



Pan American Health Organization



Regional Office of the
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Working to Achieve Health Equity with an Ethnic Perspective: What has been Done and Best Practices

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This document will address issues relating to health equity and victims of racial discrimination. As in previous PAHO contributions to the HCHR working groups, the documents focus on the collection and analysis of health data disaggregated by racial/ethnic origins.

The data are not systematic, but the existing information produced by scholars and health services of selected countries is concurrent in showing a persistent and unjust gap against certain ethnic groups. I will therefore not refer to those issues again. The questions I want to raise today are: What has been done, what are the successful experiences that can be used as good practices and adapted to local realities, and what else can be done to ensure that ethnic groups have equal access to health information and health services?

A *best practice* is a concept that has its origins in medical science and refers to the evaluation of medical procedures using living organisms, chemical substances and equipment. It's been recently adopted by social sciences and evaluation techniques to select successful experiences that can inspire others in the implementation of policies and programs.

The assumption that the best evidence of an intervention's efficacy from carefully controlled trials could be generalized as the best practice for widely varied populations and situations has been intrinsic from the beginning of research and evaluation in every field of engineering and human service. It is straightforward enough to appreciate how the laws of physics and material sciences can be counted on to apply consistently across applications in different situations.

Best Practice has served medicine and agriculture especially well. These fields have the advantage over other human activities in the homogeneity of the biological specimens they intervene upon. The cultural social and behavioral aspects of social activities, on the other hand, must make more adjustments of their interventions, not just in their extent. They must adjust their content and extent, not only by age and sex as in medicine but also according to the social, cultural, economic and occupational circumstances of the individual. These variations are compounded in public health population interventions in which individual, group and organizational variations multiply in their various combinations within populations.

After reviewing a vast amount of literature, we concluded that "*best practices*" in health policies and programs are those practices that have at least three of the following features:

1. Health sector involvement in the process
2. Civic society leadership and participation
3. Financial sustainability
4. A comprehensive health perspective basis
5. Benefits to and empowerment of the ethnic communities

Best practices can be identified in several areas as follows:

1. Policies

A significant case of long-term and sustainable government effort is found in Canada. In 1904, a General Medical Superintendent was appointed as the head of the Department of Indian Affairs to start medical programs and develop health facilities.

In 1945, the department of National Health and Welfare was created. The Medical Services Branch was formed in 1962 by merging Indian Health and Northern Health Services with other independent federal field services.

In 1974, the Minister of National Health and Welfare formulated the policy of the Federal Government concerning Indian Health Services. The Federal government wanted to ensure “the availability of services by providing it directly where normal provincial services (were) not available, and giving financial assistance to indigent Indians to pay for necessary services when the assistance (was) not otherwise provided”.

In 1979, a new Indian Health Policy was announced. The policy also recognized the need for community development and a strong relationship between Indian people, the federal government and the Canadian health system. In the mid-1970s through the Strategic Policy, Planning and Analysis Directorate, the Medical Services Branch started to transfer control of health services to First Nations and Inuit communities and organizations.

After the report of the Royal Commission on Aboriginal Peoples was released, the federal government announced Gathering Strength -- Canada's Aboriginal Action Plan. In the action plan, Health Canada was committed to initiating diabetes and tuberculosis programs, developing the Aboriginal Healing Foundation and, in partnership with the Department of Indian Affairs, creating a healing strategy to address the legacy of Indian residential schools.

In 1984, when the Canadian Public Health Association Conference dealt with inequalities in health, the idea of healthy public policy came to life.

Two years later in 1986, with close collaboration with the European Office of WHO, the Ottawa Chart for health promotion proposed five steps to reduce health disparities, including recommendations to improve health of aboriginals.

In 1993, the first Hemispheric Workshop on Indigenous Peoples and Health was held in Winnipeg, Canada, bringing together sixty-eight participants from different sectors of eighteen countries to discuss the draft declaration on the rights of indigenous peoples within the United Nations. The framework that year was set by the Declaration of the International Year of the World's Indigenous People, the International Decade of the World's Indigenous People and progress in the discussion of the draft declaration on the rights of Indigenous peoples within the United Nations. In 2002, Australia, Canada and New Zealand signed a tripartite memorandum of understanding on indigenous health and agreed to share expertise.

To conclude, Canada has implemented large number of programs and research initiatives to serve the multicultural needs of Canadian society, including specific programs and divisions within the Department of Health devoted to the needs and interests of members of indigenous populations, such as First Nations and Inuit. The Department of Health invests more than CAD\$ 1.3 billion per year in health services, health insurance, environmental health, and health promotion and prevention programs for these populations. This investment complements services provided at the provincial and territorial levels, such as hospital and physician care.

The Department of Health is committed to understanding better the health trends and emerging issues of First Nations and Inuit by obtaining data on health status, health outcomes, and quality service. These data are revised in collaboration with provincial and territorial partners as well as national Aboriginal health organizations. Reducing gaps in the health status of the indigenous population is one of the long-term goals of the Canadian Government. The Department of Health also contributes to the development of indigenous institutions in health, including the Institute of Aboriginal Peoples Health (IAPH) of the Canadian Institutes of Health Research and the National Aboriginal Health Organization (NAHO).

The Government of Canada recognizes that membership in a particular ethnic group is an important health determinant that should be taken into account in the development of health programs and strategies. This is reflected in Canada's application

of a population-based health approach, which recognizes that any analysis of the health of the population should go beyond traditional simple assessments of the health situation. This approach takes into account a broad range of factors and situations related to mental and social well-being, quality of life, income, employment and working conditions, education, culture, gender, and other factors that have been shown to influence the health of subgroups of the Canadian population. International cooperation is also developed in the research field.

2. Disaggregated Information

In several countries, the World Bank is supporting efforts to upgrade demographic and socioeconomic information systems. Disaggregating information by ethnic origins is part of the effort. These initiatives are expected to have an enormous impact in the medium term. In the Region of the Americas, the initiative has also been supported by the IDB, with a number of countries incorporating disaggregated data on race/ethnicity in their 2000 population censuses. These nations include Argentina, Belize, Bolivia, Brazil, Chile, Costa Rica, Ecuador, Honduras, Jamaica, Mexico, Paraguay, and Venezuela.¹ The United States already included such information and continues to do so. Peru is in the process of incorporating the race/ethnicity variable, while Colombia and Guatemala already included it in their last censuses and may maintain it. The next step will be to incorporate this variable into data collection forms for national household surveys in order to complement the information with socioeconomic data. This is already being done in Argentina, Belize, Bolivia, Brazil, Chile, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, and Peru.

In the health sector, it is also very important to introduce the ethnicity/race variable into birth, death, morbidity, and health service records, but less progress has been made in this area. That is one reason why is so important to count on the Census and Survey disaggregated socioeconomic data. This information permits designing programs using geography-targeting tools such as “poverty maps”. A recent study sponsored by the

¹ Information presented by Juan Antonio Mejía at the meeting “Todos contamos” [“We All Count”], sponsored by the World Bank in Lima (Peru), on 22-23 October 2002.

World Bank demonstrated the added value of geographic targeting when designing projects to reduce poverty. The study analyzing cases from Cambodia, Ecuador and Madagascar concludes that surveys and census data offer a promising avenue for measuring the impact of policies and constitutes a tool for transferring benefits to deprived communities. This tool is especially useful, and the gains are larger when budgets are modest because of the low cost of geography targeting.

However, some countries have disaggregated health data by ethnicity and race. The United States is a good example. Other countries, such as Uruguay, which includes information on ethnic/racial origin in death certificates, and Brazil, which includes it in information on reportable diseases such as HIV/AIDS in some states, also do it. In addition, the Latin American Center for Perinatology and Human Development has produced a new perinatal care information collection form that asks about the mother's ethnic/racial origin and her interest in having her newborn screened for sickle cell anemia. These modifications will not only afford benefits for mothers, but will also enhance the generation of reliable, disaggregated information and the training of health workers in how to administer the questionnaire.

3. Creation of new institutions within the state reform process

Probably the best example in this area is the creation of a new secretariat to deal with Racial Equity Promotion Policies in Brazil. The Special Secretariat (SEPPIR) was created by Law No. 10.078 in May 2003. Its institutional mission is to develop initiatives to reduce racial inequalities, and its goals are to:

- Promote equality and human rights protection
- Coordinate with other Ministers and Governmental institutions
- Provide follow-up to programs with private sector and international institutions
- Promote the enforcement of international treaties and conventions
- Cooperate with the Minister of External Relations on international cooperation with African countries

The main activities reflected in the organization chart are internal relations, program definition and development, and affirmative actions. The Special Secretariat

Cabinet is under the leadership of Matilde Ribeiro, who holds ministerial rank. The health issues are developed in collaboration with Brazilian Minister of Health.

4. Special units at the technical level

We have already referred to the Canadian First Nation and Inuit Health services. Another initiative that can be considered in this area is the U.S. Indian Health Service.

The Indian Health Service is an agency within the Department of Health and Human Services (HHS) that provides a comprehensive health service delivery system for approximately 1.5 million of the nation's estimated 2.4 million American Indians and Alaskan natives. Its annual appropriation is approximately \$2.6 billion. The IHS strives for maximum tribal involvement in meeting the health needs of its target population, who are federated in more than 560 tribes and live mainly on or near reservations and in rural communities in thirty-five states, mostly in the western United States and Alaska. Created in 1955, the IHS goals are to assist Indian tribes in (a) developing their health programs; (b) coordinating health planning; (c) providing comprehensive health care services and health programs, and (d) serving as a federal advocate to ensure comprehensive health services for American Indians and Alaskan natives. Since 1960, more than 230,000 homes have benefited from IHS funding of water and sewage facilities, solid waste disposal systems, and technical assistance. IHS employs approximately 15,000 people, including members of virtually every discipline. All 100 percent of the IHS senior executive service staff is of American Indian or Alaskan descent.

5. Special programs .

For almost a century, some countries have formulated and implemented vertical programs oriented to ethnic communities, including initiatives to promote traditional medicine practices and protect community knowledge on the curative potential of plants. These types of programs and projects expanded after the Decade on Indigenous Peoples in 1990. In the last few years, for example, several ministries in the Region of the Americas (Argentina, Bolivia, Brazil, Canada, Colombia, Chile, Ecuador, El Salvador,

Guatemala, Honduras, Panama, and the United States) have implemented programs to promote the health of indigenous peoples. Some of these programs may be considered as best practices to be taken as references for other ethnic groups in the near future.

Another noteworthy initiative is “Healthy People 2010,” introduced by the Department of Health and Human Services of the United States in January 2000.² This initiative proposes, as one of its central objectives, to reduce disparities in health conditions and access. It establishes focus areas with specific objectives for infant mortality, early detection of cancer, cardiovascular disease, diabetes, HIV/AIDS, and immunization. Healthy People 2010 has strengthened the collection and analysis of statistical data disaggregated by race and ethnic group as an instrument for ensuring the initiative’s implementation and success.

Other best practices come from the decentralization and civil society participation processes. However, the Durban Conference broadened the concept of groups affected by racial discrimination to include African-descendants, migrants, Romani people, refugees, etc. Durban has also brought discrimination to light, unveiling its role as a macro-determinant to human health.

In the field of research, some of the efforts under way have won international recognition. One example is the work of the Chronic Diseases Research Center, in Barbados, which for several years has been carrying out comparative studies on the prevalence of certain diseases (blindness, diabetes, and hypertension) in populations of diverse ethnic origin. This research is receiving support from the State University of New York at Stony Brook and the London School of Medicine.

In New Zealand, the Health Research Council³ has had a legislative requirement since its formation in 1991 to develop research for the Maori population. It has a statutory committee on Maori health, which is empowered to review and fund research

² The Healthy People initiative was launched in 1979. In 1990, the objectives were redefined and organized into twenty-two priority areas under the Healthy People 2000 plan. At the start of the new century, the initiative was revised again, and new objectives were set for the year 2010.

³ For more information, see <http://www.hrc.govt.nz> on the World Wide Web.

applications. Two of the ten members of the governing board are Maori, a third member is a kaumatua (cultural elder), and the secretariat has a Maori research manager. The government has identified a modest, dedicated fund for Maori development research (research under Maori control that seeks to support health and development outcomes for Maori) to augment the "public good health research" budget. Progress has been carefully guided by a number of senior Maori health specialists who have been board members. A strategic plan and guidelines for researchers have been developed.^{[9](#)}^{[10](#)}

6. Traditional medicine

There have been developments and advancements in traditional medicine, both in terms of the legal framework for its practice (Bolivia, Colombia, Ecuador, and Mexico) and in education and training in intercultural approaches for health professionals.

7. Civic society participation

NGOs have played a very positive role in this area, and national and municipal governments have recognized them as valid counterparts. In Brazil, representatives of several NGOs, supported by the UNDP and PAHO, participated in a group created to follow up on the Durban Conference. The group, which was charged with drafting a plan of action at the national level to promote racial equality, has been organized into thematic subgroups, one of which is devoted to health. PAHO provided technical cooperation to support this work. The plan of action has been discussed with the Health Minister and focal points have been designated for assuring implementation. Another example of action in the area of health is an initiative of the municipal health services of Montevideo (Uruguay), which have opened up channels for collaboration between technical personnel and the Afro-descendant community, organized through Mundo Afro, a network of local NGOs with strong leadership capacity. Another example comes from British Columbia, Canada, where the First Nations Summit in 1996 was alarmed by the Royal Commission on Aboriginal People's Report on the situation of aboriginal people⁴. As a consequence, First Nation Chiefs' Summit passed a resolution to create the First Nations Chiefs' Health Committee. One year after, the Committee defined its mission to support the development of health programs and to advocate for First Nations self-determination when addressing policy issues with Canada and British Columbia authorities.

To achieve its mission, the Committee formed a partnership with the B.C. Ministry of Health to implement projects to improve the health of the First Nations with a strong component on prevention. In the spring of 2001, the First Nations' Health

⁴ This Report stated that despite "the extent the medical services ... aboriginal people still suffer from an unacceptable high rate of physical and mental illness".

Committee had, in partnership with the B.C. Ministry of Health, implemented another project to provide community information and education sessions to remote, rural and isolated communities. The purpose of this partnership was to reduce the disparities in services that exist among reserve, off reserve, rural remote and urban settings. For example in Northern and remote communities, access is the major health problem. Another notable effort was developed by UNFPA working with communities and faith-based organizations and has been reported in a publication “Culture matters,” which describes case studies from country programs.

Health reproductive and HIV/AIDS projects are based on the creation of partnerships among governments, the UNFPA, and religious and community leaders. The *Cultural Matters Report* lists the following as major findings: (1) faith-based organizations play a key role in caring for the spiritual, material and physical needs of people affected by HIV/AIDS; (2) religious institutions and churches have a large infrastructure that may be used for these type of projects; (3) before designing advocacy work for grass roots communities, it is important to ensure that leaders are approached; (4) finally, providing hard data is one of the best advocacy tool to win a faith-based partner.⁵

A project of the Ministry of Social Protection in Colombia to respond the request of the ROM people to access to health services may be cited as another successful example. Providing services to ROM people constitute a challenge for health authorities since they are nomads; thus services cannot be provided in a static location.

8. Creation of Alliances

Since 1999, PAHO has been participating in an interagency coordination effort in Washington, D.C., together with the World Bank, the IDB, the Inter-American Dialogue, the Inter-American Foundation, the Ford Foundation, the Rockefeller Foundation, the Organization of American States, and community representatives. The initiative seeks to

⁵ For further information, see Culture Counts, UNFPA , 2004.

facilitate the sharing and analysis of information on the situation of Afro-descendants in the Americas and to promote joint activities.

9. Legislation

The ILO convention No. 169 addressed indigenous populations and tribes in independent countries. Probably the main legacy of the ILO convention is the definition of indigenous peoples and tribes⁶, which at the present time is not suitable to represent all the ethnic groups but can be used as an example. There are two health-related articles:

Article 24 establishes that social security schemes shall be extended progressively to cover the peoples concerned, and applied without discrimination against them.

Article 25 has four sections:

- a. Governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.
- b. Health services shall, to the extent possible, be community-based. These services shall be planned and administered in cooperation with the people concerned and take into account their economic, geographic, social, and cultural conditions as well as their traditional preventive care, healing practices, and medicines.
- c. The health care system shall give preference to the training and employment of local community health workers, and focus on primary health care while maintaining strong links with other levels of health care services.
- d. The provision of such health services shall be coordinated with other social, economic and cultural measures in the countries

⁶ Peoples in independent countries who are regarded as indigenous on account of their descent from the populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or colonization or the establishment of present State boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural, and political institutions. Self-identification as indigenous or tribal shall be regarded as a fundamental criterion for determining the groups.

10. Poverty Reduction Strategic Programs (PRSP)

In June 2004, the World Bank Board of Executive Directors approved a \$34 million loan to support the development of indigenous and Afro-descendent communities in Ecuador.⁷ The Second Indigenous and Afro-Ecuadorian Peoples' Development Project (PRODEPINE II) will help to empower indigenous and Afro-Ecuadorian communities and to improve their access to natural and financial resources. It follows a highly successful first phase, PRODEPINE I, which was co-financed by the World Bank and the International Fund for Agricultural Development, benefiting some 62,000 families with productive and social infrastructure investments, such as irrigation, drinking water systems, solar panels and rural schools, according to the priorities established through participatory processes.⁸

The new loan will support the following project objectives: (a) strengthening social organizations with indigenous and Afro-Ecuadorian membership; (b) promoting educational and culture-based initiatives to help target groups improve their human capital and increase their incomes; (c) financing small-scale rural investment projects by eligible communities; (d) helping the target population improve management of natural resources through increased access to and control of land, water and other vital resources; (e) Enhancing the Government of Ecuador's capacity to formulate intercultural policies and programs while taking into consideration the concerns of indigenous and Afro-descendant peoples.

⁷ "This project will benefit over 1.5 million people in the poorest rural communities in Ecuador. It will help the government to tackle the social exclusion that constitutes one of the key obstacles to poverty reduction in Ecuador, making social programs more effective and sustainable." Marcelo Giugale, World Bank Director for Bolivia, Ecuador, Peru and Venezuela. World Bank press release, June 22, 2004.

⁸ In its first phase, the project also supported the titling of more than 250,000 hectares of ancestral lands and formation of 580 women's credit groups benefiting 14,000 families, as well as training and cultural activities. "PRODEPINE I developed skills in project management among indigenous and Afro-Ecuadorian professionals which will be valuable in implementing future development projects to benefit their communities. Thus the project has served as a model both for similar initiatives in other countries with indigenous and Afro communities, and to continue building on the positive results in Ecuador." McDonald Benjamin, World Bank Country Manager in Ecuador. World Bank press release, June 22, 2004.

The fixed-spread specific investment loan is repayable in 18 years, with a four-year grace period. The total project cost is \$45 million, including expected financing from the Government of Ecuador (\$6 million) and local farmer organizations (\$5 million).

The World Bank also approved a \$15 million loan to the government of Honduras to support community development projects to benefit indigenous and African-descendants. The Nuestras Raíces, or "our roots", program serves the country's nine ethnic groups, whose total population of approximately 440,000 includes Honduras' poorest citizens. The Bank has supported Nuestras Raíces since 1997, two years after the government initiated the program, under implementation by the Honduran Social Investment Fund (FHIS).⁹

Recent community projects have included health projects, housing rehabilitation, and construction of water systems. The key to Nuestras Raíces is the community planning process. In its new phase, the program will assign facilitators to help the 2,000 indigenous and afro-Honduran communities assess their needs and to design strategic community development plans, including prioritized small-scale projects. Elements of these plans will become part of national and municipal development strategies.

The program has been characterized by a highly participatory approach with decisions on all aspects made jointly among representatives of the nine ethnic groups, the Honduran government, and the Bank.¹⁰ The US\$15 million, multi-currency International Development Association (IDA) credit has 40 years to maturity, including a 10-year grace period. The total cost of the project is US\$ 16.7 million.

Other Poverty Reduction initiatives taking into consideration indigenous populations are those from Bolivia (PRSP and Indigenous people development program), Brazil (VIGISUS Program phase I for indigenous population phase II for Afro communities and Bolsa Brazil), Chile (Chile solidario), Guatemala (Guatemala Poverty

⁹ Jane Armitage World Bank's Country Director for Central America. Press release, 2004.

¹⁰ Andrea Vermehren, Sr. Social Protection Specialist for the World Bank and Project Manager for Nuestras Raices. Press release, 2004.

Assessment Program GUAPA/MECOVI) Mexico (Programa de Educación, Salud y Educación, PROGRESA), Nicaragua (PRSP), and Perú (Indigenous People and Sustainable Development Program).

What else can be done?

One priority for the near future is to bring the human rights perspective into the implementation of the Millennium Development Goals, especially those related directly to health. These include Goal No. 4, target 5: Reduce by two-thirds between 1990-2015 the under five mortality rate; Goal No. 5, target 6: Reduce by three-fourths between 1990-2015 the maternal mortality rate, and Goal No 6: Combat VIH/AIDS, malaria and other diseases, present a window of opportunities for policy makers and civic society to participate in this process at the national and international level.

In a previous study published by PAHO, we had estimated the benefits of targeting victims of discrimination. The case study using Brazilian Surveys data (PNAD) concluded that 500,000 deaths could be prevented among children under age 5 by the year 2015 by creating a more equitable situation.

What lessons did we learn?

Policies and programs to promote the well-being of ethnic groups and victims of racial discrimination have a vast list of experiences that we can learn from. When these national initiatives are analyzed, some common characteristics appear:

- In some countries, the health of ethnic groups has been considered since the early part of the last century.
- Vulnerable groups had increasing participation in the design and implementation of the programs.
- In the 1980s, some of these initiatives were decentralized to allow for increased participation of local authorities and communities.
- The decade of the Indigenous People had a positive impact on the promotion of policies and programs aimed at protecting indigenous populations.

- ✓The Durban Conference changed the lenses we used to look at health problems, as follows:

? Discrimination is being visualized as a health macro determinant that impacts health status and access to the health care system.

? An equity perspective has been introduced relating the health status and access to services of the discriminated ethnic group.

? Mainstreaming ethnic/racial equality took over vertical health programs at the institutional level.

? A comprehensive perspective is being promoted to solve health problems including cultural heritage respect, and recognition of traditional medicine.

The biggest obstacle to addressing racial/ethnic inequalities is the financial commitment that is needed to fund the various initiatives. If governments can commit funds and engage these ethnic groups in the design and implementation of programs, we would see a significant reduction in inequities/inequalities.

Main priorities areas

Listed below are the priority areas toward incorporating ethnic sensitivity in health policy with an equity perspective:

- Work in coordination with UNDP and the national institutions responsible for following up on the Millennium Summit, with a view to developing ethnically sensitive indicators to monitor progress in meeting the Millennium Development Goals.
- Work with the institutions responsible for statistical data collection and with the ministries of health to introduce the ethnic variable into national statistics and ensure that this information becomes a key instrument in policy-making.

At the same time, efforts should be devoted to:

- Collecting information and systematizing successful experiences in the field and in the organization of services to enable these institutions to disseminate these methodologies.
- Support ministries of health in reformulating health policies, plans, and programs to make them ethnically sensitive.
- Promote the introduction of an ethnic perspective in the health plans developed as part of poverty reduction strategies in countries that are applying them.

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