T20 POLICY BRIEF

Task Force 01

FIGHTING INEQUALITIES, POVERTY, AND HUNGER

Equity And Historical Reparation - Social Policies for Latin American and Caribbean Afro-Indigenous Women

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Abstract

Intersecting factors such as class, race/ethnicity, and gender (foundational pillars of capitalism) produce inequalities and shape the way people live, experience illness, and die. Within this hierarchy, Latin America and the Caribbean afro-indigenous women find themselves at the bottom of the social pyramid. Comprehending the societal health landscape and devising effective solutions force an expansion of knowledge systems. It requires fostering ancestral and academic wisdom convergence and promoting emancipation and humanization within caregiving relationships. Enhancing the living conditions of racialized women involves pondering their needs and their territories' characteristics. Advocacy for historical reparations policies is emphasized as a means to address historical injustices arising from the actions or inactions of the State, like the processes of enslavement and genocide of afro-indigenous. Recommendations extend to urging G20 nations to prioritize conditional cash transfer programs aligned with a synergistic and intersectoral approach between health, education, work/income, housing, and other sectors. This commitment should be marked by positive conditionalities and a dual-focused resource allocation: for women's benefit and the establishment or continuation of programs. This strategy ensures that investments contribute to the fortification of policies and services and raising living conditions for racialized women. These programs should be developed and managed in a collegial and participatory decision-making process, enhancing dialogue with local needs. Local Management Committees should be created for defining priorities, planning, and ensuring representative parity (managers, professionals, and women's associations/movements). The direct execution of policies can be carried out by government management or by

Non-Governmental Organizations managed by racialized women, regulated by the state, and subject to a performance and impact evaluation system.

Keywords: Historical reparations; Inequalities; Racism; Intersectionality; afro-indigenous women; policy conditionalities.

Diagnosis of the Issue

Current challenges for a historical issue

The social inequalities prevalent in Latin American are predicated upon the maintenance of a specific pattern of oppression and wealth accumulation, stemming from the historical legacy of colonial slavery and the capitalist model. Within the social hierarchy, Afro-indigenous Latin American women find themselves at a disadvantage compared to the majority of other social groups.

These intersecting inequalities, such as those of class, race and gender constitute a foundational pillars, sustained through the alignment of political and economic interests of dominant groups since the colonial process (Gonzalez 1984). They persist substantially within contemporary coloniality.

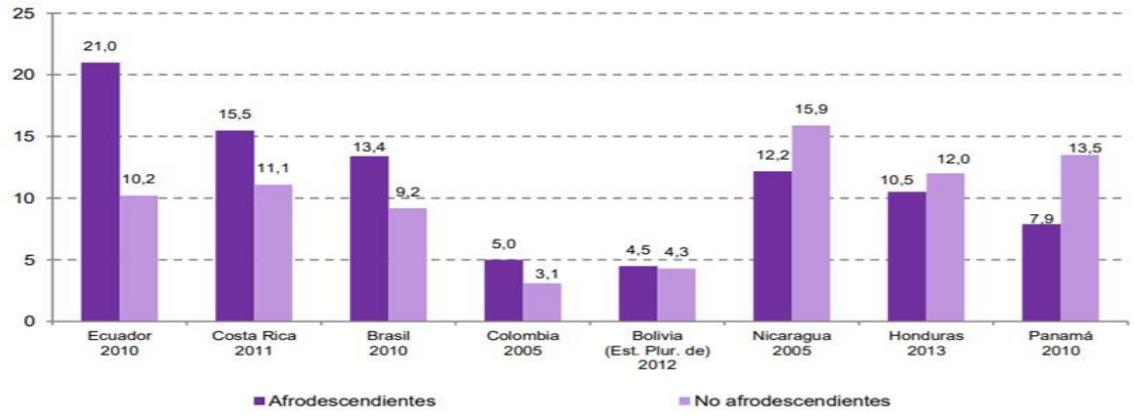
A research conducted in Brazil (Brasil, 2023) indicates that race/color/ethnicity is one of the primary drivers of inequalities in this country, intersecting with gender, age, origin, income, and other factors. Upward social mobility, therefore, is hindered when these characteristics coalesce, as seen in the case of low-income black women. Besides gender intersecting within a patriarchal society, socio-economic background, and geographical residence, there is membership in a historically discriminated racial group subjected to institutional racism in various fields such as health, education, and employment.

The impacts of these political, social and economic dynamics have negative repercussions, taking the Brazilian case as an example, one can see: in prenatal care, black and indigenous women receive the worst care: they are the least likely to initiate follow-up in the first trimester and have the fewest consultations. One consequence is higher stillbirth rates for this population group; black women were the most infected with

syphilis in 2021 (58.9%), and the same applies to cases of congenital syphilis. Between 2011 and 2021, the proportion of black women was over 70%; regarding violence, more than 2/3 of the victims of physical assault during pregnancy are black or brown women.

In the labor market, the income of white individuals continues to be 69% higher regardless of the level of education. When observing individuals with incomes below the poverty line, blacks represent twice as many as whites. Black women prevail in informal occupations, which represent a more precarious labor insertion without social protection and with the lowest and most disparate incomes, 44% lower compared to those earned by white men. Within households, disadvantages also present themselves more intensely for black women: there is excessive household crowding and fewer permanent assets in the household arrangements of unmarried women with children, resulting in a greater burden of domestic work (Grafic 1).

Graphic 1- Latin America (8 countries): domestic salaried workers aged 15 or more, according to condition ethnic-racial, last year available (Percentages).



Source: Comisión Económica para América Latina y el Caribe (CEPAL). *Panorama Social de América Latina, 2016* (LC/PUB.2017/12-P), Santiago, 2017

Recommendations

Historical reparation as a government agenda

We conceive health as a process that unfolds differentially across territories, collectives, and individuals, expressed in various dimensions corresponding to different spaces of life reproduction. Within the process of health-illness-care, determined by collective conditions of life, the oppressions experienced by Black, Indigenous, and Afro-Caribbean women, including those based on race, class, and gender, among others, shape and configure their practices concerning life and health.

This proposal is put forth by women who have experienced these oppressions firsthand, drawing from our experience and trajectory in the fields of health and critical academic thinking. Hence, we understand that racialized women in Latin America and the Caribbean are pivotal in transforming their living conditions, territories, and communities.

This strategy allows for a shift from the paradigm of healthcare focused on illness, to an promotional strategies for well-living and comprehensive health care. It involves developing new care management initiatives, engaging in the construction of an ecology of knowledge within communities, coupled with a transdisciplinary reinvention of political-health training, especially aimed at comprehensive, humanized, complex, and intercultural clinical-community care. It is understood that the synergy of public policies is closely linked to the social determinants of health. There is a proposal to prioritize Afro-Latin American and Caribbean women, as it is recognized how health policies aimed at them can have a significant impact on social fabric.

Acknowledging the colonial history and processes of enslavement, genocide, and patriarchy inherent in modernity and coloniality, as well as the extractivist capitalist accumulation system, it is understood that States, within a given global geopolitics, should sustainably provide **historical reparations policies** as a governmental device.

The urgency imposed by the context of inequalities, which produces disadvantages for Afro-Latin American and Caribbean indigenous women, leads us to propose the prioritization of this social group in a significant and broad set of synergistic public policies, from an intersectional perspective, strategically organized. The commitment to promoting policies aimed at these women presupposes the widely debated social impact on the living and health conditions of numerous families, given the recognition of the role that 'racialized' women occupy in the social fabric. Successful experiences of social policies such as the "*Bolsa Família*" (Brasil, 2023) can be cited, whose significant impacts on the reduction of extreme poverty are seen in a maternal and child health, for example in infant and neonatal mortality.

The strongest association of the cash transfer with reduced child mortality was found among Black individuals, a group that is historically underprivileged socially and economically and in access to health in Brazil [43,44]. Studies have suggested that women exposed to a CCT program engage in higher maternal and child health service utilization and show substantial schooling accumulation. Both healthcare utilization and maternal education are significant predictors of child mortality, especially among preterm babies, which could explain the stronger association between the CCT program and child mortality among preterm babies (Ramos et al. 2021).

These lessons learned regarding the impact on improving the living conditions of an extended social group, by prioritizing the social role of women.

In this sense, it is recommended that G20 countries commit to Conditional Cash Transfer programs in synergy with other social policies, from an intersectoral perspective. It is proposed to promote and implement such policies aiming at improving the living conditions of 'racialized' women, which synergistically encompass governmental actions such as: **conditional cash transfer programs**; **comprehensive health care**; **increased schooling and vocational training**; **social assistance**, among others, depending on the country's context.

The proposal consists of offering Conditional Cash Transfers, prioritizing access to existing policies and programs in countries, thus transforming the access logic, as well as promoting the creation of new programs, depending on their local-regional realities. It is grounded on the synergy of social policies, in dialogue with the needs and potentials of various Latin American contexts. For some contexts, it may not necessarily imply the creation of a new income transfer policy, but rather the establishment of priority for 'racialized' women, in lines of provision and access to programs, services, and actions, which may be new or existing. However, for other national contexts, the creation and implementation of income transfer policies are strategic. This represents the gateway to access other social policies, depending on the profile of needs.

The basic financial floor of the income transfer program may have an increase in amounts allocated to women, based on their participation in aforementioned programs and their conditionalities. However, the provision of resources can also be offered in a dual manner, meaning that funds can be allocated both to women and to the management of social programs, to enhance their qualification and performance. The calculation of allocated resources can be based on demographic profiles and needs (vulnerable women), as well as through a Performance and Impact Evaluation System, both of which are

previously agreed upon. This approach aims to generate impacts on both the improvement of living and health conditions for women and their families, as well as the enhancement and qualification of social policies and facilities. Therefore, countries should establish effective Monitoring and Evaluation Systems for the policy.

To this end, the proposal is for the policy manager register Afro-indigenous women in situations of social vulnerability in the income transfer program and, in addition, in a conditioned manner, provide a priority access door for the other previously mentioned policies and programs. In this sense, it is recommended to to strengthen and/or create, implement and institutionalize a governmental structure in the countries, such as Ministries, or Secretariats or even Departments, whose mission is focused on **Comprehensive Care for Women**, with the consequent definition of priorities and guidelines for women in vulnerable situations, whose composition is known to be historically occupied by Afro-indigenous women. This governmental structure must have the leading role in implementing the actions, in partnership with the other government sectors called to participate, through intersectorality as the governance matrix of the program, formulated in an integrated and intersectoral manner.

It is also suggested to formulate mechanisms for international collaboration in financial terms, knowledge exchange and joint monitoring and evaluation strategies with a view to mutual and collective learning among countries. It is possible to think of an **International Strategy**, with a focus on Latin America, that can count on initiatives to capture resources from both the public and the private sector and from multilateral cooperation institutions, with a view to creating of an International Fund for the Care of Latin American and Caribbean Women. The international induction of the Program can

be led by international organizations[1], whose responsibilities, shared with countries that join the program, include the creation and management of both the aforementioned Fund and the generation of a knowledge exchange platform, in whose actions it is possible to envisage the implementation of (i) formulation of guidelines and protocols for adherence to the program; (ii) a bank for recording and sharing experiences and good practices from countries, and, (iii) the creation of a permanent Discussion Forum for exchanging challenges/problems and solutions, with a view to systematic sharing between countries; (iv) creation of a Monitoring and Evaluation System, with the establishment of previously agreed goals and schedule; (v) carry out periodic qualitative and quantitative research, with the objective of evaluating the impact of the Program, in the economic, social, educational and health dimensions.

There is also a commitment to the participatory, shared, and community-based management of this program. To this end, Territorial Base Management Committees should be established, with agreed-upon responsibilities including: needs analysis, priority setting, action and service planning, as well as program management, monitoring, and evaluation. Decision-making processes should be participatory and collegial. The composition of the Committee will include equal participation from managers, professionals in the social policy areas, and women's associations and movements, with recognized and proven public engagement. The delivery and execution of the policy can be through direct governmental management or through Non-Governmental Organizations, managed by women with recognized engagement in defending the rights and citizenship of “racialized” women and marginalized/peripheral classes. The

[1] Some agencies may be involved, such as UNFPA (United Nations sexual and reproductive health agency) and UN Women, for example.

Committees will also be responsible for encouraging and implementing institutional support and advocacy actions, to qualify and support the full exercise of the policy and its outcomes[2].

[2] The participatory monitoring model can be based on some strategies, such as the social cartography space: territory, territoriality and territorialization; on a temporal scale (memory of experiences, ethnography of processes, flowchart of planning processes); and in analysis units (Communal Assemblies, Interview Techniques/Discussion Groups). These are methodological resources that support the production of knowledge for the construction of a new "know-how and finally a work of planning, participation and organization" (Basile, 2022)

Scenario Of Outcomes

For another possible world for women in vulnerable situations

We conceive comprehensive health care as a network of efforts occurring at different levels, not only restricted to the the biomedical model. This involves incorporating a new categorical framework based on critical epidemiology, political economy of health, interculturality, and decolonial feminism. It advocates for the integration of academic knowledge with ancestral wisdom and the humanization of care, as articulated by Feo y Basile (2024).

Discussions on improving health outcomes and programs sensitive to gender issues have emerged as a means to accelerate the Sustainable Development Goals in the TF-6 of 2023 in India (Think20 India 2023). By endorsing the prioritization of “racialized” women, the following strategies and their respective outcomes are expected to be developed:

A. Comprehensive healthcare for 'racialized' women, with objectives including:

1. Reduction of maternal and infant mortality, increasing prenatal consultations, increasing the use of pain relief during vaginal delivery when indicated, eliminating congenital syphilis, ensuring the presence of a companion during childbirth when desired by the woman giving birth, and other actions aimed at addressing Obstetric Racism.
2. Promotion of sexual education and effective access to contraceptives for pregnant individuals, aiming to promote planned pregnancies.

3. Reduction of the incidence and prevalence of communicable diseases such as HIV/AIDS, Tuberculosis, Leprosy, Syphilis, among others, through a therapeutic approach to comprehensive health care that considers socio-ethnic-racial aspects and territorial dynamics leading to disadvantaged living conditions. This involves strategies for promotion, prevention, and treatment adherence to reduce abandonment rates.
4. Mental Health Care, considering the conditions and daily lives of oppressed and vulnerable individuals, particularly those subject to various forms of violence, including those perpetrated by Racism as a source of mental suffering.
5. Prevention of non-communicable diseases, such as Hypertension, Diabetes Mellitus, and conditions related to food and nutritional insecurity, such as hunger and obesity.
6. Reduction of institutionalized racial violence in healthcare settings, impacting the health conditions of lesbian, transgender, transvestite, and transgender men who are pregnant.
7. Comprehensive care for elderly women, particularly focusing on non-communicable diseases, food insecurity, and mental health care for cases of senile dementia, among others.
8. Early detection and provision of comprehensive and longitudinal care for Sickle Cell Disease.
9. Access to dental care for comprehensive oral health.

B. Increase in education level through programs for youth and adult education offered publicly or through community associations.

C. **Professionalization**, entry into the workforce, and income generation by providing access to vocational training courses, either publicly offered or through partnerships, as well as through intersectoral collaboration with policies for decent work.

D. **Inclusion in actions and programs of Social Assistance,** whether existing or new, based on analyses of the set of social disadvantages faced by women in that territory, from an intersectional perspective. Prioritization is envisioned in referrals to other policies such as housing.

We understand that the approach to health processes is multidimensional, and materializes in three dimensions closely linked to spaces of determination: the unique dimension of each person/family, the particular dimension of its community/territory, and the general dimension of society in a geopolitics relations. Therefore, it is necessary to simultaneously understand and act in these three dimensions if we want to promote public health and prevent and respond to health damage in a comprehensive perspective. The first step is to break with the traditional model of attention to health problems only through medical interventions and understand that improving the living conditions, it means improving the work processes, housing, education, and with this we can influence the processes of health/illness/care, improving the living conditions of racialized and Afro-Latina women in their territories.

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