



Unit 11

Addressing the social determinants
of health through a program on
social and economic rights (POSER)

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Cover photo: A student receives school supplies from the POSER program in Malawi



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“The children in our education program are literally transformed—they become more confident and develop personal and professional goals that were previously unattainable.”

– Presler Jean, Director of Adolescent and Adult Learning at Zanmi Lasante, PIH's sister organization in Haiti

INTRODUCTION

While health is identified as a right in many international human rights documents, it is also one component in a category of intersecting and interdependent rights known as economic, social, and cultural rights (ESC rights). A body of scholarship identifies the link between these rights and health as the social determinants of health.¹ In resource-poor settings, the social and economic factors at the root of much disease and illness are often obvious, evident in disparities that increase disease risk for those who are poor.² These disparities result from “a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics...and are responsible for a major part of health inequities between and within countries.”³ Expanding healthcare program objectives to include social and economic activities, provisions, and resources may improve health outcomes in the community in the short term as well as the long term. Initiatives to address these broader problems can include, among other activities, education, nutrition, housing, water, and community economic development.

¹ Marmot, M. & Wilkins, R.G. (eds). (2005). *Social determinants of health*. 2nd ed. New York: Oxford University Press.

² Farmer, P. (2003). *Pathologies of power: Health, human rights, and the new war on the poor*. Berkeley, CA: University of California Press.

³ World Health Organization. (2008). *Closing the gap in a generation: Health equity through action of the social determinants of health*. Geneva: World Health Organization. Retrieved online at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

This unit discusses how a program or initiative on social and economic rights can be a part of your healthcare delivery system to specifically address patients' basic social and economic needs. Such a program differs from a development project in that it is an integral aspect of patient care, with the goal of improving patients' health. The program can comprise one or a range of economic or social activities, and will depend on the most important social and economic needs in your community, the local context, and available resources. The activities may change with the circumstances of the population you serve. Being flexible in your response to evolving economic and social situations will allow your organization to more effectively respond to acute challenges such as, for example, flooding and other natural disasters, migration, or violence. How you adapt economic and social initiatives to your healthcare delivery services will require you to consider the context in which you work and other factors that may go beyond the ideas and examples outlined in this unit. Most governments recognize that addressing social welfare is a central part of their mandate. It is therefore important that the programs you develop are integrated into community-based initiatives and government programs. Working collaboratively with the public sector and with the community, and in solidarity, also helps to ensure that your program strategy is aligned with local priorities and concerns.

While other organizations involved in global health care have similar programs and initiatives, this unit describes the basic components of a healthcare initiative that PIH has developed, in many different forms, within what we call POSER, an acronym for a program on social and economic rights. The focus is on examples from PIH-supported sites and the different ways we have approached the problems that contribute to disease in settings of great poverty. As our core abilities are in healthcare delivery, PIH works with partners, organizations who are expert in their sectors and with local communities, to help design and run our POSER programs.

1. WHY POSER?

Unlike the 1948 Universal Declaration of Human Rights (UDHR), which is a consensus document that has no legal power of enforcement, both ESC rights and civil and political rights are encoded in respective international covenants, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR).⁴ Countries that sign these two covenants are legally bound to comply with them or face international criticism, sanction, and potential corrective intervention.

⁴ ESC rights are encoded in *the International Covenant on Economic, Social and Cultural Rights*, G.A. res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 49, UN Doc. A/6316 (1966). Retrieved online at: <http://www2.ohchr.org/english/law/cescr.htm>. For civil and political rights, see the *International Covenant on Civil and Political Rights (ICCPR)*, G.A. Res. 2200A (XXI), Art. XX, (1966). Retrieved online at: <http://www2.ohchr.org/english/law/ccpr.htm>.

The ICESCR affirms the right of all persons to six basic economic, social, or cultural rights: adequate housing, education, food, social security, decent work, and “the highest attainable standard of physical and mental health.” For each of these rights, the respective United Nations Committee has issued General Comments that serve to interpret these standards as they affect each country’s obligation to ensure that people’s rights are realized in practice. The right to health is interpreted in the United Nations’ Committee on Economic, Social and Cultural Rights General Comment 14.⁵

By grouping together the human rights to housing, health, education, food, social factors that provide security, and work, the ICESCR implicitly recognizes that these six elements are intersecting and interdependent. The idea that health depends on one’s culture and environment as much as (and often more than) it depends on the internal physical factors of disease risk has led to an extensive body of work about what are usually called the social determinants of health. (See *Resources* at the end of this unit.) As health is strongly influenced by circumstances in one’s environment, effective health care should also include treatment that addresses the problems in these areas, including housing, education, and employment, even though they do not traditionally fit into the common view of health care. By expanding your program’s focus to include the broader spectrum of social and economic rights in the way you address health in your community, your organization sharpens and substantially strengthens its potential for improving health outcomes and enhancing the overall quality of life in the area that you serve.

POSER programs may challenge some commonly held ideas about what it means to provide health care. For example, treating a sick and very poor patient who lives in substandard housing by building him or her a new house may not seem appropriate work for an organization delivering health care. However, this patient’s ill health may be directly related to the poorly ventilated and overcrowded house he or she lives in. POSER programs recognize that the realization of health as a human right requires economic and social action to address the factors that most severely affect illness and disease in the local community.



Figure 1: POSER programs at Zanmi Lasante in Haiti provide support to patients and their families

The next section draws on examples from PIH-supported sites to illustrate some of the many ways POSER programs might work. Understanding what such programs can and do look like in practice, what challenges they face, and how they can impact individual and community health may make it easier for you to plan a POSER program that will fit the community you serve. (See *Section 3, Planning the program.*)

⁵ Committee on Economic, Social and Cultural Rights, General Comment No. 14, *The Right to the Highest Attainable Standard of Health*, UN Doc. No. E/C.12/2000/4 (2000). Retrieved online at: <http://www.unhcr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En>.

2. POSER PROGRAM COMPONENTS

The POSER programs at PIH-supported sites include projects and initiatives that address economic barriers to accessing health care, education, housing, water and sanitation, as well as microfinance and agriculture. The examples in this unit reflect initiatives that have developed slowly, over a number of years. A small or newly established organization may only be able to implement a small selection of activities. The activities that comprise your POSER program will emerge from your collaboration with the local community and partners.

2.1 Reducing economic barriers to accessing health care

As an organization that provides health care, your setting may lead you to prioritize POSER interventions that are based on services that have a more specialized or direct impact on patient care. Eliminating user fees for healthcare services and/or expanding exemptions from payment of fees is one way to increase access to care, especially in settings where the burden of poverty and disease are greatest. PIH works to ensure that cost does not prevent access to primary health care for the poor. The PIH-supported site in Lesotho, for example, eliminated user fees at Mamohau Hospital after agreeing to support the facility with the Government of Lesotho and the Christian Health Association of Lesotho. In just two days, the number of patient visits per day more than tripled, from 55 per day to 175 per day. At the PIH-supported site in Rwanda, everyone must pay an annual fee to a national health insurance program. However, to ensure that all who need access to care are treated, the poorest in the communities and those infected with HIV have their fees covered by PIH. The poorest people who cannot pay their fees are identified by village-level assemblies, and, among those who are selected, priority is given to the oldest people, the orphans, widows, and widowers.

You may choose to fund specialized economic or social services such as transportation costs to the clinic, clothing or shoes for those who have none and must walk long distances to seek care, or childcare for parents who must be hospitalized. Even when medical care is available free of charge, these needs often pose barriers that can prevent people from accessing health care. Evaluation for these and other needs may be the role of social workers in discussion with clinical teams. Many beneficiaries of these services are likely to be widows and other vulnerable women who are enrolled in health programs, as well as orphaned children and other children living with or affected by HIV/AIDS. Offering solutions that overcome obstacles in access to care and adherence may result in improved health outcomes for the most vulnerable populations in your target area.

2.2 Educational support

Recognizing that access to education is essential to breaking the cycle of poverty and improving health, payment of school fees and provision of school supplies and uniforms can be an important part of a POSER program.⁶ When possible, as in the PIH POSER programs in Rwanda and Malawi, providing school supplies and uniforms helps to support the

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⁶ On the role of education in improving health in resource-poor settings, see *Resources* at the end of this unit.

government policy of free primary education. If you choose to include education in your POSER program, you will need to decide very early what and how many education-specific ingredients you will provide. For example, you may consider paying school fees beginning in preschool and up through secondary school, depending on the local circumstances.

A POSER program can also support much needed renovations and refurbishments to local schools, and provide classroom materials, furnishings, as well as salary supplements to underpaid community school teachers. While PIH does not make its support contingent on students' performance, other programs that connect health with educational resources often do include a conditional cash transfer.⁷ A "school fees package" might fund a number of the most essential items that will help children to attend school. Depending on the setting, these may include:

- tuition payment
- school uniforms
- shoes
- pens
- pencils
- notebooks
- backpacks

If you include an education component in your POSER program, you may need to decide whether to focus support on primary or secondary school. In many countries primary school is free (in principle but often not in practice), while secondary school frequently requires fees. Even if education is free, the need for school supplies and uniforms can serve as a major barrier to a student's ability to attend regularly enough to complete the program and graduate with the appropriate level of skills. Therefore, it is important to understand the local obstacles to education experienced by the community in developing this aspect of your POSER program.



Figure 2: A classroom of elementary school students in Rwanda, where the first nine years of education are free

⁷ One well-known example is that of Mexico's Oportunidades conditional cash transfer program. For more information on this program and its interrelated health and education components, see http://www.oportunidades.gob.mx/Portal/wb/Web/oportunidades_a_human_development_program. The program's evaluation process is summarized at: <http://evaluacion.oportunidades.gob.mx:8010/en/index.php>.



At Abwenzi Pa Za Umoyo (APZU), the site in Malawi, PIH provides primary school students with essential items, including school uniforms, shoes and writing materials, while also paying school fees for a smaller number of secondary school students. This choice was made because of low completion rates in primary schools. Although enrolling in primary school is free in Malawi, children need to have uniforms to attend, so those who are too poor to afford the uniform do not go to school. Paying for the cost of the uniform is a small investment with a big impact. In contrast, at Inshuti Mu Buzima (IMB), the PIH-supported site in Rwanda, PIH focuses more on secondary school in order to address the problem of low attendance: only a small minority of those enrolled in primary school go on to secondary school, largely due to the cost and economic demands on older children. Increasing access to education may also have an impact that goes beyond immediately tangible results: in Rwanda, education also builds reconciliation as children of all backgrounds study side by side.

Navigating the educational system in different contexts may also present a challenge to determining the best way to serve the needs of the children (and adults). In Rwanda, for example, the school system includes both public and private schools, which charge a range of registration fees and have varying enrollment requirements. Children are often moved between schools based on academic performance but they may not be able to pay for the full cost of the new school. After struggling to monitor the students’ progress, social workers at IMB in Rwanda increased their follow-up efforts for students who changed schools. Even then, however, the social workers found it difficult to track all of the students within the POSER program while fulfilling their other program responsibilities. Because they recognized the critical importance of education in health, the staff at the site decided to hire an education manager whose sole job would be to administer the school fee assistance program and evaluate students and their needs on a case-by-case basis. (See *Section 5, Staffing and funding the program.*)

2.2.1 Nutrition as part of education programs

Food is a basic right in the ICESCR, and the eradication of hunger and malnutrition has been an international concern for decades.⁸ Although nutrition programs are often organized and administered as part of clinical programs within a health care or community clinic setting, they may also be included in education programs. When nutrition is provided as part of the educational program, it is possible to reach children



Figure 3: Pupils in Haiti eating school lunches provided by Zamni Lasante

⁸ For the ICESCR General Comment on the right to adequate food, and the *Universal Declaration on the Eradication of Hunger and Malnutrition*, see *Resources* at the end of this unit.

with the essential resources of food who might not come to a health facility even though they lack necessary food for normal growth and development. This is a particularly important strategy since most supplemental nutrition programs tend to focus on the critical growth period of ages one through five, and school-age children over the age of five years may be overlooked.

One strategy for using schools to improve child nutrition is to provide a school lunch program in areas where children are at high risk of malnutrition. In Haiti, where the prevalence of protein-energy malnutrition is high, students are given a high-protein, low-cost, nutritious meal. Even though the meal is intended to be a supplement to the other foods that children are expected to eat at home or with their families, the school lunch program in Haiti is sometimes the child's only meal for that day. A team employed by Zanmi Lasante (ZL), PIH's sister organization in Haiti, provides oversight for the program across schools at each site's catchment area, and manages the monthly distribution of food to all schools. Local leadership at each school is responsible for storing and tracking food at each site, while local people are hired to prepare the daily hot lunches. In this way, the program also provides employment opportunities for the community.



TIP: *If you are initiating an education program, consider also the possibility of including a supplemental food program. This may improve children's health status and academic performance, and may also serve as an incentive for attendance.*

2.2.2 Adolescent and adult education

Many low-resource settings have high rates of adolescent and adult illiteracy—particularly among women. One innovative program at Zanmi Lasante in Haiti, run in collaboration with the Ministry of Education (MOE), focuses on literacy among adolescents who have never attended school. The curriculum was designed by the Ministry, but as the government of Haiti was unable to finance it, Zanmi Lasante worked with the MOE to put this curriculum to use. ZL runs a four-year program at its Centres Scolarisations, where it fills a critical gap. It enables these adolescents to finish their primary education by the time their contemporaries finish their conventional primary school. Like their counterparts in the traditional primary education system, they take the state certificate exam and can continue to secondary school. In Malawi, APZU has supported adult education classes through multiple community-based organizations (CBOs). They offer those who are willing to learn the opportunity to attend classes at their local CBO.

Providing adults with the opportunity to learn to read, write, and gain basic math competencies can also build marketable skills that open the doors to employment and increase self-esteem. For example, in Haiti, some graduates of adult education classes go on to participate in microfinancing programs that help them launch small businesses. In some cases, they work with our partners, such as Fonkoze, a micro-lending institution in Haiti, and are able to attain greater financial security.⁹ (See *Section 2.5, Microfinance* for more information.) In addition, adults who are literate are more likely to send their children to school and participate in their education.

⁹ Fonkoze is the largest microfinancing institution in Haiti. For more information, see <http://www.fonkoze.org/aboutfonkoze/whoweare.html>.



At Zanmi Lasante, hospital social workers identify those who want to learn how to read and write. The only requirement is that the person must be over 15 years of age and have low literacy skills. The government provides training manuals and all instructors must have prior teaching experience. At the end of the six-month program, students should be able to read and write their names. Their progress is evaluated twice during the course, once at the half-way point and again at the end of the semester. Despite the challenges—which include high absenteeism during the heavy rains or during the harvest so that students often take longer than six months to finish—the program is proud of its graduates. One patient in the Haiti adult education program who lived alone in the Central Plateau joined the program hesitantly and only after a visiting community health worker encouraged her to try it. Now she can read and sign her name, has been able to open a bank account and obtain a voting card, and is proud to tell her story to others in the community.

2.2.3 Vocational training

Vocational training provides people with a chance to improve their quality of life by building skills that can lead to employment opportunities. In resource-limited settings, formerly ill patients often lack opportunities for work even after they have recovered their health and are physically ready to support their families. At IMB in Rwanda, the PIH staff built a construction workshop on the grounds of Rwinkwavu Hospital. This workshop serves two purposes. First, it provides a place where local residents can build basic furniture and other equipment that hospitals and health centers need, keeping costs to a minimum for the facilities. Second, it offers vocational training for patients and others in the community. The program provides patients with HIV with six months of vocational training in carpentry and welding. Participants produce hospital beds, cribs, IV poles, crutches, desks, chairs, shelves, doors, and windows for the hospitals and clinics, while giving people the opportunity to learn and apply new skills. The POSER program at APZU in Malawi also includes training in woodworking and carpentry. Patients attend training sessions for six months, and after graduation they receive a set of tools and a small stipend with which they are encouraged to start their own business. Some participants form partnerships and go into business together.



Figure 4: The workshop at Rwinkwavu, Rwanda provides vocational training to patients and local residents



Figure 5: A woman in the POSER tailor project for HIV patients and guardians of HIV/AIDS orphans in Malawi

Sewing workshops provide another opportunity for patients to gain skills. At both the PIH-supported sites in Rwanda and Malawi, patients receive training on how to use sewing machines and learn to make and repair clothes. Participants in Malawi sew school uniforms, which PIH purchases for students in the education program (described earlier). Hospital uniforms are also made by patients and purchased by PIH, providing an income for participants and saving PIH additional procurement dollars.



PIH NOTE

An art center in Haiti's Central Plateau has been transformed from one symbol of hope to another. Before the January 2010 earthquake, the center was a place in which women could learn to sew, embroider, and crochet. It provided employment and income to the women, as well as a sense of community—a place for them to find companionship amidst their personal struggles. Now, after the earthquake has changed their country forever, women make use of the center as a place where they can help not only themselves but also earthquake victims who suffered directly. In response to the large number of people who lost arms, for example, the women at the center learned to make bags tailored especially for amputees. The bags are given to the survivors free of charge (PIH subsidizes the labor and materials), and are one way that women on the Central Plateau can choose to express their solidarity with earthquake survivors.

Other PIH POSER programs train people in knitting as well as traditional art and beading. At IMB in Rwanda and the PIH-supported site in Lesotho, people can make a living by producing and selling their artwork and jewelry; at APZU in Malawi and at Socios En Salud (SES), PIH's sister organization in Peru, knitting cooperatives provide women with the opportunity to learn life skills such as tracking household expenses while they help to support their families through the sale of their merchandise. The knitted goods are sold both in-country and, with the help of international partners, around the world.

If you choose to incorporate vocational and/or professional training into your plans for a POSER program, consider the local commercial needs and skills. Is there a need for carpenters? Tailors? Are there people who can train students in these skills, or will such a program require bringing in people who have this expertise from outside the community? While it may seem obvious, the training must offer a relevant and desirable skill that can lead to employment.

In planning skill-building programs that produce marketable goods, be prepared to address any special requirements that might be related to the anticipated scope



Figure 6: A woman in Peru embroiders and sells her work as part of an income-generation project for women recovering from MDR TB
Photo: Socios En Salud

of your sales, whether local, national, or international. If you plan to export any of the goods, such as jewelry or textiles, make sure you can deal with issues that could arise from shipping them to other countries for sale. You may need to consider customs regulations and costs, other fees or taxes, as well as the logistics of receiving payment from distributors and sending sales income back into your community to pay the artisans who created the product. You may want to connect with a group that specializes in marketing and selling developing country crafts as Zanmi Lasante did when it sold jewelry made by women's cooperatives in Haiti.

2.2.4 Additional teacher training

Once an educational program is established, you may be in a position to offer teacher training in schools with which you have partnerships. Teacher training workshops on health education can cover topics such as HIV/AIDS, hygiene and sanitation, reproductive health, and nutrition. The opportunity to partner with schools can also help you identify and access opportunities for prevention initiatives. For example, in collaboration with the Ministry of Health (MOH), staff at IMB in Rwanda initiated school-wide prevention education and voluntary counseling and testing for HIV/AIDS, as well as providing education about dental care, personal hygiene, and safe water use at local primary schools. This effort reached more than 10,000 children.

2.3 Housing

In resource-poor settings, many patients live in substandard housing. Poor housing conditions are one of the major contributors to high rates of infectious disease, especially tuberculosis (TB). While construction methods differ across climates and regions, many homes consist of mud walls, dirt floors, and thatched-roofs, which are typically damaged during the rainy season. These conditions, coupled with overcrowding create an environment that places individuals at high risk for infectious disease. This is particularly problematic for those who are immunocompromised, such as persons living with HIV/AIDS. You may choose to include in your POSER program a plan to prioritize the provision of stable, secure, and well-ventilated housing for those at greatest risk in your community.

A housing component that is part of a POSER program in a resource-poor country might have a number of points of similarity and difference when compared to home-building models familiar to volunteers from the United States (such as Habitat for Humanity, as one example). In a POSER program, housing is provided as a human right that is linked to essential provision of health care. Those eligible for housing assistance in the POSER program are selected on the basis of their extreme health needs and social and economic risk as it relates to disease rather than the more prevalent models that focus largely on economic development. (See *Section 4, Selecting and tracking patients.*)



PIH NOTE

Because substandard housing affects a patient's overall health, PIH provides housing support at all of the sites where we work. In some cases houses are completely rebuilt, while in others, renovations help to increase airflow and ventilation. Renovations also include replacing dirt floors with cement, adding extra rooms to an existing structure, and replacing thatched roofs with a waterproof substance such as corrugated iron. PIH staff members perform a home assessment for all patients who have HIV/AIDS and/or tuberculosis. During these assessments they also conduct home visits for others living in the area to identify households that may also benefit from the program. POSER assessments are conducted by a variety of professionals at PIH-supported sites. At APZU in Malawi, staff members whose work is dedicated specifically to POSER activities perform the assessment; at Zanmi Lasante in Haiti, community health workers and the site social worker take on this responsibility. A few of the basic criteria that are used to identify patients in greatest need of housing support include:

- *Patient has no roof or a roof made of permeable material (e.g. thatch)*
- *Patient had a mud or dirt floor*
- *House has no partitions to physically separate a very sick patient from rest of household*
- *House is in extreme disrepair*
- *More than six people live in one room*
- *More than three people sleep in one bed*

After thoroughly assessing the patient's living situation, the POSER staff can confirm specifically who has inadequate housing and give assistance that will improve their lodging. As a basic tenet in PIH POSER programs, priority is given to households that demonstrate the greatest need.

The amount of time needed to provide housing for selected POSER patients will depend upon the weather conditions and the location of the land. Transport of materials is often a significant challenge. Boucan Carré, a commune in Haiti where Zanmi Lasante has one of its sites, for example, is situated on a steep mountainside. While the road to the town itself is in good condition, the roads in the communities within the commune are particularly poor. The challenges of transporting materials—especially during the rainy season—often prolong construction activities.



Figure 7: A patient's former house beside its new replacement (right), provided by the POSER program at Zanmi Lasante, Haiti



TIP: *Include resources in your budget for regular vehicle maintenance in order to minimize construction delays that might be caused by transportation issues.*

Land rights may also be a concern in housing activities. If a POSER participant has land on which to build, the project can be quite straightforward. However, patients who do not own the land they live on will need land purchased for them before they can start to build or renovate adequate housing facilities. In some cases land purchase is simple, and title to the land is easy to obtain. In other places, however—particularly those with a history of civil unrest—obtaining land title can be a long and complicated process that requires extensive negotiations with government partners and private landowners. Such complications will generally increase both the time and funding required for completing a housing project. When constructing houses, it is also important to identify and respect any national building standards.



TIP: *Conflicts among neighbors over who will benefit from new housing can be ameliorated by sharing leftover construction materials with the whole community.*

Jealousy among people who do not receive a house or housing support through the program is another common challenge. If your program opts to include a housing initiative, you will need to ensure that clear criteria are in place to define the specific characteristics of those families who will be eligible for rebuilt homes. These criteria must be communicated widely across the community. POSER staff should inform the community about why certain people have been selected to receive a house, while not violating the privacy or confidentiality regarding the medical condition of the recipient, if applicable. Being an advocate for POSER beneficiaries, and minimizing any conflicts that POSER activities may provoke is part of the job of POSER staff. (See *Section 5, Staffing and funding the program.*) At IMB in Rwanda, it is the staff social work and community health teams who work closely with local officials in their patients' villages to develop a plan that ensures equity and complies with district housing standards.



PIH NOTE

After the Haiti hurricanes of 2008, many houses in Petite Rivière were completely destroyed. Of about 40 houses that had been literally built together before the hurricanes, POSER only had the resources to rebuild about a dozen houses. This caused much jealousy among neighbors who didn't receive help from POSER. To address this tension, social workers, POSER supervisors, Zanmi Lasante program staff, and Dr. Paul Farmer all took part in extensive visits and discussions with this community. At length, after much personal conversation to lessen the tension with the neighbors of those who had benefited from housing assistance, most people eventually understood why POSER could only afford to rebuild houses of patients who were very ill.

2.4 Water and sanitation

The lack of clean water and resultant burden of diarrheal disease in resource-poor settings may justify the development of water projects as part of your POSER program. Before embarking on any project of this nature, however, it is critical to find out what national standards exist and how they relate to international standards for water quality and access.



TIP: *Keep in mind that preliminary estimates for the local water needs in a given location may underestimate the actual need. Access to water improves when programs can ensure a level that, if possible, exceeds the minimum water requirements.*

Water projects can take many forms, and your most effective program initiatives will depend on the context in which you are working. (See *Unit 3: Building site infrastructure* for more information about increasing water supply.) If sufficient wells or boreholes do not exist in your catchment area, you may consider building these structures; be sure, first, that you obtain the advice of those who have the technical expertise and knowledge about the local environment. If water sources are locally available, are they potable? To evaluate water quality in your target area, local laboratories may donate their services or you can purchase reliable rapid tests online.¹⁰ If your organization does not have the technical skills, confer with an expert about the best way to assess the potability of the local water.

If your site has its own water source, will it always provide a consistent supply of water? Keep in mind, too, that water taps in some settings may not flow adequately during the dry season. If your site does not have sufficient access to a local source—if there are limited spigots or other access barriers or constraints—you may choose, perhaps as a pilot project, to increase the available access points. Find out, first, how the available access points are distributed throughout the local area. A community may have an acceptable overall ratio of water points for its population, but these water points (such as pumps or spigots) may be unequally distributed so that entire sections of the village do not have sufficient access to water.



PIH NOTE

In Malawi, the district where PIH works is divided into four Traditional Authorities (TAs). Although there is an urgent need for water throughout the district, the lack of clean water is particularly problematic in two TAs, Mlauli and Symon, the latter of which is the most populous TA in the district. The aquifers in this area have a high salt content, and boreholes that have been drilled are often abandoned because the water is too salty to drink. As a result, many community members rely on unprotected shallow wells, streams, or the nearby river as their primary water source. These surface water supplies are vulnerable to contamination from human and animal waste, which contributes to a high incidence of diarrhea and cholera relative to other areas in Malawi. PIH responded to this situation by focusing on 17 communities in Mlauli and Symon that had experienced recurring outbreaks of cholera and diarrheal diseases, as identified by the site's clinicians and community health workers. Over 800 people gained access to water when the POSER program built protected shallow wells outfitted with mechanical hand pumps for these communities.

¹⁰ For example, The All-In-One Home Drinking Water Test Kit. Retrieved online at: <http://www.h2okit.com/site/1286521/product/WS-425B>.

Working with water engineers, or those who have adequate expertise if your organization does not have this skill set, is crucial for developing and sustaining a successful water project. It is equally important to work with the local water authority and/or whatever local committees exist to ensure that any project is supported by the community. Working collaboratively with the community in development of a new water project will provide local employment as well as increase the uptake of the program.

Water has been a priority for PIH in Haiti for many years.¹¹ Each of the water projects PIH has initiated has a community-elected water point committee (WPC) made up of community members who oversee and maintain the new water source. At Zanmi Lasante, the committees are comprised of seven people each, three of whom must be women. In Malawi (where ten people are on each committee), WPC members undergo a three-day training program in operation and maintenance that prepares them for interacting with the water project's contractor, who is often an outside expert. Members are trained in the site selection, construction, operation, and maintenance of their water point. Once the well is completed, the WPCs monitor the well and are responsible for its maintenance.



Figure 8: Working with a community-based organization to rehabilitate a hand pump for a village well in Malawi

2.5 Microfinance

Microfinance is a common—and in many cases effective—way to help people lift themselves out of extreme poverty. Microfinancing initiatives provide small loans accompanied by training and follow-up services that empower participants to start small businesses or cooperatives. Much like vocational training that accompanies microfinancing loans, training in a POSER microfinancing program might consist of workshops to build specific skills such as accounting or program evaluation, as well as leadership development and community-building sessions.

¹¹ See, for example, Varma, M.K., Satterthwaite, M.L., Klasing, A.M., Shoranick, T., Jean, J., Barry, D., Smith Fawzi, M.C., McKeever, J., & Lyon, L. (2008). *Wòch nan soley: The denial of the right to water in Haiti*. Robert F. Kennedy Memorial Center for Human Rights, Center for Human Rights and Global Justice at NYU School of Law, Partners In Health, and Zanmi Lasante. Retrieved online at: <http://www.chrgj.org/projects/docs/wchnansoley.pdf>. A short, summary of this report was also published in 2008 in *Health and Human Rights: An International Journal*, 10(2): 67–89. Retrieved online at: <http://www.hhrjournal.org/index.php/hhr/article/view/82/152>.

Zanmi Lasante in Haiti partners with Fonkoze, in its program, Chemen Lavi Miyò (“the Road to a Better Life”), the phrase name Fonkoze chose for its approach to poverty alleviation for the poorest of the poor. Chemen Lavi Miyò replicates a program started by the Bangladeshi Rehabilitation Assistance Committee (BRAC), called Challenging the Frontiers of Poverty Reduction (CFPR), which helps women in Bangladesh move out of extreme poverty.¹² The Fonkoze program consists of 6 key components:

- Targeting the extreme poor
- Enterprise development and training
- Capital investment grants
- Social development training
- Essential health care
- Microcredit

Participants are selected through Participatory Wealth Ranking meetings by the communities, themselves. (See *Section 4.1, Selecting the target audience.*) The women are given assets to establish income-generating activities: goats, chickens, merchandise to sell. In addition to the training and assets, their houses are repaired in order to best protect their assets. Fonkoze case workers frequently visit beneficiaries to help them address problems they confront, financially accompanying the women while keeping careful track of their progress. Other training revolves around confidence-building activities that are designed to help a woman learn to feel as though she and her family could live another way. These activities include specific programs like one-on-one basic literacy lessons; they also encourage beneficiaries to notice what they are doing well and to imagine what they are capable of improving. After 18 months, when the woman is prepared to receive a loan, she forms solidarity groups with other beneficiaries of the program in the village who then form credit centers. When the enterprise is producing enough income to support the family and make loan repayments, the woman receives her first loan of \$50. After she finishes repaying that loan in three to six months, her group then joins an existing Fonkoze credit center in the area where she continues to borrow and repay through a system that is transparent enough to ensure responsible accounting, but does not require the extensive ongoing program activities that were required for her first loan.

At IMB in Rwanda, borrowers receive their loans through 30 different HIV associations. In 2008, a revolving fund was established for patients affected by HIV/AIDS and TB, other infectious diseases, and malnutrition, in order to provide loans to small groups of four to six



Figure 9: A former TB patient, who now operates a successful restaurant as part of a microfinancing program in Peru
Photo: Socios En Salud

¹² BRAC is an organization that since 1972 has been dedicated to alleviating poverty by empowering the poor. For more information, see <http://www.brac.net/>.

people who were launching or continuing to implement microfinancing projects. Loan officers, who are employees of a microfinancing organization, meet with loan recipients monthly, provide support when it is needed, and make sure that projects are progressing.

Another microfinancing strategy that can increase economic activity in a target area is that of offering small- to medium-sized loans to local healthcare facility staff. APZU in Malawi launched a pilot project in which its staff could obtain loans at relatively low interest rates from the Malawi Savings Bank. The project maintains limits by capping loans at six months of the employee's salary and offering this service to those who have been working with APZU for at least two and a half years. Employees have used the funds to build new homes as well as start family businesses.



Figure 10: A staff member from the site in Malawi in front of the home he built with support from the POSER program

2.6 Agricultural support

If your project is located in a rural setting where subsistence farming is common, providing agricultural support will help to prevent malnutrition and may increase patients' incomes. Five examples from PIH POSER programs in different countries, given below, illustrate agricultural initiatives that other organizations might replicate in similar settings.

In Haiti, agricultural support often takes the form of providing participants with fertilizer and seeds. Zanmi Lasante in Haiti also offers tools, saplings, training, and overall support to families enrolled in the agriculture program. Ajan agrikol—agricultural extension agents—provide the necessary training; these agents are community members trained, employed, and paid by Zanmi Lasante to work directly with participant families. During training, participants learn about topics such as soil conservation, terracing, crop rotation, identifying plant diseases, animal husbandry, and irrigation. An ajan agrikol visits each family at least once a week to provide follow-up and accompaniment. The participants for the agricultural assistance program are chosen from among the poorest families who bring children to the malnutrition clinic for treatment.



Zanmi Agrikol (ZA), the agricultural arm of Zanmi Lasante, was founded in 2002 to combat malnutrition in Haiti's Central Plateau and contribute to economic development in the region. In the aftermath of the earthquake in January 2010, ZA employed roughly 100 farmers, working closely with local farmers' associations to train farming families to communally cultivate a crop of fast-growing corn. After the initial training, participating families received seeds, fertilizer, water from irrigation channels, access to tools, assistance with labor costs for planting and harvest, and technical assistance and support from ZA agronomists and technicians. The first harvest yielded enough corn to fill about 200 bags with roughly 50 ears each, and the produce was distributed to families who had been displaced by the earthquake. ZA also addressed local post-earthquake food needs by hiring and training an additional 20 ajan agrikol (agricultural agents from the local community) to help support the agricultural efforts of about 1,000 families.

Another agricultural initiative is in place in Haiti to scale up the process of producing Ready to Use Therapeutic Food (RUTF). When complete, the local staff at Zanmi Lasante as well as members of small farming cooperatives will have full responsibility for harvesting the ingredients (primarily peanuts and corn from an on-site farm), processing, and packaging the product. It will then be distributed free of charge to patients being treated for malnutrition.



Figure 11: Women employed by Zanmi Lasante in Haiti prepare locally grown peanuts to produce a ready-to-use therapeutic food to treat malnourished children

At IMB in Rwanda, parents of children suffering from malnutrition, patients with HIV/AIDS, or patients of children recently discharged from the malnutrition ward at Rwinkwavu Hospital also benefit from agricultural training through the Agricultural Training Center. This Center provides training to Agricultural Assistance Workers (AAWs) who then visit enrolled patients' households on a weekly basis, working with them to develop agricultural goals. The Center itself had its roots in a microfinancing project. It developed from a community garden started at the hospital by a cooperative that had received initial technical support and a loan from IMB's agricultural program.



Figure 12: Women learning farming techniques from the agricultural assistance program in Rwinkwavu, Rwanda

At APZU in Malawi, POSER patients receive fertilizer, seeds, and training in how to maintain a permaculture garden, focusing on the importance of plant diversification and

organic gardening while harvesting food for their families. Currently, nine gardens are being maintained throughout the district. One garden is just outside the district hospital in Neno; another is located at the women's empowerment center in Zalewa. As many as 30–40 people per day visit the gardens to learn about sustainable farming from a POSER staff member. This project has been an effective way to help patients transition from time-limited nutritional support—part of their clinical treatment for HIV/AIDS or TB—to provide a more sustainable support toward economic independence.

Finally, Socios En Salud in Peru has successfully run a similar project for many years. This initiative provides TB patients and their families the opportunity to learn about small-scale urban farming and to plant small garden plots near their homes. Participants benefit from both the nutrition education and the fresh food.



TIP: *As you set up an agricultural program, research local agriculture to ensure that you will be supporting plants that can grow successfully at the site and are part of the local culture.*

3. PLANNING THE PROGRAM

The examples provided at length in the previous section outline basic aspects of economic and social rights and resources that you can choose from to shape your POSER program. You will need to decide what material and social priorities will make the greatest difference to the health of your community, what activities fit under the umbrella of your program, and what can be done within the financial and human resources you have available. With an understanding of the essential components of a POSER program, you are ready to plan your own. Actively engaging the community on strategies to address local needs should serve as the starting point.

3.1 Meeting local needs

Talk with community leaders and local service providers to find out what they see as the main priorities. Organizing focus group discussions with members of the community representing different age and/or gender groups may offer a broad perspective on the primary concerns locally. For example, you may have thought that an agricultural support program was needed. Through focus group discussions you may find that the younger people in the community are interested in activities that would provide them with employment, while in contrast, the older population may be interested in agricultural activities. Similarly, men and women may have different perspectives. Obtaining these views will offer a better understanding of the diverse interests and needs in your community and how different ideas might support and build on each other to mutual advantage.



TIP: *Brainstorming in a collaborative way with different groups in the community is beneficial for developing your POSER program to match local needs.*

If there are diseases or related environmental risks that affect the entire community, you may also need to complement this approach with a public health orientation. There may be a significant burden of diarrheal disease among children under five years of age, for example, which would suggest the need for a water quality project as part of your POSER program. This may not be expressed as a high priority by the local community, given the possibility of many competing problems; however, you may consider it as part of your POSER program based on the public health implications of severe illness and death in young children.

You may also consider adapting models or approaches from other settings. Before using another model as part of your POSER program, however, it is helpful to review its program strategy. Simply because it has been effective in one context does not mean it will work well in yours; think about how the settings may be similar and different. For example, if one program found that increasing access to small-scale microfinancing endeavors improved retention in secondary school, this finding may not apply to your program's setting if the local community does not place a high value on secondary education compared to seeking employment.



Figure 13: Children from a village in rural Haiti have no other option than to collect contaminated drinking water from a stagnant spring

3.2 Determining strategies and resources

The needs outlined by the community may be greater than the resources you have immediately available, so you may want to create a two-tiered plan. Start by looking at the resources available and the immediacy of the needs. Consider, for instance, the burden of malnutrition among children under five years of age in your target population. What is your program's capacity to address this problem? Think about a broad range of strategies to improve food security in the immediate present and near future. Simultaneously think about a long-term plan of agricultural sustainability or job creation that can be built into your program. A timeline to achieve the short-and long-term goals can serve as a management tool to ensure that the programmatic objectives are being met in a timely manner.

In addition to the time and resources necessary for POSER initiatives, consider whether your current program staff and/or community members have the technical capacity to

implement different aspects of your program. If your current staff do not have the technical skills, you may be able to identify a partner agency to assist you. (See *Unit 10: Working with partners* for more details on different partnerships.) Many of the POSER initiatives at PIH-supported sites are supported and often run by partners from local community and other organizations.

Having a pilot phase may allow you the time and flexibility to change strategies based on early observations of whether a specific initiative is working or not; follow-up focus group discussions can be useful for this. If the topic of interest is sensitive in nature (if, for example, there is an adult literacy program but people are reluctant to mention that it is not benefiting them), then individual open-ended interviews may yield more useful information. Addressing any obstacles and making revisions to your program *before* scaling up to address other areas will improve the program's chances of success.

4. SELECTING AND TRACKING PATIENTS

The specific POSER activities you are able to provide will depend on the needs of the people you are hoping to serve and your resources. Once you have made these decisions, you can move on to determining criteria for selecting the beneficiaries of these services.

4.1 *Selecting the target audience*

As you think about who will need POSER services most and how to reach them, consider how the resources available will have the largest impact. Ask yourself whether you want to focus exclusively on people suffering from a particular disease, such as those infected with HIV/AIDS, or on the whole community where you work. Will you give priority to the poorest of the poor, or will you include those who may not be viewed as the destitute sick? Will you provide services regardless of age, or will children take precedence? Will orphans and vulnerable children (OVC) receive extra consideration, or will other children, such as those who are living with one or both parents, also be included? These decisions may be based upon the goals and the long-term strategic plan of your organization.

Think about how you will involve the community to help select those at greatest risk and/or those who will be eligible to receive services. This, too, may be a sensitive topic, and confidentiality must be respected with regard to details such as HIV status. Fonkoze in Haiti (see *Section 2.5, Microfinance* in this unit), uses a community participatory wealth ranking system to obtain community input on who is most vulnerable and in greatest need of the microfinancing program. This community-based ranking system offers transparency to the selection process and reduces the risk that people who benefit from the program would experience hostility or discrimination from their neighbors who are not receiving aid.

4.2 Identifying participants

Once you have decided on your target population, you can make decisions about the selection criteria you will use within that group. Selecting patients requires a high level of delicate discernment and diplomacy, as they will be receiving benefits that other members of the community will not receive. Both your staff and members of the local community may question why one patient is eligible for the construction of a new house while another must continue to dwell in an old and likely equally inadequate structure. A transparent and clearly documented process will equip your program to address such questions as they arise and help to avoid conflict and misunderstandings.

At PIH-supported sites, identifying patients takes different forms depending on the local context. At APZU in Malawi, for example, patients enrolled in the HIV/AIDS program are assessed by clinicians who refer them to a POSER case worker. The case worker visits the patient at home and completes an assessment form, which includes questions about who lives in the house, household income, and education level. These factors make it possible for the case worker to determine the family's level of need, and the case worker can then recommend the patient for enrollment to receive the appropriate resources from the available POSER program initiatives.

Differing populations and different available resources will mean that POSER programs may focus on varying constituencies, and this too affects how patients are identified and selected. At the site in Lesotho, where the program focuses on orphans because there is an overwhelming presence of unaccompanied children, the selection process is relatively simple: orphan beneficiaries must have had a parent (now deceased) who was an HIV/AIDS or TB patient at a PIH-supported health center. Beneficiaries must also be under 18 years of age, and not receiving support from any other organizations. The POSER selection committee at IMB in Rwanda, composed of social workers, nurses, and community health workers at the health center and district levels, meets at least four times a year to review POSER referrals and determine whether patients can be added to the program. A special emergency committee is also now in place at the district level in order to expedite the process for the most urgent cases. In the case of school fees programs, the social workers approach HIV associations, who identify the neediest children.

In Haiti, the selection of patients at each of the sites under Zanmi Lasante who are eligible for new or renovated housing is the responsibility of physicians. The doctor identifies HIV and TB patients who are most in need of housing and refers them to a social worker who in turn gives the POSER team a monthly list of patients who need houses. The POSER director uses the list to identify the most critical cases from each site and then compiles a smaller list of those selected to receive a POSER house in the next construction cycle.



Figure 14: PIH's partner organization in Lesotho runs a project to provide a safe home, a foster parent, and schooling for children orphaned by MDR TB

The director then determines, by consulting the budget, how much money can go towards salaries, materials, and transport. The original lists are retained so that POSER assistance can be offered if more resources become available or if an individual patient's situation worsens.

4.3 Follow-up

Individual follow-up is essential for all patients identified and enrolled in a POSER program. Exactly what follow-up takes place will differ according to the services that beneficiaries are receiving. For example, once a house is built and a family moves in, they will need less frequent follow-up than before it was complete. A student whose education is supported by a POSER program, on the other hand, should receive regular visits in order to determine whether she or he is thriving and might need additional support.

The staff you select to perform these follow-up plans will also depend on local factors, such as your program size and the composition of your staff. You may have dedicated POSER employees who can do follow-up, or you may need or choose to assign this role to social workers or other case workers. Whoever meets with the beneficiaries, it is important that patients receive the visits in their homes—as opposed to a clinic or school. With a home visit, the case worker can obtain a comprehensive view of the patient's situation and best maintain patient confidentiality.



TIP: *Transportation can be a major barrier to patient follow-up; if possible, include resources in your budget to ensure that staff have the transportation resources they need to visit patients at home.*

5. STAFFING AND FUNDING THE PROGRAM

Education, food, housing, and other necessary social and economic resources vital for health can be costly and time-intensive to provide. Staffing and budgeting for a POSER program can be a major challenge. This is one reason that it is vital to identify clearly what services you can provide through your POSER program, the target population, and the eligibility criteria. Such clear goals and priorities will help guide your staffing and budgeting process.

5.1 Staffing the program

Staffing for PIH POSER programs is organized in several different ways but with a common thread: all POSER programs are run by local staff who can respond to community needs and set priorities in a resource-limited setting. In recruiting a potential project director, consider hiring someone with a background in social work or education, and who can understand how the program will intersect with your clinical services. If possible, hire people from the community in which you work. Providing jobs to local residents not only helps the local economy but also avoids any conflicts among people who may feel it is unfair to give jobs to people from another region if employment is just as desperately needed

locally. It is not always possible to find the best qualified candidate for a job among the local community, however. We have found that when someone with expertise in a particular area is required, we may at times hire people from outside the community because they have appropriate qualifications, and in such cases we make sure that POSER staff help make the community aware of the reasons behind such decisions.



PIH NOTE

In Haiti, there are 35 POSER staff members, including office staff, field supervisors, and drivers. We also hire construction workers on a project-by-project basis. Salaried workers are paid on a regular schedule, while construction workers receive payments in cash. Typically cash payments are made when the house is finished, but sometimes workers need money up front to feed or clothe their families. PIH makes these allowances whenever feasible.

If your program is initially quite small, you may not have the resources to have staff dedicated solely to POSER activities. If you have social workers on staff, they may be able to work across programs, and participate in POSER referrals and follow-up. At IMB in Rwanda, for example, social workers combine their POSER work with their clinical and mental health work. Malawi's POSER program, in contrast, is quite large, with several POSER workers responsible for all referrals and follow-up, with some staff focusing on specific projects. Different again is the way POSER is staffed in the Lesotho program, which is managed jointly by the Monitoring and Evaluation coordinator, the Community Director, and the OVC Coordinator.

Consistent and supportive supervision is vital in any POSER program, particularly one with multiple interventions and/or spread across multiple sites. We have found that effective POSER supervisors are usually people who have previous knowledge and experience, often in construction, or who have been with the program for a long time. While they generally focus on one location or geographic area, they can be transferred if necessary to help resolve or avoid conflicts—such as issues with a construction team. Supervisors in Haiti meet on an ad hoc basis in the city of Mirebalais (which is centrally located and has good roads) to discuss and seek to resolve problems or needs that arise. The supervisors also communicate regularly using cell phones that the project provides.



Figure 15: A POSER staff member from the PIH-supported site in Malawi interviewing a patient for the program

5.2 Funding the program

The financial resources that you can dedicate to your POSER program will depend on your overall budget. At PIH-supported sites, POSER programs are generally less than 10 percent of the total project budget. This includes both administrative costs (including salaries, computers, cell phones, and transportation) as well as program costs. However, at some sites, some of the services described in this unit are covered under clinical programs.

Raising funds specifically for POSER programs can help you ensure sufficient resources. Interested individual donors or foundations may include those who understand the importance of comprehensive care and want to support such activities. (See *Unit 9: Creating a development strategy* for more information.) If you do seek funding that would be restricted and targeted to your POSER programs, be aware that measuring the impact of such projects can be difficult. Nonetheless, monitoring and evaluation (M and E) of POSER programs is just as important as M and E for your other, more clinical or research-based programs. Indeed, building a strong monitoring and evaluation program in conjunction with your POSER program can assist you in showing both its long- and short-term impact. (See *Unit 12: Using monitoring and evaluation for action.*) As long as funders understand this challenge and you can maintain regular communication with them, you may find that people will be enthusiastic about supporting a project that has such tangible results as building a house or sending a child to school.

CONCLUSION

Healthcare delivery that is based on a human rights approach can be most effective when it includes services that address social and economic determinants of health as a matter of course. At PIH-supported sites these services are brought together in a program on social and economic rights (POSER). Such programs may include providing or supplementing the patients who are most in need—and their families—through providing education, housing, food, clean water, job training, and/or other special services or training opportunities. How you choose to design your POSER components will depend on your community's input, context, and needs. POSER initiatives work within the community to distribute essential goods on a selective basis using predetermined criteria, and thus require particular discernment and diplomacy in development and administration. The goal of a POSER program is to overcome those barriers that cause disparities which undermine health. Whatever components you choose to include in your POSER initiatives—and whatever you call them—such programs need effective support, monitoring, and evaluation to bring lasting hope to those they serve.



Resources

WORKS CITED

The All-In-One Home Drinking Water Test Kit.

<http://www.h2okits.com/site/1286521/product/WS-425B>

BRAC

<http://www.brac.net/>

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Fonkoze

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World Health Organization. (2008). *Closing the gap in a generation: Health equity through action of the social determinants of health*. Geneva: World Health Organization.

http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

SELECTED RESOURCES

Economic and Social Rights and the Right to Health

Beetham, D. (1995). What future for economic and social rights? *Political Studies*, 43:41–60.

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This chapter presents a summary of the structural forces that affect health and strategies to address them.

Gauri, V. (2005). Social rights and economics: Claims to health care and education in developing countries. In Alston, P. & Robinson, M. (eds). **Human rights and development: Towards mutual reinforcement**. New York: Oxford University Press, pp. 65–83.

The author argues for social rights in an economic approach to health care and education.

Health and Human Rights: An International Journal. 12, 2(2010).

This theme issue was devoted to the social determinants of health. Articles of particular interest to the topics discussed in this unit:

- Braveman, P. **Social conditions, health equity, and human rights**, pp. 31–48. <http://www.hhrjournal.org/index.php/hhr/article/view/367/564>
- Chapman, A.R. **The social determinants of health, health equity, and human rights**, pp. 17–30. <http://www.hhrjournal.org/index.php/hhr/article/view/366/561>

- Cullen, K.A. & Ivers, L.C. **Human rights assessment in Parc Jean Marie Vincent, Port-au-Prince, Haiti**, pp. 61–72.

<http://www.hhrjournal.org/index.php/hhr/article/view/369/569>

Joint Learning Initiative on Children and HIV/AIDS (JLICA)

<http://www.jlica.org>

This is the website of the Joint Learning Initiative on Children and HIV/AIDS (JLICA), a time-limited network (ending in June 2009) of policy makers, practitioners, community leaders, researchers, and people living with HIV that mobilized research and discussion on children affected by HIV/AIDS. Topics covered include: strengthening families; community action; expanding access to services and protecting human rights; and social and economic policies. Materials on these topics are available in its online Publications section.

Keshavjee, S. & Becerra, M. (2000). Disintegrating health services and resurgent tuberculosis in post-Soviet Tajikistan: An example of structural violence.

Journal of the American Medical Association, 283(9):1201.

<http://jama.ama-assn.org/content/283/9/1201>

The article shows how health crises such as the resurgence of tuberculosis in the former Soviet Union demonstrate the effects of structural violence, and that forms of social organization can lead to groups of individuals being marginalized by economic, racial, and gender inequality.

Manderson, L. et al. (2009). Social research on neglected diseases of poverty: Continuing and emerging themes.

PLoS Neglected Tropical Diseases, 3(2):e332.

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<http://www.plosntds.org/article/info:doi/10.1371/journal.pntd.0000332>

This article highlights the importance of social research in drawing attention to the role of gender and economic variables for ensuring effective and sustained interventions against neglected tropical diseases. It also notes the importance of community participation in these interventions.

Marmot, M. & Wilkins, R.G. (eds). (2005). **Social determinants of health**. 2nd ed. New York: Oxford University Press.

The National Economic and Social Rights Initiative (NESRI)

<http://www.nesri.org>

NESRI was founded to build legitimacy for human rights in general and economic, social, and cultural rights in particular, in the United States. The search filter on the Resources page of the NESRI website sorts online resources by the six ESC rights themes. Although these are focused on examples within U.S.-based settings of poverty, many aspects may also be relevant to international settings.

Pogge, T. (ed). (2007). Freedom from poverty as a human right: Who owes what to the very poor? New York: Oxford University Press.

The book contains several chapters directly related to health and one on enforcing economic and social rights.

Porter, D. (2006). **How did social medicine evolve, and where is it heading?** *PLoS Med*, 3(10):e399. doi:10.1371/journal.pmed.0030399.

<http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0030399>

This article examines the history and evolution of social medicine as an academic discipline, specifically at the Anglo-American context and Latin American social medicine.

Social determinants of health

http://www.who.int/social_determinants/en/

This website contains the work of the Commission on Social Determinants of Health, established to support countries and global health partners to address the social factors leading to ill health and inequities. Its work is supported by the World Health Organization. The site includes tools and publications.

Economic Security and Health

Edström, J. & Young, I. (2006). **Social and economic policy and thinking on the protection and support to vulnerable children in an era of HIV and AIDS: Rapid literature review for Joint Learning Initiative on Children and HIV/AIDS (JLICA), Learning Group on Social & Economic Policies.** Boston: Joint Learning Initiative on Children and HIV/AIDS (JLICA).

<http://www.jlica.org/userfiles/file/Jerker%20E%20lit%20review%20Oct%2006.pdf>

This frame-setting literature review for the JLICA project intentionally focused on certain issues related to the protection of vulnerable children and on literature on the evidence base for certain social and economic policies and approaches in social protection, including education, social transfers, food security and legal reforms. It explicitly did not address health programs, as they are covered in other project publications.

Huda, K. & Simanowitz, A. (2008). **Chemin Levi Miyò – midterm evaluation.** Dublin: Concern Worldwide.

This evaluation assesses the effectiveness of the Fonkoze project, Chemin Lavi Miyò, to improve the lives of the poorest women in Haiti, and the challenges it faces. It looks at early indicators of progress, including the targeting of the very poor through the community participatory wealth ranking system, and five other areas: enterprise development and training, capital investment, social development, essential health care and microcredit.

Zoll, M. (2008). **Integrated health care delivery systems for families and children impacted by HIV/AIDS: Four program case studies from Kenya and Rwanda.** Boston: Joint Learning Initiative on Children and HIV/AIDS (JLICA).

http://www.jlica.org/userfiles/file/Integrated%20Health%20Care%20Delivery%20Systems_101508.pdf

This document describes four family- and community-centered approaches to caring for and treating HIV-affected children and households, one of which is Inshuti Mu Buzima, the PIH-supported site in Rwanda. The author argues that one element that made the four programs successful is the broadened definition of health care to include the linked provision of nutritious foods and access to psychosocial support, education, economic security, legal protections, clean water, and basic shelter.

The Right to Education

Oportunidades

http://www.oportunidades.gob.mx/Portal/wb/Web/oportunidades_a_human_development_program

This is the website (in English with links in Spanish) of the Mexican government's program to support families living in extreme poverty. The program aims to improve their lives and well-being through education, health, and nutrition options.

Jukes, M., Simmons, S., Smith Fawzi, M.C. & Bundy, D. (2008). **Educational access and HIV prevention: Making the case for education as a health priority in sub-Saharan Africa**. Boston: Joint Learning Initiative on Children and HIV/AIDS (JLICA). <http://www.jlica.org/userfiles/file/JLICA%20Education%20Access%20and%20HIV%20Prevention%20091308.pdf>

The paper reviews the links between HIV risk and educational attainment, educational access issues, and provides models to increase educational access.

The Right to Adequate Food and Water

Gillespie, S. (2008). **Poverty, food insecurity, HIV vulnerability, and the impacts of AIDS in sub-Saharan Africa**. Boston: Joint Learning Initiative on Children and HIV/AIDS (JLICA).

<http://www.jlica.org/userfiles/file/JLICA%20Gillespie%20IDS%20poverty%203%20July.pdf>

Focusing on southern Africa, the author argues that although poverty per se may not be the most important risk factor for exposure to HIV, it is the poor in these countries, especially poor women who struggle the most with the impacts of AIDS.

Varma, M.K., Satterthwaite, M.L., Klasing, A.M., Shoranick, T., Jean, J., Barry, D., Smith Fawzi, M.C., McKeever, J., & Lyon, L. (2008). **Wòch nan soley: The denial of the right to water in Haiti**. Robert F. Kennedy Memorial Center for Human Rights, Center for Human Rights and Global Justice at NYU School of Law, Partners In Health, and Zanmi Lasante.

<http://www.chrgj.org/projects/docs/wochnansoley.pdf>

The document discusses the Inter-American Development Bank approval of a package of loans to provide infrastructure and water development in Port-de-Paix and the subsequent blocking of the disbursement of those loans by the U.S. and others. It argues for a rights-based approach to the development and implementation of water projects in Haiti.

Varma, M.K., Satterthwaite, M.L., Klasing, A.M., Shoranick, T., Jean, J., Barry, D., Smith Fawzi, M.C., McKeever, J., & Lyon, L. (2008). **Wòch nan soley: The denial of the right to water in Haiti**. *Health and Human Rights: An International Journal*, 10(2):67–89.

<http://www.hhrjournal.org/index.php/hhr/article/view/82/152>

A shorter, article-length summary and discussion of the right-to-water report noted above.

The Right to Housing

Kothari, M. (1997). **The global struggle for the right to a place to live.** *Development in Practice*, 7(1):5–16.

The problem of inadequate housing is situated within the framework of human rights, and of international recognition of the basic rights to a place to live, and to gain and sustain an adequate standard of living. The author draws on the experience of Habitat International Coalition (HIC) in supporting a comprehensive range of actions at local, national, regional, and international levels, and suggests some of the elements required for sustained changes.