Intersectionality in the Healthcare and Scientific Workforces

Perspectives on the intersection of race and ethnicity, immigration status, and sexual and gender minoritised status among clinical and scientific workforces in Latin America

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The Lancet Regional Health - Americas 2025;41: 100975
https://doi.org/10.1016/j.lana.2024.100975

Summary

Latin America is a highly diverse region comprised of populations with multiple intersecting identities. In this paper, we explore how race and ethnicity, immigration status, and sexual and gender minoritised status combine to affect entry into and advancement within clinical and scientific workforces in Latin America. Drawing upon intersectionality theory and existing evidence, we explain how individuals with multiple marginalised identities are particularly disadvantaged in accessing high-level positions and face barriers such as discrimination, poverty, and statistical omission. We also discuss that increasing diversity in the clinical and scientific workforces will likely benefit from system-level changes addressing educational and workplace inequality, creating mentorship opportunities, designing educational campaigns to reduce stigma and discrimination, and improving survey measures to better understand the diversity of populations. Prioritising diversity and inclusion in the clinical and scientific workforces can improve research and healthcare delivery, ultimately reducing existing economic and health inequities in the region.

Keywords: **Intersectionality; Latin America; Clinical and scientific workforce; Health disparities; Race and ethnicity; Sexual and gender minoritized populations; Immigrant health**

Introduction

Intersectionality theory posits that various systems of oppression interact in multiplicative ways to affect individuals based on their complex social identities.[1,2] Rooted in Black feminist scholarship, this theory highlights how individuals with multiple marginalised identities experience intersectional discrimination, which is unique to the combination of their social statuses (e.g., being a Black woman) and not merely the additive effects of sexism and racism accompanying each individual status.[1] A visual representation and a deeper historically contextualised discussion of intersectionality can be found in the first two papers of this series, respectively.[3,4] Although intersectionality was originally developed and predominantly studied in the US context, the diversity of Latin America makes it an apt region to assess social issues through an intersectionality framework. Substantial proportions of the population in Latin America consider themselves part of a group that is discriminated against in society, from 10.4% in El Salvador to 31.3% in Bolivia.[5]

In this personal view, we explore how race and ethnicity, immigration status, and sexual and gender minoritised (SGM) status combine to affect diversity within the clinical and scientific workforces in Latin America. We recognise that these issues intersect with other social characteristics, especially gender and socioeconomic status, as well as geographic origin and Spanish language proficiency. However, examining all these intersections is beyond the scope of the current manuscript. Further discussions of some of these social statuses can be found in the other two papers of this series.[3,4]

We start with an overview of the conceptualisations and measurements of race and ethnicity, immigration

DOIs of original articles: https://doi.org/10.1016/j.lana.2024.100974, https://doi.org/10.1016/j.lana.2024.100973
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Translation: For the Spanish translation of the abstract see the Supplementary Material section.

status, and SGM status in Latin America before delving into how intersectional inequity manifests in the clinical and scientific workforces in the region. Because research data on intersectionality and workforce diversity that includes SGM status is scarce in Latin America, we draw upon literature from the US to inform this discussion. We conclude with some potential strategies to be considered in the inclusion of racial and ethnic minoritised, immigrant, and SGM populations in the clinical and scientific workforces in Latin America, which can ultimately improve healthcare delivery[6] and generate better science.[7,8]

Race and ethnicity, immigration status, and SGM status in Latin America

Before discussing the intersectional barriers to entry and advancement in clinical and scientific workforces in Latin America, it is important to first detail the social statuses and categories used to define the region's populations. While in the USA race and ethnicity are studied as a marker of stratification above and beyond socioeconomic status,[9] the importance of race and ethnicity as a demographic social determinant is less emphasised in Latin America, with socioeconomic status considered to be the principal determinant of inequity.[10] Due to this different emphasis, and because there are 21 unique countries comprising the region, there is no consistent way that race and ethnicity are measured in Latin America. However, some broad generalisations can be made.

First, the racial and ethnic categories measured in official surveys and studied in Latin America tend to focus on two minoritised identities: Indigenous and Afro-Latino (Table 1).[16] Second, asking about African descent to define the Afro-Latino population is still a relatively new development in Latin America. For example, Argentina and Mexico only began including a question about African heritage for all respondents on their most recent censuses, in 2022 and 2020, respectively.[17,18] In contrast, questions regarding Indigenous identity, affiliation, and language use were among the first racial- and ethnic-related questions included on censuses employed in Latin America.[19] The emergence of race- and ethnicity-related questions on national surveys began in Latin America in the 1990s,[19] and redefining the questions and categories has gained momentum ever since due to the advocacy of activists, researchers, and local, national, and international individuals.[5]

This emphasis on African and Indigenous heritage reflects the region's history of colonialism and slavery. Beginning in the 16th century, the Spanish and Portuguese invaded what is now Latin America and coerced the local Indigenous peoples into slavery, primarily on sugar plantations and in mines.[5] As the brutal conditions of enslavement, as well as the spread of infectious diseases from Europe, caused the deaths of millions of Indigenous persons, the Spanish and Portuguese forcefully brought an estimated 5 to 10 million African individuals to the Americas to be enslaved on their plantations.[5,20] Today, the region is home to approximately 42 million Indigenous individuals, 80% of whom live in Bolivia, Guatemala, Mexico, and Peru.[21] Another estimated 150 million individuals are of Afro-Latino or Black descent, most of whom reside in Brazil (105 million), Venezuela (17 million), and Colombia (5 million).[5] The ramifications of the oppression and enslavement of African and Indigenous persons in Latin America continue to be felt today and manifest in territorial segregation and persistent social, political, and economic exclusion.[5]

Importantly, the focus on Indigenous and Afro-Latino identity in surveys and research does not capture the nuance of racial and ethnic diversity in Latin America. Centuries of interracial unions between African, European, and Indigenous individuals led to the establishment of a varied system of social and racial classification. In eighteenth-century Mexico, for example, up to 53 racial categories have been documented, the majority of which described different generations of individuals of mixed African descent.[22] Despite not being captured on most national censuses, a mixture of Black and White populations is common in many places today, including Brazil, Cuba, and the Dominican Republic, and may lead to an identity with one or the other racial group or as *Mulato*. The corresponding statistical omission of the *Mestizo* population, which is primarily composed of individuals with mixed Indigenous and White backgrounds, is notable given that they are the majority in many Latin American countries, such as Colombia, Mexico, and Peru. Moreover, although infrequently studied in the region, holding a White identity in Latin America is historically and contemporarily associated with social and economic privileges above all other racial and ethnic identities.[16] Yet, except for Brazil, none of the Latin American countries highlighted in Table 1 ask about White or *Mestizo* identities. Thus, when discussing race and ethnicity in Latin America, it is imperative to highlight the extensive diversity within and across countries and acknowledge that this diversity is not adequately reflected in present-day official or research measures.

The second marker of stratification we discuss is immigration status, a standard measure on censuses in Latin America. Foreign-born populations comprise around 2%–3% of the total populations of countries in the region,[23] which is a markedly lower proportion than in the USA (13.6%).[24] Still, immigration between Latin American nations has increased from 5.3 million people in 2010 to 11.3 million people in 2020, with individuals moving from places with limited opportunities and widespread social unrest to areas that show recent and

Country	Question(s) in English	Question(s) in original Language
Argentina—2022[11]		
Race and ethnicity	[1] Do you recognize yourself as Indigenous or descendant from Indigenous or native peoples? [Yes, No] [If yes], Do you speak and/or understand the language of that Indigenous or native group? [Yes, No] [2] Do you recognize yourself as Afro descendant or as having Black or African heritage? [Yes, No]	[1] *¿Se reconoce indígena o descendiente de pueblos indígenas u originarios?* [Sí, No] *¿Habla y/o entiende la lengua de ese pueblo indígena u originario?* [Sí, No] [2] *¿Se reconoce afrodescendiente o tiene antepasados negros o africanos?* [Sí, No]
Sexual and gender identity	In terms of gender identity, do you consider yourself... [A] Woman [B] Transgender woman [C] Man [D] Transgender man [E] Non-binary [F] Other identity/None of the above [G] Prefer not to answer	*De acuerdo a la identidad de género ¿se considera...* [A] *Mujer* [B] *Mujer trans/travesti* [C] *Varón* [D] *Varón trans/Masculinidad trans* [E] *No binario* [F] *Otra identidad/Ninguna de las anteriores* [G] *Prefiero no contester*
Brazil—2022[12]		
Race and ethnicity	[1] Your skin colour or race is: [A] White [B] Black [C] East Asian [D] Brown [E] Indigenous [2] For people living in Indigenous areas, do you speak an Indigenous language at home? [Yes, No] [3] For people living in Quilombola areas, do you self-identify as Quilombola[b]?[13] [Yes, No]	[1] *A sua cor ou raça é:* [A] *Branca* [B] *Preta* [C] *Amarela* [D] *Parda* [E] *Indígena* [2] *Para pessoa, em área indígena, Fala língua indígena no domicílio?* [Sim, Não] [3] *Para pessoas em área Quilombola, Você se considera Quilombola*[b]*?*[13] [Sim, Não]
Colombia—2018[14]		
Race and ethnicity	[1] In terms of your culture, peoples, or physical features, do you recognize yourself as: [A] Indigenous [B] Gypsy or Roma [C] Raizal from the San Andrés Archipelago, Providencia, or Santa Catalina [D] Palenquero from San Basilio [E] Black, Mulato, African descendant, Afro Colombian [F] None of the ethnic groups [If yes], Do you speak the native language of your people? [Yes, No]	[1] *De acuerdo con su cultura, pueblo o rasgos físicos ... es o se reconoce como:* [A] *Indígena* [B] *Gitano(a) o Rom* [C] *Raizal del Archipiélago de San Andrés, Providencia y Santa Catalina* [D] *Palenquero(a) de San Basilio* [E] *Negro(a), mulato(a), afrodescendiente, afrocolombiano(a)* [F] *Ningún grupo étnico* *¿ ... habla la lengua nativa de su pueblo?* [Sí, No]
Mexico—2020[15]		
Race and ethnicity	[1] Do you consider yourself Afro Mexican, Black, or African descendant? [Yes, No] [2] Do you speak any Indigenous dialect or language? [Yes, No]	[1] *¿Se considera afromexicano(a) negro(a) o afrodescendiente?* [Sí, No] [2] *¿Habla algún dialecto o lengua indígena?* [Sí, No]

[a]Only Argentina has census question on sexual and gender identity. [b]Quilombola people are descendants of Afro-Brazilian slaves who escaped from slave plantations in Brazil prior to the abolition of slavery in the country in the 19th century.

Table 1: **Census questions on race and ethnicity and sexual and gender identity[a] in the four most populated countries in Latin America.**

sustained economic growth.[25] The largest number of immigrants is in Argentina (2.3 million individuals or 5% of the population), followed by Colombia, Chile, Mexico, Peru, and Brazil, with more than a million immigrants each.[23] Venezuelan individuals comprise the largest immigrant population in the region, most notably in Colombia and Peru, where they make up 92% and 84% of the immigrant populations, respectively.[23] Immigration within Latin American countries has led to a second generation that identifies with the new country and increased the presence of that group within the population. For example, immigrants from Paraguay and Peru, who are often *Mestizo* or Indigenous, add to the diversity of Argentina.

Lastly, SGM individuals include those who identify as lesbian, gay, bisexual, transgender, gender non-conforming, or intersex. The SGM population in Latin America is still largely overlooked, at least in political and statistical terms. Nevertheless, there has been significant progress in recognising and protecting SGM individuals and their rights in the region over the past decade, in conjunction with local and international social movements.[26] Official recognition and acceptance of SGM individuals tend to be more common in some South American countries and Mexico compared to Central America and parts of the Caribbean (with some exceptions, such as Cuba and Puerto Rico).[26,27] In 2022, Argentina became the first country in Latin America to

ask its residents about their gender identity, in addition to sex assigned at birth, on its national census (Table 1).[18] Uruguay followed soon after in 2023,[28] and Brazil passed legislation to include such questions in all future censuses in the same year.[29] Other countries have started to implement surveys drawing specifically from the SGM community, such as the Dominican Republic,[30] Ecuador,[31] and Peru,[32] while others, like Brazil[33] and Mexico,[34] have recently included questions regarding SGM status on social and health surveys. Still, to date, there are few nationwide, reliable estimates of the SGM population in Latin America. In Mexico, the SGM population was estimated to include 5 million people (5.1% of the population ages 15 years and older) in 2021,[34] while 8293 (0.2%) of the population in Argentina identified as non-binary on the 2022 census.[35]

Although discussed in this section as separate entities, race and ethnicity, immigration status, and SGM status are interacting social identities. For example, in the Dominican Republic, SGM status often overlaps with immigration status and having a Black identity, with 6.5% of SGM individuals born abroad (vs. 4% in the general population[36]) and 15.1% identifying as Black (vs. 18.3% in the general population).[30] While individuals may experience discrimination based on one identity (e.g., being a transgender woman or being Black), those with multiple marginalised statuses also experience intersectional discrimination, which is unique due to the combination of their social statuses and not merely the additive effects of each individual status. Understanding how these identities intersect to shape social integration is the first step in addressing the intersectional disparities experienced by these individuals. Although data on SGM status are scarce in Latin America, and data on race and ethnicity are inconsistently collected, researchers are increasingly examining experiences and outcomes related to the intersection of these, and other, social identities in the region. We draw upon this emerging evidence in the following sections.

Intersectionality and the clinical and scientific workforces

The labour market is an important sector to examine intersectional inequity, given that it both reflects and creates socioeconomic inequities in society. An intersectional lens will help illuminate how race and ethnicity intersect with other social identities, namely immigration and SGM status, in determining entry into and advancement in the clinical and scientific workforces. Both clinical and scientific fields require advanced education and training and are accompanied by social prestige and higher levels of compensation. Even so, clinical workers primarily focus on providing direct care to patients and scientific researchers focus on the advancement of knowledge. Ultimately, the goal of many researchers, especially health researchers, is to have this knowledge translated into practice, by clinicians and others, to improve people's health and well-being. Having a diverse workforce is integral to both fields, as varied perspectives can generate research questions and clinical solutions that consider a broader set of experiences and benefit a wider proportion of society. Thus, increasing diversity within the clinical and scientific workforces has the potential to improve population health along an entire continuum, from the science produced to individual- and population-level outcomes.

The proportion of the population working in high-status careers, such as physicians, nurses, and researchers, varies across Latin America (Fig. 1). Individuals with marginalised social statuses, and particularly those with multiple marginalised identities, are poorly represented in such occupations. Conversely, immigrants and racial and ethnic minoritised populations are overrepresented in "low-profit" sectors in Latin America,[10] including microenterprises, part-time self-employment, and domestic services.[42] For example, due to intersecting oppressions of gender, race and ethnicity, and immigration status, Black and Indigenous Peruvian women in Chile are pushed into jobs lacking security, despite having higher levels of education on average than their Chilean-born coworkers.[43–45] Although some immigrants are able to access high-status careers in certain places, such as the medical field in Argentina,[46,47] these individuals tend to come from relatively advantaged backgrounds in other ways, like higher socioeconomic status. SGM populations are also disadvantaged in the Latin American labour market, with high rates of unemployment[30] and employment in sex work,[48] an especially stigmatised profession. Having intersecting marginalised social statuses can create greater barriers than just one marginalised status in both entry into the clinical and scientific workforces and advancement in these fields. Below we highlight some of the many ways in which this inequity manifests.

Intersectional barriers to entry into clinical and scientific workforces

Individuals with intersectional marginalised statuses face challenges in entering the clinical and scientific professional workforces because of the lack of economic and educational opportunities. Racial and ethnic minoritised populations[5,21] and immigrants[49] experience high rates of poverty in Latin America. For example, in Colombia, the poverty rate of Afro-Latino persons is 41%, compared to 27% among other persons.[5] This patterning of poverty is a contemporary manifestation of the legacy of slavery, with Afro-Colombians geographically segregated into socially and economically disadvantaged communities on the Atlantic and Pacific

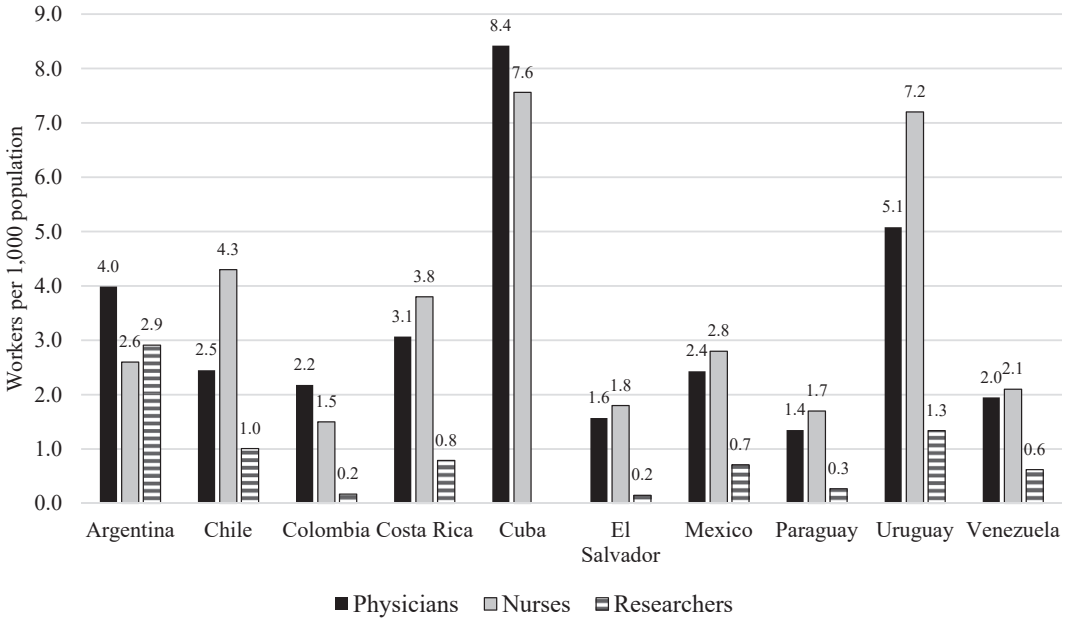

Fig. 1: **Clinical and research workforce in ten Latin American countries.** Notes: Nurses include midwives and researchers include full time employees only; Data for researchers in Cuba not available; Data come from latest years available in each country. Compared to U.S.: 2.6 doctors,[37] 15.7 nurses,[38] and 4.4 researchers[39] per 1000. Sources: Data adapted from OECD and the World Bank, Health at a Glance: Latin America and the Caribbean 2023,[40] and UNESCO, UNESCO Science Report: The Race against Time for Smarter Development, Chapter 7: Latin America.[41]

coasts, areas that were once the sites of slave trade and labour.[50] Immigrants in Colombia are also more likely to be impoverished, with 44.2% of Venezuelan immigrant households living in poverty compared to 16.6% of non-immigrant households.[49] Afro-Venezuelan or *Mulato* immigrants in Colombia likely experience socioeconomic hardship as a result of disadvantages and discrimination related to both their racial identity and being from Venezuela, as well as stressors particular to the unique combination of these social statuses. The economic disadvantage may be exacerbated for those who additionally identify as SGM, as is the case for minoritised racial and ethnic and sexual and gender groups in the USA.[51]

Poverty creates, and reinforces, inequities in educational attainment, which is a prerequisite to entering the clinical and scientific workforce. Disparities in access to and the quality of education and degree completion rates exist by race and ethnicity[10] in many Latin American countries and, although evidence remains scarce, by SGM status as well.[52] One study in Brazil found that 44.9% of the transgender individuals surveyed did not finish primary school.[52] Discrimination and mistreatment can drive individuals who have been socially marginalised to drop out of school, including the 32.2% of transgender respondents in Brazil who reported their reason for not finishing school was due to being transgender[52] and related to the discrimination and stigmatisation of holding this identity. Although unexplored in the study,[52] intersectionality theory would predict that the 10.9% of transgender individuals who identified as Black encountered additional impactful experiences, likely adverse, in the Brazilian educational system. Intersectional disadvantage has been found in Chile, Colombia, and Peru, where Indigenous women living in rural areas experience the highest rates of illiteracy and less than 4 years of schooling compared to all other racial and ethnic, gender, and regional groups.[53] Further barriers to completing a basic education or pursuing higher education include difficulty covering school-related expenses, lack of mentorship and support networks to help individuals navigate systems of higher education, low (or no) pay while training to become a clinical or scientific professional, and geographic distance from universities.

Even after accounting for disparate starting points in terms of poverty and educational attainment, there are substantial employment and economic disparities among populations that have been systematically marginalised in Latin America. For example, higher levels of education do not lead to the same employment outcomes among Afro-Latino or Indigenous populations compared to non-Afro Latino and/or non-Indigenous populations in Brazil,[10] Mexico,[54] and Uruguay.[10] SGM persons, who may also be Afro-Latino or Indigenous, fare poorly in the labour market as well, with only 39.8%

of SGM individuals employed in the Dominican Republic.[30] Because of these systemic barriers to inclusion, the clinical and scientific workforces in Latin America are less diverse in terms of race and ethnicity, immigration status, or SGM status, especially at the leadership level. It is these barriers to advancement to which we turn next.

Intersectional barriers to advancement in clinical and scientific workforces

Individuals with multiple marginalised statuses who successfully enter the clinical and scientific workforces face challenges related to access to resources that improve career development and recognition and respect in the workplace. For example, medical students in the USA who identify as racially or ethnically minoritised, female, and SGM report significantly more discrimination, burnout, and exhaustion than their White, male, heterosexual counterparts.[55] Although not assessed as an identity that intersects with other social identities, emerging studies in Latin America also indicate that SGM status affects experiences in school and the workplace. In Colombia[56] and Peru,[32] SGM individuals report high levels of stress due to discrimination in the labour market, which causes fear, feelings of exclusion, tiredness and exhaustion, irritability, and sleep problems. Furthermore, sexually minoritised men are significantly more likely to be victims of work-related violence than heterosexual men in Brazil.[57] Among a predominantly female sample of nursing students in Colombia, 70% of individuals reported discriminatory acts such as abuse of authority, taunts, gestures, and obscene compliments, and these acts were more commonly reported by SGM, Black, and Indigenous students.[58]

There are few resources for individuals to report such experiences or effective mechanisms to implement anti-discrimination protocols in Latin America. Legal protections are especially scarce for SGM individuals, particularly in countries in the Caribbean and Central America.[26] Exposure to such stressors can inhibit a person's mental well-being and ability to effectively perform their job, and can affect their career opportunities and chances of promotion.

Subsequently, individuals with multiple marginalised statuses are less likely to be promoted to leadership positions. In Brazil[59] and Uruguay,[60] Afro-Latino populations are inordinately underrepresented in supervisor, manager, executive, and director roles. Moreover, based on the limited available data, no Indigenous or Black woman has ever served in a senior leadership role in a Peruvian university.[61] This labour market disadvantage extends to other social statuses as well, with immigrants more likely to be overqualified for their jobs and hold informal positions compared to their native-born counterparts in Latin America.[23] In summary, disproportionate exposure to socioeconomic disadvantages, discrimination, burnout, and lack of support prevents most racial and ethnic minoritised, immigrant, and SGM populations from entering and/or advancing within the clinical and scientific workforces (Fig. 2).

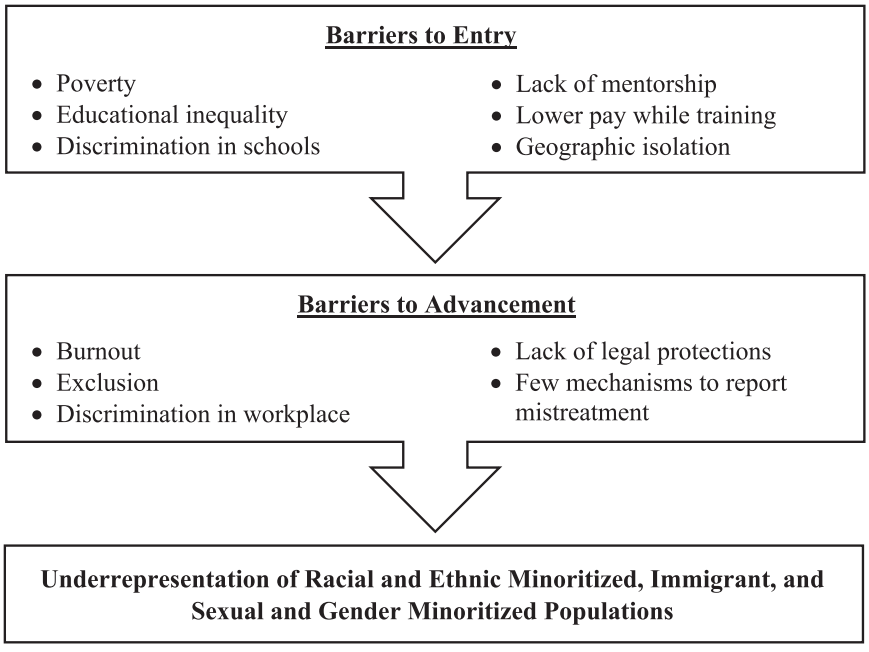

Fig. 2: **Barriers to entry and advancement in the clinical and scientific workforces in Latin America.**

Addressing intersectional inequity in the clinical and scientific workforces

Improving the representation of individuals with multiple marginalised statuses in the clinical and scientific workforces may have benefits. Diversity within the healthcare workforce reduces bias and improves treatment, especially for populations with intersections of marginalisation. For example, healthcare professionals in the USA with a minoritised racial and SGM status demonstrate higher SGM cultural competency than those without, or with one, marginalised social status.[62] Conversely, the lack of diversity in the clinical workforce can increase exposure to discrimination and inhibit the quality of treatment received by patients,[6] as in the case of Nicole, a Senegalese immigrant to Argentina, illustrated in Box 1.

Likewise, the sociodemographic composition of the scientific workforce impacts the topics studied and the science produced.[63] One study estimates that, in the absence of racial and gender inequalities in the US scientific workforce, there would have been 29% more articles published in public health, 29% more on gender-based violence, 25% more on gynaecology and gerontology, and 20% more on immigrants and minoritised populations over the past 40 years.[63] The inadequate inclusion of SGM populations and underrepresented immigrant populations in the scientific workforce likely changes the focus of research produced in multifaceted but unknown ways. Increasing the representation of individuals who have been socially marginalised among those conducting research could help shift the focus of studies towards topics that are relevant to the health and lives of the entire population instead of only reflecting the interests of narrow segments of the population.

Because intersectional identities are rooted in power and structures, alleviating intersectional inequity in clinical and scientific workforces in Latin America may benefit from institutional remediation to address the structures that uphold assumptions, policies, and practices that favour some segments of the population to the disadvantage of others.[64] Below we highlight five possible systems-level strategies to lessen inequity and improve representation in the clinical and scientific workforces by race and ethnicity, immigration status, and SGM status (Table 2). These strategies will likely be most effective if implemented concurrently and with an intersectional approach in order to address inequity in the many ways it manifests for individuals with multiple social vulnerabilities.[64]

First, educational inequity needs to be addressed to increase diversity in the clinical and scientific workforces. Several Latin American countries already have universal education policies which provide higher education in public institutions free of charge—e.g., Argentina, Brazil, Bolivia, Cuba, Ecuador, Paraguay, and Uruguay.[65] These policies remove a substantial financial barrier to accessing post-secondary education for students from low socioeconomic backgrounds and lead individuals to migrate to these countries from other Latin American nations to take advantage of educational opportunities. While about two-thirds of Latin American countries have affirmative action or scholarships specifically for racial and ethnic minoritised populations, Argentina is the only country in Latin America to explicitly include SGM individuals in their higher education inclusion policies.[65] No Latin American countries have policies to promote access to education for immigrants, although there is free access in countries where public universities have no cost.[65]

While beneficial, universal education will not translate to equity unless other barriers are simultaneously addressed. As the case of universal healthcare illustrates, 40.7% of transgender women sampled in Argentina reported avoiding healthcare, despite being free, and this avoidance was associated with having experienced stigma and discrimination in healthcare settings.[66] To address educational inequity, schools may need to consider how to be inclusive spaces, such as having zero-tolerance discrimination policies, implementing teacher training, and creating complaint mechanisms for reporting and redressing

Box 1.

Intersectional barriers in healthcare—case study from an Argentine clinician in Buenos Aires.[a]

In May 2023, Nicole, a 38-year-old woman born in Senegal who had arrived in Argentina a year earlier, came to the ambulatory clinic. She did not speak Spanish, only very basic French, and had no companion to help her communicate. Nicole came to the University Hospital with ulcerated lesions on the soles of her feet that had been evolving for several months. The health centres where she had previously gone mistreated her because of her skin colour and inability to communicate and ultimately did not heal her wounds. After evaluation by the health team, including a French-speaking doctor, Nicole explained that she lived in a room she rented with three friends. She worked as a street vendor and the money she earned was sent to Senegal to support her three children who had been left in the care of their grandmother. The team agreed that blood tests and a skin biopsy were necessary. However, the hospital laboratory, where people without health insurance must be treated free of charge, would not accept the samples because Nicole did not have Argentine documents. When the tests were finally run, it was discovered that Nicole had HIV infection. The doctor in charge started administrative steps to help Nicole and when the doctor asked for an interview to explain her case to the hospital director, the doctor was told by an assistant to the director, "Ahhh, are you here for the Black woman with HIV?" Although treatment for people living with HIV is free under Argentine law, Nicole was initially barred from accessing care because she did not have documents. Social workers were also resistant to helping her because they did not understand her. Finally, Nicole was admitted to the HIV Care Program, where she has recovered and continues care.

[a]Narrative data comes from author RM's personal experience. The name and the country of origin of the patient have been changed to protect her privacy.

Address educational inequality	• Financial incentives for schools to meet recruitment targets • Universal education policies • Programs to support SES disadvantaged persons • Scholarships, including for non-tuition expenses • Zero-tolerance discrimination policies • Anti-bias training for teachers • Complaint mechanisms for reporting discrimination • Preparatory and remedial courses and tutoring
Hire diverse individuals	• Opportunities for SES disadvantaged populations • Consider lived experiences of qualified applicants in hiring decisions
Promote mentorship	• Strategies that encourage, recognize, and reward mentors • Multi-mentor systems • Leadership programs
Reduce stigma and discrimination	• Educational campaigns • Perspective-taking exercises and interventions • Mechanisms to redress discriminatory acts
Improve data collection	• Sexual and gender minoritized status measures on surveys • Expanded racial and ethnic identity options on surveys

***Table 2*: Potential strategies that may improve diversity and inclusion in the Latin American clinical and scientific workforces.**

discriminatory acts.[67] Additionally, it may be beneficial to provide supplemental economic and educational support beyond tuition to socioeconomically disadvantaged and geographically isolated individuals enrolled in university programs, such as scholarships that cover travel and housing expenses. Educational inequity may also be lessened through provision of financial incentives for primary schools to meet completion and quality targets and, at the post-secondary level, preparatory courses and tutoring to address the differential quality of primary and secondary education.[65]

Second, incentives for hiring underrepresented individuals after their completion of a degree may also help. Some countries in Latin America have already taken steps to intentionally recruit individuals who have been historically and contemporarily marginalised into the labour force. For instance, governments in Argentina[68] and Uruguay[69] have established a target for recruiting transgender individuals in the public sector to bolster their integration into the labour market. Similarly, Brazil has implemented guidance for Black persons in national service work.[70,71] These initiatives have been successful in improving transgender and Afro-Latino representation in the public sector.[71,72] Still, it is important for policies to consider individuals with multiple marginalised identities given that relatively more empowered individuals in a population are more likely to benefit from them, as illustrated by the case of Argentine-born transgender women being significantly more likely to access their rights under the 2012 Gender Identity Law than foreign-born transgender women in Argentina.[73] As such, the expansion of relevant policies would affirm diversity in terms of race and ethnicity, immigration status, SGM status, and their intersections, among clinicians, researchers, educators, and policymakers.

Third, enhancing diversity within the clinical and scientific workforces could be promoted through robust mentorship structures and continuous support for all individuals, including as a priority, those with marginalised intersectional statuses.[74] Mentorship relationships can provide a range of benefits, including professional and psychological support,[75] and are therefore integral to retention, advancement, and well-being in the clinical and scientific workforces.[76,77] Mentors can be encouraged, recognised, and rewarded as strategies by education and labour institutions. Given the scarcity of racial and ethnic, immigrant, and SGM diversity at leadership levels in the clinical and scientific workforces, organisations can leverage multi-mentor systems, which includes peer-to-peer mentoring and group mentoring, as well as leadership programs that include individuals with marginalised statuses, to achieve their diversity and inclusion goals.[76]

Fourth, institutional changes may face backlash from the general population if not also partnered with campaigns to reduce stigma and discrimination against minoritised populations. Structural racism in Latin America persists, as evidenced by rampant inequity by race,[5,21] and highly publicised examples, such as the repeated racist and sexist attacks leveraged against Colombia's first Afro-Latina woman vice-president, Francia Márquez.[78,79] This has been accompanied by a rise in anti-immigrant sentiment in recent years,[80] with increased immigration from Venezuela being met with fears regarding crime,[81] insufficient jobs, and cultural erosion.[82] Lastly, although SGM communities and organisations are becoming more vocal in the region, there is a lack of legal protections for SGM populations in many countries[26] and SGM individuals continue to be pathologised and even persecuted,[27,83,84] resulting in an estimated life expectancy of transgender individuals in the Americas of only 35 years.[85] Expressed tolerance of homosexuality is particularly low in places such as Bolivia, Guatemala, Nicaragua, and Peru, but even countries with relatively high tolerance (e.g., Argentina) have not reached wide societal acceptance levels.[27] Research has shown that discrimination can be reduced and prosocial feelings increased through perspective-taking exercises and interventions that address misinformation or generate connections between different populations.[80] Therefore, to be successful, changes to social policies may be accompanied by educational campaigns to reduce stigma and discrimination against groups that have been marginalised, as well as robust mechanisms to redress discriminatory acts when they occur.

Finally, improvements in the data collected in Latin America would help advance existing knowledge, and address ensuing findings, on intersectional inequity. The information regarding intersectional inequity

presented here is based on a nascent body of literature and limited data. The intersectional disparities that exist in the clinical and scientific workforce, and beyond, in Latin America will remain invisible until various social statuses are incorporated into official surveys and more research on workforce diversity is conducted. Although many countries now estimate their Afro-Latino and Indigenous populations on national surveys, measures related to the population who are of mixed race (*Mestizo* or *Mulato*) or White, with European and Middle Eastern heritage, are less common. In addition, measures related to SGM status are exceedingly rare. Without these comprehensive measures, it is difficult to determine the extent of disparities, and which populations are privileged or disadvantaged in society. Monitoring and investigating cases of discrimination, as exemplified by the national registry to review cases of racism in Brazil[70] and various forms of discrimination in Argentina,[86] could help illuminate the often obscured ways in which racism and discrimination permeate Latin American society.

Conclusion

The diversity of Latin America makes it an apt region to explore how complex social statuses intersect to influence integration into the workforce. Populations who are at risk of marginalisation and exclusion from the clinical and scientific workforces in Latin America include racial and ethnic minoritised, immigrant, and SGM individuals. However, as intersectionality theory posits, it is not simply that each of these social characteristics affects integration into the labour market, it is the combination of these statuses that generate unique experiences of discrimination, stigma, and disadvantage. We propose that initiatives to increase diversity in the clinical and scientific workforces based on race and ethnicity, immigration status, and SGM status in Latin America need to consider systems-level changes that are attentive to intersectional vulnerabilities, including in education and the labour market, national government, and research communities. Greater attention to intersectional inequities in research and society may help improve the profound economic and health disparities that persist in Latin America.

Contributors

All authors provided input and expertise to all sections. RAZ wrote the first draft of the manuscript. EJR, RM, and EPS performed critical revisions of the manuscript and contributed to the writing and concepts. RAZ created the tables and figures, and RM wrote Box 1. EPS served the supervisory role. All authors read and approved the final manuscript.

Declaration of interests

None.

Acknowledgements

Funding source: The funding source is through the Division of Intramural Research, National Heart, Lung, and Blood Institute, National Institutes of Health. Role: None.

Disclaimer: This material should not be interpreted as representing the viewpoint of the U.S. Department of Health and Human Services (HHS) or the National Institutes of Health (NIH).

Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.lana.2024.100975.

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