

**WHO's Contribution to the
World
Conference
Against
Racism, Racial
Discrimination,
Xenophobia
and Related
Intolerance**

*Health and
freedom from
discrimination*

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HEALTH AND FREEDOM FROM DISCRIMINATION

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**WHO's Contribution to the
World Conference
Against Racism, Racial Discrimination,
Xenophobia and Related Intolerance:**

*Health and freedom
from discrimination*



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Photo: WHO/PAHO/Carlos Gaggero

1 - Introduction

- 1 - The Constitution of the World Health Organization (WHO) of 1948 declares that “[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”¹. It defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and prohibits discrimination in its enjoyment.²

(1) *Basic documents. Forty-third edition. Geneva, World Health Organization, 2001. The Constitution was adopted by the International Health Conference in 1946.*

(2) *Id. Preamble.*



Photo: WHO/PAHO/Carlos Gaggero

- 2 - The World Health Organization recognizes the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance as presenting a unique opportunity for the development and adoption of a new approach to addressing the health impact of racism, racial discrimination, xenophobia and related intolerance.



Photo: WHO/PAHO/Carlos Gaggero

2 - Background

2.1 HEALTH, HUMAN RIGHTS AND DISCRIMINATION

- 3 - Vulnerable and marginalized groups in society bear an undue proportion of health problems. Many health disparities are rooted in fundamental social structural inequalities, which are inextricably related to racism and other forms of discrimination in society. Mortality and health in general rarely diverge far from economics and social relations, which leads to the conclusion that to eliminate differentials in health outcomes requires addressing the underlying social inequalities that so reliably produce them.
- 4 - Human rights provide a useful framework to identify, analyze and respond directly to the societal determinants of health. Vulnerability to ill-health can be reduced by taking steps to respect, protect and fulfil human rights. Government efforts towards meeting their human rights obligations must be deliberate, concrete and targeted as clearly as possible.
- 5 - Freedom from discrimination on account of race and ethnicity, sex and gender roles, and language and religion, is an overarching and fundamental norm relevant to all aspects of public life. While the International Covenant on Economic, Social and Cultural Rights provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes various obligations of immediate effect. Of particular importance in this regard is the “undertaking to guarantee” that relevant rights “will be exercised without discrimination...”.
- 6 - Overt or implicit discrimination violates one of the fundamental principles of human rights and often lies at the root of poor health status. Discrimination against women; the elderly; ethnic, religious and linguistic minorities; persons with disabilities; indigenous populations and other marginalized groups in society both causes and magnifies poverty and ill-health.
- 7 - The observance of human rights is permeated and characterized by the principle of freedom from discrimination. Governmental responsibility for nondiscrimination includes ensuring equal protection and opportunity under the law, as well as de facto enjoyment of rights such as the right to public health, medical care, social security and social services. The International Convention on the Elimination of All Forms of Racial Discrimination places an obligation on States parties to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone without distinction as to race, colour of the skin or national or ethnic origin, and equality before the law, notably in the enjoyment of the above-mentioned rights.



Photo: WHO/PAHO/Carlos Gaggero

- 8 - A general comment on the right to the highest attainable standard of health, recently adopted by the Committee which monitors the International Covenant on Economic, Social and Cultural Rights, enumerates the grounds for non-discrimination in health by proscribing “any discrimination in access to health care and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health”.³

(3) General comment on the right to health adopted by the Committee on Economic, Social and Cultural Rights on 11 May 2000, paragraph 18. (E/C.12/2000/4, CESCR General comment 14, 4 July 2000.)

2.2 INEQUALITIES IN HEALTH DUE TO DISCRIMINATION

- 9 - Research has shown that inequalities in the health and health care of ethnic and racial groups⁴ are evident and that racism is the most disturbing of the explanations for these inequalities.⁵ It has thus been suggested that attention be devoted to gender, ancestry and ethnicity, socioeconomic status, disability, sexual orientation and rural living affecting health outcomes as well as the health effects that institutions, laws, policies and programmes may have on ethnic and racial groups.⁶

(4) See Annex: Variations in health and service access indicators: A regional perspective.

(5) Bhopal R. Spectre of racism in health and health care: lessons from history and the United States. *British medical journal*, 27 June 1998, 316 (7149):1970–1973.

(6) Kurland J. Public health in the new Millennium II. *Social exclusion*, July/August 2000, 115(4):298–301

Respect for human rights, the standards of which are contained in numerous international human rights instruments, is an important tool for protecting health. It is those who are most vulnerable in society—women, children, the poor, persons with disabilities, the internally displaced, migrants and refugees—who are most exposed to the risk factors which cause ill-health. Discrimination, inequality, violence and poverty exacerbate their vulnerability.

It is therefore crucial not only to defend the right to health but to ensure that all human rights are respected and that the root economic, social and cultural factors that lead to ill-health are addressed.

Mary Robinson, UN High Commissioner for Human Rights, 9th International Congress of the World Federation of Public Health Associations, Beijing, 2–6 September 2000

- 10 - Gender is a cross-cutting theme in all matters concerning health and development which concerns how policies and programmes impact differently on women and men. Another important dimension to consider is how racial discrimination combines and multiplies in relation to other grounds for discrimination, such as sex and gender roles; age (children and the elderly); sexual orientation; religion; political affiliation; physical and mental disability; and other health status. For example, the combination of racial and gender discrimination has resulted in increased vulnerability for women of African descent, many of whom are subjected to sexual exploitation and trafficking in the Western hemisphere. In many countries of Latin America, HIV/AIDS incidence is high among Afro-Latin American men and women. This requires special attention to the added difficulties resulting from multiple discrimination.

3 - Determinants to inequalities in health

3.1 HEALTH SECTOR DETERMINANTS

11 - The most pertinent factors, which relate to the health sector, to explain the discrepancies in the health situation and service access indicators are:

◆ **Access to health services.** Barriers to health service access are a key factor in differential health outcomes among different population groups within a society. There are several practical reasons for these, including location and cost. Historically, physical segregation on the basis of race and ethnicity has been operative in neighbourhoods and/or regions. Coincidentally, public services in these areas, including health services, may be of lower quality and less efficient. For example, physicians, equipment, and services are highly concentrated in urban areas. Critical services are needed to ensure access to health services such as subsidized transport.

General comment on the right to the highest attainable standard of health adopted by the Committee which monitors the International Covenant on Economic, Social and Cultural Rights, May 2000:

“Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. These include the requirement that they be within safe physical reach for all sections of the population. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas.”

◆ **Cultural sensitivity.** There are other exclusionary factors associated with language and cultural values. The cosmic vision of health and disease are part of belief systems, which vary with each ethnic group. According to some, disease can be caused by human beings with potent powers, by supernatural forces, or by accidents, excesses or deficiencies. These beliefs can make people reluctant to use modern health services grounded in science. In these cases, traditional medicine plays an important role in disease prevention and cure. The provision of modern health services thus need to carefully account for different cultural beliefs in order to be sufficiently culturally sensitive so as not to limit access of ethnic minorities for this reason.

The ILO Convention (No. 169) concerning Indigenous and Tribal Peoples in Independent Countries, 1991, obligates ratifying governments to ensure that:

1. 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.

2. Health services shall, to the extent possible, be community-based. These services shall be planned and administered in cooperation with the peoples concerned and take into account their economic, geographic, social and cultural conditions, as well as their traditional preventive care, healing practices and medicines.



Photo: WHO/PAHO/Dana Downing

3. 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.

4. The provision of such health services shall be coordinated with other social, economic and cultural measures in the country

◆ **The quality of services** 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.

General comment on the right to the highest attainable standard of health adopted by the Committee which monitors the International Covenant on Economic, Social and Cultural Rights, May 2000:

As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

◆ **The timeliness** of access to services is another relevant aspect to consider. People may have access to health services but can only take advantage of them late in some cases, making successful medical treatment impossible. This 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 has an expanded comprehensive, ethnic and sensitive perspective in the way that services are organized and delivered.

WHO’s measurement of health systems’ responsiveness recognizes prompt attention as “immediate attention in emergencies, and reasonable waiting times for non-emergencies”.

In addition, international human rights principles include the obligation of governments to respect the right of individuals to seek, receive and impart information and ideas concerning health issues. The provision of and access to health-related information is also considered an “underlying determinant of health” and, as such, an integral part of the realization of the right to the highest attainable standard of health.

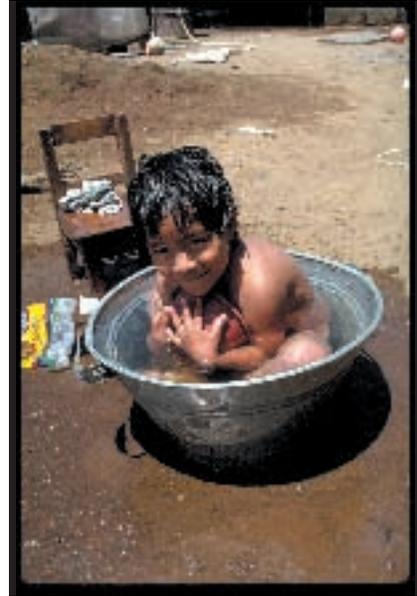


Photo: WHO/PAHO/Carlos Gaggero

◆ **Discrimination in the health system.** Finally, the effect of the segregation and discrimination practised against minority patients by the health services themselves. This is an area less explored in the available literature. However, it is possible that in some instances, health systems may also engage in the same stereotyping found in the society at large, thus reinforcing discrimination or even exacerbating it. In this regard, there is increasing recognition of the need to sensitize and train health professionals about human rights, with particular emphasis on freedom from discrimination, and how to address this in all its dimensions in practical situations.

12 - Discrimination has caused social exclusion and marginalization of specific population groups. This process can, in turn, increase these groups’ vulnerability to poverty and ill-health. Thus, often rooted in discrimination, these broader determinants of health generated from the historical, cultural and socioeconomic development, which has introduced biases in the equality of opportunity for individuals from minority and indigenous populations.⁷

(7) 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):839-840; Navarro V. Race or class versus race and class: Mortality differentials in the United States. *Lancet*, 1990, 336:1238-1240.

Article 1. International Convention on the Elimination of All Forms of Racial Discrimination: Racial discrimination means “any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin” which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise of human rights, including the right to health care, education, work and adequate housing.

3.2 SOCIOECONOMIC DETERMINANTS

- 13 - Research shows that mortality rates are higher for the poor than for the rich at all ages. The differential is particularly high during infancy and childhood.⁸
- 14 - Segregation relegates certain segments of the population to neighbourhoods with fewer resources, poorer services and a degraded human and physical environment. Populations subjected to discrimination are more likely than others to inhabit areas affected by environmental pollution and degradation, and are more likely to be negatively affected by lifestyle factors such as diet, substance abuse (tobacco, alcohol, and drugs), and social behaviour (violence and accidents).
- 15 - 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. Studies show that the mother's education is an important factor in family health care (births in an institutional setting, medical check-ups, etc.).



Photo: WHO/H. Anenden

It is no coincidence that the idea to establish a world health organization emerged from the same process that identified the universal value of human rights. WHO's mandate is also universal. Our constitution...stat[es] that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

***Dr Gro Harlem Brundtland, Director-General, World Health Organization, Paris, France, 8 December 1998
Fiftieth Anniversary of the Universal Declaration of Human Rights***

(8) Gwatkin, 1999, *World health report*, Geneva, World Health Organization, 1999.

4 - Conclusions

16 - The fundamental principles of equality and freedom from discrimination have been identified as key components in all matters concerning health. This includes non-discrimination in access to health facilities, goods and services,



Photo: WHO/Armando Waak

es, paying particular attention to the most vulnerable or marginalized sections of the population. It also means that, to the extent possible, health facilities, goods and services must

be within safe physical reach for all parts of the population. They should also be culturally appropriate – that is respectful of the culture of individuals, minorities and indigenous populations – and sensitive to gender and life-cycle requirements.

17 - The differences in the health situation of minority and indigenous groups, compared to the general population, 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 health and health care.

18 - Biases in the treatment of indigenous and ethnic minorities should be corrected through systematic efforts and a variety of mechanisms such as training, skill-building and awareness-raising among health professionals of the human rights implications of their work, all of which should be backed up with appropriate policies and legislation.

19 - National policies and programmes need to be planned and implemented with due regard for the legitimate interests of persons belonging to minorities.⁹ This includes respect for the beliefs, knowledge and language of the beneficiaries, as well as attention to their right to participate in matters concerning their health and development. In addition, health policy instruments and programmes need to be developed by health sector authorities with an intersectoral perspective for effective targeting on indigenous peoples and ethnic minority communities in order to reduce health inequalities and in the light of international human rights obligations which are addressed to government as a whole as prime duty-bearer.

20 - WHO notes with interest recommendations relating to discrimination and health, addressed to governments, which have emerged from the preparatory process of the World Conference. Notably, WHO wishes to draw attention to the following:

◆ **The importance** of increased research into the impact of discrimination on access to health care. Routine monitoring of the situation of marginalized racial and ethnic groups could be instituted through periodic sampling and compilation of statistical information disaggregated by race or ethnic group, particularly with regard to such fundamental health indicators as infant mortality rate, life expectancy and access to health services. In this regard, WHO concludes that further research be conducted to explore the linkages between health outcomes and racism, racial dis-

(9) Article 5, Declaration on the Rights of Persons Belonging to National or Ethnic, Religious or Linguistic Minorities, Adopted by General Assembly resolution 47/135 of 18 December 1992, The General Assembly.

crimination, xenophobia and related intolerance. Such research would inform and form the basis for countries to take appropriate action. It would also help to differentiate the relative contribution of race versus poverty in the causation of poor health outcomes.

- ◆ **The need** for comprehensive legislation, specifically prohibiting all forms of discrimination and providing civil and criminal penalties and remedies in all spheres of public life, including in relation to health and health care. In addition, the need to strengthen the capacity of governments to review health-related laws and policies to determine whether on their face or application there is inherent discrimination. Similarly, governments should be supported in developing national health legislation which conforms with their human rights obligations.
- ◆ **The need** for central government, together with health sector authorities, to allocate sufficient financial resources in the national budget to ensure adequate health prevention, promotion and care programmes which target indigenous peoples and ethnic minority communities.
- ◆ **The importance** that institutions responsible for providing statistical information on the population take explicit account of the existence of indigenous peoples, people of varying descent and other ethnic groups, capturing the component parts of their diversity according to their needs and characteristics, designing strategies to evaluate the human rights policies concerning ethnic groups, and exchanging experiences and practice with other States. To that end, the development of participatory strategies for these communities in the processes of collecting and using information need to be devised. On the basis of existing statistical information, the importance of establishing national programmes, including affirmative action measures.
- ◆ **The urging** that measures be taken to eliminate disparities in health status experienced by disadvantaged racial and ethnic groups by the year 2010, including disparities pertaining to health issues such as malaria, tuberculosis, HIV/AIDS, cancer, cardiovascular disease, diabetes, tobacco, maternal health, food safety, mental health, safe blood and health systems.
- ◆ **The special** emphasis to be put on gender issues and gender discrimination, particularly the multiple jeopardy that occurs when gender, class, race and ethnicity intersect and the importance of public policies being adopted which give impetus to programmes on behalf of indigenous women and ethnic minority women, with a view to promoting their civil, political, economic, social and cultural rights; to putting an end to this situation of disadvantage for reasons of gender; to dealing with urgent problems affecting them in health, including reproductive health and gender-based violence; and to ending the situation of aggravated discrimination they suffer as women in manifestations of racism and gender discrimination.



Photo: WHO

- ◆ **The need** to consider situations of children subjected to racial discrimination, especially those who find themselves in circumstance of particular vulnerability, such as abandoned children;

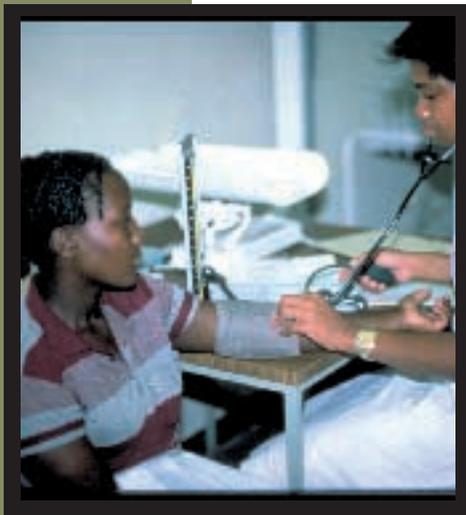


Photo: WHO/PAHO/Carlos Gaggero

children who live or work in the street; child victims of trafficking and economic exploitation; sexually-exploited children; children affected by armed conflict, and child victims of poverty, and, in this context, the importance of collecting and

analysing statistical data to assess how policy and legislation affect children's lives. In all matters concerning health and discrimination of children, the best interests of the child shall prevail.

- ◆ **The need** to adopt measures to provide a proper environment for disadvantaged groups, including action to reduce and eliminate industrial pollution that affects them disproportionately, to take measures to clean and redevelop contaminated sites located in or near where they live and, where appropriate, to relocate, on a voluntary basis and after consultation with those affected, racially and ethnically disadvantaged groups to other areas when there is no other practical alternative for ensuring their health and well-being.
- ◆ **Public** and private sector efforts are required to strengthen the capacity of indigenous peoples'

representatives and minority communities to exercise their rights to participation. This requires skill-building in how to negotiate, as well as how to access social and political processes. The right of individuals and groups to active, free and meaningful participation in setting priorities, making decisions, planning, implementing and evaluating programmes that may affect their development is an integral component of a rights-based approach to health.

- 21 - WHO looks forward to participating in the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance in South Africa and urges the Conference to consider the link between racial discrimination and health. Overall in the conference documents, WHO stresses the importance of including health whenever other economic, social and cultural rights are mentioned, such as education, work and housing.

We inhabit a universe characterized by diversity. There is not just one planet or one star, there are galaxies of different sorts, a plethora of animal species, different kinds of plants, and different races and ethnic groups. How can one have a soccer team if all the members of the team are goalkeepers? How could it be an orchestra if all members played the French horn?

Archbishop Desmond Tutu speaking at the Special Debate on Tolerance and Respect during the 57th Session of the United Nations Commission on Human Rights, March 2001.

Annex

VARIATIONS IN HEALTH AND SERVICE ACCESS INDICATORS: A REGIONAL PERSPECTIVE

WHO Regional Office for the Americas has examined the question of variations in health and service access indicators among the different ethnic groups in the Americas in the light of available empirical information.¹

1. Studies in the USA indicate health disparities among the different ethnic groups.² For example, mortality is higher among African-Americans than among the white population: the two leading causes of death in the USA are cancer, with a ratio of 1:2, and cardiovascular diseases with a ratio of 1:6. African-Americans also have higher infant mortality rates and higher mortality from diabetes, homicide and HIV/AIDS. 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. Another U.S. study recently confirmed higher mortality among African-Americans in 107 cities across the country.³

2. The information is not as consistently available 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 as Piura (93 per 1000 live births), Lambayeque (68 per 1000), and Tacna (64 per 1000), while the lowest rates are found in Lima and El Callao (with 45 and 41 per 1000 respectively).⁴ 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.⁵ Infant mortality in Brazil, estimated with 1996 data, reveals sharp disparities: 62 per 1000 live births for the Afro group and 37 per 1000 among whites.⁶ Infant mortality indicators speak volumes: 16% of women over the age of 15 have lost at least one child born alive. When analysed 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 12.83% among white women.

3. In Guatemala, the data illustrate that mortality among indigenous children is higher. Neonatal mortality, mortality in children aged 0 to 1 year and mortality in children under 5 are higher among the indigenous population (32 per 1000, 64 per 1000 and 94 per 1000) than for the Latino population (27 per 1000, 53 per 1000 and 69 per 1000). 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.⁷

4. Concerning access to insurance services, the studies show

that by 1986, 39% of Hispanics in the USA had no coverage, a figure three times higher than that of whites and double that of African-Americans.⁸ In Guatemala, more than 70% of Guatemalan women receive some form of care at the time of delivery, but while 50% of Latino 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, at an average age of 20 to 25. In most of the Latin American and Caribbean (LAC) Region, health services are highly concentrated. In the outlying neighbourhoods of Caracas and Maracaibo, the Afro-Venezuelan population lacks services; health workers, in turn, do not want to work in the neighbourhoods where this population lives because of violence and a lack of security.⁹ Other examples of lack of services and isolation concern black communities on the Pacific Coast of Colombia, in the Valle del Chota or Esmeraldas Province of Ecuador and in the Garífuna and Criollo communities of the South Atlantic Autonomous Region (RAAS) of Nicaragua.

5. Other significant statements can be made regarding access to modern health technologies. Compared to elderly white people, elderly African-Americans in the USA see fewer specialists, receive less preventive care (mammograms, Pap smears) and poorer quality hospital services, and lack access to sophisticated technologies (for cardiovascular problems, orthopaedic conditions, kidney transplants) and to intensive treatment programmes

for prostate cancer, immunodeficiencies and depression. These disparities are also evident in other minority groups.¹⁰ There is no scientific evidence that these differences are due to genetic causes.¹¹ Poverty, distance to services and lack of information are possible explanations to these disparities. These factors may, in turn, be rooted in racial discrimination.

6. Data related to lifestyle and ethnicity also shows significant impact on health. With regard to death attributable to violence in Brazil, 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%).¹²

7. In Guatemala, 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 corresponding figure for the Latino population group was 36.7%. Acute malnutrition (weight-for-age) is 34.6% among the indigenous population, while it is 20.9% among Latinos. Moreover, the percentage of low birthweight is 9.94% for indigenous children and 8.94% for Latino.¹³

8. In the context of examining health disparities among ethnic groups, it is interesting to note also that they are underrepresented within the medical profession. For example, only 2% of cardiologists in the USA are



Photo: WHO/PAHO/Armando Waak

African-American.¹⁴ In general, Brazilian data on the health profession, such as physicians, dentists and other specialists, reveals the following distribution: 82.93% are white, 12.42% brown, and 1.01% black. For medical auxiliaries, the participation of minority groups increases: 59.09% white, 32.79% brown, and 7.6% black.

9. Finally, traditional medicine has an important role to be considered within the ethnic groups. For example, in Petit Goave (Haiti) half of the population uses traditional healers (herbalists, midwives or sorcerers who practise voodoo). In this zone, there are 15 healers for every 1000 people, while the ratio of physicians to population is 15 per 10000.¹⁵

(1) Equity in Health: from an Ethnic Perspective, Dr. Cristina Torres, Regional Policy Advisor, WHO Regional Office for the Americas.

(2) U.S. Department of Health, 1991; Nickens HW. Race/ethnicity as a factor in health and health care. Health services research, 1995, Part II; 151-177.

(3) Williams D. 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). Conference: Income on Equality, Socioeconomics Status and Health, Washington, D.C., 2000; Williams D, House J. Understanding and reducing socioeconomic and racial/ethnic disparities in health, Atlanta, Institute of Medicine of the National Research Council, 2000.

(4) Cowater International Inc. Comunidades de Ancestría Africana en Costa Rica, Honduras, Nicaragua, Argentina, Colombia, Ecuador, Perú, Uruguay y Venezuela. Washington, D.C., Banco Interamericano de Desarrollo, 1996.

(5) Id.

(6) FOASE. Housing, services, child health all lag far behind. Latin news (12):2000.

(7) Valladares R, Barillas E. Inversiones en salud, equidad y pobreza: Guatemala. The World Bank, PNUD y PAHO, 1998.

(8) Bollini, 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.

(9) Cowater International Inc. Comunidades de Ancestría Africana en Costa Rica, Honduras, Nicaragua, Argentina, Colombia, Ecuador, Perú, Uruguay y Venezuela. Washington, D.C., Banco Interamericano de Desarrollo, 1996.

(10) Fiscella K et al. Inequality in quality: Addressing socioeconomic, racial and ethnic disparities in health care. Journal of the American Medical Association, 2000, 283(19):2579-2584.

(11) Lillie-Blanton M, LaViest T. Race/ethnicity, the social environment and health. Social science and medicine, 1996, 43(1): 83-91.

(12) Barbosa, da Silva MI. Racismo e saúde. São Paulo, Tese de doutorado, 1998.

(13) Valladares R, Barillas E. Inversiones en salud, equidad y pobreza, Guatemala. The World Bank, PNUD y PAHO, 1998.

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

(15) Clerismé C. Medicina tradicional y moderna en Haití, Boletín de la Oficina Sanitaria Panamericano OPS/OMS, Washington, D.C., Mayo 1985, 98:5,431-439.



“Vulnerable and marginalized groups in society bear an undue proportion of health problems. Many health disparities are rooted in fundamental social structural inequalities, which are inextricably related to racism and other forms of discrimination in society... Overt or implicit discrimination violates one of the fundamental principles of human rights and often lies at the root of poor health status.”

The World Health Organization’s contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance urges the Conference to consider the link between racial discrimination and health, noting in particular the need for further research to be conducted to explore the linkages between health outcomes and racism, racial discrimination, xenophobia and related intolerance.

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