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BIBLIOGRAPHIC REVIEW

Higher education in health and social vulnerability: analysis of barriers and inclusive policies

Educación superior en salud y vulnerabilidad social: análisis de barreras y políticas inclusivas

Ensino superior em saúde e vulnerabilidade social: análise de barreiras e políticas inclusivas

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ABSTRACT

Introduction: parental educational level, family income, and ethnic and racial affiliation are closely related to gaps in access to higher education. For those who grow up in this unequal reality, considering pursuing a university degree in health is often more of an exception than a legitimate expectation. **Objective:** to analyze the structural, pedagogical, institutional, and cultural barriers that limit the access and retention of vulnerable students in health-related careers, with an emphasis on the Latin American context and, in particular, on the Dominican Republic. **Method:** a critical narrative review of scientific literature and public policy documents was conducted, identifying factors that shape unequal educational trajectories, especially for those from rural contexts, ethnic minorities, those with disabilities, or those facing socioeconomic hardship. **Results:** the findings showed that inclusive policies, when approached comprehensively, could generate more democratic, culturally relevant, and ethically engaged learning environments. Strategies such as affirmative action, teacher training in inclusive pedagogies, intersectoral coordination, and the incorporation of the Diversity, Equity, and Inclusion framework emerge as key to transforming health education systems. **Conclusions:** it is concluded that promoting equity is not only an ethical imperative but also a way to strengthen educational quality and health justice. Student diversity, far from being a difficulty, represents an opportunity to reconfigure academic spaces toward truly transformative education that is sensitive to differences and committed to communities.

Keywords: educational equity; social inclusion; health education; cultural competence; public policies; Dominican Republic

RESUMEN

Introducción: el nivel educacional de los padres, el ingreso familiar o la pertenencia étnico-racial están profundamente relacionadas con las brechas de acceso a la educación superior. Para quienes crecen en esta realidad desigual, pensar en llegar a una carrera universitaria en salud suele ser más una excepción que una expectativa legítima. **Objetivo:** analizar las barreras estructurales, pedagógicas, institucionales y culturales que limitan el acceso y la permanencia de estudiantes en situación de vulnerabilidad en carreras del área de la salud, con énfasis en el contexto latinoamericano y, en particular, en la República Dominicana. **Método:** se realizó una revisión narrativa crítica de literatura científica y documentos de política pública, donde se identificaron factores que configuran trayectorias educativas desiguales, especialmente para quienes provienen de contextos rurales, pertenecen a minorías étnicas, viven con discapacidad o enfrentan precariedad socioeconómica. **Resultados:** los hallazgos evidenciaron que las políticas inclusivas, cuando son abordadas de forma integral, pueden generar entornos de aprendizaje más democráticos culturalmente pertinentes y éticamente comprometidos. Estrategias como las acciones afirmativas, la formación docente en pedagogías inclusivas, la articulación intersectorial y la incorporación del marco Diversidad, Equidad e Inclusión emergen como claves para transformar los sistemas educativos en salud. **Conclusiones:** se concluye que promover la equidad no es solo un imperativo ético, sino también una vía para fortalecer la calidad formativa y la justicia sanitaria. La diversidad estudiantil, lejos de ser una dificultad, representa una oportunidad para reconfigurar los espacios académicos hacia una educación verdaderamente transformadora, sensible a las diferencias y comprometida con las comunidades.

Palabras clave: equidad educativa; inclusión social; formación en salud; competencia cultural; políticas públicas; República Dominicana

RESUMO

Introdução: o nível educacional dos pais, a renda familiar e a afiliação étnica e racial estão intimamente relacionados às lacunas no acesso ao ensino superior. Para aqueles que crescem nessa realidade desigual, considerar a busca por um diploma universitário em saúde é muitas vezes mais uma exceção do que uma expectativa legítima. **Objetivo:** analisar as barreiras estruturais, pedagógicas, institucionais e culturais que limitam o acesso e a retenção de estudantes vulneráveis em carreiras relacionadas à saúde, com ênfase no contexto latino-americano e, em particular, na República Dominicana. **Método:** foi realizada uma revisão narrativa crítica da literatura científica e de documentos de políticas públicas, identificando fatores que moldam trajetórias educacionais desiguais, especialmente para aqueles de contextos rurais, minorias étnicas, pessoas com deficiência ou que enfrentam dificuldades socioeconômicas. **Resultados:** os resultados mostraram que políticas inclusivas, quando abordadas de forma abrangente, podem gerar ambientes de aprendizagem mais democráticos, culturalmente relevantes e eticamente engajados. Estratégias como ações afirmativas, formação de professores em pedagogias inclusivas, coordenação intersetorial e a incorporação do referencial de Diversidade, Equidade e Inclusão emergem como fundamentais para a transformação dos sistemas de educação em saúde. **Conclusões:** promover a equidade não é apenas um imperativo ético, mas também uma forma de fortalecer a qualidade educacional e a justiça em saúde. A diversidade estudantil, longe de ser uma dificuldade, representa uma oportunidade para reconfigurar os espaços acadêmicos rumo a uma educação verdadeiramente transformadora, sensível às diferenças e comprometida com as comunidades.

Palavras-chave: equidade educacional; inclusão social; educação em saúde; competência cultural; políticas públicas; República Dominicana

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INTRODUCTION

In much of Latin America, universities function as spaces where social inequalities not only persist, but also in many cases are exacerbated. This is particularly true in health-related careers, which have historically been linked to social groups with greater economic and cultural advantages [1]. For young people from poverty, exclusion, or remote areas, entering programs such as Medicine, Nursing, or Bioanalysis involves facing not only already high academic demands; but also rigid social structures that often limit their opportunities, even before reaching university.[2,3,4]

Various studies have documented how variables such as parents' education level, family income, and ethnic-racial affiliation are deeply related to gaps in access to higher education [5]. There is evidence, for example, that parents' educational level does not have the same positive impact on ethnic minority students as it does on their white peers, reinforcing the idea that inequalities do not operate in isolation[6]. Therefore, the way resources (schools, housing, and services) are distributed reinforces existing differences and ultimately affects entire generations. It's a long and difficult chain to break.[7,8]

From the earliest years of schooling, many girls and boys already experience accumulated disadvantages. Poor-quality education, a lack of teaching and technological resources, limited vocational guidance, and the almost nonexistent presence of emotional support networks are just some of the elements that shape an unequal reality [9,10]. For those who grow up in these environments, thinking about pursuing a university degree in health is often more of an exception than a legitimate expectation, not because they lack the skills but because the path is fraught with obstacles that few can overcome.[3]

In this sense, speaking of equity in education cannot be reduced to counting how many students enter university. It also has to do with the real conditions that allow or impede their retention, advancement, and graduation. UNESCO clearly points this out: if medical training does not include young people from diverse socioeconomic backgrounds, the health system loses necessary voices, perspectives that better the understanding of the social and cultural complexities of historically ignored sectors. Ultimately, this is a question of justice, but also of effectiveness and relevance.[11]

In the Dominican Republic, policies have been developed that attempt to close these gaps. Education Policy No. 7, integrated into the Ten-Year Education Plan 2008–2018(12), proposed supporting students from vulnerable sectors as one of its main pillars.[13] Even so, the transition from high school to university health programs is marked by deep inequalities. This highlights the fact that beyond the regulations, there are structural processes that have yet to be fully transformed.

This article aims to reveal, from a critical perspective, how structural conditions and the educational system impact the access and retention of vulnerable youth in university health programs.

Drawing on the Dominican case and some Latin American experiences, it seeks to provide elements that allow for rethinking public policies from a more inclusive perspective, one that is more connected to the reality of the regions and, above all, more committed to educational equity.

METHOD

This study adopts a qualitative approach, more specifically an interpretive one, aimed at critically reviewing academic literature and public policy documents related to equity and access in higher education.[14,15] The focus is on health-related programs, where multiple forms of exclusion have historically been concentrated. A narrative review strategy was chosen, allowing for the incorporation of different types of sources and perspectives, without following the strict steps of a systematic review, but with a careful analysis that clearly reflects the theoretical frameworks used.[16]

Three central thematic lines were defined to organize the review. First, the issue of equity in university access in contexts of social vulnerability was explored. Then, the conditions that affect entry and retention in health training programs were addressed. Finally, the public policies and regulations that govern these processes were analyzed, both in the Dominican Republic and in other Latin American countries. The search for sources included academic databases such as Redalyc, SciELO, and Dialnet, as well as reports from international organizations and state entities, including UNESCO, the OECD, PAHO/PAHO, and the Dominican Ministry of Education (MINERD).

The analysis of the collected materials was organized into thematic categories. This strategy allowed the content to be organized based on various factors: structural, pedagogical, economic, and sociocultural, all of which are relevant when considering access to health careers. In parallel, experiences considered good practices were incorporated, many of them emerging in other regional contexts, which helped put the Dominican case into perspective within a broader and more diverse Latin American landscape.

To ensure the methodological rigor of the qualitative analysis, a systematic process of identifying, selecting, and evaluating documentary sources was carried out. A framework adapted from the PRISMA model was followed. This process included the initial search of academic databases and complementary sources, the elimination of duplicates, a review of titles and abstracts, and a detailed evaluation of the full texts. The screening allowed us to exclude records that did not align with the thematic, geographic, or methodological criteria defined for this study. Table 1 presents a summary of the selection process for the documents and articles that formed the basis for the analysis.

Table 1: Document and article selection flow applied in the research

Phase	Description	Quantity (n)
Identification	Records identified through database searches	467
	Additional records identified through other sources (manual, institutional)	12
	Total records identified	**479**
Screening	Records after removing duplicates	297
	Records reviewed (title and abstract)	297
	Records excluded at this stage (do not meet initial criteria)	110
Eligibility	Full-text articles evaluated	187
	Articles excluded after full evaluation (by quality or relevance)	125
Included	Studies finally included	**62**

Although this study adopts a narrative approach and not a strictly systematic review, the PRISMA diagram has been adapted to illustrate the process of selecting, filtering, and synthesizing the literature used. Sixty-two unique sources were included that directly contributed to the thematic analysis of the problem.

Beyond describing what the sources say, the methodology employed has a reflective purpose. It seeks to offer a critical perspective that makes visible not only the progress or consensus around the topic, but also the tensions, omissions, and contradictions. All of this is done from a position that recognizes higher education as a right and is committed to social justice as the political and ethical horizon of research.

RESULTS

Barriers to access and retention of vulnerable students in health-related careers

The path to health-related careers for those living in vulnerable conditions is often crisscrossed by a set of barriers that are neither simple nor isolated. Structural, pedagogical, economic, and psychosocial factors intertwine, forming a persistent network of obstacles. These barriers not only complicate university admission, but also profoundly affect the training process and often, also the emotional health of those who manage to access spaces that demand so much in such a short time.

Structural and Institutional Barriers

Significant limitations that hinder real inclusion persist in universities. Adequate infrastructure is lacking, support services are scarce, and institutional policies often fail to adapt to the specific needs of students with complex backgrounds. The lack of services such as mental health, personalized tutoring, or academic support, for example, ends up having a greater impact on those who already arrive with accumulated disadvantages. Especially after the pandemic, these students report higher levels of anxiety, loneliness, and a constant feeling of being out of place.[17]

Additionally, many of the policies that govern institutional functioning are outdated or simply do not consider diverse realities. The lack of physical accessibility on campuses, coupled with a low response to students with disabilities, reinforces exclusion.[18,19] Accelerated digitalization highlighted another problem: not all students had access to devices, connectivity, or basic technological skills, which seriously affected their participation in remote classes.[20]

Furthermore, the existence of support programs—scholarships, psychological support, and tutoring—is often unknown. This is exacerbated in rural communities, where there is less access to information and little institutional presence. And, as if that were not enough, the precariousness of health services in border or remote areas, along with the lack of support for implementing collaborative training strategies, remain structural barriers that are difficult to overcome.[21,22,23]

Pedagogical Barriers

On the pedagogical level, there are also many limitations. Health careers require ongoing, practical learning with close supervision. However, methodologies are not always tailored to students who need specialized support. There is little curricular flexibility, limited intercultural dialogue, and often insufficient teacher support.[24] A lack of prior experience with educational technologies also limits learning. Some students navigate digital environments without even having a computer at home.[25,26]

Institutions also generally fail to incorporate cultural and linguistic diversity into their approaches. Little attention is paid to the ways of life, beliefs, or languages of indigenous, migrant, or foreign communities, which complicates their adaptation to a normative and homogeneous environment such as universities, especially in medical schools.[27]

Health professionals also face these tensions. Véliz-Rojas et al.[28] show how the lack of knowledge about the lifestyles of indigenous and migrant peoples limits the care they can provide. Urrutia et al.[29] confirm this: without culturally relevant training, it is not possible to guarantee adequate care. In the educational field, Marmolejo Caicedo and Grajales Alzate[30] warn that many indigenous students fail to adapt to academic language or university codes. There is a clear lack of institutional adaptation to sociocultural diversity. All this points the need to move towards intercultural training, both in education and health.

Socioeconomic Barriers

Economic conditions remain one of the biggest obstacles to accessing and maintaining careers such as Medicine or Nursing. The costs of tuition, materials, transportation, and food become unaffordable without scholarships or support networks. However, these networks do not always exist. For many students, studying means working simultaneously, with exhausting journey and diminishes academic performance. [31, 32, 33, 34]

This economic burden is exacerbated in specific cases: women with children, migrants, and rural students. For them, university is not just an intellectual challenge; it is a life commitment that is often made without certainty of being able to sustain it. Furthermore, forms of structural discrimination against students of African descent, Indigenous peoples, or other minorities have been documented, both in the admissions process and in everyday university life.[35, 36, 37]

Psychosocial and Cultural Barriers

The invisible barriers should not be underestimated: psychosocial barriers. The stigma surrounding issues such as mental health, disability, or poverty prevents many students from seeking help, even when they know they need it. There is fear, shame, and mistrust. Furthermore, the absence of role models, mentoring networks, or emotional support spaces fuels isolation. Schools such as medical schools tend to be hierarchical, competitive, and inhospitable to those who do not fit the traditional profile. [17, 19, 38, 39]

The feeling of not belonging is constant. When the curriculum does not reflect the country's social realities, when there is no representation in teachers or in the matters, this disconnection is exacerbated. That weighs heavily. Dropping out, in many cases, begins as a feeling of discomfort, of not finding a place, and ends in abandonment. Therefore, considering equity cannot be limited to admissions figures: we must rethink academic spaces from a more humane, culturally relevant, emotionally sustainable, and socially just perspective.

As shown in Figure 1, each includes specific aspects: from a lack of infrastructure and institutional support to discrimination and emotional isolation. This set of factors creates a complex reality that requires comprehensive responses, articulated between educational and health policies, with a rights-based approach and sensitivity to diversity.

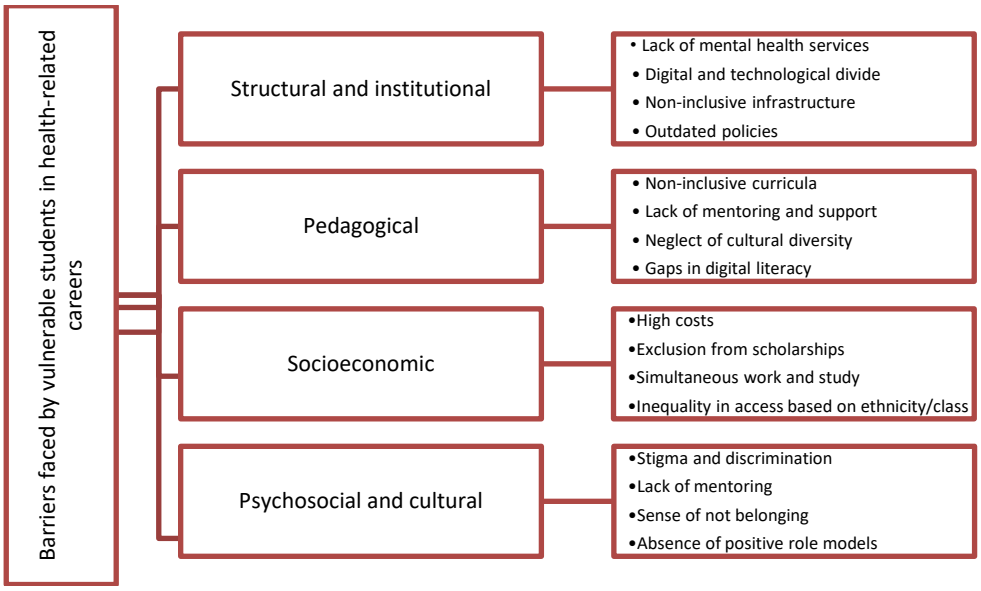

Fig. 1: Typology of barriers faced by students in vulnerable situations

Approaches and policies to promote equity in access to health-related careers

In Latin America, attempts to reduce inequalities in university access, especially related to health-related careers, have taken quite diverse paths. There are affirmative action policies, cultural inclusion strategies, proposals based on pedagogical and digital innovation, as well as broader approaches that link different sectors. In the Dominican Republic, many of these advances are already present in specific laws and programs, although rigid structures still limit their true reach, especially for the most excluded populations.

Affirmative Action Policies and Differential Access

One of the approaches that has gained the most relevance in the region is affirmative action policies. Countries such as Brazil, Mexico, and Colombia have implemented quota systems, special scholarships, and differentiated admission mechanisms that seek to correct historical inequalities. These measures have been designed primarily to expand access for indigenous, Afro-descendant, migrant, and low-income youth.[40] In the Dominican Republic, some universities have attempted to replicate these initiatives, although highly competitive admissions models still predominate, which, in practice, exclude the same old students.[41]

Funding and Institutional Support

It is widely documented that scholarships and financial aid make a real difference in the retention of students in vulnerable situations. It is not just the money: institutional support, mentoring programs, and tutoring matter. Techera et al.[42] emphasize that this type of close support favors academic performance and reduces dropout rates. At the national level, the 2030 National Development Strategy and some fiscal measures have had a moderate impact on improving the inclusion of women and youth in areas where they have historically been underrepresented.[43]

Educational Inclusion and Attention to Diversity

The importance of valuing diversity, whether cultural, linguistic, or functional, is increasingly recognized. In Central American and Caribbean countries, curricular reforms and specific programs have been promoted to serve students with disabilities or from diverse ethnic groups. However, the results remain very disparate between and within countries.[44,45] In the Dominican Republic, documents such as Departmental Order 33-2019 and PLANEG III promote gender equity as a cross-cutting principle, although their concrete application still faces many limitations.[46]

Some university institutions have created observatories to monitor gender equity and inclusion. Bermúdez Rico et al.[47] highlight how these bodies can foster a culture of accountability. Of course, these practices still need to be consolidated beyond the symbolic.

Pedagogical Innovations and Digital Inclusion

The pandemic forced a rethinking of many things, including the ways we teach and learn. Some Dominican universities began to develop spaces that foster critical thinking, creativity, and collaborative work. These proposals have helped generate more equitable learning environments, especially for those who do not fit traditional molds.[48] On the other hand, initiatives such as República Digital have attempted to reduce the technological gap. Although some progress has been made, there are still groups that remain marginalized due to lack of connectivity, devices, or technological skills.[49]

An interesting experience has been the HEARTS program, collaboration between the Ministry of Public Health and international actors. This initiative has facilitated free access to quality medical content, especially on topics such as hypertension.[50] The problem is that without prior training in digital tools, the impact of these platforms is limited. Therefore, there is an urgent need to combine digitalization with technological literacy policies and measures that ensure full inclusion.

Intersectoral Coordination and a DEI Approach in Health

Policies that cross the boundaries between health and education have gained traction in recent years. In this context, the EquIR approach proposes incorporating equity across all stages of health policy design and implementation. It also aims to train professionals with a more community-based perspective, more sensitive to social contexts.[51] From another perspective, Saxena et al.[52] insist that integrating Diversity, Equity, and Inclusion (DEI) principles into medical education is key to addressing health inequalities. This requires reviewing content, admissions practices, and institutional culture.

There are experiences in the United States and Canada where these ideas have taken concrete form: programs have emerged to increase the representation of marginalized groups in medicine, nursing, and dentistry. And these policies have been accompanied by direct actions against institutional racism, as well as proposals to strengthen the cultural competence of healthcare personnel.[53] Although the Latin American context is different, these experiences offer valuable lessons.

Teacher Training and Inclusive Leadership

An aspect that is often overlooked but essential is the role of teachers. Training teachers with a perspective on equity, rights, and gender can transform learning spaces. In the Dominican Republic, some continuing education programs, review of teaching methods, and more student-centered pedagogical proposals have been promoted [54, 55, 56].

At the regional level, Bada et al. [57] point out that without inclusive leadership; structural barriers are difficult to overcome. Institutional policies must be aligned with the Sustainable Development Goals, especially SDG 4, which aims to guarantee inclusive, quality education for all.

The diversity of policies and approaches deployed in Latin America and the Dominican Republic shows an increasingly clear desire to build more equitable education systems, especially with regard to access to health careers, where inequalities have been naturalized for too long. Although they vary in design and scope, these strategies share a common objective: to close structural gaps through affirmative action, financial support, pedagogical innovation, and cross-sector coordination.

Figure 2 summarizes these lines of action, grouped into six dimensions that have been recognized in the literature and in recent experiences as key to advancing toward truly inclusive higher education in the health field.

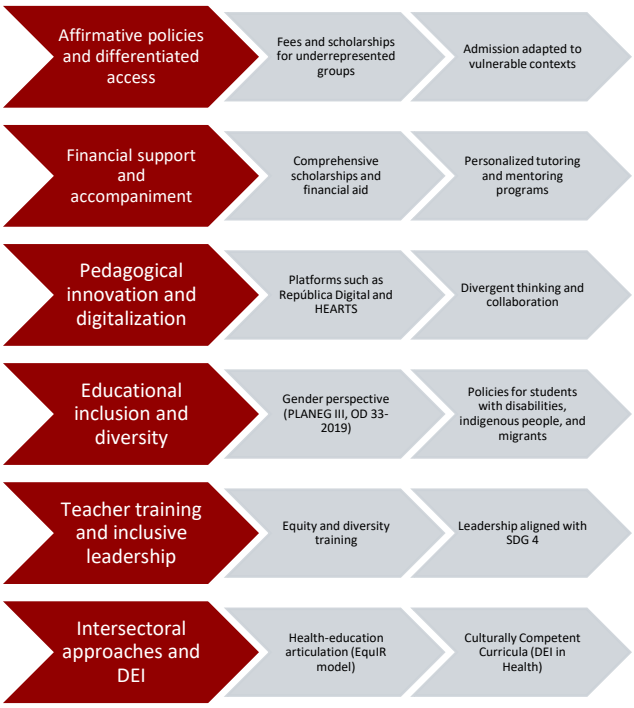

Fig 2: Approaches and policies to promote equity in access to health careers

Inclusive Policies and Transformative Training of Health Professionals

A truly inclusive educational policy is not limited to removing obstacles to university admission; it goes further. It involves changing the spaces where learning takes place, rethinking curricula, and reviewing how institutions relate to the communities that surround them. In the health field, this makes even more sense: professionals in training need not only technical knowledge, but also social sensitivity, ethical commitment, and a true understanding of the diversity that exists among their future patients. There is growing consensus in the literature on this. Universities that implement inclusive strategies not only open doors, but also ensure that their graduates are better prepared to face complex contexts, with inequalities that cannot be resolved with simple procedures. [58, 59, 60]

For a fundamental transformation to occur, we must first ensure that students from marginalized groups can actually enter and remain in university. It is not a matter of access: retention also counts. Actions such as quotas, scholarships, mentoring programs, and the existence of institutional observatories are important tools if implemented with real commitment. It is not enough simply write them down in documents. When they work well, they broaden the student base and allow diverse profiles to enter healthcare careers.[47] And this, in turn, has an impact on the healthcare system: professionals with firsthand knowledge of inequalities can offer more humane and fair care.

The way curricula are designed is also a key. If the content does not connect with the country's cultural and social realities, it will be difficult to develop people capable of acting with sensitivity and critical thinking. There are initiatives that have shown that the inclusion of topics such as social justice, global health, structural racism, and discrimination not only improves education but also strengthens the link between academic knowledge and the community. This was the case with the Sanos y Fuertes program, aimed at low-income Latino families, which demonstrated how cultural relevance can transform the educational process.[61] How it is taught also matters: reflective workshops, spaces for dialogue, and equity activities allow for the development of skills that go beyond technical knowledge. We talk about empathy, advocacy, and awareness of one's own biases.[52,60,62]

Cultural competence has begun to be considered a central dimension of educational quality. It is not just an ideal; it is measured, evaluated, and incorporated into accreditation systems. And as Sharon et al.[63]) have pointed out, current instruments reflect this new priority, although there are still debates about how it should be taught and evaluated.

Furthermore, the incorporation of collaborative approaches in healthcare training, such as interprofessional education, has opened up possibilities for working more holistically with communities. By sharing experiences and responsibilities across different areas of health, a broader perspective is developed that is more committed to collective well-being.[23] It's not just about preparing students to work together, but also about understanding that health care is a shared effort with the community. These partnerships not only enrich learning but also increase the likelihood that graduates will return to work in their communities, which is especially important in rural or underserved contexts.[64,65]

All of this requires a shift in the teaching staff. Teacher training on equity, diversity, and inclusive pedagogy becomes essential. Teachers who are able to recognize biases, adapt their methods, and value cultural diversity help build safer environments where students not only learn, but also feel part of the community.[54] And when that happens, retention improves and the academic climate changes, although it is not easy. Limitations in infrastructure, resources and training persist, as Torres-Torres and Bonilla-González warn [66] but there are efforts that show that progress can be made.

Universities that promote inclusive leadership, that create spaces where the diversity of personal histories and social trajectories are valued, make learning more meaningful. Not because it is easier, but because it becomes more real, more connected to the lives of those who study.

The DEI framework has gained ground as a comprehensive guideline in medical training. It is not just about increasing diversity in access. It is a deeper transformation: rethinking content, assessment, and the relationship with patients. Experiences in countries like Brazil, Canada, and the United States show that when this approach is integrated into health and education models, real improvements in health outcomes are achieved. Inequalities do not disappear, but they are reduced, and are addressed with strategies more tailored to the realities of each group. [52,67,68]

Cultural competence, understood as the ability to provide respectful care adapted to social and cultural differences, improves when there is ethical training, community immersion, and reflective processes. It is not just about learning concepts. It's about changing attitudes and cultivating a different sensibility, as Bauer & Baum point out.[69] This is particularly important in contexts where structural discrimination still creates significant health gaps.

Finally, we cannot forget access to technology. Strengthening digital literacy and ensuring access to accessible content are conditions that define equity in education today. If a student with a disability or a young migrant cannot access educational platforms, if they do not understand the language or lack connectivity, exclusion persists, even if the content is excellent. Policies must ensure that these tools reach everyone, without exception.[70,71] Only then will it be possible to speak of educational trajectories that are truly fair and sustainable.

DISCUSSION

The findings of this study clearly show that the barriers faced by vulnerable students in accessing and maintaining careers in the health field are not only numerous and persistent, but also overlap and reinforce each other. These are not isolated obstacles, but rather a network that acts as an exclusionary structure on different fronts. These barriers—pedagogical, institutional, socioeconomic, psychosocial—cannot be analyzed separately, as together they contribute to the reproduction of long-standing inequalities. Even when they manage to enter university, many students face a path fraught with tensions, restrictions, and inequalities that do not disappear with access. [17, 24, 31]

From this perspective, thinking about equity cannot be reduced to formal entry into the system. It implies going much further. Educational justice is discussed as the redistribution of resources, as recognition of diversity, and as a real possibility for participation. It requires transforming how we teach, what we teach, and who we teach for,[52] because if opportunities are not redistributed and the diverse voices that inhabit the system are not represented, then we cannot speak of inclusion in the deepest sense.

The situation becomes even more complex in the health sciences. Academic demands, rigid curricula, and a lack of institutional flexibility tend to exacerbate differences of origin. Material conditions are not conducive: infrastructure is not adapted, mental health services are insufficient or nonexistent, and personalized academic support continues to be the exception. All of this not only hinders learning but also directly affects the emotional well-being of students who already arrive with high levels of stress or insecurity.[19,72]

Furthermore, the pandemic exposed a digital inequality that was already present, but which, during and after the lockdown, became impossible to ignore. Lack of connectivity, lack of devices, and poor mastery of digital tools: all of this affected those from rural areas or low-income households the most, which further widened the gap.[20,49] Digitalization, far from being an equalizer, deepened the differences when not accompanied by accessibility policies and adequate training.

Therefore, any inclusive policy that aims to address these inequalities must focus on more than just income. It must guarantee sustainable, emotionally healthy, and culturally relevant careers. Scholarships, fees, and tutoring are undoubtedly important steps, but they lose their impact if they are not part of a structural transformation. If the environment remains hostile, if pedagogy does not change, if content does not connect with students' realities, then inclusion ends up being partial, often symbolic.[40,41]

Achieving real educational transformation implies moving from a deficit-centered logic to one that recognizes and values diversity as constitutive of the university space. Not as a tolerated exception, but as a wealth that is actively incorporated, with policies that redistribute power, resources, and legitimacy. Curricular content must engage with life, with historically denied experiences, with knowledge that is often not included in the classroom but is fundamental to health care.[52,61,62,67]

And here another important tension arises: the gap between what universities say and what they actually do. Many institutions have adopted inclusive discourses, signed declarations, and created committees or bodies to address the issue. At the same time, they maintain rigid structures, standardized evaluation models, and a meritocratic logic that subtly but consistently excludes those who do not fit the hegemonic profile. This gap between discourse and practice is expressed daily: in teaching settings, in offices, in hallways.[28, 35]

Students who lack a space where they feel recognized, whom face micro-aggressions, stigma, or simply institutional indifference, will find it difficult to perform academically on equal terms. Moreover, this occurs despite regulatory advances. The mainstreaming of the gender approach, the creation of equity observatories, and inclusion programs—all these factors are unacceptable. All of this exists, but often without resources, without follow-up, without a real political commitment to change.[30,38,47]

Furthermore, teacher training on these issues remains insufficient. Many educators lack the necessary tools to work on diversity, detect biases, or adapt their methods. Moreover, it is not just a matter of technical training; it is a cultural transformation. It requires time, institutional will, and collective effort. Above all, it requires stopping understanding equity as an add-on and starting to see it as an organizing principle of the educational system.[54,73]

These tensions intensify when it comes to health-related careers. The curriculum, in many cases, is deeply regulated. A classic biomedical logic predominates, leaving little room for other ways of knowing, other approaches, or other voices and this limits both academically and socially. There is still little room to include culturally relevant perspectives or to engage with community or territorial knowledge [64,71]. In fact, the results suggest that if university structures and the values on which they are based are not thoroughly reviewed, inclusion policies can remain symbolic: actions that look good on paper, but fail to alter the hierarchies and power relations that permeate university life.

Faced with these limitations, coordination between the health and education sectors appears to be a key strategy, especially in regions like Latin America, where inequalities are so marked. Territorial gaps, cultural differences, and inequalities in access to basic services are also reflected in the distribution of health personnel. In this context, intersectoral policies play an important role: they allow for synergies between academic training and the real needs of communities. Examples such as the EquIR framework or the HEARTS program in the Dominican Republic show that it is possible to design strategies that connect training with health justice in the region[50,51], and that this connection improves the quality of training, but also its social relevance.

Transforming universities from an inclusive perspective also involves reviewing leadership, management, and, of course, teacher training. Institutions that commit to training their faculty in equity, diversity, human rights, and sensitive pedagogies build more democratic environments, more aware of differences, and, in general, more conducive to collective learning.[54,55] Data show that when faculty are prepared, they are better able to identify invisible barriers, adapt to student needs, and encourage more active and meaningful participation.[73]

Furthermore, inclusive leadership, when based on principles of social justice and commitment to community, can make a real difference. It is not just about changing institutional language, but also about orienting decisions toward equity. This type of leadership has been recognized as a strategic factor to reduce forms of discrimination that persist, although sometimes subtle, and to encourage the permanence of students who otherwise would not be able to stay in the system.[57]

Along these lines, the DEI framework has become an increasingly important reference within medical education. In countries such as Canada and the United States, its mainstreaming has yielded concrete results: not only in terms of student representation, but also in the quality of care provided to marginalized communities.[52,67]

In Latin America, these approaches are still in their early stages, but there are clear signs that they can become powerful tools for transforming both training and professional practice. In fact, models such as those developed in Brazil, oriented toward cultural inclusion in healthcare, have had positive impacts on Indigenous and Afro-descendant populations. This reinforces the need to incorporate these experiences into training processes.[68]

Another component that is becoming increasingly central is cultural competence. It is not an accessory; it is a fundamental capability: providing care that is respectful, adaptive, and attentive to cultural, ethnic, and social differences. Evidence suggests that this competence cannot be taught through theory alone. It is strengthened through immersion practices, critical reflection workshops, and assessment mechanisms that invite us to look inward, recognize our own prejudices, and cultivate an ethic of care that is also based on humility.[69] In contexts where diversity permeates all dimensions of social life, this training is not optional: it is a structural necessity.

The digital dimension cannot be ignored either. Access to educational technologies, up-to-date bibliography, and interactive virtual environments is part of the health training experience. Nevertheless, if access conditions are unequal, if there is no connectivity, if there is no training on how to use the tools, the gap widens. Digital literacy, in this sense, becomes a central element of any inclusion policy. Simply distributing devices is not enough. It is necessary to ensure that rural, migrant, and disabled students can use these resources under truly equitable conditions.[49,70,71]

The different axes discussed throughout the analysis allow for the visualization of an integrative proposal. A conceptual model that articulates inclusive policies with health education processes from a transformative perspective. This model is based on five key dimensions: access and retention for vulnerable students, the cultural relevance of the curriculum, teacher development, intersectoral coordination, and digital inclusion. Together, they form a strategic framework that seeks to develop professionals who are not only technically competent, but also ethically engaged and socially representative.

Figure 3 graphically summarizes this proposal. It highlights how these dimensions connect to respond coherently to contexts marked by high diversity and structural inequality.

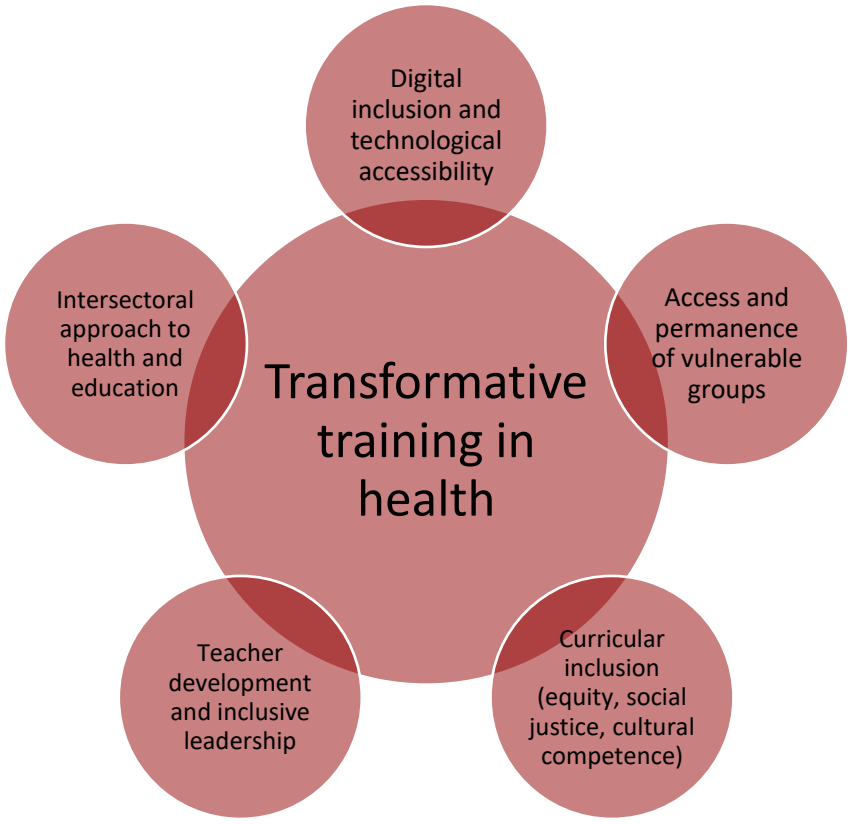

Fig. 3: Integrative equity model in the training of health professionals

CONCLUSIONS

The barriers that hinder the entry and retention of vulnerable students in health programs are multidimensional: structural, pedagogical, institutional, and cultural factors intersect and reinforce inequality, especially for young people from rural areas, Indigenous communities, racialized communities, people with disabilities, or those in contexts of social precariousness. Overcoming this reality requires a comprehensive transformation focused on equity, beyond isolated programs, supported by inclusive policies that recognize diversity as an essential part of learning and that articulate affirmative action, social justice content, cultural competence, and inclusive leadership.

The DEI approach is presented as a strategic guide for redesigning health education, orienting it toward culturally competent professionals committed to social reality. This requires sustained institutional commitment, ongoing teacher training, rigorous evaluation, and an active critique of current regulatory models. Ensuring equity in access and retention not only responds to educational justice but also to an ethical responsibility toward the right to health and dignity of excluded territories. Universities, as public institutions, must lead the democratization of knowledge and the creation of environments where all people can learn, contribute, and grow on equal terms.

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