarding care rooted in African and Indigenous cultures, found that these professionals were unfamiliar with the historical and religious context of the ethnic groups they served and undervalued their self-care practices, prioritizing practices based on the biomedical model. Given this, the authors emphasize the need to expand discussions on cultural competence in both education and professional practice to promote a healthcare perspective aligned with discourses on diversity, transculturation,

spirituality, Indigenous health, the National Health Policy for the Black Population, the Health Policy for Indigenous Peoples, and related topics.

Discussion

The analysis of the selected material revealed significant contributions regarding the guiding questions of this study, namely: how cultural competence is conceptualized and whether it points toward an intercultural and dialogical perspective of healthcare work; and what perspectives emerge regarding the relationships between social markers of difference, the health-disease process, and the production of culturally sensitive, congruent, and competent care. The selected studies emphasize that intersections between social markers of difference are not addressed in most health education curricula, which impacts the provision of culturally sensitive, congruent, and competent care, as well as efforts to reduce health disparities. They reveal attempts to incorporate discussions related to the social determinants of health and intersectionality into undergraduate and postgraduate programs, particularly in medical schools, to enhance the educational process, knowledge, skills, physician-patient communication, critical reflexivity, and the evaluation of biomedical and sociocultural aspects in healthcare services (Bi et al., 2020; Muntinga et al., 2016; Namer & Wandschneider, 2021; Nguyen, 2020; Onyeabor, 2016; Powell Sears, 2012).

From a critical perspective within the field of Latin American Collective Health, studies conducted in Brazil and Chile assign cultural competence an analytical role, challenging the boundaries and limitations of reductionist and objectified conceptions of health and care (Freitas Júnior et al., 2018; Lima et al., 2016; Pérez et al., 2018). Linked to the "political and scientific process that led to the recognition of the social determinants of the health-disease-care process" (Teixeira, 2020, p. 44), this critical view asserts that "social conditions are effectively the basis for the health standards of a population, just as an individual's position in society is a foundation for their own health" (Fleury-Teixeira, 2009, p. 384). From this perspective, the health-disease-care process is seen as a web in which cultural, social, and biological factors, as well as the individual and collective dimensions of health, are inseparable. In this view, "biological, psychological, behavioral, economic, cultural, and ethno-racial factors, as well as social stratification, influence the occurrence of health problems and their risk factors within the population" (Merhy et al., 2023, p. 3).

Thus, the political and scientific agenda of countries like Brazil, which propose the concept of the Social Determinants of Health, advances in reinterpreting the causes of illnesses and inequities, positioning itself critically against reductionist approaches to health that fail to consider such phenomena from a historical and cultural perspective. In Latin American studies, explanations of the health-disease-care process are sought in social relations and the interactions between the state, economy, society, and health. Particular emphasis is placed on analyzing the tensions and antagonisms inherent in the capitalist mode of production, the dominance of macro-ideological structures through processes of subjectivation, acculturation, and various forms of epistemicide. These elements collectively impact ways of living and producing, as well as the health conditions and patterns of illness within populations.

The selected material identified a critical line of thought that, albeit timidly, advances its analysis by focusing on the health care work process itself, proposing an understanding of the social determinants of health care, as highlighted by Correia et al. (2022). These perspectives emphasize that:

> Any reference for the production of health care must question the hegemony (or empire?) of biomedical rationality and its technicism, which, in conjunction with the pharmaceutical and medical-

> hospital material industries, reinforces the pathologization of life and the biomedicalization of society. This process obscures the production of vulnerabilities stemming from the exploitation of some living beings, inherent to capitalism, where everything becomes a commodity. (Cabral, 2023, p. 4)

In this direction, theoretical and methodological efforts converge to integrate interculturality as a key element in the procedural perspective of the social determinants of the health-disease-care process. This aligns with the intersectional approach present in studies addressing the "structural oppressions of the modern colonial matrix" by analyzing the intersections between different axes of subordination (Akotirene, 2019, p. 24). From this perspective, the intersectional lens stands out in certain studies on cultural competence, such as those by Al'Uqdah et al. (2019), Case (2015), Kivlighan et al. (2019), Lekas et al. (2020), and Wesp et al. (2018), demonstrating its analytical strength in addressing the complexity of social markers of difference – such as class, gender, race/ethnicity, sexual orientation, generation, nationality, religion, and ability. These markers coexist and mutually shape one another, forming the "multidimensional nature of health inequities" (Collins & Bilge, 2021, p. 3). In this work of intersections, some authors highlight the challenge of integrating intersectional structures into clinical practices and public policies to produce alternative comprehensibility for understanding the health-disease processes. They also stress the complexity of elevating the commitment to improving health conditions to the level of social justice (Collins & Bilge, 2021; Viveros, 2023). Academic contributions draw attention to the interpenetration of multiple forms of socially constructed differences across a broad spectrum. This includes differences that preexist the subjects themselves and affect their bodies, daily life experiences, and healthcare work processes.

As a result, these studies are considered to contribute to the understanding that: "is a model that views cultural competence as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)" (Campinha-Bacote, 2002, p. 181). This process is necessarily connected to the recognition of the psychosocial determinants that intersectionally shape the health-disease process and the sociocultural affiliations of the work subjects themselves in the ways they produce health care. It is considered, as C. P. Müller et al. (2007, p. 860) argue, that "health professionals need to understand this construction, concerning the user, family, and community under their responsibility, as well as their own development as social subjects, embedded in a cultural and historical context". This implies that "professionals must recognize the role of culture in their own lives and its influence on how they act and think, developing critical awareness of their own ethnocentrisms" (M. R. Müller et al., 2023, p. 3).

In summary, the contributions of the studies selected for this review are both epistemological-conceptual and instrumental in nature, addressing the understanding of the health-disease process, health inequalities, and the training of workers to operate in intercultural contexts. They also address the limitations and challenges related to public health education processes and the need for new teaching and learning strategies. The studies further indicate that, despite the significant lag in addressing these gaps in the health field, there is a clear silencing of intersectional perspectives in the constitution of various public policies, particularly in the implementation of global health policies that are genuinely open to intercultural diversity in light of social markers of difference, as highlighted by Rodrigues et al. (2023). Above all, this review demonstrates the scarcity of studies guided by an intersectional perspective and cultural dimensions when addressing the health-disease-care process. Likewise, studies exploring the relationship between cultural competence and health equity are also limited.

Final Considerations

Addressing cultural competence in health through the intersectional perspective of social markers of difference, as proposed in this study, aimed to support the treatment of a substantive issue related to the construction of equitable public policies. Achieving health equity relies on respecting differences, adopting a broader lens to view social subjects, and conducting a socially situated and culturally sensitive reading of social markers of difference in their intersectional complexity. However, a gap in the scientific literature was identified regarding the integration of these ideas, especially when considering the establishment of dialogue from a critical intersectional perspective connected to the social determinants of the health-disease-care process. Intersectionality, as a conceptual framework, has yet to be incorporated into many fields of knowledge. Consequently, its association with cultural competence in health is still absent. Additionally, there is a certain degree of invisibility in the literature regarding the relationship between the lack of cultural competence in healthcare practices and unsatisfactory outcomes in terms of effectiveness, access, and resolution. This, in turn, compromises the guarantee of health equity. Achieving comprehensive and equitable care with social justice requires acting sensitively and engaging in dialogue with the cultural context of each individual and community. This necessitates not only new teaching and learning strategies in academic training but also operational mechanisms within everyday healthcare practices. Ultimately, this involves processes that foster new relational experiences of recognizing and valuing cultural differences and the intersectional aspects present in the social determinants of the health-disease-care process. This ongoing transformation entails expanding theoretical-methodological and technical-professional efforts in the field of health studies to analyze and make visible the relationships between cultural competence, intersectionality, and equity. It is perhaps researchers with accumulated expertise in critical studies and a commitment to building public policies that address historical health inequalities and inequities, working alongside communities and social movements, who are best positioned to rise to this challenge in favor of culturally sensitive healthcare models.

References

Akotirene, C. (2019). *Interseccionalidade*. Pólen Produção Editorial Ltda.

Al'Uqdah, S. N., Hamit, S., & Scott, S. (2019). African American Muslims: intersectionality and cultural competence. *Counseling and Values, 64*(2), 130-147. https://onlinelibrary.wiley.com/doi/full/10.1002/cvj.12111

Amaral, C. E. M., Treichel, C. A. D. S., Francisco, P. M. S. B., & Onocko-Campos, R. T. (2021). Assistência à saúde mental no Brasil: estudo multifacetado em quatro grandes cidades. *Cadernos de Saúde Pública, 37*, 1-3. https://doi.org/10.1590/0102-311X00043420

Bi, S., Vela, M. B., Nathan, A. G., Gunter, K. E., Cook, S. C., López, F. Y., & Nocon, R. S., & Chin, M. H. (2020). Teaching intersectionality of sexual orientation, gender identity, and race/ethnicity in a health disparities course. *MedEdPORTAL, 16*, 1-10. https://doi.org/10.15766/mep_2374-8265.10970

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*, 181-217. http://periodicos.capes.gov.br/index.php/acervo/buscador.html?task=detalhes&id=W4251415427

Cabral, B. E. (2023). Da urgência de flechar a formação e o trabalho em saúde em exercício contracolonizador. *Interface-Comunicação, Saúde, Educação, 27*, 1-5. https://doi.org/10.1590/interface.230353

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: a model of care. *Journal of transcultural nursing, 13*(3), 181-184.

Case, K. A. (2015). White practitioners in therapeutic ally-ance: an intersectional privilege awareness training model. In A. Dottolo & E. Kaschak, *Whiteness and white privilege in psychotherapy* (pp. 97-112). Routledge. https://doi.org/10.1080/02703149.2015.1059209

Castro-Nunes, P. D., & Ribeiro, G. D. R. (2023). Equidade e vulnerabilidade em saúde no acesso às vacinas contra a COVID-19. *Revista Panamericana de Salud Pública, 46*, 1-6. https://doi.org/10.26633/RPSP.2022.31

Collins, P. H., & Bilge, S. (2021). *Interseccionalidade*. Boitempo.

Correia, D., Mendes, A. N., & Carnut, L. (2022). Determinação social do processo saúde-doença no contexto latino-americano: a importância do pensamento crítico em saúde. *Crítica Revolucionária-Revolutionary Criticism, 2*, 1-24. https://criticarevolucionaria.com.br/revolucionaria/article/view/11

Cuevas, A. G., O'Brien, K., & Saha, S. (2017). What is the key to culturally competent care: reducing bias or cultural tailoring? *Psychology & Health, 32*(4), 493-507. https://pubmed.ncbi.nlm.nih.gov/28165767/

Damasceno, R. F., & Silva, P. L. N. (2018). Competência cultural na atenção primária: algumas considerações. *Journal of Management & Primary Health Care, 9*, 1-8. https://doi.org/10.14295/jmphc.v9i0.435

Dantas, C. M. B., Dimenstein, M., Leite, J. F., Macedo, J. P., & Belarmino, V. H. (2020). Território e determinação social da saúde mental em contextos rurais. *Athenea Digital, 20*(1), 1-21. https://atheneadigital.net/article/view/v20-1-dantas-dimenstein-leite-et-al

Drevdahl, D. J., Canales, M. K., & Dorcy, K. S. (2008). Of goldfish tanks and moonlight tricks: can cultural competency ameliorate health disparities? *Advances in Nursing Science, 31*(1), 13-27. https://pubmed.ncbi.nlm.nih.gov/20531266/

Estevan, M. D., & Ruíz, M. C. S. (2017). La aplicación del modelo de competencia cultural en la experiencia del cuidado en profesionales de Enfermería de Atención Primaria. *Atención Primaria, 49*(9), 549-556. https://www.sciencedirect.com/science/article/pii/S0212656716302475

Fleury-Teixeira, P. (2009). Uma introdução conceitual à determinação social da saúde. *Saúde em Debate, 33*(83), 380-389. https://www.redalyc.org/pdf/4063/406345800005.pdf

Freitas Júnior, R. A. O., Santos, C. A. D., Lisboa, L. L., Freitas, A. K. M. S. O., Garcia, V. L., & Azevedo, G. D. (2018). Incorporando a competência cultural para atenção à saúde materna em população Quilombola na educação das profissões da saúde. *Revista Brasileira de Educação Médica, 42*(2), 100-109. https://doi.org/10.1590/1981-52712015v42n2RB20170086

Freshman, B. (2016). Cultural competency: best intentions are not good enough. *Diversity and Equality in Health and Care, 13*(3), 240-244. https://www.primescholars.com/articles/cultural-competency--best-intentions-are-not-goodenough.pdf

Gouveia, E. A., Silva, R. D. O., & Pessoa, B. H. S. (2019). Competência cultural: uma resposta necessária para superar as barreiras de acesso à saúde para populações minorizadas. *Revista Brasileira de Educação Médica, 43*, 82-90. https://doi.org/10.1590/1981-5271v43suplemento1-20190066

Ida, D. J. (2007). Cultural competency and recovery within diverse populations. *Psychiatric Rehabilitation Journal, 31*(1), 49-53. https://psycnet.apa.org/doiLanding?doi=10.2975%2F31.1.2007.49.53

Jackson, C. S., & Gracia, J. N. (2014). Addressing health and health-care disparities: the role of a diverse workforce and the social determinants of health. *Public Health Reports, 129*, 57-61. https://journals.sagepub.com/doi/10.1177/00333549141291S211

Kersey-Matusiak, G. (2012). Culturally competent care: are we there yet? *Nursing, 42*(2), 49-52. https://pubmed.ncbi.nlm.nih.gov/22252069/

Kivlighan, D. M., Hooley, I. W., Bruno, M. G., Ethington, L. L., Keeton, P. M., & Schreier, B. A. (2019). Examining therapist effects in relation to clients' race-ethnicity and gender: an intersectionality approach. *Journal of Counseling Psychology, 66*(1), 122-129. https://doi.org/10.1037/cou0000316

Lekas, H. M., Pahl, K., & Lewis, C. F. (2020). Rethinking cultural competence: shifting to cultural humility. *Health Services Insights, 13*, 1-4. https://journals.sagepub.com/doi/10.1177/1178632920970580

Lima, M. R. A, Nunes, M. L. A., Klüppel, B. L. P., Medeiros, S. M., & Sá, L. D. (2016). Atuação de enfermeiros sobre práticas de cuidados afrodescendentes e indígenas. *Revista Brasileira de Enfermagem, 69*(5), 840–846. https://doi.org/10.1590/0034-7167.2016690504

Mendonça, T. T., Schafer, J. L., Costa, A. B., Pan, P. M., Caye, A., Gadelha, A., Miguel, E., Bressan, R. A., Rohde, L. A. P., & Salum, G. A. (2021). Disparidades em saúde mental entre jovens lésbicas, gays, bissexuais, transgêneros, queer e assexuais no Brasil: resultados de um estudo de base comunitária. *Clinical and Biomedical Research, 41*, 29. https://lume.ufrgs.br/handle/10183/234712

Merhy, E. E, Slomp Junior, H., Feuerwerker, L. C. M., & Moebus, R. L. N. (2023). A promoção da saúde vista genealogicamente como uma prática discursiva na sua produção de mundos e uma leitura micropolítica dos determinantes sociais. *Interface-Comunicação, Saúde, Educação, 27*, 1-15. https://doi.org/10.1590/interface.220231

Müller, C. P., Araujo, V. E., & Bonilha, A. L. L. (2007). Possibilidade de inserção do cuidado cultural congruente nas práticas de humanização na atenção à saúde. *Revista Eletrônica de Enfermagem, 9*(3), 858-865. https://revistas.ufg.br/fen/article/download/7513/5329/28118

Müller, M. R., Lima, R. C., & Ortega, F. (2023). Repensando a competência cultural nas práticas de saúde no Brasil: por um cuidado culturalmente sensível. *Saúde e Sociedade, 32*, 1-12. https://doi.org/10.1590/S0104-12902023210731pt

Muntinga, M. E., Krajenbrink, V. Q. E., Peerdeman, S. M., Croiset, G., & Verdonk, P. (2016). Toward diversity-responsive medical education: taking an intersectionality-based approach to a curriculum evaluation. *Advances in Health Sciences Education, 21*, 541-559. https://link.springer.com/article/10.1007/s10459-015-9650-9

Namer, Y., & Wandschneider, L. (2021). Skills building seminar: How to integrate social identities in public health education–an intersectional approach. *European Journal of Public Health, 31*, 3. https://academic.oup.com/eurpub/article/31/Supplement_3/ckab164.376/6405316

Nguyen, T. V. (2020). Update on medical education, insurance coverage, and health care policy for lesbian, gay, bisexual, transgender, questioning, intersexual, and asexual patients. *Dermatologic Clinics, 38*(2), 201-207. https://doi.org/10.1016/j.det.2019.10.004

Oliveira, E. D., Couto, M. T., Separavich, M. A. A., & Luiz, O. D. C. (2020). Contribuição da interseccionalidade na compreensão da saúde-doença-cuidado de homens jovens em contextos de pobreza urbana. *Interface-Comunicação, Saúde, Educação, 24*, 1-15. https://doi.org/10.1590/Interface.180736

Onyeabor, S. (2016). Addressing health disparities at the intersection of disability, race, and ethnicity: the need for culturally and linguistically appropriate training for healthcare professionals. *Journal of Racial and Ethnic Health Disparities, 3*, 389-393. https://pubmed.ncbi.nlm.nih.gov/27294732/

Organização Pan-Americana de Saúde. (2020). *Por que a desagregação de dados é essencial durante pandemias*. PAHO. https://iris.paho.org/handle/10665.2/52072

Passarelli-Araujo, H. (2023). Mapeando as disparidades socioeconômicas de saúde urbana: um estudo comparativo entre seis capitais brasileiras. *Revista Brasileira de Estudos de População, 40*, 1-25. https://doi.org/10.20947/S0102-3098a0251

Pérez, C., Pedrero, V., Bernales, M., & Chepo, M. (2018). Competencia cultural: la necesidad de ir más allá de las diferencias raciales y étnicas. *Atención Primaria, 50*(9), 565-567. https://pmc.ncbi.nlm.nih.gov/articles/PMC6837153/

Plaza, S. H. (2014). ¿Diversidad cultural o desigualdad social? Una aproximación crítica a la competencia cultural en la salud a partir de las necesidades sentidas por mujeres en contextos de diversidad, injusticia social y austeridad. *Configurações*: *Revista Ciências Sociais,* (14), 103-128. https://journals.openedition.org/configuracoes/2290

Polidoro, M., Mahoche, M. J., Bairros, F., Meneghel, S. N., Rainone, F. N., & Canavese, D. (2023). Geografia das disparidades em saúde entre brancos e negros em Porto Alegre, Rio Grande do Sul. *Cadernos Saúde Coletiva, 31*, 1-13. https://doi.org/10.1590/1414-462X202331010454

Polster, D. S. (2018). Confronting barriers to improve healthcare literacy and cultural competency in disparate populations. *Nursing, 48*(12), 28-33. https://pubmed.ncbi.nlm.nih.gov/30383570/

Powell Sears, K. (2012). Improving cultural competence education: the utility of an intersectional framework. *Medical Education,* 46(6), 545-551. https://pubmed.ncbi.nlm.nih.gov/22626046/

Rodrigues, L. S., Miranda, N. G., & Cabrini, D. (2023). Obesidade e interseccionalidade: análise crítica de narrativas no âmbito das políticas públicas de saúde no Brasil (2004-2021). *Cadernos de Saúde Pública, 39*, 1-14. https://doi.org/10.1590/0102-311XPT240322

Santos, R. G. S., Cunha, M. P., & Rego, M. A. (2020). O racismo institucional sob a perspectiva da ética do cuidado, nos serviços de saúde: revisão integrativa. *Saúde Coletiva, 10*(56), 3198-3213. https://doi.org/10.36489/saudecoletiva.2020v10i56p3198-3213

Schilder, A. J., Kennedy, C., Goldstone, I. L., Ogden, R. D., Hogg, R. S., & O'Shaughnessy, M. V. (2001). "Being dealt with as a whole person". Care seeking and adherence: the benefits of culturally competent care. *Social Science & Medicine*, *52*(11), 1643-1659.

Souza, M. T. D., Silva, M. D. D., & Carvalho, R. D. (2010). Revisão integrativa: o que é e como fazer. *Einstein* (São Paulo), *8*, 102-106. https://www.scielo.br/j/eins/a/ZQTBkVJZqcWrTT34cXLjtBx/?format=pdf&lang=pt

Teixeira, R. R. (2020). Produzir saúde na produção do mundo. *Revista do Centro Pesquisa e Formação, 10*, 43-62. https://portal.sescsp.org.br/files/artigo/5e492dae/ca91/424f/b6da/fcc504c8aa4b.pdf

Venkatachalam, D., Mishra, G., Fatima, A., & Nadimpally, S. (2020). 'Marginalizing' health: employing an equity and intersectionality frame. *Saúde em Debate, 44*, 109-119. https://doi.org/10.1590/0103-11042020S109

Viveros, M. (2023). *Interseccionalidad. Giro decolonial y comunitario*. CLACSO.

Wesp, L. M., Scheer, V., Ruiz, A., Walker, K., Weitzel, J., Shaw, L., Kako, P. M., & Mkandawire-Valhmu, L. (2018). An emancipatory approach to cultural competency: the application of critical race, postcolonial, and intersectionality theories. *Advances in Nursing Science, 41*(4), 316-326. https://pubmed.ncbi.nlm.nih.gov/30285982/

Zambrana, R., Molnar, C., Munoz, H., & Lopez, D. (2004). Cultural competency as it intersects with racial/ethnic, linguistic, and class disparities in managed healthcare organizations. *American Journal of Managed Care, 10*, 37-44. https://pubmed.ncbi.nlm.nih.gov/15481435/

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