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POLICY ON ETHNICITY AND HEALTH

Introduction

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

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

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

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

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

Background

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

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

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

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

Situation analysis

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

Health information systems

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

Social determinants of health

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

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

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

Health situation

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

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

Proposed Policy on Ethnicity and Health

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

Production of evidence

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

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

Promotion of political action

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

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

Social participation and strategic partnerships

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

Recognition of ancestral knowledge and traditional and complementary medicine

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

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

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

Capacity development at all levels

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

Action by the Executive Committee

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

Annexes

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Annex A

Glossary

The following is a glossary of key terms related to ethnicity and health to facilitate the reader's understanding of this policy document.

- *Afro-descendants:* In Latin America and the Caribbean, this refers to the different black or Afro-American cultures that emerged from the descendants of Africans who survived the transatlantic human trafficking, or slave trade, that flourished from the 16th to the 19th century.[1]

- *Culture:* The values, attitudes, norms, ideas, customs, and internalized perceptions, as well as concrete forms or expressions that are adopted and largely shared by a group of people. According to UNESCO (Mexico City Declaration, 1982), culture "gives man the ability to reflect upon himself. It is culture that makes us specifically human, rational beings, endowed with a critical judgment and a sense of moral commitment. It is through culture that values are discerned and choices are made. It is through culture that man expresses himself, becomes aware of himself, recognizes his incompleteness, questions his own achievements, seeks untiringly for new meanings and creates works through which he transcends his limitations."[2]

- *Collective rights:* In the international sphere, it has been recognized that the members of indigenous peoples and Afro-descendant groups have the right, individually or collectively with other members of their group, to exercise the following specific rights without discrimination: *a)* The right to property and to the use, conservation, and protection of lands traditionally occupied by them and to natural resources, in cases where their ways of life and culture are linked to their utilization of lands and resources; *b)* The right to their cultural identity, to keep, maintain, and foster their mode of life and forms of organization, culture, languages, and religious expressions; *c)* The right to the protection of their traditional knowledge and their cultural and artistic heritage; *d)* The right to prior consultation with respect to decisions which may affect their rights, in accordance with international standards.[3]

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[1] Definition coined by anthropologist Jhon Antón Sánchez, academic and activist of the Afro-descendant social movement. See Schkolnik S. La inclusión del enfoque étnico en los censos de población de América Latina. Notas de Población [Internet]. 2009 [cited 2017 Apr 14]; 36(89):57-99. pg. 65. Available in Spanish from:
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- *Knowledge dialogue:* A communication process in which different epistemologies – those based upon scientific knowledge and those based upon cultural wisdom – are brought together to interact, with the clear intention of fostering mutual understanding. This process implies recognition of "the other" as different, with different forms of knowledge and views. It is not at odds with intentionality in education if it is designed to promote freedom and autonomy, enabling each individual to make the decisions that are most appropriate for his or her particular situation and context. It is a scenario in which different truths, forms of knowledge, feelings, and reasoning are in play in the search for consensus, all the while respecting dissent. It is an encounter between human beings – learners and educators – in which both parties grow and are strengthened: a dialogue in which both parties are transformed.[4]

- *Cultural diversity:* The multiplicity of ways in which the cultures of groups and societies are manifested. These expressions are transmitted within groups and societies and also among them.[5]

- *Intercultural approach in health:* The intercultural approach to health promotes coexistence, respect, and mutual acceptance between the culture of the conventional health system and other cultures through collaboration between human resources for health and the community, the family, and social leaders.[6] The intercultural approach promotes their coexistence with respect and mutual acceptance between the institutional medical culture and indigenous cultures, with the close collaboration of social stakeholders, health workers, the family, the community, and community leaders.

- *Ethnic origin/Ethnicity:* Ethnicity is a purely social concept that refers to the characteristics common to a group of people that differentiate it from another group. Acquired through learning that begins in childhood, these characteristics are normally related to cultural practices, language, history, or ancestry. Members of a particular ethnic group view themselves as culturally different from those of other social groups, and they, in turn, are likewise viewed by others.[7]

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[6] Pan American Health Organization. *Op. cit.* (Note 2)

[7] OEA, Manual para la Transversalización de la temática Afrodescendiente en los Programas de cooperación técnica de la secretaria general de la OEA. Glosario de términos. Available from: http://www.oas.org/dil/esp/afrodescendientes_taller_transversalizacion_04-27-2011_manual.pdf

- *Ethnic Group***:** A group that identifies itself and is identified by others through certain common elements such as language, religion, tribe, nationality, race, or a combination thereof and that shares a common sense of identity. It can therefore be said that, thus defined, ethnic groups can also be considered peoples, nations, nationalities, minorities, tribes, or communities, depending on their different contexts and circumstances, making the concept broad and flexible enough to permit the inclusion, *inter alia,* of indigenous peoples and Afro-descendants.[8]

- *Interculturalism:* Interculturalism can be understood as the ability to recognize, harmonize, and negotiate the countless differences that exist within each society. It is also the communicative interaction between two or more human groups with different cultures, whether ethnic groups, societies, cultures, or communities. It is considered an interactive social process of recognition and respect for the differences that exist within or between cultures, which is essential for building a just society in the political, social, cultural, linguistic, gender, age, and generational sphere. In health, interculturalism implies an effort in and among all sectors to promote comprehensive[9] well-being. Thus, the *intercultural approach in health* is understood as all the elements and variables of interculturalism (culturally sensitive interventions in health services, recognition of traditional medicine) that are accepted, included, and respected in the health services – for example, ensuring culturally sensitive childbirth practices and prenatal care, etc.

- *Complementary medicine*: The terms "complementary medicine" and "alternative medicine" refer to a wide range health care practices that are not part of the tradition or conventional medicine of a particular country or fully integrated into the predominant health system. In some countries, these terms are used indistinguishably to refer to traditional medicine.[10]

- *Traditional medicine*: The sum of the knowledge, capacities, and practices derived from the theories, beliefs, and experiences of different cultures, whether explainable or not, used to maintain health and prevent, diagnose, improve, or treat physical and mental illnesses.[11]

- *Traditional and complementary medicine (TCM):* Fusion of the terms "traditional medicine" and "complementary medicine," it includes all the products, practices, and

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[8] Definition adopted by Rodolfo Stavenhagen, United Nations Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people. (2001-2006). See Schkolink S, Del Popolo F. Los censos y los pueblos indígenas en América Latina: Una metodología regional. Seminario Internacional Pueblos indígenas y afrodescendientes Pueblos indígenas y afrodescendientes de América Latina y el Caribe: relevancia y pertinencia de la información sociodemográfica para políticas y programas; 27-29 April 2005; Santiago de Chile, Chile. Santiago de Chile: CEPAL; 2005 [Accessed 14 April 2014]. Available from:
http://www.cepal.org/celade/noticias/paginas/7/21237/FdelPopolo-SScholnick.pdf

[9] Pan American Health Organization. *Op. cit.* (Note 2)

[10] WHO. Traditional Medicine Strategy 2014-2023 [Internet]. Geneva, Switzerland: WHO: 2013 [Accessed 14 April 2017] Available from:
http://www.who.int/medicines/publications/traditional/trm_strategy14_23/en/

[11] *Ibid.*

professionals related to these concepts.[12]

- *Indigenous peoples:* Indigenous communities, populations, and nations that, having historical continuity with the pre-colonial societies that existed prior to the invasion of their territories, consider themselves distinct from other sectors of the societies that now prevail in those territories or part of them. No longer the dominant sectors of society, today they are determined to preserve, develop, and transmit their ancestral lands and ethnic identity to future generations to ensure their continued existence as peoples with their own cultures, institutions, and legal systems.[13]

- *Race:* This is a sociological concept, since humanity is indivisible (definition adopted by the United Nations System). The concept of race has been developed to justify phenotypical differentiation between human beings and has been used not as an empirically demonstrated biological reference but as a social construct that employs some visible biological traits as classification criteria, despite the fact that genetics has shown that the human species has no such racial division (on the contrary, all human beings share the same biological traits, with phenotypical differences found in just 0.05% of DNA).[14]

- *Roma:* The term "Roma" refers to heterogeneous groups, the members of which live in various countries under different social, economic, cultural and other conditions. The term Roma thus does not denote a specific group but rather refers to the multifaceted Roma universe, which is comprised of groups and subgroups that overlap but are united by common historical roots, linguistic communalities and a shared experience of discrimination in relation to majority groups. "Roma" is therefore a multidimensional term that corresponds to the multiple and fluid nature of Roma identity[15]. In the Region of the Americas, a majority of the Spanish and Portuguese speaking countries refer to Roma as Gypsies or Ciganos (Portuguese). However, some preferred "Roma people"[16].

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[12] *Ibid.*

[13] International organizations have reached a consensus on the definition developed by Martínez Cobo, Special Rapporteur of the United Nations Commission on Human Rights, charged with examining the human rights situation of indigenous peoples (1971-1986). This consensus was expressed in Convention 169 and has been included in other conventions and instruments of the Inter-American System and the United Nations System. See Schkolnik S. *Op. cit.* pg. 64 (Note 1)

[14] Organización de los Estados Americanos. *Op. cit.* (Note 7).

[15] Human Rights Council. Comprehensive study of the human rights situation of Roma worldwide, with a particular focus on the phenomenon of anti-Gypsyism [Internet]. Thirty ninth Session of the Human Rights Council; 11 May 2016; Geneva, Switzerland: United Nations Special Rapporteur on Minority Issues. HRC; 2015 (Document A/HRC/29/24) [cited 2017 Apr 14]. Available from: http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session29/Pages/ListReports.aspx

[16] Regional workshop on the situation of Roma in the Americas [Internet]. Thirty-first Session of the Human Rights Council; 29 February-24 March 2016; Geneva, Switzerland: United Nations Special Rapporteur on Minority Issues. HRC; 2016 (Document A/HRC/31/CRP/2) [cited 2017 Apr 14]. Available from:
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjJ18jt9_zTAhVFNSYKHX4YCRcQFggiMAA&url=http%3A%2F%2Fwww.ohchr.org%2FEN%2FHRBodies%2FHRC%2FRegularSessions%2FSession31%2FDocuments%2FA.HRC.31.CRP.2_E.docx&usg=AFQjCNHyTXHyTwWnEIngLjvyMXFdDn6tpg

Annex B

International human rights instruments applicable to the health and ethnicity context not previously cited in other PAHO resolutions[1] (non-exhaustive list)

International human rights instruments applicable to the health and ethnicity context

United Nations Human Rights System:

a) Indigenous and Tribal Peoples Convention, No. 169 (International Labour Organization, 1989)
http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312314

b) International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1965)[2]
http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx

Inter-American Human Rights System

a) Inter-American Convention against Racism, Racial Discrimination, and Related Forms of Intolerance (Organization of American States, 2013)[3]
http://www.oas.org/en/sla/dil/inter_american_treaties_A-68_racism.asp

b) Inter-American Convention against All Forms of Discrimination and Intolerance (Organization of American States, 2013)[4]
http://www.oas.org/en/sla/dil/inter_american_treaties_A-69_discrimination_intolerance_signatories.asp

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

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

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

[4] *Idem*.

International human rights standards applicable to the health and ethnicity context

United Nations System:

a) United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007)
http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

b) Vienna Declaration and Programme of Action (World Conference on Human Rights, 1993)
http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx

c) The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights). General Comment No. 14 (2000). (Committee on Economic, Social and Cultural Rights, United Nations, 2000)
http://undocs.org/en/E/C.12/2000/4

d) General Recommendation XXVII on discrimination against Roma.
(Committee on the Elimination of Racial Discrimination, 2000)
http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCERD%2fGEC%2f7499&Lang=en

e) General Recommendation No. 34 on Racial Discrimination against People of African Descent (Committee for the Elimination of Racial Discrimination, 2011)
http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?TreatyID=6&DocTypeID=11

f) Declaration on the Rights of Persons Belonging to National or Ethnic, Religious, and Linguistic Minorities (United Nations General Assembly, 1992)
http://www.ohchr.org/EN/ProfessionalInterest/Pages/Minorities.aspx

g) Directrices de protección para los pueblos indígenas en aislamiento y en contacto inicial de la región amazónica, Gran Chaco y región oriental del Paraguay (Oficina del Alto Comisionado de las Naciones Unidas para los Derechos Humanos, 2012)
http://acnudh.org/wp-content/uploads/2012/03/Final-version-Guidelines-on-isolated-indigenous-peoples-february-2012.pdf

Inter-American System

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

Global and regional consensuses applicable to the context of the health of indigenous peoples, Afro-descendants, Roma, and other ethnic groups (non-exhaustive list)

a) World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance (2001)
http://www.un.org/WCAR/durban.pdf

b) Rio Political Declaration on Social Determinants of Health (World Health Organization, 2011)
http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf?ua=1

c) World Summit of African Descendants (2011)
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=9&ved=0ahUKEwisgoGdv_7TAhXGMyYKHSaCAmEQFghJMAg&url=http%3A%2F%2Fwww.summit-americas.org%2Fcs%2Fmeetings%2F081711%2Fsas.doc&usg=AFQjCNGJdvOWfWbrk_rFsoDeemE8W6drrw&cad=rja

d) International Decade for People of African Descent 2015-2024 (2013)
http://www.un.org/en/events/africandescentdecade/

e) World Conference on Indigenous Peoples (2014)
http://www.un.org/en/ga/69/meetings/indigenous/#&panel1-1

f) 2030 Agenda for Sustainable Development (2015)
http://www.un.org/sustainabledevelopment/

g) Plan of Action for the Decade for Persons of African Descent in the Americas (2016)
http://www.oas.org/en/sare/documents/res-2891-16-en.pdf

160th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 26-30 June 2017

PROPOSED RESOLUTION

POLICY ON ETHNICITY AND HEALTH

THE 160th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the *Policy on Ethnicity and Health* (Document CE160/15),

RESOLVES:

To recommend that the Pan American Sanitary Conference adopt a resolution in the following terms:

POLICY ON ETHNICITY AND HEALTH

THE 29th PAN AMERICAN SANITARY CONFERENCE,

(PP1) Having reviewed the *Policy on Ethnicity and Health* (Document CSP29/__);

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

(PP3) Recalling the principles enshrined in the Durban Declaration and Programme of Action (2001); the United Nations Declaration on the Rights of Indigenous Peoples (2007), the Rio Political Declaration on the Social Determinants of Health (2011); the World Summit of Afro-descendants (2011); the International Decade for People of African Descent 2015-2024 (2013); the World Conference on Indigenous Peoples (2014); and the 2030 Agenda for Sustainable Development (2015), as well as the principles enshrined in other international instruments related to ethnicity and health;

(PP4) Referring to the framework of PAHO mandates related to the health of indigenous peoples, the mainstreaming of ethnicity as a cross-cutting theme of the PAHO Strategic Plan, and the lessons learned;

(PP5) Recognizing the importance of PAHO as a whole (PASB and Member States) emphasizing efforts to strengthen the intercultural approach to health to guarantee the enjoyment of the highest attainable standard of health by indigenous peoples, Afro-descendants, Roma, and other ethnic groups, as appropriate, based on their respective national context;

(PP6) Bearing in mind the need to adopt the necessary measures to guarantee the intercultural approach to health and equal treatment of indigenous peoples, Afro-descendants, Roma, and other ethnic groups from the standpoint of equality and mutual respect, considering the value of their cultural practices, which include their lifestyles, value systems, traditions, and world views,

RESOLVES:

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

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

a)   promote public policies that address ethnicity as a social determinant of health from the perspective of indigenous peoples, Afro-descendants, Roma, and other ethnic groups;

b)   foster better access to quality health services, among other things, promoting intercultural health models that, through dialogue, include the perspective of the ancestral and spiritual wisdom and practices of indigenous peoples, Afro-descendants, Roma, and other ethnic groups, as appropriate, based on the respective national context;

c)   strengthen institutional and community capacity in the Member States to produce sufficient quality data and generate evidence for policy-making with respect to the inequalities and inequities in health experienced by indigenous peoples, Afro-descendants, Roma, and other ethnic groups for intersectoral policy-making in health;

d)   strengthen institutional and community capacity at all levels to implement the intercultural approach to health systems and services, helping to guarantee access to quality health services;

e)   increase, promote, and ensure the social participation of all indigenous peoples, Afro-descendants, Roma, and other ethnic groups in the regulatory translation and

implementation of health policy, considering gender differences and life-course perspective;

f)   promote the generation of knowledge and dedicated spaces for ancestral medicine and wisdom to strengthen the intercultural approach to health;

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

h)   promote intersectoral cooperation for the sustainable development of indigenous peoples, Afro-descendants, Roma, and other ethnic groups.

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

a)   advocate for the inclusion of strategic components on ethnicity and health in the Health Agenda for the Americas 2018-2027 and the PAHO Strategic Plan 2020-2025;

b)   prioritize technical cooperation to assist countries in strengthening health system capacity to include ethnicity as a social determinant of health from the perspective of indigenous peoples, Afro-descendants, Roma, and other ethnic groups, in line with the Sustainable Development Goals (SDGs) and the framework of applicable international and regional human rights instruments;

c)   continue prioritizing ethnicity as a cross-cutting theme of PAHO technical cooperation, in harmony with gender, equity, and human rights;

d)   strengthen interinstitutional coordination and collaboration mechanisms to achieve synergies and efficiency in technical cooperation within the United Nations and Inter-American systems and with other stakeholder entities working in the field of ethnicity in health, especially subregional integration mechanisms and pertinent international financial institutions.

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

1.	**Agenda item:** 4.5. Policy on Ethnicity and Health
2.	**Linkage to** PAHO Program and Budget 2016-2017 **a)** **Category:** 3. Determinants of Health and Promoting Health throughout the Life Course: Promoting good health at key stages of life, taking into account the need to address the social determinants of health (social conditions in which people are born, grow, live, work and age) and implementing approaches based on gender equality, ethnicity, equity, and human rights. **b)** **Program areas and outcomes:** Program Area: 3.3. Gender, Equity, Human Rights, and Ethnicity. Outcome 3.3: Increased country capacity to integrate gender, equity, human rights, and ethnicity in health.
3.	**Financial implications:** a) **Total estimated cost for implementation over the lifecycle of the resolution (including staff and activities):** Approximately US$ 1,836,000 per biennium, on approval of the policy and during the time it remains in force. The estimate corresponds to the biennium in which the strategy or plan is implemented for execution of the policy. The Organization's budget and operating plans will be incorporated in the program for its monitoring and evaluation. Of the total amount, an estimated US$ 734,400 will be allocated to staff and US$ 1,101,600 to activities. The current budget for ethnicity for the 2016-2017 biennium is estimated at US$ 1,100,000; this implies an additional financial commitment of US$ 736,000 for executing the policy in subsequent bienniums. **b)** **Estimated cost for the 2016-2017 biennium (including staff and activities):** US$ 220,300 (cost of implementing the policy from September to December 2017). **c)** **Of the estimated cost noted in *b)*, what can be subsumed under existing programmed activities?** US$ 100,000.
4.	**Administrative implications:** **a)** **Indicate the levels of the Organization at which the work will be undertaken:** All levels of the Organization will be involved: programmatic, national, regional, and subregional. Active participation by the ministries of health of the Member States and subregional organizations and mechanisms will also be necessary.

b) **Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**
There is currently a post for a full-time cultural diversity advisor (P4) and a half-time gender and ethnicity advisor working on the generation of evidence. A full-time specialist in cultural diversity (P3) and a half-time medical anthropologist (P4) will also be needed.

c) **Time frames (indicate broad time frames for implementation and evaluation):**
Execution will begin as soon as they policy is approved by the Directing Council to ensure its inclusion in the new Strategic Plan and the Program and Budget.

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES
1. Agenda item: 4.5. Policy on Ethnicity and Health
2. Responsible unit: Gender and Cultural Diversity/Department of Family, Gender, and Life Course (FGL)
3. Preparing officer: Dr. Andrés de Francisco Serpa
4. Link between Agenda item and Health Agenda for the Americas 2008-2017**:**   Execution of the Policy on Ethnicity and Health offers the opportunity to contribute to progress in the following areas, as defined in the Health Agenda for the Americas: tackling health determinants; increasing social protection and access to quality health services, and diminishing health inequalities among countries and inequities within them. Moreover, one of the principles and values in the Agenda is equity in health, which calls for eliminating all avoidable unjust, and remediable inequalities in health among populations and groups.
5. Link between Agenda item and PAHO Strategic Plan 2014-2019**:**   This item falls under Category 3, "Determinants of Health and Promoting Health throughout the Life Course": "Promoting good health at key stages of like, taking into account the need to address the social determinants of health (social conditions in which people are born, grow, live, work and age) and implementing approaches based on gender equality, ethnicity, equity, and human rights."   As stated in the Strategic Plan, work in this category includes the ethnicity approach as a cross-cutting component in technical cooperation efforts across the Organization. Moreover, this approach is essential for addressing the social determinants of health and equity to improve health outcomes in the Region, especially among ethnic groups.
6. List of collaborating centers and national institutions linked to this Agenda item: • Ministries of health and national health institutions   • Other government agencies and entities that work with indigenous peoples, Afro-descendants, Roma, and other ethnic groups--in particular, those connected with intercultural health   • PAHO/WHO Collaborating Centers   • Civil society organizations and the organizations of indigenous peoples, Afro-descendants, Roma, and other ethnic groups   • Universities   • United Nations agencies and specialized entities   • Treaty bodies and other mechanisms of the United Nations system relevant to the health of indigenous peoples, Afro-descendants, Roma, and other ethnic groups, as appropriate, and

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

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

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

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

8. Financial implications of this Agenda item:

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

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