briefing

Minority Rights Group

HEALTH POVERTY ACTION

Maternal and reproductive health: Voices of indigenous women and girls

Claire Thomas and Natalie Sharples

Featured image: An indigenous midwife attends a workshop at San Bartolome Jocotenango, Guatemala.
Credit: Tolo Balaguer / Alamy Stock Photo.

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Minority Rights Group

Minority Rights Group (MRG) is the leading international human rights organization working to secure the rights of ethnic, religious and linguistic minorities, and indigenous peoples, and to promote understanding between communities. We are guided by the needs expressed by our worldwide network of over 300 partner organizations in more than 60 countries. Together, we challenge power structures that exclude and silence those who are different. We understand how age, class, gender, sexuality and disability can have multiplying impacts on discrimination for minorities.

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About the authors

Claire Thomas became Executive Director of Minority Rights Group in March 2025 having been Deputy Director for the previous 27 years, leading on areas including programme design and fundraising. Personal highlights include the innovative minority inclusion audit approach to bring issues facing minority community members to the forefront and a programme that ultimately brought street theatre against racism performances to 100,000 audience members across the Middle East and North Africa.

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Introduction

Around the world, indigenous women and girls are more likely to die in childbirth and pregnancy than the majority community. They experience significantly worse maternal and sexual health outcomes than non-indigenous populations. Although there is a dire lack of data in this area, previous research has found that 'indigenous women and adolescent girls are significantly less likely to benefit from services and have worse maternal health outcomes.'[1] For instance, a birth rate for Amerindian adolescent girls being twice that of the general Guyanese population, Maasai women in Kenya being twice as likely to have had no antenatal care, or San women in Namibia being ten times more likely to give birth without skilled attendance.'[2]

The reasons for this situation are multifaceted. Indigenous peoples have a concept of health which is far removed from the biomedical model prevalent in many national health systems. For indigenous peoples health is understood holistically, and is very closely bound up with community, spirituality, access to land and resources. The gap between these views of health and that of professional healthcare staff can leave indigenous women and girls feeling disrespected and disparaged, particularly where professional staff are ignorant about or fail to take indigenous perspectives into account. These tensions are exacerbated by displacement, land dispossession, poor sanitation, food insecurity, malnutrition and climate change impacts. All these structural factors, themselves stemming from or exacerbated by histories of colonialism, racism and territorial dispossession. Indigenous women and girls also experience linguistic barriers, geographical inaccessibility, inadequate transport and infrastructure. At times, lower budgets and levels of service provision lead to generally inadequate healthcare provision in areas where indigenous peoples live. This complex web of intersecting factors creates barriers between indigenous women and girls and their right to health.

For this briefing, we sought out the voices of indigenous women and girls, to unearth their experiences accessing maternal and reproductive healthcare. A focus group discussion was held in Kenya with 12 young women aged 18–25 from the Borana and Turkana indigenous communities. The individuals were identified by an indigenous- and female-led partner organization based in northern Kenya. The hybrid discussion involved two groups of women, took place in the office of a non-governmental organization and was facilitated by an indigenous woman. The conversation was loosely based on a set of questions provided to the team and followed a semi-structured format, exploring participants' experiences of five key indicators of maternal and reproductive health (access to contraceptives, adolescent pregnancy, place of delivery, access to antenatal care and skilled birth attendance) as well as examining how women felt sexual and reproductive health services could be improved.

The same set of questions was adapted to conduct semi-structured key informant interviews with 10 indigenous women aged 18–49 from six countries (the Democratic Republic of the Congo, Ethiopia, Kenya, Mexico, Rwanda and Uganda) who each had a disability. The interviews took place online with interpretation between English and the local language.

In addition, four examples of good practice were explored: Guatemala, based on desk research and key informant interviews with two Health Poverty Action staff members and the Intercultural Coordinator for Totonicapán Province; Brazil, extracted from the findings of the existing United Nations Population Fund (UNFPA) Latin America and Caribbean Region Office good practice case study; Canada, based on a presentation at a recent UNFPA symposium on indigenous midwifery and reviewed by the presenter and a colleague; and Nepal, based on desk research and reviewed by UNFPA colleagues in Nepal.

More data on this topic is urgently required to show policymakers where and how they must act. Indigenous women and girls must be foregrounded in any data collection efforts in order to reverse the marginalization that has resulted in these disastrous health outcomes. Whilst quantitative data is essential, this report's intention is to amplify the voices of indigenous women and girls speaking for themselves, to put on record their feelings, decisions and experiences that shed light on the disparities revealed by statistics. This report presents therefore quotations from our research discussions at length, as an urgent contribution to the available data on this topic.

Kenya

As part of our research we conducted an in depth focus group discussion with 12 indigenous women in Kenya. Conversations revealed a communication breakdown between health service personnel and the community. This stems from overworked, underpaid and under-resourced personnel with inadequate training and whose attitudes to the communities they serve is, at times, negative. Whilst many of these problems may apply to all women in Kenya, it is clear that the cultural and linguistic barriers that exist between most professional medical staff and their patients in these indigenous areas exacerbate treatment approaches which are experienced as disrespectful and uncaring:

'In my experience, there are some nurses who are very rude. … Female nurses will not sympathize with you, they will just shout at you "Open your legs!" without any sympathy, "Was I with you when you were being impregnated?", "Open your legs or I will tie you up!" and many such abusive comments. … They abuse you so much that you feel like the child should go back into the womb and you should go elsewhere and seek proper services. In private hospitals there is much more respect for expectant mothers.'

'The nurses don't listen to expectant mothers. When you climb onto the bed where you are supposed to give birth, they tell you to stop wasting their time because according to them you are not ready to give birth. We witness so many expectant mothers giving birth on their own without any support from nurses.'

indigenous women and girls report preferential treatment for some patients:

'One of the bigger healthcare facilities in our area has two doors, one in front and a back door. Some patients, who are favoured, use the back door to access the services and hence avoid waiting for their turn. Many expectant mothers do not go to clinic as a result of the way they are treated.'

Women and girls had real doubts about the quality of care:

'I attended clinic at the local dispensary. The healthcare centre does not have a laboratory. Most of the diagnosis is guesswork. For any need for medical tests we travel further to the healthcare centre to get blood tests and others. Where I come from, due to these challenges myself and many other expectant mothers in my village we do not receive proper ante-natal care services.'

'Those who are pregnant feel the fear and refuse to go to hospital during delivery. If you look at the records, the number of women who deliver at home is higher than ever before.'

As well as a lack of equipment, the women and girls noticed a lack of available fully qualified staff:

'We fear going to public hospitals because intern nurses from Kenya Medical Training Colleges (KMTC) are the only ones serving expectant mothers. There are no skilled officials. We feel like they are there to practice on us.'

'There was a day I took my sister to the public health facility. She has [high] blood pressure. It was 10 pm. The experienced nurse had retreated to her staff quarters. The intern nurses were the only ones who were left in charge. The student nurse we found there, due to her lack of experience, she expressed fear, because she did not understand what to do. The experienced nurse did not want to be disturbed because she told us that we have a nurse at the facility. We had to transfer our patient to a private hospital for better services.'

One indigenous woman who has a friend who works in the health service even told us that the authorities actually encourage less caring or respectful treatment approaches:

'I once asked a [member of health clinic] staff who is also a friend about why they treat clients or patients with no respect. She told me that the ratio of nurses to patients is too high. Each nurse is expected to attend too many people which can lead to exhaustion. She also revealed to me that they are overworked and sometimes they attend to expectant mothers when they are hungry and tired. She further revealed that the healthcare staff are told not to be too merciful with patients because this can have a negative impact on their health as staff. They are told to do what they can and not to care too much about the patients.'

Even women who have not had direct personal experience of inexperienced, rushed or disrespectful treatment, may hear about it from others:

'It is unfortunate that these experiences we face are shared in women groups when they meet for table banking [financial cooperative]. Those who are pregnant feel the fear and refuse to go to hospital during delivery. If you look at the records, the number of women who deliver at home is higher than ever before.'

Financial costs were acknowledged to be a problem for some women, particularly in that women could not afford private hospitals where treatment quality was perceived to be better.

'Many expectant mothers do not go to clinic as a result of the way they are treated. Expectant mothers in urban areas are the ones who attend ante-natal care clinics. Those from rural areas do not attend clinic. They say they have no money to attend clinic. Expectant mothers are charged Ksh. 500 during their first visit.'

There was, however, also a strong sense that women would be more motivated to prioritize finding the money to pay for services if they knew that they would receive high quality and respectful treatment:

'[The] majority of us prefer private hospitals. But not all us have the needed resources to seek healthcare services from private centres. Public health units especially at the lower levels are closed for the day from 4 pm on days of the week. Some of the expectant mothers deliver at home due to these challenges. We prefer giving birth at home because the traditional birth attendant does not charge us for their services. It is free. All you need is a new pair of gloves and new razor blade. They are always ready and willing to assist expectant mothers during delivery.'

'I knew I was supposed to attend the ante-natal care clinic but I did not go. It was due to stigma. I was ashamed of getting pregnant before marriage. People have a lot of expectations from you as a youth. I had not come into terms with the fact that I was pregnant. Shame, stigma and not accepting my situation were the key factors that prevented me from visiting the clinic. … I had a business and was working on various jobs so I can't say that I lacked money to go to clinic. I was near the hospital, I had money, healthcare services were accessible to me. When I made my first visit at 6 months, the healthcare worker asked me for my clinic card. I said I do not have any. I was scolded by the doctor.'

indigenous women also spoke of social stigma as a reason for low take up of services. This could be around being pregnant prior to marriage or linked to HIV/AIDS:

'I knew I was pregnant when it was 3 months after conception. I heard people get tested and find they have dangerous diseases [like HIV/AIDS] and I was scared of going as a result. If you go for a test and get to know you are infected with HIV, that will be the end of your life. That is what we believe in our Manyatta [village]. It's better when you don't know that you are infected. However, fellow villagers encouraged me and I was convinced and gathered courage and later went to the ante natal care clinic. However, I was around 8 months pregnant. I accepted to go because I was feeling a little unwell. The healthcare workers shouted at me so much for the delay but they helped me a lot.'

Social, religious and familial pressures were particularly important concerning contraception and for those indigenous communities where the Islamic faith is prevalent:

'In remote areas there is stigma against Muslim women who use family planning. Other Muslim women may judge you if you use family planning. They say that you engaged in adultery that is why you are using family planning.'

Reports of family planning affecting future fertility also circulate:

'If you fail to get pregnant after a period of using family planning, you are blamed for that failure to get pregnant. They tell you "tell the injection to give you a baby". They refer to the family planning as a self-inflicted problem in case you fail to become pregnant again.'

Whilst women knew of instances whereby husbands had prevented their wives from attending clinics or seeking treatment for themselves and their children, they also said that they personally would

attend a clinic secretly without seeking a male relative's permission if they needed to do so. indigenous women saw the involvement of traditional birth attendants (TBAs) or community health workers as the way forward, noting that their knowledge of local languages and cultures allowed them to bridge the existing communication gap. It was suggested that this should be combined with better training and resourcing of clinics and their staff:

'indigenous women are less likely to use modern contraceptives because we don't know enough especially on their side effects. We would love to learn more especially through Community Health Volunteers (nowadays known as Health Promoters) before we make the final decisions on this matter. We prefer community health volunteers because they speak our language. When we go to the health facilities, the staff sometimes speak to us in a lot of English leaving us confused. Community Health Volunteers are readily available to us, they speak our language, and we don't fear asking them questions. This is the way to go.'

'Government should pay the staff well and on time in order for them to settle and treat expectant mothers well.'

'Nurses should be trained on the different kinds of women that they will serve in their healthcare facilities because these women face many challenges. Staff should help reduce or eradicate stigma. Staff should not be the source of stigma.'

'The government should increase the number of Health Promoters to encourage expectant mothers to attend ante-natal clinics. The government should also consider introducing mobile clinics to improve access to sexual [and] reproductive health [and] rights for pastoralist women and have specific days for visiting various communities. This will bring services closer to the people.'

It was also suggested that women should be encouraged to report health staff who are rude or refuse treatment or put women's or babies lives at risk:

'We should be recording the rude and disrespectful staff so that they can be sacked by the government and new respectful staff be employed in their place.'

What barriers do indigenous women with disabilities face to accessing healthcare?

For this part of our research we foregrounded an intersectional approach in our interviews with indigenous women with disabilities. Intersectionality, a concept introduced by African-American lawyer Kimberlé Crenshaw in 1989, explores how systems of oppression – such as heteropatriarchy, racism, ableism, xenophobia, classism, capitalism and colonialism – interact to shape individuals' lives. It highlights the compounded, layered or intersecting nature of discrimination, emphasizing that these systems do not operate independently but reinforce one another and that the resultant forms of multiple discrimination cannot be understood through any one lens alone. Intersectionality recognizes that inequalities in society are the result of these systems of oppression and the unequal power relations they produce.

Through detailed discussions with ten indigenous women with disabilities from a range of countries, we sought to uncover the intersections between indigeneity and disability that prevent access to adequate maternal and reproductive health services. We also looked at the ways in which the impacts of structural barriers are themselves compounded by disability. An intersectional approach allowed us to explore how their experiences of disability intersect with their indigeneity and other forms of marginalization to shape their interactions with health systems.

Physical barriers

Several women described how their disability meant that they were unable to travel to health clinics alone. One woman who was blind described how she was unable to walk the 9km over hilly terrain to the health clinic: 'My contraception is causing me a lot of problems, I want to go back to the doctor's but it is 9km, I can't walk on my own so I can only go if my mother will agree to take me'.

Communication barriers

Language barriers, in addition to lack of knowledge of sign language were cited as barriers for

indigenous women with disabilities, with additional concerns raised relating to women with sensory or neurological disabilities: 'people in the health sector shout, as if by raising their voices they will be better understood'; and 'a member of my extended family with both visual and hearing impairments carried a pregnancy to term without knowing she was pregnant. Unfortunately, the lack of prenatal care resulted in the child having brain complications.'

Stigma

Our respondents told us about beliefs that women with disabilities should not get married or have children, whether inside or outside of marriage. They reported that husbands or partners are likely to leave women and their children because of their disabilities, leaving women as stigmatized single mothers. With regards to health services, they reported failures to provide women with disabilities with relevant sexual and reproductive health and rights information. The forced sterilization of women with intellectual disabilities was also raised.

'The stigma of us being sexual women is one of the reasons why information is not created, the data on how many of us there are does not exist, and we are not involved. The information is created from a desk assuming that we require one thing or another but not from our actual needs as indigenous women with disabilities.'

'Lots of us are single parents because our husbands have left us because of our disability and we are seen as a burden.'

'There is no information on sexual and reproductive rights for women with disabilities. The government is currently preparing a booklet, but it does not include the holistic vision of indigenous peoples.'

'indigenous women with disabilities are not invited to undergo tests such as pap smears, mammograms or any test that can be used to detect any sexually transmitted disease.'

'indigenous women have been the object of study practices and in the case of indigenous women with disabilities, we are still forced to undergo sterilization, primarily women with intellectual disabilities. Contraception should be an option for indigenous women with disabilities. Infantilizing and assuming we will not marry – when in fact we could decide to become single mothers – removes our right to choose motherhood or not.'

Poverty

Women described how their disability meant they were unable to work making health services unaffordable and a reason they were less likely to give birth in a health facility. The impact of their disability on access to education and employment, was also raised as well as the impact on other family members, such as parents or children who may be unable to work or attend school due to the necessity of caring for family members with disabilities:

'As I am blind I have no source of income, I'm poorer than other people.'

'We can't always afford health insurance, and without it healthcare is very expensive. As a result sometimes women give birth at home where there can be complications or death.'

'indigenous women with disabilities are poor and cannot afford treatment.'

'If it was up to me and if I actually had the money, I would have preferred to go to the hospital as opposed to having to give birth either at home with the traditional doctors. But I didn't have any money. Some indigenous women with disabilities do go to the hospitals, but the staff know that most of them don't have money, and they chase them away.'

Discrimination

Almost every single interviewee reported having experienced discriminatory and substandard treatment from healthcare workers. For many of the women it was clear that poverty was an important compounding factor in their experience of life:

'As a woman with a disability, I have always faced discrimination, that that has just been my reality, all my life.'

'If you are indigenous with a disability, if you have money you are OK, but if you are poor you are not.'

'Most of us actually prefer giving birth in the house because there's no one who will look at us badly when we're in the house, as opposed to in the hospital.'

'When I got to the hospital to give birth I was waiting a really long time. Then I couldn't get onto the bed because of my disability. The doctor left me and didn't help me. I was alone when the baby was born. I think they disrespected me both because of my disability and my appearance – they could tell I am poor.'

'We've seen that, when pregnant women go along for antenatal care, we're very often not treated very well, not in a humane way. […] Sometimes they'll use stereotypes, to address us in a pejorative way. And these things mean that women won't want to return. They feel they've been mistreated at the health facility and they won't come back next month.'

A woman who became pregnant after she was raped as a child reported: 'when I was treated for the birth of my first baby, the doctor told me … "why are you getting pregnant and especially with your problem, you shouldn't have children, you are only going to bring them suffering".'

'They assume that my [physical] disability condition limits my understanding when in reality I understand perfectly.'

'I was waiting a very long time, the doctor was late. It's because both myself and my birthing partner have disabilities and because they know my family and know we are marginalized and indigenous.'

'I think it is because there is a stigma that indigenous people are dirty, foolish and that people with disabilities do not understand, that we do not feel pain.'

'There is dehumanization towards us in order to be able to exercise violence and hide behind stereotypes.'

'The doctor and nurses at the community health centre did not want to remove my IUD, they could not explain the reasons but insisted that I was lying when I said I had one. I arrived at 6.30 am and at approximately 5pm after treating me in an appalling manner they removed it without giving me any additional instructions.'

'During my abortion I managed to get a bed, a doctor came by and asked me the reason I was there, I explained and he asked me, are you bleeding? I answered no and he lifted my legs and put his hand inside me, I felt a tug inside me and he said "… now you are bleeding". I never understood why he caused me to bleed.'

'In our experience, it's always been that indigenous women with any form of disability are treated differently. We don't receive the same sort of care when we go to the hospital because it is automatically assumed that we don't have money to be able to acquire the services.'

'If we were richer we would have been treated better.'

Poor clinical understanding of disability

Women also discussed medical staff treating women in accordance with a medical standard for enabled people, without taking their disabilities into account. For example, one woman described how due to her disability which affects her nervous system she should have been given a reduced dose of anaesthesia. However she was given a full dose, causing a myocardial infarction resulting in lifelong heart problems.

In a separate incident she had appendicitis but because the lower part of her body is not sensitive to pain, health staff were slow to diagnose this. As a result, she ended up with a burst appendix and complications which resulted in her having to have a hysterectomy, removing her ability to have any further children.

How do indigenous women with disabilities want care to be improved?

Extend services into communities

This includes expanding health workers and clinics into the communities to limit the physical distance as well as providing appropriate education for women with disabilities about how to access services.

'We need them to build a hospital medical facility, dispensaries closer to the community because the nearest hospital is very far.'

'Governments need to localize issues, because in remote areas services are poor.'

Adapt clinical services for women with disabilities

'Indigenous women with disabilities should work together with midwives so that we can support them when bringing into the world a baby of a woman with a disability…the positions for giving birth may need to be different from other women. In the case of women with hearing disabilities, it is important that the midwife knows that she must have a close relative of the woman to support her when giving instructions.'

'Women with disabilities, particularly those with learning or sensory disabilities, need specialized training on sexual and reproductive health. This is because some of these women, due to their disabilities, may not realize they are pregnant, which can lead to serious consequences.'

'Giving birth with a traditional midwife is ideal because the mother is always accompanied by a person who knows her world view and will not judge her, and who recognizes her as part of her same identity and language.'

'What I suggest is that traditional midwifery be revalued and placed within health centres, in addition to providing constant training so that pregnant women can choose who they want to bring their baby into the world.'

Remove financial barriers

This includes financial support, free medication, wider welfare programmes and work-based training to support women to earn an income and reduce poverty.

'We need free drugs and to help people afford treatment.'

'Provide women with training to help us get into work and earn money for our families. We need a better standard of living to have our basic needs met.'

'We want to [be] support[ed] to work, women feed families, a woman is the heart of the whole family.'

End discrimination by health workers

'Nurses and doctors need training on how to treat people with disabilities and indigenous peoples. Previously indigenous communities didn't give birth in hospital, things are now changing. Going to the hospital is a big step for indigenous women but we need to be treated properly when we get there.'

'What we should be looking for is for the processes to be less ableist and the violence to be less disproportionate.'

Indigenous female leadership

Suggestions included support to establish organizations of indigenous women with disabilities and targeting interventions to the needs of indigenous women with disabilities.

'We need targeted and deliberate action to bring on board women with disabilities.'

'The UN should provide resources to facilitate a collective umbrella organization for indigenous women with disabilities to help us come together and provide us with training and support.'

'Governments should look at views of women, customize and tailor services to populations. There is a disparity between what it says in the Constitution and action.'

Robust and regular monitoring of services

This must include meaningful input from indigenous women:

'In my region there is an evaluator who must evaluate the health service monthly. However, they do this without a real consultation. They give a badge to the local health centre indicating that they provide quality of care. By giving this badge without consultation, it prevents the care from being properly evaluated. Why is this survey not being conducted with indigenous women with disabilities?'

What do service providers say?

For many indigenous women, indigenous midwives or TBAs are an essential part of pre- and post-natal care. Their traditional knowledge and skills meet the specific needs of indigenous women and girls. In many countries, due to colonial, Western-centric models of medicine, indigenous midwifery was marginalized or outright suppressed amid broader violations of indigenous women's sexual and reproductive rights, such as forced sterilization. UN agencies have a history of recognizing the importance of indigenous midwifery. However a policy shift in the 1990s towards 'skilled birth attendants' reinforced this marginalization, since, due to the ancestral or cultural nature of their expertise, TBAs and indigenous midwives may often lack formal qualification.

Today, indigenous midwifery is thankfully experiencing a resurgence. Although women are still prevented from fully accessing the care they need by a lack of resources or ongoing racist laws and policies, in many places, indigenous midwives are rebuilding what was lost:

> 'Being a midwife is very important to me, because for indigenous people, sometimes there is no nurse to help, so they call the midwives a lot.'
> – indigenous midwife

Mainstream medicine is beginning to understand the importance of indigenous midwifery. Indigenous midwives or TBAs complement mainstream medicine by bringing trust, cultural connection and language competency:

> 'Everyone has limitations, shamans, traditional midwives, but the doctor also has limitations and the nurse, so we all have limitations. That is why we need to dialogue in a more integrated way so that we can complement the knowledge that we each have. … There are fantastic things that they tell us, but they are absent from the prenatal care that is carried out in that territory. The project enables them to be included.'
> – Social scientist at Fiocruz

We spoke to medical practitioners who are part of the growing movement to reincorporate TBAs into women's healthcare. It is important to deliver training and information in a way that is both linguistically and culturally compatible with the indigenous community or communities in question, in order to ensure effective participation and a trusting relationship:

> 'Ministry of Health staff often take a classroom approach using projectors, presentations, flip charts and so on, which are all in Spanish and are all very technical. So indigenous midwives/TBAs weren't learning effectively. That's why we introduce sessions that are more dynamic and participatory and in the Maya language.'
> – Staff member, Health Poverty Action Guatemala

Our discussions also emphasized the vital importance of mutual learning; medical practitioners must not merely tolerate the presence of indigenous birthing practices, rather they must allow their relationship with TBAs or indigenous midwives to be a transformative one. They must rethink their own positionality and worldview to make space for indigenous ways of knowing and being, in order to achieve better health outcomes for indigenous women:

> 'They [health professionals] have to go through a process of de-whitening …. let go of some of what they learned, and allow themselves to leave behind this colonization, to receive this new knowledge. Otherwise it will be very difficult for them to work in the territory if they do not acknowledge that there are indigenous specialists there and that it is necessary to work together with them if we want to achieve a reduction in infant mortality, a reduction in maternal mortality and morbidities.'
> – Nurse and health researcher

> 'Working with TBAs, there's an incredible richness of community beliefs and practices, which can, if wrongly interpreted, be seen as contradictory to the Ministry of Health approach. But in reality, no, we're doing the same things as TBAs, but we just do it in a different way. When we begin to understand the richness of the symbolism of everything that TBAs do with regard to maternal health and newborn health, that gives added value to the work that the Ministry of Health is doing.'
> – Ministry of Health Intercultural Coordinator, Guatemala

In Totonicapán, Guatemala, indigenous midwifery has not merely been bolted on to mainstream medicine. Rather, the presence of an Interculturality Coordinator, whose role is to

support partnership between TBAs and medical staff, has strengthened feedback mechanisms and transformed ways of working:

> 'We undertake user surveys, regarding how Maya women have been treated, whether they were communicated with in their language and so on. If we find that health staff aren't providing culturally appropriate care in line with the Ministry of Health's guidelines, I raise it with my manager in order to prompt action, such as having him authorize renewed training for health staff.'
>
> – Interculturality Coordinator for Totonicapán Health Department

> 'The Ministry of Health Interculturality Coordinators initiative has been of great benefit to give impulse to the Ministry's own guidelines and their implementation because there is someone who is from the Ministry itself. They've been able to give impetus, to ensure that there is an improved focus on the importance of approaches that are culturally appropriate for us. For example, steam baths which we consider to be medicinal and necessary for pregnant women and for women who have recently delivered. We are now finding the Ministry of Health more accepting of those – for instance Health Poverty Action has just installed a traditional steam bath in one of the health centres at the request of the Ministry of Health.'
>
> – Staff member, Health Poverty Action Guatemala

Notes

[1] UNPFA, UNICEF and UN Women, *Indigenous Women's Maternal Health and Maternal Mortality*, March 2018.
[2] Ibid.

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Around the world, indigenous women and girls are more likely to die in childbirth and pregnancy than the majority community. They experience significantly worse maternal and sexual health outcomes than non-indigenous populations. Yet there is a dire lack of data in this area.

The reasons for this situation are multifaceted. Indigenous peoples have a concept of health which is far removed from the biomedical model prevalent in many national health systems. For indigenous people health is understood holistically, and is very closely bound up with community, spirituality and access to land and resources. The gap between these views of health and that of professional health care staff can leave indigenous women and girls feeling disrespected and disparaged, particularly where professional staff are ignorant about or fail to take indigenous perspectives into account. These tensions are exacerbated by displacement, land dispossession, poor sanitation, food insecurity, malnutrition and climate change impacts.

All these structural factors, themselves stemming from or exacerbated by histories of colonialism, racism and territorial dispossession. Indigenous women and girls also experience linguistic barriers, geographical inaccessibility, inadequate transport and infrastructure. At times, lower budgets and levels of service provision lead to generally inadequate healthcare provision in areas where indigenous peoples live. This complex web of intersecting factors creates barriers between indigenous women and girls and their right to health.

More data on this topic is urgently required to show policymakers where and how they must act. Indigenous women and girls must be foregrounded in any data collection efforts in order to reverse the marginalization that has resulted in these disastrous health outcomes. Whilst quantitative data is essential, this report's intention is to amplify the voices of indigenous women and girls speaking for themselves, to put on record their feelings, decisions and experiences that shed light on the disparities revealed by statistics. This report presents therefore quotations from our research discussions at length, as an urgent contribution to the available data on this topic.

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