Health, Resilience, and Human Security

Moving Toward Health for All

Marcelo Korc, Susan Hubbard,
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Overview

The year 2015 was an important milestone in the world of international development and global health. It marked the deadline for the Millennium Development Goals (MDGs) and the launch of the 2030 Agenda for Sustainable Development. From a global health perspective, the MDGs represented an important turning point, as three of the eight goals focused explicitly on health. By focusing on three very specific and widespread challenges—child health, maternal health, and communicable diseases—these goals drew attention and resources to these issues, leading to vast improvements in the health of millions of people around the world. However, the MDGs have been criticized for failing to address in-country disparities in progress toward the targets and for not taking into account the ways in which the challenges they addressed relate to one another or to other challenges that were not included in the agenda.

The question on many people's lips now is, "Will the success of the MDGs be sustained and expanded to all citizens of the world and will the success in these specific areas translate into success more broadly?" In other words, have the MDGs helped make the most vulnerable people in our societies more resilient to the challenges they face on a daily basis? Only time will tell.

The 2030 Agenda for Sustainable Development has taken a more comprehensive and aspirational approach with 17 goals, each with multiple targets. While it will likely prove more difficult to rally support and resources around such a nebulous agenda, it does attempt to tackle the interconnections among challenges and to explicitly promote equity in attaining the goals.[1] The comprehensive nature of the new agenda and its focus on equity—ensuring that the most vulnerable people in a society have the same opportunities to enjoy the same level of livelihoods, wellbeing, and dignity as everyone else—is reminiscent of the concept of human security, which is the subject of this report. If implemented effectively, this approach has the potential to build more resilient communities around the world.

The purpose of this document is to explain to experts in the health and development fields what a human security approach is and show how it can be applied in an attempt to put individuals and communities on a path toward achieving a virtuous cycle of good health, wellbeing, and resilience. In particular, the document focuses on how the human security approach addresses the linkages among different sources of health threats and ensures that interventions are integrated so as to build and sustain health resilience at the individual, community, and institutional levels as a path toward health for all through universal health coverage (UHC).[2] It also focuses on how human security can help translate health gains into improvements in wellbeing on a larger scale. In other words, an emphasis on human security can help us to move beyond focusing on survival to focusing on livelihoods, wellbeing, and dignity. Policymakers and funders will benefit from a clearer understanding not only of the added value of human security to health concerns but also of the opportunities that exist to integrate principles of human security into both new and existing health initiatives.

This document will also allow health and development experts to make the best use of the human security approach in their activities. Most public health and development practitioners are aware of—and are likely using—one or more aspects of the approach. But they generally are unfamiliar with the full picture, so they may not be consciously adopting the approach in a comprehensive manner. In other words, the individual components of human security approaches are not new, and many of them are found in existing health programs. In fact, research conducted during the preparation of this report found that many health interventions include components of the human security approach even though they do not necessarily use the term "human security" or even connect the components with the approach. It is our hope that this document can be used to accelerate the process of integrating human security components into new and existing activities by

allowing readers to learn from the experience of their colleagues in the field, thus accelerating the progress toward achieving the freedom from fear, the freedom from want, and the freedom to live in dignity for one and all.

This document starts with a brief overview of the evolution of human security and the key principles that guide the field. Next it outlines recent trends in the global health field, followed by a discussion of the nexus between health and human security and the introduction of the idea of resilience as a key goal of human security. The following sections discuss the added value of human security in the health field and explore situations that may benefit from a human security approach. Finally, concrete examples are given of human security approaches based on case studies of human security activities in Africa, Latin America, and Asia. Most of the cases described in the final section were developed by experts conducting research in their home regions specifically for this project during the period from 2011 to 2014. Several additional projects supported by the United Nations Trust Fund for Human Security (UNTFHS) are included, with project descriptions based on project summaries prepared by the UNTFHS and on previous human security research carried out by the Japan Center for International Exchange (JCIE).

The Evolving World of Human Security

In 2003, the Commission on Human Security defined the objective of human security as being "to protect the vital core of all human lives in ways that enhance human freedoms and human fulfillment."[3] More recently, in 2012, the UN General Assembly adopted a resolution agreeing on a common understanding on the concept of human security (see box 1).

Based on the commission's work and their own subsequent research, JCIE and the Pan American Health Organization (PAHO) have identified the following seven key principles of human security:

1. Address the linkages among freedom from fear, freedom from want, and freedom to live in dignity.
2. Focus on the ways in which people experience vulnerability in their daily lives and acknowledge that different threats feed off one another and thus need to be addressed in a comprehensive manner.
3. Engage the most vulnerable population groups[4] in all stages of programs to address their vulnerabilities, from the needs and resource assessment through the design and implementation to the monitoring and evaluation phases of activities.
4. Understand the local-specific context and ensure that all decisions and interventions take that context into consideration.
5. Include all relevant sectors and actors in the planning, decision-making, and implementation processes.
6. Focus on prevention to the extent possible.
7. Create synergy between protection and empowerment actions.

Human security can serve three roles (see fig. 1). First, it can be used as an overarching philosophy embraced by both political leaders and citizens that aims to prioritize the enhancement of human freedoms (freedom from fear, freedom from want, and freedom to live in dignity) and human fulfillment throughout all government policies. Second, it can serve as a policymaking concept that provides concrete guidance to policymakers at the governmental and institutional levels on developing policies that will help enable each individual to take advantage of opportunities and make choices to fulfill his or her own potential. Finally, human security can be a tool to guide practitioners' day-to-day programming in the field aimed at reducing the sources of vulnerability facing individuals, communities, and institutions; mitigating the impact of threats to their lives, livelihoods, and dignity; and building resilience to future threats.

While all three roles are described briefly in this section, this document examines the utility of human security as an approach to guide actual health policymaking and programming. That is, this document examines the use of human security in its latter two roles—as a

Box 1. The Evolution of the UN's Definition of Human Security

The 2005 World Summit Outcome Document contained the following paragraph on human security, marking the first time the UN officially committed to exploring the topic:

> We stress the right of people to live in freedom and dignity, free from poverty and despair. We recognize that all individuals, in particular vulnerable people, are entitled to freedom from fear and freedom from want, with an equal opportunity to enjoy all their rights and fully develop their human potential. To this end, we commit ourselves to discussing and defining the notion of human security in the General Assembly.

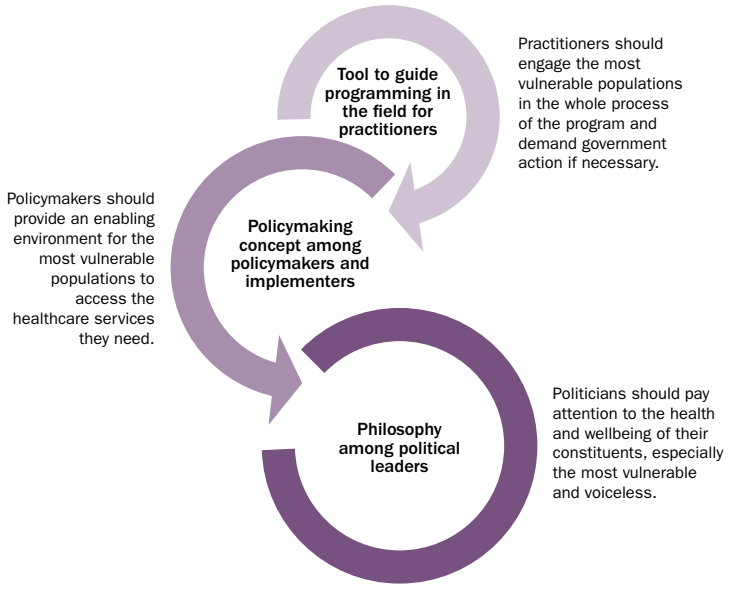
Following up on that paragraph, the UN General Assembly adopted a resolution* in 2012 that further defined the human security approach:

- acknowledging that everyone has the right to live free from fear, free from want, and in dignity
- encompassing the principles of the centrality of individuals and communities, comprehensive and context-specific analysis of threats and implementation of responses, prevention, and synergy between protection and empowerment
- recognizing the intricate ways in which peace, development, and human rights are interrelated
- respecting national ownership and the responsibility of the domestic governments concerned

* For the full text of UN Resolution 66/290 on human security, see Appendix.

policymaking concept and a tool to guide programming—and aims to provide suggestions for integrating human security into existing health initiatives.

Figure 1. Human security's role in the health field



Human Security as a Political Philosophy

It has been 20 years since the introduction of human security in the United Nations Development Programme (UNDP) "Human Development Report, 1994."[5] Since then, various assessments have tried to look at the development of human security and where it fits in among several other approaches.[6] For some, human security belongs to a particular moment in global policymaking—during the 1990s and early 2000s. In certain circles it may even be considered a concept whose moment has passed. However, the momentum around it remains, at least in the UN.

During the development of the 2030 Agenda for Sustainable Development, some argued in favor of adopting human security as an overarching guiding principle. The Institute of Development Studies in the United Kingdom suggested that adopting a human security framework would improve the post-2015 agenda by acknowledging interactions among different threats, promoting more cross-disciplinary thinking, addressing in-country inequalities, creating more linkages between people and their governments, and transcending borders of all types.[7]

The 2030 Agenda for Sustainable Development places strong emphasis on inclusion and on the social, economic, and environmental aspects of sustainability. Human security can be a useful guiding principle as it looks at the root causes of vulnerability throughout the life course and promotes structural change by integrating empowerment and protection.

The global community recognizes that the MDG framework has helped to galvanize development efforts at the global and national levels; however, progress is uneven within and across countries and regions.[8] This sheds light on the importance of prioritizing inclusion and of paying more attention to structural issues. Three of the eight MDGs dealt directly with health, and the remaining five dealt with determinants of health. But the epidemiological and demographic landscape has changed since 2000, and noncommunicable diseases have become more prominent than they were when the MDGs were adopted, putting different pressures on weak health systems. The international community recognized that these new challenges need to be addressed at the same time that efforts to meet the unmet MDGs are being accelerated, and efforts are being made to address them simultaneously rather than prioritizing one over the other. At the same time, the 2030 Agenda for Sustainable Development has gone beyond the MDG agenda and is now integrating economic, social, and environmental aspects as essential and interconnected elements in the effort to achieve sustainable development in all its dimensions.[9]

The UN System Task Team on the Post-2015 UN Development Agenda suggested three "core values" for the next global development agenda—human rights, equality, and sustainability—and identified four key dimensions for further progress: inclusive social development, inclusive economic development, environmental sustainability, and peace and security.[10] Similarly, the synthesis report of the UN secretary-general on the post-2015 development agenda proposed six essential elements to help frame and reinforce the universal, integrated, and transformative nature of a sustainable development agenda and to ensure that the ambition expressed by member states is delivered at the country level (see fig. 2).

Human security can serve as an overarching framework for achieving this agenda based on the principles outlined above. The emphasis on comprehensive approaches that take into account the interconnected nature of threats will help bring the various values and dimensions together. The emphasis on people-centeredness will help define what each of these values and dimensions means at the community level and ensure that the most vulnerable populations in our societies are among those not left behind. Human security's emphasis on prevention will

be essential to achieving sustainable results in all of the four key dimensions, dealing with social development, economic development, the environment, and peace and security. The emphasis on integrating protection and empowerment will help in particular in achieving sustainability and building effective, open, and accountable institutions. Human security can be shared as a common goal and principle among stakeholders in various sectors as well as at various levels—community, subnational, national, regional, and global—to facilitate partnership among them with an emphasis on inclusion.

Several countries have adopted human security as part of their national-level political philosophy as well. Keizo Obuchi was the first Japanese prime minister to refer to human security by name when he declared, "With human security in mind, we have given, as one of the most important pillars of our support, assistance to the poor, the aged, the disabled, women and children, and other socially vulnerable segments of population on whom economic difficulties have the heaviest impacts."[11] Since then, successive Japanese leaders have continued to rely on this political philosophy as part of their foreign policy. In the domestic context, Shinzo Abe and other prime ministers have often used rhetoric proclaiming the importance of providing public and mutual assistance to the vulnerable while emphasizing self-help and self-reliance.[12] In a number of ways, human security is a natural fit for Japan, where it is often looked to as a guiding principle for the country's approach to pacifism in the face of an ever-evolving global environment.

Human Security as a Policymaking Concept

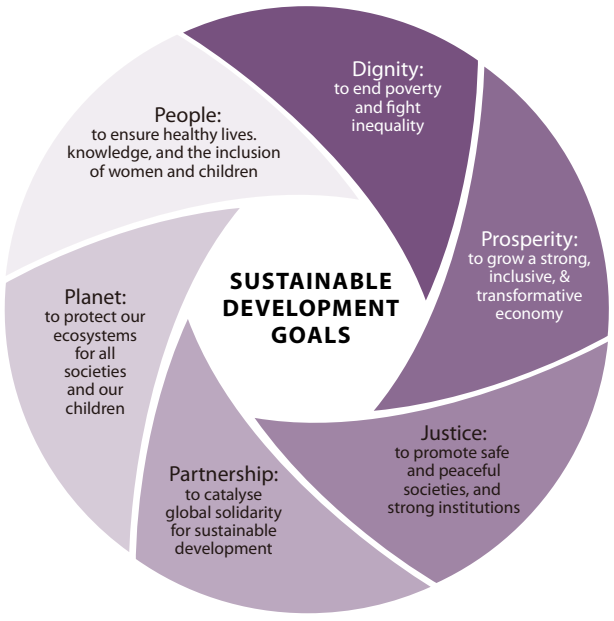
Some countries and intergovernmental organizations have adopted human security as a policymaking concept to guide their own actions, both domestically and in their foreign policy. In 2010, PAHO became the first multilateral international organization to have one of its governing bodies issue a mandate urging member states to consider how the concept of human security could be integrated into their national health plans.[13] In 2012, it compiled a technical reference document to support the dialogue on the close relationship between health and human security.[14] This document was one stepping stone along the path of health policies and interventions geared toward ensuring that individuals and communities are free from fear, free from want, and free to live in dignity.

El Salvador adopted the human security approach as a policymaking concept to reduce the proliferation of firearms, in part as an outgrowth of a project in the department of Sonsonate supported by the UNTFHS. Ecuador later adopted human security as a political philosophy in its 2008 constitution. Peru adopted the human security approach in the development of its local early warning systems for natural and man-made sudden events, an outgrowth of a UNTFHS-funded project in the Andean Mountain Region.[15]

The African Union has explicitly recognized the importance of adopting a human security framework if countries in the region are to meet the MDGs and future goals, and the Pacific Islands Forum went so far as to adopt a Human Security Framework for the Pacific 2012–2015.[16] Similarly, as noted above, the Japanese government has remained steadfast in its support of human security despite the country's frequent changes of political leadership.[17] The Japanese government adopted human security in its official development assistance (ODA) charter in 2003, having recognized that the complexity of challenges on the ground requires a comprehensive approach, that a framework was needed that linked development and peace, and that peace and development around the world are only possible when people's needs are met everywhere.[18] This concept was retained in the charter when it was revised in 2014.

While several other countries—notably Mongolia and Thailand—have adopted the term "human security" in their legislation, national

Figure 2. Six essential elements for implementing the post-2015 development agenda



Source: UN General Assembly, *The Road to Dignity by 2030: Ending Poverty, Transforming All Lives and Protecting the Planet* (synthesis report of the secretary-general on the post-2015 sustainable development agenda [A/69/700], 2014), http://www.un.org/ga/search/view_doc.asp?symbol=A/69/700&Lang=E.

plans, and administrative structures, others have adopted the principles of human security without necessarily calling it by name. For example, Kenya has made protection and empowerment central pillars of its Kenya Vision 2030, and Lithuania has expanded its national security strategy to encompass all three of the essential freedoms—freedom from fear, freedom from want, and freedom to live in dignity. Mexico's National Development Plan 2013–2018 is a comprehensive, multisectoral plan that recognizes both the interconnections among various threats and the vital importance of an emphasis on prevention and on leveraging local capabilities and resources.[19]

One of the reasons human security has survived in the global policy discourse may be its equal emphasis on the three freedoms and its emphasis on overcoming an often complex web of multiple threats facing individuals and communities, especially the most vulnerable populations in our societies.

Human Security as a Tool for Programming

Despite this momentum at the global level, efforts to narrow the gap between the concept and its implementation are still relatively new and inadequate. A notable exception is the UNTFHS, which has been providing funding since 1999 to UN agencies and their partners for projects that explicitly take a human security approach. Through its funding, the UNTFHS is allowing for valuable experimentation with human security approaches on the ground by funding projects that aim to reduce threats to the survival, livelihood, and dignity of vulnerable communities; integrate top-down protection approaches with bottom-up empowerment approaches; promote partnerships across sectors and agencies; and focus on individual and community assets and unmet needs.[20] Based on its foreign policy emphasis on human security, the Japanese government added a line item for "grant assistance for grassroots human security projects" to its ODA budget in 2003. These grants target nonprofit organizations that implement development project at the grassroots level mainly aimed at improving basic human needs. Recipients include nongovernmental organizations (NGOs), local public authorities, educational institutions, and medical institutions.

The Evolving World of Health

The Meaning of Health

The World Health Organization (WHO) defines good health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[21] In 2011, Machteld Huber et al. proposed changing this definition to emphasize "the ability to adapt and self manage in the face of social, physical, and emotional challenges," bringing the question of resilience squarely into the health field.[22] Health is a positive concept emphasizing social and personal resources as well as physical capabilities. In 1946, the member states of the WHO agreed on a fundamental international principle whereby "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[23] In 1968, the 59th Session of the Executive Committee of PAHO began to discuss the relationship between health and international human rights instruments in the context of the technical cooperation that PAHO provides to its member states.[24] In 2007, ministers and secretaries of health of the Americas underscored their commitment to the above-mentioned international principle in the Health Agenda for the Americas (2008–2017). In doing so, they placed human rights among this instrument's principles and values and reconfirmed the importance of ensuring the highest attainable standard of health by stating, "With a view to making this right a reality, the countries should work toward achieving universality, access, and inclusion in health systems that are available for individuals, families, and communities."[25] In 2010, the 50th Directing Council of PAHO agreed to work to improve access to healthcare for vulnerable groups by promoting and monitoring compliance with international human rights treaties and standards.[26]

UHC to Achieve Inclusive and Sustainable Health for All

Since the Declaration of Alma-Ata in 1978, countries have expressed the need for urgent action by governments, health and development workers, and the world community to protect and promote the health of all people around the world. Recently, significant momentum has been growing globally around the concept of UHC.[27] (For the purpose of this document, UHC implies both universal access to health and universal health coverage as defined in box 2.) Indeed, in 2014, PAHO member

Box 2. What is Universal Access to Health and Universal Health Coverage?

Access is the capacity of individuals to use comprehensive, appropriate, timely, quality health services when they are needed. This requires interventions that are culturally, ethnically, and linguistically appropriate. It also requires taking into account differences in needs based on gender, ethnicity, and other characteristics in order to promote health, prevent disease, and offer the necessary short-, medium-, and long-term care.

Universal access is defined as the absence of geographic, economic, sociocultural, organizational, and gender barriers. It is achieved through the progressive elimination of barriers that prevent all people from having equitable use of a comprehensive set of health services.

Health coverage is defined as the capacity of the health system to serve the needs of the population, including the availability of infrastructure, human resources, health technologies (including medicines), and financing. Universal health coverage, or UHC, implies that the organizational mechanisms and financing are sufficient to cover the entire population. Universal coverage is not in itself sufficient to ensure good health for all, but it lays the necessary groundwork. Universal access to health and universal health coverage imply that all people and communities have access, without discrimination, to comprehensive, appropriate, timely, and quality health services and medicines that respond to their needs, while ensuring that the use of such services does not expose users, especially populations in situations of vulnerability, to financial difficulties. Universal access to health and universal health coverage require designing and implementing policies and actions through a multisectoral approach to address the social determinants of health and promote a societywide commitment to fostering health and wellbeing.

Source: PAHO, "Strategy for Universal Access to Health and Universal Health Coverage," 2014.

states adopted by consensus the Strategy for Universal Access to Health and Universal Health Coverage.[28] The strategy makes explicit not only the capacity of a health system to serve the needs of all people but also the absence of geographic, economic, sociocultural, organizational, or gender barriers. It should be noted that several of the PAHO countries are also enduring proponents of human security, including Costa Rica, Chile, Ecuador, and Panama.

Regardless of their development level, nations across the globe are increasingly acknowledging UHC as being both important and imperative as a stepping stone toward a more viable and sustainable future. In fact, Japan has adopted UHC as a centerpiece of its new global health diplomacy strategy, which was prompted in part by its own experience achieving UHC in 1961 and the benefits that this achievement brought to Japan as a developing country at the time.[29] UHC represents the possibility of citizens' access to health coverage, regardless of social or economic status and without risk of financial hardship. Moreover, UHC is a driver of social and economic development because healthier people achieve higher levels of productivity, entrepreneurialism, and educational performance. In this way, UHC is in and of itself a recognition of health as a key element of human welfare and wellbeing and of sustained social and economic development.[30]

Though UHC is not a new concept, it has been reassessed recently as countries are looking to make their health systems more people-centered, integrated, and sustainable. It calls for a double-pronged approach to equitable healthcare that is both technical and political. Technically, UHC must strive to deliver access to effective and adequate services to respond to all health threats across the preventive, promotive, curative, rehabilitative, and palliative dimensions of healthcare. Politically, UHC requires health policies, plans, and programs that are equitable and efficient and that respect the differentiated needs of the population. **Equity in health** refers to the absence of unfair differences in health status, in access to comprehensive and timely health services of high quality, in copayments, and in access to healthy spaces. Gender, sexual orientation, disability status, ethnicity, age, and economic and social status are specific social determinants that can have either a positive or negative impact on health inequities.[31]

Equity in health: The absence of unfair differences in health status, in access to comprehensive and timely health services of high quality, in copayments, and in access to healthy spaces.

Though the path toward UHC is fraught with challenges, it has proven to be a viable course of action for achieving social justice and eradicating inequities that result in differentiated health outcomes between populations.[32] Its feasibility depends on, and indeed demands, the strong and concerted commitment of a broad spectrum of actors and sectors.[33] The latter is particularly true as UHC faces several issues in its implementation: (1) services are not always culturally or linguistically appropriate; (2) health systems are often fragmented, with limited communication or collaboration across different parts of the system; (3) systems are often not designed to respond to different health needs among different communities and individuals within communities; (4) there are significant imbalances and gaps in the availability, distribution, composition, competency, and productivity of human resources for health, particularly at the first level of care; (5) access to and rational use of safe, effective, quality medicines and other health technologies are limited; (6) financing is inadequate and resources are often used inefficiently; and (7) there is little effective coordination with other sectors, in part because of the limited leadership capacity to successfully implement intersectoral initiatives that address the social determinants of health.[34]

Yet, despite the many challenges facing UHC, there are encouraging examples in low- and middle-income countries that show that the achievement of universal coverage is possible and is not the exclusive prerogative of high-income countries. For example, under the Japan–World Bank Partnership Program for UHC, 11 low-, middle-, and high-income countries that have committed to UHC as a key national aspiration were analyzed. The countries included in the study (Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam) have not all fully achieved UHC but they are all approaching it in different ways and are at different points along the path toward achieving or sustaining it. Some are developing and piloting new ways of expanding coverage, while others are putting new systems in place, leveraging new systems to garner political leadership and public support, or maintaining mature systems of UHC.[35]

Health and Human Security

Challenges to Security and Beyond

Framing health as a security issue is not new. It was first included in the Declaration of Alma-Ata at the International Conference on Primary Health Care (PHC) in 1978: "The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace."[36] It was also included as one of the key dimensions of human security in the UNDP's seminal 1994 Human Development Report.[37] In 2000, then US Vice President Al Gore brought the idea that health challenges are security challenges to the global political stage when he spoke very passionately in front of the UN Security Council about the toll of AIDS.[38] Since then, the close link between health and the security of nations has gained wider recognition, particularly in the case of pandemics, which ignore national borders and can devastate societies when virulent strains spread widely.

But health challenges threaten not only nations and societies but also individuals and communities. Failure to address health challenges in a timely manner can threaten people's security, human rights, and fundamental freedoms, as well as their ability to lead a productive, fulfilling life in dignity. Large-scale health threats can cause ripple effects in societies that are ill prepared to deal with them, sometimes leading to widespread social instability. HIV infection, for example, tends to hit people during their most productive years, and AIDS has devastated workforces in many hard-hit communities, particularly in its early days before effective treatment became widely available. The handling of the epidemic also eroded public trust in government when it took too long for antiretroviral treatment to be made available to several of the world's most vulnerable populations that needed it. Public dissatisfaction with how the epidemic was being handled led to the creation of our generation's most visible health movement and a recognition of the need to adopt the principles of human security in the fight against HIV infection and its effects.

The 2014–2015 Ebola outbreak in West Africa is another stark example of a health challenge that has ripple effects far beyond the health sector. Fears about transmission brought economic activity to a standstill in parts of the three countries where the epidemic was concentrated—Guinea, Liberia, and Sierra Leone.[39] The inability of these three countries' health systems to treat people who were infected with the virus and prevent further transmission led to riots, looting of health facilities, and physical violence against healthcare workers.

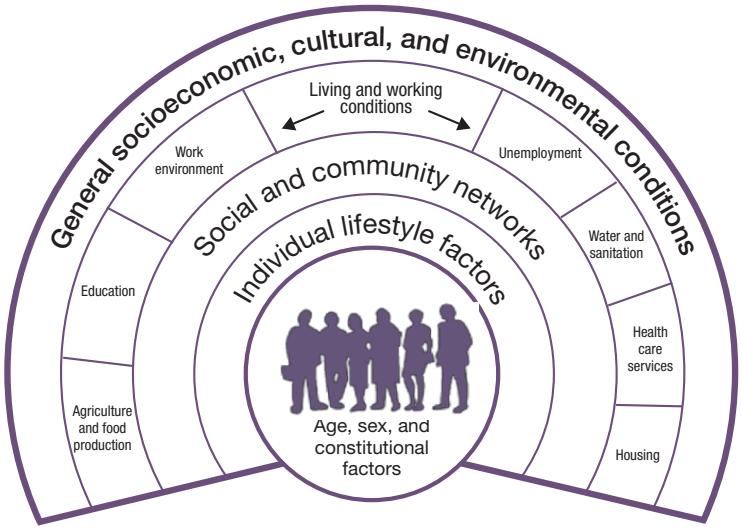
Illness, impairment, and limited physical, mental, and social wellbeing can also lead to stigmatization, exclusion, inequalities, and discrimination. As such, health is also closely related to dignity and the enjoyment of basic human rights. For example, people with communicable diseases are often stigmatized and denied economic, educational, housing, and social opportunities and rights; and people who live with noncommunicable diseases or other physical or mental impairments are often excluded because of assumptions that their illness or impairment prevents them from being productive members of society. According to public health experts and specialized agencies of the United Nations and Inter-American System for the protection of human rights, as well as organizations created by international human rights treaties, the violation of or failure to enforce human rights can adversely affect the physical, mental, and social wellbeing of all people.[40]

Overall, the ability to achieve the highest attainable standard of health varies based on age, sex, and constitutional factors; individual lifestyle factors; social and community networks; and general socioeconomic, cultural, and environmental conditions (see fig. 3). Thus, in order to mitigate the impact of poor health on individuals and communities, societies need to overcome challenges not only within the health domain but also beyond it.

Human Security and Public Health

The human security and public health frameworks share much in common. Both contain

Figure 3. The main determinants of health



Source: Göran Dahlgren and Margaret Whitehead, *Policies and Strategies to Promote Social Equity in Health* (Stockholm: Institute for Futures Studies, 1991).

compatible concepts and principles that make their use mutually beneficial. Public health creates an entry point for the human security approach by offering evidence-driven interventions that in practice also result in making people's lives more secure.[41] Most importantly, public health can offer the availability, acceptability, and accessibility of good quality services to all, especially in the context of PHC, which is necessary to achieve human security.[42] Conversely, when health services are denied to many, in particular to the most disadvantaged population groups, human security is jeopardized.[43] Deficiencies in the quality of and access to health services can go even further and seriously destabilize the social, economic, and political structures of countries and communities.[44] As such, health threats are central to human insecurity. Ensuring available, acceptable, accessible, and good quality health services through self-reliance and self-determination of the most vulnerable population groups is one of the ultimate goals of human security in the health field.

Human Security and UHC: A Complementary Partnership

The human security approach can be a useful tool for helping overcome the challenges along the path toward implementing UHC. It injects the promotion of resilience into the process of implementing UHC. In particular, it can guide all stakeholders to be better prepared in the face of health threats so that they can bounce back more quickly and emerge stronger from these threats at every stage of their development in the spirit of self-reliance.[45]

Conceptually, there are many commonalities between human security and UHC. Given that UHC is a process for achieving universal access to good quality health services, it aligns with the fundamental pursuits of human security, including people's freedom from want,[46] freedom from fear,[47] and freedom to live in dignity.[48] Moreover, in the journey toward achieving those goals, UHC and the human security paradigm share many principles, both aiming to be people-centered, multisectoral, comprehensive, context-specific, and preventive- and promotion-oriented, while encouraging more synergy between top-down protection and bottom-up empowerment.[49]

Notwithstanding UHC and human security's common conceptual aims and compatible approaches, once they are closely analyzed, both paradigms exhibit certain limitations in their implementation. Those limitations relate to the reach of each paradigm. In the case of UHC, the limitations pertain to the partial spectrum of health services that are offered and are accessible, particularly to marginalized population groups.[50] For example, until recently, health services in the United States have focused primarily on disease-specific medical services. These services, though necessary, tend to be more costly and inefficient and may not cover the most marginalized population groups.[51] With the passage of the Patient Protection and Affordable Care Act in 2010, coverage is expected to extend to certain marginalized population groups, particularly the poor and informally employed or underemployed, an important step toward UHC.[52]

To achieve health and sustainable health services for all, national health systems must ensure the provision of **patient-oriented healthcare**. They must also practice a balance between services focusing on individuals (preventive, promotive, curative, rehabilitative, and palliative) and those focusing on populations (primarily preventive and promotive). Furthermore, national health systems should strive for financial protection and equity in the delivery of needed services, as well as the inclusion of the most disadvantaged population groups.[53] Individual- and community-based PHC is the key to achieving equitable health for all under the new development agenda.[54]

In the case of human security, the major limitation is the lack of examples of successful operationalization and measurement of its impact. Human security has reached a threshold where its principles need to be translated into actions and used as a framework for individual- and community-oriented policy and for the formulation and application of programs.[55] In

Patient-oriented healthcare: Healthcare that focuses on the whole patient as a human being rather than on specific health conditions of the patient, taking into account patient preferences and beliefs in developing a screening, diagnosis, and treatment plan.

addition, the comprehensiveness of the concept has been criticized as unhelpful in prioritizing target issues under situations with limited resources. The gap, however, can be narrowed, and the brief discussion below of ideal situations in which to take human security approaches is one step toward that goal.

Human security's emphasis on a balance between individual- and community-based interventions provides a framework that can assist in the work toward UHC's wider reach. In addition, human security can facilitate UHC by making explicit the importance of including strategies that reduce the risks of economic threats and a need-, asset-, and human rights–based approach that affords the most disadvantaged population groups the culturally competent healthcare they require using their own resources and capacities to the extent possible. At the same time, the empowerment component helps disadvantaged populations gain self and collective agency. Human security can also help extend the interconnections between health and other challenges and bring a broader focus on resilience to future threats to UHC's objectives. Conversely, the path toward UHC offers a concrete area where the concept and principles of human security can be operationalized.

Resilience and Health

The ultimate goal of human security is to help prepare people around the world to cope with a wide range of sudden and pervasive threats—both natural and man-made—that can have major health consequences. Resilient individuals, communities, and institutions are able to handle daily adversities and a wide and unpredictable range of incidents that have the potential to negatively affect their lives, livelihoods, and dignity. These include infectious disease outbreaks, climate change, environmental degradation, migration pressures, limited health services, violence, political turmoil, and many others. Advances in science and technology and the development of institutions for global governance have made states and their residents better able to prevent and prepare for these threats. However, governments cannot protect their residents from all adversities that threaten people's survival, livelihoods, and dignity, and they have tended to focus primarily on specific identified threats. Therefore, if communities are going to be better prepared for all potential health threats, they need to focus on developing maximum individual and community self-reliance and to participate in all aspects of health actions—planning, organization, implementation, monitoring, and evaluation—making fullest use of local, national, and other available resources.

While it is crucial to prevent and prepare for disasters and other crises that can to some extent be anticipated, resilience goes beyond that and connotes a state of more comprehensive readiness to deal with the "unknown unknowns." To be secure from the negative impacts of a wide spectrum of known and unknown threats, countries should also focus on the sustained ability of their individuals, communities, and institutions to withstand, mitigate, and recover from adversity quickly. This requires a preemptive approach in which those abilities are nurtured before negative events occur.[56] Regardless of the type of threat—pervasive or sudden, man-made or natural, known or unknown—to which resilience is being built, the process starts with an identification of existing resources within each community.[57] Leveraging existing resources tends to be more efficient than creating new systems and processes, and it may be more acceptable to communities than bringing in solutions from the outside. At the same time, the many resources within a community interrelate and can be mutually supportive, so by identifying those resources, communities can protect those that are not threatened in order to compensate for those that are when crisis hits.[58]

Health is an integral part of the larger concept of resilience in which many sectors contribute to the wellbeing of individuals, communities, and institutions (see box 3). But it is also important to remember that health resilience is only a part of the equation. Without resilience built in other parts of their lives, people's resilience to health threats is still at risk in the same way that weak health resilience weakens resilience in other areas. In the end, they cannot be separated.

These components of resilience—preparing for negative impacts before sudden events

Box 3. Defining Health Resilience

In the context of health and wellbeing, resilience is referred to in this document as the ability or capacity of individuals, communities, and systems to leverage various assets to care for their health and wellbeing—in particular that of the most disadvantaged population groups—by adapting as sudden events arise (e.g., natural disasters, serious acute illnesses, famines, or violent conflicts) and as pervasive challenges persist (e.g., gradual effects of climate change, chronic diseases, inconsistent employment opportunities, human rights abuses, and domestic violence).

Source: Adapted from Rockefeller Foundation, "City Resilience Framework" (2014), http://www.rockefellerfoundation.org/uploads/files/0bb537c0-d872-467f-9470-b20f57c32488.pdf.

arise, strengthening existing resources, and looking at how resources interrelate and provide mutual support—can be achieved through the application of the principles of human security. In May 2006, not long before Surin Pitsuwan was appointed secretary-general of the Association of Southeast Asian Nations (ASEAN), he referred to human security as focusing on the "soft safety nets" that complement social safety nets, the latter focusing primarily on providing for people's material needs. Among the soft safety nets that are key to human security, he included "the attitude, the ability, the willingness, the quality, and the capability [of individuals, communities, and institutions] to get involved in solving [their] problems." He described human security as aiming for a "system [that] will be able to solve the problems that the people have through their own participation and contributions. The system can run on autopilot on its own."[59] This internal ability to solve problems as they arise is what we strive for in building resilience.

Added Value of Human Security in the Health Field

The human security approach helps us advance down the path toward health for all by transforming leadership and promoting equitable governance for health systems. Specifically, the human security approach addresses the social determinants of health at the local level, seeks the establishment of power-sharing governance for health, and promotes self-reliance and self-determination among individuals and communities.

Human security can shape health resilience by identifying existing resources in the community and addressing how collective decisions are made, interpreted, implemented, and challenged.[60] People's opportunities for a healthy life are closely linked to the conditions of their environment. Resilient individuals, communities, and institutions respond proactively to new or adverse situations; prepare for social and environmental change; and cope better with crises and other insecurities. Public health approaches included in UHC—PHC,[61] health promotion,[62] and health in all policies[63]—have been successful in identifying and addressing health challenges. However, they have been limited in their ability to ensure that interlinkages among the sources of these challenges are recognized and that the responses are integrated. Human security adds value to efforts to achieve health for all by focusing on a governance system that recognizes the interlinkages among peace, development, and human rights. The human security approach requires that a government (or political system) be flexible so that policy priorities can be adjusted and new issues can be selected according to the reality faced by target populations. They also need to provide an enabling environment for other actors—especially civil society organizations—to address the interlinked threats that the government cannot fully handle. This will help improve the accountability and responsiveness of governance systems.

Human security and public health, as compatible paradigms, share a number of principles that are applied to varying degrees by each, that afford actors in the field of development a set of "operational tools,"[64] and that can guide and complement an inclusive journey toward the achievement of UHC with equity. Among the principles of human security we have identified, three—a people-centered approach that places the individual at the core of analysis, the focus on context-specific understandings to advance contextualized responses to a given situation, and an orientation toward prevention and promotion that identifies and addresses the root causes of threats leading to poor health—apply to both paradigms. Both paradigms also require comprehensive multisectoral and multi-institutional perspectives and responses that are underpinned by analyses on multiple levels in an attempt to solve complex problems and achieve far-reaching gains in health. In addition, they strive for a harmonious protection and empowerment framework where individuals and communities are capable of producing their own protection and strengthening their own resilience.[65]

It is important to note that some of these features are already thoroughly developed at a conceptual level and are being implemented in a number of health initiatives around the world. However, they are not yet fully employed as deliberate actions by national health systems despite their complementary nature and wide recognition as playing a key role in the journey toward health for all. In fact, deliberately or inadvertently, health services have emphasized individual-oriented, disease-specific actions—in contrast to the human security approach—resulting in limited health services

Box 4. Defining Governance for Health

Governance for health is the complex of formal and informal institutions, mechanisms, relationships, and processes between citizens and organizations—both governmental and nongovernmental—through which collective health interests are articulated, rights and obligations are established, and differences are mediated.

Source: Adapted from Ramesh Thakur and Thomas G. Weiss, *The UN and Global Governance: An Idea and its Prospects* (Bloomington, IN: Indiana University Press, 2006).

Box 5. Existing Mechanisms for Program Design

Development practitioners have already developed several tools and mechanisms that can be used for designing specific actions based on the principles of human security:

- The SEED-SCALE (Self Evaluation for Effective Decision-making and Systems for Communities to Adapt Learning and Expand) process builds actions on community successes; implements actions grounded on objective data; establishes three-way partnerships among governments, communities, and experts; and promotes changes in community behavior.[67]
- The "positive deviance approach" examines why some people succeed where others do not achieve the same outcomes. It can bring about sustainable behavioral and social change by identifying context-specific solutions already existing in a society.[68]
- The "asset-based approach" can help identify assets or talents that are available within a community and use people's existing talents to solve their own context-specific problems.[69]
- The "livelihood approach" can help identify primarily household-based capabilities, assets, and activities required for a family to have the means of making a living.[70]
- The influence that social relationships and social capital may have on individual and community empowerment can be utilized through social networks and social support interventions, such as the use of community workers and helpers as important members of the healthcare workforce,[71] or a "contagious health" strategy through social networks.[72]
- The photovoice analytical participatory method, which combines photography with grassroots community activities, can build leadership skills, empower people, and increase community competence.[73]

The human security approach acts as an overarching framework in which these and other evidence-based tools and mechanisms should be used as a group, following the roadmap developed by the UN Human Security Unit.[74]

and financial constraints on individuals.[66] It is rare that health services balance individual and community-based interventions or that they are comprehensive across all dimensions of healthcare—promotive, preventive, clinical, rehabilitative, and palliative care. They are also too often unaffordable for the most marginalized populations. As a result, it becomes more difficult for health services to be sustainable and secure for all.

The following is a description of the five features of a human security approach as they relate to health.

People-Centered Approach

Human security advances the notion of a people-centered approach to security, development, and human rights.[75] By making it people-centered, there is a recognition that people are facing multiple threats beyond any single disease. This has the potential to change the framework through which priorities are established for using limited resources more effectively and equitably. However, aiming to place individuals at the core of policies that advance UHC requires a recognition that inequities in access to health services do exist, particularly for the most disadvantaged population groups. Vulnerable population groups face significant inequities in the opportunities available to them for attaining their full potential as a result of limited availability of health services. In addition, these population groups usually do not participate in the decision-making process. For example, there is evidence that health systems shortfalls deprive women of healthcare because of financial barriers[76] and that undocumented migrants may not have access to health and social services because of their legal status.[77] Thus, in the path toward UHC, a people-centered approach, such as people-centered PHC,[78] involves plans that contain the necessary mechanisms to reach all population groups, giving emphasis to groups historically excluded and discriminated against. In addition, they must ensure community ownership and the empowerment of the most marginalized population groups in the decision-making process.

Context-Specific Approach

The people-centered approach described above leads to a recognition that a one-size-fits-all approach may not help solve problems as intended. In responding to insecurities, the human security paradigm therefore underscores the importance of context-specific approaches[79] that require decentralized systems and capacity at the local level. By being "flexible" and "dynamic," the human security framework is applicable across countries and communities where insecurities vary as they are uniquely shaped by complex forces. Because insecurities manifest differently across communities and countries, a "flexible approach" that builds on people's perceptions and experiences of vulnerability is most effective.[80] It allows communities, heterogeneous as they might be, to identify their specific needs and develop appropriate responses grounded on local realities. Thus, communities rely on the utilization of local resources, beyond national or international policies that might contradict their priorities, cultural practices, and past successes. In order to resolve the contradiction between the local reality and national and even global policies, a political or administrative mechanism that can narrow the gap and enhance the responsiveness of governance to local realities is needed.

Comprehensive Perspective and Multisectoral Framework

Just as the ways in which people experience insecurities in their lives differ across contexts and individuals, their insecurities rarely stem from only one source of vulnerability. The comprehensive perspective in the human security paradigm is one that seeks to analyze and address threats and insecurities in an integrated manner by bringing to the fore security, development, and human rights. A comprehensive perspective involves the identification and understanding of the social determinants of health, which refers to the conditions that shape how individuals are "born, grow, live, work, and age."[81] Such a perspective serves to identify the stakes in a given situation, the "threshold below which human life is intolerably threatened,"[82] and the sectors and actors that must be engaged in a given course of action. In addition, a comprehensive perspective also serves to identify how the health of a community affects its social and economic development.[83] For example, a comprehensive perspective for addressing a high prevalence of HIV cases in a community would focus not only on overcoming the direct health threat but also on enabling people to overcome other threats such as poverty and discrimination.

As actors seek to address the full range of social determinants that might evolve into potential threats and insecurities, a multisectoral framework is imperative. This involves a conceptual and integrated response that brings into action all the sectors and actors needed to respond to a threat and thus "ensure[s] the survival, livelihood and dignity of individuals and communities"[84] using a common language. It strives to accomplish "policy coherence and coordination across traditionally separate fields and doctrines" through "knowledge-sharing and results-oriented learning."[85]

The importance of the principles of comprehensiveness and multisectoral engagement lies in the understanding that UHC will be achieved when all health service dimensions are addressed interdependently and through a multidisciplinary vision at the individual and community levels—that is, a vision that actively secures the cooperation and equal footing of all actors in achieving or restoring equitable health coverage. Yet, as conceptually developed and understood as these two principles might be, their practice or enactment in the path toward the achievement of UHC has been limited.

Prevention- and Promotion-Oriented Approach

While the sections above deal with existing insecurities, it is always better to prevent threats from becoming sources of insecurity rather than deal with their implications later. A defining feature of the human security paradigm is its concern with "early prevention" as opposed to "late intervention."[86] This prevention/promotion-oriented approach is manifested as a concern for addressing the root causes of human insecurities and devising mechanisms that are preventive or that help mitigate damaging effects when crises occur. An individual- and community-based preventive/promotion approach involves a series of actions or "levels," ranging from strengthening the knowledge and skills of individuals, to the promotion of community education; to the education of providers; to the fostering of social networks, coalitions, and partnerships; to changing practices within organizations; to influencing legislation and policy.[87] This spectrum of prevention helps health systems move beyond the perception that community prevention and promotion is primarily disease-specific, individual-oriented education interventions.

This kind of an approach requires strengthening existing institutions in a way that makes them more resilient to future challenges. Often, faced with unforeseen crises, existing institutions are called on to work in ways that go beyond their established mission because of the relationships that they have with affected communities. This was the case, for example, with the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (GHESKIO) in the immediate aftermath of the January 2010 earthquake in Haiti. While GHESKIO's primary focus since its founding in 1982 has been dealing with AIDS and opportunistic infections, the fact that it already had strong connections with the local community (and that its staff is made up almost entirely of Haitians) meant that it understood the needs in the community as well as the opportunities for mobilization, and, very importantly, it had the trust of the communities in Port-au-Prince that were most in need of health services after the devastating earthquake struck. Since people knew and trusted GHESKIO, they came to the organization not only for health services but also for food, water, and shelter, and GHESKIO was able to leverage its community orientation to link those in need with those who were coming from outside to provide various forms of support.

Self-efficacy: An individual's belief in his or her capacity to execute behaviors necessary to produce specific performance attainments.

Awareness: The knowledge of one's rights and responsibilities.

Action coping: A person's patterns to master, tolerate, reduce, or minimize stressful events.

Collective efficacy: A group's shared belief in its joint capabilities to organize and execute behaviors necessary to produce specific performance attainments.

Protection and Empowerment Framework

Achieving all of the components described above requires deliberate action by both the individuals and communities themselves and those actors whose responsibility it is to protect and provide services for the communities. Among the building blocks in the achievement of human security is the harmonious protection and empowerment of communities and individuals vis-à-vis a "dual policy framework" or "hybrid approach." Such an approach emphasizes the need to ensure and protect human rights through the establishment of the rule of law and social protection instruments by governments, while at the same time, it promotes the development and strengthening of individual and community capabilities so that they become more self-reliant and have more self-determination. The resulting synergy between actions taken by the government and by the people is manifested in inclusive governance systems where the government and the people are accountable and responsive.[88]

The dual policy framework or hybrid approach has the potential to ensure the sustainability of programs through individuals' and communities' ability to act preventively on their own behalf and against threats, thus becoming more resilient. Yet, given UHC's fragmented focus and limited integration of all its dimensions, protection and empowerment might be disjointed. Consequently, if human security's pillars of protection and empowerment are going to be of critical importance to UHC, it will be because of their capacity to strengthen resilience to health threats for the most disadvantaged population groups. In particular, the protection-empowerment framework should focus on the following:

- Personal factors—enabling and supporting disadvantaged individuals to develop **self-efficacy, awareness**, and **action coping**.
- Community factors—enabling and supporting disadvantaged population groups to develop **collective efficacy**; participate in civil society, public-private partnerships, and social networks; and develop the ability to discuss health concerns and determine solutions.
- Societal or institutional factors—enabling and supporting the involvement of disadvantaged population groups in decision-making processes, ensuring complete and consistent information is shared with the public, and ensuring that human, technical, and financial resources are available.[89]

Applying Human Security in Health

While a human security approach can be valuable in some situations, it is not necessarily the best approach in all situations. The human security approach is likely to be more successful than other existing approaches in situations where the freedom from want, the freedom from fear, and the freedom to live in dignity need to be addressed simultaneously.

In these situations, the comprehensive nature of human security and its focus on the interrelationships among various causes of vulnerability—regardless of which freedom(s) they address—can be more effective at enhancing the three freedoms simultaneously. With that in mind, the following describes several situations, by no means exhaustive, where a human security approach may bring added value.

Marginalized populations: When discrimination against a particular population group is the major underlying source of its vulnerability

A human security approach is particularly useful in addressing the needs of those individuals and communities that have slipped between the cracks of existing services and policy frameworks. They may be marginalized for many reasons, including race, ethnicity, religious or political beliefs, impairment, gender, age, occupation, geographic location, sexual orientation, or disease. Or they may be migrants without legal status in the location where they are living. These types of populations are the primary targets of a human security approach.

In these situations, a human security approach does not create parallel systems for dealing with these disadvantaged populations' needs. Rather, the emphasis is on creating linkages between disadvantaged population groups and existing public systems and on making sure that current needs are met while encouraging public sector responsibility over the longer term. Public sector recognition of vulnerable disadvantaged populations is implicit in the principle of integrating protection and empowerment. However, convincing governments to take an equity approach and prioritize the needs of the most vulnerable in their societies takes time and may never be fully achieved. For this reason, emphasis on strengthening resilience by integrating protection and empowerment is particularly critical so that marginalized communities are not fully reliant on governments that do not or cannot provide adequately for their needs. In such cases, social movements can be particularly adept at helping to make such connections between vulnerable populations and political leaders. In Brazil, for example, the relentless activism of the *sanitarista* (public health) movement was largely responsible for the eventual introduction of principles of universalism into the 1988 constitution. In Thailand, an organization of rural healthcare professionals successfully advocated for expansion of access to healthcare during the 2001 elections.[90]

Perhaps the best known example of this was the AIDS movement of the 1980s. The cornerstone of that effort was a gay rights movement that demonstrated to the world the human suffering that can be caused when certain populations are excluded from healthcare services and from health policymaking decisions. Despite profound improvements in inclusion in many places, certain groups who are disproportionately infected with HIV—men who have sex with men, commercial sex workers, injecting drug users, women, and adolescents—still face barriers to receiving adequate and appropriate prevention, treatment, and care services. Even where services are available to everyone, some people in these vulnerable groups will not use the services for a variety of reasons, including not knowing about the services and feeling discriminated against and misunderstood by mainstream healthcare service providers. In these cases, a human security approach can be effective by engaging marginalized communities in a process to identify the barriers they face and develop solutions that are likely to work for their community. Human security's emphasis on both protection and empowerment is needed to make sure that vulnerable populations get the culturally competent services they

require using the assets they have and that they make decisions about their own behavior that will reduce transmission and ensure treatment adherence for those who are infected.

Leprosy is another example of a health challenge that is characterized by exclusion and that might be best tackled through a human security approach, as demonstrated in one of the case studies described below. People afflicted with leprosy, and sometimes their family members as well, often find it difficult not only to access healthcare services but also to be accepted at school or gain employment. The exclusion from education and employment compounds their challenges, making it difficult to earn a livelihood and make a contribution to society. While the ultimate goal may be to eliminate discrimination and break down barriers to their full participation in mainstream institutions, activities that deliberately target communities affected by leprosy with healthcare services and income-generating opportunities are also needed in the meantime.

Undocumented migrants are another example of a marginalized population that may benefit from a human security approach. In most countries, accessing health services is difficult for anyone without documentation. However, from a public health perspective, providing primary and secondary preventive health services to everyone regardless of their residency status is imperative. This is rather clear when it comes to communicable diseases, which do not discriminate between migrants and citizens. But it is also the case for noncommunicable diseases, as prevention and early treatment often prove less costly—in terms of both human suffering and healthcare costs—than late treatment. Ensuring that migrant populations know about preventive services and are empowered to access them without fear of deportation benefits everyone in a society.

Complex webs of multiple threats: When multiple sources of vulnerability interact in a complex manner

Several of the challenges that people face have clear solutions that are achieved through targeted responses that do not require a comprehensive approach. In fact, in many instances, the time and effort that go into engaging all stakeholders in identifying needs and assets, developing strategies, and coordinating multisectoral activities is actually counterproductive and can exacerbate the challenges that a community faces. But when a community faces multiple challenges that feed off of one another, such as extreme poverty, environmental degradation, or conflict, just addressing one problem may turn out to be ineffective as other unaddressed challenges threaten to undo any progress that is made. In these situations, human security's emphasis on addressing multiple threats simultaneously in a coordinated and flexible manner is invaluable.

Noncommunicable diseases such as diabetes, heart disease, and many cancers often cannot be traced to a single cause and are instead brought about by a complex set of physical, biological, environmental, social, and behavioral factors. Focusing purely on diet to reduce heart disease while ignoring the effect of stress, smoking, a sedentary lifestyle, the built environment, and other living and working conditions will not be effective. Similarly, addressing cancer only in a medical setting and not touching on behavioral, social, and environmental factors will hardly make a dent in morbidity or mortality. While there has been a lot of work done on the social determinants of health, less has been done on the ways in which all of the determinants interact with one another. Looking at threats from the perspective of the individual, rather than from the perspective of one agency or sector, makes the complex interrelations among threats clearer.

Asthma is another example of a chronic condition that cannot be approached purely from a medical standpoint. Proper diagnosis and treatment are crucial to controlling asthma and mitigating its impact, but empowering patients and their families to identify triggers and avoid them to the extent possible is crucial to reducing the incidence and severity of attacks. At a broader community and policy level, reducing air pollution is critical to reducing asthma incidence in a given population.

Acute and chronic illnesses that are associated with poverty require that special attention be paid to the ways in which different threats interconnect. Getting regular checkups, learning about diet and exercise, and making the choice to live a healthy lifestyle are all important steps in staying healthy. But a person who cannot afford wholesome food or who lives in a place where it is not safe to walk outside will still find it difficult to achieve a healthy lifestyle regardless of their determination to do so. A human security approach recognizes this reality and addresses health challenges in the local setting and in the context of other related challenges.

Man-made and natural disasters: When the root causes of vulnerability result from fundamental changes in the community or sudden events

Major upheavals in a community may require a human security approach as the community

prepares to deal with the new challenges created by the change. For example, after a natural disaster, initial relief and recovery efforts focus on immediate life-threatening needs and are rarely able to include human security approaches. However, in the longer term, the affected community needs to adjust to the loss of infrastructure and institutions and the change in community structure resulting from the disaster while still being able to access healthcare services for acute and chronic conditions. This phase can benefit from a human security approach and its focus on developing sustainable processes that will bear fruit over the long term. The emphasis on engaging communities in identifying needs and assets and on mobilizing local capacities and know-how to address persistent challenges can help bring a sense of hope and pride to people dealing with the overwhelming nature of a major sudden loss. When institutions are lost and daily habits are interrupted, people need to be more self-reliant and employ more self-determination, whether that be in terms of engaging in preventive behavior, knowing when to seek care, or managing medications.

For example, after the 2011 earthquake and tsunami in northeastern Japan, the initial medical response was to find people who were injured in the disaster or who became ill in shelters and provide them with curative services. But it quickly became clear that the focus had to expand as people—particularly elderly people with chronic conditions—needed to learn ways to manage their conditions in a drastically changed environment. This emphasis on strengthening and integrating protection and empowerment in a way that makes people and institutions more resilient to future challenges is indispensable in communities recovering from such major changes. But the example also offers other lessons for human security, as health in a way helped to open the door for health service delivery organizations to learn more about other, nonhealth needs of people displaced by the disaster, as described in the case studies below. Organizations conducting surveys of the health needs of displaced populations found that, as they got to know the people they were interviewing, conversations very naturally turned to other challenges, such as the lack of transportation and access to schools, shopping centers, and workplaces; social isolation; loss of income; and lack of legal knowledge. These concerns would not have come up if the conversations had not started from the standpoint of health.[91]

Similarly, communities accepting migrant populations fleeing a violent conflict or natural disaster in another community often experience challenges from the added strain on local infrastructure and public services, the language and cultural differences, and the inequalities that can emerge when only new arrivals settling in a community are offered special services. In these cases, a human security approach can help both the original and the migrant community to identify the needs that they experience in the context of the new situation and to look for ways in which the resources and capabilities of both communities can be leveraged to deal with these challenges.

Key Findings: Take-Away Messages

In many instances, using a human security lens to design health programs helps to make them more effective and sustainable. But properly integrating human security approaches into health interventions requires that policymakers and program managers maintain an awareness of the main criteria for human security throughout the program design, implementation, and evaluation phases—including the overall goals of human security and its added value, the seven principles of human security identified in this report, and the key features of successful human security approaches.

The following section comprises a series of case studies that the study team analyzed to explore what human security approaches really look like when applied to concrete projects. In particular, the seven principles prove helpful in evaluating when human security approaches are successfully integrated. While none of the initiatives profiled through these case studies manage to fully incorporate every one of these seven, the degree to which they take up some of them is a useful yardstick for assessing how likely it is that the projects will succeed and lead to sustainable improvement in the target population's wellbeing. Hopefully, these principles, as well as the key features outlined below, can provide health policymakers and program managers with a guide for more effectively implementing the human security approach in their work.

Goals of human security in the health field

1. To enhance the resilience of the most vulnerable population groups by enabling them to enjoy good health

2. To ensure that good-quality health services are available, acceptable, and accessible by promoting the self-reliance and self-determination of the most vulnerable population groups

3. To promote health through an understanding of the root causes of vulnerability, which vary depending on the local context and most often involve a web of interconnected threats

Added value of human security to the health sector

1. An emphasis on human security can help us to move beyond focusing on survival to focusing on livelihoods, wellbeing, and dignity. This requires involving non-health stakeholders, such as those dealing with issues of welfare, employment, and other programs.

2. The human security approach addresses the social determinants of health at the local level, seeks the establishment of power-sharing governance for health systems, and promotes individual and community self-reliance and self-determination.

Seven principles of human security

1. Address the linkages among freedom from fear, freedom from want, and freedom to live in dignity

2. Focus on the ways in which people experience vulnerability in their daily lives and acknowledge that different threats feed off one another and thus need to be addressed in a comprehensive manner

3. Engage the population groups in the highest conditions of vulnerability in all stages of programs, from the needs assessment through the design and implementation to the monitoring and evaluation phases of activities

4. Understand the local-specific context and ensure that all decisions and interventions take that context into consideration

5. Include all relevant sectors and actors in the implementation, monitoring, and evaluation processes

6. Focus on prevention to the extent possible

7. Create synergy between protection and empowerment actions

Features of the human security approach

1. Utilizes existing resources

Human security can shape resilience by engaging communities in identifying needs and assets and in mobilizing local capacities and know-how to address persistent challenges. This process can help bring a sense of hope and pride to people dealing with the overwhelming nature of a major sudden or insidious catastrophe.

2. Offers the optimal approach in complex situations

The human security approach is likely to be more successful than other existing approaches in situations where the freedom from fear, the freedom from want, and the freedom to live in dignity need to be addressed simultaneously, such as when (a) discrimination against a particular population group is the major underlying source of its vulnerability, (b) multiple sources of vulnerability interact in a complex manner, and (c) the root causes of vulnerability result from fundamental changes in the community or sudden catastrophic events.

3. Enhances responsiveness and accountability

The human security approach emphasizes the creation of linkages between disadvantaged population groups and existing public systems. It requires that a government (or political system) take responsibility for ensuring that current needs are met and for equipping itself with a mechanism for adjusting policy priorities or identifying new issues according to the reality faced by target disadvantaged populations. It also requires an enabling environment for other actors, especially civil society organizations, to address the interlinked threats that the government cannot fully address.

Disadvantaged population groups need greater political knowledge and awareness of their rights and obligations, requiring the establishment of mechanisms that include both top-down processes (such as elections, hearings, and consultations) and bottom-up strategies (such as participatory budgeting, social mobilization, and citizen monitoring). Social movements can be particularly adept at helping to make such connections between vulnerable populations and political leaders.

4. Minimizes inequities through people-centered approaches

Governments should take an inclusive and equitable approach and prioritize the needs of the most vulnerable in their societies. Policies, programs, plans, and projects should contain the necessary mechanisms to reach all population groups.

Community leadership, ownership, and oversight, as well as the participation and empowerment of the most marginalized population groups need to be ensured in the decision-making process.

Considering the limitations on resources and the rigidity of political systems, human security approaches emphasize that strengthening resilience by integrating protection and empowerment is particularly critical so that marginalized communities are not fully reliant on governments that do not or cannot provide adequately for their needs.

5. Encourages decentralized action

Context-specific approaches require decentralized systems and capacity at the local level, including a mechanism that can narrow the gap between local realities and national policies and enhance the responsiveness of governance to local realities.

6. Identifies social determinants of health

A comprehensive perspective stems from understanding the social determinants of health in a given community and leads to the development of a multisectoral framework. This requires a mechanism that ensures policy coherence and coordination across traditionally separate fields, sectors, doctrines, and administrative boundaries through the sharing of knowledge and results-oriented learning. In many places, nongovernmental entities may be better equipped than governments to implement a multisectoral and comprehensive framework.

7. Applies a preventive approach at various levels

An individual and community-based preventive/promotion approach enhances the sustainability of programs and the resilience of the community.

It involves a series of actions or "levels," ranging from strengthening the knowledge and skills of individuals to the promotion of community education; the education of providers; the fostering of social networks, coalitions, and partnerships; the transformation of practices within organizations; the influencing of legislation and policy; and the strengthening of existing institutions in a way that makes them more resilient to future challenges.

8. Promotes synergy between protection and empowerment for structural change

A human security approach requires looking at the root causes of vulnerability throughout the course of people's lives and promoting structural change by creating more synergy between empowerment and protection.

A protection and empowerment framework requires a recognition of the role of national and local governments and their responsibility to implement a protective structure, including providing necessary healthcare services. At the same time, it requires the development of individual and community capabilities so that people can make informed choices and act on their own behalf, which is key to the sustainability of programs.

Case Studies: Examples of Human Security Approaches in the Health Field

The remainder of this document is comprised of a number of illustrations of interventions where the human security approach was applied to address health threats. Some of these are case studies developed specifically for this project and chosen with the intention of providing examples of how the principles of human security outlined above are being applied in real life. The others are based on descriptions of projects funded by the UNTFHS, all of which went through a rigorous vetting process by the trust fund to ensure that they would advance the cause of human security. The projects are in various stages of implementation, and full information was not available for some of the projects. Therefore, not all of the case analyses can demonstrate actual impact on the target communities, but it is hoped that each will provide some insight into how the principles of human security are being integrated into health-related activities at the community level.

The case analyses attempt, where possible, to answer the following questions about each project, reflecting the seven principles of human security outlined above:

1. How are the three freedoms (freedom from fear, freedom from want, and freedom to live in dignity) linked and how are those linkages addressed?
2. How do health threats feed off other threats or vice-versa and how are they addressed in a comprehensive manner?
3. How do the disadvantaged population groups participate in the health decision-making process?
4. What is the local-specific context and how do health decisions take that context into consideration?
5. How are the relevant sectors and actors included in the health planning, decision-making, and implementation processes?
6. How are promotion- and prevention-oriented interventions implement?
7. Is there a link made between protection and empowerment actions, and if so, how?

Case Studies

Marginalized Populations

CASE 1: **Human Security for Adolescents: Empowerment and Protection against Violence, Early Pregnancy, Maternal Mortality, and HIV/AIDS** (Bolivia)*

CASE 2: **Leprosy Control Program** (Indonesia)

CASE 3: **Community Mental Health and Development in Vientiane Capital Project** (Lao PDR)

CASE 4: **Monitoring Access to Quality Health Care Service for Vulnerable Groups** (Uganda)

CASE 5: **Preventing HIV in Vietnam Project** (Vietnam)

Complex Webs of Multiple Threats

CASE 6: **BRAC Health Nutrition and Population Programme** (Bangladesh)

CASE 7: **Healthy Municipality Project in Northeast Brazil** (Brazil)

CASE 8: **Green and Healthy Environments Program (PAVS): Constructing Integrative Public Policies in Sao Paulo, Brazil** (Brazil)

CASE 9: **Improvement of Human Security Conditions in Soacha through the Development of an Integrated, Participatory, and Sustainable Social Protection System** (Colombia)

CASE 10: **Faces, Voices, and Places: The Food Security Strategy and Nutrition in Local Development Processes, Boca de Mao** (Dominican Republic)

CASE 11: **Strengthening Local Capacities for Peace and Development through a Human Security Approach in the Northern Border Zone of Ecuador** (Ecuador)*

CASE 12: **Fostering Peaceful Coexistence and Improving Citizen Security in Three Municipalities in the Department of Sonsonate** (El Salvador)*

CASE 13: **Reduction of Vulnerabilities to Contribute to the Process of Rural Development Program in the Municipalities of the Basins del Coatan and Alto Suchiate, San Marcos Department** (Guatemala)

CASE 14: **Association for Reproductive and Family Health** (Nigeria)

CASE 15: **Oriade Initiative** (Nigeria)

CASE 16: **Improving Water Quality, Health and Nutrition in Vietnam—Project SWAN** (Vietnam)

CASE 17: **Human Dignity Initiative: Community-Based Safety Nets as Tools for Human Development** (Cambodia, Indonesia, Lao PDR, Thailand, and Vietnam) **

CASE 18: **Project for Strengthening Community-Based Child Health Promotion System in Urban Areas** (Zambia)

Man-Made and Natural Disasters

CASE 19: **Improving Health and Recovering Community following a Devastating Natural Disaster** (Japan)

CASE 20: **Natural Disasters in Peru's Andes Mountains: From Damage Limitation to Risk Management and Prevention** (Peru)*

* *Based on summaries based on reports from UNTFHS*[92]

** *Based on a case study developed by JCIE in 2004*[93]

	Question 1 (three freedoms)	Question 2 (comprehen-siveness)	Question 3 (disadvantaged group)	Question 4 (local context)	Question 5 (multisectoral)	Question 6 (prevention-oriented)	Question 7 (protection & empowerment)
Case 1: Human Security for Adolescents (Bolivia)							
	✓	✓	✓		✓		✓
Case 2: Leprosy Control Program (Indonesia)							
		✓	✓		✓	✓	✓
Case 3: Community Mental Health and Development (Lao PDR)							
		✓	✓			✓	✓
Case 4: Monitoring Access to Quality Health Care (Uganda)							
				✓	✓		
Case 5: Preventing HIV (Vietnam)							
		✓		✓	✓		
Case 6: BRAC Health Nutrition and Population (Bangladesh)							
	✓	✓	✓		✓		
Case 7: Healthy Municipality Project in Northeast Brazil (Brazil)							
	✓	✓			✓		✓
Case 8: Green and Healthy Environments (Brazil)							
	✓	✓		✓	✓		
Case 9: Improvement of Human Security Conditions (Colombia)							
	✓	✓		✓	✓		
Case 10: Faces, Voices, and Places (Dominican Republic)							
	✓	✓	✓		✓	✓	
Case 11: Strengthening Local Capacities (Ecuador)							
	✓			✓			✓
Case 12: Fostering Peaceful Coexistence (El Salvador)							
	✓	✓	✓	✓			✓
Case 13: Reduction of Vulnerabilities (Guatemala)							
	✓	✓	✓				
Case 14: Association for Reproductive and Family Health (Nigeria)							
			✓	✓			✓
Case 15: Oriade Initiative (Nigeria)							
			✓	✓			✓
Case 16: Improving Water Quality, Health and Nutrition (Vietnam)							
		✓	✓		✓		
Case 17: Human Dignity Initiative (Southeast Asia)							
	✓	✓	✓	✓			✓
Case 18: Community-Based Child Health Promotion (Zambia)							
		✓	✓	✓		✓	✓
Case 19: Improving Health and Recovering Community (Japan)							
	✓	✓	✓				
Case 20: Natural Disasters in Peru's Andes Mountains (Peru)							
	✓	✓	✓				

Marginalized Populations

CASE 1

Human Security for Adolescents: Empowerment and Protection against Violence, Early Pregnancy, Maternal Mortality, and HIV/AIDS

(BOLIVIA)

Summary

This project aimed at improving the capacity of healthcare workers to offer female adolescents integrated gender- and culture-sensitive training on human rights, health, and sex. It also aimed to develop public policies to strengthen social protection mechanisms for youth. Adolescents are among the most disadvantaged population groups in Bolivia, with about one-third of them having been victims of violence or witnessed violent acts.

This project was a collaboration among PAHO/WHO; UNFPA; UNICEF; Bolivia's Ministries of Health and Sports, Education, Indigenous Affairs, and Sustainable Development; and various NGOs and other civil society organizations. It was funded by the UNTFHS from 2008 to 2010.

Situation analysis

- Health threats: malnutrition, HIV/AIDS and other sexually transmitted infections (STIs), early pregnancy
- Fear: domestic and sexual violence
- Want: poverty
- Dignity: domestic and sexual violence, ethnic discrimination

How do health threats feed off other threats or vice-versa?

In Bolivia—one of the poorest countries in Latin America—adolescents are among the country's most disadvantaged groups, facing high levels of violence and discrimination based on gender and ethnic background. They also lack adequate access to basic services. Sexual violence was identified as occurring primarily in schools, and girls and indigenous adolescents were particularly vulnerable in the poorest districts of Beni and Cochabamba, where malnutrition, social exclusion, domestic and sexual violence, HIV/AIDS and other STIs, and early pregnancies further complicate their lives.

Actions

Is there a link made between protection and empowerment actions, and if so, how?

The project worked with healthcare workers to offer services that respected indigenous adolescents' cultures and were sensitive to their particular needs. At the same time, the project provided sex education so that teenagers in the district capitals could make more informed decisions about their own sexuality. The project also sought the development of public policies to protect adolescents from violence, STIs, and early pregnancy, while also empowering them to assert their rights in these areas.

How are the relevant sectors and actors included in the health planning, decision-making, and implementation processes? How are promotion- and prevention-oriented interventions implemented?

The project trained more than 500 youth leaders and about the same number of school teachers in subjects such as violence prevention, STIs, birth control, and early pregnancy. Participants also learned about the concept of human security. The youth leaders who took part in the training then developed a plan for reaching out to their peers in 20 municipalities.

The teachers also attempted to expand the knowledge base on safe sex by organizing activities with more than 100 parents in their communities.

Changes

The project helped to increase advocacy efforts and enhance knowledge on safe sex, prevention of violence and exploitation, and the dangers of substance abuse and other high-risk practices not only among project participants but also among their peers and in their schools, health clinics, and local public institutions.

CASE 2
Leprosy Control Program

(INDONESIA)

Summary

Indonesia had the third largest number of new cases of leprosy in the world after India and Brazil in 2011. The National Leprosy Control Program achieved a prevalence of less than one case per 10,000 people in 2003 as part of its goal of eliminating leprosy. However, the number of new cases was 17,980 and the new case detection rate was 7.35/100,000 people in 2012. Among new cases, the proportion with grade-2 disabilities—defined as the part affected or visible changes present—was 11.5 percent, and child cases were 10.9 percent. For people affected by leprosy, however, it is not only a health threat but also a threat to their dignity. Stigma and discrimination toward people affected by leprosy prevent them from participating in educational, social, and economic activities. They experience difficulties running small businesses, gaining employment, and going to school, and their access to public transportation and public facilities is limited. These situations lead to social exclusion and poverty, and the low social status afforded people affected by leprosy invites further stigma and discrimination.

The Indonesian government ratified the UN Convention on the Rights of Persons with Disabilities in 2011. Through this, the government recognizes the importance of rights-based approaches for persons with disabilities in Indonesia, including persons with disabilities related to leprosy. Following the enhanced global strategy for 2011–2015, the Indonesian government expanded the National Leprosy Control Program. This strategy takes over the aim of the previous global strategy of detecting new cases in a timely manner and providing free treatment with multidrug therapy. In addition, it puts emphasis on sustaining the provision of high-quality patient care and reducing the burden of disease by reducing disabilities, stigma, and discrimination and providing social and economic rehabilitation to people affected by leprosy. For the Ministry of Health, reducing the disease burden due to leprosy is relatively easy. However, the ministry itself is not well equipped to reduce stigma and discrimination, which is what encouraged it to create the network with the relevant ministries and other actors.

Situation analysis

- Health threats: leprosy
- Want: limited employment and business opportunities
- Dignity: discrimination, exclusion from society

Actions

How are promotion- and prevention-oriented interventions implemented?

Although it was successful at reducing leprosy in Indonesia, the Ministry of Health found itself not well equipped to prevent stigma and discrimination against people affected by leprosy, which has remained even after the elimination of leprosy in accordance with WHO standards in 2000. Advancing a prevention- and promotion-oriented approach, the Ministry of Health is leading a network consisting of the Ministry of Social Welfare, the WHO, NGOs, and local governments for the purpose of mapping out the issues and sharing responsibility in reducing

stigma and discrimination. Sharing responsibility with all of the above agencies, the National Leprosy Control Program is now able to promote and encourage the self-advocacy work of people living with the disease so that they can fulfill their rights in the educational, social, and economic realms of life. In addition, the People Affected by Leprosy Association (PerMaTa) was established by 12 representatives from East Java and East Nusa Tenggara in 2007 to address problems of stigma. PerMaTa's mission includes advocacy, achievement of equality, and improvement in the quality of life for people affected by leprosy. The goal of strengthening the participation of people affected by leprosy was included in the Leprosy National Strategic Plan, which follows the WHO guidelines issued in 2011. Based on this policy, the Ministry of Health, in collaboration with PerMaTa, Nippon Foundation, Netherlands Leprosy Relief, and the WHO, was able to use past experience and expertise to reduce stigma.

Is there a link made between protection and empowerment actions, and if so, how?
Patients' associations have been active in bringing their health challenges to the government. People affected by leprosy established 192 self-care groups with the encouragement of the Indonesian government, a quarter of which evolved into self-help groups that focus not only on managing their own health but also on developing income-generation activities. These include small businesses, raising chickens and goats, tending crabs pools, and offering carpentry and electronic maintenance services. People affected by leprosy have been given advocacy training so that they can better convey their needs to policymakers and other stakeholders. Moreover, self-help group members are often invited by local government officials to participate in workshops. Provided for the first time with the opportunity to have their voices heard by the government, people affected by leprosy share their experiences in public, strengthening their sense of their own worth within their community. They are expected to become a major stakeholder in putting pressure on the government to protect the rights of people affected by leprosy and their families.

Changes

The group activities have empowered people affected by leprosy not only to manage their health and disability but also to demand their social, economic, and educational rights. They and their families are now able bring up their issues with government officials through patients' associations, and participation in social life has increased their self-confidence and self-efficacy so that they can contribute more to their communities.

CASE 3

Community Mental Health and Development in Vientiane Capital Project

(LAO PDR)

Summary

People in Lao PDR have a strong belief in spirits, and mental illnesses are often thought to be caused by a person being possessed by evil spirits. Since stigma and discrimination exists in the community, people with mental disorders feel disgraced and do not want the community to know about their illnesses.

The only two mental health units available in the country are the psychiatric units at Mahosot Hospital and at 103 Military Hospital in Vientiane, which provide outpatient and inpatient care for those suffering from mental illness. There are only 2 psychiatrists, 1 neurologist, 10 general practitioners, 18 nurses, and 11 others health workers (auxiliary staff, non-doctor PHC workers, health assistants, medical assistants, and professional and paraprofessional psychosocial counselors) who are currently providing mental health services for the whole population of Lao PDR. As a result, access to mental health facilities is uneven across the country. In addition, most medical professionals are not properly trained to recognize mental health problems, so consequently many psychosomatic symptoms are dismissed as inconsequential.

Many mentally ill people and their families are also not getting adequate information on the treatment and side effects of drugs, resulting in relapses and non-adherence to treatment. Spiritual and traditional healers play important roles in terms of care-seeking behavior of mentally ill persons and their families.

The Community Mental Health and Development Project was launched in 2007 by BasicNeeds Lao PDR, funded by the UK Department for International Development. This project aims to satisfy the basic needs of people with mental illness and respect their basic rights. It does so by implementing the Mental Health and Development Model developed by BasicNeeds to provide assistance to improve the quality of life of those suffering from mental health conditions. This model consists of five interrelated modules: capacity building, community mental health, promoting sustainable livelihoods, policy research and advocacy, and program management and administration.

Situation analysis

- Health threats: mental illnesses, lack of access to treatment
- Want: lack of employment opportunities
- Dignity: discrimination

Actions

How are health threats addressed in a comprehensive manner?

First, prior to implementation, the project established a foundation for partnership with the government health services and governance structures within the Ministry of Health, including the mental health unit of Mahosot Hospital and the Vientiane Capital Health Department. In addition, the project organized a community meeting with various stakeholders such as district officers, village chiefs, women's unions, youth unions, elders' unions, health workers, village volunteers, people with mental disorders, and their caregivers in order to get them involved in the project. The participants were informed about the project's five modules and about mental health, and then they were divided into small groups to take part in interactive workshops. The participants in the meeting were asked to identify psychiatric symptoms, such as illusions and hallucinations, as well as behaviors of people with mental disorders, treatment options, and the feelings that people with mental disorders may feel. They were then asked about their needs, strengths, and problems and about how the community could support people with mental disorders.

The project has also provided mental health training to medical doctors, nurses, and village volunteers at district hospitals in order to establish mental healthcare services and to provide mental health treatment and outreach at the community level. Training in supervision, evaluation, and monitoring were also provided to district hospital staff. Now, mental healthcare services are integrated into general healthcare services. As the capacity of the health system is being built, all of the district mental health teams in 12 district hospitals in the project sites independently deliver weekly psychiatric outpatient services. Activities have also sprouted up spontaneously in the district. The doctors who have been trained and empowered by the project have started training other doctors and nurses in their free time in order to expand mental healthcare services at their hospitals. This spontaneous training occurred because the directors of district health offices had encouraged and motivated those doctors.

After treatment, the project supports patients, almost all of whom are living in real poverty, to get back to work or to engage in other productive household activities like agriculture. The project was involved in a broad range of sectors such as agriculture, education, and vocational training in an attempt to promote sustainable livelihoods. For instance, agricultural training and non-monetary support such as seeds, equipment, poultry, and goats were provided to some of the patients through collaboration with the district agriculture sector. Currently, three students are also learning computer skills at a vocational training center in Vientiane. One who has schizophrenia has been recognized as an outstanding student by the school. Participants are then able to contribute productively to family and community life again. Some of them have become volunteers and support ongoing project activities.

Changes

As one example of a success story, after one woman, Tip, was properly diagnosed with a mental illness and treated at a BasicNeeds-organized mental health clinic in Xaythani District of

Vientiane, her symptoms of mental illness have significantly decreased. She can now communicate with people and has started looking after herself. Tip is also doing productive work with her family, helping her mother cook rice and doing some cleaning. The BasicNeeds program provided her with two goats and now she has six goats. So far, she has been able to earn about 3 millions kip (roughly US$370) from selling two of her goats. She is now able to assist her family in looking after their small family shop and takes care of her nieces and nephew. Moreover, nowadays she is the one in her family who is responsible for selling fruit at the local market.

CASE 4

Monitoring Access to Quality Health Care Service for Vulnerable Groups

(UGANDA)

Summary

Uganda's national health policy for 2011–2020 ensures people's right to health services and accountability, but not all of the government's policies are implemented and infrastructural facilities are often not available in places where the most vulnerable communities can access them. The most vulnerable population groups include orphans and children, the elderly, women (particularly widows), people with disabilities, people living in large households, youths, groups affected by conflict, internally displaced people, and refugees fleeing wars. This project is being carried out by the Action Group for Health Human Rights and HIV/AIDS (AGHA), which is dedicated to improving the health of people aged 65 and older, women of all ages, people with disabilities, and people living with HIV in Pallisa and Lyantonde Districts so that they are able to access the health services they need. The target areas and populations were identified based on the National Health Policy and the Health Sector Strategic and Investment Plan. AGHA also conducts baseline surveys and advocacy in support of the health and human rights of vulnerable groups.

Situation analysis

- Health threats: malaria, tuberculosis, lack of access to healthcare services, and health workers' high rates of absenteeism
- Fear: violence, conflicts among policymakers, health workers, and patients
- Dignity: people with disabilities face stigma

Actions

How do health threats feed off other threats or vice-versa and how are they addressed in a comprehensive manner?

AGHA is collaborating with civil society organizations in other sectors, such as education, gender, water, the environment, and the media, to advocate for health and human security in Uganda by organizing coordination meetings and setting up various sector committees on such topics as human resources and infrastructure.

How do the disadvantaged population groups participate in the health decision-making process?

The project mobilizes communities to learn about the health issues they face and empowers them through capacity building, media campaigns, education and communication materials on their health and human rights, input on policies and laws, and training workshops. They engage the communities and health workers in health facility assessments, creating an important interface between health workers and the most vulnerable health consumers.

Are health interventions primarily promotion and prevention oriented? What are they and how are they implemented?

The project promotes awareness raising at the community level and organizes dialogues and sensitization meetings. It also collaborates with the media to strengthen the capacity of

individuals to utilize health services, monitor them and engage in safe and healthy practices, and advocate for more government investment in disease prevention rather than curative interventions. It also advocates for better remuneration for health workers.

Is there a link made between protection and empowerment actions, and if so, how?
Through this project, AGHA advocates for the mainstreaming of health-related issues—e.g., HIV/AIDS, emergency responses, and gender inequality—into planning and budgeting processes and for the provision of quality health services for vulnerable groups and efficient resource utilization. Based on health facility assessments made by the communities, feedback meetings with policymakers are organized at the district and national levels to identify emerging issues and corrective actions to be taken.

Changes

The 2012–2013 budget included an investment of 49.5 billion Ugandan shillings to recruit 6,172 health workers. By mid-year a total of 5,707 health workers had been recruited and doctors' salaries had been increased. The project also led to increased collaboration between the parliament and civil society organizations in the policy development process. At the district level, new health committees were put in place to monitor the provision of health services to vulnerable groups, and local councilors gave their communities information on the budget so that they could use it to demand accountability in the provision of health services. At the community level, awareness of patients' rights among health workers and vulnerable groups has increased, and accountability mechanisms in health facilities have been developed. For example, suggestion boxes are being used by patients to express their health needs and grievances, which has provided a platform for vulnerable groups to have their voices heard. Some health centers reported that the communities they serve were able to contribute their own resources toward construction of a basement rainwater harvesting tank.

CASE 5
Preventing HIV in Vietnam Project

(VIETNAM)

Summary

In 2007, there were 292,930 people in Vietnam living with HIV, and the adult HIV prevalence was estimated at 0.54 percent. Of all reported HIV cases, 78.9 percent were in the 20–39 age group, and males accounted for 85.2 percent. The highest sero-prevalence among key populations at higher risk was found in people who inject drugs, female sex workers, and men who have sex with men, with the highest HIV prevalence among people who inject drugs—a national average of 20 percent. Although drug use emerged as a social problem during the 1990s, it continues to cause harm, especially to the younger generations. As many as 172,000 people in Vietnam were registered as injecting drug users at the end of June 2012.

How are promotion- and prevention-oriented interventions implemented?
Injecting drug use was once referred to as a "social evil" in Vietnam. People who inject drugs used to face poverty, unemployment, and a lack of access to healthcare because they were highly stigmatized and discriminated against by the wider community. With significant funding from the World Bank, a harm reduction program began in 2004 with the passage of the AIDS Law. By 2007, several elements of the essential package of services for the prevention and treatment of HIV among people who inject drugs were started including outreach, needle and syringe exchange programs, and the 100 percent condom program. After the national Methadone Maintenance Treatment (MMT) program began in Vietnam, people who use drugs started to gain more dignity as human beings. This program was piloted in Ho Chi Minh City and Hai Phong in 2008. It has now expanded to a total of 20 provinces

providing methadone to almost 12,400 drug users in 60 sites with strong support from the Communist Party, ministries, and government at all levels. As part of the MMT Program, the Preventing HIV in Vietnam Project, with funding from the UK Department for International Development and the Norwegian Agency for Development Cooperation, provided prevention and harm reduction interventions against HIV in 21 of 64 provinces and later merged with a World Bank project. Initially, it was co-managed by the Ministry of Health and the WHO, but the Ministry of Health has been fully responsible for the project since 2006. Since 2013, harm reduction activities have been funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan for AIDS Relief (mainly MMT) with the Vietnamese government taking an ever greater share of the financial responsibility.

Situation analysis

- Health threats: drug dependency, HIV infection
- Want: limited job opportunities
- Dignity: discrimination

Actions

How are the relevant sectors and actors included in the health planning, decision-making, and implementation processes?

The project's emphasis on multisectoral engagement has been credited with its success. As the highest decision-making body, the Joint Steering Group—chaired by the vice minister of health and composed of representatives of the Ministry of Labour, War Invalids and Social Affairs; the Ministry of Public Security; the Ministry of Finance; the Ministry of Planning and Investment; the Ministry of Foreign Affairs; and major donors—held biannual meetings and provided strategic guidance and budget approval. At the national level, the project established the Central Project Management Unit to monitor and report on the project's progress. Provincial Project Steering Committees were established in every city and province, where they were in charge of reviewing and endorsing plans and budgets. Each Provincial Project Management Unit implemented the work plans while collaborating with mass organizations and NGOs, and they supported the District Preventive Medicine Centre (DPMC) with technical guidance. The DPMC coordinated its activities with other ministers and local and international NGOs through the staff of the Commune Health Station (mainly doctors and nurses) in charge of supervising peer educators for sex workers and injecting drug users. Thanks to the peer educator approach, the project could identify hard-to-reach populations, and the involvement of injecting drug users and sex workers was generally accepted by local authorities. Rapid scale-up was enabled by the central government's leadership to mainstream sensitive interventions such as peer outreach, distribution of needles and syringes, and promotion of condom use. Also, as it allowed the district and commune governments to manage the project themselves, each local government implemented region-specific activities, such as drop-in centers, needle and syringe program voucher schemes, and recruitment of current injecting drug users. As demand for needles, syringes, and condoms grew as a result of the project, private pharmacies committed to reaching out to consumers on the ground. Both health- and non-health-related organizations were involved, and the national MMT program provided not only medical equipment and services but also job opportunities and support for peer educators, who in turn effectively empowered targeted populations. Though the project focused on a complex set of objectives, given the health threat posed by drug dependency, the Ministry of Health was given overall management responsibility. The strategy of appointing leaders at the national, provincial, district, and local levels made it possible to mobilize the necessary inputs such as medical professionals and materials (including condoms).

Changes

Across the country, local police reports show that security has improved in communities where the MMT clinics are operating. The percentage of conflicts within families and neighborhoods caused by injecting drug use have fallen to below 1 percent from 41 percent before the start of the treatment program. Moreover, a large number of methadone patients have returned to gainful employment, and they have reported feeling valued, accepted, and trusted by their families.

Complex Webs of Multiple Threats

CASE 6
BRAC Health Nutrition and Population Programme

(BANGLADESH)

Summary

BRAC commenced its intervention as a relief and rehabilitation organization in 1972 to help refugees reestablish livelihoods that had been destroyed during Bangladesh's war of liberation. Historically, BRAC's vision has been to foster a society that is "just, enlightened, healthy, and democratic . . . free from hunger, poverty, environmental degradation, and all forms of exploitation based on age, sex, religion, and ethnicity."[94] Recognizing that health is a fundamental right, health intervention has been an integral aspect of BRAC's holistic and rights-based approach to development since its inception. Two major objectives of the BRAC health program are to improve maternal, neonatal, and child health and to reduce vulnerability to infectious and other common diseases. Responsiveness to client needs, adaptation of proven technology, cost-effectiveness, and delivery through partnership with communities and government have been the guiding principles of its health programs as they have expanded both in coverage and scope of activities. To address these guiding principles, the BRAC health program has adopted an epidemiology-experimentation-expansion-evaluation model of program development and delivery. Lessons learned from past experiences have enabled the program to extend preventive, promotive, remedial, and rehabilitative health services to 100 million people in the country. The health program took its present shape by integrating all proven health interventions under one umbrella with different components. These include essential healthcare; tuberculosis and malaria control; maternal, neonatal, and child health; and water, sanitation, and hygiene. BRAC's health centers and its limb and brace center were also brought under the health program. The main target population is women in poor households. It currently serves 113 million people. BRAC has received financial support from the Embassy of the Kingdom of the Netherlands, the UK Department for International Development, the Australian Agency for International Development, the Canadian International Development Agency, the Swiss Agency for Development and Cooperation, the University Research Company, the World Bank, the World Food Programme, Micronutrient Initiatives, the Aga Khan Foundation, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Situation analysis

- Health threats: food insecurity, effects of climate change on health (infectious and water- and vector-borne diseases), malnutrition
- Fear: climate change
- Want: loss of crops
- Dignity: lack of a sustainable livelihood

How do health threats feed off other threats or vice-versa?

New health challenges in Bangladesh include high food prices and food insecurity; climate change and its effects on health; disability; and regional disparities. Projections show that Bangladesh will suffer immensely due to climate change—mainly as a result of increasing temperatures and rising sea levels. Warmer weather increases natural disasters and the subsequent effects on health. As Bangladesh is close to the sea, the situation will be more severe in terms of people's security. Hotter weather will increase the incidence of heat stroke, dehydration,

and the aggravation of cardiovascular disease in elderly people. Meanwhile, the loss of crops from these changes will increase the number of malnourished people in the country, further increasing their vulnerability to infectious and water- and vector-borne diseases. In addition, increased coastal flooding will accelerate the displacement of coastal populations and exacerbate health problems, such as cholera, diarrhea, malnutrition, and skin diseases.

Actions

How are health threats addressed in a comprehensive manner?

To deal with these challenges, BRAC works with the ultra poor (those living on US$1.25 or less per day) to help them create an asset base for sustainable livelihoods; ensure that they have access to health, education, social welfare, and legal services; create public awareness; assist in the formulation and adoption of social protection policies and programs; engage in adaptive research to address emerging challenges in the agricultural sector; demonstrate to farmers higher productive, cost-effective, and environmentally sustainable crop and natural resource management technologies; and build capacity to respond to natural disasters. These various activities are coordinated by an advisory board committee, which includes academics, obstetricians, pediatricians, public health specialists, epidemiologists, research specialists, and gender and management specialists who provide technical and management support to the project. The committee is a voluntary entity that works with various professional bodies to introduce current knowledge and innovative practices into the project management. In addition, a project management cell was established at the central level with a project manager who is responsible for coordinating and managing the field operations and health center activities.

How do the disadvantaged population groups participate in the health decision-making process?

BRAC's programs promote participation, mobilization, and interaction at the community level to raise people's awareness and form advocacy groups. It also mobilizes the media to sensitize opinion leaders, service providers, and civil society through advocacy. It uses the power of the media to give voice to those who would otherwise be unheard, such as migrant workers and the ultra poor.

How are the relevant sectors and actors included in the health planning, decision-making, and implementation processes?

BRAC has always acted as a complement and supplement to the government whenever possible. Its facilitation of the Expanded Programme on Immunization, family planning facilitation, and national nutrition program are notable examples of this tendency. Through tuberculosis and malaria control programs, the Health, Nutrition and Population Programme works closely with government health departments. This partnership has helped in rapid scaling up, health system strengthening, and joint planning and resource mobilization. In order to make the partnership effective, the capacity of each partner is built up.

Changes

BRAC is credited with having contributed to lowering maternal mortality to 194 deaths per 100,000 births, increasing the literacy rate to 56.7 percent, and achieving a GDP growth rate of over 6 percent. BRAC's programs have also empowered the poor, especially women, by mobilizing communities to translate awareness into action. They have reached 950,000 families, giving them the tools to increase their human, social, and political assets to claim their entitlements, resist exploitation, and play active roles in public life. An integrated network of development programs, enterprises, and investments has resulted in a unique synergy that supports a holistic approach for alleviating poverty and improving health.

CASE 7
Healthy Municipality Project in Northeast Brazil

(BRAZIL)

Summary

Poor natural conditions in Pernambuco State in Brazil have led to high social disparities, and the community living there suffers from low incomes, high levels of drug abuse, domestic and child violence, and adverse environmental conditions that are exacerbated by misuse of agricultural chemicals. The community has high rates of mortality and morbidity from noncommunicable diseases, particularly lifestyle-related diseases. While Brazil has committed to UHC as a human right, many of the elderly in Pernambuco are not able to access health services.

This project employs the "Bamboo Method," a facilitated, participatory approach to engaging people in a dialogue aimed at identifying needs in their communities, taking stock of existing resources, developing strategies for applying those resources to community problem solving, and developing proposals for initiatives that require assistance from outside the community.

This initiative grew out of a partnership among the Center of Public Health and Social Development of the Federal University of Pernambuco, the Planning Secretary of the Pernambuco State Government, and the Japan International Cooperation Agency (JICA). This method was developed based on the philosophies and concepts of health promotion and healthy cities and municipalities promoted by the WHO. JICA was a catalyst for developing and scaling up this method and administered the project with the university and the state government, with the JICA team remaining present throughout the five-year project period. JICA facilitated the exchange of experiences among experts from Japan, Brazil, and other areas, and it also provided initial funds for this new initiative.

Situation analysis

- Health threats: high rates of mortality and morbidity from noncommunicable diseases, lack of access to health services
- Fear: adverse environmental conditions
- Want: low incomes
- Dignity: drug abuse, domestic and child violence

Actions

How are the relevant sectors and actors included in the health planning, decision-making, and implementation processes?

The Healthy Municipality Project in Northeast Brazil was part of a strategy for achieving sustainable development, and there have been various instances of networks of healthy municipalities being created based on each region's local context. The State Planning Department has been involved in the initiative, which eventually led to Pernambuco State incorporating it into its official community development plan. The state-level network is coordinated by this department, while other departments are also involved. The Center of Public Health and Social Development of the university is responsible for the training, monitoring, evaluation, and technical support of the network.

Is there a link made between protection and empowerment actions, and if so, how?

The bamboo method engages local community members in identifying needs, resources, and know-how in the community and developing strategies to address those needs using existing resources and know-how. It is a gradual approach that uses a flexible, evolutionary process in order to respond to changing contexts. It has a strong emphasis on strengthening social capital, solidarity, and unity. The goal of the bamboo space is to integrate top-down and bottom-up efforts by allowing local input into policymaking in an attempt to make policies more responsive to local needs, and it has successfully brought community members together with government officials.

The project trains residents and government officials from all sectors to come together for training in implementation of the bamboo method. They learn about the importance of community preservation, but they also learn skills in cross-sectoral cooperation, community mobilization, meeting facilitation, and facilitation of respectful exchange of opinions. The trained facilitators then organize meetings in their communities to identify strengths in the community, determine together the kind of community they want to create, develop and prioritize goals, and devise a workplan. The participants in the meeting go on to implement the workplan and monitor progress. When the workplan requires outside assistance, the facilitator discusses the possibility of receiving support with the municipal authorities.

Changes

This project raised awareness of health and living conditions among the community members; enhanced appreciation for the natural environment, which prompted them to begin sorting garbage for recycling; and increased the income of women's groups by developing and selling folk art products. Introduction of the model to other provinces has been explored, and it has been disseminated in other countries by a third-country training program.

CASE 8

Green and Healthy Environments Program (PAVS): Constructing Integrative Public Policies in Sao Paulo, Brazil

(BRAZIL)

Summary

PAVS was created in 2005 through an agreement signed by the Sao Paulo Municipal Secretaries of Environment, Health, and Social Development. These agencies identified a need to implement integrated policies that included environmental issues in health promotion actions. The agenda took into consideration the integration of health, culture, and the environment with active community participation. To understand the local physical and social environments in the communities and to implement context-specific interventions, PAVS trained and used community agents from the Family Health and Social Protection Strategies.

In its origins, the project had financial resources from the Municipality of Sao Paulo, the Inter-American Development Bank, the Secretary of Health, and the United Nations Environment Programme. Between 2005 and 2008, over 5,000 community agents were trained by 80 general trainers and 12 environmental especialists. They established community planning roundtables that included regional and local delegates from government institutions and civil society. Topics included environmental pollution, water, energy, biodiversity, healthy coexistence with animals, responsible consumption, and a culture of peace. In 2008, environmental and health problems were identified and prioritized and about 400 local projects were implemented to address the problems.

Situation analysis

- Health threats: environmental contamination, zoonotic diseases, water-borne diseases, malnutrition
- Fear: inter-personal violence
- Want: poverty
- Dignity: the most vulnerable population of Sao Paulo (45 percent of the metropolitan area) with an emphasis on poor children and adolescents

Actions

How do the disadvantaged population groups participate in the health decision-making process?

Community members who took part in the project decided together what their most urgent needs are and how they should be address. They were then responsible for designing and implementing the projects themselves.

How are the relevant sectors and actors included in the health planning, decision-making, and implementation processes?

Once the training process was finalized in 2008, PAVS became a program within the Family Health Srategy of the Primary Health Care Coordination of the Municipal Secretary of Health. The objective of the program has been to strengthen inter-sectoral and inter-secretarial collaboration among the health, environment, and social protection sectors to strengthen and empower local communities on environmental and health issues through integrated health promotion interventions.

On August 3, 2011, the Municipal Secretary of Health put in place an innovative ordinance to implement the program as an integrated public policy of the Sao Paulo Municipality. As of December 2011, the program had coordinated 1,454 local context–specific projects including healthy diet, environmental education and peace culture, solid wate management, and recovering of public spaces projects. In 2011, there were 251 PHC units participating in the program.

CASE 9

Improvement of Human Security Conditions in Soacha through the Development of an Integrated, Participatory, and Sustainable Social Protection System

(COLOMBIA)

Summary

This project aimed to improve the living conditions of people who had been displaced by violent conflict and were living in overcrowded, unplanned communities. The project was designed through a participatory process that brought together representatives from the government, civil society, local corporations, and individuals from the target community. The focus was on improving access to health services and education and developing land for cultivation to reduce malnutrition and raise farmers' incomes. The social cohesion formed through the project helped to reduce violence in the target community, and the improved agricultural practices helped reduce environmental degradation, which in turn helped to reduce vulnerability to natural disasters.

The project was a collaborative effort among the UN Office for the Coordination of Humanitarian Affairs (OCHA), PAHO/WHO, UNICEF, UN Office on Drugs and Crime (UNODC), UNIFEM, UN Refugee Agency (UNHCR), Food and Agriculture Organization (FAO), World Food Programme (WFP), the Social Protection Ministry, the Colombian Institute of Family Welfare, local government agencies, and various other civil society organizations. It was funded by the UNTFHS from 2010 through 2012.

Situation analysis

- Health threats: limited access to basic healthcare services, poor sanitation and hygiene, food insecurity
- Fear: armed conflict, forceful gang recruitment, violent crimes, robberies
- Want: extreme poverty, poor housing conditions, limited access to training, lack of opportunity for formal employment
- Dignity: limited access to education, historically excluded and marginalized population

How are the three freedoms linked?

After nearly 50 years of armed conflict, Colombia has about 3 million internally displaced individuals. These people have historically been excluded and marginalized, and their settlement in informal communities on the outskirts of Bogota left them even more vulnerable to natural sudden events, disease, and malnutrition. Many of them found themselves in a vicious cycle of poverty, low levels of education, and few vocational opportunities. Violent crime and

intimidation were rampant in the informal communities, leaving residents further impoverished and unable to improve their situation.

Actions

How are the linkages among the three freedoms addressed?

Local community members and other stakeholders engaged in a participatory process to determine the sources of vulnerability in the target community. The project partners then worked closely with community members to develop their vocational skills and opportunities, build schools and allow more flexibility in their offerings, cultivate vegetable gardens at schools and homes, and install a system for harvesting rainwater that was used to improve irrigation and hygiene.

What is the local-specific context and how do health decisions take that context into consideration?

The improvement of human security conditions in Soacha was limited to the 6th Commune, reaching primarily internally displaced women, adolescents, and children. By involving members of the community in the design and implementation of the interventions, the project ensured that activities targeted the needs that the community felt were most seriously threatening their daily lives.

How are health threats addressed in a comprehensive manner?

The project took into account the various challenges that were threatening the community and designed programs to help them improve their education levels, vocational skills, crop yields, and hygiene all at the same time. The rainwater-harvesting systems helped improve their agricultural productivity as well as sanitation in the community, both of which ultimately led to enhanced food security and lower disease transmission and thus produced better health outcomes. Improved incomes also helped reduce violence, as fewer people resorted to crime.

Changes

Crime rates in the community fell as 520 young participants who were at risk of engaging in illegal activities used their time instead to take part in extracurricular and income-generating activities. Local families gained more reliable sources of food and income through the gardens and the accompanying irrigation system. The project also helped to initiate dialogue and cooperation between the community and the local government and demonstrated to both that they could achieve sustainable improvements in the community by working together.

CASE 10

Faces, Voices, and Places: The Food Security Strategy and Nutrition in Local Development Processes, Boca de Mao

(DOMINICAN REPUBLIC)

Summary

This was a PAHO effort through the Faces, Voices, and Places initiative. It aimed at reducing health inequalities in the Boca de Mao region of the Dominican Republic through a participatory process. Boca de Mao is a district in the rural municipality of Valverde, one of the poorest areas in the Dominican Republic, and situated close to the border with Haiti. The project promoted intersectoral and interagency activities with a view toward accomplishing the MDGs. Besides implementing activities at the community level, the initiative developed a training plan on health, the environment, food security, and health and nutrition surveillance.

Situation analysis

- Health threats: HIV/AIDS, lack of access to basic health services
- Fear: natural environmental threats
- Want: poverty, lack of minimum basic services
- Dignity: exclusion from society

Actions

How do the disadvantaged population groups participate in the health decision-making process?

The inhabitants of Boca de Mao are mainly migrants from Haiti who work primarily in the production of bananas and rice. The population is young (38 percent are under 15 years of age) with a high prevalence of HIV/AIDS. The district lacks minimum basic services and is highly vulnerable to natural environmental threats such as cyclones, floods, and droughts.

The highest authority in the district is the Community Development Council, formed by representatives of neighborhood boards. The council included a democratically elected representative from the Haitian community to make sure that the needs of the local Haitian population were being met. The common practice of the Catholic religion was instrumental in strengthening the social fabric of the district. In addition, the presence of a local women's association in the council helped to shed light on gender identity issues in the decision-making process.

How are promotion- and prevention-oriented interventions implemented?

As the need to reduce malnutrition, improve sanitary conditions, and prevent vector-borne and sexually transmitted diseases became evident, the community of Boca de Mao began to take on greater responsibility for improving their living conditions through this initiative. The community's active participation on the Health Committees contributed to bringing a doctor to their Health Center, to the installation of safe water systems, and to the use and management of latrines installed with the support of the association of banana producers. On the government side, the agriculture and health sectors were involved in the initiative at the national, regional, and local levels. The agricultural sector provided technical assistance on family and community gardens. The health sector was responsible for the management and maintenance of the water system in rural clinics; the training of local health promoters on health, food, and nutrition; and the provision of information. Local school authorities also provided their facilities for a laboratory for treating water for human consumption. The local media also got involved by reporting on project events, such as a health fair, horticultural activities, the dredging of channels, and other activities.

Changes

This participatory approach helped Haitian migrants and women to live their lives with dignity and strengthened social cohesion in the community living in the Dominican Republic on the border with Haiti.

CASE 11

Strengthening Local Capacities for Peace and Development through a Human Security Approach in the Northern Border Zone of Ecuador

(ECUADOR)

Summary

This initiative was financed by the UNTFHS through two projects, one that ran from 2006 to 2009 and the second from 2013 to 2015. These projects aimed at strengthening peace and development in the area near Ecuador's northern border where refugees from armed conflict in Colombia, criminal groups, indigenous populations, and Afro-Ecuadorians share a common

territory. The ongoing armed and social conflicts, coupled with geographical isolation and weak public institutions, have resulted in higher levels of unemployment and food insecurity, lower access to basic social services, and increased human trafficking, prostitution, sexual exploitation, and illicit trade of drugs and weapons. The projects focused on limiting the recurrence of violence and crime in the region, establishing community preparedness plans, and building more resilient communities.

This initiative is a long-term collaborative effort among UNDP, UNHCR, UNICEF, UNESCO, WFP, UNFPA, the Ministry for Coordination of Security, Servicio Ecuatoriano de Capacitación Profesional, Instituto de la Niñez y la Familia, Ministries of Health and Education, local governments, and various civil society organizations.

Situation analysis

- Health threats: food insecurity, lack of access to essential healthcare
- Fear: armed violence and crime, human trafficking, illicit trade of drugs and weapons
- Want: high levels of poverty, unemployment
- Dignity: exclusion from education, discrimination against refugees, prostitution, and sexual exploitation

How are the three freedoms linked?

In recent years, illegal armed groups and criminal networks in Colombia have been crossing into Ecuador. Consequently, several border provinces have experienced an increase in violence and crime, with disenfranchised youth increasingly joining criminal groups. This proliferation of crime and violence has consequently exacerbated existing social and economic vulnerabilities, including competition over land use; high levels of poverty, unemployment, and food insecurity; and limited access to healthcare and education. In addition, refugees (particularly unaccompanied children) have often been excluded from access to basic services. Moreover, women and girls—primarily refugees and migrants—have been trapped in networks of prostitution and sexual exploitation.

Actions

Is there a link made between protection and empowerment actions, and if so, how?

One example of how the projects harmonized protection and empowerment actions is that they provided training to law enforcement, health workers, and education professionals to prevent human trafficking, as well as to support peacebuilding and improve assistance to victims. Meanwhile, they provided vocational training to women, refugees, and disenfranchised youth. In addition, the projects engaged local communities and civil society organizations in the decision-making process to improve access to health and education services—primarily for unaccompanied child refugees—and to develop community preparedness plans.

Changes

The projects brought together local public institutions and civil society organizations to monitor the enforcement of the rights of children and adolescents to receive basic social services. They established refugee integration centers to ensure local integration of refugee children into schools. Moreover, they helped local authorities and communities improve their timely responses to potential refugee inflows.

CASE 12

Fostering Peaceful Coexistence and Improving Citizen Security in Three Municipalities in the Department of Sonsonate

(EL SALVADOR)

Summary

This project aimed at building the capacity of local authorities to tackle violence and crime and at engaging communities in regenerating urban areas in the poorest department of El

Salvador. Sonsonate had one of the highest homicide rates in the country with a proliferation of youth gangs, drug trafficking, firearms, and gender-based violence. In addition, it had limited access to health services and education.

This initiative was a collaborative effort among UNDP, UNICEF, PAHO/WHO, ILO, the Council on Public Security of El Salvador, and local municipalities funded by the UNTFHS from 2008 through 2011. The project was developed through coordination units comprised of government institutions, UN agencies, and civil society organizations, and it emphasized the importance of strengthening state-society relationships.

Situation analysis

- Health threats: limited access to PHC, high homicide rates
- Fear: youth gangs, drug trafficking, firearms, gender-based violence
- Want: high levels of poverty, limited access to social services
- Dignity: gender-based violence, limited access to legal services and education

How do health threats feed off other threats or vice-versa?

The residents of Sonsonate have experienced the county's highest levels of poverty and been faced with limited access to social services, including PHC, education, and law enforcement. In addition, while other parts of the country were benefitting from reductions in crime and conflict as well as improvements in human development, these impacts did not travel as quickly to this area. This situation allowed the proliferation of youth gangs, drug trafficking, firearms, and gender-based violence. As a result, Sonsonate had one of the highest homicide rates in the country in 2005.

What disadvantaged population groups exist?

Children, youth, and women were most affected by the proliferation of youth gangs, drug trafficking, firearms, and gender-based violence in three municipalities in Sonsonate.

Actions

How are health threats addressed in a comprehensive manner?

The project advanced coordination between national institutions and civil society organizations by providing training on community policing mechanisms and by improving the safety and security of urban spaces through the building and refurbishing of a community center, high school facilities, sports grounds, and a playground. It also reduced violence through a municipal firearms ban and awareness-raising efforts on the dangers of firearms. Project partners also worked to prevent family violence, sexual exploitation, and human trafficking, while simultaneously promoting efforts to reduce gender inequalities.

What is the local-specific context and how do health decisions take that context into consideration?

Integrated local coordination units tailored their support to the needs and capacities of each municipality based on the results of situational analyses that included local data and municipal policies, plans, and strategies.

Is there a link made between protection and empowerment actions, and if so, how?

The project enhanced the capacity of police forces and civil society organizations to provide community policing and enhanced the leadership skills of local mayors to establish more inclusive decision-making processes. It also ensured that communities were engaged in the development of municipal firearm bans and local awareness campaigns on the dangers of firearms.

Changes

The establishment of local coordination units resulted in more context-specific, coherent, and efficient solutions that integrated health, education, and public safety. In addition, state-society relationships were strengthened, creating a broader and more comprehensive vision of how institutions and communities identify their respective roles and responsibilities in building citizen security and maintaining peaceful coexistence. These changes contributed to a 16 percent reduction in crime rates between 2009 and 2010.

CASE 13

Reduction of Vulnerabilities to Contribute to the Process of Rural Development in the Municipalities of the Basins del Coatan and Alto Suchiate, San Marcos Department

(GUATEMALA)

Summary

This project aimed at improving the health and housing conditions of local rural communities, expanding the participation of women in local development, and enhancing the capacity of municipalities, municipal development councils (COMUDEs), and community development councils (COCODEs) in local development planning. The Basins del Coatan and Alto Suchiate have been marginalized areas, affected by armed conflicts, where the presence of national and local public institutions has been weak. About 90 percent of their residents live in poverty, with limited access to basic social services, adequate food, or housing.

This case was a collaborative effort among UNDP, PAHO/WHO, FAO, the National Secretary of Planning, the Ministry of Agriculture, the Ministry of Health, COMUDEs, COCODEs, and civil society organizations. It was funded by the Swedish International Development Cooperation Agency from 2010 to 2013.

Situation analysis

- Health threats: chronic malnutrition among children, high levels of maternal mortality, early pregnancy, traditional health practices
- Fear: smuggling, cyclical droughts, family violence
- Want: poverty
- Dignity: addiction, family violence, early pregnancy and abortion, exclusion of women

How do health threats feed off other threats or vice-versa?

The residents of the Basins del Coatan and Alto Suchiate in San Marcos, Guatemala, have been engaged primarily in farming and illegal activities such as smuggling and poppy production. The area has a long history of Mayan culture with exclusionary attitudes toward women and a reliance on traditional health practices. Inappropriate farming practices, unplanned establishment of human settlements, and cyclical droughts and frosts have deteriorated the local social and physical environment. As a consequence of these environmental and social vulnerabilities and cultural practices, children present high levels of chronic malnutrition and there are high levels of maternal mortality, addiction, family violence, early pregnancy, and abortion.

Actions

How are health threats addressed in a comprehensive manner?

The project strengthened the capacity of the COMUDEs, COCODEs, and community-based organizations to take part in planning mechanisms, risk management, emergency prevention, and the implementation of early warning mechanisms. In addition, it established participatory approaches to improve health centers, food production, water and sanitation, and housing, as well as to strengthen the role of women in municipal offices.

Changes

The project improved water, sanitation, and housing conditions for 700 families; provided sustainable food production for 2,600 families; and strengthened local water management in 10 micro-basins. It also strengthened the participatory planning process and early warning mechanisms of COMUDEs and COCODEs.

CASE 14
Association for Reproductive and Family Health

(NIGERIA)

Summary

This project aimed to improve women's health by making family planning methods better available in underserved areas. The project provided training to traditional birth attendants and voluntary health workers to provide accurate information on contraception and raised awareness among men and women in the community about the benefits of planning parenthood. Health workers were also supported in farming techniques and poultry raising so that they could better afford to volunteer their time for the project. The Association for Reproductive and Family Health received funding from UNFPA for this project and worked closely with local government agencies and local NGOs.

Situation analysis

- Health threats: unintended pregnancies, STIs, maternal mortality and morbidity
- Fear: crime against health workers from outside the community
- Want: limited access to health services
- Dignity: women's limited control over their own reproductive health

What disadvantaged population groups exist?

Sub-Saharan Africa accounts for over half of the global burden of maternal, newborn, and childhood mortality, and over 90 percent of malaria deaths. As Africa's most populous nation, Nigeria's development has significant implications for both its own progress and that of the region as a whole toward socioeconomic development and achieving the MDGs. Worrisome health indicators in Nigeria include a maternal mortality ratio of 545 per 100,000 live births, placing it second only to India in global estimates. For every female mortality there are 20 to 30 others left to suffer short- or long-term disabilities related to reproductive health, such as obstetric fistula, ruptured uterus, or chronic pelvic pain due to pelvic inflammatory disease, and women are disproportionately affected by the nation's HIV epidemic.

Actions

How are the linkages among the three freedoms addressed?

Community members who volunteer to be traditional birth attendants or volunteer health workers are introduced to "self-help projects," such as in poultry and farming, to help sustain the morale of these health volunteers, recognizing that creative ways are needed to maintain an engaged and professional work force in settings where funds are not always available for financial remuneration.

Is there a link made between protection and empowerment actions, and if so, how?

Obstacles to family planning and contraceptive use are not solely issues of access. Barriers also include social, cultural, or religious obstacles as well as incomplete or incorrect knowledge about different methods and the fear of side effects. The Association for Reproductive and Family Health emphasizes sensitization and empowerment of community members and local stakeholders to stimulate acceptance and increased use of family planning and reproductive health services. It involves the decision makers in families and communities so that they are more eager to encourage women to choose effective family planning methods. By engaging a diverse set of stakeholders in both planning and implementation, the program has resulted in closer and formalized coordination with local governments and public-sector health institutions, which provide oversight and government facilities for program use at an affordable cost.

How do the disadvantaged population groups participate in the health decision-making process?

The Association for Reproductive and Family Health aims to support women and help them access family planning services that can protect them from the dangers of childbirth.

Recognizing that there is a complex web of obstacles to accessing family planning services, "community stakeholders workshops" are held in each project state to engage multiple stakeholders in planning and to allow them to talk about the real challenges they face to scaling up family planning. Local NGOs are engaged to help identify vulnerable communities.

What is the local-specific context and how do health decisions take that context into account?

Originally, this project, which aims to increase use of family planning methods in an attempt to reduce maternal mortality and morbidity, focused primarily on training female traditional birth attendants to encourage more family planning use. But they discovered that, given the strong religious traditions of the community, the men were the ones making family planning decisions. As a result, the project began to emphasize sensitization activities targeting men and training male volunteer health workers, although improved women's health is still the ultimate goal of the project.

Changes

By having more control over their fertility and participating in self-help programs, women in the target group were able to improve their livelihoods, giving them a sense of being able to support themselves and make greater contributions to their communities.

CASE 15
Oriade Initiative

(NIGERIA)

Summary

This program helps develop and implement the co-financing and co-management of local health development programs that are adaptable, feasible, and based on local practices. Communities that have a history of implementing self-help measures, have an active civil society, are willing to collaborate with public sector authorities, and gain the consent of their traditional leaders are eligible to take part. Community members make low voluntary contributions to a pool of funding that is used to finance development operations within the community. This program is operated by the Centre for Health Sciences Training, Research and Development.

Situation analysis

- Health threats: lack of access to healthcare services and safe drinking water
- Want: poverty
- Dignity: limited resources to provide for their families

Actions

How do the disadvantaged population groups participate in the health decision-making process?

Roughly 40 percent of Nigeria's population lives in absolute poverty, with about 80 percent of the poor living in rural areas. Almost half of the population lacks access to healthcare services, and more than half lack access to safe drinking water. To address these dismal indicators, the Oriade Initiative has developed a community co-financing program, in which communities pool small voluntary contributions to finance local development initiatives.

Is there a link made between protection and empowerment actions, and if so, how?

One important mechanism financed by the pooled community funds is a Poverty and Health Development Profile (PHDP), an annual cross-sectional survey of registered members that monitors indicators of health and access to social assets such as safe water, sanitation, and healthcare services. The data collected are used to map the distribution of poverty and inequity in the communities, and for community evaluation and planning of current and future

programs. The assessment of poverty is based on a combination of public health, social, and economic indicators that are set by the community, giving its members an often overlooked voice in defining their own state of poverty and the landscape of physical, social, and economic threats that they face. The PHDP is conducted annually and funded through community co-payments combined with a subsidy from either local government or a development partner. Quarterly town hall meetings are held for local management committees to report back to the community and discuss new challenges and priorities.

Changes

By allowing the community members to determine their own priorities, based on an annual cross-sectional analysis of different dimensions of poverty in the community, the pooled funding ends up being used for a wide range of challenges, reflecting the real threats facing the community.

CASE 16

Improving Water Quality, Health and Nutrition in Vietnam—Project SWAN

(VIETNAM)

Summary

Due to the lack of physical infrastructure and financial capacity in Vietnam, people have limited access to a safe water supply, which has resulted in safe water shortages throughout the country. Although Vietnam has improved its water supply situation by constructing more than 8,000 water treatment facilities in the past few decades, many of them were not appropriately managed. As a result, the consumers had to drink contaminated water without knowing that the water was causing multiple threats to them. Because of this complex background, improving water quality alone has limited benefit for the Vietnamese. Related issues, including health and nutrition—especially of children—along with access to safe water, became increasingly more crucial for the wellbeing of the community.

Project Safe Water and Nutrition (SWAN) was launched in 2001 by the International Life Sciences Institute (ILSI) with funding from JICA to establish models for sustainable safe water supplies, food hygiene, and nutritional improvements by increasing the capabilities of local authorities across the water, health, and nutrition sectors in rural and suburban areas. In the beginning, a project team (ILSI Japan and the National Institute of Nutrition) led the activities, but from the latter half of the project, local water management unions led activities in local areas with the support of the project team and community efforts.

Situation analysis

- Health threats: childhood diarrhea and underweight
- Want: lack of physical infrastructure and financial capacity for the water treatment facilities
- Dignity: lack of knowledge and awareness about the impact of contaminated water

Actions

How do the disadvantaged population groups participate in the health decision-making process?

This project persuaded community leaders to understand and prioritize the safe water project and obtain funding for it. The goal was to accomplish this through a participatory approach by (1) enhancing knowledge of the importance of safe drinking water, food safety, and nutrition at the household level; (2) optimizing the operation of water treatment facilities and supplies of safe water; and (3) establishing effective management systems to enable the sustainability of community-based participatory approaches. Another unique aspect was that it took an asset-map approach by allowing the people in the community to identify the potential for growth. SWAN helped the community to increase knowledge to identify invisible threats by correctly identifying the insecurities that the inhabitants faced.

How do health threats feed off other threats or vice-versa and how are they addressed in a comprehensive manner?

The project featured a unique concept, combining the water sector (Ministry of Agriculture and Rural Development) and the health and nutrition sector (Ministry of Health) into one project, taking a multisectoral approach in order to build a human security framework.

Changes

Awareness of the need for clean water was raised among the community members, and incidences of childhood diarrhea and underweight have decreased while the number of households receiving treated water has increased. Capacity building has made local governments better able to assess the problems of water provision and health in the communities, implement solutions, evaluate their activities, and share feedback with the communities. In 2013, the local government compiled a three-year plan for implementing the SWAN model in other communities using its own budget.

CASE 17

Human Dignity Initiative: Community-Based Safety Nets as Tools for Human Development

(CAMBODIA, INDONESIA, LAO PDR, THAILAND, VIETNAM)

Summary

This initiative started in 2000 and continued for five phases, targeting two types of poor communities: geographical (defined by their physical proximity) and non-geographical (defined by similar situations or conditions). Activities in Thailand, Cambodia, Vietnam, and Lao PDR were aimed at enhancing poor communities' social and economic conditions through the use of tools and mechanisms based on social mobilization and participation by community members. This Economic and Social Commission for Asia and the Pacific (ESCAP) initiative was funded by the UNTFHS.

Situation analysis

- Health threats: disability, HIV/AIDS, poor access to healthcare
- Fear: lack of safe pedestrian pathways, natural disasters
- Want: lack of social safety nets, poverty, lack of clean water, lack of access to education
- Dignity: marginalized in their societies

Actions

How do the disadvantaged population groups participate in the health decision-making process?

ESCAP did not instill any of its own ideas of what the target communities needed or should achieve through the project. Rather, members of the target communities were responsible for identifying their needs together, designing a project plan, requesting funding from ESCAP, and implementing their plans.

What is the local-specific context and how do health decisions take that context into consideration?

Community leaders in select communities in each of the target countries were trained in the use of tools for social mobilization and participatory decision making to develop proposals for activities to enhance their communities' social and economic conditions. All of the communities engaged in the project participated in training on participatory processes and then used those skills to determine what their project would be and how they would implement it. It then provided funds for projects that were designed and implemented through participatory processes in the target communities.

Is there a link made between protection and empowerment actions, and if so, how?
By working with existing community groups—and helping create them in places where they did not already exist—and by insisting that the community groups take full responsibility for designing and implementing their projects, ESCAP encouraged ownership and facilitated capacity development within the communities. Linkages between these groups on the one hand and public sector organizations and NGOs on the other aimed to open lines of communication and strengthen ties between the two, and training for government officials aimed to increase their responsiveness to demands from marginalized communities.

CASE 18

Project for Strengthening Community-Based Child Health Promotion System in Urban Areas

(ZAMBIA)

Summary

In 1998, the Zambian government introduced a program for Community-Integrated Management of Childhood Illnesses, but its focus has been on rural areas. The Project for Strengthening Community-Based Child Health Promotion System in Urban Areas focuses on children under five years of age in "compounds"—unplanned residential districts in urban areas—in Lusaka, Kabwe, Ndola, and Solwazi Districts. Compounds have been created due to large-scale and rapid migration from rural areas that has outpaced urban planning. People usually move to these areas in search of employment opportunities and often have no choice but to live in horrendous conditions, sometimes surrounded by piles of abandoned trash and daily household waste and using simple holes in the mud as toilets. This is largely because public social infrastructure, including electricity, roads, clean water supplies, and sanitation, are not able to catch up with the rapid population growth in the compounds. This project was implemented from March 2011 to March 2014 by district medical offices and health centers with financial support from the government of Zambia and JICA, which also provided technical assistance in collaboration with a Japanese NGO, the Association of Medical Doctors of Asia. A package of activities was designed and implemented, consisting of three components: Growth Monitoring Plus (GMP+), Participatory Hygiene and Sanitation Transformation (PHAST), and Income Generating Activities (IGAs). Training courses and implementation tools were developed for each component to strengthen the capacities of health officers at the Directorate of Public Health and Research at the Ministry of Health and at provincial and district health offices as well as those of health service providers at select health centers in target districts and of community health volunteers.

Situation analysis

- Health threats: childhood illnesses (measles, malnutrition, diarrhea, cholera, malaria, acute respiratory infections), environmental health, and sanitation
- Want: poverty, lack of social services such as electricity, roads, clean water, and sanitation
- Dignity: bad housing conditions

Actions

How do health threats feed off other threats or vice-versa and how are they addressed in a comprehensive manner?
GMP+ is a comprehensive program to promote the growth of children under the age of five. One GMP+ session includes services for children under five and their caregivers, including growth monitoring (regular weight checks), immunizations, nutrition counselling, deworming, health education, micronutrient supplementation, and family planning. GMP+ was provided at both health centers and outreach points called "GMP+ sites" in close collaboration with community volunteers trained by the project.

How do the disadvantaged population groups participate in the health decision-making process?

Children under five years old in overpopulated unplanned settlements are vulnerable to communicable diseases stemming from the unsanitary environment and lack of safe water. The overburdened urban environment with its high population density gave rise to mass outbreaks of cholera during the rainy season, helped the spread of HIV/AIDS and other STIs, and contributed to a rapid increase in tuberculosis and measles cases. Under PHAST, this project aimed to foster community volunteers and improve community hygiene through the involvement of its residents. The project engages Neighborhood Health Committees and community volunteers to identify the issues in the community that need to be addressed as well as implement the package of interventions. Through the IGAs, the project helped to run small ventures, such as pay toilets and brick making, with community volunteers and health centers financing health-related community-based services and providing some monetary incentives to community volunteers. An Environmental Health Committee was formed to conduct activities that address high-priority issues such as collecting garbage, improving the sewage system, and constructing toilets, among others.

What is the local-specific context and how do health decisions take that context into consideration?

The project ran cohort and knowledge, aptitude, and practices surveys with community volunteers and health centers to measure the project impact as well as capture the real situation facing child health in the communities.

How are promotion- and prevention-oriented interventions implemented?

PHAST aims to foster community volunteers and improve the hygiene of the community through the involvement of its residents. Under PHAST, participatory workshops are held, community problems related to environmental sanitation and hygiene are analyzed by residents, and possible solutions are discussed. Through these activities, residents gained knowledge about environmental sanitation and how to prevent environmental health issues.

Is there a link made between protection and empowerment actions, and if so, how?

In addition to the day-to-day operation and coordination by the district medical offices and health centers, the Directorate of Public Health and Research at the Ministry of Health and the Directorate of Mother and Child Health at the Ministry of Community Development were engaged in project implementation and monitoring, and they helped strengthen the capacities of district-level health workers and community volunteers. This helped enhance the link between protection and empowerment.

Changes

This project strengthened community ties among residents and collaboration between the government and the community. By involving residents and enabling them to take the lead in health activities, the project helped them gain knowledge about environmental sanitation and the ability to conduct necessary plans and activities to solve their own community challenges.

Man-Made and Natural Disasters

CASE 19

Improving Health and Recovering Community following a Devastating Natural Disaster

(JAPAN)

Summary

On March 11, 2011, the most powerful earthquake in the history of Japan struck Tohoku, the northeastern region of the country. The earthquake generated a massive tsunami, which caused tremendous local devastation in the coastal areas of Tohoku and also the northern island of Hokkaido. More than 18,000 people had been reported dead or missing as of 2013. The disaster ultimately resulted in a complex emergency in terms of both humanitarian crisis and economic devastation, and recovery efforts in the affected communities are still underway. The health of injured and displaced people was an immediate concern. The combination of Tohoku's rigorous climate and the shortage of healthcare personnel and facilities made the situation more difficult for everyone, especially the elderly above 65 years of age, who made up close to 60 percent of the population. Physical problems including dehydration, hypothermia, insomnia, deep vein thrombosis, and pulmonary embolism, as well as psychosocial problems including symptoms of stress, survivor guilt, depression, and post-traumatic stress disorder were widely reported. Physical settings of the afflicted made the situation even more difficult. While some sought temporary shelter at residential camps, others decided to stay in their own homes, where they felt more comfortable and secure despite the potential for collapse due to damage caused by the earthquake and tsunami. Overcrowding in the residential camps as well as elderly living alone triggered various health problems, threatening the human security of the people in the community. The elderly who were living alone were the most likely to be isolated from the community, thus lacking proper access to health services when they needed them.

This project was initiated in response to the Great East Japan Earthquake by a private physician, Dr. Shinsuke Muto, in Ishinomaki, Miyagi Prefecture. His motivation in the beginning was to open a free clinic that would serve the community as well as provide home healthcare to those who chose to stay at home after the disaster. The clinic ultimately served as a place for people to meet and get to know each other. Providing a chance for human interaction was vital to people in the community at the time so that they could get back on their feet. Staff not only provided healthcare, but they also provided input into the process of developing the clinical practice in a way that sought to enhance their patients' daily lives and overall welfare, and addressed the nursing care needs of other family members, transportation challenges for the elderly, local infrastructure gaps, and employment. Later on, Dr. Muto and his colleagues decided to launch the Health and Life Revival Council in Ishinomaki District and initiated an assessment that looked more closely at the living conditions of afflicted people. Numerous major private organizations helped with the assessment data, including Fujitsu, which provided its cloud system for their use. Fujitsu employees also volunteered to input the results into the system.

Situation analysis

- Health threats: lack of healthcare personnel and facilities, physical and psychosocial problems
- Fear: earthquake and tsunami
- Want: poor housing conditions, unemployment
- Dignity: isolation

Actions

How do health threats feed off other threats or vice-versa and how are they addressed in a comprehensive manner?

Based on the assessment of health and living conditions of the afflicted communities, clinic staff took three steps to expand their activities beyond health. First, they established systems for home healthcare visits. Second, they launched linkages between medical service providers and long-term care providers to provide seamless services for the elderly in need. And third, they established a platform among local government offices, businesses, and NGOs to provide comprehensive information and services to the elderly by using information and communication technology and coordinators who compiled a database of people's needs and matched the needs with available services.

How do the disadvantaged population groups participate in the health decision-making process?

In the course of building a clinic in one of the areas that was most severely afflicted by the 2011 earthquake and tsunami, there was input from the healthcare workers who were serving the community regarding patients' daily lives and welfare, the role of family members in providing care, transportation of the elderly, local infrastructure, and employment. The clinic's doctor and his colleagues decided to initiate an assessment of the living conditions of the afflicted people more closely. Local health outreach workers originally performed an informal assessment of the people in the community, and programs were expanded based on their findings. The assessment questionnaire asked people in the community not only about their health but also about their lives after the disaster, including socioeconomic status, changes in their social networks, nutritional status, transportation methods, utilization of legal consultation, and housing in order to identify what aspects of life pose the greatest challenge.

CASE 20

Natural Disasters in Peru's Andes Mountains: From Damage Limitation to Risk Management and Prevention

(PERU)

Summary

In an attempt to reduce the impact of recurrent natural disasters on communities in Peru's Andes Mountains, a wide range of actors came together, including such international organizations as UNDP, UNICEF, PAHO/WHO, FAO, and WFP; Peruvian civil defense district committees, local governments, and regional authorities; and civil society organizations and networks. The project, which was funded by the UNTFHS from 2006 to 2009, focused on improving local residents' capacity to prepare for natural disasters and achieve better baseline levels of health and food security before such disasters hit. Participating communities also formed mobile health brigades that serve as early warning systems for emergent threats.

Situation analysis

- Health threats: lack of access to basic health services
- Fear: repeated cycles of natural sudden events
- Want: extreme poverty, poor housing conditions, lack of economic opportunities
- Dignity: hopelessness about the future

How are the three freedoms linked?

Agrarian communities in the Andes Mountains with poor access to health and education services, limited economic opportunities, and poor housing are further exposed to recurrent natural sudden events that threaten the survival and livelihood of their residents on a regular basis. The cycle of poverty left residents feeling helpless and in constant fear of losing what little they have.

What disadvantaged population groups exist?

The project focused on extremely poor small-scale farmers and people raising alpacas and llamas, as well as on the children, teachers, and local officials in communities that suffer from the cumulative effect of severe droughts, frost, snowstorms, landslides, earthquakes, and forest fires.

Actions

How are the linkages among the three freedoms addressed?

Improving farming techniques in the communities so that they can better withstand natural sudden events helps improve their food security, which in turn protects them from the impact of malnutrition on their health. Training in early warning monitoring and disaster risk preparedness helps them protect themselves not only from the immediate dangers posed by natural sudden events but also from the longer-term effects on their livelihoods.

How do the disadvantaged population groups participate in the health decision-making process?

Local communities participated in the situational analysis, describing their actual social and environmental conditions and projecting the conditions they expected for the future. In addition, they participated in the development of an alert early warning system as part of mobile health brigades.

Changes

A solar heating system was built with the community's help to raise the temperature inside residents' homes, which—along with the polar fleece jackets and blankets that were provided through the project—helps protect newborns and children from the harsh weather, improving their health. Mobile health brigades of local women teach poor families how to prevent and treat diarrhea and pneumonia, and this helped reduce incidences of both among children in the communities. In addition, agricultural training and construction of livestock sheds—using local materials—is protecting crops and livestock from the inevitable natural disasters, which in turn has improved the communities' food security.

Appendix: UN Resolution on Human Security

Resolution adopted by the General Assembly on 10 September 2012

[*without reference to a Main Committee (A/66/L.55/Rev.1 and Add.1)*]

66/290. Follow-up to paragraph 143 on human security of the 2005 World Summit Outcome

The General Assembly,

Reaffirming its commitment to the purposes and principles of the Charter of the United Nations, and international law,

Recalling the 2005 World Summit Outcome, especially paragraph 143 thereof, and its resolution 64/291 of 16 July 2010,

Recognizing that development, human rights and peace and security, which are the three pillars of the United Nations, are interlinked and mutually reinforcing,

1. *Takes note with appreciation* of the report of the Secretary-General on follow-up to General Assembly resolution 64/291 on human security;
2. *Takes note* of the formal debate on human security organized by the President of the General Assembly, held on 4 June 2012;
3. *Agrees* that human security is an approach to assist Member States in identifying and addressing widespread and cross-cutting challenges to the survival, livelihood and dignity of their people. Based on this, a common understanding on the notion of human security includes the following:
   (a) The right of people to live in freedom and dignity, free from poverty and despair. All individuals, in particular vulnerable people, are entitled to freedom from fear and freedom from want, with an equal opportunity to enjoy all their rights and fully develop their human potential;
   (b) Human security calls for people-centred, comprehensive, context-specific and prevention-oriented responses that strengthen the protection and empowerment of all people and all communities;
   (c) Human security recognizes the interlinkages between peace, development and human rights, and equally considers civil, political, economic, social and cultural rights;
   (d) The notion of human security is distinct from the responsibility to protect and its implementation;
   (e) Human security does not entail the threat or the use of force or coercive measures. Human security does not replace State security;
   (f) Human security is based on national ownership. Since the political, economic, social and cultural conditions for human security vary significantly across and within countries, and at different points in time, human security strengthens national solutions which are compatible with local realities;
   (g) Governments retain the primary role and responsibility for ensuring the survival, livelihood and dignity of their citizens. The role of the international community is to complement and provide the necessary support to Governments, upon their request, so as to strengthen their capacity to respond to current and emerging threats. Human security requires greater collaboration and partnership among Governments, international and regional organizations and civil society;
   (h) Human security must be implemented with full respect for the purposes and principles enshrined in the Charter of the United Nations, including full respect for the sovereignty of States, territorial integrity and non-interference in matters that are essentially within the domestic jurisdiction of States. Human security does not entail additional legal obligations on the part of States;
4. *Recognizes* that while development, peace and security and human rights are the pillars of the United Nations and are interlinked and mutually reinforcing, achieving development is a central goal in itself and the advancement of human security should contribute to realizing sustainable development as well as the internationally agreed development goals, including the Millennium Development Goals;
5. *Acknowledges* the contributions made so far by the United Nations Trust Fund for Human Security, and invites Member States to consider voluntary contributions to the Trust Fund;
6. *Affirms* that projects funded by the Trust Fund should receive the consent of the recipient State and be in line with national strategies and priorities in order to ensure national ownership;
7. *Decides* to continue its discussion on human security in accordance with the provisions of the present resolution;
8. *Requests* the Secretary-General to submit to the General Assembly at its sixty-eighth session a report on the implementation of the present resolution, seeking the views of Member States in that regard for inclusion in the report, and on the lessons learned on the human security experiences at the international, regional and national levels.

127th Plenary Meeting
10 September 2012

Notes

1. Sustainable Development Knowledge Platform, "Post-2015 Development Agenda," https://sustainabledevelopment.un.org/post2015.
2. "Health for all" refers to the state of complete physical, mental, and social wellbeing of all individuals. "Universal health coverage" means ensuring that all people can use the promotive, preventive, curative, rehabilitative, and palliative health services they need and that those services are of sufficient quality to be effective and do not expose the user to financial hardship.
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