IFMSA Policy Document

Ethnicity and Health

Proposed by DENEM-Brazil and TurkMSIC-Turkey

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Policy Statement

Introduction:

Across the world, political ethnic minority populations face discrimination, vulnerabilities and violence with the potential to lead to poor health status and access to healthcare. The concept of minority in this case is not related strictly to quantitative aspects since many times these groups represent a great share of a country's population. In this sense, the concept is rather related to their access to social human rights and consequent capacity to intervene in a society's dynamic. Generally, ethnic groups such as Afro-Descendant people, Indigenous populations, Romani, and others, suffered consequences of colonization and imperialist expansion. Many of these groups were decimated and expelled from their original territories and relegated to a situation of social marginalization. Currently, these sub-populations endure multiple forms of discrimination resulting in significant inequities, including high levels of poverty and violence, and consequently, the denial of their individual rights and their collective rights.

IFMSA's position:

Against this backdrop, IFMSA recognizes and promotes the individual and collective rights of ethnic minority populations. IFMSA encourages healthcare students from all around the globe to stand up against different forms of discrimination, racism, vulnerabilities, and violence and to advocate for the necessary social change to tackle these inequities and result in a higher access to healthcare and better conditions of life to these political minority ethnic groups.

Call to action:

Therefore, IFMSA calls on:

Governments, according to ability, to:

- Design mechanisms to identify and acknowledge disparities in health across ethnic groups;
- Employ equity programs to target these groups and increase access to healthcare, as well as treatment and health outcomes;
- Collaborate with representatives of political minority ethnic groups to devise public policies aiming to develop comprehensive strategies for improving the health and opportunities of Indigenous peoples;
- Include the involved groups in all steps of discussions and decision-making processes regarding health, environment and climate change, energy sources and land use;
- Recognize and promote the rights of Indigenous peoples to cultural identity and self-determination in their provision of healthcare;
- Fund research related into the structural deficits in healthcare systems that enable racism in medicine to occur;
- Promote Indigenous sovereignty of land and recognize that disruption of the commonly held value of connection to land has carry-on effects to health outcomes of political minoritary ethnic groups.

International organisations and non-governmental organisations (NGOs) to:

- Produce regional and global reports addressing this theme;
- Develop targeted programs to address which groups should be engaged more directly in health care in each country being actioned, as well as the different mechanisms with which these groups will be engaged;

- Ally with local governments to address these disparities in socio-economic factors that limit access to both education and health care, and form action plans to rectify this;
- Devise plans so as to empower communities that are identified as at risk, as well as enable community members to access medical education to pursue careers in the healthcare sector.

The Health Sector, Universities and Medical Faculties to:

- Recognise barriers to higher education such as socio-economic factors that limit the achievability for a student from a minority population to be accepted into a Medical School, let alone complete their education within the expected timeframe;
- Include the debate on why certain population groups have such a disparity in health status, rather than repeating statistics that perpetuate ideas into new medical professionals;
- Create scholarships, as well as access pathways, to afford the cost of leaving a community to attend university, as well the difference in quality of education;
- Develop research on the topic, using a participatory approach in partnership with political minority ethnic groups, social movements and their representative organizations;
- Discuss and implement an integrative model of healthcare, enabling the provision of holistic and culturally safe health care;
- Promote and deliver holistic and patient-centered care to Indigenous patients in a culturally safe and competent manner;
- Collaborate with representatives of Indigenous groups to devise public policies aiming to develop comprehensive strategies for improving the health and opportunities of Indigenous peoples.

IFMSA National Member Organizations (NMOs) and medical students to:

- Strive to reduce biases in the education they receive from their institution;
- Recommend that medical schools within their country/region advocate for curricular frameworks that promote political minority ethnic groups' health and cultural safety as key components of medical education;
- Devise racism policies with clear ramifications for any student identified as bullying and/or harassing students based on gender, race, cultural background or sexual orientation;
- Consider vulnerabilities related to ethnicity while placing support networks (e.g. mentorship programmes), in conjunction with medical schools;
- Join other social movements in the struggle against racism in your countries;
- Advocate for their students, and attempt to supplement cultural safety education through conferences and education opportunities where possible.

Position Paper

Background

Across the world, political minority ethnic populations face several conditions of discrimination, vulnerabilities and violence which might lead to poorer health status and access to healthcare. It is important to note that the concept of minority in this case is not related strictly to quantitative aspects since many times these groups represent a great share of a country's population. In this sense, such concept is rather related to their access to social rights and consequent capacity to intervene in a society's dynamic. Generally, ethnic groups such as Afro-Descendant people, Indigenous populations, Romans, and others suffered consequences of colonization and Imperialist expansion, in a way that many of them were decimated and expelled from their original territories and relegated to a situation of social marginalization. Currently, these populations often endure multiple forms of discrimination resulting in significant inequities including high levels of poverty and violence, and consequently, the denial of their individual rights and their collective rights. Against this backdrop, IFMSA seeks to recognize and promote the rights of these populations, encouraging healthcare students from all around the globe to stand up against different forms of racism and to struggle for the necessary social changes that will tackle these inequities and result in a higher access to healthcare and better conditions of life of these political minority ethnic groups.

Discussion

Who are these political minority ethnic groups?

Definition of racism is the discrimination suffered by a population that is subjugated historically, politically or economically by the other (the ethnicity difference between the two populations is the determining factor). This phenomenon is not only presented in its direct form, which is when an individual suffers verbal violence, for example, but also presents itself in an institutional form, as a form of collective consciousness. Institutional racism is defined by the failure of institutions in providing services to a population because of the characteristic ethnicity/colour of that population (1). The capitalist system in various ways appropriates work to produce even more profit. Throughout history in several populations, similar instances were seen. An example is slavery where the availability of free labour is made possible to reduce costs in production and therefore, generate a greater margin of profit. For instance, nowadays, after the abolishment of slavery, salary differences based ethnicities/color is a way to appropriate the racism for the increase of profit (2).

The historical process that has shaped and influenced several societies brought consequences, most of the populations subjugated in the past, mainly blacks, Indigenous (Native Americans), etc.; today go through immense problems, as a lower rise social in a general way. In different regions across the world, Indigenous people, Afro-descendants, Roma, and members of other political minority ethnic groups continue to experience structural discrimination, exclusion, and inequality. Despite of the lacking data addressing this, available information shows that these populations exhibit higher levels of poverty, lack of access to basic services such as water and sanitation, low levels of education, low rates of participation and representation in decision-making processes, and higher employment in low-paying jobs. Indigenous groups currently account for around 17% of those living in extreme poverty in Latin America, even though they represent less than 8% of the population **(3)**.

Furthermore, despite the lack of precise data on the size of the Roma population, available information shows that Roma households often live in extreme poverty, lacking electricity, clean water, and sanitation facilities, as well as access to public health services **(4, 5)**. In the past, these groups suffered a high burden of violence, being expelled from territories they used to live in, and, since then, they faced a process of social marginalization. Invisibility and discrimination persists even in current days, putting them in a situation of high vulnerability. That is the reason why these ethnic groups are often regarded as minorities – it is not a matter of quantitative aspects, but it is rather related to social inclusion and participation.

It is impossible not to observe correlations between health and socioeconomic conditions (6), so the health of these populations and the differences observed in the indicators come directly from the historical process in which they are inserted. Defining ethnicity may not be an easy task in some countries as it is in others. In some countries, such definition becomes complicated due to intense population miscegenation. Even so, when we look at some health indicators, the correlation between ethnicity and access to health is observed. Data is alarming and there is still the problem of sub-notification of them and the lack of more comprehensive and solid research on the subject.

According to James Nazroo (7), it is not possible to have access to mortality data categorized by ethnicity in the UK, however it is possible to observe significant differences on the health data of the different immigrants, for example, individuals from Bangladesh and Pakistan present lower health levels. In 1845, Engels identified higher mortality rates among the Irish who lived in the United Kingdom, which he attributed to worst socioeconomic conditions (7). In Brazil, maternal mortality rate among black women is considerably higher than among white women (the rate is double among black women), also, when analyzing the Brazilian Health Data System (DATASUS) a higher rate of tuberculosis is observed among the non-white population (8, 9). In United States, greater cases of depression and suicide are observed among the black population (10), and it is impossible not to mention the violence of the state that causes higher mortality rates arising from violent death, as well as higher rates of diseases such as cancer, stroke, asthma, influenza, pneumonia, HIV/AIDS. In addition, population rates covered by health insurance are lower among the African American population (11).

It is worrying that explanations that consider cultural stereotypes and genetic difference still persist, despite of the growing number of researches that says exactly the opposite about differences on health between the ethnics groups, as Nazroo (7) said, "*the obvious social and economic inequalities faced by ethnic minority groups are like to be a fundamental explanation*". Considering the social determination of health disease process, it is necessary to evaluate the socioeconomic conditions from certain populations and the connection with the largest rates of illness of this population. The lack of access to rights such as health care, basic sanitation and the unpreparedness of some professionals to deal with the specifics of certain populations causes gap between the health indicators and even the collection of data in the health system is impaired.

Community and Socioeconomic Factors

The United Nations adopted the Declaration of the Rights of Indigenous Peoples in 2007, In line with Article 23 of the declaration, IFMSA advocates for community-directed models of healthcare, whereby collaboration with, autonomy and self-determination of Indigenous communities is paramount. The health of Indigenous people and that of their communities is influenced by a myriad of complex and interrelated factors which also intersect with gender, age, sexuality, disability, socioeconomic status and other determinants. The literature consistently indicates that Indigenous people have fewer opportunities to access healthcare education, employment, proper housing, quality

food, clean water, and equitable income. Such poor social determinants of health translate into observable diseases: "for many Indigenous people who have migrated to urban areas, including in the developed world, urban diets are a severe health threat, resulting in malnutrition, diabetes and obesity." (12) Many of these populations suffer the consequences of significant health gaps, and the available data on indigenous and Afro-descendant groups show inequities in comparison with the general population.

Addressing the social determinants of health is the cornerstone of preventative healthcare regarding Indigenous health inequality.

Several mental health issues such as depression, substance abuse and suicide have been identified as connected to the historical colonization and dispossession of Indigenous peoples, which has resulted in the fragmentation of Indigenous social, cultural, economic and political institutions. Targeted culturally sensitive mental health campaigns and mental health services for the vulnerable group of Indigenous persons with mental illness should be promoted. One of the main determinants in Indigenous health relates with their access to land. Many Indigenous people were conquered and their land stolen, generating conflicts that persist for decades. Access to land goes beyond physical space. It has to deal with productive space, in order to guarantee habits of strativism and hunt. Moreover, health is affected by the constant conflict situation of land disputes, as seen on the countryside of Brazil, where Indigenous people may flee to cities and confront poor conditions of housing in urban areas. Connection to land is a common ideology held among Indigenous populations. Forced removal, damage to and eviction from land have an impact on Indigenous mental and physical health. Thus, promoting Indigenous access and rights to their land improves health while tackling food safety, proper housing, violence and immigration issues. For those who had to flee their country or region, lack of access to healthcare is even more problematic. Other than physical damage, they might be suffering from due to lack of land, housing and clean water as already mentioned, we need to address the mental health issue due to big change and possible cultural shock.

In maternal health, even though these groups have a fertility rate that is roughly 50% higher than in the general population, they receive less, inequitable, and culturally inappropriate care in pregnancy, childbirth, and the puerperium, (13). In sexual health, the lower levels of access to education mentioned earlier have negative implications for access to sex education. Despite the limited information in this regard, it has been found in some countries that HIV infection rates are more than nine times higher among Afro-descendants than Caucasians, while the indigenous population exhibits a higher degree of risk behaviors, such as low condom use (14). Malnutrition among indigenous children in the Region is higher than among the non-indigenous population (13). In the case of Guatemala, 58% of indigenous children suffer from chronic malnutrition and 23% from severe malnutrition, while 34% of non-indigenous children have chronic malnutrition and 10% suffer from severe malnutrition (15). Even with underreporting, in some countries these populations have higher rates of violence against women and suicide (13).

Racism gives rise to increased rates of violent crimes committed against Indigenous people. In Canada, Indigenous women are almost three times more likely to be killed by a stranger than non Indigenous women (12). Incidents of rape, gang rape and attempted rape often exceed all other forms of gender-based violence, particularly in Uganda and Bangladesh (16).

In the majority of the cases, perpetrators are from a non-Indigenous background, and the authorities (i.e. police, army) are often involved. In this matter, the lack of access to the justice system, systemic racism and the absence of crime investigations entertain a strong culture of impunity. Systemic, hierarchical racism and a lack of access to adequate legal representation combined

with often lower socioeconomic status of Indigenous populations leads to higher incarceration rates of Indigenous persons compared with their non-Indigenous counterparts. Thus, beyond mere access to medical services, the health of Indigenous peoples reflects the broader social, political and economic environment in which they function.

Indigenous Health

From the Arctic lands to the South American deserts; the North African mountains to the Polynesian islands, Indigenous peoples account for greater than 370 million people worldwide according to the United Nations Permanent Forum on Indigenous Issues. These populations, due to the historical and ongoing implications of colonization, discrimination, assimilation, paternalism and marginalization, continue to suffer negative health impacts today. Indigenous health is often stereotyped as a rural health issue, but the data shows that these populations are settled and access health care across the entire spectrum of healthcare settings. IFMSA endorses preventative medicine and as such, the focus of improving Indigenous health outcomes should be directed at, but not limited to, the community-based primary health care. This can happen daily for those caring for patients of all ages in a wide variety of settings, including rural communities, urban environments, or tertiary care centers. It is important to not only build cultural capacity among the current health workforce but to strive for parity in Indigenous representation amongst multidisciplinary teams within the system; health care students, workers, professionals and policy-makers. Health care also needs to be delivered in a culturally safe manner.

Indigenous peoples around the world continue to suffer from disproportionately high rates of morbidity, mortality, poverty, illiteracy, crime and human rights violations. Access to culturally sensitive health care and education are significant issues throughout the world.

• Life Expectancy:

- In Australia, an Indigenous child can expect to die 20 years earlier than his non-Indigenous counterpart;

- In Nepal the life expectancy gap is also 20 years;

- In Guatemala the life expectancy gap is 13 years;

- In New Zealand the life expectancy gap is 11 years

• Mental Health:

- In the United States, a Native American is 62 per cent more likely to commit suicide than the general population.

• Infectious Diseases:

- In the United States, a Native American is 600 times more likely to contract tuberculosis.

• Non-Communicable Diseases:

- In Ecuador, Indigenous people have 30 times greater risk of throat cancer than the national average;

- Worldwide, more than 50 per cent of Indigenous adults suffer from Type 2 diabetes (17).

Climate Change and Indigenous Health

Indigenous peoples are often closely related to and dependent on their land and its resources. Due to living predominantly in isolated environments, having stronger dependence on local ecosystems and often suffering from lower socio-economic statuses, it comes with no surprise that Indigenous peoples are amongst the first to face the consequences of climate change, despite the fact that they contribute little to greenhouse emissions. Climate-related health consequences and mortalities arise from environmental disruptions in various regions of the globe: in the Himalayas, glacial melts will lead to water shortage in the long term, affecting hundreds of millions of inhabitants. In the Amazon, droughts and forest fires have and are likely to continue to impact the local Indigenous communities. In the Arctic, the disappearance of traditional food source due to changing ice and weather conditions, coupled with higher risk of drowning when fishing and hunting on thinner ice, presents important threats to food security. Finally, the rising temperatures, extreme weather conditions and loss of vegetation in the African Kalahari basin threaten once again the food sources and the survival of local Indigenous communities. Indigenous peoples worldwide are thus faced with higher risks of mortality and tremendous dangers to their health, food security, as well as cultural identity and traditions (18).

Nonetheless, as shown by many examples around the world, Indigenous communities, with their long history of coping with environmental hardships, often showcase creative ways to respond to climate impacts (18). For example, in Bangladesh, one of the countries most affected by rising sea levels due to climate change, an Indigenous technique is used to cultivate floating vegetable gardens to avoid flood. Therefore, Indigenous peoples should constitute important allies in tackling climate change.

Cultural Safety and Competence

Cultural safety is a concept originating from New Zealand that confronts the views, discourses and assumptions of health care workers that impact Indigenous peoples seeking health care (19). It requires health practitioners to provide care in a manner that is respectful of a person's culture and beliefs, and that is free from discrimination. Cultural safety in the context of health care training does not focus on learning about a culture and goes beyond cultural competence. Rather, it entails continual self-reflection and examination of one's own identity and cultural beliefs. Furthermore, it explores the ways in which these biases can manifest in the interactions with those one cares for (20). The Indigenous Physicians Association of Canada also emphasizes; "a central tenet of cultural safety is that it is the patient who defines what 'safe service' means to them" (21). Medical students and health care providers to practice a duality of both cultural competence, so as to practice in harmony with local Indigenous values, culture and traditions, as well as cultural safety, an ongoing reflection of one's own cultural biases.

The provision of holistic healthcare and appreciation of health in a cultural context is essential in improving the health of Indigenous peoples and their communities. In a major study of the cultural competence evidence-base in health care, the National Center for Cultural Competence found culturally safe practice improved health outcomes, patient satisfaction and engagement (22).

Health care professionals should adopt a holistic approach in offering advice and care for their patients. They should practice cultural humility by respecting local traditions, including traditional medicine and medicinal practices, and by being careful not to impose their own values. Indigenous peoples widely have a more inclusive and diverse conceptualization of health and healing than is allowed for by the biomedical model of health (23). In this appreciation for differences, and by allowing one's Indigenous patients to define culturally safe services; physicians can understand how best they can provide truly holistic care, at the benefit of patients of all cultural origins.

Health Workforce

All medical school curricula, especially in countries, which count Indigenous inhabitants, should adequately and appropriately prepare medical students for work with Indigenous populations. Curricula must differ between medical schools and countries depending on local Indigenous culture, beliefs and practices, however it should foster fundamental knowledge, skills and competencies required for practice in a culturally safe manner. This would not only serve to benefit Indigenous patients, but would open doors for improved understanding of communication complexities with patients of other marginalized and disenfranchised populations. Despite increasing concern regarding Indigenous health, there continues to be an underrepresentation of Indigenous people in health care disciplines. Increasing Indigenous representation in medicine and policy making will improve access of Indigenous peoples to physicians who share their culture and language. This is in keeping to the endorsed concept of self-determination of Indigenous communities.

Lessons from the experiences of Afro-descendant peoples:

Whilst the following section applies specifically to examples of people of Afro descent, it is important to acknowledge that the issues highlighted apply broadly to all ethnic minorities and that strategies to redress racism within healthcare settings should appreciate this.

General overview

For centuries, people of African descent living in the African Diaspora, were marginalized as part of the legacy of slavery and colonialism. There is a growing consensus that racism and racial discrimination have caused people of African descent to be relegated in many aspects of public life, they have suffered exclusion and poverty and are often "invisible" in official statistics. For instance, Indigenous and Afro-descendant peoples in Latin America represent 40 percent of the total population—a sizeable share—yet they remain a disproportionate segment of the poorest of the poor (24). In several settings, Afro Descendant People have higher rates of maternal and infant mortality, lower education level compared to caucasian population, are more vulnerable to violent situations and have less access to health care, besides often occupying positions of lower social prestige (25). Such health disparities, faced by different ethnic groups, are the result of a set of barriers related to social classes, work, access to health services and cultural factors.

Psychological impact of racism

Racism is a pernicious, pervasive and persistent social problem, in a way that it has been a central and defining topic in social psychology. As a complex social issue, multiple perspectives have been advanced to understand and theorise racism, ranging from accounts that locate the causes within

the psychology of the individual to those that emphasise the political and structural determinants of intergroup hostility. In many ways, social psychology has assumed responsibility for understanding racism as the litmus test of its own value as a sub-discipline of psychology and on its practical value to solving real social problems.

Although the notion of a biological hierarchy between groups is generally eschewed today and is associated with old-fashioned and blatant forms of racism, it has been replaced more recently with beliefs in a cultural hierarchy between groups where the dominant group's social values, norms and practices are represented as superior to those of less dominant groups. This is generally referred to as 'new racism' or modern racism (26).

Racism causes many psychological problems related to self esteem, anxiety, depression in people suffering from racism daily (27, 28). Perceived racial discrimination (PRD) is a risk factor for a wide range of undesired health outcomes across populations, particularly racial and ethnic minorities. Among Black youth, PRD increases risk of mental health problems such as psychological distress, suicidal ideation as well as psychiatric disorders such as anxiety and depression (29, 30). Experiences of microaggressions, a form of covert everyday discrimination, have been linked to multiple negative mental health outcomes as well, including serious psychological distress, depression and decreased life satisfaction, mood and substance use disorders, somatic symptoms, anxiety, obsessive-compulsive disorder, and increased suicide risk.

Harms caused by chronic exposure to microaggressions of racism may be compared best to harms caused by other chronic interpersonal stressors, such as bullying and sexual harassment. Even though this is a neglected subject, the few existing research shows that because of racial discrimination, the afro descendant people have damage to their mental health (31). At a broader level, institutional racism also sustain disparities amongst ethnic groups, in a way that black people face prejudice and have less opportunities in several levels of society.

Maternal health

It is important to think of racism in its most common form, in social life as a whole, and to perceive the black woman as a social victim of this already legitimized system. From basic care, black women have more difficulty accessing these ambulatory care than white women. Maltreatment by health teams ranges from lack of information to neglect of advanced medical treatment.

Taking the case of Southeast Region of Brazil, one can notice that rates of maternal mortality, for example, is more than double for black women while compared to white women (4.79 and 2, 09 women per 100,000 population, respectively). Mortality rates due to HIV contamination are also higher among black people (12.29 women per 100 thousand inhabitants) than among white people (5.45). The proportion of those who could not be met in the first maternity sought was 31.8% among the black women, and 28.8% among the brown women. Among white mothers, the rate is significantly lower, of 18.5%. Also, black women were victims of rape more frequently than white women in the country (32).

The dossier "The Human Rights Situation of Black Women in Brazil" also shows that 62% of women who die during childbirth are black. Of the total number of pregnant black women, only 55% performed the seven prenatal consultations recommended by the World Health Organization (WHO) and provided by the Stork Network, the policy that structures assistance to pregnant women and babies in the SUS. Pregnant African American women encounter multiple physical, psychological, and social stressors. The four themes included knowledge of preterm birth, risk factors for preterm birth, protective factors for preterm birth, and preterm birth inevitability. Risk factors for preterm birth were health-related conditions, stressors, and unhealthy behaviors. Stressors included lack of social and financial support,

interpersonal conflicts, judging, dangerous neighborhoods, racism, and pregnancy and mothering related worries. Protective factors for preterm birth included social support and positive coping/self-care (33, 34). In spite of being a report detailing the case of one specific country, such findings are relevant for other realities and highlight the need for research related to the topic, which is still neglected in academia. Not only in the country cited above, but in different other realities, black women appear as the majority of victims in various indicators of human rights violations.

Organic diseases

There are several deadly diseases that strike Black people harder and more often than they do other groups, particularly white people. But, there are few studies about specific treatment to this population. Around 7.6 percent of black women have heart disease, compared to 5.8 percent of white women, according to Centers for Disease Control and Prevention data from 2011-2013. And while white women's diabetes diagnosis rate is 5.4 per 100, that number is 9.9 per 100 for black women, according to CDC data from 1980-2014. Black women have a 1 in 9 chance of developing breast cancer; for white women the odds are 1 in 8, according to the American Cancer Society. But black women are more likely to die from the disease: White women's probability of dying from breast cancer is 1 in 37, while black women's is 1 in 31. Along with BRCA mutations, black women are more likely to get triple-negative breast cancer—a particularly aggressive form of the disease—than women of other races. Then there are the environmental factors, like socioeconomic issues that lead to trouble accessing early diagnosis and treatment (35).

One of the neglected diseases whose prevalence rate in the population is high, especially among black people, is sickle cell anemia and this is a clear demonstration of how racism influences science, services, and the construction of public policies, because there is few studies about this condition. Sickle cell anemia is a common genetic disease in Brazil, with about 200,000 cases per year. The deformation in the red cells brings serious health complications, such as pains, ulcers and implications in the circulatory system.

Diabetes mellitus is also more common in afro descendant people (type II), whose mortality rate, per 100 thousand inhabitants, affects 34.1 in the black population, in the brown population it reaches 29.1 and, among the white, 22.7. (36) Another disease that, while treatable, has higher mortality rates and lower treatment success rates in the afro descendant population is high blood pressure. Although there is important evidence that there is progress in controlling the pressure, this gain did not occur to the same extent for white people and black people. Among the former, the reduction of this contribution was more significant than among the latter. The medical literature has recorded that black people have higher blood pressure levels and are more difficult to control them. For instance, there are some specific classes of antihypertensive drugs that show to be resistant in black people. Such information is barely commented in medical schools, though. This occurs even among people who are continuously treated with antihypertensive medications and an explanation involves the genetic factor. However, we can not ignore other possible variables, such as the socioeconomic conditions of Afro-descendants, which tend to be lower than those of the white population, having a general impact on organic diseases (37).

Patient Care

Racial discrimination has been increasingly reported to have a causal link with morbidity and mortality of Black Americans, yet this issue is rarely addressed in a public health perspective. Racism affects health at different levels: institutional racism is a structural and legalized system that results in differential access to health services; cultural racism refers to the negative racial stereotypes, often

reinforced by media, that results in poorer psychological and physiological well-being of the minorities. Lastly, interpersonal racism refers to the persistence of racial prejudice that seriously undermines the doctor-patient relationship. For instance, racial minority populations have lower levels of access to medical care, higher morbidity and mortality rates, and poorer quality of care (38).

Racism can be thought about as institutional, cultural, and interpersonal. Institutional racism is the structural and legalized system of policies, practices, and norms that results in a differential access to goods and services (39). Although segregation was officially abolished in the 20th century, Black Americans still have limited access to quality education, gainful employment, and appropriate medical facilities. Interpersonal racism refers to the persistence of racial prejudice that negatively affects the doctor-patient relationship. Indeed, on one side, the Black patient, facing a mostly non-Black health care system, feels uncomfortable and not understood; on the other, the doctor thinks of the patient as inferior and therefore provides care of less quality. This implicit makes it harder to detect disease and leads to higher mortality rates. For example, although Black women are less likely to contract breast cancer, once contracted, they are more likely to die from it as there is less screening available and they are treated less effectively (40).

In some Latin American countries, there are programs to try to reduce racism in patient care. However, few of them are effective because they do not combat the problem of institutional racism. There is a subtle difficult to detect discrimination that occurs when treatment begins to be conducted; in the interaction between the professional and the patient; in the choice of some specific technique; in the motivation of the health team to perform or not to perform some diagnostic examination, in a way that more research in this field is needed (41).

Way Forward: Finding Strategies as Medical Students

As medical students, en-route to be medical doctors, it is important that the inequalities of healthcare, based on ethnicity and color of individuals are well understood and fought against. Our main aim as good doctors is to provide universal health for all, regardless of age, gender, race and background. It is first and foremost a personal conviction to consciously make an effort not to fit into the norm of healthcare discrimination against the minorities in our population. This form of discrimination could lead to consciously or unconsciously providing a lower quality of healthcare service. In addition to these personal convictions, a system of regulation should be put in action where students found to engage in racism or ethnic discrimination either against fellow students or patients from minority populations, face clear sanctions to deter others from doing so. Secondly, we should endeavour to target the factors that promote discrimination against the minorities of our population and engage the bodies that are responsible for influencing these factors. A key factor is the socioeconomic devices where the minority groups associated with poorer standards of living are more prone to illness, yet are least able to afford healthcare. Governmental bodies and non-governmental organisations alike should be sensitised in putting in policies that bridge the socioeconomic gap between majority and minority groups of the population. In addition, when given research opportunities, neglected diseases more prevalent in minority populations should be considered, to help improve the health standards of minority populations like the indigenous population and afro descendant people. Educational outreaches for medical students would be beneficial. It would serve as a platform where racism and its impact on healthcare is made known to all medical students. You cannot tackle a problem if it has not been identified as a problem in the first place. Finally, medical students should act as the piece of the puzzle in dealing with institutional racism. It is only with maximal collaborative effort between the various stakeholders of ethnicity and health would our cause be optimally effective.

Resources:

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