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# HR Series

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# 48

## THE PUBLIC HEALTH WORKFORCE

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### ITS CHARACTERIZATION AND DEVELOPMENT FROM AN ETHNIC PERSPECTIVE

ADVISORY GROUP

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# 1. INTRODUCTION

In the late 1990s, the Pan American Health Organization/World Health Organization (PAHO/WHO) launched a hemispheric initiative designed to strengthen health authority capacity in public health and improve public health practice through the definition and measurement of the Essential Public Health Functions (EPHF).

The EPHF performance measurement undertaken in 41 Latin American and Caribbean countries and territories in 2001-2002 found that function 8 (Human Resources Development and Training in Public Health) was the second most deficient among the 11 EPHF examined—a finding that coincided with other assessments of what the developed countries have come to call the current crisis in human resources for health. Regarding these resources, several forums have recommended focusing greater attention in the immediate future on the public health work force (PHWF) with a view to improving the EPHF and contributing to the attainment of the Millennium Development Goals (MDGs).

With the object of ensuring a comprehensive approach to the PHWF, the World Federation of Public Health Associations and PAHO brought together experts from the Region in San José, Costa Rica, from 16 to 18 August 2005 to map out the basic elements of a proposal for the characterization and development of the PHWF<sup>1</sup>. This forum recognized the need to adopt an approach with a perspective that included the fundamental social determinants of health, such as gender and ethnicity, that influence the characterization and development of the PHWF. As a result, the Human Resources for Health and the Gender, Ethnicity, and Health Units of PAHO embarked on a joint exploration of the relationship between these social determinants and the PHWF and of mechanisms to achieve both development responsive to the particular needs of specific populations and a composition characterized by ethnic and gender equity.

This approach came together in the joint organization of two consultations on these matters, the first, with gender experts (San José, Costa Rica; 11-13 October 2005)<sup>2</sup> and the present one, with ethnicity and health experts (Lima, Peru, 30 May-1 June 2006).

The general objective of the present Consultation on the characterization and development of the PHWF from an ethnic/racial perspective was to contribute to better characterization of the PHWF and improvement in its performance, identifying and upgrading its critical competencies in order to tackle the new challenges posed by the search for greater equity in health.

Its specific objectives were:

- to reinforce the validity of the general elements used for the characterization of the PHWF from an antidiscriminatory ethnic perspective
- to identify some critical capacities to develop in the PHWF to better adapt it to the differentiated needs of women and men in different ethnic groups, above all in those that have historically suffered discrimination

The expected results were:

- methodological aspects and indicators or variables to consider in the general characterization of the PHWF from an ethnic/racial perspective
- technical and strategic aspects to consider in the development of the PHWF from an ethnic/racial perspective, in particular those related to the quality of its performance

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<sup>1</sup> Organización Panamericana de la Salud. Fortalecimiento de la capacidad de la Fuerza de Trabajo en Salud Pública en apoyo a las Funciones Esenciales de Salud Pública y a los Objetivos de Desarrollo del Milenio. San José, Costa Rica, 16-18 August 2005. Consultation with experts.

<sup>2</sup> Pan American Health Organization. The Public Health Workforce: Its Characterization and Development from a Gender Perspective. San José, Costa Rica, 11-13 October 2005. Advisory Group.

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It should be noted that the objectives of the Consultation and the expected results were based on the recommendations and plan of action of the Third World Conference against Racism, Racial Discrimination, Xenophobia, and Related Forms of Intolerance<sup>3</sup>.

The participants in this technical Consultation are experts in the fields of ethnicity and health and the PHWF, representing diverse institutions and sectors. Based on their contributions, the principal guidelines for the characterization and development of the PHWF from an antidiscriminatory ethnic perspective were defined. They are summarized below.

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<sup>3</sup> UN. World Conference against Racism, Racial Discrimination, Xenophobia, and Related Forms of Intolerance, organized by the United Nations and held in Durban, South Africa, in 2001.

## 2. FRAME OF REFERENCE

As mentioned earlier, the PAHO exercise in measuring EPHF performance in 2001-2002 found that “Human Resources Development and Training in Public Health” was the second most deficient function. This finding coincided with that of other assessments of the current situation of human resources for health, a problem whose causes and magnitude in the Region of the Americas are reflected in the shortages in certain types of personnel, their inequitable distribution in the countries, planning in terms of these resources, their performance in institutions, and their training, which lacks context and is technology-centered.

Strengthening the EPHF and contributing to the attainment of the Millennium Development Goals (MDGs) require greater attention to the PHWF. Thus, partnerships must be promoted among the different actors involved (PAHO/WHO, public health associations and schools of public health, governmental and nongovernmental agencies, etc.), agreements must be reached, and inclusive, comprehensive objectives must be established to better orient efforts aimed at meeting the larger challenge.

The agenda for developing the PHWF is still under construction. Taking advantage of the window of opportunity opened by the Declaration of the Decade that began in 2006 as the Decade of Human Resources for Health is a strategic challenge for every organization involved in health. If human resources for health are considered public goods, it is essential that greater attention be paid to the factors that affect their productivity and responsiveness to users of the services. Investment is essential to ensure that what they do is also compatible with the demands generated by health events, specific programs, population groups, and relevant social determinants.

### 2.1. CONCEPTUAL ELEMENTS

Public health is the organized effort of a society, primarily through its public institutions, to promote, protect, restore, and improve the health of the population through collective action.

In this process, the Governing Bodies of PAHO defined the essential public health functions (EPHF) as “the specific actions that should be taken to achieve the primary objective of public health: to improve the health of populations. Essential is understood as what is fundamental, and even indispensable, for achieving public health objectives and defining public health<sup>4</sup>.” The 11 EPHF are: 1. Monitoring, Evaluation, and Analysis of Health Status; 2. Public Health Surveillance, Research, and Control of Risks and Threats to Public Health; 3. Health Promotion; 4. Social Participation in Health; 5. Development of Policies and Institutional Capacity for Planning and Management in Public Health; 6. Strengthening of Institutional Capacity for Regulation and Enforcement in Public Health; 7. Evaluation and Promotion of Equitable Access to Necessary Health Services; 8. Human Resources Development and Training in Public Health; 9. Quality Assurance in Personal and Population-based Health Services; 10. Research in Public Health; 11. Reduction of the Impact of Emergencies and Disasters on Health.

The public health workforce (PHWF) consists of all health workers responsible for contributing—either directly or indirectly—to the performance of the essential public health functions, regardless of their profession or the institution in which they actually work (PAHO, 2002). From an ethnic perspective, the PHWF consists of professionals in the health and social sciences, i.e. technical and auxiliary personnel in the health sciences, health promotion agents (who belong to the system), traditional health agents (who act at the community level)<sup>5</sup>, and other professionals or technicians<sup>6</sup>.

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<sup>4</sup> Pan American Health Organization. Public Health in the Americas: Conceptual Renewal, Performance Assessment, and Bases for Action. Scientific and Technical Publication No. 589. Washington, D.C.: PAHO, 2002.

<sup>5</sup> Midwives, shamans, and spiritual healers, who possess traditional and ancestral knowledge and employ herbology and other healing methods associated with traditional medicine.

<sup>6</sup> Including policymakers.

There is only one human species, and diverse phenotypes do not imply biological or genetic differences that justify the classification of individuals by race<sup>7</sup>; this leads to an awareness that the differences among individuals are rooted in social, historical, ideological, and cultural factors that result in stratification, which in turn generates poverty and social and health inequities in general through mechanisms of exclusion and access barriers.

The social conditions in which people's lives unfold are determined largely by level of income/production and education (characteristics usually used to define social class, ethnicity, and culture.)

Thus, the WHO Commission on Social Determinants of Health considers the *structural determinants of health* to be those that generate social stratification, including traditional factors such as income and education and other, less traditional factors, such as gender, ethnicity, age, and sexual orientation.

According to the definition employed by the International Labor Organization (Convention 169), indigenous or tribal peoples are: a) peoples living in independent countries whose social, cultural, and economic conditions distinguish them from other sections of the national community, and whose status is regulated wholly or partially by their own customs and traditions or by special laws or regulations, and b) peoples in independent countries who are regarded as indigenous on account of their descent from populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or colonization or the establishment of present State boundaries, and who irrespective of their status, retain some or all of their own social, economic, cultural, and political institutions.<sup>8</sup>

To complete this approach, it is necessary to clarify the mechanisms through which ethnic and cultural identities function as the stratifiers of access to productive and nonproductive resources, social relations (formal and informal), social and health conditions, and access to the services, their activities, and their benefits and to personalized, quality care.

First, it should be remembered that *identity* is an individual's sense of belonging to a group through the recognition of common characteristics, which may be religious, cultural, phenotypical, based on common ancestry, history, a shared world view, etc. The best-known identities are gender, ethnicity, national origin, culture, sexual orientation, and socioeconomic status.

When human groups are consulted about their identities, it is found that some of them have highly structured cultural legacies that include language, territory, traditions, authorities, standards, symbols, beliefs, a set of values, etc.

In the Region of the Americas, this group includes indigenous peoples, some groups of African descent that preserve their original language, the Rom peoples (or Gypsies), the descendants of people from India in the English-speaking Caribbean, and people of Asian origin in countries such as Brazil, Peru, and the United States.

Other individuals identify with a particular human group through the identification of a common ancestry. In this case, their collective awareness derives from cultural aspects in addition to phenotype, as in African ancestry (Afro-descent). We also find individuals who identify with a particular language, birthplace, and immigrant status<sup>9</sup>.

In short, ethnic/cultural identities make it possible to distinguish different groups, regardless of their demographic importance, who share special circumstances in life and are confronted with barriers that limit their access to the benefits of State action (social policies), as a result of direct or indirect discriminatory mechanisms at the institutional level (organizational structure, policies, or programs) and in interpersonal

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<sup>7</sup> According to the definition adopted by the United Nations system "there is only one human species". Race is a sociological concept used by some human groups to identify their own ethnicity, as in the case of the descendants of Africans who inhabit the Americas.

<sup>8</sup> ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989).

<sup>9</sup> National origin is a cohesive element that fosters the construction of a collective awareness ranging from the settlement of the Region, which led to the creation of diverse groups (Italians, Irish, Catalonians, etc.) to the current immigrant groups, such as the Paraguayans, Uruguayans, and Bolivians in Argentina, the Nicaraguans in Costa Rica, and the Hispanics in the United States, just to mention a few.

relations. These mechanisms persist in societies that have not yet developed a real respect for differences or recognized diversity as the foundation of democracies.

According to the ILO<sup>10</sup>, institutional discrimination may also be direct or indirect.

- Direct institutional discrimination is characterized by actions at the organizational or community level that have an intentional negative differential impact on members of subordinate or minority groups.
- Indirect institutional discrimination occurs when the standards, procedures, or practices of an organization or institution do not exclude or explicitly favor members of dominant groups but end up favoring or penalizing a particular group. In this case, two variants can be distinguished:
  - ♦ Discrimination with a collateral impact, which occurs when discriminatory practices, either direct or indirect, intentional or unintentional, employed in one area produce inequalities and discrimination in another.
  - ♦ Current discrimination derived from the past, which consists of ostensibly neutral practices in the present that reflect or perpetuate the effects of the intentional discrimination historically practiced in the same organizational or institutional area

As mentioned earlier, in the majority of the countries, when disaggregated social and health data are found, the evidence shows that populations have limited access to social protection networks, difficulty gaining access to productive and nonproductive resources and to the services and their activities and benefits, enjoy less protection from health problems, and are less able to resolve them.

In the Region of the Americas, ethnic/racial inequality is one of the main structural causes of the lack of access or unequal and limited access to employment, infrastructure, and social services in health, education, housing, and sanitation; that is, ethnic/racial inequality is a strong determinant of the poverty and social exclusion suffered by men and women throughout life. The health sector, a reflection of these societies, reproduces these barriers and biases, which in turn are manifested in the composition, skills, and performance of the PHWF.

## 2.2. SOCIODEMOGRAPHIC CONTEXT

The Region of the Americas is a complex demographic reality from the standpoint of its ethnic/racial composition, with an estimated 400 indigenous groups—approximately 42 million people—representing 6% of the Hemisphere's population and 10% of the Latin American population. Some 80% of the indigenous population lives in Central America and the Andean region and almost 90% of that population is found in Peru, Guatemala, Ecuador, Mexico, and Bolivia<sup>11</sup>.

The nations of the Hemisphere in which Afro-descendants account for over 45% of the total population are: Brazil, Colombia, Haiti, the Dominican Republic, the English-speaking Caribbean countries, and Venezuela. Brazil, with an official estimate of almost 75 million, is the country with the largest population of Afro-descendants in the Region, followed by the United States, with 36 million (12.9%). These two nations have the largest black population outside of Africa<sup>12</sup>.

Despite the marked demographic presence of indigenous and Afro-descendant peoples in the Region, only very recently have official surveys included a question about ethnic/racial origin in their data collection forms and have systematic studies been conducted that would make it possible to draw conclusions about the situation. The results of these efforts underscore the fact that in the majority of the countries, these groups are socially and economically worse off than the general population (in terms of absolute and relative poverty

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<sup>10</sup> See the bibliography in note 10.

<sup>11</sup> Torres, C. *Etnicidad y salud: otra perspectiva para alcanzar la equidad*. OPS WDC, 2001.

<sup>12</sup> See bibliography in note 4.

rates, employment rates, educational levels, individual and family income, etc.)<sup>13,14</sup>. Measuring health by classical indicators such as maternal and child mortality and life expectancy at birth, it can be seen that these groups are also vulnerable<sup>15,16</sup>, indicating that they have limited access to productive and nonproductive resources, social protection networks—services, with their activities and benefits—and enjoy less health protection and less capacity to resolve health problems.

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<sup>13</sup> Ferranti D, Perry GE, Ferreira FHG, Walton M, Coady D, Cunningham W, et al., (editors). Group based inequalities: the roles of race, ethnicity and gender. In: Advance Conference Edition of Inequality in Latin America and the Caribbean breaking with History? Washington DC: The International Bank for Reconstruction and Development/World Bank; 2003. pp. 81-126.

<sup>14</sup> Organização Internacional Do Trabalho. Manual de Capacitação e Informação sobre Gênero, Raça, Pobreza e Emprego: guia para o leitor. Modulo 1. Tendências, problemas e enfoques: um panorama geral. Brasília: OIT/Secretaria Internacional do Trabalho; 2005.

<sup>15</sup> Banco Interamericano de Desarrollo. Equidad e Indicadores Sociales (EQxIS), estimates based on national housing surveys. Available at [www.iadb.org/xindicadors](http://www.iadb.org/xindicadors)

<sup>16</sup> Brazil. Saúde Brasil 2005 – uma análise da situação de saúde no Brasil. Brasília: Ministério da Saúde; 2005.

## 3. CHARACTERIZATION OF THE PHWF: CONTRIBUTIONS FROM AN ETHNIC PERSPECTIVE

### 3.1. COMPOSITION

Most countries in the Region lack official data on the presence in the PHWF of men and women from different ethnic groups. Meanwhile, there is a wealth of empirical evidence that indigenous peoples, Afro-descendants, and other groups that have historically suffered discrimination are underrepresented in the PHWF serving in communities or civil society organizations as volunteers or in the less prestigious positions—formal or informal employment; they are likewise underrepresented in the more prestigious positions that demand higher professional skills. It is important to underscore that analysis of the socioeconomic life cycle of these people reveals that the lack of opportunity and discrimination begin before they enter the labor market.

It is well-known that access to formal education and staying in school for a number of years are more difficult for the members of these groups. In Brazil, for example, while Afro-descendants account for half the total population, in 2001 only 2.5% had some academic degree.<sup>17</sup> Among graduates, the majority were women. The most common careers are generally related to teaching; for women, other common careers are care-related (nursing, psychology, physical therapy, occupational therapy)<sup>18</sup>. Among graduates, black men and women spend more time searching for jobs than white and ethnic Asian men and women.<sup>19</sup>

#### *3.1.1. Discrimination, Work, Employment: Ethnic/Racial Inequalities in the Composition of the PHWF*

Ethnic/racial inequalities in the labor market are the product of several factors or elements fundamental to their reproduction. In businesses, institutions, and organizations, HR management procedures (recruitment, selection, promotion and dismissal, education and training policies and programs) are not exempt from more or less direct forms of bias and discrimination against workers of African descent, indigenous people, and immigrants, men and women alike.

Social stereotypes and biases result in unequal opportunities for indigenous people, Afro-descendants, immigrants, and women, although other factors also create distinctions among people—i.e., competencies, experience, and skills.

Discrimination is the act of treating people differently and less favorably because of personal attributes, such as sex, ethnicity, skin color, class or status, nationality, political opinions, religion, or sexual orientation, that are unrelated to the merits or skills necessary to do the job or exercise the function.

Discrimination in the labor market (within businesses, institutions, and organizations) involves a number of actors—supervisors, subordinates, clients, and users of the services. Each nurtures biases and stereotypes that reproduce the daily expressions of ethnocentrism, racism, xenophobia, and related forms of intolerance.

The discriminatory act is not always directly motivated by bias. Discrimination perpetuates and legitimizes the asymmetries in power relationships. Those who have power and are interested in maintaining

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<sup>17</sup> Organização Internacional Do Trabalho. Manual de Capacitação e Informação sobre Gênero, Raça, Pobreza e Emprego: guia para o leitor. Módulo 2. Questão racial, pobreza e emprego no Brasil: tendências, enfoques e políticas de promoção da igualdade. Brasília: OIT/Secretaria Internacional do Trabalho; 2005.

<sup>18</sup> See note 17.

<sup>19</sup> See note 17.

the status quo justify discriminatory acts and procedures as the only “rational” way of protecting the interests of society<sup>20</sup>.

From an ethnic perspective, the people who comprise the PHWF can be found in training facilities such as universities, technical schools, NGOs, and health system and health care institutions (services) in state or private agencies and communities. They are health and social sciences professionals, university graduates (physicians, nurses, dentists, occupational therapists, psychologists, biologists, pharmacists, biomedical personnel, physical therapists, nutritionists), technicians and auxiliary health sciences personnel, health promoters (belonging to the system), community volunteers, religious leaders, nurse-midwives, community midwives, and other traditional agents (who serve in communities), policymakers (whether or not they represent these groups), other professionals and technicians.

Characterizing the PHWF from an antidiscriminatory ethnic perspective requires a description of all those employed in the PHWF by sex, age, immigration status, training, work locale, type of contract, duties, type of work schedule, wages/salary, working conditions, training and professional development opportunities, job promotions, occupational and worker’s health, etc.<sup>21</sup>

In the characterization process, it is important to ensure that:

- the ethnic variable adopted is consistent with the country’s classification criteria.<sup>22</sup>
- seniority, function, sex, age, and other factors that describe the worker are considered in order to evaluate whether he/she is being discriminated against in terms of opportunities.
- the different knowledge of all workers in the PHWF is described and valued.
- the questions asked during the characterization are appropriate for the country’s situation, the institutions and organizations (public or private), the NGOs, the community, etc.

Regarding opportunities and service delivery, it is important to bear in mind that the negative images and social representations of women in general and of immigrant men and women and members of the ethnic groups that are discriminated against may be subtly manifested, but their impact is real and cruel. Moreover, there are always people in institutions, organizations, or businesses who verbalize their biases; it is unnecessary to blame such people directly, since they are but expressions of the system. In most cases, they cannot be identified (and there is not need to identify them) because they are the result of the discriminatory process that reveals institutional tendencies.

Annex 1 shows the concepts, arising from the perspective under analysis, as categories or dimensions of the PHWF characterization, with its corresponding indicators and variables.

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<sup>20</sup> See bibliography in note 14.

<sup>21</sup> The experts suggest that the variables presented by the gender experts be considered. See Annex 1.

<sup>22</sup> In Brazil, for example, there are questions about skin color, using the following categories: yellow, white, black, brown, indigenous. In Ecuador, ethnic elements, such as mother tongue, are prioritized.

## 4. DEVELOPMENT OF THE PHWF: CONTRIBUTIONS FROM AN ANTIDISCRIMINATORY ETHNIC PERSPECTIVE

As mentioned earlier, there are two forms of institutional discrimination (ILO definition):

- direct discrimination — when regulations, laws, or policies explicitly exclude certain people or put them at a disadvantage based on their personal attributes
- indirect discrimination — which is derived from ostensibly impartial regulations and practices that result in harm and disadvantages for many members of specific groups

Institutional discrimination, which includes all institutional practices that unequally distribute benefits, opportunities, or resources among different groups, occurs regardless of whether the individual involved explicitly expresses his biases or intention to discriminate. All policies that result in greater ethnic inequality, however unintentional, can be considered institutional discrimination.

Likewise, the objective of developing the PHWF from an antidiscriminatory ethnic perspective is to promote equal opportunities for men and women of different ethnicities, including immigrants, and to help reduce the unjustifiable and avoidable inequalities in health<sup>23</sup> that today systematically affect human groups distinguished by their culture (values, religion, way of life, language, artistic expression), their ancestors, skin color, historical trajectory or circumstances. In this regard, we must be aware that there is no possibility of valuing differences and diversity or promoting interculturalism without reducing biases and eliminating stereotypes. Education and persuasion are necessary for reducing biases and eliminating stereotypes; meanwhile, eliminating discrimination will also require the adoption of legal measures, or the symptoms of inequalities will not disappear. Changes in discriminatory behavior come from changes in culture. Thus, in addition to sanctions, both incentives that foster change and compensatory policies or affirmative action<sup>24</sup> are needed to offset the results of systematic discrimination. One such strategy is to include cultural competency in the skills required of human resources for public health.

### 4.1. EDUCATION/SKILLS OF THE PHWF

The basic frame of reference for human resources education in public health (in academic, technical, and other institutions) should be human rights. The gender and ethnic equality perspective should be mainstreamed within that framework at the institutional, organizational, service or personnel management level.

The demands of the 21st century, the challenges of globalization, the attainment of the MDGs, the strengthening of the EPHF, as well as the advances in science and technology and demographic change call

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<sup>23</sup> The term *inequalities in health* refers to differences between individuals and groups, without any ethical judgment about the situation, while the term *inequities in health* refers to inequalities that are considered unjust and avoidable.

<sup>24</sup> *Affirmative action* is a coherent set of temporary measures promoted by the State and society—whether compulsory, optional, or voluntary—whose basic objective is to address and eliminate the historic inequality experienced by certain social groups that lack the same opportunities and access to the benefits of public action as dominant or majority groups. Affirmative action should include general policies that promote equity, aimed at ensuring equal opportunities to work, prevent health problems, or protect oneself from undesirable consequences.

for workers with the capacity to make decisions, adapt to changing situations, and respect the rights of individuals, in addition to being competent in the technical aspects of their position<sup>25</sup>.

#### *4.1.1. Redefining Essential Competencies and Skills for the PHWF from an Antidiscriminatory Ethnic Perspective*

It has been suggested<sup>26</sup> that the competencies that should be taught in the education of public health professionals include analytical capacity, communication skills, cultural competency, and the ability to monitor the health situation, and that they are related to: policy development/program planning; knowledge of and ability to interpret the law; the public health sciences; information management; financial planning, regulation, and management; disease prevention and control; health promotion; social participation and empowerment; adequate services for vulnerable populations; the promotion and protection of environmental health; improvements in the quality of health services with a guarantee of equity; and human resources development.

It is essential to adopt an ethnic and gender perspective when designing plans and programs for the attainment of the MDGs<sup>27</sup>. This poses a challenge for the Americas, and especially Latin America, where income distribution is markedly unequal and where neglected ethnic and immigrant groups account for most of the poorest, most vulnerable populations. Current public health initiatives have spelled out and developed the necessary cultural competencies, which serve as an analytical and operational framework to support training for human resources in ethnic and gender issues.

Consultations with experts<sup>28</sup> indicate and support new domains for consideration in the definition of competencies. These domains are related to the development of PHWF skills in cultural matters, especially those that are gender, ethnicity, and generation related. Only thus can better performance be obtained for the exercise of the EPHF and attainment of the MDGs. For the present Consultation, two sets of competencies need to be strengthened: those that the experts deemed basic or general, which are useful for all levels of action and for the PHWF as a whole, whether workers are part of the health system or not; and those that are specific to the level of action (for the PHWF that is part of the system). Both sets are described in the tables below (Tables 1 and 2), and their application in the development and performance evaluation process is presented in Annex 2.

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<sup>25</sup> See note 2.

<sup>26</sup> Ruíz, L. De la realidad a las disciplinas: Estructuración de las respuestas educacionales con base en las competencias de las instituciones y de la fuerza de trabajo. In: "Educación en salud pública: Nuevas perspectivas para las Américas". Organización Panamericana de la Salud. Washington, D.C.: 2001. pp 134-159.

<sup>27</sup> OPS. Trabajando para alcanzar la equidad étnica en salud: asegurando que los objetivos de desarrollo del milenio incluyan una perspectiva étnica. Relatoría final. This Workshop was a regional initiative for Latin America and the Caribbean. PAHO Representative Office, Brasilia, Brazil. 1-3 December 2004.

<sup>28</sup> See notes 1 and 2.

4. DEVELOPMENT OF THE PHWF CONTRIBUTIONS  
FROM AN ANTIDISCRIMINATORY ETHNIC PERSPECTIVE

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TABLE 1. CORE/GENERAL COMPETENCIES FOR ALL LEVELS OF ACTION (ENTIRE PHWF)

<b>Core competencies (all levels of action)</b>
Visionary leadership and commitment
Communication, including expanded listening
Collaboration and teamwork
Formation of partnerships and construction of the notion of shared responsibility (co-responsibility), including citizens
Conflict resolution
Use of health information
Research, identification of needs considering social determinants, risk factors, and evaluation of the corresponding interventions
Analytical capacity, critical thinking, proactivity
Decision-making capacity
Creativity, sensitivity, and the personal touch
Cultural competency (including knowledge of languages, different concepts of health, care, and disease, respect for and articulation with traditional medicine)
Ethical evaluation and knowledge of standards in health
Capacity to recognize one's limits, guaranteeing referral to other levels and counterreferral, if needed
Capacity to transfer technology and disseminate knowledge, information, and lessons learned

TABLE 2. SPECIFIC COMPETENCIES BY LEVEL OF ACTION OF PHWF IN THE SYSTEM.

<b>Specific competencies/levels of action</b>	
<b>Administration and management</b>	<b>Comprehensive care (promotion, prevention, treatment, and rehabilitation)</b>
<ul style="list-style-type: none"> <li>• Administrative and management capacity (including identification of needs; definition of priorities; material, human, and financial resources)</li> <li>• Clarity of the expected results.</li> <li>• Ability to establish intra- and intersectoral links</li> <li>• Commitment to reducing disparities and promoting equity (definition of standards of equity, changes in work procedures, periodic monitoring and evaluation)</li> <li>• Commitment to developing and carrying out affirmative action, a positive discrimination mechanism for the PHWF</li> <li>• Commitment to developing and executing activities to identify access barriers and discriminatory practices</li> <li>• Investment in the education of professional staff and technicians, with emphasis on nondiscrimination, sensitivity, and cultural competency</li> <li>• Commitment to implementing mechanisms and strategies to prevent discrimination and combat and prevent ethnocentrism, racism, sexism, and intolerance</li> </ul>	<ul style="list-style-type: none"> <li>• Ability to operate in a pluralistic intercultural environment with respect, adaptability, sensitivity, and professionalism</li> <li>• Ability to create an environment where traditional and western knowledge are shared</li> <li>• Knowledge of the history and cultural features and mores that generate health risks (skill developed through contact with the community and ethnic groups)</li> <li>• Capacity to transform the act of care-giving and educate for health in action involving the sharing of values, expectations, and commitments</li> <li>• The ability to motivate users and their families to participate in prevention, treatment, or rehabilitation (establishment of co-responsibilities)</li> <li>• Use of the language of the group served</li> </ul>

## 4.2. PERFORMANCE

The ethnicity and health experts consulted agreed that the development of health workers requires adequate working conditions, performance incentives, and appropriate knowledge and skills to promote quality performance and good practices and thereby achieve work objectives and contribute to better health care<sup>29</sup>.

Undoubtedly, defining new competencies to improve PHWF performance helps to identify the urgent needs of the workforce, fostering better performance, and developing incentives that encourage good practices, especially when the goal is to guarantee human rights, and to include new perspectives in this approach.

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<sup>29</sup> See reference in note 3.

## 5. FINAL CONSIDERATIONS

The main challenges for the health sector in adopting an antidiscriminatory ethnic perspective in the development of the PHWF are:

- adopting a rights-based approach in training and education for health<sup>30</sup>;
- knowledge and respect by all members of the PHWF for the fundamental aspects of the culture of each human group in the country or locality where the health services are located;
- education to ensure that the PHWF recognizes ethnocentrism, racism, discrimination, and intolerance as determinants of health status and care;
- including contents in vocational training and continuing education activities that address the issues of ethnocentrism, racism, multiculturalism, interculturalism, and their link with the health of populations;
- encouraging and increasing the participation of members of marginalized ethnic groups in the PHWF that works in schools of health and the health system, including the more prestigious jobs and responsibilities.
- expanding and evaluating the communication between health promoters and caregivers whose practices are based on traditional knowledge and wisdom and those whose practices are based on western medicine;
- setting up information systems to make it possible to describe and analyze the health and health conditions of the different ethnic<sup>31</sup> groups;
- identifying and recognizing the specific health needs of ethnic groups;
- information and communication using appropriate ways of presenting the evidence of inequity in health, with the object of contributing to system administration and service management for social monitoring and better training and education for health;
- including political and social actors in health planning, promotion, and protection;
- setting priorities and allocating resources to differentially address the specific needs of groups;
- defining work processes in health that address the needs and demands of the different human groups with adaptability, sensitivity, and professionalism (organization of the system, structure of the services, human resources, and types of care);
- defining appropriate, sensitive indicators for monitoring and assessing the impact of policies, programs, and actions on different human groups.
- prioritizing and implementing mechanisms and strategies to reduce disparities between and among groups to promote equity.

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<sup>30</sup> The regional mobilization sparked by the World Conference on Racism, Racial Discrimination, Xenophobia, and Related Forms of Intolerance, convened by the United Nations Organization in August 2001, opened many possibilities for effective, coordinated efforts between governments and civil society. One of the goals of the Millennium Declaration, adopted during the 55th UN General Assembly in September 2000, is to respect fully and uphold the Universal Declaration of Human Rights. The Declaration also urged the Member States to spare no effort to encourage respect for human rights, including those of minorities, and “to take measures to ensure respect for and protection of the human rights of migrants, migrant workers and their families, to eliminate the increasing acts of racism and xenophobia in many societies”.

<sup>31</sup> The description of the health situation of the different human groups should take into consideration that ethnic minorities are normally socially underprivileged, have difficulty accessing material and nonmaterial resources, suffer from the unequal distribution of power, and their rights, including the right to health, often are not guaranteed.



CHARACTERIZATION OF THE PHWF. PROPOSED CATEGORIES AND VARIABLES FOR THE SYSTEM WORKFORCE, FROM AN ANTIDISCRIMINATORY ETHNIC AND GENDER PERSPECTIVE<sup>32</sup>

1. Context

INSTITUTIONAL			
Dimension	Categories	Data	
<b>Where are they?</b>	<b>A. Institutional profile</b>	Name and geographical location	Name of the institution/organization; address; location (urban or rural); work process
		Type of institution or organization	Nature of the institution (services, research, education); Level of care provided (primary, secondary, tertiary, special)
		HR development policies, programs, and initiatives	In-house and outside training programs; promotions; incentives and encouragement for workers
		Antidiscrimination policies, programs, and initiatives	Existence of antidiscrimination initiatives or programs Existence of positive discrimination programs or initiatives to favor members of excluded ethnic groups or the disabled (affirmative action) Incentives and encouragement for leaders who work for inclusion, integration, or no discrimination between male and female members of excluded ethnic groups or the disabled
		Health services for workers	Existence of disease prevention programs and occupational health protection for workers Existence of appropriate environments for workers with disabilities Programs for monitoring workers' health
	<b>B. Labor rights</b>	Type of contract	Male and female workers from the different ethnic groups with fixed term, permanent, assignment-based, or professional service contract and without a contract
		Job security	Men and women from the different ethnic groups holding interim, substitute, and other positions
		Work schedule	Men and women from the different ethnic groups by the time devoted (full-time, half-time, part-time); and shift (day, night, mixed, special)
		Regulations	Professional or institutional
		Remuneration and retirement plans	Wage in dollars and other components, such as specie, per diem, discounts, incentives, overtime, professional career path, exclusive commitment, prohibition, zoning, for women and men from the different ethnic groups
	Cultural aspects	Existence of labor rights consistent with freedom of religion and independent of the age and ethnic identity of workers	

<sup>32</sup> Proposal based on the results of the work of the gender advisory group.

PUBLIC HEALTH WORKFORCE:  
ITS CHARACTERIZATION AND DEVELOPMENT FROM AN ETHNIC PERSPECTIVE

INDIVIDUAL*		
Dimension	Categories	Data
<b>Sociodemo- graphic</b>	Marital status	Single, common-law union, married, divorced, separated, widowed
	Nationality	By birth or naturalization
	Age	...in years
	Immigration status	Documented, undocumented, temporal, permanent
	Sex	Male or female
	Ethnicity	Ethnic group**
<b>Homes</b>	Status in the household	Head of household Spouse Son/daughter Other
	Type of household and relationships	Nuclear, blended, extended, single-person family; presence of people under 18, older and disabled adults who cannot take care of themselves
<b>Schooling</b>	Education	Basic education, intermediate, university, post-graduate
	Profession	Physician, nurse, dentist, occupational therapist, psychologist, biologist, pharmacist, biomedical personnel, physical therapist, nutritionist, laboratory worker, nursing auxiliary, health promoter
<b>Employment</b>	Work areas	Managerial, administrative, operational, miscellaneous
	Job	Profession or trade
	Seniority	Years of service, age entered the workforce
	Income	Gross amount in local currency, its equivalence in minimum payment for work units, or its correspondence with national scale of jobs and salaries
	Work promotions	Job training, promotions received, date of last promotion, number of promotions
	Work load	Number of jobs currently held, type of employment, number of hours of work per week (total for all jobs) type of contract in each job
<b>Health</b>	Disabilities	Disaggregated by type of disability
	Chronic diseases	Disaggregated by disease

**How many are there?** This will be obtained by applying the methodology for characterizing the PHWF.

\* Data should be disaggregated by sex, ethnicity and, if possible, age.

\*\* The ethnic variable used should be consistent with the country's classification criteria.

## 2. Function and Quality of Performance

	DIMENSION	DESCRIPTION
<b>What do they do? *</b>	Type of function Functions of the position Functions exercised	Taxonomy of the position; professional profile for the position; vocational or technical training
<b>How do they do it?</b>	Use of their time Review of process and procedures Compliance with standards Quality of performance Interdisciplinary work Commitment to equity Commitment to the local community.	Availability and application of standards and techniques; performance gaps, observed or perceived educational needs (indicate five tracer examples to verify what they do); initiatives to identify access barriers and discriminatory practices among workers and between workers and users (indicate five tracer examples to verify what they do); definition of equity standards (describe strategies or mechanisms for meeting the standards)

\* Data should be disaggregated by sex, ethnicity and, if possible, age. The ethnic variable used should be consistent with the country's classification criteria.

## 3. Quality of the Results

	DIMENSION	DESCRIPTION
What do they yield? *	Production and productivity Satisfaction of general demands and the demands of specific groups	Number of activities carried out by type; geographical and population coverage; ties to programs and plans; participation in the planning of activities; definition of monitoring and evaluation mechanisms

\* Data should be disaggregated by sex and ethnicity. The ethnic variable used should be consistent with the country's classification criteria.

DEVELOPMENT OF THE PHWF. PROPOSED DIMENSIONS AND STRATEGIES FROM AN  
ANTIDISCRIMINATORY ETHNIC AND GENDER PERSPECTIVE<sup>33</sup>

DIMENSION	CATEGORY	DATA
<b>Education-training</b>	Training	Men and women from the various ethnic groups that have received in-service training, disaggregating by study schedule (day, evening, night); training modality (presential, tutorial, virtual); payment method (fellowship, loan, own resources)
	Areas of training	Technical, personal development, associativism, human rights, diversity and interculturalism, interpersonal communication, knowledge of the languages spoken by the local community
	Opportunities	Taken advantage of, rejected, missed
	Obstacles	Related to formal education, training and updating, languages, professional performance, seniority, health status, disability, cultural identity; ethnic identity; sexual orientation; religious affiliation; political affiliation
<b>Promotion in the workplace</b>	Promotion criteria	Age, sex, place of residence, ethnicity, immigration status, formal education, training and updating, languages, performance, seniority, disability
	Number of promotions	Men and women who have been promoted in the past ... years, disaggregating by ethnicity, immigration status, and age
	Participation in promotion processes	Participation in the formulation of criteria Participation in committees for the evaluation of candidates
<b>Performance</b>	Review of standards, processes, and procedures	Adherence to the principles of nondiscrimination, comprehensiveness, and equity
	Utilization of standards	Complies with them, knows them, they are available, they are clearly established, they are within the reach of all people
	Interdisciplinary work	With other disciplines and professions; working group or team; frequency of interdisciplinary work
	Contact with nondominant ethnic groups	As an interdisciplinary working group or team; in paid community activities; as a volunteer in community activities; other situations Frequency of contact with minority ethnic groups
	Planning	Participation in the process; participation in decision-making; community participation (including members with a different ethnic identity and immigration status)
	Perceptions and attitudes	Respect for differences and diversity; sensitivity and ethnic and gender equity
	Quality of performance and impact of the results	Monitoring and evaluation mechanisms and strategies

<sup>33</sup> Idem note 20.

DIMENSION	CATEGORY	DATA
	Information and communication	<p>Communication products and processes to reach the different areas of the health sector and other strategic sectors defined (education, residence, work and employment, social development)</p> <p>Communication products and processes to reach and strengthen the community defined</p>
	Job satisfaction	<p>Remuneration adequate to the function;</p> <p>practice consistent with the profile of the post; motivation to work; commitment to the organizational mission; organizational climate and culture; adequate training</p>



