STRATEGY AND PLAN OF ACTION
ON ETHNICITY AND HEALTH 2019-2025
IMPACT AND PROCESS INDICATORS

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

IMPACT AND PROCESS INDICATORS

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ACKNOWLEDGMENTS

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The compendium of indicators was prepared by the following PAHO units: Office for Equity, Gender and Cultural Diversity, in collaboration with the Department of Evidence and Intelligence for Action in Health; the Family, Health Promotion and Life Course Department; Latin American Center for Perinatology, Women and Reproductive Health; and the Communicable Diseases and Environmental Determinants of Health Department.

The contributions of Pedro Avedillo, Bremen De Mucio, Pablo Durán, Roberto Garza, Norman Gil, Susana Gómez, José Milton Guzmán, Óscar Mújica, Dionne Patz, and Bernardino Vitoy are especially appreciated.
### ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>fAG</td>
<td>final absolute gap</td>
</tr>
<tr>
<td>iAG</td>
<td>initial absolute gap</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>ln</td>
<td>natural logarithm</td>
</tr>
<tr>
<td>MMR</td>
<td>maternal mortality ratio</td>
</tr>
<tr>
<td>OAS</td>
<td>Organization of American States</td>
</tr>
<tr>
<td>PC</td>
<td>percent change</td>
</tr>
<tr>
<td>PPC</td>
<td>period percentage change</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>U5MR</td>
<td>under-5 mortality rate</td>
</tr>
</tbody>
</table>
INTRODUCTION

This compendium contains technical specifications for the impact and process indicators included in the Strategy and Plan of Action on Ethnicity and Health 2019–2025. These have been developed by the Pan American Health Organization (PAHO) to help Member States implement the guidelines of its Policy on Ethnicity and Health. Appropriate definitions and measurement criteria are provided for each indicator to facilitate a systematic approach to monitoring and reporting on the strategy and plan of action, which in turn will contribute to the interim outcome of the Strategic Plan of the Pan American Health Organization 2020–2025 (SP20-25). This is the first time that PAHO has a strategy and plan of action on ethnicity and health; therefore, it is also the first time that a compendium of this kind has been produced.

In presenting these indicators, a standardized template has been used, adapted to the format of other technical documents of the Pan American Sanitary Bureau, such as the compendium of impact indicators and the compendium of interim outcome indicators of the SP20-25.

The guidance on indicators in this compendium is subject to adjustments in order to align with the Sustainable Development Goals (SDGs) indicators and the interim outcome indicators of the SP20-25. The specifications for measuring indicators will be updated as needed. Baselines and targets are subject to validation with updated information from Member States and PAHO country offices.
DESCRIPTION AND USE OF THE TECHNICAL SPECIFICATIONS

Each technical specification contains specific aspects to situate the objective and its respective indicator, as they are set forth in the *Strategy and Plan of Action on Ethnicity and Health 2019–2025*, both for those described at the impact level and for those at the process level, disaggregated according to each of the five strategic lines of action prioritized in the *Policy on Ethnicity and Health*.

Each technical specification also includes aspects such as the utility of the indicator; key concepts related to it; type of indicator; the unit and scale of measurement; the frequency with which the indicator will be measured in relation to the progress report and the final report, for monitoring and evaluating the Strategy and the Plan of Action; a section related to the calculation of the indicator, specifying its specific measurement attribute and, sometimes, other related estimates that may be necessary to determine compliance with that attribute; the current sources from which information for the estimates is expected to be obtained (which in some cases may vary over time, depending on the type of data, evolution of the information systems, and general characteristics of each country and territory). The technical specifications also indicate some of the main limitations on measurement; the PAHO technical units responsible for providing guidance and monitoring and for measuring the indicator; and references for some of the indicators.
The first two impact indicators (in the calculations section) have precise instructions for countries to estimate the reduction in the ethnic inequality gap for the maternal mortality ratio (MMR) and the under-5 mortality rate (U5MR) by determining the period percentage change (PPC) in the three prioritized ethnic groups. For the third impact indicator, instructions are given to calculate the percent change (PC) in the tuberculosis (TB) incidence rate in the Indigenous population, in line with the measurement of the high-level indicator of the WHO End TB Strategy, which refers to the TB incidence rate starting in 2020 (first milestone), with 2015 as the baseline year.

For process indicators, the calculation section of the technical specification specifies how to determine whether the attribute defined by the indicator is met.¹

TECHNICAL SPECIFICATIONS FOR THE INDICATORS INCLUDED IN THE STRATEGY AND PLAN OF ACTION ON ETHNICITY AND HEALTH 2019–2025

IMPACT INDICATORS

Strategy and Plan of Action on Ethnicity and Health 2019–2025
IMPACT AND PROCESS INDICATORS
The maternal mortality ratio (MMR) is the most commonly used measure to estimate the risk of dying from pregnancy, childbirth, or the puerperium. Maternal mortality is widely acknowledged as a general indicator of the overall health of a population, the status of women in society, and the functioning of the health system.¹

The MMR is one of the SDG Indicators (3.1.1) related to Target 3.1 (reducing maternal mortality by 2030), as well as the Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030 (Survival Goal 1) and the Sustainable Health Agenda for the Americas 2018–2030 (Goal 1.2).

There is evidence that the steady decline in maternal mortality shown in national averages hides marked inequities, expressed in higher maternal mortality in groups with different conditions of vulnerability. In this case, the social determinant linked to ethnicity is one that negatively affects the health of women in general, and pregnant women in particular.²

This indicator seeks to focus the analysis of maternal mortality on different ethnic groups, to make visible the inequities that affect them.

**KEY CONCEPTS**

Female
Maternal mortality
Indigenous, Afro-descendants, and Roma
Maternal mortality gap
<table>
<thead>
<tr>
<th>TYPE OF INDICATOR</th>
<th>Impact indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNIT OF MEASUREMENT</td>
<td>Number of countries and territories</td>
</tr>
<tr>
<td>SCALE OF MEASUREMENT</td>
<td>Absolute (counting)</td>
</tr>
<tr>
<td>FREQUENCY OF MEASUREMENT</td>
<td>Every three years, starting from a baseline to be built for 2019 (with retrospective information to help determine how many countries in that year had disaggregated MMR data for at least one of the three prioritized ethnic groups). Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).</td>
</tr>
</tbody>
</table>
Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Reduction of the maternal mortality gap by at least 30% in at least one of the following populations: Indigenous, Afro-descendant, and Roma.

This indicator is expected to measure an ambitious reduction in the maternal mortality gap during the 2019–2025 period, of 30% or more in at least one of the prioritized ethnic groups: Indigenous, Afro-descendant, and Roma.

Knowing whether a country or territory achieved the reduction proposed by the indicator will include:

1. Measuring the specific MMR in Indigenous, Afro-descendant, and Roma populations (this will depend on the ethnic composition of each country).

2. Measuring the reduction of the gap (inequality or inequity) by defining a population that acts as an equity reference group; in this case, the general population, from which the MMR value will be taken (national average).

The MMR can be calculated by dividing recorded (or estimated) maternal deaths by total recorded (or estimated) live births in the same period, and multiplying the result by 100 000. This measurement requires information on pregnancy status, time of death (during pregnancy, childbirth, or within 42 days of end of pregnancy), and cause of death.

3. Calculating the **initial absolute gap (iAG):** This is the arithmetic difference (subtraction) between the ethnic MMR and the reference MMR, in the specific year that measurement begins within the period to be evaluated.

4. Calculating the **final absolute gap (fAG):** This is the arithmetic difference (subtraction) between the ethnic and the reference MMRs, in the specific year that measurement ends within the period to be evaluated.

5. Determining the period percentage change (PPC), with the following formula:

   \[ \text{PPC} = \ln(ABS(fAG)) - \ln(ABS(iAG)) \times 100 \]

   The PPC value indicates the magnitude of change: a negative result indicates a reduction over time (which for this indicator is expected to be -30%), and a positive result indicates an increase over time.
**SOURCES**

**Numerator:** national mortality systems, vital statistics, and maternal mortality surveillance.

**Denominator:** national live birth registration systems, and vital statistics.

Many developing countries lack fully functioning registration systems that accurately record all births and deaths. Therefore, household surveys, such as Demographic and Health Surveys and Multiple Indicator Cluster Surveys, have become an important source of data.¹

**LIMITATIONS**

The availability of reliable and timely national maternal mortality data is a serious limitation for this indicator; however, even more serious is the lack of availability of maternal mortality data disaggregated by groups of interest.

**RESPONSIBLE UNITS**

The PAHO Department of Evidence and Intelligence for Action in Health and PAHO Office for Equity, Gender and Cultural Diversity, and the Latin American Center for Perinatology, Women and Reproductive Health.

**NOTES:**


3. Disaggregated by Indigenous, Afro-descendant, or Roma population, as appropriate to the ethnic composition of each country.
OBJECTIVE 2
REDUCE THE UNDER-5 MORTALITY RATE

INDICATOR
NUMBER OF COUNTRIES AND TERRITORIES THAT HAVE REDUCED THE MORTALITY GAP IN CHILDREN UNDER 5 BY AT LEAST 30% IN AT LEAST ONE OF THE FOLLOWING POPULATIONS: INDIGENOUS, AFRO-DESCENDANT, AND ROMA

UTILITY
Under-5 mortality rates (U5MR) measure childhood survival, but also reflect the social, economic, and environmental conditions in which children (and other members of society) live, including their health care. Since data on disease incidence and prevalence (morbidity data) are frequently unavailable, mortality rates are often used to determine vulnerable populations.¹

U5MR is one of the SDG Indicators (3.2.2), related to Target 3.2, ending preventable deaths of children under 5 years of age by 2030. It is also included in the Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030 (Survival Goal 1).

KEY CONCEPTS
Childhood
Under-5 mortality rate
Indigenous, Afro-descendants, and Roma
Social, economic, and environmental conditions
Vulnerable populations

TYPE OF INDICATOR
Impact indicator
UNIT OF MEASUREMENT

Number of countries and territories

SCALE OF MEASUREMENT

Absolute (counting)

FREQUENCY OF MEASUREMENT

Every three years, starting from a baseline to be built for 2019 (with retrospective information to help determine how many countries in that year had disaggregated U5MR data for at least one of the three prioritized ethnic groups). Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).
Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Reduction of the under-5 mortality gap by at least 30% in at least one of the following populations: Indigenous, Afro-descendant, and Roma.

Indirect measure of the risk of a child dying before the age of 5 years.

This indicator is expected to measure an ambitious reduction in the under-5 mortality gap during the 2019–2025 period, of 30% or more, in at least one of the prioritized ethnic groups: Indigenous, Afro-descendant, and Roma.

Knowing whether a country or territory achieved the reduction proposed by the indicator will include:

1. Measuring U5MR in Indigenous, Afro-descendant, and Roma populations (depending on the ethnic composition of each country).

2. Measuring the reduction of the gap (inequality or inequity) by defining a population that acts as an equity reference group; in this case, the general population, from which the U5MR value (national average) will be taken.

   U5MR can be calculated by dividing the total number of deaths of children aged 0 to 4 years by the total number of live births in the same period, and multiplying by 1000.¹

3. **Calculating the initial absolute gap (iAG):** This is the arithmetic difference (subtraction) between the ethnic and the reference U5MRs, in the specific year that measurement begins within the period to be evaluated.

4. **Calculating the final absolute gap (fAG):** This is the arithmetic difference (subtraction) between the ethnic and the reference U5MRs, in the specific year that measurement ends within the period to be evaluated.

5. Determining the PPC, with the following formula:

   \[ PPC = \ln(\text{ABS}(fAG)) - \ln(\text{ABS}(iAG)) \times 100 \]

The PPC value indicates the magnitude of change: a negative result indicates a reduction over time (which for this indicator is expected to be –30%), and a positive result indicates an increase over time.
SOURCES

**Numerator:** national mortality systems, vital statistics, and surveillance of prioritized events in children under 5 years of age related to mortality.

**Denominator:** United Nations Population Division and census bureaus.

Many developing countries do not have fully functioning registration systems that accurately record all births and deaths. Therefore, household surveys, such as Demographic and Health Surveys and Multiple Indicator Cluster Surveys, have become an important source of data on under-5 mortality in developing countries, although there are some limits to their quality and representativeness.¹

LIMITATIONS

Civil registration systems are the preferred source of data on child mortality. However, some countries in the Region have registration systems that face challenges related to data quality and coverage of births and deaths.

RESPONSIBLE UNITS

PAHO Department of Family, Health Promotion and Life Course; PAHO Department of Evidence and Intelligence for Action in Health; and PAHO Office for Equity, Gender, and Cultural Diversity.

NOTE:

The incidence of tuberculosis (TB) measures the behavior of the epidemic over time. Constant and increasing reductions in the indicator will reflect the impact of the implementation of the End TB Strategy.

The TB incidence rate is one of the SDG Indicators (3.3.2) related to Target 3.3, which seeks, by 2030, to end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases, and to combat hepatitis, waterborne diseases, and other communicable diseases; moreover, this is one of the three high-level indicators of the End TB Strategy.

At the global level, the End TB Strategy sets milestones and targets for 2020 and 2035 that seek to reduce the TB incidence rate by 90% and to reduce the absolute number of TB deaths by 95% compared with baseline values for 2015.¹

With the available information, this indicator will require defining a reference value for the ethnic groups² in 2015 in each country, in line with the year of comparison, to measure the indicator according to the End TB Strategy.

**KEY CONCEPTS**
- TB incidence
- End TB Strategy

**TYPE OF INDICATOR**
- Impact indicator
UNIT OF MEASUREMENT

Number of countries and territories

SCALE OF MEASUREMENT

Absolute (counting)

FREQUENCY OF MEASUREMENT

Every three years, starting from a baseline to be built for 2019 (in the case of this indicator, retrospective information is required from countries that since 2015 had disaggregated data on the incidence of TB in at least one of the three prioritized ethnic groups, in line with the milestones and targets of the End TB Strategy). Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).

This indicator will have an additional retrospective measurement that is related to the year of comparison proposed by the End TB Strategy, which is 2015, since the assessment of the reduction of 50% or more in the incidence rate will be made with reference to information from that year.
**CALCULATION**

Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Reduction of TB incidence by at least 50% (compared to 2015) in at least one of the following populations: Indigenous, Afro-descendant, and Roma.

This indicator aims to assess an ambitious reduction in the TB incidence gap for the 2015–2025 period, of 50% or more, in at least one of the prioritized ethnic groups: Indigenous, Afro-descendant, and Roma.

Knowing whether a country or territory achieved the reduction proposed by the indicator will include:

1. Measuring the specific incidence of TB in Indigenous, Afro-descendant, and Roma (depending on the ethnic composition of each country).
2. Calculating TB incidence by dividing the number of new TB cases and relapses in a specific population (Indigenous, Afro-descendant, or Roma) by the total of that same specific population in the same period, and multiplying this by 100,000 population.
3. Calculating the percent change (PC) in TB incidence in the specific ethnic population for which information is available, between the baseline (2015) and the most recent year (e.g., 2020), as follows:

\[
\text{PC in ethnic TB incidence} = \left( \frac{\text{Ethnic TB incidence 2020} - \text{Ethnic TB incidence 2015}}{\text{Ethnic TB incidence 2015}} \right) \times 100
\]

The PC value indicates the magnitude of change over time: a negative result indicates a reduction (which for this indicator is expected to be –50%) and a positive result indicates an increase.

**SOURCES**

**Numerator:** Ministries of health and national tuberculosis programs.

**Denominator:** United Nations Population Division and census bureaus.
LIMITATIONS
Availability of information disaggregated by ethnicity in countries and territories.

RESPONSIBLE UNITS
HIV, Hepatitis, Tuberculosis and Sexually Transmitted Infections Unit; Department of Evidence and Intelligence for Action in Health; and Office for Equity, Gender and Cultural Diversity.

NOTES:
2. Disaggregated by Indigenous, Afro-descendant, or Roma population, as appropriate for the ethnic composition of each country.
TECHNICAL SPECIFICATIONS FOR THE INDICATORS INCLUDED IN THE STRATEGY AND PLAN OF ACTION ON ETHNICITY AND HEALTH 2019–2025

PROCESS INDICATORS
OBJECTIVE 1.1
PROMOTE THE PRODUCTION OF DISAGGREGATED DATA AND INFORMATION ON THE HEALTH OF DIFFERENT ETHNIC GROUPS AND THEIR DETERMINANTS

INDICATOR 1.1.1
NUMBER OF COUNTRIES AND TERRITORIES THAT INCLUDE ETHNIC SELF-IDENTIFICATION AS A VARIABLE IN THEIR VITAL STATISTICS (BIRTH AND DEATH RECORDS)

UTILITY
Enables the quantification and monitoring of inequalities in vital areas that are determined by ethnic identity.

KEY CONCEPTS
Vital statistics
Ethnic self-identification
Ethnic variable

TYPE OF INDICATOR
Process indicator

UNIT OF MEASUREMENT
Number of countries and territories

SCALE OF MEASUREMENT
Absolute (counting)

FREQUENCY OF MEASUREMENT
Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).

STRATEGIC LINE OF ACTION 1: PRODUCTION OF EVIDENCE
### CALCULATION
Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Ethnic self-identification included as a variable in the birth and death records of vital statistics.

The American Declaration on the Rights of Indigenous Peoples recognizes self-identification as the “right to belong to one or more indigenous peoples, in accordance with the identity, traditions, customs, and systems of belonging of each people.”

The attribute will only be considered available if the country records it on both registries (births and deaths).

### SOURCES
- Statistical offices of the Ministry of Health
- National statistical institutes
- Control bodies (e.g., comptroller’s office)

### LIMITATIONS
The diversity of ethnic self-identification can limit comparability between countries. So-called self-identification may actually be registered according to the perception of third parties.

### RESPONSIBLE UNITS
Office for Equity, Gender and Cultural Diversity and Department of Evidence and Intelligence for Action in Health.

### NOTE:
**OBJECTIVE 1.1**
Promote the production of disaggregated data and information on the health of different ethnic groups and their determinants

**INDICATOR 1.1.2**
Number of countries and territories that capture data on ethnic self-identification in their administrative health records

**UTILITY**
Enables the quantification and monitoring of inequalities in vital areas that are determined by ethnic identity.

**KEY CONCEPTS**
- Vital statistics
- Ethnic self-identification
- Ethnic variable

**TYPE OF INDICATOR**
Process indicator

**UNIT OF MEASUREMENT**
Number of countries and territories

**SCALE OF MEASUREMENT**
Absolute (counting)

**FREQUENCY OF MEASUREMENT**
Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).
**CALCULATION**

Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Ethnic self-identification included as a variable and captured through administrative health records.

The attribute of the indicator is considered met in those Member States in which the attribute is contained in any of their administrative health records.

**SOURCES**

Ministry of Health and other health sector units

**LIMITATIONS**

The diversity of ethnic self-identification can limit comparability between countries. In some cases, “self-identification” may actually be registered based on the perceptions of third parties.

**RESPONSIBLE UNITS**

Office for Equity, Gender and Cultural Diversity and Department of Evidence and Intelligence for Action in Health.
**UTILITY**

Identifies the existence of institutional capacities to transform data into evidence communicable to different audiences and to inform decisionmaking with an ethnic equity approach.

**KEY CONCEPTS**

Ethnic approach
Updated national profile
Health situation

**TYPE OF INDICATOR**

Result indicator

**UNIT OF MEASUREMENT**

Number of countries and territories

**SCALE OF MEASUREMENT**

Absolute (counting)

**FREQUENCY OF MEASUREMENT**

Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).
CALCULATION

Counting the number of countries and territories with the attribute defined in the indicator.

Attribute: Up-to-date national profile document on the health situation, with data disaggregated by ethnicity and sex.

The attribute of the indicator is considered met by the existence of a published, up-to-date country profile document.

SOURCES

Ministry of Health

LIMITATIONS

Not applicable

RESPONSIBLE UNITS

Office for Equity, Gender and Cultural Diversity and Department of Evidence and Intelligence for Action in Health.
OBJECTIVE 1.3
Promote research on the health of indigenous, Afro-descendant, and Roma populations, and other ethnic groups

INDICATOR 1.3.1
Number of countries and territories whose research agenda includes an explicit commitment to examine ethnicity and health

STRATEGIC LINE OF ACTION 1: PRODUCTION OF EVIDENCE

Utility

Identifies the prioritization of issues related to ethnicity and health in national research agendas and policies in countries with such policies or agendas, as well as those that are in the process of developing them.

Key Concepts

Research agenda
Line of research
Ethnicity and health

Type of Indicator

Process indicator

Unit of Measurement

Number of countries and territories

Scale of Measurement

Absolute (counting)

Frequency of Measurement

Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).
**CALCULATION**

Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Explicit commitments to examining ethnicity and health included in national health research agendas and policies in countries with such policies or agendas, as well as those in the process of developing them.

Considered to be met if at least one of the three prioritized ethnic groups (Indigenous, Afro-descendant, and Roma populations) are included.

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**SOURCES**

Ministry of Health

Ministry of Science and Technology or the institution exercising its functions in the country

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**LIMITATIONS**

A mere mention of this line of research on the agenda does not mean that research is being carried out, nor that it is informing decisions, priorities, or health interventions aimed at eliminating ethnic inequities.

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**RESPONSIBLE UNITS**

Department of Evidence and Intelligence for Action in Health and Office for Equity, Gender and Cultural Diversity.
**OBJECTIVE 1.3**
Promote research on the health of indigenous, Afro-descendant, and Roma populations, and other ethnic groups

**INDICATOR 1.3.2**
Number of countries and territories that have completed studies on barriers to equitable access to health services

<table>
<thead>
<tr>
<th><strong>UTILITY</strong></th>
<th>Produces generalizable knowledge and scientific evidence on the relevance of ethnicity and the discrimination associated with ethnic identity as a barrier to equitable access to health services.</th>
</tr>
</thead>
</table>
| **KEY CONCEPTS** | Research  
Indigenous peoples  
Afro-descendant people  
Roma  
Other ethnic groups  
Barriers  
Equitable access to health services |
| **TYPE OF INDICATOR** | Process indicator |
| **UNIT OF MEASUREMENT** | Number of countries and territories |
| **SCALE OF MEASUREMENT** | Absolute (counting) |
**FREQUENCY OF MEASUREMENT**
Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).

**CALCULATION**
Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Completed study on barriers to equitable access to health services in ethnic groups. Considered to be met if at least one of the three prioritized ethnic groups (Indigenous, Afro-descendant, and Roma populations) is included.

**SOURCES**
- Ministry of Health
- Universities
- Research centers

**LIMITATIONS**
All three groups are not always taken into account.

**RESPONSIBLE UNITS**
Department of Evidence and Intelligence for Action in Health and Office for Equity, Gender and Cultural Diversity.
OBJECTIVE 1.4
Promote mechanisms to disseminate information on ethnicity and health, and its use in decisionmaking, promotion of this approach, and accountability.

INDICATOR 1.4.1
Number of countries and territories that use health information on different ethnic groups in the development of policies, strategies, plans, and programs.

UTILITY
Transmits, reports, and makes available data and information on ethnicity and health in institutions for decisionmaking and accountability, as well as for advocacy purposes.

KEY CONCEPTS
Decisionmaking
Advocacy
Accountability
Dissemination mechanisms
Ethnic groups

TYPE OF INDICATOR
Process indicator

UNIT OF MEASUREMENT
Number of countries and territories

SCALE OF MEASUREMENT
Absolute (counting)

STRATEGIC LINE OF ACTION 1:
Production of evidence
FREQUENCY OF MEASUREMENT

Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).

CALCULATION

Counting the number of countries with the attribute defined in the indicator that demonstrate the use of data from at least one specific mechanism for disseminating information on ethnicity and health.

Attribute: Use health information on different ethnic groups in the development of policies, strategies, plans, and programs.

Mechanisms for disseminating information on ethnicity and health include:

» Health situation analysis.
» Epidemiological profiles.
» Forums, meetings, and technical workshops.
» Posters, journals, and different types of scientific publications.

SOURCES

Ministry of Health
Other institutions in the health sector

LIMITATIONS

Not applicable

RESPONSIBLE UNITS

Department of Evidence and Intelligence for Action in Health and Office for Equity, Gender and Cultural Diversity.
**OBJECTIVE 2.1**
Promote public policy actions that address ethnicity and health

**INDICATOR 2.1.1**
Number of countries that have ratified International Labour Organization (ILO) Convention 169 on Indigenous and Tribal Peoples

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**STRATEGIC LINE OF ACTION 2:**
Promotion of political action for universal access to health

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**UTILITY**

ILO Convention 169 is the frame of reference for countries to guarantee the rights of Indigenous and tribal peoples.

**KEY CONCEPTS**

Ratification of ILO Convention 169

**TYPE OF INDICATOR**

Process indicator

**UNIT OF MEASUREMENT**

Number of countries

**SCALE OF MEASUREMENT**

Absolute (counting)

**FREQUENCY OF MEASUREMENT**

Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).

**CALCULATION**

Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Ratification of ILO Convention 169 on Indigenous and Tribal Peoples.
LIMITATIONS
A country may have ratified the Convention and not implemented it at the national level.

RESPONSIBLE UNITS
Office for Equity, Gender and Cultural Diversity.

NOTE:
| **UTILITY** | Policy response to the health needs of the prioritized groups. |
| **KEY CONCEPTS** | Indigenous peoples  
Afro-descendant people  
Roma |
| **TYPE OF INDICATOR** | Process indicator |
| **UNIT OF MEASUREMENT** | Number of countries and territories |
| **SCALE OF MEASUREMENT** | Absolute (counting) |
| **FREQUENCY OF MEASUREMENT** | Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020-2022 (for the progress report) and 2023-2025 (for the final report). |
| **CALCULATION** | Counting the number of countries and territories with the attribute defined in the indicator.  
**Attribute:** Implementation of at least one policy addressing ethnic inequities in health.  
The policies mentioned in the indicator attribute should, at a minimum, address ethnic inequities in health that result in different kinds of obstacles to accessing health services, such as geographical and economic obstacles and cultural differences.¹ |
| **SOURCES** | Ministry of Health |
| **LIMITATIONS** | Having a public policy does not guarantee its effective implementation. All three groups are not always taken into account. |
| **RESPONSIBLE UNITS** | Office for Equity, Gender and Cultural Diversity. |

### NOTE:

OBJECTIVE 2.1
Promote public policy actions that address ethnicity and health

INDICATOR 2.1.3
Number of countries and territories that have included ethnicity and health in their national development agendas

STRATEGIC LINE OF ACTION 2: Promotion of political action for universal access to health

<table>
<thead>
<tr>
<th>Utility</th>
<th>Contributes to the national development agenda with an ethnic perspective.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Concepts</td>
<td>National development agenda</td>
</tr>
<tr>
<td></td>
<td>Ethnic perspective (three groups)</td>
</tr>
<tr>
<td>Type of Indicator</td>
<td>Process indicator</td>
</tr>
<tr>
<td>Unit of Measurement</td>
<td>Number of countries and territories</td>
</tr>
<tr>
<td>Scale of Measurement</td>
<td>Absolute (counting)</td>
</tr>
<tr>
<td>Frequency of Measurement</td>
<td>Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).</td>
</tr>
</tbody>
</table>
CALCULATION

Counting the number of countries and territories with the attribute defined in the indicator.

Attribute: Explicit incorporation of ethnicity into national development agendas.

The incorporation of an ethnic (ethno-racial) perspective in the design and execution of public policy involves, in the short term, the incorporation of the ethno-racial variable in the systems of information records, plans, services, benefits, and social programs, among others, to gradually adjust public institutions in order to improve the capacities of their officials, operators, and managers.¹

Considered to be met if at least one of the three prioritized ethnic groups (Indigenous, Afro-descendant, and Roma populations) is included.

SOURCES

National government (Ministry of Health, national planning department or directorate, and others)

LIMITATIONS

All three groups are not always taken into account.

RESPONSIBLE UNITS

Country and Subregion Coordination Office and Office for Equity, Gender and Cultural Diversity.

NOTE:

### STRATEGIC LINE OF ACTION 2: PROMOTION OF POLITICAL ACTION FOR UNIVERSAL ACCESS TO HEALTH

#### OBJECTIVE 2.2
**Promote culturally appropriate health systems and services for all**

#### INDICATOR 2.2.1
**Number of countries and territories that have developed or are operating health systems with an intercultural approach**

<table>
<thead>
<tr>
<th><strong>UTILITY</strong></th>
<th>Responds to the need to articulate health systems and ensure culturally relevant health systems.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KEY CONCEPTS</strong></td>
<td>Health systems</td>
</tr>
<tr>
<td></td>
<td>Intercultural approach</td>
</tr>
<tr>
<td><strong>TYPE OF INDICATOR</strong></td>
<td>Process indicator</td>
</tr>
<tr>
<td><strong>UNIT OF MEASUREMENT</strong></td>
<td>Number of countries and territories</td>
</tr>
<tr>
<td><strong>SCALE OF MEASUREMENT</strong></td>
<td>Absolute (counting)</td>
</tr>
<tr>
<td><strong>FREQUENCY OF MEASUREMENT</strong></td>
<td>Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020-2022 (for the progress report) and 2023-2025 (for the final report).</td>
</tr>
</tbody>
</table>
Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Having, or having in development, health systems with an intercultural approach.

Intercultural health is considered a subfield of public health.\(^1\)

Health systems with an intercultural approach should incorporate three main actions: rationalization of curative care; disease prevention and health promotion; and strengthening of their own health system.\(^2\)

Considered to be met if at least one of the three prioritized ethnic groups (Indigenous, Afro-descendant, and Roma populations) is included.

**SOURCES**

National government (Ministry of Health and others)

**LIMITATIONS**

There is no consensus system or mechanism for monitoring and evaluating health systems in Latin America and the Caribbean.

**RESPONSIBLE UNITS**

Department of Evidence and Intelligence for Action in Health and Office for Equity, Gender and Cultural Diversity.

**NOTES:**


OBJECTIVE 2.2
PROMOTE CULTURALLY APPROPRIATE HEALTH SYSTEMS AND SERVICES FOR ALL

INDICATOR 2.2.2
NUMBER OF COUNTRIES AND TERRITORIES THAT HAVE POLICIES THAT ADDRESS DISCRIMINATION IN THE HEALTH SYSTEM BASED ON ETHNIC ORIGIN

UTILITY
Implements access to and coverage of culturally relevant health services as a quality criterion.

KEY CONCEPTS
Stigma
Discrimination
Barriers to access to services
Cultural belonging
Quality of services

TYPE OF INDICATOR
Process indicator

UNIT OF MEASUREMENT
Number of countries and territories

SCALE OF MEASUREMENT
Absolute (counting)

FREQUENCY OF MEASUREMENT
Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).
CALCULATION

Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Having at least one policy that addresses ethnic discrimination in the health system.

Considered to be met if at least one of the three prioritized ethnic groups (Indigenous, Afro-descendant, and Roma populations) is included.

SOURCES

National government (Ministry of Health and others)

LIMITATIONS

All three groups are not always taken into account.

RESPONSIBLE UNITS

Office for Equity, Gender and Cultural Diversity.
UTILITY

Promotes social and political instruments and practices for dialogue between governments, ethnic communities, and their organizations, to generate transparency and conditions of trust between citizens and their government, in addition to strengthening social oversight.

KEY CONCEPTS

Accountability
Reduction of inequities in health
Social and political practices
Dialogue between governments and communities
Social oversight

TYPE OF INDICATOR

Process indicator

UNIT OF MEASUREMENT

Number of countries and territories

SCALE OF MEASUREMENT

Absolute (counting)

FREQUENCY OF MEASUREMENT

Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).
**CALCULATION**

Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Production of a periodic report to provide accountability for the reduction of ethnic inequities in health.

This report can be part of the accountability materials published by institutions and organizations on their websites, such as dashboards and transcripts of government hearings, whether national (e.g., Senate) or local (e.g., town halls).

Health inequities are unjust differences in the health of people from different social groups, and can be associated with different disadvantages, such as poverty, discrimination, and lack of access to services or goods. While health inequity is a normative concept, and thus cannot be precisely measured or monitored, health inequality – observable differences between subgroups within a population – can be measured and monitored, and serves as an indirect means of evaluating health inequity.\(^1\) To talk about reducing inequities involves evaluating changes over time, with at least two reference points.

Considered to be met if at least one of the three prioritized ethnic groups (Indigenous, Afro-descendant, and Roma populations) is included.

**SOURCES**

Ministry of Health, oversight committees, and ombudsman's offices

**LIMITATIONS**

Reporting does not guarantee that corrective measures will be implemented for unfavorable findings about management and transparency.

**RESPONSIBLE UNITS**

Department of Health Systems and Services and Office for Equity, Gender and Cultural Diversity.

**NOTE:**

OBJECTIVE 3.1
PROMOTE THE PARTICIPATION OF DIFFERENT ETHNIC GROUPS IN THE DEVELOPMENT OF HEALTH-RELATED POLICIES AND ACTIONS

INDICATOR 3.1.1
NUMBER OF COUNTRIES AND TERRITORIES THAT ENSURE SOCIAL PARTICIPATION BY DIFFERENT ETHNIC GROUPS IN NATIONAL MECHANISMS HEALTH-RELATED POLICIES AND ACTIONS

UTILITY
Facilitates participation with voice and vote of different groups in designing policies and actions in health.

KEY CONCEPTS
Ensuring social participation
Participation mechanism
Social oversight

TYPE OF INDICATOR
Process indicator

UNIT OF MEASUREMENT
Number of countries and territories

SCALE OF MEASUREMENT
Absolute (counting)

FREQUENCY OF MEASUREMENT
Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).

STRAEGIC LINE OF ACTION 3:
PROMOTE SOCIAL PARTICIPATION AND STRATEGIC PARTNERSHIPS
Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Ensuring the social participation of any of the prioritized ethnic groups, in at least one of the national mechanisms related to health policies and actions.

Considered to be met if at least one of the three prioritized ethnic groups (Indigenous, Afro-descendant, and Roma populations) is included.

National mechanisms related to health policies and actions can be diverse and changing, since the institutional landscape changes as resources to support public policies are distributed among a multitude of national and supranational institutions. The number of institutional loci of expertise, often specialized in some aspect of public policy, has increased considerably, spanning a broad range of institutional forms, including research centers, foundations, academic units, independent consortia and think tanks, projects, technical agencies, and assorted initiatives.¹

**SOURCES**

Ministry of Health

**LIMITATIONS**

All three groups are not always taken into account. Mechanisms can vary greatly from one country to another, making comparison difficult.

**RESPONSIBLE UNITS**

Office for Equity, Gender and Cultural Diversity and Department of Family, Health Promotion and Life Course.

**NOTE:**

OBJECTIVE 3.1
PROMOTE THE PARTICIPATION OF DIFFERENT ETHNIC GROUPS IN THE DEVELOPMENT OF HEALTH-RELATED POLICIES AND ACTIONS

INDICATOR 3.1.2
NUMBER OF COUNTRIES AND TERRITORIES THAT HAVE FORMAL MECHANISMS FOR SOCIAL PARTICIPATION IN REPORTING ON THE REDUCTION OF ETHNIC INEQUITIES IN HEALTH

STRATEGIC LINE OF ACTION 3: PROMOTE SOCIAL PARTICIPATION AND STRATEGIC PARTNERSHIPS

UTILITY
Responds to the need for monitoring, evaluation, and transparency on inclusion of the ethnic perspective in health policies and their derived actions.

KEY CONCEPTS
Official mechanisms for social participation in accountability
Social participation
Social oversight
Health-related policies and actions

TYPE OF INDICATOR
Process indicator

UNIT OF MEASUREMENT
Number of countries and territories

SCALE OF MEASUREMENT
Absolute (counting)

FREQUENCY OF MEASUREMENT
Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).
CALCULATION

Counting the number of countries and territories with the attribute defined in the indicator.

Attribute: Having official social participation mechanisms regarding accountability to reduce ethnic inequities in health.

Considered to be met if at least one of the three prioritized ethnic groups (Indigenous, Afro-descendant, and Roma populations) is included.

Government accountability initiatives can be a way for political representatives to make better-informed decisions or to ensure that they respond to the real demands of society. This category includes initiatives such as direct consultations with citizens via referendums or advisory councils, citizen juries (working sessions with randomly selected citizens), workshops with key actors, sectoral panels and forums, social participation councils, management of programs and teams, and volunteer campaigns.¹

SOURCES

National government (Ministry of Health and others)

LIMITATIONS

All three groups are not always taken into account.

RESPONSIBLE UNITS

Office for Equity, Gender and Cultural Diversity.

NOTE:

OBJECTIVE 4.1
PROMOTE RECOGNITION, RESPECT, AND PROTECTION FOR TRADITIONAL, ANCESTRAL, AND COMPLEMENTARY MEDICINES IN NATIONAL HEALTH SYSTEMS

INDICATOR 4.1.1
NUMBER OF COUNTRIES AND TERRITORIES THAT HAVE LAWS, POLICIES, OR STRATEGIES TO RECOGNIZE, RESPECT, PROTECT, AND INCORPORATE TRADITIONAL, KNOWLEDGE-BASED ANCESTRAL, AND COMPLEMENTARY MEDICINE IN NATIONAL HEALTH SYSTEMS

UTILITY
Recognizes the different medical systems and responds to the specific health needs of each group.

KEY CONCEPTS
Traditional medicine
Ancestral medicine
Complementary medicine
Law
Policy
Strategy
Holders of traditional knowledge
Ancestral therapists

TYPE OF INDICATOR
Process indicator

UNIT OF MEASUREMENT
Number of countries and territories

SCALE OF MEASUREMENT
Absolute (counting)

STRATEGIC LINE OF ACTION 4: RECOGNITION OF ANCESTRAL KNOWLEDGE AND TRADITIONAL AND COMPLEMENTARY MEDICINE
FREQUENCY OF MEASUREMENT
Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).

CALCULATION
Counting the number of countries and territories with the attribute defined in the indicator.

Attribute: Having at least one law, policy, or strategy to recognize, respect, protect, and incorporate traditional, ancestral, and complementary medicine into national health systems.

Definitions to consider within this attribute:

» **Recognize**: Examine something or someone to know their identity, nature, and circumstances. Establish the identity of something or someone. Admit or accept something as legitimate. Admit or accept that someone or something has a certain quality or condition. Accept something as true.

» **Respect**: Have respect, veneration, adherence.

» **Protect**: Protect, favor, defend someone or something.

» **Incorporate**: Join one person or one thing to another or others to make a whole with them.

The definitions of traditional, ancestral, and complementary medicine to consider are:

» **Traditional medicine**: Sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement, or treatment of physical and mental illness.

» **Complementary medicine**: The terms “complementary medicine” or “alternative medicine” refer to a broad set of healthcare practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant healthcare system. In some countries, these terms are used interchangeably to refer to traditional medicine.

» **Traditional and complementary medicine**: “Traditional and complementary medicine” merges the terms “traditional medicine” and “complementary medicine,” encompassing products, practices, and practitioners.

Considered to be met if at least one of the three prioritized ethnic groups (Indigenous, Afro-descendant, and Roma populations) is included.
Impact and Process Indicators

SOURCES
Ministry of Health

LIMITATIONS
Illegality of traditional medicines, nonrecognition of complementary alternative medicines, and stigma and discrimination against representatives and users of traditional medicine.

RESPONSIBLE UNITS
Department of Health Systems and Services and Office for Equity, Gender and Cultural Diversity.

NOTE:
**OBJECTIVE 4.1**

Promote recognition, respect, and protection for traditional, ancestral, and complementary medicines in national health systems.

**INDICATOR 4.1.2**

Number of countries and territories that have institutional entities and guidance instruments to promote respect for traditional healers and ancestral therapists in the health sector.

**STRATEGIC LINE OF ACTION 4: RECOGNITION OF ANCESTRAL KNOWLEDGE AND TRADITIONAL AND COMPLEMENTARY MEDICINE**

<table>
<thead>
<tr>
<th>Utility</th>
<th>Advances health systems that recognize the plurality of medical systems.</th>
</tr>
</thead>
</table>
| Key Concepts | Hegemony of the Western medical system  
Ownership of spaces or entities  
Holders of traditional knowledge  
Ancestral therapists |
| Type of Indicator | Process indicator |
| Unit of Measurement | Number of countries and territories |
| Scale of Measurement | Absolute (counting) |
| Frequency of Measurement | Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report). |
Impact and Process Indicators

CALCULATION

Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Have in place institutional entities and guidance instruments to promote respect for traditional healers and ancestral therapists in the health sector.

National guidance bodies and tools related to the health sector can be diverse and changing; this is because the institutional landscape shifts as resources to support public policies are distributed among a multitude of national and supranational institutions. The number of institutional loci of expertise, often specialized in some aspect of public policy, has increased considerably, spanning a broad range of institutional forms, including research centers, foundations, academic units, independent consortia and think tanks, projects, technical agencies, and assorted initiatives.¹

Considered met if there is at least one institutional body or guidance tool to promote respect within the health sector for holders of traditional knowledge and ancestral therapists in at least one of the following ethnic groups: Indigenous peoples, Afro-descendants, and Roma.

SOURCES

Ministry of Health

LIMITATIONS

All three groups are not always taken into account.

Ministries of health without institutional references that help to assess the importance of traditional medicine.

RESPONSIBLE UNITS

Department of Health Systems and Services and Office for Equity, Gender and Cultural Diversity.

NOTE:

### OBJECTIVE 5.1
**STRENGTHEN INSTITUTIONAL AND COMMUNITY CAPACITIES IN ETHNICITY AND HEALTH**

### INDICATOR 5.1.1
**NUMBER OF COUNTRIES AND TERRITORIES THAT HAVE INCORPORATED INTERCULTURALISM INTO THE CURRICULAR CONTENT OF PROFESSIONAL TRAINING IN THE HEALTH SCIENCES, OR THAT HAVE TRAINING IN INTERCULTURAL COMPETENCIES FOR HEALTH PROFESSIONALS**

**UTILITY**

Monitors the incorporation of interculturalism into the curricular content of professional training in the health sciences, or of training in intercultural competencies for graduates from the health sciences professions.

**KEY CONCEPTS**

- Interculturalism
- Curricula
- Professional degrees
- Health sciences
- Intercultural competencies
- Mechanism for monitoring the incorporation of interculturality

**TYPE OF INDICATOR**

Process indicator

**UNIT OF MEASUREMENT**

Number of countries and territories

**SCALE OF MEASUREMENT**

Absolute (counting)

**FREQUENCY OF MEASUREMENT**

Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).
Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Incorporation of interculturalism into the curricular content of professional training in the health sciences, or training in intercultural competence into institutions of higher education.

Different models have been proposed since the beginning of intercultural education and training in interculturalism. Almost all of them agree on the need to develop certain “intercultural competencies,” understood as a set of knowledge, attitudes, and skills necessary for the effective performance of work in contexts of cultural diversity, and which comprise three fundamental dimensions:

- Cognitive – knowledge: cultural, contextual, and structural, first of “us” and then of “them”.
- Affective – empathy.
- Behavioral – communication and relationship skills.

Considered met if interculturality is included in the curricula of professional health sciences degrees or intercultural skills training in institutions of higher education.

**SOURCES**
Ministry of Health, Ministry of Education, and others

**LIMITATIONS**
There is not always coordination between the ministries of health and of education regarding health education with an intercultural perspective.

**RESPONSIBLE UNITS**
Department of Health Systems and Services and Office for Equity, Gender and Cultural Diversity.

**NOTE:**
OBJECTIVE 5.1
STRENGTHEN INSTITUTIONAL AND COMMUNITY CAPACITIES IN ETHNICITY AND HEALTH

INDICATOR 5.1.2
NUMBER OF COUNTRIES AND TERRITORIES WITH INSTITUTIONAL MECHANISMS TO INCORPORATE PROFESSIONALS FROM DIFFERENT ETHNIC GROUPS INTO THEIR HEALTH SERVICES

UTILITY
Monitors opportunities for health professionals from different ethnic groups to be included as workers in health services.

KEY CONCEPTS
Institutional mechanisms

TYPE OF INDICATOR
Process indicator

UNIT OF MEASUREMENT
Number of countries and territories

SCALE OF MEASUREMENT
Absolute (counting)

FREQUENCY OF MEASUREMEN
Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).

STRATEGIC LINE OF ACTION 5:
CAPACITY DEVELOPMENT AT ALL LEVELS
CALCULATION

Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Having at least one mechanism to incorporate professionals from different ethnic groups into health services.

Mechanisms to advance the incorporation of professionals of ethnic origin in health services can be diverse and changing in the countries of the Region, according to such factors as their regulations, nature of the health service, and level of complexity. It is important to emphasize that ethno-racial inequality in access to the labor market is also a consequence of inequities in access to formal and professional training, which places the majority of Afro-descendants and Indigenous people in the Region at a disadvantage in the face of modernization processes.¹

SOURCES

Ministry of Health and others

LIMITATIONS

The availability of professionals of ethnic origin will depend directly on the training opportunities that existed previously for each of the different groups. Having mechanisms such as ethnic criteria in selection processes does not necessarily lead to permanence and retention.

RESPONSIBLE UNITS

Department of Health Systems and Services and Office for Equity, Gender and Cultural Diversity.

NOTE:

Utility

Monitors that Member States have formal mechanisms promoting intercultural training of health staff working at the community level with Indigenous, Afro-descendant, or Roma populations.

Key Concepts

Institutional mechanisms
Health workforce
Community level

Type of Indicator

Process indicator

Unit of Measurement

Number of countries and territories

Scale of Measurement

Absolute (counting)

Frequency of Measurement

Every three years, starting from the baseline of 2019. Two periods will be evaluated: 2020–2022 (for the progress report) and 2023–2025 (for the final report).
**CALCULATION**

Counting the number of countries and territories with the attribute defined in the indicator.

**Attribute:** Having formal mechanisms that promote intercultural training for health staff at the community level.

Formal intercultural training can take place through study plans at all levels of schooling, specific short courses focusing on certain elements of intercultural competencies, and formalized experiential learning opportunities (e.g., through vocational training, or study or work abroad). It is important to note that some research\(^1,2\) has shown that the development of intercultural competencies is a lifelong process, so that a single training or experience is insufficient, if the objective is to fully develop such competencies.

There are many different types of intercultural training tools that are used in a wide variety of settings (e.g., education, business, government, and community development), including simulations, role play, case studies, and group activities or online tools and training, which require communication. These intercultural training tools are often used in a formal learning environment, such as a workshop or a course, and are usually provided by trainers with prior knowledge of intercultural theories, coupled with excellent skills. Typically, these tools should be used in a long-term context, beyond a single training session.\(^3\)

**SOURCES**

Ministry of Health and others
LIMITATIONS

Having training mechanisms in place does not ensure that staff will necessarily develop some of the fundamental dimensions of “intercultural competencies,” such as empathy, communication, and relationship skills.

RESPONSIBLE UNITS

Department of Health Systems and Services and Office for Equity, Gender and Cultural Diversity.

NOTES:


The purpose of this publication is to provide continuity to technical cooperation with the Member States of the Pan American Health Organization (PAHO) in estimating and monitoring the targets and indicators proposed by the Strategy and Plan of Action on Ethnicity and Health 2019–2025 in the different countries and territories, to measure the processes and impact derived from implementing the guidelines contained in the Policy on Ethnicity and Health.

The compendium and technical specifications that make up this publication are aimed in particular at cooperating partners and those in the health sector and other sectors who provide support for intercultural action in health. This mainly involves the ministries of health of the countries and territories, along with other government ministries and institutions, together with the support of key associates and cooperating partners.

The design of this technical tool, in line with the Policy on Ethnicity and Health, was guided by the basic objective of calculating and recording the progress to be achieved in the Region of the Americas between 2019 and 2025 in developing the measures necessary to guarantee an intercultural approach in providing access to health care and services. It has taken into account the social determinants of health, from a standpoint of equality and mutual respect, valuing the cultural practices of the Region’s ethnic groups, including their lifestyles, social organization, value systems, traditions, and worldviews.