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71st SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

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STRATEGY AND PLAN OF ACTION ON ETHNICITY AND HEALTH 2019-2025

Introduction

1. In the framework of universal health, the Member States of the Pan American Health Organization (PAHO) have prioritized actions to ensure that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate, timely, and quality health services. However, asymmetrical power relationships and domination have led to conditions in which members of certain ethnic groups—including indigenous, Afro-descendant, and Roma populations—systematically experience different forms of discrimination and exclusion that give rise to inequities and social injustice. Marginalization and discrimination based on ethnicity,¹ including institutional racism, interact negatively with other structural determinants such as gender, creating health inequities in a region characterized by its rich ethnic and cultural diversity.
2. Recognizing this unjust situation, together with the need to take joint action on social determinants and eliminate discrimination, as well as the potential for culture to improve people's quality of life, PAHO adopted the Policy on Ethnicity and Health (CSP29/7, Rev.1) (1), reflecting the commitment to advance toward the achievement of the highest attainable standard of health for the entire population of the Americas. This policy is aimed at taking the necessary action to ensure an intercultural approach to access to health care and services, taking into account the social determinants of health, from a standpoint of equality and mutual respect, and valuing the cultural practices of the Region's ethnic groups, their lifestyles, social organization, values systems, traditions, and world views. Likewise, it is noteworthy that the High-level Commission "Universal Health in the 21st Century: 40 Years of Alma-Ata" observed in its report the need to develop people-

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 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.

and community-centered primary-health-care-based models of care that take into account human diversity, interculturalism, and ethnicity (2).

3. With a view to cooperating with the Member States in the implementation of the guidance contained in the Policy on Ethnicity and Health, this document presents the Strategy and Plan of Action on Ethnicity and Health 2019-2025.

Background

4. In the Region of the Americas, there are different obstacles to recognizing and respecting the human rights of members of indigenous, Afro-descendant, and Roma populations, and members of other ethnic groups. Throughout the life course, people belonging to ethnic groups continue to experience structural discrimination and poor representation and inclusion in decision-making processes, which impedes their access to health services and affects the quality of care they receive, with an overall impact on their living conditions. This was underscored in the report of the PAHO Commission on Equity and Health Inequalities in the Americas, which indicated that indigenous and Afro-descendant people in the Americas are subject to multiple disadvantages that damage their health (3).²

5. Recognizing these inequalities, PAHO's Member States are implementing policies, plans, and programs to reduce inequities, promote social justice, and eliminate barriers to health services faced by people belonging to these groups. Furthermore, different ethnic groups in the Americas have made great efforts to strengthen their organizational capacity. This is expressed in their increased participation in national and international consultation and consensus-building forums. For example, 17 countries in the Region have created a governmental agency or mechanism with a specific mandate to manage intercultural health (4).

6. As mentioned in the Policy on Ethnicity and Health (1), United Nations agencies, among others, have established international instruments and standards to respond at the global and regional levels in cases where the human rights of members of these population groups are not respected. This Strategy and Plan of Action is aligned with these instruments and standards, including the 2030 Agenda for Sustainable Development, which makes an explicit commitment to leave no one behind (5).

Situation Analysis

7. People belonging to ethnic groups, including indigenous, Afro-descendant, and Roma populations, are very often statistically invisible in national information systems and

² This Strategy and Plan of Action focuses on actions to address discrimination and the health inequities facing these ethnic groups, while recognizing the differences that exist between the groups, as well as between and within countries.

in national censuses because some countries do not include ethnic self-identification as a variable.

8. According to the available data for 2015, the Afro-descendant population in Latin America was estimated at 130 million people (6). In Brazil, Afro-descendants accounted for over 50% of the total population, according to the latest census, and in the United States there are an estimated 40 million people of African descent, equivalent to 13% of the total population (7). It is estimated that in 2010 there were at least 44.8 million indigenous persons in the Region, representing 826 indigenous peoples, mainly concentrated in Mexico (17 million people) and Peru (seven million), followed by Guatemala and Bolivia (six million each) (4). Although the presence of first Roma populations in the Americas dates back to the colonial era, it is not possible to precisely determine the size of the population currently living in the Region because censuses do not include that variable, contributing to their invisibility in national statistics. In Brazil alone, in 2015, the Roma population exceeded half a million people (8).

9. The figures from household surveys show that when the ethnic dimension is included, indigenous and Afro-descendant populations suffer higher levels of poverty and extreme poverty, indicating significant ethnic gaps (6). In order to analyze the ethnicity-related health situation, it is necessary to take an approach that can identify the processes that cause differences between the living conditions of these groups and those of other populations. The situation appears worse if an intersectional analysis of ethnicity and gender is included; and worse still, if other identity-related factors such as age, religion, and sexual orientation are included.

Analysis of Health Inequalities

10. Despite the limited amount of disaggregated data in health information systems, the health inequalities affecting these populations are evident. In areas with indigenous populations, the available evidence shows that the epidemiological profile of these groups reflects persistently high incidence and mortality rates from infectious diseases such as tuberculosis and noncommunicable diseases such as diabetes, associated with malnutrition and obesity (9). A person who self-identifies as indigenous in Paraguay, for example, is nine times more likely to suffer from tuberculosis than non-indigenous persons; and in Brazil, Venezuela, Panama, and Colombia, two to three times more likely (10). In the Americas, people who self-identify as indigenous accounted for 13% of all malaria cases and 7% of all deaths between 2010 and 2016 (11).

11. Intersectional analysis of gender and ethnicity shows even greater inequalities for women who belong to indigenous, Afro-descendant, and Roma populations. For example, although the maternal mortality ratio has declined in most countries of Latin America and the Caribbean in recent decades, it remains high among Afro-descendant women. Since birth and death registries in some countries of the Region include ethnic-racial self-identification—for example, Brazil, Colombia, and Ecuador—evident inequalities can be observed. For example, the maternal mortality ratio in Brazil is 1.4 times higher among

Afro-descendant women, while in Colombia, it is 2.3 times higher than for the nation as a whole, and in Ecuador it is nearly four times higher (12). The situation is similar with respect to maternal mortality rates in indigenous populations. In Mexico, predominantly indigenous municipalities that are highly marginalized and geographically and socially isolated report that the risk of maternal mortality among indigenous women is up to nine times higher than in municipalities with greater access to health care and services (13, 14).

12. Several studies based on the information available in surveys on reproductive, maternal, newborn, and child health reveal the inequalities experienced by members of indigenous and Afro-descendant populations in the Region, in comparison with Euro-descendant populations and people with mixed ancestry (15-17).

13. An analysis of mortality, fertility, and nutritional outcomes in nine countries indicates that under-5 mortality in 2010 was 31% to 220% higher among indigenous children than non-indigenous children, except in Costa Rica, where the difference was only 2% (18) (see Annex A, figure 1).

14. Another analysis of coverage of reproductive, maternal, newborn, and child health interventions in 16 countries in the Region (13, 17) shows that the size of ethnic gaps varies substantially from one country to another. The results indicate that in most countries the use of modern contraceptives, prenatal care, and care in childbirth was lower among indigenous women. With respect to vaccination against diphtheria, whooping cough, and tetanus, only three countries showed significant gaps resulting in lower coverage among indigenous children. After adjustment for wealth, education, and place of residence, the differences were attenuated but they nevertheless persisted. Women and children of African descent showed similar coverage to the reference group in most countries.

15. Intersectional analysis of ethnicity and family wealth shows that, in Guatemala for example, the prevalence of stunting in children (i.e., short height for age), an indicator of long-term malnutrition, is higher in indigenous children than in non-indigenous children with the same level of family wealth (19). The prevalence of stunting in indigenous children in 2014 was higher than the rates observed in non-indigenous children in 1995, indicating a 20-year lag in the nutritional situation of the indigenous group (see Annex A, figure 2).

16. As was pointed out above, the literature in the Region shows ethnic gaps with respect to other health problems such as tuberculosis, suicide, alcoholism, parasitic diseases, and sexually transmitted diseases, among others (20). These differences should be analyzed in the context of historical exclusion, discrimination, and lack of culturally adequate responses to these population groups.

17. Structural inequalities contribute to inequalities in the incidence and prevalence of mental illness and inequities in access to effective mental health treatment. Such inequalities are seen among different ethnic groups in the Americas, as well as among different socioeconomic groups, and between men and women (3).

18. Despite being a population group with its own identity and culture, little is known about the situation of Roma populations in many countries of the Region. The size of the population is not known, nor is its socioeconomic and health situation, among other aspects. The Roma population faces considerable barriers to health service access: in some countries, for example, due to discrimination, parents have difficulty vaccinating their children (8).

Advances on policy issues

19. Some countries of the Region have strengthened their institutional capacity to address the issue of ethnicity and health with an intercultural approach. For example, fostering differentiated approaches for different ethnic groups is considered an essential tool to address the health priorities of different groups, improve health services, and eliminate discrimination. Likewise, there has been increased recognition of traditional medicine and its coordination with health systems. Among the countries that have made headway in this area are Bolivia, Brazil, Chile, Colombia, Cuba, Ecuador, Mexico, Nicaragua, and Peru.

Proposal

20. This strategy promotes intercultural approaches to health and foment action to tackle the social determinants of health, with the participation of groups involved and incorporating a gender perspective, in order to operationalize the five priority strategic lines of action of the Policy on Ethnicity and Health, namely: *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.

Strategic Lines of Action

21. Consistent and integrated implementation of the lines of action proposed in this plan of action, as applicable to national contexts and priorities, will have a positive impact on the health of indigenous, Afro-descendant, and Roma populations, will reduce health inequities, and will contribute to attaining the following impact targets:

Objective	Indicator	Baseline (2019)	Target (2025)
1. Reduce the maternal mortality ratio	Number of countries and territories that have reduced the maternal mortality gap by at least 30% in at least one of the following populations: indigenous, Afro-descendant, and Roma	0	12

Objective	Indicator	Baseline (2019)	Target (2025)
2. Reduce the under 5 mortality rate	Number of countries and territories that have reduced the mortality gap in children under 5 by at least 30% in at least one of the following populations: indigenous, Afro-descendant, and Roma	0	12
3. Reduce the incidence of tuberculosis	Number of countries and territories that have reduced the incidence of tuberculosis in indigenous, Afro-descendant, or Roma populations by at least 50% compared to 2015	0	8

Strategic Line of Action 1: Production of evidence

22. This strategic line of action focuses on the production, integrated management, and analysis of health information disaggregated by ethnicity, including the determinants of health, for decision-making on public health policies.

Objective	Indicator*	Baseline (2019)	Target (2025)
1.1 Promote the production of disaggregated data and information on the health of different ethnic groups and their determinants	1.1.1 Number of countries and territories that include ethnic self-identification as a variable in their vital statistics (birth and death records) and/or other data sources (e.g. census)	8	15
	1.1.2 Number of countries and territories that capture data on ethnic self-identification in their administrative health records	8	15
1.2 Strengthen institutional capacities to analyze the health situation with a focus on ethnicity.	1.2.1 Number of countries and territories that have an up-to-date national profile of the health situation, with data disaggregated by ethnicity and sex	10	15
1.3 Promote research on the health of indigenous, Afro-descendant, and Roma populations, and other ethnic groups.	1.3.1 Number of countries and territories whose research agenda includes an explicit commitment to examine ethnicity and health	8	12
	1.3.2 Number of countries and territories that have completed studies on barriers to equitable access to health services	24	36

Objective	Indicator*	Baseline (2019)	Target (2025)
1.4 Promote mechanisms to disseminate information on ethnicity and health, and for its use in decision-making, promotion of this approach, and accountability	1.4.1 Number of countries and territories that use health information on different ethnic groups in the development of policies, strategies, plans, and programs	16	36

* Disaggregated by indigenous, Afro-descendant, and Roma populations, as appropriate to each country's ethnic make-up.

Strategic Line of Action 2: Promotion of political action for universal access to health

23. This line of action involves interventions that recognize and implement an intercultural and intersectoral approach, together with action on social determinants and the elimination of discrimination. This makes it necessary to identify regulatory gaps with respect to international standards; propose policy frameworks that respect the right to the enjoyment of the highest attainable standard of health for all people, favoring and promoting equity, interculturalism, and access to quality health care and services according to the specific needs of people throughout the life course, taking into account the national and local context.

Objective	Indicator*	Baseline (2019)	Target (2025)
2.1 Promote public policy actions that addresses ethnicity and health	2.1.1 Number of countries and territories that have ratified International Labor Organization (ILO) Convention 169 on indigenous and tribal peoples	13	15
	2.1.2 Number of countries and territories that implement policies that address ethnic inequities in health	17	26
	2.1.3 Number of countries and territories that have included ethnicity and health in their national development agendas	13	19

Objective	Indicator*	Baseline (2019)	Target (2025)
2.2 Promote culturally appropriate health systems and services for all	2.2.1 Number of countries and territories that have developed or are operating health systems with an intercultural approach	16	26
	2.2.2 Number of countries and territories that have policies that address discrimination in the health system based on ethnic origin	6	12
2.3 Promote accountability mechanisms for the reduction in health inequities	2.3.1 Number of countries and territories that produce a periodic report on the reduction in ethnic inequities in health	0	6

* Disaggregated by indigenous, Afro-descendant, and Roma populations, as appropriate to each country's ethnic make-up.

Strategic Line of Action 3: Promote social participation and strategic partnerships

24. This line of action seeks to foster social participation and accountability, while respecting the organizational structures of indigenous, Afro-descendant, and Roma populations, and other ethnic groups. It also seeks to forge strategic partnerships with these groups and other relevant actors to develop health-related policies and actions, so that they can participate in the design, implementation, evaluation, and reformulation of health plans, programs, and policies.

Objective	Indicator*	Baseline (2019)	Target (2025)
3.1 Promote the participation of different ethnic groups in the development of health-related policies and actions	3.1.1 Number of countries and territories that ensure social participation by different groups in national mechanisms for health-related policies and actions	15	26
	3.1.2 Number of countries and territories that have official mechanisms for social participation in reporting on the reduction of ethnic inequities in health	8	16

* Disaggregated by indigenous, Afro-descendant, and Roma populations, as appropriate to each country's ethnic make-up.

Strategic Line of Action 4: Recognition of ancestral knowledge and traditional and complementary medicine

25. Recognition of ancestral knowledge is essential in order to harness traditional medicine’s potential contribution to universal access to health and universal health coverage, including the coordination or integration of services in national health systems and the adoption of interventions for self-care with intercultural approaches.

26. This priority line seeks to strengthen knowledge dialogue that facilitates the development and strengthening of intercultural health models as a way to focus attention on the needs of people and communities. To this end, consideration should be given to the diverse world views of indigenous, Afro-descendant, and Roma populations, and other ethnic groups, as applicable to the national context.

Objective	Indicator*	Baseline (2019)	Target (2025)
4.1 Promote recognition, respect, and protection of knowledge-based traditional, ancestral, and complementary medicines in national health systems.	4.1.1 Number of countries and territories that have laws, policies, and/or strategies to recognize, respect, protect, and incorporate traditional, knowledge-based ancestral, and complementary medicine in national health systems	17	24
	4.1.2 Number of countries and territories that have institutional entities and guidance instruments to promote respect for traditional healers and ancestral therapists, within of the health sector	10	24

* Disaggregated by indigenous, Afro-descendant, and Roma populations, as appropriate to each country’s ethnic make-up.

Strategic Line of Action 5: Capacity development at all levels

27. This line of action promotes training for institutional and community health workers to facilitate and foster intercultural action and the conditions for knowledge dialogue. It also promotes the strengthening of practices and knowledge of practitioners of knowledge-based traditional medicine. It fosters the inclusion of interculturalism and action on social determinants in the curricula of professional programs and continuing education in the health field. It also promotes representativeness, within health systems, of indigenous, Afro-descendant, and Roma populations, as appropriate to the country’s situation, in order to ensure that health care is culturally pertinent, empowers the community, and responds to specific needs. This line of action also seeks to help eliminate all forms of racism and discrimination in health services, which various ethnic groups frequently suffer.

Objective	Indicator*	Baseline (2019)	Target (2025)
5.1 Strengthen institutional and community capacities in ethnicity and health.	5.1.1 Number of countries and territories that have incorporated interculturalism into the curricular content of professional training in the health sciences and/or that have included training in intercultural competencies for health professionals	10	15
	5.1.2 Number of countries and territories that have institutional mechanisms to incorporate professionals who belong to different ethnic groups into their health services	10	15
	5.1.3 Number of countries and territories that have formal mechanisms to build health worker capacities in interculturalism at the community level	5	10

* Disaggregated by indigenous, Afro-descendant, and Roma populations, as appropriate to each country's ethnic make-up.

Monitoring and Evaluation

28. This Strategy and Plan of Action will contribute to outcome 26 of the PAHO Strategic Plan 2020-2025. Its strategic lines of action will be operationalized through the Organization's Program Budget. The Pan American Sanitary Bureau will prepare methodological guidelines to support measurement of the indicators established in this Strategy and Plan of Action. A progress report will be issued in 2023 to evaluate the progress made toward the targets. A final report will be issued in 2026, when implementation of the Plan of Action has concluded.

Financial Implications

29. The total estimated cost of PAHO technical cooperation to implement the complete cycle of this Strategy and Plan of Action, from 2019 to 2025, including personnel and activity costs, is US\$ 4,375,000. Financing of country initiatives will be assumed by the Member States. Annex C provides more detailed information.

Action by the Directing Council

30. The Directing Council is invited to review the Strategy and Plan of Action on Ethnicity and Health 2019-2025, make any recommendations it deems relevant, and consider approving the proposed resolution that appears in Annex B.

Annexes

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Annex A

Figure 1. Under-5 mortality rate in indigenous and non-indigenous communities in nine countries of the Region, 2000 and 2010

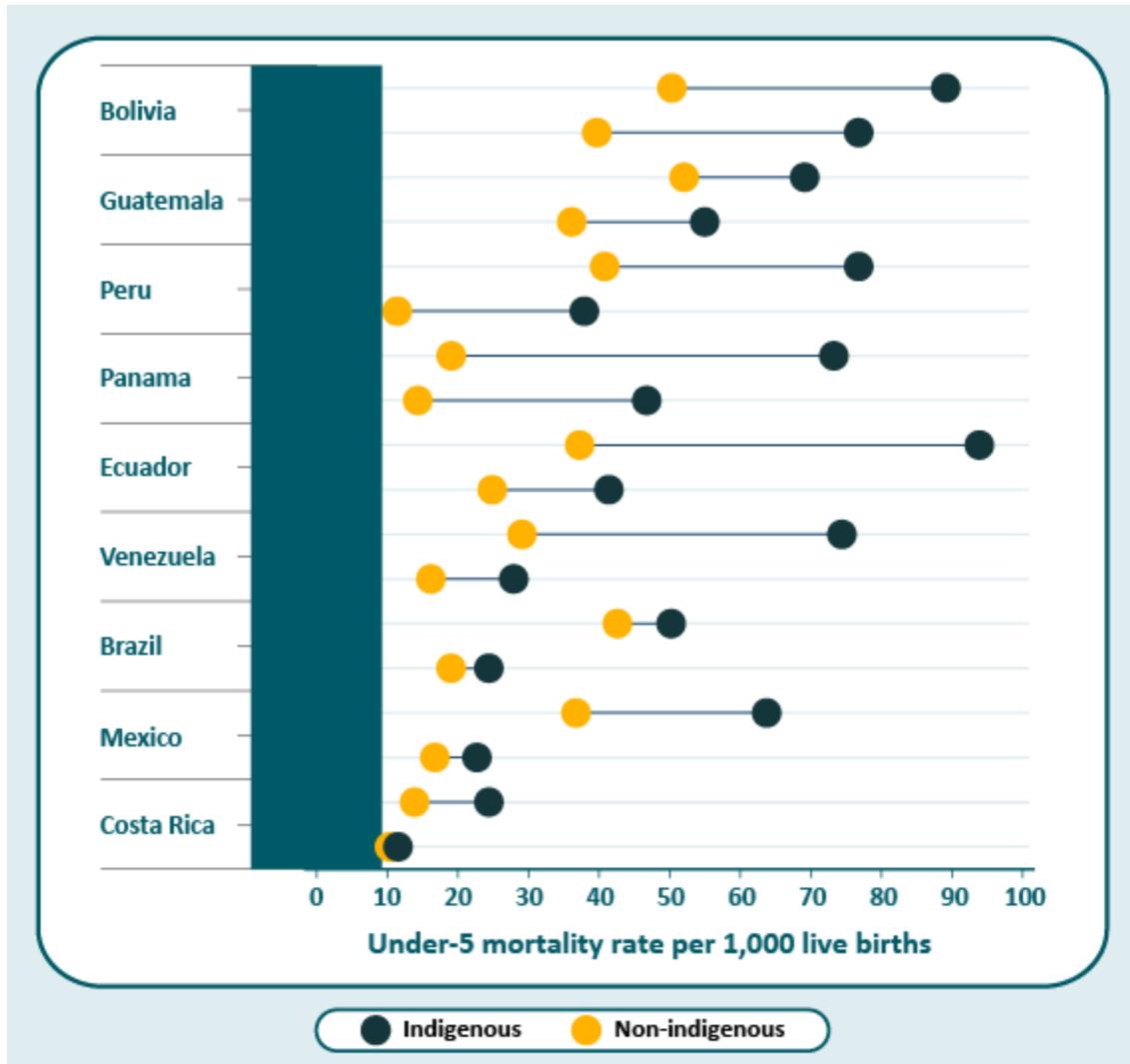
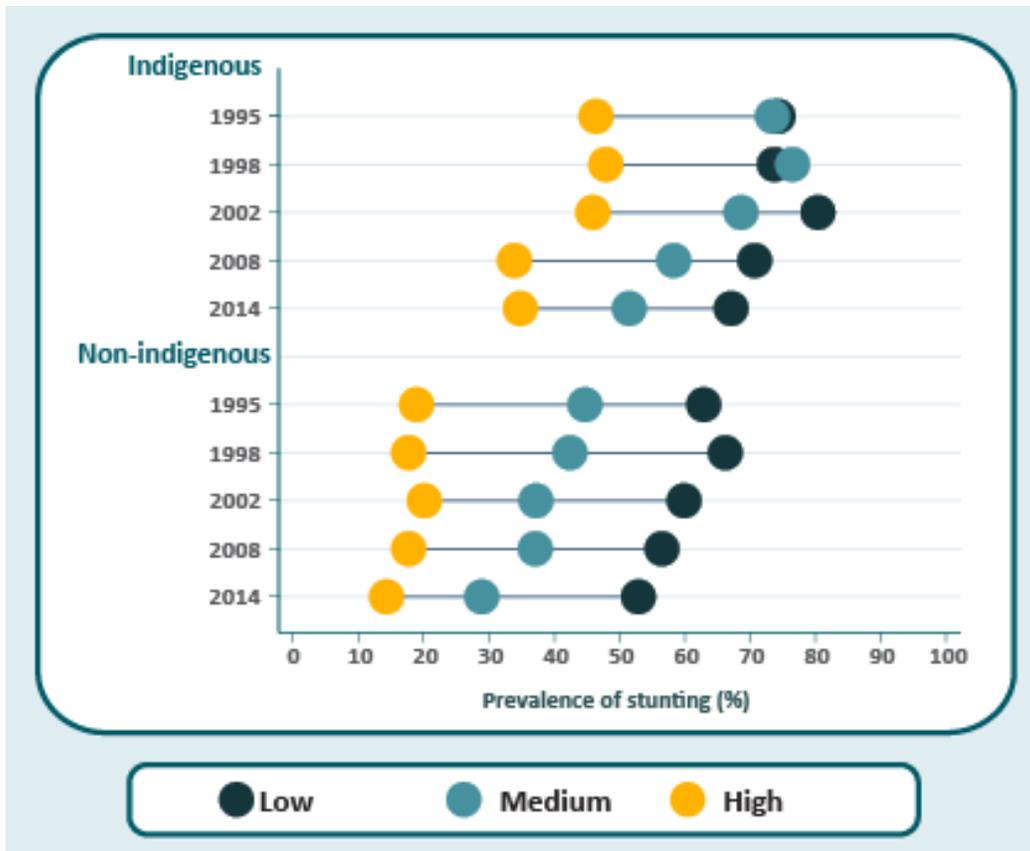


Figure 2. Prevalence of stunting in children under 5, by ethnic group and wealth tercile, in Guatemala, 1995 and 2014



57th DIRECTING COUNCIL

71st SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

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Annex B
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PROPOSED RESOLUTION

STRATEGY AND PLAN OF ACTION ON ETHNICITY AND HEALTH 2019-2025

THE 57th DIRECTING COUNCIL,

(PP1) Having examined the *Strategy and Plan of Action on Ethnicity and Health 2019-2025* (Document CD57/13);

(PP2) Considering that, in September 2017, the 29th Pan American Sanitary Conference adopted the Policy on Ethnicity and Health, whose resolution requests the Director to continue to prioritize ethnicity as a linchpin of technical cooperation by the Pan American Health Organization (PAHO), in harmonization with gender, equity, and human rights;

(PP3) Considering that the Constitution of the World Health Organization (WHO) declares that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic or social condition”;

(PP4) Observing that the adoption of measures within the framework of intercultural health that could help to improve the health outcomes of indigenous, Afro-descendant, and Roma populations, and members of other ethnic groups, in line with the PAHO Strategic Plan 2020-2025, its strategic objectives, its expected results at the regional level, and its indicators;

(PP5) Considering the lessons learned and the already-adopted resolutions that recognize the need to strengthen intercultural health in health interventions;

(PP6) Embracing the vision of the Sustainable Development Goals, the Sustainable Health Agenda for the Americas 2018-2030, the Strategic Plan of the Pan American Health Organization 2020-2025, the PAHO Gender Equality Policy, the Resolution on Health and Human Rights, the Strategy for Universal Access to Health and Universal Health Coverage, and the Plan of Action on Health in all Policies,

RESOLVES:

(OP)1. To approve and implement the *Strategy and Plan of Action on Ethnicity and Health 2019-2025* (Document CD57/13).

(OP)2. To urge the Member States, taking into account their contexts and needs, to promote the achievement of the objectives and indicators of the Strategy and Plan of Action on Ethnicity and Health 2019-2025 in order to advance more expeditiously on the route proposed in the Policy on Ethnicity and Health.

(OP)3. To request the Director, within the financial possibilities of the Organization, to:

- a) provide technical support to the Member States for implementation of the Strategy and Plan of Action on Ethnicity and Health 2019-2025;
- b) maintain ethnicity and health as a cross-cutting theme in PAHO's technical cooperation;
- c) strengthen mechanisms for interinstitutional coordination and collaboration to achieve synergies and efficiency in technical cooperation, including within the United Nations system and the Inter-American system, and with other stakeholders working in the area of ethnicity and health, especially subregional integration mechanisms and relevant international financial institutions;
- d) report periodically to the Governing Bodies on the progress made and the challenges faced in the execution of the Strategy and Plan of Action.

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

1. Agenda item: 4.11 - Strategy and Plan of Action on Ethnicity and Health 2019-2025

2. Linkage to the proposed PAHO Program Budget 2020-2021:*

Outcome 26: Strengthened country leadership and capacity to advance health equity and gender and ethnic equality in health, within a human rights framework.

** The proposed PAHO Program Budget 2020-2021 was presented to the 13th Session of the Subcommittee on Program, Budget, and Administration and the 164th Session of the Executive Committee. The 57th Directing Council will review the proposed Strategic Plan in September 2019. Therefore, the final version of the Program Budget may have some changes to the outcomes, which will be reflected in this Strategy and Plan of Action as well.*

3. Financial implications:

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

The total estimated cost for the plan of action is US\$ 4,375,000. This estimate takes into account the total amount necessary for the activities of the Pan American Sanitary Bureau. However, the results will only be achieved if Member States also increase their strategic investments in the health of indigenous, Afro-descendant, and Roma peoples. Therefore, the total amount needed for key activities at the country level is not reflected in this estimate. The estimated amount for human resources (see table below) takes into consideration PAHO staff members at the regional and country levels. The estimated amounts for the activities (training, consultants, travel and meetings, publications, and supplies) were calculated considering the regular funds and voluntary contributions that should be mobilized during the implementation period of the strategy and plan of action.

Areas	Estimated cost
Human resources	1,093,750
Training	1,531,250
Consultants/service contracts	656,250
Travel and meetings	437,500
Publications	437,500
Supplies and other expenses	218,750
Total	4,375,000

b) Estimated cost for the 2018-2019 biennium (including staff and activities):

The estimated cost for the 2020-2021 biennium is US\$ 1,750,000.

c) Of the estimated cost noted in b), what can be subsumed under existing programmed activities? US\$ 930,000: estimate includes the activity of a full-time P4 advisor, full-time P3 specialist, and part-time P4 advisor (50%).

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, country, regional, and subregional). Active participation will also be needed from the ministries of health of the Member States, and from subregional organizations and mechanisms.

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

Currently, there is a full-time advisor on cultural diversity (P4) and a part-time (50%) advisor on gender and ethnicity in health, focused on production of evidence. An additional full-time position for a cultural diversity specialist (P3) will be required.

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

Implementation will begin as soon as this strategy and plan of action is approved by the Directing Council in order to ensure its inclusion in the new Strategic Plan and in the Program Budget. A progress report will be issued in 2023 to evaluate the progress made towards the achievement of the goals. When implementation of the plan of action ends in 2026, a final report will be issued.

Analytical Form to Link Agenda Item with Organizational Mandates

1. Agenda item: 4.11 - Strategy and Plan of Action on Ethnicity and Health 2019-2025
2. Responsible unit: Equity, Gender and Cultural Diversity Office
3. Preparing officer: Dr. Sandra del Pino
4. Link between Agenda item and Sustainable Health Agenda for the Americas 2018-2030: It is linked to Goal 11, "Reduce inequality and inequity in health through intersectoral, multisectoral, regional, and subregional approaches to the social and environmental determinants of health". This goal is important in order to address the persistent inequities surrounding health in the Region. In line with the principles of this Agenda and the 2030 Agenda for Sustainable Development (to "leave no one behind"), this goal considers multisectoral strategies to reduce health inequities by promoting health and well-being through actions on the determinants of health, including social protection, while addressing issues of gender, ethnicity, and human rights.
5. Link between Agenda item and the proposed PAHO Strategic Plan 2020-2025:* <i>Outcome 26: Strengthened country leadership and capacity to advance health equity and gender and ethnic equality in health, within a human rights framework.</i> <i>* The proposed PAHO Strategic Plan 2020-2025 was presented to the 13th Session of the Subcommittee on Program, Budget, and Administration and the 164th Session of the Executive Committee. The 57th Directing Council will review the proposed Strategic Plan in September 2019. Therefore, the final version of the Strategic Plan may have some changes to the outcomes, which will be reflected in this Strategy and Plan of Action as well.</i>
6. List of collaborating centers and national institutions linked to this Agenda item: <ul style="list-style-type: none"> • National ministries of health and national health institutions. • Other government agencies and entities that work with indigenous, Afro-descendant, and Roma populations, and members of other ethnic groups, particularly those related to intercultural health. • PAHO/WHO Collaborating Centers. • Civil society organizations and organizations of indigenous, Afro-descendant, and Roma populations, and members of other ethnic groups. • Universities. • United Nations agencies and specialized agencies. • Treaty bodies and other mechanisms of the United Nations system relevant to the health of indigenous, Afro-descendant, and Roma populations, and members of other ethnic groups, as appropriate, such as United Nations special procedures. • Organization of American States and Inter-American Commission on Human Rights. • Other international partners in the field of cooperation in health.

- Subregional integration mechanisms linked to intercultural health and indigenous, Afro-descendant, and Roma people, and members of other ethnic groups, as appropriate.

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

- Several countries in the Region have models for indigenous intercultural health, which harmonize traditional knowledge and Western medicine: Brazil, Bolivia, Chile, Colombia, Cuba, Ecuador, Mexico, Nicaragua, and Peru.
- Several countries have also developed tools to operationalize policies, standards, and protocols, for example:
 - Implementation of mental health care routes with emphasis on suicide prevention for indigenous people in Colombia.
 - Guidelines for approaching the health of isolated indigenous peoples in Peru.
 - Community Code Red with an intercultural approach in Paraguay.

8. Financial implications of this Agenda item:

The total estimated cost of the plan of action for 2019-2025 is US\$ 4,375,000. This takes into account the total amount corresponding to the activities of the Pan American Sanitary Bureau, including capacity-building at the regional level and technical support to Member States. The estimated cost for the 2020-2021 biennium is US\$ 1,750,000.
