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# RACISM, RACIAL DISCRIMINATION, XENOPHOBIA AND ALL FORMS OF DISCRIMINATION:

# COMPREHENSIVE IMPLEMENTATION OF AND FOLLOW-UP TO THE DURBAN DECLARATION AND PROGRAMME OF ACTION

## Report of the Regional Workshop for the Latin American and the Caribbean Region on "Ensuring that the Millennium Development Goals contribute to overcoming discrimination based on race, colour, descent, national and ethnic origin"

## Note by the High Commissioner for Human Rights

The High Commissioner for Human Rights has the honour to transmit to the Commission on Human Rights the report of the Regional Workshop for the Latin American and the Caribbean Region on "Ensuring that the Millennium Development Goals contribute to overcoming discrimination based on race, colour, descent, national and ethnic origin", held in Brasilia from 1 to 3 December 2004.

* The submission of the report was delayed because the seminar took place in December 2004.

** The annexes are circulated in the language of submission only.

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**Summary**

The present document contains the report on the Regional Workshop for Latin America and the Caribbean Region on "Ensuring that the Millennium Development Goals contribute to overcoming discrimination based on race, colour, descent, national and ethnic origin" organized jointly by the Office of the High Commissioner for Human Rights and the Pan-American Health Organization. The workshop, held in Brasilia from 1 to 3 December 2004, was hosted by the Government of Brazil, which has prioritized racial equality in its plans for the social sector and has recently created the Special Secretariat for the Promotion of Racial Equality Policies (SEPPIR). The workshop provided a forum at which States and non-governmental organizations of the Latin American and Caribbean region could exchange information and discuss their experiences in the development and implementation of health policies as they relate to groups vulnerable to discrimination within the context of the Millennium Development Goals and the Durban Declaration and Programme of Action.

Fifteen experts participated at the workshop as panellists and presented papers on the respective agenda topics. Representatives of States of the region, United Nations specialized agencies, national human rights institutions and non-governmental organizations also took part in the workshop.

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## Introduction

1. As part of the follow-up to the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, the Office of the High Commissioner for Human Rights (OHCHR) and the Pan-American Health Organization (PAHO), organized a regional Workshop for Latin America and the Caribbean Region on "Ensuring that the Millennium Development Goals contribute to overcoming discrimination based on race, colour, descent, national and ethnic origin". Held in Brasilia on 1-3 December 2004, the workshop was hosted by the Government of Brazil, which has established racial equality as a priority. The workshop provided a forum at which representatives of States of the region, United Nations specialized agencies, national human rights institutions and non-governmental organizations (NGOs) of the Latin American and Caribbean region exchanged information, discussed their experiences, and identified best practices in the development and implementation of health policies as they relate to groups vulnerable to discrimination. Participants and panellists at the workshop included senior government officials and policy makers, representatives of national human rights institutions and NGOs in consultative status with the Economic and Social Council, as well as those that had been accredited to the Durban World Conference; United Nations agencies, the United Nations Development Programme and the United Nations Children's Fund were also represented. Mr. Juan Martabit, Permanent Representative of Chile to the United Nations Office at Geneva, chaired the workshop.

2. The discussion was held within the context of the Millennium Development Goals, the right to health and the principle of non-discrimination, as established in a broad array of international and regional instruments and comprised within the anti-discrimination agenda of the Durban Declaration and Programme of Action. The focus of participants and panellists was directed toward practical means to implement these documents as part of a worldwide effort to eradicate poverty, eliminate discrimination and promote human dignity and equality. The agenda, consisting of seven topics, is attached as annex I.

## A. Opening of the workshop

3. In his opening statement, Dr. Miguel Malo, Coordinator of Health Promotion, PAHO Brazil, spoke on access to medicines and other critical public health supplies as a global priority as endorsed by the United Nations Millennium Development Goals. While stressing the importance of considering the ethnic dimension of the Millennium Development Goals, he spoke on the persistent social disparities in Latin America and the Caribbean and the need to implement policies toward achieving health-care equity of ethnic groups and victims of racial discrimination, including access to essential medicines and other public health commodities. The involvement of all stakeholders in developing relevant strategies and transparency in decision-making are essential in strengthening the public health system, services and fundamental functions.

4. The representative of the Office of the High Commissioner for Human Rights, Mr. Pierre Sob, stated that discrimination continues to be a present and direct threat to human dignity and entails an enormous and lasting negative impact on development opportunities in all areas: social and economic, political and cultural. The High Commissioner has made

the struggle against racism, racial discrimination and xenophobia her priority, placing it as a cross-cutting issue in OHCHR activities. This programme is based on the assumption that the eradication of the evils of discrimination can only be achieved by combining efforts at the international level and feeding them at the national level.

5. Dr. Paulo Carvalho, representing the Health Minister of Brazil, spoke on health care free of discrimination as a prerequisite for the enjoyment of human rights. Brazil attaches primary importance to combating racism within the framework of the Durban Declaration and Programme of Action and undertakes various activities toward the effective elimination of discrimination including on the basis of race, ethnicity, gender and sexual orientation. While recognizing the many challenges that remain in reaching equity in various aspects of social and economic life, Dr. Carvalho expressed satisfaction at some of the achievements which are already noticeable as a result of consistent efforts.

6. Ms. Matilda Ribeiro, Minister, Chief of the Special Secretariat for the Promotion of Racial Equality Policies (SEPPIR) in Brazil, asserted that the Government is working toward achieving racial inclusion and equity, a problem that has had a cumulative effect over the years. To this end, the Government undertakes several steps, including the adoption of affirmative action and imposition of quotas in order to facilitate access of people of African descent and indigenous people to university, employment, health care and other fields. Ms. Ribeiro spoke on the mandate and goals of her department, created in March 2003 by the President upon the request of organizations of people of African descent. Health is an important task on the agenda of SEPPIR and the workshop will contribute to facilitate understanding in the promotion of social and health policies. She asserted that concerns pertinent to people of African descent and indigenous people are being increasingly addressed in Latin America and the Caribbean. Twelve countries in the region have created similar ministries to address discrimination in general with emphasis on racial and ethnic problems. These steps represent great progress for the region. The institutionalization of the recommendations emerging from this workshop will contribute to secure affirmative-action policies contributing to support effectively the anti-discrimination agenda in the region. These steps can also help to consolidate action at the regional level.

## I. PRESENTATIONS BY PANELLISTS AND DISCUSSION

### A. Panel 1: Human rights and the Millennium Development Goals - toward an international framework to define an agenda to reduce health inequalities (Chairperson: Ms. Maria Inés Barbosa)

7. Mr. Juan Martabit presented an overview of the work of the Intergovernmental Working Group on the effective implementation of the Durban Declaration and Programme of Action, of which he is the Chairperson-Rapporteur. At its third session (Geneva, 11-22 October 2004), the Intergovernmental Working Group examined the topic of racism and health and recommended that States include an anti-discrimination perspective in health policies and programmes, especially those developed within the framework of poverty reduction strategies.

In this respect, programmes should be designed in a manner which could ensure that health services are accessible, affordable and culturally and linguistically appropriate to all sectors of society, including to vulnerable groups and victims of multiple forms of discrimination. There is a need to tackle disparities in health conditions around the world, including the Latin American and Caribbean region, particularly in view of the fact that certain ethnic and racial groups disproportionately suffer from various diseases such as HIV/AIDS, tuberculosis, leprosy and malaria. The set of recommendations adopted by the Intergovernmental Working Group contains strategies, the implementation of which could serve to tackle the issue of discrimination and health. It is also to be noted that at its second session (Geneva, 26 January-6 February 2004), the Working Group addressed the phenomenon of poverty as an expression as well as a consequence of racism. Referring to the relevant commitments made in Durban which have yet to be realized, the Working Group appealed to States to adopt and enhance their policies and measures to reduce income and wealth inequalities, with the ultimate goal remaining the total eradication of poverty.

8. Representing the Office of the United Nations High Commissioner for Human Rights, Mr. Pierre Sob reminded participants of the importance attached to strengthening partnerships at the national and international levels to help mainstreaming anti-discriminatory measures, actions, policies and programmes in health-care systems. He moved on to speak on the legal conceptual aspects of the right to health within the context of human rights. He drew attention to human rights law as it offers a binding legal framework that is underpinned by compelling moral values imposing the obligation on States to promote non-discrimination and equal treatment. Under international human rights law, the right to health and the right to be free from discrimination are contained in the provisions of various regional and international instruments and conventions and are accompanied by a monitoring mechanism to ensure that States are discharging their obligations.

9. He referred to the recognition of the right to health as emerging most notably in the Constitution of the World Health Organization (WHO), adopted in 1946. Two years later, the Universal Declaration of Human Rights laid the foundations for the international legal framework for the right to health. The most extensive treaty elaboration of the right to health is contained in the Convention on the Rights of the Child, which has been ratified by the vast majority of States. The International Covenant on Economic, Social and Cultural Rights also provides for the right to health under article 12, as do more than 100 national constitutions.

10. Mr. Sob submitted that the right to health encompasses both health care and healthy conditions, including environmental and living conditions that constitute social determinants of health. He referred to the Special Rapporteur on the right to health of the Commission on Human Rights, Paul Hunt, who supports the view that social determinants to the right to health encompass safe drinking water, adequate sanitation and access to health-related information, including on sexual and reproductive health. The right to health also includes entitlements, such as the right to a system of health protection culturally acceptable and of good quality. Overall, the right to health has many elements, including access to essential drugs. It requires that health facilities, goods and services be available. Although the right to health is subject to progressive realization, it imposes some obligations of immediate effect, including the guarantee of non-discrimination.

11. Mr. Sob concluded that the right to be free from discrimination is set out in many regional and international human rights instruments and conventions. The international human rights system offers a wealth of experience on non-discrimination and equality that can help to identify policies that will deliver health to all individuals and groups, including the most disadvantaged ethnic minorities.

12. In the discussion that followed, one participant pointed out that capacity must be built within communities to allow people of African descent to have access to health. Another speaker stated that health systems and programmes themselves have a discriminatory dimension which support discriminatory attitudes and it is important to examine the defects of health programmes in the region which themselves support racism.

13. One participant raised the linkage between maternal mortality and lack of access to health services as a reality in many communities since access to health care of many pregnant women is limited to traditional midwives as the only existing alternative. The participant mentioned the failure of the State and its inability to guarantee access to basic health services and medicines.

14. Another participant referred to some progress that has been achieved in her country with respect to tackling discrimination since the adoption of the Durban Declaration and Programme of Action. However, she opined that the continued existence of "neglected diseases" constitute proof of the need for the Millennium Development Goals to address diseases that mainly afflict the poorest people living in the world's poorest countries.

15. One participant mentioned that ancestral therapeutic practices and knowledge about healing diverse illnesses of the body and the mind, in close relationship with nature, have not made their way into clinical health services. As part of the cultural patrimony and knowledge of indigenous peoples; traditional health services are discriminated against and are not recognized in the health plans of many countries in the region.

### B. Panel 2: Access to health and the impact of discrimination based on race, colour, descent, national and ethnic origin

16. Dr. Fátima Oliveira, Professor at the Universidade Federal de Minas Gerais in Brazil, said that the Millennium Development Goals do not focus on the problem of racism. They mention racism only once, without explaining what it means. The Millennium Development Goals do not meet the expectations of social movements nor are they relevant to feminist movements or the black movement. They are not the only model for solving the population's problems, and other meetings and summits on the topic of racism must be taken into account. She stressed the importance of ethnic and racial components and suggested that PAHO should promote non-discriminatory health activities.

17. Using various graphs, Mr. Federico Hernández Pimentel, representative of PAHO in Guatemala, demonstrated the disparities in Guatemala as regards access to health-care facilities of indigenous people as opposed to the rest of the population. An examination of health indicators pertaining to Guatemala reveals clearly the relationship between poverty and the indigenous populations (41 per cent of the population). He also showed that, according to

disaggregated data, the disproportionate number of child mortality and other deaths related to various treatable diseases among indigenous populations and people of African descent almost double that of the rest of the population.

18. He also asserted that indigenous people and people of African descent in Guatemala are disproportionately affected by poverty, marginalization, illiteracy, unemployment and lack of access to health services. Racial barriers to health care are based, in large part, on the unavailability of services in certain communities. The lack of health-care facilities in proportion to the population is an issue that plagues indigenous communities and those of Afro-descendants. The serious lack of facilities in these communities includes not only hospitals but also clinics, dental clinics, and mental health clinics.

19. Mr. Gustavo Makanaky of Colombia submitted that racial disparities in health-care treatment do not occur as a result of overt, intentionally discriminatory behaviour. Manifestations of racial discrimination in health care are likely to result from unconscious bias or disproportionate impact of policies and practices. Fundamental to discrimination in many countries of Latin America is the lack of acknowledgement of the existence of the segment of the population which is of African-descent. The problem Mr. Makanaky asserted is one of visibility and perception. Decision and policy makers in the region consider the marginalization of people of African descent as a normal phenomenon. The degree of the phenomenon is such that even some people of African descent in Latin America who themselves are discriminated against refuse to admit that they are victims of discrimination. However, they tend to view the problem as one that is simply economic as opposed to discriminatory. He considers that the health deficit disproportionately affecting vulnerable groups is due in large part to institutional racism, which significantly impacts access to quality health care. Institutional racism is based on policies, practices, regulations and laws that have a disparate negative impact on particular groups. He suggests that the implementation of comprehensive long-term programmes incorporating affirmative action and quota systems designed to achieve equity and remove social and economic barriers would serve to alleviate discrimination and lead to equality of access to health care and other services and opportunities.

20. During the debate, the point was raised that discrimination occurs within the population displaced by the conflict and that Colombia's health-care systems do not take account of its multicultural population. Physicians and the indigenous population speak different languages, which limits their interaction. It was also pointed out that information systems still have not incorporated traditional medicine into health systems. Two points were raised in this connection, namely that health information systems should be strengthened in terms of their coverage, quality and content, and that use should be made of community-based assessment systems to complement the standard system, beyond isolated research with private objectives, to ensure systematic assessment for monitoring and tracking coverage.

### C. Panel 3: Gains to be expected if the Millennium Development Goals are achieved within an ethnic framework - Is there a need for new policy design?

21. The panellists presented case studies with a view to raising the participants' awareness of the need for new health policies to achieve the Millennium Development Goals across the region in a context of ethnic equity.

22. Dr. Cristina Torres of PAHO/WHO explained why health-sector decision makers needed to adopt for new health policies to achieve the Millennium Development Goals. She presented the findings of a study conducted in 2002 by the Economic Commission for Latin America and the Caribbean (ECLAC) based on simulation models in 18 countries and highlighted some of the recommendations of the study, including the need to focus on new categories of urban poverty such as single-parent families headed by a woman, first-time young job seekers, and households consisting of elderly persons living alone; the need to incorporate an ethnic/racial dimension when redesigning programmes and policies, given that the worst socio-economic indicators are recorded for these historically neglected groups; and the need to set in train processes to address a number of tasks simultaneously, namely disaggregation of data to facilitate monitoring, resources training, promotion of social participation in policy formulation, intersectoral coordination, and strengthening of primary health care.

23. Dr. Oscar J. Mujica of PAHO/WHO, based in Washington, D.C., presented two case studies. The case study on Brazil, entitled "Achieving the Fourth Millennium Development Goal with Equity", made use of official data provided by the Integrated Health Service Information Department (DATASUS) of the Brazilian Ministry of Health. It aimed to explore the possible impact on equity in health care of various strategies to reduce the risk of infant mortality. The concept of two "naturally occurring" and clearly differentiated socio-economic strata in the Brazilian population was adopted for the purposes of the study. This is the "trickle-down" thesis, according to which initiatives are concentrated in the more affluent stratum, on the assumption that the benefits thus obtained might have positive repercussions for the population as a whole.

24. The Panama case study focused on ethnic diversity and the way that this is reflected in social exclusion. A presentation was made of the evidence gathered from an exploratory study of socio-economic inequality in the health sector prepared in conjunction with the Health Ministry in 2003. Statistics show that indigenous peoples currently make up 10 per cent of Panama's population and suffer most from social exclusion. The benefit of modest changes in income redistribution policy would be significant in improving conditions of extreme importance for national public health, since it would have direct repercussions on infant mortality, the incidence of disease, family trends, regional productivity and national human development. It was emphasized that 8 out of 10 Panamanians have access to benefits associated with the middle and upper levels of human development, which would suggest the feasibility of achieving significant health equity gains by applying redistribution strategies with a gender and ethnic dimension.

25. Dr. Marianela Corriols of PAHO Nicaragua recalled that non-discrimination on the grounds of race, ethnicity, sex, gender, language and religion is an all-embracing and fundamental norm relevant to all aspects of public life, and stressed that the Millennium Development Goals can only be achieved in a context of ethnic equity. She indicated the need to adopt comprehensive policies in the areas of development, the economy, the environment, health care, education and gender, and to institute new policies and new ways of thinking about the scope of the goals and to make the transition from fact-finding to awareness-raising and action.

26. As the second poorest country in Latin America, Nicaragua has been implementing poverty reduction strategies and recently participated in the Heavily Indebted Poor Countries (HIPC) Debt Initiative with its focus on the ethnic component in development, social and health policy in the two stages of the poverty reduction strategy. In the field of health care, in connection with investment in human capital, she reported just one telemedicine pilot project on the Atlantic coast and the rehabilitation of certain facilities of the primary and secondary health-care network. As to determining factors, there was a relationship between action in the fields of food security, water and basic sanitation and development projects. More recently, the Government had drawn up the National Development Plan for 2004-2015. The principle of equity in social policy had been broached with a view to raising income levels, increasing wealth and reaching high levels of gender and ethnic group equity.

27. The Second Consolidated Strategy for Economic Growth and Poverty Reduction (ERCERP), drawn up pursuant to the National Development Plan, outlines action in the areas of education, training, employment, health and nutrition, social welfare, service provision, drinking water and basic sanitation. It represents a significant step forward in comparison with the previous strategy. Since May 2004, health policies include a specific (sectoral) policy for the Atlantic coast. The operational framework of the strategy incorporate the Millennium Development Goals relating to maternal and infant mortality, malnutrition, HIV/AIDS, malaria and tuberculosis. Programmes have been outlined in the areas of extension of medical coverage, provision of a basic package of health services, construction and rehabilitation of hospitals, and medical and non-medical inputs.

### D. Panel 4: Consideration of good practices for identifying and addressing inequalities in access to health

28. Dr. Oscar Bermúdez from Costa Rica presented the case of the Ngobe-Buglé people, who migrate from Panama to Costa Rica to harvest coffee, and described the reasons why these immigrants are considered to be a vulnerable group: poverty, their indigenous status, their "invisibility" to the health monitoring system, poor health with high prevalence of infectious and occupational diseases, continual displacement, unhealthy working conditions, and lack of recognition of and respect for their culture. In addition, the existence of many small farms in the coffee-growing areas made it difficult to take concerted action to improve the health situation of the indigenous people who migrate at harvest time.

29. He put forward a proposal comprising the following aspects: a bilateral approach (technical cooperation among countries), targeted insurance and health-care schemes, reorganization of the health monitoring system, intercultural training for health personnel, raising the awareness of the "recipients", regularization of employment and the promotion of "mirror services" on both sides of the border. Lastly, he listed some of the achievements to date: technical cooperation between Costa Rica and Panama; bilateral health monitoring; training; development of a targeted health scheme; the preparation of audio-visual resources and occupational health and safety.

30. The Colombian anthropologist Dr. Gina Carrioni reported that the Colombian Ministry of Social Welfare had been established on 3 February 2003 and had assumed the functions of the former Ministry of Health. She referred to the Health Programme for 2002-2006 of the Ministry

of Social Welfare; the Programme's goals include the extension of health coverage for the four ethnic groups that make up the Colombian population (indigenous peoples, Afro-Colombians, island communities and gypsies). She mentioned some of the activities being undertaken by the Department for Social Welfare, highlighting the formulation of a plan or roadmap to improve care for displaced ethnic groups. A pilot project would soon be launched in Bogotá. Lastly, she referred to an agreement with PAHO that includes an assessment of the health situation and the establishment of guidelines on extending social welfare coverage using different models to suit the needs of each ethnic group.

31. Dr. Valcler Rancel, Under-Secretary for Planning at the Brazilian Ministry of Health, placed the health problems of Brazil's black population in the context of the population as a whole. He restated the principles that underpinned Brazil's Integrated Health System (SUS), namely universality, comprehensiveness, equity, social participation and decentralization. The sheer complexity of the situation was striking: a surface area of 8.5 $km^2$, a patchwork economic and social structure, the coexistence of diseases prevalent in developing countries with a demand for advanced technology, and the existence of the SUS. He also mentioned the *quilombo* communities, of which there are 743 throughout Brazil. He produced maps showing the extent of coverage by family health teams, which have been in operation for about a decade.

32. Dr. Alexandre Padilha, Director of the Indigenous Health Department at the Ministry of Health, said that the total indigenous population of Brazil was 411,132 distributed among 367 municipalities, almost entirely in the Amazon. In line with the principles of the SUS, it has been possible to organize health care for indigenous peoples on a different basis from that established by the SUS. Thus, Brazil has 34 special indigenous health districts whose boundaries do not coincide with those of municipalities or States. He cited a number of indigenous health indicators: immunization coverage (currently between 50 and 60 per cent), lack of data on nutrition, the high prevalence of tuberculosis and malaria, infant mortality (which, although still high, has fallen by about 50 per cent over the past six years, from approximately 97 to 43 per 1,000, which is a sharper decline than for Brazil as a whole). He identified various challenges: the re-empowerment of indigenous peoples in their own lands (coexistence of a modern health-care system with their traditional system, accessibility, reference and counter-reference, etc.); training for health-care personnel that focuses on the cultural values of indigenous peoples; budgetary management and strengthening the administration of the districts in cooperation with the SUS; improving health indicators; and strengthening traditional medicine.

33. Among the topics raised during the discussion were: border problems; the possibility of retaining the names of diseases used by indigenous peoples; the presence of transnational banana companies on the Costa Rica-Panama border and their impact on seasonal migrations in this region; techniques for training health personnel in matters affecting ethnic groups; the need to establish ministries of ethnic affairs; the need to dovetail the issue of gender with that of indigenous peoples; the possible link between health issues and the political demands of indigenous populations; the inclusion of ethnicity as a variable in poverty distribution; a higher profile for persons of African descent; the relative importance of Afro-Colombians in the achievement of the Millennium Development Goals; and the need to monitor the allocation and use of resources in communities of persons of African descent.

34. Some participants also stressed the fact that, in certain countries in the region, issues affecting ethnic groups were dealt with only by NGOs. They referred to the need to provide training to various groups, such as health teams, the academic community and trade unions, on the topic of ethnicity. Ethnic communities were also urged to patent traditional medicines. It was suggested that these countries should establish an integrated health system that caters equitably for indigenous people and people of African descent.

## E. Panel 5: Racism and HIV/AIDS

35. Mr. Edgar Carrasco, Chief Coordinator of Acción Ciudadana contra el SIDA, based his presentation on the study on racism and HIV/AIDS carried out by the Latin American and the Caribbean Council of AIDS Service Organizations (LACCASO). He laid emphasis on the following points: the invisibility of the problem of HIV/AIDS among indigenous populations and populations of African descent; the failure to address issues of racism, xenophobia and other types of discrimination at the level of global, regional and national HIV/AIDS campaigns; the dearth of special policies to prevent, monitor and treat HIV/AIDS in indigenous communities; and the marked tendency towards social exclusion on racist grounds. The study recognized that civil society organizations keep alive the hopes of people living with HIV/AIDS. The principal recommendations of the study, as highlighted by Mr. Carrasco, were to include these issues in prevention, monitoring and treatment strategies through regional community networks and horizontal technical cooperation projects; to identify solutions to the problem of the invisibility of racism and HIV/AIDS by strengthening community participation and promoting the establishment of alliances between civil society organizations working with populations of African descent and indigenous populations and organizations working with people living with HIV/AIDS.

36. Dr. Manuel Chávez from the National Independent University of Honduras referred to the scale of the coordination efforts undertaken in the wake of Hurricane Mitch in 1998, which led to the development of the 1999-2021 poverty reduction strategy incorporating the sixth Millennium Development Goal, on HIV/AIDS, and the need for an in-depth social process to address the institutional and public emergency caused by the current HIV/AIDS crisis in Honduras. A representative of the Garifuno population who is a member of Enlace de Mujeres Negras was invited to talk about what was being done to prevent HIV/AIDS among the Garifuno population. She stressed that efforts to prevent HIV/AIDS have been going on for 10 years, and reported significant inequalities in the management of the national programme for the allocation of resources to prevent, monitor and treat HIV/AIDS among the Garifuno population.

37. The representative of Brazil's National AIDS Programme reported the very recent inclusion of the theme of racism in the National Programme's agenda, as a result of the mobilization of various civil society institutions. The fact that some populations are not receiving treatment under the Programme justifies the need to view sexual and ethnic diversity as important aspects in the area of human rights protection. The pauperization and feminization of the HIV/AIDS epidemic in Brazil indicate that the black population is at a social disadvantage in efforts to control the epidemic. Accordingly, emphasis was placed on the goal of reducing the

impact of the social, individual and systemic vulnerability of persons exposed to HIV infection. Racism and HIV/AIDS was presented as a human rights issue comprising social inclusion; action to combat stigma and discrimination; respect for differences and diversity; the involvement of civil society in decision-making at all levels; and universal free access to antiretroviral therapy. The main challenge in the application of human rights to HIV/AIDS policy is to ensure that the right to health is recognized as underlying all other rights.

### F. Panel 6: Health sector mobilization for the implementation of the Millennium Development Goals' focus on victims of racism

38. With reference to the need to incorporate racial equality in all government policies, Dr. Maria Inés Barbosa of the Special Secretariat for the Promotion of Race and Equality (SEPPIR), referred to the study on the development of ethnic and racial themes over the past decade. She reviewed almost 10 years of milestone achievements for Afro-Brazilians that culminated in a series of meetings in Brasilia focusing on various topics. The study was subsequently submitted to President Cardozo. In this context, a number of demands were taken up at a round table on health, including the incorporation of race and skin colour in health statistics. Since the establishment of SEPPIR in 2004, cross-cutting activities embracing the entire public sector have been developed. The Department of Health is making headway in drawing up a plan to improve health conditions for the Afro-Brazilian population. A number of achievements were recorded in 2004: The disaggregation of data, an initiative approved in 1996, is starting to bear fruit. It entails a process of codification and analysis that will culminate in the preparation by the Ministry of Health of a report containing disaggregated data. Another important area of activity for SEPPIR is the work that it does in *quilombo* communities to extend citizenship to a historically neglected section of the population. Progress is currently being made through a programme of action to improve the health of Afro-Brazilians; the programme adopts a new cross-cutting approach to breaking down the barriers imposed by discrimination. The Millennium Development Goals are another tool for addressing the real health problems of ethnic communities.

### G. Panel 7: Civil society organizations in the field of racism and vulnerable groups - mobilization for the implementation of the Millennium Development Goals

39. Dr. Ximena Avellaneda from the Rosario Castellanos Women's Studies Group in Mexico raised the issue of the role of civil society in implementing the Millennium Development Goals. She described the emergence and development of NGOs and civil society movements that promote development against a backdrop of worsening social problems. These NGOs and civil society movements are in close contact with those sectors of the population most affected by such inequities as lack of access to health services, poor quality of services, shortage of human resources, lack of cultural sensitivity, and non-participation in health management processes. She stressed that the Millennium Development Goals were being taken into account in NGO activities through the development of innovative fund-management strategies. As an example of good practice undertaken by her organization, she cited the foundation of a scholarship fund for young indigenous women. She also highlighted the problems of maternal mortality and violence and called for intersectoral cooperation and the development of experience-sharing mechanisms. The efforts of NGOs should be acknowledged and greater resources should be made available to them.

40. Dr. Luz Marina Vega, a medical doctor and traditional medicine coordinator of the Cotacachi Cantonal Council (Ecuador), reported on the experience of Cotacachi municipality, outlining the geographical and socio-economic context and drawing attention to the existence of the first indigenous mayor in the 124-year history of the canton, whose government is based on age-old principles that are currently reflected in for cooperation and participation mechanisms. She recognized the importance of legal frameworks and the opportunity to make the most of existing legal norms. She stressed that civil society could and should have an influence on local government decision-making. She explained the co-management model being developed in the municipality. Policies focused on quality of life, community development and civic participation. Cultural survival hinges not only on the revival of cultures but also on the incorporation into government policy of an intercultural approach. She recommended that positive health indicators should be included in information and that the range of health determining factors should be broadened.

41. Mr. Fernando Murillo of the Afro-America XXI Association (Colombia) acknowledged that there were forums to discuss the problems facing communities of African descent. He considered it a positive development that persons of African descent were treated as an ethnic group rather than a vulnerable group and that, since the Durban Conference, the topic of countries with populations of African descent was beginning to be addressed. The fact that PAHO had incorporated this theme in its work programme was important. He referred to the challenge of ensuring that the topics dealt with were addressed in practical terms, inter alia, by improving living conditions, ensuring that networks continued to function and intensifying initiatives that had been launched.

42. In their comments, the participants noted that it was necessary to provide training in civic participation and to develop public impact plans. One participant enquired about models that operate with links between civil society, government bodies and NGOs. Another participant commented on work in alliances and networks. The discussion concluded with emphasis on the need to institutionalize the involvement of civil society. The participants also stressed the importance of negotiating with donors and other organizations to amend proposals that are generally put forward in order to ensure a better intercultural approach.

### H. Panel 8: Perspective of the international financial institutions and the United Nations system as regards identifying and addressing inequalities in access to health

43. Ms. Elena Oliveira of UNICEF, highlighting the problems faced by Brazilian children and factors such as poverty and its impact on childhood development, drew attention to the problems of black children and young persons in the context of unequal access to health care. She explained how UNICEF addresses the Millennium Development Goals in coordination with other United Nations agencies, with the overriding objective of reducing inequities.

44. Mr. Diva de Medeiras of UNDP acknowledged Brazil's efforts to achieve the Millennium Development Goals and stressed the importance of the ethnic and racial dimension in ensuring the achievement of the goals. He said that, by disaggregating and analysing Brazil's population data from the standpoint of ethnicity, the goals could be met in the white population, but that the creation of government bodies to promote racial equality was not enough to ensure that the goals could be met for black and indigenous populations.

45. The participants noted that financial organizations had failed to attend the workshop. They stressed that inter-agency cooperation was very important for the preparation of replies from the various countries in the region. One participant stated that indigenous peoples were invisible in the statistical component of the presentations. Another asked the workshop for its view on the link between the Millennium Development Goals and international and national human rights programmes.

46. The replies focused on the coordination strategy developed by UNICEF and its work on specific themes within the United Nations system. With regard to the lack of visibility of indigenous peoples, it was explained that, as had been done with data presented for populations of African descent, a similar analysis was being conducted for the indigenous population, and that these data also reflected the impact of discrimination on health. The representative of UNDP explained that the representative of the World Bank had been unable to attend owing to unforeseen circumstances, and that the theme had provoked interest. According to the moderator, the most important lesson of the workshop was that there was no substitute for the political will of each country to deal with its own problems.

## II. CONCLUSIONS

47. At the closing meeting, 22 recommendations were adopted and made available to the participants. Ms. Matilda Ribeiro, Chief of the Special Secretariat for the Promotion of Racial Equality Policies (SEPPIR) in Brazil, delivered closing remarks.

48. Overall, the workshop served to: (a) identify obstacles posed by racism, racial discrimination, xenophobia and related intolerance to achieving Millennium Development Goals 4, 5 and 6 in the Latin American and Caribbean regions; (b) identify obstacles to implement the related commitments contained in the Durban Declaration and Programme of Action; (c) promote discussion between policy makers, community leaders, victims of racism and health experts on strategies to achieving the Millennium Development Goals and the recommendations contained in the Durban Declaration and Programme of Action; (d) identify and share best practices from Latin American and Caribbean countries by integrating human rights, and the principle of non-discrimination in particular, in the development and implementation of health policies; and finally (e) suggest a set of recommendations which provides some strategies to integrate the principle of non-discrimination into initiatives aimed at achieving the Millennium Development Goals as regards the right to health.

## III. RECOMMENDATIONS

49. **This document is the result of the assessment made by the workshop participants. It takes account of the relevant provisions of the Millennium Declaration (2000) and the Durban Declaration and Programme of Action (2001). The participants make the following recommendations:**

**(a) States should develop policies, strategies and sectoral financing plans aimed at closing the gaps caused by health inequities, paying particular attention to victims of racism and other forms of discrimination. States should also ensure that victims of discrimination living in remote areas have access to health care, specifically in order to reduce infant mortality;**

**(b) States should develop regional health-care models that include participation by victims of "discrimination" with a view to identifying needs-based strategies for the organization and provision of services. This implies access to physical and mental health care and healthy environmental conditions;**

**(c) States should incorporate an anti-discrimination perspective in their health policies and programmes, particularly in the training of health professionals in order to ensure that the latter are conscious of and sensitive to issues of race, ethnicity and culture;**

**(d) States should strengthen international cooperation and technical assistance and national, regional and international networks to help developing countries to incorporate, as a matter of priority, measures, activities, policies and programmes to combat discrimination and racism in their health-care systems, including in the framework of poverty reduction strategies;**

**(e) States should mobilize resources and intensify their efforts to ensure access to medicines, including quality generic drugs to treat HIV/AIDS. They should also train health professionals and adapt health infrastructures to reduce mortality, particularly among victims of discrimination;**

**(f) States should ensure that their national human rights programmes incorporate affirmative action measures and temporary quota systems in order to put an end to under-representation of victims of discrimination by offering them equal opportunities to participate in the administration of justice, politics, education, the health services, employment and all other public- or private-sector services;**

**(g) States should support the generation of reliable data, disaggregated by race, sex and socio-economic factors, on the health and health care of victims of discrimination. Data should be collected in order to prepare and follow up policies and programmes. Such data should be gathered with the consent of the individuals who provide it;**

**(h) States should request PAHO to prepare, by the end of 2005, national studies in support of a regional analysis of the health of persons of African descent, indigenous peoples, women, refugees, migrants, internally displaced persons, the disabled, the elderly, young people and children;**

**(i) Governments in the region and PAHO, in cooperation with community organizations of Latin Americans of African descent and indigenous peoples, should develop a strategy to incorporate the ethnic/race and gender variables in health statistics systems, which should include the following phases:**

- **A process of regional discussion and training for representatives of Latin Americans of African descent and indigenous and other ethnic groups on the design and application of disaggregated data-collection processes with an ethnic component, for implementation by October 2005;**

– **A study of the health situation of persons of African descent and indigenous peoples in Latin America and the Caribbean as a fundamental step towards constructing an epidemiological profile of the Latin Americans of African descent and indigenous and other ethnic groups. This study should be prepared by PAHO, the health ministries of the countries in the region, and the civil society organizations involved. The study should be submitted in December 2005;**

**(j) Governments in the region, PAHO and the Office of the United Nations High Commissioner for Human Rights should recognize traditional medicine as a legitimate practice of Latin Americans of African descent and indigenous communities that contributes to and facilitates access to health care. States must carry out health-care research and ensure that their programmes incorporate traditional knowledge that is translated into actual clinical practice. Accordingly, traditional medicine should be included in public health administration in countries throughout the region to ensure linkage with the various existing health-care systems. Likewise, Governments in the region, PAHO and the Office of the High Commissioner should ensure that the communities concerned retain intellectual property rights over their ancestral medical knowledge and support the activities of the various networks and regional and local alliances of Latin Americans of African descent, indigenous and other ethnic communities;**

**(k) Governments in the region, in cooperation with PAHO and the United Nations, should commit themselves to fighting such known yet "neglected" diseases as Hansen's disease, malaria and leishmaniasis; diseases that have a particular impact on ethnic groups, such as sickle cell anaemia, cardiovascular disorders and diabetes; emerging diseases, such as cholera, measles, malaria, dengue fever and yellow fever; and mental health problems connected with discrimination. States should make financial assistance available for research and development programmes in these areas;**

**(l) Governments, PAHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) should pay special attention to promotion and prevention activities in the field of sexual and reproductive health, HIV/AIDS and sexually transmitted diseases, by implementing programmes devised with input from communities of Latin Americans of African descent and from indigenous communities, in accordance with their ancestral practices;**

**(m) Governments in the region should pay special attention to migrants and displaced persons, and take special measures to protect the reproductive health of migrant, displaced and refugee women, ensuring that they have guaranteed access to social security. Special attention needs to be paid to the internal displacement situations in Colombia and Haiti;**

**(n) The health ministries in countries throughout the region should establish units and/or programmes that incorporate the ethnic perspective in health policies and programmes for communities of Latin Americans of African descent and indigenous and**

**other ethnic communities. They should also ensure that round tables and cooperation forums on the topic of health for persons of African descent and indigenous peoples are held in those countries where such communities exist (and to establish them where they do not); this initiative should be undertaken with the direct involvement of civil society organizations and PAHO;**

**(o) The health ministries in the region and PAHO should agree to identify and replicate programmes that are examples of good health practice in order to incorporate diversity into health management and, in particular, to redouble their efforts to develop programmes and activities for the benefit of communities of Latin Americans of African descent and indigenous and other ethnic communities with a view to following up the Durban recommendations in the health sphere;**

**(p) PAHO, the Office of the United Nations High Commissioner for Human Rights, other relevant international organizations and Governments in the region should initiate a process of awareness-raising and conclusion of national agreements with health ministries and national representatives of PAHO on the importance of developing activities based on the cultural, socio-economic, political and religious peculiarities of communities of Latin Americans of African descent and indigenous and other ethnic communities, as a basic step towards achieving the Millennium Development Goals. This process should be developed in the course of 2005;**

**(q) The Office of the United Nations High Commissioner for Human Rights and PAHO should ensure that the topic of health and ethnicity is incorporated into follow-up events to the Durban Conference (Santiago +5) by making this topic a programme priority and facilitating the participation of delegates from organizations of Latin Americans of African descent and indigenous peoples belonging to the various networks and alliances in Latin America and the Caribbean;**

**(r) PAHO, through its Gender, Ethnicity and Health Unit, should over the next two years develop staff training and awareness-raising programmes to lay the groundwork for devising activities and implementing programmes for communities of Latin Americans of African descent and indigenous and other ethnic communities that take account of their ancestral and cultural knowledge;**

**(s) The Intergovernmental Working Group on the Effective Implementation of the Durban Declaration and Programme of Action and the Working Group of Experts on People of African Descent of the Commission on Human Rights should consider the recommendations of this regional workshop and make specific proposals in this regard at their forthcoming sessions;**

**(t) WHO and other relevant international organizations should promote and carry out activities to reveal the impact of racism, racial discrimination, xenophobia and related forms of intolerance as important social determining factors in physical and mental health, including the HIV/AIDS pandemic, and accordingly should develop specific projects, particularly research projects, in order to ensure that victims of racism and other forms of discrimination have equal access to health systems;**

**(u) In the context of its strategic plan for the period 2003-2007, PAHO should work with States to identify groups experiencing inequalities in health care or access to services, focusing its initiatives on victims of racism and other forms of discrimination;**

**(v) The participants agree on the need to forge closer cooperation, establish associations and consult regularly with civil society organizations in order to benefit from their experience and know-how with a view to drafting laws, policies and programmes to eliminate all forms of racism.**

# ANNEXES

## Annex I

## AGENDA

1. Opening of the workshop.

2. Adoption of the agenda, election of Chairperson-Rapporteur.

3. Panel 1: Human Rights and the Millennium Development Goals - toward an international framework to define an agenda to reduce health inequalities.

4. Panel 2: Access to health and the impact of discrimination based on race, colour, descent, national and ethnic origin.

5. Panel 3: Gains to be expected if the Millennium Development Goals are achieved within an ethnic framework - Is there a need for new policy design?

6. Panel 4: Consideration of good practices for identifying and addressing inequalities in access to health.

7. Panel 5: Racism and HIV/AIDS.

8. Panel 6: Health sector mobilization for the implementation of the Millennium Development Goals' focus on victims of racism.

9. Panel 7: Civil society organizations in the field of racism and vulnerable groups - mobilization for the implementation of the Millennium Development Goals.

10. Panel 8: Perspective of the international financial institutions and the United Nations system as regards identifying and addressing inequalities in access to health.

11. Adoption of recommendations and closing of the workshop.

## Annex II

## LIST OF PARTICIPANTS

**Panellists**

Ms. Ximena Avellaneda, Grupo de Estudios sobre la mujer “Rosario Castellanos” de México

Ms. Maria Inés Barbosa, Chief of Staff of the Special Secretariat for the Promotion of Racial Equality Policies (SEPPIR), Brazil

Mr. Oscar Bermúdez, Director de Área, Región Huetar Atlántica, Ministerio de la Salud, Costa Rica

Mr. Edgar Carrasco, Coordinador General de Acción Ciudadana contra el SIDA (LACCSO)

Ms. Gina Carrioni, antropóloga, Colombia

Mr. Paulo Carvalho, Ministry of Health, Brazil

Mr. Manuel Chávez, Universidad Nacional Autónoma de Honduras

Ms. Marianela Corriols, OPS Nicaragua

Mr. Diva de Medeiras, Programa de las Naciones Unidas para el Desarrollo (PNUD)

Mr. Federico Hernandez Pimentel, Pan-American Health Organization (PAHO) Guatemala

Mr. Gustavo Makanaky, Colombia

Mr. Miguel Malo, Coordinator of Health Promotion, PAHO Brazil

Ambassador Juan Antonio Martabit, Permanent Representative of Chile to the United Nations Office at Geneva

Mr. Oscar J. Mujica, Unidad de Políticas y Estrategias Organización Panamericana de la Salud (OPS)/Organización Mondial de la Salud (OMS), Washington D.C.

Mr. Fernando Murillo, Asociación Afro-America XXI, Colombia

Ms. Elena Oliveira, UNICEF

Ms. Fátima Oliveira, Profesora, Universidade Federal de Minas Gerais, Brasil

Mr. Alexandre Padilha, Director del Departamento de Salud Indígena (DESAI) Ministerio de la Salud, Brasil

Mr. Valcler Rancel, Subsecretario de Planning del Ministerio de la Salud, Brasil

Ms. Matilda Ribeiro, Minister, Chief of the Special Secretariat for the Promotion of Racial Equality Policies in Brazil (SEPPIR)

Mr. Pierre Sob, Representative of the Office of the United Nations High Commissioner for Human Rights

Ms. Cristina Torres Parodi, Regional Adviser, Gender, Ethnicity and Health Unit, PAHO/WHO

Ms. Luz Marina Vega, médica, Coordinadora de Medicina Tradicional del Consejo Cantonal de Cotacachi, Ecuador

**States Members of the United Nations**

Bolivia; Bahamas; Barbados; Brazil; Chile; Dominican Republic; El Salvador; Guatemala; Haiti; Honduras; Jamaica; Mexico; Nicaragua; Suriname; Trinidad and Tobago.

**United Nations bodies and specialized agencies**

Pan-American Health Organization (PAHO), United Nations Development Programme (UNDP), Office of the United Nations High Commissioner for Human Rights (OHCHR), United Nations Children's Fund (UNICEF).

**Non-governmental organizations**

Alianza Estratégica de Afro descendientes de Latinoamérica y el Caribe; Enlace de Mujeres Negras de Honduras; Centro de desarrollo de la Mujer Negra Peruana (CEDEMUNEP); Movimiento Cultural Saya Afro-boliviano; Afro-América XXI.

**Observers**

Asociación de la Juventud Indígena Argentina; Rights of Children, Guyana.

## Annex III

## LIST OF DOCUMENTS

| *Symbol* | *Title* |
|---|---|
| HR/LAC/SEM/RAC/2004/1 | Provisional agenda |
| HR/LAC/SEM/RAC/2004/2 | Information note |

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