Strengthening primary health care to tackle racial discrimination, promote intercultural services and reduce health inequities

Research brief

World Health Organization

Cover credits:
Charlie Tjararu Tjungurrayi
Pintupi c.1921-1999
Kapi Tjukurrpa (Water Story) 1972
Synthetic polymer paint on compressed fibre board
53.3 x 50.5 cm
Gift of the Department of Aboriginal Affairs, 1975. Museum and Art Gallery of the Northern Territory Collection (WAL 144).
© Estate of the artist. Licensed by Aboriginal Artists Agency Ltd/Papunya Tula Artists

Strengthening primary health care to tackle racial discrimination, promote intercultural services and reduce health inequities

Research brief

World Health Organization

Strengthening primary health care to tackle racial discrimination, promote intercultural services and reduce health inequities: research brief

ISBN 978-92-4-005710-4 (electronic version)

ISBN 978-92-4-005711-1 (print version)

© World Health Organization 2022

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (http://www.wipo.int/amc/en/mediation/rules).

Suggested citation: Strengthening primary health care to tackle racial discrimination, promote intercultural services and reduce health inequities: research brief. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Sales, rights and licensing. To purchase WHO publications, see http://apps.who.int/bookorders. To submit requests for commercial use and queries on rights and licensing, see https://www.who.int/copyright.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Contents

List of boxes iv

Preface v

Acknowledgements vi

Executive summary vii

1. Introduction 1

Working definitions 2

2. Health systems and racial discrimination 6

3. PHC – embedding actions to tackle racial discrimination and health inequities 11

Strategic lever 1: Political commitment and leadership 11

Strategic lever 2: Governance and policy frameworks 13

Strategic lever 3: Funding and allocation of services 15

Strategic lever 4: Engagement of community and other stakeholders 16

Operational lever 5: Models of care 18

Operational lever 6: PHC workforce 20

Operational lever 7: Physical infrastructure 22

Operational lever 8: Medicines and other health products 23

Operational lever 9: Engagement with private sector providers 24

Operational lever 10: Purchasing and payment systems 25

Operational lever 11: Digital technologies for health 26

Operational lever 12: Systems for improving the quality of care 27

Operational lever 13: PHC-oriented research 28

Operational lever 14: Monitoring and evaluation 29

4. Conclusion 32

References 34

List of boxes

Box 1. Racism 4

Box 2. Examples of health inequities faced by populations experiencing racial discrimination 7

Box 3. A whole-of-government approach to health inequities in New Zealand 12

Box 4. National health plan for people of African descent in Costa Rica 13

Box 5. Government action to promote the health of indigenous peoples in Canada 14

Box 6. Promoting the rights and freedoms of people of African descent and indigenous peoples through national legislation in Bolivia 15

Box 7. A race equity toolkit in the United States of America 16

Box 8. Developing childhood health strategies through engagement with indigenous peoples in Greenland 17

Box 9. "Birthing on Country" in Australia 19

Box 10. Intercultural health in Suriname 20

Box 11. Decolonizing medical education in Northern Ontario, Canada 22

Box 12. Floating PHC units in Brazil 23

Box 13. Traditional and complementary medicine in Congo 24

Box 14. Improving health care services for tribal populations in India 25

Box 15. Telemedicine through TulaSalud in Guatemala 26

Box 16. Improving quality of maternal care for indigenous peoples in Colombia 27

Box 17. Reflecting on community-based participatory research in Ghana 28

Box 18. Global network for indigenous women's participatory research 29

Box 19. The EU's 2020–2030 Roma strategic framework for equality, inclusion and participation 30

Box 20. Research, monitoring and strategics to address inequalities in COVID-19 transmission and vaccination uptake in England 31

Preface

The Thirteenth General Programme of Work 2019–2023 commits the World Health Organization (WHO) to work for populations in vulnerable situations who are facing marginalization, exclusion and discrimination. Structures of disadvantage, marginalization, exclusion and discrimination that have historical roots and present day manifestations drive socioeconomic and health inequities. Since 2021, WHO's Ethnicity and Health workstream has aimed to support tackling health inequities that are linked to racism, racial discrimination and intersecting forms of social exclusion. It does this by providing evidence, working across the levels of WHO to support national authorities, and working together with other United Nations System agencies to mainstream a focus on racial discrimination and protection of minorities. One activity within this workstream focuses on supporting national and local authorities in strengthening primary health care (PHC) to address racial discrimination and reduce health inequities affecting indigenous peoples, as well as people of African descent, Roma and other ethnic minorities.

Kunming, China - Three members of one of China's ethnic minorities by Steve Evans / CC BY

Literature that informed this research brief was identified from a range of sources. Academic databases and websites of intergovernmental organizations were searched with key terms for relevant literature. Searches were structured around the 14 strategic and operational levers of WHO's operational framework for PHC. Academic literature searches were carried out via MEDLINE, EMBASE and Google Scholar, while intergovernmental organization websites included that of WHO (headquarters and regional offices), the World Bank, the European Commission and United Nations agencies. There were additional targeted searches to obtain literature from all six WHO regions. The authors included relevant literature from their own knowledge and consulted with experts in the field for additional sources. A snowballing approach was used, where the references of relevant literature were screened to identify further relevant studies.

Included literature was prioritized based in its relevance to intercultural health, racism and racial discrimination in relation to health and PHC. This included studies evaluating interventions related to tackling racial discrimination and intercultural health within health systems, and theoretical literature on the issues. Exemplars were selected based on relevance and to ensure geographical representation.

Acknowledgements

This document was commissioned by WHO to Thomas Hone (Imperial College London). The need for it was identified by through a cross-departmental technical collaboration led by Theadora Swift Koller (Senior Technical Advisor, Health Equity) and Susana Gomez (Consultant for Ethnicity and Health) from the Gender, Equity and Human Rights team at WHO headquarters, and Shannon Barkley, Primary Health Care Special Programme, WHO headquarters; these WHO staff provided oversight for the document's conceptualization and development while also co-authoring the text. Additional co-authoring inputs came from Mala Rao (Imperial College London) and Andrêa Ferreira (Instituto Gonçalo Moniz, Fundação Oswaldo Cruz Bahia).

Sincere thanks for the inputs received during series of peer reviews to Sandra del Pino (PAHO/WHO), Berbardino Vitoy (PAHO/WHO in Brazil), Yamira Del Villar (PAHO/WHO in Dominican Republic), Claude Cahn (Office of the United Nations High Commissioner for Human Rights), Matthew Nielson (WHO/headquarters), Fadhi Dkhimi (WHO/headquarters) Mariam Wallet Mohamed Aboubakrine (Association Tin Hinane), Myrna Cunningham (Fund for the Development of the Indigenous Peoples of Latin America and the Caribbean) and Sridhar Venkatapuram (King's Global Health Institute). WHO also thanks Francene Larzelere and Novalene Alsenay Goklish (Johns Hopkins Center for American Indian Health), Patricia Da Silva (United Nations Population Fund) and Christina Viskum Lytken Larsen (National Institute of Public Health, Denmark).

Particular gratitude goes to Princess Nothemba Simelela (Assistant Director-General for Family, Women, Children and Adolescents), Suraya Dalil (Director of the WHO Special Programme on Primary Health Care) and Erin Maura Kenney (Acting Gender, Equity and Human Rights Team Leader) for their strategic guidance. The publication was funded through the WHO and Government of Canada project "Strengthening local and national primary health care and health systems for the recovery and resilience of countries in the context of COVID-19".

Executive summary

As countries aim to progress towards the Sustainable Development Goals (SDGs) and achieving universal health coverage, health inequities driven by racial discrimination and intersecting factors remain pervasive. Inequities experienced by indigenous peoples as well as people of African descent, Roma and other ethnic minorities are of concern globally; they are unjust, preventable and remediable.

Indigenous peoples as well as people of African descent, Roma and other ethnic minorities are more likely to experience adverse socioeconomic conditions, often influenced by racial discrimination, and compounding and intersecting forms of disadvantage across many aspects of their lives. Inequities affecting populations facing discrimination are rooted in racism shaped by the legacies of slavery, indentured servitude, colonialism, imperialism, war, ultra-nationalism, ethnic absolutism, xenophobia and hate speech; they are reflected in persistent and multigenerational social and economic disadvantages. This is despite international human rights obligations that prohibit racial discrimination in all its forms and guarantee everyone's rights before the law, without distinction as to race, colour, or national or ethnic origin.

Health systems themselves are important determinants of health and health equity, including for people of African descent, Roma and other ethnic minorities, as well as indigenous peoples. Health systems can perpetuate health inequities by reflecting structural racism and discriminatory practices of wider society. For instance, systemic racism (for example, linked to where services are located or requirements for accessing them), implicit bias, misinformed clinical practice, or discrimination by health professionals contributes to health inequities. In addition, lack of intercultural care can be a reflection of health services orientated more towards certain populations, languages or cultures, with insufficient or lack of regard for differing patient preferences, languages and cultural beliefs. However, health systems can also be a leading force for tackling the inequities faced by populations experiencing racial discrimination. They can advocate for support across sectors to address racial discrimination, highlighting evidence that it adversely impacts health. In addition, through the application of equity, gender and human rights-based approaches, health systems can deliver intercultural and equity-oriented health services that result in the reduction of health inequities and the fulfilment of other fundamental human rights (for example, the right to participation).

Primary health care (PHC) is the essential strategy for reorientating health systems and societies to become healthier, equitable, effective and sustainable. In 2018, on the 40th anniversary of the Declaration of Alma-Ata, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) renewed the emphasis on PHC with their strategy, *A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals*. The strategy asserts that PHC is indispensable for achieving universal health coverage and the SDGs, including the SDGs for health (SDG 3) and equality (SDG 10).

PHC-oriented health systems strengthening, as a platform for societal change, can contribute to tackling racial discrimination and reduce the health inequities affecting populations experiencing such discrimination. This is because PHC addresses the root causes of poor health and inequities, focuses on social justice (including racial justice action), calls for intersectional and multisectoral approaches to health and well-being, and gives attention to the empowerment of all communities.

WHO outlines 14 strategic and operational levers for policy-makers to strengthen PHC. Within each lever, there are multiple potential entry points for targeted actions to address racial discrimination, foster intercultural care, and reduce health inequities experienced by indigenous peoples as well as people of African descent, Roma and other ethnic minorities. A non-exhaustive overview of such entry points, based on a rapid review of literature, is provided in Table below. A comprehensive analysis of the state of health and specific health needs of the indigenous peoples, people of African descent, Roma and other ethnic minorities is beyond the scope of the present brief.

PHC is an ideal platform for integrating actions to address health inequities affecting populations experiencing racial discrimination because it is an agenda for societal change, has a commitment to leaving no one behind, includes far-reaching actions to address the wider social determinants of health, and has an explicit focus on tackling inequity and the root causes of inequity. That said, research gaps remain, and strengthening the evidence base is key to build action to address health inequities. Moving forward, key areas include strengthening participatory approaches in research, further interdisciplinary conceptual refinement at global levels, addressing the lack of data disaggregation by ethnicity and other relevant social stratifies, deepening the knowledge base on tackling compounding and intersecting forms of disadvantage that interact with racial discrimination, expanding the understanding of different populations' needs and beliefs based on differing worldviews, recognition of the value of culture and diversity, and identifying promising practices and interventions to address racism and racial discrimination.

Potential action areas for addressing racial discrimination, by PHC lever

PHC levers	Entry points for addressing racial discrimination and ensuring intercultural care
Strategic levers	
1. Political commitment and leadership	■ Incorporate specific policy objectives for addressing health inequities experienced by populations affected by racial discrimination. ■ Build a strong commitment to PHC strengthening in geographic areas with higher indices of multidimensional deprivation and where populations experiencing racial discrimination are more likely to live. ■ Foster PHC reforms based on progressive universalism. ■ Take a stand on xenophobia, racist disinformation, hate speech, stereotyping and discriminatory practices, and ensure the negative impacts of these on health and well-being are clearly articulated. ■ Promote policies and interventions that recognize and implement an intercultural and intersectoral approach, together with action on social determinants to combat racial discrimination. ■ Recognize that political and high-level structures themselves must change to include and ensure the participation of diverse actors in decision-making processes.
2. Governance and policy frameworks	■ Strengthen existing or adopt new antidiscrimination legislation to combat discrimination that aligns with international human rights standards. ■ Use policy frameworks to explicitly tackle xenophobia, racist disinformation, hate speech and media stereotyping. ■ Institutionalize multisectoral synergies between health and other sectors to address the intersecting and compounding social determinants of health affecting populations experiencing racial discrimination. ■ Build respect for and strengthen the organizational, social and cultural institutions of indigenous peoples as well as people of African descent, Roma and other ethnic minorities, while supporting their right to participate fully in political, economic, social and cultural life. ■ Ensure that the health sector has policies, codes of conduct, guidelines for and enforcement of antidiscrimination measures, as well as functional grievance redress mechanisms.
3. Funding and allocation of services	■ Ensure equity-oriented budgeting approaches for PHC and health systems strengthening, so that more disadvantaged areas with greater health needs will receive adequate resources. ■ Incorporate an ethnicity lens to better understand the role of health system financing in tackling inequities. ■ Introduce financing arrangements that enable joined up funding between health and other sectors; for example, for joined up health and social services. ■ Advance participatory budgeting approaches where communities can be involved in deciding how budget allocations can best meet community needs. ■ Ensure the appropriate allocation of funds for antidiscrimination mechanisms and the coordination or integration of intercultural health services, as applicable to the national context.

PHC levers	Entry points for addressing racial discrimination and ensuring intercultural care
4. Engagement of community and other stakeholders	■ Foster social participation and accountability platforms for indigenous peoples as well as people of African descent, Roma and other ethnic minorities experiencing racial discrimination, stigma and exclusion. ■ Ensure opportunities for meaningful and equitable participation of indigenous peoples as well as people of African descent, Roma and other ethnic minorities in matters that would affect their rights, while respecting their organizational structures and accounting for gender considerations. ■ Invest in building capacities of health professionals and communities experiencing racial discrimination to ensure equitable opportunities for participation. ■ Take into account linguistic, geographic, financial, gender and other barriers to participation. ■ Advocate for and empower health professionals from communities that face racial discrimination to have a fair say and assume leadership positions.
Operational levers	
5. Models of care	■ As a health equity priority, health systems should be orientated towards high-quality primary care, ensuring equitable access across the continuum and levels of care. ■ Invest in increasing the accessibility of primary care services, especially for indigenous peoples, as well as people of African descent, Roma and other ethnic minorities with lower levels of access. ■ Promote continuity in primary care and address specific barriers to providing care over time for populations experiencing racial discrimination. ■ Develop integrated people-centred health services that are tailored to identities, beliefs, preferences and health needs, while also being respectful of people's dignity, social circumstances and culture. ■ Build comprehensive primary care services integrating preventive, curative and rehabilitative care that is based on person-centred approaches. ■ Strengthen primary care services by incorporating intercultural approaches based on knowledge dialogues between conventional and traditional medicines and practices as a way of achieving person- and community-centred health care.
6. PHC workforce	■ Invest in and deliver anti-racism, antidiscrimination and cultural competency training for health professionals. ■ Consider expanding the PHC workforce to include professionals specifically focused on intercultural care, in addition to expanding intercultural competencies of existing staff. ■ Build team-based structures that promote coordinated action to address health inequities experienced by populations facing discrimination. ■ Encourage medical schools to increase diversity and representativeness of indigenous peoples as well as people of African descent, Roma and members of other ethnic minorities, as applicable in the national context. This is relevant for the training of the full spectrum of health care professionals and should be backed by efforts to support educational institutions with related legal and policy frameworks. ■ Reduce barriers to promotion and ensure training of medical professionals from ethnic and racial groups experiencing discrimination to ensure representativeness across the hierarchy of seniority. ■ Introduce and/or strengthen curricula of medical schools, educational institutions and in-service training on the topics of intercultural health, discrimination-related health inequities, racism and exclusion, and the role of health services in exacerbating and alleviating these inequities.
7. Physical infrastructure	■ Install equity-enhancing resource allocation systems that address historical underinvestment in areas disproportionately inhabited by persons experiencing social exclusion, including indigenous peoples, as well as people of African descent, Roma and other ethnic minorities. ■ Provide flexible, locally tailored and culturally appropriate health care facilities that align with the needs and preferences of local communities. ■ Ensure the provision of services for mobile/nomadic communities.
8. Medicines and other health products	■ Critically evaluate current and future medicines and medical devices for the influence of conscious and unconscious racial or ethnic bias. ■ Tackle, through regulation, the affordability of health care products where the costs can disproportionately affect populations experiencing social exclusion, such as persons affected by racial discrimination. ■ Promote recognition, respect and protection of – and coordination with – knowledge-based traditional, ancestral and complementary medicines in national health systems.

PHC levers	Entry points for addressing racial discrimination and ensuring intercultural care
9. Engagement with private sector providers	■ Ensure that private sector providers uphold practices relating to non-discrimination and conform with human rights standards when providing health care, through regulation, enforcement, and stewardship of the private system. ■ Regulate to reduce the impacts of private industry on the wider social determinants of health to address health inequities experienced by populations facing racial discrimination.
10. Purchasing and payment systems	■ Build strategic purchasing and contracting mechanisms that are equity-enhancing, such as contracting with local, minority-owned service providers. ■ Harness payment systems to incentivize actions to reduce health inequities. ■ Incentivize active rather than passive community engagement with populations experiencing racial discrimination through purchasing and payment systems.
11. Digital technologies for health	■ Invest in accessible and universal digital technology platforms. ■ Employ telemedicine as an important tool for reducing access barriers to health care.
12. Systems for improving the quality of care	■ Use a national quality policy and strategy as an entry point for strategic dialogue on the role of the health system in addressing health inequities. ■ Make addressing the health inequities experienced by indigenous peoples, as well as people of African descent, Roma and other ethnic minorities, one of the goals and priorities of national quality policies and strategies. ■ Explicitly incorporate the perspectives of indigenous peoples as well as people of African descent, Roma and other ethnic minorities into local definitions of quality, especially in relation to equitable and person-centred care. ■ Require that clinical and managerial teams responsible for implementation reflect inclusivity and a commitment to reducing inequity in their own approach and values. ■ Expand quality improvement mechanisms to specifically target inequities in health care quality for populations affected by racial discrimination.
13. PHC-oriented research	■ Promote participatory research approaches for the health of indigenous peoples as well as people of African descent, Roma and other ethnic minorities. ■ Document and evaluate effective interventions that can tackle underlying determinants of health inequities, barriers to accessing high-quality primary care, and service-based discrimination. ■ Invest in flexible research approaches to trial new interventions to address racial discrimination and the health inequities affecting indigenous peoples as well as people of African descent, Rome and other ethnic minorities. ■ Advance documentation of “promising practices” and case-studies relating to interventions addressing health inequities affecting populations experiencing racial discrimination. ■ Prioritize health equity in health research. Funders of research should encourage the prioritization of health equity and intersectional approaches that assess people’s capacities and deprivation across multiple intersecting dimensions, as well as measures for redress.
14. Monitoring and evaluation	■ Invest in routine data collection systems that permit self-identification and facilitate the collection of data disaggregated by ethnicity as well as other equity stratifiers. ■ Ensure a human rights-based approach to data, where the data are not identifiable and robust data protection mechanisms and procedures are in place. ■ Ensure access to data, in line with confidentiality and safeguarding processes, is provided for independent research and monitoring of the health system, public policies and society in relation to health inequities affecting populations experiencing racial discrimination. ■ Deliver open, accessible and transparent platforms for data on health inequalities. ■ Ensure data monitoring and evaluation activities integrate approaches that respect local cultures and are devised with community support. ■ Measure the extent to which synergistic and cross-sectoral approaches to addressing health inequities of populations affected by racial discrimination occur. ■ Measure the cultural competency of providers and the extent of intercultural services. ■ Invest in the monitoring and safeguarding roles of health services and in promoting cross-sectoral dialogue.

1 Introduction

Countries worldwide have committed to progressing the United Nation's Sustainable Development Goals (SDGs) by 2030, including target 3.8 for universal health coverage. Countries are aiming to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" *(1)*. Primary health care (PHC), as a foundation for health systems strengthening, is key to achieving universal health coverage, meeting the SDG targets for health and also advancing other non-health SDGs, including reducing inequalities *(2,3)*.

Health inequities are a pervasive challenge for all countries. The 2030 Agenda for Sustainable Development is underpinned by the universal principle of "leaving no one behind" and SDG 10 is to "reduce inequality within and among countries" *(1)*. Inequality inhibits progress towards the SDGs by reducing economic growth, constraining poverty alleviation, eroding trust in governments and destabilizing political systems *(4)*.

Inequality inhibits progress towards the SDGs by reducing economic growth, constraining poverty alleviation, eroding trust in governments and destabilising political systems.

In alignment with Article 1 of the International Convention on the Elimination of All Forms of Racial Discrimination (1965), racial discrimination is understood as a differentiated treatment for the purpose or effect of impairing particular rights or freedoms based on 5 prohibited grounds: race, colour, descent, or national or ethnic origin. Also, consistent with Article 1 of the UNESCO Declaration on Race and Racial Prejudice Racism and Racial Discrimination, providing that "all human beings belong to a single species and are descended from a common stock", "race" is understood as a social construct which imply differences, hierarchies, and privileges between certain groups.

Indigenous peoples as well as people of African descent, Roma and other ethnic minorities are generally at higher risk of poverty than the general population. They also face substantial disadvantages in access to health care, education and employment, and often live in rural and remote areas that lack adequate infrastructure and services *(5)*. Racial discrimination, racism or exclusion on the basis of their characteristics or identity results in unequal power relations, which in sequence operate in the formulation of social policies and the delivery of public services, including health services *(5)*. Globally, over 476 million indigenous peoples live in 90 countries *(6)*. There is an estimated 150 million people of African descent living in Latin American and the Caribbean – and many millions living in Europe and Asia *(7,8)*. In 2015, the United Nations Special Rapporteur on Minority Issues estimated that there were 11 million Roma in Europe, with 6 million residing in the 27 European Union (EU) member states *(9)*.

Global attention to racial discrimination and its impact has increased in recent decades. This has been driven by calls for action, such as: the Durban Declaration of 2001 *(10)*; evidence of stark inequities from human rights monitoring bodies; increased availability of data disaggregated by ethnicity; the work of the global Commission on Social Determinants of Health *(11)*; regional commitments such as those by the WHO Regional Office for the Americas on ethnicity and health *(12,13)*; awareness-raising by social justice movements such as Black Lives Matter; and, most recently, the stark inequities exacerbated by COVID-19 *(14)*.

Indigenous peoples as well as people of African descent, Roma and other ethnic minorities continue to experience stigma, racial discrimination and lack of recognition of their rich and unique history, culture and traditions. This limits their influence on decision-making, impedes their active participation, prevents the incorporation of their worldviews and health needs in policies and services, and drives health inequities. Part of a PHC-oriented approach to health systems strengthening is to address these issues.

Based on a rapid review of literature conducted in the second half of 2021, this brief aims to equip policy-makers, civil society organizations, researchers and other development partners with knowledge of potential entry points for addressing racial discrimination, promoting intercultural services, and reducing health inequities in and through PHC. Each of WHO's 14 strategic and operational levers are reviewed, and example actions are outlined that can shape and strengthen PHC. It is beyond the scope of this brief to highlight all of the potential entry points; rather, the brief provides some sample actions and specific case-studies as a means of highlighting potential issues to be considered in PHC strengthening approaches.

Working definitions

The principles and definitions outlined below guide the discussion in this report.

Racial discrimination as defined by the 1965 International Convention on the Elimination of All Forms of Racial Discrimination is 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, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life" (Article 1). See also definitions of racism (Box 1).

For the purpose of this document, the concept of "racial discrimination" is aligned with Article 1 of the International Convention on the Elimination of All Forms of Racial Discrimination (1965), which establishes 5 grounds for discrimination based on race, colour, descent, or national or ethnic origin. Also, consistent with Article 1 of the UNESCO Declaration on Race and Racial Prejudice Racism and Racial Discrimination, providing that "all human beings belong to a single species and are descended from a common stock", "race" is understood as a social construct which imply differences, hierarchies, and privileges between certain groups.

The principle of **"leaving no one behind"** entails reaching the poorest of the poor, but also motivates combatting discrimination and rising inequities within and among countries, and their root causes. This is grounded in the United Nations normative standards, including the principles of equality and non-discrimination that are foundational principles of the Charter of the United Nations, international human rights laws and national legal systems across the world. As part of the leaving no one behind pledge, countries must take actions to identify who is being marginalized including those facing discrimination and exclusion *(15)*.

The concept of **"othering"** is valuable framework for considering how and why discrimination and racism exist in societies, and can help to identify the populations experiencing discrimination and exclusion *(16)*. Othering outlines the common mechanisms that drive exclusion across contexts, including discrimination, prejudice, implicit (unconscious) bias, denialism, segregation and violence. Othering, as a concept, can help in recognizing the social practices, norms and other forces that drive marginalization of certain groups *(16)*.

An **intersectional lens** is vital when identifying local populations experiencing discrimination *(17)*. Intersectionality analysis illuminates how discrimination can occur across multiple dimensions and confers differing levels of disadvantage across individuals and social groups. Individuals within different ethnic and racial groups cannot be considered to be homogenous, since each is exposed to intersecting forms of discrimination based on ethnicity as well as on the basis of sex, age, sexual orientation, place of birth, language, religion, disabilities or poverty. Intersectionality is not just the cumulative effects of multiple deprivations, but rather how different social classifications interact to confer different levels of privilege and disadvantage for specific individuals and groups *(18)*.

There is no internationally agreed definition of indigenous peoples or ethnic minorities. Considering the diversity of **indigenous peoples**, the United Nations System has instead developed an understanding of this term based on the following major characteristics: self-identification as indigenous peoples; social, cultural and economic conditions distinguish them from other sections of the national community; they have distinct language, culture and beliefs; they form non-dominant groups of society; and, a resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities *(8,19)*. Throughout this brief, the term "indigenous peoples" is used as distinct from "ethnic minorities" because in principle indigenous peoples are subject to a specific normative framework under international human rights laws, especially the United Nations Declaration on the Rights of Indigenous Peoples that recognizes, among other rights, the right to self-determination and self-identification *(20)*. Therefore, many people who self-identify as indigenous peoples oppose categorization as minorities for reasons including both their unique identity as the first and original occupants of land, as well as due to the comparatively weaker international rights framework for minorities *(21,22)*.

Ethnicity is understood to be based on perceived common ancestry, history and cultural practices *(14)*. The term "**ethnic minority**" generally refers to "ethnic or racial groups in a given country in which they are in a non-dominant position vis-à-vis the dominant ethnic population" *(5)*. In this brief, the term refers to a group of people that meets one or more of the following criteria: the group is numerically smaller than the rest of the population; it is not in a [social, economic, or politically] dominant position; it has a culture, language, religion or ethnicity that is distinct from that of the majority; and its members have a will to preserve those characteristics *(5,21)*.

People of African descent, as indicated by the Working Group of Experts on People of African Descent, may be defined as "descendants of the African victims of the Tran-Atlantic and Mediterranean Sea slave trade. The group includes those of the sub-Sahara slave trade. Descendants of the victims of the trans-Atlantic trade live primarily in the diaspora of North, Central and South America and the Caribbean". Also, this definition includes "Africans and their Descendants who emigrated to other parts of the world where they have experienced racial discrimination" *(14,23)*.

Roma, as stated by the former United Nations Special Rapporteur on minority issues, Rita Izsák, refers to "heterogeneous groups, the members of which live in various countries under different social, economic, cultural and other conditions" *(9)*. She noted that the term Roma "does not denote a specific group but rather refers to the multifaceted Roma universe, which is comprised of groups and subgroups that overlap but are united by common historical roots, linguistic communalities and a shared experience of discrimination in relation to majority groups. "Roma" is therefore considered a multidimensional term that corresponds to the multiple and fluid nature of Roma identity" *(9)*. The term Roma used at the Council of Europe refers to "Roma, Sinti, Kale and related groups in Europe, including Travellers and the Eastern groups (Dom and Lom), and covers the wide diversity of the groups concerned, including persons who identify themselves as Gypsies" *(24)*.

This report acknowledges that the **terms** "**race" and "ethnicity**" have no internationally agreed-upon definitions *(25,26)* and that their conceptualization varies based on country, historical, political and cultural contexts. Thus, the report emphasizes that "race" and "ethnicity" are social constructs for grouping human populations, and as a social construct they are highly variable between and within countries, over time, and from different perspectives. This report also emphasizes the United Nations position that considers humanity to be indivisible and the differences between individuals to be of a political, cultural and symbolic nature.[1] In the same line, the existence of racial categories has been widely discredited from a genetic perspective *(25,26)*.

The **principle of self-identification** which according to the principles of international law, (including Article 27 of the International Covenant on Civil and Political Rights, the Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities and General Comment No. 23 (1994) of the Human Rights Committee) states that minority identity does not depend on recognition by a State, but rather on individual self-identification.

Cultural competency is the ability of a health system to provide care to patients with diverse values, beliefs and behaviours, including the tailoring of service delivery to meet patients' social, cultural and linguistic needs. Barriers to culturally competent care include a lack of diversity in the health leadership, poorly designed systems, and poor communication and dialogue with populations of different ethnic and cultural backgrounds *(9)*.

[1] The UNESCO 1978 Declaration on Race and Racial Prejudice states that "all human beings belong to a single species and are descended from a common stock. They are born equal in dignity and rights and all form an integral part of humanity" (Article 1).

Interculturalism can be understood as the ability to recognize, harmonize and negotiate the multiple cultural differences that exist within society. It is also the communicative interaction between two or more human groups with different cultures and is considered an interactive social process of recognition and respect for the differences that exist within or between cultures. It includes the interaction between cultures from positions of equivalence, horizontality and mutual respect that allows setting a harmonious relationship between different human communities. In health care, an intercultural approach is understood as all the elements and variables of interculturalism (such as adaptation of health services, recognition of traditional medicines) that are accepted, included and respected in the health systems – for example, adaptation to cultural practices in childbirth, the approach to prenatal care, and so on. **Intercultural competence** goes beyond cultural competency, as it additionally includes the need for interaction and dialogue between different cultures and embraces the notion of cultural humility *(27,28)*.

Interculturalism includes the interaction between cultures from positions of equivalence, horizontality and mutual respect that allows setting a harmonious relationship between different human communities.

Box 1

Racism

Racism is an ideological construct that assigns a certain race and/or ethnic group to a position of power over others on the basis of physical and cultural attributes, as well as economic wealth, involving hierarchical relations where the "superior" race exercises domination and control over others. Article 2 of the United Nations Educational, Scientific and Cultural Organization (UNESCO) 1978 Declaration on Race and Racial Prejudice states that *"racism includes racist ideologies, prejudiced attitudes, discriminatory behaviour, structural arrangements and institutionalized practices resulting in racial inequality as well as the fallacious notion that discriminatory relations between groups are morally and scientifically justifiable; it is reflected in discriminatory provisions in legislation or regulations and discriminatory practices as well as in anti-social beliefs and acts" (29)*.

Racism comes in many forms *(30)*:

- **individual racism** is an individual's own racist beliefs, assumptions or ideas about either their own or others' race or ethnicity. It is often called implicit bias, or prejudice. It can either be conscious or unconscious.
- **interpersonal racism** is the manifestation of personal racist beliefs and refers to racist actions between individuals. These can be activities such as racist comments, discriminatory actions, hate crimes or violence.
- **institutional racism** refers to discriminatory attitudes and practices that are embedded in institutions. These can be educational, criminal justice, health care, political and social welfare institutions, or private companies such as banks and corporations. It stems from laws, regulation, policies or power systems that disadvantage individuals based on their perceived race or ethnicity.
- **systemic (or structural) racism** is racism that arises across society from the interactions of institutions and individuals. It is the cumulative, long-term effects from power inequities or unequal opportunities across systems.

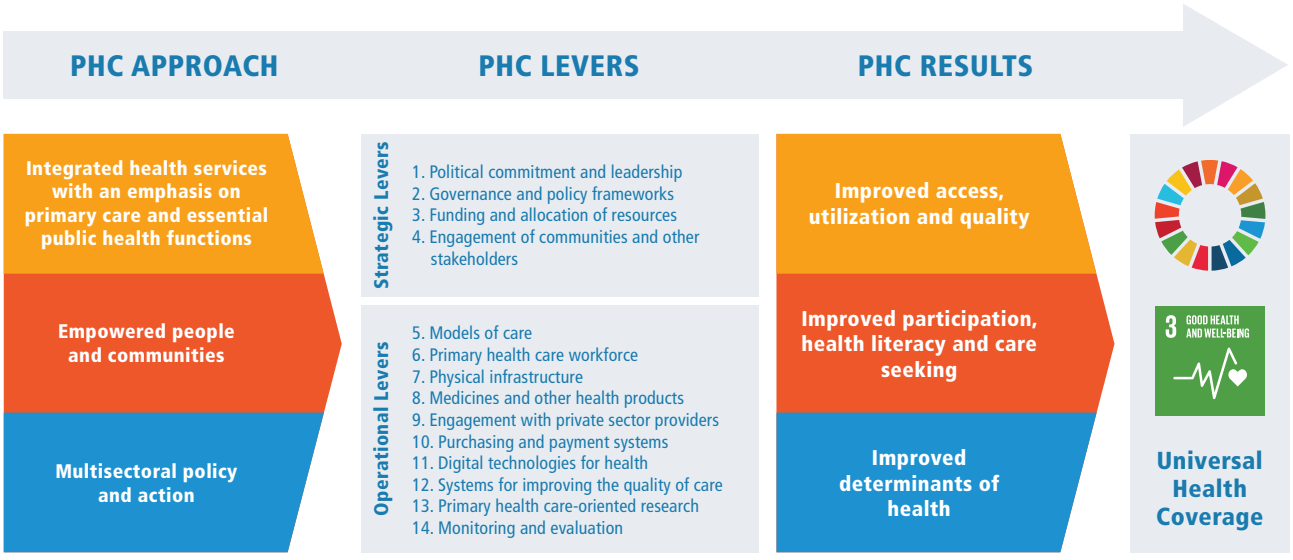
Primary health care (PHC) is a whole-of-society approach to health. It was first outlined in the 1978 Declaration of Alma-Ata. Forty years later, in 2018, WHO and UNICEF updated the vision of PHC for the modern day with the strategy *A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals (3,31)*. PHC is defined as a whole-of-government and whole-of-society approach to health that combines: multisectoral policy and action; empowered people and communities; and primary care and essential public health functions as the core of integrated health services. PHC aims to equitably maximize the level and distribution of health and well-being, by focusing on people's health needs and preferences as early in life as possible and as close as feasible to people's everyday environment. It is embedded in the community, and equity and social justice are at the heart of PHC. These key attributes are why health systems based on PHC are best positioned to tackle racial discrimination in health to ensure accessible, quality and culturally sensitive services and address persistent health inequities.

Primary care services, which are the core of PHC, can reduce inequities in access to health care and can facilitate access to other social welfare programmes *(32)*. Primary care services are effective in addressing the wider unmet health needs in a population and can also address the greater barriers to accessing health care experienced by more deprived populations *(33–36)*. They also have an important role in linking patients with specialist care when required and in addressing determinants of health inequities, across the whole life course *(37)*. High-quality primary care services are defined by the attributes of accessibility, continuity, comprehensiveness and coordination *(36)*.

PHC is defined as a whole-of-government and whole-of-society approach to health that combines: multisectoral policy and action; empowered people and communities; and primary care and essential public health functions as the core of integrated health services.

WHO's operational framework for PHC (Fig. 1) demonstrates the links between PHC and improved health, equity, health security and cost-efficiency. Fourteen strategic and operational levers are outlined as potential action areas for policy-makers to strengthen PHC *(38)*.

Fig. 1. WHO's operational framework for PHC



Health systems and racial discrimination

Stark health inequities affect people of African descent, Roma and other ethnic minorities as well as indigenous peoples. Despite the pervasiveness of these health inequities and growing attention to the issue, scientific/health data and evidence of health inequities across populations experiencing racial discrimination are sparse and are often available mostly in high-income countries (Box 2). Against this background, the COVID-19 pandemic has had major implications for the 2030 Agenda for Sustainable Development and has further exposed the challenges of ethnicity-based inequities. In June 2021, the World Bank estimated that 97 million people were driven into extreme poverty (i.e. living on less than US$ 1.90 a day) in 2021 due to COVID-19 *(39)*, with indigenous peoples, people of African descent, Roma and ethnic minorities worldwide likely to be disproportionately affected.

African American mother
"Safe to sleep" by NICHD / CC BY

Box 2

Examples of health inequities faced by populations experiencing racial discrimination

- The Centers for Disease Control and Prevention, in the United States of America, identified that African American women were three times more likely to die from a pregnancy-related cause than white American women over the period 2007–2016 *(40)*.
- According to a King's Fund report in 2021, although stillbirth and infant mortality rates in England and Wales have fallen since 2007 across populations of different ethnicities, infant mortality remains higher among ethnic minorities. For example, persons of Pakistani and African descent had infant mortality rates of 6.8 and 6.5 per 1000 live births, respectively, compared to 3.2 for those of European ethnic origin over the period 2017–2019 *(41)*.
- A cross-sectional study of 14–15-year-old children at schools in Cape Town, South Africa, in 2009, found that children of African descent were twice as likely to have depression or post-traumatic stress disorder compared to children of European ethnic origin *(42)*.
- A Government of Australia analysis of national mortality records identified Aboriginal and Torres Strait Islander peoples had a 10.6 and 9.5 years shorter life expectancy than non-indigenous males and females, respectively, over the period 2008–2012 *(43)*.
- A study on indigenous health over the period 1997–2014 found that Baka Pygmies in Cameroon died on average 22 years earlier than non-Pygmy populations *(44,45)*.
- According to the 2018 report *State of the world's indigenous peoples* by the United Nations Department of Economic and Social Affairs, the infant mortality rate in Ecuador among indigenous children is 67.6 per 1000 live births, compared to 30.0 for the general population (based on the 2011 census) *(8)*.
- In Viet Nam, in 2002, the under-5 mortality rate of indigenous Vietnamese was 41 per 1000 live births compared to 28 for non-indigenous Vietnamese (according to the national Demographic and Health Survey 2002) *(45,46)*.
- Responses from the Prospective Urban and Rural Epidemiology (PURE) survey in China, between 2005 and 2007, found the prevalence of hypertension in Chinese ethnic minorities was 42.4% compared to 34.4% in Han Chinese, with lower control and treatment rates for Chinese ethnic minorities *(47)*.
- A study states that according to available data up to 2006, Pygmy peoples (the Aka in the Central African Republic and the Twa in Uganda) have infant mortality rates 1.5–4 times higher than the neighbouring non-Pygmy populations *(48,49)*.

Hmong minority people in traditional clothes. Sa Pa, Vietnam, by Pal Szilagyi Palko/Scopio

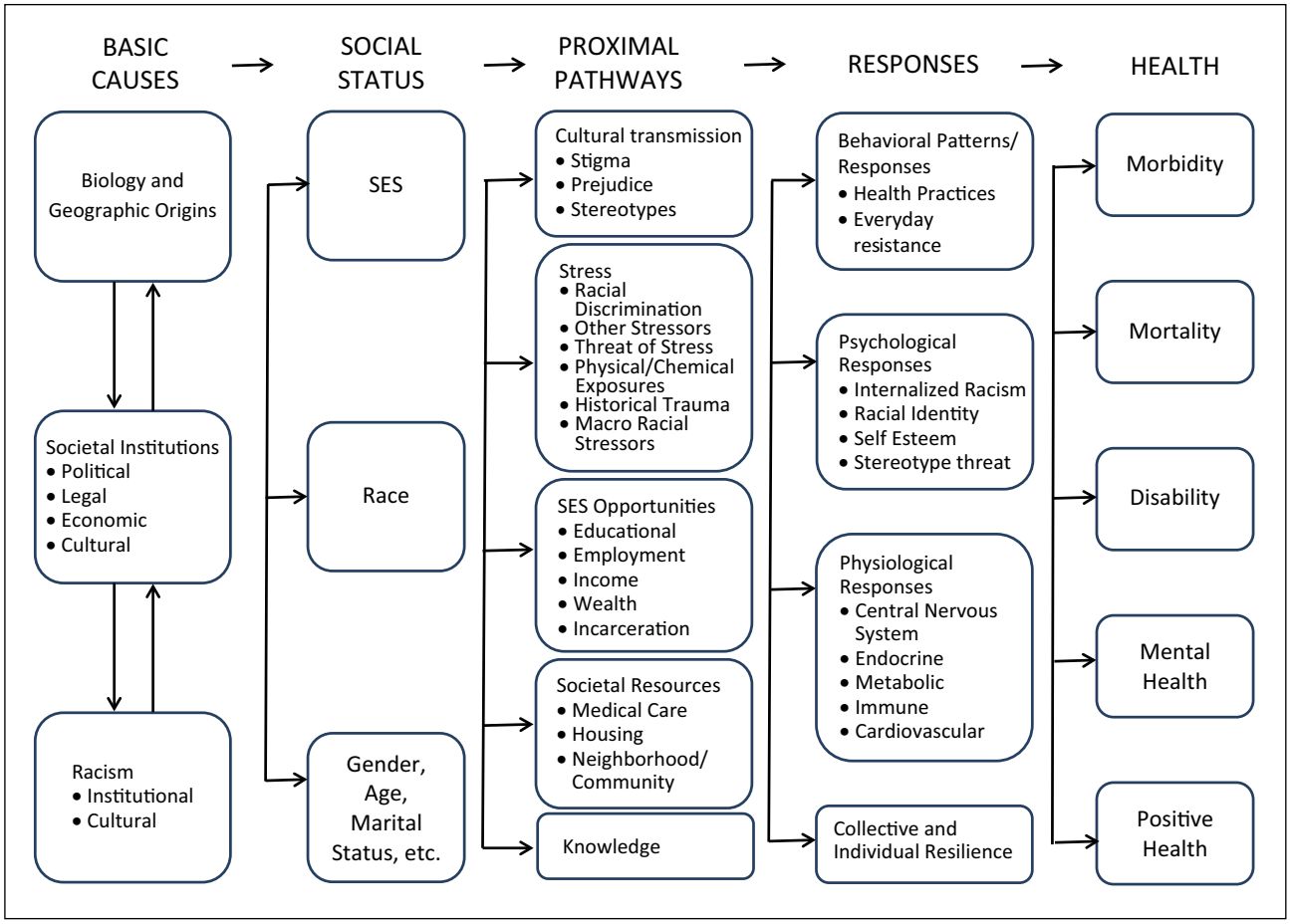
- The 2014 European Commission report on the health status of the Roma population in Europe reviewed country-level data on life expectancies and found that the life expectancy of Roma populations across Europe was approximately 10–15 years shorter than non-Roma populations *(50)*.
- The Tanzania Demographic and Health Survey of 2010 found that 59% of Maasai pastoralist children were stunted in Tanzania, with higher rates of fever, diarrhoea and pneumonia compared to other majority ethnic populations *(51,52)*. Moreover, the Tanzania National Nutrition Survey 2018 found that Manyara, with a high population of indigenous peoples, is one of the regions with high prevalence of stunting (36.1%) *(53)*.
- An analysis of the 2010 Brazilian National Demographic Census found that indigenous children and adolescents (aged less than 20 years old) have higher mortality rates compared to their non-indigenous counterparts, including those identifying as African descents and other ethnic minorities, in both rural and urban residential settings *(54)*.
- A study analysing the 2003 Nigeria Demographic and Health survey found that in Nigeria, compared with children of Hausa/Fulani mothers, those from Igbo, Yoruba and other ethnic groups had a 40%, 57% and 19% lower risk of dying, respectively *(55)*.

Health inequities affecting populations experiencing racial discrimination are interrelated with, and driven by, the wider social determinants of health and accumulate over generations (see the Commission on Social Determinants of Health *(11)*). These inequities are rooted in racism shaped by the legacies of slavery, indentured servitude, colonialism, imperialism, war, ultra-nationalism, ethnic absolutism, xenophobia and hate speech. This history has resulted in persistent and multigenerational social and economic disadvantage. Racism and racial discrimination remain fundamental social determinants of health *(32,56)*. As one of the potential frameworks to unpack this issue, Williams & Mohammed (2013) provide an overview of the pathways by which racism, racial discrimination, socioeconomic status, the social determinants of health and health are connected (Fig. 2).

Racism – from the individual to systemic level – leads to "othering" or the development and propagation of negative attitudes (prejudice) and beliefs (stereotypes) towards certain populations, and results in differential treatment of these people. Individual racism and structural racial discrimination can reduce opportunities and deny access to health improving activities (such as health care) and contribute to poorer socioeconomic status (for example, through employment, housing and education opportunities). Individuals who experience racism or perceive discrimination have poorer mental health outcomes *(57,58)*, higher blood pressure *(59)*, increased levels of inflammatory and stress hormones *(60,61)*, and increased mortality *(62)*. Experiencing everyday discrimination is also associated with lower birth weight *(63)*, cognitive impairment *(64)*, poorer sleep *(65)* and higher levels of visceral fat *(66)*.

Racism and racial discrimination remain fundamental social determinants of health.

Fig. 2. A framework for the study of racism and health



Source: Williams DR, Mohammed SA. Racism and health I: pathways and scientific evidence. Am Behav Sci. 2013;57(8):10.1177/0002764213487340. https://doi.org/10.1177/0002764213487340.

Health systems are important determinants of health and health equity of all people, including indigenous peoples as well as people of African descent, Roma and other ethnic minorities *(67)*. Health systems can reduce health inequities, but also exacerbate or widen them *(68.69)*. There are multiple ways in which health systems can influence and are influenced by racial discrimination, as described below.

i. **Structural discrimination in health systems.** Health systems reflect the societies in which they operate, including wider structural drivers of discrimination-related health inequities. Without actions to address the situation of disadvantage faced by populations experiencing racial discrimination, health systems can perpetuate inequities. For example, many populations experiencing racism and racial discrimination live in geographical areas where there is low availability of quality health services and, when available, such services are often at high direct and indirect costs. Health systems can also present barriers, such as one dominant language, limited understanding of group-specific health needs, insufficient linkages with social care, financial barriers linked to employment type and access to financial protection, and lack of cultural competence by providers *(28,70)*.

ii. **Differential patient preferences, in part based on differing worldviews and in part based on past experiences of discrimination**. Indigenous peoples as well as people of African descent, Roma and other ethnic minorities can have differing health practices, preferences and beliefs and are more likely to experience discrimination when accessing health care services, fuelling mistrust and discouraging the use of services. The lack of an intercultural approach to health can affect health care-seeking behaviour, service use, interactions with professionals and treatment adherence *(71)*. A poll in October 2020, conducted by The Undefeated and the Kaiser Family Foundation, found that 70% of African Americans feel they are treated unfairly by the health system, and 55% of African Americans do not trust the health system *(72)*. Studies in the United States, analysing survey responses between 1994 and 2007, found that ethnicity concordance between doctors and patients is associated with higher trust and compliance with care *(73–75)*. Similarly, a qualitative study collected data via unstructured in-depth interviews in 2010 and found that indigenous women in Limpopo, South Africa, prefer traditional birth attendants to hospital midwives due to issues of trust and providers' attitudes to indigenous beliefs *(76)*.

Ndebele Tribe in South Africa.
Two mothers from the Ndebele tribe wait for their sons to start marching and dancing after their initiation ceremony.
UN Photo/Peter Mugubane

iii. **Differential treatment within health systems.** Potentially discriminatory and paternalistic attitudes and the lack of cultural competency among some health care providers can exacerbate health inequities. Racism and conscious and unconscious bias may lead to misdiagnosis and mistreatment of illness. For instance, the subjectivity, variability and uncertainty of clinical symptoms, as well as the discretion of health professionals can interact with implicit bias and discriminatory attitudes to drive unequal treatment *(77)*. The prevalence of implicit bias within the medical profession is at similar levels to that of the wider population *(78)*. Different treatments can be offered to different individual patients, even when clinical considerations are the same, if health professionals make presumptions or expect differential treatment adherence *(79,80)*. For example, under-prescription of pain medications is based on implicit racial bias when health professionals hold false beliefs regarding levels of pain, or weigh subjective testimonies by indigenous peoples or certain ethnic minorities differently to those of other population groups *(81)*.

Unequal treatment can also be intentional discrimination. For example, providers can discount the legitimacy of patients' narratives or deprioritize timely treatment *(82)*. Racism and discriminatory attitudes can also drive unequal treatment. A 2010/2011 cross-sectional survey of 755 Aboriginal Australians in Victoria, Australia, found that nearly one third of respondents experienced racism within health settings *(83)*. In Brazil, the 2013 National Health Survey identified that 10% of the population report experiencing racism and discrimination in health services, with higher rates among the poorest groups, females, indigenous peoples, and persons of African or Asian descent *(84)*.

Differential treatment and discrimination drives poorer health services for indigenous peoples as well as people of African descent, Roma and other ethnic minorities by affecting patient–provider interactions, treatment decisions and treatment adherence.

Differential treatment and discrimination drives poorer health services for indigenous peoples as well as people of African descent, Roma and other ethnic minorities by affecting patient–provider interactions, treatment decisions and treatment adherence *(85)*. Discrimination is associated with lower trust in providers, lower perceived quality of care, reduced satisfaction with care and patient–provider relationships, increased delays in seeking health care, and reduced treatment adherence *(86,87)*. Discriminatory attitudes drive wider system inequities, such as influencing medical students' willingness to work with certain ethnic groups *(77)*.

iv. **Health systems addressing health inequities.** Equity-oriented health systems can reduce the health inequities experienced by persons affected by racial discrimination, including through the approaches described in this brief. Health systems can also provide evidence and advocate for multisectoral action to reduce racial discrimination as a determinant of (ill-) health.

PHC – embedding actions to tackle racial discrimination and health inequities

For each PHC strategic and operational lever, there are multiple potential entry points for tackling racial discrimination and related health inequities. A non-exhaustive sample of these entry points are discussed below, by lever.

Strategic lever 1: Political commitment and leadership

This lever encompasses political commitment and leadership that places PHC at the heart of efforts to achieve universal health coverage and recognizes the broad contribution of PHC to the SDGs *(38)*. Health system leaders and health care professionals can be powerful political forces in driving societal change. Health system leaders can adopt specific policy objectives for addressing health inequities experienced by populations affected by racial discrimination (Box 3). Such measures can include prioritizing intercultural care, addressing specific health inequities, or collecting data by ethnicity and intersecting factors *(88)*. Relatedly, there is also a need to strengthen health leadership and build a strong commitment to PHC-strengthening in geographic areas with higher indices of multidimensional deprivation and where populations experiencing racial discrimination are more likely to live. High-level commitment is vital for mobilizing the health sector and guiding multisectoral actions for health across the wider government *(89)*, and for building cross-sector support for actions to tackle racial discrimination and the intersecting drivers of health inequities *(90)*.

There is also a need to foster PHC reforms based on progressive universalism, so that PHC reforms benefit more disadvantaged, socially excluded subpopulations at least as much as more affluent and advantaged subpopulations *(91)*.

This should be done by articulating the moral imperative and society-wide benefits of reducing inequities. Equity-enhancing approaches alter power balances and can encounter resistance, and political leadership with widespread support is vital *(4)*. In keeping with the findings of the Commission on Social Determinants of Health, policies should enable universal coverage with services, backed by targeted measures for those populations who fall through the cracks of universal systems *(11)*.

It is necessary to ensure that health sector leaders, at all levels, take a stand on xenophobia, racist disinformation, hate speech, stereotyping and discriminatory practices, and ensure that the negative impacts of these on health and well-being are clearly articulated. This raises the profile of the issues of structural racism and discrimination, gives voice to affected communities and strengthens the agenda for change *(32)*. Strong, consistent and visible leadership is key to building sustainable change *(88)*.

Equity-enhancing approaches alter power balances and can encounter resistance, and political leadership with widespread support is vital.

Within this lever, consideration can be given to promoting policies and interventions that recognize and implement an intercultural and intersectoral approach, together with actions on social determinants and to combat racial discrimination *(12)* (Box 4). This makes it necessary to:

- identify regulatory gaps with respect to international human rights standards (strategic lever 2);
- propose policy frameworks that respect, promote and fulfil the right to health and other rights such as the right to birth registration (for example, persons who do not have birth certificates and therefore lack legal identity, and who may disproportionately constitute members of an indigenous population or ethnic minority, may face access barriers to health care facilities, goods and services where identification is a prerequisite);
- favour and promote equity-oriented approaches to service delivery that account for supply- and demand-side barriers;
- provide intercultural health services; and
- enable access to quality health care and services according to the specific needs of people throughout the life course, considering the national and local context.

In addition, it is important to recognize that political and high-level structures themselves must change to include and ensure the participation of diverse actors in decision-making processes, including indigenous peoples as well as people of African descent, Roma and other ethnic minorities. Diverse leadership can improve organizational culture, service performance and patient outcomes *(92)*.

Box 3

A whole-of-government approach to health inequities in New Zealand

Since 2000, New Zealand has undertaken a whole-of-government approach to reducing inequities in health – particularly around the interactions between racial discrimination and socioeconomic inequities. This included collecting data on ethnicity in the health sector, and is supported with protocols on ethnicity enshrining the principles of self-identification and participation, and legislation governing data protection and confidentiality *(93,94)*. It also included the use of small area deprivation measures to boost cross-sectoral action to tackle health inequities, facilitate discussion about the root causes of inequities, increase social participation, and equip agencies to plan programmes and policies to address health inequities *(11)*. In 2019, the Whānau Ora initiative was launched as a cross-government, culturally-grounded, family-based approach to health services and empowering communities *(95)*. As a result of these efforts, New Zealand has made progress in the reduction of ethnic inequities in health in recent decades *(96)*.

New Zealand: Maori Culture
by Steve Evans / CC BY

Box 4

National health plan for people of African descent in Costa Rica

The United Nations Working Group on the Universal Periodic Review for Costa Rica reported, in 2019, the important steps adopted by Costa Rica to improve the quality of life of people of African descent. In 2014, a Presidential Commissioner for issues related to persons of African descent was appointed, with the responsibility of coordinating government action to promote the advancement of people of African descent. Costa Rica has also advanced in the design and implementation of a national health plan for Afro-descendant persons for 2018–2021. The plan aims to improve the quality of life of the Afro-descendant population through intersectoral actions, intercultural health care, promoting revitalization of the culture, and the implementation of interventions in the context of social determinants of health *(97,98)*.

Boys in San Jose, Costa Rica by Mark Zilberman / CC BY

Strategic lever 2: Governance and policy frameworks

Strategic lever 2 covers governance structures, policy frameworks and regulations that support PHC to build partnerships within and across sectors (multisectoral action for health) and promote community leadership and mutual accountability *(38)*. A key step for policy-makers is to strengthen existing – or adopt new – antidiscrimination legislation which aligns with international human rights standards (Box 6). This includes aligning national legislation with the international human right frameworks as applicable to the national context relevant to indigenous peoples as well as people of African descent, Roma and other ethnic minorities, such as:

- the International Convention on the Elimination of All Forms of Racial Discrimination *(99)*;
- the International Labour Organization's Indigenous and Tribal Peoples Convention, 1989 (No. 169) *(100)*;
- the United Nations Declaration on the Rights of Indigenous Peoples *(20)*; and
- the United Nations Declaration on the Rights of Minorities *(101)*.

Specific laws can be focused on antidiscrimination or equality legislation that includes a duty for all public authorities to promote equality *(102)*. Policy frameworks and legislation should be used to explicitly tackle xenophobia, racist disinformation, hate speech and media stereotyping. In particular, such practices are incompatible with countries' obligations under the International Convention on the Elimination of All Forms of Racial Discrimination to ensure equality before the law, to discourage racial divisions and to eliminate practices of racial discrimination by all persons, groups and organizations *(99)*.

Confronting hate speech is crucial for progress across the 2030 Agenda by helping to prevent armed conflict, end violence against women and other violations of human rights, and promote inclusive and just societies *(103)*. The health sector can play an important role by identifying patterns of intersectional hate speech (i.e. hate speech that targets individuals or groups on the basis of more than one identity factor), by promoting mutual respect, social cohesion, inclusion and diversity, and by upholding communication that discredits and deconstructs the narratives on which hate speech is based *(104)*.

Policies are also essential for institutionalizing multisectoral synergies between health and other sectors to address the intersecting and compounding social determinants of health affecting populations experiencing racial discrimination. Multisectoral interventions to improve the social determinants of health can contribute to reductions in health inequities *(105)*, and are key to addressing racism, stigma and racial discrimination due to the complex and interacting root causes that lie outside the direct influence of the health sector. A strong cross-government mandate is essential to build multisectoral action, and policies must foster cross-sector action, build ownership, increase exposure to collaborative opportunities, align policy priorities, harmonize policy-making and facilitate conflict resolution. Vertical and horizontal governance structures can overcome departmental boundaries to establish joint responsibility, while ministries of health have an importance role to play in investing in and facilitating integration, linkages and synergies *(89)*. Legislative frameworks for multisectoral action are important for strengthening and sustaining change *(89)*.

Policy frameworks are key to building respect for and strengthening organizational, social and cultural institutions of indigenous peoples as well as people of African descent, Roma and other ethnic minorities, while supporting their right to participate fully in political, economic, social and cultural life (Box 5). It is also necessary to ensure that the health sector has policies, codes of conduct, guidelines for and enforcement of antidiscrimination measures, as well as functional grievance redress mechanisms**.** These policies and legislative frameworks drive system change and provide the regulatory basis for many entry points within the PHC levers. An enabling policy environment is key to building strong community engagement (strategic lever 4), supporting wider system reform, strengthening primary care services, and adapting models of care to promote interculturality (operational lever 5).

Policies and legislative frameworks drive system change and provide the regulatory basis for many entry points within the PHC levers.

Box 5

Government action to promote the health of indigenous peoples in Canada

For indigenous peoples, harmonizing of national health policies with the United Nations Declaration on the Rights of Indigenous Peoples is essential to building a health system that can address discrimination and health inequities. In 2019, the Government of Canada established the Indigenous Services Canada and Crown-Indigenous Relations and Northern Affairs Canada. Indigenous Services Canada has the specific mandate to "to improve access to high quality services for First Nations, Inuit and Métis" and "to support and empower Indigenous Peoples to independently deliver services and address the socio-economic conditions in their communities" *(106)*.

In June 2021, the United Nations Declaration on the Rights of Indigenous Peoples Act came into force as federal law in Canada. The Act requires that national law be consistent with the United Nations Declaration on the Rights of Indigenous Peoples, and requires taking concrete actions to achieve the objectives and monitor progress of the Declaration. It also includes measures to "address injustices, combat prejudice and eliminate all forms of violence, racism and discrimination against Indigenous peoples" and to promote mutual respect and understanding *(107)*.

Squamish Nation canoe approaching Bella Bella, Canada
International Year of the World's Indigenous People, 1993
UN Photo/John Isaac

Box 6

Promoting the rights and freedoms of people of African descent and indigenous peoples through national legislation in Bolivia

According to the Economic Commission for Latin America and the Caribbean, in 2014 Bolivia had the largest proportion of indigenous persons in its total population of any country in the region: over 60% of Bolivia's 11.5 million population is indigenous (6 million). Bolivia also has one of the most advanced constitutions globally for legally recognizing and protecting indigenous peoples. While many countries recognize the principle of equality in national legalisation, the 2009 Constitution of Bolivia explicitly prohibits discrimination, recognizes the contribution of indigenous peoples and people of African descent as part of the Bolivian Nation, and enshrines the right to self-identification *(108,109)*.

Bolivia by M M / CC BY

Strategic lever 3: Funding and allocation of services

Strategic lever 3 focuses on adequate financing for PHC that is mobilized and allocated to promote equity in access, to provide a platform and incentive environment to enable high-quality care, and to minimize financial hardship *(38)*. Equitable health financing is a vital determinant of wider health system equity. As a priority, policy-makers can ensure equity-oriented budgeting approaches for PHC and health systems strengthening, so that more disadvantaged areas with greater health needs will receive adequate resources. This can include subnational fund distribution formulas that account for local deprivation and needs, and budgets that consider local population mobility and unregistered populations. Budgets matter because they determine how governments mobilize and allocate public resources and are used to shape policies and set priorities *(110)*. In addition, disaggregated and up-to-date data on local health needs, and monitoring gaps in health service access and provision, are essential to inform financing decisions (operational lever 14) and appropriate distribution and allocative mechanisms for targeting resources in relation to need.

Relatedly, financing decisions should incorporate an ethnicity lens to better understand the role of health system financing in tackling inequities (Box 7). This builds on approaches such as "gender budgeting" *(102,111,112)* and is not solely additional funds for different demographic groups but an assessment of the impact of fiscal and monetary measures on different groups, including populations experiencing racial discrimination. Both spending and resourcing should be examined to evaluate the equality impact of policies, in tandem with community engagement (strategic lever 4).

Participatory budgeting can provide voice and an opportunity to influence decisions for marginalized and excluded groups, including those experiencing discrimination.

Key to supporting multisectoral action for health are financing systems that enable joined up financing between health and other sectors. Within health services this can be, for example, jointly with the social sector for multisectoral service points such as "one stop shops" offering support for navigating health and social services *(89)*. More broadly, this can be joint budgets between sectors, such as housing and public health, to deliver targeted action towards improving the social determinants of health. PHC should also advance participatory budgeting approaches where communities can be involved in deciding how budget allocations can best meet community needs. Participatory budgeting can promote education, engagement and empowerment of local citizens, and with enhanced transparency and accountability can help to reduce government inefficiencies and corruption *(113,114)*. Evidence indicates that participatory budgeting can provide voice and an opportunity to influence decisions for marginalized and excluded groups, including those experiencing racism and discrimination *(115,116)*.

Within this lever, policy-makers can consider enacting policies to ensure the appropriate allocation of funds for antidiscrimination mechanisms and the coordination or integration of intercultural health services as applicable to the national context.

Box 7

A "racial equity toolkit: an opportunity to operationalize equity" in the United States of America

A "Racial equity toolkit: an opportunity to operationalize equity" has been developed by the Government Alliance on Race and Equity in the United States, and is one example of integrating equity considerations into decision-making and budgeting *(117)*. The city of Seattle has used a "race equity approach" to examine city policies, projects, initiatives and budget decisions since 2004 (under the "Seattle Race and Social Justice Initiative") and has influenced policies ranging from housing to recreation and health *(118)*.

National Center for Children & Families and African American Health Program by Elvert Barnes / CC BY

Strategic lever 4: Engagement of community and other stakeholders

WHO defines this lever as the engagement of communities and other stakeholders from all sectors to define problems and solutions, and prioritize actions through policy dialogue *(38)*. It is integral to actions tackling racial discrimination. Participation is a social determinant of health and a core principle of a human rights-based approach to ensure effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health *(119)*. Participation in decision-making is important as:

- communities can provide important perspectives on their health needs *(119)*;
- representatives can provide information on how health programmes or policies work in practice and where they can be improved *(119)*;
- biases that favour more advantaged social groups can be reduced *(114)*;
- coordination and coherence of different actors and services can be increased *(114)*; and
- accountability can be strengthened *(114)*.

Community engagement and community-based primary care are important for reducing health inequities *(120)* by helping to reach remote populations and more rapidly expanding service coverage *(121)*. Community engagement interventions are cost-effective and can improve health behaviours, self-efficacy and perceived social support outcomes *(122)*, and can reduce non-health inequalities through human and social capital gains *(122)*.

To achieve strong community engagement, policy-makers can consider fostering social participation and accountability platforms for indigenous peoples as well as people of African descent, Roma and other ethnic minorities experiencing racial discrimination, stigma and exclusion in the design, implementation and evaluation of health plans, programmes and policies. Mechanisms include:

- involving local leadership in the planning and management of activities;
- engaging communities in actions to adapt local services;
- involving women's groups in participatory learning and peer–to–peer education;
- facilitating community participation; and
- establishing long-term partnerships for sustainable systems *(121)*.

It is important to ensure opportunities for meaningful and equitable participation of indigenous peoples as well as people of African descent, Roma and other ethnic minorities in matters that would affect their rights, while respecting their organizational structures and accounting for gender considerations. This is vital for a real engagement with populations that have been historically marginalized and for developing policies and strategies that align with the cultures, needs and preferences of populations experiencing racial discrimination (Box 8) *(123)*.

There is a need to invest in building capacities to ensure equitable opportunities for participation, as called for by the WHO handbook on social participation for universal health coverage, targeting both health professionals not familiar with participatory approaches and also communities experiencing racial discrimination *(124)*. This capacity-building needs to take place both within government and health professional institutions and within populations experiencing discrimination to build technical skills, recognition skills and communication skills *(124)*. Because the process of participation and engagement can reflect wider discriminatory practices in society, it is important to take into account linguistic, geographic, financial, gender and other barriers to participation that may be faced by populations experiencing racial discrimination and intersecting types of disadvantage *(112)*. It is necessary that health sector leaders advocate for and empower health professionals from communities that face racial discrimination to have a fair say and assume leadership positions. This relates to operational lever 6 (workforce), with a range of actions to improve workforce diversity and representativeness.

Box 8

Developing childhood health strategies through engagement with indigenous peoples in Greenland

In 2020, the Government of Greenland (the Naalakkersuisut) adopted the *Inuuneritta III* (the 2020–2030 co-operation strategy for good childhood), in which participation of indigenous Greenlanders was central to the development *(125)*. The indigenous Greenlanders call themselves Kalaallit and are an Inuit people (Inuit meaning "human being") constituting 85% of the population of Greenland *(126)*. The strategy included the development of a social determinants of health framework from the perspective of – and with the collaboration of – Innuit Greenlanders, underpinning cross-sector strategies for child health. *Inuuneritta III* is a multisectoral collaboration between the Department of Social Affairs, Family and Justice, the Department of Health, and the Department of Education, Culture and Church, which aims to address the social determinants of health of Greenlandic children. The strategy is based on the development of new institutional capacities related with higher levels of autonomy and self-governance by the Inuit Greenlanders *(125)*.

Indigenous Women of Uummannaq, Greenland
UN Photo/Mark Garten

Operational lever 5: Models of care

Operational level 5 refers to models of care that promote quality, people-centred primary care and essential public health functions as the core of integrated health services *(38)*. The inverse care law is particularly pertinent to the issue of health inequities affecting populations experiencing racial discrimination, because, as these groups are often more socially disadvantaged, they are more likely to experience lower access to quality health care *(127,128)*, Therefore, to address the inverse care law and as a health equity priority, health systems should be orientated towards high-quality primary care to ensure equitable access across the continuum and levels of care. Quality primary care is defined by the concepts of first-contact accessibility, person-focused continuity, coordination and comprehensiveness *(36,129)*.

A key entry point within this lever is a call to invest in increasing the accessibility of primary care services, especially for indigenous peoples as well as people of African descent, Roma and members of other ethnic minorities with lower levels of access. This is because the accessibility of primary care can contribute to reductions in health inequities *(33–36,130)*, especially through efforts to cover areas and populations with greater health needs *(131,132)*. Deprived areas, which are often disproportionately inhabited by populations experiencing racial discrimination, have greater health needs but are often poorly served *(133)*. Strategies for reducing health workforce inequities and building strong primary care include *(134)*:

- decentralizing health professional training programmes;
- expanding rural health training;
- flexible incentives for professionals (operational lever 6); and
- needs-based allocations of funds and resources (strategic lever 3).

Access to health services can also be improved for populations experiencing racial discrimination through outreach work and community-based services, as these are critical for bridging the gaps between services and socially excluded populations by, for example, building trust *(135)*. This includes trained and motivated community health workers recruited from local communities, who can be vital for reducing health inequities *(136)*.

The health system should promote continuity in primary care and address specific barriers to providing care over time for populations experiencing racial discrimination. Continuity builds patient–provider trust and is associated with health benefits *(137,138)*, particularly for those with chronic conditions and of lower socioeconomic status *(139)*. Often, indigenous peoples as well as people of African descent, Roma and other ethnic minorities face barriers to continuity of care due to language, cultural differences, or socioeconomic and geographical barriers. Actions to address these barriers include:

- strengthening intercultural models of care;
- establishing linkages between health and social care *(140)*;
- ensuring a diverse and representative health care workforce;
- promoting knowledge dialogues to reduce communication barriers;
- strengthening integrated care systems and data sharing platforms *(141–144)*; and
- promoting policies that address key demand-side barriers to health services that are linked to adverse determinants of health (strategic level 2).

Policy-makers can also develop integrated people-centred health services that are tailored to identities, beliefs, preferences and health needs, while being respectful of people's dignity, social circumstances and culture (Box 9). Integrated health services by design enhance equity; they encourage the selection of services based on the holistic needs *(145)*.

An integrated approach requires coordination with and beyond the health sector *(145)*. Primary care's important role in coordinating care pathways can deliver health gains *(146,147)* and is also valuable for facilitating access to other sectors, such as social welfare programmes and community services *(32,148)*. Primary care services also have a role in ensuring appropriate referral to services and support that promote holistic recovery and the well-being of people who are the victims of racism, intolerance and hate speech *(149)*.

It is also necessary to build comprehensive primary care services integrating preventive, curative and rehabilitative care that is based on person-centred approaches (Box 9**.** Comprehensive primary care includes prevention and promotion, education, and early life determinants of health, which are essential for addressing health inequities affecting populations experiencing racial discrimination. Community health workers are key to increasing the comprehensiveness of primary care services in many countries *(136)*. Evidence shows that early life factors are important longer term determinants of health inequities,

for example, in mental health outcomes *(150)*, and that increasing the comprehensiveness of primary care can increase equity in health outcomes *(147)*. Person-centred care also relates to the comprehensiveness of primary care, as it centres the "person" within their wider familial, cultural and social context. Person-centred care improves patient–provider interactions for indigenous peoples as well as people of African descent, Roma and other ethnic minorities *(151)*, reduces the impact of providers' unconscious bias, and can help to identify and address the wider social determinants of health *(152)*.

A vital entry point for PHC to tackle inequities experienced by populations affected by racial discrimination is to strengthen primary care services by incorporating intercultural approaches based on knowledge dialogues between conventional and traditional medicines and practices as a way of achieving people- and community-centred health care *(11)*. Intercultural dialogues entail the sharing of ideas and differences with the intent of developing a deeper understanding of different perspectives and practices, and of bringing health services closer to local users, by conducting horizontal and two-way communication from a standpoint of mutual respect and equality aimed at reaching consensus *(153,154)*.

Cultural competency of health care can be promoted through user engagement (of local communities), commitment of managers, training of health care professionals, and audit and quality improvement approaches *(155)*. These interventions can help to increase access, utilization and quality of health services, as well as to improve patient–provider relationships and health outcomes (such as improved medication use and mental health conditions) *(155)*. Local interventions to improve cultural competency of health care can be effective at driving wider system change and national policies *(155)*.

Person-centred care improves patient–provider interactions for indigenous peoples, as well as people of African descent and other ethnic minorities, reduces the impact of providers' unconscious bias, and can help to identify and address the wider social determinants of health.

Box 9

"Birthing on Country" in Australia

A study from Charles Darwin University, Brisbane, examined intercultural care for First Nations Peoples in Australia, specifically "Birthing on Country" (which refers to an Aboriginal mother giving birth to her child on the lands of ancestors). It outlines how maternity services in Brisbane, Australia, were redesigned in 2013 to provide intercultural care for Aboriginal and Torres Strait Islander families through engagement workshops and co-design. Key components of the redesigned birthing services included:

- First Nations leadership and involvement in the steering committee;
- community-based midwifery groups providing continuous care from early pregnancy to 6 weeks post-birth;
- education and training of First Nations health care workforce;
- cultural training of frontline staff;
- holistic wraparound services focused on connecting and interacting with others and Elders through community drop-in days and cultural activities; and
- coordinated care practices from a dedicated community-based service manager.

The study also reported on a trial involving 1422 mothers of First Nations babies, between 2013 and 2019, which found intercultural care through service redesign led to increased antenatal care, reduced pre-term births and increased breastfeeding *(156)*.

Aboriginal couple walking in evening light - Darwin by fvanrenterghem / CC BY

Box 10

Box 10. Intercultural health in Suriname

A 2017 report of the Inter-American Development Bank highlighted a case-study in the southern area of Suriname related to intercultural care for indigenous peoples, where clinics for both conventional medical care and traditional indigenous medicine operate. Within the clinics, there is space for several healers to practice traditional medicine, and shamans, physicians and staff of nongovernmental organizations to lead workshops to raise awareness among health professionals about traditional health practices, important medicinal plants, and indigenous concepts of health and illness. The workshops also train traditional healers on basic primary care and preventive health. As a result, both primary care workers and shamans have altered their practices. Depending on the diagnosis and type of treatment required, referrals are routinely made between the two clinics. With the goal of preventing the disappearance of traditional knowledge, the Shamans and Apprentices programme encourages young apprentices to learn from the elder shamans and to preserve the knowledge of medicines from the Amazon rainforest. Apprentices are also trained to complete record forms that document conditions and treatments utilized for each patient at the traditional medical clinics *(157)*.

Suriname by Virgil Kapel, Pan American Health Organization PAHO / CC BY

Operational lever 6: PHC workforce

WHO defines this lever as adequate quantity, competency levels and distribution of a committed multidisciplinary PHC workforce that includes facility-based, outreach and community-based health workers supported through effective management supervision and appropriate compensation *(38)*.

To make steps towards addressing discrimination and racism within health services, inappropriate clinical practices and knowledge that are based on paternalistic, discriminatory, racist or colonial thinking should be identified and addressed. Addressing this issue can be done through PHC-oriented research and participatory research methods involving persons experiencing racial discrimination. Such research could be around prescribing practices or treatment regimes based on false biological beliefs *(79,80)*.

Unconscious bias, stereotypes and prejudice can be targeted through workforce training on culturally competent care, self-reflection, privilege and clinical decision-making.

Relatedly, another key entry point for this lever is investing in and delivering anti-racism, antidiscrimination and cultural competency training for health professionals. Unconscious bias, stereotypes and prejudice can be targeted through workforce training on culturally appropriate care, self-reflection, privilege and clinical decision-making *(88)*.

Interventions to improve cultural competency can improve the knowledge, skills and attitudes of providers, increase health care access and utilization for populations experiencing racial discrimination, and in some settings improve patient outcomes (such as diabetes control and user satisfaction) *(158)*. Measures to improve intercultural care include:

- increased representation of indigenous peoples as well as people of African descent, Roma and other ethnic minorities in the health workforce;
- training of health professionals on providing intercultural care;
- culturally-tailored health programmes for patients and local populations;
- interpreter presence and provision of multilingual services;
- peer education;
- patient navigators; and
- exchange programmes *(158)*.

In addition to expanding the cultural competencies of existing staff, policy-makers can consider expanding the PHC workforce to include professionals specifically focused on intercultural care. Intercultural mediators can serve to improve communication and understanding between patients and health care professionals by reducing linguistic and sociocultural differences *(70)*. Quality primary care services should also be team-based and thus better equipped to promote coordinated action to address discrimination-related health inequities and the multiple and intersecting factors of discrimination, such as adverse gender norms, religion, disability, socioeconomic status and migration status. Team-based primary care is associated with improved patient satisfaction and health outcomes (for conditions such diabetes, depression and dementia), as well as higher provider satisfaction and retention *(159)*.

Policy-makers can encourage medical schools to increase diversity and representativeness of indigenous peoples as well as people of African descent, Roma and other ethnic minorities, as applicable in the national context. This is relevant for the training of the full spectrum of health care professionals and should be backed by efforts to support educational institutions with related legal and policy frameworks (Box 11). It is vital that the health care workforce reflects the diversity of the populations they serve, thereby increasing the provision of more culturally appropriate care and empowering the communities that these health professionals represent. Policy-makers can recruit, retain and elevate clinicians from these communities, taking into account their lived experience, more extensive knowledge of the community health assets and barriers to health services, and connections with the community. Health care professionals can be actively engaged in developing solutions and advocating for cross-sectoral change.

Relatedly, health systems need to reduce barriers to promotion and ensure training of medical professionals from ethnic and racial groups experiencing discrimination to ensure representativeness across the hierarchy of seniority (Box 11). These medical professionals are more likely to serve in the underserved communities they represent and clinical care can be improved when there is ethnic concordance between patients and providers *(160)*. Indigenous peoples as well as people of African descent, Roma and other ethnic minorities are often under-represented in medical schools *(161,162)*; however, in many countries, data on ethnicity in medical schools and the health workforce are not collected *(134)*. Actions for increasing medical school diversity include *(163)*:

- investing in and expanding institutions with good track records of recruiting ethnic minorities;
- offering outreach programmes and “gateway” courses;
- changing admission interviews to reduce unfair advantages from coaching; and
- reserving specific places (for example, for local indigenous applicants).

Another entry point within this lever is to introduce and/or strengthen curricula of medical schools, educational institutions and in-service training on the topics of intercultural health, discrimination-related health inequities, racism and exclusion, and the role of health services in exacerbating and alleviating these inequities (Boxes 11 and 16). It is necessary to acknowledge the inequitable and often discriminatory practices in medical education that drive poorer quality care for populations experiencing racial discrimination. Medical curricula must teach that health inequities affecting populations experiencing racial discrimination are a consequence of structural racism and discrimination, and should aim to expose and address pre-existing implicit racial biases *(164,165)*. Medical education must also foster and institutionalize intercultural approaches to health care *(8)* from the start of a medical career *(166)*. Education based on structural competency and cultural humility can encourage long-term commitments to self-reflection and addressing of racial and ethnic power imbalances *(30)*.

Box 11

Decolonizing medical education in Northern Ontario, Canada

Since 2003, the Northern Ontario School of Medicine has provided examples of decolonizing medical education, with a focus on community engagement (strategic lever 4) with local indigenous peoples. In addition to reserved places for indigenous applicants, the course includes modules on indigenous health as part of the core curriculum *(167)*. All medical students undertake a one-month residency programme living and working in indigenous communities, and there is an option for specialization in indigenous health. Remote learning approaches are in place, which can be important for students from indigenous backgrounds. Lastly, a wide range of peripheral activities are promoted through the medical school related to advocacy and public health of indigenous communities, including knowledge-sharing circles, cultural interest groups, and networking and mentorship schemes *(168)*.

Two members of the Quileute Nation displaying the intricate patterns of their button blankets, during the Qatuwas Festival of the indigenous nations of the Pacific Rim.
Bella Bella, Canada
International Year of the World's Indigenous People, 1993
UN Photo/John Isaac

Operational lever 7: Physical infrastructure

Operational lever 7 focuses on ensuring secure and accessible health facilities that can provide effective services with reliable water, sanitation and waste disposal/recycling, telecommunications and power, as well as transport systems *(38)*. Inequities in effective health service coverage of indigenous peoples as well as people of African descent, Roma and other ethnic minorities can stem from inadequate or limited health facilities, as many live in areas which are historically underserved, remote or lacking other essential services.

In tandem with financing actions (strategic lever 3), models of care (operational lever 5) and workforce investments (operational lever 6), policy-makers can install equity-enhancing resource allocation systems that address historical underinvestment in areas disproportionately inhabited by indigenous peoples as well as people of African descent, Roma and other ethnic minorities. This can contribute to addressing the systemic inequities that continue to perpetuate health inequities.

Relatedly, it is essential to provide flexible, locally tailored and culturally appropriate health care facilities that align with the needs and preferences of local communities. This can include the adaption of physical infrastructure, for example, to local geographies to reduce barriers to accessing care (Box 10). In addition, for populations that are nomadic, mobile or live in specific geographical areas (for example, remote islands or river systems) appropriate service adaptations are required, i.e., mobile health clinics, boat clinics, and so on.

Box 12

Floating PHC units in Brazil

A review article from 2019 outlines how PHC is being adapted in Brazil to meet the needs of populations living near or on major river systems – particularly indigenous peoples. The River PHC Units are boats that include River Family Health Teams, and necessary furniture and equipment to serve the riverside populations in the Brazilian Amazon and Pantanal. They seek to respond to the specificities of these regions, ensuring care for indigenous peoples, *quilombolas* and ethnic minorities engaged with fishing, forestry and coconut breaking. River PHC Units must include at least a medical, dental and nursing office, a room for storing and dispensing of medicines, a laboratory, vaccination room, bathrooms, cabins with enough beds for the entire team of health professionals, a kitchen and a procedure room *(169)*.

Children in the window of their home
The Dos Santos children in the window of their home in Rio Canoas in the Amazon region of Brazil, near Manaus. The houses are built on tilts and many dry foodstuffs by hanging them in the structure. Brazil.
Julio Pantoja / World Bank / CC BY

Operational lever 8: Medicines and other health products

WHO defines this lever as the availability and affordability of appropriate, safe, effective, high-quality medicines and other health products through transparent processes to improve health *(38)*. Policy-makers, clinicians and technology producers need to critically evaluate current and future medicines and medical devices for the influence of conscious and unconscious racial or ethnic bias. For instance, the adjustment of medical instruments and devices based on ethnicity (for example, estimated glomerular filtration rates and pulmonary lung function tests) can inappropriately affect treatment outcomes, and should be replaced with more precise analytics *(164)*.

Policy-makers can also tackle, through regulation, the affordability of health care products where the costs can disproportionately affect populations experiencing racial discrimination**.** These actions include controlling price speculation from pharmaceutical companies.

Improving equitable access to safe, quality and effective traditional and complementary medicine can potentially meet communities' needs and build sustainable and culturally sensitive health services *(170).* Traditional and complementary medicine contributes to empowering people and communities and provides important modalities for prevention, promotion, treatment, rehabilitation and palliation in primary care *(170)*. It is important to promote recognition, respect and protection of – and coordination with – knowledge-based traditional, ancestral and complementary medicines in national health systems (Box 13). This can support disease prevention or treatment, health maintenance and health promotion, in line with patient choices and expectations *(170)*.

Box 13

Traditional and complementary medicine in Congo

The *WHO global report on traditional and complementary medicine 2019* reports on Congo's national policy dedicated to traditional and complementary medicine (Politique Nationale de Médecine Traditionnelle), which was launched in 2006. Indigenous traditional medicine is considered important in the country and is used by over 80% of the population. The Government officially recognizes traditional and complementary medicine education including apprenticeships, certified programmes and training programmes for providers. In 2006, there were 2084 indigenous traditional and complementary medicine providers in Congo *(171)*.

Onchocerciasis Prevention and Control - Congo 2019
© WHO

Operational lever 9: Engagement with private sector providers

Operational lever 9 refers to sound partnership between the public and private sectors for the delivery of integrated health services *(38)*. Private providers are important components of the health system and are particularly important in places where the public system is weaker, such as in rural or remote areas where often indigenous peoples, as well as people of African descent, Roma and other ethnic minorities live.

The strategy report of the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage notes that private sector actors can be successfully engaged in health service delivery. In Mexico, for example, pharmacy chains have helped to increase access to high-quality generics through affordable prices, while in Thailand there is strong integration of public and private primary and in-patient care *(172)*.

However, in many health systems, the private sector is poorly regulated. A key entry point under this lever is to ensure that private sector providers uphold practices relating to non-discrimination and conform with human rights standards when providing health care, through regulation, enforcement and stewardship of the private system *(173)*.

Regulation, legislation, monitoring and accountability systems are essential tools for policy-makers, as are appropriate systems for investigating and redressing discriminatory practices.

Regulation, legislation, monitoring and accountability systems are essential tools for policy-makers, as are appropriate systems for investigating and redressing discriminatory practices. Evidence suggests it is important to regulate to reduce the impacts of private industry on the wider social determinants of health that underpin discrimination-related health inequities. This includes, for example, recognizing indigenous peoples' right to lands, territories and resources in accordance with international law. It includes regulating extractive and manufacturing industries which may indirectly infringe upon the right to health by polluting water, air and soil in areas disproportionately inhabited by indigenous peoples and other ethnic minorities experiencing social exclusion. It can also be the targeting of advertisements for unhealthy products, such as for tobacco *(174)* or junk food *(175)*, to populations of lower socioeconomic status or to racial and ethnic groups experiencing higher rates of deprivation and poor health.

Operational lever 10: Purchasing and payment systems

Operational lever 10 covers purchasing and payment systems that foster a reorientation in models of care for the delivery of integrated health services with primary care and public health at the core. Purchasing and payment systems are underused levers to reduce disparities and they offer opportunities to advance equity in multiple ways *(176)*; there is a growing call to use these systems more effectively to enhance equity *(177)*. One entry point under this lever is building strategic purchasing and contracting mechanisms that are equity-enhancing, such as contracting with local, minority-owned service providers *(178)*. It also includes leveraging new service delivery platforms (such as community health workers) or including supplemental benefits (such as food, structural home modifications and transportation) to address social drivers to inequities in health *(177)*. This can contribute to addressing inequities created by historical disinvestment through strengthening community and business partnerships and by creating jobs and incomes. Equity-enhancing purchasing and payment systems also include allocation and distribution mechanisms that account for population deprivation and health needs *(179)*, allowing providers that cover populations with greater health needs (such as those experiencing racial discrimination) to receive additional resources. This can include both risk adjusting quality measures for social factors at the patient level and area- and community-based adjustment criteria *(177, 180)*.

Policy-makers can also harness payment systems to incentivize actions to reduce health inequities *(181)* (Box 12). Bundled or global payment mechanisms with targets and pay-for-performance (P4P) can incentivize actions to reduce inequity *(182)*, and evidence demonstrates that some carefully devised P4P mechanisms can reduce health inequities *(183)*. Incentives can explicitly focus on equity by adjusting payments to account for deprivation and risk, and by rewarding providers that reduce inequities or introduce effective interventions for tackling inequities *(176)*. Fee-for-service models limit the ability of providers to address the factors outside of health services that affect health *(176)*, and sustained and flexible funding is key for successful multisectoral approaches *(89)*.

Lastly, there is the option to incentivize active rather than passive community engagement with populations experiencing racial discrimination through purchasing and payment systems**.** This can include mandating the engagement as part of financing requirements and providing funds to facilitate activities.

Incentives can explicitly focus on equity by adjusting payments to account for deprivation and risk, and by rewarding providers that reduce inequities or introduce effective interventions for tackling inequities.

Box 14

Improving health care services for tribal populations in India

India is home to over 104 million indigenous tribal peoples whose health indicators lag behind the national average. A 2013 review article examined India's health systems provision for tribal populations, highlighting the Government of India's national framework and roadmap to improve health services for tribal peoples. Local health system reform has focused on tribal health and wellness centres and new governance arrangements. Health services recruit local staff from tribal areas, there has been expanded training of staff, and traditional healers have been incorporated into the services. This reform has been facilitated by new financing mechanisms including flexible recruitment and contracting mechanisms, encouraging public–private partnerships, and funding corporate social responsibility activities *(184)*.

Tribal Woman by Praveen Rao Kaliga / UN Women Asia and the Pacific / CC BY

Operational lever 11: Digital technologies for health

Operational lever 11 covers the use of digital technologies for health in ways that facilitate access to care and service delivery, improve effectiveness and efficiency, and promote accountability *(38)*. On the patient side, policy-makers should consider investing in accessible and universal digital technology platforms that can contribute to reducing health inequities. Technology can reproduce or exacerbate existing social inequities if cost, connectivity or digital literacy barriers exist and benefits are disproportionately accrued by healthy, affluent early adopters *(185)*. However, reducing barriers to accessing and using technologies can reduce inequities by increasing access to health care, fostering accountability, and promoting health literacy and healthy behaviours *(186)*. Routine health data, disaggregated by ethicality, can be harnessed using digital technologies to highlight service deficiencies and inequities. However, it is vital to ensure data protection legislation and protocols are in place to guard against human rights abuses and possible misuse of data. These include legal provisions covering data confidentiality, the preferential use of sample surveys instead of full count (census) data-gathering, and the grouping of published responses and data to prevent identification of individuals *(155)*.

Health systems can employ telemedicine as an important tool for reducing access barriers to health care (Box 15). Many indigenous peoples as well as people of African descent, Roma and other ethnic minorities live in remote areas and telemedicine can be important for expanding access, coordination and continuity of care. Telemedicine programmes must be culturally tailored, properly financed and resourced, and facilitated by trained health professionals – and roll out must be supported by improving connectivity and users' digital literacy *(187)*. For health care professionals, digital technologies can be used to overcome the lack of cultural competence of health professionals and low health service provision that could affect people of African descent, Roma and other ethnic minorities, as well as indigenous peoples.

Reducing barriers to accessing and using technologies can reduce inequities by increasing access to health care, fostering accountability, and promoting health literacy and healthy behaviours.

Box 15

Telemedicine through TulaSalud in Guatemala

The TulaSalud initiative in Guatemala aims to reduce maternal and child mortality and improve health services for Guatemala's rural and indigenous populations by focusing on interculturalism, a gender approach, and the use of information and communication technologies. At the centre of the service are 195 community health workers, known as *tele-facilitadores*, who serve over 600 communities in 10 health districts in Alta Verapaz. These health workers come from the local communities and speak local languages. Each community health worker has a cell phone with internet access, basic medical-surgical equipment, and emergency medicines to respond to health problems in local communities. They also coordinate referral and transfer to emergency, secondary and tertiary services, and keep detailed records (via an app) about the health of local populations *(188)*.

A Young Guatemalan Girl Gets Weighed
by Tory Taylor / USAID / CC BY

Operational lever 12: Systems for improving the quality of care

WHO defines this lever of the PHC framework as systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health care services *(38)*. Quality health care is effective, safe, people-centred, timely, efficient, equitable and integrated *(189)*. However, indigenous peoples as well as people of African descent, Roma and other ethnic minorities often receive lower quality care than other populations and may have differing needs that require specific consideration.

A national quality policy and strategy can systematize and strengthen efforts to improve quality of care *(189)*. Given equity is a key dimension of quality, policy-makers can use a national quality policy and strategy as an entry point for strategic dialogue on the role of the health system in addressing health inequities. Orientation of services around the needs, preferences and engagement of all populations, accounting for ethnic considerations, is an important step to institutionalize inclusive quality of care *(189)*. Key elements of national policies can be strengthened to specifically consider health inequities of populations affected by racial discrimination. Another entry point is to make addressing the health inequities experienced by indigenous peoples, as well as people of African descent, Roma and other ethnic minorities, one of the goals and priorities of national quality policies and strategies (Box 14).

The local definitions of quality should explicitly incorporate the perspectives of indigenous peoples as well as people of African descent, Roma and other ethnic minorities into local definitions of quality**.** Within the context of inequities affecting populations experiencing racial discrimination,

Orientation of services around the needs, preferences and engagement of all populations, accounting for ethnic considerations, is an important step to institutionalize inclusive quality of care.

these definitions of quality must understand inequities in quality of care and differing patients' experiences *(189)*. Delivering quality reforms that are inclusive of populations experiencing racial discrimination requires that the clinical and managerial teams responsible for implementation reflect inclusivity and a commitment to reducing inequity in their own approach and values.

There are multiple quality improvement mechanisms that can shape health services, and there is a need to expand such mechanisms to specifically target inequities in health care quality for populations affected by racial discrimination**.** Where countries have developed a national quality policy and strategy, there will often be a defined set of quality interventions *(186)*. Many of these interventions can be examined and refined through a health equity lens. Actions to improve quality of care in relation to racial discrimination can be, for example:

- establishing standards and targets for health care quality that include health inequities of populations affected by racial discrimination;
- incorporating intercultural care as part of professional accreditation; and
- utilizing point-of-care quality improvement capacities to identify variations in care and develop local solutions *(189)*.

Box 16

Improving quality of maternal care for indigenous peoples in Colombia

In northern Colombia, an interagency strategy to reduce maternal and neonatal mortality of Wayúu and Arhauco peoples has focused on improving the quality of maternal care. Actions include training in maternal nutrition for traditional practitioners and health teams, and guidelines on adapting sociocultural services and maternal and perinatal care during the COVID-19 pandemic. Health workers have been trained to respect indigenous practices and customs, for example, allowing mothers to be accompanied during the birth and using certain traditional medicines. Nurses, midwives and community workers from local indigenous communities have been recruited and trained, which has promoted trust as they speak local languages and understand indigenous belief systems. Actions to address ethnicity-based health inequities are being supported by digital tools on disaggregated tracer indicators for health and maternal and perinatal care *(190)*.

Colombia
by Pan American Health Organization PAHO / CC BY

Operational lever 13: PHC-oriented research

Operational lever 13 covers research and knowledge management, including dissemination of lessons learned, as well as the use of knowledge to accelerate the scale-up of successful strategies to strengthen PHC-oriented systems *(38)*. PHC research on health inequities of populations affected by racial discrimination is infrequently carried out. It is the responsibility of policy-makers, research funders, research institutions and civil society to foster systems that promote and value such research.

Firstly, it is necessary to promote participatory research on the health of indigenous peoples as well as people of African descent, Roma and other ethnic minorities (Box 17)**.** Participatory research implies that the research process, the goals, objectives, methods, analysis, interpretation and dissemination should be collaborative and be agreed between the researchers and the local population *(124,191–194)*. A lack of participation in research can negatively affect populations experiencing racial discrimination, and also advance situations of repression, colonial control and scapegoating *(192,195)*. It is crucial that an ethical research approach is based on consultation, strong community participation, and methods that acknowledge the diverse ways of learning and teaching ("ways of knowing") of indigenous peoples as well as people of African descent, Roma and other ethnic minorities *(123,195)*. Additionally, consideration should be given to intersecting forms of disadvantage, for example, by ensuring the participation of women belonging to populations facing racial discrimination and promoting their empowerment in research (Box 18) *(196)*. Participatory research must also align with data protection standards and confidentiality, ensure adequate informed consent, and limit access to the data to avoid misuse *(195)*.

Participatory research implies that the process, the goals, objectives, methods, analysis, interpretation and dissemination of research should be collaborative and be agreed between the researchers and the local population.

Health system actors, civil society, governments and local communities can all contribute to promoting this research. Research should include documenting and evaluating effective interventions that can tackle underlying determinants of health inequities, barriers to accessing high-quality primary care, and service-based discrimination. This knowledge is key for informing ongoing health systems strengthening efforts *(56)*, and it is important the research is conducted with the participation of the communities it affects *(194)*.

Key to building the evidence base is expanding research funding and investing in flexible research approaches to trial new interventions to address racial discrimination and the health inequities affecting populations experiencing such discrimination. This permits implementors to adapt interventions during roll-out to meet changing needs and emerging evidence on effectiveness. In the longer term, the research community can work towards creating repositories of "promising practices" and case-studies relating to interventions addressing health inequities affecting populations experiencing racial discrimination. These case-studies could identify which policy, governance or financing arrangements facilitated the success of certain interventions, and which posed barriers.

Lastly, efforts should be made to prioritize health equity in health research. Funders of research should encourage the prioritization of health equity and intersectional approaches that assess people's capacities and deprivation across multiple intersecting dimensions, as well as measures for redress *(197)*.

Box 17

Reflecting on community-based participatory research in Ghana

A commentary reflecting on the process of conducting community-based participatory research in Ghana (between 2015 and 2017) noted key ethic-cultural issues when using this research approach. According to the study, it is necessary to build relationships and trust, promote confidentiality, ensure informed consent, and respect cultural values and practices to safeguard the integrity of the research. Additionally, measures were implemented to reduce barriers to participation, including designing intervention sessions to be practicable, interactive and delivered in the native language of participants *(198)*.

Traditional Medicine and Universal Health Coverage (UHC) Ghana
WHO / Ernest Ankomah

Box 18

Global network for indigenous women's participatory research

The Foro Internacional de Mujeres Indigenas (International Indigenous Women's Forum) is a global network that enables indigenous women's organizations from around the world to strengthen capacities and develop leadership skills, and to ensure the participation of women in research and decision-making processes. One example of their work is the Indigenous Women's Observatory against Violence, developed in 2010, which is a mechanism to monitor and shed light on the situation of violence against indigenous women, as a response to the lack of relevant data and information. It also aims to ensure a participatory and interactive approach for research studies and documentation of cases at the local level *(199)*.

Guatemala - Rural Women Diversify Incomes and Build Resilience by UN Women / CC BY

Operational lever 14: Monitoring and evaluation

Operational lever 14 covers monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors *(38)*. Understanding of the scale of challenges faced by the health system, including health inequities, and strengthening health systems accordingly requires reliable, detailed and up-to-date data. However, in many countries, health data are rarely disaggregated by ethnicity.

To build a foundation for addressing health inequities affecting populations experiencing racial discrimination, it is necessary to invest in routine data collection systems that permit self-identification and facilitate the collection of data disaggregated by ethnicity and other equity stratifiers. These data are key to informing goals and objectives of interventions to reduce discrimination and racism, and also drive system improvements and foster accountability. For example, allocation formulas for resourcing and processes for local adaptations of services rely on these data *(200)*. All data collection processes must be in line with a human rights-based approach to data, where the data should not be identifiable and robust data protection mechanisms and procedures are in place *(201)*. Legislation and protocols are key to supporting this process (strategic lever 2; operational lever 11) *(155)*.

High-quality data are necessary for research and for promoting system accountability to support other actions to tackle inequities affecting populations experiencing racial discrimination (strategic lever 4; operational lever 13). Access to data, in line with confidentiality and safeguarding processes, should be provided for independent research and monitoring of the health system, public policies and society in relation to health inequities affecting peoples experiencing racial discrimination. Policy-makers can consider utilizing digital technologies (operational lever 11) to deliver open, accessible and transparent platforms for data on health inequities to raise awareness and promote accountability within the health system, and to engage and equip communities to demand change (strategic lever 4). This could be documenting, in different local contexts, the health service access and quality gaps. Relatedly, there is a need to ensure that data monitoring and evaluation activities integrate approaches that respect local cultures and are devised with community support. This includes co-developing data collection processes and the types of data collected with local communities. This can improve understanding of how different groups self-identify and which processes are important (to beneficiary communities) and should be measured.

Understanding of the scale of challenges faced by the health system, including health inequities, and strengthening health systems accordingly requires reliable, detailed and up-to-date data. However, in many countries, health data are rarely disaggregated by ethnicity.

Monitoring processes should be applied to multisectoral actions for health, and there is an option to measure the extent to which synergistic and cross-sectoral approaches to addressing health inequities of populations affected by racial discrimination occur *(176)*. For example, measuring the extent to which health care providers connect patients to social and wider services in communities *(176)*. There is also the opportunity to expand monitoring and evaluation of health services by measuring the cultural competency of providers and the extent of intercultural services as part of health care quality metrics *(202)*. Better measurement can identify quality gaps and be used to identify areas for improvement *(203)*.

Lastly, health care services can play an important role in tackling racism and racial discrimination by identifying the early signs of (repeat) victimization through sub-criminal incidents *(149)*. This role can be strengthened by investing in the monitoring and safeguarding roles of health services and by promoting cross-sectoral dialogue (such as with policing or social welfare sectors).

Box 19

The EU's 2020–2030 Roma strategic framework for equality, inclusion and participation

The European Commission strategy *A union of equality: EU Roma strategic framework for equality, inclusion and participation* states that many of the 10–12 million Roma peoples in the European continent (2012 estimates) continue to face discrimination. The strategy focuses on diversity among Roma to ensure national strategies meet the needs of different groups, such as Roma women, youth, children, EU mobile citizens, stateless, and older Roma, as well as those living with disabilities. The strategy encourages an intersectional approach, considering how different aspects of identity can combine to exacerbate discrimination. It also includes a measurement framework with objectives and indicators that map to the SDGs. These include measuring health care access for Roma peoples and differences in health outcomes between Roma and non-Roma populations *(204)*.

A large Roma family, matriarch with her daughters, daughter-in-laws and grandchildren
WHO / Malin Bring

Box 20

Research, monitoring and strategics to address inequalities in COVID-19 transmission and vaccination uptake in England

The Government of the United Kingdom's final report on progress to address COVID-19 health inequalities, published in December 2021, examined why COVID-19 was having a disproportionate impact on ethnic minorities in the country, and planned improvements to the government response. Research collaborations involving universities, multiple government departments and the Office for National Statistics identified risk factors for COVID-19 transmission (including occupation, multigenerational households, poor air quality and deprivation), leading to specific actions to protect ethnic minorities (for example, guidance on infections in multigenerational households) and to reduce barriers to vaccine uptake. Such actions included building trust with ethnic minorities by including them in COVID-19 research, as well as ethnic minority government ministers taking part in vaccine trials. Targeted interventions included:

- using places of worship as vaccination centres;
- providing vaccination buses and taxis to pop-up venues in local communities;
- targeted campaigns to address vaccine concerns and promote uptake;
- collaborating with faith leaders and prominent ethnic minority celebrities and influencers to build trust and encourage vaccination uptake;
- tackling vaccine misinformation on social media channels with myth-busting content and targeted approaches *(205)*.

The United Kingdom: COVID-19 vaccination
WHO / Blink Media – Chiara Luxardo

Conclusion

Health inequities affecting populations experiencing racial discrimination are significant and remain pervasive across many countries. They are driven by interactions between the wider social determinants of health and structural racism and discrimination in society. The evidence presented in this rapid review identifies that health systems, being one of the basic social institutions, have a vital role to play in reducing health inequities affecting populations experiencing racial discrimination. Without specific and targeted actions that address the fundamental causes of health inequities, health systems can perpetuate and exacerbate inequities by reinforcing structural racism and discrimination. On the other hand, health systems can play a central role for mobilizing or reforming societies to tackle health inequities.

Without specific and targeted actions that address the fundamental causes of health inequities, health systems can perpetuate and exacerbate inequities by reinforcing structural racism and discrimination. On the other hand, health systems can play a central role for mobilizing or reforming societies to tackle health inequities.

PHC is an ideal platform for integrating actions to address health inequities experienced by populations facing racial discrimination and driving health system change. It is well positioned to do this because:

- PHC is an agenda for societal change;
- PHC is part of the SDG agenda and the commitment to leaving no one behind;
- PHC has an explicit focus on tackling inequities and the root causes of inequity;
- PHC includes far-reaching actions to address the wider social determinants of health;
- PHC encompasses high-quality, accessible health care services; and
- PHC engages and empowers local communities.

PHC is a "whole of society" and "whole of government" approach to health and well-being, which is essential to addressing the health inequities of populations affected by racial discrimination – limited and standalone interventions will not be sufficient to deliver change. Addressing inequities in health has synergies with and spillover effects into other sectors.

This rapid review has identified key evidence, but sizeable research gaps remain. Health policy and systems research relating to people of African descent, Roma and other ethnic minorities, as well as indigenous peoples, is substantially lacking in many domains. This is underpinned by limited collection of data disaggregated by perceived race and/or ethnicity in many countries. To fill key gaps, future research may include:

- strengthened conceptualization at the global level of the issue of racial discrimination in relation to health, building on existing frameworks and literature across countries, and working to align different perspectives and build census across disciplines;
- continued demographic, epidemiological and health systems studies examining inequities across groups experiencing racial discrimination;

- expanded understanding of the health needs, preferences, cultural beliefs and worldviews of different populations experiencing racial discrimination;
- improved knowledge on the multiple and intersecting factors that can drive discrimination (such as adverse gender norms, religion, disability, socioeconomic status and migration status) and that interact with racial discrimination, and the associated health impacts;
- continued studies on the impact of interventions aiming to tackle racial discrimination both within the health system and health-related sectors;
- strengthening a health equity lens across the range of health-related research, including health policy and systems research *(206,207)* and implementation research *(208)*;
- global syntheses of evidence and best practices relating to health inequities affecting populations experiencing racial discrimination, with efforts to identify barriers to success in specific contexts.

At the global level, political, intergovernmental and civil society efforts are needed to build support for actions to address racial discrimination in relation to health and its determinants, across sectors, including:

- continued strengthening of the role of the United Nations Network on Racial Discrimination and Protection of Minorities, and advancing cooperation and collaboration across the United Nations to support country efforts and activities to tackle racial discrimination and advance the protection of minorities *(209)*;
- aligned efforts to address racial discrimination and strengthen the protection of minorities under the umbrella of the Secretary General's Call for Action for Human_Rights, which identifies seven thematic areas including human rights at the core of sustainable development, rights in times of crisis, gender equality and women's empowerment, and public participation and civic space *(210)*;
- continued support of international platforms for strengthening research on indigenous peoples as well as people of African descent, Roma and other ethnic minorities; one example is The Lancet's Group for Racial Equality (GRacE), which aims to advance racial and ethnic equality by examining its own publishing practices, editorial policies and workforce, as well as promoting research on these populations *(211, 212)*.

The 2030 Agenda for Sustainable Development is underpinned by the universal principle of "leaving no one behind" – a value at the heart of PHC. The COVID-19 pandemic and increased attention to racial discrimination-related inequity globally have demonstrated that many people are still "far behind" and are at risk of being "left behind". Racism and discrimination, including within the health system, are direct antagonists to the leaving no one behind agenda. Emphasizing and strengthening PHC offers the opportunity for system change to fundamentally tackle health inequities by addressing racial discrimination and promoting an intercultural approach to health, as articulated in the Declaration of Alma-Ata – to deliver Health for All "in the spirit of social justice".

References

1. United Nations. Sustainable Development Goals (SDGs) [website]. New York, NY: United Nations; 2018 (https://sustainabledevelopment.un.org/sdgs, accessed 8 January 2022).
2. Hone T, Macinko J, Millett C. Revisiting Alma-Ata: what is the role of primary health care in achieving the Sustainable Development Goals? Lancet. 2018;392(10156):1461–72. doi:10.1016/S0140-6736(18)31829-4.
3. WHO and UNICEF. A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/328065, accessed 18 June 20210.
4. World social report 2020: inequality in a rapidly changing world. New York, NY: United Nations Department of Economic and Social Affairs; 2020 (https://www.un.org/development/desa/dspd/world-social-report/2020-2.html, accessed 30 June 2021).
5. Promoting inclusion through social protection: report on the world social situation 2018. New York, NY: United Nations Department of Economic and Social Affairs; 2018 (https://www.un.org/development/desa/dspd/wp-content/uploads/sites/22/2018/07/1-1.pdf, accessed 8 November 2021).
6. International Day of the World's Indigenous Peoples. Leaving no one behind: indigenous peoples and the call for a new social contract [website]. New York, NY: United Nations; 2021 (https://www.un.org/en/observances/indigenous-day, accessed 5 February 2022).
7. People of African descent [fact sheet]. Geneva: Office of the United Nations High Commissioner for Human Rights; 2015 (https://www.ohchr.org/Documents/Issues/Racism/PAD.pdf, accessed 9 September 2021).
8. State of the world's indigenous peoples: indigenous peoples' access to health services. New York, NY: United Nations Department of Economic and Social Affairs; 2018 (https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/03/The-State-of-The-Worlds-Indigenous-Peoples-WEB.pdf, accessed 8 September 2021).
9. Report of the Special Rapporteur on minority issues, Rita Izsák: comprehensive study of the human rights situation of Roma worldwide, with a particular focus on the phenomenon of anti-Gypsyism. New York, NY: United Nations Human Rights Council; 2015 (https://digitallibrary.un.org/record/797194?ln=en, accessed 5 February 2022).
10. World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance: Declaration and Programme of Action (held from 31 August to 8 September 2001 in Durban, South Africa). New York, NY: United Nations Department of Public Information; 2002 (https://www.ohchr.org/Documents/Publications/Durban_text_en.pdf, accessed 19 October 2021).
11. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008:1–256 (http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf, accessed 9 April 2021).
12. Policy on ethnicity and health. Washington, DC: Pan American Health Organization; 2017 (https://iris.paho.org/handle/10665.2/34447, accessed 10 September 2021).
13. Strategy and plan of action on ethnicity and health 2019-2025. Washington, DC: Pan American Health Organization; 2019 (https://iris.paho.org/handle/10665.2/51744, accessed 10 September 2021).
14. WHO, UNESCO, OHCHR, IOM, UNDCO and UNDESA. Frontier dialogue consultations on addressing structural, racial and ethnicity-based discrimination: key action areas for COVID-19 recovery plans. Geneva: World Health Organization; 2021 (https://www.who.int/publications/m/item/frontier-dialogue-consultations-on-addressing-structural-racial-and-ethnicity-based-discrimination, accessed 26 January 2022).
15. Leaving no one behind: a UNSDG operational guide for UN country teams, interim draft. Geneva: United Nations Sustainable Development Group; 2019 (https://unsdg.un.org/sites/default/files/Interim-Draft-Operational-Guide-on-LNOB-for-UNCTs.pdf, accessed 8 November 2021).
16. Powell JA, Menendian S. The problem of othering: towards inclusiveness and belonging [website]. In: Othering & Belonging: Expanding the Circle of Human Concern. Berkeley, CA: The Haas Institute for a Fair and Inclusive Society; 2016;1:14–40 (https://www.otheringandbelonging.org/the-problem-of-othering/, accessed 7 September 2021).
17. Lewis TT, Van Dyke ME. Discrimination and the health of African Americans: the potential importance of intersectionalities. Curr Dir Psychol Sci. 2018;27(3):176–82. doi:10.1177/0963721418770442.
18. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. Stanford Law Rev. 1991;43(6):1241–99. https://doi.org/10.2307/1229039.
19. Who are indigenous peoples? [fact sheet]. New York, NY: United Nations Permanent Forum on Indigenous Issues; n.d. (https://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf, accessed 4 February 2022).
20. United Nations Declaration on the Rights of Indigenous Peoples. New York: United Nations; 2007 (https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf, accessed 5 February 2022).
21. Office of the United Nations High Commissioner for Human Rights. Minority rights: international standards and guidance for implementation. New York and Geneva: United Nations; 2010 (https://www.ohchr.org/Documents/Publications/MinorityRights_en.pdf, accessed 8 February 2022).
22. United Nations Network on Racial Discrimination and Protection of Minorities. Checklist to strengthen UN work at country level to combat racial discrimination and advance minority rights. New York, NY: United Nations; 2021 (https://www.ohchr.org/Documents/Issues/Minorities/AnnotatedChecklist.pdf, accessed 5 February 2022).
23. Kasanda PL. Identification and definition of "people of African descent" and how racial discrimination against them is manifested in various regions: working paper. Working Group of Experts on People of African Descent, 3–7 February, Geneva, 2003. Geneva: UN Commission on Human Rights; 2003 (https://digitallibrary.un.org/record/486012, accessed 2 April 2022).
24. Council of Europe descriptive glossary of terms relating to Roma issues. Strasbourg: Council of Europe; 2012 (http://a.cs.coe.int/team20/cahrom/documents/Glossary%20Roma%20EN%20version%2018%20May%202012.pdf, accessed 5 February 2022).
25. Collins FS. What we do and don't know about 'race' , 'ethnicity', genetics and health at the dawn of the genome era. Nat Genet. 2004;36:S13–5. doi:10.1038/ng1436.
26. Yudell M, Roberts D, DeSalle R, Tishkoff S. Taking race out of human genetics. Science. 2016;351(6273):564. doi:10.1126/science.aac4951.
27. Una visión de salud intercultural para los pueblos indígenas de las Américas. Washington, DC: Organización Panamericana de Salud Pública; 2008 (https://www.paho.org/hq/dmdocuments/2009/54-VisionSaludInterculturalPI.pdf, accessed 12 February 2022).
28. Migration and health: enhancing intercultural competence and diversity sensitivity. Copenhagen: WHO Regional Office for Europe; 2020 (https://apps.who.int/iris/bitstream/handle/10665/332186/9789289055055-eng.pdf, accessed 12 February 2022).
29. Declaration on Race and Racial Prejudice. Paris: United Nations Educational, Scientific and Cultural Organization; 1978 (http://portal.unesco.org/en/ev.php-URL_ID=13161&URL_DO=DO_TOPIC&URL_SECTION=201.html, accessed 21 June 2021).

30. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. Lancet. 2017;389(10077):1453–63. doi:10.1016/S0140-6736(17)30569-X.

31. WHO and UNICEF. Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization; 2022 (https://apps.who.int/iris/handle/10665/352205, accessed 2 April 2022).

32. Adams J, White M, Moffatt S, Howel D, Mackintosh J. A systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings. BMC Public Health. 2006;6:81 doi:10.1186/1471-2458-6-81.

33. Shi L, Macinko J, Starfield B, Politzer R, Xu J. Primary care, race, and mortality in US states. Soc Sci Med. 7;61(1):65–75. doi:10.1016/j.socscimed.2004.11.056.

34. Hone T, Rasella D, Barreto ML, Majeed A, Millett C. Association between expansion of primary healthcare and racial inequalities in mortality amenable to primary care in Brazil: a national longitudinal analysis. PLoS Med. 2017;14(5):e1002306. doi:10.1371/journal.pmed.1002306.

35. Hone T, Saraceni V, Medina Coeli C, Trajman A, Rasella D, Millett C et al. Primary healthcare expansion and mortality in Brazil's urban poor: a cohort analysis of 1.2 million adults. PLoS Med. 2020;17(10):e1003357. doi:10.1371/journal.pmed.1003357.

36. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457–502. doi:10.1111/j.1468-0009.2005.00409.x.

37. Bhutta ZA, Ali S, Cousens S, Ali TM, Haider BA, Rizvi A et al. Interventions to address maternal, newborn, and child survival: what difference can integrated primary health care strategies make? Lancet. 2008;372(9642):972–89. https://doi.org/10.1016/S0140-6736(08)61407-5.

38. WHO and UNICEF. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337641, accessed 8 September 2021).

39. Mahler DG, Yonzan N, Lakner C, Castaneda Aguilar RA, Wu H. Updated estimates of the impact of COVID-19 on global poverty: turning the corner on the pandemic in 2021? [website]. Washington, DC; World Bank; 2021 (https://blogs.worldbank.org/opendata/updated-estimates-impact-covid-19-global-poverty-turning-corner-pandemic-2021, accessed 3 June 2021.

40. Petersen EE. Racial/ethnic disparities in pregnancy-related deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep. 2019 ;68(35):762-765. doi:10.15585/mmwr.mm6835a3.

41. Raleigh V, Holmes J. The health of people from ethnic minority groups in England [website]. London: The King's Fund; 2021 (https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england, accessed 25 June 2021).

42. Das-Munshi J, Lund C, Mathews C, Clark C, Rothon C, Stansfeld S. Mental health inequalities in adolescents growing up in post-apartheid South Africa: cross-sectional survey, SHaW Study. PLoS One. 2016;11(5):e0154478. doi:10.1371/journal.pone.0154478.

43. Freeman T, Baum F, Lawless A, Labonté R, Sanders D, Boffa J et al. Case study of an Aboriginal community-controlled health service in Australia. Health Hum Rights. 2016;18(2):93–108. PMID:28559679.

44. Anderson I, Robson B, Connolly M, Al-Yaman F, Bjertness E, King A et al. Indigenous and tribal peoples' health (The Lancet-Lowitja Institute Global Collaboration): a population study. Lancet. 2016;388(10040):131–57. doi:10.1016/S0140-6736(16)00345-7.

45. Vietnam Demographic and Health Survey 2002. Calverton, MD: Committee for Population, Family and Children and ORC Macro; 2003 (https://dhsprogram.com/pubs/pdf/FR139/FR139.pdf, accessed 5 February 2022).

46. Dang HH. Vietnam: a widening poverty gap for ethnic minorities. In: Hall G, Patrinos H, editors. Indigenous peoples, poverty and development. London: Cambridge University Press; 2012 (https://papers.ssrn.com/abstract=2346307, accessed 9 September 2021).

47. Gu H, Li W, Yang J, Wang Y, Bo J, Liu L. Hypertension prevalence, awareness, treatment and control among Han and four ethnic minorities (Uygur, Hui, Mongolian and Dai) in China. J Hum Hypertens. 2015;29(9):555–60. doi:10.1038/jhh.2014.123.

48. Fa JE, Nasi R, Funk SM. The COVID-19 pandemic endangers Africa's indigenous Pygmy populations. Ecohealth. 2021;18(4):403–5. doi:10.1007/s10393-021-01528-w.

49. Jackson D. The health situation of women and children in Central African Pygmy peoples. Indigenous Affairs. 2006;1(06):38–45 https://www.iwgia.org/images/publications/IA_1-2006.pdf.

50. Roma health report: health status of the Roma population – data collection in the Member States of the European Union. Brussels: European Commission; 2014 (https://ec.europa.eu/chafea/health/archives/documents/health/roma-health-report-2014_en.pdf, accessed 13 February 2022).

51. Lawson DW, Mulder MB, Ghiselli ME, Ngadaya E, Ngowi B, Mfinanga SGM et al. Ethnicity and child health in northern Tanzania: Maasai pastoralists are disadvantaged compared to neighbouring ethnic groups. PLoS One. 2014;9(10):e110447. doi:10.1371/journal.pone.0110447.

52. Micronutrients: results of the 2010 Tanzania Demographic and Health Survey. Dar es Salaam: National Bureau of Statistics Tanzania and ICF Macro; 2011 (https://www.nbs.go.tz/nbs/takwimu/references/2010TDHSMicronutrientsReport.pdf, accessed 5 February 2022).

53. Tanzania national nutrition survey using SMART methodology (TNNS) 2018. Dar es Salaam: Ministry of Health, Community Development, Gender, Elderly and Children (Tanzania Mainland), Ministry of Health (Zanzibar), Tanzania Food and Nutrition Centre, National Bureau of Statistics, Office of the Chief Government Statistician (Zanzibar) and UNICEF; 2018 (https://www.tfnc.go.tz/uploads/publications/sw1564647893-New%20Tanzania%20National%20Nutrition%20Survey%20_25%20June%202019.pdf, accessed 2 April 2022.

54. Santos RV, Borges GM, Campos MB de, Queiroz BL, Coimbra CEA, Welch JR. Indigenous children and adolescent mortality inequity in Brazil: what can we learn from the 2010 National Demographic Census? SSM Popul Health. 2020;10:100537. doi:10.1016/j.ssmph.2020.100537.

55. Antai D. Inequalities in under-5 mortality in Nigeria: do ethnicity and socioeconomic position matter? J Epidemiol. 2011;21(1):13–20. doi:10.2188/jea.JE20100049.

56. Williams DR, Lawrence JA, Davis BA. Racism and health: evidence and needed research. Annu Rev Public Health. 2019;40:105–25. doi:10.1146/annurev-publhealth-040218-043750.

57. Lewis TT, Cogburn CD, Williams DR. Self-reported experiences of discrimination and health: scientific advances, ongoing controversies, and emerging issues. Annu Rev Clin Psychol. 2015;11(1):407–40. doi:10.1146/annurev-clinpsy-032814-112728.

58. Paradies Y, Ben J, Denson N, Elias A, Priest N, Pieterse A et al. Racism as a determinant of health: a systematic review and meta-analysis. PLoS One. 2015;10(9):e0138511. doi:10.1371/journal.pone.0138511.

59. Hicken MT, Lee H, Morenoff J, House JS, Williams DR. Racial/ethnic disparities in hypertension prevalence: reconsidering the role of chronic stress. Am J Public Health. 2014;104(1):117–23. doi:10.2105/AJPH.2013.301395.

60. Berger M, Sarnyai Z. "More than skin deep": stress neurobiology and mental health consequences of racial discrimination. Stress Amst Neth. 2015;18(1):1–10. doi:10.3109/10253890.2014.989204.

61. Brody GH, Yu T, Miller GE, Chen E. Discrimination, racial identity, and cytokine levels among African-American adolescents. J Adolesc Health. 2015;56(5):496–501. doi:10.1016/j.jadohealth.2015.01.017.

62. Barnes LL, de Leon CFM, Lewis TT, Bienias JL, Wilson RS, Evans DA. Perceived discrimination and mortality in a population-based study of older adults. Am J Public Health. 2008;98(7):1241–7. doi:10.2105/AJPH.2007.114397.

63. Earnshaw VA, Rosenthal L, Lewis JB, Stasko EC, Tobin JN, Lewis TT et al. Maternal experiences with everyday discrimination and infant birth weight: a test of mediators and moderators among young, urban women of color. Ann Behav Med Publ Soc Behav Med. 2013;45(1):13–23. doi:10.1007/s12160-012-9404-3.

64. Barnes LL, Lewis TT, Begeny CT, Yu L, Bennett DA, Wilson RS. Perceived discrimination and cognition in older African Americans. J Int Neuropsychol Soc. 2012;18(5):856–65. doi:10.1017/S1355617712000628.

65. Lewis TT, Troxel WM, Kravitz HM, Bromberger JT, Matthews KA, Hall MH. Chronic exposure to everyday discrimination and sleep in a multiethnic sample of middle-aged women. Health Psychol. 2013;32(7):810–9. doi:10.1037/a0029938.

66. Lewis TT, Kravitz HM, Janssen I, Powell LH. Self-reported experiences of discrimination and visceral fat in middle-aged African-American and Caucasian women. Am J Epidemiol. 2011;173(11):1223–31. doi:10.1093/aje/kwq466.

67. Elo IT, Beltrán-Sánchez H, Macinko J. The contribution of health care and other interventions to black–white disparities in life expectancy, 1980–2007. Popul Res Policy Rev. 2014;33(1):97–126. doi:10.1007/s11113-013-9309-2.

68. White M, Adams J, Heywood P. How and why do interventions that increase health overall widen inequalities within populations? In: Social inequality and public health. Bristol: Policy Press; 2009. doi:10.1332/policypress/9781847423207.003.0005.

69. Chopra M. Addressing health systems strengthening through an health equity lens. BMC Health Serv Res. 2013;13(2):S13. https://doi.org/10.1186/1472-6963-13-S2-S13.

70. Verrept H. What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region? Health Evidence Network (HEN) synthesis report 64. Copenhagen: WHO Regional Office for Europe; 2019 (https://apps.who.int/iris/bitstream/handle/10665/327321/9789289054355-eng.pdf , accessed 1 July 2021).

71. Fiscella K, Sanders MR. Racial and ethnic disparities in the quality of health care. Annu Rev Public Health. 2016;37:375–94. doi:10.1146/annurev-publhealth-032315-021439.

72. Black Americans see a health-care system infected by racism, new poll shows [website]. National Geographic; 2020 (https://www.nationalgeographic.com/history/article/black-americans-see-health-care-system-infected-racism-new-poll-shows, accessed 7 February 2022).

73. LaVeist TA, Nuru-Jeter A. Is doctor-patient race concordance associated with greater satisfaction with care? J Health Soc Behav. 2002;43(3):296–306. https://doi.org/10.2307/3090205.

74. Strumpf EC. Racial/ethnic disparities in primary care: the role of physician-patient concordance. Med Care. 2011;49(5):496–503. https://www.jstor.org/stable/23053808.

75. Street RL, O'Malley KJ, Cooper LA, Haidet P. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. Ann Fam Med. 2008;6(3):198–205. doi:10.1370/afm.821.

76. Ngomane S, Mulaudzi FM. Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabelo district in Limpopo, South Africa. Midwifery. 2012;28(1):30–8. doi:10.1016/j.midw.2010.11.002.

77. Smedley BD, Stith AY, Nelson R, editors. Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press; 2003 (https://www.ncbi.nlm.nih.gov/books/NBK220358/, accessed 14 February 2022).

78. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics. 2017;18(1):19. doi:10.1186/s12910-017-0179-8.

79. LaVeist TA, Isaac LA. Race, ethnicity, and health: a public health reader, 2nd ed. San Francisco, CA: Jossey-Bass; 2013.

80. Barr DA. Health disparities in the United States: social class, race, ethnicity, and health (2nd ed.). Baltimore, MD: Johns Hopkins University Press; 2014.

81. Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proc Natl Acad Sci USA. 2016;113(16):4296–301. doi:10.1073/pnas.1516047113.

82. Hamed S, Thapar-Björkert S, Bradby H, Ahlberg BM. Racism in European health care: structural violence and beyond. Qual Health Res. 2020;30(11):1662–73. https://doi.org/10.1177/1049732320931430.

83. Kelaher MA, Ferdinand AS, Paradies Y. Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. Med J Aust. 2014;201(1):44–7. doi:10.5694/mja13.10503.

84. Boccolini CS, Boccolini P de MM, Damacena GN, Ferreira AP de S, Szwarcwald CL. Factors associated with perceived discrimination in health services of Brazil: results of the Brazilian National Health Survey, 2013. Cienc Saude Coletiva. 2016;21(2):371–8. doi:10.1590/1413-81232015212.19412015.

85. Hall WJ, Chapman MV, Lee KM, Merino YM, Thomas TW, Payne BK et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. Am J Public Health. 2015;105(12):e60–76. doi:10.2105/AJPH.2015.302903.

86. Ben J, Cormack D, Harris R, Paradies Y. Racism and health service utilisation: a systematic review and meta-analysis. PloS One. 2017;12(12):e0189900. doi:10.1371/journal.pone.0189900.

87. Williams DR, Lawrence JA, Davis BA, Vu C. Understanding how discrimination can affect health. Health Serv Res. 2019;54(S2):1374–88. https://doi.org/10.1111/1475-6773.13222.

88. Hassen N, Lofters A, Michael S, Mall A, Pinto AD, Rackal J. Implementing anti-racism interventions in healthcare settings: a scoping review. Int J Environ Res Public Health. 2021;18(6):2993. doi:10.3390/ijerph18062993.

89. Key learning on health in all policies implementation from around the world – information brochure. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/272711, accessed 9 April 2021).

90. Greszczuk C. Implementing health in all policies. London: The Health Foundation; 2019 (https://www.health.org.uk/publications/reports/implementing-health-in-all-policies, accessed 9 August 2021).

91. Gwatkin DR, Ergo A. Universal health coverage: friend or foe of health equity? Lancet. 2011;377(9784):2160–1. doi:10.1016/S0140-6736(10)62058-2.

92. Robertson R, Williams E, Buck D, Breckwoldt J. Ethnic health inequalities and the NHS. London: The King's Fund and NHS Race and Health Observatory; 2021 (https://www.nhsrho.org/wp-content/uploads/2021/06/Ethnic-Health-Inequalities-Kings-Fund-Report.pdf, accessed 29 June 2021).

93. Sensitive personal information and the Privacy Act 2020. Wellington: Office of the Privacy Commissioner of New Zealand; 2021 (https://www.privacy.org.nz/assets/New-order/Your-responsibilities-/Privacy-resources-for-organisations/Sensitive-Personal-Information-and-the-Privacy-Act-2020.pdf, accessed 4 February 2022).

94. HISO 10001: 2017 ethnicity data protocols. Wellington: Ministry of Health; 2017 (https://www.health.govt.nz/system/files/documents/publications/hiso_10001-2017_ethnicity_data_protocols_may-21.pdf, accessed 2022 Feb 4].

95. Hobbs M, Ahuriri-Driscoll A, Marek L, Campbell M, Tomintz M, Kingham S. Reducing health inequity for Māori people in New Zealand. Lancet. 2019;394(10209):1613–4. doi:10.1016/S0140-6736(19)30044-3.

96. Disney G, Teng A, Atkinson J, Wilson N, Blakely T. Changing ethnic inequalities in mortality in New Zealand over 30 years: linked cohort studies with 68.9 million person-years of follow-up. Popul Health Metr. 2017;15(1):15. https://doi.org/10.1186/s12963-017-0132-6.

97. National report submitted in accordance with paragraph 5 of the annex to resolution 16/21 of the Human Rights Council: Costa Rica (A/HRC/WG.6/33/CRI/1). New York, NY: United Nations; 2019 (https://www.upr-info.org/sites/default/files/document/costa_rica/sesion_33_-_mayo_2019/a_hrc_wg.6_33_cri_1_e.pdf, accessed 14 February 2022).

98. Ministerio de Salud de Costa Rica. Plan Nacional de Salud para Personas Afrodescendientes 2018-2021 [National health plan for Afro-descendant persons 2018-2021]. San José: Ministerio de Salud; 2018 (in Spanish) (https://www.ministeriodesalud.go.cr/index.php/biblioteca-de-archivos/sobre-el-ministerio/politcas-y-planes-en-salud/planes-en-salud/3909-plan-nacional-de-salud-para-personas-afrodecendientes/file, accessed 5 February 2022).

99. International Convention on the Elimination of All Forms of Racial Discrimination. New York, NY: United Nations; 1965 (https://www.ohchr.org/en/professionalinterest/pages/cerd.aspx, accessed 8 June 2021).

100. ILO, C169 - Indigenous and Tribal Peoples Convention, 1989 (No. 169). Geneva: International Labour Organization; 1989 (https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C169, accessed 3 April 2022).

101. General Assembly resolution 47/135. Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities. New York, NY: United Nations; 1992 (https://www.ohchr.org/en/professionalinterest/pages/minorities.aspx, accessed 3 April 2002).

102. Payne S. How can gender equity be addressed through health systems? Copenhagen: WHO Regional Office for Europe; 2009 (https://apps.who.int/iris/bitstream/handle/10665/107956/Policy-brief-12-1997-8073-eng.pdf?sequence=9&isAllowed=y, accessed 9 August 2021).

103. United Nations strategy and plan of action on hate speech. New York, NY: United Nations; 2019 (https://www.un.org/en/genocideprevention/documents/advising-and-mobilizing/Action_plan_on_hate_speech_EN.pdf, accessed 5 April 2021).

104. United Nations Strategy and plan of action on hate speech detailed guidance on implementation for United Nations field presences. New York, NY: United Nations; 2020 (https://www.un.org/en/genocideprevention/documents/UN%20Strategy%20and%20PoA%20on%20Hate%20Speech_Guidance%20on%20Addressing%20in%20field.pdf, accessed 5 February 2022).

105. Bambra C, Gibson M, Sowden A, Wright K, Whitehead M, Petticrew M. Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. J Epidemiol Community Health. 2010;64(4):284–91. doi:10.1136/jech.2008.082743.

106. Indigenous Services Canada: Mandate [website]. Ottawa: Government of Canada; 2018 (https://www.sac-isc.gc.ca/eng/1539284416739/1539284508506, accessed 14 September 2021).

107. Backgrounder: United Nations Declaration on the Rights of Indigenous Peoples Act [website]. Ottawa: Government of Canada; 2021 (https://www.justice.gc.ca/eng/declaration/about-apropos.html, accessed 14 September 2021).

108. The situation of people of African descent in the Americas. Washington, DC: Inter-American Commission on Human Rights; 2011 (https://www.oas.org/en/iachr/afro-descendants/docs/pdf/afros_2011_eng.pdf, accessed 12 September 2021).

109. Añaños Bedriñana KG, Hernández Umaña BA, Rodríguez Martín JA. "Living Well" in the Constitution of Bolivia and the American Declaration on the Rights of Indigenous Peoples: reflections on well-being and the right to development. Int J Environ Res Public Health. 2020;17(8):2870. doi:10.3390/ijerph17082870.

110. Sharp R. Budgeting for equity: gender budget initiatives within a framework of performance oriented budgeting. New York, NY: United Nations Development Fund for Women (UNIFEM); 2003 (https://www.unwomen.org/en/digital-library/publications/2003/1/budgeting-for-equity-gender-budget-initiatives-within-a-framework-of-performance-oriented-budgeting, accessed 4 February 2022.

111. Cavaghan R. The possibilities and constraints for intersectional practice in gender budgeting activism. Soc Polit Int Stud Gend State Soc. 2020;27(4):670–93. https://doi.org/10.1093/sp/jxaa030.

112. Gender mainstreaming for health managers: a practical approach. Facilitators' guide. Geneva: World Health Organization; 2011 (https://apps.who.int/iris/handle/10665/44516, accessed 4 February 2022)

113. Shah A. Participatory budgeting. Public sector governance and accountability. Washington, DC: World Bank; 2007 (https://openknowledge.worldbank.org/handle/10986/6640, accessed 10 August 2021).

114. Francés F, La Parra-Casado D. Participation as a driver of health equity. Copenhagen: WHO Regional Office for Europe; 2019 (https://apps.who.int/iris/bitstream/handle/10665/324909/9789289054126-eng.pdf?sequence=1&isAllowed=y, accessed 22 October 2021).

115. Campbell M, Escobar O, Fenton C, Craig P. The impact of participatory budgeting on health and wellbeing: a scoping review of evaluations. BMC Public Health. 2018;18(1):822. doi:10.1186/s12889-018-5735-8.

116. Su C. Beyond inclusion: critical race theory and participatory budgeting. New Polit Sci. 2017;39(1):126–42. https://doi.org/10.1080/07393148.2017.1278858.

117. Nelson J, Brooks L. Racial equity toolkit: an opportunity to operationalize equity. USA: Government Alliance on Race and Equity; 2015 (https://www.racialequityalliance.org/resources/racial-equity-toolkit-opportunity-operationalize-equity/, accessed 9 August 2021).

118. Gooden ST. Social equity and evidence: insights from local government. Public Adm Rev. 2017;77(6):822–8. https://doi.org/10.1111/puar.12851.

119. The Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook. Geneva: World Health Organization; 2016 (https://www.who.int/publications-detail-redirect/9789241511391, accessed 1 July 2021.

120. Boyce T, Brown C. Engagement and participation for health equity. Copenhagen: WHO Regional Office for Europe; 2017 (https://www.euro.who.int/__data/assets/pdf_file/0005/353066/Engagement-and-Participation-HealthEquity.pdf, accessed 6 August 2021).

121. Black RE, Taylor CE, Arole S, Bang A, Bhutta ZA, Chowdhury AMR et al. Comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 8. summary and recommendations of the Expert Panel. J Glob Health. 2017;7(1):010908. doi:10.7189/jogh.07.010908.

122. O'Mara-Eves A, Brunton G, McDaid D, Oliver S, Kavanagh J, Jamal F et al. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. Public Health Res. 2013;1(4):1–526. doi:10.3310/phr01040.

123. Towards equity in health: comparative study of national health surveys in Roma population and general population in Spain. Spanish Ministry of Health and Social Policy; 2006 (https://www.sanidad.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/folletoGitanosIngles.pdf, accessed 5 February 2022).

124. Voice, agency, empowerment – handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/342704, accessed 22 October 2021).

125. Inuuneritta III: Naalakkersuisuts strategi for samarbejdet om det gode børneliv 2020-2030 [Government co-operation strategy for good childhood 2020–2030]. Nuuk: Government of Greenland; 2020 (in Danish) (https://r.search.yahoo.com/_ylt=AwrlNNmyIlVi_WIABQ00AopQ;_ylu=Y29sbwNpcjIEcG9zAzEEdnRpZAMEc2VjA3Ny/RV=2/RE=1649805107/RO=10/RU=https%3a%2f%2fpaarisa.gl%2f-%2fmedia%2fpaarisa%2fmaterialer%2ffilm-og-udgivelser%2frapporter%2finuuneritta-iii-sep20-naal-da-web_final.pdf/RK=2/RS=Y18hxIQiEPlNvNEjrQwHc_s9tdo-, accessed 10 February 2022).

126. Facts about Greenland [website]. Nuuk: Government of Greenland; n.d. (https://naalakkersuisut.gl/en/About-government-of-greenland/About-Greenland/Facts-about-Greenland, accessed 7 February 2022).

127. Tudor Hart J. The inverse care law. Lancet. 1971;297(7696):405–12. doi:10.1016/s0140-6736(71)92410-x.

128. Cookson R, Doran T, Asaria M, Gupta I, Mujica FP. The inverse care law re-examined: a global perspective. Lancet. 2021;397(10276):828–38. doi:10.1016/S0140-6736(21)00243-9.

129. The world health report 2008: primary health care - now more than ever. Geneva: World Health Organization; 2008:1–148 (https://apps.who.int/iris/handle/10665/43949, accessed 15 February 2022).

130. Kringos DS, Boerma W, van der Zee J, Groenewegen P. Europe's strong primary care systems are linked to better population health but also to higher health spending. Health Aff (Millwood). 2013;32(4):686–94. doi:10.1377/hlthaff.2012.1242.

131. Macinko J, Starfield B, Erinosho T. The impact of primary healthcare on population health in low-and middle-income countries. J Ambul Care Manage. 2009;32(2):150–71. doi:10.1097/JAC.0b013e3181994221.

132. Kruk ME, Porignon D, Rockers PC, Van Lerberghe W. The contribution of primary care to health and health systems in low- and middle-income countries: a critical review of major primary care initiatives. Soc Sci Med. 2010;70(6):904–11. doi:10.1016/j.socscimed.2009.11.025.

133. Fiscella K, Shin P. The inverse care law: implications for healthcare of vulnerable populations. J Ambul Care Manage. 2005;28(4):304–12. doi:10.1097/00004479-200510000-00005.

134. Dussault G, Kawar R, Castro Lopes S, Campbell J. Building the primary health care workforce of the 21st century - Background paper to the Global Conference on Primary Health Care: From Alma-Ata Towards Universal Health Coverage and the Sustainable Development Goals. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/328072, accessed 3 April 2022).

135. Anstey Watkins J, Griffiths F, Goudge J. Community health workers' efforts to build health system trust in marginalised communities: a qualitative study from South Africa. BMJ Open. 2021;11(5):e044065. doi:10.1136/bmjopen-2020-044065.

136. What do we know about community health workers? A systematic review of existing reviews. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/340717, accessed 5 February 2022).

137. Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open. 2018;8(6):e021161. doi:10.1136/bmjopen-2017-021161.

138. Chan K-S, Wan EY-F, Chin W-Y, Cheng WH-G, Ho MK, Yu EY-T et al. Effects of continuity of care on health outcomes among patients with diabetes mellitus and/or hypertension: a systematic review. BMC Fam Pract. 2021;22(1):145. doi:10.1186/s12875-021-01493-x.

139. Palmer W, Hemmings N, Rosen R, Keeble E, Williams S, Imison C. Improving access and continuity in general practice: practical and policy lessons. London: Nuffield Trust; 2018 (https://www.nuffieldtrust.org.uk/files/2018-11/improving-access-and-continuity-in-general-practice-summary-final.pdf, accessed 15 February 2022).

140. Poverty and social exclusion in the WHO European Region: health systems respond. Copenhagen: WHO Regional Office for Europe; 2010 (https://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf, accessed 6 February 2022).

141. Scheppers E, van Dongen E, Dekker J, Geertzen J, Dekker J. Potential barriers to the use of health services among ethnic minorities: a review. Fam Pract. 2006;23(3):325–48. doi:10.1093/fampra/cmi113.

142. Bierman AS, Lurie N, Collins KS, Eisenberg JM. Addressing racial and ethnic barriers to effective health care: the need for better data. Health Aff (Millwood). 2002;21(3):91–102. doi:10.1377/hlthaff.21.3.91.

143. Llamas A, Mayhew S. "Five hundred years of medicine gone to waste"? Negotiating the implementation of an intercultural health policy in the Ecuadorian Andes. BMC Public Health. 2018;18(1):686. doi:10.1186/s12889-018-5601-8.

144. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep. 2003 Jul 1;118(4):293–302. doi:10.1093/phr/118.4.293.

145. Integrating health services. Geneva: World Health Organization; 2018 https://apps.who.int/iris/handle/10665/326459, accessed 3 April 2022).

146. McDonald KM, Sundaram V, Bravata DM, Lewis R, Lin N, Kraft SA et al. Review of systematic reviews of care coordination interventions. In: Closing the quality gap: a critical analysis of quality improvement strategies (vol. 7: care coordination). Rockville, MD: Agency for Healthcare Research and Quality (US); 2007 (https://www.ncbi.nlm.nih.gov/books/NBK44016/, accessed 16 February 2022).

147. Kringos DS, Boerma WG, Hutchinson A, van der Zee J, Groenewegen PP. The breadth of primary care: a systematic literature review of its core dimensions. BMC Health Serv Res. 2010;10(1):65. doi:10.1186/1472-6963-10-65.

148. O'Neill B, Ferrer R, O'Brien P, Watt G, Gottlieb L, Pinto A et al. Improving equity through primary care: proceedings of the 2019 Toronto International Conference on Quality in Primary Care. Ann Fam Med. 2020;18(4):364. doi:10.1370/afm.2560.

149. Tricket L. Hate crime and health services [website]. International Network for Hate Studies; 2014 (https://internationalhatestudies.com/hate-crime-health-services/, accessed 5 February 2022).

150. Kristensen P, Gravseth HM, Bjerkedal T. Influence of early life factors on social inequalities in psychiatric outcomes among young adult Norwegian men. Eur J Public Health. 2010;20(5):517–23. doi:10.1093/eurpub/ckq083.

151. Beach MC, Rosner M, Cooper LA, Duggan PS, Shatzer J. Can patient-centered attitudes reduce racial and ethnic disparities in care? Acad Med. 2007;82(2):193–8. doi:10.1097/ACM.0b013e31802d94b2.

152. Kressin NR, Chapman SE, Magnani JW. A tale of two patients: patient-centered approaches to adherence as a gateway to reducing disparities. Circulation. 2016;133(24):2583–92. doi:10.1161/CIRCULATIONAHA.116.015361

153. Metodología de los diálogos de saberes. Washington, DC: Pan American Health Organization; 2021 (https://iris.paho.org/bitstream/handle/10665.2/55670/9789275324707_spa.pdf?sequence=1&isAllowed=y, accessed 4 February 2022).

154. Inter-cultural dialogue [website]. New York, NY: United Nations; n.d. (https://www.un.org/en/academic-impact/inter-cultural-dialogue, accessed 4 February 2022).

155. McCalman J, Jongen C, Bainbridge R. Organisational systems' approaches to improving cultural competence in healthcare: a systematic scoping review of the literature. Int J Equity Health. 2017;16(1):78. doi:10.1186/s12939-017-0571-5.

156. Kildea S, Gao Y, Hickey S, Nelson C, Kruske S, Carson A et al. Effect of a Birthing on Country service redesign on maternal and neonatal health outcomes for First Nations Australians: a prospective, non-randomised, interventional trial. Lancet Glob Health. 2021;9(5):e651–9. doi:10.1016/S2214-109X(21)00061-9.

157. Mignone J, Bartlett J, O'Neil J, Orchard T. Best practices in intercultural health: five case studies in Latin America. J Ethnobiol Ethnomedicine. 2007;5;3:31. doi:10.1186/1746-4269-3-31.

158. Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Serv Res. 2014;14(1):99. doi:10.1186/1472-6963-14-99.

159. Wohler D, Liaw W. Team-based primary care: opportunities and challenges. Washington, DC: Starfield Summit; 2016 (https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/StarfieldSummit_Report_TeamBasedPrimaryCare.pdf, accessed 5 February 2022).

160. Williams WW. Medical school admissions — a movable barrier to ending health care disparities? N Engl J Med. 2021;384(17):1659–60. doi:10.1056/NEJMe2102832.

161. Lett LA, Murdock HM, Orji WU, Aysola J, Sebro R. Trends in racial/ethnic representation among US medical students. JAMA Netw Open. 2019;2(9):e1910490. doi:10.1001/jamanetworkopen.2019.10490.

162. Souza PGA de, Pôrto ACC de A, Souza A de, Silva AG da, Borges FT. Socio-economic and racial profile of medical students from a public university in Rio de Janeiro, Brazil. Rev Bras Educ Médica. 2020,44(3):e090. https://doi.org/10.1590/1981-5271v44.3-20190111.ING.

163. Heller A. Diversity in the medical workforce [website]. London: The King's Fund; 2020 (https://www.kingsfund.org.uk/blog/2020/02/diversity-medical-workforce-progress, accessed 11 August 2021).

164. Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti-racist uprisings call us to act. Lancet. 202010;396(10257):1125–8. doi:10.1016/S0140-6736(20)32076-6.

165. Chandler CE, Williams CR, Turner MW, Shanahan ME. Training public health students in racial justice and health equity: a systematic review. Public Health Rep. 2021;00333549211015665. doi:10.1177/00333549211015665.

166. Sorensen J, Norredam M, Dogra N, Essink-Bot M-L, Suurmond J, Krasnik A. Enhancing cultural competence in medical education. Int J Med Educ. 2017;8:28–30. doi:10.5116/ijme.587a.0333.

167. Jacklin K, Strasser R, Peltier I. From the community to the classroom: the Aboriginal health curriculum at the Northern Ontario School of Medicine. Can J Rural Med. 2014;19(4):143–50. PMID:25291039.

168. Social participation, inclusion and community engagement approaches for the health of indigenous peoples in rural and remote areas [webinar]. Geneva: World Health Organization; 2021 (https://www.who.int/news-room/events/detail/2021/08/09/default-calendar/webinar-social-participation-inclusion-and-community-engagement-approaches-for-the-health-of-indigenous-populations-in-rural-and-remote-areas, accessed 9 September 2021).

169. Kadri MRE, Santos BS dos, Lima RT de S, Schweickardt JC, Martins FM. Unidade Básica de Saúde Fluvial: um novo modelo da Atenção Básica para a Amazônia, Brasil [Floating primary health center: a new approach to primary care in the Amazon, Brazil]. Interface (Botucatu). 2019;23:e180613. https://doi.org/10.1590/Interface.180613.

170. Traditional and complementary medicine in primary health care. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/326299, accessed 26 January 2022).

171. WHO global report on traditional and complementary medicine 2019. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/312342, accessed 10 December 2021).

172. Engaging the private health service delivery sector through governance in mixed health systems: strategy report of the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage. Geneva; 2020 (https://apps.who.int/iris/handle/10665/341057, accessed 9 February 2021).

173. Ibañez XA, Dekanosidze T. The State's obligation to regulate and monitor private health care facilities: the Alyne da Silva Pimentel and the Dzebniauri cases. Public Health Rev. 2017;38(1):17. doi:10.1186/s40985-017-0063-6.

174. Barbeau EM, Wolin KY, Naumova EN, Balbach E. Tobacco advertising in communities: associations with race and class. Prev Med. 2005;40(1):16–22. doi:10.1016/j.ypmed.2004.04.056.

175. Gilmore JS, Jordan A. Burgers and basketball: race and stereotypes in food and beverage advertising aimed at children in the US. J Child Media. 2012;6(3):317–32. https://doi.org/10.1080/17482798.2012.673498.

176. Anderson AC, O'Rourke E, Chin MH, Ponce NA, Bernheim SM, Burstin H. Promoting health equity and eliminating disparities through performance measurement and payment. Health Aff (Millwood). 2018;37(3):371–7. doi:10.1377/hlthaff.2017.1301.

177. Sandh S, Saunders RS, McClellan MB, Wong CA. Health equity should be a key value in value-based payment and delivery reform [website]. Washington, DC: Health Affairs Blog; 2020. doi:10.1377/hblog20201119.836369.

178. Lohrentz T. Contracting for equity: best local government practices that advance racial equity in government contracting and procurement. USA: Insight Center for Community Economic Development, and Government Alliance on Race and Equity; 2015 (https://www.racialequityalliance.org/resources/contracting-equity-best-local-government-practices-advance-racial-equity-government-contracting-procurement/, accessed 9 August 2021).

179. The world health report 2010: health system financing – the path to universal coverage. Geneva: World Health Organization; 2010:1–102 (https://apps.who.int/iris/handle/10665/44371, accessed 8 February 2022).

180. Alberti P, Teigland C, Nerenz DR. To design equitable value-based payment systems, we must adjust for social risk [website]. Washington, DC: Health Affairs Blog; 2020. doi:10.1377/hblog20200911.279192.

181. Weissman JS, Hasnain-Wynia R, Weinick RM, Kang R, Vogeli C, Iezzoni L et al. Pay-for-performance programs to reduce racial/ethnic disparities: what might different designs achieve? J Health Care Poor Underserved. 2012;23(1):144–60. doi:10.1353/hpu.2012.0030.

182. Adler NE, Glymour MM, Fielding J. Addressing social determinants of health and health inequalities. JAMA. 2016;316(16):1641–2. doi:10.1001/jama.2016.14058.

183. Epstein AM, Jha AK, Orav EJ. The impact of pay-for-performance on quality of care for minority patients. Am J Manag Care. 2014;20(10):e479-486. PMID:25414986.

184. Kumar MM, Pathak VK, Ruikar M. Tribal population in India: a public health challenge and road to future. J Fam Med Prim Care. 2020;9(2):508–12. doi:10.4103/jfmpc.jfmpc_992_19.

185. Weiss D, Rydland HT, Øversveen E, Jensen MR, Solhaug S, Krokstad S. Innovative technologies and social inequalities in health: a scoping review of the literature. PLoS One. 2018;13(4):e0195447. doi:10.1371/journal.pone.0195447.

186. Azzopardi-Muscat N, Sørensen K. Towards an equitable digital public health era: promoting equity through a health literacy perspective. Eur J Public Health. 2019;29(Suppl 3):13–7. doi:10.1093/eurpub/ckz166.

187. Dawson AZ, Walker RJ, Campbell JA, Davidson TM, Egede LE. Telehealth and indigenous populations around the world: a systematic review on current modalities for physical and mental health. Mhealth. 2020;6:30. doi:10.21037/mhealth.2019.12.03.

188. PAHO eHealth - eHealth in action: TulaSalud, a telemedicine initiative in Guatemala [website]. Washington, DC: Regional Office for the Americas of the World Health Organization; 2022 (https://www3.paho.org/ict4health/index.php?option=com_content&view=article&id=210:ehealth-in-action-tulasalud-telemedicine-in-guatemala&Itemid=204&lang=en, accessed 26 January 2022).

189. Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/272357, accessed 28 October 2021).

190. Maternal health for all: indigenous communities in Colombia. Geneva: World Health Organization; 2021 (https://www.who.int/news-room/feature-stories/detail/towards-access-to-maternal-health-services-for-all-in-colombia-indigenous-communities, accessed 29 October 2021).

191. Baum FE. Power and glory: applying participatory action research in public health. Gac Sanit. 2016;30(6):405–7. doi:10.1016/j.gaceta.2016.05.014.

192. Indigenous peoples and participatory health research. Planning & management, preparing research agreements: draft for comments. Geneva: World Health Organization; 2013 (https://www.mcgill.ca/cine/files/cine/partreresearch_english.pdf, accessed 6 February 2022).

193. Dadich A, Moore L, Eapen V. What does it mean to conduct participatory research with indigenous peoples? A lexical review. BMC Public Health. 2019;19(1):1388. doi:10.1186/s12889-019-7494-6.

194. Loewenson R, Laurell AC, Hogstedt C, D'Ambruoso L, Shroff Z. Participatory action research in health systems: a methods reader. Harare: TARSC, AHPSR, WHO, IDRC Canada, Equinet; 2014 (http://equinetafrica.org/sites/default/files/uploads/documents/PAR_Methods_Reader2014_for_web.pdf, accessed 6 February 2022).

195. Cochran PAL, Marshall CA, Garcia-Downing C, Kendall E, Cook D, McCubbin L et al. Indigenous ways of knowing: implications for participatory research and community. Am J Public Health. 2008;98(1):22–7. doi:10.2105/AJPH.2006.093641.

196. Wheeler J, Shaw J, Howard J. Politics and practices of inclusion: intersectional participatory action research. Community Dev J. 2020;55(1):45–63. doi:10.1093/cdj/bsz036.

197. Brownson RC, Kumanyika SK, Kreuter MW, Haire-Joshu D. Implementation science should give higher priority to health equity. Implement Sci. 2021;16(1):28. https://doi.org/10.1186/s13012-021-01097-0.

198. Appiah R. Community-based participatory research in rural African contexts: ethico-cultural considerations and lessons from Ghana. Public Health Rev. 2020;41(1):27. doi:10.1186/s40985-020-00145-2.

199. Research and issues of impact on the lives of indigenous women [website]. Lima: Foro Indigena de Mujeres Indigenas (FIMI); 2019 (https://fimi-iiwf.org/research-program/?lang=en, accessed 7 February 2022).

200. Love-Koh J, Griffin S, Kataika E, Revill P, Sibandze S, Walker S. Methods to promote equity in health resource allocation in low- and middle-income countries: an overview. Glob Health. 2020;16(1):6. doi:10.1186/s12992-019-0537-z.

201. A human rights-based approach to data: leaving no one behind in the 2030 Agenda for Sustainable Development. Geneva: Office of the United Nations High Commissioner for Human Rights; 2018 (https://www.ohchr.org/documents/issues/hrindicators/guidancenoteonapproachtodata.pdf, accessed 10 December 2021).

202. Ahmed S, Siad FM, Manalili K, Lorenzetti DL, Barbosa T, Lantion V et al. How to measure cultural competence when evaluating patient-centred care: a scoping review. BMJ Open. 2018;8(7):e021525. doi:10.1136/bmjopen-2018-021525.

203. Damberg CL, Baker DW. Improving the quality of quality measurement. J Gen Intern Med. 2016;31(Suppl 1):8–9. doi:10.1007/s11606-015-3577-y.

204. Communication from the Commission to the European Parliament and the Council. A union of equality: EU Roma strategic framework for equality, inclusion and participation. Brussels: European Commission; 2020 (https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=COM:2020:620:FIN, accessed 5 April 2022).

205. UK Government Race Disparity Unit and Equality Hub. Final report on progress to address COVID-19 health inequalities. London: Government of the United Kingdom of Great Britain and Northern Ireland; 2021 (https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities, accessed 5 February 2022).

206. Strategy on health policy and systems research: changing mindsets. Geneva: World Health Organization; 2012 (https://www.who.int/alliance-hpsr/alliancehpsr_changingmindsets_strategyhpsr.pdf, accessed 9 February 2022).

207. World Report on health policy and systems research. Geneva: Alliance for Health Policy and Systems, World Health Organization; 2018 (https://apo.who.int/publications/i/item/2018-07-13-world-report-on-health-policy-and-systems-research, accessed 5 February 2022.

208. Peters D, Tran N, Adam T. Implementation research in health: a practical guide. Geneva: Alliance for Health Policy and Systems Research, World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/91758/9789241506212_eng.pdf?sequence=1&isAllowed=y, accessed 6 February 2022).

209. The UN Network on Racial Discrimination and Protection of Minorities [website]. Geneva: Office of the United Nations High Commissioner for Human Rights; 2021 (https://www.ohchr.org/EN/Issues/Minorities/Pages/UNNetworkRacialDiscriminationProtectionMinorities.aspx, accessed 7 February 2022).

210. Guterres A. The highest aspiration: a call to action for human rights. New York, NY: United Nations; 2020 (https://www.un.org/sg/sites/www.un.org.sg/files/atoms/files/The_Highest_Asperation_A_Call_To_Action_For_Human_Right_English.pdf, accessed 6 February 2022).

211. Racial and ethnic equality—time for concrete action. Lancet. 2020;396(10257):1055–6. doi:10.1016/S0140-6736(20)32077-8.

212. Advancing equity, diversity, and inclusion [website]. London: The Lancet; ND (https://www.thelancet.com/racial-equality, accessed 5 April 2022).

9789240057104
9 789240 057104