AMRO

AMERICAS REGION

REGIONAL GUIDE

AMWHO

2023 AMWHO INTERNATIONAL CONFERENCE

PLANETARY HEALTH AND THE HUMAN CONDITION

Introduction

Within the framework of the World Health Organization (WHO), the Americas region, which includes North, Central, South America, and the Caribbean, is a diverse area with 35 countries and territories that each have unique histories and political landscapes.[1] In addition to the WHO, the Pan American Health Organization (PAHO) is the specialized international health agency for the Americas, working with the Americas to promote health as a human right.[1] In exploring the conference theme of "Rectifying Historical and Contemporary Prejudices and Oppressions Undermining Global Health" it is important to acknowledge the role played by the AMRO region and the PAHO. The PAHO's efforts in advocacy for universal healthcare and collaboration across diverse sectors contribute to addressing past injustices, supporting the overall goal of inclusive and fair global health for everyone in the Americas.[1] The historical context of the Americas shaped by colonization and struggles for independence has had a lasting impact on health disparities that exist today. These disparities are evident from their effects on indigenous communities to present-day socio-economic challenges faced by the region.

Countries within the region such as Brazil, Mexico, and Venezuela offer distinct perspectives on this conference theme. Brazil's cultural richness combined with inequality has contributed to healthcare disparities influenced by historical legacies.[2] Mexico's blend of heritage alongside contemporary challenges presents unique health issues influenced by its political landscape.[3]

Venezuela serves as an example of action needed to address both historical and contemporary oppressions due to its political turmoil, economic instability, and mass migration to safeguard global health.[4] Additionally, recognizing the broader context of countries like Canada, Haiti, Panama, Anguilla, and others is also essential to understanding the health inequalities in the AMRO region. For instance, Canada has a commitment to inclusivity by aiming to ensure equitable healthcare services to all its residents, while Haiti faces socio-economic and healthcare infrastructure instability.[5,6]

The conference theme serves as an invitation to unravel the connections encouraging conversations and plans that address past injustices and current biases. By delving into the dimensions of the AMRO region's healthcare landscape, the WHO aims to work together toward a global vision of health that encompasses fairness, inclusivity, and justice for everyone.

Racism in Healthcare

The problem of racism in healthcare becomes apparent when observing the disproportionate healthcare outcomes for marginalized communities in the United States and South America. In the US, Black women face disparities in maternal health leading to higher mortality rates due to implicit bias, discrimination, and socioeconomic factors.[9] Power imbalances during interactions between doctors and patients result in the neglect of pain management resulting in reduced access to adequate pain treatments for Black patients.[11] These issues highlight the need for systemic reforms within the healthcare system. Additionally, concerns regarding domestic violence further jeopardize the well-being of Black women seeking medical attention.[12]

In Venezuela, indigenous populations experience disparities in health and healthcare due to cultural differences, economic challenges, and a lack of representation within the healthcare sector.[15] Elevated rates of diabetes, infant mortality, and alcohol abuse underscore the need for targeted interventions.[15] Challenging living conditions worsen health issues, which emphasizes that addressing systemic problems is vital for improving overall healthcare outcomes.

Case Study #1: Examining Disparities in Maternal Health and Healthcare Access for Black Women in the United States

In the United States, Black women face a significantly higher risk of maternal mortality, being four times more likely to die during childbirth than women from other racial and ethnic groups.[8] The urgent need to address healthcare inequalities for African-American women, rooted in implicit bias, discrimination, and socioeconomic disparities, highlights the significant impact of factors like income, education, and healthcare access on the health outcomes of Black women.

Recent discussions have shed light on the disparities in healthcare and in obtaining treatment for Black women compared to their White counterparts. They face concerns in a number of areas including Intimate Partner Violence (IPV). According to an article in Journal Women's Health, "non-Hispanic Black and Native American/Alaska Native women reported higher prevalence rates of lifetime IPV (43.7% and 46%, respectively) compared to non-Hispanic White women (34.6%)".[8] Furthermore, Black women in the United States experience elevated maternal mortality rates and reduced life expectancies when compared to women of different racial backgrounds.[9] In 2021, the maternal mortality rate for Black women stood at 69.9 deaths per 100,000 live births, which was 2.6 times higher than the rate for White women.[8] These statistics call for a more in-depth exploration of the disparities faced by Black women in the healthcare system. Engaging in a dialogue about the implications of these disparities is essential, as they render African-American women more vulnerable to mortality or medical complications stemming from a healthcare system in need of improvement.

African-American women experience a significant power imbalance when interacting with their healthcare providers.[8] This imbalance means that doctors and medical professionals conducting crucial procedures on Black women often wield more control over their bodies than the women themselves.[8] Research has revealed a troubling pattern of overlooking the genuine pain experienced by Black women.[7] When it comes to pain management, African American patients are less likely to be prescribed pain relief medication, and even when they do receive it, they are often given lower doses due to deep-seated prejudices.[7]

Research findings indicate that approximately 74% of white patients are substantially more likely to be administered analgesic medications in the emergency department compared to their black counterparts, even when their medical records show similar pain complaints.[9] Moreover, the data reveals that black patients face a 66% higher risk of not receiving any analgesic treatment in the emergency department when compared to white patients.[9] In another study that focused on pain management for patients dealing with metastatic or recurring cancer, it was observed that 35% of patients from racial minority backgrounds were prescribed medications following the World Health Organization (WHO) guidelines, whereas 50% of non-minority patients received the appropriate prescriptions.[10] This underscores the significant influence that medical professionals hold over the well-being of Black patients. Particularly during childbirth, this dynamic contributes to the disproportionately high maternal mortality rates among Black mothers.[9] In the context of intersectionality, this unequal power dynamic is pervasive among the majority of Black women, regardless of their other social classifications.[11]

Authority significantly shapes the quality of healthcare received by Black women in the United States, as they are frequently subjected to heightened surveillance.[11] African-American women often encounter more disciplinary measures than support when seeking care for traumatic incidents such as gunshot wounds.[11] Women from ethnic minority groups are also disproportionately affected by intimate partner violence.[11] Based on data from the 2010 National Intimate Partner and Sexual Violence Survey, it was found that non-Hispanic Black and Native American/Alaska Native women had higher reported prevalence rates of lifetime intimate partner violence, with rates of 43.7% and 46%, respectively, in contrast to non-Hispanic White women, whose rate was 34.6%.[11]

This is significant because Black women are often subjected to suspicion rather than empathy by healthcare providers while being treated for injuries resulting from domestic violence.[12] There have been numerous instances where these women have faced inquiries before, during, or after receiving care, inquiring about the cause of their injuries, effectively placing blame on the victim and jeopardizing the well-being of these marginalized women.[12]

While the WHO and United Nations International Children's Emergency Fund have recognized and addressed issues related to maternal mortality and healthcare disparities, specific actions or initiatives related to the disparities experienced by Black women in the United States have not been a primary focus.[13] Their efforts have been mainly global in scope, with a specific focus on alleviating disparities in maternal and child health within low and middle-income countries.[13] Notable instances of their initiatives include global immunization campaigns, contributions to humanitarian relief efforts, and the implementation of programs dedicated to child nutrition.[13] The stark maternal mortality disparities and power imbalances experienced by Black women in the United States underscore an urgent need for systemic change within the healthcare system. The WHO can play a pivotal role in addressing these issues by advocating for policies and programs aimed at reducing disparities in education, housing, and economic opportunities, as these factors heavily influence healthcare outcomes for Black women.[1] By prioritizing these fundamental solutions, the WHO can contribute to developing a more equitable and just healthcare system that upholds the rights and dignity of all women, regardless of their racial or ethnic background. Collaborative efforts among governments, healthcare institutions, communities, and individuals are essential to bring about the necessary change and enhance the health and well-being of Black women in the United States.

Case Study #2: Mental Health Disparities and Healthcare Challenges Among Indigenous Communities in Venezuela

There are several disparities in the indigenous population's mental health and healthcare in the South American region, with a specific focus on Venezuela.[15] The indigenous population of Latin America houses over 500 different ethnic groups.[15] Cultural differences, lack of representation in the industry, and economic situation account for a number of the vast disparities observed.[15]

One glaring example of these disparities is evident in Venezuela, where a study focused on the Carib people revealed alarming rates of alcohol misuse.[14] The study discovered "that a striking 86.5% of men experienced problem drinking— one of the highest rates in the world".[14] This substantial percentage of the population misusing alcohol is reflective of poor mental health and a lack of resources for intervention as alcohol can quickly become a coping mechanism.[14]

In recent years, Venezuela has dealt with a notable issue of hunger, distinct from many other countries.[17] This crisis stems from food shortages and years of hyperinflation, making basic needs unaffordable.[17] These basic needs go beyond food and water, they also pertain to medicine and health products.[17] Due to the shortages, the substantial emigration of healthcare personnel and the deterioration of infrastructure have compounded the challenges, significantly lowering the system's ability to meet the health needs of the population.[17] Furthermore, there is a lack of representation of indigenous people in physicians in the area.[14] In Ecuador, for example, "[almost] 32 years after the graduation of the first two indigenous physicians, there are still only five Quichua physicians and only one psychiatrist for an estimated population of six million indigenous peoples in Ecuador."[14] A lack of representation in the industry is a key concern with poor patient care and mental health.

Mental health issues are further compounded in Venezuela by high poverty rates and poor living conditions.[15] Additionally, there is overall limited access to health services, as "50 percent of indigenous adults over 35 years of age suffer from type 2 diabetes; life expectancy is 20 years less; and infant mortality is 3 to 5 times greater than in the rest of the population in Venezuela and Brazil.[15]" Disproportionate diabetes and infant mortality is a dire matter that must be addressed. Despite the 8% representation of the Latin American population, 17% of the population lives in extreme poverty.[15] It describes how "material poverty affects 43 percent of indigenous households in the region —that is, double the proportion of the rest of the population—and extreme poverty is 2.7 times greater."[15] The poor standard of living creates great disparities in mental health. Further, a higher susceptibility to economic conditions results from prevalence in low-skilled jobs with seasonal income or limited income in different conditions.[15]

Impact of Colonialism and Imperialism on Global Health

This subtopic delves into the extensive consequences of past historical events on two distinct fronts: how colonialism continues to cast a shadow over the mental well-being of indigenous communities in North America, and how generational trauma has created obstacles in providing culturally-sensitive healthcare.[16] Additionally, this sub-theme examines the influence of imperialism, focusing on the United States' impact on global healthcare. These case studies highlight the need for comprehensive, proactive interventions and the adoption of a multi-level systemic approach to address the lasting effects of historical injustices and imperialistic influences.

Case Study #1: The Lingering Impact of Colonialism in Canada and Its Influence on Addressing Historical Trauma

The history of colonization in North America has had a lasting impact on various Indigenous populations' overall health and well-being in Canada, including the Cree, Inuit, and others.[16] These communities experienced land theft, forced relocations, and the suppression of their practices, sowing deeply rooted, generational trauma extending from the initial interactions with European settlers to generations facing the loss of lands, broken treaties, and the forced assimilation of children into residential schools.[16]

In Canada, Inuit communities face comparable difficulties due to the long-lasting effects of residential schools contributing to intergenerational trauma.[18] Studies reveal variations within the Inuit Nunangat region, where the Inuit community exhibits a suicide rate ranging from 5 to 25 times higher than the national average in Canada.[18] From 2009 to 2013, Canada's overall suicide rate was 11 per 100,000 people.[18] However, within areas like the Inuvialuit Settlement Region and Nunatsiavut the rates were much higher at 60 and 275 per 100,000 respectively.[18]

The Canadian Community Well-Being Index of Indigenous communities has increased over the last three decades.[22] However, the gap between the non-indigenous and Indigenous communities remains high.[21] In 2015, the unemployment rate of Indigenous populations was 12.4% and for the Canadian population, it was 6.8%.[21] Additionally, there is a significant wage gap in the median total income between the First Nation people with $21,875, and the non-indigenous population with $34,604.[21] Because this is lower than the low-income cutoff, most Indigenous people are not able to afford additional insurance for health services that are not covered by provincial or territorial governments.[21]

To address trauma within these specific tribes in Canada, it is crucial but difficult to understand their unique cultural contexts, due to a neglect of indigenous knowledge and insensitivity towards their culture.[19] There is also a need for representation of Indigenous perspectives in mainstream healthcare. Cultural competency plays a role in healthcare when engaging with these communities, through integrating healing practices, respecting sacred traditions, and recognizing the importance of community in the healing process.[20]

If changes are not made to healthcare practices, the gap in mental health outcomes will widen. The trauma and mental health crises experienced by specific tribes in Canada must be addressed. The WHO can help by providing mental health interventions that integrate traditional healing practices specific to each tribe.[1] This may involve collaborating with traditional healers and community leaders to incorporate culturally relevant approaches to therapy.[1] To create effective interventions and support the healing and resilience of these communities, the lasting effects of colonialism must be confronted immediately to prevent harm and pave the way for holistic well-being.

Case Study 2: Impact of Powers of Imperialism on Global Healthcare for AIDS medication on Guatemala

Imperialism may broadly be defined as "an expansion of economic activities—especially investment, sales, extraction of raw materials, and use of labor to produce commodities and services—beyond national boundaries, as well as the social, political, and economic effects of this expansion."[22] Imperialism has critical effects on several industries, especially healthcare systems and policies.

The Guatemala Syphilis experiment serves as a direct example of the extent to which imperialism mindsets can result in extremely unethical studies as shown in a medical research project which lasted from 1946 to 1948 utilized amoral methods.[31] According to Britannica, "Approximately 1,308 soldiers, prisoners, sex workers, and psychiatric patients, ranging from age 10 to 72, were intentionally exposed to STDs during the study".[31] The diagnostic and laboratory work was carried out in a hospital in Guatemala City as the city housed the target population for the study of prisoners and others. The 300 bed hospital was used in collaboration with local Guatemalan physicians. Further, due to negotiations between the Pan American Sanitary Bureau and the Guatemalan government, the research directors gained access to "public health centers, government hospitals, mental institutions, and orphanages."[31] Additionally, as a measure of 'goodwill' , there was an STD treatment program as well, though 820 subjects received treatment for their infections and over 650 were in the deliberate exposure group.[31] It is noted though that the 'normal exposure' approach was fairly ineffectual and this study aimed to work around this barrier.[31] Investigations followed and in 2010, former president Barack Obama formally apologized for the "unethical nature of the research."[31]

It is critical to keep in mind that the very cause of HIV/AIDS was the globalization of European imperialism.[23] According to OSU.edu, "HIV is derived from simian immunodeficiency virus, and we hypothesize that it crossed over to humans through blood-to-blood contact, probably during butchering or hunting chimpanzees. When the simian virus entered the human's bloodstream, it gradually took over cells in the immune system, hijacking CD4 cells to make new copies of the virus before killing the cells".[23] Due to the complex functioning of the virus, cure and treatment research has been at the forefront of the industry for some time; with imperialistic powers such as the United States, efforts to preserve control on the industry may inadvertently prohibit further research and more effective treatment.[23] For example, according to the monthlyreview.org, "Acting on behalf of pharmaceutical corporations, the U.S. government invoked the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) of WTO in working against attempts by South Africa, Thailand, Brazil, and India to produce low-cost, antiretroviral medications effective against AIDS."[22] Though this serves to preserve intellectual property, the community may benefit from additional research and resources.

As described, medication for AIDS has become one of many major areas in which imperialism has directly impacted patient care, not only due to such legal efforts but also due to prominent philanthropic organizations.[24] The Gates foundation, for example, has affected healthcare processes in a positive way to an extent; however, some patients in other countries would try to get AIDS simply to access the funds and resources to get well from other illnesses.[24] According to an article in *The American Journal of Economics and Sociology,* "BMGF is the prime mover behind prominent "multi-stakeholder initiatives" such as the "Global Fund to Fight AIDS, Tuberculosis and Malaria," and the GAVI Alliance (a Gates-funded PPP linking the World Health Organization with the vaccine industry)."[24] This significant involvement and new method to tackle health issues was greatly valued, but can inadvertently create disparities for treatments. Patient care becomes strategically misused to access resources rather than a process focused on healing the present conditions.[24]

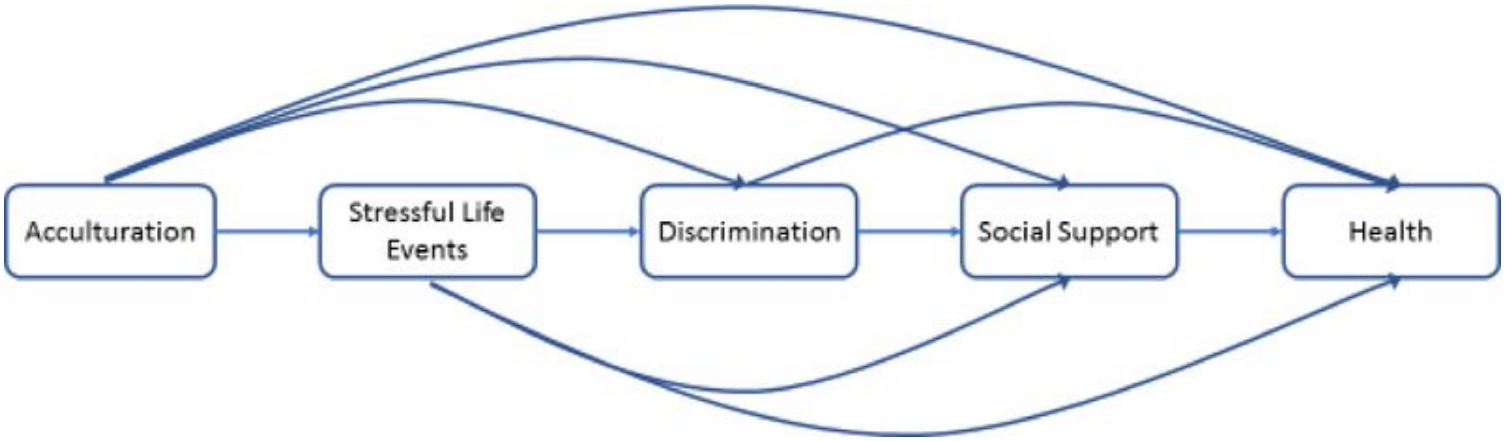
Migrant Health and Religious Persecution

This analysis critically examines the hurdles faced by migrant populations when it comes to accessing healthcare, drawing insights from diverse contexts and shedding light on the common issues experienced by refugees and migrants worldwide.[25] These challenges include misunderstandings, internal biases, and systemic obstacles that contribute to mental and physical health outcomes.[25] One universal factor that exacerbates healthcare disparities is discrimination, which affects both patient treatment and overall access to healthcare resources.[25] The diverse health needs of migrants as well as their process of adapting to a new culture (known as acculturation) further shape the healthcare landscape for them.[25]

Moreover, this examination extends to exploring the discrepancies in healthcare across different regions with a particular emphasis on the amplified difficulties caused by factors like the COVID-19 pandemic.[28] The study reveals how stressful living and working conditions have an impact on mental well-being, underscoring the importance of providing adequate accommodation and support systems for migrants.[28] Barriers such as lack of insurance coverage, discrimination, language/cultural differences, and fear of deportation add further complexity to accessing healthcare for migrants.[28] By exploring these overarching challenges, the goal is to promote a thorough understanding of how migration affects health worldwide.[1]

Case Study 1: Challenges in Obtaining Healthcare for Refugees and Migrants in the United States

Refugees and migrants in the United States share numerous challenges in personal healthcare which has resulted in poor mental and physical health.[25] Prevalent misunderstandings in how healthcare for this population would affect society and the economy, coupled with internal biases, have resulted in severe health consequences.[25] According to Szaflarski and Bauldry, "there are multiple challenges to optimal health status for immigrants and refugees in the US, such as linguistic and cultural barriers, socioeconomic limitations, access to health care, stress due to adaptation and everyday living, and social integration issues (e.g., isolation)."[25] A number of attributes that shape migrant and refugee health over time can be condensed into the following: (a) Acculturation, (b) Stressful Life Events, (c) Discrimination, (d) Social Support, which then affects (e) Health.[25]



The foremost cause for these healthcare discrepancies is racial discrimination which, when coupled with other challenges, creates cause for concern. This form of discrimination often manifests by mistreatment based on perceived attributes of skin tone and language proficiency, specifically darker skin tones and lower language proficiency.[25] The perception of this discrimination plays a critical role in mental and physical health.[25] Furthermore, these hardships are associated with a number of health behaviors and outcomes "smoking, alcohol use, obesity, hypertension, breast cancer, depression, anxiety, psychological, distress, substance use, and self-reported health across ethnoracial groups.., as well as physical health problems including hypertension, self-reported health, and breast cancer, as well as health risk factors, such obesity, high blood pressure, and substance abuse."[25] These tend to muddle how the exact impact of discrimination is classified; however, it's clear that discrimination extends beyond the scope of patient treatment and to overall access to healthcare as monitored by administrative bodies. The 1996 federal *Personal Responsibility and Work Opportunity Reconciliation Act* (PRWORA) and other state legislation serve to prevent "unauthorized immigrants and recent arrivals from accessing the public benefits such as Medicaid and the Children's Health Insurance Program (CHIP)."[26] Beyond eligibility for these programs, there is an initial barrier to accessing any digital healthcare resources, access to critical documents, and achieving English proficiency in writing and comprehension.

According to Alarcon, "Unfortunately, many lawfully present immigrants who are eligible for coverage remain uninsured because immigrant families face a range of enrollment barriers, including fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges."[27] Requirements to provide verification paperwork which may include proof of income/ employment, birth certificates, and SSN information–all of which are difficult to locate, access, and provide to higher authorities.[26]

Another aspect to consider is differing health needs and acculturation. Acculturation can be defined as "the process of learning and adapting to the host country's culture while maintaining the values, norms, beliefs, language, etc. of the country of origin, has received much attention."[25] This period of adjustment may often lend itself to negative health habits such as substance misuse.[25] Creating self-identity in a new environment is inherently stressful and can manifest in many health concerns, including hypertension, chronic illness, smoking, and diabetes.[25] Furthermore, the specific healthcare needs vary from those of natural citizens which may result from a number of potential reasons.

For example, "Compared to natives, immigrants have a lower incidence of all cancers combined, fewer chronic health problems and functional limitations, and lower rates of infant mortality, obesity, and overweight status…This study also showed that immigrants had a 3.4-year higher life expectancy than natives. "[25] Not only are they more likely to have certain conditions, there are certain conditions that they are less likely to have.

Additionally, religious persecution appears in healthcare and is seen in the migrant population after major crises further exhibiting Islamophobia.[30] Islamophobia is vastly present in the United States, appearing in everyday interactions for the population. This affects health directly in side effects of the daily encounters of negative experiences. According to a journal article 'Islamophobia and Public Health in the United States',

> " Everyday experiences of discrimination are also associated with a wide variety of physical and mental health outcomes, such as coronary artery calcification, high levels of C-reactive protein, high blood pressure, giving birth to low-birth-weight infants, cognitive impairment, poor sleep, visceral fat, depression, psychological distress, anxiety, and mortality, as well as risk factors for poor health such as substance abuse".[30]

The manifestation of such physical health concerns serves as a daunting reminder of the extent to which mental health impacts physical health and the true impact of religious persecution and racism. These health concerns can be applied to several populations and further identified in the Islamic population in the United States. Also, harmful stereotyping can result in vast negative health outcomes in direct patient care. In the same formerly mentioned article, it describes how "in a qualitative study of Iraqi refugees, participants described health care providers as unhelpful, patronizing, and having stereotypical attitudes toward Muslim women—believing they are excessively pious, have too many children, and are oppressed by their husbands."[30] These misconceptions of migrants further aforementioned negative health outcomes.

Case Study 2: Migrant Healthcare Disparities in Chile

Similar to the United States, there are numerous barriers to receiving healthcare for the population of migrants in Latin America and the Caribbean. Amplified by the COVID-19 pandemic, there are numerous causes for the vast disparities in health status and access to healthcare for this population.[28] Notably, a survey in Chile revealed that 45% of migrants reported suffering from depression and almost 30% reported anxiety during the 2016-2017.[28] The stress and trauma from living an unstable lifestyle and working conditions contribute significantly to migrants' mental health challenges.[28]

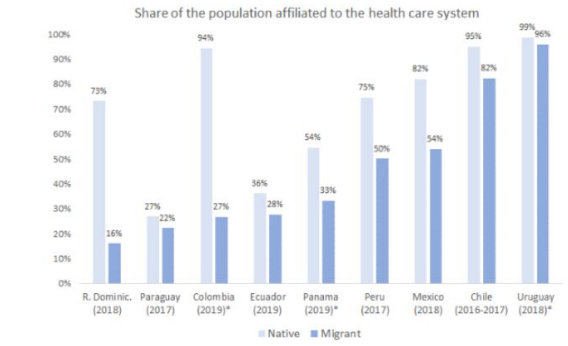
The coronavirus pandemic inarguably created adverse barriers for the people of the Americas, but migrant populations suffered disproportionately.[29] In an article published by Global Health Promotion, there was a study conducted to identify knowledge of COVID-19 and its preventative measures as well as immediate needs and concerns regarding the pandemic and its aftermath for the Chilean immigrant population.[29] It describes work and living conditions, economic instability, regularization traps, lack of support to international migrants, and overall access to healthcare for physical and mental needs.[29] The processes involved in migration in and of themselves prove to be stressful and can often negatively impact physical and mental health, often their health varies before, during, and after.[29]

Further, it is described how there is "a dimension of social vulnerability experienced by international migrants seems to stem from two main aspects of 'being a migrant': migratory status, which leads to 'regularization traps', and lack of social support and networks."[29]

The exemplified vulnerability and ignorance quickly became a pertinent issue. Many feared legal repercussions and the potential consequences of any misstep in trying to obtain healthcare.[29]

The main sources of distress, aside from the pandemic, can be condensed to lack of coverage, discrimination, linguistic/cultural barriers, lack of information, and fear of deportation.[28] Lack of coverage is a recurring theme in the Americas due to rigid administrative systems and legalities concerning access to any level of healthcare.[28] However, this article from the Inter-American Development Bank (IDB) puts into perspective the percentage of each population affiliated to the healthcare system:[28]

Figure 1



Source: Authors' calculations based on National Household Surveys, except in Chile (National Health Survey) and Mexico (National Health and Nutrition Survey).
The figures on migrants' access should be considered indicative. The Household surveys are not designed to be representative of the migrant population.
*Affiliation to the public health care system only. In all other countries figures include affiliation to both public and private health care systems.

This lack of affiliation lends itself to disparities in healthcare and there is minimal coverage with insurance and other policies.[28] Discrimination against migrants also serves as a barrier that may induce physiological and psychological effects.[28] The discrimination appears in forms of taste-based discrimination and clinical uncertainty though additional research is necessary to pinpoint the differences in quality of care for migrants and natives in LAC.[28] Linguistic barriers present themselves predominantly for migrants of communities that are monolingual and indigenous.[28]

According to the aforementioned article from IDB, most intra-regional immigrants in LAC speak the official language of the host country, however, this does not apply everywhere.[28] A mitigation corridor such as Haiti to Chile, is an area where immigrants may not speak the official language of the destination country.[28] These migrants are more prone to linguistic barriers.[28] Lastly, a lack of information and fear of deportation prevents migrants from accessing care regardless of their legal status or the healthcare that they are entitled to.[28] This may be remedied by more effective patient care systems, professional training for healthcare professionals in the area, and awareness of the issues at hand for the given population.[28]

Conclusion

When considering the exploration of the Americas (AMRO) region within the framework of the World Health Organization (WHO) and the conference theme of "Rectifying Historical and Contemporary Prejudices and Oppressions Undermining Global Health," it becomes clear that the AMRO region is influenced by a combination of legacies, political landscapes, and health disparities. The deep impact of colonialism on the well-being of indigenous populations as well as the influence of imperialistic powers on global healthcare highlights an urgent need to address historical injustices. The existence of racism in healthcare is evident when examining the disparities faced by women in both the United States and South America emphasizing the necessity for systemic reforms. Migrant health, which is shaped by persecution and systemic barriers emerges as a crucial subtheme that requires comprehensive solutions beyond geographical boundaries. The overarching theme calls for a commitment to unravel interconnected issues and develop strategies that promote fairness, inclusivity, and justice. The WHO's role in navigating climates within AMRO nations is essential for advancing a vision of global health that prioritizes well-being, for all individuals regardless of their historical context or circumstances. This emphasizes the importance of adopting a holistic approach to achieve global health equity.

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