Africa Regional Workshop, Cape Town South Africa, 27 to 30 June 2016

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Introduction and Objectives of the workshop

People's Health Movement (PHM) held an Africa Regional workshop/International People's Health University which took place from the 27th to 30 June 2016 at the University of Western Cape (UWC), Cape Town, South Africa. It was attended by approximately 35 PHM members from South Africa, Democratic

Republic of Congo (DRC), Kenya, Uganda, Tanzania, Zimbabwe, Zambia, Benin and Eritrea. The workshop was organised within the framework of the PHM / International Development Research Centre (IDRC) Research project on Civil Society Engagement for Health for All.

Objectives for the workshop

A four day regional workshop/IPHU took place in Cape Town South Africa at the University of Western Cape, School of Public Health. The objectives of the workshop included:

- sharing the results of the action research on civil society engagement in the struggle for Health For All which took place in South Africa and DRC;
- to learn more about the current forms/experiences of mobilisation for health in Africa;
- to reflect together on challenges in movement building (e.g. fragmentation, alliances and networks, mobilisation, movements), and on the strategies to address them;
- to discuss concrete action to protect health systems and promote social determinants of health (develop plans for countries and the region);
- to strengthen national and regional solidarity, alliances and struggles, towards a greater role of civil society in shaping policy and society in the people's interest; and
- to strengthen/build relationships within and across movements/countries.

Background and Approach of the workshop

The workshop was organised within the framework of the IDRC action Research project on Civil Society Engagement for Health for All focusing on sharing the results of research from South Africa and DRC which focused on five themes which are; Movement Building, Campaign and Advocacy, Capacity Building, Health governance through policy dialogue and Knowledge Generation and Dissemination. The same themes were used to guide shared country experiences and discussions to strengthen the health movement in Africa. The workshop was framed under the following themes as explained in the IDRC Research:

Theme 1: Campaigning and advocacy-A campaign is defined as sustained action, advocacy and activism around an issue/set of issues that have relevance while promoting HFA Campaigns may be around health systems (e.g. access to medicines, workforce reform, comprehensive primary health care, health care financing, etc.) or around the social determinants of health (e.g. food sovereignty, tobacco control, sanitation and water supply, air pollution, income inequality). They may be directed at the community generally (smoking, gender relations, health literacy) or particular institutions (corporate accountability, community accountability of health care providers, employers in relation to occupational health, etc.) or governments (health care financing, corporate regulation, trade and investment agreements, etc.).

Theme 2: Movement Building-Progress towards HFA is driven by: Community mobilisation / campaigning Network strengthening (local, vertical, intersectoral) Stronger social movement (shared analysis, objectives, identity) These drivers depend on infrastructure and process: country, regional (and global) coordination, community level activists participating in international activities (such as PHM's global programs), community level activists making links with various networks with a more specialist focus (nutrition, health system, access to medicines, mining, etc) resources for interpreting and translation, relationship building (personal contact, lists, communication, conferences, visits, collaboration). Some strategies for movement building at the country level include:

- identifying local priorities and resources,
- identifying and mobilising in areas and issues where there is need and potential for activism,
- building a base in communities; involvement in community struggles and actions,
- structured guides to movement building, • building capacity among activists,
- outreach from more specialist networks and global projects (including PHM's global programs),
- Solidarity exchanges of activists between countries including experienced activists.

Theme 3: Capacity Building-Capacity building among health activists is a crucial part of building a global HFA movement. HFA will be promoted by building a stronger social movement for health and by enhancing the effectiveness of PHM programmes and activities. In the case of the PHM, (where relevant/possible) the IPHU contributes to strengthening PHM and allied health movements through participants acquiring new knowledge and skills, reimagining themselves as activists and building relationships. Other training experiences of PHM activists and/or activities organised by other CSOs contribute.

Theme 4: Health governance through policy dialogue-Long term, sustained and effective civil society engagement in the dynamics of global governance, including global health governance (GHG), is manifest in:

- Improved decision making by intergovernmental bodies such as the WHO (or other intergovernmental and/or multilateral bodies such as the WTO) ;
- A stronger policy voice exercised by progressive governments from the global South (democratisation of GHG) ;
- Stronger accountability of national governments for their contribution to global health governance.

Theme 5: Knowledge Generation and Dissemination-Knowledge generation and dissemination by civil society contributes to movement building, strategies, actions and impact.

The workshop engaged a variety of interactive learning methods as described below:

Presentations: On each day, there were presentations which included the context of the region, theory, results of the action research, strategies, country experiences, etc, within health activism. See link to all the presentations: WORKSHOP PRESENTATIONS/PHOTOS/VIDEOS

Field visits- a visit to meet with other activists groups (see description below).

Group work and plenary discussions: Building on the introduction to each theme and presentations, participants were divided into different groups(mixed and sub-regional) to discuss possible priorities and actions. Plenary discussions were used to consolidate the discussions after presentations from the research and introduction to the theme.

Group discussion

Selection criteria and Preparation prior to the workshop

In Mid-May. a small team consisting of the secretariat and the regional representative met to discuss the possibility of a regional workshop. Based on logistics, funding, programme and a reflection of PHM activities in the region it was agreed to select a few countries. Most of the countries selected included activists that have shown a commitment to building the health movement over the past few years through PHM and non PHM led activities. The list was not exhaustive but also considered sub-regional representation. Other countries would be considered in future processes. The selection of countries was completed at the beginning of June. The countries had a mixture of active and embryonic circles to allow for the exchange of experiences. Thirteen countries were included in the selection (Ghana, Benin, Uganda, Kenya, Zimbabwe, Zambia, Tanzania, Gabon, Cameroon, Democratic Republic Congo(DRC), Benin, Togo and South Africa).

An email was then sent out to countries to select participants from their country circle through a consultative process at country level. Several emails were sent to countries with a clear background to the workshop and included a call for two PHM activists from the country to be selected. However, due to several factors including visa processes, limited time, financial constraints, Cameroon, Togo and Gabon could not attend the workshop.

Based on the themes of the IDRC research project, a country guide was developed and sent to countries. The guide explained the background of the IDRC research project, eachof the themes and included questions to guide participants to prepare presentations on country experiences to be shared during the four day workshop. It was available in both French and English. All communication was translated withthe

help of volunteers. South Africa and DRC also made available the IDRC reports and in each country selected presenters to share the findings of the research.

Attending the South African National Health Assembly (NHA)

Participants from the region attended the NHA organised by PHMSA and partner organisations as an opportunity to learn how PHMSA works with other partners to organise processes and campaigns. The NHA was organised by PHM, TAC and Section 27 and was attended by health activists from all the nine provinces within South Africa. Prior to the NHA, provincial health assemblies took place in the different provinces.

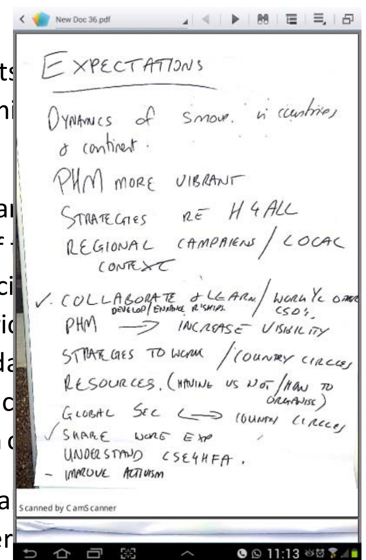
Programme/agenda development

The agenda was developed by a small team based on the IDRC research project and shares similarity with the IPHU in Brussels and Colombo workshop. It was agreed that the workshop should look at key actions to strengthen the movement in Africa and therefore the programme combined result findings, country experiences, theory, regional context of issues and discussions on movement building. (Click link to view theFinal programme). The programme was further reviewed after day one of the workshop to ensure participatory approaches to engage participants.

Workshop proceedings

Participants-Approximately 35 participants attended the workshop from Ghana, Kenya, Uganda, Eritrea, Tanzania, South Africa, Zambia, Zimbabwe, Benin and DRC.

Day one (27 June) – Overview and Campaigning and Advocacy



Bridget, PHM Global coordinator, welcomed everyone to the workshop. Participants expectations on pieces of paper which were read out and pasted on the wall as a remi four days.

The first session: the session was organised for participants to develop an understa background to the workshop. Therefore presentations were done on the overview of project at global level, in South Africa and DRC and objectives of the workshop. Partici presentation by David Sanders on the Historical and Social Context of ill health in Afric PHM Global which gave a context to strategies to be discussed throughout the four da (PHMSA SC member) introduced the theme campaigning and advocacy with a historic African health activism. Importantly he raised the question "Does the Right to Health c

Most African countries have ratified the International Covenant on Economic, Socia (ICESCR) but for example, Congo ratified the covenant and not the protocol. However translated to implementation and for example groups such as Treatment Action Campaign in South Africa have used litigation for demanding treatment access for HIV.

Participants divided into buzz groups to discuss common issues on health, campaign activities and platforms to utilise. The group discussions were guided by the questions below:

- -What are the common issues impacting on health across the region?
- -What regional platforms exist to campaign/ or for advocacy?

- -How could we strengthen our local struggle through regional and global solidarity?
- -What campaign activities should PHM prioritise in your country?

Research findings on campaigning and advocacy

The second session presented research findings from South Africa and DRC on campaigning and advocacy and health activism. Lauren from SA shared findings on various campaigns which show health activism Post-Apartheid in South Africa with reference to the right to health according to General comment no. 14. Examples of such campaigns included decriminalization of sex workers, access for women, Lesbian Gays Bisexual,trans, and/or intersex (LGBTI), People living with HIV/AIDS (PLWHA), National Health Insurance (NHI), Food security, education, treatment access (TAC's role), standardised training programme for community health workers in SA, and gender based violence.

Megan Harker shared the findings outlining activities on campaigning and advocacy towards Health For All (HFA) led by both PHMSA and with PHMSA partners. These included a discussion paper released by the NHIC Coalition, Cell phonesms's elicited from civil society to provide community based feedback,NHIC coordination of meetings and empowerment workshops in communities analysing the

SocialDeterminants of Health specific to their community. i.e. drug use, excessive clinic waiting times, radio talk shows, media statements, pamphlets etc.

Billy Mwangaza from DRC shared the results of the research on Campaigning and advocacy. He gave several examples of campaigns and how they have been organised such as the book campaign which promotes reading as part of education, SDH, Human rights and HIV, advocacy on water, Sexual Violence based on gender.

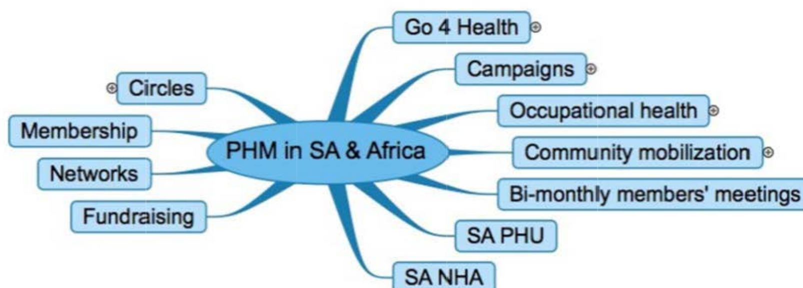
Last session of the day: In the last session of the day, report backs were done exploring key social and health issues affecting the region and role players These discussions were important and would feed into the last day (4th day) of the workshop to discuss how to strengthen the movement and key actions to take forward.

Day two (28 June 2016) – Capacity Building and Field Visit

Presentations on research findings on capacity building

South Africa:

Louis and Michelle began with a presentation on capacity building findings that PHMSA and other partners have been involved in. PHMSA has partnered with several partners to implement activities as illustrated in the diagram below:



In their presentation, capacity building activities included popular education, public meetings on topical issues relevant to health, South African People's Health University – SAPHU, "But Why?" – trainings (e.g. Women on Farms, health committees), Tailor made trainings (NEHAWU, other unions), National Health Assembly and Social Media.

Melanie gave a specific presentation on the South African Health University (SAPHU) as an example of capacity building among health activists. It is an annual 5 day course held in South Africa for activists. SAPHU builds on the same principles as the IPHU and organised through partner organisations. Two courses have been held in 2014 and 2015 respectively, which were specific to South African issues such as the National health insurance and community health workers.

DRC presentation on capacity building findings and short discussion

Nicole from CODIC in DRC, presented findings on capacity building. PHM Congo has never organised capacity building activities but member organisations are involved in such activities in their respective organisations. Therefore the results presented were activities from member organisations. For example CODIC, a PHM member is involved in training communities on social determinants of health such as water and sanitation; M3M has strengthened the young dynamic youth of Mondas on management methods to structure the movement. Organisations identify needs through surveys or during other training and capacity building activities are mainly through workshops/trainings. Events are normally attended by 15 to 20 peopleand the committees are the ones who select the people. PHM members are all over Congo but RTH activities are only held in the North and South. There is a member of PHM in each province but the circle is based in Kinshasa.

Experience from India-JSA

Dr Sundararaman gave a brief enlightening presentation on the health movement in India, JSA or People's Health Movement India. He explained how it was formed in 2000 when 18 national networks came together for the PHA processes. Activities such as national and state workshops, people's health enquiries in about 200 districts, state health assemblies and people's health trains were held. A national health Assembly was held on 30 Nov. – 1 Dec. 2000 which had over 2000 delegates from 19 states and an Indian people's health charter adopted. It was then decided to form a continuing campaign platform on 1 Dec. 2000 called 'Jan SwasthyaAbhiyan' (People's Health Campaign or Movement). JSA has a national coordination committee and a secretariat and contact persons in 20 states. It is increasingly involved in local rights initiatives and campaigns such as right to food, stock outs, social audits of rural hospitals, material development to build public understanding of health policy issues and dialogue with policy makers.

Country experiences on campaigning and advocacy and capacity building

Country representatives presented their experiences on campaigning and capacity building from each country. Prior to attending the workshop, participants received a guide to prepare presentations which would share their experiences in their countries on health activism. The guide was based on the five themes mentioned above. In the workshop from day one, participants were given a space to tell detailed stories of their activist practice. This was important to learn about some of the PHM and non- PHM led actions which participants can learn to strengthen their work. So each country presented on campaigning and advocacy, capacity building, health governance through policy dialogue and knowledge generation and dissemination. Many of the issues shared were discussed to be useful to build on to the manual being developed on

movement building. Country experiences and forms of action PHM and non PHM were shared by the following:

- Uganda by Denis Bukenya and Danny Gotto
- Benin by PacomeTometissi and MichaelTchokpodo
- Kenya by Erick and David Oginga
- Ghana by Nancy Ansah
- Tanzania by Lucy Tesha and Godfrey Philimon
- Zimbabwe by CaiphasChimhete and Esther Sharara
- Zambia by Dorothy Chanda and JackKafwanka

Brief on IDRC-Qamar

Qamar from IDRC gave a brief of the organisation.IDRC started in 1970 and is a government agency which supports research and development. They work with other funding agencies and through calls in line with their 2015-2020 strategic plan (large scale positive change, leadership and partnerships). IDRC supports initiatives such as the maternal and child health initiative with country teams and health policy research (West Africa, East Africa); Global financing facility on strengthening civil registration systems (12 countries) and think tank initiatives such as on health. He encouraged countries if they would like to get involved. Activities have both operation research and policy components and engagement for evidence based processes.

Group work on capacity building

Participants then divided into groups to discuss capacity building for health activists guided by the following questions: what are the three (3) key roles of health activists in the African context; what are the skills and information do health activists need to fulfil this role and what are the capacity building activities that PHM (country circle) should prioritise in your country? (Click to see report back combined).

Field visit to meet other activists groups

On Tuesday 28 June in the afternoon, participants visited various activist groups in Cape Town to learn about their struggles and how they are mobilising closely linked with discussions in the workshop.

The group met with members from the Treatment Action Campaign (TAC), Equal Education, Workers' World Public Transport Voice and Social Justice Coalition. All the organisations are based in Khayelitsha, Cape Town but working nationally throughout South Africa. Struggles raised include dealing with HIV among adolescents, HIV drug regimens, education-limited access to text books especially in rural areas, infectious diseases spreading in overcrowded transport, unemployment, xenophobia, rape and other problems as a result of a neglect in addressing social determinants of health.

Day Three: 29 June 2016 Knowledge Generation And Policy Dialogue

Morning session

Participants engaged with Peter in his presentation on the role of social media in health activism. He outlined that majority or almost everyone has a cell phone or access to phones from the simplest phone to the technologically advanced (basic, feature and smartphones) and therefore have the tools/phones to support health activism. Peter presented on two aspects; mobile phones and Health which is called mhealth and how to use phones for health activism. Mhealth works to improve communication efficacy in the health system through its different strategies, an example outlined was MomConnect. An examples of a campaign using mobile phones is the Y mobilise targeted at youth to use mobile tools to increase activism, engagement, community mobilisation and participation (see presentation.

Research findings on knowledge generation and dissemination

South Africa

Community care workers case study:As part of knowledge generation and dissemination, Zara Trafford presented on the role of research in Health activism. Her presentation focused on the case study on community care workers and health activism in South Africa. The research aimed to explore how CCWs respond to/interact with PHM-SA and others in their network of relationships with civil society and to identify and better understand how community care work(ers) and health activism currently articulate, particularly in light of critical local policy shifts and global health concerns and priorities. Qualitative research was done comprising in-depth interviews and participant observation in five SA provinces. Activities included PHM-SA knowledge dissemination workshops, public events (e.g. Free State CHW trial), and one-on-one and focus group-style interviews. Summarised in the presentation, the workshops focused heavily on the nature of community health work, the circumstances of CHWs, and encouraging CHWs to think critically about responsibilities in the provision of government health services. There was also a strong emphasis on their support for CHWs and their conviction that CHWs are key to uplifting the country's health and wellbeing, as well as in advocating on behalf of their communities. The response to these workshops was almost universally positive. Having known very little about the policy changes before, CHWs generally appreciated any information and if anything, wanted more contact with PHM. They seemed to enjoy the chance to get together with other CHWs (as well as an out of towner audience) and share their anger and frustration – often specifically at the government and the formal health system.

Critical health perspectives: Louis gave a short presentation on the PHMSA critical health perspective, a short publication, as a form of knowledge generation and dissemination. He explained how a small group of PHMSA members created an editing to team to collect and write critical issues happening in SA. Participants were given hand-outs of previous CHPs produced. Louis suggested the possibility to consider similar processes in other African countries. Different forms could be a blog, on-line publication, regional CHP, or to integrate with an existing platform such as Ground Up etc. He highlighted the importance of an editorial collective and content.

DRC

Gaston presented their research findings on knowledge generation and dissemination in DRC. PHM DRC has been involved in a series of activities to generate knowledge in relation to health for all and the right to health. These include:

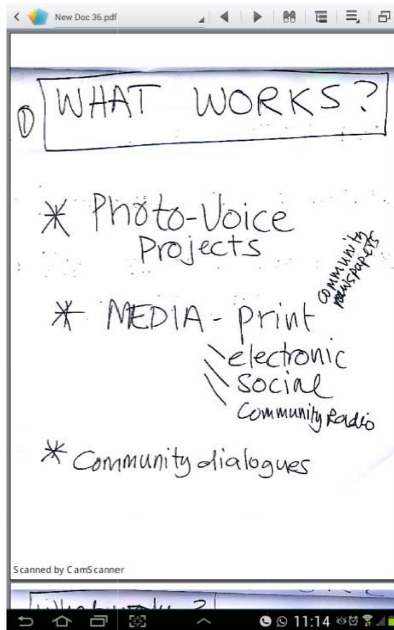
- Workshops on the right to health and social determinants of health. Different delegates from provinces made recommendations and solutions on “water, sanitation and community participation”;
- Standardization of training modules on the right to health;
- Social survey of three social determinants of health in three areas: Katanga, Kivu and Kinshasa; the results of this investigation resulted in the development of the specifications on the three social determinants of health;
- Production of reports of activities and the report of the IDRC project of two researchers in the Democratic Republic of Congo.

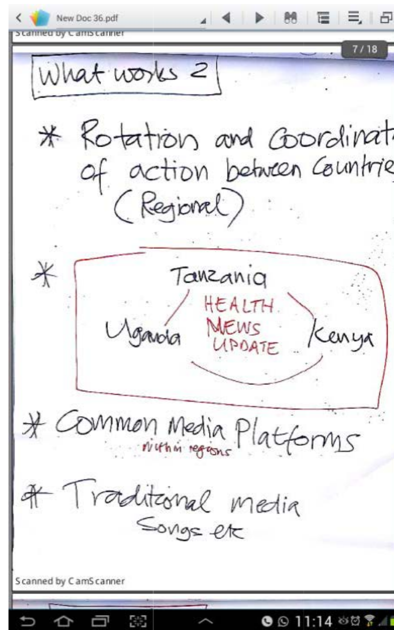
Knowledge is disseminated through several communication channels: Website, Facebook, written reports, specifications, banners, audio visual programs, exchange of experiences, newspapers and newsletter. This spread is reserved for training purposes of information, popular health education, awareness, organization of health activities for all. All this knowledge stimulates social practices of self- management and empowerment of people at grassroots level.

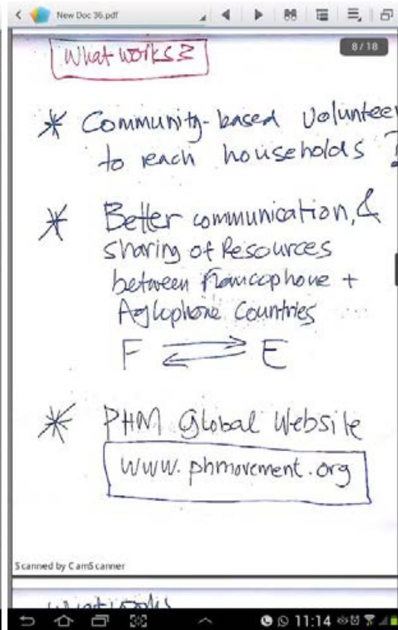
Country representatives presented on how they generate information and disseminate information. Some examples included policy briefs, collects news clips from the media and webpage, collect some research studies released on weekly basis, twitter, sms, comic, Facebook, Google group, blog, position papers, newspaper articles, articles in magazines, reports, posters, t-shirts, etc.

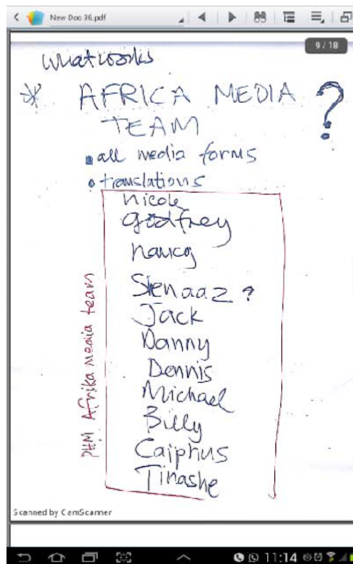
T-shirts for a RTH campaign in Kenya

Knowledge generation and dissemination was discussed in plenary to look at some concrete processes to communicate effectively in health activism. From the discussion a PHM Africa media was established to revive all the PHM Africa communication platforms and ensure that all PHM members make use of PHM available resources such as the website, GHW and various PHM analysis, for example on Ebola, SDGs, etc. It was acknowledged that there are many resources on the current PHM platforms but we would need to look at ways to use them more often in our work. Participants also committed to develop sub-regional news updates which could feed into a regional CHP (similar to the example of the SA CHP) or an Africa Health Watch.









Some forms of what works in knowledge generation and dissemination

Afternoon session

WHO Watch and other forms of policy dialogue by Linda Shuro

Linda Shuro (Africa Outreach coordinator) introduced the role of policy dialogue for health governance at local, regional and global level. She presented the WHO watch which is a Democratising Global Health Governance Initiative by PHM with a focus on the WHO as the leading global health governing body. The WHO watch

- seeks to generate support for a reformed WHO restored to its proper place in global health governance.
- supports delegations from smaller countries who are seeking resources on issues that they are concerned about.
- Delegates from small countries are over-stretchedtrying to cover a very wide range of issues andWHO-Watch provides a resource for delegates toWHO governing bodies(see more in the presentation).

Country circles can be involved in giving input into commentaries, statements and watching at the different levels. Denis Bukenya from Uganda shared his experiences as a watcher at the World Health Assembly.

The trickle of the information to countries is not so much. Uganda has attempted to engage Ministry and also a feedback meeting. Through the WHO watch, David explained that PHM has developed many policy briefs which are targeted at the members attending. There are about 192 member states. Many delegations do not read the documents as they are huge so the policy briefs which are summarised and provide a critical analysis. The team also engages with friendly delegates such Thailand, SA to lobby but also distributes itself in different side meetings to voice their input.

Discussion

DRC IDRC research findings -Policy dialogue in health activism by Erick

Erick presented the different policy dialogue platforms and activities that DRC has been involved in. these include

- DRC Policy Dialogue report,
- Focused on article 47-dialogue with authorities and population
- Collaboration with other organisation
- Construction of dynamics with health authorities
- Stand of PHM
- National movement for RTH with PHM members

Discussion: it was raised that the DRC group should link with Heal Africa for peace discussion and action they raised and also they will be put you in touch with other organisations. The group from Palestine has also been linked to DRC.

Country experiences on policy dialogue

In plenary participants explored platforms that exist for dialogue and what strategies and issues should PHM prioritise at country and regional level. From the discussion SDGs came up and questions on how to dialogue on different health issues. As a result David then gave a presentation on SDGs as it is a common issue in Africa

Sustainable Development Goals (strengths and weaknesses) by David Sanders

In summary, PHM was critic on MDGs especially on equity issues. While some countries may have reached the average-target but yet the poorest wouldn't have reached. The average masks the best and worst. SDGs are now more improved to address these and one slogan included is "leave no man behind". SDGs are better than MDGs as they started to address equity. His presentation pointed out that if we do not change the economic order then SDGs won't be reached and we won't reach HFA. So as health activists engage we need to critically analyse processes in achieving HFA (see more in the presentation.

Discussion on the manual for movement building

A facilitated discussion took place based on the recent document of the 9th of June which has a draft structure of the manual. Participants welcomed the manual as a good step. Unfortunately most had not familiarised themselves with the call and were unaware of the process. Only three countries (Kenya, Uganda and Tanzania) had engaged with the process to submit the collection of experiences. It was noted that the manual is being developed from the collection from countries. It was emphasised that it is important that the introduction should include the history/journey of PHM from the beginning up to date and also that the manual should have examples of how PHM has been built in other countries. As a way forward country representatives committed to facilitate a process to collect experiences in their countries for the manual and to submit them by 31 July 2016. Ugandan and Kenyan colleagues mentioned that they developed a working group and it took them about a month to develop a document for submission.

Annual lecture of David: participants attended the evening lecture organised at the School of Public Health. The guest speak was Dr Sunda who gave a presentation on Strengthening Public Health systems, what works what doesn't?

DAY 4: BUILDING THE HEALTH MOVEMENT

Movement building

Anneleen gave a presentation on the National Health Insurance (NHI) coalition which started in response to the release of the NHI Green Paper. A civil society submission was needed and therefore PHM drafted such a statement and invited like-minded organisations to join the statement. They did an SMS survey about the NHI and out of that a coalition was formed with SoulCity, S27, TAC, BlackSash, RHAP, Ruresa, Rudasa, Passop, Earthlife Africa, Nehawu and African Health Placements. Coalition was formed and meetings held but organisations conducted activities independent from the coalition. However through this process:

- PHM organised community workshops that analysed NHI and their situation (10 points to evaluate..)
- South African People's Health University on NHI with Nehawu
- TAC continued awareness raising on the NHI with its members

In summary, whilst the coalition faded a foundation was built towards building a health movement. These organisations now work closely towards HFA as evidenced in the recent NHA.

David added that PHMSA understands the perspective of the global movement which rests on two main plugs-we recognise the fundamental importance of SDHs and a movement that insists on comprehensive primary health care. Therefore PHM brought into this coalition a perspective on SDH and health systems e.g. the battle of treatment won but the system is not working e.g. stock outs due to management issues, corruption, etc. Therefore PHMSA is working with other partners as agreed in the NHA on a few campaigns-HRH and CHW-more CHWs who can do more and a cost analysis/economic calculations benefits of investing with more HR and work with economists were this money would come from. Other countries could do similar work e.g. if we look at the different countries you will see that tax has been dropped for the rich and corporates so money is there but it's not going into the national budget fiscus.

Key forms of action for the health movement in Africa

From the previous discussions, presentations and country reports a plenary was facilitated were everyone agreed that there was there was a need for a strong health movement and identified Human Resources for Health as a common issues to build a campaign in the region. This will take different forms in the different countries and some countries would have other parallel campaigns specific to their context such as pushing for free health care in Kenya, people's participation in processes for DRC and Benin and food sovereignty in Tanzania.

Participants were divided into sub-regions (East, Southern and Francophone Africa), groups to discuss a more concrete plan of action which they would share with the country circles for further discussion (see group questions for the discussion below).

A plan of action around these 3 campaign areas:

- Identify partners / networks / organisations to be involved (local, regional, global); What specific actions (in countries, region and globally as required);
- What capacity development, knowledge, policy dialogue/engagement etc is required? Next steps on returning to respective countries and who responsible
- How can we work more effectively as a region and build a strong health movement and regional solidarity?
- -How do we need to structure our region to strengthen movement building / the people's health movement?
- -What communication platforms could best strengthen the movement?
- -Who are the actors/drivers? (other networks / organisations / movements that exist in the countries or region); How could we better network with existing coalitions?
- -Are there any forums / meetings / platforms we could use / piggy back on

Discussion of specific key actions to take forward

The discussion was centered at looking at actions going back to respective countries and think of key actions relevant to each country context-what is feasible and what is an issue that will mobilize for example at the SA NHA they agreed on two HRH issues to focus on CHWs and work with CHWs to organize a summit where this evidence will be important to discuss. Work with TAC members on the ground to do an inventory of skills gap and posts that have not been filled at PHC level

ZIMBABWE: CWGH has a big network-use that network to do a research e.g. on critical skills shortage-testimonies/stories of people denied health care because there was no one at the health facility- so to use the power of numbers (through research) and power of stories (testimonies)-recent HW protests on non-payment.

ZAMBIA: look at CHWs and learn from the research like SA. Then combine the research evidence and using that for campaigning. Groups such as TAC have been successful as they get evidence e.g. stock out campaigns

SOUTH AFRICA: cost based analysis of CHWs and implementing the resolutions of the NHA

UGANDA -one of the building blocks is the institutionalization of CHWs. PHM Uganda action will look at cost based analysis of CHWs: costs and benefits of CHWs, savings in Health Care, how much jobs can you generate. They could use a similar methodology from South Africa could will be passed on to Uganda and they can collaborate with ACHEST and other partners and bring in something new on cost based analysis.

TANZANIA-speed up the institutionalization of CHWs and look at the form that it will take. A role to look at the Ugandan and SA example as a reference for the cost based analysis-work with SA via Linda.

Tanzania and Uganda can also share their experience to SA of how CHWs are working in their countries for South Africa to use in their campaign

KENYA-THE focus for Kenya as highlighted in the group discussion is on free health care. They would need to partner with other CSOs e.g. UNICEF and share how in many countries that there is free health care e.g. SA-Produce evidence that there is benefits of free care for MCH. They could take the legal route for courts to explain the right in the constitution-benefits of free care and why women need it- coalition with legal

groups that can take it forward-already have a coalition that has produced an alternative civil society report to the UN on ESCR.

DRC-community participation in health processes (budgeting, etc), educate people on RTH, promote participation in health with other CSOs.DRC will work with other coalitions to push for participation

BENIN-community participation in health processes (budgeting, etc) working network organisations working on Health,

Outcomes of the workshop and Follow up plans

The workshop ended with specific outcomes to take forward and motivated activists to strengthen the movement. These include:

- Shared findings of the IDRC research project which formed a basis for the workshop
- Health activists were better equipped with knowledge and skills for future evidence basedAdvocacy and campaigning, capacity building, knowledge generation and dissemination to strengthen the health movement in addition to addressing the social determinants of health.
- Existing PHM country circles (active and embryonic) were strengthened through the exchange of information and experiences especially attending the NHA and meeting with similar health activists
- A unified regional campaign on Human Resources for Health which will take different form in the countries
- Action plans for future country-based work developed and will be led by young health activists and assisted by the PHM secretariat and IPHU resource persons.
- A PHM Africa youth league was established
- APHM Africa media team established to revive and look at new channels to ensure exchange of information
- Short videos of solidarity

Follow up plans

At regional level

- To encourage more involvement of French speaking countries in PHM Global programmes.
- To develop the workshop report-how do we move forward and carry on these countries-
- Establish a regional follow up platform which includes everyone who attended the workshop.
- The key actions identified should be the focus and the secretariat will assist as when where we can- start using a forum of these actions to build the health movement
- As part of big study, a report will be combined of all the country studies and a plan developed for a way forward to use the information
- Sharing of the IDRC report-Global report
- Use of country webpages by countries -put forward to the PHM Africa Media Platform
- Roll out of the HRH campaign and have a one day of action on HRH-do something different in each country- a day that lead forwards towards action. we have an Africa day of action - work

more on concrete plans and launch a day for the campaigns. PHM Uganda has been involved in the Everyone campaign is involved –learn from this campaign

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HEALTH FOR ALL, NOW!!