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Voices of inequality: a qualitative exploration of barriers and perceptions in achieving health equity

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ABSTRACT

Purpose: This study explores how intersecting social identities shape experiences of health inequity, focusing on rural communities, immigrant families, and low-income women managing chronic illnesses. This study sought to understand the barriers, perceptions, and resilience strategies in pursuit of equitable healthcare.

Design/methodology/approach: This study adopts a qualitative, case-based design underpinned by intersectionality theory. Data were drawn from semi-structured interviews (n = 12), three focus groups, and relevant policy documents. Thematic analysis, combining deductive and inductive coding, was conducted to capture both the structural barriers and lived experiences of inequity.

Findings: Three themes emerged: (1) systemic exclusion and bureaucratic barriers, (2) perceived inequities in treatment and quality of care, and (3) resilience and adaptive strategies. Rural participants reported geographic isolation and invisibility in health planning; immigrant families encountered language exclusion, documentation barriers, and stereotyping; and low-income women faced financial constraints and dismissive clinical encounters. A unifying thread was **systemic invisibility**, with participants consistently perceiving their needs as deprioritized by health systems. Resilience strategies, such as pooled transport, diasporic networks, and peer support, were vital but framed as coping responses to systemic neglect.

Research limitations/implications: The case-based design prioritizes depth over statistical generalizability. The findings reflect specific contexts, although they offer transferable insights into the patterned nature of health inequities. Future research should adopt mixed-methods or longitudinal designs.

Practical implications: Health systems should embed intersectional sensitivity in policy and practice, institutionalize participatory decision-making, and strengthen culturally competent care to address systemic invisibility in healthcare.

Social implications: Achieving health equity requires shifting responsibility from marginalized groups back onto systems, ensuring structural accountability rather than reliance on community resilience alone.

JEL Classification - I140

Originality/value: By comparing three distinct contexts through an intersectional lens, this study demonstrates how inequities emerge in context-specific, but structurally patterned, ways. It highlights systemic invisibility as a cross-cutting driver of inequity, providing actionable insights for health policies and practices.

INTRODUCTION

Health equity has emerged as a central priority in global health, rooted in the principle that all individuals should have the opportunity to attain their full health potential without disadvantage due to their social position or identity (Mcloughlin et al., 2024). Despite long-standing commitments, such as the World Health Organization's call to eliminate avoidable health disparities, inequities persist across race, gender, socioeconomic status, geography, and migration status (Albandar, 2024). These disparities are evident in differences in morbidity, mortality, and quality of care, disproportionately burdening the marginalized populations.

Much of the existing research on health inequities relies on quantitative indicators, which provide valuable evidence of disparities in outcomes, such as maternal mortality, chronic disease burden, and life expectancy (Zipfel et al., 2021). However, these approaches often obscure the subjective realities of individuals navigating unequal health systems. Lived experiences, including perceptions of exclusion, mistrust, and resilience, reveal dimensions of inequity that aggregate data alone cannot capture (Prall, 2024). Consequently, policies and interventions may risk being technocratic, overlooking how individuals at the intersection of multiple social identities experience health systems. Intersectionality theory provides a critical framework for addressing these gaps. First articulated by Crenshaw (1989) and further developed in health research, intersectionality emphasizes how overlapping social categories such as race, gender, class, and migration status interact to create compounded disadvantages. From an intersectional perspective, health inequities cannot be reduced to single axes of difference; rather, they emerge from the interlocking effects of structural oppression and social exclusion (Kapilashrami et al., 2015). Applying this lens to health equity research highlights how systemic barriers and individual perceptions are shaped by intersecting identities and contexts of individuals.

Qualitative research, particularly case-based inquiry, is well-suited to operationalizing intersectionality in empirical studies. By foregrounding the narratives of marginalized groups, qualitative approaches illuminate how multiple dimensions of inequity converge in lived experiences (Lapalme et al., 2019). Such methods not only generate deeper insights into the barriers to equitable care but also affirm the epistemic value of voices that are often excluded from policymaking. This study contributes to the literature by adopting a case-based qualitative approach to explore barriers to and perceptions of health equity across diverse contexts. Drawing on three illustrative cases (1) rural communities in low-resource settings, (2) immigrant families in urban environments, and (3) low-income women with chronic illnesses this study poses the following questions: What barriers do individuals and communities perceive in their pursuit of equitable healthcare? How do systemic and structural factors shape these experiences? What insights can be derived from these narratives to inform policies and practices aimed at achieving health equity in the future?

By situating these cases within an intersectional framework, this study highlights how inequities are experienced at the intersections of geography, socioeconomic status, gender, and cultural identity. Ultimately, this study argues that achieving health equity requires not only structural reforms but also recognition of the complex, intersecting realities of marginalized populations.

LITERATURE REVIEW

Research on health inequities has largely been dominated by quantitative approaches that emphasize indicators such as morbidity, mortality, and life expectancy. These studies have provided strong evidence of disparities across race, gender, socioeconomic status, and geography; however, they often obscure the subjective realities of individuals navigating unequal systems of care (Lett et al., 2022). Quantitative data alone cannot capture how exclusion, mistrust, and resilience are experienced in everyday interactions with health systems. Consequently, policies shaped by such evidence may risk being overly technocratic and inattentive to lived experiences (Sone et al., 2024).

Intersectionality has emerged as a critical framework for addressing these issues. First introduced in legal scholarship and later expanded in health research, intersectionality emphasizes how overlapping social identities such as race, class, gender, and migration status interrelate to produce compounded disadvantage (Agénor, 2020). From this perspective, inequities cannot be understood as the sum of isolated disadvantages but as the patterned effects of structural oppression and social exclusion. Despite its conceptual strength, much of the existing scholarship has focused on single populations or identity categories, with fewer studies employing comparative designs to explore how intersectional inequities manifest across diverse contexts (Simon et al., 2021). Closely related is the literature on structural violence, which highlights how systemic neglect and institutional arrangements reproduce health inequities across populations. Rural communities, for example, are often excluded from planning processes and remain underserved in terms of resources, while migrants frequently encounter bureaucratic obstacles, discrimination, and linguistic exclusion in urban systems (Alarcão et al., 2021). Although these dynamics are well documented, they are typically analyzed within separate population groups, leaving unanswered questions about the common mechanisms underpinning inequities across different marginalized settings.

Another relevant strand of scholarship concerns epistemic injustice, which draws attention to how marginalized voices are minimized, dismissed, or silenced within health systems. This injustice is evident in clinical encounters, where patient narratives are disregarded, and in policy frameworks that exclude community perspectives. Qualitative research has increasingly been recognized as essential for addressing this problem by foregrounding lived experiences and validating the knowledge of those most affected by inequity. However, there has been limited comparative exploration of how epistemic injustice operates across multiple marginalized groups simultaneously. Finally, a substantial body of work has examined resilience and coping strategies in disadvantaged communities. Studies have shown how marginalized populations draw on social capital, community-based support, and collective practices to navigate systemic exclusion (Okoroji et al., 2023). While such strategies reveal agency and adaptability, scholars caution that celebrating resilience without addressing its structural causes risks normalizing inequitable systems and shifting responsibility onto those already marginalized (King et al., 2021).

Taken together, the literature demonstrates three clear trends. First, health inequities are well documented through quantitative measures; however, these often miss the nuanced dimensions of lived experience. Second, intersectionality, structural violence, and epistemic injustice provide strong theoretical frameworks, but their empirical applications remain limited in comparative and multi-context analyses. Third, while resilience research highlights important coping strategies, it risks obscuring systemic accountability if it is interpreted uncritically. This study seeks to address these gaps by adopting a case-based qualitative approach across rural communities, immigrant families, and low-income women with chronic illnesses. Foregrounding participant narratives contributes to a deeper understanding of how inequities are produced, perceived, and navigated at the intersections of geography, migration, socioeconomic position, and gender.

METHODOLOGY

This study employed a qualitative, case-based design based on intersectionality theory. Intersectionality, as articulated by Crenshaw (1989) and expanded upon in health research (Agénor, 2020), provides a framework for analyzing how multiple social identities interact with structural systems to produce health inequities. The case-based approach allowed for an in-depth exploration of lived experiences while situating them within wider social and institutional contexts. This combination is particularly appropriate for examining health equity, as it foregrounds both structural barriers and individual perceptions of inequality.

Three cases were purposively selected to capture diverse intersections of disadvantage: (1) a rural community in a low-resource setting, (2) an immigrant family residing in an urban environment, and (3) a low-income woman managing a chronic illness. These cases were not chosen for statistical representativeness but for their theoretical potential to illustrate how overlapping identities, such as geography, migration status, gender, and socioeconomic position, shape inequitable healthcare experiences. This purposive strategy reflects the intersectional principle that inequities emerge in contextually specific, yet structurally patterned, ways. Data collection relied on multiple sources to enhance the depth and credibility of the findings. Semi-structured interviews (n = 12) were conducted with individuals directly engaged in each case, focusing on healthcare access, perceptions of fairness, and the role of identity in shaping their experiences. Three focus groups (6–8 participants each) were held to capture community perspectives and shared narratives. Additionally, relevant policy documents and local health service reports were reviewed to situate the participant accounts within systemic frameworks. Interview guides were designed to encourage participants to reflect on how different aspects of their identity including gender, class, ethnicity, and migration status shaped their health encounters.

Data analysis was conducted using a thematic approach and a hybrid coding strategy. Deductive codes were informed by intersectionality theory (e.g., overlapping disadvantage, structural exclusion, invisibility within systems), while inductive codes emerged from participants' narratives (e.g., mistrust, navigating bureaucracy, prioritizing family over treatment). Coding was supported by NVivo software, and themes were synthesized across cases to identify both commonalities and context-specific dynamics of the data. Consistent with the intersectional analysis, attention was given to how barriers intersected rather than simply adding up, producing unique forms of disadvantage in each case.

Ethical principles were central to the research design of this study. Informed consent was obtained from all participants, and pseudonyms were used to ensure confidentiality of the data. In line with intersectionality's emphasis on voice and representation, care was taken to avoid homogenizing experiences and acknowledge participants' agency. Where feasible, member checking was conducted, allowing participants to validate or challenge preliminary interpretations. This reflexive process ensured that the knowledge generated remained grounded in the lived realities of those most affected by inequities.

RESULTS

The analysis revealed how structural constraints and intersecting identities shape participants' experiences of healthcare access and equity. Three overarching themes emerged: (1) systemic exclusion and bureaucratic barriers, (2) perceived inequities in treatment and quality of care, and (3) resilience and adaptive strategies in navigating health systems. While these themes were shared across all groups, their manifestations varied depending on the social, geographic, and cultural contexts.

Case 1: Rural Communities in Low-Resource Settings

Participants emphasized geographic isolation and under-resourced facilities as the primary barriers. Health centers were often several hours away, and poor transportation infrastructure intensified delays in seeking treatment in the past. One mother explained:

"If my child has a fever at night, there is nothing I can do. The nearest clinic is three hours away, and we do not have a car. By the time we get there, it may already be too late."

A recurring perception was invisibility in broader health planning processes. Participants felt that policies prioritized urban populations, with rural areas receiving fewer resources and less qualified providers. Women highlighted that caregiving responsibilities and cultural expectations further limited their ability to travel for treatment. Despite these disadvantages, communities mobilized collective strategies, such as pooling money for transport or relying on traditional healers, when biomedical services were inaccessible. These strategies reflected resilience but were framed by the participants as survival mechanisms rather than sustainable solutions.

Case 2: Immigrant Families in Urban Environments

For immigrant families, barriers stemmed less from geography and more from institutional exclusion and discrimination. Many reported difficulties in navigating bureaucratic requirements for insurance and registration. One father recounted:

"They kept asking for documents I did not have. I felt like the system was designed to push me away."

Language barriers were emphasized repeatedly. Participants described being excluded from medical decision-making when interpretation services were unavailable. Women, in particular, bore the burden of navigating systems for their families, often acting as informal interpreters despite their limited proficiency.

Perceptions of stereotyping were also prevalent. As one woman shared:

"The nurse assumed that I did not understand because of my scarf. She spoke to my husband instead of me."

To cope, families turned to diasporic networks and community-based organizations that offered informal translation, knowledge sharing, and advocacy. These strategies eased access but underscored the systemic neglect by formal health institutions.

Case 3: Low-Income Women Managing Chronic Illness

For women with chronic illnesses, socioeconomic status and gender intersect to create distinctive disadvantages. Participants described fragmented care, long waiting times, and high out-of-pocket expenses. Financial burdens frequently force difficult trade-offs.

"I sometimes skip my medicine. If I buy it, then I cannot pay for my children's food."

Financial pressures were inseparable from gendered responsibilities, as women often prioritized household needs over their own health. Several patients also reported feeling dismissed in clinical encounters, with providers attributing their conditions to stress or lifestyle choices.

"The doctor told me I was just tired from housework. He didn't take my pain seriously."

To cope, women created peer support groups, informally shared medications, and exchanged practical advice with each other. These practices provided solidarity but simultaneously highlighted systemic gaps in the equitable provision of chronic care.

Cross-Case Synthesis

Taken together, the three cases illustrate how inequities are produced at the intersection of structural, institutional, and interpersonal dynamics. Rural communities face geographic neglect, immigrant families experience bureaucratic and linguistic exclusion, and low-income women encounter socioeconomic and gendered vulnerabilities.

Despite the contextual differences, a unifying theme was systemic invisibility. Participants across all groups felt deprioritized or misunderstood within formal health systems, whether due to geography, migration status, or social position. Resilience strategies, such as pooling resources, leveraging diasporic networks, or forming peer groups, were significant but consistently framed as responses to institutional neglect rather than adequate solutions.

These patterns are visually summarized in Figure 1, which illustrates how multiple social locations (geography, socioeconomic status, gender, and migration/cultural identity) overlap to produce systemic invisibility and inequitable outcomes. The figure also highlights how resilience emerges at the margins as a coping strategy.

To complement this, Table 1 provides a detailed cross-case synthesis, mapping barriers, inequities, and resilience strategies across the three cases, linking them to relevant theoretical frameworks. Together, the figure and table demonstrate how intersectional disadvantages converge to shape healthcare experiences, while also revealing the patterned nature of inequities across different contexts.

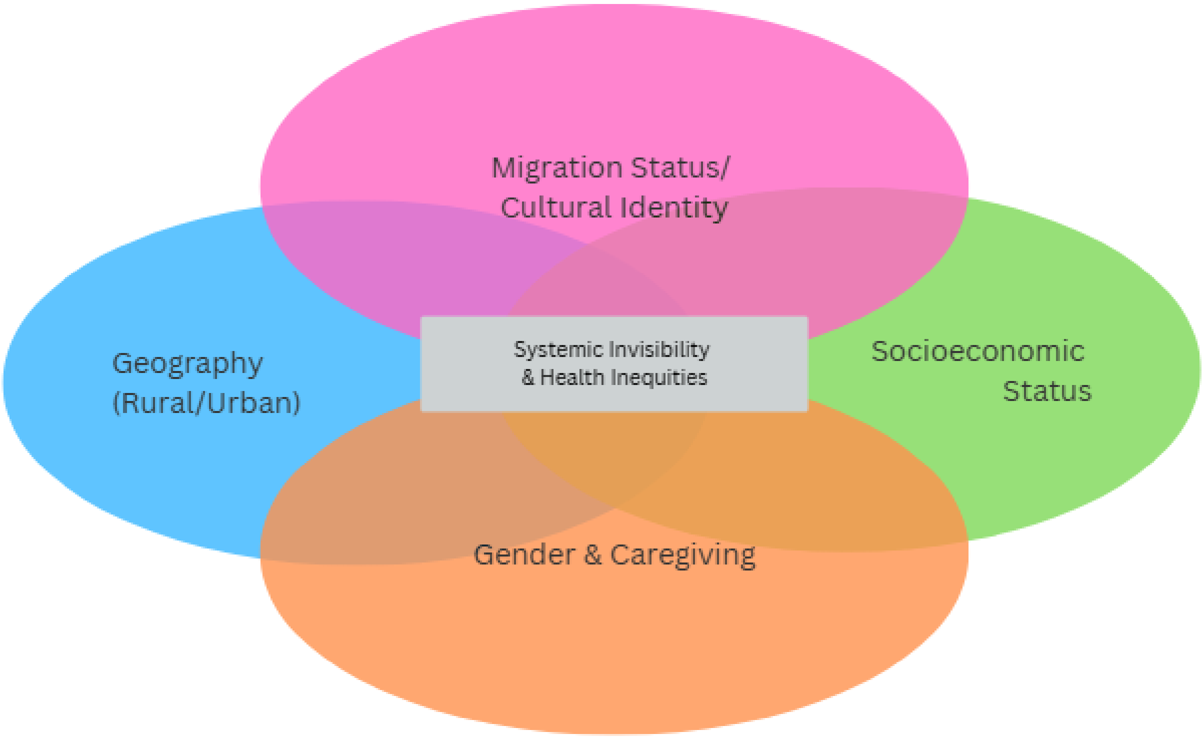

Figure 1 here: Conceptual Framework Diagram of Intersectional Barriers and Outcomes

The conceptual framework in Figure 1 illustrates how intersecting social determinants of geography, socioeconomic status, gender and caregiving roles, and migration status/cultural identity overlap to produce compounded barriers to health equity. At their intersection lies systemic invisibility, a recurring experience across all cases in which participants felt marginalized, deprioritized, or dismissed within formal health systems. The diagram also highlights how communities respond to this exclusion through resilience and coping strategies, including pooling resources, relying on diasporic networks, and forming peer-support groups. While these adaptive practices demonstrate agency, they are not substitutes for systemic reform; rather, they underscore the insufficiency of existing health structures and the burdens placed on marginalized groups to compensate for institutional neglect. By visualizing these overlapping determinants and their consequences, the framework emphasizes the necessity of an intersectional approach to understanding and addressing health inequities.

Table 1: Cross-Case Synthesis of Barriers, Inequities, and Resilience

Theme	Rural Communities	Immigrant Families	Low-Income Women with Chronic Illness
Systemic Exclusion & Bureaucratic Barriers	Geographic isolation, limited facilities, and invisibility in health planning. Theoretical anchor: *Structural Violence (Farmer, 2004)*	Documentation and insurance hurdles; language exclusion; administrative complexity. Theoretical anchor: *Institutional Racism / Exclusion (Williams & Mohammed, 2009)*	Financial barriers, fragmented care, and women prioritizing family over self-care. Theoretical anchor: *Gendered Health Inequities (Sen & Östlin, 2007)*

Perceived Inequities in Treatment & Quality of Care	Undertrained providers, urban bias in resource allocation, and gendered burden of travel. Theoretical anchor: *Health Inequity Frameworks (Marmot, 2015); Intersectionality (Crenshaw, 1989)*	Discrimination and stereotyping in encounters; exclusion due to cultural assumptions. Theoretical anchor: *Intersectionality (Crenshaw, 1989); Institutional Racism (Williams & Mohammed, 2009)*	Symptoms are dismissed or minimized; the invisibility of chronic conditions in women. Theoretical anchor: *Epistemic Injustice (Fricker, 2007)*
Resilience & Adaptive Strategies	Pooling transport resources; reliance on traditional healers. Theoretical anchor: *Community Resilience (Norris et al., 2008)*	Diasporic networks and community-based organizations for support and navigation. Theoretical anchor: *Social Capital (Putnam, 2000); Community Resilience*	Peer groups for chronic illness management; informal exchange of medication and advice. Theoretical anchor: *Collective Coping (Ungar, 2011)*

These findings demonstrate that while barriers to health equity manifest differently across rural, immigrant, and low-income women's contexts, they are all shaped by the intersecting structural, institutional, and interpersonal dynamics. Importantly, the synthesis highlights that systemic invisibility is a unifying thread across cases, with participants consistently reporting that their needs were deprioritized or misunderstood in formal health systems. The integration of theoretical perspectives ranging from intersectionality to structural violence, epistemic injustice, and resilience frameworks underscores that these inequities are not isolated incidents but patterned outcomes of broader social structures. Recognizing these patterns offers critical leverage for rethinking how health systems design policies, allocate resources, and engage with marginalized voices. In the following discussion, we connect these case-based insights to the existing scholarship on health equity and intersectionality and consider their implications for both policy and practice.

DISCUSSION

This study examined how systemic barriers and intersecting identities shape experiences of health inequity across three contexts: rural communities in low-resource settings, immigrant families in urban environments, and low-income women with chronic illnesses. By applying an intersectionality lens, the analysis revealed not only the diversity of inequities but also their shared foundation in systemic invisibility.

Intersecting Barriers and Structural Reproduction of Inequity

As illustrated in Figure 1, health inequities were not experienced along single axes of identity but at the intersection of geography, socio-economic status, migration, and gender. For example, rural residents described invisibility in health planning, compounded by caregiving responsibilities, while immigrant families faced language exclusion and bureaucratic hurdles shaped by their migration status. Low-income women with chronic illnesses face socioeconomic constraints layered with gendered responsibilities that limit their ability to prioritize health. These findings echo the broader critique of structural violence in health systems (Farmer, 2004), where institutional neglect, discriminatory practices and fragmented care reproduce inequities. Importantly, Table 1 demonstrates that while the forms of disadvantage varied across contexts, the processes through which inequities were produced systemic exclusion, inequitable treatment, and reliance on resilience were both patterned and recurrent.

Epistemic Injustice and the Value of Lived Experience

Participants' narratives highlighted the epistemic dimensions of inequity, wherein marginalized voices were minimized, dismissed, or excluded from clinical and policy contexts. For instance, women with chronic illnesses have reported their symptoms being attributed to stress or lifestyle factors, exemplifying epistemic injustice (Heggen & Berg, 2021). Immigrant families described exclusion from decision-making due to language barriers, while rural participants felt that their needs were invisible in planning processes. These accounts underscore the importance of centering lived experiences in health equity research and policymaking. Qualitative insights reveal dimensions of exclusion, such as mistrust, invisibility, and stereotyping, which aggregate quantitative data often cannot capture (Hyett et al., 2019).

Resilience as Coping, Not Solution

Across cases, the participants mobilized adaptive strategies, such as pooling resources for transport, leveraging diasporic networks, or forming peer support groups. As shown in Table 1, these forms of resilience align with the theories of social capital (Putnam, 2000) and community resilience (Lade et al., 2020). However, participants consistently emphasized that such strategies were coping responses to systemic neglect, rather than genuine solutions. This distinction is crucial. While resilience highlights agency and solidarity, it must not be used to justify the persistence of inequitable systems that disadvantage certain groups. Health equity requires system-level accountability, not outsourcing responsibility to already marginalized communities.

Implications for Policy and Practice

The findings have three key implications for advancing health equity.

Moving beyond technocratic solutions. Policies must recognize that inequities are embedded in intersecting social positions. Tailored strategies that respond to the specific realities of rural populations, immigrant families, and low-income women are needed.

Institutionalize marginalized voices. Mechanisms for participatory planning, investment in culturally competent care, and partnerships with community organizations are critical to ensuring inclusion. This would help address the systemic invisibility and epistemic injustice identified in this study.

Train providers in intersectional sensitivity. Healthcare education should explicitly address how stereotypes, dismissive practices, and systemic neglect reinforce inequity. Embedding intersectional awareness into professional practice can help mitigate discrimination and improve patients' trust.

Positioning Within Global Health Equity Agendas

These findings resonate with global policy frameworks. The WHO's Universal Health Coverage agenda and Sustainable Development Goals (SDG 3: Good Health and Well-Being) emphasize equitable access to healthcare. However, the systemic invisibility documented here suggests that without intersectional approaches, such global commitments risk overlooking those most marginalized. Similarly, the Astana Declaration on Primary Health Care calls for community participation, an area where the study findings demonstrate both urgency and opportunity.

Limitations and Future Research

This study’s case-based design emphasized depth over breadth, thereby limiting statistical generalizability. The findings reflect specific contexts and may not capture the full spectrum of inequities across marginalized groups. Reflexivity is also critical; researcher positionality may have influenced interpretation despite member checking and ethical safeguards. Future research could extend these insights through multi-country qualitative comparisons or mixed-methods studies that combine subjective experiences with quantitative indicators. Longitudinal qualitative studies would also illuminate how resilience strategies evolve in response to policy changes or systemic shocks.

Health inequities are not isolated outcomes but products of intersecting structural, institutional, and interpersonal dynamics. As demonstrated in Figure 1 and Table 1, systemic invisibility is a unifying thread across contexts, whereas resilience represents both agency and systemic failure. Achieving health equity requires more than reforming systems on paper; it demands recognition of lived experiences, inclusion of marginalized voices in decision-making, and an intersectional commitment to dismantling compounded disadvantages.

CONCLUSION

This study demonstrates that health inequities are not isolated incidents but rather patterned outcomes of intersecting structural, institutional, and interpersonal barriers. Across rural communities, immigrant families, and low-income women with chronic illnesses, participants described experiences of systemic invisibility, inequitable treatment, and the burden of navigating exclusionary healthcare systems. While communities mobilized resilience through collective transport, diasporic networks, or peer support, these were framed as coping strategies born of necessity, not adequate solutions. True health equity requires shifting responsibility back onto systems, ensuring that marginalized groups are not left to compensate for institutional neglect of their needs.

The findings underscore three imperatives: recognizing intersectionality in policy and practice and tailoring strategies to the realities of marginalized populations. Institutionalize marginalized voices through participatory decision-making and provide culturally competent care. Embedding intersectional sensitivity in provider training can help reduce stereotyping and dismissive practices. Global health equity commitments, such as Universal Health Coverage and the Sustainable Development Goals, will remain aspirational unless they explicitly address the compounded disadvantages revealed here. Achieving equity requires not only structural reforms but also genuine recognition of lived experiences and the inclusion of marginalized voices in shaping health systems.

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