Report on the Regional Meeting on Health and Human Security in the Americas

Pan American Health Organization

Regional Office of the World Health Organization

110th ANNIVERSARY

Sustainable Development and Environmental Health Area

December 18, 2012

In accordance with Resolution CD50.R16, which urges Member States to incorporate the concept of human security into country plans, the SDE area has been actively working to promote awareness, build knowledge, and facilitate integration of human security approaches into health policies and programs within the Region. In continuation of these efforts, the SDE area and the Japanese Center for International Exchange (JCIE) co-hosted a the regional meeting, Health and Human Security in the Americas (hereafter referred to as the "Regional Meeting") in Lima, Peru from 6 to 8 September 2012. The following report summarizes activities related to the Regional Meeting, main conclusions reached from this event, and remaining challenges/areas of work/follow-up

I. Background:

The Regional Meeting represents a continuation of SDE's activities to advance discussion, understanding and application of human security in the Region of the Americas. These activities have included the organization of two subregional workshops examining the relation between health and human security (H&HS), and an international technical consultation to consider the approach of public health towards human security as well as to review a draft technical reference document on H&HS. This document, *Human Security: Implications for Public Health*, was finalized and subsequently published in August 2012. Therefore, one objective for the Regional Meeting consisted of distributing and disseminating information about this new publication.

However, the larger goal of the Regional Meeting was to identify the added value of human security approaches to health in the Region, with a view to explore the possibility of developing policy guidelines and methodological tools for integrating the human security approach in health programs and activities. An additional objective included promoting awareness for personnel in PAHO and Member States, academic institutions, civil society and other organizations of issues and approaches to addressing human security and its relationship with health.

The proposal for this event and to collaborate with JCIE in its organization grew out of the May 2011 seminar *Health and Human Security in Africa* (Dakar, Senegal). JCIE, which has been a leader in the advancement of human security, particularly in the health field, invited PAHO's participation in this event. The organizations' shared goals were recognized at this time. A partnership was thus established between PAHO and JCIE to implement the Regional Meeting in efforts to meet the mandates of the above-mentioned resolution, to build a stronger knowledge base of the role of human security in the health field, and to begin developing policy guidelines and methodological tools for the incorporation of human security within the context of health.

An integral element of this event and PAHO's and JCIE's ongoing collaborative work involves the identification and analysis of initiatives in the Region which incorporate, or have attempted to incorporate, aspects of a human security approach into the implementation of health-related activities. The experience of these 'case studies' provided a basis for analysis and exploration with Regional Meeting participants in order to identify the added value of human security in the Region as well as elements for future guidelines on H&HS.

Additional supporting activities of the PAHO project team leading up to the Regional Meeting included creating the Health and Human Security website and conducting outreach through social media channels to publicize information about the Regional Meeting.

II. Summary Events – The Regional Meeting consisted of the following events and activities:

Symposium – Health and Human Security in the Americas *(see Annexes* 1 *and 2 for agenda and attendees list)*

The Regional Meeting opened with the Symposium on Health and Human Security in the Americas on 6 September 2012. More than 120 attendees were present and an additional 133 attendees joined online via Elluminate. Attendees included stakeholders from multiple sectors with representatives from national, regional and international organizations, including key decision-making, policy development and funding institutions across the Latin American, Caribbean, Asian and African regions. The objectives of this event included dissemination of the human security concept and PAHO's technical reference document, presentation of the UN Secretary General's 2012 Report on Human Security, and exploration of Regional experiences in integrating health and human security through the presentation of selected case studies. Discussions throughout the day elaborated upon how health is ideally situated as an entry point for human security and examined the integration of human security into public policies. Following presentation and analysis of H&HS case studies, afternoon panel members discussed ways to promote human security in Peru and the Americas by using examples of the approach in action.

Workshop *(see Annexes 3 and 4 for agenda and participants list)*

Health professionals in the field and related subject matter experts were invited to participate in a technical workshop held at the PAHO/WHO Representation in Lima on 7 September 2012. The 55 participants who took part in this workshop engaged in a more in-depth analysis of the case studies presented during the Symposium in order to identify elements necessary for effective integration of H&HS in policies and programs, and which might serve as the subject of future guidelines to effectuate this integration. Activities and discussion throughout the day were interactive and dialogue-based. These included small-group break-out sessions to debate the following key thematic issues for operationalizing H&HS approaches: defining roles for different sectors and actors; coordination mechanisms for multisectoral action; balancing protective and empowerment strategies and promoting participation; mechanisms to ensure sustainability; how human security approaches, the health sector and primary health care have, and should, intersect in integrated measures to maximize H&HS. The following points represent some of the key themes, messages and conclusions reached during the workshop *(see Annexes 5 and 6 for more information on group discussions and key messages)*:

- Community-driven, participatory approaches are critical in creating accepted, context-specific interventions capable of building community empowerment
- Weak evidence-base for H&HS initiatives poses a significant challenge which calls for more evaluations, impact assessments, as well as the development of appropriate measurement instruments and indices

- Methods to create spaces for information/knowledge exchange and shared decision-making between communities and other actors/executing parties was identified as a priority area for operational guidelines
- Intersectoral action is crucial, for which key operation strategies include establishing a common agenda and agreeing upon leadership roles and responsibilities among actors
- Continued need exists to disseminate and raise awareness of the human security concept and its relation to health
- Governments have mandate to protect populations and foster community participation and empower, but role and level of responsibility variable between different levels of government and over time

Strategic Planning Meeting *(see Annex 7 for agenda)*
Events in Lima concluded on 8 September 2012 with a closed strategic planning meeting for PAHO, JCIE, and selected partners to discuss next steps over the short- and long-term to follow-up on the Lima meetings and to move forward with case study analyses and the development of guidelines.

Case Studies and Field Visits
PAHO, JCIE and partnering researchers developed and provided PWRs and country advisors with a screening tool to identify initiatives in the Region which might serve as case studies of the implementation of human security approaches. In total, 29 initiatives were received for consideration representing 11 countries, distributed as follows: 4 in South America (Bolivia, Brazil, Colombia and Peru), 5 in Mesoamerica (El Salvador, Guatemala, Honduras, Mexico, and Nicaragua) and 2 in the Caribbean (Haiti and the Dominican Republic). More in depth information on these initiatives was next solicited through use of a second survey instrument provided to original respondents and project leaders. Responses were collected electronically, from personal and teleconference interviews, and supplemented by review of publicly available information. Complete information was available for 17 initiatives across nine countries at the time of the Regional Meeting. These included: Bolivia, Brazil, Colombia, Dominican Republic, Guatemala, Honduras, Mexico, Nicaragua, and Peru.

Eight case studies were chosen for presentation during the symposium, with selection being based on the degree to which screening tool criteria were met, and with the goal of achieving a diverse representation by region, initiative setting, and type of human security threat addressed *(see Annex 8 for information on case studies presented).* The five case studies below were also selected for field visitation in Peru—the Regional Meeting host country—and Brazil coinciding with the Regional Meeting:

Peru Field Visits (3 to 5 September 2012)
- *Tupac Amaru Network initiative for integrated control of urban dengue in Comas, Lima*
- *Project for control of cisticercosis in humans through an integrated community approach to pig production and byproduct handling in Tumbes*
- *Sustainable Health and Agriculture: Intermittent dry irrigation in rice cultivation for malaria vector control in the North Coast, Chiclayo*

Brazil field visits (9 to 11 September 2012)
- *Sao Paulo Human Security Project Initiatives*

- *Green and Health Environments Project Initiatives*

Field visits were attended by members of the PAHO (HQ & Peru) project team and of the JCIE delegation for the purpose of having contact with national and local authorities, generating greater insight into the challenges and opportunities facing human security initiatives and a better understanding of progress made and associated impacts on health and well-being. The

Case study analysis and select field visitation has continued since the Regional Meeting, but key reflections from analysis at that time which were discussed during the workshop included the fact that most initiatives can be characterized as top-down rather than bottom-up, that collaboration between the health sector and academic institutions is the most common form of intersectoral action identified, that most initiatives have not performed evaluations or impact assessments, and that the threats most frequently addressed by initiatives were violence, food insecurity, poverty, water and environmental problems. *(See Annex 9 for more information on case studies and findings from analysis)*

III. Conclusions and Future Directions

The Regional Meeting provided participants with a valuable opportunity to gain a better understanding of the human security concept and how this relates to health, not only in theory, but in practice. The symposium and workshop created a forum for sharing experiences that helped identify important elements for guidelines. Insights from field visits and ongoing case study analysis further enrich these perspectives. Taken together, the lessons learned are adding to the body of knowledge in this area. The SDE human security project team will draw upon this knowledge foundation as it moves forward to develop policy guidelines and methodological tools for integrating H&HS, whose exploration is requested by Resolution CD50.R16. PAHO's work to develop these guidelines will continue to benefit from the collaboration of JCIE and be supplemented by findings from a complete synthesis of case studies (now under development). The team will work to offer PAHO/WHO Representatives and country advisors support in developing H&HS projects beyond these guidelines, by forging stronger links with the United Nations Trust Fund for Human Security and other key resources.

Additional supporting activities include preparing a progress report for the UN Secretary General's consideration in the next report and participation in the upcoming June seminar on health and human security in the Asian Region (being organized by JCIE, dates TBD). Parallel work involves continued awareness raising efforts, including dissemination of information products developed such as the H&HS technical reference document, which will be facilitated by building and maintaining the Health and Human Security internet site. A related strategic effort is the establishment of the Health and Human Security Advancement Network (HAHSAN) for professionals and practitioners. By launching this network in January 2013, we hope to build a community of practice, creating a space for dialogue and information exchange which will generate knowledge and help identify best practices in the Region and beyond as we advance from human security theory to implementation strategies for health.

Annexes

Annex 1 – Symposium Agenda

Regional Meeting on Health and Human Security

Agenda **Symposium: Health and Human Security in the Americas**

Thursday, 6 September 2012

Hotel Melia Lima Avenida Salaverry 2599 San Isidro, Lima

Co-hosted by the Pan American Health Organization/World Health Organization (PAHO/WHO) and the Japan Center for International Exchange (JCIE) with the support of the Japan International Cooperation Agency (JICA) and the Bill & Melinda Gates Foundation

Objectives:

- *To disseminate the concept and to present the UN Secretary General's Report on Human Security (2012)*
- *To analyze the experience of health and human security interventions or those that resemble these approaches*

08:00-08:30	**Registration**
08:30-09:30	**Opening Session**
	Fernando Leanes, PAHO/WHO Representative in Peru
	Keizo Takemi, Chair, Global Health and Human Security Program, Japan Center for International Exchange (JCIE)
	Masahiro Fukukawa, Ambassador of Japan to Peru
	Rebeca Arias, Resident Coordinator of the United Nations in Peru
	Opening Address and Official Inauguration
	Dr. José Carlos Del Carmen Sara, Vice Minister of Health, Peru
09:30-10:30	**Integration of Human Security into Public Policies**
	Moderator: Fernando Leanes, PAHO/WHO Representative in Peru
	Keizo Takemi, Chair, Global Health and Human Security Program, JCIE: *Health and Human Security in Japan*
	Luiz Augusto Galvão, Manager, Sustainable Development and Environmental Health Area (PAHO/WHO): *Regional Perspective: PAHO/WHO 2012 Report, "*Human Security: Implications for Public Health"
	Mehrnaz Mostafavi: Officer-in-Charge, Human Security Unit, Office of the Coordination of Humanitarian Affairs (OCHA), United Nations: *Presentation of the 2012 United Nations Secretary General's Report on Human Security*
	Q&A
10:30-11:00	**Coffee Break**

11:00-12:45	**Presentation of Case Studies: Experiences Integrating Health and Human Security**
	Moderator: Masamine Jimba, Professor and Director, Department of Community and Global Health, Graduate School of Medicine, The University of Tokyo, Japan
	Q&A
12:45-13:45	**Lunch**
13:45-15:15	**Presentation of Case Studies: Experiences Integrating Health and Human Security (continued)**
	Q&A
15:15-15:45	**Coffee Break**
15:45-17:15	**How Can We Promote Human Security in Peru and the Americas?**
	Panel Members: Moderator: Susan Hubbard, Senior Associate, JCIE Martha Hijar, Researcher, Fundación Entornos, Mexico Ernesto Gozzer, Associate Professor, Universidad Peruana Cayetano Heredia Carlos Santos-Burgoa, Senior Advisor, Human Security, Coordinator, Environmental and Occupational Health, Sustainable Development and Environmental Health Area (SDE), PAHO/WHO Flavio Mirella, United Nations Office on Drugs and Crime (UNODC), Representative in Peru and Ecuador Dr. Ariel Frisancho, Coordinator of National ForoSalud, Peru Mr. Artur Custodio M. De Sousa, MORHAN, Brazil Q&A
17:15-17:30	**Concluding Remarks**
	Luiz Augusto Galvão, Manager, SDE, PAHO/WHO Keizo Takemi, Chair, JCIE Representative from the Ministry of Health of Peru

This meeting is being broadcast live via Elluminate: Join online at
www.paho.org/virtual/PeruPAHOEvents
And find more information at www.paho.org/healthandhumansecurity and
http://www.jcie.or.jp/cross/globalhealth/index.html

Annex 2 – Symposium Attendees

Regional Meeting Symposium Attendees September 6, 2012

APELLIDO	NOMBRE
Abal Abarca	SANDRA
Albán Márquez	Wendy
Aliaga	FELIPE
Aliaga Rojas	ELMER
Almonacid	CARLOS
Alvarado	BEATRIZ
Andía	BETHSABÉ
Araujo Zapata	Milagritos
Arca	JOSÉ MIGUEL
Arias	REBECA
Arismendi Ríos	BEATRÍZ
Ávila Herrera	José
Balabarca	PERCY
Bartolo	Marco
Beingolea More	LUIS FRANCISCO
Beteta Ventosilla	IRMA
Brito Vásquez	CECILIA
Brownstein	KIRSTEN
Cabanillas	WILLIAM
Cáceres Cruz	JORGE ANTONIO
Cano Salinas	JISETT JENIFER
Castro Castañeda	RITA
Chea	LILIAN

Annex 2 – Symposium Attendees

Chicchon Valer	LUISA
Cifuentes	Carmen
Ciriani Anchorena	BRUNO
Colino Monroy	PAUL
Collazos Cerrón	JESÚS
Contreras	Carlos
Cowl	AMANDA
Custodio de Souza	ARTUR
Dare	LOLA
D'Onadio Caro	GUERY
Eagin	BETSY
Elenes	JO JEAN
Espino Ledesma	GRISELDA
Espinoza	RUBÉN
Espinoza	ELIZABETH
Ferro	MARCIAL
Franco	RONICE MARÍA
Frisancho	ARIEL
Funakushi	TOMOE
Gómez Pónce de León	RODOLFO
Gonzales	ELOY
Gozzer	ERNESTO
Grillo	PEDRO
Guerrero	JUAN
Guevara Zapata	TOMÁS
Hermoza	JOSÉ
Hijar	MARTHA
Hilario Villegas	MELI

Annex 2 – Symposium Attendees

Regional Meeting Symposium Attendees September 6, 2012

Huamaní Rocha	CARLOS
Hubbard	SUSAN
Infante	Federico
Jimba	MASAMINE
Kawagoe	HARUYO
Kimura	HIDEO
Kishimani	EUNICE EMIKO
Kishimoto	MIDORI
Laca	FERNANDO
López	ADOLFO
López Quispe	MARY
Loza	JAVIER
Mahecha	ANA MARÍA
Mamanillo	IRIS
Mazimba	ANGELA
Medrano Rivas	ROSA
Meirim	Ana Claudia
Mirella	FLAVIO
Monreal	Julio
Morishima	KEIJI
Mostafavi	MEHRNAZ
Muñoz	JORGE
Nagata	TAKESHI
Nino	ALFONSO
Noa Yarasca	EFRAÍN
Núñez Ponce	FREDY
Ocampo	JOVANA
Ogusuku	ELENA
Ordoñez	ROSA
Orozco	YOLANDA

Annex 2 – Symposium Attendees

Orozco	JUAN GUILLERMO
Ospina Salinas	ESTELA
Ostos	BERNARDO
Padilla	LUIS
Peña	RONALD
Peña	Victor
Pérez	OCTAVIO Lenín
Pezua Vivanco	JORGE
Pineda	Malena
Polo	CÉSAR
Quevedo	ADRIANA
Ramírez Reyna	JORGE
Recinos	MAYRA
Rivera Vidal	NEY
Riviere-Cinnamond	Ana
Rodriguez	Diana
Rojas Esteves	CÉSAR
Sakakura	NORIJI
Sánchez	IZASKUN
Sánchez	CARLOS
Santos-Burgoa	Carlos
Shah	LENA
Shimabuku	Roberto
Siles Nava	ROXANA
Soto Bautista	MARGARITA
Sotomayor	PERCY
Suárez	LUIS
Suárez Janampa	HENRY ANDRE

Annex 2 – Symposium Attendees

Regional Meeting Symposium Attendees September 6, 2012

Suzuki	TOMOKO
Takemi	KEIZO
Taminez Torres	María Teresa
Tena Ysla	Víctor
Torreao Brito	EDJANE MARÍA
Treasure	Ana
Urcia	Fernando
Valencia	BRAULIO
Vallejos	LORENZO
Varas Catoira	OSCAR
Viguria Chávez	Yolanda
Villarán	VERÓNICA
Villavicencio	JAIME
Yamamoto	Víctor
Yermenos	BEATRIZ
Yoshioka	KOTA
Yuasa	MOTOYUKI
Zúñiga	RICARDO

Pan American Health Organization
Regional Office of the World Health Organization

110th ANNIVERSARY

JCIE

Regional Meeting on Health and Human Security

Agenda **Workshop: Health and Human Security in the Americas**

Friday, 7 September 2012

PAHO/WHO Representation in Lima, Peru
Calle Los Pinos 251, Urbanización Camacho, La Molina

Co-hosted by the Pan American Health Organization/World Health Organization (PAHO/WHO) and the Japan Center for International Exchange (JCIE) with the support of the Japan International Cooperation Agency (JICA) and the Bill & Melinda Gates Foundation

Objectives:	*Identify elements needed to integrate into policy and operational guidelines* *Explore case studies further for in depth analysis through dialogue* *Set one year goals for advancing development of policy and operational guidelines*
08:30-09:00	**Registration**
09:00-09:30	**Opening Session**
	Welcoming Remarks: *Fernando Leanes, PAHO/WHO Representative in Peru*
	Opening Remarks: *Keizo Takemi, Chair, Global Health and Human Security Program, JCIE*
	Overview of Agenda and Goals for Workshop: *Susan Hubbard, Senior Associate, JCIE*
09:30-12:30	**Further Exploration of Lessons Learned at the Symposium**
	Open Discussion Session Moderator: *Carlos Santos-Burgoa, Senior Advisor, Human Security, Coordinator, Environmental and Occupational Health, Sustainable Development and Environmental Health Area (SDE), PAHO/WHO*
	In-Depth Analysis of Cases Presented: *Martha Hijar, Researcher, Fundación Entornos, Mexico*
	Presentation of Case Analysis Framework: *Professor Hideo Kimura, Professor, Graduate Program on Human Security, The University of Tokyo*
10:45-11:15	**Coffee Break**
	Further dialogue with case studies
	Open discussion of cases, experiences and presented elements
12:30-13:30	**Lunch**
13:30-16:00	**Breakout Sessions**
16:00-16:30	**Presentation of Breakout Session Results and Discussion**
16:30-18:00	**Plenary Discussion: Toward the Creation of Guidelines**
18:00-18:15	**Concluding Remarks**
	Keizo Takemi, Chair, JCIE
	Carlos Santos Burgoa, SDE, PAHO/WHO

Please visit www.paho.org/healthandhumansecurity and http://www.jcie.or.jp/cross/globalhealth/index.html for additional information

Annex 4 – Workshop Participants

Regional Meeting Workshop Attendees September 7 ,2012

INSTITUCIÓN	APELLIDO	NOMBRE	Email
Seguro Integral de Salud	Aldana Carrasco	JOSÉ	None Listed
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PAHO / WHO	Brownstein	KIRSTEN	brownsteink@paho.org
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Ministerio de Salud	D'Onadio Caro	GUERY	None Listed
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MINSA	López Quispe	Mary	
PAHO - Colombia	Mahecha	ANA MARÍA	mahecha@col.ops-oms.org
Banco Mundial	Marmanillo	IRIS	marmanillo@worldbank.org
CHESTRAD - Nigeria	Mazimba	ANGELA	research@chestrad-ngo.org
PAHO / WHO	Morales	SOFÍA LETICIA	moraless@paho.org

WORKSHOP – KEY MESSAGES

In-Depth Analysis of (Latin American) Cases Presented (Martha Hijar, Researcher, Fundacion Entorno Mexico)

- Cases presented illustrative examples of how human security approaches are being attempted within the context of health interventions in the Latin American Region, but should not be regarded as a representative sample of all such initiatives within the Region. Cases analyzed included 29 initiatives representing 11 countries (4 South America, 5 Central America, 2 Caribbean).

- Most of these could be characterized as employing more top-down, rather than bottom-up approaches. *Health threats were not usually the catalyst to intervention*, but were rather incorporated as an element within initiatives created. The most frequently identified threats included: violence, food insecurity, poverty, water and environmental problems.

- A minority of initiatives were characterized as bottom-up in nature. *Among the remaining majority of more top-down initiatives, intersectoral action was more easily identified*, with the most frequent partnerships existing between the health sector and academia.

- Some key reflections included the fact that most initiatives identified have *not performed evaluations or impact assessments*, thus posing a challenge that ought to be solved in the short term; it is often not recognized that the community itself is the primary stakeholder; target populations are not often defined; and the concepts 'resilience' and 'social fabric' not frequently employed by initiatives.

Preliminary Findings from African Cases (Lola Dare, CHESRAD)

- Analysis represented 65 case studies submitted from 28 different organizations across 28 countries.

- Presentation highlighted the importance of community-driven approaches and empowerment to identify priorities and implement appropriate interventions, as well as the need for leadership by officials, national government

- *'Pathway to Community Empowerment'* presented key framework, or lens, through which to understand different local realities in regards to the dynamic between communities and officials in processes of priority setting, program design and planning, and implementation and evaluation.

- *Access, empowerment, sustainability and accountability* are areas that initiatives should directly address.

- *Access to health services* was the most common human security area addressed, youth populations were among those most frequently targeted by initiatives, and the health sector was the most common sector involved.

- Now and moving forward, learning and sharing knowledge with other institutions is priority in order to better advocate for the health and human security approach.

Case Analysis Framework (Kimura)

- Noted *importance of definitions* and distinctions between types of organizations, associations, needs versus interests, etc.
- *Individual* (basic unit of the human security concept); *community*, colective of individual institutions to assure survival; *association,* created, some incommunity, different depending on the objective, build the "social fabric". Therefore, the development of the individual's capacity (empowerment).
- Human security, the basis for multidiscipline and multisector practice. An open concept, flexible, neutral.
- Similarly, many assumptions are involved in, or questions raised by, defining 'threat', 'empowerment' (e.g. threat to who and from what, empowerment of who, to do what?)
- Importance of clear and commonly understood definitions of threat, survival, empowerment, protection, needs/wants/interests, health sector/system/services, etc.
- Needed the articulation of knowledge and language.

Participant Dialogue: Key Themes and Messages

Some messages to consider:

- Several elements were highlighted: becarefull with citizen and "I empower you".
- Survival from a threat drives resilience. *Sustainable survival is a goal*. Instead of need, use the concept of interest. Consider solidarity and reciprocity.
- *Non- ideological,* based on the evidence of the most critical and pervasive threats. Use health impact assessment in health and human security. Measure the budget impact on individual's security.
- Nothing for us without us. *Empowerment (individual and community) has to be sustainable. No protection without empowerment (synchronization). As the empowerment evolves, the protection has to adjust itself.*
- *Indicators needed* for NGOs participation: even within high national councils. Use "local dialogue" to assure contdtualization.
- Health promotion, a key element. Need to provide tools, and walk with the countries. Integrated health care /PHC.
- *Need to have State / Nation Plans,* that go beyond one administration. Involve political parties and parliaments. Policies also need to go beyond health policy to also include other relevant policies (e.g., environment, development, etc.)
- *Concept of Association, the framework has to adopt it.* Association as a catalyst for emppowerment and protection. We have to differentiate supply side and demand side associations (*and be catalysts*).

- *Elements: threat (cohesion in front of the lion) moves from individual to colective response; resilience (more than empowerment), construction of citizenship from popular knowledge; universality, promotion, coherence, social (fabric) network, evaluation, training for movilization.*

- Intersectorial action. Needs a space for intersectorial action. Develop intersectorial index for use at national and local level

Messages delivered:

- One of the most key messages was the importance of *community-driven approaches* in which community members identify the priorities. This is critical in creating accepted, context-specific interventions which are able to build community empowerment.
    - Related challenges are for *practitioners/policy makers to learn how to listen*, and to identify tools/mechanisms with which to actually create the spaces and structures necessary to facilitate the community's participation.
    - It's also important to remember that empowerment and community participation don't just happen. Communities need to be convinced that it is in their own interests to engage. The community's role often changes as it goes through the different stages of empowerment; likewise, the role of government will be different in every initiative and will likely change over time.
    - Another key topic of discussion was the role of risk perception, particularly with respect to the community, and in the process of identifying needs/wants and setting priorities itself. *Participatory diagnosis* was cited as a potentially useful methodology/tool for this process of identifying threats, priorities.

- A challenge to be addressed includes the *scarcity of evaluations and impact assessment* data. This data is important in building the necessary evidence base for human security approaches, for creating human security indicators/indices, for improving learning and intervention effectiveness, and for demonstrating the added value of the human security approach.
    - *On-going monitoring and evaluation (performed with active participation of the community)* sited as a recommended operational mechanism to increase intervention effectiveness and sustainability.

- Budgets and funding availability/sources were identified as important considerations to take into account, in addition to the need to identify mechanisms for efficient resource management since this latter aspect is experienced as a current challenge in the Region. In the case of donor funding, there should be a path toward (eventual) government funding.

- Understanding the local power structure and gaining political will are critical.

Annex 5 – Workshop Key Messages (draft)

- Consensus exists on the continued need for dissemination of the human security concept and for raising awareness of this approach, which may not be widely known at present among different sectors/actors.

- Consensus exists on the need to *act boldly and become strong champions* in order to move beyond rhetoric and the historical level of inaction that's existed with regards to addressing human insecurity, social determinants...and challenges of a systemic/structural nature in general.

- *Training* was identified as a key need (for professionals, academics...across sectors)

- There was acknowledgement that human security is perceived intimidating by some, in some quarters.

- A recurring theme was the importance of *creating spaces for information/knowledge exchange and shared decision-making between communities and other actors/executing parties*; therefore, identifying policy and operational mechanisms with which to create such spaces is a priority for guidelines.

- Several criteria were suggested with which to identify human security cases, including the presence (degree of) 1) spirit of cohesion 2) resilience 3) citizenship-building, popular know-how. Additionally, the nature of existing threats (specifically, their degree of criticality, pervasiveness) were suggested as possible criteria to aid practitioners in identifying lines along which to implement human security approaches.

- Whereas silo'ed approaches and institutional arrangements are the present norm in most participants' experience, they *recognized intersectoral action as a crucial element* required in health and human security approaches.
    - The establishment of *common agendas* and goals between different actors was identified as an important aspect of intersectoral collaboration.
    - Leadership roles and responsibility are also important elements to be defined and agreed upon, where it was acknowledged that health sector leadership may not always be indicated, and it may be appropriate for leadership to be shared in some cases.
    - Participants expressed the importance of collaborating with the education sector in particular, and academic institutions were identified as an additional key strategic partner (e.g. in aiding knowledge dissemination, impact measurement, etc.)
    - The governments have lost their hegemony to provide security, so HS is good for governance.

- Within the *health sector, we are still challenged to move beyond medical/treatment-based paradigms to more holistic* and preventive focus characteristic of the public health perspective and human security approaches. Health sectors/actors must better position human security by placing it within agendas, etc.

- Importance of creating an evidence base for human security approaches was stressed. In addition to the already-needed evaluations, etc., conducting an inventory of everything that's been done across different sectors that could be said to be human security was one suggested measure to take to help build the body of knowledge and evidence.

- The health and *human security guidelines that are developed should be interactive, feasible, and implementable*; they should transcend local/national/regional experience to be broadly applicable, and should attract more adherents to and advocates of the human security approach. They should help to build the legitimacy and momentum behind the adoption and implementation of human security approaches.

Finaly, a recomendation: *1st, difusion; 2nd do buy doing with the other sectors; 3rd, accompaniament and monitoring.* Guidelines should be useful for the interaction; generate a node for HS implementators assets in those attnding the workshop). Build advocacy, a social movement.

Break Out Session Summary

Question 1: How do we define the ideal roles of government (national, subnational, local), civil society, and target communities in a human security approach? How is this different from the roles they play in other approaches? How do we define the roles of external players, such as donors, international organizations, foundations, international NGO's. etc. in a health and human security approach? How is this different from the roles they have played in other approaches?

- Intervention levels & Government type vary
  - Group feels it's the Central Governments 'Mandate' to fulfill the approach
  - Mandate to create space for advocacy and civil society where Community ID's threats, government is responsible to prevent
- Promote Demand Side
- It's the Donors Responsibility to accept the risk (Financial risk) that would be too much for the community to handle
- Case Study emphasized the importance of making sure that if the government is involved, that they are liked/trusted by the community- recommended that each case find their own balance for amount of involvement
- All emphasized that with De-Centralization in many countries, the best point of entry and the 'hoops' to jump through are different and that some local governments are figuring out where their role fits within the bigger picture. Others noted the importance of starting with the Central Government. (Which part of government needs to be approached first was debated among the group, the conclusion being that it is very context/location specific).
- Further exploration of government's role and examples were encouraged by the group

Question 2: If human security requires addressing multiple sources of vulnerability with a focus on their interconnections, what kind of coordination structures and mechanisms are needed to ensure that the interconnections are addressed appropriately?

Four different levels of coordination, each with a different approach are requried:

1. Multilateral- MoH Meetings, State agencies, where coordination mechanisms are established
2. Interagency- Sectorial tables- donor coordination
3. National- Coordination of sectorial working meetings- intersectoral meetings
4. Local- Community involvement

It is important to define roles of each actor to avoid overlapping of roles that can occur during execution.

Coordinate the definition of 'verifiable' interventions. Verifiable actions and indicators are critical for different interventions and to strengthen accountability. They help ensure credibility of the state to the communities involved.

Question 3: How can empowerment and protection be integrated? Where do the two intersect? What mechanisms do we need to develop truly participatory approaches? How do we ensure that the balance between protection and empowerment is dynamic and appropriate to the local context?

- Empowerment and Protection should be simultaneous.
- Empowerment should be aimed at both the community and of individuals.
- Concept of HS is dynamic and appropriate- tools should be flexible to cultures, regions and the context. The methodology should be effective and proven so that it can be transferred to each situation. Mechanisms to involve the community and 'subjects' are required to ensure that solutions DO fit the local situation. Locals know their situation best. Different instruments should be utilized for different groups
- The process and balance between empowerment and protection are dynamic and will 'self-regulate' and *can* change over time for each situation.
- Important to avoid having a paternal state: state should promote the participation of the community and community actions

Question 4: 1: What mechanisms are needed to ensure sustainability? 2: How can the experiences from human security approaches to health be translated into existing public policies and programs to ensure their institutionalization?

- Mechanisms for sustainability included having a common objective/shared vision. The importance of intersectoral coordination and cooperation toward a shared goal is critical. All actors need to have clearly defined, and understood roles.

- Sustainability requires that National/State plans and policies are aligned with the Human Security approach. Government DOES play an important role in the process and is often the provider of the protection side. Policies must be for the long and short term, despite changing political climates and parties.

- Having both Empowerment and protection are critical to long term success. The project must be defined by the community and those involved. It will not succeed without both aspects

- Finding a balance with the 'traditional'' medical paradigm of treatment (vs. prevention) is a challenge, but one that can be achieved through intersectoral action

- Achieving results will take at least a generation- Patience is needed. Policy routes need to be laid out well so that as governments change the framework for the effort remains.

- Threats that unite communities can be the catalyst for a shared vision and can bring together multiple sectors that previously did not work together.

Question 5: In the experiences reviewed, what role has been played by health systems at the local and/or state level? Has this role gone beyond medical care towards a renovated and expanded primary care? Have health systems and services been used to provide a platform for more comprehensive and intersectoral action to improve population health? What level of involvement and synergies must exist with health systems to maximize health and human security?

Consensus was that very few examples presented could be analyzed by the group further for the involvement of the health system. On a broader level, the role of the Health System was suggested to be at two levels:

a. At state level- role to regulate- set policies related to protection of people against threats- propose empowerment strategy to build capacity at local/state level
b. At local level- ID priorities based on local context, local health system may require transfer of knowledge- need to understand the environment

Pan American Health Organization

110th ANNIVERSARY

JCIE

Regional Meeting on Health and Human Security

Preliminary Agenda **Strategic Planning Meeting**

Saturday, 8 September 2012

Hotel Melia Lima

Co-hosted by the Pan American Health Organization/World Health Organization (PAHO/WHO) and the Japan Center for International Exchange (JCIE) with the support of the Japanese International Coordination Agency (JICA)

Objectives: ▪ *To discuss next steps*

9:00-9:15	**Opening Comments** Carlos Santos-Burgoa, Senior Advisor , Human Security, PAHO/WHO Keizo Takemi, Chair, Global Health and Human Security Program, Japan Center for International Exchange (JCIE) Moderator: Susan Hubbard, Senior Associate, JCIE
9:15-9:30	**Milestones: Visualizing the future**
9:30-10:00	**What should we aim for in the short and long term?**
10:00-10:30	**Where do we stand now?** • **findings from Dakar and Lima seminars** • **case studies**
10:30-12:00	**How to move forward with the case studies and guidelines?** • **templates** • **site visits** • **schedule** • **division of labor**
12:00-12:30	**Follow-up on the Lima meetings** • **website and network** • **next meeting**

Please visit www.paho.org/healthandhumansecurity and http://www.jcie.or.jp/cross/globalhealth/index.html for more information

Case Study Presentations

Seguranca Humana

São Paulo, Brazil

Seguranca Humana was started in August of 2008 to address human security issues throughout São Paulo through actions in education, health and community. The project combines empowerment of communities, families and individuals with efforts to inform policy and encourage participation among local government, civil society and community members. The initiative has resulted in improved health and greater health seeking behaviors, strengthened community networks and better equipped schools.

Education oriented intervention to improve resilience and empowerment of children and adolescents and their families (MARIPOSA)

Mexico

This project, based in Mexico focuses on development, community integration and educational for children and families. Its participatory approach, driven by meetings of individuals, families and children, allows annual changes in program offerings as determined by the community and aims to help residents address the most pressing issues they face, including violence, mental health issues and insecurity.

Joint Program: Indigenous and Afrocolombian Communities of Chocó Promoting Food Security and Nutrition.

Chocó Colombia

This project was started in 2009 and works with local communities to improve economic, social and cultural conditions in indigenous and afrocolombian populations as well as to improve food and nutritional security for children and breastfeeding or pregnant mothers. The program uses an innovative community based model to empower community members and strengthen the capacity of local institutions.

Alliance for Nutrition

Cajamarca, Peru

This program to reduce chronic malnutrition was initiated in 2008 and aims to address the persistence of chronic child malnutrition, acute diarrheal diseases, acute Respiratory Infections, prevalence of water unsafe for human consumption and food insecurity. The program aims to strengthen administrative groups and uses community committees and monitoring to ensure goals are being reached. The project has resulted in decreased malnutrition, diarrheal and respiratory disease rates.

Reduction of Vulnerabilities to Contribute to Rural Development in five municipalities in the watersheds of rivers in the department of San Marcos

Guatemala

This three year program, in the San Marcos department of Guatemala works to reduce vulnerabilities in health and community and to create opportunities for rural population with a focus on gender and cultural relevance. Areas of work include improved water resource management and access to safe drinking water, maternal health, as well as capacity building of local government and civil society.

Bamboo Method

Pernambuco, Brazil

This project was launched in Pernambuco, Brazil, in December 2003 and is ongoing. Community leaders are trained to facilitate workshops to identify needs in their communities as well as existing resources for addressing the needs from within the community. The idea is to enhance the dignity of the community members and the sustainability of their efforts by identifying their own strengths and applying them to solutions rather than depending on outside assistance. The initiative has resulted in higher incomes in the project areas, increased health awareness and subsequent behavior change, and environmental improvements.

FORSA Model

Santa Cruz, Bolivia

This model was developed in 2001 and has been implemented in numerous other places. It is now being implemented in Santa Cruz, Bolivia. The model aims to enhance community-based health promotion activities by training facilitators to participatory workshops in their communities on health promotion. The project has contributed to an improvement in the health-related quality of life in the communities that have taken part.

Chagas Disease Control Project

Nicaragua

This project was launched in 2009 in Nicaragua and is ongoing. The project aims to mobilize people in communities where Chagas disease has been a particular problem to recognize the insects that cause the disease and the kinds of environments where they are likely to thrive and to alert health personnel when they find suspicious bugs so that they can initiate spraying to prevent transmission.

Posters being Presented

Project Green and Healthy Environments (PAVS)

Sao Paulo, Brazil

The PAVS project aims to promote health, design and build healthy places and sustainable places. The project was developed to strengthen the efforts of public managers in the construction of an agenda for health and environment with integrated approach for developing environmental health policies, guided by the performance of an intersectoral project, interdisciplinary participation and several actors and co-management. PAVS educators and Community Health Workers have been incorporated into Primary Care programs and the project is now coordinated by the Municipal Secretariat of Health.

Economic Governance in Water and Sanitation

Honduras

This project, started in 2008, focuses on National Policy on water and sanitation, capacity building for monitoring water quality, water safety plans and solid waste inventories. The project works on technical ability, financing and logistics to keep ensure that achievements are sustainable.

Annex 9 – ***Health and Human Security in the Americas: A Review of Cases***

September 2012

HEALTH AND HUMAN SECURITY IN THE AMERICAS: A REVIEW OF CASES

Report Prepared for Health and Human Security Regional Meeting | Lima, Peru

Pan American Health Organization
Regional Office of the World Health Organization

110th ANNIVERSARY

JCIB

SURVEY OF HEALTH AND HUMAN SECURITY CASES IN THE REGION OF THE AMERICAS: PRELIMINARY RESULTS[1]

This report presents preliminary findings from an exercise aimed at better understanding the pertinence and value added of the human security approach to health in the Americas. This collaborative effort with the Pan American Health Organization is part of a larger project, launched by the Japan Center for International Exchange, to explore the application of human security approaches in the health field in Africa, Asia, and the Americas. Researchers in all three regions are gathering information from existing initiatives that employ at least some of the following principles of human security in their approaches to improving the health of their populations :

1. Involve the target community as the key actors in identifying needs, designing and implementing solutions, and monitoring and evaluating progress.

2. Address the root causes of insecurity at the community level.

3. Acknowledge the interconnections among multiple threats affecting a community's lives, livelihoods, and wellbeing and design responses that address those interconnections.

4. Integrate top-down Protection approaches with bottom-up Empowerment strategies.

5. Aim ultimately to build the resilience of target communities to existing and future threats.

Human security is by its nature multisectoral and multidisciplinary. As such, it may appear counterintuitive to explore its value added through the perspective of just one field, in this case health. Therefore, this project looks at health as an entry point to better understanding human security and explores the way a human security approach allows health-related initiatives perspectives to contribute to addressing some of the other most pervasive insecurities that affect the region of the Americas, such as basic water and sanitation, environmental degradation, malnutrition, occupational hazards and labor risks for children, the many challenges faced by the informal sector, inadequate housing and unplanned urban and metropolitan growth, limited social protection and access to health, and pervasive violence. All of these are particularly pertinent to such vulnerable populations as children and youth, women, and elders.

Pursuant to the Pan American Health Organization/World Health Organization (PAHO/WHO) Resolution OPS CD50.R16 on Health, Human Security and Well-being, on developing guidelines for policy and implementation of interventions, the project researchers reached out to policymakers and practitioners through to PAHO/WHO network to identify community-based health interventions, which by their similarity to the concept of human security, are exceptional examples for the application of a health and human security approach. The identification of the initiatives described in this report allows for further analysis of the value added of this approach in the region and beyond.

[1] This preliminary report has been prepared only for the Seminar on Health and Human Security held in Lima, Peru on September 6th, 2012.

In the region Health has just recently identified itself as playing a key role on human security local projects. but several local projects closely contain elements that illustrate how human security can be improved with an entry of the local prctice to the local practice. In May 2012, the researchers designed two instruments to identify examples whose approach may resemble and gives the opportunity to learn from the practical reality the challenges, solutions and feasibility.

A. Initial Screening of Cases to Be Included in the Study

The first one was a screening tool with the goal to identify promising examples and identify as many possible initiatives using the criteria for selecting cases to apply the second instrument:

I. The interventions should be community-based, public health actions that meet most of the following criteria:

1) Address any solution(s) for the most widespread and pervasive insecurities affecting a population, such as water and sanitation, environmental threats in relation to exposure to toxic substances, nutritional insecurity, extreme poverty, job insecurity and occupational hazards especially for children, the informal economy, insecurity in housing, unplanned urban growth, risk of injury, destruction of social structure, limited social protection in health, widespread violence, etc.

a) Address one or more of these

b) Address their interrelations

2) Integrate

a) Various stakeholders and approaches at the local level

b) The dual action of empowerment approaches for individuals, families and communities on the one hand and protection and service provision by the public sector on the other

c) Health sector interventions as a central pillar of activities

3) That is linked to primary health care (preferably extended)

a) With community participation

b) Resulting from inter-sectorial participation (government, private sector, OSC, professional associations, community leaders, etc.)

II. The interventions should also preferably meet some or all of the following criteria:

1) Seek to develop the capacity for increasing social capital and rebuilding the social fabric

2) Pose solutions to local problems that generate a sense of belonging, promote resilience, and are sustainable

3) Promote capacity building for individuals or communities to make better-informed decisions about their health

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4) Have an evaluation component

5) Have the possibility of promoting the exercise of governance and the use of instruments to promote targeted and consistent responses to the social context in which they apply

6) Engage a leader in the intervention who can be linked with the project and to the broader process of developing better human security approaches to health

B. Template format

A second instrument was designed and applied: a template format to obtain more specific information about the initiatives that were identified through the application of the screening format. Both instruments were piloted and revised based on the pilot test results. Data was collected via the questionnaires, website reviews, and personal and teleconference interviews with those who are responsible for the selected initiatives. The design of this format was a joint contribution with the African and Japanese researchers.

Results of Screening Process in the region of the Americas

PAHO/WHO representatives in 27 countries and the Caribbean program coordinator were contacted with requests for cases. The United Nations Trust Fund of Human Security and the Japanese International Cooperation Agency also provided sources for case studies In response, 29 initiatives were received from 11 countries, distributed as follows: 4 in South America (Bolivia, Brazil, Colombia and Peru), 5 in Mesoamerica (El Salvador, Guatemala, Honduras, México, and Nicaragua) and 2 in the Caribbean (Haiti and Dominican Republic).. Table 1 shows the distribution of initiatives by country.

TABLE 1 RELATION OF COUNTRIES AND NUMBER OF PROPOSED INITIATIVES

COUNTRY	INITIATIVE 1	INITIATIVE 2	INITIATIVE 3	INITIATIVE 4	INITIATIVE 5
BOLIVIA (1)	Adolescent: Empowerment and Protection against Violence, Early Pregnancy, Maternal Mortality and HIV/AIDS				
BRASIL (2)	Green and Healthy Enviornments in the City of Sao Paulo	Improvement of Human Security in the City of Sao Paulo through Humanization Actions in Public Schools, Health Services and Communities.			

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COLOMBIA (2)	Promoting food and nutrition security on " Indigenous and Afro-Colombian population at Chocó	Improving the Human Security in vulnerable populations in The community of Soacha			
EL SALVADOR((3)	Prevention of Mortality and morbidity due to Road traffic injuries	Approval and implementation of the anti tobacco law in El Salvador	Support to the ministry of Health at the E12 emergency		
GUATEMALA (1)	Reducing vulnerabilities to contribute to rural development in five municipalities in the watersheds of rivers and Alto Coatán Suchiate				
HAITI (1)	Medical Waste Disposal and Management				
HONDURAS	improvement of human security and reducing vulnerability, protecting and empowering indigenous people of Western side of the country	Economic Governance in Water and Sanitation	Joint Program for the Support of Human Security in Honduras		
MEXICO (5)	Prevention of Violence and injuries in the cities of the United States-Mexico border	Resilience and empowerment of children adolescents and their families at the	La Casita del Agua, promotion of responsible and efficient management	Maternal House LARRAINZAR	Cooperation between the Government and PAHO / WHO for

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		Ajusco	of water		Healthy Housing	
NICARAGUA (2)	Reduction of Human Insecurity in Alto Wangki Bocay Nicaragua	JICA Chagas disease control project				
PERU (6)	Natural Disasters in Peru: from Damage Limitation to Risk Management and Prevention	The only opportunity: Human Security for the Development of Women and Children in Peru	Strengthening the Agenda for the Decade of Action for Road Safety in Peru	Nutrition Alliance en Cajamarca	Health and sustainable agriculture: Irrigation for malaria vector control at the North Coast	Control human cysticercoids through an integrated community management of pig production and products
o REPUBLICA DOMINICANA (3)	Nutrition applied and HIV in Boca de Maio	Nutrition applied in Pinzón	Improving Human Security in the Bateyes of the Dominican Republic by Securing Documentation and Ensuring that Vulnerable People´s needs are met			

As identified in table 2, most of the initiatives were started through top-down approaches (protection) with the following general characteristics:

- The initiatives are promoted by organizations and institutions that work in their respective fields to protect people from critical and pervasive threats.
- They recognize that the threats people face are beyond their control.
- They recognize that dealing with the threats requires protecting people in a systematic, comprehensive, and preventative way and includes the establishment of the rule of law, good governance, accountability, and social protection instruments.

Only four of the initiatives were initiated as bottom-up approaches (empowerment), three from México and one from Brazil. In other words, the relevant communities made demands for the initiatives to address the pervasive threats that they face. They had the following general characteristics:

- The initiatives emphasize enabling people to develop their resilience to difficult situations.

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•They aim to develop the capabilities of individuals and communities to make informed choices and to participate in solutions that not only ensure human security for themselves but also for others, such as those in the health field.

TABLE 2 TYPE OF ORGANIZATION THAT PROMOTES THE INITIATIVE, BY COUNTRY

COUNTRY	ORGANIZATION PROMOTED
BOLIVIA	UNTHFS
BRASIL	UNTHSF, ICLEI-Gobiernos Locales por la SusT. (http://www.iclei.org/index.php?id=469) consultado el 19 de Julio 2010
COLOMBIA	PNUD, UN, PMA, FAO, OPS, UNICEF
GUATEMALA	PNUD,FAO,GOBIERNO DE GUATEMALA
ELSALVADOR*	
HAITI*	
HONDURAS	FAO, PMZ, UNICEF, OPS
MEXICO	Fundación Comunitaria Morelense, Fundación Justicia y Amor, Gobierno Federal y Gobiernos Estatales y Municipales (México) OPS http://www.todossomosjuarez.gob.mx/ consultado el 19 de Julio
NICARAGUA	UNTHFS
PERU	UNTHFS, CDC.USAID, BILL and Melinda Gates Foundation
REPUBLICA DOMINICANA	UNTHFS, OPS, INCAP, SS (Red de promotores comunitarios)

*The information provided during screening is not sufficient to identify the organization promoting it.

The screening tool helped the PWR to pinpoint the projects that would be a better fit with the criteria developed by the researchers, and table 3 maps out the results of the screening process in terms of the extent to which the criteria included at the screening format were satisfied. Two of the initiatives are not covered in the analysis because they were judged not to have met enough the criteria to be considered as a case study.

TABLE 3 DISTRIBUTION OF THE 29 INITIATIVES ACCORDING TO THE ANSWERS AT THE SCREENING FORMAT

Criteria	Component	Criteria Satisfied Yes	%	No	%
Addresses widespread insecurities					
	Addresses one or more of these	29	100		
	Addresses their interrelations	25	85	4	15
Integration					
	at the local level	29	100		
	With dual action of empowerment of individuals, families and communities	28	96	1**	4
	With cross-protective actions by the state	24	80	5	20
	Which have a central role the health sector	25	85	4	15
Links with primary care					
	Extended Primary Care	28	96	1	4
	Community Participation	28	96	1**	4
	Intersectoral	28	96	1	
In Addition					
	Increases social capital	21	73	8	27
	Rebuilds social fabric	17	59	12	41
	Pose solutions to local problems that generate a sense of belonging, promote resilience, and sustainability	29	100		
	Build capacity to make better informed decisions about their health	27	93	2	7
Promote the Exercise of Governance According to the Social Context		23	83	6	17
The manager or leader of the intervention / project is:					
	Clearly identifiable	29	100		
	Has the capacity to discuss methodically in an international forum (in their native language)	29	100		
	Able to continue to link the development of human health and safety	29	100		

Table 4 lists the most pervasive threats that were listed as being addressed by the initiatives on the templates, suggesting that these are key threats to be confronted using a human security approach to health. The most frequents threats cited were violence, food insecurity, poverty, water, and environmental problems. Eight of them are ongoing and the remaining six are already finished.

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TABLE 4 *Relation of initiatives by country according to pervasive threats and stage of development (Includes only those initiatives (17) that sent their template formats at the middle of August)*

COUNTRY	PERVASIVE THREATS	STAGE OF THE INITIATIVE AND FUNDING ORGANIZATION
BOLIVIA	Violence, early pregnancy, maternal mortality and HIV/AIDS in adolescent population	**FINISHED** (JULY 2008-SEPT 2010) WHO/PAHO; UNFPA; UNICEF
BRAZIL	Human insecurity in the City of São Paulo on different settings	**FINISHED** (August 2008 - July 2011) PNUD, UNTHFS, PAHO, UNICEF Municipal secretariats of Education, Health and social welfare and development, and NGO´s municipality of São Paulo
	Poverty, Environmental degradation and displaced population	**IN PROCESS** Gestión descentralizada y compartida entre los representantes de las secretarías, las instituciones asociadas del PSF/SP, el equipo de salud de la familia, instituciones de PAVS, los administradores locales y regionales
COLOMBIA	Food insecurity on indigenous and minorities population	**IN PROCESS** SPAIN GOVERNMENT, UNTHFS PMA, FAO, PAHO, UNICEF, PNUD.
GUATEMALA	Poverty in high marginalized rural settings	**IN PROCESS** CURRENTLY FINISHING SECOND YEAR. SUEEDEN COOPERATION AGENCY (ASDI) PNUD,FAO,GOBIERNO DE GUATEMALA
HONDURAS	Violence in vulnerable population (young adolescents)	**FINISHED** (June 2008-February 2010) UNDP; UNICEF; PAHO/WHO; FAO; UNFPA and UNV
	Poverty, environmental problems , water sanitation	**FINISHED** (JULY 2008 JUNE 2011)

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		Fondo SNU España PNUD) Y Fideicomiso Multidonante FFMD
MEXICO	Water supply and sanitation, food safety in a community with high level of marginalization	**IN PROCESS** Fundación Comunitaria Morelense, NGO
	Violence, poverty and Mental health of children adolescents and families living in a high risk settings	**IN PROCESS** Fundación Justicia y Amor, NGO. Fundación QUIERA, A.C. Fundación SERTULL AND LUZ SAVIÑON.
	Violence on border settings	**IN PROCESS** UNTIL DEC 2012 (SECOND PHASE) USAID, WHO/PAHO Gobierno Federal y Gobiernos Estatales y Municipales (México)
PERU	Poor health and education in vulnerable population (child, adolescents and women)	**FINISHED** (January 2007 to September 2010) UNTHFS, UNFPHA, UNICEF, WHO/PAHO
	Natural disasters	**FINISHED** (JUNE 2006 TO MARCH 2009) PNUD; UNICEF; FAO; OPS; PMA
	Health and Malaria vector control	**IN PROCESS** USAID and PAHO
	Health and Cysticercosis Control	**IN PROCESS** Bill and Melinda Gates Foundation
REPUBLICA DOMINICANA	Food insecurity and AIDS	**IN PROCESS** UNTHFS, OPS, INCAP, SS (Red de promotores comunitarios)
	Poverty, migration, natural disasters	**IN PROCESS** PAHO

Table 5 shows the distribution of received screening formats by country and of them, those who send the template format , according the pervasive threat that they are trying to address with the proposed initiative. Violence, Poverty, rural, displaced population, Health, food insecurity water supply and sanitation are the most frequent insecurities mentioned as the issues to solve through the proposed initiatives There is a distribution of almost 50% for rural settings

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TABLE 5 NUMBER OF INITIATIVES RECEIVED AND WITH COMPLETE TEMPLATE FORMAT BY COUNTRY AND PERVASIVE THREATS ADDRESSED

COUNTRY	NUMBER OF INITIATIVES	TEMPLATE COMPLETE	THREATS
BOLIVIA	1	1	Violence, early pregnancy, maternal mortality and HIV/AIDS in adolescent population **Urban setting**
BRASIL	2	2	Violence, Poverty, Environmental degradation and displaced population. **Urban settings**
COLOMBIA	2	1	Food insecurity on indigenous and minorities population **Rural setting**
EL SALVADOR	3		Health Injuries, natural disasters **Urban setting**
GUATEMALA	1	1	Poverty in high marginalized **Rural settings**
HAITI	1		Natural disasters.**Urban Settings**
HONDURAS	3	2	Violence In vulnerable population Poverty, environmental problems , water sanitation. **Rural settings**
MEXICO	5	3	Water supply and sanitation, food safety in **Rural settings** Violence, poverty and Mental health in a high risk **Urban settings** Violence on **border cities México USA**
NICARAGUA	2	1	Health problems vector transmitted (Chagas) in vulnerable and poor settings **Rural settings**
PERU	6	3	Health and education in vulnerable population Health problems vector transmitted (Malaria, and cysticercoids) in poor and **Rural settings**
REPUBLICA DOMINICANA	3	3	Food insecurity and AIDS **Rural settings** Poverty, migration, and natural disasters **Urban settings**
TOTAL	29	17	

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PRELIMINARY LESSONS FOR HUMAN SECURITY

It is important to point out that with the number of initiatives analyzed we were not looking for a representative sample of the initiatives underway in the field of human security in the Americas, either for a complete census or representative sample of studies, but to identify notable experiences that could help us illustrate the challenges, historical and social background and possibilities of the region Rather, we sought to identify experiences that provide useful illustrations of the application of this approach to specific cases, in different contexts, different sub-regions, and different threats..

The analysis presented on this document refers to those initiatives received through various sources, identified at a given point in time, as examples of the field of health and human security. However, having reviewed the initiatives, it is clear that all of them responded to threats to human security and to people's real needs. The major difference among them is the type of body organization from which they emerged, either the government or organized civil society. As such, they can be grouped into the following four categories:

a) Those that emerged as a result of government action (top-down) at the national level, or that was initiated by international organizations, with clear strategies for promoting the concept of human security as a way of confronting various threats facing the population. These bodies have the resources needed to support implementation, so their operation depends on these resources being awarded during a given time. This raises a concern about how those that already completed will be able to ensure the sustainability of the initiatives that are generated in this manner. (UNTFHS, UNFPHA, PAHO, etc.)

b) Those that were generated through the action of civil society with local needs identified by the target population (bottom-up). Initiatives that fit in this category have sought various sources of financial sustainability and have been able to stay on target. Since these initiatives were born out of empowerment exercises, their implementation more naturally promotes the activities of the population. (Casita del agua, PAVS, Ajusco and Juarez)

c) Those that emerged as reactions to emerging crisis situations (e.g., natural disasters) and that seek to address very specific issues, such as the Haiti initiative and initiative on road safety in Peru. None of these cases met the criteria to be considered a human security approach.

d) Those generated as a result of the displacement of populations to a new social, economic, or cultural context, which further impacts people who are already dealing with other threats, and compounds existing threats in the communities to which they are being displaced. (Bateyes case from Dominican Republic)

In general, health threats were not the triggers for launching of the initiatives. Rather, health-related activities were incorporated as elements of the initiatives, having been identified as a cause or consequence of other threats.

The most frequently identified threats outside the health field are those that deal with the consequences of poverty, translated into food insecurity, structural violence, family violence, environmental degradation, migration, and forced displacement.

In the health field, the identified threats range from malnutrition, zoonotic diseases, mental health problems, infectious diseases, AIDS, early pregnancy, etc., to those that focus on quality of and access to health services, and primary health

The inter-sectorial component is very easy to identify in initiatives arising from top-down approaches, as this is a common concept in the formal structures of government. However, initiatives emerging from the bottom up included NGOs in their activities, and the most frequent interrelations were with academia and the health sector.

The identification of key actors depends on the type and origin of the initiative. However, all of the analyzed initiatives demonstrated the important role that local authorities and leaders of civic organizations have on implementation of the initiatives.

Unfortunately, few of the initiatives have done evaluation reports. The few cases that have considered evaluation did not include impact assessments, in terms of an increase in the welfare of the population, decrease of poverty, violence, etc., or the corresponding indicators. This is a task that in the short term should be included as one of the challenges to be resolved in current and future initiatives on human security.