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*Provisional Agenda Item 4.5*

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### POLICY ON ETHNICITY AND HEALTH

#### Introduction

1. The Region of the Americas is a multi-ethnic<sup>1</sup> multicultural region inhabited by indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups,<sup>2</sup> 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 rights and, for indigenous peoples, their collective rights.

2. This policy is based on recognition of the differences that exist between different ethnic groups, both between countries and within them, and on the recognition of the differences in their challenges, needs, and respective historical contexts, as well as the need for an intercultural approach to health 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, for indigenous peoples, collective rights.<sup>3</sup>

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<sup>1</sup> 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 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.

<sup>2</sup> 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.

<sup>3</sup> See Annex A, which contains the international human rights instruments relevant to the health and ethnicity context that have not previously been cited in other PAHO resolutions.

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## Background

3. This policy is framed in the context of major global commitments and initiatives that recognize the need to respect the human rights of members of ethnic groups and for the health systems to respect these groups, as well as the need to refocus health services by adopting an intercultural approach to advance with equity and social justice toward promoting on a non-discriminatory basis the enjoyment of the highest attainable standard of health and other human rights by indigenous persons, Afro-descendants, Roma, and members of 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 populations have different needs that require differentiated sociocultural approaches to improve their health (1). The commitments to sustainable development in the United Nations 2030 Agenda for Sustainable Development, relative to leaving no one behind and reaching the furthest behind first, also serve as a frame of reference, aligned with the regional commitments established 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 at all levels of the Organization, consistent with gender, equity, and human rights (9).

5. The Member States have also signed international instruments in this regard. The United Nations Declaration on the Rights of Indigenous Peoples, one of the most important instruments for protecting the rights of indigenous peoples, enshrines, among others, 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 the right of everyone to equality before the law, without distinction as to race, color, or national or ethnic origin, notably in the enjoyment of the right to health and medical care, among others. Likewise, to date, 15 countries of the Region have ratified the Indigenous and Tribal Peoples Convention (Convention 169) of the International Labour Organization (ILO), under which health services should be organized in cooperation with the peoples concerned, taking 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 members of other ethnic groups persist, sometimes due to a failure to recognize and appreciate their

cultures. It is therefore important to reach consensus on commitments and draft guidelines to strengthen technical cooperation on ethnicity and health.

### **Situation Analysis**

7. In the Region of the Americas, indigenous peoples, Afro-descendants, Roma, and members of 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). At the Regional Conference of the Americas, held in Santiago de Chile in 2000, States recognized the existence of a close connection between poverty and the racism experienced by the Afro-descendant population, which in turn leads 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 situation*

8. Many of these populations suffer the consequences of significant health gaps, and the available data on indigenous and Afro-descendant groups show inequities in comparison with the general population. In maternal health, even though these groups have a fertility rate that is roughly 50% higher than in the general population, they receive less, inequitable, and culturally inappropriate care in pregnancy, childbirth, and the puerperium, (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 infection rates are more than nine times higher among Afro-descendants than Caucasians, while the indigenous population exhibits a higher degree of risk behaviors, such as low condom use (21). Malnutrition among indigenous children in the Region is higher than among the non-indigenous population (18). In the case of Guatemala, 58% of indigenous children suffer from chronic malnutrition and 23% from severe malnutrition, while 34% of non-indigenous children have chronic malnutrition and 10% suffer from severe malnutrition (22). Even with underreporting, in some countries these populations have higher rates of violence against women and suicide (15, 18).

9. 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 indigenous children under 1 year of age remains systematically higher than in non-indigenous children: in Panama and Peru, for example, infant mortality in indigenous children is three times higher than in non-indigenous children (18). As to maternal mortality, despite the limited availability and poor quality of the information, the available data from local and specific studies show greater 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 (23). 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.

### *Social determinants of health*

10. In addition to poverty, data show how other social determinants of health place the indigenous and Afro-descendant populations of the Region at a disadvantage. For example, educational achievement is lower among Afro-descendants in some countries that have data in this respect (17). In addition, data from the analysis of 11 countries reveals a more than 20-point illiteracy gap between indigenous and non-indigenous populations, with a 25-point gap between indigenous and non-indigenous 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).

11. Given the geographic dispersal common to these population groups in rural areas, 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, 24, 25). 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 childbearing, in some countries the rate is 40% higher among Afro-descendant adolescents than among non-Afro-descendants (26). In some countries this rate may be even twice as high among indigenous adolescents as it is in the non-indigenous population (18).

### *Health information*

12. Information systems do not sufficiently collect the ethnicity variable. One of the main limitations is the lack of disaggregated data needed to obtain an accurate picture of the health situation of many of these populations in order to design and implement evidence-based public policies (16). At the national level, many countries in the Region have put in place mechanisms to disaggregate health data by ethnic origin. However, these mechanisms have not been implemented systematically and ethnicity is identified in different ways in censuses, health records, and surveys (17). Lack of quantitative and qualitative data—for example with respect to knowledge about the diversity of health concepts, diseases specific to these groups, and their traditional

wisdom and knowledge—remains a barrier to understanding the health determinants and health situations of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups, and to formulating appropriate responses and ensuring accountability.

### **Proposed Policy on Ethnicity and Health**

13. Bearing in mind PAHO's commitment to the diverse populations of the Region, this policy urges the Member States to consider the connection between ethnicity and health, and to promote an intercultural approach that will contribute, among other aspects, to the elimination of access barriers to health services and improve the health outcomes of indigenous peoples, Afro-descendants, Roma, and members of 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 production of evidence; *b)* the promotion of policy 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 members of other ethnic groups, as well as its determinants, taking human rights and gender into account in decision-making on intersectoral public health policies. Furthermore, research should be promoted to generate knowledge about the diversity of health concepts, diseases specific to these groups, and traditional wisdom and knowledge.

15. This implies improving the production of sound quantitative and qualitative data and information on the health of these populations, disaggregated by relevant stratifiers such as sex, age, and place of residence. Prioritizing indigenous peoples, Afro-descendants, Roma, and members of 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 record their ethnic identity or origin, or other obstacles are encountered. Thus, qualitative data collection is an important complement. Participation in data collection and use by the communities involved and their individual members—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 policy action**

16. In order to promote effective policy 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 policy gaps with respect to international standards; *b)* proposing policy frameworks based on the progressive realization of the right to the enjoyment of the highest attainable standard of health that favor and promote equity, an intercultural approach, and access to quality health services, considering the national context; *c)* promoting the review, adaptation, and effective implementation of existing policies in keeping with an intercultural approach; and *d)* promoting and facilitating the full participation of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups as applicable to the national context, in health and well-being. The formulation, implementation, monitoring, and evaluation of public policies should ensure the participation of the populations involved, respect for human rights, an intercultural approach, and gender equality. Modalities should be utilized that acknowledge the diversity of populations and cultures, with a focus on ensuring equity. This objective is aimed at ensuring shared, intercultural public policy-making that incorporates the knowledge, practices, and spheres of action of indigenous peoples, Afro-descendants, Roma, and members of 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 members of 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 seeks 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 promoting knowledge dialogue to facilitate the development and strengthening of intercultural health models as a way of achieving people- and community-centered health care. To this end, national policy frameworks, instruments, resources, and procedures should consider the different world views of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups, as applicable to the national context.

19. As a prerequisite for knowledge dialogue it is necessary to foster a new appreciation of traditional knowledge, practices, and cultural expressions, and to promote these through each culture's own transmission mechanisms. This should be taken into account not only in relation to care in sickness but also for health promotion and appropriate care at death.

20. Harnessing the potential contribution of traditional and complementary medicine to health, wellness, and people-centered health care is one of the goals of the WHO Traditional Medicine Strategy 2014-2023 (27). Recognition of ancestral knowledge is essential for tapping the potential of traditional medicine to contribute to universal access to health and universal health coverage, including the linkage or integration of these services in 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 comprehensive care that is coordinated with other sectors to produce timely, culturally appropriate, and non-discriminatory health care. Furthermore, the integration of an intercultural approach should be promoted in the design of technical and professional health curricula. The representation of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups, based on the respective national context, should also be promoted to guarantee culturally appropriate health care.

### **Action by the Pan American Sanitary Conference**

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

Annexes

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## Annex A

### **International human rights instruments that may be relevant to the health and ethnicity context, not previously cited in other PAHO resolutions<sup>1</sup> (non-exhaustive list)**

#### **International human rights instruments relevant to the health and ethnicity context**

##### *United Nations Human Rights System:*

- a) Indigenous and Tribal Peoples Convention, No. 169 (International Labour Organization, 1989)  
[http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100\\_INSTRUMENT\\_ID:312314](http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312314)
- b) International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1965)<sup>2</sup>  
<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx>

##### *Inter-American Human Rights System*

- a) Inter-American Convention against Racism, Racial Discrimination, and Related Forms of Intolerance (Organization of American States, 2013)<sup>3</sup>  
[http://www.oas.org/en/sla/dil/inter\\_american\\_treaties\\_A-68\\_racism.asp](http://www.oas.org/en/sla/dil/inter_american_treaties_A-68_racism.asp)
- b) Inter-American Convention against All Forms of Discrimination and Intolerance (Organization of American States, 2013)<sup>4</sup>  
[http://www.oas.org/en/sla/dil/inter\\_american\\_treaties\\_A-69\\_discrimination\\_intolerance\\_signatories.asp](http://www.oas.org/en/sla/dil/inter_american_treaties_A-69_discrimination_intolerance_signatories.asp)

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<sup>1</sup> For a more extensive list of binding and nonbinding international human rights instruments related to health, see Pan American Health Organization. Health and Human Rights. Concept Paper [Internet]. 62nd Session of the Regional Committee of WHO for the Americas; 27 September-1 October 2010; Washington, D.C. Washington, D.C.: PAHO; 2010 (Document CD50/12) [Accessed 14 April 2017]. Available from: <http://www2.paho.org/hq/dmdocuments/2010/CD50-12-e.pdf>

<sup>2</sup> States Parties: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, and Venezuela.

<sup>3</sup> Adopted 5 June 2013 during the 43rd Regular Session of the OAS General Assembly. It had not entered into force when this policy was drafted; it will do so after the deposit of the second ratification instrument or instrument of accession.

<sup>4</sup> *Idem.*

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## **International human rights standards relevant to the health and ethnicity context**

### *United Nations system:*

- a) United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007)  
[http://www.un.org/esa/socdev/unpfii/documents/DRIPS\\_en.pdf](http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf)
- b) Vienna Declaration and Programme of Action (World Conference on Human Rights, 1993)  
<http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx>
- c) The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights). General Comment No. 14 (2000). (Committee on Economic, Social and Cultural Rights, United Nations, 2000)  
<http://undocs.org/en/E/C.12/2000/4>
- d) General Recommendation XXVII on discrimination against Roma. (Committee on the Elimination of Racial Discrimination, 2000)  
[http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCERD%2fGEC%2f7499&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCERD%2fGEC%2f7499&Lang=en)
- e) General Recommendation No. 34 on Racial Discrimination against People of African Descent (Committee for the Elimination of Racial Discrimination, 2011)  
[http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/TBSearch.aspx?TreatyID=6&DocTypeID=11](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?TreatyID=6&DocTypeID=11)
- f) Declaration on the Rights of Persons Belonging to National or Ethnic, Religious, and Linguistic Minorities (United Nations General Assembly, 1992)  
<http://www.ohchr.org/EN/ProfessionalInterest/Pages/Minorities.aspx>
- g) Directrices de protección para los pueblos indígenas en aislamiento y en contacto inicial de la región amazónica, Gran Chaco y región oriental del Paraguay (Oficina del Alto Comisionado de las Naciones Unidas para los Derechos Humanos, 2012)  
<http://acnudh.org/wp-content/uploads/2012/03/Final-version-Guidelines-on-isolated-indigenous-peoples-february-2012.pdf>

### *Inter-American system*

- a) American Declaration on the Rights of Indigenous Peoples (Organization of American States, 2016)  
[http://cdn7.iitc.org/wp-content/uploads/AG07150E06\\_web.pdf](http://cdn7.iitc.org/wp-content/uploads/AG07150E06_web.pdf)

**Global and regional consensus relevant to the context of the health of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups (non-exhaustive list)**

- a) World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance (2001)  
<http://www.un.org/WCAR/durban.pdf>
- b) Rio Political Declaration on Social Determinants of Health (World Health Organization, 2011)  
[http://www.who.int/sdhconference/declaration/Rio\\_political\\_declaration.pdf?ua=1](http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf?ua=1)
- c) World Summit of African Descendants (2011)  
<http://www.hchr.org.co/afrodescendientes/index.php/unete-al-ano-de-los-afrodescendientes/archive/view/listid-1/mailid-41.html> (in Spanish)
- d) International Decade for People of African Descent 2015-2024 (2013)  
<http://www.un.org/en/events/africandescentdecade/>
- e) World Conference on Indigenous Peoples (2014)  
<http://www.un.org/en/ga/69/meetings/indigenous/#&panel1-1>
- f) 2030 Agenda for Sustainable Development (2015)  
<http://www.un.org/sustainabledevelopment/>
- g) Plan of Action for the Decade for Persons of African Descent in the Americas (2016)  
<http://www.oas.org/en/sare/documents/res-2891-16-en.pdf>

# 29th PAN AMERICAN SANITARY CONFERENCE

## 69th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 25-29 September 2017

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CSP29/7, Rev. 1  
Annex B  
Original: Spanish

### ***PROPOSED RESOLUTION***

#### **POLICY ON ETHNICITY AND HEALTH**

##### ***THE 29th PAN AMERICAN SANITARY CONFERENCE,***

(PP1) Having reviewed the *Policy on Ethnicity and Health* (Document CSP29/7, Rev. 1);

(PP2) Considering the need to promote an intercultural approach to health to eliminate health inequities among indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups, as applicable to the national context;

(PP3) Recognizing the differences among ethnic groups between and within countries and acknowledging the differences in their challenges, needs and respective historical contexts;

(PP4) Recalling the principles enshrined in the Durban Declaration and Programme of Action (2001); the United Nations Declaration on the Rights of Indigenous Peoples (2007); the Rio Political Declaration on the Social Determinants of Health (2011); the World Summit of Afro-descendants (2011); the International Decade for People of African Descent 2015-2024 (2013); the World Conference on Indigenous Peoples (2014); and the 2030 Agenda for Sustainable Development (2015), as well as the principles enshrined in other international instruments related to ethnicity and health;

(PP5) Referring to the framework of PAHO mandates related to the health of indigenous peoples, the mainstreaming of ethnicity as a cross-cutting theme of the PAHO Strategic Plan, and the lessons learned;

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(PP6) Recognizing the importance of PAHO as a whole (PASB and Member States) emphasizing efforts to strengthen the intercultural approach to health to achieve the enjoyment of the highest attainable standard of health by indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups, based on their respective national context;

(PP7) Bearing in mind the need to adopt the necessary measures to guarantee the intercultural approach to health and equal treatment of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups from the standpoint of equality and mutual respect, considering the value of their cultural practices, which include their lifestyles, value systems, traditions, and world views,

***RESOLVES:***

(OP)1. To adopt the *Policy on Ethnicity and Health* (Document CSP29/7, Rev. 1).

(OP)2. To urge the Member States, as appropriate, and taking their national context, regulatory frameworks, priorities, and financial and budgetary situation into account, to:

- a) promote public policies that address ethnicity as a social determinant of health from the perspective of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups;
- b) foster better access to quality health services, among other things, promoting intercultural health models that, through dialogue, include the perspective of the ancestral and spiritual wisdom and practices of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups, based on the respective national context;
- c) strengthen institutional and community capacity in the Member States to produce sufficient quality data and generate evidence for policy-making with respect to the inequalities and inequities in health experienced by indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups for intersectoral policy-making in health;
- d) strengthen institutional and community capacity at all levels to implement the intercultural approach to health systems and services, helping, among other things, to guarantee access to quality health services;
- e) increase, promote, and ensure the social participation of all indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups in the development and implementation of health policies, considering gender differences and life-course perspective;
- f) promote the generation of knowledge and dedicated spaces for ancestral medicine and wisdom to strengthen the intercultural approach to health;



- g) integrate the ethnic approach and vision of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups in the implementation of the *Plan of Action on Health in All Policies* (Document CD53/10, Rev.1 [2014]), in keeping with national realities;
- h) promote intersectoral cooperation for the sustainable development of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups.

(OP)3. Request the Director, as the financial resources of the Organization permit, to:

- a) advocate for the inclusion of strategic components on ethnicity and health in the Sustainable Health Agenda for the Americas 2018-2030 and the PAHO Strategic Plan 2020-2025;
- b) prioritize technical cooperation to assist countries in strengthening health system capacity to include ethnicity as a social determinant of health from the perspective of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups, in line with the Sustainable Development Goals (SDGs) and applicable international and regional human rights instruments;
- c) continue prioritizing ethnicity as a cross-cutting theme of PAHO technical cooperation, in harmony with gender, equity, and human rights;
- d) strengthen interinstitutional coordination and collaboration mechanisms to achieve synergies and efficiency in technical cooperation within the United Nations and Inter-American systems and with other stakeholder entities working in the field of ethnicity in health, especially subregional integration mechanisms and pertinent international financial institutions.

## Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

**1. Agenda item:** 4.5 - Policy on Ethnicity and Health

**2. Linkage to [PAHO Program and Budget 2016-2017](#)**

- a) **Category:** 3. Determinants of Health and Promoting Health throughout the Life Course: Promoting good health at key stages of life, taking into account the need to address the social determinants of health (social conditions in which people are born, grow, live, work and age) and implementing approaches based on gender equality, ethnicity, equity, and human rights.

b) **Program areas and outcomes:**

Program Area: 3.3. Gender, Equity, Human Rights, and Ethnicity.

Outcome 3.3: Increased country capacity to integrate gender, equity, human rights, and ethnicity in health.

**3. Financial implications:**

a) **Total estimated cost for implementation over the lifecycle of the resolution (including staff and activities):**

Approximately US\$ 1,836,000 per biennium, on approval of the policy and during the time it remains in force. The estimate corresponds to the biennium in which the strategy or plan is implemented for execution of the policy. The Organization's budget and operating plans will be incorporated in the program for its monitoring and evaluation. Of the total amount, an estimated US\$ 734,400 will be allocated to staff and US\$ 1,101,600 to activities.

The current budget for ethnicity for the 2016-2017 biennium is estimated at US\$ 1,100,000; this implies an additional financial commitment of US\$ 736,000 for executing the policy in subsequent bienniums.

b) **Estimated cost for the 2016-2017 biennium (including staff and activities):** US\$ 220,300 (cost of implementing the policy from September to December 2017).

c) **Of the estimated cost noted in b), what can be subsumed under existing programmed activities?** US\$ 100,000.

**4. Administrative implications:**

**a) Indicate the levels of the Organization at which the work will be undertaken:**

All levels of the Organization will be involved: programmatic, national, regional, and subregional. Active participation by the ministries of health of the Member States and subregional organizations and mechanisms will also be necessary.

**b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**

There is currently a post for a full-time cultural diversity advisor (P4) and a half-time gender and ethnicity advisor working on the generation of evidence. A full-time specialist in cultural diversity (P3) and a half-time medical anthropologist (P4) will also be needed.

**c) Time frames (indicate broad time frames for implementation and evaluation):**

Execution will begin as soon as the policy is approved by the Pan American Sanitary Conference to ensure its inclusion in the new Strategic Plan and the Program and Budget.



## ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** 4.5 - Policy on Ethnicity and Health

2. **Responsible unit:** Gender and Cultural Diversity/Department of Family, Gender, and Life Course (FGL)

3. **Preparing officer:** Dr. Andrés de Francisco Serpa

4. **Link between Agenda item and [Health Agenda for the Americas 2008-2017](#):**

Execution of the Policy on Ethnicity and Health offers the opportunity to contribute to progress in the following areas, as defined in the Health Agenda for the Americas: tackling health determinants; increasing social protection and access to quality health services, and diminishing health inequalities among countries and inequities within them. Moreover, one of the principles and values in the Agenda is equity in health, which calls for eliminating all avoidable unjust, and remediable inequalities in health among populations and groups.

5. **Link between Agenda item and [PAHO Strategic Plan 2014-2019](#):**

This item falls under Category 3, “Determinants of Health and Promoting Health throughout the Life Course”: “Promoting good health at key stages of life, taking into account the need to address the social determinants of health (social conditions in which people are born, grow, live, work and age) and implementing approaches based on gender equality, ethnicity, equity, and human rights.”

As stated in the Strategic Plan, work in this category includes the ethnicity approach as a cross-cutting component in technical cooperation efforts across the Organization. Moreover, this approach is essential for addressing the social determinants of health and equity to improve health outcomes in the Region, especially among ethnic groups.

6. **List of collaborating centers and national institutions linked to this Agenda item:**

- Ministries of health and national health institutions
- Other government agencies and entities that work with indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups--in particular, those connected with intercultural health
- PAHO/WHO Collaborating Centers
- Civil society organizations and the organizations of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups
- Universities
- United Nations agencies and specialized entities
- Treaty bodies and other mechanisms of the United Nations system relevant to the health of indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups, as appropriate, and special United Nations proceedings

- Organization of American States and the Inter-American Commission on Human Rights
- Other international health cooperation partners
- Subregional integration mechanisms connected with intercultural health and indigenous peoples, Afro-descendants, Roma, and members of other ethnic groups, as appropriate

**7. Best practices in this area and examples from countries within the Region of the Americas:**

The Region of the Americas has made progress toward addressing ethnicity-based health inequities, adopting, *inter alia*, intercultural approaches that give access to the most marginalized and vulnerable populations, while taking different cultural perspectives into account. For example, with respect to the intercultural approach, health services have brought in traditional healers (indigenous men and women who provide services in suitable spaces, respecting community practices and customs) (Bolivia, Mexico).

PAHO is promoting knowledge sharing, including knowledge on intercultural approaches in health.

**8. Financial implications of this Agenda item:**

The estimated proposed budget (US\$ 1,836,000) corresponds to the biennium in which the strategy or plan of action is implemented for the execution of the policy. The Organization's budget and operating plans will be incorporated in the program for its monitoring and evaluation.

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