HEALTH OF INDIGENOUS PEOPLES AND MARGINALIZED ETHNIC POPULATIONS: THE WORK OF WHO

The purpose of this paper is to share information on various aspects of WHO’s work which may be of interest and relevance to the Permanent Forum. It covers salient features of the outline Global Strategy on health of marginalized ethnic populations adopted by the World Health Assembly in May 2002, and outlines activities being undertaken by WHO Regional Offices. Background on health data issues is given, and attention drawn, inter alia, to a new multistakeholder initiative on children’s environmental health, in which a place for indigenous children can be envisaged.

1. OUTLINE GLOBAL STRATEGY ON HEALTH OF MARGINALIZED ETHNIC POPULATIONS

At the request of WHO’s Governing Body, the World Health Assembly (WHA), an outline of a Global Strategy was prepared in consultation with all WHO Regions and presented to the 55th World Health Assembly in May 2002. This outline Strategy was adopted by the WHA, with the recommendation that the Secretariat work closely with interested Member States and the Permanent Forum in elaborating it further.

The outline Strategy recommended action in five areas:

1. Health and demographic data and information
2. Health promotion
3. Health systems and access to care
4. Influencing the determinants of health
5. Promoting enhanced political commitment and national capacity.

The outline Strategy is based on a linked health and development approach. It aims to provide a broad, multistakeholder framework, which can be adapted to national and local situations and context. A number of suggested activities in each area have been included and work at both policy and technical levels is proposed. The suggested activities reflect the appropriate respective roles of national and international actors. At the international level, strong emphasis is placed on common UN mechanisms now being put in place, such as the Millennium Development Goals, the Poverty Reduction Strategy process, and WHO’s Country Focus Initiative. The outline Strategy can be consulted on WHO’s website at http://www.who.int/gb/EB_WHA/PDF/WHA55/ea5535.pdf

WHO’s role within a global strategy

WHO’s work will take account of ethnicity as it is taken forward within countries, and when specific subject areas are being pursued – including child health, women’s health, health and HIV/AIDS, food and nutrition issues, and environmental health.
2. REGIONAL ACTIVITIES

Western Pacific Region

Reviews of the health situation of indigenous peoples or ethnic minorities are being undertaken in three countries by WHO’s Western Pacific Regional Office – the Philippines, Malaysia, and Vietnam. The first two are expected to be completed by August this year. Agreement over the Vietnamese review has only recently been reached, and final results are not expected before early 2004.

African Region

In follow-up to the outline Global Strategy, and in the context of its work on health and poverty, AFRO plans a series of sub-regional assessments on health and ethnicity. HQ is seeking funding to support these. The assessments will focus on identifying at-risk ethnic populations and data gaps in respect of these. This preliminary work will identify countries interested in specific follow-up work, based on the outline Strategy. National and local NGO partnerships will also be investigated.

Pan American Health Organization

One of the many roles of the Pan American Health Organization (PAHO) is to function as the WHO Regional Office for the Americas. In its capacity as an independent organization, PAHO will report separately on recent activities of its Indigenous Health Initiative. WHO/HQ has provided limited financial support to PAHO in the course of 2002 to help advance work in the area of data disaggregation by ethnicity. WHO and PAHO will continue to mutually support each other in this important area. The Country Profiles available on PAHO’s website provide analyses by population groups, and are a major resource for data and information on indigenous peoples’ health status in the region (http://www.paho.org).

3. DATA COLLECTION AND DISAGGREGATION

WHO already disaggregates health information with respect to gender, age, and in many cases, poverty. Where appropriate, within a national setting, information will also reflect ethnicity. All WHO’s work with countries reflects agreed WHO co-operation strategies. At the same time, it is also designed to help national authorities pursue and then realise the MDGs.

WHO anticipates supporting country work to disaggregate data with respect to relevant variables. This will contribute to the PF’s own priorities. However, as indicated in the UN joint paper on this topic, there are a number of technical and political constraints to accessing reliable data disaggregated by ethnicity.

WHO’s efforts in this direction from 2001 – to date are briefly outlined below:

Report to WHA in 2001

WHO’s report to the World Health Assembly in May 2001 showed that beyond a small number of developed countries, and some countries in Latin America,
systematic information on demographics and health statistics concerning indigenous peoples or ethnic populations is scarce. Even in Latin America, data is often considered incomplete. Data and evidence from research on issues of health and ethnicity is sporadic, often small-scale and methodologically inconsistent. Results are therefore not generalizable, and insufficient to inform policy. Data quality varies greatly. Nevertheless, a general pattern indicates that indigenous peoples and marginalized ethnic populations in many countries have lower life expectancy and health status than other population groups.

World Health Survey

A tool that has the potential to improve current levels of information on ethnicity is the evolving World Health Survey (WHS). Until recently, WHO drew its data from secondary sources, for example national health surveys. In creating its own survey system, WHO intends to generate systematic, comparable, consistent, and reliable data to help identify health inequalities and track performance against investment in health. In time, the WHS is expected to become a major health survey mechanism worldwide. It will also serve as an instrument through which progress on the health-related MDGs will be monitored.

Data instruments have been set up, tested, and modified in 61 countries. In this test phase, representative samples of populations are being surveyed, pending national exercises when the testing is complete. Countries chosen for the test surveys are those where little or no data is available, or where significant changes affecting health are taking place.

A major goal is to improve the currently weak capacity for data analysis in developing countries. WHO is currently organizing data analysis workshops, and report-writing workshops aimed at training nationals to transform the data findings into appropriate policy measures.

A question has been included in the WHS on ethnic/racial/cultural group, and on mother tongue(s). It is also envisaged that components on particular issues can be added to the “core” elements of the survey. This could provide an opportunity for interested Member States to expand and refine data collection instruments in relation to ethnicity.

Millennium Development Goals

As noted by the PF, the data collection and reporting exercises being put in place in pursuit of the Millennium Development Goals (MDGs) are relevant to the quest for data on ethnicity.

WHO shares lead-agency responsibility with UNICEF for reporting on child mortality, maternal health, childhood nutritional status, malaria-prevention measures, and access to clean water; WHO and UNAIDS collaborate in the achievement of HIV-prevention targets. Country consultation for the validation of data on Development Goals will take place in partnership with UNICEF, UNDP, and UNFPA. WHO, as the lead authority for health content of the Development Goals within the UN Country Teams, will play an important role in the country consultative
process and in ensuring that conflicting health data are not reported through parallel channels. The reporting process will go through the following steps:

- Setting data quality standards:
- Developing measurement tools, strengthening national health information systems and national capacity to analyse and use data
- Consultation within countries
- Reviewing and validating data, ultimately through global peer review.
- Dissemination of data through WHO’s country websites and the annual World Health Report.

Ways to include ethnicity as a criterion for national-level reporting will need to be sought across the UN system and at country level.

**Data on Non-communicable Diseases**

A series of workshops on data in relation to the major risk factors which predict serious non-communicable diseases (NCDs) is currently being held in 10 Pacific Island countries (American Samoa, the Cook Islands, the Federated States of Micronesia, Fiji, Kiribati, the Marshall Islands, Nauru, Palau, Samoa, and Tonga).

The latest in these, held in February 2003, addressed the current availability of data in respect of tobacco and alcohol use, physical inactivity, consumption of fruit and vegetables, high blood pressure, obesity, and diabetes. The workshops aim to help these countries develop a plan for establishing a surveillance system for these risk factors, for managing and analysing the data, and for turning the data into policy and programme action. In due course, it will be possible to compare the distribution of risk across adult Polynesian and Melanesian populations.

### 4. HEALTHY ENVIRONMENTS FOR CHILDREN ALLIANCE (HECA)

During the World Summit on Sustainable Development (WSSD) in Johannesburg, South Africa, in September 2002, WHO introduced the concept of a new alliance to act for children – the Healthy Environments for Children Alliance (HECA). This alliance, which forms a central part of WHO’s response to WSSD, is being developed through the joint efforts of national governments, agencies and organizations of the UN system, intergovernmental bodies, and non-governmental organizations. It provides an opportunity for intensified, multistakeholder action worldwide on the environmental risks to children’s health that arise from the settings where they live, learn, play, and sometimes, work.

Millions of children die each year from ill-health conditions resulting from household water insecurity; poor hygiene and sanitation; air pollution; insect vectors of disease; unsafe use of chemicals; and accidents and injuries. A substantial proportion of the global burden of disease can be attributed to environmental risk factors, and over 40% of this burden falls on children under five years of age. This unacceptable burden has prompted WHO, UNICEF and UNEP, together with a wide range of other partners and stakeholders, to initiate the **Healthy Environments for Children Alliance** (HECA). WHO acts as the Secretariat for the Alliance.
A Task Force is now being formed to identify future directions, methods of work, and next steps for the alliance. These will focus strongly on intersectoral action and community participation.

In simultaneously addressing issues of health, environment, children, and poverty, the HECA addresses can provide a broad operational platform inside and outside the UN system. WHO envisages a focus on indigenous children within this work.

5. PLANNING AND MANAGEMENT OF PARTICIPATORY RESEARCH

A draft document on issues requiring particular attention in planning and managing participatory research with Indigenous Peoples will shortly be issued by WHO and the Centre for Indigenous People’s Nutrition and Environment (CINE) in Canada. This incorporates comments from English-speakers. The draft is being translated into Spanish to facilitate a further round of comments. Funding for translation into other languages is being sought.

6. POLICY FOR RELATIONS WITH NONGOVERNMENTAL ORGANIZATIONS

The Principles governing relations between WHO and nongovernmental organizations are currently being reviewed. A new policy is being considered, consisting of elements of accreditation and collaboration. This may, if approved by WHO’s Governing Bodies, replace the current system which is now felt insufficient to meet the current needs of WHO and the aspirations of civil society. Information about WHO’s work with civil society and the proposed new policy can be found at http://www.who.int/governance/civilsociety/en/. The PF will be kept informed of progress in this respect.