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# Assessing equitable care for Indigenous and Afrodescendant women in Latin America

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**ABSTRACT**

**Objective.** *To identify and understand the barriers to equitable care within health care settings that women of ethnic minorities encounter in Latin America and to examine possible strategies for mitigating the issues.*

**Methods.** *This was a comprehensive review of the literature from 2000–2015 available from the online databases PubMed, Google Scholar, EBSCOhost, and SciELO in Spanish, English, and Portuguese, using a keyword search that included the Region and country names.*

**Results.** *Health provider discrimination against Indigenous and Afrodescendant women is a primary barrier to quality health care access in Latin America. Discrimination is driven by biases against ethnic minority populations, women, and the poor in general. Discriminatory practices can manifest as patient-blaming, purposeful neglect, verbal or physical abuse, disregard for traditional beliefs, and the non-use of Indigenous languages for patient communication. These obstacles prevent delivery of appropriate and timely clinical care, and also produce fear of shame, abuse, or ineffective treatment, which, in addition to financial barriers, deter women from seeking care.*

**Conclusions.** *To ensure optimal health outcomes among Indigenous and Afrodescendant women in Latin America, the issue of discrimination in health care settings needs to be understood and addressed as a key driver of inequitable health outcomes. Strategies that target provider behavior alone have limited impact because they do not address women's needs and the context of socioeconomic inequality in which intra-hospital relations are built.*

**Key words** Equity; health inequality; ethnicity and health; minority health; health of Indigenous peoples; health services, Indigenous; social discrimination; prejudice; gender and health; Latin America; Caribbean Region.

In 2010, there were at least 826 Indigenous groups in Latin America, comprising approximately 45 million people or 8% of the total population (1). While many countries in Latin America lack comprehensive data on ethnicity, existing reports indicate that as a proportion of each country's population, Afrodescendant communities range from less than 0.1% in Guatemala to 31% in Belize to 51% in Brazil (2). The map in Figure 1 shows Indigenous and Afrodescendant populations as a percentage of the total population, by country.

In many parts of Latin America, Indigenous and Afrodescendant populations are subject to widespread social exclusion and discrimination (1, 3, 4); that is, they are denied of rights, resources, and services available to the dominant ethnic groups, based on racist, prejudicial treatment. Moreover, poor, Indigenous or Afrodescendant women receive "triple discrimination;" by being female, being an ethnic minority, and of low-socioeconomic status, they have far fewer opportunities for educational, political, social, and economic participation (4–6). In fact, in 2014, the United Nations (UN) Economic Commission for Latin America and the Caribbean (ECLAC) reported that none of its countries had achieved the UN standards for recognizing the territorial rights of Indigenous populations; that in 2000–2005, a disproportionate number of Indigenous children had suffered some

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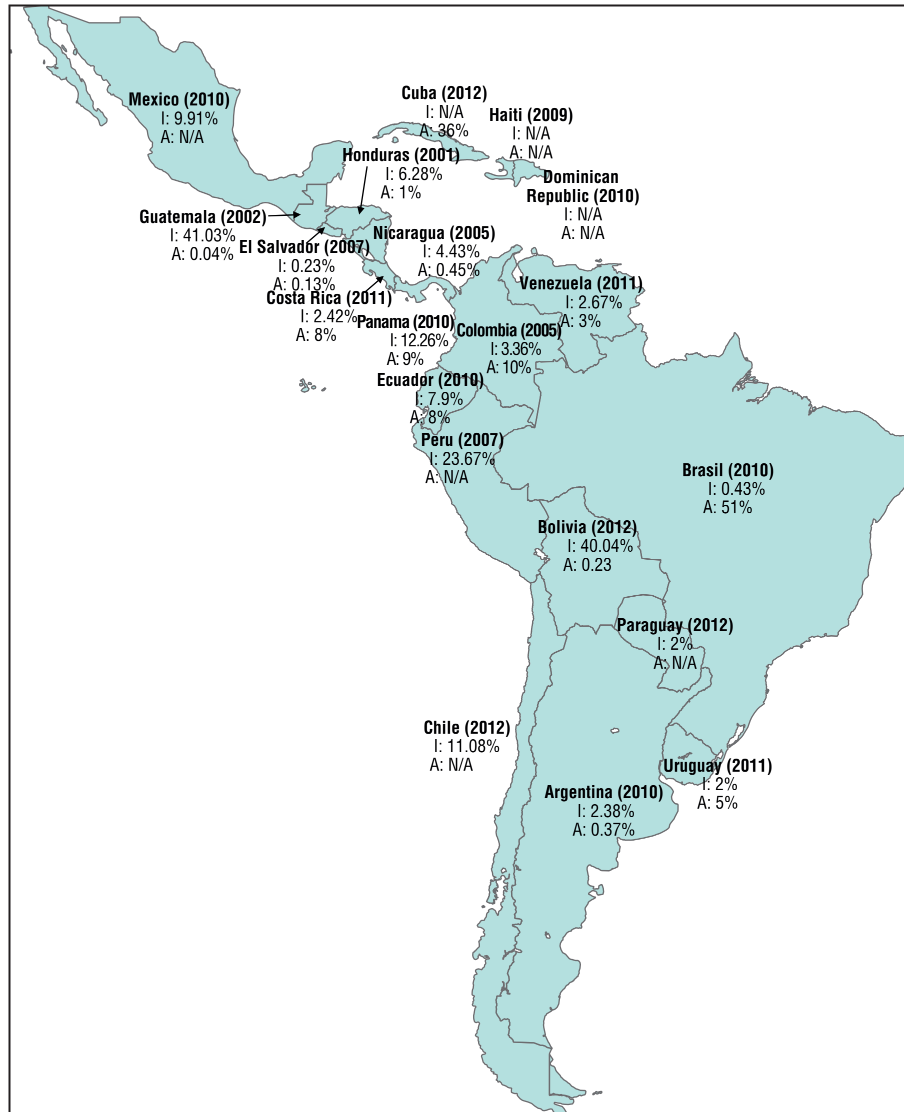
**FIGURE 1. Percentage of Indigenous and Afrodescendant populations in Latin America, by country, 2002–2012**




I: Percent of Indigenous people within each country; A: Percent of Afrodescendant people within each country; N/A: Census did not collect this variable.
***Source:*** Based on most recent census data that included information on self-identified ethnicity. The census year is within parenthesis.

form of material deprivation (88% vs. 63% of the area's total population); and that Indigenous women remain widely underrepresented in decision-making positions at the political party, municipal, and federal levels, although Indigenous men are gaining increased political representation in Bolivia, Guatemala, Nicaragua, and Panama (1).

Throughout the world, broad social exclusion and discrimination against women, ethnic minorities, the poor, sexual minorities, and other populations whose rights are often infringed upon have a significant negative impact on mental and physical health that result from stress responses (7, 8). In segmented health systems in which users of public health facilities are overwhelmingly from the lowest wealth quintiles, the clinical encounter in the public system becomes the locus of reproduction of unbalanced social and gender power dynamics between patients and healers (doctors, nurses, and nurse assistants) (9) and between and within health care providers and other workers of different hierarchical strata. In these contexts, discrimination is systematically embedded as an intrinsic component of the clinical encounter, contributing to differential health outcomes, not only as a stressor, but as a result of poor quality of care or outright neglect. Therefore, differences in access to quality health care and in health outcomes that result from exclusion and discrimination constitute forms of health inequity—they are "unnecessary, avoidable, unfair, and unjust" (10).

In 2014, the World Health Organization published a statement advocating for the elimination of disrespect and abuse of women during childbirth in health facilities through the improvement of quality of care (11). But incisive calls for action at the global level have stressed the importance of studying the root causes of this phenomenon as the power structure of the medical field (12) and as "a symptom of fractured health systems" (13) that needs to be addressed by focusing on the intentional mistreatment of women (14)—even though the intent may be so ingrained that discriminatory practices may be generated spontaneously (12). Given how deeply rooted social and gender discrimination can be in health care, some authors have argued that it not be considered just another quality of care issue or a lack of professional ethics, but rather, a complex sociological problem (12) requiring structural transformation.

Although several countries in Latin America have enacted measures to achieve universal health care (UHC), national and regional reports indicate that health equity remains elusive, standing as an impediment to reaching UHC (15–18). This may be particularly true regarding Indigenous and Afrodescendant women, who frequently suffer worse health outcomes and shorter life expectancy (15, 16), and migrant women, who may experience difficult access to timely and quality health care (17, 18), among others.

Consequently, this study seeks to assess how social exclusion and discrimination in the health care setting affect Indigenous and Afrodescendant women in Latin America in order to raise awareness and identify strategies for improving health equity in response to their needs; that is, responsive to women's living conditions, concerns, and priorities. Although a global, systematic review of mistreatment of women during childbirth has been published and it included studies from Latin America (19), to the authors' knowledge this is the first review of discrimination against Indigenous and Afrodescendant women in the health care setting in Latin America.

## MATERIALS AND METHODS

This was a comprehensive review of the literature published in 2000–2015 available from the online databases PubMed, Google Scholar, EBSCOhost, and SciELO. In addition to the Region and individual country names, the following key word search was conducted in English, Spanish, and Portuguese, respectively: (a) Afrodescendants, barriers to care, discrimination, disrespect, equity, health care, Indigenous, inequality, intercultural care, maltreatment, marginalization, maternal health, minority, quality of care, rejection, shame, women; (b) *afrodescendientes, atención médica, barreras, calidad, desigualdad, discriminación, estigmatización, equidad, etnia, indígenas, interculturalidad, maltrato, salud, servicios de salud;* and (c) *afro-descendentes, barreira de acesso, desigualdade em saúde, desumanização, discriminação, equidade, estigmatizacão, indígenas, maltrato, saúde.* Only documents pertaining to Latin America were retained.

## RESULTS

Results included a total of 60 publications—reports, journal articles, books, and other scholarly papers—published in 2000–2015; of these, 32 were in English, 18 in Spanish, and 10 in Portuguese. For analysis, they were grouped into three categories:

(a) Studies of discrimination against women in the health care setting: 40 publications, of which 26 specifically focused on women of ethnic minorities; the remaining did not mention ethnicity specifically, but had been conducted in areas inhabited by Indigenous and Afrodescendant populations.

(b) Studies on the causes of discrimination and its effects on health outcomes: 15 publications.

(c) Studies or reports on interventions and strategies aimed at reducing discrimination in the health care setting: 17 publications.

Nineteen of the publications fell into more than one category.

### Discrimination in the health care setting as a public health issue

A synthesis of existing literature—based on studies conducted in Argentina, Brazil, Bolivia, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Guatemala, Mexico, and Peru—indicates that widespread provider discrimination and violence are chief barriers that prevent women of ethnic minorities from accessing quality health services in Latin America. The majority of these studies ($n = 28$) draw primarily from qualitative research methods, including interviews and focus groups with women of ethnic minority, health care providers, indigenous medicine practitioners, and others; 5 studies used mixed qualitative and quantitative methods; and 7 studies employed only quantitative methods. Descriptions of these studies (5, 6, 12, 17, 18, 20–55) can be found in order of publication in Table 1.

As shown in Table 1, discrimination and violence can manifest through numerous behaviors practiced by medical personnel. Primarily, language and communication barriers, which occur frequently, can constitute forms of discrimination (46) by promoting inequitable power structures between doctors and patients (6, 21, 23) and limiting the provider's ability to address patient needs. Cultural insensitivity and a lack of intercultural care are also common among health care providers throughout Latin America (47). Specific examples include: disregard for a woman's opinion concerning her condition and treatment (33, 42, 44, 49); condemnation of traditional concepts of medicine and healing (6, 46); and active rejection of benign or even beneficial cultural practices, such as giving birth in a vertical position (30), drinking tea after childbirth, or giving birth in a room with a warm temperature (6). Additionally, provider discrimination can take the form of verbal abuse, such as patient blaming, public humiliation, scolding, and name-calling (22, 24, 30, 34, 37, 50, 54)—causing shame and creating exclusion (17, 34, 36, 54). Physical abuse is another form of discrimination, in which providers perform unnecessary procedures or hit, slap, or touch women in painful or uncomfortable ways (20, 23, 37) or refuse to administer pain medication (28, 37). Discrimination also appears in providers' purposeful neglect of patients, such as was found among Nicaraguans living in Costa Rica (17), Indigenous women in Peru (6), Haitian women in the Dominican Republic (41), Afro-Brazilian women in Brazil (28), and Mayan women in Guatemala (43). Finally, research highlights incidents of Indigenous women in Peru (18) and Nicaraguan immigrants in Costa Rica (17) being denied medical attention for both minor and life-threatening health concerns.

Further regarding issues of humiliation, a 2013 study of Jalisco in northwestern Mexico found reports of Huichol Indigenous women feeling shame and being treated as morally and intellectually inferior by the local health personnel (50, 54). Similar experiences of shame were reported among Nicaraguan health care users in Costa Rica (17), Indigenous women in Peru and in the Yacapaní area of Bolivia (6, 34), and Peruvian women seeking care in Chile (18). A 2011 study in Guatemala concluded that social exclusion of Indigenous people was particularly manifest in clinical settings, where non-Indigenous health care providers often reject the Mayan people and their beliefs, and blame their illnesses on cultural practices (43). Similarly, a 2008 study from Colombia described inequities within health care systems as the product of broader social and structural patterns of exclusion for Afrodescendants and other ethnic minorities (32). Reports from Peru also suggest that shortages of human health resources and medical supplies in health facilities may fuel increased provider discrimination (6).

### Health outcomes and discrimination in health facilities

Thus far, few studies have specifically quantified the effects of discrimination on health outcomes among Indigenous and Afrodescendant women in health facilities in Latin America. However, the studies included in this review indicate numerous short and long-term effects that may result from this phenomenon. Primarily, health care discrimination may fuel inequitable health outcomes between women of dominant and those of minority ethnicity. A 2010 ECLAC report attributed the high maternal mortality ratio (MMR) in Latin America and the Caribbean to health system discrimination against Indigenous and Afrodescendant women (40). This report claimed that unequal health outcomes between women of dominant ethnic groups and those of ethnic minorities resulted from institutionalized racism (40). A 2007 report by Physicians for Human Rights also

**TABLE 1. Review of literature that offers evidence of discrimination against women of ethnic minority in health care settings in Latin America, 2000 – 2015**

| Author(s), year (reference) | Geographic area | Study population | Study design | Findings |
|---|---|---|---|---|
| Castro, 2000 (20) | Rural Morelos area, Mexico | Women using health services | In-depth interviews | Health provider discrimination against women, including inappropriate sexual comments, condescension, asserting their superiority, demanding subordination, reprimanding women for screaming or "misbehaving" during labor. |
| Coimbra Jr. & Santos, 2000 (21) | Brazil | Indigenous people | Review of country data | Ethnic minorities experienced exclusion, marginalization, and discrimination that exposed them to higher rates of morbidity and mortality than national levels, malnutrition and hunger, occupational risks, and sexual violence. |
| de Oliveira & Madeira, 2002 (22) | Belo Horizonte, Minas Gerais, Brazil | Eight adolescent women, a public hospital | Open interviews | Participants reported feeling violated during childbirth, particularly during vaginal exams. Women reported that staff were unresponsive to pain and were verbally abusive. |
| Castro & Erviti, 2003 (23) | Mexico | Women delivering and receiving reproductive health services, public hospitals | Three-phase study using random sampling of case reports, 200 individual testimonies, and systematic observations in delivery rooms | Widespread trends of physical and psychological abuse during labor and delivery, including health staff controlling/intimidating women, promoting obedience and passivity, discounting opinions and suffering, threats and physical punishment, using coercion, and inappropriate sexual allusions. These abuses reflect broader discrimination against women that has become largely normalized as standard procedure among staff. |
| Miller et al., 2003 (24) | Dominican Republic | Women, public maternity hospitals | Observations of maternity facilities; patient and staff interviews; review of national statistics | High rates of maternal mortality in Dominican hospitals were attributed to a lack of quality care in maternity facilities. Medical providers severely lacked respect for women's dignity, neglected patients, and inconsistently followed national childbirth and delivery norms. |
| Alarcón-Muñoz, et al., 2004 (25) | Auracanía area, Chile (poorest with highest proportion of Mapuche) | Mapuche Indigenous people, Chile | Descriptive study using probability sampling | Mapuches, particularly women, expressed a need for developing health policy to improve intercultural care at health facilities. Cultural insensitivity and ethnicity-based discrimination from health providers, exacerbated by lack of supervision from health authorities. Non-Indigenous health providers did not see the need for any policies to acknowledge Mapuche health traditions or improve providers' cultural competency or non-discriminatory practices. |
| Roost, et al., 2004 (26) | San Miguel Ixtahuaca´n, Guatemala (mostly inhabited by Maya-descendants) | Maya traditional birth attendants | Qualitative interviews using purposive sampling | Traditional birth attendants explained that Mayan women choose home birth due to feared verbal or physical mistreatment from medical personnel, discrimination at facilities, and unnecessary cesareans, originating from personal experience or hearsay/ recommendations. |
| Alarcón-Muñoz & Vidal-Herrera, 2005 (27) | Auracanía area, Chile (poorest with highest proportion of Mapuche) | Women of Mapuche and non-Mapuche descent, Chile | 94 in-depth interviews | Mapuche women expressed that health providers lacked cultural competence, and did not possess the knowledge/skills to address the health needs of Mapuche women and their children. |
| Leal et al., 2005 (28) | Brazil | Afrodescendant, mixed ethnicity, and white women, public maternity hospitals | Cross-sectional study using interviews and review of medical records | Afrodescendant and women of mixed ethnicity were significantly more likely than white women to be turned away from the first hospital they visited, to experience childbirth without anesthesia, to be less satisfied with prenatal, labor, and newborn care. They also were shown to suffer broader social inequalities, e.g., lack of access to education, adolescent pregnancy, and poverty. |
| Fernando-Juárez, 2005 (29) | Bolivia (country with a high proportion of Indigenous people) | Indigenous healers and non-Indigenous maternal health care providers | Anthropological field study | Indigenous women seeking biomedical health care often faced barriers to accessing care in clinical settings. Health care professionals dehumanized birthing and lacked the language skills, cultural competency, and/or respect to enable a positive birthing experience. |
| Teixeira & Pereira 2006 (30) | Cuiabá, Mato Grosso, Brazil | 10 women, hospitals of Cuiabá | In-depth interviews | Women associated the hospital with suffering, abandonment, fear, and anguish, and reported hostility from medical personnel, disrespectful language, and difficulty receiving permission for a vertical-position birth. Some reported that staff used language they did not understand. |
| Hautecoeur, et al., 2007(31) | Rabinal district, Guatemala (primarily Mayan) | Indigenous Mayan people and Ladino (mestizos who primary language is Spanish) health providers | 20 in-depth interviews | Mayan participants experienced communication barriers with health care providers who did not understand Mayan languages or belief systems. Also reported unfair differences in the quality of care provided to Mayan versus Ladina women. |

(Continued)

**TABLE 1. (Continued)**

| Author(s), year (reference) | Geographic area | Study population | Study design | Findings |
|---|---|---|---|---|
| Yamin, et al., 2007 (6) | Rural areas, Peru (country with a high proportion of Indigenous people) | Indigenous women at medical facilities | Key informant interviews; in-depth interviews of close contacts of women who died of maternal causes; semi-structured staff interviews; review of medical records; physical retracing of paths to care | The health system of Peru both showcases and exacerbates patterns of social exclusion of Indigenous women, particularly illiterate and extremely poor. Included case studies and overall trends of mistreatment, discrimination, delays, and neglect by health services serving Indigenous women; examined individual- and structural-level contributing factors. |
| Ariza-Montoya & Hernández-Álvarez, 2008 (32) | Bogotá, Colombia | Ethnic minorities | 39 in-depth interviews and six focus groups with Afrodescendants, Indigenous people, and ethnic minorities | Ethnic discrimination was a primary barrier to accessing care in clinical settings in Bogotá. Other barriers included conflicting cultural conceptions of health and provider discrimination toward patients of low socioeconomic status. |
| Nagahama & Santiago, 2008 (33) | Maringá, Paraná, Brazil | 569 women that gave birth at two public hospitals | Cross-sectional design, analyzing hospital patient charts and interviews | Barriers to humanized care included: a lack of knowledge of reproductive rights during labor and birth on the part of women and their companions; a resigned attitude by women and their companions; asymmetrical relationship between health professionals and patients; insufficient provision of information; lack of preparation by the health team to welcome the companion; medical personnel providing only basic standards of care during labor without establishing a dialogue with the women or addressing their personal needs. |
| Otis & Brett, 2008 (34) | Yapacaní, Bolivia | Women, rural and urban Yapacaní area (mostly Indigenous) | Key informant interviews, semi-structured interviews, participants' observations | 37% cited fear of embarrassment/humiliation by medical personnel as the primary reason for not seeking maternal health care at a facility. Reports of providers scolding women, failing to offer privacy, and rejecting their cultural beliefs regarding childbirth. Medical personnel described as unwelcoming/hostile towards Indigenous women. |
| Almeida & Silva, 2008 (35) | Salvador, State of Bahia, Brazil | Women at the public hospital | 25 interviews of women self-identified using adjectives related to Afrodescendance *negra*, *parda*, *morena*, *morena oscura*, *branca*, *marrom*, and *sarara*. | Experienced dehumanizing care at the hospital; no assurance of good quality care; complaints, questions, and concerns were devalued. Some descriptions of treatment were "horrible" and "humiliating." |
| Goldade, 2009 (17) | Costa Rica | Nicaraguan migrant workers at public health facilities | 1 000+ interviews, and observations | Migrants were portrayed as morally inferior, excessively demanding on the system, seen as undeserving of medical citizenship. Reports of denied consultation for emergency and chronic health issues. Nicaraguan migrants reported shame seeking care at hospitals. |
| Roost et al., 2009 (36) | La Paz, Bolivia | Indigenous women who experienced severe morbidity during/after childbirth | In-depth interviews | The study found that particularly women from rural areas did not seek facility-based medical care for delivery because they felt excluded by and distrusting of personnel in the facilities. However, few women cited cultural barriers as factors that discouraged facility utilization, which implies the presence of structural disadvantages, rather than solely cultural barriers, that affect Indigenous women who might access maternal health care. |
| Bowser & Hill, 2010 (37) | Global study | Women delivering in medical facilities throughout the world | Review of published and gray literature, key informant interviews, focus groups | Identified various studies that observed women of ethnic minorities as more frequently subjected to disrespect and abuse. Classified seven types of disrespect and abuse during labor and delivery in clinical settings throughout the world: physical abuse (including sexual abuse), non-consented care (unwanted C-sections, episiotomies, sterilization), non-confidential care (including lack of physical privacy), non-dignified care (humiliation, shame, blaming), discrimination based on specific patient attributes (ethnicity, age, HIV status, traditional beliefs, socioeconomic status, education), abandonment of care, detention in facilities. |
| Castro, 2010 (38) | Mexico | Reproductive health services personnel | 11 focus groups | Shows that medical providers' mistreatment and abuse of women is institutional violence that is embedded in Mexico's medical education systems and rigid hospital hierarchies. Personnel view themselves as authorities/superior, and women patients as subordinate/inferior. |
| Castro & López, 2010 (39) | Brazil, Chile, Mexico, Brazil | Women using reproductive health services and the attending medical personnel | Interviews, direct observations, surveys | This book presents a series of case studies of provider discrimination/abuse of women. E.g., in Brazil, found that medical education leads medical personnel to view women patients as subordinates; two studies in Mexico found that providers largely viewed women as undeserving of medical citizenship; a study in Uruguay found that negative provider attitudes can form a barrier to care for women seeking voluntary abortion services. |

(Continued)

**TABLE 1. (Continued)**

| Author(s), year (reference) | Geographic area | Study population | Study design | Findings |
|---|---|---|---|---|
| Oyarce & Pedrero, 2010 (40) | Latin America | Indigenous and Afrodescendant populations | Review of country data | A "situation of systematic violence" exists that prevents Afrodescendant and other women of minority ethnicity from accessing care in medical facilities. Health programs have failed to address their health needs in health care settings and daily life. |
| Felker-Kantor, 2011 (41) | Elías Piña area, Dominican Republic | Haitian women seeking medical care | Interviews, direct observations | Reports that many Dominican medical personnel discriminated against Haitian women through neglect, verbal abuse, and public humiliation. |
| García-Jorda et al., 2011 (42) | Havana, Cuba | Women giving birth in maternity facilities, their partners, attending obstetricians | 36 interviews/observations of women in labor | Women reported receiving over-medicalized non-humanized care; perceiving power structures between doctors and patients; a lack of autonomy over their body during labor; restrictions on companion involvement; and physical violence. |
| Rohloff, et al., 2011 (43) | Rural areas, Guatemala (mostly Mayan communities) | Mayan people seeking institutional health services | Summary of authors' past studies and recorded observations | Antagonism towards the rural Indigenous poor, which permeates social/cultural life, was manifest in the clinical setting; the majority of providers were critical of Indigenous/traditional health models. Patients expressed fear and mistrust of doctors. Providers routinely displayed negligence/ignorance toward Indigenous patients; most had little fluency in Mayan languages. |
| Enderle et al., 2012 (44) | Brazil | 269 adolescents who gave birth at Universidade Federal do Rio Grande | In-depth interviews | Adolescent women frequently reported neglect by medical personnel; expressions of pain were ignored; and opinions concerning procedures, disregarded. |
| Ishida, et al., 2012 (45) | Guatemala (country with a high proportion of Indigenous people) | Indigenous and non-Indigenous women | Logistic regression analyses of random samples from 2009 National Survey of Maternal and Infant Health | Institutional delivery was about half as common among Indigenous women as among Ladina. The met need for modern contraceptives was also significantly lower. These ethnic differences were attributable in part to Indigenous women not speaking Spanish. |
| Muñoz Bravo, et al., 2012 (46) | Cauca, Colombia | Nasa Indigenous pregnant women seeking biomedical care, Indigenous midwives, local health promoters | Ethnographic study using in-depth interviews, a broad survey, focus groups | Barriers to care for Nasa women seeking maternal services were: a disregard of Nasa traditions, communication and language barriers, restricted visiting hours, under-staffing and frequent rotation of staff, lack of financial resources, and geographic inaccessibility. Nasa women and traditional attendants attribute little credibility to health facilities. |
| Wurtz, 2012 (47) | Latin America | Indigenous women of reproductive age | Literature review | Throughout Latin America, Indigenous women suffer higher rates of unintended pregnancy and unsafe abortion than do non-Indigenous. Family planning programs/services were slow to reach Indigenous populations, particularly in remote areas, and often do not provide culturally-appropriate care. |
| Aguiar et al, 2013 (48) | São Paolo, Brazil | 18 medical providers from the public and private sectors | Semi-structured interviews | Health workers acknowledged the existence of discrimination/disrespectful practices toward women during prenatal, childbirth, and postpartum care; however, they also acknowledged that medical personnel do not consider verbal threats/negative remarks to be violent. |
| Van Dijk, et al., 2013 (49) | Guatemala | Medical personnel, *comadronas* (Mayan birth attendants), and Mayan women using facilities for childbirth | 107 semi-structured interviews | Despite a national policy established in 2000 to incorporate traditional birthing practices into medical facilities, many *comadronas* reported feeling disrespected/disregarded by medical personnel and several Mayan women reported still being unable to access culturally-appropriate care. Mayan women felt neglected and that their traditional beliefs were ignored. |
| Gamlin, 2013 (50) | Jalisco area, Mexico | Huichol Indigenous migrant workers | Ethnographic study using in-depth interviews and observations | Extreme inequity between Huichol Indigenous people and health care providers. Reported that doctors reprimanded them for their 'unhealthy' cultural/social practices and had the power to deny them their *Oportunidades* (conditional cash transfer program) payments. Study participants, mostly women, reported feeling shame/humiliation from medical personnel. |
| Yajahuanca, et al., 2013 (51) | Iquitos, Loreto region, Peru | Kukama Kukamiria women | 25 individual interviews of pregnant women, nursing women, midwives (male and female), herbal doctors, and health partners, and observation of services | A preference for traditional care is justified based on feelings of neglect and vulnerability at institutionalized health centers, resulting from the lack of consideration by the health services for the cultural and well-being specificities of the Kukama Kukamiria women. |

(Continued)

**TABLE 1. (Continued)**

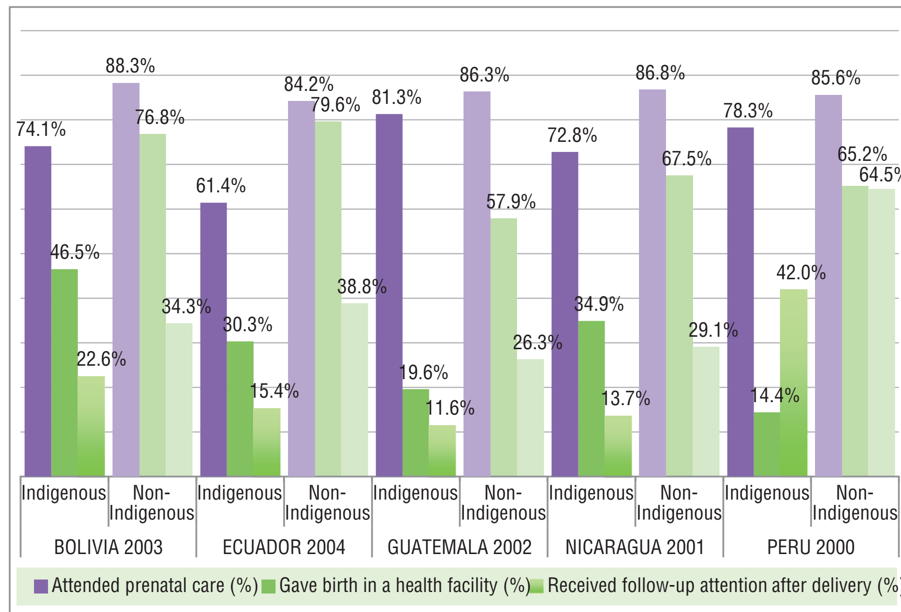
| Author(s), year (reference) | Geographic area | Study population | Study design | Findings |
|---|---|---|---|---|
| Castro, 2014 (12) | Mexico | Reproductive health services personnel | Observations in delivery rooms, focus groups, literature review | Abuse/disrespect of female patients in Mexico stems from education/training of medical students. During medical school, internships, and residencies, new doctors are surrounded by a hierarchical environment that subordinates women and promotes passivity. Punishment as a teaching method reoccurs when doctors in turn punish patients to incite/discourage certain behaviors. |
| Castro & Erviti, 2014 (52) | Mexico | Women who gave birth in a medical facility, attending medical personnel | Review of 25 years of studies on obstetric violence | Violence against women delivering in medical facilities in Mexico is a persisting proble, but it has been largely framed as a "quality of care" issue, rather than as violence or human rights violations. |
| Chomat, et.al., 2014 (53) | Quetzaltenango department, Guatemala | Mayan women who recently gave birth | Cross-sectional study, including 15-minute field surveys | Extremely low rates of medical facility utilization for delivery and antenatal care due to: lack of confidence in biomedical treatments, perception of poor quality of care, discriminating/condescending treatment, inability of medical staff to speak Indigenous languages, embarrassment over being examined, greater confidence in midwives. Other factors may be a previous experience with health personnel/facilities, influence of spouse/relatives, beliefs regarding pregnancy/appropriate care. |
| Scozia Leighton, et al., 2014 (18) | Chile | Peruvian migrant women seeking health care | In-depth interviews | Peruvian women reported discrimination from Chilean health providers and being treated as undeserving of care. |
| Valeggia, 2014 (5) | Gran Chaco, northern Argentina, and department of Sololá, Guatemala | Toba Indigenous women (Argentina) and Tzutujil Mayan women (Guatemala) | Literature review | In Guatemala, Tz'utijil women experienced "triple discrimination: being poor, being a woman, and being Indigenous" in health settings, and health care providers blamed cultural practices for women's health issues. In Gran Chaco, medical personnel did not treat the specific needs of Indigenous women. |
| Gamlin & Hawkes, 2015 (54) | Jalisco area, Mexico | Huichol Indigenous migrant women | Ethnographic study using in-depth interviews and observations | Many chose to give birth without medical assistance due to fear of mistreatment/shaming by medical providers who see Indigenous women as morally inferior. |
| Planas et al., 2015 (55) | Lima, Peru | Women with Indigenous and mestizo profiles | Crossover randomized controlled trial in 351 public health facilities. Women posed as patients seeking family planning, followed a script and enacted Indigenous/mestizo profiles | Although no statistically-significant differences were found between the two ethnic profiles, health providers only performed 37% of technical tasks required by Peruvian family planning guidelines–a very low level of quality standards. The study did not allow comparison with women from a dominant ethnicity. |

attributed high maternal mortality ratios in Peru to the social and political marginalization of Indigenous women manifested in the country's health care system (6).

Latin American maternal and infant mortality statistics support these arguments. As an example, in 1996, the infant mortality rate (IMR) among Afro-Brazilian children was 62.3 per 1 000 live births, which was almost double the 37.3 IMR among children of predominantly European descent (56). Data from six countries showed that Indigenous and Afrodescendant infants experienced higher infant IMR than other infants (57). Additionally, in 2006, Indigenous women in Latin America experienced MMRs that were 2–3 times higher on average than national ratios (58). According to a 2013 report from the International Federation of Red Cross and Red Crescent Societies, the highest MMRs in Bolivia, Guatemala, Guyana, Honduras, and Panama are all found in primarily Indigenous areas (59). Data from 2007 (3) showed drastic inequities in MMR between Brazilian women identified as black (*preta*) and those identified as white (*branca*): in the 20–24 year age group, black women had an MMR of 44.5 per 100 000 live births, while white women had a ratio of 23.4; for those 25–29 years of age, it was 61.9 for black women and 40.5 for white.

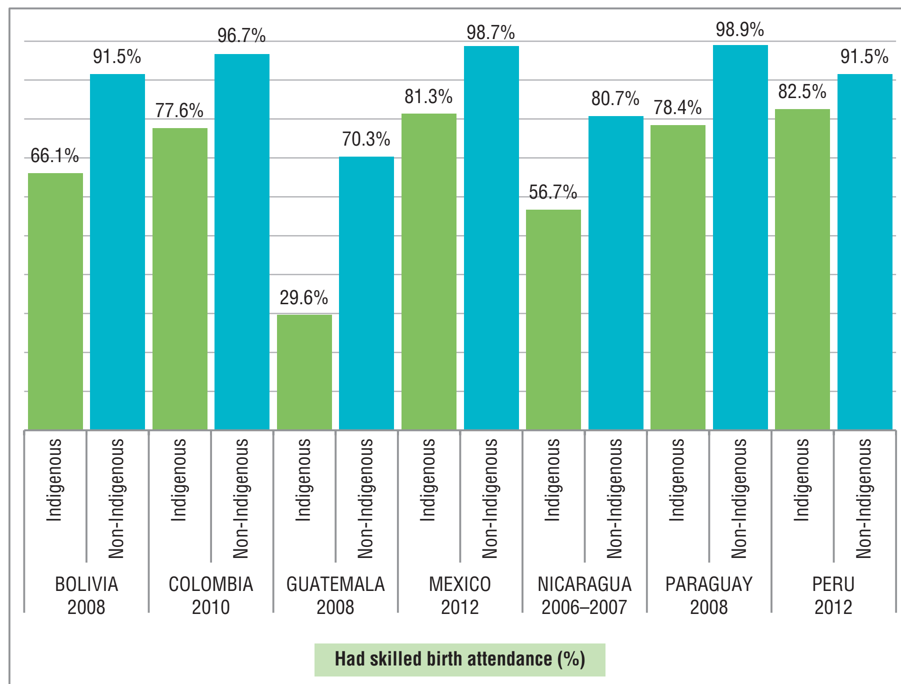
The effects of provider discrimination directly compromise access to treatment (60). Various qualitative studies state that provider discrimination, coupled with financial barriers, affect health care utilization rates among women of ethnic minorities (6, 25, 26, 31, 34). A 2010 ECLAC report identified the cultural and language inaccessibility of maternal health services as a key factor deterring women of ethnic minorities from seeking medical care (40). Among community-level studies, three found that in 2004, 2007, and 2014, numerous Mayan women in Guatemala chose to give birth at home due to fear of personnel neglect, verbal abuse, and culturally inappropriate treatment (26, 31, 53). Indeed, only 13% of the women participants in the 2014 study delivered in a hospital because they feared a lack of quality care, communication barriers with doctors, and mistreatment from personnel (53). Similarly, in a 2008 study in the Yacapaní Indigenous area of Bolivia, 37% of women participants cited fear of mistreatment

**FIGURE 2. Percentage of Indigenous and non-Indigenous pregnant women in Bolivia, Ecuador, Guatemala, Nicaragua, and Peru who attended prenatal care, gave birth in a health facility, and received follow-up care, 2000–2004**




***Source:*** Oyarce AM RB, Pedrero M. Salud materno-infantil de pueblos indígenas y afrodescendientes de América Latina: aportes para una relectura desde el derecho a la integridad cultural. Santiago: Economic Commission for Latin America and the Caribbean; 2010.

**FIGURE 3. Percentage of Indigenous and non-Indigenous women with skilled birth attendance in Bolivia, Colombia, Ecuador, Guatemala, Mexico, Nicaragua, Paraguay, and Peru, 2004–2012**




***Source:*** Economic Commission for Latin America and the Caribbean. Guaranteeing Indigenous people's rights in Latin America. Santiago: ECLAC; 2014.

by staff as a key deterrent to seeking medical care (34). A 2007 report also found that the perceived low quality and inappropriateness of maternal health care services discouraged Indigenous women in Peru from seeking care (6).

Two ECLAC reports included disaggregated health care utilization according to the Indigenous status of women in five and seven selected countries, respectively. Figure 2 shows that in Bolivia, Ecuador, Guatemala, Nicaragua, and Peru, the percentage of Indigenous women who attended prenatal care, gave birth in a health facility, and received follow-up attention was systematically lower than among the non-Indigenous (40). Similarly, skilled birth attendance in Bolivia, Colombia, Ecuador, Guatemala, Mexico, Nicaragua, Paraguay, and Peru (Figure 3) was more frequent among non-Indigenous than among Indigenous women (1).

Health provider discrimination against Indigenous and Afrodescendant women may also obstruct the development or implementation of policies promoting Indigenous rights (25, 61). As discussed in a 2004 qualitative study from Chile, medical providers should have a role in the development and advocacy of policies to mandate intercultural care practices, but providers are not likely to support such policies if they view intercultural care as unnecessary or if they deem Indigenous health as unworthy of special initiatives (25). Furthermore, medical personnel with racial biases may not comply with anti-discrimination policies that are enacted.

## Reducing discrimination in health care

Thus far, numerous countries and organizations have enacted small-scale initiatives that have shown promise in mitigating discrimination against women of ethnic minorities in Latin American health care settings. Such initiatives can be grouped into two categories according to purpose. The first includes various initiatives that promote the humanization of medical care and focus on improving women's experiences during labor and delivery (37, 49, 62). These humanization-of-childbirth programs seek to empower women giving birth with the agency to communicate openly with their health providers, express concerns and wishes for their birthing experiences, and receive safe, evidence-based care. Effective humanization-of-childbirth initiatives train professionals to provide culturally appropriate, non-discriminatory, and high quality care to women from all ethnic, social, and economic backgrounds

and should inspire medical personnel to respect female patients as humans rather than treat them as merely laboring bodies (62).

The second group of interventions have focused on promoting intercultural care. Designed to improve the quality of medical attention for Indigenous or other ethnic minorities, intercultural care incorporates languages spoken by ethnic minorities and recognizes the existence of alternative models of health and healing (25). Intercultural care practices are tailored to suit the needs of the specific populations they serve and ultimately seek to create cultures of non-discrimination, respect, and cultural competency within health care systems (25). Specific components of intercultural care programs frequently include: communication workshops for medical staff to learn Indigenous languages as well as techniques for establishing an open dialogue with patients (25, 26, 63), training sessions to promote cultural sensitivity and humility among providers (64–66), and installations of traditional medicine practitioners within biomedical health facilities (26, 61). Programs have both been implemented directly into medical and educational systems by local governments and health ministries or have been implemented as separate training programs overseen by independent organizations.

The list of interventions addressing provider discrimination can be found in Table 2 (40, 49, 61, 64, 66–72). Of note, the vast majority of interventions have focused on Indigenous women or Indigenous populations in general. This literature search did not find evidence of interventions specifically targeted to women of Afrodescendant or other minority backgrounds. As described in Table 2, humanization-of-care and intercultural health programs have achieved varying levels of success, with some interventions offering important lessons for future strategies in reducing provider discrimination against Indigenous, Afrodescendant, or other women of ethnic minorities. First, some interventions demonstrate that program success relies heavily on consistent Ministry of Health funding and support. The Cuetzalán Hospital in Puebla, Mexico, temporarily decreased its number of intercultural services in 2000 when the State Health Secretariat stopped funding culturally-focused programs as a cost-saving measure (64); whereas the 2012 case study of the Makewe Hospital in Chile revealed that a lack of Ministry of Health support posed one of the chief barriers to continuation of the hospital's successful intercultural care program to address the needs of the Mapuche populations (71).

Another lesson from these interventions is that incorporating traditional medicine practitioners into biomedical service facilities does not necessarily ensure the provision of non-discriminatory care. While the United Nation's Children's Emergency Fund (UNICEF) and the Ministry of Health of Peru were able to improve maternal health care by incorporating culturally-appropriate maternity houses, vertical-position birthing chairs, and other physical structures into medical facilities (40), other interventions achieved less. For example, a 2013 study in Potosí, Bolivia, found that medical providers showed little respect for or desire to collaborate with traditional healers, placed in public health facilities to improve intercultural care for the indigenous (61). Similarly, although Guatemala created a law in 2000 to incorporate traditional Mayan birth attendants in medical facilities, a 2013 study discovered that many felt disregarded by medical staff and that Mayan women expressed barriers to accessing culturally-appropriate care (49).

As these programs illustrate, successful interventions need to go beyond merely implementing a legal framework dictating that traditional and biomedical practitioners coexist in medical facilities. Collaboration likely requires increased cultural humility and respect from medical providers; some interventions offer insights on possible strategies to accomplish that goal. First, a program in Guatemala demonstrated that simulation-based training could effectively improve cultural humility among providers (66). Another project in Brazil also proved it could augment the humanization of childbirth by conducting in-service training of medical staff (67). While a 2002 project in Peru did not measure outcomes specific to personnel discrimination and attitudes, its results showed increased satisfaction and health care utilization rates among Indigenous women, implying that the human-rights approach may be an effective strategy for encouraging non-discriminatory practices among medical providers (68). Furthermore, many of the successful intercultural care programs listed in Table 2 encouraged and included the target population's direct participation in its design and administration (70, 71).

## DISCUSSION

Discrimination in the health care setting can deter Indigenous and Afrodescendant women from seeking medical care in the first place. When they do seek care, women of ethnic minorities may be more vulnerable than other women to receiving substandard quality of care or be subjected to longer delays—both of which preclude optimal health outcomes—along with experiencing shame, humiliation, exclusion, and other forms of human rights violations. Even though under-staffing, medication shortages, outdated or unrepaired medical equipment, lack of adherence to protocols, and weak referral systems, among others, are known to compromise quality of care for health services users regardless of ethnicity, discrimination in the health care setting is a driver of inequitable health outcomes that needs to be better understood and addressed.

This initial review can make a few overarching points. First, discrimination and violence against women of ethnic minorities in clinical settings in Latin America are pressing and overlooked issues that merit further investigation and action at the national and Regional levels. The impunity with which these violations occur and how normalized they are by women and providers alike is a reflection of society at-large (13). Second, critical to reducing discrimination is the formation of collaborative and horizontal partnerships between women of ethnic minorities and their health care providers. This form of community participation must occur within the context of broader discussions concerning gender equity and the rights of Indigenous and Afrodescendant populations. Third, health providers should be trained in the impact of discrimination and violence on health outcomes of minority ethnic groups and on their contribution to persistent health inequity.

Finally, alleviating discrimination requires health system-wide policy and structural changes that go beyond targeting individual health provider behaviors. We contend that strategies aimed solely at changing providers' behaviors will have limited impact because

**TABLE 2. Review of literature on the topic of interventions to mitigate health care provider discrimination against women of ethnic minorities in Latin America, 2008–2015**

| Reference | Location (year), organization | Program | Target population | Description | |
|---|---|---|---|---|---|
| | | | | Processes | Outcomes |
| Misago et al., 2001 (67) | Ceará area, Brazil (1996–2001), Japanese International Cooperation Agency & the Ministry of Health | *Projeto Luz* (also called the Maternal and Child Health Improvement Project) | Traditional birth attendants, medical personnel at hospitals in five municipalities of Ceará | The program integrated midwives and traditional birth attendants into biomedical facilities, and conducted a series of workshops, seminars, and training sessions to increase empathy and communication strategies among medical personnel over 5 years. | A study using the Rapid Anthropological Assessment Procedure declared the program to be successful in establishing a culture of humanization within maternal health facilities. *Projeto Luz*'s experience was later expanded to other municipalities in the State of Ceará, and to other states in northeast Brazil. |
| Duarte-Gómez et al., 2004 (64) | Puebla, Mexico (2003 – present), Ministry of Health and State Health Secretariat | *Hospital Integral con Medicina Tradicional* (Integral Hospitals with Traditional Medicine) | Health care providers, traditional medicine practitioners, and Indigenous persons seeking health care | The Puebla Health Secretariat created a series of policies and programs to transform five existing hospitals into "Integral Hospitals" that would offer intercultural care to encourage health care utilization among Indigenous populations. Local Indigenous councils participated in advising the hospitals´ remodeling. Traditional medicines and practices became available at the facilities and medical personnel received intercultural care training. | A case study examining the transformation of the Cuetzalán Hospital into an "Integral Hospital with Traditional Medicine" showed that financial considerations affected the development of intercultural care policies. However, review of hospital data and interviews with medical providers and Indigenous patients showed that the hospital´s intercultural care programs showed promise in encouraging health service utilization and offering effective care. |
| Kayongo et al., 2005 (68) | Peru (2002), CARE and the Averting Maternity Death and Disability Project | Foundations to Enhance Management of Maternal Emergencies | Health care providers and patients | The program conducted multiple workshops at five maternal health facilities that focused on quality of care, human rights, and non-discrimination against Indigenous women. Medical facilities also adopted new signs written in local languages, vertical-birthing chairs, privacy curtains, among others. | The number of emergency obstetric care visits increased and improvements were reported in referral systems and overall atmosphere. However, the program produced no hard evidence regarding respectful and non-discriminatory practices, and overall quality improvements were not measured. |
| Vivar, 2007 (69) | Ecuador (2005) Family Care International, Ecuador, Quality Assurance Project, and the Tungurahua Health District | Untitled – project to understand Indigenous needs and values in health care | Providers and Indigenous patients | The project's goal was to humanize and culturally adapt childbirth through dialogue between traditional and modern medicine health providers and users. | The project discovered that the freedom to choose the childbirth position, quality of care, and comprehensive information were the most important cultural components of care. Tungurahua's public health services are incorporating these into standard delivery services. Outcomes of these new practices were not specified. |
| Bowser & Hill, 2010 (37) and USAID, 2008 (70) | Ecuador (2008), University Research Company, FCI, Quality Assurance Project & Health Care Improvement Project of USAID, and Ecuador Child Survival Project | Untitled – cultural adaptation of births programs | Providers and Indigenous patients | The program in four regional hospitals sought to make health care more responsive to users' cultural expectations through coaching visits during 2008 to support improvement teams. | The project was reported to increase the presence of family members during delivery, user satisfaction, and the total number of institutional deliveries. |
| Oyarce & Pedrero, 2010 (40) | Peru (2004), UNICEF and Ministry of Health | Untitled –program to improve maternal health | Indigenous women, health care providers | The program created maternity houses near medical facilities for women and their families to stay prior to delivery. It also renovated maternal health facilities to include vertical-birthing chairs, enacted policies to ensure women can bring companions into the labor and delivery wards, and permitted traditional birth attendants in facilities. For health care providers, the program worked to conduct intercultural care training. | After initial success, this program was adopted by the Ministry of Health of Peru to be a norm in medical facilities throughout the country. |

(Continued)

**TABLE 2. (Continued)**

| Reference | Location (year), organization | Program | Target population | Description | |
|---|---|---|---|---|---|
| | | | | Processes | Outcomes |
| Torri, 2012 (71) | Chile (1999 –present), Chilean Indigenous Association, regional and municipal governments of Chile | Makewe Hospital | Mapuche Indigenous peoples and health care providers who serve them | One of the first intercultural hospitals in Chile, Makewe is mostly directed by local Indigenous Association leaders and incorporates local healers and Mapuche traditional practices into the biomedical delivery model. Signs and literature in the hospital are written in both Spanish and Mapudungun. Medical personnel are strongly encouraged to study Mapuche culture. | 25 of 32 patients interviewed chose the hospital because of its high quality services. Most patients reported that communication with medical providers was “comprehensible and satisfactory” and many doctors reported close relationships with local Mapuche leaders. Other patients expressed that intercultural health systems were not truly intercultural, as they had not improved the poverty and exclusion affecting the Mapuche. Other outstanding issues include a lack of national regulation concerning intercultural care practices and minimal government funding for intercultural health programs. |
| Fahey, et al., 2013 (66) | Four northern districts of Guatemala (2011–2012), project approved by internal review boards of numerous universities, funded by WHO and Bill & Melinda Gates Foundation | *Programa de Rescate Obstétrico y Neonatal: Tratamiento Óptimo y Oportuno* (PRONTO) | Health care providers and *comadronas* (traditional birth attendants) | Already operating in Mexico and Kenya, PRONTO was adapted for implementation at community clinics in Guatemala. The program first held focus groups to identify the specific barriers to facility-based care and then held cultural humility training for providers that included the participation of *comadronas* and simulation scenarios requiring cultural competency. | The experience of PRONTO in Guatemala indicates that interactive learning, including simulation, is an effective way to promote cultural fluency among health care providers. Core activities of the program could be applied in other settings with minor adjustments to suit the specific cultural context in which it is applied. |
| Torri & Hollenberg, 2013 (61) | Tinguipaya, Potosí area, Bolivia (2007), Cooperazione Internazionale & Tinguipaya municipal health care network | *Salud Familiar Comunitaria Intercultural* (Intercultural Community Health) | Health providers and traditional healers at health center designed to provide culturally-appropriate services | The pilot project sought to increase health care utilization among Indigenous women, and raise their satisfaction. Project staff constructed a health center to incorporate both biomedicine and traditional medicine, conducted workshops to increase cultural sensitivity and competency among health care providers, and installed traditional healers alongside biomedical practitioners. | Interviews with biomedical practitioners, traditional healers, and women users revealed that traditional healers felt disregarded or discriminated against by the biomedical practitioners. While progress is being made to improve culturally-appropriate care for Indigenous women, additional efforts must focus on improving communication and respect between traditional healers and biomedical practitioners. |
| Van Dijk, et al., 2013 (49) | Multiple departments of Guatemala (2000 – present), Unidad de Atencion de la Salud de los Pueblos Indígenas e Interculturalidad en Guatemala, Ministry of Health | National Program of Traditional and Alternative Medicine (PNMTA). | Biomedical maternal health care practitioners and *comadronas*, traditional Mayan birth attendants | The Ministry of Health offered multidisciplinary trainings for personnel in health facilities throughout the country, to explain traditional obstetric practices, emphasize the importance of culturally-appropriate services and enhance acceptance of the *comadronas* in maternal care services. Some facilities were reconstructed/redecorated to appeal to Indigenous women. *Comadronas* were either permanently stationed at health facilities or allowed to accompany women through birthing experiences. Women received care in Mayan languages, either through bi-lingual staff or through *comadrona* interpreters. | The extent to which the programs had been implemented and had succeeded in improving intercultural care varied greatly by department and health facility. In many cases, biomedical providers condescended to *comadronas* and tried to “correct” their practices, creating a power structure between traditional and biomedical providers. Many women users still report barriers to obtaining culturally-appropriate care. While the program has improved care seeking among many Mayan women, more efforts are needed to improve attitudes, as well as respect and awareness for Indigenous rights and culture among providers. |
| Diehl & Langdon, 2015 (72) | Tierra Indígena Kaingáng (TIK), Brazil (2000), Brazilian Indigenous Health Care System | Kaingáng (Indigenous population) | Analysis of tensions and negotiations before/after the implementation of the Indigenous Health care Subsystem in Brazil | In the 1990s, the availability of health services in TIK was intermittent. There was an infirmary/health post in the major village of TIK. Eventually, mobile teams made up of doctors, dentists, and nurses visited villages providing vaccinations, initial diagnosis, distribution of medications, and dental assistance. Since 1998, a dentist and a doctor see patients once a week in the major town. | The Indigenous Health Care Subsystem created new roles for the Indigenous population encouraging their participation in the planning and execution of health services, as well as respect for their culture and organizational structures. However, in 2004, policy shifted toward more centralization, increasing the role of municipalities in health services delivery and decreasing the role of Indigenous organizations. The Indigenous people have since experienced a loss of autonomy and self-determination. |

they fail to address the broader context: women's needs and the socioeconomic inequality in which intra-hospital relations are built. As argued by numerous studies conducted in Mexico, the mistreatment of female patients is a form of institutional violence, embedded in both the country's medical education system and in the hierarchical power structures within hospitals. Discriminatory actions by medical providers certainly reflect personal prejudices, however, they also stem from the medical field's overarching norms that all too often portray women as inferior or undeserving of medical citizenship and other rights (12, 38). Larger-scale policies and strategies that transform power dynamics inside medical schools, health facilities, and in society at-large are critical to uprooting the cause of a prevalent manifestation of health care inequity, that is, social discrimination and violence against women and ethnic minorities.

This review did not find clear evidence of such large-scale interventions in Latin America, save in a recent case. In 2007, the Government of Venezuela enacted the "Right of Women to a Violence-free Life" law (Ley Orgánica Sobre el Derecho de las Mujeres a una Vida Libre de Violencia) to address discrimination and economic, social, and political inequalities affecting women throughout the country and to define "obstetric violence" as a criminal offense subject to fines (73, 74). According to a study of 500 medical personnel surveyed 3 years later, 89% were familiar with the term "obstetric violence" and 87% with the law's existence; however, 73% were unfamiliar with the procedures for reporting these offenses (75). Consequently, while the legal criminalization of obstetric violence sets a precedent for future policy strategies, their success requires complementary programs that familiarize health care staff with specific definitions of obstetric violence and with accountability mechanisms.

## Limitations

Some limitations of this review should be noted. Despite important advances, such as including ethnicity data in census and surveys across Latin America since 2000, there continues to be a dearth of information on health outcomes among ethnic minorities, particularly the Indigenous and Afrodescendants. In addition, this search was limited to studies with published results that could be identified via searchable databases. This excluded most books and chapters in books. Furthermore, by focusing on ethnic minorities, this review may have excluded women, who regardless of their ethnicity, might have experienced health care discrimination due to poverty or other stigmatizing conditions.

## Conclusions

Health provider discrimination against Indigenous and Afrodescendant women is a primary barrier to quality health care access in Latin America. Ultimately, discriminatory practices deter women from seeking care. That said, strategies that target only provider behavior have limited impact because they do not address women's needs and the context of socioeconomic inequality present in the health care setting. To ensure optimal health outcomes for people of all ethnicities in Latin America, discrimination in health care settings needs to be understood as a key driver of inequitable health outcomes and eradicated.

Overall, more research is needed to determine the various forms and effects of discrimination and violence experienced by Indigenous and Afrodescendant women in health care settings, as well as to define best practices for designing, implementing, and evaluating programs to promote non-discriminatory care and to respond to women's needs.

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**RESUMEN**

## Evaluación de la equitatividad de la atención a las mujeres indígenas y afrodescendientes de América Latina


***Objetivos.*** Determinar y comprender las barreras que impiden en los entornos de atención de salud de América Latina la asistencia equitativa a las mujeres pertenecientes a minorías étnicas, y analizar las posibles estrategias dirigidas a mitigar los problemas.

***Métodos.*** Se llevó a cabo una evaluación exhaustiva de la bibliografía publicada del 2000 al 2015 en las bases de datos en línea PubMed, Google Académico, EBSCOhost y SciELO en español, inglés y portugués, mediante una búsqueda de palabras clave que incluyó los nombres de la Región y los países.

***Resultados.*** La discriminación por parte de los proveedores de servicios de salud contra las mujeres indígenas y afrodescendientes constituye una barrera primaria que impide a estas el acceso a una atención de salud de calidad en América Latina. La discriminación surge de los prejuicios contra las poblaciones de minorías étnicas, las mujeres y los pobres en general. Las prácticas discriminatorias se pueden manifestar en forma de culpabilización de las pacientes, negligencia intencionada, maltrato verbal o físico, falta de respeto a las creencias tradicionales y no utilización de los idiomas indígenas para comunicarse con las pacientes. Estos obstáculos impiden la prestación de una atención médica apropiada y oportuna, y también provocan temor a pasar vergüenza, al maltrato o a un tratamiento ineficaz que, junto a las barreras económicas, disuaden a las mujeres de acudir en busca de asistencia.

***Conclusiones.*** Para garantizar resultados óptimos en materia de salud entre las mujeres indígenas y afrodescendientes de América Latina, es preciso comprender y abordar el problema de la discriminación en los entornos de atención de salud como factor clave de los resultados no equitativos en materia de salud. Las estrategias dirigidas exclusivamente al comportamiento de los proveedores tienen una repercusión limitada, porque no abordan las necesidades de las mujeres y el contexto de desigualdad socioeconómica en el que se forjan las relaciones intrahospitalarias.


**Palabras clave:** Equidad; desigualdades en la salud; origen étnico y salud; salud de minorías; salud de poblaciones indígenas; servicios de salud del indígena; discriminación social; prejuicio; género y salud; América Latina; Región del Caribe.