# Equidad en salud:

desde la perspectiva de la etnicidad

# Equity in Health:

From an Ethnic Perspective

# Equidade em saúde:

pelo prisma da etnicidade


**Programa de Políticas Públicas y Salud**
**División de Salud y Desarrollo Humano**

**Public Policy and Health Program**
**Division of Health and Human Development**

**Programa de Políticas Públicas e Saúde**
**Divisão de Saúde e Desenvolvimento Humano**



**Organización Panamericana de la Salud**
**Pan American Health Organization**
**Organização Pan-Americana da Saúde**

**Washington, D.C. / Junio /June/Junho 2001**

**Referencia:**

Organización Panamericana de la Salud
Equidad en salud: desde la perspectiva de la etnicidad
Washingon, D.C.: OPS, © 2001.
—236p. —

ISBN 92 75 07386 4

I. Título II. Cristina Torres III. del Río, Mercedes IV. Organización Panamericana de la Salud

1. GRUPOS ETNICOS
2. CARACTERISTICAS DE LA POBLACION
3. EQUIDAD EN EL ESTADO DE SALUD
4. EQUIDAD EN EL ACCESO
5. DEMOGRAFIA
6. JUSTICIA SOCIAL

NLM WA300.T693 2001



Ilustraciones en la cubierta:
-“African Bowl Bearer”
-Máscara de oro precolombina
-Caligrafía china

Revisión y diagramación de textos
diseño de cubierta:
*Clara Inés Rodríguez*

# Contenido / Contents / Conteúdo

Presentación ..... 1

Etnicidad y salud: Otra perspectiva para alcanzar la equidad ..... 3

Etnia, pobreza y salud en la Región de las Américas:
Una mirada histórica para entender esta relación ..... 53

Presentation ..... 79

Ethnicity and Health: Another Perspective Towards Equity ..... 81

Ethnicity, Poverty, and Health in the Region of the Americas:
A Historical Perspective to Understand this Relationship ..... 129

Apresentação ..... 153

Etnicidade e saúde: Outra perspectiva para alcançar a equidade ..... 155

Etnia, pobreza e saúde na Região das Américas:
Una visão histórica para compreender esta relação ..... 205

# Presentation

At the beginning of the new millennium, the Pan American Health Organization has shown, once more, to be attentive to the concern of governments and of the international community to reduce the social and health inequities as a way of contributing to the improvement of the democratic systems and to the development of the Region.

It is in this regard that the Organization incorporates, in the cooperation activities of its Health and Human Development Division, the ethnic and racial perspective for analyzing health inequities understood as unjustifiable and unjust differences among human groups.

It is our conviction that, together with the differences based on gender and socioeconomic status, ethnic-racial discrimination constitutes a barrier to access to health care, to information and to equal care that generates differences in the health situation of individuals belonging to minority ethnic groups.

It is in this framework that the Public Policy and Health Program has initiated a line of work involving the conceptual development with regard to this subject, the collection of empirical evidence for a regional diagnosis about it and the proposition of policy alternatives to deal with its implications.

On this occasion, I am proud to present two of the works prepared with this purpose. I hope that they will contribute to the on-going reflection about this topic in many countries of our Region, both at the level of governments and in the academic area.

I want to express my gratitude to the team that, under the direction of doctor Cristina Torres, was responsible for this task. I like to thank, particularly, Prof. David Williams of the University of Michigan and Senator Piedad Córdoba from Colombia, two recognized experts in the field, who were the first to read the preliminary version of these works, and whose observations and suggestions contributed to improve our perspective and vision on this matter.

Finally, I wish to transmit the hope, shared by all those committed to this area of work, that in this new century that has just begun it may be possible to fulfill the aspirations for a more just and equitable social world with health for all in the Region of the Americas.

César Vieira
Public Policy and Health Program
Division of Health and Human Development
PAHO/WHO

# Ethnicity and Health: Another Perspective Towards Equity

Cristina Torres

# Contents

Introduction ---------- 85

The Ethnic Approach in the Regional Policy Agenda and in the Technical Cooperation Agencies and International Financing Organizations ---------- 87
Regional Policy Agenda ---------- 87
Technical Cooperation Agencies and International Financing Organizations ---------- 89

The Ethnic Perspective in a Demographic Look at the Region ---------- 92

Ethnicity and Health Indicators by Ethnic Group ---------- 99

Case Studies ---------- 104
Brazil ---------- 104
Guatemala ---------- 111

Conclusions ---------- 116

Conceptual Glossary ---------- 119

Bibliography ---------- 123

**Tables**
1. Estimated Indigenous Population of the Americas ---------- 93
2. Population in Latin America with African Ancestors ---------- 94
3. Population of Brazil by Race and State (1996) ---------- 105
4. Crude Birth Rate, Crude Death Rate, Infant Mortality, and Life Expectancy at Birth in Brazil, by States (1997) ---------- 110
5. Percentage and Life Expectancy of the Indigenous Population by Gender and Geographical Distribution in Guatemala ---------- 115

**Figures**
1. Afro Latin American Populations ---------- 95
2. Distribution of Brasilian Population by Ancestry ---------- 106
3. Distribution of the Guatemalan Population by Ancestry ---------- 112

# Ethnicity and Health: Another Perspective Towards Equity

**Cristina Torres, Ph.D in sociology**[1]

## Introduction

At the core of today's development policy agenda is the notion that poverty can be reduced only by increasing equity. It is understood that for specific population groups to bridge the development gap, action in this direction should not be confined to introducing corrections in the labor market. Rather, the asymmetries in access to education and health services and in political representation must also be addressed. There is an awareness today of new, explanatory factors for structural exclusion, such as gender and ethnicity, which had never before been considered in policy design.

This approach was needed, given the less-than-impressive results of the past and the evidence that the earlier strategy had not only failed to guarantee sustained growth but had widened the existing gaps. Latin America and the Caribbean (LAC] constitute the region with the widest disparities in income, as well as in other determinants of the quality of life, including health and access to services.

In the various sectors—particularly the national area—public policy-making has been reenergized to bring about a positive redistribution that benefits disadvantaged groups (policies and programs to combat poverty). This has been coupled with a growing interest in employing successful targeting mechanisms to reach vulnerable groups, within the context of efficient use of available resources. The current challenge in the health sector is to reduce poverty by increasing equity.

In addition, the Pan American Health Organization (PAHO/WHO) shares the concern of the Latin American and Caribbean governments about alleviating poverty, and is therefore directing part of its efforts to reducing inequities in health. For this reason, the Division of Health and Human Development (HDP/PAHO) has centered its technical cooperation on *Equity and Health*. Within this general context, the

[1] Regional Policy Adviser, Program on Public Policy and Health, Division of Health and Human Development, PAHO/WHO. Doctors Mercedes del Río (Research Associate of the Department of Anthropology, Smithsonian Institution), Teresinha Fagundes (Institute of Collective Health, Federal University of Bahía), and Pamela Henderson, Consultant, Public Policy and Health Program, PAHO/WHO, collaborated in the various stages of production of the document.

purpose of this paper is to contribute to the study of inequities in health, exploring the link between health and ethnicity.

The central ideal of this paper is that racial discrimination is a social factor responsible for health differentials among individuals. Discrimination in health operates in different ways: either directly, in the form of barriers in access to services, poor quality services, and inadequate information for decision-making; or, through indirect mechanisms linked with lifestyles, place of residence, type of occupation, income level, or *status* of the individual. The real historical process of the Region subordinated ethnic minorities and slowed the building of identity among these groups. As a consequence, they are denigrated as "the Other," and are sometimes identified by their skin color or especially noticeable aspects of their culture, such as language or dress. This process of segregation and self-exclusion in itself generates disease by imposing greater stress on individuals, harsher living conditions, and barriers in access to health services.

Reducing the gaps in health, therefore, not only contributes to a concrete improvement in health and living conditions but helps to reverse the historical process of deprivation, and create the basic conditions for undoing the damage done and strengthening the cultural identify of ethnic minorities. This empowerment will boost their potential to exert a positive influence on multiculturalism in the Region.

It should be pointed out that ethnic relations in the Region are extremely heterogeneous (cultural diversity) due to the large number and cultural complexity of the population groups that have inhabited this territory over the past 500 years or so—indigenous peoples, Europeans, groups of African origin, and others—sharing an economic and political process. This paper focuses on the link between the health situation and ethnicity in Latin America, even though the situation in the United States and/or the Caribbean is often cited to add depth to the analysis and underscore its indisputably social nature.

In order to accomplish this task, a number of questions need to be answered. The first is, how are regional political authorities and agencies reacting to this issue? The second is, do health conditions vary among ethnic groups and why are such variations present throughout the Region despite the marked regional and historical differences? The third is how do ethnic determinants articulate with socioeconomic determinants and what is the influence of each? And finally, how can we clear up the matter of how to measure health inequities stemming from racial or ethnic discrimination?

In the chapters that follow we will attempt to address these issues. The paper ends with conclusions intended to provoke discussion and contribute to the design of public policies aimed at identifying and reducing health inequities of ethnic origin.

# The Ethnic Approach in the Regional Policy Agenda and in the Technical Cooperation Agencies and International Financing Organizations

## a. Regional Policy Agenda

The celebration marking the 500th anniversary of the discovery of the Americas ignited a debate on the impact of colonialism in terms of the current marginalization and exclusion of indigenous peoples from mainstream society. However, it should be noted that on that same occasion, the issues of the African diaspora and contemporary forms of discrimination were not accorded the same visibility.

The II Ibero-American Summit held in Madrid (1992) laid the groundwork for the creation of a Fund for the Development of the Indigenous Peoples of Latin America and the Caribbean as a concrete expression of the objectives of the Declaration of Guadalajara (1991). However, the political will to respect ethnic pluralism and defend the right to cultural identity was not confined solely to this resolution but manifested in other major forums in the 1990s.

By way of example it should be recalled that at the I Summit of the Americas in Miami (1994), the presidents of the Hemisphere emphatically declared:

> *It is politically intolerable and morally unacceptable that some segments of our populations are marginalized and do not share fully in the benefits of growth. With an aim of attaining greater social justice for all our people, we pledge to work individually and collectively to improve access to quality education and primary health care and to eradicate extreme poverty and illiteracy. The fruits of democratic stability and economic growth must be accessible to all, without discrimination by race, gender, national origin or religious affiliation.*

This forceful recommendation led to the preparation of the Declaration and Program of Action of Copenhagen during the World Summit for Social Development in 1995. Among its numerous commitments, this document, which contains a set of ambitious goals aimed at the eradication of poverty, social marginality, and violence, calls for the promotion of social integration based on non-discrimination and respect for diversity, a concept that includes the most vulnerable and disadvantaged groups in society.

It is of the utmost importance to mention that during that same decade, the U.S. Government recognized the key role that sociocultural factors (for example, race and ethnicity) can play in addressing development problems and in introducing positive changes into the U.S. health system. Indeed, Surgeon General Dr. David

Satcher's project, "Healthy People 2010 Objectives," (1998) links the presence of particular diseases or limitations to health service access with specific ethnic groups, U.S. racial minorities, and sex and age indicators. The project seeks to promote health and prevent health problems through community programs, education, and health services, and it underscores that a deterioration in health or in prevention is closely associated with socioeconomically and culturally linked behaviors (diet, environment, tobacco use, and others) found in the country's different social groups.

That same year, at the conference *Eliminating Racial and Ethnic Disparities in Health: a Chartbook*, organized by Grantmakers in Health (GIH) and the U.S. Department of Health and Human Services, former president, Bill Clinton, noted that racial and ethnic disparities still persist in the U.S. population in certain areas such as infant mortality, HIV/AIDS, cancer, diabetes, heart disease, and immunization.

In addition, confirming these recent trends, the presidents of the countries of the Hemisphere, gathered at the II Summit of the Americas (Chile, 1998), again underscored the importance of working on social and cultural variables to address poverty in a comprehensive manner. Thus, in their final declaration they stated that extreme poverty and discrimination continue to adversely affect the lives of many families in the Hemisphere, preventing them from contributing to our nations' progress. In order to secure a prosperous future for all, the countries will facilitate regularization of the deeds to urban and rural property, redouble efforts to improve access to credit and technical support for microenterprises, and protect the basic rights of workers. The Presidents pledged to eliminate all forms of discrimination against women, indigenous communities, marginalized racial and ethnic minorities, and other vulnerable groups. They also pledged to improve the quality of life for all the peoples of the Americas by working to ensure access to adequate health services, improved health technologies, drinking water, and good nutrition, pointing out that these activities would facilitate the inclusion of all inhabitants, without exception, in the economic and democratic transformation of the Hemisphere.

Finally, in their final declaration, the Ibero-American Presidents gathered in Cuba (1999) noted the opportunities offered by globalization to achieve development and the well-being of the peoples of the Hemisphere, which has led their countries to work to achieve the greatest possible benefits under the new conditions of the global economy. However, noting that the countries still face obstacles to reducing economic and social inequalities, they considered it necessary to strengthen social policies to achieve that end, to ensure that the most vulnerable sectors have access to the opportunities offered by globalization, and to close the gap not only between the developed and developing countries but between the highest- and lowest-income segments of the population.

The year 2001 will be a key year, in light of the UN World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance. At the preparatory meeting for the Region of the Americas, the governments, in numeral 111 of the Declaration request "the Pan American Health Organization to promote activities for the recognition of the variant race/ethnicity/gender as a significant variable in health matters and to prepare specific projects for prevention, diagnosis and treatment among people of African descent".

## b. Technical Cooperation Agencies and International Financing Organizations

Following the mandates of the political fora mentioned above, many technical and financial cooperation agencies have sought to improve knowledge and gear interventions to providing programs for poverty reduction with an approach that takes gender, ethnicity, and/or race into account, thus making them more effective.

The World Bank and the Inter-American Development Bank (IDB) have been the two most influential institutions in terms of financing the countries of the Region, promoting policies to meet the needs of indigenous communities in terms of environmental issues, the struggle against poverty, and more recently, combating inequity in Afro populations. These institutions have revamped the concept of development, promoting sustainable, endogenous social development. Thus, they consider sociocultural and participatory factors fundamental, since they are at the heart of the economic development process.

In 1991, the World Bank expanded its indigenous peoples-centered approach, adopting a participatory self-management strategy for its development programs. Between 1992 and 1996 some 31 projects were approved. In the public health sector, the Bank supported four projects in Latin America to identify indigenous populations at risk owing to their environmental sanitation and health conditions. Moreover, to strengthen indigenous organizations, in 1993 the Bank provided support for a training program that targeted the indigenous population (Uquillas, 1996).

By the year 2000, the World Bank, in conjunction with the IDB and the Inter-American Dialogue (IAD), sponsored a meeting in Washington, D.C., entitled "Race and Poverty: Interagency Consultation on the Afro-Latin American," in which NGOs representing Afro communities in the Region participated.

Earlier, at the managers' meeting corresponding to the Eighth Replenishment, the IDB adopted a recommendation that the Bank strengthen areas devoted to promoting equity. This paved the way for a program to alleviate poverty among minority groups in Latin America (1995-1996), financed by the IDB and executed by Cowater

International (Canada). Numerous local initiatives were carried out in the Latin American countries with marginalized, impoverished ethnic minorities.

It should also be pointed out that the topic was introduced in a very innovative fashion, and that studies were undertaken of the situation of Afro groups in nine Latin American countries (Argentina, Costa Rica, Colombia, Ecuador, Honduras, Nicaragua, Peru, Uruguay, and Venezuela)[2] . These studies constitute an extremely valuable effort to heighten the interest in inequities among Afro groups, placing the issue on a par with the situation of marginalized indigenous populations.

Within the framework of this initiative, in 1996 delegates from 13 countries came together and coincided on the importance of this issue for meeting equity targets in the next millennium. The result was the joint "Afro-America XXI" declaration, which contains a plan of action and a proposal to establish a network.

Consistent with the activities described above, in 1998, prior to the XXXIX Annual Meeting of its Board of Governors, the IDB held a colloquium in Cartagena de Indias (Colombia) on Social Programs, Poverty and Citizen Participation. As a corollary to this activity, an agreement was reached to promote the strengthening of civil society and citizen participation as the engine of change in Latin America, in the understanding that sustained economic growth and modernization are incompatible with the profound internal socioeconomic inequalities in the Region and the problems stemming from exclusion. The analysis of 32 case studies in the seminar's workshops yielded a recommendation that governments develop participatory projects and social policies (Jarquin and Caldera, 2000).

Furthermore, the attention focused on this topic by the United Nations should also be noted. The U.N. has had the problem of racial discrimination on its agenda since 1948, the year in which the General Assembly adopted the Universal Declaration of the Rights of Man,[3] which expressly calls for the elimination of prejudice and discrimination. Some years later, in 1965, the General Assembly adopted the International Convention on the Elimination of All Forms of Racial Discrimination and for the first time organized a Committee on the Elimination of Racial Discrimination, which commenced activities in 1969. The closing decades of the last century witnessed the Declaration on Race and Racial Prejudice (1978), the Declaration on the Elimination of All Forms of Intolerance and of Discrimination based on Religion or Belief (1981) and the Declaration on the Rights of Persons Belonging to National or Ethnic, Religious or Linguistic Minorities (1992). At the same time, programs of action were implemented (1973-2003) that focused on

[2] This program was sponsored by Cowater International under the direction of M. Sanchez and M. Franklin of the Organization of Afro-Americans.

[3] Adopted by the 58 Member States, it declares the right to freedom of association, political elections, opinion, and expression, the right to employment and collective development.

ending discrimination through educational campaigns, the preparation of national legislative models that contain these objectives, and other measures.

The United Nations is currently organizing a World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance (South Africa in 2001)[4]. A United Nations committee, with support from the Rockefeller Foundation, is in charge of the preparations and has consulted with experts and NGOs in several countries to develop recommendations on a series of burning issues such as racism, globalization, ethnic conflicts, and others. Among these efforts was the Conference held in Bellagio, Italy (2000) . In the text of the declaration issued by the Conference, the committee noted that indigenous peoples, people of color in the Americas, and "excluded majorities" such as Afro-Brazilians are currently the victims of racial discrimination and intolerance. Although the roots of this situation lie in colonialism and slavery, the experts felt that economic globalization, multiple identities, and unequal development models are significant factors that, if not carefully controlled, can exacerbate the situation. Although they understood that these problems are global in nature, they demanded concrete plans of action and proposed that social aspects be utilized to reduce exclusion and prevent racism and cultural stereotyping[5] .

The Inter-American Human Rights Commission from the Organization of American States (OAS) has been also working on issues related with racial discrimination and indigenous population's rights. The Commission has produced several reports on national situations.

UNICEF has also promoted health programs among Afro-Ecuadorian populations in the Province of Esmeraldas. In addition, the Pro-Andes Program is emphasizing the cultural contributions of upland indigenous populations and the African groups along the Guayaquil coast.

Finally, this chapter cannot end without mentioning the "Convention Concerning Indigenous and Tribal Peoples in Independent Countries"[6] of the International Labour Organization (ILO). Adopted in 1989, this Convention promotes respect for the values, practices, and identities of ethnic groups and their right to create their own development projects, own the lands they work, and use their natural resources. It also promotes the extension of social security, health, and education services to these peoples.

---

[4] Resolution 52/111 of the General Assembly 12-12-97.

[5] The Presidents, Heads of State, and Prime Ministers of the member countries were invited to this Conference. Working groups met for eight days and then came together in a plenary session. There was a NGO forum prior to the start of the Conference.

[6] This Convention went into effect in 1991 and was ratified by 13 countries: Argentina, Bolivia, Colombia, Costa Rica, Denmark, Ecuador, Fiji, Guatemala, Honduras, Mexico, Norway, Netherlands, Paraguay, and Peru.

## The Ethnic Perspective in a Demographic Look at the Region

The Region of the Americas exhibits one of the most complex demographic realities from the standpoint of its ethnic composition. Its history of conquest, colonialism, and immigration led to the confluence of more ethnic groups than any other region in the world.

Despite limitations with respect to the quantification of the different ethnic groups both among and within the countries of the Region, with the current estimates it is possible to gauge the numerical significance of groups of African and indigenous origin.

The statistics below, taken form different sources, provide a brief sketch of the numerical incidence of ethnic groups in the Region.

The total indigenous population of Latin America and the Caribbean is estimated at 45 to 50 million (10.18% of the total population). Approximately 90% of this population is concentrated in Central America and the Andes. In addition, the indigenous population in the United States numbers 1.6 million (0.65%).

The 1999 estimates for Latin America show that the countries with the highest percentage of indigenous population are Bolivia, Guatemala, Peru, and Ecuador, with figures ranging from a high of 70% down to 40%. Nine countries (Belize, Honduras, Mexico, Chile, El Salvador, Guyana, Panama, Suriname, and Nicaragua) have between 20% and 5%. Fourteen countries (Colombia, Costa Rica, Argentina, Venezuela, Paraguay, French Guiana, and the Caribbean islands) have only between 4% and 1%. Finally, Brazil and Uruguay have less than 1% (Meentzen 2000) (See Table 1).

The three countries with the largest indigenous populations in absolute terms are Mexico, Peru, and Guatemala (13, 11, and 7 million, respectively).

There is general agreement that the indigenous population tends to be underestimated in the official statistics, especially in Latin America.

This underestimation is also reflected in the demographic figures for Afro populations, since many countries lack statistical data on the population of African origin or with African ancestors. Some recent publications offer estimates as high as 150,000,000 people—that is, one-third of the total population of Latin America.

The countries where over 45% of the population is of African descent are: the Dominican Republic (over 84%), Cuba (62%), and Brazil, (46%). Those with between 40% and 5% are Colombia (over 21%), Panama (over 14%), Venezuela (over 10%), Nicaragua (over 9%), and Ecuador (over 5%). In the meantime, the countries where

under 5% of the population is of African descent are Paraguay (3.5%), Uruguay (over 3%), Honduras (2%), Costa Rica (2%), Bolivia (2%), and Mexico (0.5%).

**Table 1. Estimated Indigenous Population of the Americas**

| Countries by percentage of indigenous population | Country | Indigenous population | |
|---|---|---|---|
| | | Millions | % Total population |
| *Group 1* More than 40% | Bolivia | 4,9 | 71 |
| | Guatemala | 5,3 | 66 |
| | Peru | 9,3 | 47 |
| | Ecuador | 4,1 | 43 |
| *Group 2* 5%-20% | Belize | 0,029 | 19 |
| | Honduras | 0,7 | 15 |
| | Mexico | 12 | 14 |
| | Chile | 1 | 8 |
| | El Salvador | 0,4 | 7 |
| | Guyana | 0,045 | 6 |
| | Panama | 0,14 | 6 |
| | Suriname | 0,03 | 6 |
| | Nicaragua | 16 | 5 |
| *Group 3* 1%-4% | Fr. Guyana | 0,014 | 4 |
| | Paraguay | 0,1 | 3 |
| | Colombia | 0,6 | 2 |
| | Venezuela | 0,4 | 2 |
| | Jamaica | 0,048 | 2 |
| | Puerto Rico | 0,072 | 2 |
| | Canada | 0,35 | 1 |
| | Costa Rica | 0,03 | 1 |
| | Argentina | 0,05 | 1 |
| *Group 4* Less than 1% | United States | 1,6 | 0,65 |
| | Brazil | 0,3 | 0,2 |

***Source*:** Meentzen, 2000, op. cit.

**Table 2. Population in Latin America with African Ancestors**

| Countries | % total population | | Estimates (millions) | |
|---|---|---|---|---|
| | Infoplease | OAA | High | Low |
| Bolivia | N/D | 2 | 0.158 | 0.158 |
| Brazil | 44 | 46> 70 | 111 | 73 |
| Colombia | 21 | 30>50 | 17 | 10 |
| Costa Rica | 2 | 2 | N/D | 0.066 |
| Cuba | 62 | 34>65 | 6.8 | N/D |
| Dominican Rep. | 84 | 90 | 7 | N/D |
| Ecuador | 10 | 5-10 | 1.1 | 0.550 |
| Honduras | 2 | 2>50 | 2.8 | 0.112 |
| Mexico | <1 | 0,5-10 | 9 | 0.450 |
| Nicaragua | 9 | 10-50 | 2.3 | 0.599 |
| Panama | 14 | 14-77 | 1.9 | 0.350 |
| Paraguay | N/D | 3,50 | 0.162 | 0.162 |
| Peru | < 3 | 5-10 | 2.3 | 1.1 |
| Puerto Rico | N/D | 23-70 | 2.4 | N/D |
| Uruguay | 4 | 3-6 | 0.192 | 0.096 |
| Venezuela | 10 | 15-70 | 14 | 3.1 |
| United States | 12 | N/D | 29.9 | N/D |

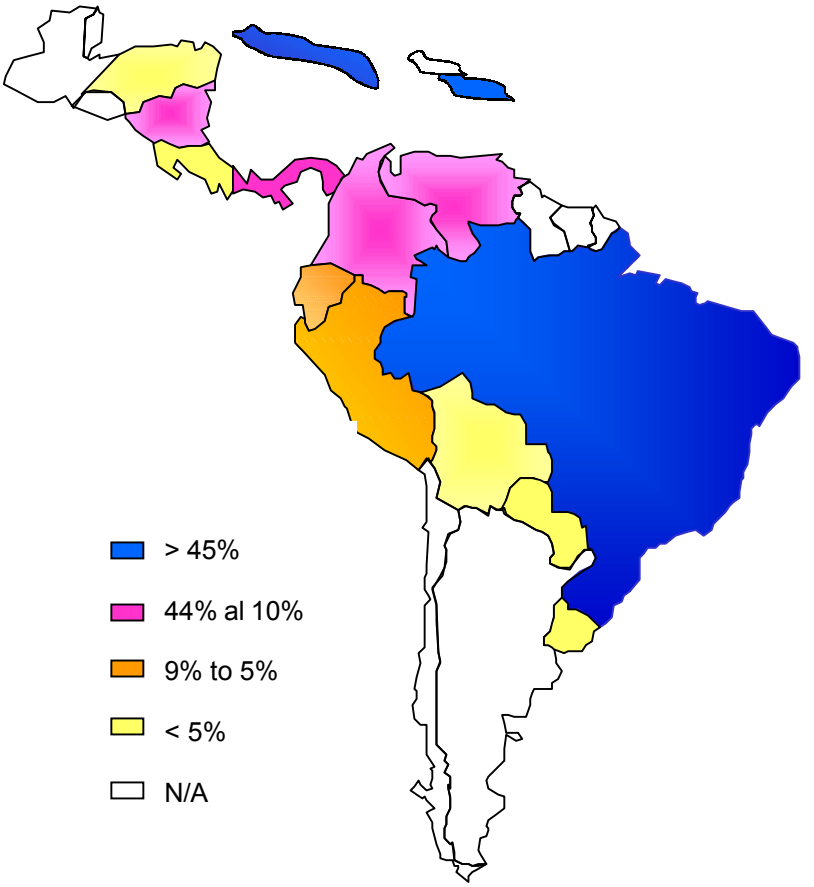
***Source***: Infoplease.com/ipa/AO855617.html and Organization of Africans in the Americas (OAA) for columns 2-3-4. For the United States, 1990 Census.

***Note***: The current data are still very rough estimates that the specialized entities will surely continue to refine.

In the present analysis, it is pertinent to complement the gaps in reliable statistical data with a typology of the distribution of Afro groups based on the way in which they are organized in the different countries. This regrouping will consider not only the number of people of African descent, but particular aspects of their geographical distribution, cultural identity (language, customs, ancestry), self-determination—territory, political representation—with the understanding, moreover, that the more

concentrated the settlement patterns, the stronger the ethnicity. These criteria have been selected to easily identify two elements that are necessary for policy-making. That is, geographical location and the institutions that facilitate social participation (NGOs; religious, cultural, and community organizations, among others).

**Figure 1. Afro Latin American Populations**




The different situations of Afro-populations can be broken down as follows:

a) They are the majority and have political power, a high degree of self-determination, autonomy, territorial control, and broad political representation without discrimination, as in the case of the English-speaking Caribbean countries.

b) They are the most important minority due to their numbers. It should be emphasized here that despite the importance of the absolute number of people of African descent in these countries—in contrast to point a)—these populations do not

enjoy significant political power but are part of a national reality in which their participation is limited. From the standpoint of ethnic identity, the population is not distributed uniformly and includes groups that are very active and others comprised of individuals who do participate in public, community, or political activities. Examples are: Brazil, Colombia, Venezuela, and Panama, among others.

c) They are minorities representing a numerically smaller percentage of the general population but nevertheless have a distinct identity. They can be subdivided into two groups:

1. Structured, relatively isolated rural communities, sometimes with their own language or dialect, who have inhabited the territory for many decades and are poorly integrated into the national economies. However, they have a strong sense of community, identity, and self-determination. Some examples are: the *Miskitos* on the Atlantic Coast of Nicaragua and Honduras[7]; the *Black Creoles* of Guatemala, Nicaragua, and the Bay Islands of Honduras; and the *Garífunas*[8] of Belize, Honduras, Livingstone (Guatemala), and Pearl Lagoon (Nicaragua). Examples of Afro communities in South America can be found in Esmeraldas Province on the Ecuadorian coast, in Yapateras, Paita, on the Pacific Coast of Colombia, the *Camba Cuá* community in Paraguay[9], the Afro communities of the *Yungas paceñas* in Bolivia,[10] and the *quilombos* of Brazil and Colombia.[11]

2. *Periurban* or low-income neighborhoods (*barrios)* in country capitals or industrial cities. It is precisely in the larger cities where the most impressive examples of multi-ethnicity can be found, that is, where social groups hold to values, interests, emotional ties, and symbols that differentiate them from the larger national society. In pluralistic societies, class and ethnic lines often

---

[7] The Miskitos are Miskitu-speaking fisherman and, to a lesser extent, subsistance farmers of African and indigenous descent.

[8] They have strong ties based on respect for ritual and networks in which women play a predominant role. This group migrated from the island of Saint Vincent.

[9] Their ancestors were people of African descent who belonged to Uruguay's popular militias during the war of independence under the command of Artigas and who, after their military and political defeat, went into exile in Paraguay with their leader, settling on the outskirts of Asunción.

[10] In a clear example of re-constructed ethnicity, former slaves from colonial plantations adopted the models of social organization, customs, and attire of their original peoples.

[11] Quilombos are a type of social organization—populations who have occupied lands since the twilight of slavery and who provided shelter for freedmen and runaways of African origin. Across Brazil some 724 quilombos have been identified, whose residents are demanding the right to their lands and formal recognition of their status. The highest concentration is found in the State of Bahía (259 quilombos), followed by Pará and Maranhao (New York Times, 2001/01/23).

intersect. Ethnic groups are segments of the population that are unequally incorporated into the State, constituting "corporate groups" that fight to preserve their ethnic or cultural heritage (Smith1996). This can be seen in several *barrios* of Puerto Limón (Costa Rica), the *barrios* and slums of São Paulo and Rio de Janeiro (Brazil), Piura, Lima, and Nasca (Peru), Caracas (Venezuela), Guayaquil (Ecuador), and others. At this level, identity is constructed through organizations such as NGOs, cooperatives, neighborhood associations, musical groups. These are legally registered organizations administered by Latin Americans of African ancestry that assist Afro communities in the creation of social capital, promote the preservation of the group's historical heritage, fight discrimination, or pursue particular objectives such as fellowships and other assistance[12].

d) They are part of the national society in countries with a high degree of *racial mixing,* where the majority of people of African ancestry do not live in their own neighborhoods or communities and have little sense of belonging to a distinct ethnic group. The lack of statistical information, group institutions, and community work makes it impossible to determine the percentage of people of African ancestry in the total population, thus contributing to the social invisibility of this group. It is assumed that the degree of cultural identity here is lower than in other situations.

It should be pointed out that in the proposed typology, the percentage of the population represented by the groups, their degree of ethnicity, and their geographical concentration have been emphasized in order to identify the situations in which the life of the different Afro groups unfolds.

Some observations should be made in this regard.

First, it should be noted that in some English-speaking Caribbean countries, both political and social power and control over economic mechanisms lie in the hands of representatives of Afro groups, constituting experiences without parallel in the indigenous world.

Second, in certain countries where their percentage of the population is very high, different forms of organization coexist. For example, in Brazil we have a gamut of situations that range from Afro-Latins in marginal urban neighborhoods to rural concentrations such as the quilombos, which are demanding formal ownership of the land and are more cohesive groups.

In the same country it is possible to find groups of African ancestry who identify closely with their origins and have their own social and cultural networks, and others who are less linked to community organizations and community life.

[12] By way of example, among the numerous organizations the following can be cited: the Association of Women of the Atlantic Caribbean, the Association of Black Nicaraguans, the Francisco Congo Movement (Perú), Afromundo, the Club Uruguay de Melo, the Cultural and Social Association of Black Uruguay.

Third, when social and political conditions permit self-identification that does not entail discrimination or exclusion, group four will probably be redefined. It is very likely that the 21st century will culminate in a more precise social map in countries whose historical legacy is still waiting to be rediscovered.

Fourth, it should be emphasized that even though socioeconomic studies find that Afro populations are, by and large, among the most disadvantaged segments of Latin American societies, it is a mistake to ignore their presence in other segments of the population.

As a general conclusion, considering the numerical weight of ethnic populations of indigenous and African origin in Latin America and the Spanish-speaking Caribbean, it is recommended that an ethnic approach be introduced into the collection of statistical data on health and living conditions. Statistics on demographics, the socioeconomic situation, and health are a very important tool in quantifying relations and measuring the gaps among the various groups.

The economic and political costs of such an effort should be understood as a social investment and are clearly justified, since more reliable statistics will constitute a solid foundation for the design of social policies, especially in health, and their subsequent evaluation.

**Main problems in collecting and analyzing demographic and health information by ethnic group**

- The absence of an ethnic approach in data collection. Difficulties in adopting an ethnic approach in policy-making and data collection instruments are the result of society's limited awareness of the problem.
- Problems related to the ethnic identification of individuals, when this variable exists, given ethnicity's complexity as a social concept. Interviewees and interviewers alike find this difficult, because the majority of people in Latin America have a multi-ethnic background and move in a multicultural context, making it hard to choose one ethnic identity over another when asked to identify the group to which it belongs.
- The use of heterogeneous criteria from different conceptual frameworks. The statistics and census bureaus of some countries and the international organizations devoted to the study of this subject (World Bank, OIT, UN), have developed different criteria for the identification of ethnic groups. For example, for indigenous populations (Meentzen 2000), some emphasize language and geographical location, while others stress attachment to a particular territory and the continuity of social, economic, and political institutions, although all of them agree on the importance of a self-awareness of ethnic identity and self-determination.
- Furthermore, for people of African ancestry, the identification becomes difficult because the concept of race is still commonly used with a devaluing content. They may not be included as a category, having to classify them under "others."

## Ethnicity and Health Indicators by Ethnic Group

We are now in a position to examine the question of variations in health and service access indicators among individuals from different ethnic groups in light of the available empirical information.

A review of the literature confirms that studies in the United States indicate health disparities (U.S. Department of Health, 1991; Nickens 1995) among the different ethnic groups. For example, mortality is higher among African-Americans than among the white population: the two leading causes of death in the United Sates are cancer, with a ratio of I to 2, and cardiovascular with a ratio of 1 to 6. African-Americans also have higher infant mortality rates and higher mortality from diabetes, homicide, and HIV/AIDS. However, these studies also show evidence of higher mortality from selected diseases in the African-American population than in other minority groups such as Native Americans and Hispanics.

The information is not as consistent for the rest of the Region, and the studies are more sporadic. However, the results coincide. For example, studies in Peru reveal high infant mortality rates in provinces with higher concentrations of Afro-Peruvians, such Piura (93/1000), Lambayeque (68/1,000 live births), and Tacna (64/1,000 live births), while the lowest rates are found in Lima and El Callao, with 45 and 41/ 1,000 respectively (Cowater, op. cit.). In Panama the probability of dying before completing the first year of life is 3.5 times higher among indigenous children than among non-indigenous children (OPS 1996). Infant mortality in Brazil, estimated with 1996 data, reveals sharp disparities: 62 per 1,000 live births for the Afro group and 37 per 1,000 among whites. (FOASE. In: *Latin News* 2000).

Concerning access to the health services, the figures for 1976 show that in the United States, 16% of the white population, 23% of the African-American population, and 26% of Hispanics did not have access. The studies show that this situation subsequently deteriorated among the Hispanic minority and that by 1986 the gap had widened to 39% of Hispanics, a figure three times higher than that of whites and double that of African-Americans (Bollini and Siem 1995).

Other significant differences can be found in the quality of the services, especially in access to modern health technologies. Compared to elderly white people, elderly African-Americans in the United States see fewer specialists, receive less preventive care (mammograms, Pap smears) and poorer quality hospital services; and, lack access to sophisticated technologies (for cardiovascular problems, orthopedic conditions, kidney transplants), and to intensive treatment programs for prostate cancer, immunodeficiencies, and depression. These disparities are also evident in other minority groups (Fiscella et al.2000).

However, ethnicity not only explains the differences within a single age group such as the elderly or children[13]; it has also been shown to reveal differences within a single socioeconomic stratum and also across gender lines.

Another eloquent finding is the evidence of higher percentages of auto-perception of disease in Afro populations (regardless of income level) than in white and Hispanic populations (Ren et al. 1996).

Another U.S. study recently confirmed higher mortality among African-Americans in 107 cities across the country (Williams, 1999, 2000).

As mentioned earlier, there is no scientific evidence that these differences are due to genetic causes, and only a segregationist rationale could be used to justify these arguments (Lillie-Blanton and Laveist 1996). On the contrary, two questions must be answered to clarify this situation. The first is, what causes the gaps in the health situation and service access indicators? And the second is, why are these gaps always at the expense of ethnic minorities?

Some of the possible keys to the first question are listed below. Direct and indirect factors affect health status.

1. The most relevant factors under health sector control are:

- **Barriers to health service access**

  These are a key factor in differential health outcomes among human groups within a society.

  These barriers can arise through different mechanisms, such as location and cost, and are the easiest to understand. Historically, physical segregation has been operative in neighborhoods and/or regions. Coincidentally, public services in these localities, including health services, may be poorer in quality and less effective. For example, physicians, equipment, and services are highly concentrated in urban areas. In the outlying neighborhoods of Caracas and Maracaibo, the Afro-Venezuelan population lacks services; health workers, in turn, do not want to work in the neighborhoods where this population lives because of violence and a lack of security (Cowater op.cit.).

  In addition to location and cost, there are other exclusionary mechanisms associated with language and cultural values.

  The cosmic vision of health and disease are part of the belief system, and they vary with each ethnic group. According to some of these groups, disease can be caused by human beings with potent powers, by supernatural forces, or by

[13] In Brazil, children of African descent constitute the majority of the 7 million street children.

accidents, excesses, or deficiencies. These beliefs can make people reluctant to use modern health services grounded in science. In these cases, traditional medicine plays a very important role in disease prevention and cure, since it is better adapted to the ethnic group's view of the world.

Traditional healers, herbalists, midwives, and shamans effect a cure through community rituals and divination or medical practices, using medicinal plants, purges, and massages, among others. For example in Petit Goave (Haiti), half the population uses traditional healers (whether herbalists, midwives, or sorcerers that practice voodoo). In this zone there are 15 healers for every 1,000 people, while the ratio of physicians to population is 15/10,000 (Clerismé, 1985).

- **The quality of the services**

It is another aspect that must be considered to account for the differences between the health indicators of majority and minority groups. Two dimensions of the quality of care should be analyzed. First, the relationship between physician and patient, in which the ideological biases of the staff and the services can come into play, leading to differences in the quality of care within the same institutional health service provider. Second, the training and size of the professional team and the availability and use of technology, in addition to the health model employed by the health team: practices geared to disease prevention and health promotion (or the lack thereof) lead to differences in health indicators.

- **The timeliness of access**

This is another relevant aspect to consider. People may have access to health services but can only take advantage of them late in the health/ disease process, which in some cases makes successful medical treatment impossible and could account for the differential indicators. The reasons why individuals or groups delay consultation are in part related to the aspects mentioned above—cost, location, and language. However, they are also related to people's understanding of the health/disease process and to the knowledge and information available to them on the role of disease prevention and health promotion. People will seek assistance more readily when the health sector employs a comprehensive, rather than a curative/restorative, approach.

- **Segregation and discrimination practiced by the health services themselves**

Finally, an attempt should be made to explore the effect of the segregation and discrimination practiced against minority patients by the health services themselves. This is an area less explored in the available literature. However, it is possible that the health system also engages in the same stereotyping found in the society at large, thus reinforcing the general discrimination or even exacerbating it.

2. Socioeconomic factors

These are related to *living conditions* (which are the fruit of historical, cultural, and socioeconomic macrodevelopment), which introduce biases into the opportunities for individuals from minority groups (Thomas 1992, Navarro 1990). These limited opportunities arise from:

- **Income levels and type of employment**

  Since the 1970s, the Black Report in England noted that people in the lowest occupational strata had the poorest health status and were two and a half times more likely to die before retirement, compared to individuals in the highest occupational strata, such as managers and professionals. Some job categories entail more exposure to risk than others, enjoy less occupational health or social security coverage, and generate income levels that limit the worker's ability to assume out-of-pocket costs or obtain private financing. In the United States, the figures indicate that managers and professionals have lower mortality from cardiovascular disease (37 per 10,000) than industrial or service workers (86 por10,000). Analysis by income yields the same type of result. With data from 1986, it was calculated that the mortality in workers earning less than US$ 10,000 per year is 4 to 6 times higher than that of individuals earning more than US$ 35,000. (Navarro op. cit.). Since minorities are employed in lower-paying, less specialized occupations, this will result in below-average health indicators.

- **Place of residence**

  Segregation relegates certain segments of the population to neighborhoods with fewer resources and a degraded human and physical environment.

  In the United States, high levels of residential segregation persist for the African-American population (more so in the North than in the South), with low indexes of movement by blacks to white neighborhoods to achieve integration (Willliams 2000; Williams and House 2000). This is reflected in the concentration of poverty in certain residential areas. However, poor whites do not live in areas of concentrated poverty.

  In Latin America, physical segregation is in many cases superimposed on the urban/rural dichotomy, with indigenous and Afro populations located in rural areas where there is also limited access to services—for example, the black communities on the Pacific Coast of Colombia, or the South Atlantic Autonomous Region (RAAS) of Nicaragua, where the Garífuna and Criollo communities predominate (Cowater op.cit). Usually, indigenous and Afro groups are located largely in peri-urban areas—for example, the outskirts of Guayaquil (Ecuador), where 95% of the Afro-Ecuadorian population of the city is located. In addition,

Telles (cited by Coimbra op. cit.) comments that in Brazil, middle class neighborhoods are typically white, and the slum areas, typically black (instead of black, the population in the slums of the large cities of the Amazonas region is largely Indian or Caboclo).

Studies of these communities point to deficient drinking water, sewerage, and electricity services, and in transportation and other means of communication, as well as in access to the health services. The fact that minorities work in low-paying occupations results in indicators that are below average.

- **Lifestyles**

This category covers aspects linked to diet, substance abuse (tobacco, alcohol, and drugs), social behavior (violence and accidents), and barriers to access to services (Thomas op.cit). Field studies and statistical analyses in the United States confirm the prevalence of diseases linked to behavioral patterns, as in the case of alcoholism in young Native Americans and the identity problems of those living on reservations. In certain countries, young indigenous women have little access to medical personnel and rarely give birth in an institutional setting due to cultural barriers.

- **Quality of and access to education**

There is a close link between the location of housing and access to the public schools. However, there is also a link between the concentration of poverty and the racial composition of schools. (Williams 2000). In the United States, for example, two-thirds of African-American and three-quarters of Hispanic students attend schools where more than half the students are black or Hispanic.

In the Caribbean, the poorest groups lack access to a university education; in Jamaica, 1.6, and in Guyana, 1% manage to receive one. However, per capita spending on tertiary education is 15 to 25 times higher than spending on secondary education and 50 times higher than spending on primary education (Baker 1997:137, cited by Trouillot op.cit). On Colombia's Pacific Coast, where the Afro groups are located, urban and rural illiteracy is double the national figure (Cowater op. cit.).

The educational situation has an impact not only in terms of the limits it imposes on equitable access to the job market and the perpetuation of poverty but also of its consequences for health. Recent studies show that the mother's education is an important factor in family health care (births in an institutional setting, medical checkups, and other).

The other educational area is the training of human resources for the biomedical field. Medical school graduates tend to be from the majority group. For example, only 2% of cardiologists in the United States are African-American[14], and clinicians rose from 2.5% in 1968 to 2.9% in the 1990s.

## Case Studies

As mentioned previously, the ethnic approach is relatively new in the Region. The limited amount of available information on ethnicity explains why few studies on the topic have been carried out in Latin America and the Caribbean—and fewer still that focus on the relationship between health disparities and ethnicity. For this reason, two case studies are presented below; one refers to Afro-Brazilians, and the other to indigenous peoples of Guatemala.

## Brazil

Brazil was selected as one of the featured case studies, because the country furnishes official statistics that include the ethnicity variable under an approach that questions the interviewee as to his/her ethnic group membership (race), although limited to health questions.[15]

The 1996 PNAD survey form[16] provides the following categories for the ethnicity variable: indigenous, black, brown, white, and yellow. In order to facilitate analysis of the data, these categories will remain unchanged.

According to this source, by the end of the last century, the total population of Brazil was over 160 million inhabitants. The indigenous population is the least represented group within the total population, accounting for 0.14% of the population. Brazil currently has some 230 ethnic groups, whose members speak more than 90 languages and 300 dialects. These groups have settled in approximately 400 towns (Alderete 1999),[17] concentrated primarily in the central and western part of the country (Amazonas, Mato Grosso, and Goiás). (See Table 3.)

---

[14] This information was provided by the Association of Black Cardiologists (ABC), Washington, D.C.

[15] The form for the 1996 PNAD has 12 sections. Most of these are geared toward defining occupation, and include a question that asks whether the respondent contributes to social security. Moreover, the questionnaire includes status, migration, education level, housing characteristics, and social mobility. Health questions are geared toward fertility.

[16] Unfortunately, the data collected in 1998 is not yet available. It included an extensive module on health. Analysis of this information will be included in due course.

[17] The main groups are the Yanomami, Macuxi, Guajajara, Kirkati, Guaja, Kaiapo, Xucuru, Aikewar, and Ava-Guarani.

**Table 3. Population of Brazil by Race and State (1996)***

| States** | White | Black/ Brown | Yellow | Indigenous | No Inform. | Total |
|---|---|---|---|---|---|---|
| Acre | 33,00 | 71,50 | --- | --- | --- | 100 |
| Alagoas | 46,50 | 52,50 | 0,30 | 0,60 | --- | 100 |
| Amapá | 33,80 | 86,20 | --- | --- | --- | 100 |
| Amazonas | 26,00 | 73,60 | 0,10 | 0,30 | --- | 100 |
| Bahía | 27,80 | 71,40 | 0,20 | 0,50 | 0,00 | 100 |
| Ceará | 30,10 | 69,70 | 0,00 | 0,10 | 0,00 | 100 |
| Distrito Federal | 48,20 | 51,30 | 0,40 | 0,10 | --- | 100 |
| Espírito Santo | 48,60 | 51,00 | 0,00 | 0,30 | 0,10 | 100 |
| Goiás | 45,40 | 53,90 | 0,40 | 0,10 | 0,00 | 100 |
| Maranhão | 19,40 | 80,40 | 0,10 | 0,10 | 0,10 | 100 |
| Mato G. do Sul | 88,80 | 35,50 | 0,90 | 2,20 | 0,00 | 100 |
| Mato Grosso | 43,00 | 56,10 | 0,90 | 0,00 | --- | 100 |
| Minas Gerais | 53,90 | 46,00 | 0,10 | 0,00 | 0,00 | 100 |
| Pará | 24,70 | 74,60 | 0,60 | 0,10 | 0,00 | 100 |
| Paraiba | 44,20 | 55,70 | 0,00 | --- | --- | 100 |
| Paraná | 79,10 | 19,90 | 0,90 | 0,20 | 0,00 | 100 |
| Pernambuco | 34,80 | 65,10 | 0,00 | 0,10 | 0,00 | 100 |
| Piauí | 19,70 | 80,30 | --- | 0,00 | --- | 100 |
| R. G. do Norte | 41,80 | 58,10 | 0,10 | --- | --- | 100 |
| Río de Janeiro | 58,50 | 41,20 | 0,20 | 0,20 | 0,00 | 100 |
| R. G. do Sul | 88,80 | 11,00 | 0,00 | 0,10 | 0,00 | 100 |
| Rondonia | 42,60 | 57,10 | 0,30 | --- | --- | 100 |
| Roraima | 24,30 | 75,10 | --- | 0,60 | --- | 100 |
| Santa Catarina | 92,10 | 7,80 | 0,00 | 0,00 | 0,00 | 100 |
| São Paulo | 75,20 | 23,70 | 1,10 | 0,00 | 0,00 | 100 |
| Sergipe | 17,60 | 82,10 | 0,10 | 0,20 | --- | 100 |
| Tocantins | 26,80 | 71,70 | 1,60 | 0,40 | --- | 100 |

***Source***: IBGE-PNAD, 1996.

(*) Does not include people who did not indicate their color.

(**) Does not include the population of the rural areas of Rondonia, Acre, Amazonas, Roraima, Pará, and Amapá.

Another minority group is the Asian population, made up for the most part of the descendants of a wave of Japanese immigrants who arrived at the beginning of the 20th century,[18] accounting for 0.4% of the population.

The country's white population (55.2%) are descendants of various European immigration flows, including Portuguese, Germans, Italians, Poles, as well as of the contingent of Lebanese, Turks, and Syrians. The white population is concentrated in the south and southeast—the most developed regions of Brazil.[19]

Blacks make up the Afro-Brazilian group (6%), which for the most part resides in urban areas of the southeast and northeast (Rio de Janeiro, São Paulo, Bahia, and Minas Gerais). Finally, the brown (dark-skinned) population accounts for 38.2% of the total population, more than half of which lives in rural and poor areas of the north and northeast[20] (Heringer 2000).

**Figure 2. Distribution of Brazilian Population by Ancestry**


[18] This constitutes the second largest migration after Hawaii. This population primarily resides in São Paulo.

[19] Especially in São Paulo; with lesser values in Minas Gerais, Rio Grande do Sul, Paraná and Rio de Janeiro. More than half the population of these states is white.

[20] More than half of the population of states in the north and northeast are brown (dark-skinned); for instance, Bahía, Maranhão, Pernambuco, Sergipe, Ceará, Piauí, and others.

The absence of discriminatory laws and a longstanding tradition of tolerance have caused some to label the country a "racial democracy" (a mixture of ethnic and racial groups).[21] Interracial couples account for 20% of married couples. Moreover, in 58% of Brazilian families, at least one spouse self-classifies him or herself as nonwhite. It is clear, however, that this is most often seen among the poorer groups on the social scale. The difficulties faced by nonwhites (black and brown) in terms of social mobility are explained by historical factors of socioeconomic origin—factors that are the basis for prejudice and racial discrimination. In fact, it has been found that mulattos (the symbol of national identity and the absence of prejudice, according to the official rhetoric) face more discrimination than does the black population, suffering greater disadvantages throughout the life cycle (Silva 2000)[22].

With respect to the analysis of the 1996 PNAD, it was found that poverty is unequally distributed among the different racial groups. Upon analyzing *income distribution*, it can be observed that 62.57% of the indigenous population is located in the first two quintiles. Black (45%) and brown (55%) citizens are also disproportionately represented in these low-income quintiles. Conversely, only 30% of whites and 16% of people of Asian origin are included in these income levels. This disparity is also observed in the high-income group (fifth quintile), where 76% are white, 20% are brown, and 3% are black.

Another way of perceiving the unequal distribution of poverty due to ethnicity is to analyze income distribution by ethnic group in the 20% of the population with the lowest income (first quintile). With respect to this income quintile, it is observed that whites are underrepresented (13.37%), whereas other groups such as brown-skinned persons (29%) and blacks (23%) are over-represented.

Average household income ranges from 1 to 13, with an average income for the first and second quintiles of approximately R$216, whereas in the fifth quintile this figure is R$2,925. However, if we look at per capita income in the first, second, and fifth quintiles, the differences are greater for blacks (1 to 20)[23].

---

[21] This concept was developed by Brazilian sociologist Gilberto Freyre.

[22] This author maintains that, according to the 1988 PNAD, the ethnic breakdown of families whose per capita income did not exceed one fourth of the minimum wage was the following : 14.7% white, 30.2% black and 36% brown. The brown population lives in less developed and rural areas. In any case, the author maintains that brown and black urban populations present major differences with respect to the white population.

[23] It is important to mention that by age 9, 12% of black and brown children had entered the job market, while the corresponding figure for white children was only 6% (Silva, op.cit.).

With respect to the distribution of poverty by ethnic group, it becomes clear that age plays an important role. Accordingly, 52% of black children are in the first and second quintiles, as opposed to only 36% of white children. Moreover, 66% of children born to the country's poorest households (first decile) are brown.

The analysis of *education level* by ethnic group also reflects disparities. Access to education and level of schooling attained are closely linked to job opportunities, salary/wages, and social mobility.

Approximately 26% of Brazil's population is illiterate; however, this figure is almost 45% for the indigenous population, 33% for the brown population, and 29.24% for blacks. The percentages are lower-than-average for whites (20%), while only 10% of people of Asian origin are illiterate.

Upon analyzing data for children between the ages of 6 and15, we find that 9.75% do not attend school. However, the analysis of school performance by ethnic group provides some very interesting data, as absenteeism among black children is almost double that of their white counterparts. Moreover, we observe that 13.24% of black children do not attend school, while this figure is 12.21% for brown children and 7.18% for white children.

Another significant aspect concerns the distribution of people over age 24 by level of education attained. Accordingly, 68.28% of young people over age 24 that completed secondary education are white, while only 5.34% are black, and 25.36% are brown. These differences are greater at the level of higher education, where only 8% of young people over age 24 have a diploma. Of this group, 83.54% are white, almost 13% are brown, and 1.83% are black.[24]

It bears remembering that the *geographical distribution* of the population also reflects differences from the ethnic perspective. With respect to the case under study, this distribution is clearly seen in that 51% of the indigenous population resides in rural areas, whereas this figure is only 14% for the white population. In the cities and other smaller urban areas, white (57%) and brown (36.69%) population segments are strongly represented, accounting for more than 90% of inhabitants. Moreover, while whites account for the majority in urban centers of the south and southeast, the majority in cities of the north and northeast are brown. Blacks have a strong urban presence, especially in Rio de Janeiro and Salvador.

It is recognized that differences in place of residence are also accompanied by differences in access to some services. *Household utility connections* are one indicator that is directly related to the quality of life[25] and also has a direct or indirect impact

[24] It has been shown that at the same level of family income, Afro-Brazilians receive less schooling and are left back in school more often than the white population (Valle Silva, op.cit.).

[25] A weighted quality of life index has been developed.

on health conditions. For example, only 33% of the indigenous population is served by the drinking water network, compared to 80% of whites and 64.7% of the Afro population (black and brown). With respect to the total population, 70% have access to this service. However, this percentage is very unequally distributed among the groups. For example, only one third of the indigenous population have access to this service. Considered from the standpoint of those with access to piped water, 73.6% of the white population has access to this service, while the corresponding figure for the black and brown groups is less than 50%. These figures can be complemented with the data from the 1987 PNAD. For example: a) percentage of population living in dwellings without electricity: 10.2% white, 21.7% black, and 28% brown; b) percentage of population living in areas without refuse collection: 18.3% white, 34.1% black, and 39.5% brown; c) percentage of population living in substandard dwellings: 3.4% white, 13.9% blacks, and 13.3% brown (Heringer op.cit.).

However, upon analyzing the relationship between ethnic group and *quality of life*[26], it is observed that at the highest level, whites are over-represented. Thus, while 58.17% of whites enjoy a high level of comfort, achieving level 4 and 5 values on the quality of life index, 69.97% of the brown population do not surpass level 3 on this index.

Employment conditions is the other category where differences among ethnic groups have been confirmed. Accordingly, 34% of blacks begin working before the age of 14, while only 30% of whites join the workforce at an early age. Moreover, *employment in the informal sector* is also unequally distributed when we analyze it by ethnic group: 13% black, 11.84% brown, and 8.55% white. Thus, there are consequences in terms of access to social security services: 64% of Brazilians between the ages of 10 and 65 who pay into the Social Security Institute are white, while the corresponding figure for Afro-Brazilians (black and brown) is 34.76%.

Another finding that emerges from analysis of data on occupation is that health professionals, such as physicians, dentists, and other specialists, are distributed as follows: 82.93% are white, 12.42% brown, and 1.01% black. With regard to medical auxiliaries, the participation of minority groups increases: 59.09% white, 32.79% brown, and 7.6% black.

Infant mortality indicators speak volumes: 16% of women over the age of 15 have lost at least one child born alive. When analyzed by ethnic group, the distribution is as follows: 33% of indigenous women over age 15 have lost at least one child, whereas this figure was 19% among black women, and 13% among white women.

[26] The quality of life index uses a scale of 1 to 5, which combines and weights the following elements: electricity, water, type of sanitation, quality of dwelling construction, number of rooms, household connections.

**Table 4. Crude Birth Rate (CBR), Crude Death Rate (CDR), Infant Mortality Rate (IMR), and Life Expectancy at Birth (LEB) in Brazil, by States (1997)**

| States | CBR | CDR | IMR | LEB |
|---|---|---|---|---|
| Acre | 30,97 | 6,36 | 45,25 | 67,35 |
| Alagoas | 30,38 | 9,00 | 74,07 | 62,20 |
| Amapá | 32,15 | 5,28 | 32,12 | 68,13 |
| Amazonas | 31,70 | 5,41 | 35,37 | 67,94 |
| Bahía | 22,73 | 7,05 | 51,00 | 66,76 |
| Ceará | 27,52 | 8,13 | 56,26 | 65,44 |
| Distrito Federal | 21,51 | 5,32 | 24,84 | 68,53 |
| Espírito Santo | 20,71 | 6,26 | 28,45 | 69,47 |
| Goiás | 20,39 | 5,80 | 27,13 | 68,84 |
| Maranhão | 27,58 | 7,71 | 60,94 | 63,93 |
| Mato G. do Sul | 21,91 | 5,82 | 26,98 | 69,53 |
| Mato Grosso | 24,51 | 5,41 | 28,57 | 68,29 |
| Minas Gerais | 19,96 | 6,64 | 28,84 | 69,55 |
| Pará | 29,54 | 5,70 | 36,22 | 67,85 |
| Paraiba | 25,37 | 9,81 | 65,21 | 63,48 |
| Paraná | 20,43 | 6,27 | 28,47 | 69,49 |
| Pernambuco | 22,45 | 9,26 | 62,74 | 62,72 |
| Piauí | 25,10 | 7,94 | 51,95 | 64,72 |
| R. G. do Norte | 24,13 | 8,38 | 74,07 | 65,49 |
| Río de Janeiro | 17,00 | 8,62 | 25,60 | 67,14 |
| R. G. do Sul | 17,96 | 6,91 | 19,66 | 71,03 |
| Rondonia | 27,32 | 5,55 | 35,02 | 67,35 |
| Roraima | 31,96 | 5,62 | 38,85 | 66,59 |
| Santa Catarina | 19,75 | 5,83 | 23,37 | 70,70 |
| São Paulo | 19,17 | 6,76 | 24,63 | 69,55 |
| Sergipe | 25,94 | 7,17 | 54,09 | 66,22 |
| Tocantins | 28,77 | 6,21 | 33,74 | 67,49 |

***Source:*** IBGE/Demographic estimates and projections.

***Note:*** CBR and CDR per 1000 population, IMR per 1000 live births, and LEB in number of years.

This effect is more marked among women in the lowest income quintile (first quintile), where, on average, 26% of women over 15 have lost at least one child. With respect to this group of women with limited financial resources, infant mortality increases: 42% of indigenous women have lost at least one child, while this figure is 29% among Afro-Brazilian women (black and brown), and 23% among poor white women.

Another approximation, through analyses of the data by state, confirms the trend in the infant mortality differential: in Bahía, with a high percentage of population of African ancestry, the infant mortality rate is 51.00, while in the southern states, where the population is predominantly European in origin, the figure drops by one-half or even more: São Paulo, 24.63, or Rio Grande do Sul, 24.63.

With regard to death attributable to violence, the figure is 23.4% in the black population (second leading cause of death), while it is the fourth leading cause of death in the white population, or less than half (11.4%) (Barbosa, 1998).

In terms of the analysis, the values of all the variables that make up the concept of sustainable human development are lower for ethnic groups, which reveals the inequality of opportunity in all fields, despite racial mixing and the rhetoric of racial equality[27].

With respect to many indicators, it should be pointed out that the values achieved by the black population are better than those achieved by the brown population. All the studies coincide on this point. Some experts have suggested that this may be attributable to the idea that assuming black identity in contemporary Brazil probably leads to more solid intellectual development and integration into society, thus providing the individual with an opportunity to assert his/her ethnicity. Another hypothesis holds that blacks have better access to some services by virtue of the fact that they live in cities, although primarily in marginal urban areas.

## Guatemala

Guatemala is one of the Latin American countries with the largest indigenous population[28]. It has collected statistical data from its last census (1994), as well as indigenous health data through the 1998-1999 National Survey on Maternal and Child Health.

---

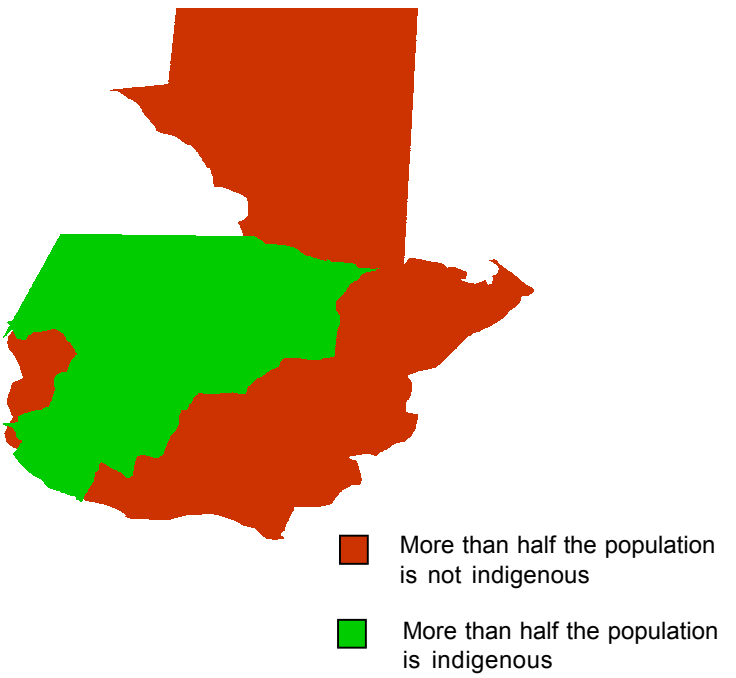
[27] Human development "has five components that are inexorably linked: health, education, economic growth, a healthy environment, and a gamut of freedoms for individuals, among which are democracy and human rights" (Alleyne, 1996).

[28] The Latin American countries with indigenous populations greater than 40% are Bolivia, Guatemala, Peru and Ecuador (Alderete, op.cit).

According to the Bureau of Statistics data compiled from the last census, the population was divided into two categories: a) indigenous population, and b) *Ladinos* (non-indigenous). This simplification constitutes a serious limitation, since it associates the concept of "ethnic group" with the colonial category of "Indian," thus hindering observation of intense multi-ethnicity within the same. The three largest ethnic groups are the Xinca, Garifuna, and Mayans, which in turn, are further broken down into numerous dialects. Failure on the part of the statistical data source to take these differences into account prevents a broadening of the analysis of inter-ethnic inequalities in the distribution of poverty and health conditions. Despite this limitation, the statistical data source makes it possible to at least identify and measure the disparities between the two large macro-categories, which in itself constitutes an innovative perspective.

Guatemala has an indigenous population of 3,535,722 (42.3% of the total population), largely distributed in rural areas in the northern, northwestern and southwestern regions of the country. In turn, the department of Guatemala, which includes the metropolitan area, has the greatest concentration of urban indigenous population, although this group is no more than 3% of the total indigenous population. Some studies indicate that the highest rates of poverty and extreme poverty are found in the northern and northwestern regions, precisely those with the highest indexes of indigenous population (Valladares and Barillas 1998).

**Figure 3. Distribution of the Guatemalan Population by Ancentry**



Both the 1994 census and 1998-1999 National Survey on Maternal and Child Health show a statistically unequal distribution of poverty between the indigenous and Ladino categories. Identification and measurement of this situation will be demonstrated through certain indicators such as working conditions, quality of life, educational situation, housing conditions, health, and access to these services.

In general, the economically active population of Guatemala (Ladino and indigenous) is found largely in the agricultural sector (52.5%), indicating a limited supply of skilled labor. However, the active indigenous population works primarily in agriculture, hunting, and fishing (71.3%) and accounts for 53.6% of labor in the agricultural sector. In contrast, the white population is concentrated in two sectors: 40% work in the agricultural sector and another 15.6% in manufacturing, textiles, and the food industry. In addition, it bears mentioning that there is a marked division of indigenous labor by sex, with men dominating the agricultural sector (76%) and women diversified between agriculture (37.8%), services (30.7%), and commerce (18.5%).

It is important to point out that two-thirds of Ladinos (60.3%) are in a dependent relationship—that is, they have stable jobs, giving them *access to health services*. However, only 30% of the indigenous population is employed and its participation in the public sector is very limited. Two-thirds of the indigenous population are either self-employed (especially males in rural areas) or unremunerated family members and are consequently less likely to have access to health systems. The fact may indicate the absence of absorption and/or discrimination policies by the state sector. It should be emphasized that the category "unremunerated family members" is more significant for the indigenous population than for the Ladino sector, and is especially concentrated in rural areas. These results could be related to cultural values such as reciprocity, mutual assistance and solidarity, which no doubt often constitute a survival strategy in indigenous cultures and facilitate the survival of the community as such.

Viewed in another light, we observe that half of the economically active population of Guatemala have stable jobs, although 70% is Ladino and only 27% indigenous population. Very few people in the economically active population are employers (1.2%); for the most part these are white. In contrast, both groups are equally represented in the informal sector.

When analyzing *status*, it is observed that in Guatemala the role of head of household is notably exercised by men in both the Ladino and indigenous population; few women exercise this function (6.6%) and those who do are primarily Ladino (65%). In some cases, culture is clearly a favorable factor in terms of reducing poverty. In Guatemala, the structure of the indigenous family is more solid than that of other groups. This not only accounts for the fact that there are fewer female heads of household in indigenous families, but for the willingness of other family members

to assume responsibility for orphaned children. Moreover, this family structure helps to reduce the incidence of some social pathologies, such as suicide.

Disparities in *access to education* make it possible to link the absence of schooling with the level of poverty and discrimination. Some 37.5% of the Guatemalan population over the age of 15 is illiterate (36% among Ladinos and 61% among the indigenous population). However, there is another important relationship: while 55.6% of the indigenous population does not overcome illiteracy, the figure is only 22.4% among Ladinos[29]. This has a significant impact on health conditions among the indigenous population, particularly with respect to prenatal care and care in childbirth.

Upon analyzing school absenteeism, we observe that 48.7% of indigenous children aged 7 to 9 do not attend school, while among Ladino children, this figure is 28.3%. This trend doubles and increases markedly among children between the ages of 10 and 12, reaching 31.7% among indigenous children, while the corresponding figure for Ladino children is 12.7%.

With regard to the educational level of young adults, we observe that among the indigenous population, 54% of young adults between the ages of 24 and 34 never attended school, while only 18.9% of Ladinos in this age group are illiterate. For the same age group, 15.5% of Ladinos completed secondary education, while this figure was only 2.7% for the indigenous population.

With regard to the *level of housing and quality of life* attained in Guatemala, we observe that three out of every four indigenous people (78.7%) are in the lowest category 1 in terms of consumer goods (radio, TV, car, refrigerator, and others), whereas this figure is 43% for the Ladino population. In terms of the quality of life, while half of Ladinos reach level 3, half of the indigenous population is at level 2.

Almost two-thirds of the Ladino population (62.78%) enjoys the highest level of housing infrastructure (piped water, sewer and electricity service, and adequate roofing, amont others), while the corresponding figure for the indigenous population is less than one-fourth.

Finally, with regard to *health*, there is also an inferred correlation between indigenous population and unmet basic needs. The most significant diseases among the indigenous population are those that involve situations of deficiency, such as infectious diseases (respiratory infections, diarrheal diseases, and perinatal infections).

The 1998 National Survey on Maternal and Child Health revealed chronic and acute malnutrition among indigenous children under 5. The survey showed chronic malnutrition (height-for-age) of 67.8% among the indigenous population, while the

[29] In the indigenous population the illiteracy rate is higher among women than men.

corresponding figure for the Ladino population group was 36.7%. Acute malnutrition (weight-for-age) is 34.6% among the indigenous population, while it is 20.9% among Ladinos. Moreover, 53.4% of indigenous women of reproductive age have not had schooling, compared to just 16% of Ladino women (Valladares and Barilla 1998). The percentage of low birthweight is 9.94% for indigenous children and 8.94% for Ladino children.

**Table 5. Percentage and Life Expectancy of the Indigenous Population by Gender and Geographical Distribution in Guatemala**

| | % Indigenous | Life Expectancy at Birth | | |
|---|---|---|---|---|
| **Health Areas** | **Population** | **Female** | **Male** | **Total** |
| Ixcán | 98,0 | 70,63 | 65,23 | 67,86 |
| Totonicapán | 96,92 | 62,88 | 59,26 | 61,04 |
| Sololá | 95,16 | 66,17 | 62,11 | 64,09 |
| Alta Verapaz | 90,75 | 70,19 | 64,8 | 67,43 |
| Quiché | 85,82 | 70,63 | 65,23 | 67,86 |
| Chimaltenango | 79,39 | 68,51 | 63,92 | 66,16 |
| Huehuetenango | 65,9 | 70,78 | 65,36 | 68 |
| Quetzaltenango | 60,73 | 67,2 | 62,94 | 65,02 |
| Suchitepequez | 58,08 | 67,85 | 63,35 | 65,55 |
| Baja Verapaz | 56,49 | 71,06 | 65,58 | 68,25 |
| San Marcos | 43,54 | 67,71 | 53,22 | 65,41 |
| Sacatepéquez | 42,64 | 70,5 | 65,35 | 67,86 |
| Jalapa | 38,43 | 67,07 | 62,57 | 64,77 |
| Retalhuleu | 34,01 | 70,26 | 65,21 | 67,67 |
| Chiquimula | 30,12 | 67,76 | 62,83 | 65,23 |
| Petén Norte | 26,93 | 70,04 | 64,37 | 67,14 |
| Petén Sur Oriental | 26,93 | 70,04 | 64,37 | 67,14 |
| Petén Sur Occidental | 26,93 | 70,04 | 64,37 | 67,14 |
| Izabal | 23,27 | 71,8 | 65,92 | 68,91 |
| Guatemala Norte | 12,84 | 74,3 | 68,66 | 71,41 |
| Guatemala Sur | 12,84 | 74,3 | 68,66 | 71,41 |
| Amatitlán | 12,84 | 74,3 | 68,66 | 71,41 |
| Escuintla | 6,59 | 66,01 | 62,12 | 64,02 |
| Jutiapa | 5,2 | 67,86 | 63,04 | 65,39 |
| Zacapa | 4,46 | 71,7 | 65,81 | 68,69 |
| Santa Rosa | 2,69 | 68,9 | 63,55 | 66,16 |
| El Progreso | 2,09 | 68,51 | 63,39 | 65,89 |

***Source***: PAHO-2000.

The table above shows the strong association between life expectancy and population distribution by department. There is a differential of almost 10 years between people born in Guatemala City and people born in Totonicapán

The data illustrates that mortality among indigenous children is higher. Neonatal mortality in children aged 0 to 1 year and mortality in children under 5 are higher among the indigenous population (32/1,000, 64/1,000 and 94/1,000) than for the Ladino population (27/1,000, 53/1,000 and 69/1,000). With respect to total under-5 mortality, 67.6% of these deaths correspond to the indigenous population and 32% to the non-indigenous population, attributable to limited access to health services (Valladares and Barillas op. cit.)

Maternal mortality among indigenous women is also high, especially in the department of Alta Verapaz, which contains the country's highest concentration of indigenous people. In 1998, there were 250 deaths per 1,000 live births in this department—a rate approximately five times higher than the national average. Undoubtedly, this fact coincides with high illiteracy on the one hand, and deficient budgetary allocation on the other.

With respect to indigenous women, 74% have between few and far too few prenatal check-ups. Among illiterate women, the most significant cause for this fact is the distance to health centers. However, among women who have completed primary education, the causes include mistrust, poor services, or the unwillingness of their families to let them seek care. Those who do seek care are seen by physicians at health centers or are attended by midwives. Conversely, 67% of Ladino women have normal prenatal care and, in most cases, are seen by physicians.

More than 70% of Guatemalan women receive some form of care at the time of delivery, but while 50% of Ladino women are cared for by physicians, only 14.46% of indigenous women receive medical care. Moreover, 87% of indigenous women give birth in the home.

Finally, it is noteworthy that the disability rate for both the Ladino and indigenous populations is very low: 0.65% for the indigenous population and 0.76% for the Ladino population. However, we also observe that 40% of disability cases among the indigenous population occur in people under age 20, while it is 28% for the Ladino population in the same age group.

## Conclusions

In closing, some pertinent reflections are in order with respect to this first PAHO/WHO effort, one that incorporates the ethnic perspective in the search for equity in health. The following ideas are put forward with a view to stimulating an internal discussion as well as a debate with the principal counterparts.

1. The differences in the health situation of minority groups are related to structural factors such as poverty, to factors directly attributable to the organization of health services and their quality, and to the level of information available to the public regarding its health care. Thus, it is a priority that the health sector address the second group of factors, since these fall directly under its purview.

2. Biases in the treatment of minority patients can be corrected through systematic efforts within health institutions. Such efforts are needed because the causes are not apparent but hidden and are based on unspoken aspects of the established social order.

3. The marginalization seen today has a history that must be taken into account when rethinking perceptions and self-perceptions in order to create a better balance in relations among ethnic groups.

4 The gaps in health indicators for ethnic groups can be corrected through targeted efforts that respect the beliefs, knowledge, and language of the beneficiaries. Only through participatory efforts can citizenship be progressively expanded to the most disfranchised members of the population.

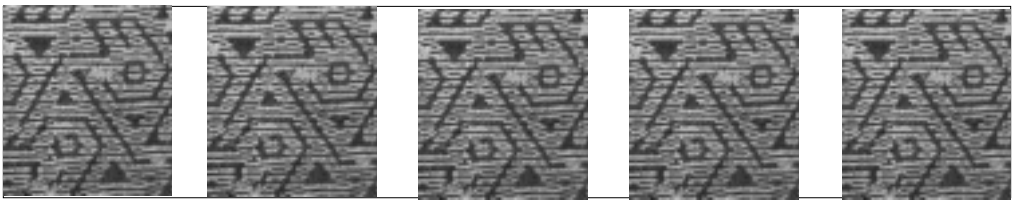
5. The ethnic perspective encompasses both indigenous peoples and Afro populations, and given the common roots of their marginality, makes it possible to address their situation at the same time. However, it is clear that the identification and analysis of the problems of social exclusion experienced by Afro groups in the Region of the Americas have received less attention than have those neglected indigenous groups.

6. The ethnic perspective is innovative in that it facilitates better definition of the problem as well as the solution. Accordingly, the solution lies in developing solidarity as well as family and community reciprocity. These elements will make it possible to rebuild fractured identities and bolster the capacity of groups to overcome their own vulnerability. Without social participation it will be impossible to strengthen the ethnicity of neglected groups.

7. Introducing these new concepts in the area of health poses a formidable challenge. Current policies are not always sensitive to ethnicity/race variables, and this requires targeting in order to prevent a regressive distribution of health resources.

Finally, there is the question of how to move this process forward. Some immediate tasks are listed below:

1. Improve the available information through new case studies;
2. Collaborate with national institutions to improve data collection instruments to make them more sensitive to the variables of ethnicity and race;
3. Work to expand knowledge of developments in cultural diversity related to health occurring in the Caribbean and Canada;
4. Develop and select health policy instruments for effective targeting of populations whose ancestors were indigenous and Afro peoples;
5. Develop the capacity of Afro communities in selected countries to participate in the design and evaluation of health programs and policies; and
6. Identify best practice in the Region with respect to the promotion of health programs for ethnic groups, with intersectoral support and community collaboration, so that they serve as positive examples to emulate.



## Conceptual Glossary

*Assimilation* is the process of group interaction that tends to blur the boundaries of the group and thus destroy the values of cultural diversity. It includes four subprocesses that are not always successive: 1) biological racial mixing[30]; 2) psychological identification with the greater society; 3) acculturation; and finally 4) structural integration (Yinger 1981).

Assimilationists assume that the differential features characteristic of sociocultural and economic pluralism idyllically disappear in the context of modern urban societies. Thus, the subordinated group (the ethnic minority) would be subsumed within the dominant group, gradually assimilating its behavioral patterns in a single direction, because the group neither visualizes nor is aware of the cultural characteristics that differentiate it and accepts the classification system imposed by the elites.

However, assimilationist responses are not linear processes, nor do they always occur successfully, since culture shock tends to produce syncretic cultures, ethnogenesis, and exclusion.

*Discrimination*. The social order represents a particular power relationship among society's participants, who have different or conflicting interests related to land ownership, rights of succession, the circulation of capital, production technologies, and productivity. Conflicts of interest frequently translate into social intolerance and lead to *discrimination*.

---

[30] The concept of racial mixture or hybridization is very complex. In Latin America a genetic, social, and religious synthesis occurred between the colonizer and the colonized that culminated in the triumph of the Spanish language, Christianity, and westernization (Klor de Alva 1995). The populations enmeshed in these processes (mestizos, creoles, and mulattos) had ambiguous social and ethnic identities whose internal boundaries were constantly created and broken down. In English America, less racial mixture is currently visible in terms of the relationship between white and Afro groups. Changes are taking place in this behavioral pattern. For example, marriages between people of African descent and whites increased from 2% to 6% between 1979 and 1990. Other groups, such as Asian- and Hispanic-Americans exhibit higher percentages of intermarriage with persons from other groups.

The segregationist model was reinforced by the cultural values of the first immigrants, who were settlers who arrived in family units. In this context, marriage had a stronger social and religious value than in Spanish and Portuguese America. Not only did the law punish interracial paternity and marriage, prohibiting sexual contact, but illegitimate children were also discriminated against; hence, the illegitimacy rates barely exceeded 3%, and racial mixture was almost nonexistent (Bernard1994).

Discrimination operates through *stigma*[31], ascribing particular character and/or behavioral traits (aggressiveness, passivity, apathy, and others) to phenotypical characteristics such as skin color, height, or hair texture (Coimbra 1999). Discrimination can be seen in social patterns that differ in nature and scope, such as racism, *segregation* and *assimilation,* which can occur in either the public or the private sphere.

*Ethnicity* refers to the construction of a collective identity. Naturally, this concept has a historical dimension and is closely linked with the problems involved in classifying people and group relationships (how a group classifies itself, how it classifies others, and its place in the social hierarchy). As a result, ethnicity not only describes a series of relationships between groups within a social order but is also a type of changing awareness in time.

Ethnicity involves the sharing of one more of the following elements: myths, ancestors or common origins, religion, territory, memories of a collective past, clothing or dress, language, or even physical features such as skin color.

Ethnicity makes it possible to distinguish groups with their own differentiated identities, based on selected traits or random ethnic markers: a territory or lands of origin, even though the group may not necessarily occupy them, as in the case of diasporas (Hutchinson & Smith 1996), a dialect, or physical features. By constructing ethnicity, the group generates solidarity among its members. Physical features (skin color, hair texture, or shape of the eyes) or physical mutilation (tattoos, circumcision, scarification), are not important in themselves but for the symbolic value and attention ascribed to them when group identities are constructed.

Minority or minority group. Minorities are defined in terms of size, power, and ethnicity (Schermerhorn 1996). If numerically a group represents more than half the population but is subordinate, it is considered an "ethnic mass." In the United States, minorities reflect the intersection of ethnic and racial status combined with economic disadvantages. Groups that have historically suffered from discrimination and have not been satisfactorily assimilated are minority groups (Nelson & Tends 1985, cited by Williams in *Ethnicity*…, who indicates that minorities can be identified by religion, language, or ethnicity).

[31] S*tigma* consists of the unequal ascription of behavioral characteristics (positive or negative) to certain human groups identified by their physical characteristics.

*Multiculturalism*. The most recent view in this field promotes the concept of *multiculturalism*, understood as the coexistence of culturally diverse groups within a framework of respect for the specific nature of "the Other." (Jameson and Zizek 1998). "The Other" may be highly diverse and refer to immigrants, ethnic minorities, women, the elderly, religious groups, or sexual minorities. What is paradoxical about multiculturalism, however, is that although it implies a lifting of the barriers of subordination, it also demands that dynamic actors intensify their own ethnicity in order to develop advocacy skills, representation, and autonomy equal to that of the other groups involved.

*Race* is basically a sociological concept that has no foundation in specific, immutable biological traits (physical or genetic markers)[32]. Since the dawn of history, there have been many successive processes of biological and cultural racial mixing that have called into question the existence of fixed racial boundaries. It has even been proven that there is greater variation within each racial group than between two different races[33]. As a result, although the concept of race is an abstraction and lacks an "objective" existence, it becomes very operational if understood as a cultural and political construct, regardless of whether it has a biological reality (Ericksen 1993, Pincus & Ehrlich 1994)[34].

The racial taxonomy that identifies a limited number of races differentiated hierarchically by physical features (predominantly skin color), is the historical product of Western colonialism and today clearly constitutes an obsolete view of the world.

Genetic factors should be ruled out as an independent variable for explaining health differentials among human groups but can, however, play a limited role

---

[32] The interaction among the various human groups has been analyzed by different currents of thought and disciplines (for example, anthropology, biomedicine, and sociology), which have each emphasized limited aspects such as physical and cultural traits. It is well accepted today that the roots of conflicts among human groups lies more in cultural aspects (beliefs and values) than in biological differences.

[33] Marvin Harris states that genetically speaking, the only thing we can be sure of is that an individual is a human being. That to belong to a race in biological terms is to be a member of a population that exhibits a specific frequency of genes of a certain type. Individuals do not exhibit frequencies of genes; they merely have a complement of a large and unknown number of genes, the majority of which are shared by all individuals. (Beyond Racism 2000).

[34] The differentiation between race and ethnicity can only be justified to facilitate the methodological approach. From this perspective, race is used to identify the biological features that differentiate human groups (skin color, stature, hair texture, or other), with ethnicity referring to cultural and religious factors that make it possible to visualize the existence of a people and sometimes a nation. In this regard, race is the categorization of individuals (Banton 1996) according to a physical trait (white, black, yellow, and brown), while ethnicity is the identification of human groups (Chiriwano, Sioux, Aymara, or other) and not a characterization of the individual.

in explaining the unequal distribution of disease. This residual role is closely linked to the social and cultural factors in these individuals' lives. People from these groups are usually exposed to unhealthier work environments, reside in neighborhoods with fewer services, and lack the information needed to prevent disease, face barriers with regards to access.

*Racism* is a form of discrimination against groups and/or individuals, based on an ideology of inferiority that tends to negatively differentiate minority groups or adversely affect their interests[35]. Racism, which can be institutional or personal, is related to preconceptions, stereotypes, and social prejudices that lack a rational or scientific basis. Although invisible, it sometimes forms an integral part of the beliefs and values system of societies or communities.

*Segregation* is the exclusion of a minority group within a society. It can assume various forms, such as physical and occupational separation (ghettoization, slavery, apartheid), and is the result of an unequal power struggle for the acquisition of resources. Minorities remain apart, conserving their traditional lifestyles without achieving full participation. When they lose the cultural traits necessary for organizing and dealing with change and culture shock without replacing them with those of the dominant or greater society, *marginalization,* loss of identity, and alienation ensue.

[35] *Prejudice* refers to hostile thoughts or feelings used to justify negative attitudes.

# Bibliography

Aldrete E. The Health of Indigenous Peoples. *World Health Organization* 1999; (99)1.

Albrecht G. Fitzpatrick R. and Scrimshaw S. *Handbook of Social Studies in Health and Medicine*. London: Sage Publications; 2000.

Alleyne G. *La Salud y el Desarrollo Humano*. Washington, DC: Organización Panamericana de la Salud/Organización Mundial de la Salud; 1996.

Banco Interamericano de Desarrollo. *Afroamerica XXI Plan de Acción 1998-2021: La Visión de los Pueblos Afroamericanos en el Tercer Milenio*. Cartagena de Indias: BID; 1998.

Banton M. The Actor's Model of Ethnic Relation. In: Hutchinson et al. *Ethnicity*; 1996:98-104.

Bartas P. MB. Análisis de la Situación de Salud del Pueblo Maya en Guatemala (paper).

Barton Smith D. Addressing Racial Inequalities in Health Care: Civil Rights Monitoring and Report Cards. *Journal of Health Politics, Policy, and Law* 1998; 23(1): 75-105.

Bollini and Siem. No Real Progress towards equity: health of migrants and ethnic minorities on the eve of the year 2000. *Social Science Medicine* 1995 (41)6:819-828.

British Medical Association Board of Science and Education. *Deprivation and Ill-Health* London, England; May 1987.

Broman C. The health consequences of racial, discrimination: a study of African Americans. *Ethnicity & Disease* 1996. Vol 6. N 1-2:148-153.

Butt J. Gorbach P. Ahmad B. *Equally Fair: A Report on Social Services Departments' Development, Implementation and Monitoring of Services for the Black and Minority Ethnic Community*. United Kingdom: Crown; 1994.

Calman NS. Out of the shadow. *Health Affairs* 2000; 19(1):170-174.

Caravantes de Dubois L. *Investigación de las Principales Fuentes de Información Científica y/o Técnica sobre Salud del Pueblo Indígena en Guatemala*. Washington, DC: OPS; 1997.

Centro Latinoamericano de Demografía/Instituto Nacional de Estadística, Guatemala. *Estimaciones de Población por Departamento según Sexo y Edad, 1990-2000 y Estimaciones de Población por Municipio según Sexo, 1990-2005*. CELADE/Instituto Nacional de Estadística Guatemala; 1997.

Cowater International Inc. *Comunidades de Ancestria Africana en Costa Rica, Honduras, Nicaragua, Argentina, Colombia, Ecuador, Perú, Uruguay y Venezuela*. Washington, DC: Banco Interamericano de Desarrollo; 1996.

da Silva Barbosa MI. *Racismo e Saúde*. São Paulo Tese de doutorado; 1998.

Deruyttere A. Native People by the Numbers. *América* 1999; 15.

Ericksen T. Ethnicity, Race, Class and Nation. *Ethnicity* 1993. Hutchinson and Smith (eds.).

Ferrer M. *Los Módulos de Salud en las Encuestas de Hogares de América Latina y el Caribe*. Washington DC: Organización Panamericana de la Salud; 2000. (Serie de Informes Técnicos No. 72 del Programa de Políticas Públicas y Salud de la OPS).

Fiola J. Race Relations in Brazil: A Reassessment of the "Racial Democracy Thesis". *Program in Latin American Studies, Occasional Papers* 1990; (24).

Fiscella K, Franks P, Gold MR, Clancy CM. Inequality in Quality: Addressing Socioeconomic, Racial and Ethnic Disparities in Health Care. *Journal of the American Medical Association* 2000; 283(19): 2579-2584.

Gepkens A, Gunning-Schepers LJ. Interventions to Reduce Socioeconomic Health Differences: A Review of the International Literature. *European Journal of Public Health* 1996; ( 6): 218-226.

Guendelman S, Schwalbe J. Medical Care Utilization by Hispanic Children: How Does it Differ from Blacks and White Peers? *Medical Care* 1986; 24(10): 925-940.

Gunning-Schepers LJ, Stronks K, Inequalities in Health: Future Threats to Equity. *Acta Oncológica* 1999; 38(1): 57-61.

Henry J. Kaiser Family Foundation. *Key Facts: Race, Ethnicity, and Medical Care*. Henry J. Kaiser Family Foundation; 1999.

Herman A. Toward a Conceptualization of Race in Epidemiologic Research. *Ethnicity & Disease* 1996; vol 6. N 1-2 :7-20.

Heringer R. *Race Inequalities in Brazil*. Escritorio Nacional Zumbi dos Palmares; 2000.

House JS, Williams D. Understanding and Reducing Socioeconomic and Racial/ Ethnic Disparities in Health. *Capitalizing on Social Science and Behavioral Research to Improve the Public's Health* Atlanta; 2000. (Paper).

Hutchinson J, Smith A. *Ethnicity*. Oxford; 1996.

International Human Rights Law Group. Bellagio Consultation on UN World Conference agains Racism. 2000.

Jarquim E, Caldera A. (editors) *Sociales, Pobreza y Participación Ciudadana*. BID; 2000.

Jameson F, Zizek S. *Estudios Culturales, Reflexiones sobre el Multiculturalismo*.(introducción E. Grüner). Buenos Aires: Paidós; 1998.

Kaiser Family Fondation. *Key Facts: Race, ethnicity and medical care*. United States: Kaiser Fundation; 1999.

Kilborn PT. Racial Health Gap Continues, Studies Say. *The New York Times;* January 26, 1998.

Lantz PM, House JS, Lepkowski WDR, Mero RP, Chen J. Socioeconomic Factors, Health Behaviors, and Mortality: Results from a Nationally Representative Prospective Study of US Adults. *Journal of the American Medical Association* 1998; 279(21): 1703-1708.

Latin News. Housing, Services, Child Health all Lag Far Behind. *Latin News* 2000; (12).

Lillie-Blanton M, LaViest T. Race/Ethnicity, the Social Environment, and Health. *Social Science and Medicine* 1996; 43(1): 83-91.

Lillie-Blanton M, Martinez RM, Kidd Taylor A, Garman Robinson B. Latina and African-american Women: Continuing Disparities in Health. *International Journal of Health Services* 1993; 23(3) 555-584.

Lundmark K, McBride S, Muirhead B. The Politics of Exclusion: Public Policy in Peripheral Regions: Canada and Sweden. Presented at the XVth World Congress of the International Political Science Association-Session on Intergovernmental Relations in the Policy Process, Buenos Aires; 1991.

Meentzen A. *Estrategias de Desarrollo Culturalmente Adecuadas para Mujeres Indígenas*, Banco Interamericano de Desarrollo; 2000.

Metzger X. Conceptualización e Indicadores para el Término Equidad y Su Aplicación en el Campo de la Salud. Organización Panamericana de la Salud: 1-43. (Document #INEQ).

Navarro V. Race or Class versus Race and Class: Mortality Differentials in the United States. *The Lancet* 1990; 336: 1238-1240.

Nickens HW. Race/Ethnicity as a Factor in Health and Health Care. *Health Services Research* 1995; Part II; 151-177.

Northington Gamble V. Subcutaneous Scars. *Health Affairs* 2000; 19(1): 164-169.

Organización Panamericana de la Salud. *Disparidades de Salud en América Latina y el Caribe: El Rol de los Factores Determinantes Sociales y Económicos*. OPS; 1999.

Pan American Health Organization. *Health in the Americas*. Vol.1. Washington, DC. OPS; 1998.

Pappas G, Queen S, Hadden W, Fisher G. The Increasing Disparity in Mortality Between Socioeconomic Groups in the United States, 1960 and 1986. *New England Journal of Medicine* 1993; 329: 103-109.

Pincus F, Ehrlich H. *Race and Ethnicity Conflict: Contending Views on Prejudice, Discrimination, and Ethnoviolence*. Boulder, Colorado: Westview Press; 1994.

Ren XS, Amick, BC III. Race and Self Assessed Health Status: The Role of Socioeconomic Factors in the USA. *Journal of Epidemiology and Community Health* 1996; (50): 269-273.

Rothman J. *Issues in Race and Ethnic Relations*. University of Michigan: F.E. Peacock Publishers, Inc; 1977.

Shi L. Experience of Primary Care by Racial and Ethnic Groups in the United States. *Medical Care* 1999; 37(10): 1068-1077.

Silva N. Raza, Pobreza y Exclusión social en Brasil. In: Gacitúa et al.(comp) *Exclusion Social y Reduccion de la Pobreza en América Latina y el Caribe* Facultad Latinoamericana de Ciencias Sociales/Banco Mundial 2000: 151-187.

Sorlie PD, Backlund E, Keller JB. US Mortality by Economic, Demographic, and Social Characteristics: The National Longitudinal Mortality Study. *American Journal of Public Health* 1995; 85(7): 949-956.

Taipale V. Ethics and Allocation of Health Resources: The Influence of Poverty on Health. *Acta Oncologica* 1999; 38(1): 51-55.

Thomas VG. Explaining Health Disparities between African-American and White Populations: Where Do We Go From Here? *Journal of the National Medical Association* 1992; 84(10): 837-840.

United Nations. 8th Annual Inter-Agency Consultation on Indigenous and Tribal Peoples. *International Labour Office* 1997.

US Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment*. US Health Department of Health and Human Services; 1998.

Uquillas J. Política del Banco Mundial sobre los Pueblos Indígenas: su aplicación en América Latina. Quito: Ponencia en el Parlamento Andino; 1996.

Valladares R y Barillas E. *Inversiones en Salud, Equidad y Pobreza: Guatemala*. Banco Mundial, Programa de Naciones Unidas para el Desarrollo y Organización Panamericana de la Salud; 1998.

Whitehead MM. Setting Targets to Address Inequalities in Health. *The Lancet* 1998; (351): 279-1282.

Whitehead MM. Where Do We Stand? Research and Policy Issues Concerning Inequalities in Health and in Healthcare. *Acta Oncologica* 1999; 38(1): 41-50.

Williams D, Williams-Morris R. Racism and Mental Health: the African American experience. *Ethnicity & Health* 2000; 5(3/4):243-268.

Williams D. Ethnicity, Race and Health (ms) prepared for the International Encyclopedia of Social & Behavioral Sciencies Neil Smelser & Paul Batles (eds). Pergamon Press. "Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination." *Annals of the New York Academy of Sciences* 1999; 986: 173-188.

Williams D. Race and Health: Trends and Policy Implications. Paper presented at the Conference: Income on Equality, Socioeconomics Status and Health. Washington, DC; 2000.

Williams D, House J. *Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health*. (paper) Atlanta: Institute of Medicine of the National Research Council; 2000

Yinger JM. Toward a Theory of Assimilation and Dissimilation *Ethnic and Racial Studies* 1981; 4(3):249-264.

# Ethnicity, Poverty, and Health in the Region of the Americas: A Historical Perspective to Understand this Relationship

Cristina Torres
Mercedes del Rio

# Contents

Introduction ---------- 133

Segregation in the Colonial Period ---------- 134

The Abolition of Slavery and Postcolonial Cultural Diversity ---------- 139

Cultural Diversity in the Nation-States, the Decline of Segregation, and Strengthening of the Ethnic Identity of Minority Groups ---------- 140

Health in the Construction of Cultural Diversity ---------- 145

Some Final Reflections on Building Cultural Diversity in the Region of the Americas ---------- 147

Bibliography ---------- 151

**Tables**

1. Imports of slaves to the Americas (1451-1810) ---------- 135

2. Distribution of African Population in the Americas at the end of the 18th Century by Subregions and Condition ---------- 137

# Ethnicity, Poverty, and Health in the Region of the Americas: A Historical Perspective to Understand this Relationship

**Cristina Torres ***
**Mercedes del Rio****

## Introduction

Poverty and discrimination are so intertwined that it is now difficult to determine whether individuals are poor because of ethnic discrimination or are discriminated against because they are poor. What is not open to question, however, is that poverty maps overlap with those of ethnic groups. Societies build up barriers that prevent minorities and ethnic and racial groups from enjoying equal opportunities.

These barriers are invisible because the ideology of most countries in the Region subscribe to the principle of non-discrimination by ethnic, racial, or religious reasons, which was stated in the first article of the Declaration of Rights of Men and Citizens (1789). The laws and the constitutions of a large number of countries in Latin America and the Caribbean embrace these principles. However, the minorities face restrictions when it comes to opportunity in the working place, in housing, in education, and in health.

Only through a longitudinal look can it be understood that the intercultural relations arising out of the historical process in the Hemisphere are what produced the systematic deprivation of minorities, resulting in the structural poverty of these groups.[1]

Present-day cultural diversity is the result of over 500 years of contact among five different human groups, within the framework of a political and economic process. These groups are: a) the original peoples that inhabited the territory (more than 25 million people)[2] before the discovery of America; b) Iberian and Northern European

* Regional Policy Adviser, program on Public Policy and Health, Division of Health and Human Development, PAHO/WHO.

** Research Associate, Department of Anthropology, Smithsonian Institution, Washington, D.C.

[1] Here the term *Poverty* will be freed from the economic reductionism that linked it with income level and used to mean an unjustifiable situation of deprivation, not only in terms of material goods but also of restricted access to services, information, and the opportunties for participation and representation. In this reconceptualization, poverty is viewed as a multicausal phenomenon of varying dimensions, whose determinants are not always simultaneously present.

[2] The figures are approximate and range from 8.4 to 112 million inhabitants. The native population of Latin America was 8 to 17 times larger than that of English America (Socolow, 1994).

groups, who arrived during the conquest and colonization; [3] c) populations of African origin (between 10 and 15 million) who were forcibly brought to the Hemisphere for economic reasons; d) groups of diverse origin (Asians, Europeans, free Africans, and others) who subsequently arrived of their own free will in successive waves of immigration—basically for economic and/or political reasons; and later, e) intraregional immigrants (Mexicans to the United States, Nicaraguans to Costa Rica, or Bolivians to Argentina, the Caribbean and others[4]), who are also there by choice for political or economic reasons.

The object of this work is to help understand how the social, political, and economic relations in which the relationships between the human groups mentioned above were unfolding created the general framework for living conditions and health differentials, as well as access to health services for individuals, based on the group to which they belong.

Living a healthy life, becoming ill, or dying are not independent of an individual's ethnic group, since ethnicity determines beliefs, traditions, social capital, and often the geographical location and the definition and exercise of rights.

The main features of relationships between human groups in different stages of economic and political development are described below, accompanied by a brief diagnosis of the health situation of the ethnic groups in each period.

## Segregation in the Colonial Period

Cultural diversity was born in the colonial world. In the colonial, Americas segregation and open exclusion were practiced, grounded in slavery (the African and rebellious indigenous populations) and subjection of the majority indigenous population.

With regard to the African population, the slave trade—which began in the 16th century—imported some 12 to 15 million Africans to the Hemisphere, who were then distributed among the 13 colonies to the North, the Caribbean, the Spanish colonies, and the Portuguese colonies to the South. The lowest figures, however, are

[3] In the United States he colonial European immigration was continuous, unlike in Spanish America, where there was a sharp decline in the 17th century. Between the 16th and 17th century, English immigration was three times higher than the Portuguese and Spanish immigration together. The British were the first Europeans to arrive in North America in the 17th century. Almost a century later, Scots, Irish, Germans, and Sephardic and French Jews migrated. However, the most numerous contingent was the 300,000 Europeans who arrived at the end of the 17th century (Socolow, op. cit.).

[4] Studies indicated that in the 80s some 20% of the total population of the Caribbean emigrated (Trouillot, 2000).

observed in Spanish America, which had 300,000 slaves at the end of the mass importation of the mid-17th century[5].

**Table 1. Imports of slaves to the Americas 1451-1810 (in thousands)**

| Destination | Period | | | Total | % |
|---|---|---|---|---|---|
| | 1451-1600 | 1601-1700 | 1701-1810 | | |
| Spanish America | 75.0 | 292.5 | 578.6 | 946.1 | 12.63 |
| Brazil | 50.0 | 560.0 | 1 891.4 | 2 501.4 | 33.38 |
| English America | | | 348.0 | 348.0 | 4.64 |
| English Caribbean | | 263.7 | 1 401.3 | 1 665.0 | 22.22 |
| French Caribbean | | 155.8 | 1 348.4 | 1 504.2 | 20.08 |
| Dutch Caribbean | | 40.0 | 460.0 | 500.0 | 6.67 |
| Danish Caribbean | | 4.0 | 24.0 | 28.0 | 0.37 |
| **Total** | **125.0** | **1 316.0** | **6 051.7** | **7 492.7** | **100.0** |
| % | 1.67 | 17.56 | 80.77 | 100.00 | |

***Source:*** Philip D. Curtin. *The Atlantic Slave Trade: A Census.* University of Wisconsin Press, Madison; 1969, p.268 (Cited by Susan Socolow, 1994:225).

The northern European colonization (British, French, Dutch) of the Caribbean and the Portuguese colonization of Brazil produced a slave-based plantation system. Slaves were utilized as a work force basically on the plantations. However, they also worked as day laborers and domestic servants on the estates. At the time, slaves from the various regions of Africa were considered more resistant to disease, had a longer life expectancy, and were better adapted to working on plantations than was the indigenous population; in fact, slaves were used because of the scarcity of indigenous labor.[6]

The crossing from Africa in overcrowded ships with no sanitation led to the death of approximately 1.5 to 2 million slaves. Even though Africans were better adapted than Europeans to the tropical climate, the harsh working conditions and repression

[5] African slaves worked on the plantations along the coast and in the interior of Peru, although their greatest economic impact was in the cities, where they engaged in specialized occupations: food preparation, tailoring, street vending, tanning, butchering, shoe-making, mule transport, etc. The trend was different in Mexico because slaves there were used in mining, although the African workforce never had the numbers or the impact that it had in Peru.

[6] As will be seen further on, the indigenous population was decimated during the initial stages of the discovery and colonization, which was why slaves were brought in.

produced high mortality rates (Klein 1986). Unlike the indigenous population, Africans had had contact with European populations for millenia, giving them greater immunity to contagious diseases; however, their high mortality is explained by the deaths during the crossing to the Americas, to which can be added the cases of suicide, infanticide, abortion[7] , accidents, and disease in the New World.

In the initial stage, high mortality and low birth rates (Meyer 1998) forced plantation owners to replenish their supply of workers every seven to 10 years. For example, from the 17th to the 19th century, 70% of the slaves in Brazil had been born in Africa, (Senegal, Cameroon, Angola, and Congo).

It was not until the early 19th century with the banning of the slave trade[8] that slaves were considered capital. At this point their value increased and owners began to provide them with more health care.

Continuous population flows led to a breakdown in these human conglomerates and hindered the development of a sense of belonging and ethnogenesis. The African population, forced into the diaspora of slavery, lost its dialects, traditional systems of authority, and family relationships; it was even forced to follow European cultural dictates. The initial uprooting was compounded by the possibility of intense interregional mobility. The social category of "slave" was created, with a fragmented self-identity. Slaves lacked their own organizations and linkages, their own territory, common ancestors, and historical memory; what bound them together were their syncretic religious beliefs and their language (Creole).

The reconstruction of Afro ethnicity remained in the hands of freed and runaway slaves, who usually settled in inaccessible areas for greater security. Although in Brazil, the Crown promoted the development of a numerically significant group of freed slaves, the British and French Crowns did not.

With regard to original peoples, the segregation began by lumping the different ethnic groups into a single category, that of "Indian" or "indigenous population", erasing the marked pre-Hispanic ethnic differences from the official language. This category of people was stigmatized with pejorative language; "Indians" were called savage, lazy and superstitious, qualities that were the opposite of the settlers view of themselves. In just a few decades after the conquest, this social, physical, and legal segregation was formally institutionalized under the formula the "Republic of the Spanish" and the "Republic of the Indies," enshrined in the Laws of the Indies[9] . The two republics functioned as parts of a compartmentalized society that mirrored the Spanish classes of nobility and commoner with different actors.

[7] There were groups of slaves who escaped and lived in villages (quilombos), subsisting on agriculture and robbery. Less frequently, they were freed by their masters.

[8] The slave trade was abolished by the United States in 1808 and by the great European powers in 1818.

[9] Spaniards, blacks, mestizos, and mulattos were not allowed to live in indigenous areas.

**Table 2. Distribution of African Population in the Americas at the end of the 18th Century by Subregions and Condition**

| Subregions | Slave | | Free | | Total | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| **English America:** | | | | | | |
| North America | 575 420 | 19.38 | 32 000 | 2.47 | 607.420 | 14.25 |
| Antilles | 467 000 | 15.73 | 13 000 | 1.01 | 480 000 | 11.26 |
| **Brazil** | 1 000 000 | 33.69 | 399 000 | 30.86 | 1 399 000 | 32.83 |
| **Spanish America:** | | | | | | |
| Continental | 271 000 | 9.13 | 650 000 | 50.27 | 921 000 | 21.61 |
| Antilles | 80 000 | 2.70 | 169 000 | 13.07 | 249 000 | 5.84 |
| **French America:** | | | | | | |
| Antilles | 575 000 | 19.37 | 30 000 | 2.32 | 605 000 | 14.20 |
| **Total** | **2 968 420** | **100.0** | **1 293 000** | **100.0** | **4 261 420** | **100.0** |

***Source***: Herbert Klein, African Slavery, pp.285 and 296 (Cited by Susan Socolow, 1994:224).

Communities were allowed to retain their original lands indivisibly and inalienably and obtain the rights to the usufruct in exchange for a fee and forced labor. The Spanish had quickly understood the importance of preserving pre-Hispanic government structures[10] and some of the institutions of the major Meso-American and Andean empires in order to mobilize native workers. However, segregation does not always imply alienation of "the Other," and this is one case where the "Republic of the Indies" permitted the social reproduction of highly autonomous native communities throughout the colonial period.

The other instrument of subjection operated through the organization of production and the impressment of Indians into the work force under the "mita"[11] and "yanaconaje"[12] systems. The principal type of production was mining (in Potosí, Bolivia and Zacatecas, Mexico) where the "mita" was the predominant way of working. The other two economic activities, textile workshops and plantations, were also based on forced labor, absorbing segments of the female and child population.

[10] Noblemen and chieftans served as intermediaries between the indigenous and European world.

[11] The *mita* was a revolving turn at forced labor for indigenous men between the ages of 18 and 50. There were different types of *mita* , but the most important was in mining. The mining sector received this free labor subsidy from the Crown. The silver sent to Spain laid the foundation for the development and expansion of European capitalism.

[12] The *yaconaje* (sharecropping) was another form of labor that linked the campesino to the plantations. Campesinos obtained a parcel of land in exchange for unpaid work and were tied to the land. The plantation owner was required to pay the campesino's taxes to the Crown.

In North America, although the strategy for dealing with the original tribes varied, they were systematically pushed westward and harassed for almost a century. A political solution was achieved through the signing of treaties[13] in which the tribes were granted new territory, a reservation, in lieu of their lands of origin, giving members of "the nations" the means of subsistence and lands for settlement. In these territories, native peoples had relative sovereignty and meted out their own justice, which helped to preserve the group identity as "another" nation, though considerably weakened.

With regard to health, the recurrent smallpox, measles, and influenza epidemics introduced by the Europeans to a population lacking immunological defenses, in addition to the toll taken by the wars of conquest, raids, and mistreatment, caused the demographic curve to plummet, recovering only in the 18th century. Recent studies have shown the dramatic effects of European diseases on the original inhabitants of the New World, with estimates putting the survival rate at 20% to 23%, depending on the region (Socolow op. cit.). In Brazil for example, the indigenous population was decimated by epidemics of hemorrhagic dysentery and influenza as early as 1560 and by the raids to capture Indian slaves[14]. This was compounded by the demographic losses from violence and the harsh working conditions in that region. By way of example, it should be recalled that during the first four decades of the colonial period, the population of Guatemala was reduced by 80% (Luján Muñoz et al. 1994).

It is estimated that the Caribbean stage of the Spanish conquest left 3,500,000 indigenous people dead between 1494 and 1510—the result of smallpox epidemics, famine, collective suicide, raids, and the exploitation of labor in the gold-panning areas (Alponte 1992, Wassermann 1991).

Intercultural relations were based on the segregation model both for the indigenous population and the slaves. This strategy became more complex in the Iberian colonies with the growing population of mestizos, "castizos" (whites and mestizos), mulattos, and zambos that developed within these categories, causing them to lose their rigidity and complicating the classification by phenotype that determined people's rank in

---

[13] Treaties were a political tool used widely in the United States and Canada. The records show more than 100 treaties signed between the representatives of the different tribes and the Federal Government between 1770 and 1820. Up to 1871 the U.S. government negotiated treaties with the indigenous tribes as if they were foreign powers. Many of the treaties address the issue of title to the land, but also the preservation of the peace, the "dependent status" of the tribal nations, the regulation of trade, fishing and game rights, etc. This mechanism was systematically utilized in the United States and Canada until the late 19th century.

[14] Backwell, chap. XIII. The *bandeirantes* were bands of armed men who ventured into the interior from the coast in search of riches, be it indigenous people to enslave or precious stones. The *bandeirantes* from São Paulo were mestizos (known as mamelucos) who spoke Tupí and not Portuguese.

the social hierarchy. Many of these new racial mixtures were the result of consensual unions. At the dawn of independence, mestizos represented 27% of the population, (Bakewell op. cit.), while the population of mulattos and freed slaves was much larger than the slave population.

This racial mixing, which occurred from the beginning,[15] was already common in the 17th century, and mestizos acquired status as social actors in the period of independence.

## The Abolition of Slavery and Postcolonial Cultural Diversity

Imbued with the European liberal principles of equality and the free market, Ibero-American independence movements in the 19th century[16] devoted themselves to building a monolingual, culturally homogeneous, territorially limited model of the nation-state, strongly grounded in law. Postcolonial nationalism adopted an assimilationist strategy for dealing with race and ethnicity in reaction to the segregationist failure of the final period of colonialism.

In Latin America, the State attempted to erase the presence of Indians and their communities from society by promulgating laws and decrees. The goal was to transform these groups into a new fiction, that of "independent producers" (small rural landholders) or simply "citizens"[17] . With colonial power overthrown, the identity of the young republics was built around the negation of their pre-Columbian past and ethnic differences.

One of the most important milestones in this period was the abolition of slavery. In the majority of the Ibero-American republics, the abolition of slavery was a gradual process that grew out of independence, although it took longer in Brazil and the island colonies of Spain. In the Caribbean, in contrast, with the exception of Haiti, independence and abolition were unconnected, and the rupture with the mother country occurred 100 years after abolition. In another dynamic, slavery in the Caribbean was condemned by the French authors of the Enlightenment, the more

[15] Especially because few European women were available. There were frequent unions between the conquistadors and the indigenous elite. It was very common for illegitimate children to receive economic compensation on the death of their father. There were more illegitimate children in the cities than in the indigenous world.

[16] The majority between 1810 and 1828. Cuba and Puerto Rico in 1898, while in 1808 the Portuguese monarchy moved to Brazil, which gained its independence in 1822.

[17] However, they were classified as destitute and were unable to fully exercise their rights. In Peru and Mexico the use of the word "Indian" was banned, and communities were deprived of their legal status.

radical currents of Protestantism, the proselytism of English associations, and pressure from rebellious and freed slaves. As a result, the British abolished slavery in 1834, the French in 1848, and the Dutch, in its West Indian colonies and Suriname, in 1863. Haiti formally cut its colonial ties in 1804 after the slave revolt (1791) and the success of the mulatto revolution. However, it survived violence and the consolidation of slavery in the hands of a mulatto elite up to well into the 20th century.

In many areas, former slaves were not integrated into society and went on to form "Maroon" communities in isolated locations (Colombia, Ecuador, Venezuela, the Guianas, Jamaica); in some areas, they became small farmers (Caribbean, Northeast Brazil). Some former slaves intermarried in the cities (Uruguay and Argentina) or the countryside (the Miskitos and zambos of Honduras; the Garífunas on the Atlantic coast of Guatemala), but always in the lower strata of society.

Notwithstanding the liberal declarations of the leaders of these emerging nations, colonial racial, ethnic, and cultural differences (groups and castes) remained and found their way into the new countries—concealed and never publicly acknowledged. In this model, though not excluded the indigenous population and the descendants of Africans remained in a subordinate position. Subordination operated in this stage through four mechanisms: a) the curtailing of rights; b) deprivation of the means of production (land, capital, and credit); c) lack of political representation; and d) cultural breakdown.

## Cultural Diversity in the Nation-States, the Decline of Segregation, and Strengthening of the Ethnic Identity of Minority Groups

Major social transformations took place between 1880 and the end of the 20th century, and important points of no return were reached in the construction of ethnic identity among the indigenous and Afro populations.

The first salient characteristic of this period is the expansion and growing complexity of intercultural relations as a result of heavy waves of new immigration.

For example, in the late 19th century the English-speaking Caribbean received a strong influx of immigrants from Asia (some 500,000 Indians and 14,000 Chinese or Javanese laborers) and Africa (32,000) to perform the work once done by slaves. In addition, the jobs that the slaves of Brazil and various areas of Spanish America had abandoned were filled by Mediterranean groups (Italians and Spaniards), Russians, Germans, Lebanese, Syrians, Japanese, free Africans, or local campesinos who were white or of mixed blood. Many of these population movements were fostered by the State through financial assistance in the belief that the immigrants

would bring progress and development. Thus, despite the poverty that marked the beginning of their odyssey in the Americas, within a generation the new immigrants had reversed their situation and attained acceptable levels of political, economic, and social integration. This was a successful integration model, for while these groups lost their mother tongue and some of their cultural traditions, their skills were welcome in the job market of the nascent industry, and they were rapidly able to reestablish networks for representation and solidarity that significantly increased their social capital.

With regard to health, in many countries these large waves of immigrants introduced a new variable into health care delivery: mutual aid societies, which, through private financing, succeeded in covering the majority of second-generation immigrants.

The second characteristic of this period is the intensification of the strategy to promote industralization and integration in the modernization processes begun by the Benevolent State. Latin American states during this period made great strides in building a middle class and in social integration through universalist public policies.

The elites permitted racial mixing as long as European cultural patterns were adopted. Moreover, the consolidation of the middle class (professionals, medium-scale merchants, salaried employees) produced racial integration with the same characteristics. Furthermore, some countries witnessed ideological and political articulation among the emerging middle class, campesinos, and the urban work force, which enthusiastically embraced the nationalistic ideals in vogue between 1920 and 1970[18] . Within this framework, the issue of indigenous marginality and the need to reabsorb this population into the concept of nation was introduced.[19]

With a view to promoting modernism, the Latin American social welfare states implemented indigenous integration and assimilation policies in education, legislation, and support for community development plans (Favre 1998). They held that the longstanding economic and social neglect could be rectified only through modernization and the merging of the indigenous population with the hybrid population. However, in this period the theory did not include communities with significant African ancestry.

The counterpoint to this strong, state-promoted integrationist wave was the dominant sector's fear of violence by the poor, the spread of disease, and the "degeneration" of the species. These fears found expression in medicine, which,

[18] Indigenism was very strong in Mexico and Peru, especially in art and literature.

[19] Indigenism is a movement linked with nationalism that was born in the late 19th century. It involves a mestizo and creole reflection on the Indian that exalts indigenous culture as the foundation of the national identity and the rupture with Europe.

grounded in Darwinian theory, developed eugenics. The goal of eugenics was to improve the human species by avoiding miscegenation with individuals of undesirable race. Eugenics was highly discriminatory, since it considered the white European race to be the race with the most sincerity, which was derived from "…power, vigor, and health, [while] cunning, the dominant quality in inferior races [was what characterized] Indians and blacks…" (Mateo Legnani [1918] In: Barrán,1995).

It is very interesting to point out, however, that while this ideological process was unfolding, the structure of the job market followed another logic. Industrial development basically attracted people from the literate urban sectors, many of whom came from the new waves of immigrants, and it bypassed indigenous communities and the descendants of Africans, who were more readily absorbed by the agrarian or services sector.

At this time in the British Caribbean, the crisis of the entrenched white plantation aristocracy[20] led to the emergence of a small middle class (merchants, professionals, and medium-scale landowners, as well as people of free African descent and new immigrants). Democratization and the confrontation with the old order were the result of economic diversification, expanded public education, and the spread of evangelical religions and syncretic cults, political institutions, and workers' organizations. In other words, in the Caribbean, the consolidation of civil and political institutions occurred prior to the shift in the economic order. Despite its paternalistic and reformist tone, the British colonial government could not withstand the pressure from the new emerging groups and granted independence in the 1960s.

The third characteristic of this period, more pertinent to the topic at hand, is the change in the paradigm of race relations in the United States, which occurred in the mid-20th century.

This change occurred as a result of the civil rights movement in that country, which began in the 1950s and continued through the mid-1970s. The struggle for equal rights led by Martín Luther King, Jr. helped to reduce segregation[21], making it illegal to discriminate on the basis of skin color or race and creating a new political consciousness based on egalitarianism. What is important about the civil rights movement is not only that it achieved legal institutional change, but that it also

---

[20] These groups were backed by the Crown and controlled the representative assemblies.

[21] The doctrine of "separate-but-equal," ruled legitimate in 1896, lasted 60 years. It meant separation and isolation of the minority group in terms of the use of private and public facilities (schools, parks, hotels, etc.) The 1950s witnessed the first access to the universities, and in 1965 the right to vote was confirmed. The movement had a broad spectrum of activists, from those who espoused nonviolent integrationist strategies to secure civil, political, and economic rights, to those who called for confrontation and separatist violence (led by Malcom X).

made possible an important phase in the reconstitution of African-American culture and collective identity (Singer 1962).

Despite these achievements, which are reflected in the rule of law, de facto discrimination still persists in the private sphere in the form of residential segregation, negative stereotyping of minorities (allegations that they are violent, lack the motivation to lift themselves out of poverty, or others), and inadequate implementation of policies that promote equal job opportunities (Williams op.cit). For example, certain statistics speak volumes: in 1966, the percentage of the U.S. population living in poverty was 13%, with poverty among whites at 11% and among African-Americans, 30%. At the same time, the lowest 20% of the population received less than 5% of the national income, while the highest 20% received 45%; unemployment among blacks was 9%, while among whites it was 4%[22].

Concomitantly, in Latin America indigenous[23] and Afro organizations and movements[24] began to emerge, seeking autonomy and self-determination for their peoples. These movements reject out of hand the idea of hybrid integration in national states, since they maintain that such processes are ethnocidal and designed to swallow up indigenous identity and/or color in a national identity. They struggle to regain their lands, and for respect for their language, history, and culture, and retain a multicultural, heterogeneous concept of the social body. However, they have also given their struggles a historical focus, transforming the ethnocide, losses, stereotyping, and racial hierarchies of the past into new ethnic identities (for example, the Maroons of Jamaica and Suriname, the Curiepes of Venezuela, and others), which, they fully intend, will attain a respectable place in history (Hill 1996).

These indigenous or Afro movements produced an increased social capital and the political visibility necessary for cultural reconstruction and served as the basis for the heightened awareness observed toward the end of the last millennium. They are social forces that oppose a state ideology that seeks to erase racial and cultural heterogeneity through the "myth of racial democracy," creating a duality in which racial discrimination persists but is not recognized (Guss 1996).

Finally, the last characteristic of this stage is linked to the intensification of democratization in the Region over the past 20 years and involves the revamping of

---

[22] *Beyond Racism: Embracing an Interdependent Future.* The Southern Education Foundation; 2000.

[23] Unión de Naciones Indias (Brasil), Movimiento Tupaq Katari (Bolivia), Confederación de Nacionalidades Indias (Ecuador), Coordinación Regional de los Pueblos Indios de México y América Central, Asociación de los Indios de Colombia, Organización Nacional de los Indios de Colombia, Consejo Indio Sudamericano, Organizaciones Indias de la Cuenca del Amazonas, Parlamento Indígena de América, and others.

[24] Comunidad Afroparaguaya Camba Cuá, Federación de Municipios del Litoral Pacífico Colombiano, Mundo Afro, Fundación Palmares Movimiento Negro Unificado (Brasil).

the idea of citizenship, the recognition of social rights, and the development of greater sensitivity to differences. Globalization, which has rapidly progressed during this period, implies the transnationalization of culture and the crisis of the European model of the nation-state as the foundation for political development.

Democratization and the crisis of nationalism opened the door to the revitalization of old ethnic identities, the emergence of new ones whose boundaries do not always coincide with current political boundary lines, and certainly the Latin American debate on the characterization of its states.

It has been necessary to wait until the closing decades of the 20th century for at least the indigenous populations of Latin America to obtain ethnic recognition by a State that, respects their autonomy instead of pursuing assimilationist objectives. This recognition is undoubtedly a very important step in enabling these peoples to become the agents of their own development and to overcome poverty and exclusion. The Constitutions of Guatemala (1985), Colombia (1991), Paraguay (1992), Ecuador (1993), Peru (1993) Bolivia (1994), and Mexico[25] explicitly recognize the plurinationalism and multiculturalism of their nations. Furthermore, Bolivia approved a Popular Participation Law (1995) and the INRA law (1996), which legally recognized the "ayllu" (traditional associations based on kinship, land ownership, and ritual) and the territories of Puna and Valle. Likewise, Paraguay and Colombia recognized their indigenous territorial entities. In addition, the international organizations (United Nations, International Labor Organization) have lent their support and recognized the demands of indigenous organizations, shifting the debate to the global plane.

The other important factor is the insertion of the issue of Afro groups into the political agendas, which was addressed earlier on this paper. In the 1990s, this recognition by states[26] and government representatives in the various forums was accompanied by the formation of networks to coordinate the organizations that deal with the development of Afro communities. Numerous community organizations and NGOs are engaged in activities related to training, service delivery, culture, the arts, and others in different Latin American countries (Argentina, Bolivia, Colombia, Costa Rica, Ecuador, Honduras, Nicaragua, Panama, Uruguay, Venezuela). This phenomenon follows the dynamic of the United States, where, over the past four

[25]Article 4 of the Constitution (amended en 1991) recognizes the multiethnic nature of Mexican society.

[26]Colombia has advanced in its approach to the issue through Law 70 dated 27 August 1993. Section 1 establishes that its "object is to recognize the black communities that have been using the unoccupied rural lands along the riverbanks of the Pacific basin according to their traditional practices, the right to collective property..." In Peru, article 1 of the annex to Law 26772 of 1997 maintains that "job offers and access to the means of education shall contain no provisions that constitute discrimination, nullification, or abridgement of equal opportunity," defining discrimination in the next article as the abridgement of equal opportunity or treatment based on sex, race, age, or others.

decades a very broad network has been established that includes foundations, universities, and NGOs.

As a corollary to the strengthening of political will and advocacy in civil society, initiatives are being launched to generate information and target social policies to overcome the poverty of those segments of the Latin American population.

## Health in the Construction of Cultural Diversity

The relationship between ethnicity and poverty has been described in the preceding sections, making it clear through the longitudinal analysis that the restrictions on human and civil rights imposed by a cultural diversity out of balance have worked to the detriment of certain minority groups, limiting their opportunities in the job market and their ability to obtain satisfactory living conditions. Generated through the same process, poverty and subordinated ethnicity (that is, minority groups) are confused.

Strictly in terms of health, there are a number of fields where direct links are created through the building of interculturalism.

In terms of the health situation as such, as mentioned earlier, both the original inhabitants of the Hemisphere and the slaves were confronted with risks to their health and even their lives in the initial stage of colonization, which resulted in a drastic decline in the population in various parts of the colonial world.

Vulnerability to epidemics was a constant. Several studies report 14 important epidemics of infectious diseases (small pox, measles, and others)in Meso America during the XVI century. In the Andean region 17 epidemics produced massive mortality between 1520 and 1600.

The other important area of interaction between ethnicity and health lies in the definition of "knowing how to cure," which leads to culture shock.

In the early centuries of the colonial period, there was a certain complementarity between traditional medicine and the knowledge of healing of medieval Europe. This was evident in Mexico, where colonial medicine adopted many Nahuatl therapeutic practices; many indigenous drugs were even used in Europe. In the Colegio de Santa Cruz Tlatelolco, a group of indigenous people held a chair in native medicine. It was there that the first text on indigenous pharmacology and botany was written *Herbal de la Cruz-Badiano* (Trabulse 1983).

Another aspect of this same process was the foundation of hospitals for Indians throughout Latin America from the very beginning of the colonial period. These were charitable organizations founded by the Spanish as an act of piety. With revenues

from private donations and the Church tithe, they were administered by religious orders, the secular clergy, the confraternities, or the donors' heirs[27]. However, these initiatives were rather insensitive to ethnicity, which meant that very few indigenous people in that era went to the hospitals, preferring instead to adhere to their traditional practices. An example of this was the Kallawayas, natives of the Charazani valleys between Lake Titicaca and the Amazon River in Bolivia. The Kallawayas are a famous indigenous group of itinerant healers whose therapeutic knowledge has been passed down from generation to generation, reaching back to the pre-colonial era. In fact, their empirical medicine and magic was taught during trips that lasted up to two years. Today, they continue to travel vast expanses to heal people (from Panama to Argentina). The most significant contribution of the Kallawayas, however, is their plant pharmacopeia, which is one of the most important in the world, with 980 botanical species, 30% of which produce effective action similar to that of remedies prescribed by official medicine (Girault 1987).

In the 19th century, European medicine gained the upper hand, supplanting all forms of popular wisdom, which contained important indigenous and African healing knowledge (medicinal herbs, the practices of healers, and other empirical knowledge).

During this period, hospitals supported by private donations and the Church were on the decline, and the young republics had difficulty assuming their financing. Although some leaders of the independence demonstrated the political will to address this problem, the fragile economic reality of the Latin American nations did not permit decisive action. Health care revolved around controlling epidemics (yellow fever, cholera, smallpox, and scarlet fever). In 1825, the first smallpox vaccination program in the Americas was set up in Bolivia, and an ineffective attempt was made to eradicate endemic malaria through sanitation measures (cleaning canals, and others) (Lofstrom 1983).

In the microcosm of medicine, the conflict over the hegemony of one culture over another was replicated. It is for this reason that science-based medicine, exerting its hegemony over knowledge of the health-disease process, resorted to the regulation

---

[27] The foundation of the first indigenous peoples hospitals under the guidelines of the Utopia of Moro was the responsibility of the Bishop of Michoacán, Vasco de Quiroga. In the 16th century, Mexico had numerous hospitals, such as the Amor de Dios Hospital (for venereal and skin diseases ), the San Lázaro Hospital (leprosy), Hospital for Abandoned Children (the first foundling home), the Hospital de la Concepción (founded by Hernán Cortés), and the San Hipólito Hospital in the Mexican city of Perote, founded in 1541 in Veracruz Crf. Josefina Muriel de de la Torre. (Los Hospitales de la Nueva España, 1956), In Bolivia, in 1568 the Communities and Hospitals for Pariahs were established with a donation from the encomendero Aldana. They were administered by the Augustinians until the time of the Republic and then passed to the Charity Fund (del Río, 1996). Alto Peru had seven hospitals run by the Bethlehemites and the brothers of San Juan de Dios. The Santa Barbara Hospital was founded in 1554 and is possibly the oldest hospital in the Americas.

of professional practice. The number of professionals, including those with academic degrees obtained within the Region, increased and they began private practice basically in urban centers (Barrán,1992); however, the minorities excluded from the formal educational systems did not and do not train human resources. The regulation of professional practice produces the marginalization of other types of healers whose skills will not be recognized by medical personnel, the States, or the monopoly exercised by the majority groups in the management of medical personnel and health institutions.

The other phenomenon contributing to the segregation of minority groups occurred well into the 20th century with the introduction of social security health services. These emerged as a result of industrial-sector organization. However, coverage was generally limited to members of the formal segment of the workforce and their dependents. It should be remembered that during this period, workers' health held strategic importance for the production and export of goods. Accordingly, emphasis was placed on the control of tuberculosis, syphilis, and alcoholism. In addition, the topic of child health began to attract attention, owing to the ravages of poliomyelitis and diphtheria.

Given their occupations, minority groups in most countries of Latin America will remain outside the scope of these social security health systems. Most affected in this regard are rural indigenous populations that work primarily in the agricultural sector and low-income urban dwellers, which, depending on the country, include a high concentration of mestizos, people of African descent, and mulattos. These populations, who live in marginal areas on the outskirts of cities and work in the services sector, are not covered by the Social Security health systems of most Latin American countries.

## Some Final Reflections on Building Cultural Diversity in the Region of the Americas

In the Region of the Americas, the existence of mature multiculturalism has yet to be confirmed. Instead, the Region is immersed in an intermediate stage in which one social group dominates the rest, although much progress has been made from the standpoint of formal rights.

In most countries of the Region, immigrant representatives of the principal colonial powers, and later on their descendants, became the elite of the emerging national states and assumed primacy over the remaining human population groups (indigenous population, Afro population and later migrants).

While the indigenous peoples were better poised to maintain their ethnicity, the uprooting experienced by their counterparts of African descent put this group at a

clear disadvantage in this sense, resulting in slower social construction of ethnicity. Inherent in the subordinate status of both groups was the widespread deprivation in terms of living and working conditions, leading almost inevitably to poverty in a sizable number of countries.

These common features notwithstanding, there is no reason to assume that the results of cultural diversity were identical throughout the Region. On the contrary, there are at least three different models for relations among human groups: that of the countries of the north, of Hispanic Latin America and the Caribbean, and of the English-speaking Caribbean.

In the countries formerly under Iberian rule, the cultural assimilation model combined greater racial mixing or *mestizaje*[28] with human settlements having very specific ethnic profiles. Examples include the Afro populations of the Atlantic coasts of Honduras, Nicaragua, and Guatemala, those located in the Pacific regions of Colombia and Peru, and indigenous settlements in Bolivia, Ecuador, Guatemala, Paraguay, and Peru.

The "borders" between whites, the indigenous population, and people of African origin have been eliminated (at least ideologically) or fall under the broader label of Ibero-American racial mixing ("cosmic race")[29], which is considered, at least in the official 20th-century narrative, as the essence of the Latin American reality. In this regard, the *mestizaje* process is the myth (seriously questioned at present) sustaining the construction of the State and national cultures as opposed to the idea that it is sustained by the Indian and the European. Nevertheless, racial mixing does not represent the absence of prejudice. Quite to the contrary, very subtle forms of discrimination exist, since it has always carried the stigma of the irregularity of its origins[30].

In countries of the Region with an Anglo-Saxon heritage, two different patterns are observed: one in the United States[31] and the other in the English-speaking Caribbean.

---

[28]The population of African origin is located primarily in Brazil, Panama, the Dominican Republic, and Cuba (Cowater/Inter-American Development Bank). The case of Brazil is paradigmatic, as the demographic representation of the Afro population is such that it should not be considered a minority, but rather an excluded majority (Coimbra, cit).

[29] The term coined by Mexican philosopher José Vasconcelos.

[30] Children of the Spanish born to mestizo or Indian mothers were illegitimate. The Spanish were aware of the importance of the legitimacy conferred by "pure blood."

[31] Analysis of the situation in Canada is not within the scope of this document but will be examined in future analyses.

With respect to the United States, its segregation model for Afro-Americans remained intact until the 1950s and 1960s, when profound changes in ethnic relations occurred. And for indigenous communities "reservations" were at once entities for cultural preservation and exclusion.

The English-speaking Caribbean exhibits a different set of features, given that the white population is a notable minority and that there has been minimal racial mixing. Nevertheless, ethnic homogeneity has not been complete. Currently, social tensions in the Caribbean frequently center on ideological aspects (models of African vs. European traditions) and religious beliefs (Christian/non-Christian),[32] and in ethnic relations (Indian, that is, Hindu, and Afro groups) concerning access to land, as in Trinidad and Guyana.

Caribbean ethnicity is formed in opposition to the idea of whiteness, highlighting the values of "blackness" and popular culture in the national identity. Moreover, the emergence of an elite of color with solid forms of political representation made it possible to assume leadership of the States and occupy the most important government posts. This gave rise to the most refined experiences in terms of the link between culture and policy. However, some authors claim that a persistent pattern of assigning greater social status to whites remains in effect, carried over from the heritage of slavery (Trouillot 2000).

In conclusion, it should be noted that during the social and political formation of the Region, groups of African descent, as well as other original peoples, went through stages of extreme deprivation in legal economic, and social terms, marked by political/military subjugation and slavery. This no doubt left an imprint over the centuries, leading to the limited social and political participation by minorities and ethnic groups that is still part of the current social landscape.

In short, despite the social and historical differences between the northern and southern areas of the Region of the Americas, the cultural diversity present in both subregions shares common features: white hegemony and discrimination against subordinated groups—segregation in the north and assimilation in the south. This imbalance has led to fewer opportunities for subordinated groups, which impoverishes these communities. In the English-speaking Caribbean, history produced the unique evolution of colonial slavery in black nations, whose characteristics were different from those mentioned above.

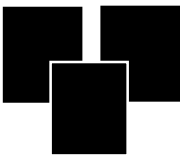
Health is the product of a process in which various factors intervene, such as the quality of life, the type of work performed, and the environment—factors that permeate power relationships among human groups.

---

[32] Among those of African and Hindu origin in Guyana and Trinidad; between Creole and European languages.

The statistics, when they are available, make it clear that differentials in the health situation of individuals still persist, in detriment to original peoples and groups of African descent, together with unequal opportunities in terms of access to health care and information on healthy lifestyles.

The knowledge and structures possessed by ethnic groups, though present in the cultural process that produced the dominant cosmic visions, were often ignored and supplanted by other practices and other types of knowledge.



## Bibliography

Alponte JM. *Cristóbal Colón: Un ensayo histórico*. México. Fondo de Cultura Económica; 1992.

Bakewell P. *A History of latin America*. Malden: Bakewell; 1997.

Barrán JP. *Medicina y Sociedad en el Uruguay del Novecientos: La Invención del Cuerpo, Tomo 3*. Montevideo: Ediciones de la Banda Oriental; 1995.

_____ *Medicina y Sociedad en el Uruguay del Novecientos: La Invención del Cuerpo. Tomo 1*. Montevideo: Ediciones de la Banda Oriental; 1992.

Bernard C. *Descubrimiento, Conquista y Colonización de América a Quinientos Años*. México. Fondo de Cultura Económica; 1994.

Bilby K. "Ethnogenesis in the Guianas and Jamaica: Two Maroon Cases" In: Hill (ed.) *History, Power, and Identity*. pp. 119-141.

Cabieses F. (ed.) *Medicina Tradicional, Legislación y Relaciones Políticas en el á'rea Azteca, Maya y Andina*. Lima: Imetra; 1994.

Coimbra Jr. CEA. Minorías Etnico Racionales, Desigualdad y Salud: Consideraciones Teóricas Preliminares. *Salud, Cambio, Sociedad y Política; 1999*.

Cose E. Pride and Power. *Newsweek* March 9; 1998. pp 41-48.

del Rio M "Riquezas y Poder: las Restituciones a los Indios del Repartimiento de Paria". In: *Saberes y Memorias en los Andes*. Bouysse-Cassagne (comp.) Paris/ Lima: Instituto Francés de Estudios Andinos; 1997: pp. 161-278.

Favre H. *El Indigenismo*. México: Fondo de Cultura Económica; 1998.

Girault R. *Los Kallawayas*. La Paz; 1987.

Guss D. Cimarrones, Theater and the State. En: Hill. History, Power and Identity; 1996. pp. 180-192.

Hill J (ed.) *History, Power, and Identity: Ethnogenesis in the Americas, 1942-1992*. Iowa Press; 1996.

Hutchinson J y Smith A. *Ethnicity*. Oxford; 1996.

Jameson F. y Zizek S. *Estudios Culturales, Reflexiones sobre el Multiculturalismo* (Introducción Gruner E.) Buenos Aires: Paidós; 1998.

Klein H *La Esclavitud Africana en América Latina y el Caribe*. Madrid: Alianza; 1986.

Klor de Alva J. The Postcolonization of the (Latin)American Experience: a reconsideration of "Colonialism", "Postcolonialism", and "Mestizaje". In: Prakash G. (comp.) *After Colonialism*. Princeton; 1995.

Lofstrom W. *El Mariscal Sucre en Bolivia*. La Paz: Alenkar; 1983.

Luján Muñoz J, Chincilla Aguilar E. *Historia general de Guatemala*. Guatemala: Editorial Aguilar; 1994.

Meyer J. *Esclaves et Négrie*. Paris: Gallimard; 1998.

Singer L. Ethnogenesis and Negro Americans today. *Social Research* 29(4) 1962. pp. 419-432.

Socolow S. La Población de la América Colonial. En: Bernard C (Comp.) *Descubrimiento, conquista y colonización de América a quinientos años*. México: Fondo de Cultura Económica 1994. pp. 218-248.

Trabulse J. *La Medicina de México*. México: Fondo de Cultura Económica; 1983.

Trouillot M. Exclusión Social en el Caribe. In: Gacitúa et al. (Comp.) *Exclusión Social y Reducción de la Pobreza en América Latina y el Caribe*. Facultad Latinoamericana de Ciencias Sociales/Banco Mundial; 2000. pp. 113-149.

The Black. *Little Known Facts About Facts About Slavery.* Website: theblackmarket.com

The Southern Education Foundation. *Beyond Racism: Emracing an Interdependent Future*. Atlanta: The Southern Education Foundation; 2000.

Wasserman J. *Cristóbal Colón*. Buenos Aires: Losada; 1991.

Yinger JM. Toward a Theory of Assimilation and Dissimilation. *Ethnic and Racial Studies 1981. 4(3): 149-264.*