HEALTH OF AFRO-DESCENDANT PEOPLE IN LATIN AMERICA
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Summary

Problem addressed

An analysis of the health situation of the world’s population shows that significant progress has been made in terms of general trends. For example, in 2016 life expectancy at birth was 72 years (74.2 for women and 69.8 for men)—a 5.5 year increase over year 2000 and the most rapid increase in the last 60 years. The gap between women and men (4.3 years in 2000) remained nearly the same in 2016 (4.4 years). In addition, there was a 43.9% reduction in maternal deaths from 1990 to 2016, improvements in child health, and a considerable decrease in deaths from malaria, as well as positive indicators in the diagnosis and treatment of diseases such as malaria, tuberculosis, and measles. Significant progress was also made in the control of the human immunodeficiency virus (HIV)/AIDS epidemic.

However, these promising results are not homogeneous across populations and the uneven distribution of health progress between and within countries highlights the gap between the rich and the poor as well as significant lags in certain population groups. Afro-descendant people are greatly affected by much of this adverse situation, which is even worse in Latin America and the Caribbean, considered the most unequal region in the world. As a result, different factors related to discrimination and stigmatization, along with gender inequalities and social and economic disadvantages, account for the health outcomes of Afro-descendant people.

In certain places and circumstances, Afro-descendant people have limited access to quality comprehensive health services that include a gender and cultural acceptability approach. This translates into lower life expectancy, high maternal mortality rates, early pregnancy, and epidemiological profiles in which sickle cell diseases, chronic diseases such as diabetes and hypertension, and HIV prevail. It should be noted that epidemiological profiles are associated with demographic characteristics, since the incidence of communicable and noncommunicable diseases varies, depending on the age structure of the population, as do morbidity and mortality and the relationship between the two.

1 World Health Organization (WHO). The Global Health Observatory (GHO). Global Health Estimates: Life expectancy and leading causes of death and disability. [Internet]. [Available at: https://www.who.int/gho/mortality_burden_disease/life_tables/life_tables/en/]
**Study and Methodology**

This document is the outcome of an analysis of secondary information sources. Based on an analytical review of information on inequalities and the health and social protection conditions of Afro-descendant people in the Americas, we examined the indicators available for 18 countries with respect to the existence of inequalities between Afro-descendant people and non-Afro-descendants, and depending on the availability of data, between men and women.6

The most relevant information included the results of a review of the literature on the health and living conditions of Afro-descendant people from an ethnographic and gender perspective, with an emphasis on the culture and social and cultural traditions of this population.

**Findings**

As a result, inequalities affecting Afro-descendant people are reflected in the different health indicators related to factors such as discrimination due to ethnicity and geographical location, and socioeconomic factors such as income, occupation, and educational level.

More than 80% of the countries analyzed7 have inequalities that reflect disadvantages for Afro-descendant people in areas related to poverty levels, access to employment, and income, followed by indicators of maternal mortality, infant mortality, and access to complete vaccination programs. Other inequalities are found in access to adequate housing and basic sanitation.

The countries with the most available data disaggregated by ethnicity such as Brazil, Colombia, Ecuador, Peru, and Uruguay, have wide inequality gaps in most of the indicators analyzed. In these countries, the percentage of Afro-descendant people with unmet basic needs may be three times higher than the percentage of non-Afro-descendants.

Inequalities related to maternal and child health persist despite the different strategies that have been implemented at the global, regional, and national levels to reduce them. For example, the maternal mortality gap for Afro-descendant mothers is nearly triple the overall mortality rate in Ecuador and 1.3 times higher in Colombia, while in Brazil it is 36% higher.

Some factors that are advantageous to the health of Afro-descendant people are related to the prevalence of exclusive and prolonged breastfeeding, which is beneficial for infants. Women of African descent also have a lower rate of caesarean deliveries and the rate of institutional deliveries and deliveries attended by qualified personnel is nearly 90% (or even higher), similar to that of other population groups.

In countries such as Argentina, Belize, Guyana, Honduras, and Panama, there are no significant inequalities in the conditions of Afro-descendant people compared to those of non-African-descent. Likewise, there are no major differences in the infant mortality rate in Afro-descendant people compared to those of non-African descent in Argentina and Guyana, unlike in the other 12 countries analyzed.8

It is important to note that the quantity, quality, and time window of the available information analyzed varies widely between countries and that the data is quite limited in some of them, which makes it difficult to draw generalized or comparative conclusions that accurately reflect the true situation of Afro-descendant people. It is even possible that the best conditions of Afro-descendant people, as reflected by certain indicators, are due to biases stemming from the inability of information systems to adequately capture the true situation of that population.

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6 Information from the following countries was analyzed: Argentina, Belize, Bolivia (Plurinational State of), Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador. El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela (Bolivarian Republic of).

7 For these results, information from the following countries was consolidated: Argentina, Belize, Bolivia (Plurinational State of), Brazil, Colombia, Costa Rica, Cuba, Ecuador. El Salvador, Guatemala, Guyana, Honduras, Nicaragua, Panama, Peru, Suriname, Uruguay, and Venezuela (Bolivarian Republic of).

8 These countries are: Belize, Brazil, Colombia, Costa Rica, Ecuador, Honduras, Nicaragua, Panama, Peru, Suriname, Uruguay, and Venezuela (Bolivarian Republic of).
Conclusions

Based on the foregoing, it may be concluded that: 1) despite the limited availability of data, inequalities that are detrimental to Afro-descendant people are found in all of the indicators analyzed, regardless of the size of the gaps and whether they are recorded in some countries and not in others; and 2) data is not available in all countries and in those countries where it is, there is no national coverage. Furthermore, the lack of a standardized methodology to measure and capture variables makes it impossible to analyze trends and make forecasts.

There are gaps in terms of research studies that could shed light on the health and living conditions of women and men of African descent over the life course, given the different dimensions of a reality defined by gender roles and relations, history, culture, traditions, and the contexts of modern society and multiculturalism—in sharp contrast with the deeply ingrained processes of discrimination and inequality found throughout the Region of the Americas.

To improve public policies in the Region, there must be a deeper and better understanding of the dynamics and conditions that explain better performance in terms of guarantees that benefit Afro-descendant people in countries such as Honduras, Costa Rica, and Cuba, where progress has been made in the formulation and implementation of public health policies that incorporate the specific knowledge and ancestral practices of Afro-descendant people, a respect for their autonomy, culture, and customs, and the creation of participatory scenarios conducive to equal opportunities for all.9

Finally, it would be desirable to systematize processes to monitor and evaluate public policies with the participation of Afro-descendant organizations and build regional synergies to generate and share information and good practices.

These are urgent issues that cannot be put off if the aim is to ensure equitable and inclusive processes that guarantee the right to health for all Afro-descendant people.

Introduction

The presence of Afro-descendant people is a source of great multicultural richness in the Region of the Americas, a richness that is at odds with the current reality, marked by deep social and economic inequalities (especially in the area of health) that are based on historical processes of exclusion and discrimination. Despite significant global, regional, and national initiatives to reduce these inequalities and despite the progress made, a large number of Afro-descendant people remain in precarious living conditions (1).

Analyzing and generating evidence on the health of Afro-descendant people in the Region is an ethical, technical, and political imperative that is consistent with human rights and that supports initiatives seeking to transform the negative impacts on their health and living conditions. Based on this premise, the Pan American Health Organization (PAHO) focuses part of its work on producing knowledge on this subject, identifying key issues that should be addressed by regional, subregional, and national initiatives, and providing guidance on these issues as a contribution to public health policies with a gender, ethnicity, and equity approach within the framework of human rights.

This document is the outcome of a critical and synthetic analysis that integrates information on different areas of health and the social protection of Afro-descendant people. The results will facilitate the formulation of proposals to effectively address the health needs of women and men of African descent.

This is in line with a scenario that promotes the incorporation of intercultural approaches into health systems, in accordance with the intrinsic goal of "increasing the ability to respond to the population’s expectations" to improve health and ensure the fairness of the financial contribution. This would help optimize the ability of health care systems to equitably address the legitimate needs of citizens (2).

Indeed, the PAHO Strategy for Universal Access to Health and Universal Health Coverage (3) establishes the need to eliminate any type of discrimination that imposes barriers to receiving comprehensive, timely, and quality health services. In this regard, an equitable response is sought based on the needs of the different population groups, especially the most vulnerable, by formulating and implementing policies and actions with a multisectoral approach that addresses the social determinants of health and ensures the commitment of society as a whole to promote health and well-being (4).

Objective

To present a synthesis of the living and health conditions of Afro-descendant people in the Region of the Americas. This includes the social determinants of health—such as gender—as factors that explain the inequalities and inequities observed in the Region.

Methodology

Secondary sources of information were used for this analysis. We started by analytically reading information previously compiled by PAHO on inequalities, health conditions, and social protection of Afro-descendant people in the Americas.

This document is the result of consolidating that information, with priority given to the most recent references. The most relevant contributions were included to explain the health conditions of Afro-descendant people in view of the inequalities faced by this population compared to non-Afro-descendants.

Finally, the narrative was supplemented by updated information on the COVID-19 pandemic and other issues in order to facilitate a better understanding of health-disease processes related to interculturality. This last component was based on a review of the specialized literature on the health and living conditions of Afro-descendant people from an ethnographic and gender perspective, with an emphasis on culture and social and cultural traditions.
CHAPTER 1

AFRO-DESCENDANT PEOPLE IN THE REGION OF THE AMERICAS

The origin of Afro-descendant people in the Americas is related to the "millions of Africans who were forcibly enslaved and transported in the framework of the inhumane practice of the transatlantic slave trade, between the fifteenth and nineteenth centuries, which caused indescribable hardship to this population who continue to suffer the effects of slavery" (5).

The term "Afro-descendants" was recognized by Member States and the United Nations as a legal and political concept adopted during the Regional Conference of the Americas held in Chile in 2000, in preparation for the Third World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance that was held in Durban, South Africa in 2001 (6).

Afro-descendant people are united by a common ancestry with different expressions in the Region, ranging from Afro-indigenous communities such as the Garifuna of Central America, to huge segments of society such as the Pardos of Brazil. In most countries, the adoption of the term "Afro-descendant" is still partial, and the different name variations (negro, moreno, pardo, preto, zambo, creole, saramaka, yudka, boni, palenqueras, raizales) are linked to the concepts of race and race relations in Latin Americans, and are associated with stigmas and biases derived from a long history of discrimination and racism. So, in Venezuela most moreno people (mixed descent) reject the term and its implications, while in the Dominican Republic the majority of mixed race Afro-descendant people prefer to identify as indios (4, 7). However, the category "Afro-descendant" is conceptualized in the framework of the Regional Conference of the Americas held in Santiago, Chile in 2000, in preparation for the Third World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance held in Durban in 2001 (8).

According to certain estimates of the time period and number of Africans forcibly transported to the Americas, the first arrivals were in the year 1518 and the last in 1873, although it appears that some additional slave ships arrived in the Region after that date. This means that for at least 355 years, American history recorded the greatest coercive relocation of human beings known to history. It is estimated that at least 9.5 million African people arrived in the Region and were forced to work primarily in the production of sugar, coffee, tobacco, cotton, and rice, as well as in mining (9).

In this context, Afro-descendant people are recognized as victims of the adversities of racial discrimination and slavery, with the consequent denial of rights. This has created marginalization, poverty, and exclusion expressed in varying degrees, depending on the country in the Region, as profound social and economic inequalities that persist to this day, despite efforts to reverse the situation (10).
1.1 Geographic and Population Distribution

The invisibility of Afro-descendant people is rooted in eugenic concepts and ideas of Latin American societies, where ethno-racial make-up was considered an impediment to development. During the 20th century, ideas about miscegenation and racial democracy affirmed that "owing to the predominantly mixed-race composition of the population and the anecdotic presence of non-Whites in positions of power, Latin American societies had achieved racial equality" (7).

As a result, in many countries, indicating a person’s Afro-descendant status in statistical tools was considered to contribute to racism. This led to information gaps on the demographic and socioeconomic status of Afro-descendant people in the Region. In the 1960s, only Brazil and Cuba included racial variables in their censuses (7).

The concept of Afro-descendant people has become broader as a result of the frequent and large-scale migrations taking place around the world, and now includes new descendant populations that have not necessarily experienced slavery. Thousands of Africans scattered around the world come to the Americas from Europe, Russia, Australia and other countries, bringing with them with new cultural and social expressions (14).

Since the 1990s and the beginning of the 21st century, the initiatives of various representatives of culture, academia, and different religions led to the formation of different regional networks of Afro-descendant organizations. As a result, a political agenda has gradually been created for the Afro-descendant movement in the Americas, with priorities such as promoting the visibility of Afro-descendant people, recognizing their contributions to the development of countries and cultural diversity, putting an end to the injustice represented by all forms of racism and racial discrimination, and guaranteeing the full inclusion of Afro-descendant people and their communities in development processes, as well as the enjoyment of human rights (15).
It is currently estimated that there are around 175 million Afro-descendant people in the Americas (16). When expressed as a percentage of the Region’s total population, these figures can vary from 20% to 30%. The identification of Afro-descendant people is still a complex issue, starting with a lack of agreement on who Afro-descendant people are, even within a given country. There are significant semantic differences related to different levels of subjectivity in the definition of ethnicity, which makes it difficult to come up with estimates in this regard (17).

In Caribbean countries such as Haiti and the Dominican Republic, Afro-descendant people are the majority, comprising more than 80% of the total population. In Cuba, they account for 35.9% of the total population. In Central and South America, the largest number of Afro-descendant people is in Brazil (50.9% of the population). After those countries, the nations with the most Afro-descendant people are Colombia (10.5%), Panama (8.8%), Costa Rica (7.8%), and Ecuador (7.2%). In other countries, the figures are below 5%.

With respect to areas of residence, the Afro-descendant population is highly concentrated in urban areas (82%), similar to the population that does not belong to any ethnic group (80%). They may live in groups or be more widely scattered, with socio-cultural practices that are a cross between different traditions of African origin and the traditions present in other groups they have coexisted with (18).

At the national level, the areas inhabited by Afro-descendant people include areas where activities typical of the colonial period of enslavement were carried out (plantation agriculture, mining, etc.), where safe havens and areas that resisted slavery were established (free societies called cimarronas), and other areas that were the result of mobility and urban development within the countries. It should be noted that a significant number of Afro-descendant people live along the Atlantic and Pacific coasts (4).

1.2 INFORMATION AND KNOWLEDGE MANAGEMENT FOR THE HEALTH OF AFRO-DESCENDANT PEOPLE

It is indisputable that having information and knowledge about the living and health conditions of ethnic populations is essential for implementing specific and effective measures aimed at guaranteeing full exercise of the rights of all indigenous and Afro-descendant people (13, 18).

Although there are still problems in the systematic collection of ethnically disaggregated data for Afro-descendant people, censuses since 2000 have included questions to identify this population in several Latin American countries. At the same time, representative samples and ethnicity-specific questions have been included in other tools such as demographic, health, household, and quality of life surveys. This has made it possible to perform analyses that provide valid knowledge contributing to a better understanding of the health situation and social and economic inequalities and inequities faced by many Afro-descendant people throughout the Region of the Americas. Efforts continue to be made to include the ethnic variable in other sources of information, such as vital statistics and health records (19).

At present, all policies in the global and regional population and development agendas recognize the need to increase the availability of disaggregated data and information. This can be seen in the 2030 Agenda for Sustainable Development, the Montevideo Consensus on Population and Development, and the International Decade for People of African Descent 2015–2024 (1). General Assembly Resolution 69/16 of 18 November 2014, Programme of Activities for the Implementation of the International Decade for People of African Descent calls for assigning particular priority to projects devoted to the collection of statistical data (20).

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10 This refers to non-indigenous people and people of non-African descent.
The inability to measure ethnicity as a dimension of inequality and conduct comparative analyses is due to the great difficulty and complexity in categorizing a social construct based on variables related to descent, cultural customs and traditions, phenotype, place of birth, and shared histories that bring a sense of ethnic belonging (21).

Population and housing censuses are the sources of information on which most available reports and studies are based. In the 2000 round of censuses, only nine Latin American countries included ethnic or racial self-identification in data collection tools and several analysts say the quality of the information obtained was insufficient in some cases. In the 2010–2020 round of censuses, the 16 Latin American countries that included variables to collect information on Afro-descendant people in their censuses (7) adopted a framework that addresses four basic dimensions: a) recognition of identity or self-recognition; (b) "common origin," which refers to having descended from common ancestors; (c) "culture," which refers to attachment to the culture of origin, social and political organization, language, worldview, knowledge, and ways of life; and (d) "territoriality," which relates to a people's heritage and collective memory (22).

Although progress has been made in the countries in terms of including the ethnic variable in information systems, there are still challenges that need to be addressed. For example, there have been significant improvements in Brazil, but underreporting in some subsystems continues to limit the monitoring of ethnic inequalities. Information on notifiable diseases such as malaria, leprosy, and syphilis in pregnant women is recorded in more than 90% of cases, unlike HIV, dengue, viral hepatitis, congenital syphilis, and tuberculosis, where more than 10% and up to 35% of cases are omitted in the hospital information system (2009) (20, 21). In the maternal and child information system, there are still problems related to the quality of the data captured and the completeness of the race variable. The problems relate to a lack of clarity in the conceptualization of the variable or its inclusion as a sociodemographic variable. In addition, the informant is not specified, and there can be discrepancies depending on whether the respondent is a family member or if someone responsible for taking information in a care center (medical, nursing, or administrative staff) records it without asking (23).

In Peru, ethnicity is addressed and measured in different ways depending on the objective: a) determine the poverty status and social exclusion of ethnic groups; (b) characterize and describe the values and culture of ethnic groups; c) identify ethnic groups as subjects of individual and collective rights; and d) analyze the discrimination processes that victimize them (22).

One of the biggest challenges is for current statistical systems to include the different approaches and information needs within a framework that guarantees rights. Adjustments or innovations in information systems range from the inclusion of questions about ethnic identity in all data sources and administrative records, to the adoption of mechanisms allowing Afro-descendant people to effectively participate in the design, implementation, and evaluation of information and knowledge management strategies.

For this reason, we must go beyond the objective of having only statistical metrics. Although we are looking for evidence on the situation experienced by Afro-descendant people, we also need information on other issues, such as living circumstances and different aspects of health and its determinants, from an ethnic, gender, and generational perspective (24). It is necessary to establish and analyze the causes of the health outcomes of Afro-descendant people, the interaction between the numerous factors that lead to inequalities, the contexts in which these people live their lives, and the factors that explain the precarious conditions described in this document (24).

Based on the perspectives and the expected progress on this issue, proposals have been made by Afro-descendant organizations themselves as part of the actions defined for the International Decade for People of African Descent 2015–2024, in order to ensure that the 2020 round of censuses obtain the data and information needed to characterize the situation of Afro-descendant people in the Region; to implement more robust methods of analysis to ensure a more in-depth analysis of inequalities; and to develop effective tools to invest and optimize the resources allocated to public policies in order to move toward fulfillment of all rights of this population (25).
According to the social inequality matrix approach, belonging to an ethnic group is a core factor that, when combined with other factors such as gender, socioeconomic level, stage in the life course, and territorial variables, configures a web of conditions that accumulate over time and can define the vulnerabilities that limit access to social progress and the effective enjoyment of rights such as education, health, decent work, social protection and participation, among others (26).

The situation of Afro-descendant people is one expression of the inequality matrix. The historical processes of marginalization that they have suffered have widened inequalities and limited the possibilities of Afro-descendant people to enjoy the fundamental right to health (1). Some historical longitudinal analyses have shown that the relationship between ethnicity and exclusion has produced worse living conditions for population groups who declare they belong to an ethnic group different than others (27–29).

In this scenario, the situation of the Afro-descendant people in the Region is described below, based on the dimensions proposed in the inequality matrix.

2.1 ETHNICITY, RACISM AND DISCRIMINATION

The complexity of the concepts of race, ethnic identity, and ethnicity are the subject of extensive debate about the meanings and scientific, political, and ethical implications of their use in different contexts. However, all of them have been historically related to situations of inequality, discrimination, and oppression by majority groups that are supposedly superior and thus have better and legitimate rights with respect to "others" that they then exclude and devalue.

Generally speaking, the words race and ethnic identity are not synonymous and correspond to social constructs. Historically, race has been linked to the natural sciences and the classification of species based on phenotype, physical traits, and biological differences such as anatomical measurements, head size, and skin color. The use of the word ethnicity is more recent and its etymological origin, ethnos, means people or nation (30).

Ethnic identity has been introduced as a deeper and more stable concept, which is related to a set of attributes that an ethnic community collectively shares from one generation to the next, and that has the value of reflecting cultural changes and the geographic mobility of people in the modern world (31).
At present, there is a scientific and anthropological consensus on the lack of justification for dividing and classifying human beings into different races. In this sense, there is only “the human race.” Therefore, the concept of race is not applicable to a biological entity and must be understood against the backdrop of history and social relations. Racism is understood as a system of domination and social inequality that stems from the abuse of power of one group over another through different forms of discrimination, marginalization, and exclusion on the part of individuals and social institutions.

Discrimination and racism have been reproduced for centuries in almost every society, as a result of policies and institutions that favor White people and exclude the descendants of indigenous and African peoples. Consequently, these peoples have the worst socioeconomic indicators and little cultural recognition, and face barriers to equitable access to goods and services that facilitate individual and collective progress within society.

From a social perspective, racism correlates with disadvantages in employment, housing, education, income, and access to health services. This entails increased occupational risks, exposure to toxic substances and allergens in the home, limited access to healthy food, increased likelihood of using illegal drugs and alcohol, and living in unsafe environments.

From an individual perspective, being discriminated against for belonging to a certain ethnic group has been linked to stressful everyday events that increase one’s vulnerability and propensity to negative emotional states; behavioral responses that result in unhealthy practices (tobacco use and alcohol abuse, lack of sleep and exercise, failure to comply with medical regimens); and psychological and behavioral responses that lead to structural and functional changes in the neuroendocrine, autonomic, and immune systems.

An analysis from a social perspective that helps discover the relationships between biological mechanisms and the institutional and political context will facilitate the formulation of rigorous explanations of the population’s patterns of health, disease, and well-being.

In this regard, the International Decade for People of African Descent 2015–2024 emphasizes that discrimination and racism perpetuate the poverty conditions of Afro-descendant people, reduce their access to quality health services, education, and housing, social security and the administration of justice, reduce their participation and political representation, and are reflected in the alarming rates of police violence that these people face. The proposals emphasize health, work, sexual and reproductive health, and decisive action to prioritize policies that fight racism and racial discrimination.

In addition, the document Just Societies: Health Equity and Dignified Lives -- Executive summary of the report of the Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas, Revised edition recognizes that colonialism, slavery, and consequent racism are detrimental to the opportunities and health of the ethnic population. As a result, in 2018 PAHO adopted the Policy on Ethnicity and Health with the aim of promoting an intercultural approach that contributes to the elimination of inequities in the health of indigenous peoples, Afro-descendant people, and other ethnic groups, and emphasizes respect for their cultural practices (ways of life, value systems, traditions, and world views).

2.2 SOCIOECONOMIC INEQUALITIES

2.2.1 Poverty and income

Figures on poverty in Latin America show that the situation of Afro-descendant people is worse than that of the rest of the population. While they represent no more than 30% of the Region’s inhabitants as a whole, they account for 40% of people in poverty. Despite declining poverty levels, the percentage of poor people who belong to ethnic groups continues to be higher than that of the rest of the population. This can be attributed to the exclusion of Afro-descendant people from access to physical and symbolic goods available to society as a whole, which should be equally offered to people in different population groups.

Figure 1 shows inequalities by wealth and geographic area of residence (rural or urban). The ethnic gradient shows that in urban areas of countries such as Brazil, Peru, and Uruguay, the percentage of Afro-descendant people below the poverty line may be as much as double the percentage of non-Afro-descendants.

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11 “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.” See Pino-S del, Coates AR, Guzmán JM, Gómez-Salgado J, Ruiz-Frutos C, Política sobre etnicidad y salud: Construyendo soluciones equitativas frente a las desigualdades étnicas [Ethnicity and health policy: Building equitable solutions in the face of ethnic inequalities]; Revista Española de Salud Pública. 2018;92. Available at: https://dialnet.unirioja.es/servlet/articulo?codigo=7020720. Sources of information using the terms “race” and “racial” have been used in the preparation of this report; when they appear in this text they should be understood only in a referential context. To the extent possible and so long as the message of the source text is not changed, the term “ethnicity” will be used.
Notes: Selected countries of Latin America. Non-Afro-descendants do not include those who identify as indigenous or cases where the ethnic dimension is not known. Data for Brazil, Colombia, Panama, Peru, and Uruguay is from 2018, and data from Ecuador is from 2017. In Ecuador, the question on ethnic identification only applies to those over the age of 5, and in Peru, over the age of 14.

To supplement this information, Figure 2 shows the results of a study on 10 countries in the Region in which the likelihood of Afro-descendant people belonging to three different groups according to level of wealth was measured, i.e.: a) poorest, b) middle income, and c) richest.

**Figure 2.** Distribution of Afro-descendant people, by wealth tertile

<table>
<thead>
<tr>
<th>Wealth terciles</th>
<th>Poorest</th>
<th>Middle income</th>
<th>Richest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Afro-descendants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reference</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Notes: Selected countries of Latin America. The reference group includes people of European descent and people of mixed descent in the countries analyzed. The indigenous population was excluded from the analyses. The color red indicates the presence of inequality that is detrimental to Afro-descendant people, yellow indicates that there are no significant differences with respect to the reference group, and green indicates inequality in favor of Afro-descendant people.*


The worst situation in this regard is seen in Brazil, Colombia, Suriname, and Uruguay. In Uruguay, 67% of Afro-descendant people are in the poorest tertile, compared to only 26% of the reference group (people of European descent and people of mixed descent). The most encouraging scenario is in Belize and Panama, where Afro-descendants are about 15 and 7 percentage points, respectively, below the estimated percentage of non-Afro-descendants in the poorest tertile. Similar conditions are reported in countries such as Guyana, Costa Rica, and Ecuador, where there are no differences in the distribution of both population groups in the three wealth tertiles.
It can therefore be concluded that Afro-descendant people are overrepresented in the poorest segments of the population and thus have fewer possibilities of meeting their basic and health needs. Furthermore, the overrepresentation of Afro-descendant children aged 0 to 14 years in the first income quintile illustrates their disadvantages compared to children not of African descent. The worst conditions are observed in Uruguay, where 71% of Afro-descendant children and adolescents were in the first income quintile, compared to 48% of children and adolescents not of African descent, followed by Brazil, where the figures are 54% and 32%, respectively (41) (see Figure 3).

Furthermore, the overrepresentation of Afro-descendant children aged 0 to 14 years in the first income quintile illustrates their disadvantages compared to children not of African descent. The worst conditions are observed in Uruguay, where 71% of Afro-descendant children and adolescents were in the first income quintile, compared to 48% of children and adolescents not of African descent, followed by Brazil, where the figures are 54% and 32%, respectively (41) (see Figure 3).

**Figure 3. Distribution of the population aged 0 to 14 years, by ethnicity and household income per capita quintile**

<table>
<thead>
<tr>
<th>Quintile I</th>
<th>Quintiles II, III, IV</th>
<th>Quintile V</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>55</td>
<td>43</td>
<td>52</td>
</tr>
<tr>
<td>30</td>
<td>45</td>
<td>27</td>
</tr>
<tr>
<td>24</td>
<td>36</td>
<td>5</td>
</tr>
<tr>
<td>46</td>
<td>71</td>
<td>2</td>
</tr>
</tbody>
</table>

Brazil | Ecuador | Panama | Peru | Uruguay |

Notes: Selected countries of Latin America. Non-Afro-descendants do not include those who identify as indigenous or cases where the ethnic dimension is not known.

### 2.2.2 Education

Barriers to education have been described as one of the main causes of exclusion that impedes the development of Afro-descendant people. Added to this are worse educational outcomes, which translate into unequal achievement in educational level and unequal access to the labor market, with significant effects on remuneration and decent work, health, housing, infant mortality, and life expectancy (7, 36).

In Bolivia, Brazil, Colombia, Costa Rica, Ecuador, Uruguay, and Venezuela, attendance at an educational facility is lower for young Afro-descendant people aged 18 and 24 compared to their non-Afro-descendant peers. In contrast, Argentina, Honduras, Nicaragua, and Panama have a more favorable situation in terms of the percentage of young non-Afro-descendants who attend school. The same is true for children and adolescents aged 12 to 17. The largest gap is seen in Uruguay, where the percentage of young Afro-descendant people is only half that of young non-Afro-descendants. In all of the countries analyzed, the attendance rate is higher among females (15). This is encouraging, as the higher educational achievement of women unquestionably acts as a multiplier of the development and well-being of families, communities, and society at large (see Figure 4).
A study on educational achievement using census ethno-racial identity and skin color as stratifying variables of inequality in eight Latin American countries (Bolivia, Brazil, Colombia, Dominican Republic, Ecuador, Guatemala, Mexico, and Peru) reached two key conclusions (42):

1) Race and ethnicity are important predictors of education, even when controlling for social class and other variables thought to affect socioeconomic status. Light-skinned people systematically had 1 to 1.5 more years of schooling than dark-skinned people. Dark-skinned people also had a lower rate of completion of primary and secondary education in all countries except Mexico, where the results were not statistically significant.

2) Skin color turned out to be a more consistent and robust stratifier of inequality measures than the stratifier based on ethno-racial identity, especially for Afro-descendant people in Colombia, Ecuador, and the Dominican Republic. Greater differences can be seen in Brazil, Ecuador, and Uruguay. In Uruguay, only 8 out of 100 young Afro-descendant people have higher or post-secondary education, compared to 28 out of 100 young non-Afro-descendants (see Figure 5).
Figure 5. Percentage of youth aged 20 to 29 years who attain higher education, by ethnicity

<table>
<thead>
<tr>
<th>Country</th>
<th>Afro-descendants</th>
<th>Non-Afro-descendants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>35.2</td>
<td>30.9</td>
</tr>
<tr>
<td>Bolivia</td>
<td>37.3</td>
<td>21.1</td>
</tr>
<tr>
<td>Brazil</td>
<td>31.0</td>
<td>12.5</td>
</tr>
<tr>
<td>Colombia</td>
<td>25.8</td>
<td>16.3</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>29.9</td>
<td>17.7</td>
</tr>
<tr>
<td>Cuba</td>
<td>38.9</td>
<td>40.6</td>
</tr>
<tr>
<td>Ecuador</td>
<td></td>
<td>40.6</td>
</tr>
<tr>
<td>Honduras</td>
<td></td>
<td>14.68</td>
</tr>
<tr>
<td>Nicaragua</td>
<td></td>
<td>12.1</td>
</tr>
<tr>
<td>Panama</td>
<td></td>
<td>10.1</td>
</tr>
<tr>
<td>Uruguay</td>
<td></td>
<td>17.2</td>
</tr>
<tr>
<td>Venezuela</td>
<td></td>
<td>30.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27.3</td>
</tr>
</tbody>
</table>

Note: Selected countries of Latin America. 

2.2.3 Occupation

Being at a given socioeconomic level depends on the productive organization of the environment surrounding a person and the positions held by the person and their family in that environment over time. This, in turn, is commensurate with the distribution of production and financial resources within society. The labor market plays a key role, since work income accounts for an average of about 72% of total household income in Latin American households (34, 20).

Access to the labor market is highly unequal, not only as a result of the quality of one’s education, but also due to discrimination associated with ethnicity, sex, disability status, immigration status, sexual orientation, and gender identity. However, working in dignified conditions is one of the main components of a person’s physical and mental health and determines the possibility of obtaining sufficient economic income to finance basic subsistence needs, generate recognition and social inclusion, and access health insurance and social protection systems (43).

Unemployment

It has been documented that unemployment rates among Afro-descendant people are higher than those of their non-Afro-descendant peers in most Latin American countries. When the gaps are favorable to Afro-descendant people, the differences are much smaller (44). Overall, the evidence shows that being of African descent, a woman, or a young person entails greater disadvantages, not only because of the likelihood of unemployment, but also because of the risk of remaining in that situation for a longer period of time (24, 45–48).

In Ecuador, the unemployment rate of Afro-descendant people aged 15 to 29 is approximately twice that of non-Afro-descendants in the same age group. In Panama that figure is roughly 50% higher, and 30% higher in Uruguay. In terms of gender, unemployment affects Afro-descendant women to a greater extent, with the exception of Panama where the rates are similar (see Figure 6).
Poor quality jobs and low pay

Some studies have found that being of African descent reduces the likelihood of accessing better jobs and pay. In Cali (Colombia), the second largest Latin American city with the highest percentage of Afro-descendant people after Salvador de Bahia in Brazil, being of African descent reduces the likelihood of having a medium or high quality job by about 1.5% and increases the likelihood of having a poor quality job by 2.8% \( (49) \). There is a 42% wage gap: 9% of that percentage reflects characteristics explained by differences in human capital and 33% is associated with employment discrimination \( (50) \).

Figure 7 shows the average hourly income (in dollars) in five Latin American countries (Brazil, Ecuador, Panama, Peru, and Uruguay) by race, sex, and educational level. The results show a more unfavorable situation for Afro-descendant people and income inequality between women and men, which is worse for women. This situation is repeated at all levels of education and the gap is wider in people with post-secondary education, as non-Afro-descendant men earn 65% more than Afro-descendant women.

Racial/ethnic discrimination in the workplace

When entering the labor market, Afro-descendant professionals have lower hiring rates than the non-Afro-descendant population, despite having a similar level of education. In the case of Peru, for every 10 curriculum vitae sent by a White professional, an Afro-Peruvian has to send 16 to have a similar chance of being hired for a skilled position \( (51) \).
Moreover, episodes of workplace discrimination result in stressful situations and unhealthy practices, such as alcohol and tobacco use. According to the results of a U.S. study on different work environments, discrimination was more prevalent among non-Hispanic Blacks (21%), Hispanics (12%), and other ethnic minorities (11%) than among non-Hispanic Whites (4%). In the total sample, discrimination was associated with current smoking (risk ratio \( RR = 1.32; 95\% \) confidence interval \( CI = 1.19-1.47 \)), daily smoking (\( RR = 1.41; 95\% \) CI = 1.24-1.61), and excessive alcohol consumption (\( RR = 1.11; 95\% \) CI = 1.01-1.22) (52).

Inclusion in the labor market can be summarized in the following statement: At least two factors are at play in the inclusion of indigenous and Afro-descendant young people in the labor market: first, less formal education, which is associated with lower-quality jobs; and second, the racial/ethnic discrimination that persists when being hired for a job, despite the good educational levels achieved (53).

Despite this recognition, an enormous number of people lack adequate living spaces and environments, and live in overcrowded conditions, makeshift settlements, or dangerous and unhealthy conditions. For a dwelling to be considered adequate, it must have access to safe drinking water, health facilities, and facilities for washing, as well as means to store food and eliminate waste, and energy for cooking, etc. (55).

In terms of the situation of Afro-descendants, it has been noted that the majority live in urban dwellings with precarious infrastructure, and are more exposed to crime and violence (56). In light of this, the International Decade for People of African Descent calls on States to ensure decent living spaces.

The right to adequate housing is linked to the social inequality matrix and the social determinants of health. The adequacy of a dwelling is determined based on family income (a structuring axis of socioeconomic level), which in turn places people of African descent (with ethnicity as a structuring axis) in the lower-income social strata. Women are the most affected by the lack of water and sanitation, since, due to traditional gender roles, they are responsible for managing the household. Children are also over-represented among people living in poverty and are more likely to live in inadequate housing.

2.2.4 Access to basic infrastructure services

Various international, regional, and national legal frameworks recognize people’s right to adequate housing as part of an acceptable standard of living and as a basis for the enjoyment of all economic, social, and cultural rights (54).
papeles tradicionales de género son las responsables de la gestión del hogar. Asimismo, los niños y las niñas están sobrerepresentados en las personas en situación de pobreza y tienen mayores probabilidades de vivir en viviendas inadecuadas.

A study conducted in Brazil shows the intersection of gender, race, life course, and socioeconomic status. It noted that girls and adolescents (from 0 to 14 years old), and brown and indigenous females with lower educational levels in the lower income strata have less access to treated water. The highest percentages of women who lacked access to water on a regular basis were those in the 20- to 59-year-old age group, along with Afro-descendant women with lower levels of education and income. Lack of sewerage was higher among indigenous and Afro-descendant women (57).

Below are results from the censuses of 13 countries in the Region (Argentina, the Plurinational State of Bolivia, Brazil, Colombia, Costa Rica, Cuba, Ecuador, Honduras, Nicaragua, Panama, Peru, Uruguay, and the Bolivarian Republic of Venezuela regarding levels of deprivation among the Afro-descendant population with regard to overcrowding, access to drinking water, and access to health services. These issues take on even greater importance in the context of the COVID-19 pandemic.

**Overcrowding**

According to information from 13 countries, the highest percentages of overcrowded populations are in the Plurinational State of Bolivia, Colombia, Ecuador, Honduras, and Nicaragua. Overcrowding is less acute in urban areas (see Figure 8). In the case of the Afro-descendant population, levels vary between 23% in Nicaragua and 37% in Ecuador, where overcrowding among Afro-descendants is 14 percentage points higher than for non-Afro-descendants. Although Argentina, Brazil, Costa Rica, Cuba, and Uruguay have lower levels of overcrowding, Afro-descendants in those countries experience greater inequalities than the general population. For example, in the case of Brazil, Cuba, and Uruguay, while overcrowding among non-Afro-descendants tops out at 7%, the rate for Afro-descendants is nearly double that figure.

**Figure 8.** Urban population with severe or moderate deprivation due to overcrowded households, by ethnicity

<table>
<thead>
<tr>
<th>Afro-descendant population</th>
<th>Non-Afro-descendant population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe overcrowding</td>
<td>Severe overcrowding</td>
</tr>
<tr>
<td>Moderate crowding</td>
<td>Moderate crowding</td>
</tr>
<tr>
<td>Total overcrowded</td>
<td>Total overcrowded</td>
</tr>
</tbody>
</table>

Notes: Selected Latin American countries. The non-Afro-descendant population does not include people who self-identify as indigenous, or cases in which ethnicity is unknown. The indicator for severe deprivation due to overcrowding is defined as an average of more than five people per bedroom in the dwelling. The indicator for moderate deprivation due to overcrowding is defined as an average of more than three people per bedroom in the dwelling. Included are data from Peru, based on the 2017 census, which considers only people 12 years of age and older.

In rural areas (see Figure 9), the Afro-descendant population living in overcrowded conditions ranges from 32% (Honduras) to 46% (Nicaragua). The largest differences are in Brazil and Cuba, where the proportion of Afro-descendants living in overcrowded conditions is nearly double that of the non-Afro-descendant population, in and Uruguay, where there is a threefold difference.

**Figure 9. Rural population with severe or moderate deprivation due to overcrowded households, by ethnicity**

<table>
<thead>
<tr>
<th>Afro-descendant population</th>
<th>Non-Afro-descendant population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe overcrowding</td>
<td>Severe overcrowding</td>
</tr>
<tr>
<td>Moderate crowding</td>
<td>Moderate crowding</td>
</tr>
<tr>
<td>Total overcrowded</td>
<td>Total overcrowded</td>
</tr>
</tbody>
</table>

Notes: Selected Latin American countries. The non-Afro-descendant population does not include people who self-identify as indigenous, or cases in which ethnicity is unknown. The indicator for severe deprivation due to overcrowding is defined as an average of more than five people per bedroom in the dwelling. The indicator for moderate deprivation due to overcrowding is defined as an average of more than three people per bedroom in the dwelling. Included are data from Peru, based on the 2017 census, which considers only people 12 years of age and older.


People of African descent in the Plurinational State of Bolivia, Ecuador, and Nicaragua live in more crowded conditions than the general population, both in rural and urban areas. Nicaragua has the highest levels of overcrowding by area of residence and ethnicity, reaching up to 55% in rural areas.

**Access to safe drinking water**

The overall population suffers some degree of deprivation in terms of this right, in both urban and rural areas. In 12 countries, this situation is exacerbated for those living in rural and Afro-descendant areas. The worst situation is in Uruguay, where the proportion of Afro-descendants with limited access to drinking water (42%) is almost double that of non-Afro-descendants (24%). In contrast, this segment of the population in Honduras fares better (23%) than the non-Afro-descendant population (28%) (see Figure 10).
Notes: Selected Latin American countries. The non-Afro-descendant population does not include people who self-identify as indigenous, or cases in which ethnicity is unknown. The criteria for determining whether deprivation is severe or moderate are based on the origin of the water and, in some countries, on the distribution of water within households. Included are data from Peru, based on the 2017 census, which considers only people 12 years of age and older.


In urban areas, Afro-descendants in Nicaragua fare worst (81%), with a figure more than doubles that of the non-Afro-descendant population (35%). Following, in descending order, are the Plurinational State of Bolivia (48%), Ecuador (39%), Colombia (35%), and Cuba (34%) (see Figure 11).
Figure 11. Rural population with severe or moderate deprivation due to lack of access to water, by ethnicity

Notes: Selected Latin American countries. The non-Afro-descendant population does not include people who self-identify as indigenous, or cases in which ethnicity is unknown. The criteria for determining whether deprivation is severe or moderate are based on the origin of the water and, in some countries, on the distribution of water within households. Included are data from Peru, based on the 2017 census, which considers only people 12 years of age and older.


Sanitation

In all of the countries analyzed, people of African descent were more affected than the general population by precarious sanitation conditions, with the exception of urban areas of Costa Rica, where Afro-descendants do not suffer severe deprivation with regard to sanitation services (see Figure 12).
In rural areas (see Figure 13), the populations of many countries lack adequate waste disposal systems. For example, in Brazil, Cuba, and Peru, more than 70% of the population suffers severe or moderate deprivation in terms of access to sanitation services, and in most countries, the situation of the Afro-descendant population is worse than that of the general population.
Notes: Selected Latin American countries. The non-Afro-descendant population does not include people who self-identify as indigenous, or cases in which ethnicity is unknown. The criteria for determining whether deprivation is severe or moderate are based on the existence of sewer connections and the availability of sanitation services. Included are data from Peru, based on the 2017 census, which considers only people 12 years of age and older.


Use of clean fuels for cooking

Globally, the use of clean environmentally friendly and healthy technologies has increased steadily since 2000. Except in the Plurinational State of Bolivia (64%), Paraguay (66.2%), and Peru (75.6%), the majority of Latin American households (more than 90%) use clean energy.

Data on the Afro-descendant population, available for 10 countries (see Figure 14), show that figures for Colombia, Costa Rica, Suriname, and Uruguay are representative of overall coverage in Latin American households. This situation contrasts with the reality in Honduras, where only 44.1% of the population has health-protecting technologies of this type. In the case of the Afro-descendant population, this percentage is as high as 69.7%, while the figure for the reference group (people of European descent and people of mixed ancestry) is 45%.
Figure 14. Coverage of access to clean fuels for cooking

Notes: Selected Latin American countries. The reference group includes people of European descent and people of mixed descent in the countries analyzed. The indigenous population was excluded from the analyses.

Source: Analysis of survey data conducted in Latin American countries between 2004 and 2018 with information on reproductive, maternal, neonatal, child and adolescent health carried out by the International Center for Equity in Health. The sources for each country were: Belize: Multiple Indicator Cluster Survey, 2015; Colombia: Demographic and Health Survey, 2015; Costa Rica: Multiple Indicator Cluster Survey, 2011; Guyana: Multiple Indicator Cluster Survey, 2014; Honduras: Demographic and Health Survey, 2011; Suriname: Multiple Indicator Cluster Survey, 2018; and Uruguay: Multiple Indicator Cluster Survey, 2012.

Health and social protection

The labor market in Latin America has been showing positive trends. This, added to strategies to strengthen contributory and subsidized social security systems, has increased the general population’s opportunities to join health care systems and have a pension that covers their risk of illness and old age. While membership may provide a gross estimate of coverage, it does not automatically translate into effective access to the quality services and benefits demanded by the population (58, 59).

Data from household surveys on membership among wage earners show that women have higher rates of participation than men, due to their greater participation in the formal labor market. Consideration of income quintiles and educational levels shows significant gaps in access (especially with respect to the pension system); these gaps tend to be lower in terms of membership in health systems. With regard to age group, while membership rates have increased, both in the pension system and the health system, the highest level of membership occurs in the middle stages of working life (58, 59).

Membership in and access to health systems

Since the early 2000s, Latin America and the Caribbean have made significant progress toward universal health coverage, with the addition of 46 million people in nine countries, and with at least nominal guarantees of affordable health services (60). In many cases, this right is not fully exercised and a distinction must be made between legal and effective coverage. The former reflects legal provisions and describes citizens’ right to health care, while the latter refers to the extent to which quality services are available and accessible.

Although membership mechanisms have been created, with insurance increasing the likelihood that the services will be used, ethnicity has been linked to inequalities in affiliation and use of health services, a situation that affects Afro-descendants to a greater extent than non-Afro-descendants (61).

Among the countries for which up-to-date information is available (see Figure 15), Uruguay has the highest level of membership in health systems.
Figure 15. Employed persons 15 years of age and older who belong to a health system, by ethnicity and sex

<table>
<thead>
<tr>
<th></th>
<th>Both sexes</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ecuador</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Afro-descendants</td>
<td>45</td>
<td>41</td>
<td>63</td>
</tr>
<tr>
<td>Afro-descendants</td>
<td>67</td>
<td>73</td>
<td>75</td>
</tr>
<tr>
<td>Panama</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Afro-descendants</td>
<td>40</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Afro-descendants</td>
<td>60</td>
<td>70</td>
<td>80</td>
</tr>
<tr>
<td>Peru</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Afro-descendants</td>
<td>70</td>
<td>75</td>
<td>90</td>
</tr>
<tr>
<td>Afro-descendants</td>
<td>90</td>
<td>95</td>
<td>98</td>
</tr>
<tr>
<td>Uruguay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Afro-descendants</td>
<td>90</td>
<td>95</td>
<td>98</td>
</tr>
</tbody>
</table>

Note: The non-Afro-descendant population does not include people who self-identify as indigenous, or cases in which ethnicity is unknown.

Source: The data are calculated based on special tabulations of household surveys from four countries, conducted by the Economic Commission for Latin America and the Caribbean in 2017.

(nearly 100%), while the lowest percentage of membership is in Ecuador (less than 50%). Panama and Peru rank in the middle, with values ranging around 60% and 70%. In terms of ethnic inequalities, there are no significant gaps in this area. Lastly, when considering the variable of sex, the most prominent gaps are in Panama and Peru, where women rank 10 and 5 points higher, respectively, than men.

With regard to access to and quality of health services, the available information indicates that Afro-descendants receive lower-quality care and are less satisfied with care than non-Afro-descendants. This could constitute a major barrier to the demand for health services by the Afro-descendant population, even when they have or perceive the need for health services (61–63).

Access to health care involves a complex combination of structural factors in the health systems, along with cultural factors and individual patient preferences, combined with the characteristics and practices of health professionals.

Factors such as racism, stereotypes, prejudices, discrimination, and the characteristics of the health services delivery system—including the composition of the workforce, financing, distribution of infrastructure and equipment, cost of access, citizen participation in the development of health policies, and sensitivity to cultural differences, among other factors—favor or hinder the demand for medical care (53, 64).

Given this situation, deficiencies in the quality and effectiveness of responding to the health needs of Afro-descendants can be linked to three factors:

1. Preconceptions or discriminatory attitudes on the part of health service providers
2. Individual preferences when seeking health services
3. Factors related to the geographic accessibility of health services (63).

Although specialists are cautious when associating discriminatory practices toward Afro-descendants with health outcomes, much of the specialized literature suggests a connection between the two. A report by the Peruvian Ombudsman’s Office highlights shortcomings in the care of Afro-Peruvians. Poor quality and discriminatory treatment have deterred the Afro-descendant population from using the country’s institutional health services. This issue is even more complex for
women, who report receiving sexual comments at health facilities (8).

The results of a study on obstetric violence in the Dominican Republic, based on interviews with women who gave birth in public hospitals, reveal episodes of abuse and discrimination: harsh and disrespectful language, public humiliation, scolding and insults, failure to communicate information on procedures and processes, language and communication barriers, sociocultural discrimination based on socioeconomic status, cultural insensitivity, and a lack of care with sensitivity to intercultural differences, among other factors. This reality contrasts, however, with the women's positive perceptions of the quality of care. Thus, while the women in the study acknowledged experiencing abuse during their hospital stays, few described these problems as negative; they had low expectations and described situations of abuse as unavoidable incidents or episodes (65). Discrimination by health service providers toward indigenous and Afro-descendant women is considered a primary barrier to accessing health care in Latin America (66).

A case study on the relationship between ethnicity and the use of health services in Colombia indicates that the Afro-descendant population is at a greater disadvantage than the general population. Based on the results of two quality-of-life surveys, the probability of using health services was evaluated based on whether Afro-Colombians had insurance through the General Social Security Health System.12 A distinction was made between persons who belonged to subsidized, contributory, or special schemes, versus those without coverage (67) (see Figure 16). Taking into account the different levels of insurance status, the Afro-Colombian population was less likely to access medical care than the non-Afro-descendant population (61).

Figure 16. Adjusted probability of using health services in Colombia, by ethnicity

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Afro-descendants</th>
<th>Non-Afro-descendants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidized</td>
<td>0,43</td>
<td>0,49</td>
</tr>
<tr>
<td>Contributory</td>
<td>0,60</td>
<td>0,70</td>
</tr>
<tr>
<td>Special regimen</td>
<td>0,57</td>
<td>0,65</td>
</tr>
<tr>
<td>No insurance</td>
<td>0,24</td>
<td>0,33</td>
</tr>
</tbody>
</table>


Other variables incorporated in this analysis include sex, age, area of residence, and probability of using preventive health services (see Table 1). As can be seen, the results show that the population self-identifies as non-Afro-descendant has the highest probability of using health services, and except in the case of children under 1 year old, there is a greater than 10-point difference.

---

12 Membership in the subsidized regime is for people who do not have the financial means to pay into the contributory system. The contributory regime is made up of workers or affiliated individuals with the ability to pay, while the special regime is for workers who are guaranteed coverage in the contributory regime based on belonging to sectors such as the military forces or the education system. Lastly, there is a segment of the population that does not belong to the health system.
Among the determinants of the use of health services, ethnicity must be considered a fundamental factor in understanding the reality of the different population groups and in the inequality caused by discrimination.

- **Access to contributory pensions**

The percentage of people who have some form of social security that will provide a pension (or that will protect them in case of temporary or permanent inability to work) is an important indicator of the quality of work and of access to social protection.

According to estimates of the percentage of people 65 years old and older who received contributory pensions in five Latin American countries (see Figure 17), the highest coverage was in Brazil and Uruguay (above 80%), while in the other countries this figure did not exceed 60%. Ecuador and Peru had the lowest

### Table 1. Probability of using health services in Colombia, by ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Sex</th>
<th>Area of residence</th>
<th>Age group</th>
<th>Use of preventive services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Children under 1 year old</td>
</tr>
<tr>
<td>Afro-descendants</td>
<td></td>
<td>0.42</td>
<td>0.44</td>
<td>0.26</td>
</tr>
<tr>
<td>Non-Afro-descendants</td>
<td></td>
<td>0.53</td>
<td>0.44</td>
<td>0.55</td>
</tr>
</tbody>
</table>


Notes: Selected Latin American countries. The non-Afro-descendant population does not include people who self-identify as indigenous, or cases in which ethnicity is unknown. Source: The data are calculated based on special tabulations of household surveys from four countries, conducted by the Economic Commission for Latin America and the Caribbean in 2017.
percentages, while Panama ranked in the middle. There appear to be no racial gaps in Brazil and Uruguay, while in the case of Panama, the percentage of people of African descent who receive a pension is higher than among non-Afro-descendants. In Peru and Ecuador, the opposite is true: In Peru, 20% of Afro-descendants receive pensions, compared to 36% of non-Afro-descendants, while in Ecuador, the figures are 21% and 28%, respectively.

Regarding the relation between sex and race, the greatest gaps are observed in Afro-descendant people in Ecuador and Peru, where men have a 20 percentage point advantage over women (see Figure 17). Thus, the more precarious employment of Afro-descendants affects the indicators of health and protection in old age.

2.3 GENDER AND ETHNICITY

Added to inequalities related to ethnic and socioeconomic status are those related to gender, since gender roles, norms, and relationships determine different lifestyles, levels of exposure to risk factors, and causes of illness and death (68).

Despite the fact that Afro-descendant women play a fundamental role in the nuclear family as caregivers, with responsibility for maintaining ancestral practices at the individual, household, and community levels (69), a World Bank report notes that Afro-descendant households headed by women experience greater precariousness and worse living conditions than those in which Afro-descendant men act as heads of household (7).

Promoting an ethnic and gender approach to health means taking into account the roles and norms socially assigned to men and women in Afro-descendant and indigenous populations, and identifying those who are experiencing exclusion and discrimination, based on constructs reproduced by society that limit their access to health services. The intersectionality approach of both determinants makes it possible to analyze the specific needs of the various population groups, and to develop health strategies that foster inclusion, reduce health inequities, eliminate communication barriers, and increase cultural and gender sensitivity (70).

Analyzing the health conditions of Afro-descendant women in regard to sexual and reproductive health makes it possible to develop a means of addressing ethnic and gender inequalities.

2.3.1 Afro-descendant women and their sexual and reproductive health

Poor Afro-descendant women can suffer a triple vulnerability that impacts their health (8).

In the United States, the authors of a study examining changes over time in the survival of African-American and White women diagnosed with cervical cancer concluded that, overall, women of African descent had more advanced forms of the disease and worse indicators for prognosis and survival than White women. Other studies show that ethnic differences account for a lower likelihood of diagnosis and differences in treatment and subsequent follow-up (71).

In Brazil, the results of a follow-up report on racial inequalities showed that, although women’s access to cervical cancer screening increased between 2000 and 2008, 15% of women had not yet taken advantage of this, and among women of African descent, this figure was 17% (62).

Another qualitative-ethnographic study conducted in Colombia regarding Afro-descendant women’s perceptions of breast and cervical cancer indicated that the difficulties faced by this population are compounded by a health system with limited coverage in some remote regions of Chocó and areas of the Pacific coast, with services concentrated in urban centers. Thus, adding to the tragedy of the disease itself is the problem of having to travel to locations beyond their communities, along with high out-of-pocket expenses and the loss of social and emotional support involved in leaving their home environments (69).

According to information on the quality of health services in Brazil, the degree of dissatisfaction among Afro-descendant women is 0.4% higher than that of Afro-descendant men, 5.3% higher than that of White women, and 5.6% higher than that of White men (72).
Traditional conceptions and practices are another important factor in the health of Afro-descendant women. These include special dietary practices based on the use of infusions, and greater restrictions on the consumption of certain foods during menstruation, gestation, and puerperium, in addition to practices such as bathing more frequently during menopause, which contribute to preventing health problems throughout life (73).

These findings demonstrate the need to promote differential health responses directed at Afro-descendant women, while also addressing the challenges imposed by triple inequality due to gender, ethnicity, and lower socioeconomic status.

In view of the above, the Region needs to promote strategies to highlight the particular conditions and demands of the Afro-descendant population, taking into account the factors that limit access to health care, and making efforts to overcome them through effective, gender-based, culturally acceptable health policies.

### Prenatal and childbirth care

Care by trained personnel before, during, and after childbirth can save the lives of mothers and newborns.

Factors preventing women from receiving or seeking care during pregnancy and childbirth include distance from health facilities, lack of economic resources and information, women’s inability to make decisions about their own health, lack of adequate and culturally relevant services, and the particular practices of individual cultures. Many women die from complications during pregnancy, childbirth, or puerperium that are largely preventable or treatable. Other complications may predate pregnancy but are aggravated in gestation, especially if left untreated (74).

A recent analysis of 10 countries in the Region (Belize, Brazil, Colombia, Costa Rica, Ecuador, Guyana, Honduras, Panama, Suriname, and Uruguay) shows broad coverage of reproductive health interventions, care, prenatal care, and medical examinations (a requirement for receiving conditional-transfer benefits), with very small gaps between the reference group and Afro-descendant women.

Timely prenatal care (during the first trimester of pregnancy) and vaccination against tetanus present the greatest challenges in terms of access and reducing inequalities. These challenges are particularly acute in Suriname, due to the breadth of the gap, as can be seen in Figure 18.

### Figure 18. Coverage of prenatal care in the first trimester and access to tetanus vaccination

#### Prenatal checkup (4+ visits)

<table>
<thead>
<tr>
<th>Country</th>
<th>Afro-descendants</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guyana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honduras</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panama</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suriname</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Tetanus vaccine

<table>
<thead>
<tr>
<th>Country</th>
<th>Afro-descendants</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guyana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honduras</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suriname</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: Selected Latin American countries. The figure on the left shows prenatal care consisting of four or more visits.

Data on skilled care in childbirth and institutional childbirth indicate high levels of coverage in Guyana, Honduras, and Panama, with slightly higher coverage for Afro-descendant women. Among the countries analyzed, the lowest coverage was in Honduras. Afro-descendant women fare worst in Colombia and Ecuador (see Figure 19).

According to a report by the United Nations Population Fund (UNFPA), indigenous and Afro-descendant women with lower incomes and fewer years of schooling often have greater difficulties accessing family planning services and skilled care in childbirth (75).

**Figure 19.** Births attended by skilled personnel and institutional births, by ethnicity

---

**Skilled personnel**

- **Coverage**
  - Afro-descendants
  - Non-Afro-descendants

<table>
<thead>
<tr>
<th>Country</th>
<th>Afro-descendants</th>
<th>Non-Afro-descendants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize</td>
<td>98.1</td>
<td>98.4</td>
</tr>
<tr>
<td>Brazil</td>
<td>99.7</td>
<td>99.6</td>
</tr>
<tr>
<td>Colombia</td>
<td>99.9</td>
<td>99.8</td>
</tr>
<tr>
<td>Ecuador</td>
<td>94.6</td>
<td>94.1</td>
</tr>
<tr>
<td>Guyana</td>
<td>99.9</td>
<td>99.4</td>
</tr>
<tr>
<td>Honduras</td>
<td>90.5</td>
<td>89.5</td>
</tr>
<tr>
<td>Panama</td>
<td>99.1</td>
<td>98.5</td>
</tr>
<tr>
<td>Suriname</td>
<td>97.5</td>
<td>98.0</td>
</tr>
</tbody>
</table>

**Institutional deliveries**

- **Coverage**
  - Afro-descendants
  - Non-Afro-descendants

<table>
<thead>
<tr>
<th>Country</th>
<th>Afro-descendants</th>
<th>Non-Afro-descendants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize</td>
<td>96.2</td>
<td>97.2</td>
</tr>
<tr>
<td>Brazil</td>
<td>94.7</td>
<td>96.7</td>
</tr>
<tr>
<td>Colombia</td>
<td>98.3</td>
<td>98.6</td>
</tr>
<tr>
<td>Ecuador</td>
<td>87.9</td>
<td>84.1</td>
</tr>
<tr>
<td>Guyana</td>
<td>98.4</td>
<td>97.4</td>
</tr>
<tr>
<td>Honduras</td>
<td>88.7</td>
<td>83.1</td>
</tr>
<tr>
<td>Panama</td>
<td>92.2</td>
<td>95.2</td>
</tr>
<tr>
<td>Suriname</td>
<td>92.2</td>
<td>95.2</td>
</tr>
</tbody>
</table>

Note: Selected Latin American countries.

Maternal mortality

Maternal mortality is one of the main indicators of sexual and reproductive health, and serves as an important indirect indicator of inequalities, living conditions, health, and access to quality health services. Reducing the maternal mortality ratio (MMR) is one of the Sustainable Development Goals (SDGs) and a goal of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030), presented during the 2015 United Nations General Assembly (74).

While the maternal mortality ratio is difficult to measure, and obtaining information disaggregated by ethnicity is even more difficult, the countries of the Region are taking steps to provide this information. In three countries for which information is available (see Figure 20), Afro-descendant women are at a disadvantage compared to non-Afro-descendant women, with a MMR that is nearly four times higher in Ecuador and twice as high in Colombia, with a slightly smaller gap in Brazil (1.4 times higher). The data analyzed and the gaps detected show the importance and urgency of having data on maternal mortality and other indicators related to sexual and reproductive health disaggregated by ethnicity.

Factors that could account for the lagging indicators in the ethnic population in terms of expected outcomes in this area include geographic and economic barriers and women’s lower trust in health personnel. This, in turn, translates into inadequate

**Figure 20.** Maternal mortality ratio, by ethnicity and skin color

<table>
<thead>
<tr>
<th>Country</th>
<th>Afro-descendants</th>
<th>National total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil (2011)</td>
<td>68.8</td>
<td>50.6</td>
</tr>
<tr>
<td>Colombia (2010-2013)</td>
<td>152.9</td>
<td>66.5</td>
</tr>
<tr>
<td>Ecuador (2010-2013)</td>
<td>272.5</td>
<td>69.1</td>
</tr>
</tbody>
</table>

Notas: Países seleccionados de América Latina. Número de defunciones maternas por 100.000 nacidos vivos.

*Fuente:* Adaptada de Comisión Económica para América Latina y el Caribe, Organización Panamericana de la Salud, Fondo de Población de las Naciones Unidas. Situación de las personas afrodescendientes en América Latina y desafíos de políticas para la garantía de sus derechos. [Internet]. Santiago de Chile: CEPAL; 2017.

While the majority of lesbian, gay, bisexual, transgender, and queer (LGBTQ) people report being victims of discrimination, those who belong to ethnic groups experience even higher levels of discrimination compared to White LGBTQ individuals. Thus, the intersection of race/ethnicity and sexual orientation creates elevated levels of risk of discrimination and stigmatization, with resulting negative effects on mental health that can lead to depression, anxiety, post-traumatic stress, substance abuse, and suicidality, which also have an effect on seeking health care (78).

Indeed, the results of a 2017 survey of a nationally representative sample of adult LGBTQ people in the United States indicate that people who self-identified as Black, Latino, Asian American, or Native American were twice as likely to report discrimination because of their gender identity when applying for work and interacting with police, compared to White LGBTQ people (79).

It has also been documented that, in the United States, the proportion of gay and bisexual Black men with HIV is much higher than that of their White peers, even though their sexual risk behaviors are not significantly different from those reported for the White population. Explanations of this involve a complex interaction between individual, interpersonal, and contextual factors. For example, gay and bisexual Black men are twice as likely to be unemployed and to have low levels of income and education, compared to other men. In addition, Afro-descendants’ distrust of health service providers has been cited, owing to a long history of discriminatory treatment and stigma that affects their mental health, self-esteem, and likelihood of seeking HIV-prevention services (79).

Within the framework of the gender perspective and the inequality matrix, the reality of Afro-descendants with diverse sexual orientations and gender identities and expressions represents one of the greatest challenges.

There are obvious gaps in information on this topic, perhaps even greater than those highlighted in connection with other issues that help explain the health conditions and health determinants of the Afro-descendant population. However, scientific output from the United States shows that the worst physical, mental, and spiritual health outcomes for people of African descent are due to the intersection of ethnicity, social class, gender, and sexual orientation (77).

2.3.2 Afro-descendants:
Diverse sexual orientations and gender identities and expressions

In any case, there is an indisputable need to incorporate the concepts of acceptability and cultural relevance into health systems, in order to ensure respect for the cultural traditions of indigenous and Afro-descendant people so that women feel comfortable within the health service and accept the recommendations of health personnel. Some advances in this area focus on promoting best practices aimed at eliminating barriers related to lack of cultural relevance by incorporating practices such as childbirth care by traditional midwives, vertical birth, use of infusions, presence of family members, and maternal homes located near second-level hospitals (75).
The situation of the U.S. LGBTQ population is complemented with a report on the situation facing gay Afro-Caribbean men in Colombia who are socially censured for betraying one of the most important values of Afro-Colombian males, namely, the pressure for Black men to exhibit virility and masculinity. Similarly, the submissive role of women has been normalized and reproduced primarily through the family context (80).

In the struggle for recognition and access to better living conditions for this population, civil society organizations belonging to the Latin American and Caribbean Network of Afro-descendants with Diverse Sexual Orientations and Gender Identities and Expressions and the Afro Network of Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) people of Latin America and the Caribbean issued a statement during the 49th General Assembly of the Organization of American States (OAS) (held in Colombia in June 2019), calling for (81):

- Recognition of the intersectionality of ethnicity and sexual orientation, and gender identity and expression as a major issue requiring specific statistics and data, with a view to developing action plans aimed at eliminating the multiple burdens of discrimination that place the Afro-descendant LGBTI population in a position of increased vulnerability.
- Understanding that marginalization is a structural problem that adversely affects the full exercise of citizenship by LGBTI Afro-descendants in the Region.
- Guaranteeing and promoting full access to and exercise of the rights of LGBTI Afro-descendants in the Region, and effectively combat and promote the multiple, exacerbated, and structural discrimination of which they are victims.

2.4 HEALTH PROBLEMS

2.4.1 Child mortality

The health of minors reflects the state of health of the general population, as well as the social and economic conditions in which society develops. A significant proportion of child deaths result from respiratory infections or diarrhea that no longer threaten children born in developed countries, but that continue to affect those born in developing countries. Many early childhood deaths could be avoided if health problems were properly treated (17). Reducing child mortality is set forth in goal 3.2 of SDG 3, which is to end preventable deaths of newborns and children under 5 years of age by 2030.\(^\text{13}\)

Although child mortality has generally registered positive changes worldwide since 1990, some analyses show that national averages obscure differences that exist within each country, between different geographic areas, and between different social and demographic groups (82). Indeed, several studies point out the persistent gaps and health inequality between children of African descent and children in the overall population, differences that can be seen even in developed countries such as Canada and the United States (83).

Analysis of child mortality in the Afro-descendant population in 13 Latin American countries, based on the most recent census data or on available demographic and health surveys, reveals that Argentina and Guyana are the only countries in which ethnicity-related inequities are absent (see Figure 21). Overall, however, children in Guyana face worse situations than in the other countries examined. By contrast, the best situation for children has historically been in Costa Rica (84). The inequality gaps affecting people of African descent are most evident in Belize, Brazil, Colombia, and Honduras, where the difference is as high as seven more deaths per 1,000 live births.

\(^{13}\) The goal has been to reduce neonatal mortality to no more than 12 deaths per 1,000 live births, and under-5 mortality to no more than 25 deaths per 1,000 live births in all countries of the world. World Health Organization (WHO). Children: improving survival and well-being. 9 September 2020. https://www.who.int/news-room/-fact-sheets/detail/children-reducing-mortality
Paradoxically, the disadvantageous conditions of Afro-descendant children under 1 year old overlap with aspects in which Afro-descendants as a whole fare better than people who self-describe as not belonging to an ethnic group. An example of this is the prevalence of exclusive and prolonged breastfeeding in Belize, Guyana, and Suriname, where the rate for Afro-descendants is 20% higher than in the reference population. These results coincide with analyses indicating that rural and indigenous women with lower income and lower levels of education begin breastfeeding earlier and breastfeed for longer. However, the available data show a trend toward decreased breastfeeding (69).

Ranking lowest in this regard is Panama, where the prevalence of exclusive breastfeeding in the first six months is 9.1% in Afro-descendants and 18.8% in the reference group. In any case, the overall low levels of exclusive breastfeeding in the first six months (only 13.9% on average) are a matter of concern (see Figure 22).
According to various analyses, inequalities in infant mortality persist even when controlling for area of residence, and figures for Afro-descendants are higher than for non-Afro-descendants in both urban and rural areas (with the exception of urban areas of Argentina) (15).

According to an analysis of data from six countries (Belize, Brazil, Colombia, Guyana, Honduras, and Suriname) child mortality among people of African descent is closer to the rate in the reference population.

The mother's income and educational level have been identified as the main determinants of differences in perinatal, neonatal, infant, and under-5-year-old mortality in Latin America. In El Salvador, mortality rates in children under 1 whose mothers have little education are seven times higher than those of mothers who completed secondary or higher education, and three times higher in the Plurinational State of Bolivia, Colombia, Guatemala, and the Dominican Republic (85).

In order to transform the reality described above, there needs to be an improvement in the availability of basic goods and services, guaranteed accessibility to quality education, strengthening of health systems’ capacity to respond to territorial inequalities, and efforts to ensure access to drinking water and sanitation for the Afro-descendant and indigenous populations (86).

### 2.4.2 Lack of care for adolescents and youth

The majority of Afro-descendant young people live in urban areas, with a higher probability of residing in marginal areas and a lower probability of having adequate access to public goods and services. For this group, the reality is compounded by environments in which there is violence, excess mortality due to external causes, and discrimination in employment, among other variables that place them at a disadvantage in relation to other population groups (24).

Although analyses of the health conditions of young Afro-descendants indicate that their profiles are not unlike those of other young people, the conditions of vulnerability in which they live are exacerbated by a threefold exclusion: ethnic (because they are of African descent), class (because they are poor), and generational (because they are young). This can become a fourfold disadvantage in the case of women, given the problems associated with gender (24). For Afro-descendant youth, this translates into reduced expectations for a dignified life, personal development, and human security, and problems that are manifested in constant violence, and silent and systematic violations of the human rights of this population group (82).
These young people, by virtue of the conditions described above, have little visibility and receive scant care in health systems, since the events that occur are attributed to external causes and to risk behaviors typical of their ages: externally caused injuries (trauma, suicide, traffic accidents, poisonings, violent confrontations leading to homicides, and assaults, to name a few), with increased chances of contracting sexually transmitted diseases given the stage at which sexual activity begins, as well as unwanted and early pregnancies, and exposure to alcohol and drug abuse and its consequences (87).

In this regard, Article 25 of the Ibero-American Convention on the Rights of Young People, signed in Badajoz (Spain) in October 2005, directs States to “recognize the right of young people to comprehensive and quality health,” and states that this right “includes free primary care, preventive education, nutrition, specialized care, and care for youth-related health issues, promotion of sexual and reproductive health, research into health problems occurring in young people, and information and prevention against alcoholism, smoking, and drug abuse” (88).

In this context, it is essential to eliminate barriers to accessing care, so that young Afro-descendants can develop life skills and engage in activities conducive to healthy lifestyles, within the framework of a rights-based and intercultural approach (24).

2.4.3 Adolescent pregnancy

Adolescent pregnancy is another manifestation of inequality affecting young Afro-descendant women. The intersection between sexual and reproductive rights and two structuring axes of the social inequality matrix—gender and life course—results in heightened inequalities when combined with ethnicity.

This poses significant challenges, given that (a) fertility in adolescents has not followed the downward trend in overall fertility, and has even increased in some countries; (b) it is more prevalent among those living in poverty and with lower levels of education (a population in which Afro-descendants are over-represented); (c) it can trap multiple generations in the spiral of poverty; and (d) it relates to gender inequalities, since care of the baby falls mainly on young women, their mothers, and their grandmothers, regardless of marital status and whether the father lives in the home (89).

Figure 23 shows that the percentages of Afro-descendant adolescents between 15 and 19 years of age who are mothers remain high, exceeding the percentages of non-Afro-descendant adolescent mothers in seven of the 11 countries with available data. Although comprehensive and universal health policies have been implemented in several of these countries, and unwanted pregnancies at an early age have been reduced, racial inequality persists (15).

Figure 23. Adolescents 15 to 19 years old who are mothers, by ethnicity

Notes: Selected Latin American countries. The non-Afro-descendant population does not include people who self-identify as indigenous, or cases in which ethnicity is unknown. Included are data from Peru, based on the 2017 census, which considers only people 12 years of age and older.

Unmet demand for family planning is also a highly important metric with regard to women and reproductive health. The various reasons for women not using contraceptive methods include the lack of information about the different methods and where to obtain them, financial barriers to accessing them, fear of side effects, religious beliefs, and opposition by the woman's partner (8).

Figure 24 shows the low coverage of use of contraceptive methods in eight countries of the region (excluding Honduras).

Figure 24. Use of and access to modern contraceptive methods

Note: The reference group includes people of European descent and of mixed descent (mestizo population).


2.4.4 Violence

The rate of violent deaths among Afro-descendants is higher than in the non-Afro-descendant population. For example, an analysis of mortality patterns in Colombia, based on census data from 2005 and 2010 for the city of Cali and the department of Valle del Cauca (both of which have a significant

Afro-descendant populations), shows that deaths from homicide (which are higher in men in general) begin to increase around age 10, and become the leading cause of death among adolescents and youth, especially among Black males. At age 14, approximately 40% of deaths of Afro-descendant
males are the result of murders. This percentage reaches 80% between the ages of 15 and 19, and increases slightly for the 20- to 24-year-old age group. In the case of White-mestizo males, the percentage of deaths from homicide is 30% at age 14, rising to 70% between the ages of 15 and 19, then decreasing by a few percentage points between the ages of 20 and 24. It has also been established that after the age of 45, the mortality rates of Afro-descendant men tend to approach the mortality rates of non-Afro-descendant men (90).

Brazil is one of the few countries in which data on violence are systematically collected. In 2017, the homicide rate of Brazil's Afro-descendant population was 43.1 per 100,000 people, compared to 16.0 per 100,000 people for the non-Afro-descendant population. (Between 2007 and 2017 the rate increased by 33.1% for the Afro-descendant population and 3.3% for the non-Afro-descendant population.) The rate of homicides among young Afro-descendants was 69.9 per 100,000 inhabitants (91).

Another recent study concluded that, in Brazil, skin color increases the probability of an individual being the victim of a homicide, a statement supported by the statistics: Considering the proportion of population groups by race/color, five of every seven individuals killed are of African descent. These findings are conclusive and were statistically controlled for the effects of confounding variables such as socioeconomic and geographic factors. One of the most worrying findings of the study relates to the differences, by ethnicity, in homicide deaths of adolescents between the ages of 14 and 17. While the probability of a non-Afro-descendant adolescent dying violently is 74.6% lower than for a non-Afro-descendant adult, an Afro-descendant adolescent is just as likely to be killed as an Afro-descendant adult (92).

Once again, there is clearly a need to generate statistics disaggregated by race and ethnic group, in order to better understand both the risk factors of the victims and the characteristics of the aggressors. Encouraging the generation and dissemination of disaggregated data will help to improve public policies and allow for a more effective allocation of spending on social prevention measures (93).

2.4.5 Mental health

Mental health issues need to be given greater attention, particularly with regard to young Afro-descendants. According to a U.S. study of attempted suicides in schoolchildren from 1991 to 2017, African Americans had the worst outcomes, while there were no significant changes among White adolescents, and the rate of suicides among Hispanic Americans, and those of Asian or Pacific Island descent decreased (94).

These data are a cause for alarm in the U.S. public health system. In terms of possible reasons for lower rates of mental health treatment among Black adolescents, compared to their White counterparts, this could be attributable to the former not wishing to be considered weak, and refusing to acknowledge the symptoms of mental illness. There is also the possibility that Black adolescents may refuse to undergo mental health treatments due to a lack of trust in health care providers, preferring instead to seek help from family and peer networks. This situation means that a significant number of people with mental health problems are without controls or supervision, leading to an increase in self-harming behaviors. Lastly, the social determinants of health disproportionately affecting Black adolescents include racial discrimination and negative childhood experiences, often marked by abuse, neglect, and poverty (94).
Added to all of this is the fact that young Afro-descendants are exposed to the phenomenon of bullying, which constitutes a serious public health problem worldwide, since it can generate episodes of mental suffering, compromise the teaching and learning process, and affect a person’s response to social demands throughout the life course. In a study of Brazilian adolescents, aimed at determining the characteristics and motives they associate with bullying, the incidence of bullying was estimated at 7.2%, with a higher prevalence in male, younger, dark-skinned and indigenous students whose mothers lacked education. Among the causes or motives for bullying are bodily appearance (18.6%), facial appearance (16.2%), race or skin color (6.8%), sexual orientation (2.9%), religion (2.5%), and region of origin (1.7%); 51.2% of the adolescents surveyed did not cite a specific cause (95).

### 2.4.6 Chronic diseases

Chronic diseases are related (though not exclusively) to the aging of the population. As a result of the decrease in fertility rates, a reduction in mortality, and longer life spans, the Afro-descendant population is at an advanced stage of the demographic transition, though to a lesser extent than the non-Afro-descendant population in some countries (96).

With regard to the age composition of the Afro-descendant population, the countries of the Region with the highest proportion of older Afro-descendants (more than 10%) are Argentina, Cuba, Panama, Uruguay, and the Bolivarian Republic of Venezuela, with Cuba having the highest proportion (15.2%). In the Plurinational State of Bolivia and Ecuador, the relative proportion of older Afro-descendants is less than 7% (96).

Despite being at an advanced stage of the demographic transition, the Afro-descendant population is younger than the rest of the population in most countries of the Region, overall. However, in countries such as Honduras, Nicaragua, Panama, and the Bolivarian Republic of Venezuela, the opposite is true: the Afro-descendant population is older than the rest of the population (96).

The fact that Latin America has an Afro-descendant population that is still benefiting from the demographic bonus (a higher proportion of people of working age compared to those who are presumably inactive) suggests the need for reflection and action to address health inequalities. Otherwise, the demographic pressures of aging and the accumulated risks for this population will lead to increased health inequalities in old age, manifested in a low quality of life and greater demand for health services (97).

Older Afro-descendants suffer a higher incidence of chronic diseases (such as diabetes and hypertension) than the non-Afro-descendant population. This is the result of worse living conditions, since this type of pathology is related to people’s living conditions and lifestyles (44).

Based on data from Colombia’s National Survey of Health, Well-being, and Aging 2015 (SABE), the prevalence, awareness, treatment, and control of high blood pressure in the country’s over-60-year-old population were estimated, based on ethnicity. Of the 23,694 seniors who participated in the survey, categorized according to skin color, 54.5% were classified as “light skinned,” 35.5% as “medium,” and 10.9% as “dark.” Women accounted for 54.5%, and 78.1% lived in urban areas. It was estimated that half of the population over 60 years of age suffered from high blood pressure; women, especially those with dark skin, were the most affected (98) (see Table 2).
Table 2. High blood pressure in older people in Colombia, by sex and skin color

<table>
<thead>
<tr>
<th>High blood pressure</th>
<th>Light (IC 95%)</th>
<th>Medium (IC 95%)</th>
<th>Dark (IC 95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>53.2% (48.7-57.7)</td>
<td>49.6% (44.5-54.7)</td>
<td>49.4% (41.0-57.8)</td>
</tr>
<tr>
<td>Women</td>
<td>62.5% (60.5-64.5)</td>
<td>61.7% (57.8-65.6)</td>
<td>69.9% (63.6-76.2)</td>
</tr>
</tbody>
</table>

Notes: Included people 60 years old and older. Data are for 2015. CI: Confidence interval.

The article noted that 98% of the population with high blood pressure received treatment, and 93.9% were aware of the diagnosis. The percentage of people under control was higher among women (55.5%) than among men (42.5%). When examining regular physical activity as a protective factor in the prevention and control of high blood pressure, it was found that only 21.8% of the population engaged in some type of regular physical activity (98).

Other data reveal that three out of four older people receive no income (99). A further finding was that the percentage of dark-skinned people with low socioeconomic levels, living in rural areas, and belonging to the subsidized health regime (i.e., people without the economic capacity to pay into Colombia's health insurance system) was higher than the population whose skin color was classified as "light" or "medium" (98).

In view of the above, it is necessary to adopt analytical approaches that take into account the exclusion and discrimination that make Afro-descendants more vulnerable over the course of their lives, in efforts to improve their living conditions, including the particularities and expectations of this population with respect to health systems and models.
CHAPTER 3
OTHER CHALLENGES TO THE HEALTH OF THE AFRO-DESCENDANT POPULATION

3.1 THE CHALLENGES OF COVID-19

The impact of the COVID-19 pandemic poses major challenges for populations, health systems, and economies around the world (100).

The inequalities that affect the Afro-descendant population take on added importance in this scenario. Once again, there is evidence of global inequalities. While some factors (such as poverty, old age, and comorbidity) are known to expose different population groups to greater vulnerability, preliminary data suggest that in countries such as the United Kingdom and the United States, people of African, Hispanic, or Asian origin and people belonging to ethnic minority groups have a disproportionate risk of serious complications and death from the virus (101).

Possible factors associated with the increased burden of disease in people belonging to ethnic groups, compared to the rest of the population, include socioeconomic, cultural, and lifestyle factors, genetic predisposition, and pathophysiological differences in susceptibility or response to infection. The socio-economic conditions of people belonging to ethnic minorities often lead to extended families living in overcrowded conditions and inadequate housing, and an increased likelihood of precarious, low-paying jobs. This makes it difficult to meet physical distancing requirements and to adopt other recommended preventive practices, thus increasing the risk of transmission of the virus (100).

Another factor highlighted in analyses aimed at understanding differences based on ethnic identity concerns the limited ability of information systems to capture and monitor the health status of different ethnic groups. Indeed, most publications do not present data disaggregated by ethnicity, prompting an urgent call for policymakers to ensure the inclusion of ethnicity in the minimum set of data collected, so that possible risk factors can be identified, and health outcomes can be analyzed, with adjustments for recognized confounding variables (102).

The achievements and economic growth in the Region face significant threats due to the global pandemic, which is unfortunately deepening the disadvantages of ethnic populations. According to the Economic Commission for Latin America and the Caribbean (ECLAC), the COVID-19 pandemic has a strong impact in the field of health and profound implications for economic growth and social development. The impact on the most vulnerable population groups is of concern, given their increased risk of infection and death due primarily to the fact that they cannot work from home, but combined with overcrowded conditions, lack of access to water and sanitation, increased incidence of pre-existing health conditions (such as pulmonary and cardiovascular diseases and diabetes), and barriers to accessing adequate medical care (27).
CHAPTER 4
THE HEALTH OF AFRO-DESCENDANTS FROM AN INTERCULTURAL PERSPECTIVE

The notion of interculturality in health assumes a balanced relationship between different sets of knowledge, beliefs, and cultural practices regarding health and disease processes. Recently this has become a fundamental concept in addressing the needs of the various ethnic communities.

The disparities faced by people of African descent with regard to the different health indicators are related to their geographic location, language, socioeconomic factors, and ethnicity. Those living far from city centers, who are impoverished, and who live in areas with high rates of violence tend to have fewer opportunities to access health services. It has also been shown that, for some members of ethnic groups, Western health services do not always provide appropriate spaces for addressing their physical or mental problems, and that traditional practices and knowledge have been threatened by globalization, colonization, and years of delegitimization by Western hegemonic knowledge.

In some rural Afro-descendant communities, particularly those that have existed for many decades, traditional medicine and ancestral knowledge play a fundamental role. Shamans, healers, midwives and birth assistants make up for the lack of health services, and in some cases supplement them. In some places, traditional medicine remains the only health option, and plays an indispensable role in people’s well-being.

Although data on the status of traditional Afro-descendant medicine in the Region of the Americas remain scarce, it is important to highlight some significant findings on the subject. A study conducted in the late 1980s revealed that in Petit Goave, Haiti, there were 150 healers and only 15 doctors per 10,000 inhabitants; thus, for a large portion of the population, in addition to preferring ancestral knowledge, it was their only option. This is not unlike the current situation in the rest of the country; the work of healers is recognized throughout the nation. Healers are divided into four types: the yerbatero doctor, the midwife, the hougan (sorcerer who practices voodoo), and the piquriste (who has some degree of technical training). According to the findings, 82% of people with some type of health need resorted initially to inherited knowledge, attempting to heal themselves using natural medicines. If this was unsuccessful, 85% then resorted to the yerbatero, and only a small proportion sought Western medical services.

Similarly, Afro-Colombian communities on the Pacific Coast have used traditional medicine for centuries, and for some, such knowledge and forms of care still remain the only option for dealing with their physical and mental health needs. The Association of United Midwives of the Pacific (ASOPARUPA), founded in 1998, aims to recognize and preserve the knowledge of traditional healers, midwives, and birth assistants who have attended and cared for the members of their communities for generations, based
These women accompany other women during pregnancy, childbirth, and puerperium, attending to between 4,500 and 5,000 deliveries per year. However, the medical practices of midwives are still not officially sanctioned by the State (107).

Ecuador’s public health system has made some progress in adopting a holistic approach that combines ancestral and Western medicine. In Ecuador, “the practitioners of ancestral medicine (men and women of wisdom) are legalized and legitimized as leaders in the art of healing and protecting the population, within a framework of interculturality and balance with nature” (108). A study conducted between 2007 and 2012 in the province of Guayas conceived of intercultural health as the “process in which different perceptions and practices of health-disease-care operate in different medical systems, are implemented and coordinated, and complement each other in the care process, care strategies, actions to prevent and cure disease, and accidents and death in multi-ethnic contexts. This involves integrating ancestral cultural practices, as well as bringing traditional practitioners together with intercultural facilitators, and using native languages in the health care system.” Within this framework, it is proposed that the process of communication and intercultural adaptation should be included in the training component, namely: (a) cultural adaptation of health services; (b) establishing intercultural spaces (vertical birth, maternal waiting homes, and the presence of family members); (c) intercultural health communication (education and training in traditional ancestral medicine); and (d) enhancing communication capacity (respect for cultural diversity and skills in intercultural communication).

This shows that access to health services is limited for some people and does not always meet the expectations of Latin America’s various population groups. There is clearly a need to strengthen the intercultural approach to health in a sustainable way, with the goal of reducing health inequities affecting groups in situations of increased vulnerability, such as people of African descent.

CONCLUSIONS

This document has discussed the reality of Latin America’s Afro-descendant population in light of the different dimensions of the determinants of health that shape the possibility of enjoying human rights under conditions of equality and with equal opportunities. In this regard, the following factors merit consideration:

- In most Latin American countries, inequalities persist, creating greater disadvantages for the Afro-descendant population, primarily in terms of poverty levels, quality of housing, access to infrastructure and basic sanitation, unemployment, and ethnic discrimination in the labor market. Lags in indicators that track health, such as infant mortality and maternal mortality, highlight the challenges in eliminating inequities within the countries.

- Improving information sources and systems in the various countries to ensure efficient decisions and effective, evidence-based policies aimed at the Afro-descendant population remains a priority that must not be postponed. Two fundamental challenges in this area are: (a) obtaining data disaggregated by (at a minimum) sex, age, and ethnicity, and by other variables such as sexual orientation, gender identity, socioeconomic level, area of residence (urban or rural), etc., according to the context and priorities of each country (for example, the category “victims of armed conflict” is important in Colombia); and (b) incorporating innovative methods and qualitative approaches that supplement the analysis of gaps with information on the living and health conditions of Afro-descendants, in light of ethnic and gender factors (perceptions, barriers to accessing services, uses, customs, traditions, worldviews, etc.).

- In addition to the undeniable and incalculable multicultural wealth and economic, social, and cultural contributions of Afro-descendants throughout the history of the Region of the Americas, there must be a recognition of the persisting effects of slavery and the practices of discrimination and exclusion, which prevent Afro-descendants from fully enjoying their rights as citizens. This requires the commitment of States to increase initiatives and investments focused on improving the living conditions of Afro-descendants, for the benefit of all people in the Region.
• While recognizing that a number of countries in the Region have implemented intercultural health initiatives, important challenges remain in adopting health practices and approaches that integrate traditional knowledge and practices from different cultures, which should be viewed as complementary to the dominant health care approaches.

• Important work has been done by most countries, along with efforts by human rights and international cooperation organizations such as the United Nations, the Inter-American System, and civil society organizations, to achieve equity and guarantee human rights. The commitments embodied in a range of international instruments are an example of these efforts. The results highlight several important areas for action to reduce inequities in the health sector.

RECOMMENDATIONS

In regard to disaggregation of data and evidence, it is recommended to:

• Continue to strengthen information systems, integrating the gender perspective and ethnic diversity to ensure the availability of quality disaggregated data that generate useful information and increase knowledge. Consideration should be given to coverage and to standardizing methodologies for capturing and measuring variables.

• In collaboration with academia and research centers, promote the creation of lines of research and knowledge networks on the health conditions of the Afro-descendant population, and work to strengthen and consolidate scientific synergies. This will help develop innovative responses, cost-effective interventions, and socially acceptable measures to enhance the health of the Afro-descendant population.

• Prepare consensus reports on the health of the Afro-descendant population that provide an overview of the needs and demands for developing and maintaining health, within the framework of interculturality and the social determinants of health. This will provide visibility and strengthen the evidence and policy framework needed to promote integrative and complementary systems in public health policies.

• Create a regional observatory on the health of the Afro-descendant population that groups, organizes, and facilitates the exchange of data and information from studies, surveys, publications, successful experiences, standards, policy documents, etc., while at the same time promoting and ensuring the adoption of relevant tools. This would generate content to support the monitoring and formulation of national initiatives.

In order to establish health measures that address specific needs, it is recommended to:

• Promote mechanisms to generate and consolidate comprehensive health response models with an intercultural approach, in order to improve the health conditions of people of African descent. Interculturality should be conceived as a process involving the whole of society, including all ethnic groups, in a framework of tolerance, enrichment, and mutual learning, recognizing the potential health benefits of the various practices and traditions of the peoples and cultures in the countries of the Region.
• Strengthen human resources in the field of health, through training and awareness-building on interculturality and health. Health personnel, particularly those who provide services in territories where Afro-descendants live, should have anthropological and social skills and knowledge, so that their actions incorporate the ancestral practices and knowledge of that population.

With regard to policy development and implementation, the following are suggested:

• Promote intersectoral and ongoing coordination between ministries of health and intercultural governing bodies responsible for policies affecting Afro-descendants in the countries of the Region, in order to aid in the design, implementation, follow-up, and evaluation of joint policies, plans, programs, and projects that ensure culturally relevant health care for Afro-descendants.

• Strengthen State institutions by allocating to intercultural health directorates, ministries of health, and their decentralized subnational bodies, the necessary budget and personnel specializing in the health of Afro-descendants.

• Promote the participation of Afro-descendant people and organizations in the formulation, implementation, monitoring, and evaluation of policies and initiatives for development and health equity, thus advancing the desired transformations in the living conditions and well-being of Afro-descendants.

In addition, the following actions are recommended:

• Devote particular attention to:
  • Defining the social determinants of health in order to formulate public policies on sexual and reproductive health specific to Afro-descendant adolescents, young people, and women in the Region.
  • Implementing mental health policies that recognize the impact of racism and racial discrimination on the lives and social relationships of Afro-descendant children, adolescents, young people, and women.

• Promote timely and effective mechanisms to lend visibility to the Afro-descendant population in emerging scenarios, such as the current public health concerns related to the COVID-19 pandemic. This will make it possible to monitor the health status of this population, identify disparities, and understand how to design better strategies to fit the needs and practices of Afro-descendants during and after the pandemic, protecting their health and well-being, and avoiding a deepening of the inequality gaps that have been described.

• Strengthen the frameworks for monitoring and evaluating the performance of health systems, both nationally and within each country, reflecting the outcomes and progress of differential policies that have been adopted, and gauging Afro-descendants’ satisfaction with the treatment and response they receive.

• Consider the reports, observations, and recommendations of the United Nations Committee on the Elimination of Racial Discrimination, the United Nations Working Group of Experts on People of African Descent, and the Inter-American Commission on Human Rights (IACHR) Rapporteurship on the Rights of Persons of African Descent and Against Racial Discrimination, as well as the jurisprudence of the Inter-American Court of Human Rights on equality and non-discrimination, in recognition of the right of Afro-descendant people in the Americas to fully enjoy and exercise their right to health.

• Strengthen the dissemination and exchange of experiences in the progress and challenges in providing differential health responses to Afro-descendants in the different countries of the Region. In addition to fostering efforts to innovate, adapt, and improve initiatives within each country, this will promote regional action and alliances to support the implementation of commitments made by each State.
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Ethnic diversity contributes vast multicultural richness to the Region of the Americas. However, specifically in the field of health, this reality is marked by profound social and economic inequalities that affect various population groups, including the Afro-descendant population.

The inequalities faced by this population are rooted in historical processes of exclusion and discrimination that perpetuate the precarious living conditions of a large portion of the Afro-descendant population, despite the progress achieved in the important work carried out at the global, regional, and national levels to curb them.

This publication reflects the Pan American Health Organization’s firm determination to increase knowledge about health inequities and promote the formulation of evidence-based public health policies. It concisely analyzes the living conditions and health of Afro-descendants, and in the light of the findings, makes recommendations that will enable health systems to incorporate a cultural approach, including a gender perspective, with the aim of offering effective responses that are adapted to the specific needs of the Afro-descendant population throughout the life course.