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POLICY ON ETHNICITY AND HEALTH

Introduction

1.   The Region of the Americas is a multi-ethnic[1] multicultural region inhabited by indigenous peoples, Afro-descendants, Roma, and other ethnic groups,[2] making it essential to recognize their different health situations and needs. These populations often endure multiple forms of discrimination and exclusion, resulting in significant inequities, including high levels of poverty and violence, and consequently, the denial of their individual and, sometimes, their collective rights.

2.   While acknowledging the different situations and challenges of particular ethnic groups in diverse contexts, this policy is based on a recognition of the need for an intercultural approach to health and equal treatment of the different groups from the standpoint of equality and mutual respect, thereby contributing to better health outcomes and progress toward universal health. This requires recognition of the value of culture and the provision of guidelines that will help countries devise joint solutions and commit to developing policies that take the perspective of the various ethnic groups into account, considering gender, the life course perspective, promotion and respect for individual rights and, where applicable, collective rights.[3]

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[1] As part of the United Nations system, the Pan American Health Organization considers humanity to be indivisible and the differences between individuals to be of a cultural and symbolic nature. Although some countries, such as Brazil, use the concept of race to recognize the social relations constructed on the basis of colonialism and slavery, for the purposes of this document, the term "ethnicity" will be used. See Annex A for a more detailed explanation of the meaning of this and other terms used in this document.

[2] Hereafter, we will use these terms to refer to these groups, regardless of the different names or concepts that countries employ, such as communities, original peoples, and nations, with respect to their particular historical, political, and cultural contexts. We also recognize that the specification or characterization of ethnic groups varies according to the ethnic composition of each country.

[3] See Annex B, which contains the international human rights instruments applicable to the health and ethnicity context that have not previously been cited in other PAHO resolutions.

Background

3.   This policy is framed in the context of major global agreements and initiatives that recognize the need to guarantee respect for individual and, when applicable, collective rights and the health systems of traditional peoples, and to refocus health services by adopting an intercultural approach to advance with equity and social justice toward the enjoyment of the highest attainable standard of health and other human rights by indigenous peoples, Afro-descendants, Roma, and other ethnic groups. The policy is based on the Health Agenda for the Americas 2008-2017, which recognizes that the Region is heterogeneous and its peoples have different needs that require differentiated sociocultural approaches to improve their health *(1)*. The commitments to sustainable development in the 2030 Agenda of the United Nations, relative to leaving no one behind and reaching the most disadvantaged populations first, also serve as a frame of reference, aligned with the regional commitments reflected in the Strategy for Universal Access to Health and Universal Health Coverage and the Plan of Action on Health in all Policies *(2-5)*.

4.   Since the 1990s, the Pan American Health Organization (PAHO) has approved guidelines and supported interventions that employ an intercultural approach to the health of indigenous peoples *(6-8)*. Moreover, it has recognized the need to expand this work to other ethnic groups, such as Afro-descendants and Roma, in order to meet their different needs from an intercultural perspective. Thus, the PAHO Strategic Plan 2014-2019 has integrated ethnicity as a cross cutting theme across all levels of the Organization, in harmony with gender, equity, and human rights *(9)*.

5.   The Member States have also signed international agreements in this regard. The United Nations Declaration on the Rights of Indigenous Peoples, one of the most important standards for protecting the rights of indigenous peoples, establishes their right to have access to their traditional medicines and to maintain their health practices. Furthermore, the International Convention on the Elimination of All Forms of Racial Discrimination establishes the commitment to eliminate racial discrimination in all its forms and to guarantee, *inter alia,* the right to public health and medical care without distinction of ethnic origin. Likewise, the Indigenous and Tribal Peoples Convention (Convention 169) of the International Labour Organization (ILO) states that health services should be organized in cooperation with the peoples concerned and take into account their economic, geographic, social, and cultural conditions, as well as their preventive methods, healing practices, and traditional medicines *(10-12)*.

6.   Although significant progress has been made toward recognizing the need for an intercultural approach to health services, obstacles rooted in discrimination, racism, and the exclusion of indigenous peoples, Afro-descendants, Roma, and other ethnic groups persist, sometimes due to a failure to recognize and appreciate their cultures. It is therefore essential to reach agreement on commitments and draft guidelines to strengthen technical cooperation on ethnicity and health.

Situation analysis

7.   In the Americas, indigenous peoples, Afro-descendants, Roma, and other ethnic groups continue to experience structural discrimination, exclusion, and inequality. Although precise data is lacking, the available information shows that these populations exhibit higher levels of poverty, lack of access to basic services such as water and sanitation, low levels of education, low rates of participation and representation in decision-making processes, and higher employment in low-paying jobs *(13-18)*. Indigenous groups currently account for around 17% of those living in extreme poverty in Latin America, even though they represent less than 8% of the population *(16)*. During the Santiago Conference in 2000, States recognized the existence of a close connection between poverty and the racism experienced by the Afro-descendant population, which has led to higher levels of poverty and unemployment *(19)*. Furthermore, despite the lack of precise data on the size of the Roma population, the available information shows that Roma households often live in extreme poverty, lacking electricity, clean water, and sanitation facilities, as well as access to public health services *(20)*. The invisibility and discrimination often experienced by these populations heighten their conditions of vulnerability.

Health information systems

8.   Information systems do not sufficiently collect the ethnicity variable and one of the main constraints to obtaining an accurate picture of the dimensions of the health situation of many of these populations is the lack of disaggregated data to orientate the design and implementation of evidence based public policies *(16)*. At the national level, many countries in the Region have created mechanisms to disaggregate health data by ethnic origin. However, they have not always been implemented, and ethnicity is identified in different ways in censuses, health records, and surveys *(17)*. Lack of quantitative and qualitative data remains a barrier to understanding the health determinants and health situations of indigenous peoples, Afro-descendants, Roma, and other ethnic groups and to formulating appropriate responses and reporting.

Social determinants of health

9.   In addition to the aforementioned poverty, there are data that show how other social determinants of health place the indigenous and Afro-descendant populations of the Region at a disadvantage. For example, educational achievement among Afro-descendants in some countries that have data in this respect is low *(17)*. In addition, the data from the analysis of 11 countries reveals a more than 20-point illiteracy gap between indigenous and non-indigenous populations and a 25-point gap for women *(16)*. Lack of access to education leads to less skilled and lower-paying jobs, with an overrepresentation of women from these populations in domestic service *(19)*.

10.   Given the geographic dispersal in rural areas common to these population groups, as well as the lack of health infrastructure in the areas they inhabit, access to health

services, including maternal health services, is much lower, resulting in out-of-pocket costs that poor populations often cannot cover *(13, 21, 22)*. For the same reasons, access to clean water and sanitation is well below the national average; thus, an estimated 62.6% of indigenous children in the Region are to some extent deprived of clean water, in contrast to 36.5% of non-indigenous children *(16)*. With respect to adolescent maternity, in some countries the rate is more than 40% higher among Afro-descendent adolescents than among non-Afro-descendents *(23)*. Similarly, in some countries this rate may be even twice as high among indigenous adolescents than in the non-indigenous population *(18)*.

Health situation

11.   Many of these populations exhibit significant health gaps, and the available data on indigenous and Afro-descendant groups reveal inequities in comparison with the general population. In maternal health, even though the fertility rate in these groups is roughly 50% higher than in the general population, they receive less care in pregnancy, childbirth, and the puerperium, and what care they do receive is often inequitable and culturally inappropriate *(18)*. In sexual health, the lower levels of access to education mentioned earlier have negative implications for access to sex education. Despite the limited information in this regard, it has been found in some countries that HIV rates are more than nine times higher among Afro-descendants than Caucasians, while the indigenous population, in turn, exhibits a higher degree of risk behaviors, such as low condom use *(24)*. Malnutrition among indigenous children in the Region is higher than among non-indigenous children *(18)*. Furthermore, even with underreporting, these populations exhibit higher rates of violence against women and suicide in some countries *(15, 18)*.

12.   Although there is no regional information on life expectancy in these populations disaggregated by ethnicity, the available information shows marked disparities in mortality throughout the life course. The available information shows that infant mortality in the indigenous population remains systematically higher than in the non-indigenous population: in Panama and Peru, for example, infant mortality in the indigenous population is triple that in the non-indigenous population *(18)*. As to maternal mortality, despite the limited availability and poor quality of the information, the available data from local and specific studies, without temporal systematization, show higher rates of maternal mortality among indigenous women *(18)*. Similarly, mortality among indigenous youth in Chile is almost four times higher than among youth in the general population *(25)*. The invisibility and exclusion experienced by these populations poses a challenge for meeting the targets of the health-related Sustainable Development Goals (SDGs), including those on universal access to health and universal health coverage, tuberculosis, malaria, and mental health, among others.

Proposed Policy on Ethnicity and Health

13.   Bearing in mind PAHO's commitment to the peoples of the Region, this policy calls on the Member States to consider the connection between ethnicity and health and promote an intercultural approach that will contribute, *inter alia*, to the elimination of health service access barriers and improve the health outcomes of indigenous peoples, Afro-descendants, Roma, and other ethnic groups, as appropriate, considering their national contexts, priorities, and regulatory frameworks. PAHO will provide technical cooperation to the Member States for the implementation of actions with an intercultural approach geared to the following priority lines: *a)* the generation of evidence; *b)* the promotion of political action; *c)* social participation and strategic partnerships; *d)* recognition of ancestral knowledge and traditional and complementary medicine; and *e)* capacity development at all levels.

Production of evidence

14.   It is essential to promote the production and integrated management and analysis of information disaggregated by ethnic origin and qualitative and quantitative data on the health of indigenous peoples, Afro-descendants, Roma, and other ethnic groups, as well as its determinants, taking human rights and gender into account in decision-making on intersectoral public health policies.

15.   This implies improving the production of sound quantitative and qualitative data and information on the health of these populations, disaggregated by relevant stratifiers – especially sex, age, and place of residence. Prioritizing indigenous peoples, Afro-descendants, Roma, and other ethnic groups requires recognizing that certain populations are invisible in traditional data collection methods, because they are either excluded from civil registries due to the failure to capture their ethnic identity or origin, or other obstacles are encountered. Thus, qualitative data collection is an important complement. The participation of the peoples involved and their individual members in data collection and use, ensuring the representation of both women and men, is vital for guaranteeing the quality of the data in administrative records and vital statistics and for appropriate decision-making to respond to the particular needs and characteristics of the members of these populations. Furthermore, good-quality disaggregated data will make it possible to include ethnic groups in systems for monitoring and evaluating inequalities and inequities in health and to monitor the impact of public policies and health outcomes.

Promotion of political action

16.   In order to promote effective political action, it is essential to implement substantive interventions that recognize and employ an intercultural approach in the context of the social determinants of health. These interventions entail the following: *a)* identifying national regulatory gaps with respect to international standards; *b)* proposing regulatory frameworks based on the right to health that favor and promote equity, an intercultural approach, and access to quality health services, considering the

national context; *c)* promoting the review, culturally sensitive interventions, and enforcement of existing regulations according to interculturalism criteria; and *d)* promoting and facilitating the full participation of indigenous peoples, Afro-descendants, Roma, and other ethnic groups as applicable to the national context, in terms of health and well-being. The formulation, implementation, monitoring, and evaluation of public policies should ensure the participation of the populations involved, human rights approaches, and interculturality, and gender equality. Modalities that acknowledge territorial, populational, and cultural diversity to guarantee equity should be utilized. This objective is aimed at ensuring the shared and intercultural formulation of public policies, incorporating, as points of reference, the knowledge, practices, and spheres of action of indigenous peoples, Afro-descendants, Roma, and other ethnic groups in coordination with institutional health systems.

Social participation and strategic partnerships

17.   It is essential to promote social participation and strategic partnerships with indigenous peoples, Afro-descendants, Roma, and other ethnic groups, in keeping with the national context, ensuring the representation of women and men in the drafting of public health policies and activities**.** This area of intervention is designed to promote effective participation, joint efforts, commitment, and strategic partnerships among health authorities, other state institutions, local organizations, and the general population to foster action to increase inclusion, equity, and equality.

Recognition of ancestral knowledge and traditional and complementary medicine

18.   This priority line of action is aimed at intensifying knowledge dialogue to facilitate the development and strengthening of intercultural health models as a way of implementing health care, centered upon the needs of people- and communities. To this end, national regulatory frameworks, instruments, resources, and procedures should consider the different world views of indigenous peoples, Afro-descendants, Roma, and other ethnic groups, as applicable to the national context.

19.   A prerequisite for the knowledge dialogue is fostering a new appreciation of, and promoting, traditional knowledge, practices, and cultural expressions through each culture's own transmission mechanisms, not only for care in sickness but for health promotion and appropriate care at death.

20.   Recognition of ancestral knowledge and traditional and complementary medicine as the base for national policy-making is also one of the objectives of the WHO Traditional Medicine Strategy 2014-2023 *(26)* This knowledge is essential for tapping the potential of traditional medicine to contribute to universal access and universal health coverage, including the integration of these services into national health systems and the adoption of self-care interventions with an intercultural approach.

Capacity development at all levels

21.   Efforts should be made to train institutional and community health workers as intercultural facilitators who can create the conditions for knowledge dialogue. Consideration should be given to free and informed prior consent and comprehensive care coordinated with other sectors to produce timely, culturally appropriate, and non-discriminatory health care. Furthermore, the integration of interculturality should be promoted into the design of technical and professional health curricula. The representation of indigenous peoples, Afro-descendants, Roma, and other ethnic groups, based on the respective national context, should also be promoted to guarantee culturally appropriate health care.

Action by the Executive Committee

22.   The Executive Committee is requested to review the information presented in this document and consider adopting the proposed resolution included in Annex C.

Annexes

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