

THE CONTRIBUTION OF CIVIL SOCIETY ENGAGEMENT TO THE ACHIEVEMENT OF HEALTH FOR ALL (CSE4HFA)

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Project implementation through People's Health Movement (PHM) with Médecine pour le Tiers Monde (M3M) as financial host

Research conducted in: South Africa, India, Democratic Republic of Congo, Italy, Brazil and Colombia; as well at the global level

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- the tireless work of the scores of activist-researchers who contributed to the various studies upon which this report is based (they are listed in the relevant annexes to this report and the research reports linked from the annexes);
- the health activists whose work is reported on through this research (see next page); and
- health activists everywhere.

“You know very well, as many others know, that I have had a love affair with the People’s Health Movement since a very profound start in Bangladesh about eight or nine years ago. After that People’s Health Movement is the one single movement that has been struggling to try to revitalise the message coming out of Alma-Ata in its most profound way, not only a few lines about priorities but the whole concept of people’s own participation as individuals, as families and as communities. You [PHM] have shown that one can mobilize people at all levels in order to somehow fight for their own health and well-being, socially and in any other way too. “

“Health for All that is the spiritual dimension of primary health care, that is the value system and you must have a value system if you want to have primary health care strategy. And People’s Health Movement right away made it Health for All that was the very important part of the message coming out of Alma-Ata. I think you are the only movement having done that.”

Dr Halfdan Mahler, Third Director General of WHO (1973-1988), 9 June, 2008

[A message to PHM](#) on the 30th Anniversary of the Alma-Ata Declaration on Primary Health Care.

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Executive Summary

Chapter 1. Introduction

Between 2014 and 2018 the People’s Health Movement (PHM) undertook a large multi-centre study supported by the Canadian International Development Research Council (IDRC) exploring civil society engagement in the struggle for ‘Health for All’. Over four years, 130 activist-researchers in 10 countries produced 50 research reports.

All the research reports, generated through this project, are listed and linked from Chapter 1. This list does not include the working documents that were prepared by the various teams in the implementation of their studies.

The main findings (Chapters 5-9) are structured around the five themes which have framed this whole project: Movement building, Campaigning, Capacity building, Knowledge generation, and Engagement with global governance. Almost all of the reports generated by the study have raised implications for these five themes, although not every report has done so explicitly.

We have prepared 17 annexes to this report which provide additional background to the various studies, summarize long reports and/or explicate the thematic implications. The thematic implications have been transferred from reports and annexes to the thematic chapters herein, where they have been integrated into a coherent narrative regarding each theme. These processes are represented diagrammatically in Figure 2, below.

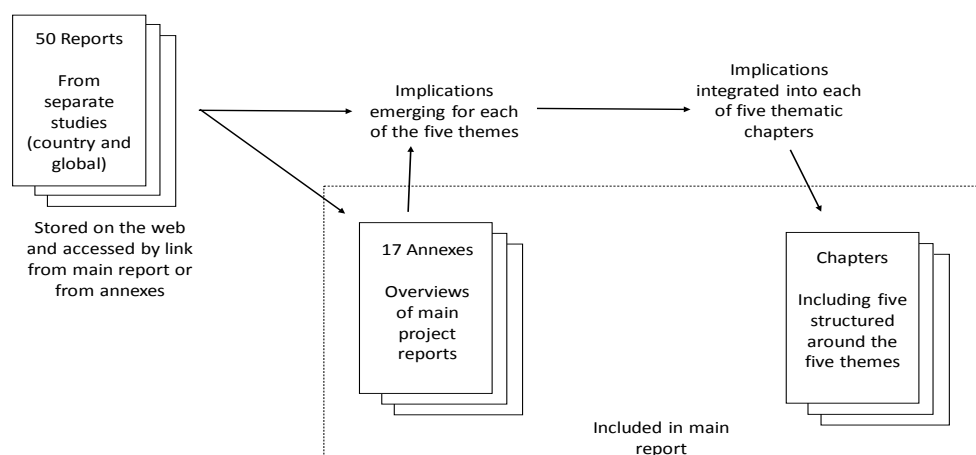


Figure 1. Relations between reports, annexes and chapters

Chapter 2. The unfulfilled promise of Health for All

This research has taken WHO’s promise of “Health for All by the year 2000” as a standard against which progress in global health since then might be evaluated and, minus the deadline, as a goal which remains to be achieved.

The Global Strategy for Health for All by the Year 2000 was adopted by the World Health Assembly in May 1981. The Global Strategy defines HFA as “the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”. The strategy emphasizes health system development based on primary health care (PHC) principles including appropriate technology and community involvement. The Global Strategy reflects a clear understanding that population health is largely created beyond the services of the health system and has a strong emphasis on intersectoral collaboration and what is now referred to as ‘health in all policies’. The commitment to intersectoral collaboration was also predicated upon a certain confidence in global economic reform symbolized by the references to the New International Economic Order (NIEO) in both the Alma-Ata Declaration and the Global Strategy.

In Chapter 2 we review the history of Health for All from 1981 to the present in relation to the evolving global macroeconomic policy regime.

We then review the progress towards ‘Health for All’ following as closely as possible the indicators which were highlighted in the Global Strategy itself, including child mortality, immunization, water and sanitation, malaria and nutrition. Despite some improvements, associated with advances in medical and public health technologies, large scale donor driven health programs, changing demographics and patterns of morbidity, and rapid economic development in China, the promise of ‘health for all’ has not been delivered. Hundreds of millions of people, particularly in the African, South East Asian and in the Eastern Mediterranean regions do not have “a level of health that will permit them to lead a socially and economically productive life”. Furthermore, the gap between these regions and the high income countries has widened.

Humanity has in aggregate sufficient material resources and technologies to deliver decent health care and healthy living conditions for all. The critical questions concern how humanity collectively decides to allocate those resources.

Too often this question is treated solely as a ‘policy question’ without regard to the relations of power which maintain inequality, prevent health system development, and reproduce the conditions which generate disease and disability. Achieving Health for All certainly requires attention to policy questions, often quite complex policy questions. However it also requires attention to the structured power relations which are instantiated in the structures of governance at all levels (including economic and political as well as health governance).

The operations of power (including the expression of power through policy) are clearly evident in the historical review presented in Chapter 2, most dramatically in the replacement of the vision of an NIEO by the current regime of global economic integration.

The case for promoting civil society engagement in the struggle for HFA rests on the prospect of both contributing to better policy making and implementation and on strengthening the voice of the various subaltern classes in the process.

Chapter 3. Civil society, social movements and globalization

The research we are reporting on has been focused on the contribution of civil society to achieving Health for All. There is a powerful historical case for the importance of civil society engagement (CSE) in the achievement of social change, locally, nationally and globally. Precedents include legal reform (e.g. abolition of slavery), institutional development (e.g. environmental protection), and cultural change (e.g. gender relations). A recent example more specific to health has been the success of the Treatment Action Campaign in affirming the legitimacy of using the flexibilities provided for in the TRIPS Agreement to facilitate access to medicines, even while they are still under patent.

In Chapter 3 we discuss our uses of the terms ‘civil society’ and focus on the ‘social movement’ as a way of exploring civil society engagement. We present a framework for describing, analyzing and improving social movement practice based on five broad domains:

- movement building (including various strategies directed to recruitment and retention, strengthening coherence, organizational and cultural development, resource mobilization, networking and leadership);
- campaigning and advocacy (including forms of action, sources of power and levers of influence);
- capacity building for both individuals and organizations (including knowledge, skills, identity, and agency for individuals and relationships, shared culture, division of labor, and leadership for organizations);
- knowledge generation, access and use (including all the different ways in which a social movement collects and generates knowledge to inform strategy and practice; including both technical knowledges and the experiential knowledge), and
- engaging with global governance (including policy dialogue regarding pathways to health improvement, linked to strategies for challenging the configurations of power which control the prevailing structures of governance).

The global transformations, known in general as ‘globalization’, are a major feature of the context in which this research project has been conceived and implemented. This has important implications for the research which we also explore in Chapter 3.

The assumption which underlies this project is that formal research into civil society engagement for Health for All might point to ways of making it more effective; including strategies for both activist practice and for policy makers and funders to more effectively support such engagement. The discussion in this chapter of the unfulfilled promise and of the significance of globalization helps to frame the questions which have guided this research project.

Chapter 4. Methodology

The People’s Health Movement (PHM) is a global network of community organizations working towards Health for All: organizing at the local, national and global levels; campaigning around specific issues; providing training; developing information resources; and engaging officials in multi-level policy dialogue.

PHM embarked on this research convinced, on the basis of many historical precedents, that civil society engagement (CSE) *can* contribute to the achievement of HFA. However, the question which follows and has driven this research is ‘how to do it better?’

In Chapter 4 we provide an overview of research methods deployed in these various studies.

Domains and themes

The data collection and analysis have been structured around five domains of activist practice introduced above. These domains of practice are conceptually distinct but in reality they are overlapping, interdependent and synergistic. For this reason we have referred to ‘generic themes’ in discussing the data collection and analysis and in the findings chapters. As ‘themes’ they wind their way inextricably through the purposes and activities which we have been studying.

Research strategies and projects

The research strategies we have deployed ranged across:

- participatory action research with inductive and interpretive generalization;
- formative program evaluation drawing on both quantitative and qualitative data collections;
- integrative and consultative synthesis;
- retrospective personal narratives with interpretive generalization; and
- desk research: literature review and synthesis.

Participatory action research examining civil society engagement was undertaken by PHM circles in six countries (Brazil, Colombia, the Democratic Republic of the Congo (DRC), India, Italy and South Africa). Guidelines for country research teams outlining the purposes, strategies and organization of the research were developed. It was explicitly provided that participating in this research was to be a useful and integral part of those country circles’ action programs. The principles of participatory action research (PAR) were central to the planning and implementation of the research; new knowledge would be generated by systematically learning from practice. The data collected in the country case studies were analyzed through *inductive* and *interpretive generalization*. Studying the *five domains in parallel in six countries*, guided by common program logics, provided the basis for induction. *Interpretation* of the findings was framed by the broad narrative within which the research was originally conceived.

Formative evaluations of three of PHM’s global programs were undertaken. These were: the International People’s Health University (IPHU), Global Health Watch (GHW), and WHO Watch.

In-depth interviews were conducted with experienced global health activists, all of whom had been active in PHM for ten years or longer, to document and reflect upon their experience of civil society engagement in the struggle for Health for All. These data were thematically analyzed.

Two of the studies undertaken were based on desk research:

- a review of research and commentary on social movements, and
- a narrative history of the global Health for All movement.

By mid-2016 all of the Stage 1 reports from participating countries had been submitted and on the basis of these reports a 'manual' on movement building was conceived and a call for further case studies was widely broadcast. The manual was drafted drawing on the Stage 1 reports and was revised in consultation with advisors from across PHM. In effect the Manual was a public report on the findings of the first stage of the research and a blueprint for implementing those findings more widely.

More detail regarding the method deployed for the various sub-projects is provided in Chapter 4.

Data collection

Several broad sets of data were collected including the case studies from participating country based research teams, reports from regional workshops, additional case studies from El Salvador and Ghana, three program evaluations, the collection of personal narratives from long standing activists, the review of published research and commentary regarding social movements; and the narrative archaeology of the Health for All movement globally. In all cases data collection and analysis were structured around the five themes corresponding to five domains of civil society engagement.

Generic program logic narratives were developed for each of the five themes and the data collection was structured with attention to these narratives. However, the country research teams were asked to adapt the generic program logics to the specific circumstances of each study and to the activism being researched and to structure their data collection around those adapted logics.

Analytic approach

The analysis was undertaken at two levels: first, by the local research teams in the preparation of their reports and second, by central research team in the context of assembling this report. In both cases the analysis was framed by the five themes.

At both levels the analysis came together over time through several inclusive workshops. The regional workshops provided opportunities for the country research teams to present their findings and discuss their conclusions. There were also several review and planning workshops at which the emerging findings from all of the different projects were reviewed and discussed.

The analytical approach adopted may be summarized as follows:

- principles of practice (insights into conditions, strategies and forms of action) are the main form of knowledge being produced;
- the *value* of the generalizations produced derives from their *usefulness in practice* in particular settings;
- as far as possible the principles (generalizations) must remain *tethered* to the case studies from which they have emerged.

Further detail regarding these analytic principles is provided in Chapter 4.

Organizing the data

All of the various sub-studies (country case studies, program evaluations, desktop studies, etc) were designed around particular objectives arising from context and content, and the reports of these studies include diverse conclusions around those objectives. In addition the researchers were asked to draw out conclusions pertaining to the five core themes of the larger project which in most cases they did.

In the annexes to the main report we have summarized the various country studies, program evaluations, etc and have itemized the conclusions arising from those studies for the five core themes. Where the local researchers did not identify thematic conclusions, these have been drawn out in the process of developing the annexes.

The main thematic chapters of the final report have been assembled through a process of narrative synthesis, building on the identified thematic conclusions from the various sub-studies.

Ethics approval

Research teams, both country and global, negotiated ethics approval through locally relevant authorities. These are described in the specific research reports. In addition Ethical Clearance for the global research project as well as the South Africa specific research was obtained at the University of the Western Cape, South Africa.

Research personnel

The principal investigators for this project were:

Chiara Bodini (University of Bologna, Italy),
David Sanders (University of the Western Cape, South Africa), and
Amit Sengupta (People's Health Movement, India).

They were supported by:

Fran Baum (Flinders University, Australia)
Ronald Labonté (University of Ottawa, Canada)
David G Legge (La Trobe University, Australia)

David Legge drafted this report in consultation the principal investigators and co-researchers.

The country research teams were a combination of senior researchers and younger researchers who have been mentored by the former during the course of the project. A full list of the researchers and co-researchers is included in [Chapter 1](#) of the main report. The country and global research teams are also identified in the reports linked from and summarized in [Annexes 1-17](#) of the main report.

Research capacity-building

Research capacity building was a core objective of this research from conception. The principal focus with respect to such capacity-building has been on young people who are already working with community organizations and networks which are working towards HFA objectives. Capacity building initiatives, including semi-formal training (in the context of workshops), mentoring and supervised experience has served to cultivate basic research skills (including critical inquiry, methods for data collection, disciplines of data analysis and report writing). These skills contribute to cultivating organizational learning as a core element of civil society engagement in the struggle for HFA.

Gender

Gender equity and sensitivity have been key concerns throughout the project, including in the composition of the country research teams, the development of research protocols and research capacity-building opportunities. 82 of 132 researchers involved in the project are women. Several of the case studies have addressed gender inequity, feminist movements and LGBTQI issues.

Impact on PHM's policies and practices

Participation in the project has contributed to movement building and capacity development in all of the participating countries, including those countries participating in the regional workshops

The project's findings are already being applied in the conduct of PHM's global programs, including the organization of WHO Watch, the development of the fifth edition of Global Health Watch (published in late 2017), the development of the Manual on Movement Building and the planning for two IPHUs in November 2018.

Chapter 5. Movement building

The effectiveness of a social movement is a function of its strategizing and organizing capacity and its political power. The modalities of power include: numbers, organization (including networks and alliances), culture, material resources, information, knowledge and skills. Movement strengthening and capacity building are key objectives of social movement strategy, including developing those modalities of power.

Our findings regarding movement building are summarized in eight principles emerging from our research:

- Attend to all levels of the movement: individuals, relationships, communities, organisations and networks;
- Understand the pathways to activism;
- Community building, including mutualism, is part of movement building;
- Collaborating with the State is a matter of judgement; weigh the benefits and the costs;
- Social movements have deep roots; know your history;
- Leadership is necessary but so is accountability;
- Build constructive links between the HFA movement and broader political movements;
- Convergence (through solidarity, networking and collaboration) is a key objective of movement building in the era of globalisation.

The findings in support of these principles are presented and discussed in more detail in Chapter 5.

Chapter 6. Campaigning and advocacy

Campaigning and advocacy are at the heart of social movement activism. Campaign strategies assume or imply particular theories of change. If they are articulated they can also be interrogated, evaluated and perhaps strengthened. Strategies are enacted through a myriad of different ‘forms of action’. While campaigning is always highly context-dependent we have identified some general issues which need to be considered in campaign planning.

Policy advocacy is necessary but should not over-shadow structural critique. A balance between policy engagement and confronting power structures is needed. A similar call for balance is seen in the micro macro principle which envisages addressing the immediate issues in ways which also contribute to structural change, including across longer term and larger scale.

Networking, building coalitions and alliances, can extend the reach and impact of the campaign. However, networking can be quite challenging.

The chapter is structured around the following three broad principles:

- Campaign strategies bring together theories of change, forms of action and unique circumstances;
- Networking for campaigning is empowering but requires investment and compromise;
- Need to balance policy advocacy with structural critique.

Chapter 7. Capacity building

Building the capacity of health activists and of civil society organizations working towards Health for All is a necessary part of movement building. However, it opens further questions about what kinds of capacity and what kinds of learning pathways. This latter question is complicated by the fact that in large degree capacity development takes place informally in the normal course of working with communities, networking, campaigning and advocating – learning by doing.

Capacity building is a critical part of movement building and direct engagement in the struggle for Health for All. It is useful to think about different kinds of capacity at both the individual and the organizational levels. Capacity at the individual level, includes: experiential and embodied knowledges and skills; technical knowledges and skills, and subjectivity (the habitus of the activist). At the organizational level, capacity includes the number and capacities of

the people who are part of the organization. It includes organizational culture and the networks and relationships which give the organization coherence and resilience.

These two levels are connected in several ways. Most obviously the training of individual activists is a contribution to organizational capacity building. Less obviously are the new relationships which are formed in training programs, which are highly valued by the participants but which are also contributing to strengthening the organization. Training opportunities which assist participants to shape and reshape their own personal subjectivity are also helping to strengthen the culture of the organization. Training which deepens individuals' reflexivity and sense of inquiry are also contributing to organizational learning.

The learning which takes place informally in the context of various movement activities plays a key role in capacity development and we have reviewed some illustrative cases. There is also an important place for more planned, structured training programs and we have reviewed some directions emerging from the IPHU evaluations.

The presentation and discussion of the research findings regarding capacity building is structured around six principles:

- Beyond individuals, think relationships, think organization, think culture;
- Think of capacity building in relation to pathways to activism (understanding, hope, resilience);
- Build on informal learning opportunities as well as organizing formally structured training programs;
- Link curriculum planning to practice opportunities;
- Bringing 'body knowledge' into discourse (through popular education and 'systematization of experience') makes such knowledge available for sharing and building upon;
- Avoid expert domination: value trust, reciprocity and dignity.

Chapter 8. Knowledge generation, access and use

Knowledges, the plural signifying different kinds of knowledges, are critical assets in the struggle for HFA. Chapter 8 is based largely on the findings of the country case studies, as well as the evaluations of Global Health Watch and the Personal Narratives study.

Changing the flow of information and knowledge can change power relations; more specifically it can empower social movement activists. We have cited examples from our case studies of new flows of scientific, technical and legal information and of activists working to create and share such information. We have also cited under this heading the widening access to indigenous knowledges, in particular, the cosmovision of Central America, and its potential to change the ways we see ourselves in the world.

We have explored different approaches to producing the knowledges that activists need. These include formal and deliberate knowledge creation, as in academic research or in knowledge programs like Global Health Watch. They also include less formalized knowledge creation with several examples of learning in practice, several instances of bringing experiential knowledge into discourse, and cases of re-appropriating history, culture and identity.

Under the heading of knowledge sharing we have summarized some experience regarding different media and methods for sharing; and we have highlighted the need to be conscious of the power relations which frame knowledge sharing and interpretation.

The presentation and discussion of the findings regarding knowledge generation and access in Chapter 8 is structured around three broad principles:

- New information flows can be empowering, including:
 - scientific, technical and legal knowledges, and
 - indigenous knowledges, such as Central American indigenous cosmovision, provide resources for new ways of understanding ourselves in the world.
- Producing the knowledges that the activists need is a core social movement strategy, including:
 - academic research,
 - research synthesis,

- learning from activist practice,
- bringing lived experience into discourse, and
- re-appropriating history, culture, identity.
- Knowledge sharing is a core social movement strategy, exemplified by
 - Global Health Watch, but attention is needed to
 - media, methods and language, and awareness that
 - knowledge sharing is embedded in relations of solidarity and relations of power.

Chapter 9. Engaging with global governance

Our discussion of global governance in Chapter 9 is structured around two broad principles:

- critical policy engagement by social movements at the national level deals with *both* national issues *and* issues which have international ramifications;
- there is also an important role for critical policy engagement by social movements operating directly at the global level, linked to complementary advocacy at the national level.

Following our discussion of these principles we review WHO Watch (one of PHM's global programs) as an experiment in critical policy engagement at the global level. We describe the strategic logic of WHO Watch and how it works. We then draw upon the country reports, the evaluation of WHO Watch and other reports to reflect upon the achievements, uncertainties and options for the further development of WHO Watch.

We use the term 'critical policy engagement' in order to emphasize the need to balance policy dialogue with structural critique; this we are referring to as 'critical policy engagement'. Policy dialogue generally focuses on explaining problems in terms of institutional failure and proposing appropriate institutional reforms. It is important to also recognize the power relations within which the structures of governance operate and to balance policy dialogue with structural critique.

We have reviewed material from the country case studies dealing with critical policy engagement regarding both domestic issues and national issues with international ramifications. These cases confirm the importance of 'critical policy engagement', policy dialogue integrated with structural critique, and of the value in many situations of aligning local activism with global power.

The second half of the chapter focuses on WHO Watch and the theoretical assumptions which have informed its design. These assumptions regarding usefulness, pathways, networking, capacity-building and convergence remain plausible but further research is needed.

Chapter 10. Suggestions for policy makers and funders

Finally we summarize some messages to policy makers and funders arising from the research presented in this report. The advice and suggestions outlined below are directed to those policy makers and funders who are committed to health equity and who do see an important role for civil society engagement in working towards this goal.

Two broad conclusions which are of particular significance for policy makers and funders are first: that CSE can be effective in moving towards HFA but there is always scope for improving practice; and second: that CSE is needed at the global as well as the local level.

Civil society engagement in working towards HFA at the national and global level could be greatly strengthened through greater support from national policy makers. We summarize the ways in which policy maker and funding support could contribute to strengthening civil society engagement for HFA in relation to the five generic themes around which this research has been structured.

Policy makers

Organizational development, networking and movement building:

- implement practical freedom of information provisions; many of the case studies collected through the country-based research have needed access to official information which is not always available;
- protect civil rights and freedoms (such as freedom of speech, and of assembly); in several of the case studies collected for this research health activists have been murdered for their defence of the right to health;
- commit to health as a right in accordance with Comment 14¹; in several of our case studies and other reports human rights standards have been egregiously breached by the state; Health for All depends on the realisation of the full suite of inalienable and indivisible human rights; and
- return to comprehensive primary health care including a commitment to meaningful community participation in health care delivery and action around the social determinants of health.

Campaigning, advocacy and mutualism:

- explore partnerships with civil society in policy and program development and implementation;
- be aware of the risks of cultivating the voluntary sector in health care delivery in circumstances where this facilitates marketization, creates barriers to establishing a national health service and encourages the delivery of narrow vertical programs.

Capacity building (individual and organizational):

- encourage educational institutions to include the provision of training for community organizations in their planning and course offerings; and
- consider the kind of cooperative training developed in El Salvador, providing the opportunity for policy officials, agency managers and health activists to come together in collaborative learning.

Knowledge generation, access and use:

- support research collaborations between activist academics and community organizations;
- ensure that there is space in academia for research methods which value experiential knowledge, which understand the framing of knowledge in the subject position of the activist and are directed to learning from practice;
- support research training in appropriate research methodologies for community groups; and
- encourage university and public libraries to facilitate public access to electronic journal articles, e-textbooks, e-encyclopedias and e-books.

Policy dialogue and engagement with global governance:

- include civil society people on your delegation to inter-governmental meetings, including meetings of WHO's governing bodies;
- open yourself up to consultative engagement regarding national positions on global issues as in the Ghana model.

Advice for funders

Civil society engagement in working towards HFA at the national and global level could be greatly strengthened through greater support from funding bodies. We suggest:

- provide core funding in support of social movement CSOs in order to strengthen the processes described in this report; processes which ultimately contribute to HFA;
- be aware of the limits and risks associated with tightly specified project funding; accountability should be based on integrity, organizational learning and core directions;
- be cautious about funding small community organizations to deliver basic health services (because of the risk of patchy and fragmented service delivery); if you are funding basic on-going health system functions do it through government;

1. United Nations Economic and Social Council (2000). [General Comment No. 14 \(2000\)](#): the right to the highest attainable standard of health (E/C.12/2000/4 (11 August 2000)), UN.

- don't demand immediate results; movement building and organizational development take years not weeks; and
- don't impose narrow or pre-determined KPIs on projects which are essentially exploratory or on organizations working in complex and dynamic settings.

Health policy is political and activists sometimes offend powerful interests. Managing this risk (for funders and politicians) through tight contractual restrictions will greatly restrict the capacity of activist organizations. If the risk is significant there may be ways of finding intermediaries through whom such funding support might be passed.

Advice to WHO

Open up regional committees and country offices to broader and deeper civil society engagement. Appreciate the potential of stronger CSE in defending the role and influence of WHO.

Chapter 1. Introduction

Between 2014 and 2018 the People’s Health Movement (PHM) undertook a large multi-centre study exploring civil society engagement in the struggle for ‘Health for All’. Over four years, 130 activist-researchers in 10 countries produced 50 research reports. This report summarizes those studies (with links to the individual reports) and distils out from them the key findings regarding civil society engagement for Health for All.

Origins and management of the research

In 2012 the Canadian IDRC (International Development Research Centre) contributed to the cost of the Third People’s Health Assembly in Cape Town in July 2012.

Following PHA3, and in discussions between PHM and the IDRC, the possibility of a research project based on evaluating, learning from and improving the work of PHM was explored. By late 2013 a research proposal on ‘Civil Society Engagement towards Health for All’ was finalised and funding agreed to.

Funding commenced in early 2014 and the project was launched at the Cape Town planning meeting in July 2014.

Researchers

The project has been managed by the three principal investigators (David Sanders, Chiara Bodini and Amit Sengupta) with three co-researchers (Fran Baum, Ron Labonté and David Legge), working in consultation with the Steering Council of the PHM.

Around 124 co-researchers have worked with this coordinating team to undertake the country level and other studies which comprise the overall project.

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<p>Belgium</p> <p>Geraldine Malaise and Lies Busselen, Katrien De Troeyer</p>	<p>Germany</p> <p>Salome Adam</p>
<p>Brazil</p> <p>Camila Giugliani, Cristianne Maria Famer Rocha, Denise Nascimento, Eliane Maria Teixeira Flores, Kátia Cesa, Patrícia Genro Robinson, Roberta Alvarenga Reis, Vânia Correa de Mello, Marta Giane Machado Torres, Neuza de Freitas Raupp Cechinel, Mariana da Rosa Martins, Cristiane Nunes Pereira, Nilvo Masulini, Francine dos Reis Pinheiro, Jandira Santana, João Werner Falk, Paula Johns, Mônica Andreis, Anne Caroline Wihbey, Claudenir Gomes da Silva, Marcelo Silva Almeida, Maria de Jesus Farias Santos, Raimunda Nonata Silva Farias, Raimundo Luis Silva Cardoso</p>	<p>Italy</p> <p>Chiara Bodini, Marianna Bettinzoli, Francesca Cacciatore, Elisa Cennamo, Martina Riccio, Alessandro Rinaldi, Angelo Lorusso, Anna Vigato, Anna Ciannameo, Annalisa Trombetta, Antonella Torchiario, Antonio Donato, Antonio Saviano, Claudio Di Giacomo, Daniel Russo, Elena Ferrillo, Federica Turatto, Francesca Zanni, Francesco Fasano, Giulia Bonanno, Giulia Maria Di Marzio, Giulia Nizzoli, Giulia Titoldini, Giuseppe Abbracciavento, Irene Pontalti, Lorenza Santoro, Maria Gobbato, Marianna Parisotto, Mario Staccioni, Martina Altamura, Martina Di Ciano, Milo Librio, Nadia Maranini, Pier Mario De Murtas, Riccardo Casadei, Rita Maffei, Sara Riezzo, Simone Cupellaro, Valeria Gentilini, Vera Todisco, Viviana Forte, Alice Fabbri, Ornella Punzo, Susanna Bolchini</p>
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<p>Democratic Republic of the Congo</p> <p>Erick Kambale, Philomene Mukendi, Georges Biongo, Paul Muntini, Gaëlle Fonteyne, Billy Mwangaza, Nicole Tsombya, Jasper Zagabe</p>	<p>South Africa</p> <p>David Sanders, Anneleen de Keukelaere, Tinashe Njanji, Lauren Paremoer, Kathryn Stinson, Megan Harker, Chris Colvin, Allison Swartz, Zara Trafford, Gavin Reagon, Penny Morrell</p>

Table 1. Researchers

Reports, Annexes and Chapters

A large number of reports have been generated through this project. Fifty reports are listed and linked below. This list does not include the working documents that were prepared by the various teams in the implementation of their studies.

The main findings chapters of this report are structured around the five themes which have framed this whole project: Movement building, Campaigning and advocacy, Capacity building, Knowledge generation and dissemination, and Policy dialogue and engagement with governance.

Almost all of the reports generated by the study have raised implications for these five themes, although not every report has done so explicitly. Accordingly we have prepared 17 annexes to this report which provide additional background to the various studies, summarize long reports and/or explicate the thematic implications. The thematic implications have been transferred from reports and annexes to the thematic chapters herein, where they have been integrated into a coherent narrative regarding each theme. These processes are represented diagrammatically in Figure 2, below.

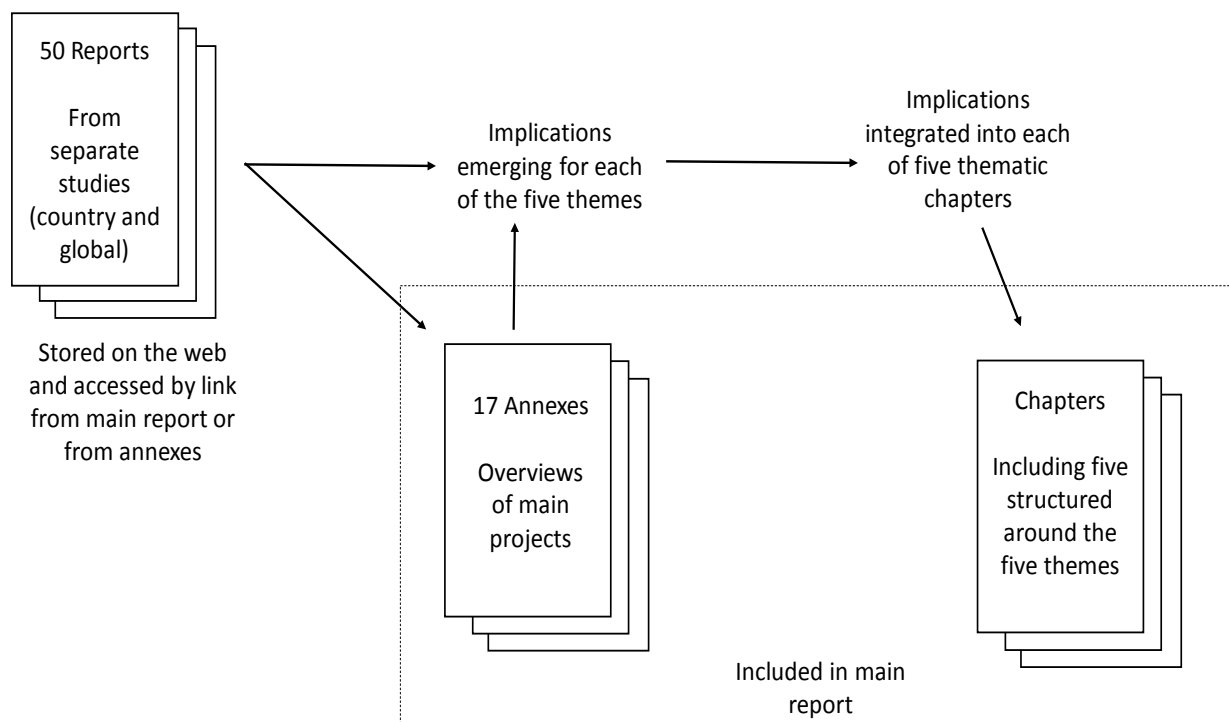


Figure 2. Relations between reports, annexes and chapters

List of, and links to, key documents generated through this project

The 50 reports listed and linked (below) and the corresponding 17 annexes have all contributed to the analysis of our five themes. However, they go far beyond this analysis and are rich products in their own right: rich for the stories that they tell, and for the wide variety of settings and issues that they describe.

This report

This final report has been assembled and drafted by David Legge in close consultation with Chiara Bodini, Fran Baum, Ron Labonté, David Sanders, and Amit Sengupta. Useful feedback was obtained from presentations in Geneva, Bologna and Brussels in May – June 2018.

Brazil POA-NHS Stage1 EN Brazil POA-NHS Stage2 Final EN Brazil Nina Rodrigues Stage1 EN Brazil Nina Rodrigues Stage2 EN Brazil ACT Stage1 EN Brazil ACT Stage2 EN Colombia Stage1 ACIN ES Colombia Stage1 ACVC ES Colombia Stage1 ASOTRECOL ES Colombia Stage1 EPLS ES (lite) Colombia Stage1 LGBT ES Colombia Stage1 ACVC Women ES Colombia Stage1 ZRC ES Colombia Stage1 HSJ ES Colombia Stage1 Synthesis Report EN Colombia Stage1 Synthesis Report ES Colombia Workshop 160902 ES Colombia Workshop 160902 EN(G) Colombia Stage2 Workshops Proposal ES Colombia Stage2 Workshops Proposal EN(G) Colombia Stage2 Reporte Taller Cañizal 170702 ES Colombia Stage2 Encuentro Carrizal Y Lejanías 170704 ES-lite Colombia Stage2 Reporte Visita De Campo Macarena 170731 ES-lite Colombia Stage2 Summary Report ES Colombia Stage2 Summary Report EN(G)	DRC Stage1 Report DRC IPHU Regional Workshop 180404 India Final Report Italy Stage1 Report (IT , EN , 32 MB each; EN-lite , 1 MB) Italy Stage2 Report: (IT , EN) South Africa Stage1 Report South Africa CHW Case Study South Africa NHI Campaign Case Study South Africa Stage2 Report South Africa SAPHU Evaluation Stage1 Guidelines for Country Teams Regional Workshops (2016, end of Stage 1) Brussels Colombo Cape Town São Luis Review Social Movements Research and Commentary The HFA Movement: a Global History Personal Narratives of Experienced Activists Movement Building Manual (2017) IPHU Evaluation Survey Report IPHU El Salvador IPHU Nepal GHW4 Reach and Impact CSE and GHG Brazil WHO Watch Report Ghana Workshop Report IPOL GHG 2014
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Table 2. Reports and links

EN(G) refers to a report originally in Spanish which has been machine translated

Acronyms and abbreviations

ACIN	Asociación de Cabildos Indígenas del Norte – Association of Indigenous Councils of the North [Colombia]	MNSSS	Movimiento Nacional por la Salud y la Seguridad Social - National Health and Social Security Movement [Colombia]
ACT+	[Brazilian] Alliance for Tobacco Control and Health Promotion	MoH	Minister of Health
ACVC	Asociación Campesina del Valle del Rio Cimitarra - Peasant's Association of Valle del Rio Cimitarra [Colombia]	MSP	Movimiento de Salud de los Pueblos (PHM)
ARVs	Antiretrovirals	MST	[Brazilian] Landless People's Movement
ASOTRECOL	Association Of Extrabajadores Enfermos of Colmotores – Association of Sick Former Employees of Colmotores [Colombia]	NGO	Non-government organizations
CHW	Community Health Worker	NHI	[South African] National Health Insurance
CSE	Civil society engagement	NIEO	New International Economic Order
CSE4HFA	Civil Society Engagement for Health for All	NR	Nina Rodrigues [Brazil]
CSO	Civil society organizations	NRHC	National Right to Health Campaign (India)
DAH	Development assistance for health	NRHM	National Rural Health Mission (India)
DGHG	Democratising Global Health Governance	NuRuNI	Outreaching and Research with Rural, Black Quilombola and Indigenous Population and Communities Nucleus (of the UFMA) [Brazil]
DRC	Democratic Republic of the Congo	PHA	People's Health Assembly
EN	English	PHC	Primary health care
EPLS	Escuela Popular de Salud - People's School of Health [Colombia]	PHM	People's Health Movement

ES	Spanish	POA	Porto Alegre
FARC-EP	Las Fuerzas Armadas Revolucionarias de Colombia - Ejército del Pueblo	PTN	Transient Normalisation Points (Puntos Transitorios de Normalización) [Colombia]
FMLN	Farabundo Martí National Liberation Movement (El Salvador)	RTH	Right to Health
FTA	Free Trade Agreement	RTHC	Right to Health Campaign
GHG	Global Health Governance	SAPHU	South African People's Health University
GHW	Global Health Watch	SDG	Sustainable development goals
GPPPs	Global public private partnerships	SISPI	Indigenous System of Own and Intercultural Health [Colombia]
HFA	Health for All	SUS	Sistema Único de Salud [Brazilian NHS]
HSJ	Hospital San Juan de Dios [Colombia]	TAC	Treatment Action Campaign [South Africa]
IMF	International Monetary Fund	TTIP	Trans-Atlantic Trade and Investment Partnership
IPHU	International People's Health University	UERGS	State University of Rio Grande do Sul [Brazil]
IPOL	IPHU on line	UFMA	Federal University of Maranhão [Brazil]
JSA	Jan Swasthya Abhiyan	UFRGS	Federal University of Rio Grande do Sul [Brazil]
LGBT	Lesbian, Gay, Bisexual and Transsexual	WHA	World Health Assembly
LMIC	Low and Middle Income Countries	WTO	World Trade Organization
M3M	Médecine pour le Tiers Monde	ZVTN	Transitional Normalisation Zones (Zonas Veredales de Transición y Normalización) [Colombia]
MDGs	Millenium Development Goals	ZRC	Zona de Reserva Campesina del Valle del Rio Cimitarra - Peasant Reserve Zone of the Cimitarra River Valley [Colombia]

Table 3. Acronyms and abbreviations

Chapter 2. The unfulfilled promise of Health for All

Why HFA?

This research has taken WHO's 1981 promise of "Health for All by the year 2000" as a standard against which progress in global health might be evaluated and, minus the deadline, as a goal which remains to be achieved.

However, Health for All (HFA) was also a global policy framework articulated as both a global strategy and a plan of action by the World Health Assembly (WHA). Positioning HFA as a key reference point in this research acknowledges that prevailing policy frameworks, in both macroeconomics and health, powerfully influence the conditions for achieving progress in global health.

In this chapter we review the content and origins of HFA and sketch the evolution of the global health policy environment since 1981, before reviewing progress towards HFA.

Origins

The promise of HFA arose from the 1978 Declaration of Alma-Ata (WHO and UNICEF 1978). Following the Alma-Ata Conference and Declaration WHO adopted a Global Strategy for Health for All by the Year 2000 (WHO 1981) and a Plan of Action (WHO 1982).

The Global Strategy defines HFA as "the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (para 1).

The strategy emphasizes health system development based on primary health care (PHC) principles including appropriate technology and community involvement. It also calls for attention to management, workforce development as well as financing.

The Global Strategy reflects a clear understanding that population health is largely created before and beyond the services of the health system. Hence the strong emphasis on intersectoral collaboration and what is now referred to as 'health in all policies'.

[HFA] cannot be achieved by the health sector alone. The coordinated efforts will be required of other social and economic sectors concerned with national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, and communications. Ministries of health or analogous authorities have an important role in stimulating and coordinating such coordinated action for health. (para 6).

However, the commitment to intersectoral collaboration was also predicated upon a certain confidence in global economic reform symbolized by the references to the New International Economic Order (NIEO) in both the Alma-Ata Declaration and the Global Strategy. The strategy elaborates

the close and complex links that exist between health and socioeconomic development. The improvement of health not only results from genuine socioeconomic development as distinct from mere economic growth, it is also an essential investment in such development (para 10).

The Strategy ... constitutes the health sector's contribution to the new International Development Strategy for the Third Development Decade, and through it to the establishment of the New International Economic Order (para 13).

The ambition of the Alma-Ata Declaration and the global HFA strategy reflected a level of optimism on the part of the newly decolonized countries of the Global South which was also reflected in the confident references to a NIEO.

Sneyd (2005) describes the NIEO as "a comprehensive package of multilateral policy options that aimed to improve the position of Third World countries in the world economy relative to the richest states". These policy options included a reliance on import substitution strategies for economic development, including relatively high levels of industrial protection (Hettne 1995).

The support for import substitution and 'infant industry protection' in the NIEO represented a major threat to the economies of the global North who depended on 'developing countries' for cheap raw materials and as markets for their manufactured goods².

The references to the NIEO recognizes that the achievement of 'Health for All' (including health system development, action on the social and economic determinants of health and overcoming inequality) was dependent on meaningful economic development and that in turn depended on a significant restructuring of global economic relations.

History

Before reflecting on progress towards HFA since 1981 it is useful to review the evolution of the global policy context within which the struggle for HFA takes place, including prevailing economic policies as well as the changing face of health care and health development.

The optimism of Alma-Ata, HFA by the year 2000 and the NIEO was sharply undercut by emerging trends in the global economy at the end of the 1970s; a combination of economic slowdown and obstinate inflation, so-called 'stagflation'. The leaders of the industrial economies, the US and UK in particular, adopted a 'fight inflation first' strategy which meant sudden and steep increases in official interest rates, directed largely to disciplining wage demands by labour by exacerbating the recession and increasing unemployment.

It was this steep interest rate hike which precipitated the Third World debt crisis in the early 1980s, as debts incurred in the early 1970s (when credit was plenty and interest rates were low) came to be rolled over. As heavily indebted countries were rebuffed by the commercial banks they were forced to turn to the IMF as the lender of last resort and with the IMF bailouts came structural adjustment conditionality.

The standard structural adjustment package included sharp reductions in social spending (health, education, food subsidies) and a range of policies directed to increased earnings from exports (in particular exchange rate depreciation, removal of tariffs, and investments in export facilitation). This sharp turn from import substitution to export facilitation was in the first instance simply a mechanism to raise hard cash to pay down debt. However, in time it was reframed as a strategy for economic development. Certainly it was the death of the NIEO.

Even before the full impact of structural adjustment was evident the Rockefeller Foundation had determined that comprehensive primary health care was too expensive and put forward the concept of selective PHC instead (Walsh and Warren 1979). In UNICEF's hands selective PHC was operationalized as four specific interventions known as GOBI: growth monitoring, oral rehydration, breast feeding and immunization (Werner and Sanders 1997).

In many countries structural adjustment had a damaging impact on health systems and on the social determinants of health (Antrobus 1988, Gibbon 1995, Breman and Shelton 2001, Breman and Shelton 2007) and by the late 1980s its legitimacy was being questioned (Cornia, Jolly et al. 1987) and there was rising resistance, particularly in the form of the Jubilee 'drop the debt' movement (Bunting 2000).

In 1993 the World Bank published 'Investing in Health' which prescribed a health policy framework which it claimed could yield good health at low cost. This framework included a private health insurance market and would restrict public providers and public financing to a safety net function. 'Investing in health' argued that public funding should be restricted to subsidizing a defined package of cost-effective interventions for lower income people.

Meanwhile the Uruguay Round of trade negotiation was coming to fruition with a new suite of trade agreements entering into force in 1995, administered through the newly established World Trade Organization (WTO). In effect the WTO agreements put in place a new framework of international law designed to entrench trade liberalization and global economic integration.

2. A more extended discussion of the NIEO is included in the historical review of the HFA movement undertaken as part of this research (here).

With the availability of antiretroviral drugs (ARVs) for AIDS/HIV the health implications of the WTO agreements, in particular the TRIPS Agreement, started to become more apparent. The struggle over access to ARVs led to the Doha Declaration on the TRIPS Agreement and Public Health in 2001 when the Ministerial Council which governs the WTO affirmed the legitimacy of using the flexibilities provided for in the TRIPS Agreement for public health objectives (WTO Ministerial Council 2001).

The Doha Ministerial Council is remembered for another set of decisions, known as the Doha Development Agenda (DDA), which articulated a set of principles through which the regulation of trade might also contribute to economic development in the Global South (Lee 2012, WTO 2018). One of these principles was 'differential and more favourable treatment' or 'non-reciprocity' meaning that there should be some degree of positive discrimination in favour of the Global South in continuing trade negotiations. The principle of non-reciprocity recalls in weaker terms the hope of the NIEO, that trade relations might be structured so as to support economic development in the South.

The Doha meeting was the beginning of the end of multilateralism in trade negotiations as the claims of developing countries for differential and more favourable treatment were deadlocked against the claims of the high income countries for continued liberalisation of trade in services and for the unfinished economic integration agenda (including increased intellectual property protection, investment protection, and trade facilitation), claims that had been resisted by the developing countries during the Uruguay Round.

With the end of multilateralism from 2001, the high-income countries' strategy changed to negotiating new agreements among like-minded partners and then pressing outside countries to join on the basis that they accept the full package. The end of multilateralism also extinguished any chance of extending the principle of non-reciprocity to promote economic development in the Global South.

The emerging regime of global economic integration (globalization) was driven through structural adjustment and locked in through the WTO agreements. However, the legitimacy of this regime was successfully challenged by the Treatment Access Campaign from 1997-2001. The idea that pharmaceutical corporations should be allowed to set drug prices at levels which denied access in order to maximize profit was unacceptable for many.

WHO's Commission on Macroeconomics and Health which reported in 2001 was in part a response to this legitimation crisis. The Commission's report declared that "globalization is on trial, partly because these benefits [the benefits of globalization] are not reaching hundreds of millions of the world's poor" and further "With globalization on trial as never before, the world must succeed in achieving its solemn commitments to reduce poverty and improve health". While the Macroeconomics and Health report does not mention Jubilee 2000 (drop the debt) (Bunting 2000), the 'Battle of Seattle' (Smith 2002) or the Treatment Action Campaign in South Africa, 1997-2001 (Heywood 2009), these all contributed to a rising popular concern regarding neoliberal globalization.

The Millennium Development Goals (MDGs) arose out of the UN Millennium Summit and its Declaration. The MDGs provided a broad narrative of purpose for what became a dramatic increase in development assistance flows, in particular to health. The advent of the MDGs was associated with an explosion of new 'global public private partnerships' (GPPPs) with close to 200 in the health sector alone since 2000. These have had a major impact on global health governance (WHO Maximising Positive Synergies Collaborative Group 2009).

The proliferation of GPPPs reflected a distrust of multilateral UN agencies on the part of the rich donor states combined with a perception that a significant increase in development assistance was necessary to shore up the fraying legitimacy of neoliberal globalization. The distrust of multilateral UN agencies, such as WHO, was a consequence of their one country one vote governance which gave the countries of the Global South significant influence over the decisions adopted by those governing bodies. By imposing a freeze on assessed contributions but supplementing their budgets through tightly earmarked voluntary contributions the rich donor states were able to retain control of the organizations' operational agenda (Adams and Martens 2015, Legge 2015). The routing of development assistance for health (DAH) through GPPPs, rather than through WHO, further marginalized the Organization.

The GPPPs have been rationalized in terms of the failure of the UN system and the need for a new approach to global governance – the multi-stakeholder partnership. This has been most explicitly outlined in the World Economic

Forum's 'Global Redesign Initiative' (World Economic Forum 2010) which projects an approach to global governance based on a partnership between the private sector (the transnational corporations and their representative associations), the large philanthropies, the large NGOs, and the G20 (including the large donor states).

DAH flows during the period of the MDGs were focused largely on the provision of selected commodities including drugs, vaccines, bed nets, diagnostics and micronutrients through narrow vertical programs. Positive outcomes were achieved, in particular, through improved vaccination rates, the diagnosis and treatment of AIDS/HIV and the prevention and treatment of malaria. However, the effectiveness of narrow vertical programs was in many cases limited by dysfunctional health systems, in many cases weakened by the internal brain drain away from the generalist health system towards the donor programs.

During the MDG years (from 2000-2015) the trade liberalization / economic integration agenda was further progressed although facing increasing resistance. However, the policy framework of export oriented development, within a regime of global economic integration, remained ascendant notwithstanding its very uneven record of achievement.

The design of the Sustainable Development Agenda (2015) was informed by the weaknesses of the MDGs and the selection of goals and targets for the Sustainable Development Goals (SDGs) was much more consultative and systematic and the metrics developed for measuring progress towards the SDGs more comprehensive. Importantly the SDGs include goals relating to health system development including financial protection. However, the strategies through which the SDGs are to be achieved are more problematic; too often limited to rhetorical commitments which assume generalized good will and fail to contemplate the power relations that need to be changed if the goals are to be achieved.

One of the core issues where unequal power relations plays a key role is the regulation of trade and investment, epitomized by the contradictions between the NIEO (and non-reciprocity) versus the current regime of global economic integration. The roles that different countries play in the global economy are critical in shaping their social and economic development which in turn are critical for health system development and addressing the social determinants of health.

Civil society engagement can play an important role in policy development and program implementation but it is also, necessarily, an intervention in power relations. New information flows, new alliances, new perspectives, new social movements all have implications for the structures and dynamics of governance, at all levels: local, national and global.

We explore the possible roles of civil society engagement in achieving HFA in Chapter 3 but before opening this discussion we reflect on the degree to which the 1981 goals of HFA have been achieved.

What has been achieved?

Much has changed since 1981 including advances in medical and public health technologies, large scale donor driven health programs, changing demographics and patterns of morbidity, and the rapid economic development in China. However, the promise of 'health for all' has not been delivered.

Mortality

The Global Strategy for 'Health for All by the Year 2000' provides an overview of the world health situation as it was in 1981. It paints a grim picture of health in the developing countries and implies that if the Strategy and Plan of Action were fully implemented this picture would be substantially improved.

Whereas the average life expectancy at birth is about 72 years in the developed countries, it is about 55 years in the developing countries; in Africa and southern Asia it is only about 50 years. Whereas only between 10 and 20 out of every 1000 infants born in the developed countries die during their first year, the infant mortality rate in most developing countries ranges from nearly 100 to more than 200 per 1000. Whereas the death rate for children between 1 and 5 years old is only

about 1 per 1000 in most developed countries, it averages about 20 in many developing countries and more than 30 in Africa south of the Sahara. (para 2)

WHO's Global Health Observatory (GHO) provides a useful data series from history 2000-2016 for life expectancy and from 1990 to 2016 for infant mortality rate. Unfortunately it does not go back to 1981.

The trend changes from 1990 to 2016 throw some light on progress towards HFA with respect to infant and child mortality. Table 4 shows that while all regions have achieved absolute improvements in infant, neonatal and under five mortality, comparing the other regions to the European region (as RR cf EU, below) reveals that Africa, South East Asia (SEAR) and the Eastern Mediterranean (EMR) regions have all been left further behind. The rate ratio for Africa has increased from 4.3 to 6.3. Significant increases in this rate ratio are also seen for SEAR and EMR. In contrast, the Western Pacific region (WPR) has achieved significant improvements in rate ratios for all three indicators.

Region	IMR (per 1000 LBs)		% imprvt	IMR as RR cf EU		NNMR (per 1000)		% imprvt	NNMR as RR cf EU		U5 MR (per 1000 LBs)		% imprvt	U5 MR as RR cf EU	
	1990	2016		1990	2016	1990	2016		1990	2016	1990	2016		1990	2016
Africa	106.5	52.3	51%	4.3	6.3	45.5	27.2	40%	3.3	5.3	177.7	76.5	57%	5.8	8.0
Americas	34.5	12.1	65%	1.4	1.5	18.2	7.5	59%	1.3	1.5	43.5	14.2	67%	1.4	1.5
SEA	83.6	31.5	62%	3.4	3.8	52.7	22.6	57%	3.8	4.4	118.5	38.9	67%	3.8	4.1
Europe	24.9	8.3	67%			13.9	5.1	63%			30.8	9.6	69%		
EMR	75.5	40.6	46%	3.0	4.9	43.4	27.7	36%	3.1	5.4	102.4	30.8	70%	3.3	3.2
WP	40	10.8	73%	1.6	1.3	26.8	6.5	76%	1.9	1.3	51.9	12.9	75%	1.7	1.3

Table 4. Trends in infant and child mortality by WHO region, 1990-2016

IMR – infant mortality per 1000 live births; NNMR – neonatal mortality per 1000 live births; U5 MR – under fives mortality rate per 1000 live births. IMR as RR cf EU – infant mortality expressed as a rate ratio against Europe as the lowest region; likewise for NNMR and U5 MR (data from WHO's Global Health Observatory (GHO), <http://apps.who.int/gho/data/view.main.CM1300R?lang=en>)

Immunization

The 1981 Global Strategy also highlights low levels of immunization.

The common infectious diseases of childhood are still rampant in the developing countries, whereas they have been reduced to minor nuisances in the developed countries. Although these diseases can be prevented by immunization, fewer than 10% of the 80000000 children born each year in the developing countries are being immunized against them. (para 3)

The GHO data show significant progress in immunization in all regions.

Region	DTP3	HepB3	MCV1	Pol3	PCV3	Rota virus
Africa	74	74	72	73	65	43
Americas	91	89	92	92	84	74
SEAR	88	88	87	87	9	3
Europe	92	81	93	94	62	23
EMR	80	80	77	80	48	23
WPR	97	92	96	96	14	2

Table 5. Immunization coverage estimates 2016 (who's GHO)

The data from the Africa region are intriguing, showing a low coverage of the core vaccines but relatively high coverage rates for the more expensive vaccines. The Africa region data stand in sharp contrast to the data from the SEAR and WPR. This appears to reflect the choices of the donors.

Water and sanitation

The 1981 Global Strategy also comments on diarrhoeal disease:

Diarrhoeal diseases are most widespread in the developing countries; they are transmitted by human faecal contamination of soil, food and water. Only about a third of the people in the world's least developed countries have dependable access to a safe water supply and adequate sanitary facilities. (para 4)

It appears from Table 6 below that not much has changed since 1981 on this front.

Region	Popn using at least basic sanitation services (%)			Popn using safely managed sanitation services (%)			Popn using at least basic drinking-water services (%)			Popn using safely managed drinking-water services (%)		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Africa	21	35	41				44				49	26
Americas	79				49	43	90				88	82
SEAR		69	51	29				94	89	54		
Europe	92				78	67	94	99				91
EMR	59		73		40					42	69	56
WPR			68			39	94		95		93	

Table 6. Sanitation and Drinking Water Services by WHO Region 2015
(see WHO/UNICEF Joint Monitoring Programme for Water and Sanitation)

Malaria

The 1981 Global Strategy noted that:

Malaria remains the most prevalent disease, in spite of the fact that in theory it can be prevented by the routine administration of inexpensive drugs or by insecticide spraying to kill the mosquito and its larvae. Some 850 million people live in areas where malaria has only been partially controlled, and another 350 million in areas that still lack active control measures. In tropical Africa alone, at least one million children die each year from malaria. (para 5)

Introducing the World Malaria Report for 2017 WHO's Director-General Dr Tedros comments that:

In 2016, 91 countries reported a total of 216 million cases of malaria, an increase of 5 million cases over the previous year. The global tally of malaria deaths reached 445 000 deaths, about the same number reported in 2015.

Although malaria case incidence has fallen globally since 2010, the rate of decline has stalled and even reversed in some regions since 2014. Mortality rates have followed a similar pattern.

The WHO African Region continues to account for about 90% of malaria cases and deaths worldwide. Fifteen countries – all but one in sub-Saharan Africa – carry 80% of the global malaria burden.

[...]

In 2016, just over half (54%) of people at risk of malaria in sub-Saharan Africa were sleeping under an insecticide-treated mosquito net – the primary prevention method. This level of coverage represents a considerable increase since 2010 but is far from the goal of universal access.

Spraying the inside walls of homes with insecticides (indoor residual spraying, IRS) is another important prevention measure. The report documents a precipitous drop in IRS coverage in the WHO African Region since 2010, as well as declines in all other WHO regions over this same period.

Prompt diagnosis and treatment is the most effective means of preventing a mild case of malaria from developing into severe disease and death. In the WHO African Region, most people who seek

treatment for malaria in the public health system receive an accurate diagnosis and effective medicines.

However, access to the public health system remains far too low. National-level surveys in the WHO African Region show that only about one third (34%) of children with a fever are taken to a medical provider in this sector.

A minimum investment of US\$ 6.5 billion will be required annually by 2020 in order to meet the 2030 targets of the WHO global malaria strategy. The US\$ 2.7 billion invested in 2016 represents less than half of that amount. Of particular concern is that, since 2014, investments in malaria control have, on average, declined in many high-burden countries.

Nutrition

In 1981 the Global Strategy noted that:

... in the developing countries, undernutrition afflicts hundreds of millions of people, reducing their energy and motivation, undermining their performance in school and at work, and reducing their resistance to disease. In these countries as many as a fourth of the people have a food intake below the critical minimum level. Whereas the average per capita daily energy supply in the developed countries is about 3400 kilocalories (14.23 MJ), a figure far in excess of standard requirements, it is about 2400 (10.04 MJ) for most developing countries and only 2000 (8.37 MJ) for the least developed. In addition, there are great inequalities within countries; this is catastrophic for the underprivileged in many developing countries. (para 8)

The data in Table 7 are taken from the UNICEF, WHO, World Bank Joint child malnutrition estimates.

WHO Regions	1990	2017
	% stunted	% stunted
Africa	48.2	33.6
The Americas	14.9	6.3
SEA	59.6	33.0
EMR	39.8	24.6
Europe	-	-
WPR	35.6	6.9

Table 7. Moderate and Severe Stunting: percentage of children aged 0–59 months who are below minus two standard deviations from median height-for-age of the WHO Child Growth Standards.

Stunting refers to a child who is too short for his or her age. Stunting is the failure to grow both physically and cognitively and is the result of chronic or recurrent malnutrition. The devastating effects of stunting can last a lifetime.

The data in Table 7 show that there has been some improvement in all regions, particularly in Western Pacific Region. However, the continuing prevalence of moderate and severe stunting in Africa, South East Asia and the Eastern Mediterranean is shocking.

The need for civil society engagement

There have been significant improvements in access to decent health care and the conditions for healthy living since HFA by 2000 was announced. These may be attributed to economic development, particularly in China; to

donor funded disease programs including immunization; and to improvements in health systems and public health programs generally.

However, the improvements are very uneven and far from reaching the promised standard of 'health for all'. The 1981 definition of HFA ("the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life") was cautious. However it was not achieved by 2000 and still not achieved in 2018.

Humanity has in aggregate sufficient material resources and technologies to deliver decent health care and healthy living conditions for all. The critical questions concern how humanity collectively decides to allocate those resources.

Too often these questions are treated solely as 'policy questions' without regard to the relations of power which maintain inequality, prevent health system development, and reproduce the conditions which generate disease and disability. Achieving health for all certainly requires attention to policy questions, often quite complex policy questions. However it also requires attention to the structured power relations which are instantiated in the structures of governance at all levels (including economic and political as well as health governance).

The operations of power (including the expression of power through policy) are clearly evident in the historical review presented above, most dramatically in the replacement of the NIEO by the current regime of global economic integration.

The 2013 World Development Report alludes to the structures of power in the following passage.

Indeed, one can go further and state that there is a "south" in the North and a "north" in the South. Elites, whether from the North or the South, are increasingly global and connected, and they benefit the most from the enormous wealth generation over the past decade, in part due to accelerating globalization. They are educated at the same universities and share similar lifestyles and perhaps values. (p 2)

The case for promoting civil society engagement in the struggle for HFA rests on the prospect of *both* contributing to better policy making and implementation *and* strengthening the voice of the various subaltern classes in the process. (The HFA History, linked from [Annex 8](#), refers to a number of specific episodes in support of this proposition.)

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Chapter 3. Civil society, social movements and globalization

The research undertaken for this report has been focused on the contribution of civil society to achieving Health for All. Our focus on the role of civil society does not reflect any discounting of the role of public institutions, professional organizations or government. However civil society engagement with these other agents can multiply and sometimes help to steer their contributions. Few progressive (socially equalizing or environmentally sustainable) policies have been implemented without the advocacy and mobilizing efforts of civil society organizations.

History

There is a powerful historical case for the importance of civil society engagement (CSE) in the achievement of social change, locally, nationally and globally. Precedents include legal reform (e.g. abolition of slavery), institutional development (e.g. environmental protection), and cultural change (e.g. gender relations). A recent example more specific to health has been the success of the Treatment Action Campaign in affirming the legitimacy of using the flexibilities provided for in the TRIPS Agreement to facilitate access to medicines, even while they are still under patent (Heywood 2009).

Usages

We are using the term “civil society” to denote a domain of social practice, to be distinguished from the **state** and the **market**. However, at the boundaries the distinctions between these ‘domains’ can get quite blurred.

The ‘social movement’ concept provides a useful framework for describing and analyzing civil society engagement³. We are using the term to refer to a voluntary assemblage of individuals, organizations and networks who share a core set of goals, analysis and commitments and who communicate and collaborate in various ways to achieve those goals. Under this definition ‘social movement’ includes both issue-oriented social movements (e.g. the women’s movement or the environment movement) and political movements which tend to have a more comprehensive program. The labor movement straddles this distinction in those countries where it brings together both unions and political parties. Our attention in this report is directed to ‘progressive’ social movements, i.e., those working towards social, economic, and gender equity; ecological sustainability, and challenging disequalizing forms of discriminatory practices.

A framework for describing, analyzing and improving social movement practice

Social movements deploy a repertoire of strategies which are directed to influencing the drivers and processes of social change. These strategies include: policy advocacy, institutional innovation, delegitimation, refusal, resistance, and revolution.

The effectiveness of the social movement is a function of its strategizing and organizing capacity and its political power which is in turn influenced by the configuration of opportunities. The modalities of power include: numbers, organization (including networks and alliances), commitment, material resources, information, knowledge and skills. Accordingly movement strengthening and capacity building are key objectives of social movement strategy, including developing those modalities of power.

3. See [Annex 7](#) for links to literature reviews. See also [Review of Research and Commentary](#).

However, strategy and engagement should not be seen as separate from movement building because the processes of movement strengthening and capacity building are embedded in practice; they take place in the context of engagement. For the purposes of this research we have adopted a hybrid framework which encompasses both strategy and practice and movement building. This framework includes five broad domains:

- movement building,
- campaigning and advocacy,
- capacity building,
- knowledge generation, access and use, and
- engaging with governance: policy dialogue and structural critique.

These five domains have proved to be a useful planning framework within the People's Health Movement. They represent the pre-occupations of civil society activists worrying about how to engage in the processes of health improvement and how to build capacity to engage.

Movement building includes the various strategies directed to recruitment and retention, strengthening coherence, organizational and cultural development, resource mobilization, networking and leadership. We elaborate extensively on movement building in [Chapter 5](#).

Campaigning and advocacy includes forms of action, sources of power and levers of influence; see [Chapter 6](#).

Capacity building applies at both the individual and organizational levels. For individuals it includes knowledge, skills, identity, and agency⁴; for organizations it includes relationships, shared culture, division of labor, and leadership. See [Chapter 7](#).

Knowledge development and dissemination include all the different ways in which a social movement collects and generates knowledge to inform strategy and practice. It includes both technical knowledges and the experiential knowledge and the wisdom that arises in and from practice. This may involve the use of popular education methods for bringing body knowledge⁵ into discourse; 'systematization of experience'⁶ for making sense of shared experiences; and participatory action research for learning from practice. See [Chapter 8](#).

Engaging with governance (policy dialogue and structural critique) is based on both policy analysis and structural critique, including the wider network of power relations controlling the institutional structures of governance⁷. It includes policy advocacy through dialogue with governments and other institutions with power over pathways to health improvement but linked to strategies for challenging the configurations of power which control the prevailing structures of governance. See [Chapter 9](#).

4. 'Agency is an important concept invoked in our research, and refers to individuals acting from a belief in their own ability to contribute to change; in themselves, in others, and in social relations.

5. 'Body knowledge' or embodied knowledge refers to knowledges which arise from experience but are pre-discursive, in the sense that they are tacit and implied and may have not been brought into discourse. Ollis (2010) argues that activists' learning is embodied; the whole person is central to how meaning is made. A person's learning is embedded in significant identity change as they 'learn to be and become an activist'.

6. Discussed in more detail in [Annex 2](#).

7. The term 'governance' serves to encompass, not just the formal structures of the state (including intergovernmental organizations) but also the nodes and networks of power which in varying degrees control state power. See Rosenau and Czempiel 1992, Rhodes 1997, and Burris, Drahos and Shearing 2005.

At the margins these five domains bleed into each other but the different thematic perspectives do bring to light different principles and insights.

Social movements need people (actors) and a variety of resources (material, information, and organizational) to develop the power to be heard and to influence governance decision-making and the structures of power. Policy makers can facilitate the work of social movements through resources, consultative opportunities, and other channels. Philanthropies can also assist through resource transfers and supportive terms and conditions. However, the relationships between social movements and governments (and other funders) can also be fraught. See [Chapter 10](#).

Globalization as context

The global transformations, known in general as ‘globalization’, are a major feature of the context in which this research project has been conceived and implemented. This has important implications for the research.

The term ‘globalization’ has a range of contemporary usages ranging from ‘the global village’ (focusing on transport and communications); to global economic integration (mediated by transnational corporations and trade and investment agreements); to the rising significance of global forces in global and national governance. These three usages refer to different aspects of the same set of historical changes.

Opportunities to progress HFA are rooted in local circumstances but increasingly shaped by global forces. This means that HFA strategies must address both the local specifics and the larger scale, including global, influences. These are not separable because the site of activism is always local in the sense that it takes place where the activist is located. In a complex relationship of co-determination, local struggles are shaped by and shape global power relations. The challenge lies in integrating the micro and the macro: addressing the local and immediate issues *in ways which also contribute* to redressing the larger scale and longer term dimensions (Legge, Gleeson et al. 2007).

Robinson (2004) argues that global governance is largely controlled by a small political, bureaucratic and corporate elite, and that control is exercised *in the interests* of that elite. This would suggest that achieving Health for All would require progress towards *democratizing* global governance, including global health governance. Presently the global elite (coherent, self-conscious, well networked, well-resourced) confronts a dispersed, incoherent and poorly networked assemblage of national working classes, middle classes and marginalised classes – divided by language, ethnicity, nationality, religion, gender and class.

However, the advance of globalization also means that the larger scale influences shaping multiple dispersed engagements are increasingly experienced in common by health activists in different settings. Democratization of global governance will require a *convergence* of these disparate constituencies: stronger solidarity, richer networking, more collaborative action. The conditions for such convergence are actually being installed by globalization through the increasingly shared context. The global Health for All movement reflects and contributes to this convergence: listening across difference, expressing solidarity across boundaries, collaborating in action.

On the other hand the global elite is also empowered by the processes of globalization. The labor movement provides a telling illustration of the ways in which globalization is shaping living conditions and also shaping the capacity of social movements to respond. Nationally organized unions face internationally mobile capital and a weakening labor market associated with dramatic increases in labor productivity. As a consequence the bargaining power of the unions is reduced and their capacity to resist austerity and precarious employment is likewise diminished. Through its industrial and political arms the labor movement has played a key role in many countries in achieving a living wage and income security, in pushing for universal health care financing and other forms of social protection and in lobbying for safe workplaces.

These are significant contributions to Health for All but are now vulnerable to hypermobile capital. Moreover, the convergence of labour activism across national borders while possible in theory has been limited in practice, in part because of the perception that different labour movements are competing with each other for investment and employment opportunities.

Research questions

The assumption which underlies this project is that formal research into civil society engagement might point to ways of making it more effective; including strategies for both activist practice and policy makers and funders to more effectively support such engagement. The discussion in this and the previous chapter helps to frame the questions which have guided this research project.

Impacting on social change

How does civil society engagement influence social change, in particular, towards achieving Health for All? What can we learn from the failures of the promise of Health for All by the Year 2000?

Effective implementation of social movement strategies

What can we learn about the conditions for the effective deployment of various social movement strategies, including policy advocacy, institutional innovation, delegitimation, refusal and resistance?

Implications of globalization

What are the conditions for successful civil society engagement for Health for All (CSE4HFA) in the era of globalization; in particular regarding the macro micro principle and the dynamic of convergence?

Good practice

What is good practice? What principles might guide activists and organizers? We have organized this enquiry around the five domains listed above.

Advice for policy makers and funders

And finally, what principles might guide policy makers and funders, in particular those policy makers and funders who appreciate the contribution of civil society to the achievement of HFA and would seek to support it?

In the following chapter we outline the methodology through which we have sought to answer these questions. In the succeeding six chapters we elaborate our findings and conclusions regarding the five domains and the role of policy makers and funders.

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Chapter 4. Methodology

The setting and the questions

The People's Health Movement (PHM) is a global network of community organizations, NGOs, activist networks and individuals working towards Health for All: organizing at the local, national and global levels; campaigning around specific issues; providing training; developing information resources; and engaging officials in multi-level policy dialogue.

PHM embarked on this research convinced through many historical precedents that civil society engagement (CSE) *can* contribute to the achievement of HFA. However, the question which follows and has driven this research is 'how to do it better?'

On the basis of the experience and analysis reviewed in Chapters 2 and 3, several further subordinate questions were identified:

- What are the most effective forms of CSE in terms of influencing social change, in particular, towards achieving Health for All? What can we learn from the unfulfilled promise of Health for All by the Year 2000?
- What are the conditions for the effective deployment of various social movement strategies, including policy advocacy, institutional innovation, delegitimation, refusal and resistance?
- What are the conditions for successful civil society engagement for Health for All (CSE4HFA) in the era of globalization?
- What is good practice? What principles might guide activists and organizers?
- And finally, what principles might guide policy makers and funders, in particular those policy makers and funders who appreciate the contribution of civil society to the achievement of HFA and would seek to support it?

The research has examined a range of different civil society engagements, including PHM programs and activities, at the local, national and international levels. In this chapter we provide an overview of research methods deployed in these various studies.

Research plan

Five domains, five themes

The five domains of activist practice, introduced in Chapter 3 have guided data collection and analysis:

- movement building and networking,
- campaigning and advocacy,
- capacity building,
- knowledge generation and dissemination, and
- engaging with governance: policy dialogue and structural critique

These domains of practice are conceptually distinct but in reality they are overlapping, interdependent and synergistic. For this reason we have referred to 'generic themes' in discussing the data collection and analysis and in the findings chapters. As 'themes' they wind their way inextricably through the purposes and activities which we have been studying.

Research strategies

The research strategies we have deployed ranged across:

- participatory action research with inductive and interpretive generalization;
- formative program evaluation drawing on both quantitative and qualitative data collections;
- integrative and consultative synthesis;
- retrospective personal narratives with interpretive generalization; and
- desk research: literature review and synthesis.

Participatory action research undertaken by PHM circles in six countries

Six PHM country circles were recruited to participate in this research. This was judged to be the maximum feasible given resource constraints. The criteria for inclusion were: known research capability, stable PHM organization, and geographic representation.

Guidelines, collectively discussed and provided directly and in writing, outlined the purposes, strategies and organization of the research. It was explicitly provided that participating in this research was to be a useful and integral part of those country circles' action programs.

From the earliest it was understood that the principles of participatory action research (PAR) were central to the planning and implementation of the research; new knowledge would be generated by systematically learning from practice. Conceptually this would involve:

- participatory reflection on the purpose, theory and strategy of the research and how this might apply in the specific context of each country;
- stage 1 – describe and evaluate one or more 'episode/s' of social movement practice;
- then participatory reflection and redirection (locally and in regional workshops);
- stage 2 – embark on a new engagement, drawing from such reflection and discussion;
- document, reflect, discuss **and learn** from the new engagement; and then
- recycle through the process again.

The data collected in the country case studies were analyzed through *inductive* and *interpretive generalization*. Studying the *five domains in parallel in six countries*, guided by common program logics, provided the basis for induction. *Interpretation* of the findings was framed by the broad narrative within which the research was originally conceived.

The implementation of the project and of this PAR strategy was dependent on the enthusiasm and voluntary labor of PHM activists and colleagues and in some settings it was judged neither appropriate nor feasible within the terms of this project (both financial and temporal). The Indian team, for example, prepared a detailed case study of the Indian PHM experience with wide consultation and collaborative interpretation, rather than following the PAR design. The DRC team worked across several constraints and produced a report of CSE within and around the PHM local circle. The Brazilian, Colombian, Italian and South African teams followed the disciplines of PAR through two complete cycles.

Formative evaluation of PHM programs

The whole project was planned around the participatory action research (PAR) cycle. It was intended that like the country case studies, the global program evaluations would incorporate the principles of participatory engagement and would follow the action research cycle.

Formative evaluations of three of PHM's global programs were undertaken but it was not possible to extend these evaluations formally through two cycles of action and reflection.

The global programs evaluated were:

- the International People's Health University (IPHU),
- Global Health Watch (GHW), and
- WHO Watch.

Integrative and consultative: the Manual

By mid-2016 all of the Stage 1 reports from participating countries had been submitted and an interim analysis of these reports was undertaken in a workshop held in Vancouver in November 2016.

On the basis of the Stage 1 reports a 'manual' on movement building was conceived and a call for further case studies was widely broadcast. The manual was drafted drawing on the Stage 1 reports, the Vancouver analysis and the case studies, and was revised in consultation with advisors from across PHM.

Reflective narratives with interpretive generalization

Narratives of activist histories were collected from a selection of experienced global health activists, from within PHM, to document and reflect upon their experience of civil society engagement in the struggle for Health for All. These data were thematically analyzed.

Desk research: literature review and synthesis

Two of the studies undertaken were based on desk research:

- a literature review of research and commentary on social movements, and
- a narrative history of the global Health for All movement.

Data collection

Several broad sets of data were collected:

- case studies from participating country based research teams (Brazil, Colombia, DRC, India, Italy, and South Africa);
- reports from regional workshops;
- additional case studies from El Salvador and Ghana;
- evaluations of three of PHM's global programs (IPHU, GHW and WHO Watch);
- a further collection of case studies and consultative feedback in the development of the Manual;
- the collection of personal narratives from long standing activists within PHM;
- the review of published research and commentary regarding social movements; and
- the narrative archaeology of the Health for All movement globally.

In all cases data collection and analysis were structured around the five themes corresponding to five domains of civil society engagement.

Program logics

Generic program logic narratives were developed for each of the five domains of activism and the data collection was structured with attention to it. However, researchers were asked to adapt the generic program logics to the specific circumstances of each study and to the activism being researched and to structure their data collection around those adapted logics.

Analytic approach

The analysis was undertaken at two levels: first, by the local research teams in the preparation of their reports and second, by central research team in the context of assembling this report. In both cases the analysis was framed by the five themes.

At both levels the analysis came together over time through several inclusive workshop opportunities. The regional workshops provided opportunities for the country research teams to present their findings and discuss their conclusions. There were also several review and planning workshops at which the emerging findings from all of the different projects were reviewed and discussed.

The analytical approach adopted may be summarized as follows:

- principles of practice (insights into conditions, strategies and forms of action) are the main form of knowledge to be produced;
- the *value* of the generalizations produced derives from their *usefulness in practice* in particular settings;
- as far as possible the principles (generalizations) must remain *tethered* to the case studies from which they have emerged.

Principles of practice, a library of insights

The form of knowledge which we have produced is a collection of generalizations, or principles about CSE which might inform practitioners. Few of these principles are absolute in the sense of universally applicable. None of them are sufficient in themselves. All of them are contingent, in the sense of depending upon context for relevance and application.

Collectively these principles constitute a library of insights to be drawn upon by practitioners in accordance with circumstances and judgement.

A corollary of contingency is judgment: the judgment of practitioners as to which principles might be particularly relevant and how or when they might be applied. In experienced practitioners this kind of judgment is often largely intuitive reflecting contextual patterns that have been acquired and stored. Judgments about how to proceed are then based, at least in some degree, on body knowledge⁸ rather than cognitive algorithms.

Usefulness in practice

The value of the generalizations produced in this research derives from their usefulness in practice in particular settings and for particular purposes.

We rely upon inductive, interpretive generalization on the basis of our country case studies, global program evaluations, activist narratives and desktop reviews. Validation of our study findings is based upon critical reflection on the data from these studies by civil society activists and activist/researchers.

Principles remain *tethered* to the case studies

The principles are generated through a process of generalization from quite specific circumstances. The relevance or reach of those principles depends on the generality of those circumstances.

For principles to be useful they need to remain tethered to the case studies from which they were generalized so that users have a sense of their relevance and reach. Much of the research around the practice of CSE takes the form of case study collections (Smith and Johnston 2002, Clark 2003, Thompson and Tapscott 2010). Taken without regard to context, any principles of CSE would be so general as to be useless.

Activist judgment reflects general principles applied in particular contexts. The case studies collected in this research should be valued, partly because they have formed the basis for principles derived, but also because they reflect unique contingencies where circumstance and agency have contributed to particular outcomes. Experience of these patterns, even second hand experience, nourishes activist judgment; the how and where to apply the generalizations.

Organizing the data

All of the various sub-studies (country case studies, program evaluations, desktop studies, etc) were designed around particular objectives arising from context and content, and the reports of these studies include diverse conclusions around those objectives.

In addition the researchers were asked to draw out conclusions pertaining to the five core themes of the larger project which in most cases they did.

In the annexes to this report we have summarized the various country studies, program evaluations, etc and have itemized the conclusions arising from those studies for the five core themes (or we have linked directly to the research reports where those conclusions have been discussed). Where the local researchers did not identify thematic conclusions, these have been drawn out in the process of developing the annexes.

8. See note at Footnote 6 in Chapter 3 ([here](#))

The main thematic chapters of this final report have been assembled through a process of narrative synthesis, building on the identified thematic conclusions from the various sub-studies.

Ethics approval

Research teams, both country and global, negotiated ethics approval through locally relevant authorities. These are described in the specific research reports.

In addition PHM SA obtained Ethical Clearance, at the University of the Western Cape, South Africa, for the global research project as well as the South Africa specific research.

Research personnel

The principal investigators for this project were:

- Chiara Bodini (University of Bologna, Italy),
- David Sanders (University of the Western Cape, South Africa), and
- Amit Sengupta (People's Health Movement, India).

They were supported by the following co-researchers:

- Fran Baum (Flinders University, Australia)
- Ronald Labonté (University of Ottawa, Canada)
- David G Legge (La Trobe University, Australia)

The country research teams were a combination of senior researchers and younger researchers and activists who have been mentored by the former during the course of the project. A full list of the researchers and co-researchers is included in [Chapter 1](#). The country and global research teams are also identified in the reports linked from Table 8 below and summarized in [Annexes 1-17](#).

Research capacity-building

Research capacity building was a core objective of this research from conception. The principal focus with respect to such capacity-building has been on young people who are already working with community organizations and networks which are pushing for HFA objectives. Capacity building initiatives, including semi-formal training (in the context of workshops), mentoring and supervised experience has served to cultivate basic research skills (including critical inquiry, methods for data collection, disciplines of data analysis and report writing). These skills contribute to cultivating organizational learning as a core element of civil society engagement in the struggle for HFA.

The implementation of the project in countries has provided opportunities for activists and young researchers to be mentored by senior researchers for both the country based and the global components of the research, in particular, in the context of country and regional workshops (see below). Most of the country teams were largely made up of community activists who might have not identified as researchers but who were also able to acquire new insights and skills through the training and mentorship. The particular configurations of experienced and more junior researchers (and activists) is summarized in Annexes 1-6.

The review and planning workshops organized at the global level, from 2014 to 2018 have also provided capacity building opportunities for researchers with different levels of experience.

Gender

Gender equity and sensitivity have been key concerns throughout the project, including in the composition of the country research teams, the development of research protocols and research capacity-building opportunities. 82 of 132 researchers listed in [Chapter 1](#) are women.

Several of the case studies have addressed gender inequity, feminist movements and LGBTQI issues:

- Queer movement in Italy
- LGBT movement in Colombia

- Women in the ACVC in Colombia
- CHWs, a highly gendered workforce, in South Africa
- Women's movement episodes (including long acting contraception) in India

Planning and review meetings

First meeting in Cape Town

The project was launched at a three day meeting in Cape Town (at the University of the Western Cape) from 7-10 July 2014. This was attended by the principal investigators, the research advisory group and included representatives from all of the participating countries. The focus of this meeting was on familiarisation, protocol development, country planning, and mentorship.

Meeting in Vancouver to discuss project findings and plan for Stage 2

A major review and planning meeting was held in Vancouver, 12-14 November 2016, just prior to the Global Symposium on Health Systems Research.

This provided an opportunity to discuss the Stage 1 research findings with PHM leaders and with the coordinators of PHM's global programs. This was conceived as an occasion to review the research findings and share plans for Stage 2 as well as to discuss a systematic plan for the application of the research findings in PHM's global programs (to be presented to the PHM Steering Council – see below).

PHM Steering Council meetings in Bangkok in January 2017 and January 2018

In January 2017 and again in 2018 the PHM global Steering Council met in Bangkok. In both cases reports from the various country and global studies were discussed and the conclusions of these discussions incorporated into PHM yearly planning. Additionally they have informed the thematic chapters of this report.

Case studies and sub-projects

Country case studies

General

All six of the participating countries set up research teams that took care of data collection and analysis. They were constantly in touch with the core international research group (which included the three principal investigators and the three co-researchers) for mentoring and support.

The organization of country teams was guided by the intent to rely upon and strengthen PHM presence in the country. This was both a methodological choice, linked to the principle of action-research, and a strategic one due to the need to rely to a substantial extent on volunteer work given the limited amount of available funding.

Country teams were supported through mentoring while acknowledging their autonomy in adapting the research protocol to the local context. This produced significant diversity in approaches and some limitations in the coverage of the research themes, but generated greater ownership of the results by country teams and positive developments in terms of movement building.

Despite the diversity in research approaches (described below), all countries followed a similar process in convening PHM country groups and discussing the international research guidelines in order to: a) learn about the research and gather general support; b) recruit volunteers and form research teams; c) adapt the guidelines to the country context and the local needs/priorities of the PHM group; and d) develop a country research protocol for submission for ethical approval.

Each country team developed its own protocols and data collection instruments while following common guiding principles. All country protocols were inspired by participatory action research principles but the degree of action involved varied somewhat. There was a spectrum of approaches, going from participatory action-research led

through a bottom-up process (e.g. Italy), to more rigorous and traditional research approaches informed by academic theories (e.g. Colombia). Between these two ‘extremes’, other countries organized the work using different approaches and methodologies, including formative evaluation, literature review, case study analysis, and ethnographic research (see Table 2).

Country	Research activities	Main research approach	Reports
Brazil	Porto Alegre. Action research around community participation in local health councils leading to a focus on health in schools	Participatory action research; qualitative methods	Brazil POA-NHS EN Stage 1 Brazil POA-NHS EN Stage 2 Final
	ACT (national). Case studies on tobacco control and a new alliance on food	Participant observer narratives	Brazil ACT EN Stage 1 Brazil ACT EN Stage 2
	Nina Rodrigues. PAR around local action for health	Participatory action research; retrospective and concurrent ethnographic research	Brazil Nina Rodrigues EN Stage 1 Brazil Nina Rodrigues EN Stage 2
Colombia	Nine case studies based on interviews and documents Overview synthesis paper	Ethnographic research	Colombia Stage 1 Overview and Synthesis Report: ES and EN Colombia ACIN Colombia ACVC Colombia ASOTRECOL Colombia EPLS Colombia LGBT Colombia MNSS Colombia ACVC Women Colombia ZRC Colombia HSJ
DRC	Survey of civil society activists regarding the five domains	Questionnaire and interview survey	DRC Stage 1 Report Central West Africa Regional Workshop
India	Literature review on the health movement in India Case study of PHM in India based on interviews and document analysis regarding the five domains	Summative qualitative interpretive research	India Final Report
Italy	Combined interview and questionnaire survey of CSOs regarding five themes nested within a reflexive PAR study of collective work and activist organizing	Participatory action-research; qualitative methods	Italy Stage 1 Report: IT , EN (32 MB); EN-lite , (1 MB) Italy Stage 2 Report: IT , EN

Country	Research activities	Main research approach	Reports
South Africa	Literature review on health activism in South Africa Evaluative case studies of the South African Peoples Health University (SAPHU), community health workers (CHWs) and National Health Insurance (NHI) Amended strategies and practices arising from the experience of the NHI Campaign and the SAPHU evaluation	Formative research, ethnographic research	South Africa Stage 1 Report South Africa CHW Case Study South Africa NHI Campaign Case Study South Africa SAPHU Evaluation South Africa Stage 2 Report

Table 8 Research approach in countries

The diversity of research approaches reflects the characteristics of PHM in each country which, in turn, is a sample of PHM diversity both across countries and regions, and in the global structures.

General / Data analysis and reporting

In terms of reporting, all countries were asked to conform to a specific format. However, as with the research protocols, there was a degree of flexibility to accommodate specific features of country contexts. Brazil, Colombia, Italy and South Africa produced separate reports for each of their Stage 1 and Stage 2 projects. The raw material (mainly in the form of case studies) was also made available in the original language (i.e. English, Italian, Spanish and Portuguese). India produced a single report including a number of sub-studies but did not deploy action research. DRC produced a series of case studies as its Stage 1 report and hosted a regional workshop as its main Stage 2 activity.

The reports covered a description of the research process, methodological aspects, and a summary of findings organized according to the five main domains of the research. An exception to this structure is Italy, where the final report was not organized around the original five domains but according to other ones that emerged from the research.

Generally speaking, report writing was a daunting task for most country teams, which in some cases decided to outsource some of it to paid contributors (India, South Africa), recruited through PHM country networks.

Regional workshops were held in 2016 to facilitate reflection and consultation around the direction of the various research initiatives; to provide mentoring opportunities for junior researchers; and to expose the whole project to input from a wider range of activists. See reports: [Europe \(Brussels\)](#), [Asia \(Colombo\)](#), [Africa \(Cape Town\)](#) and [Latin America \(São Luis\)](#) and [Colombia \(Pandi\)](#). The regional workshop for francophone Africa was organized in DRC (Kinshasa) in March 2018 ([see](#)).

Brazil

In Brazil three separate sub projects emerged:

- a case study of social participation in the Brazilian national health system, led by PHM Porto Alegre;
- a case study of grassroots rural activism for health, led by PHM Maranhão;
- three case studies in health promotion:
 - two case studies in tobacco control: indoor smoking and tobacco advertising, led by the Alliance for Tobacco Control and Health Promotion – ACT+;
 - a case study of coalition building around public policy for healthy and adequate diets in Brazil (the Alliance for Adequate and Healthy Food), documented and analyzed through ACT+.

Social participation in the Brazilian national health system

This project was carried out by a team of PHM researchers working with local academics, public health students and local organizations and other resource people. The project was centred in the city of Porto Alegre in the state of Rio Grande do Sul.

Stage 1. Description and evaluation of community participation in two district health councils in the Porto Alegre municipality ([Brazil POA-NHS EN Stage 1](#)).

The objective of this study was to describe and evaluate the contribution of users, health workers and managers to the achievement of community participation in the Brazilian national health system (SUS), in particular through the operations of two local health councils.

The research team was formed by PHM activists working in partnership with people who were interested in or involved in community participation plus postgraduate public health students. Academics and students from two universities participated. The work was coordinated by two PHM activists who are also academics at the UFRGS

Two health districts which had standing relationships with the two universities (UFRGS and UERGS) were approached to participate in the study. Three family health care centres (FHCCs) in each district were selected and four people were selected for interview in each centre. The project was presented to the two district health councils previously to the interviews.

Interviews were conducted in the health centres, following a semi-structured script. A total of 26 interviews were conducted across the two districts. The interviews were audio recorded and transcribed in full, following the agreement of the participants. In addition the researchers involved in the data collection participated in the local districts and health district meetings, recording their observations in a field diary.

The project followed the ethical norms of the Brazilian National Health Council and was approved by the Research Ethics Committees of the Federal University of Rio Grande do Sul and the Porto Alegre Municipal Health Department. All participants signed an Informed Consent Form.

Shortly after ethics approval in September 2015, contacts with district management commenced to select the health care centres that would be visited. Afterwards, the observation of the district health councils meetings in both districts that were included in the research was initiated. Soon after, the team started to visit the services in order to know the staff and to interview the people. The interviews were accomplished from November 2015 to January 2016. The members of the team participated in the local health councils, when they were active, as well. In January 2016, the team conducted a workshop to discuss the process of analysis and, later, two meetings to undertake the analysis.

The following material was collected: 29 interviews (10 hours, 41 minutes of recording), field diary with observations from the meetings of the district and local health councils, and field diary with observations from the visits to the health care centres.

A content analysis was undertaken based on the thematic axes which were pre-established according to the objectives of the larger research project. Other categories were created through the analysis, in an inductive process. The MAXQDA software was used to help in the organization of the data according to the categories of analysis.

The full report of this study is here: [Brazil POA-NHS EN Stage 1](#).

Reflection

Reflection on the outcomes of Stage 1 and planning for Stage 2 started in the July 2016 workshop in São Luís/Maranhão when all of the Brazilian projects in the CSE4HFA project came together to report and consider the outcomes of the Stage 1 research ([workshop report here](#)). However, the Stage 2 project really took shape in the September 2016 workshop involving the research team and several of the groups they had been working with in Porto Alegre. What emerged from this workshop was a commitment to adding other/new actors into the debate

around community participation in health and working with the community's youth, building on the existing Health in School Program and focusing on citizenship.

Stage 2. New partnerships across health and education and between community and academia, including a new focus on gardens and food

This second stage project (full report here: [Brazil POA-NHS EN Stage 2 Final](#)) evolved in a complex way involving a series of activities which emerged out of, and helped to strengthen, new relationships and alliances. The activities included:

- a community garden project within the grounds of the school involving collective exploration of permaculture principles, ideas about *buen vivir/sumak kawsay*, medicinal plants, water and environmental issues while enacting and deepening relationships of collaboration and solidarity; and
- participation in street markets with the Alliance for Adequate and Healthy Food (see below).

These activities emerged out of an organic process of new relationships, new understandings and deepening trust. In the first instance the research team built on the existing (municipal) Health in Schools program to strengthen the links between the local family health centre and the school community based in one local school. This was the initial platform but it led to new relationships with the municipal health council, with the local grassroots council, with academics at the State University of Rio Grande do Sul (UERGS), and with the Alliance for Adequate and Healthy Food.

These relationships were developed with the evolution of the community garden project and through meetings, conversations, participation in the school's Solidarity Day, filming and sharing videos, workshops around gardening (permaculture, composting, soil preparation, herbs and seasonings, etc). A significant event was a well-attended seminar in June 2017 co-sponsored by the UERGS and the Grassroots Council, focusing on population growth in the district and participatory budgeting.

[Annex 1](#) of this report provides an overview of both of the Porto Alegre projects and implications, drawn from the findings of the two stages, for the five research domains of the main project.

Grassroots rural activism for health

The research undertaken through this project was directed to describing a movement building initiative in a rural municipality (Nina Rodrigues) in the state of Maranhão (in northern Brazil) extending over a five year period and still ongoing. The description is generated in two stages. The first is a retrospective account ([Brazil Nina Rodrigues EN Stage 1](#)) of the initiative from 2012 to 2015 drawing on contemporary documents and current key informant interviews. The second is a contemporaneous account of the project ([Brazil Nina Rodrigues EN Stage 2](#)) as it has evolved from 2015, drawing on current records, interviews and participant observer documentation.

The central figure in both stories is Sister Ani (Anne Caroline Wihbey), a religious sister with the Namur Notre Dame Congregation and also a long standing member of PHM.

Sister Ani was first asked to visit Nina Rodrigues in 2012 as someone who might be able to assist a small team associated with the local parish who were confronting a range of health related problems in the various settlements of *quilombola* and indigenous descended communities distributed across the municipality.

Over the next three years Sister Ani ran monthly training and reflection workshops, using popular education methodology, with a small public health team of local volunteers; exploring possible forms of action and reflecting on the outcomes. This period is reconstructed from key informant interviews and extant contemporaneous documents (full report [here](#)) supplemented by references to the wider literature.

The second stage of the project emerged from the July 2016 workshop in São Luís/Maranhão when all of the Brazilian projects in the CSE4HFA project came together to report and consider the outcomes of the Stage 1 research ([workshop report here](#)). This second stage project maintained the popular education orientation but with a more formal participatory action research approach. The monthly meetings continued but the focus shifted from training the health team to systematically reflecting on experience, action, outcomes and new strategies. This second stage

of the project was documented by a researcher from PHM Belem drawing in interviews, document analysis and participant observation (full report in [Brazil Nina Rodrigues EN Stage 2](#)).

[Annex 1](#) of this report provides an overview of this project and implications, emerging from the two reports, for the five generic themes of the main project.

Case studies in coalition building

Two research reports have been prepared by personnel associated with ACT+ (the Brazilian Alliance for the Control of Tobacco Use and for Health Promotion). The first of these Civil Society Engagement for Tobacco Control in Brazil is a retrospective reflection on two key campaigns around tobacco control: smoke free indoor spaces and banning tobacco advertising (report here: [Brazil ACT EN Stage 1](#)). The second report provides a chronological account of the establishment of new coalition – The Alliance for Adequate and Healthy Food in 2016 and 2017 and a summary of achievements in the first year of operation ([Brazil ACT EN Stage 2](#)).

ACT+ is a coalition of academic, professional and civil society groups with a mandate to drive the implementation of the FCTC in Brazil, in particular to counter the opposition of the powerful Brazilian tobacco industry. The ACT+ network has been actively campaigning around these issues since it was formed in 2006.

The tobacco control cases are based on document analysis, a key informant group interview and eight key informant individual interviews.

The second report produced by ACT+ provides a chronological account of the establishment of The Alliance for Adequate and Healthy Food from 2016 and a summary of achievements in the first year of operation. A ‘task force’ around food had been created in 2014 but this included government representatives and a need was perceived to create a coalition outside government so that it could advocate to and put pressure on government.

The report (based on participant observation and document analysis) traces the development of the Alliance through setting objectives, negotiating a manifesto, adopting a name, advocacy training, training in strategic planning, sharing and trust building, mapping (and respecting) work being undertaken by different members, developing a governance structure, priority setting (for the Alliance)

[Annex 1](#) of this report provides an overview of these two case studies and the implications, emerging from the two reports, for the five generic themes of the main project.

Colombia

The research team comprised eight students as researchers (two PhD and two master’s students, and four undergraduates). Each of them developed their research protocols with the guidance of four mentors (teachers/researchers) from four different universities.

The overall research proposal received ethical approval from the University of Bogota, which was responsible also for the management of the research, including its financial management. An arrangement of scientific collaboration among the different universities was developed to support the participation of students from different universities.

Stage 1

The first stage of the research comprised nine case studies covering various episodes and struggles around the right to health in Colombia. The reports of these case studies are linked from [Table 1 above](#) and are described in summary in [Annex 2](#) below.

Stage 2

Following the completion of the Stage 1 case studies the team held a three day workshop (2-4 Sept 2016) to review their findings and plan for Stage 2. Participants came from the four regions where the case studies were based, plus the participating universities, with two delegates from Brazil. The case studies (above) were reviewed with a view to identifying strategies to strengthen the movement for the right to health in Colombia.

The report of the workshop (in Spanish [here](#); in Google English [here](#)) includes brief summaries of the case study presentations (of the cases above) and an overview of the theoretical resources drawn upon in those studies.

Participants worked in regional groups (Cauca Valley, Bogota, Medellin, and Valley of the Cimitarra River) and reviewed the case study reports and considered next steps. The report summarizes the final plenary discussion.

The next step was in March 2017 with the formalisation of a plan for Stage 2 of the 'Civil society engagement' project: *Permanent encounters for the collective development of capacities among community health workers and the participatory construction of the living conditions of the communities*. (See Anexo 1 in Spanish [here](#) and in Google English [here](#))

The plan (in Anexo 1) reviews the findings of the case studies from Stage 1 focusing on the local struggles around health care and the conditions of living and concludes from this work that a priority need would be training and capacity building among the communities around the enforceability of the right to health, support for participation in public debates and in the construction of health plans and programs, as well as in the recognition of subordinate actors for change.

It was proposed that Stage 2 of the CSE4HFA project would aim to help to build and develop collective capacities in the various communities in and around the ZVTNs and PTNs (working with peasant, Afro-descended and indigenous communities, including ex-guerrillas)⁹. The project would focus on supporting community health workers in order to ensure popular and proper forms of health care adapted to their needs and customs with full regard to the claims of autonomy of the ethnic and peasant communities, and the creation of their own, social, environmental, cultural and territorial conditions for health and food sovereignty and nutritional security. It would also explore the principles and directions to be expressed in the proposed National Rural Health Plan and help to build policy capacity to engage in that process.

The idea of a 'permanent encounter' was seen as a key strategy for building collaboration, policy dialogue and training opportunities and short, medium and long term objectives for the permanent encounter were identified. A series of meetings was planned to initiate this process with a focus on specific and current problems facing different communities and exploring the scope for more structured training opportunities for local community members engaged in various ways in health work.

Three meetings with peasant communities were organized to discuss the training of community health agents and to discuss the elements of a health model that would meet the health needs and circumstances of the rural communities of Colombia. The Stage 2 Activity Report (in [Spanish](#), [EN\(G\)](#)) summarizes the outcomes of these discussions.

Democratic Republic of Congo (DRC)

After the regional planning meeting held in Cape Town in mid-2014, the DRC PHM country circle developed a strategy to carry out the project. By early 2015 it had established a research team composed of three local activist-researchers, and a support committee of four senior researcher-activists. Gender balance and geographical representativeness were included among the criteria for selection, together with experience in research and grassroots work. English proficiency was considered as well.

A training and planning workshop was then carried out, in order to adapt the international research protocol to the local context, co-construct the research tool (questionnaire, interview prompt), and build capacity within the local team.

The situation in DRC is different in many respects from that in the other participating countries and presented several challenges: capacity and resources within civil society organizations, political instability, geographical diversity and accessibility, communication, and transport facilities. For example, in February 2015 all Internet and phone messaging communication was blocked by the government for almost three weeks as a reaction to political protests.

9. See [Annex 2](#) for acronyms and more details.

In order for the research to be manageable by the local team within the described constraints, a choice was made to focus on two geographical areas, i.e. the capital city Kinshasa and the Kivu region. It was, however, agreed that, if appropriate, relevant experiences in other regions could be also identified and mapped throughout the course of the study.

An interview study was planned with a view to eliciting experiences and opinions from civil society organizations affiliated with or close to PHM regarding each of the five domains. The interviews were carried out and transcribed and a report prepared (May 2016). The report of this study is here: [DRC Stage 1 Report](#); and is structured around the five domains. Its findings have informed the thematic chapters of this report.

The enthusiasm of the PHM circle was somewhat depleted following the completion of the report and planned research for Stage 2 did not proceed. However, a regional workshop was held in March 2018 and provided an opportunity for PHM activists from across the region to review the outcomes of the whole project and incorporate them in the discussion and planning for better country and regional organizing ([report here](#)).

India

The India research team sought to document and analyze the experience of the Indian 'HFA movement' (including but going well beyond PHM) in relation to each of the five domains. See full report here: [India Final Report](#).

The research team for the project consisted of one full time researcher and a team of six researchers (with day jobs in different research organizations) working as volunteers. The research project, especially the country level research work, was also discussed in the PHM-India's National Co-ordinating Committee, which provided inputs into the methodology and scope of work to be undertaken.

A literature review was commissioned and a research protocol, including theme lists and prompts for interviews, was developed based on the guidelines provided by the global research team. The protocol covered all the five themes from the global project. Ethics clearance was received through the Institutional Ethics Committee of the Peoples' Health Resource Network (PHRN) – the local host of the project in India.

The first step was a mapping (by the research team) of organizations engaged in activities related to HFA (including the broader social determinants of health). This mapping was augmented through an online questionnaire circulated in the PHM-India listserv seeking suggestions of other organizations.

Organizations and movements were listed through three sub-divisions – PHM-India, PHM-India affiliated organizations and non-PHM-India organizations and cross referenced against the five main themes. Five organizations/movements were identified whose work was cross cutting across all themes. In addition 11 other organizations were short listed for data collection on one or two themes. The selection of organizations/movements for inclusion was based on: their importance in the ecology of health related activism in India, geographical spread (making sure that all parts of the country were covered), thematic spread, and engagement with gender issues.

Key informant interviews were conducted with experienced activists from each of the selected organizations. Interviews were recorded in note form and voice recordings and analyzed in relation to the five domains.

An introduction to each domain, through study of grey literature, peer-reviewed academic literature and a few focused key informant interviews, preface the analysis of interview data collected.

Italy

The Italian research team comprised a group of around 25 volunteer researchers recruited from within a broad informal network that identifies with the PHM. The team elected to work within the participatory action research paradigm, first documenting the experience of civil society organizations working towards Health for All in Italy; then reflecting on the data collected, and then initiating new actions in accordance with the findings of the first stage of the research.

The research strategy involved, first, a mapping of relevant civil society groups, networks, and organizations active in the struggle for Health for All; second, in-depth interviews of key informants from a subset of these organizations,

covering the five research domains; and third, the preparation of case studies of (at least) two campaigns. Ethical clearance was obtained from the University of Bologna Ethics Committee. Sub-groups of volunteer researchers were created to undertake interviews and prepare reports on different areas of activism, including environment, food, housing, gender, education.

At the end of the first stage of the project (reported in Italy Stage 1 Report: [IT](#), [EN](#), 32 MB each; [EN-lite](#), 1 MB) the research collective reviewed the analysis which had emerged from the first stage and formulated three priorities for further work:

- to repoliticise the discourse on health, challenging the hegemonic biomedical perspective;
- to explore further the links between health and the ways we live; and
- to promote and sustain the process of building a movement for health in Italy.

The group decided, for the second stage of the project, to organize three open workshops focusing on these three key issues emerging from the project. The organization of these three workshops constituted the main focus of the second stage of the project. The second stage report (reported in Italy Stage 2 Report: [IT](#), [EN](#)) provides brief summaries of the discussion at each of these workshops (and links to the video reports, above) but the main focus of the report is a reflection on the research experience across the two stages of the research. This summative overview includes reflections on the five (main) project domains, constructed largely around the experience of the research collective during the first and second stages of the research.

A more extended summary of the Italian research is presented in [Annex 5](#) including a summary of the implications for the five domains adopted for the main project.

South Africa

The South African contribution to the CSE4HFA research was coordinated by the People's Health Movement South Africa (PHM SA) Steering Group. The research activities were carried out by PHM members supported by two professional researchers. Following the first Global Planning Meeting, PHM SA obtained Ethical Clearance for the global research project and for the local research at the University of the Western Cape, South Africa.

Five studies were undertaken as part of the Stage 1 Research (see [South Africa Stage 1 Report](#)):

- SA RTH Campaign. Reflections on the PHM SA's RTH Campaign (Brief memoir by coordinator);
- NHI Campaign Reflections. Reflections on the NHI Campaign, co-sponsored with Section 27, TAC, and others from 2010 (see report: [South Africa NHI Campaign Case Study](#));
- SAPHU Evaluation. Formal evaluation of the 2013 and 2014 South African People's Health University (SAPHU);
- CHW study. Health activism, mobilization and organization among community health workers (see report dated May 2016, [South Africa CHW Case Study](#)); and
- Overview history of civil society engagement in health development in South Africa (included in the body of the Stage 1 report, from page 1).

The main study undertaken as part of the second stage was based on a two day workshop held in July 2017. This workshop involved PHM researchers and members, several SPHU alumni, and representatives of some of PHM's main partners in the 2016 National Health Assembly. The workshop provided an opportunity to reflect on the experience of the projects addressed through the CSE4HFA research, the implications for the five domains, and lessons for the future. The report of the workshop forms part of the Stage 2 Report ([South Africa Stage 2 Report](#)).

Link to [Annex 6](#)

Global studies

Separate protocols were developed for a number of studies undertaken at the global level.

Literature review of academic research and commentary

A review of research and commentary on social movements in relation to health was undertaken. Google Scholar was searched using search terms: social movement, civil society, global, and health.

The full review is here: [Review Social Movements Research and Commentary](#). In [Annex 7](#) a summary of the main implications of this review for each of the five domains of the research is presented.

An archaeology of the global HFA movement

A desk review of the historical development of the global HFA movement was prepared. The researcher assembled a collection of 'episodes' or 'streams' of civil society action around health with a view to learning about enabling conditions for movement building and in particular the patterns of influence through which different currents are coming together (or not) as a global social movement.

The 'episodes' were grouped into categories by field (health care, identity movements and health, social determination of health, human rights, and peace, cooperation and disarmament) and considered in broad chronological order within each of these fields. Data from the literature were assembled in relation to each episode. The focus of the analysis was on the enabling conditions behind the emergence of each episode and on the patterns of influence stemming from them.

A further analysis was undertaken categorising the episodes in relation to different patterns of influence and possibilities for convergence across streams into a stronger globalized movement for health equity.

The interim report of this study is here: [The HFA Movement Globally](#). In [Annex 8](#) the implications arising from this study for each of the five main themes are summarized.

Personal narratives of experienced activists

The purpose of this activity was to record the personal histories of global health activists (all active within PHM and in other CSOs) and to document and analyze their reflections regarding the conditions for effective civil society engagement in the struggle for Health for All.

Participants were recruited through the global networks of the People's Health Movement and were located in different countries across the world (including South Africa, Australia, India, UK, USA, Belgium, Italy, Philippines, Vietnam, Nicaragua and Brazil). Eight of the participants were men and seven women. Interviews were conducted in a number of locations, by different interviewers and through different modes: both in person, through skype and phone.

A narrative guide was developed through email consultation with the PHM Steering Council and was sent to all participants before the interview, along with a consent form and information sheet about the project. Participants had the option of writing their answers to the questions on the narrative guide form and emailing it back, or to be interviewed.

Interviews were conducted in English, although English was not necessarily the predominant language of all interviewers or interviewees, and were recorded and transcribed. The interview data were analyzed in relation to dilemmas and choices emerging from the personal narratives and in relation to the five generic themes.

The study received ethics approval by the Senate Research Committee of the University of Western Cape and Flinders University's Social and Behavioural Research Ethics Committee (SBREC). The final report of this study is [here](#). In [Annex 9](#) the implications arising from the study for the five generic themes are summarized.

Manual on movement building

By mid-2016 all of the Stage 1 reports from participating countries had been submitted and an interim analysis of these reports was undertaken in a workshop held in Vancouver in November 2016 in association with the 4th Global Symposium on Health Systems Research.

On the basis of the Stage 1 reports a 'manual' on movement building was conceived and a call for case studies was widely broadcast. The manual was drafted drawing on the Stage 1 reports, the Vancouver analysis and the case studies, and was revised in consultation with advisors from across PHM.

The manual in full is here: [Movement Building Manual \(2017\)](#). A brief summary is included in [Annex 10](#) of this report with implications for the five themes of the research.

IPHU stakeholders survey and interviews

This study was a questionnaire survey evaluation of IPHU alumni conducted by a multidisciplinary team at the Centre for International Health in Bologna. A questionnaire was developed, tested and finalised and accessed via Survey Monkey. An integrated email list of 1,262 alumni from 38 courses was assembled and emailed seeking their participation. The responses were analyzed in terms of IPHU representation, respondent characteristics, course experience and suggestions.

The full report of the research is here [IPHU Evaluation Survey Report](#). In [Annex 11](#) the implications of the findings of this survey for capacity building generally are summarized.

Note that several other reports dealing with different IPHUs or related issues have also been prepared and are considered further in Chapter 6 below. These include:

- [IPHU El Salvador](#) Describes the program of IPHUs organized in El Salvador (see also [Annex 12](#));
- [IPHU Nepal](#) Report of IPHU short course, November 2016, Kathmandu, Nepal (see also [Annex 14](#));
- [India Final Report](#) Evaluation of IPHUs held in India, included as part of the India report;
- [Europe Regional Workshop 2016](#) includes description of Europe IPHU;
- [IPOL GHG 2014](#) Study Guide for on line IPHU course on Global Health Governance.

Evaluation of reach and impact of Global Health Watch 4

Global Health Watch was first published in 2005 ([here](#)) and subsequently in 2008 ([here](#)) and 2011 ([here](#)). GHW4 was published in 2014 ([here](#)). GHW5 was published in late 2017.

GHW4 was evaluated through a survey questionnaire completed by 19 anonymous respondents recruited through PHM's Newsletter and a survey of 9 PHM activists who had been involved in organizing launches of GHW4 when it was released.

The questionnaire sought opinions regarding: value of GHW generally, existing and possible audiences, contents, dissemination, limitations, and suggestions.

The full evaluation report is here: [GHW4 Reach and Impact](#). See also [Annex 13](#) for further background regarding Global Health Watch and for a summary of the implications arising from this study for Knowledge generation, Capacity building and Policy dialogue.

Evaluation of WHO Watch

An evaluation of WHO Watch undertaken in May 2015 and involving key informant interviews, focus group discussion, participant observations, and an online survey. See full report ([CSE and GHG](#)) for more details.

Attached as an appendix to the research report are reports of three episodes of WHO watching:

- The 138th Executive Board meeting,
- the 69th World Health Assembly, and
- the 140th Executive Board meeting.

See [Annex 15](#) for further background regarding WHO Watch and a summary of the implications arising from this evaluation for the five generic themes.

Two further reports of relevance for WHO Watch are:

- [IPOP GHG 2014](#) – the Study Guide for the online IPHU course on Democratizing Global Health Governance and WHO Watch (IPOP GHG), discussed further in [Annex 16](#);
- [Ghana Workshop Report](#) - Ghana workshop (discussed further in [Annex 17](#)).

Regional workshops

Five regional workshops ([Europe \(Brussels\)](#), [Asia \(Colombo\)](#), [Africa \(Cape Town\)](#), Brazil ([São Luis](#)) and Colombia (Pandi [ES](#), [EN\(G\)](#)) were conducted in 2016 and a further workshop in [Africa \(Kinshasa\)](#) in 2018 to deepen the analysis of data collected at country and global levels, to serve as a mentorship opportunity, to disseminate the findings of the research to date and to incorporate them into PHM regional discussions and planning. In all the regions participants for the workshop were selected keeping in mind the need to involve both young activists and senior PHM functionaries in the process of broad dissemination of the findings of the research. Gender balance was also kept in mind while drawing up participants' lists for the workshops. The workshops also provided an opportunity to discuss strengthening the movement for health in different regions, keeping in view the findings of the research. The reports of these workshops have informed the thematic chapters of this report.

Dissemination and impact

Dissemination opportunities to date have included:

- A session presentation at the Third Global Symposium on Health Systems Research in Cape Town on October 2nd 2014,
- Local workshops in the participating countries,
- A poster presentation at the Prince Mahidol Award Conference (PMAC) conference in Bangkok, 26-31 January, 2015,
- The four regional workshops in Europe, Asia, Africa and Latin America, in 2016,
- The IPHU in London in June 2016,
- The Nepal IPHU in Nov 2016,
- Presentations at the Health Systems Research Global Symposium Nov 2016,
- Side event presentation at the PMAC conference January 2017,
- Regional workshop in Kinshasa in March 2018,
- Presentations and discussion in Geneva, Bologna and Brussels in May and June of 2018.

Plans are in place:

- to encourage the country based research teams to publish journal articles based on particular projects (at least one of these is currently in press);
- to submit for journal publication two articles dealing with the whole project, one on methodology and one on findings;
- to create a nicely produced overview account of the project and its findings, based on the Executive Summary of this report;
- to organize a series of discussions on the findings of the whole project at the fourth People's Health Assembly in Savar, Bangladesh in November, 2018; and
- to include a chapter based on this research in the next edition of Global Health Watch.

Impact on PHM's policies and practices

Participation in the project has contributed to movement building and capacity development in all of the participating countries, including those countries participating in the regional workshops

The project's findings are already being applied in the conduct of PHM's global programs, including the organization of WHO Watch, the development of the fifth edition of Global Health Watch (published in late 2017), the development of the Manual on Movement Building and the planning for two IPHUs in November 2018 and is informing the development and program of the 4th People's health Assembly to be held in Savaar Bangladesh, November 2018

Strategic and programmatic discussion at SC meetings in 2017 and 2018 has been significantly informed by the emerging findings of the project.

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Chapter 5. Movement building

The effectiveness of a social movement is a function of its strategizing and organizing capacity and its political power (as well as the social and political context in which it is working). The modalities of power include: numbers, organization (including networks and alliances), culture, material resources, information, knowledge and skills. Movement strengthening and capacity building is a key objective of social movement strategy, including developing those modalities of power.

Movement strategists are working simultaneously across three fields of action:

- developing the capabilities of the organization and of the activists who embody the organization;
- communicating with the constituencies whom the organization seeks to mobilize and activate; and
- engaging with the institutional and political structures which need to change if Health for All is to be achieved.

Our focus in this chapter is on the first two fields of action which are about movement building although these are not separate in practice from policy advocacy and campaigning.

This chapter is structured around eight ‘principles’ emerging from our research.

- Attend to all levels of the movement: individuals, relationships, communities, organizations and networks;
- Understand the pathways to activism;
- Community building, including mutualism, is part of movement building;
- Collaborating with the State: a matter of judgement;
- Social movements have deep roots; know your history;
- Leadership is necessary but so is accountability;
- Build constructive links between the HFA movement and broader political movements;
- Convergence (solidarity, networking, collaboration) is a key objective of movement building in the era of globalization.

Box 1. Eight ‘principles’ for Movement Building

Attend to all levels of the movement: individuals, relationships, communities, organizations and networks

Social movements can be usefully analyzed at all of these different levels with strategies for movement strengthening also focusing at different levels.

The individuals

Movements are comprised of individuals. Movement activism is constituted by the activism of individuals in their various collectivities. Accordingly movement building is also about ‘capacity building’ (individual and organizational) which we discuss in more detail in Chapter 7.

Many activists prefer to make their contribution as members of a group or organization. In so doing they are underpinning the power of numbers; they are getting the reward of appreciated contribution; they are finding a sense of identity, as well as security and support among friends; they are becoming empowered because they are empowering their organization. *People within organizations* is discussed further below.

However, not all activists operate at all times within organizations. There are many forms of action that activists can deploy as individuals: for example, letter writing or whistle-blowing. Policy activist Ruth Roemer was instrumental in driving the Framework Convention on Tobacco Control, locking into institutional form the demands of the movement (see [HFA Movement Globally](#), from page 42). Community health entrepreneurs like the Karks, the Aroles and Chen Zhiqian (also see [HFA Movement Globally](#)) are activists who contribute by showing that services can be delivered differently.

The organization

Organizational culture

Most of the studies on which this chapter is based have pointed to or illustrated the importance of organizational culture. Culture here refers to the values and norms which are expressed in our practice and the symbols, icons and rituals through which we construct our subjectivity.

An organization which is challenging established ways of thinking, speaking and practising needs to keep working to sustain its heterodox culture, the symbols and rituals which affirm that another world is possible. For example the philosophy of *buen vivir* (living sustainably as part of nature) has been actively promoted across PHM circles in Latin America and beyond. *Buen vivir* expresses respect for the indigenous traditions from which it derives, highlights the need for frugality and care in relation to the natural environment and underlines the need to curb the growth fetish of contemporary capitalism.

'Angela', one of the informants in the [Personal Narratives](#) study describes *buen vivir* as follows:

"The People's Health Movement in Latin America has made some pretty important decisions. We have taken the philosophy of the cosmovision of native peoples to be the driving force for the People's Health Movement in Latin America and that's the whole concept of buen vivir. Right now we've been working on a paper that we're sharing now in the month of July as part of an investigation that's going on about buen vivir and how to help people understand, who are not from indigenous communities, what this really means.

The indigenous communities and some very forward-looking academics in Ecuador, understand that we are in a crisis of civilisation and the model is not working and so what model can work. The concept of buen vivir provides us with a model that is not exploitative of our planet, that recognizes that we have to take care of water and we have to source this water"

People (as 'human resources')

The organization depends on its people. This has implications for recruitment, training, identity and relationships, intrinsic rewards, and culture.

The culture of the organization is critical in generating the intrinsic rewards of participation. This includes making space for fun, for friendships, for acknowledgement and appreciation, for challenge and growth.

Burn out is not unknown in activist organizations particularly when over-work appears to yield little progress. An organizational culture which encourages relaxation and time out may help to nurture resilience. Several of the informants for the [Personal Narratives study](#) spoke about importance of self-care including engaging in healthy activities, balancing personal and activist responsibilities and looking after your mental health.

Relationships matter

Volunteer organizations which want to keep their recruits need to offer them a secure, nurturing environment at the core of which is warmth and friendship. 'This is about how we treat each other.' Many respondents to the [IPHU Alumni Survey](#) highlighted the importance of follow up, to keep in touch with the alumni and create and nurture a strong alumni network.

Group work skills

Group work skills are another aspect of organizational culture which are necessary to promote inclusiveness and broad participation. When people from very different backgrounds are trying to work together, are building solidarity, the skills of 'listening across difference' are critical. The following two examples illustrate how creative methods can be used to promote inclusive and participatory group work.

In explaining how the Italian Stage 2 report was produced the Italian research group explains:

The workshop, attended by eight people, was held in Bologna on 30 September 2017. In order to encourage freedom of expression, and promote the exchange of different ideas, the traditional

assembly discussions were combined with participatory methodologies, including non-verbal approaches (e.g. people were asked to physically position themselves to show their level of agreement/disagreement on different statements concerning the process; the different positions were then explained and discussed, creating a setting that promotes active listening and facilitates the understanding of other people's ideas and experiences).

Likewise, the Porto Alegre research group, in reporting on the final workshop of Stage 1 describes their process in the following terms:

Ten researchers, including PHM members, State University of Rio Grande do Sul (UERGS) staff, four users, two workers (including the coordinator of the MHC/POA) participated in this meeting. The dynamic of this meeting, based on theater and body expression techniques, was facilitated by a professional actress who planned and prepared the full workshop with the PHM activists/researchers. The participants were distributed in small groups according to affinities, trying to keep the balance between the research team and the invited participants. Vignettes extracted from interviewees' sayings in the 1st phase of the research were discussed, as they were related to aspects involving potentialities, difficulties or strategies of social participation in the National Unified Health System (SUS). Following the debate, each group prepared a short theatrical play to perform in front of the large group. The debate was focused on the issues in common addressed by the three groups and was aimed at the relationship between health and education.

Volunteers and paid 'staff'

One issue which volunteer organizations face is to manage the balance and the relationships between volunteer and paid activism. On the one hand full time paid activists can exercise disproportionate influence on organizational direction. On the other hand there is a risk of divisions emerging between 'volunteer directors' and 'paid implementers'. The [India Report](#) has useful comments on these issues based on the JSA experience.

Organizational learning

Strategy in social movement organizations is intrinsically uncertain and building a strong culture of organizational learning is necessary. This value has been strengthened through the robust reflection and discussion which has characterised the regional workshops organized as part of this research. Knowledge is power. We discuss organizational learning further in Chapter 8.

Working on the self

The reports from the Italian research group have highlighted the importance of cultivating individual and collective reflexivity, and explicating the challenges of steering our own becoming.

We return to the issue of organizational culture below under *Leadership*.

Material resources

Material resources matter. Many activist organizations cope with very limited resources, while self-funding for participation in meetings and actions can be inequitable and distort representation.

PHM in India (see [India Report](#)) has survived to this point, largely on 'friends and neighbours' contributions, sometimes in-kind contributions in the form of venues, hospitality and administrative support but also different organizations taking financial responsibility for different expenditures.

Fund-raising has been intensely argued in the PHM Steering Council in relation to PHM's global programs (IPHU, GHW and WHO Watch) and in relation to the People's Health Assemblies (national as well as global).

Philanthropic funds can make a big difference but not all philanthropies are closely aligned in their analysis and objectives with the purposes and directions of civil society organizations working towards Health for All. From the civil society perspective on-going secure institutional support is preferred but many philanthropies prefer project-based funding which can distort organizational priorities and carry unforeseen burdens.

The organization and the movement

The evolution of the PHM circles in India ([Annex 4](#)) and South Africa ([Annex 6](#)) illustrate different relations between individual activism, organizational development, networking, and movement building.

The PHM circle in India (Jan Swasthya Abhiyan or JSA), although not incorporated, has a relatively formal structure nationally, managed by a relatively small circle of long time activists. The National Coordinating Committee brings together national affiliates and state networks. JSA is a forum and a coordinator but the energy and commitment of the movement for health equity is generated through the organizations which are part of the network and the individuals within those organizations. JSA is a network and a key entity within the India HFA movement but there are organizations which the India research group recognizes as part of the movement which are not members of JSA.

PHM in South Africa (PHM SA) is a formally incorporated membership organization, relatively small but with growing links to the health worker unions and the mass organizations centred on the Treatment Action Campaign. The contribution of PHM in South Africa to the nation-wide movement for health equity has been more about capacity building through the SAPHU and policy analysis, informed by its strong political economy perspective. PHM SA is clearly an organization but one which is actively networking with other organizations in the HFA movement in South Africa.

Organizational life cycles

Movements wax and wane and organizations too may flower and wither. The HFA history project ([Annex 8](#)) highlights the way the form and focus of the HFA movement has changed across time and space. The factors driving such cycles may be found in the wider environment and also in the organization itself.

The ASOTRECOL story from Colombia ([Annex 2](#)) is about injured workers who organized together around getting compensation for their injuries and holding employers to account. As individual workers achieved their purpose the organization slowly shrank and then closed.

The [Stage 2 project](#) adopted by the Colombian research group (see [Annex 2](#)) was very much a response to the changing environment associated with the peace process and the need for new organizational forms and practices to adapt to the new context.

Networking

Networking is a critical part of movement building. All of the country research teams have reported experience with networking. The [Brazilian research](#) included reports on developing coalitions around tobacco control and around 'adequate and healthy food'. The [Colombian Stage 2](#) research project was predicated on strengthening relationships between peasant organizations and the more urban based PHM networks. The [Indian report](#) includes extended reflection on networking within JSA. The three global programmes evaluations (IPHU, GHW, and WHO Watch) all highlight the importance of inter-organizational collaboration and networking (see Annexes 11, 13, 15).

Networking, building relationships between organizations, starts with mutual awareness, appreciation and respect, and perhaps using each other's resources. Networking is facilitated by overlapping memberships and personal relationships. Sometimes it is just about building relationships but such relationships are deepened by collaboration. This may involve campaigning together (see [Chapter 6](#)), analyzing and strategizing together, and collaboration in research and in capacity-building. The [South African Stage 2 report](#) (from page 11) includes an extended discussion of the challenges involved in networking, coalition building and alliances.

Deepening collaboration involves: negotiating objectives, messages and strategies; ensuring mutual benefit and reciprocity; respecting dignity; building trust and solidarity. One of the key conditions for effective networking is respect for the identity of the other and caution about being seen to submerge the 'brand' of the networking partner. In developing the Stage 2 project the Colombian research team ([Annex 2](#)) invented the concept of a 'permanent encounter' to provide a forum for communication and collaboration but to avoid creating (or being seen to create) a new organization.

The movement

The concept of a movement refers to a broader constituency beyond any one organization or network. Organizations and individuals who are part of the movement are enabled and/or inspired to protest and/or make demands. Through their participation they assume and constitute the subjectivity of the movement including the shared analysis and the aspirations for change. Movements also provide a setting for discussion and debate about analysis and strategy.

Building the movement is partly about creating the opportunities for the broader constituency to come together and to act in concert. The [Indian report](#) has a very useful discussion of the role of conferences, assemblies and open fora in movement building. The report includes a detailed account of the pre PHA1 mobilization during which activists coming together in regional, state, national and international assemblies was critical to identity formation, to visualisation of possibilities, to the building of confidence and (between organizations) trust development. The [South African research team](#) has also reported on their experience of ‘the assembly’ as a strategy for movement building.

The assembly, as a form of practice, illustrates the concept of convergence in practice with activists from many different issues and regions coming together; sharing experience and finding common ground.

The discussion below about ‘pathways to activism’ (and the barriers along those pathways) is useful in thinking about how the organization can communicate with – mobilize, activate - its wider constituency.

Pathways to activism

Movement building starts with the individual and needs to recognize the different pathways to activism, the different forms of individual activism, and the pathways from individual activism to organizational participation.

Grievance to outrage

For many activists, the first step is to move from grievance or concern to outrage (or non-acceptance). This transition involves three understandings: wrongs and rights, imagining difference, agency: this is wrong; things could be different; and I/we could make a difference.

The authors of the [MNSS case study](#) from Colombia (in press), reflecting on the emergence of the health equity movement in Colombia, conclude that ‘outrage’ plays a leading role in creating a political subject who will drive the needed transformations.

“Societies must constantly express their rejection and mobilize around every unfair act in health, which goes from lack of attention, the abuse in the services, the diseases, preventable deaths and avoidable suffering by individuals, even the theft of public resources of health.”

Predisposition, triggers, enablers, barriers

The Nina Rodrigues case study from Brazil ([Annex 1](#)) starts with Claudenir, a member of the local parish, who is concerned about the living conditions in the settlements and is searching for help in mobilizing his community. He can imagine things being different and looks to find a way of contributing to that change. This case study also illustrates some of the dynamics through which more people from the settlements were able to share Claudenir’s imagination of change and sense of agency.

A critical factor was the quiet support of Sister Ani, drawing on Freirean popular education. Another was the opportunity to meet with other activists from elsewhere in Brazil during the project workshops. Also powerful was the re-appropriation of, and inspiration from, the achievements of the MST (the Landless People’s Movement) which had successfully fought for land reform and the legal right to settle in Nina Rodrigues originally.

<ul style="list-style-type: none"> • Several small peasant settlements in rural Maranhão • Colonial legacies <ul style="list-style-type: none"> • successful land reform (MST) but still living in poor circumstances • large estates given over to monoculture • Parish initiative to work on health, taken up by parish volunteers • Sister Ani brought in; long period of gentle support and conscientisation <ul style="list-style-type: none"> • workshops and small group support • Improved community spaces through collective self-help, organic gardening, recycling • Increasing activism around access to decent health care, on municipal health council, new PHM circle looking beyond the local 	<ul style="list-style-type: none"> • Predisposition <ul style="list-style-type: none"> • a sense of right and wrong and • a sense of personal responsibility • Trigger <ul style="list-style-type: none"> • exposure to wrongs (direct or indirect) • Enablers <ul style="list-style-type: none"> • understanding • hope • community • resilience • Barriers <ul style="list-style-type: none"> • no space; just coping • no sense of agency
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Box 2. Pathways to activism (Nina Rodrigues)

For people who are not directly affected by deprivation the path to activism goes via concern through outrage, to solidarity. One of the case studies collected by the Italian team, “Noi non segnaliamo! (We will not report)” ([Annex 5](#)) tells of the struggle by the Italian Society of Migration Medicine (SIMM), in collaboration with Doctors Without Borders, the Association of Juridical Studies on Immigration, and Italian Global Health Watch to force the withdrawal of a legal provision requiring health care practitioners to notify authorities when migrants, not in compliance with residence rules, seek health care attention.

This transition raises a question about ‘what is solidarity’ and who declares it? For a man to declare his solidarity with the feminist cause is different from a collective of women accepting him as a trusted comrade; likewise for a white person to declare solidarity with blacks. The difference is trust and the circumstances in which trust is earned.

From outrage to understanding, action and agency

A further step towards activism is the move from outrage to understanding and action. We have a number of case studies and other reports which speak to this transition:

- the El Salvador IPHUs ([Annex 12](#));
- the role of Sister Ani in the Nina Rodrigues story ([Annex 1](#)) and her use of popular education methodology;
- the Medellin Escuela Popular de Salud - People’s School of Health ([Annex 2](#)).

The transition from outrage to understanding to action is neither simple nor mechanical. Understanding and agency arise from action just as action is based on agency and understanding. The Colombian case studies dealing with the Peasant and Mining Movement of Valle del Rio Cimitarra (see [Annex 2](#)) tells of how the women assumed leadership of the ACVC (Asociación Campesina del Valle del Rio Cimitarra - Peasant's Association of Valle del Rio Cimitarra) during a period when the men were not available due to paramilitary repression. With action came further understanding, including appreciation of the need to challenge prevailing gender relations, and then further action. We return to these transitions under capacity-building in [Chapter 7](#).

Episodic to sustainable engagement

Finally we can recognize a transition from current or episodic involvement to sustainable commitment. This transformation is partly about the personal rewards which accrue from making a contribution which is appreciated by colleagues; partly about moving into a network of warm and secure relationships; and partly about an almost deliberate process of actively steering ‘the person whom I am becoming’ and collectively steering ‘the people whom we are becoming’. This involves actively valuing the norms, symbols and rituals which affirm the identities, subjectivities and the cultures which will support our continued activism.

This process of actively shaping 'whom we are becoming' is highlighted in both the Stage 1 and Stage 2 reports from the Italian team ([Annex 5](#)).

These personal journeys are not always easy. The Colombian story about [LGBT activism in Cali](#) tells of the intimidation, including murders, which the early activists faced and notes that for a period this dampened down the activism. Likewise the [HSJ case study](#) tells of the stresses which dampened the activism, partly the stresses on hospital workers losing their jobs and homes, and partly the stresses of maintaining the occupation of the hospital premises.

Barriers and diversions

Not everyone wants (or is ready) to be a health activist. The South African Stage 1 report includes the results of a study focusing on the role of community health workers (CHWs) in the SA health system ([here](#)). The researchers explored the readiness of CHWs for the kind of community leadership and intersectoral advocacy, imagined in the Alma-Ata Declaration on primary health care. While there were some instances of community gardens and welfare advocacy, the researchers found that most of the CHWs did not have the space in their lives to take on such an expansion of their more restricted clinical roles. Rather they were distressed by government neglect, discrimination and poor working conditions. The research report reflects on the morale of the CHWs in the context of the changing pattern of activism since 1994.

Practical implications of the pathways metaphor

The pathways metaphor can be useful in thinking about how different groups of people are positioned in relation to the organization, and to the movement, and for thinking through organizational strategies regarding such relationships: recruitment, retention, mobilizing, activating and retrieving.

The model suggested in Box 2 above suggests that in communicating to the wider movement constituency, building on people's sense of right and wrong and sense of personal responsibility is important.

The outrage principle suggests that seeking campaign participation needs to be accompanied by a clear account of the wrongs at the centre of the campaign. However, such communication needs to also project alternative worlds ('another world is possible') and offer opportunities for small as well as major forms of participation.

Once people have joined, in whatever form, they need to be encouraged to stay. This involves them experiencing impact, appreciation, community, and support.

It is also necessary to restore contact with people who have dropped out. A common issue facing volunteer organizations is the changing availability of activists associated with their changing life circumstances. Students may participate actively during a particular period but then disappear when their workload surges. Other PHM circles have found themselves dependent on retirees who have more time until they, too, drop out.

Community building, including mutualism, is part of movement building

Much of the commentary on social movements focuses on the high profile campaigning and policy advocacy. However, several of the country case studies (including the Porto Alegre and the Nina Rodrigues projects in Brazil and several of the Colombian case studies) have highlighted low profile community building activities, such as gardening as important in strengthening community and building confidence as well as meeting real community needs.

The [Stage 2 case study from Porto Alegre](#) describes how participants' environmental consciousness was raised through an exploration of permaculture as an approach to gardening and how the project grew from gardening, to selling produce at street stalls, to participating in policy advocacy through the Alliance for Adequate and Healthy Food.

The two Colombian case studies from the [Campesino Association of the Cimitarra River Valley](#) highlights the scope in community enterprise to focus attention on occupational safety and to recognize, confront and reshape traditional gender roles and relationships.

The [Indian report](#) points out that, in some circumstances, a balance needs to be struck between setting up community based services, including health services, versus demanding that the State fulfil its obligations to provide such services. Community based service development such as the Pholela Health Centre and Jamked (see [HFA History](#)) can play a vital role in demonstrating the efficacy of comprehensive primary health care. However, the Indian report raises the possibility that a proliferation of community based and NGO operated health care has enabled Indian governments to avoid investing in an effective, comprehensive national health service. The World Bank on the other hand (see [Chapter 2](#) above) celebrates voluntary health care provision as part of the marketization of health care delivery, including both voluntary and private providers.

The Italian research group interviewed and documented a range of organizations and campaigns in their Stage 1 research. After reflecting on this material in the context of planning for Stage 2 ([IT](#), [EN](#)) it was decided to hold three public meetings, two of which were focused in different ways on 'health commons practices'.

The first public meeting was titled "Social movements and welfare: which practices between defending public institutions and social transformation?" (Bologna, 1-3 April 2016). The meeting focused on public welfare: the practices used to defend public services from privatization, as well as the strategies of self-organization carried out by different groups and movements (self-managed popular clinics, queer "consultorie"¹⁰, occupied housing projects, etc.).

The second public meeting was titled "Building healthy spaces and communities. Practices of collective reappropriation and self-organization" (Naples, 10-12 June 2016). The meeting focused on the practices of reappropriation and self-organization of (material and symbolic) spaces, in order to explore if and how they promote health as well as new forms of community. The key points identified have been: the institutionalisation and/or legitimisation of experiences that emerge from illegal practices; the inclusiveness and/or reproduction of forms of discrimination and privilege within self-managed spaces; the creative forms of reappropriation of public spaces and the construction of new constituent collective imaginaries; the possibilities of generalisation/impact of these experiences beyond geographical and identity boundaries.

The Italian group has underlined the importance of alternative approaches to basic community needs, oriented around mutualist principles ('reclaiming the commons'). Supporting farmers' markets instead of huge supermarkets is a form of social action and consciousness raising which can play a part in challenging transnational corporate control of food systems.

Collaborating with the State: a matter of judgement

With a strong structural analysis of health issues comes a critique of the role of the State and the ways in which governments can be captured by powerful vested interests, including transnational corporate forces. With this critique comes a continuing debate within social movements about relations with the State: balancing dialogue with refusal; working with State institutions (and intergovernmental organizations) versus delegitimising them.

We have a wide range of stories collected through this project which cast light on this quandary, ranging from peasant organizations in Colombia who were subject to brutal repression during the presidency of Uribe, through to the [tobacco control case study in Brazil](#) which was undertaken in close collaboration with government.

10. Queer "consultorie" (the feminine for "consultori", territorial services dedicated to women's health) are self-organized groups that work on queer(ing) sexual health. Their aim is to foster self-determination, to promote attention to the social determinants of health, to challenge the dominant heteronormative and sexist organization of health care, while at the same time resisting the dismantling of public welfare.

The case study of user representation on the [health councils of Brazil](#) illustrates how relations with the State can change across time. The establishment of the health councils from 1988 was a powerful victory in the context of a new constitution which entrenched the right to health and the principle of ‘social control’ (community participation)¹¹. However over time the relevance of institutionalised representation to contemporary community needs appears to have waned. The case study finds that ‘representativeness’ needs to be understood in terms of the organic structures of community and that for communities facing economic insecurity, alienation and fragmentation, institutionalised user representation was less relevant than it had been in the early years of the new unified national health system. The Stage 1 and Stage 2 reports of this case study contrast the formalistic user representation in the health councils with the vibrant lived community of the school garden project.

The [Indian report](#) describes tensions within PHM in India (JSA) over initiatives that some activists thought would compromise the health movement. The Indian Right to Health Campaign (RTHC), based on community based monitoring, and working closely with the National Human Rights Commission (NHRC) was very successful but when the Campaign sought to extend the public hearings process to private health care providers the National Human Rights Commission (NHRC) was not able to cooperate because it was beyond their remit. In due course the government responded to the campaign with the National Rural Health Mission (NRHM). However, by some accounts, many of the activists who had been involved in the RTH campaign were recruited into the NRHM and their contribution to continued activism was thereby compromised.

A contrary example and a dramatic illustration of the breadth of possibilities is the strong collaboration between the National Health Forum and the Ministry of Health in the [El Salvador IPHUs](#); this in a country where not so long ago many of the organizations in the National Health Forum were subject to military and paramilitary attack by government and US covert forces.

There are trade-offs in collaborating with the State. PHM aspires first, to be a ‘broad church’ (with space for many different perspectives) and second, to provide leadership to the HFA movement in relation to the political economy of health (including critique as needed of the role of the State). These are not always in harmony.

Social movements have deep roots: know your history

The Italian report, which was prepared by cadre of younger activists, tells of a meeting organized in Bologna directed to recalling health activism from previous decades and generations, with older activists invited to share their stories. The success of this meeting and likewise the narratives of [experienced activists](#) point to the benefits of remembering history.

Sometimes the deeper structural factors emerge with greater clarity when viewed across a longer time scale. The Nina Rodrigues story from Brazil ([Annex 1](#)) tells of community members organizing around adequate sanitation and access to decent health care. The context of this struggle is a legacy of slavery, colonial expropriation, continuing encroachment by business interests (mining, forestry, corporate farming), and government neglect. The continuing challenges are much bigger than adequate sanitation and access to health care.

Activists from times past worked in different environments and adopted different strategies. Recalling the successes and the failures of those struggles can deepen activist analysis. The South African [Stage 1 report](#) includes a reflection on the dramatic changes in the character of civil society activism since 1994. Exploring the forces at play and the dynamics of these changes provides important insights into contemporary governance and activism.

The [Indian report](#) recalls the vision of the 1946 Bhore Committee which recommended a national health service with a strong primary health care orientation.

With a scathing critique of the colonial intervention in health, rigorous study of existing health systems in the west, the committee broke away from the colonial legacy by stating that “the

11. “Controle social”, meaning civil society oversight of governmental action through institutionalized social participation in Brazil’s health system, is commonly translated as “social control” or “social participation”.

comprehensive conception of what a community health service should undertake has led to the development of modern health administration, in which the State makes itself responsible for the establishment and maintenance of the different organizations required for providing the community with health protection”

The researchers proceed to explain the failure to implement the Bhore Committee recommendations and the continuing shortfalls in health care in India.

History can also be a source of inspiration. The [HFA History](#) notes the role of heroes (e.g. Rudolf Virchow, John Snow) and icons (e.g. the British NHS, Pholela) in inspiring activists and in binding the wider HFA movement. (Discussed further under Convergence, below).

Leadership is necessary but also accountability

Leadership is important for effectiveness. Bio-sketches of four well known HFA movement leaders, Mira Shiva, Anwar Fazal, Kumariah Balasubramaniam and Zafrullah Chowdhury (on the [website](#) of Health Action International Asia Pacific - one of the founding networks of PHM) provide insights into the kinds of leadership which have contributed to the HFA movement.

The research literature (see [Review of Research and Commentary](#)) refers to leadership in a range of social movement settings and considers how such leadership develops. Key elements of leadership in the context of social movements include: inspiration, understanding and foresight. Inspiration reflects a record of analysis and action vindicated by time; a personal likability which encourages people to think that ‘these are footsteps in which I might also tread’.

The concept of the learning organization (Senge 1992), including distributed leadership, has a particular resonance for volunteer based activist organizations. The learning organization combines strategic coherence (because there is broad agreement on strategic directions) and localised autonomy (because local activists know best their local circumstances). Distributed leadership also applies where different members of the group are recognized as offering different but complementary expertise. The emergence of women in the leadership of the ACVC in Colombia (see [Annex 2](#)) illustrates the resilience associated with this kind of distributed leadership.

One of the key functions of social movement leadership is to guide the development of organizational culture including (as discussed above): nurturing a secure environment at the core of which is warmth and friendship; ensuring acknowledgement and appreciation; demonstrating good meetings practice (e.g. inclusiveness, listening across difference); making space for fun and relaxation (and when necessary time out); cultivating reflexivity; and giving voice to *buen vivir* (living sustainably with nature). The [Manual](#) highlights ‘wellbeing and pleasure in doing things together’:

As activists in a health movement, we should (also) care about our own health! In many cases, however, we seem to struggle with balancing activism and well-being: over-commitment, long tiring meetings, stressful travel, challenges of working with few resources and great ambitions, managing conflict, and so on. Some PHM groups have decided to place the wellbeing generated by participating in activism at the centre.

A somewhat different perspective on organizational culture concerns our shared analysis and our thinking about priorities and strategies. In volunteer non-hierarchical organizations strategy is carried in oral culture; people often do not read or refer to written, adopted strategies or to standard operating procedures. In volunteer non-hierarchical organizations the written approved strategy co-exists with a vibrant on-going discussion about where we stand, where we are going and how.

It is useful to reflect upon the values and principles underlying concepts of democratic governance, transparent decision-making, leadership, and accountability. The operationalisation of such principles may require very different structures and processes when moving from the organization, to the network, to the movement.

There may be contradictions between the principles of democracy and leadership. An activist organization is not the same as a tennis club even if they are incorporated under the same legislation. The officers of the tennis club are required to manage the club so as to meet the expectations of the members. An activist organization is seeking to project leadership in terms of description, analysis and policy. These are matters for debate and disagreement but not necessarily for majority determination. The Italian Stage 1 report ([IT](#), [EN](#), 32 MB each; [EN-lite](#), 1 MB) includes a useful discussion of consensus decision making.

Leaders must remain accountable but a different kind of accountability applies in relation to such matters; accountability for good faith and good judgment. Such accountability is mediated through debate and experience. The [Activist Narratives report](#) comments:

Interviewees voiced concerns that not maintaining links to the local community and grass roots activism would lead to a disconnection with the people who they are supposed to be representing at the national and global levels in policy dialogue. As mentioned in the Campaigning and Advocacy section, remaining connected to local communities was about accountability.

The [Movement Building Manual](#) includes a discussion of power relations within organizations and the need to be aware of how the hierarchies of power, which the movement aims to change, can be reproduced within the activist organization itself. This awareness of power has implications for group work and decision making. The [SA Stage 2 report](#) reflects on the challenges of decision making in the presence of widely differing backgrounds

The main findings in relation to campaigns and coalitions are that they are often strained – and sometimes ultimately undermined – by a mix of “hard” and “soft” factors. Important “soft” factors that sustain campaigns, but are routinely neglected, include building good interpersonal relations, managing conflicts productively, and maintaining meaningful contact and respectful working relationships between organizations and between comrades with radically different financial, racial, and language privileges.

The Italian reports (see [Annex 5](#)) also highlight these issues.

Democratic governance of an incorporated organization with a constitution and a defined membership is practicable although not easy. However, such mechanisms are not so relevant to networks and movements. In the Brazilian case studies of coalition building and the Indian commentary on the experience of JSA as a network, the general principle which applies is to collaborate when in agreement and to stay apart when not.

Build constructive links between the HFA movement and broader political movements

In several of the research reports, the relationships between a health-focused ‘HFA movement’ and more generally oriented political movements emerged, as a matter for judgement.

An issue-oriented social movement can be relatively narrow in its scope, restricted as it is to a particular issue or sector of social practice or population. However, if a political economy lens is applied to that sector the narrowness of a purely sectoral approach becomes self-evident. Tax reform, debt relief or trade relations all illustrate policy issues which are highly relevant to health policy but which have implications which go well beyond health. Health advocates might choose to simply restrict themselves to advocating to government around health funding or medicines prices without offering a broad policy framework for addressing such issues. However, if they were not happy with this restriction and wish to locate their health advocacy within a broader policy framework they would need to consider the implications of tax reform, debt relief or trade relations in all sectors, not just health. This kind of more comprehensive policy agenda is usually a feature of a more generally oriented political movements or parties, rather than issue focused social movements.

The Colombian Stage 1 Overview and Synthesis Paper ([EN](#), [ES](#)) in its conclusion comments:

The cases of Valle del Rio Cimitarra suggest that the relationship between social movements and political parties can bring about ethical-political transformations of the social movements and victories in health. These cases show that the consolidation of the peasant, mining and coca growing movement in contexts of

high levels of repression and violent confrontations profited from its close relation with left-wing parties as these contributed to overcome purely individual, family and gremial¹² interests within the movement, define the character of the struggle and of the identity construction and practice as social and political subjects, and adjust the horizon of transformation, allowing for a shift from material transformations of the living and working conditions towards more profound changes that propose structural economic, social and political reforms. At the same time, the cases show that struggles for health are implicit in struggles for living and working conditions at the core of most of the social movements' outlook and transcend levels of consciousness and corporative or sectoral action.

The resources generated through this research do not offer clear principles which might guide social movement activists about if, when, or how, to develop closer relations with political parties. However, the [Global HFA Movement paper](#) notes a number of important health care initiatives which were introduced by political parties without high profile advocacy from health identified social movements. These include the NHS in the UK, the single payer health insurance system introduced in Saskatchewan (in Canada), and the barefoot doctors in China.

Most histories of the creation of the NHS present stories of inquiries, policies, laws, ministers, and structures. In contrast, Steve Iliffe's (1983) account of the politics underlying the creation of the NHS traces the pressures emanating from and through the trade union movement and the impact of women's movement after adult (>30) female suffrage had been achieved in 1919. In the lead up to 1948 most of this pressure was being mediated through the Labour Party and enacted in and through government. However, the struggles for universal suffrage, the health concerns of the trade unionists, and the continuing constituency pressure on Labour politicians need to be recognized. (from [Global HFA Movement report](#), page 8)

Saskatchewan pioneered single payer, universal, comprehensive, government administered health insurance in Canada and has provided a model which has informed health systems development and health advocacy in many countries.

The political drivers worked largely through the institutions of government, the political parties and electoral representation. However, behind the structures of government was a strong concern for access to health care across this dispersed and largely farming community. The electoral pressure was further modulated by on-going policy advocacy from within the medical profession. (from [Global HFA Movement report](#), page 19)

It seems that the two main channels of connection between social and political movements are policy dialogue and shared members. Activist organizations and social movements commonly engage in policy dialogue with governments, although less often with political parties. Perhaps they should increase this engagement. Activists who are members of social movement organizations *and also* political parties appear to play key roles in broadening the analysis of the social movement and deepening the analysis of political parties. There are risks in such engagement, however, such as party capture (of the movement by the party) and political sectarianism within the movement. It may be useful to distinguish between loyalty to the party versus conviction regarding the political analysis and direction of the party. The former can make open discussion within the movement difficult whereas the latter can enrich discussion within the movement. There may be some benefit to be gained through further research and analysis on this social movement - political movement relationship.

Convergence (solidarity, networking, collaboration) is a key objective of movement building in the era of globalization

The founding document of the People's Health Movement, the [People's Charter for Health](#), articulates a strong political economy analysis of health care, of the social and political determination of health, and of health equity. In the context of economic globalization there are common drivers underlying the various and often very different

12. Interests arising from memberships, in particular, union membership

deprivations faced by families and communities in different parts of the world (see [Chapter 3](#)). Accordingly PHM has an aspiration to build solidarity and convergence (understood in terms of growing solidarity, closer networking and practical collaboration) across the many movements for health equity in many parts of the world.

The [HFA history paper](#) set out to map HFA activism across time, space and issue with a view to delineating genealogical influences across time and inspirational influences across space and issue. In particular the analysis provides a framework in which to consider the possibilities of *convergence*. The paper discusses episodes of activist engagement in four categories:

1. engagements which are largely country-specific but have acquired inspirational / iconic status globally (e.g., the Pholela Health Centre, the barefoot doctors, the Mitans in Chhattisgarh in India);
2. engagements which are nationally focused but which have attracted international solidarity (e.g., pro-democracy and anti-imperial struggles);
3. engagements which are being worked through in parallel in many different settings, but where there is a sharing of experience across communities of interest spanning different countries (e.g., the labour movement, the women's movement and the environment movement); and
4. engagements which reflect common global drivers and call for shared and collaborative strategies globally (e.g., tax justice, fair trade, medicines policy).

Examples of each of these categories are listed in chronological order in Table 9 below. Also listed are some broader indications of contemporaneous historical context and of technological development.

Dates	Country specific engagements which acquired iconic status	National engagements but with international solidarity	Parallel and separate but sharing solidarity, analysis and modes of action	Similar problems with common causes and collaborative strategies	Historical context	Health care technologies
1700-1800		Abolition of slavery			Industrial revolution	
1800-1900	Urban sanitation in UK Revolutions in Paris over bread (1848) Social security in Germany (Bismark 1883) Virchow in Upper Silesia	Opposition to the opium trade (including resistance to the imperialists)	Extending democracy (eg rule of law, universal suffrage) Labour rights Anti-colonialism	Early attempts at building international labour links	Industrial revolution Intensified competition between colonial powers Revolutions in Europe	Germ theory, aseptic technique, artery forceps anaesthetics
1900-1920	USSR (feldshers, polyclinics, focus on public health, government funding)	Philippines (anti-colonial, imperial, feudal)	Extending democracy (eg rule of law, universal suffrage) Labour rights	Occupational health (in the context of employment relations)	WWI Revolution Emerging US ascendancy Monroe Doctrine	Vaccine development
1920- 1960	UK NHS China: PHC, from Ding Xian to barefoot doctors India (Bhore Committee) Pholela in South Africa	Spanish Civil War Chinese revolution Anti-colonial anti-imperial struggles in Africa and Asia	PHC, community health, New public health Public financing, universal access	NIEO and Alma-Ata	Depression, WW2, Cold War, US ascendancy, long boom, decolonisation, UN system	Antibiotics, psychotropic
1960–1980	Jamked, Solo Cuba 1959 USA 1960s (anti-racism, women's and workers' health) Canada Medicare Tobacco, Breast feeding	Anti-imperialist struggles in Latin America Anti-apartheid struggle Faith-based health care	Workers' health Women's health Environmental health Disability rights Indigenous health services	Anti-war and nuclear disarmament (IPPNW)	Bipolar world Cold war Vietnam war Stagflation	Molecular biology
1980–2000	TAC in SA	A2M / TAC in SA		Structural adjustment and debt crisis Ozone hole HIV and treatment access	1970s inflexion: Threat of capitalist crisis → SAPs Rise of the IP agenda	Genomics
2000-now	Buen vivir	Disaster, emergency, war,	Migrant and refugee solidarity	Trade and health Austerity and neoliberalism Food sovereignty	Neoliberalism	Biotherapeutics

Table 9. An Archaeology of the Global Health for All Movement: Timelines and categories of engagement (Note that some episodes appear in more than one column)

The [Global HFA History](#) paper explores first, the conditions and dynamics through which separate passages of civil society action around particular health issues in particular places and times may converge towards a global social movement for health more broadly, and second, the strategies deployed by HFA movement activists to mobilize (around local issues understood in a global context), build solidarity and converge.

The study identifies 'continuities' (mediators of influence) between and across episodes or streams of social movement activism, including: world view and political theory, icons and heroes, research and publication, personal relationships, and organizational networks.

Practice

There are many echoes in the country case studies of the conclusions reached in the Global HFA History study. Drawing on these instances we list the following forms of practice which are likely to support convergence across different currents. Some of these have already been discussed above or are discussed in later chapters.

Networking

Networking starts with mutual awareness, appreciation and respect, and perhaps using the resources of the other. Networking is facilitated by overlapping memberships and personal relationships. Deepening network collaboration involves: negotiating objectives, messages and strategies; ensuring mutual benefit and reciprocity; respecting dignity; building trust and solidarity.

We have discussed networking earlier in this chapter ([here](#)) and later in [Chapter 6](#) under campaigning.

Face to face meetings

Personal relationships can help to forge network relationships. The Global HFA History cites the Kark Cassell Geiger nexus as an illustration.

Building personal relationships can be supported through digital communication but face to face opportunities to develop strong personal relationships are also critical.

The People's Health Assemblies organized through the PHM illustrate the power of face to face meetings in strengthening communication and solidarity. The [India Report](#) provides a useful discussion of the mobilization in India leading up to the first People's Health Assembly.

The various regional workshops organized in the context of this research also illustrate the power of face to face links in organizational networking. See the reports of the 2016 regional meetings: European IPHU in [Brussels](#), the Asian regional workshop in [Colombo](#), the African regional meeting in [Cape Town](#), the Colombia-Brazil meeting in [São Luis](#) and the Stage 2 Colombia workshop in [Pandi](#). See also the report of the [DRC IPHU Regional Workshop](#) in 2018.

The World Social Forum is another venture aimed at supporting communication and networking across different social movements.

Historical awareness

The Global HFA History identifies genealogical influences as well as influences across issues and borders. Historical awareness helps to contextualize movement building in relation to influences across time and space.

In the Nina Rodrigues story the history of the previous land rights struggles was drawn upon in developing confidence; likewise coming into contact with the wider structures of Brazilian PHM helped to visualise the possibilities. The struggle to activate and protect the ZRC¹³ in Colombia (see [Annex 2](#)) similarly drew upon long-standing and ongoing struggles for land rights. The organizational forms change but the core issues remain. These continuities are mediated through documented histories, through personal relationships and through remembering activist histories. See earlier discussion above [about valuing history](#).

13. Zona de Reserva Campesina del Valle del Rio Cimitarra

Macro micro principle

In Chapter 3 we introduced the macro micro principle: addressing the local and immediate in ways that also contribute to redressing the larger scale structural issues. We discuss this further in Chapter 6.

We mention the macro micro principle here because while it is an important principle of strategy it also serves to highlight the global influences which are common across many different settings and strengthens the logic of networking and collaboration across networks.

Draw on the power of identity politics but combined with an emphasis on listening across difference

The Global HFA History salutes the power of shared identity in mobilizing and cohering health activism. The paper recognizes the women's health movement, the workers' health movement and the health oriented actions in the US civil rights movement.

However, the paper also recognizes various cautions about organizing solely around identity where singular constructions of identity can render invisible that those oppressions are also related to other axes of power. The concept of a politics of difference highlights the importance of developing norms and practices which support 'listening across difference'. We have mentioned 'listening across difference' earlier in this chapter under ['organizational culture'](#).

Building constructive links between the HFA movement and broader political movements (discussed above)

We have discussed earlier in this chapter the relationships between the HFA movement as a health-focused movement and broader political movements with a more comprehensive agenda.

The Global HFA History highlights episodes where significant health gains were achieved as a consequence of struggles which were associated with other social determinants of health although not identified as such. The paper reviews the arguments of Szreter regarding the progressive widening of adult suffrage in the UK and its contribution to sanitary reform in British cities and the argument of Iliffe regarding women's suffrage and the drive for the NHS.

Talk about theory

The Global HFA paper highlights the role of theory in linking different episodes of activism across time and space.

PHM has promoted a strong political and economic analysis of health in the context of globalization and sees this as an important contribution to convergence. This theoretical position is developed in Global Health Watch ([Annex 13](#)), IPHU ([Annex 11](#)) and in the programming of various people's health assemblies.

Cultural work

The Global HFA paper also highlights inspirational writings, songs and movies and other cultural activities and resources which have contributed to building solidarity and shared perspectives across boundaries.

The people's health assemblies have all included opportunities for sharing and participating in such resources and activities.

Conclusions

This chapter has explored movement building in relation to eight 'principles' derived from the various case studies, evaluations and commentaries prepared through this research. See Box 1 above.

As noted in [Chapter 4](#), these principles should remain tethered to the instances and cases from which they are drawn if their reach and limitations are to be appreciated. Likewise the application of such principles is also context dependent and a function of activist judgement.

Reference

Senge, P. M. (1992). [The fifth discipline: the art and practice of the learning organization](#). Sydney, Random House.

Chapter 6. Campaigning and advocacy

Introduction

In this chapter we bring together insights regarding campaigning and advocacy which have emerged from this research. The chapter is structured around the following three broad ‘principles’.

- Campaign strategies bring together theories of change, forms of action and contingency;
- Balance policy advocacy with structural critique;
- Networking for campaigning is empowering but requires investment and compromise.

Box 3. Three principles for campaigning and advocacy

As noted earlier there are significant overlaps between campaigning and advocacy and our other themes. Campaigning reflects and is part of movement building; campaigning and policy advocacy depend on capacity building and knowledge generation.

The [Indian report](#) comments that “progress towards HFA is driven by more effective campaigning which depends on building a stronger global movement and both in turn depend on stronger networking (local, vertical, global and inter-sectoral)”. The [Stage 2 report](#) from South Africa comments that “campaigns often provide a crucial “institutional home” for newly politicised activists, i.e. it offers them a political home where they can do activist work on the “personal” issue that led to their conscientisation (e.g. a routine inability to access medicine at a public health facility). As such, campaigns can be a key tool for movement building”.

Somewhere between movement building and campaigning and advocacy are small scale local actions of mutualism and community development. The [Stage 1 report](#) from Porto Alegre argues for the renewal and strengthening of community engagement with the health councils (both as members and from outside) as a way of strengthening advocacy and campaigning. However in the [second phase](#) of their research the team comments that although they did not undertake any overt campaigning during the second stage project, quite significant actions happened, like community gardening, participation in the municipal organic market, and participation in the World Food Week. Attention to high profile campaigning should not discount the social change potential of such 'low key' actions.

This chapter draws on the Review of Research and Commentary on social movements and material generated through the country case studies. Several country teams have provided detailed accounts of specific campaigns and thoughtful analyses and commentaries, in particular Colombia, India, Italy, and South Africa.

The Colombia Stage 1 report ([EN](#), [ES](#)) provides a range of case studies which are ongoing struggles over many years or perhaps one long campaign (see [Annex 2](#) below and also the Stage 1 report from Section 2.4 and 2.5). Many of the actions described are similar to those described from the other teams.

The [India report](#) includes eight rich case studies of various campaigns in which various JSA affiliates (and from beyond JSA) were involved and provides an extended analysis and commentary regarding: resource mobilization, knowledge resources, campaign strategies, enablers and barriers, campaign organization, outcomes and challenges for the future.

The Italy Stage 1 report ([IT](#), [EN](#), 32 MB each; [EN-lite](#), 1 MB) provides summary descriptions of 12 health related campaigns from recent years with detailed case studies of two of them. The team interviewed 22 informants from a wide range of civil society organizations and undertook a participatory and inclusive analysis of the interviews.

The [South Africa reports](#) describe two major campaigns that PHM SA was involved in (Right to Health and National Health Insurance) and five campaign proposals that were launched with enthusiasm but which did not bloom. The reports include critical reflection on successes and failures as well as detailed commentary on campaigning and networking.

Campaign strategies bring together theories of change, forms of action and contingency

Strategy is contingent

One size does not fit all. Several of the research teams have emphasised how context dependent campaigns are, particularly in the definition of the problem and the tactical analysis of the field.

The Colombian team point out that

in rural Colombia the right to health is tied up with right to territory, food sovereignty, agroecology, right to the recognition of ancestral knowledge, self-governance and autonomy in health as well as the right to access interculturally adequate health services constructed in the territory with professionals from the community and based on primary health care.

The LGBT case study, also from Colombia, instances a mix of quite specific human rights claims in a particular context.

The report from the Indian team also highlights the specificity and importance of context. One example of this was the challenge of extending the very successful community based monitoring in association with the National Rural Health Mission to the cities. A strategy which had attracted a lot of volunteer support and community support and which had contributed to material improvements in many rural villages did not translate well into the cities.

A related instance was the report regarding PHM South Africa's investigation of the possible application of the Indian Right to Health Campaign in South Africa. They judged it was not feasible in their circumstances but even a modified campaign, focusing on social determinants rather than health care, was not able to be maintained.

Similarly the South African report on the NHI Campaign lists a range of factors which hampered the success of the campaign. These included: competing priorities (a crisis in Eastern Cape health care), the four year gap between the publication of the Green paper and the release of the White paper¹⁴, differences of opinion among the campaign partners, and low media profile; all of which made it very hard to sustain action across this period.

A particular instance of context dependency is highlighted in the South African reference to a certain weakness of social movement activism in South Africa which the team attributes to the "NGO-isation" of civil society in South Africa, including an expectation that participation in civil society action should be paid for. This appears to be linked somehow to the availability of funds for AIDS/HIV programs and the particular dynamics of post-Apartheid South African politics.

Theories of change inform strategy

Activist strategy reflects assumptions about the dynamics of change, whether they are articulated or not. If they are articulated they can also be interrogated, evaluated and perhaps strengthened.

Among the leading theories of change:

- policy reform,
- institutional innovation,
- delegitimation, refusal and resistance, and
- movement building.

Policy reform, as a theory of change, envisages governments adopting and implementing new policies with outcomes beneficial for HFA (in Brazil, reducing inequality; in Colombia, progressing the peace agreements; in India, resisting the pressures for extreme intellectual property laws; in Italy, a more humane and rights-based approach to migrants; in South Africa, introducing national health insurance.) At the global level policy reform, as a theory of

14. The reference to Green and White Papers arises from the Westminster practice of issuing a policy paper for consultation (the Green Paper) and then once the policy is determined, a formal statement of policy (the White Paper)>

change, involves governments collectively doing the right thing; perhaps adopting a renewed version of the New International Economic Order.

Institutional innovation, not necessarily policy driven, emerges as a theory of change in several of the country case studies. In the case study from Porto Alegre the Brazilian researchers are exploring new relationships between schools and clinics as a way of bringing community into health. The ACVC case study from Colombia reported on how, in the context of ongoing conflict, a range of basic community functions (health care, education, environment, etc) had been undertaken by new structures and practices. The India report highlighted the number of stand-alone community-based health projects that have developed in the absence of a comprehensive national health service. In many cases these have broken new ground in service delivery models although there is some concern that they may have allowed government to vacate the field. The Italian researchers focused much of their attention the new ways of using place, new ways of meeting community needs through renewing and reclaiming 'the commons'. Finally the South African report includes a case study focusing on the work and concerns of community health workers and whether or how they might come to exercise leadership in relation to health development at the community level, including action on the social determinants of health.

Delegitimation, refusal and resistance is a more confrontational approach. The theory of change is that even non-democratic governments need public recognition of their legitimacy. Accordingly some policy leverage can be gained if community action has the effect of challenging such legitimacy. The fall of the Apartheid regime illustrates the complete collapse of any veneer of legitimacy. In Chapter 2 we have reviewed several episodes at the global level where the legitimacy of the prevailing economic regime was challenged including around structural adjustment and odious debts and the TRIPS Agreement and access to medicines. In the various trade agreement campaigns (from India and Italy in particular) challenging the legitimacy of special deals for transnational corporations have featured prominently.

Finally it is worth highlighting movement building (including community building, capacity development and knowledge building) as a theory of change simply because it envisages a stronger capacity to drive these other dynamics of change. Movement building is always an accompanying objective in campaigning and advocacy.

Forms of action

A myriad of different forms of action are reported in the campaign case studies collected for this research and in the published literature. The actions reported in the Indian case study (and described in more detail in the [Indian Report](#)) included:

- direct actions and protests,
- research, fact finding,
- policy advocacy,
- letters and memoranda,
- post card campaigns,
- legal action, using the courts
- public hearings about the violations,
- mass mobilization,
- media advocacy, working with particular journalists,
- press conferences,
- international advocacy,
- communications through social media (useful in leveraging international support),
- sting operations,
- working with trade unions.

This list of 'forms of action' corresponds to the 'forms of action' listed by Smith (2002) as having been deployed during the WTO demonstrations in Seattle, December 1999 (see [Annex 7](#)).

Planning action

It is not our intention to describe these forms of action in any detail. They are in most cases self-evident in principle but quite context dependent in their implementation. In this section we aim to draw out some of the considerations which appear to be important in selecting forms of action.

Well organized and implemented

Several of the informants interviewed for the India research emphasised the need to invest in the organization and administration of campaigns. The South African report likewise comments that it is not sufficient to have a big campaign launch if the capacity to sustain the campaign is lacking.

Clear messaging, personally engaging

The [Manual for Movement Building](#) highlights the importance of good communication, the message, the target/s, the media and the channels.

The case studies from Colombia instance the occupation of ancestral lands and of colonized areas as ways of conveying clearly the claims of the peasants and indigenous communities.

On the other hand the South African review of the National Health Insurance Campaign reflects on the failure of the campaign to speak to the families and communities paying user charges for substandard health care (eg long waits, stock outs, etc). The campaign organizers found it difficult to translate the complexities of the insurance debate into simple and attractive messages.

The concept of 'framing' figures prominently in the research literature; ensuring that the issues are presented in ways which point to the logic and justice of the campaign demands. Delegitimation, projecting a case which undermines official claims of propriety and justice, is an example of framing. In the various trade agreement campaigns (from India and Italy in particular) challenging the legitimacy of special deals for transnational corporations have featured prominently.

Novelty

Creative actions attract interest for their novelty. The Indian case study of the India EU FTA campaign comments:

As the EU-India Summit kicked off in Delhi, we delivered black coffins to the office of the Delegation of the EU at the swish Golf Links Enclave and the EU official was asked to sign the receipt for their delivery. The motive was to highlight the deaths of people living with HIV/AIDS across regions who are reliant on production of Indian generic pharmaceutical that will be trammelled due to India-EU FTA. After that over 2000 people living with HIV who we mobilized along with other networks across the country, marched alongside farmers in protest of the EU-India FTA.

The black coffins clearly convey the message that higher prices will yield more deaths.

Constituency building

Campaign strategists often look for actions which provide people with ways of personally engaging with the issues and perhaps reinforcing their identity as activists. Signing a petition is a low level action; participating in a demonstration requires more involvement, collecting signatures on a (hard copy) petition or preparing policy briefs as part of a campaign even more so. Community involvement in advocacy for decent health care as in Nina Rodrigues, or participating in community based monitoring as in the Indian RTHC, can reinforce a rights consciousness, strengthen one's sense of agency, and provide access to information about health care provision.

The Colombian team highlights the importance of creating spaces for dialogue, including assemblies, public hearings, high profile reports, and the creation of observatories. The Indian RTHC has likewise used public hearings to great effect. Collecting signatures, in person, provides a micro-space for dialogue.

International leverage

Another tactic has been to seek international partners so that the issue becomes a matter of national concern. Examples include the ASOTRECOL campaign from Colombia, the Patent Opposition campaign from India, and the Europe wide solidarity directed to overturning Spanish anti-abortion legislation (see Yo decido - El tren de la libertad case in the Italian Stage 1 report).

A dramatic instance of getting at the primary decision makers through their accountabilities was the lobbying by unemployed injured workers in Colombia of US unions and congress persons and GM officials in Detroit, at a time when US Colombia 'free trade' negotiations were proceeding (see [ASOTRECOL case](#)). The lobbying extended to the ILO in Geneva. The ASOTRECOL advocacy was ultimately successful and members' entitlements were progressively realized.

In two Indian campaign examples, Patent Opposition and India EU FTA, close links were forged with international campaigners who were working towards closely aligned objectives.

Resources

People are the key resource

Mobilizing people to participate in various ways is a core element of the campaign. We have discussed 'pathways to activism' in [Chapter 5](#).

Several of the campaign case studies have highlighted skill building before and during the campaign; education and awareness raising including through popular education. In the Indian patent opposition campaign a strong educational and awareness raising component working through people living with AIDS networks was critical to mobilizing those networks.

Maintaining and sustaining participation also needs attention. The author of the Indian case study on access to health care ([India](#), page 101) reported on the attempts to set up a focus on urban health care at the district level:

But because of involvement in other issues, and the lack of a driving will, it wasn't really taken care of. If you ask me now, I would say that initiative is not active. If you ask what's the need, I would say as a campaign focussed on an urban area there is a huge need but this just died out.

The [Movement Building Manual](#) comments on the increasing use of social media and refers to a useful resource ([here](#), in French) which offers hints about using Facebook and Twitter. Using social media effectively takes time and coordination.

Information resources

Many of the campaigners interviewed as part of the Indian research highlighted the role of research in generating knowledge resources as well as cultural media.

Funding

The more orthodox the campaign objectives the easier it is to get funding and therefore to deploy expensive strategies like social marketing; while tobacco control campaigns can access funds for social marketing, land rights campaigns are likely to find it much more difficult. (In relation to tobacco and other social marketing campaigns it is useful to note that campaigns that are overtly directed at behaviour change can, if well designed, carry covert policy advocacy as well.)

The South African team note that the NHI Campaign was seriously weakened by lack of funding. However, many civil society organizations have regretted taking short term project funding from government and philanthropies where the requirements of the project can actually draw human resources away from movement building. Several of the Indian interviewees commented that they do not accept project funding.

Need to balance policy advocacy with structural critique

There is a range of opinion among activists regarding the relative importance of policy advocacy as compared with structural critique directed to delegitimation, resistance and refusal. Contexts vary widely and probably explain most of the debates.

On the one hand it makes sense to package demands in ways that are implementable which may require some policy analysis and policy advocacy. On the other hand the language of policy debate can render invisible the power relations within which wrongs are perpetuated and rights are achieved. The challenge, in any particular setting, is to find the right balance between the two approaches or perhaps to integrate them.

Policy analysis; packaging demands which are implementable

One of the choices that campaigners face is how far to go in telling decision makers exactly how to solve the problems in question. Sometimes the demand is simple and straightforward: in the Colombian [ZRC](#) case, 'reinstate the Peasant Reserve Zone in the Cimitarra Valley!'

Sometimes the issues are complex but the campaigners choose simply to put their demands and insist that the duty bearers work out how to address them: the demand of the hospital workers occupying the decommissioned San Juan of God Hospital ([HSJ](#)) was simply to reopen the hospital; the details of how were left to the authorities.

Sometimes, however, campaigners need to delve further into the policy issues and to bring forward quite specific policy recommendations. The Indian research team ([here](#)) cites two cases where quite technical policy analysis was undertaken as part of formulating the demands of the campaigners. These were the patent opposition campaigns and the opposition to the proposed India Europe free trade agreement. A similar, policy-heavy example was the campaign around National Health Insurance in South Africa ([here](#)).

These policy-heavy cases raise important challenges in terms of assembling and generating the knowledge base on which the policy analysis is based and which will inform the campaign planning. These technical considerations also add complexity to the tactical analysis (above) in terms of mapping the interests of different stakeholders and constituencies in relation to the policy choices under consideration. A further challenge is to translate complex analysis into clear and attractive campaign messages. PHM SA has struggled with this in their National Health Insurance Campaign.

It is interesting here to note the comment in the [GHW4 evaluation](#) that closer links might be forged between the policy analyses presented in Global Health Watch (GHW) and various related campaigns: "GHW [could] pay more attention to follow up and creating a conversation ... by encouraging campaigning around the issues covered by particular chapters".

Addressing the configurations of power

In all of the campaign case studies, the strategies adopted reflect judgments about the power relations around the key decision makers, the loci of the key decisions. This kind of tactical analysis includes first a focus on key decision makers; then a mapping of the constituencies to which those decision makers are accountable; then a mapping of other stakeholders with interests in the field; reaching out to potential allies while anticipating the reactions of potential opponents.

The Colombian case studies of peasant struggles describe how the peasant movements brought their demonstrations to the cities to impact directly on the urban constituencies of political leaders.

The macro micro principle: addressing the immediate issues in ways which will also contribute to structural change

Choices of strategy are not always either/or choices: *either* policy advocacy *or* denunciation; *either* provide services to sick people *or* invest in prevention.

The macro micro principle highlights the search for strategies which address the immediate needs but do so in ways which also contribute to structural change.

This is the underlying logic of the Italian research group's focus on reinventing 'the commons'; finding new communitarian / mutualistic ways of meeting basic human needs. It is nicely illustrated in the story of the school gardening project from the Brazilian team which extended from permaculture to farmers' markets to a campaign for adequate and healthy food.

There are issues of scale here. The school garden project is organized locally; food systems are structured globally. For organizations, like PHM, seeking to facilitate the development of a global HFA movement, the links between local, national, regional, and global levels of the organization are critical. The goals are effective activism at the local level which is supported (information, expertise, solidarity actions) from higher levels, and that action initiated at the higher levels is supported by complementary action at lower levels. In its conclusions the [Colombia Stage 1 Overview and Synthesis paper](#) speaks about malalignments across these different levels in PHM's practice. At least part of this is due to language barriers. The [Indian Report](#) likewise is somewhat ambivalent about these relationships. This report cites comments from interviewees about the importance of personal contact across borders and across levels. The various people's health assemblies (national and global) that PHM has organized make a good contribution to bridging these boundaries but there needs to be better follow up. Likewise various occasions for international visitors, including in association with IPHUs, can be useful.

These issues are partly about awareness and strategy; partly about material resources.

Networking for campaigning is empowering but requires investment and compromise

Campaign networking can extend the reach and impact of the campaign

Networking can extend the reach and impact of the campaign while also being part of movement building. However, networking can also involve trade offs between accepting lowest common denominator messages in return for the power of numbers, and it can be challenging to establish and maintain alliances.

Networking was a major feature of almost all of the case studies of campaigns under review; collaborations, alliances, partnerships and coalitions. In the report from the Indian team it is suggested that first priority should go to building relationships and collaboration with existing community organizations and networks and secondly with researchers, officials and practitioners. The author/s of the Indian case study on the Right to Food campaign ([India report](#), page 103) comment:

We have always consciously felt that the women's groups and trade unions are the main constituencies that need to be linked in the campaign. Similarly when we take up agricultural issues, we have to reach farmers' group and ally with them more. With this there have been successes and failures on how much we have been able to build the coalition. But the issue itself determines which alliances to be built.

The case study of the Right to Food campaign also highlights the role of the World Social Forum in Mumbai in 2004 in bringing together lots of people and organizations who were keen to work on food. The campaign was boosted in numbers and reach through this event. This instance illustrates the importance of assemblies and meetings in movement building and campaigning (see discussion in [Chapter 5](#), above).

By way of contrast to this emphasis on linking with other civil society networks the comment on the Indian Right to Health Care campaign highlights the benefits in that campaign of bringing low income grassroots organizations together with middle class activists and eminent people ([India report](#), page 26).

The HSJ case study from Colombia (the occupation of the San Juan of God Hospital, [HSJ](#)) instances a coalition between significantly different constituencies. In this case bringing dismissed workers, concerned about their jobs and economic security, together with community activists concerned about urban renewal, access to health care, public provision and against privatisation.

Networking can be very challenging

Networking can be difficult. The Indian research team notes the importance of activists/ campaigners reflecting on the complexities and contradictions involved in the partnerships and how they were resolved; how decisions are taken when there are divergences of opinion.

The South African team comments:

The main findings in relation to campaigns and coalitions are that they are often strained – and sometimes ultimately undermined – by a mix of “hard” and “soft” factors. Important “soft” factors that sustain campaigns, but are routinely neglected, include building good interpersonal relations, managing conflicts productively, and maintaining meaningful contact and respectful working relationships between organizations and between comrades with radically different financial, racial, and language privileges. The “hard” factors that undermine campaigns and coalitions include inadequate resources, poor management of resources, unclear and/or ineffective processes and institutional structures for managing ongoing campaign work – particularly in contexts where activists cannot afford to work on a voluntary basis.

The South African team describes how the National Health Insurance Campaign suffered from weaknesses in the coalition; including tensions between individuals. They also comment that:

The campaign did not manage to partner with/create a broad coalition of public health facility users which could potentially have contributed to movement building through the NHI Campaign.

We have several case studies which throw light on the processes of network building; organizations reaching out to each other, exploring different options for affiliation. The Indian report describes the experience of JSA as a network of networks and part of a wider social movement. The need to come together emerged as a consequence of the first People’s Health Assembly in Bangladesh, which was the first major engagement the Indian HFA movement had with similar movements from other countries. The Indian report also describes the shared understanding of this network of networks: we work together if we all agree; organizations can go it alone if there is no consensus. This same understanding is reported from Brazil in their [case study in coalition building](#).

The Stage 1 Colombia report includes a case study on the People’s School of Health (EPLS, see [Annex 2](#)). The EPLS arose out of a coalition of 23 health related organizations within which setting up a People’s School of Health was the one activity that all the organizations could accept.

Building inter-organizational relationships requires some investment in mutual understanding and clarification of what is on offer: what do we want, and what do we have to give (financial and in-kind resources, numbers, geographical spread, health expertise, local global links, and/or political economy analysis). It also requires ongoing respect and reciprocity.

One of the limits on networking is brand conflict. Organizations which have invested over many years in developing their own brand will be cautious about any suggestion that it might be overshadowed. The Colombian research group introduced the concept of a ‘permanent encounter’ in planning for their Stage 2 research (see [Annex 2](#)) as a way of emphasising that they were not proposing a new organization which might submerge the existing peasant organizations.

The JSA experience is also useful here, as in this case it appears that participating in the coalition which is JSA actually gives individual organizations more rather than less exposure. The Indian report comments that while networks facilitate communication across a movement, the participating organizations are the agents of action, actually embarking on campaigns or projects, within the networks.

Clear objectives are important but they are not always self-evident, can change over time and may be subject to disagreement among campaign partners

The complexity of determining clear objectives is particularly clear in the Indian case study of the ongoing campaign regarding long acting contraceptives. A swirl of different issues including unethical clinical trials,

undisclosed risks, a prevailing preoccupation birth control for the poor and conversely the empowerment of women through control of own fertility.

Questions about whether to go for a blanket rejection of all hormonal contraceptives or only those which do not grant user control to women were raised. The concern was also regarding provision of safe and effective contraceptives to those demanding contraceptives. Contraceptives like injectables and implants are perceived by some as the only way poor and powerless women can have control over their lives (the contraceptive is an injectable, so neither husbands nor in laws would come to know of the contraceptive method and they can escape pregnancy). The widespread availability of Depo can dilute efforts to challenge the basic social and economic conditions that produce women's powerlessness. ([India report](#), page 107)

In commenting on the NHI Campaign in South Africa the research team commented on the challenge of getting consensus on the core demand.

There was no focus, what was the core demand. There wasn't really, you know; you need consensus at least on one core demand and I found that almost impossible to get.

Conclusions

Campaigning and advocacy are at the heart of social movement activism.

Campaign strategies assume or imply particular theories of change. If these theories are explicitly articulated they can also be interrogated, evaluated and perhaps strengthened. Strategies are enacted through a myriad of different 'forms of action'. While campaigning is always highly context-dependent we have identified some general issues which need to be considered in campaign planning.

Policy advocacy is necessary but should not over-shadow structural critique. A balance between policy engagement and confronting power structures is needed.

A similar call for balance is the micro macro principle which envisages addressing the immediate issues in ways which also contribute to structural change, including across longer term and larger scale.

Networking, building coalitions and alliances, can extend the reach and impact of the campaign. However, networking can be quite challenging.

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Chapter 7. Capacity building

Introduction

Building the capacity of health activists and of civil society organizations working towards Health for All is a necessary part of movement building. However, it opens further questions about what kinds of capacity and what kinds of learning pathways. This latter question is complicated by the fact that in large degree capacity development takes place informally in the normal course of working with communities, networking, campaigning and advocating – learning by doing.

This chapter is structured around different levels and modalities of capacity building. We start by highlighting the relationships between capacity building at the individual and organisational levels. We then review our findings in relation to informal versus formally structured training programs.

We formulate our conclusions as six ‘principles’ for social movement capacity building.

- Beyond individuals, think relationships, think organization, think culture;
- Think about capacity building in relation to pathways to activism (see discussion in Chapter 5);
- Build on informal learning opportunities as well as organizing formally structured training programs;
- Link curriculum planning to practice opportunities;
- Bringing ‘body knowledge’ into discourse (through popular education and ‘systematization of experience’) makes such knowledge available for sharing and building upon;
- Avoid expert domination: value trust, reciprocity and dignity.

Box 4. Six principles for capacity building

Capacity *building*, as used in this chapter, does *not* imply building something from nothing; some people would prefer *capacity enhancement*, to make this clearer. We agree with the principle but will retain capacity building in this chapter for a smoother flow of the narrative.

The main sources drawn upon for this chapter include the [Review of Social Movement Research and Commentary](#), the country case studies plus the analyses and commentaries prepared by the country teams, and several evaluations of different presentations of PHM’s International People’s Health University (IPHU, see [Annex 11](#)).

Beyond individuals, think relationships, think organization, think culture

It is useful to consider capacity building as applying differently at different levels, from the individual, to his/her relationships, to the organization and to the movement. We consider these different aspects below.

Individual capacity

Capacity building at the level of the individual, at the level of the individual, may refer to different kinds of capacity. We will discuss:

- experiential and embodied knowledge and skills,
- technical knowledges and skills, and
- subjectivity (ways of being in the world).

The Italian Stage 1 report ([IT](#), [EN](#), 32 MB each; [EN-lite](#), 1 MB) distinguishes between institutional knowledge (the knowledge of experts and largely learned in formal training) and non-institutional knowledge (which originates directly from people's life experience and is shared through collective processes of meaning construction).

This experiential knowledge, Ollis (2010) refers to as embodied knowledge.

The holistic practices of activists include using the physical body to develop greater skill and expertise. Indeed, the body is an important element in these activists' learning. For example, being a part of a picket line or a public protest, or scaling a large building in order to write a sign of protest are examples of skilful use of the body; it requires balance, coordination and artistry. The act of physically climbing a tree as a part of a forest blockade is another example of how activists use their bodies in protest; they also develop physical skills in music, dance and performance. Similarly, the use of humour in protest likewise contributes to the colour, culture and movement of activism.

Clearly these different types of knowing tend to be acquired through different kinds of learning pathways.

Experiential and embodied knowledge

The Nina Rodrigues story from Brazil ([Annex 1](#)) provides a living case study of Freire's popular education in action. Experiential knowledge, including embodied knowledge, is retrieved, validated, organized and brought into discourse. Claudenir had lived in Nina Rodrigues for many years. He knew about the mud, about the children who went hungry, about the use of alcohol, about the history of the settlement, about the incursions of the miners and land owners. Sister Ani helped Claudenir and his colleagues to make sense of what they already knew. There was some new information and, importantly, new relationships through joining the wider PHM networks.

These are processes which the Colombian team refers to as the 'systematization of experience'. Speaking of the People's School for Health (EPLS) the Colombian research team ([Stage 1 report](#) page 9) explains:

*The school has three components: pedagogic, communicative and research. The pedagogic component is based on **popular education**, an alternative paradigm that emerged in opposition to the idea of knowledge being transferred from someone who knows to someone who doesn't and rather values the dialogue, reflection and exchange of knowledge in encounters between people that recreate the world in order to understand and transform it towards a more equitable and democratic society. The communicative component, grounded in the idea of **communication for social change** (CSC), seeks to bring about social transformation, strengthening communication in organizational and participatory processes as a mean to foster collective growth. CSC emphasizes participation and dialogue. Therefore, it neatly complements popular education. The research component is based on **critical research** using social research methods in the construction of knowledge for action on different forms of social oppression and is directed towards the transformation of society. At the school, this translates into tutoring sessions and **the systematization of the experience**, which is a form of qualitative research that works with the classification, reconstruction, analysis and critical comprehension of lived experiences, e.g., organizational processes at the community level or educational processes. It is an exercise that seeks to understand the process and the factors that define why a process went in one direction and not another.*

These are processes that do not always need a 'teacher'. Indeed, the systematizing of experience is something that everybody does both individually and in conversation and particularly, at the site of struggle. Ollis quotes Freire (1971) as pointing out that:

Neighbourhoods and communities are often sites of education where we learn to acculturate hegemony and resist hegemonic practices in society.

... many adults bring to their learning a level of existing knowledge through having lived a long life full of complexity, with the result that some learning may not transfer, but rather synthesise with existing knowledge.

Technical knowledges and skills

HFA activism also draws on a wide range of technical knowledges and skills.

There are practical skills associated with advocacy, such as working with social media and strategic planning, which are often useful for activists. The [case study on coalition building](#) from Brazil emphasises the significance of media skills, campaign organizing, and working with social media in their advocacy.

The skills of policy analysis and policy development are core resources for policy dialogue (see Chapters 6 and 9). However, it is also necessary to access the specialist knowledges and skills associated with particular issues such as: access to medicines, trade and health, tax justice and financial regulation, and agroecology and global food systems.

Another challenge, in building a global social movement for health equity, involves articulating the links between the local and the global; the ways in which local structures and dynamics both reflect and constitute relations of power and possibility at the global level. The narratives which link the local and the global will commonly draw on the theory and methods of political economy, sociology, and epidemiology, among other fields.

Sometimes activists need high level medical knowledge. A salient example is the place of treatment literacy in the Treatment Action Campaign in South Africa (Heywood 2009). Given the speed with which medical science develops the training programs to maintain treatment literacy need to be continually revitalised.

The range and depth of these examples are matched by the variety of different learning pathways through which activists may access such knowledges and skills, including personal reading and discussion, professional training, training programs offered through activist organizations, networking with experts in and through the movement, and ‘in-service learning’ – learning by doing.

Subjectivity

Developing as an activist involves more than knowledges and skills. Perhaps more important is the shaping and reshaping of one’s subjectivity as a movement activist. Ollis (2010) argues that “A person’s learning is embedded in significant identity change as they ‘learn to be and become an activist’.”

The Italian Stage 1 report includes a detailed analysis of the findings of the interviews undertaken for their Stage 1 research including passage dealing with ‘Contradictions in the process of subjectivation: the challenge of freeing oneself from the contested model’ ([Stage 1 report](#), page 35). Regarding the concept of ‘subjectivation’ they explain:

We use this term considering the semantic shift (made by Foucault) from subject to subjectivity, and then from subjectivity to subjectivation. Subjectivity can still be considered a thing, a place, an identity, a still point. Subjectivation, instead, moves entirely from discourse to praxis. In this sense, in Foucault, the self is always at the same time the effect of an act of subjectivation and the act itself, which actually allows the production of the self.

There are no standards prescribing an activist subjectivity but for different people it might include (in no particular order):

- reflexivity and readiness to work on ‘shaping whom I am becoming’;
- sense of right and wrong and sense of personal responsibility;
- an optimism of the spirit which over-rides pessimism of the intellect;
- a sense of agency – I/we can make a difference;
- a habitus of active listening;
- inclusive style in group settings;
- active inquiry and learning;
- trustworthy and honest;
- and much more.

The process of shaping and reshaping one’s subjectivity (or collectively, our subjectivities) takes place mainly through operating in a community of practice where these characteristics are actively valued. It is largely a product of organizational culture (discussed further below). However, it is also very personal in the sense that it is an active

rather than passive process. It is not absorbed through the skin; it emerges from action, reaction and reflection. It is deliberate.

One of the stories collected in the [Narratives study](#) was that of 'Ivan':

"After graduation I went to work as a GP, a general practitioner, in a workers' community, and that was a – I was working there in a medical centre of some progressive organization, group of progressive doctors. It's called Doctors for the People, and they were working in this – they set up some medical centres in workers' neighbourhoods. So, for me, that was my first encounter with trade union activism, with local activism, with the community activists, and so this is how I got involved in what we can call health activism."

While the process of becoming an activist takes place largely in context of activist engagement, it can also be facilitated through the ways in which formal training is planned and delivered. This is a function of the culture of such programs.

Organizational capacity

Individual capacity building also adds to organizational and movement capacity. The organization and the movement will be strengthened through simply increasing the numbers of individual members who have acquired new experiences and insights or new knowledges and skills.

However, the report of the [IPHU evaluation](#) points out that one of the most appreciated benefits of the IPHU course is the networking and deepening of relationships acquired in the context of face to face training.

The appreciation of new relationships is also evident in report of the [El Salvador IPHUs](#):

"The greatest benefit I received from IPHU is to have generated friendships with all the participants whose dream is to transform and create a better world."

The El Salvador report [Annex 12](#) also speaks to the question of 'subjectivation':

"The IPHU produces an intense shock that shakes one. The contents are profound, very strong, and unveil 'real reality.' There's a break between before and after the IPHU. We're changed; nobody's the same as before."

The report (page 6) explains further:

Some health professionals see IPHU as helping to link two things: knowledge from university vocational training and social policy; i.e. medical training and militancy, that is a strong commitment to activism. The course is a link between these two ways of thinking, acting and living. "I've now lost the fear of talking about health within my political militancy." They consider IPHU valuable from the theoretical and academic point of view. There is no other space for discussing the topics developed in IPHU, such as the differences between social and collective medicine and biomedical practice. The course allows reflection and analysis on different theories and visions of public health.

It is evident that individual capacity building can contribute substantially to organizational capacity simply through numbers but also through relationships – the sinews of the organization – and also through 'subjectivation' which corresponds to organizational culture.

When training programs and other learning opportunities also facilitate the deepening of relationships and the development of organizational culture they are contributing to all of individual, organizational and movement building. Proper follow up is key to supporting this process.

It follows that organizational training and development policies in activist civil society organizations must give attention to relationship building and cultural development as well as to skills and knowledge sharing in both formal training programs and in the cultivation of informal learning opportunities.

Culture as capacity

Organizational culture can play a critical role in nurturing agency and solidarity. Learning from, and about, each other (and ourselves) are conditions for solidarity and movement building. Reflecting on practice, learning about our

movement, developing a culture of reflexivity and commitment, are part of movement building and leadership development. Learning about other struggles and movements beyond our boundaries speak to the possibilities of learning from and working with a wider range of allies and friends.

Telling the stories of our history, the activists who came before, is part of shaping our collective identity. Stories of previous struggles can inspire us to confront the issues of today. In facing the challenges of Nina Rodrigues, the history of the MST and land rights victories which are celebrated in the names of the settlements of Nina Rodrigues were powerful resources for gearing up to face the challenges of today.

The Public Event 1978-2015 organized by members of the Italian research team provided an opportunity for young activists of today to see themselves as the children of yesterday, including learning from the mistakes of yesterday.

A significant element of cultural development for activist organizations is the modelling of transgression. The norms of the establishment have a powerful hold on all of us, activists old and new. The act of transgression is part of shaping a collective identity which stands apart from those established norms, in aspiration if not always in practice.

Emphasising organizational culture points to the need to develop the skills of popular education, of non-violent communication, of good group facilitation, of story-telling as a vehicle for history and theory. Much of the work of the Italian team in this research has been directed to learning about the skills needed for this approach to collaboration and how to share those skills in ways which help people to engage with the political theory underlying such practices.

Organizational learning

For activist organizations, always working in a field of uncertainty and change, organizational learning is a critical resource, including formal evaluation and research, but also simply a culture of reflection and learning: learning from previous and parallel experiences, and learning about the systems in which we are working. It is also the collective appropriation of such learning, carrying the processes and outcomes of our learning within our shared discourse. The [Activist Narratives report](#) also highlights the importance of reflexivity as a key capacity for individuals and groups.

Informal learning opportunities

Several of the stories collected in the Narratives study point to the significance of informal (or unplanned) learning opportunities in capacity building.

Ollis (2010) comments:

Activists are active in communities and social movements. They are connected to communities; they meet with politicians, advocate for reform or change, resist dominant discourses of oppression, they socialise and meet with other activists. They develop knowledge about systems of government by understanding key players and stakeholders in their area of interest, sometimes advocating for change within the existing system and, at other times, marching in protest and taking direct action. In doing this they actively construct, renew and remake their practice. (Ollis, p 241)

Informal learning opportunities arise in many aspects of civil society activism. More explicit attention to time, resources and method might allow for more effective use of such opportunities.

The South African Stage 1 report notes that the manner in which PHM SA conducts its regular meetings generally includes learning opportunities, in some cases formal presentations but also space for reflection and discussion:

Significant activist education happens through learning-by-doing. This includes experiential learning, with its crucial elements of reflection and critique. In PHM SA in Cape Town, opportunities for this include:

- *working with others [other organizations] on local health-related issues – like on sanitation with Mamelani (a small community-based NGO) and with a number of organizations in the Eastern Cape on Child Rights Campaign; and*
- *in the bi-monthly ‘members’ meetings’ in which local issues are raised and discussed among members, experiences shared and agendas for action / support are developed;*
- *single-issue public meetings are held every alternate month. They are typically attended by 50 or more members from Cape Town civil society. PHM SA has progressive experts and/or affected persons speak on current health issues;*
- *PHM SA’s public presence in debates – through letters to the newspaper and statements it issues through newspaper articles – also serves to raise awareness about the political economy of health;*
- *PHM SA has held two national People’s Health Assemblies, where current issues were debated towards developing platforms for action.*

A case study provided through the South African research team (SA1, page 14) describes a series of workshops resourced by PHM SA in response to requests first from a local health forum on the national government’s National Health Insurance proposals and later from the Cape Metro Healthcare Forum (CMHF) on provincial proposals for health committees. The relationships forged through these trainings helped to build closer solidarity between PHM and the health committees. In relation to the proposed health committees:

PHM worked with the CMHF to help run consultative workshops on the Draft Bill so that Health Committees could get together, review the Bill in detail and make submissions. This was a way for Health Committees to have a say in shaping the Bill. Seven sub-district workshops were held. PHM also supported a CMHF protest directed to the Provincial Minister of Health and other advocacy by the CMHF protesting the inadequacy of the Bill. This experience led to the inclusion of Community Participation and the Role of Health Committees in building the Health System as a key theme of the National Health Assembly in June 2016 with a series of actions proposed nationally. This has helped to spread advocacy in the Western Cape to a national level on community participation.

The Italian research team gave considerable attention to exploring different methodologies for conducting meetings and group discussions, looking for methods that were coherent with the goals as well as with the needs/desires of the people involved. Examples included: tools to facilitate open discussions (such as word cafe, open space technology and fishbowl discussion); non-verbal means of expression such as theatre activities; and story-telling tools for producing experience-based knowledge (inspired by narrative socio-analysis). However, the team felt that they had not been fully successful in conveying the deep political meaning of these kinds of practices as well as their coherence with a social and political vision of health, perhaps because of the continuing influence of more traditional, less self-conscious ways of engaging.

Taking advantage of learning opportunities which arise in campaigns and actions has been evident in many of the case studies collected for this research. The Brazilian case study from Nina Rodrigues illustrates this in several ways. The support that Sister Ani provided to the Nina Rodrigues group drew upon popular education principles, including interrogating our realities and consciousness raising. This approach was critical in growing confidence, knowledge, skills and relationships. Sister Ani mentored members of the team in relation to their community work; learning while doing and reflection on experience. The opportunity of meeting and sharing with outside supporters through reporting and planning workshops was also important.

Capacity building is commonly a core component of campaigning and advocacy. One of the Colombian case studies from the Cimitarra Valley describes the provision of training linked to development planning in Peasant Reserve Zone ([ZRC](#)).

In the case of Valle del Rio Cimitarra the capacity building process was primarily related to the elaboration of development plans, such as the plan for the Rural Peasant Reserve Area (Zonas de Reserva Campesina), in which some lines for the development and financing of productive projects were outlined and possibilities for

social investment and infrastructure initiatives in contexts of violence and state repression that have characterized this region. The capacity building exercises included modules on human rights and the international humanitarian right, analysis of political situations and further discussed the management of water resources polluted by diverse economic activities. In the health sector, the training of midwives and community health agents as well as the management of malaria and leishmaniasis and capabilities for citizen-driven primary health care stood at the centre of capacity building activities.

By 2009 the tide was turning and in 2011 there was a major gathering of indigenous, peasant and Afro-descended communities for land and peace and in the same year the ZRC was revived and a program was initiated to address problems in “in twelve sectors: human rights, economic development, environment, health and basic sanitation, land and territory, organization and participation, mining, rural women and gender, infrastructure, education, agroecology, culture and communication”. Since 2012 there has been progress on a number of these fronts.

The [Stage 2 case study](#) from Porto Alegre provides an instance where training in life skills (gardening, permaculture, medicinal plants) was part of the action. This case study involved a community garden project within the grounds of the school involving collective exploration of permaculture principles, ideas about *buen vivir/sumak kawsay*, medicinal plants, water and environmental issues while enacting and deepening relationships of collaboration and solidarity. Training provided a platform for strengthening alliances with the local university, the local community council, the municipal health council, the family health centre and the school.

One of the campaign case studies collected by the Italian research team describes the need for education and awareness raising regarding the provisions of the Trans-Atlantic Trade and Investment Partnership (TTIP) proposals. This campaign sought to make the TTIP known and exposed to public debate and scrutiny, starting with the EU parliament, which did not seem to have access to all the information concerning the content of the negotiations, and then addressing the broader public.

Another one of the Italian campaign case studies was around a citizens' initiative for a law on a guaranteed minimum income. Promoting this proposal required extensive awareness raising and education through debates, public meetings and presentations.

The Colombian research team (in the [Stage 1 overview report](#)) comment on capacity-building through ‘the systematization of experience’. Speaking of the ACVC case study (summarized in [Annex 2](#)) the team comments that:

The case study provides an overview of the configuration of rurality in Colombia and in particular in the Middle Magdalena region and Valley of the River Cimitar. Secondly the study seeks to ‘systematize’ the organizational experience of the ACVC; to discover within it the internal understanding of its conceptions and disputes in relation to the production and distribution of health; to understand their shapes through organization and mobilization and the lessons learned from the actions, the errors, scopes and projections after the evaluation and criticism process. (The “systematization of experiences” is a qualitative research methodology what seeks to reconstruct experiences, privileging knowledge and the point of view of the builders of the action.)

Capacity building has also played an important part in the WHO Watch initiative, supporting policy dialogue at the global and national levels. The ‘watching’ of WHO’s governing body meetings has been regularly preceded by an intensive planning and training workshop, reviewing WHO’s role in the wider framework of global health governance; reviewing the specific policy issues being considered by the governing bodies; and honing the watchers’ skills in both policy analysis and policy dialogue. However, of comparable importance in terms of capacity building is the informal learning associated with the commentary development, the watching and the engagement with delegates and other civil society participants.

The role of formally structured training programs

The field of formal training programs is wide and complex. The Indian team has suggested a five-fold classification:

1. Mass political awareness and social mobilization on health related issues;
2. Formal public health training and education initiatives;
3. Skill development for community level health care provision;
4. Training for community level health leadership and action; and
5. Training for government.

We shall consider here two broad classes of organized training programs; those which are organized through civil society organizations as part of their activism (e.g. IPHU, Escuela Popular de Salud (EPLS), see [Annex 2](#)), and those which are organized as part of established vocationally oriented training, including health professional education and training for government health officials.

Civil society initiatives may be directed at accessing or improving established programs as well as setting up alternatives.

Formal health professional training and education initiatives

The Indian research team surveyed a range of vocationally oriented training programs of relevance to the HFA movement, including those providing public health training. Many of these programs provide a solid grounding in the technical disciplines of public health. From the civil society perspective there are issues of access, content and orientation.

The Colombian ACIN case study highlights the issue of equitable access for indigenous people to formal health professional training.

Without a doubt, one of the main achievements in health is having indigenous community health personnel, who operationalized SISPI [traditional health understandings and practices and the principle of interculturality] on the ground; these are the people who day by day invigorate the health process in all the components and are recognized by the community and by the authorities.

[This struggle]... has made visible the indigenous movement of Cauca as one of the stronger movements at national and international level and that through their struggle has left their mark and their shared knowledge in different spaces have allowed other peoples to take this process as an example.

Indirect contributions of several civil society initiatives are also an important component to be mentioned here, wherein the experiences/understandings of such civil society players or organizations influenced the curriculum development and other policies for such formal programs.

The South African research team reported a number of instances where PHM activists were asked to contribute to health professional training programs (eg undergraduate medical course) or have participated in the conferences of the Public Health Association of South Africa (PHASA). Commonly there are gaps in formal professional and vocational training with respect to the political economy of health, comprehensive primary health care, and action around the social determination of health.

PHM South Africa has also been involved in providing training for members of other organizations and trade unions on request – e.g. the National Education Health and Allied Workers' Union (NEHAWU). The strength of PHM's IPHU program as a movement building strategy has also been borne out in the Alumni Survey and in the analysis prepared by the Indian research team of the experience of IPHUs in India.

A somewhat different contribution to professional training arises in the Italian research and the El Salvador IPHU where a significant challenge to the hegemony of the biomedical paradigm was projected. The [evaluation of the El Salvador IPHUs](#) reports that:

The major obstacle to developing the course was the deep-rootedness of the biomedical model among the majority of health professionals, attributable to their formal education and to the traditional organization and functioning of the health system.

Initially, the medical professionals tended to look down on the NHF [National Health Forum] leadership because they are not highly educated. They didn't appreciate that as a civil society organization the NHF includes community leaders who may not have much formal education, but do have leadership skills and community support. The area of social participation, represented by the NHF since 2010 and considered in the content of the course, was an unknown for most health personnel entering the courses.

That bridging of the professional-activist gap has been mutual, thanks to IPHU. As one participant wrote: "In the course, NHF leaders have come to understand that doctors working in the communities are arrogant because they have been formed by the hegemonic system, so we hope to change the training of professionals. In the course, we learned a lot from the health personnel, but they learned about the other side of the problem and what the communities are thinking."

Similarly the Italian research group, at the end of Stage 1 of their research, concluded that the priorities were to:

- *repoliticise the discourse on health, challenging the hegemonic biomedical perspective while proposing different approaches ("what is health?");*
- *share, experiment and put into practice different ways to "make health", taking into account also the aspects of decision-making, organization, sustainability ("what makes health, and how?"); and to*
- *promote and sustain the process of building a movement for health in Italy.*

Capacity building of government health officials

The Indian research team has listed 11 training programs directed at providing training for government officials in areas such as rational drug policy, district health planning, reproductive health services and a range of more general areas.

In some instances, the civil society groups seems to have influenced the government(s) for putting its staff into such trainings; some program spaces opened up as part of the national health programs would have opened up spaces for some of the civil society groups too, to advocate for and to implement training initiatives for the government officials.

Among training programs for government health officials the IPHU in El Salvador stands out.

IPHU has formed a critical mass of sensitized health workers and NHF leaders with tools to defend health reform. They are a strategic generational replacement group in the public health system, many of whom have management-level positions in the institutions and organizations to which they belong.

El Salvador's experience with health reform and the value of IPHU to that effort is neatly summed up in this MINSAL (Ministry of Health) document titled "Diagnostico Nacional de Promocion de la Salud" (National Health Promotion Assessment), jointly prepared by representatives of both NHF and MINSAL (an accomplishment that in itself is of historical symbolic importance):

Today, in addition to the hegemonic [risk and social determinants] approaches, there is another more progressive approach to health at a global level: one that speaks of the social determination of health. MINSAL has made a commitment to implement that social determination of health approach. Participation in IPHU in El Salvador has allowed for that transformation in ideological, theoretical and practical terms. It is not simply a matter of semantics, but an understanding of the social determination of health approach, a fairly recent conception for approaching and understanding the process of health and disease.

Formal (organized) civil society training programs

In this section we review civil society training programs other than PHM's IPHUs to which we turn in the following section.

The Indian research team has surveyed civil society training in India and categorised such programs under:

1. mass political awareness and social mobilization on health and related issues;
2. skill development of community health workers for health service provision and awareness; and
3. training for community level health leadership and action

Public awareness and mobilization programs cover issues such as community health, rational drug use, local health planning, women's health, health/ health care rights, health and related policies and so on. In most of these cases, it appears that the training/ awareness needs were identified based on the campaign or program requirements, and few of them had structured curriculum planning. Most of these trainings or mass awareness initiatives seem to have been organized through a cascade of volunteers in a campaign approach. Key outcomes of these trainings have been the enhancement in public understanding on various issues around health policies and programs, and around the social determinants of their successes.

India has a rich experience of training programs directed to skill development of community health workers, structured around primary health care principles. Most of the programs listed serve populations in difficult or medically underserved areas and focus on basic health awareness and first level curative care services. Interestingly, most of these program initiatives were initiated and led by committed medical professionals, hence the focus was around provision of health services and related health education. However, the researchers also comment that most of these initiatives are standalone health programs, without strong linkages with the public health systems or primary health care institutions. The researchers were unsure of the contributions these programs made towards strengthening public health systems in the locality, or in mobilizing the communities for action around health rights.

Under 'Training for community level health leadership and action' the researchers grouped programs that sought to build the capacities of individuals to lead community level health initiatives. These programs generally cover health rights, the social determinants of health, and the politics of health and health programs. Most of the organizations offering such programs are part of PHM.

Although there is a lot of civil society health training in India, it is a huge country and we have no way of knowing whether there is 'enough'. However, it is worth noting that India stands out among low and middle income countries for the relatively small public expenditure on health. It may be that some of the civil society training is compensating for the lack of investment in system wide public sector programs, in public health, health promotion and health care.

One of the features of the Indian scene which is noteworthy is the role of fellowships as a way of providing extended 'learning through doing' opportunities.

People's School of Health

The People's School of Health in Medellin (see description in Annex 2) is a training program co-sponsored by a consortium of civil society organizations. The People's School directs its efforts towards building capacity around the enforceability of the right to health, including the improvement of health knowledge, the sharing of personal experiences in relation to the enforceability of those rights, the participation in public debates and the recognition of subaltern actors of change.

The International People's Health University (IPHU)

In contrast to the broad brush survey of training programs in India we have a more in depth evaluation of PHM's IPHU program through the survey of alumni, the comments from the India research team on IPHUs in India, the reports from the South African People's Health University (SAPHU), the report of the Nepal IPHU and the Brussels IPHU in 2016 and the El Salvador experience.

Outcomes

The alumni survey concludes:

The survey shows a high level of appreciation for the IPHU, that is widespread across regions, time, and characteristics of the IPHU such as duration. Alumni feel that the program is relevant for the range of expected impacts, including on knowledge and competences (particularly on PHM

functioning and on the social determinants of health), relations and networks, political activity, but also work/career. They are generally happy with the methodologies and with the trainers, highlighting on the one side the need to increase practical/creative activities and field trips, and on the other to strengthen aspects related to language competence. Some comments on logistics seem to be related to specific IPHUs, rather than being generalised.

Alumni share suggestions on how to improve the IPHU, starting with better/broader announcement of the opportunities to engage, followed by improved communication before the IPHU in order to share expectations and distribute material to read in advance. Also, a strong call that comes from many a respondent highlights the importance of follow up, to keep in touch with the alumni and create and nurture a strong alumni network. This would increase the retention of activists and strengthen the movement at the local, regional and global level.

The survey provides more specific feedback and suggestions on a number of issues.

International or national or local

IPHU was conceived initially as an 'international' program with the expectation that bringing people together from different countries would help to build a global social movement. However, every course has to be held somewhere and there have been tensions between addressing the needs of the local participants versus pursuing an international agenda. The Indian experience and South African experience point to the benefits of more locally focused, national courses.

Recruitment and selection

Applicants for IPHU courses range widely in their activist experience and their orientation to health equity (their 'outrage' as discussed in Chapter 5). This raises challenges in terms of matching participant expectations and preferences to course design. A significant number of IPHU participants have gained career advantages from access to high quality low cost training but have not found pathways to HFA activism. If the IPHU program is to help to build a global HFA movement close attention is needed to recruitment and selection, to preference people who are or will become activists, and to follow up, to ensure that there are pathways to activism for those alumni who are so inclined.

Curriculum

It is evident that there is no one size that fits all needs but many IPHU course organizers have been encouraged to follow the 'standard' model with a focus on the political economy of health, the politics of health care and primary health care, and the social determinants of health. This 'standard' model has been pitched generally at people with academic skills corresponding to the university level. The assumption that some kind of cascade training might follow from participation in IPHU courses has not been widely realized. The need for different levels of training is clear.

One of the findings from the IPHU evaluation has been some disappointment in relation to content areas which are in general relevant to health activism but where alumni have no opportunities to engage around those issues after the course. 'Trade and health' may be such an area: clearly of relevance to HFA but not so relevant for participants who have no prior involvement and no opportunities for involvements after the course.

It may be that increasing the emphasis on specialist IPHU courses will help to address uncertainties regarding both recruitment and selection and content. The experience of the specialist IPHU courses on medicines policy, the WHO Watch workshops and the IPOL course on global health governance would support such a shift.

Pedagogy

The pedagogical methods adopted in IPHU courses have been continually discussed. Issues like the political economy of globalization or the implications of trade agreements for health may lend themselves to 'knowledge transfer' approaches, while feedback from alumni indicate a high valuation of relationship building and the sharing of personal experience. It is evident that relationship building and the sharing of activist experience contribute

directly to organizational development and movement building whereas the value of 'knowledge transfer' to the organization and to the movement depends on the participant remaining active and being involved in campaigns or actions where that knowledge can be put to use. This raises questions about both recruitment and selection on the one hand and follow up on the other.

The participation of academics in IPHUs has been common but there are hints from the alumni survey that some academics participating in IPHU courses have deployed pedagogical approaches which, while they *may* be appropriate in academia, are less suitable for activist training.

Follow up

Reflecting on the case studies collected for this research which have linked training initiatives to specific campaigns, the links between IPHU courses and campaigning, advocacy, and community actions need to be strengthened. This has implications for course design, recruitment and follow up.

The Indian research team undertook a number of interviews regarding the Indian experience of IPHUs. The findings were positive but identified some important lessons:

- the importance of follow up,
- the importance of facilitating mentor relationships with experienced practitioners,
- the need for short courses to be complemented by fellowships and apprenticeships, and
- the need to invest adequately (people, time and money) in course planning.

The El Salvador initiative in bringing government officials and health staff together with civil society leaders opens up exciting prospects but governments with such imagination are unusual.

The South African SAPHU experience likewise suggests new prospects for more localised and more focused training programs.

Costs

The standard 8-10 day face to face IPHUs are expensive, including in particular, travel, accommodation, meals and venue hire. All of the international IPHUs have had philanthropic support.

Funding support for an expensive program raises questions (in theory) regarding opportunity cost. If a comparable level of untied funding was available to PHM would running IPHUs be the most cost effective use of such money. It is a theoretical question because in recent years while project funding for a few IPHUs has been available, few funders will commit to untied support of institutional costs.

The IPOL experiments (IPHU On Line) suggest that good technical training can be presented on line at very low material cost but the time burden on tutors was considerable and the quality of the experience for participants (particularly in terms of both relationships and the richness of the whole experience) was not comparable to the face to face IPHUs.

Conclusions

Capacity building is a critical part of movement building and direct engagement in the struggle for Health for All. It is useful to think about different kinds of capacity at both the individual and the organizational levels.

For individuals, we have distinguished between: experiential and embodied knowledges and skills; technical knowledges and skills, and subjectivity (the habitus of the activist). At the organizational level, capacity includes the number and capacities of the people who are part of the organization. It includes the networks and relationships which give the organization coherence and resilience. It also includes organizational culture.

These two levels are connected in several ways. Most obviously the training of individual activists is a contribution to capacity building at the organizational level. Less obviously are the new relationships which are formed in training programs, which are highly valued by the participants but which are also contributing to strengthening the organization. Training opportunities which assist participants to shape and reshape their own personal subjectivity

are also helping to strengthen the culture of the organization. Training which deepens individuals' reflexivity and sense of inquiry are also contributing to organizational learning.

The learning which takes place informally in the context of various movement activities plays a key role in capacity development and we have reviewed some illustrative cases. There is also an important place for more planned, structured training programs and we have reviewed some directions emerging from the IPHU evaluations.

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Chapter 8. Knowledge generation, access and use

Introduction

Knowledges, the plural signifying different kinds of knowledge, are critical assets in the struggle for HFA. In this chapter we reflect upon the use, generation and sharing of knowledges for activism. The chapter is structured around three broad principles:

- New information flows can be empowering, including:
 - scientific, technical and legal knowledges, and
 - indigenous knowledges, such as Central American indigenous cosmovision, provide resources for new ways of understanding ourselves in the world.
- Producing the knowledges that the activists need is a core social movement strategy, including:
 - academic research,
 - research synthesis,
 - learning from activist practice,
 - bringing lived experience into discourse, and
 - re-appropriating history, culture, identity.
- Knowledge sharing is a core social movement strategy, exemplified by
 - Global Health Watch, but attention is needed to
 - media, methods and language, and awareness that
 - knowledge sharing is embedded in relations of solidarity and relations of power.

Box 5. Three principles regarding knowledge generation and access

Knowledge is carried in stories; stories of description, explanation, and prediction. Such stories can be simple or complex; they can be recorded on paper, in computers or in oral culture. In this chapter our focus is on the stories which inform civil society activism in relation to health: health care, population health and health equity; how they are produced, stored, disseminated, accessed and used.

This chapter is based largely on the findings of the country case studies, as well as the evaluations of Global Health Watch (GHW, see [Annex 13](#)) and the Personal Narratives study ([Annex 9](#)).

Carroll (2015) describes ‘transnational alternative policy groups (TAPGs)’ as networks and centres within and around which ‘counter-hegemonic knowledge is produced and mobilized among subaltern communities and critical social movements’. Carroll argues that alternative knowledge makes an indispensable contribution to resisting hegemony. Carroll interviewed 91 practitioners in 16 TAPGs from both global North and South engaged in ‘alternative knowledge production and mobilization’ and identified eight ‘modes of cognitive praxis’ as summarized in Table 2 of [Review of Social Movements Research and Commentary](#) (page7). We have drawn on this framework in developing this chapter.

As previously noted there are significant overlaps between the focus of this chapter and the other thematic chapters of this report. Knowledge is carried in culture, including the culture of the organization and the movement. Knowledge is generated in action, including campaigning. Knowledge is shared through training programs and informal learning opportunities. Knowledge informs policy dialogue.

New information flows can be empowering

Scientific, technical, legal information

In several of the case studies documented through this research the generation and dissemination of technical knowledges have played an important role.

In the Colombian case study of ASOTRECOL ([Annex 2](#)) access to technical knowledge was necessary; including knowledge about work-related diseases in order to strengthen the technical arguments and respond to the demands of the employers, insurance companies, disability evaluation boards and the judicial system in general. At the same time it was necessary to acquire legal knowledge essential to follow legal proceedings in order to strengthen the action in relation to the Ministry of Labor, the Public Ministry and the judicial system. As a product of the subordination imposed by the expert knowledge of the regulators and the insurers, they needed to search for information and engage in discussions with other workers and with lawyers, medical doctors and other health professionals. Upon acquiring knowledge on their medical conditions, they disseminated it among the other workers, constituting a consultancy. The medical-legal knowledge that they acquired accordingly got directly transmitted in one-to-one dialogues and made workers and ex-workers want to seek the support and technical assistance of ASOTRECOL.

In the ACVC case study ([Annex 2](#)) a collaboration agreement was formed between Cetam (Amazonian Centre for Technological Education) and Paz University in order to undertake studies on the recovery of water sources contaminated by mercury deriving from mining activities in the region; on low-cost alternative energy projects; and on the biological characterization of Linea Amarilla (a forest reserve of approximately 70,000 hectares in the Cimitarra Valley) and the San Lorenzo wetlands.

Both ACT and the Alliance (reported in the Coalition Building case study from Brazil, see [Annex 1](#)) are producing a range of technical and advocacy publications (drawing on academia and other organizations for science, epidemiology, and policy analysis) and making them available for download and for informing specific campaigns.

In one of the [activist narratives](#) 'Indra' describes the origins and work of the People's Science Movement in India. In 1984 a Union Carbide gas leak caused the death of thousands of people at Bhopal. Questioning how scientific knowledge was being misused and silenced by the Indian government and big industries became central to the group's activism. The group focused on researching and educating through science, *"not just in the context of its potential as a liberator, but also its context of how it's misused under capitalism, and the kind of social control that you require over science"*. The People's Science Movement employed this strategy across many issues including access to medicines and the pharmaceutical industry, and a health literacy program which educated and mobilized people around issues of health care, water, sanitation and nutrition.

In another [narrative](#) 'Angela' describes how she had worked in a coastal village in Central America during the 1970s, delivering a community-based health program and training community leaders as part of a joint project with a government department and an NGO. Angela used her position in the community to empower local leaders with legal knowledge that was being withheld from them by their government. In this example Angela highlights the value of assisting marginalised people to understand their situations through sharing knowledge, and also how knowledge is tied to power relations (which in this instance eventuated in her having to leave the country).

In the Porto Alegre case study (see [Annex 1](#)) the research team highlights the knowledge regarding permaculture which had been shared through the actions in the school and the community garden. Beyond the principles of agroecology the project enabled a sharing of the vision of *buen vivir* and of the wider political economy of food systems (drawing also on contributions through the Alliance on Adequate and Healthy Food). Much of this knowledge has been captured in documents and videos and packaged and made more widely available.

PHM SA has a comprehensive political economy analysis of health systems and population health that makes it unique in South Africa and PHM SA's knowledge generation and dissemination activities are aimed at raising public awareness about the political economy of health and health systems in South Africa and beyond. However, the local research team comments that simply disseminating this analysis has not animated a mass movement for health in South Africa.

The South African observation offers a salutary warning. Knowledge may be necessary but it is not sufficient.

Role of activist experts

Activist academics and other experts have played a critical role in much of the research undertaken for this

project and in many of the stories which have been documented there have been activist academics working with the communities at the centre of those stories. Examples include:

- the 'Outreaching and Research with Rural, Black *Quilombola* and Indigenous Populations and Communities Nucleus' at the Federal University of Maranhão which participated in the Nina Rodrigues project ([Annex 1](#));
- Cetam (Amazonian Centre for Technological Education) which, with academics from Paz University supported the ACVC in a number of economic development projects ([Annex 2](#));
- academics from the University of the Western Cape and the University of Cape Town in South Africa which have contributed to the training programs of PHM SA ([Annex 6](#)); and
- academic activists from many countries who have contributed to PHM programs such as the IPHUs, WHO Watch and Global Health Watch.

Technical experts, including activist academics, have also played important roles in several of the case studies documented and analyzed by the country based researchers (as listed above). These range from undertaking (and advocating for) original research, to synthesizing and disseminating, to brokering between technical experts and community activists.

Two cases from the [Indian report](#) illustrate knowledge production and dissemination in the context of social movement campaigns.

"On the links between TB and nutrition for example there just wasn't much evidence. But we published evidence in PLOS and were then able to successfully campaign in Chhattisgarh for the provision of food for TB patients. We did operational research with action including on what the food should be and how it should be delivered. We worked with other research groups." [Respondent 6 in JSA report]

"For example, along with other groups, we undertook a fact-finding on the deaths that took place following sterilizations in one state. The fact finding provided important information and documentation of what had transpired and contributed to the campaign against such violations, policy level advocacy as well as towards justice for those who experienced morbidities or for the families of those who died. The fact finding generated this knowledge within a short duration as was required in such a situation to mobilize a campaign on this issue." [Respondent 4 in JSA report]

A particular example of highly technical expert activism is provided in the Indian report which describes the work of Networks of HIV +ve People in opposing applications from pharmaceutical companies for new drug patents in order to enable generic versions to be produced and prices to be kept low.

It is clear that activist experts including academics have a potentially powerful role to play in generating and disseminating knowledge for campaigning and advocacy around HFA. However, the reports from the Italian research group (which itself includes some academic activists) include a warning about the construction of knowledge in the established institutions of academia. The Italian group included students and recent graduates in medicine and other health science professions and, even prior to the commencement of this research project, had been starting to question the knowledge power of the teacher/doctor. In the course of this work the group had rediscovered and revisited the Critical Medicine movement which was active in Italy during the 1960s and 1970s.

The critical medicine movement originated around key reflections that strongly criticised the epistemological roots of medical knowledge and power, and of its institutions. For instance, the movement criticised the idea that science is neutral and that medicine is a technical profession, and exposed the role of social control that medical institutions (particularly hospitals and psychiatric hospitals) and doctors played.

The movement saw in the capitalistic economy/society the primary roots of the existing inequalities and social injustices, and claimed that doctors were trained to practice a medicine that served the interests of capital. Science, far from being neutral, was seen as the product of the dominant social class, therefore necessarily (re)producing forms of knowledge that served the economic and political privileges of the elite.

Members of the group noted that in their experience of academic training in more recent years, the critique of Critical Medicine had been completely absent.

The Italian group undertook a range of interviews which were then subject to an interpretive and participatory analysis. One of the 'bubbles' identified in this analysis was the relationship between knowledge and power.

While thinking of knowledge, there's a tendency to refer to the academic knowledge that is shaped in universities adopting a specific language to describe, or construct, the reality that surrounds us. However, there's another form of knowledge that western culture tends to devalue, which is non-institutional knowledge (or common knowledge). This originates directly from people's life experience, through sharing and the collective process of meaning construction.

While academic knowledge polarises power in favour of who holds it, and tends to be shared in a top down direction, common knowledge is linked to collective and participatory processes and can be liberating, as it is connected with the meaning that people give to their life experience. In the experiences interviewed, knowledge is mostly created and exchanged through participatory and collective processes.

When institutional knowledge is also used, it is through collaborative approaches or, even better, academic knowledge becomes instrumental for the construction of new knowledge, rather than an end of the education process in itself.

While not denying the potential role of academics in mediating the dissemination of technical (institutional) knowledges, including to activist organizations, the group's report underlines the need for activist academics to be aware of the power relations of institutional expertise.

Indigenous knowledges, such as the Central American indigenous cosmovision, provide resources for new ways of understanding

The empowering significance of new information flows is not restricted to technical information.

In her personal narrative 'Angela' described how the People's Health Movement in Latin America was incorporating the cosmovision philosophy of indigenous people into their program and culture. This is an example of valuing knowledges that are alternate to the mainstream and constructing new ways of viewing and experiencing the world.

"The People's Health Movement in Latin America has made some pretty important decisions. We have taken the philosophy of the cosmovision of native peoples to be the driving force for the People's Health Movement in Latin America and that's the whole concept of buen vivir.

We are in a crisis of civilisation and the model is not working and so what model can work. The concept of buen vivir provides us with a model that is not exploitative of our planet; that recognizes that we have to take care of water and we have to source this water"

Article 275 of the Ecuadoran Constitution states: "Buen vivir requires that individuals, communities, peoples and nations are in actual possession of their rights and exercise their responsibilities in the context of interculturalism, respect for diversity and of harmonious coexistence with nature." (Fatheuer 2011)

The emphasis on interculturality and harmonious coexistence with nature resonates for many in the context of a global ecological crisis. The *buen vivir* philosophy provides inspiration and gives authority to movements seeking to challenge 'economic growth' as the dominant solution to the world's problems.

Producing the knowledges which activists need

In the discussion above we have cited various cases where activist experts have facilitated new knowledge flows. These have included knowledge production as well as translation, dissemination and brokerage.

Under this heading we also discuss other, less technical, kinds of knowledge production.

Bringing lived experience into discourse

One of the themes winding through many of the case studies collected for this research is the power of experiential knowledge in making sense of the subaltern experience and the importance of various methods for bringing such knowledge into discourse and 'systematizing' it ; using it to construct new ways of viewing the world.

Many of the case studies collected through the course of this project demonstrate the scope for this kind of learning from practice, 'systematizing' the experience of health activists and their communities. This concept of the 'systematization of experience' is elaborated by the Colombian team in the ACVC case study (#2), and was described earlier in this Report.

Popular education refers to a similar process; reflecting on the lived experience of the subaltern community, questioning established truths and reframing our past, present and future. One of the key activists in the Nina Rodrigues story, Maria de Jesus, described it thus:

In 1997 I was the regional coordinator (parish and leader) of Pastoral of the Child and I worked in catechism during twenty years, which led me to accept being part of this group really was the previous experience. I saw other groups and other nuns who had also worked in Fraternity Campaigns, always participating, especially in the subject of environment and always in the community. I think that it is part of my life. Thus, I entered into this new group. I met Sister Anne [Sister Ani] and I observed for the first time that the work was done in a different way. Then I said "Let's go". I see the path until today as a process with its differences. It has more solidarity in the way, it is more "observatory" of the social realities. We never know everything, but we are always learning.

Edimilson, another member of the NR team explains:

I was invited by Maria de Jesus to participate in a "grassroots education" course. I didn't know anything about the issue, but yes, I knew it would be important. Initially I thought that they would speak about health, like blood hypertension, on our body. It was a little difficult to start this different type of study, because I didn't know everything, but I decided to stay in the group and soon I started to enter well in the team. When we started our work in the first community (Vila Esperança), it was good and I see the value of the studies and our objectives.

Commenting on the process of bringing experiential knowledge into discursive form, the Indian research team explain:

By thinking, acting and learning collaboratively with [the] community that they work with, CSOs reclaim the vast knowledge base of the marginalised communities. Such process of knowledge creation is an essential component of the very nature of the civil society engagement in the change process as they try to integrate knowledge produced into planning and decision-making.

In her interview for the Narratives study, Angela discussed how through employing popular education techniques and engaging in Paulo Freire's (1968) theories of 'conscientization', she learnt how to engage with local people to develop their political consciousness; making them aware of the social and political contradictions of their social worlds, initiating a desire to take action against the oppressive elements impacting their lives.

Re-appropriating history, culture and identity

The Nina Rodrigues project in Maranhão provides a glimpse into the power of popular education in the reappropriation of the legacy of the land rights movement, through which the Nina Rodrigues settlements were achieved, as an inspiration to commit to the struggle for the right to health.

The Colombian case study of ACIN (the Association of Indigenous Councils of the North Cauca, summarized in [Annex 2](#)) illustrates the reappropriation of indigenous history and culture as a critical part of achieving land rights, cultural integrity, political autonomy and the right to health.

The struggle of the indigenous movement over the last 20 years, in the field of health, including legislative recognition of indigenous and cultural heritage including in relation to differential health care.

Currently, there is a national round table in which indigenous peoples are able to present their positions. The SISPI (the Indigenous System of Own and Intercultural Health) was born in North Cauca, elaborated in the discussion of the national round table and has been recognized as a model of health for other indigenous peoples at the national level. The differential approach to indigenous health is strengthening and recovering traditional medicine as critical to the health for the indigenous peoples.

Political and legislative commitment affirms SISPI as the set of knowledge, cultural practices, actors and processes for the maintenance of harmony and balance between human and nature, territory and the community, without ignoring other knowledges and medical practices that daily interact within the communities.

As says a leader of the indigenous movement: "the achievement of decree 1953 of 2014 gives us power as communities to regulate our own system of health, our health development is in focus and our vision will guide the operationalization of this decree " (Communication Personal, Feliciano Valencia, 2016: 4).

The Italian group tells a similar story about rediscovering and re-appropriating the Critical Medicine tradition (described above).

Knowledge sharing is a core social movement strategy

There are a number of different functions which can contribute to knowledge sharing:

- knowledge synthesis: putting together in a single narrative the findings and conclusions of a range of reports and commentaries;
- research translation: converting research findings from technical language to more generally accessible, 'user-friendly' language;
- knowledge brokerage: facilitating constructive (potentially two way) communication between researchers and research users;
- search engines (web);
- search engines (for specific repositories).

The five booklets

A major driver of the year and half long process in India before the first National Health Assembly in Kolkata and the first Peoples Health Assembly in Dhaka was what came to be known as the magic of the 'five booklets'. These five booklets (on Globalization and Health, Health Systems, Child Health, Women and Health, and Confronting Commercialization) were written in a popular style and formed the bedrock of the massive mobilization of 1999 and 2000 in the lead up to the first PHA.

The process of writing these booklets was embedded in the participatory spirit of the 1999-2000 campaign. To build a common understanding of the program content for the pre-PHA campaign, the founding meeting for the campaign authorized a team to collect resource inputs in the form of theme papers. 30 base-papers were collected from over 30 resource persons. Then a small group worked intensively to edit and transform these base-papers into four simple popular booklets. A hundred photocopies of these booklets in draft form were brought to the next national preparatory workshop. Here over 100 delegates from at least 9 organizations went through all the four booklets, in small groups, while rapporteurs noted down their suggestions. The group then incorporated these suggestions, and the text, which was complex in places, was made readable by an illustrated, 'conversational' presentation. A fifth book was also finalized, albeit with a more limited discussion. In English 4000 sets of these five books were printed and sold. Many times this number were printed and sold in the form of translations in Hindi,

Kannada, Tamil, Telugu, Oriya, Bengali and Malayalam, and in adapted versions in other languages like Marathi and Gujarati. The sale of the five books was in itself a campaign and nearly 25,000 sets, all languages included, were sold.

The five books represented a shared understanding of the critique of existing policies as well as recommendations for change and possibilities for peoples' initiatives. It was published not in the names of individual authors or organizations but collectively by the entire group and thus became a binding force in itself.

The participatory process of the development of the 5 initial booklets, however, has not since been duplicated at that scale. With JSA developing a more organized institutional structure, the participatory process of the 1999-2000 period has weakened. Neither have subsequent booklets had the same range of readership and achieved the same popularity as the five original booklets.

Global Health Watch

GHW is PHM's main platform for knowledge sharing, principally knowledge synthesis but including some de novo research reporting. See [Annex 13](#) for brief introduction to GHW.

Each new edition of GHW starts with the appointment of an editorial group and editor-in-chief (currently Amit Sengupta of PHM). Then follows consultation regarding contents among the six civil society organizations involved in its production: People's Health Movement, ALAMES (Latin American Social Medicine Association), Health Action International, Medico International, Third World Network and Medact. Once a broad structure has been produced volunteer editors and/or writers are recruited for the proposed chapters. A very wide circle of writers has been involved in the production of the five editions so far produced. The chapters are not author-attributed. Draft chapters are circulated within the editorial group for peer review and further negotiation with authors. The finalized copy is published and distributed through Zed Books with provision for open access on the PHM website from six months after publication. PHM organizes 'launches' in various cities and in association with various events and promotes distribution and sales through this process. The full edition is published in English only but some chapters have been translated. In some instances advocacy briefs, derived from particular chapters, have been published.

The review of GHW4 ([here](#)) has commented usefully on the role of GHW and ways of improving its impact and reach.

GHW (as currently produced) is responding to a real need and has an important role in knowledge creation and dissemination to support civil society engagement in Health for All. While it is generally addressed to students, academics and policy officials these are still important audiences. It contains material of global relevance.

The reach and impact of GHW could be strengthened through including more case studies; publishing in multiple languages; producing different products (pamphlets, videos, podcasts, etc) for people with different levels of literacy; more follow up of particular issues (stoking a continuing conversation); and more effective dissemination. There is a recognized need to develop primers like the 'five booklets' (below). This needs to be undertaken at the local or regional/language group level. GHW could be used by PHM's country circles to develop their own booklets but this is not happening (for reasons of language, capacity and resources).

While the intellectual content of GHW is generated at no cost to the publication, the price (printing and distribution) is still seen as a barrier in low and middle income countries.

As part of their survey the Indian group asked respondents about their knowledge Global Health Watch (GHW) publications and their utility and the comments were generally positive. Respondents were aware of the GHW and most claimed to have used it for advocacy. They also said that it had a limited reach because of only being available in English and because the contents were not directed at local activists. It was recognized that the use value would increase if 'readers' on important issues could be created in local languages. As one JSA respondent said:

"I use GHW extensively and it is extraordinarily useful. It has the evidence I want to use and am able to quote from it in my advocacy and research work. I want both what GHW is now, and make it available to activists in different forms. People's movements have to promote changes in discourse at macro and academic level and GHW caters to this need".

The need to disseminate the contents of GHW more extensively was also articulated.

“Global PHM is also an alternate to the bleak scenario of global governance. The coming out of GHW is an important global event, though dissemination should be much more”. (JSA respondent 1)

Reports and policy briefs

Many organizations develop simple, informative, and effective information resources such as pamphlets, brochures, booklets, and posters.

JSA (PHM in India) regularly produces booklets on issues around which campaigns are ongoing or on issues in which it thinks it is useful to intervene. Generally the booklets are collaboratively written and not identified by authors. The language is as accessible as possible for JSA activists and lay readers. All JSA booklets are written and first published in English and then translated into Indian languages. Most booklets produced by the JSA are funded through local resources, via amounts pledged by JSA affiliated organizations. Almost all are linked to campaigns and are seen as important for setting positions on issues and as contributing to campaign related mobilization.

PHM SA has prepared policy briefs on current issues including the *NHI White and Green Papers*, the *National Sanitation Policy*, and the *Draft Amendment Regulations on the Consumer Protection Act Regulations* (which defined the permissible use of GMO foodstuffs and labelling requirements in this regard). One of the informants interviewed for the South African report mentioned that collaborating on policy feedback not only generates new information, but also offers health civil society organizations the chance to build (and in some cases, rebuild) working relations with each other.

Media, methods and language

The media on which knowledge is stored shapes how it can be disseminated and accessed. Options include:

- photos (as in the Nina Rodrigues report),
- videos (as in the Porto Alegre case study and the Italian report),
- paper (GHW, Five Booklets),
- cultural presentations (as in the ‘kalajaths’ in India),
- internet (GHW and IPHU resource library),
- mobile phone apps, and
- oral culture.

There are many precedents and resources to guide the use of such media. We comment further on just three.

Kalajaths

The Indian report described how ‘kalajaths’ have been used to promote an understanding of health rights as part of realizing HFA. Such initiatives are successful only when the activist communications are relevant to people’s daily lives and show them the glimpse of the world without injustice and structural violence. The mass contact program began by the science movement in India is a good example. The ‘kalajaths’, as they are widely known, communicate social and scientific messages through traditional as well as modern art forms, such as songs, street theatre and poster exhibitions.

Social media

There is widespread appreciation of the powerful role that communications through social media can play in social movement activism. One of the informants in the Narratives Study, ‘Ivan’ commented that social media plays a very important role in campaigning:

Many older activists were distributing leaflets in the street when they were younger activists, and the equivalent today is tweets on Twitter... it’s just another tool, and it doesn’t change the way activism works. It’s just another medium. It’s just another way of communicating.

However, methods for the effective use of social media can require a significant commitment in terms of person time and a certain level of strategy and expertise (see Chapter 3 of the [Manual](#)).

Accessing existing knowledge repositories

Search engines can be very helpful in accessing some of the material 'out there on the web'. There are also institutional repositories, including WHO's Global Health Observatory, World Bank resources and many others. Likewise bibliographic search facilities in libraries can yield useful material but require some familiarization in their use and often the material discovered is not accessible.

Much of the material on the web is in English. Information searchers working in other languages or on more local issues may not be so richly served.

Material on the web is sometimes evanescent; the item may be deleted and the website may disappear. One of the benefits of journal publication is indexing and inclusion on various bibliographic databases.

Internet search engines, bibliographic search facilities, Wikipedia, and online news agencies (eg Inter Press Service IPS) are powerful tools for accessing on line knowledge sources. However, they depend to some extent on the user 'knowing what they are looking for'.

Sometimes textbooks can help to direct the user but most textbooks are prohibitively expensive in hard copy and have access restrictions in electronic form. Many publishers produce handbooks and encyclopedias in particular fields. These can be very useful.

There are many knowledge sharing platforms in the health policy space. Examples include [Health Action International](#) (in relation to medicines), [bilaterals.org](#) (trade agreements) and [Knowledge Ecology International](#) (intellectual property). However, as a general rule the user still needs to know what they are looking for.

The concept of knowledge brokers is also being explored in a number of fields, including in particular in relation to the interface between research and practice in health care.

We have not ascertained in this research how urgently the HFA activist community needs new resources for knowledge broking nor how best to construct such resources. PHM does not presently have a repository in which selected books, reports and journal articles might be listed and annotated and made available to activists and certainly not in an adequate range of languages. Developing and (more importantly) maintaining such a repository would be quite resource-intensive.

Many software and technology providers sponsor online 'user communities' as well as, or even instead of, 'help desks', to mobilize the knowledge of users to provide answers to help seekers. There may be space for a health activist 'user community', perhaps drawing upon the scores of contributors to GHW.

Knowledge sharing is embedded in relations of solidarity and relations of power

Knowledge generation, dissemination and access are embedded in social relations: relations of solidarity as well as relations of power.

The role of solidarity in knowledge sharing was highlighted in the Colombian Stage 2 project (see Annex 2). The project envisaged the largely city based PHM networks resourcing training programs directed at assisting ex FARC medics to be recognized as CHWs. It also envisaged mobilizing PHM expertise to support the peasant organizations in policy dialogue around the proposed National Rural Health Plan.

However, in the early consultations around this project it was recognized that the relationship had to be more than a one-way knowledge flow; that there was rich expertise within the peasant movement and that the development of the project had to be a collaborative construction of new knowledges based on separate but shared knowledges and a deepening understanding and trust between the partners.

Knowledge is also embedded in power relations. Elites tend to hoard knowledge and seek to control knowledge generation. Elites project particular stories about how the world works; stories which suit their interests ('hegemonic' knowledges). Accordingly subaltern movements seeking to change the configurations of power, including achieving decent health care and safe living conditions, need to develop their critique of the established knowledge economy and need to develop alternative ('counter-hegemonic') methods for generating, storing and disseminating knowledge.

The challenge of knowledge generation and dissemination was considered in the final evaluation workshop (Italy), in particular, experiential knowledge. The group's approach to experiential knowledge was shaped by a concern regarding the power relations associated with possession of 'officially endorsed knowledge' linked to a confident facility with speech. At the micro level such powerful speech can render others silent; at the macro level such powerful speech can project an understanding of the world shaped in the interests of the powerful. Accordingly the group's practices were often directed to non-verbal expression and emotionally informed modes of expression, eg theatre or role play (in contrast to fact and logic paradigm). Experiential knowledge in this context involves valuing people's lived experience as a source of knowledge, validating such knowledge, bringing it into discourse and drawing on it to inform practice.

The particular challenge at the core of the Italian group is how this perspective may be used to inform a counter-hegemonic approach to health. In this context the group is committed to working with others who are already experimenting with alternative approaches to health and its determinants. The group is working towards a project directed to the co-construction of experiential knowledge under the name of 'health commons practice'.

The group draws significant lessons for this enterprise from its experience in both stages of the CSE4HFA project. The view was expressed in the final evaluation that while deploying various creative methodologies for supporting open discussion in its public meetings were appreciated it was much harder to convey the deep political logic of such practices, particularly in communities who were more familiar with more conventional activist practice. Even within the group the political logic of experiential knowledge generation was not always fully appreciated.

Conclusions

Changing the flow of information and knowledge can change power relations; more specifically it can empower social movement activists. We have cited examples from our case studies of new flows of scientific, technical and legal information and of activist academics working to create and share such information. We have also cited under this heading the widening access to indigenous knowledges, in particular, the cosmovision of Central America, and its potential to change the ways we see ourselves in the world.

We have explored different approaches to producing the knowledges that activists need. These include formal and deliberate knowledge creation, as in academic research or in knowledge programs like Global Health Watch. They also include less formalized knowledge creation with several examples of learning in practice, several instances of bringing experiential knowledge into discourse, and cases of re-appropriating history, culture and identity.

Under the heading of knowledge sharing we have summarized some experience regarding different media and methods for sharing; and we have highlighted the need to be conscious of the power relations which frame knowledge sharing and interpretation.

Reference

Fatheuer, T. (2011). [Buen Vivir: a brief introduction to Latin America's new concepts for the good life and the rights of nature](#). Berlin, Heinrich Böll Foundation.

Chapter 9. Engaging with global governance

Introduction

Outline

This chapter is structured around two broad 'principles':

- critical policy engagement by social movements at the national level deals with *both* national issues *and* issues which have international ramifications
- there is also an important role for critical policy engagement by social movements directly at the global level (linked to complementary advocacy at the national level).

Box 6. . Principles for civil society engagement with global governance

Towards the end of this chapter we review WHO Watch (one of PHM's global programs) as an experiment in critical policy engagement at the global level. We describe the strategic logic of WHO Watch and how it works. We then draw upon the country reports, the evaluation of WHO Watch and other reports to reflect upon the achievements, uncertainties and options for the further development of WHO Watch.

Terminology

We use the term 'critical policy engagement' in this chapter in order to emphasize the need to balance policy dialogue with structural critique; this we are referring to as 'critical policy engagement'. Policy dialogue generally focuses on explaining problems in terms of institutional failure and proposing appropriate institutional reforms. In Chapter 6 we emphasized the importance of also recognizing the power relations within which the structures of governance operate and highlighted the need to balance policy dialogue with structural critique.

The focus on policy engagement at the global level reflects the rising significance of globalization and economic integration and the increasing influence of global forces on health care, population health and health equity. Accordingly critical policy engagement needs to address both policy and structure, at the global as well as national and local levels.

The use of the term 'governance' in this chapter is significant. The term encompasses the structures of government plus the interests and forces impinging on government decision making and the other networks of power shaping social development. The term is particularly necessary at the international level because of the absence of 'government' at that level. There is a range of intergovernmental organizations and various treaties and agreements but no 'government'. Governance is useful in relation to 'critical policy engagement' because it can be used for both mapping the sites of policy action and delineating the structural forces at work, at both the national and global levels.

Policy engagement at the global level poses significant challenges for health movements: in particular creating the networks, capacities and leverage to engage directly at the global level, including policy dialogue and structural critique.

Sources

This chapter is based on the reports of the different research teams engaged in the country level projects and the centrally organized global studies which have addressed the different aspects of this theme.

Critical policy engagement at the national level

Regarding national issues

The case studies collected for this research reveal extensive use of policy dialogue at the national level, focusing on issues which are largely nationally specific.

The indigenous movement on Colombia (see the ACIN case study described in [Annex 2](#)) has engaged in negotiation with the State over several decades. In recent years, the Constitutional Court obliged the State to establish negotiation and agreement spaces with indigenous groups, such as the permanent platform for consultation with indigenous groups and organizations that was recognized in 2013 and which includes a chapter on health. Nonetheless, it is recognized that the State systematically fails to comply with the agreements, which has obliged the indigenous movement to draw on contentious actions. In spite of the State's breach, the indigenous groups managed to demand a judicial framework for important public policy initiatives including SISPI (Indigenous System of Own and Intercultural Health).

The LGBT movement in Cali in Colombia (see Annex 2) opened spaces for dialogue and negotiation with the State through the Sexual and Reproductive Health Roundtable, the Departmental HIV/AIDS Committee, the municipal LGBT roundtable and Departmental Congress (Confluencia Departamental). These developments allowed for the signing of a declaration of intent, the formulation of a municipal public policy which is in approval process and the publication of a public policy on the guarantee and enforceability of lesbian, gay, bisexual, transgender and intersexuals (LGBTI) rights in Valle del Cauca. Nonetheless and despite the formal advances, LGBT movements agree that in practice, the State systematically breaches the agreements.

In the ACVC case study, also from Colombia, policy dialogue at national level was important for achieving concrete action around the implementation of a range of projects brought forward under the Sustainable Development Plan for the Cimitarra Valley. These initiatives translated policy dialogue into concrete action.

The Brazilian case studies on tobacco control and the Alliance for Adequate and Healthy Food both involve policy dialogue with government.

The India report includes a wide range of case studies of civil society organizations engaging in policy dialogue with government on domestic issues and in a few cases on issues with international ramifications.

The South Africa reports also include case studies which have involved policy dialogue with government, in particular, in the case of National Health Insurance.

Issues with international ramifications

Many of the issues arising at the national level have ramifications internationally and it is appropriate in many cases for critical policy engagement at the national level to address those international aspects.

The research team involved in the Porto Alegre research (see [Annex 1](#)) comments in their report that their activities were focused on the local scene, and that they were not working with the topic of global governance. However, there are several connections where issues arising in the Porto Alegre research reflected significant international dynamics. These include:

- the political economy of global food systems and the contradictions between globalized, corporate controlled, highly processed food systems and the opposing systems of agroecology and food sovereignty; and
- pressures against providing access to water via publicly owned urban infrastructure compared with the privatisation of water supply through private utilities and plastic bottles.

Policy dialogue was not a central feature of the Nina Rodrigues story although NR/PHM is starting to build advocacy and dialogue with local health system managers. The main challenges as presented in the case study are local and national and policy dialogue which might address global issues is not prominent in this story. Nevertheless, global forces are acknowledged in various low key ways in the case study. The large estate managers are part of global supply chains which are part of corporate globalized food systems. Corporate dominated food systems do not make space for small farmers or agroecology. The global perspective is clearly present in the discourse of NR/PHM, in particular, through the repeated references to *buen vivir*, which has direct implications for food sovereignty and agroecology. Likewise the transnational mining giant Vale is a dominant influence in Maranhão

and there have been recurring clashes with indigenous and *quilombola*¹⁵ communities over exploration, mining, and transport infrastructure. While mining does not feature prominently in this story, questions about neoliberalism and the impunity of transnational corporates do appear in the reports of the health team training.

The case studies developed through the ACT research group in Brazil dealt with tobacco and food security. Policy dialogue played a central role in both campaigns and in both cases (tobacco control and food) there was a clear articulation between national policy and global dynamics, most notably in the campaign to ratify and implement the Framework Convention on Tobacco Control.

From the South African team, the preparation through PHM SA of the case study on mining for the Lancet Commission on Global Governance for Health illustrates a local issue with global ramifications ([here](#)). The case study focused on the health, environmental and socioeconomic costs of gold and platinum mining in South Africa and advocated for the implementation of laws that would prevent mining companies from externalising these costs to the public sector, workers and mining-affected communities.

An effective response to the health impact of extractive industries must be engaged at community, national and international/global levels, and must encompass not only superficial measures of health outcomes but meaningful solutions to the myriad impacts of social determinants of health shaped by extractive industries, ranging from environmental degradation to income inequality to structural violence and beyond. Governance reforms must be guided by principles of transparency, participation, accountability, community determination, reciprocity, and enforcement of laws and treaties, among others. Finally, the distribution of benefits through economic gain, employment, and community development, among other measures, is increasingly documented as highly inequitable at multiple levels. These concerns, along with the information following, suggest that improved governance of extractive industries is a key global justice issue of our time. We hope the time has come to act with clear eyes.

From Colombia, the [ASOTRECOL story](#) illustrates international solidarity action which impacted upon national policies. The ASOTRECOL activists understood that the problem they were facing could not be resolved at the local level and sought influence at the international level. Following pressure (mediated through trade union links) on General Motors in Detroit and in the US Congress, at a time when the US was negotiating a new trade agreement with Colombia, the Colombian Ministry of Labor was encouraged to address the needs of the ASOTRECOL workers.

The survey of civil society activists from India provides useful insights into the Indian experience. Among respondents who are already engaged at the international level, the local implications of global decisions hold a lot of importance. According to one respondent, analysis and advocacy regarding the links between the global and local take place within the national and global structures of their network. The international network holds regional trainings and country representatives are provided with the information and tools for using the information at the local level to hold governments accountable.

The importance of linking local civil society activity to global health governance issues was highlighted through several of the Indian cases where local groups held government accountable for international commitments. In one case where the government was planning to repeal very strong laws enacted under the Code of Marketing of Breast Milk Substitutes, local Indian organizations campaigned to prevent the repealing of the laws.

One respondent associated with PHM in India noted the importance of strengthening the connections between policy engagement at the global, national and sub national levels. The respondent commented that while there is some understanding of the international debates, based in part on information coming through PHM Exchange¹⁶, a

15. Quilombolas: are residents of [quilombos](#) in [Brazil](#). They are the descendants of [Afro-Brazilian slaves](#) who escaped from slave [plantations](#) that existed in [Brazil](#) until [abolition](#) in 1888. Quilombos are [hinterland](#) Brazilian [settlements](#) founded by people of [African origin](#) including the [Quilombolas](#). (Wikipedia)

16. PHM's global email list.

more regular process that feeds global information and analysis to the country level discussions of the JSA is required.

The challenges of aligning local activism with the dynamics of global power are several. Grassroots activists (as in Porto Alegre or Nina Rodrigues) who are preoccupied with immediate and pressing challenges may require some persuasion that addressing global forces should be a priority.

Activists seeking to have an impact at the global level need access to institutional mechanisms through which they can make their voices heard and access to political forces to help drive change. The ASOTRECOL case study illustrated international solidarity in action.

Such solidarity is not always strong enough to make a difference. The authors of the South African case study on extractive industries expressed some frustration at the lack of international solidarity after the Marikana Massacre (which involved the shooting by police of striking platinum mineworkers).

Critical policy engagement with global governance

Civil society activism around global governance

In the struggle for decent health care and for social conditions which nurture population health important synergies arise where local and global engagements are complementary. There is only limited published research throwing light on how this kind of complementary action can impact on the governance structures at the global as well as the local levels. O'Brien and colleagues (2000) trace the involvement of civil society organizations in holding the multilateral economic institutions to account. Loewenson (2003) cites global debates over infant feeding, tobacco control, and access to medicines and lists the ways in which civil society organizations have intervened in global health policy to legitimise policies, mobilize constituencies, produce resources, advocate for policies and monitor their implementation. CSOs have contributed technical expertise to policy development and have made global and international policy processes more publicly accessible through disseminating information on them, and thus helped to widen public accountability around these policies.

The Indian research team comments that:

Global governance of health is shaped by multiple agencies and by multiple interest groups. Civil society engagement with global governance for health, in any systematic manner, is fairly new in India. Earlier limited to engagement with the WHO, the changing landscape of global governance for health has prompted greater civil society interest in engaging (and often challenging) different actors that influence health outcomes. Prominent among civil society groups in India that engage in global health issues are Indian counterparts of INGOs such as MSF, Third World Network (TWN) and Oxfam. Activism around access to treatment by HIV groups has also prompted actions challenging trade agreements, especially in the context of intellectual property related issues. This has been of particular relevance in the context of India's generic industry being viewed as the key supplier of low cost generic medicines to poor patients across the world. The access campaign has, in the last decade and half, grown tremendously with the association of positive peoples' networks such as the Delhi Network of Positive People (DNP+) and of lawyers' organizations such as Lawyers' Collective.

The importance of engaging with national governments in relation to global processes was underscored by all respondents to the question about global policy engagement in the Indian survey. According to one respondent, governments are often not well prepared before they leave for WHO meetings, or other global fora and sharing language with the delegation before it leaves is useful. Strategically, this respondent noted that his/her network choose participants to attend the WHA based on whether people know delegates and will be able to have access to them as the impact on the WHA is through delegates' interventions.

It has happened to us that the country delegation reads our submission verbatim at the meeting and our submission becomes part of the country position at the global level. In February or March, we have some intelligence on the delegation that will be going and entry points for dialogue. In the case of India, the position taken at WHO is not very dynamic and tend to stick to the position decided before leaving from the capital. Frustration comes when the delegation is back and there is no action or follow up. The WHO

Resolutions are not very relevant at the national level, it is important to evaluate carefully where one wants to put energy. In many ways, the bureaucracy is unpredictable. [Respondent 10]

Another respondent to the Indian survey noted that some developing countries have a capacity problem at the global level and that they welcome the support and inputs of civil society organizations. In addition, there is a convergence of concerns on certain issues that allows CSOs and governments of low and middle income countries to work together. They pointed out that this opens the space for civil society organizations and national governments to engage in policy discussions and advocacy.

For instance, we did this on access to medicines in India. India has a position against TRIPS+ at the global level, and we followed it up at the national level, by showing what the negative impacts of agreeing to TRIPS+ provisions in trade agreements would be. [Respondent 9]

The respondent also pointed out some problems faced in holding governments accountable for their positions in international fora. While the WHO comes under the Health Ministry, the issue of antimicrobial resistance may come under the Ministry of Chemicals. In such cases it is difficult to refer back to positions taken at the WHO. Also the [Indian] Cabinet does not give clearance for positions to be taken at WHO (while it does with regard to WTO for instance). "So in practice, holding countries accountable for what they say in global fora can be difficult."

If community organizations operating at the local or national levels are to become more engaged with the global forces they need somehow to be 'represented' by civil society organizations which are positioned so they can engage at the global level and networked so that they can collaborate with widely disparate community organizations in disseminating and collecting information and in coordinated action including policy dialogue at various levels.

Oxfam, Medecins Sans Frontieres, Third World Network and the International Baby Food Action Network (IBFAN) all exemplify civil society organizations which have a significant global presence and affiliate organizations in some or many countries. IBFAN illustrates a network with a strong global presence and passionate affiliates in many countries. IBFAN illustrates the kind of institutional infrastructure which is needed to inform, coordinate, and advocate with more community based organizations.

WHO does have provision for limited civil society participation in governing body debates and commonly seeks civil society input into policy development. However, several interviewees voiced warnings about the inclusion, within WHO's definition of 'civil society', of business associations and industry-sponsored (and funded) 'patients' organizations'.

WHO Watch

WHO Watch was established in 2010 with a view to strengthening civil society engagement, at global and national levels, in WHO deliberations and operations. WHO Watch was seen as the first step in a more ambitious project: the Democratising Global Health Governance Initiative (DGHG Initiative). The broad goal of the Initiative is to improve the global environment for health development by changing the information flows, alliances and power relations which frame global health agenda-setting, decision-making and policy/program implementation. This includes strengthening civil society participation in policy dialogue at multiple levels. (See [Annex 15](#) for more about the DGHG initiative and WHO Watch.)

In this section we review our findings in relation to the strategies and practices of WHO Watch

Usefulness to L&MIC delegates and to HFA activists

The WHO Watch strategy proposes that the PHM commentary and policy briefs prepared by the watchers should be useful to L&MIC delegates and to HFA activists campaigning around issues being addressed at WHO. (This relates to 'campaigning and advocacy' discussed in [Chapter 6](#).)

The interview study ([CSE and GHG](#)) found that WHO Watch is widely appreciated by CSO representatives and by some country delegates and some WHO staff. The positives for which it is appreciated include the quality of the analysis, the comprehensive coverage, the real time broadcasting including through the Twitter and Skype feeds and the daily reports.

The Watcher's memoir from Brazil ([Brazil WHO Watch Report](#)) recalls that PHM's commentaries – available in advance through internet and provided to the delegates during the meetings are useful to delegates. She recalls that several delegates, both in PAHO and WHA meetings, looked out for the watchers either to debate their content (evidencing that they had already read the material) or to ask for printed copies. It is not possible to measure whether and how the material may influence country positions but some delegates claimed that the material was an important source for them to be informed on some of the topics in the extensive agenda of the meetings. As a considerable number of delegations are formed by few delegates, it is fair to assume that several countries face difficulties in participating fully in governing body debates.

The interview survey undertaken by the Indian research team (as part of its country case study) found that, among respondents who were aware of WHO Watch, the view was that it is important. According to one (non PHM) respondent, "the analysis provided through the WHO Watch is important. It is always good to have a team from PHM at the WHA, as for us, PHM is an ally". According to another respondent, WHO Watch is an important initiative as it has a monitoring function for local civil society regarding discussions in WHO's governing bodies.

We do not have much data to evaluate the usefulness of WHO Watch in support of civil society campaigning. Some leading issues with scope for campaigning at the global and national levels include intellectual property and medicines, antimicrobial resistance, the health implications of trade agreements, and food sovereignty. In none of these cases is PHM the leading actor; there are other more specialised networks taking this role. However, PHM materials, including GHW and WHO Watch commentaries, and People's Health Assemblies are contributing to widening the constituencies that are aware of the issues, and of the global as well as local dynamics affecting HFA.

Funding and accountability of WHO

Widespread concern within civil society regarding the funding crisis of WHO, in particular, the implications of the donor chokehold, was part of the reason to setting up WHO Watch. It was hoped that closer monitoring and dissemination would contribute to shoring up support for a properly funded and accountable WHO. (This relates to campaigning and advocacy as discussed in [Chapter 6](#).)

PHM commentaries and other information products coming out of WHO Watch have repeatedly emphasized the need to lift the freeze on assessed contributions and untie the voluntary donations. It appears that in recent years an increasing number of countries and commentators are willing to make similar calls but it is hard to attribute this to the influence of WHO Watch.

Participation in WHO Watch as a pathway to activism

Part of the logic of WHO Watch was an assumption that being involved in tracking, commenting, watching and policy dialogue would provide new pathways to activism (as discussed under 'movement building' in [Chapter 5](#)).

The selection process for watchers requires a significant record in organized activism so the role of the Watch as a pathway turns on whether watchers are somehow consolidated in their knowledge base and personal commitment as a consequence of participating. It seems likely but we do not have data.

Capacity building

The design of WHO Watch also assumed that participating in the various different functions associated with WHO Watch will contribute to individual and organizational capacity building (as discussed in [Chapter 6](#)).

The [CSE and GHG](#) report confirms that WHO Watch is valued for its contribution to capacity building. Training through the pre watch workshop was highly appreciated by watchers and by other CSO representatives who participate. Some watchers suggest that deeper pre-workshop orientation would be useful, perhaps a short online orientation (such as the IPOL on GHG, see [Annex 16](#)).

WHO Watch involves capacity building at both the individual and organizational levels. It provides opportunities for health activists from different countries to learn first-hand about the structures of global health governance, to

gain skills in policy analysis and advocacy, and to explore the links between the local and the global. It builds personal networks between activists from different countries and regions.

WHO Watch also involves knowledge generation and dissemination (as discussed in [Chapter 8](#)). The item commentaries, issue backgrounders and reports coming out of WHO Watch constitute a unique stream of information about contemporary policy issues and the politics shaping their unfolding. Knowledge about the dynamics of global health governance is being disseminated through PHM Exchange, GHW, social media, and various articles and reports arising from material generated through WHO Watch.

An experienced health diplomat from one middle income country commented “We make use of the product of WHO watch very well, people responsible for the agenda are referred to the PHM website.”

Networking

Working with other civil society organizations active around WHO governing body meetings is a core element of WHO Watch, strengthening the links between PHM and other networks in the HFA movement (as considered under networking in [Chapter 6](#)).

The WHO Watch workshops clearly provide a platform for networking among civil society organizations. One of the respondents to the survey undertaken by the Indian research team commented:

Alliances with other CSOs/networks could be on the issues of public financing, with Tax Justice Network, with Jubilee South, with Global Union Federations, such as Public Services International. It could also be on private sector influence, with organizations such as Corporate Europe Observatory, Corporate Accountability International.

Personal relationships forged during in-person collaboration can be critical in mediating inter-organizational alliances. One example of networking and campaigning arose when the sugar industry, working through one member state, sought to weaken proposed dietary guidelines in relation to sugar intake. The alert was sounded through WHO Watch and PHM worked with other civil society organizations to shore up support for the guidelines (see [Sugar Saga, 2015](#)).

PHM country circles engagement with WHO Watch

It is part of the WHO Watch concept that local activists, drawing on WHO Watch experience and information, are able to liaise with government officials before governing body meetings and to influence the policy positions adopted by those countries. Likewise that grass roots activists might be able to gain leverage from information and insights from the global level to deploy in their local and national policy dialogue. There are some early signs that such engagements are feasible and the ideas were supported in principle by country delegates.

The report of the Ghana workshop ([Ghana Workshop Report](#)) suggests that the model is feasible both in terms of domestic policy issues as well as the country’s position on upcoming global issues. However, other PHM circles have been slow to engage in this way. The development of local policy dialogue in Ghana may be related to the number of Ghanaians who have participated in the Geneva based watching. We speculate that a critical mass of experienced watchers may be needed to support such policy dialogue. It may also be the case that in some countries ministers and senior officials are easier to access and perhaps more attuned to civil society perspectives.

Respondents to the survey conducted by the Indian research team commented on civil society weakness in terms of engaging with global health governance. Some respondents attributed a general weaknesses in international activism to what was referred to as "stakeholder-isation and self-silence" due to funding influences.

Another respondent (to the India survey) who has extensive international connections and on other issues is involved with JSA indicated that on international issues they bypass JSA; thinks JSA is largely restricted to the national level. The respondent did admit that though they work closely with JSA they tend to bring global issues back to the national government but not the JSA. The discussion with JSA is limited to national policies. They also noted that they have never heard a government official use a WHA resolution as a reference point and so national organizations also do not use these as tools of advocacy.

Another JSA respondent reported having heard of the WHO Watch but not really knowing what it did.

On the WHO Watch, there is not enough corresponding effort at dissemination and engagement. When the national committee meets, there should be information shared, maybe a poster to explain it. We need more understanding on the linkages between WHO and national issues. There is reasonably good job being done on this with regard of medicines, but not that good in other areas. There is also a need to champion and reflect on the space that is accessed through the WHO so that there is a greater sense of ownership - we must show how CSO are fighting against the corporate capture of WHO and the meaningfulness of the victories in this area.

According to one JSA respondent the engagement with international processes is very important because "countries are not islands." Noting that there are different pathways of engagement at the global level, they admitted that they had been unable to find a pathway of connection with global policy dialogue. On the WHO Watch, the JSA respondent stated that they knew very little about it, had little time to get directly involved and had the impression that WHO Watch only engages certain kind of constituents – viz. academics.

Activists have limited time choose to volunteer in areas where they feel most motivated to work in. Sustained engagement with global work needs some funding support for people to engage. When people choose voluntary work they choose work that is more 'organic'. If people are to be engaged in global work then specific demands have to be placed on them -- won't happen by itself as natural course for activists is to work on local issues that they closely identify with.

Several respondents to the WHO Watch evaluation ([CSE and GHG](#)) from among the watchers urged more effort to support dialogue between activism at the global level and at the local and national levels. After each Watch there should be a realistic project for mobilization and action between events.

One JSA respondent (to the Indian survey) suggested that while the WHO Watch process seems to have been useful in influencing debate at the WHO level, based on the critiques / inputs from national organizations and networks, "it may gain from more streamlined processes that feed into the international process and also feed back into national advocacy processes".

One respondent to the India survey argued that WHO Watch work in Geneva should be complemented by follow up work by local PHM circles at national level:

WHO Watch engages with issues from a few weeks (or a couple of months) before the meetings and during the meetings. The role of country circles needs to be strengthened in the sense that at the end of this engagement and as an outcome of this effort, there should be views and perspectives that are fed back into the circles, as PHM's views. The critical time for this is that in between the EB and the WHA. There should be pilot countries where active engagement takes place between the EB and the WHA, based on the outcomes of the engagement in the EB. This means that the messages that emanate from the commentary, statements, etc should be converted into a position after the EB. And this position should be conveyed to government - through mobilization, campaigns, advocacy - towards influencing a country's position at the WHA. In addition, WHO Watch only engages during governing body meetings, but important discussions also happen at other times. Instead of choosing meetings to watch, PHM should choose 2 or 3 issues and follow them in the different forums / meetings where they come up, and all the way to the ground.

Convergence

It is part of the logic of WHO Watch that giving more prominence to the common origins of various wrongs faced in different ways and places under globalization will encourage more people to work towards 'convergence' including closer solidarity, richer communication and active collaboration across boundaries (as discussed in [Chapter 5](#)).

It is plausible that WHO Watch is contributing to a wider recognition of the ways in which global forces and dynamics affecting all countries are influencing progress towards HFA albeit in different ways. It is plausible that this wider recognition is contributing to greater willingness to work more closely across issues and borders and across other boundaries. These outcomes would be hard to measure and harder to attribute to WHO Watch.

Cost effectiveness

WHO Watch is relatively expensive (in relation to PHM's budget) largely because of the cost of travel and accommodation in Geneva for teams of 8-12 watchers. The cost is not just monetary; the project also draws on PHM's limited people resources. However, the financial cost has been alleviated somewhat since an increasing proportion of the watchers are sponsored by organizations other than PHM.

Strengthening the watching of regional committees, or a permanent Geneva presence (urged by several respondents), would add significantly to the cost of the Watch. Stepping up engagement between PHM's country circles and their governments regarding issues coming before the governing bodies would also have resource implications. Other enhancements which also have a price tag would include producing the commentary in more languages and producing more accessible information products.

On the other hand it is hard to place a value on the capacity building associated with the watching experience (including the pre-watch workshop). Likewise it would be hard to place a value on the increased transparency and accountability arising from the Watch or to the more effective participation of delegates from smaller LMICs arising from their access to the WHO Watch commentary.

PHM has continued to wrestle with the challenge of making WHO Watch more 'cost effective'. One option includes reducing the number of watchers participating or even converting the Watch entirely to simply tracking and commenting. This would impact on the capacity building function and reduce the value of the Watch for many observers.

Respondents (to the WHO Watch Evaluation) noted that there are other models for civil society participation in global decision-making, citing the role of civil society representatives at UNAIDS and at the Global Fund. These are semi-permanent representatives who acquire a high level of expertise and whose participation is underwritten by donors. Kapilashrami and O'Brien (2012) have expressed some scepticism as to the role of civil society in the governance of the Global Fund for AIDS, TB and Malaria.

A further challenge facing WHO Watch is sustainability in terms of an over-reliance on a small number of individuals. Sustainability in this respect requires the replacement of key individuals with organized systems (institutionalization); this is happening but slowly.

Practical improvements in WHO Watch

Respondents (to the WHO Watch Evaluation) suggested a number of possible improvements to the Watch.

One respondent called for more real time commentary on particular issues arising during the governing body meetings.

There were also a few criticisms of the material produced during the Watch. Some respondents to the WHO Watch evaluation recalled comments that might not have been fully informed or required more careful nuancing.

One strategic issue which surfaces from time to time is whether WHO Watch should continue its practice of producing a comprehensive analysis of the full agenda or focus instead on a more limited range of issues. In favour of the present comprehensive approach is that this is what makes WHO Watch unique. However, in terms of preparing for engagement with delegates during governing body meetings, individual watchers – who are generally not very experienced in global public health policy issues – must necessarily restrict their focus to relatively few issues.

A recurring debate among the watchers has concerned the burden of note taking. Watchers see their role as lobbyists being compromised by time taken recording the proceedings. On the other hand the stream of real time documentation produced through WHO Watch has been highly appreciated among other civil society networks and by some delegates. One respondent to the Indian survey commented:

WHO Watch should better use the existing contacts in Geneva to facilitate introduction of watchers and have targeted lobbying efforts. The work load per person in the Watch appears to be too much. Note-taking

should be lightened as it sucks out the energy out of Watchers. The Skype channel allows people to see what is happening. With the webcast now, notes can be less comprehensive and only new and controversial points need to be taken down while the reports of national activities can be cut out.

Physical presence

One of the largest budget items is the cost of bringing a team of watchers to Geneva twice a year.

Divergent views are held within PHM regarding the WHO Watch presence in Geneva. On one hand there are calls to reduce the presence in Geneva; perhaps having fewer watchers or restricting engagement to tracking and commenting. One respondent argued that engagement with WHO does not require a physical presence and 'watching' these events could mean looking at the documents, having an analysis and publicising it. On the other hand there have been calls for year round engagement rather than parachuting into Geneva for the governing body meetings. A permanent presence implies a paid position which presumably could contribute to the building of personal relations with Geneva missions and Secretariat staff, which is difficult without a permanent presence in Geneva, and to improved liaison with country-based civil society organizations.

Liaison with delegates and WHO officials

Several respondents urged PHM to reach out more effectively to WHO staff as well as country delegates based in the country mission in Geneva and government officials based at home. One suggestion was to create stronger links through the Communications Office of WHO and perhaps spend more time in Geneva visiting Secretariat staff, including senior managers as well as technical officials. Developing ongoing relations with delegates and with WHO officials is also difficult because of the continuing turnover of the watchers.

One suggestion for improving the WHO Watch tracking has been to extract from the records, and make accessible through a search function, the positions adopted by different countries on particular issues. If this were to be done centrally it would require significantly increased investment in the Tracker. On the other hand, country circles could extract such records through the Tracker regarding their own government.

One proposal is that PHM country circles should approach their governments urging that civil society activists, including from PHM, should be included in their delegations to governing body meetings. This would greatly strengthen relationships with those country delegations. In fact a number of countries already make provision for civil society inclusion in their delegations.

Regional committee watching

WHO's regional committees, which generally meet once a year, are an important part of WHO's governing structures. WHO Watch has mounted a presence at several regional committee meetings and in some cases for several annual meetings.

However, this level of engagement carries additional material costs and stretches PHM's resources in terms of finance and people capacity. The opportunity costs for PHM of this level of engagement is to be measured in terms of what initiatives are not being progressed because of this investment in WHO Watch. It would make sense to strengthen the tracking and commentary components at the regional committee level before moving to physical presence (watching, intervening and reporting).

The situation regarding regional committees is not uniform. PHM is differently situated in different regions and the significance of the regional committee events varies also.

Going beyond WHO

The original vision of the Democratising Global Health Governance Initiative was that it would be progressively extended to other fora beyond WHO.

A respondent to the India survey commented that

... the UNGA is a legitimate space for global health governance too, and there are resolutions on global health and foreign policy every year. PHM should draft a resolution and push it there, see it through.

Other respondents gave examples of their work with other global processes. One spoke of involvement in the reporting work on the Convention on Rights of the Child and the preparation of alternative country reports. Another noted that there are several global fora where the health component could be followed, such as BRICS, SDGs, UNHCR, G20/G8 and the UNGA.

On the other hand in view of the limitations of WHO Watch as it stands, the costs (in material and human terms) and the debates about opportunity costs within PHM makes it unlikely that PHM would be ready to take its watching beyond WHO at this stage.

Conclusions

In this chapter we have reviewed material from the country case studies dealing with critical policy engagement regarding both domestic issues and national issues with international ramifications. These cases confirm the importance of 'critical policy engagement', policy dialogue integrated with structural critique, and of the value in many situations of aligning local activism with global power.

The second half of the chapter has focused on WHO Watch and reviewed our findings in relation to the theoretical assumptions which informed its design. These findings regarding usefulness, pathways, networking, capacity-building and convergence are suggestive but further research is needed.

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Chapter 10. Suggestions for policy makers and funders

In this chapter we summarize some messages to policy makers and funders arising from our research. The suggestions outlined below are directed to those policy makers and funders who are committed to health equity and who do see an important role for civil society engagement in working towards this goal.

CSE can be effective in moving towards HFA and there is always scope for improved practice

Civil society organizations are making a significant contribution to improved health care and creating the social and economic conditions for population health. They are strengthening the accountability of governments and service providers and they are contributing to good policy making, partly by bringing the experience of the excluded into the corridors of power and partly through the quality of their policy ideas (consider the ACIN and the ACVC case studies). They are providing leadership in communities, working directly to improve health care and to create the conditions for good health (consider virtually all of the case studies produced through this research). Globally they are

There is enthusiasm for learning from practice in most civil society organizations. Policy makers and funders can contribute in various ways to strengthening organizational learning in CSOs.

CSE is needed globally and locally

With the advent of globalization the locus of decisions which shape health care and population health is moving inexorably from the local to the national and from the national to the global (consider the impact of tax competition on fiscal resources for health care; consider the impact of extreme intellectual property protection in trade agreements on access to medicines).

Some civil society organizations, including PHM, are working to extend civil society engagement for Health for All to the global level. This is not simply a matter of having a few people with civil society credentials appointed to various boards and councils operating at the global level. If grass roots activists and community organizations are not able to make their voices heard then their 'representatives' on the boards and councils are essentially there as tokens.

CSE at the global level needs to be closely linked to CSE at the local and national levels. We have described case studies:

- of national advocacy around issues with international ramifications including strengthening local accountability regarding compliance with human rights principles and various WHO resolutions
- where coordinated CSE at the national level can help to drive outcomes at the global level, including through the governing bodies of WHO; and
- of CSE at the global level which helps to inform local and national activism.

Advice for policy makers

Civil society engagement in working towards HFA at the national and global level could be significantly strengthened through greater support from national and international policy makers. In this section we explore the ways in which policy makers and funding support could contribute to strengthening civil society engagement for HFA in relation to the five generic themes around which this research has been structured.

Organizational development, networking and movement building:

- implement practical freedom of information provisions; many of the case studies collected through the country-based research have needed access to official information which is not always available;
- protect civil rights and freedoms (such as freedom of speech and freedom of assembly); in several of the case studies collected for this research health activists have been murdered for their defence of the right

to health;

- commit to health as a right in accordance with Comment 14; in several of our case studies and other reports human rights standards have been egregiously breached by the state; Health for All depends on the realisation of the full suite of inalienable and indivisible human rights; and
- return to comprehensive primary health care including a commitment to meaningful community participation in health care delivery and action around the social determinants of health.

Campaigning, advocacy and mutualism:

- explore partnerships with civil society in policy and program development and implementation;
- be aware of the risks of cultivating the voluntary sector in health care delivery including facilitating marketization and creating barriers to establishing a publicly funded and delivered national health service.

Capacity building (individual and organizational):

- encourage educational institutions to include the provision of training for community organizations in their planning and course offerings; and
- consider the kind of cooperative training developed in El Salvador, providing the opportunity for policy officials, agency managers and health activists to come together in collaborative learning.

Knowledge generation, access and use:

- support research collaborations between activist academics and community organizations;
- ensure that there is space in academia and policy making? for research methods which value experiential knowledge, which understand the framing of knowledge in the subject position of the activist and are directed to learning from practice (such as PAR); and
- support research training in appropriate research methodologies for community groups.

Policy dialogue and engagement with global governance:

- (if you don't already) include civil society people on your delegation to inter-governmental meetings, including meetings of WHO's governing bodies;
- open yourself up to consultative engagement regarding national positions on global issues as in the Ghana model.

Advice for funders

Civil society engagement in working towards HFA at the national and global level could be significantly strengthened through greater support from funding bodies. We suggest:

- Provide core funding in support of social movement CSOs in order to strengthen the processes described in this report, which ultimately contribute to HFA;
- Be aware of the limits and risks associated with tightly specified project funding; accountability should be based on integrity, organizational learning and core directions;
- Be cautious in funding community organizations to provide basic health services because of the risks of system fragmentation; if you are funding basic on-going health system functions do it through government;
- Don't demand immediate results; movement building and organizational development take years not weeks;
- Don't impose pre-determined key performance indicators (KPIs) on projects which are essentially exploratory or on organizations working in complex and dynamic settings.

Health policy is political and activists sometimes offend powerful interests. Managing this risk (for funders and politicians) through tight contractual restrictions will greatly restrict the capacity of activist organizations. If the risk is significant there may be ways of finding intermediaries through whom such funding support might be passed.

Advice to WHO

Open up regional committees and country offices to broader and deeper civil society engagement. Appreciate the potential of richer CSE in defending the role and influence of WHO.

Chapter 11. Overall conclusions

The 1981 promise of Health for All by the Year 2000 was not delivered in 2000 and has yet to be achieved.

This is not primarily a question of policy failure. It mainly reflects the prevailing structures of power globally. The case for promoting civil society engagement in the struggle for HFA rests on the prospect of both contributing to better policy making / implementation and on changing the configurations of political power in the process.

The concept of the social movement is a useful device for exploring the role of civil society engagement in the achievement of Health for All, hence we have conceived our research into civil society engagement in relation to the 'Health for All movement'.

The Health for All movement is probably making a difference although the attribution of influence among different agents is uncertain. However, it is certain that the movement could be more effective; we can learn from our experience. This was the purpose of the research.

Between 2014 and 2018 PHM, with the support of IDRC, undertook a large multi-centre study exploring civil society engagement in the struggle for 'Health for All'. Over four years, 130 researchers in 10 countries produced 50 research reports. We structured our data collection and analysis around five broad domains of social movement practice: movement building, campaigning, capacity building, knowledge generation and engagement with global governance.

Our findings regarding movement building are summarized in eight principles emerging from our research:

- Attend to all levels of the movement: individuals, relationships, communities, organizations and networks;
- Understand the pathways to activism;
- Community building, including mutualism, is part of movement building;
- Collaborating with the State: a matter of judgement;
- Social movements have deep roots; know your history;
- Leadership is necessary but so is accountability;
- Build constructive links between the HFA movement and broader political movements;
- Convergence (solidarity, networking, collaboration) is a key objective of movement building in the era of globalization.

Campaigning and advocacy are at the heart of social movement activism. Our findings regarding campaigning and advocacy are summarized in three principles:

- Campaign strategies bring together theories of change, forms of action and contingency;
- Networking for campaigning is empowering but requires investment and compromise;
- Need to balance policy advocacy with structural critique.

Building the capacity of health activists and of civil society organizations working towards Health for All is a necessary part of movement building. However, it opens further questions about what kinds of capacity and what kinds of learning pathways. This latter question is complicated by the fact that in large degree capacity development takes place informally in the normal course of working with communities, networking, campaigning and advocating – learning by doing.

Our findings regarding capacity building are summarized in six principles:

- Beyond individuals, think relationships, think organization, think culture;
- Think of capacity building in relation to pathways to activism (understanding, hope, resilience);
- Build on informal learning opportunities as well as organizing formally structured training programs;
- Link curriculum planning to practice opportunities;
- Bringing 'body knowledge' into discourse (through popular education and 'systematization of experience') makes such knowledge available for sharing and building upon;
- Avoid expert domination: value trust, reciprocity and dignity.

Knowledges, the plural signifying different kinds of knowledges, are critical assets in the struggle for HFA. Our findings regarding knowledge generation and access are structured around three broad principles:

- New information flows can be empowering, including:
 - scientific, technical and legal knowledges, and
 - indigenous knowledges, such as Central American indigenous cosmovision, provide resources for new ways of understanding ourselves in the world.
- Producing the knowledges that the activists need is a core social movement strategy, including:
 - academic research,
 - research synthesis,
 - learning from activist practice,
 - bringing lived experience into discourse, and
 - re-appropriating history, culture, identity.
- Knowledge sharing is a core social movement strategy, exemplified by
 - Global Health Watch, but attention is needed to
 - media, methods and language, and awareness that
 - knowledge sharing is embedded in relations of solidarity and relations of power.

Our findings in relation to global governance we have summarized around two broad principles:

- critical policy engagement by social movements at the national level deals with *both* national issues *and* issues which have international ramifications
- there is also an important role for critical policy engagement by social movements directly at the global level (linked to complementary advocacy at the national level)

We use the term 'critical policy engagement' in order to emphasize the need to balance policy dialogue with structural critique; this we are referring to as 'critical policy engagement'. Policy dialogue generally focuses on explaining problems in terms of institutional failure and proposing appropriate institutional reforms. It is important to also recognize the power relations within which the structures of governance operate and to balance policy dialogue with structural critique.

We have also reviewed the implications of our findings in relation to WHO Watch and the theoretical assumptions which have informed its design. These assumptions regarding usefulness, pathways, networking, capacity-building and convergence remain plausible but further research is needed.

Finally we have extracted from the findings some principles which are of particular significance for policy makers and funders. Civil society engagement in working towards HFA at the national and global level could be greatly strengthened through greater support from national policy makers and funders. We summarize the ways in which policy maker and funding support could contribute to strengthening civil society engagement for HFA in relation to the five generic themes around which this research has been structured.

Annexes

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Annex 1. Brazil

In Brazil four separate sub projects emerged:

- a case study of social participation in the Brazilian national health system; led by PHM Porto Alegre;
- a case study of grassroots rural activism for health; led by PHM Maranhão;
- three case studies in health promotion:
 - two case studies in tobacco control: indoor smoking and tobacco advertising; led by the Alliance for Tobacco Control and Health Promotion – ACT+;
 - a case study of coalition building around public policy for healthy and adequate diets in Brazil (the Alliance for Adequate and Healthy Food); documented and analyzed through ACT+.
- a report and reflection on participating in WHO Watch.

Social participation in the Brazilian national health system

This project was carried out by a team of PHM researchers working with local academics, public health students and local organizations and other resource people. The project was centred in the city of Porto Alegre in the state of Rio Grande do Sul. The project was carried out in two stages. The first stage was a description and evaluation of social participation in two district health councils in the Porto Alegre municipality (full report [here](#)).

One of the issues emerging from this study was a perceived lack of engagement of younger people. From this emerged the project which formed the second stage of the project which was a multi-pronged engagement built upon a developing relationship between one local school and one family health care centre and animated by the local PHM activists. This project involved a wide range of activities including diverse learning opportunities (informal and organized), a permaculture project in a community garden, and a community event with the Alliance for Adequate and Healthy Food. This project is ongoing at the time of writing. The interim report is [here](#).

Waning enthusiasm for community participation through the health council structures

The central significance of the Stage 1 study, for the wider CSE4HFA project, arises from the focus of this study which was to document the perceptions of managers, health care workers and users regarding the effectiveness of two district health councils. These are local components of an iconic Brazilian initiative to support community engagement in healthcare management and public health at all levels from the local clinic to national policy.

The study found that all stakeholder were strongly in agreement regarding the importance of community participation in health, in general and through the district health council. However it also found that the enthusiasm of local communities to participate in these structures had waned significantly since their initial establishment. A range of possible reasons for this dissonance are canvassed in the report.

The reflections of the research team are particularly useful.

Concerning the representativeness of those community people who do participate, the team questions the strength of cohesion, organization and mobilization within the community which may mitigate against the informal relations of organic legitimacy. The team suggests that this points to a focus on creating and strengthening the organic processes in the core of the community itself, so that there is a collective that is closer and stronger, resulting in more effective representation.

One of the findings of the research was that one-off assemblies were attracting more people than regular council meetings. The team questions whether this reflects a weak sense that the council structures 'belong' to the community. *"The forums and assemblies seem to have bigger attendance than the council meetings, probably due to the structure (in the evening, specific agenda, regularity in accordance with demands) and for being a call organized by the community itself."*

The findings of the research include a perception, on the part of the managers, that "people do not fight anymore because there are no needs to fight". The team comments that this is a simplistic view, which does not consider the complexity of people's needs, which are real and pressing even though they may be different from what they were previously. However, it raises questions about the conditions for community agency; confidence that we, collectively, have access to levers of change and expectation that action will be rewarded by improved outcomes.

The researchers note that training courses are commonly mentioned among the strategies to strengthen social participation. However, they comment that there have been several such courses and the results either were not satisfactory or were not sustained. They call for the use of grassroots education methods to involve the users and their culture in the construction of such training.

The team calls for some scepticism regarding participation. They reflect that countries that had major conquests in the reach of "Health for All", like some countries in Europe and Canada, have not always had strong grassroots participation. They comment that the drive for grassroots popular participation places responsibility for mobilizing on the users and their community, while the macro political and economic context is increasingly oppressing.

Decent health care and attention to the social determination of health are core elements of the right to health and satisfying rights is a responsibility of the State for its citizens. There needs to be some balance between mobilizing around direct community involvement in health care and public health versus mobilizing more broadly for a political regime in which people's basic rights are attended to.

However the team comments that in the present period the community and solidary spirit is weakened. These are times of individualism and insecurity. How to strengthen this spirit in the hegemonic capitalist system? One way is the investment on the intrinsic processes of the communities, on healthy attitudes and on grassroots popular education, starting from the local level.

New partnerships across health and education and between community and academia, including a new focus on gardens and food

The broad direction of the second stage of this project emerged in the July 2016 workshop in São Luís/Maranhão when all of the Brazilian projects in the CSE4HFA project came together to report and consider the outcomes of the Stage 1 research ([workshop report here](#)). However, the second stage of the project really took shape in the

September 2016 workshop involving the research team and several of the groups they had been working with. What emerged from this workshop was a commitment to adding other/new actors into the debate around community participation in health and working with the community's youth, building on the existing Health in School Program and focusing on citizenship.

This second stage project ([report here](#)) evolved in a complex and organic way involving a series of activities which emerged out of, and helped to strengthen, new relationships and alliances. The activities included:

- a community garden project within the grounds of the school involving collective exploration of permaculture principles, ideas about *buen vivir/sumak kawsay*, medicinal plants, water and environmental issues while enacting and deepening relationships of collaboration and solidarity; and
- participation in street markets with the Alliance for Adequate and Healthy Food (see below).

These activities emerged out of a complex and organic process of new relationships, new understandings and deepening trust. In the first instance the research team built on the existing (municipal) Health in Schools program to strengthen the links between the local family health centre and the school community based in one local school. This was the initial platform but it led to new relationships with the municipal health council, with the local grassroots council, with academics at the State University of Rio Grande do Sul (UERGS), and with the Alliance for Adequate and Healthy Food.

These relationships were developed with the evolution of the community garden project and through meetings, conversations, participation in the school's Solidarity Day, filming and sharing videos, workshops around gardening (permaculture, composting, soil preparation, herbs and seasonings, etc). A significant event was a well-attended seminar in June 2017 co-sponsored by the UERGS and the Grassroots Council, focusing on population growth in the district and participatory budgeting.

This brief description does not do justice to the complexity and organic emergence of the project and readers are referred to description and photos of the interim [report](#) (the project is ongoing).

The project builds on the principles of popular education while sharply observing the wider political economic context; it works with but goes beyond the existing institutional structures; and conceives action around health in ways which are consistent with the cultures and experiences of the community (in contrast to the formal bureaucratic agendas of the district health councils).

Implications for the five generic themes of the larger CSE4HFA project

Movement building

The structures for community participation ('social control') in the Brazilian National Health Service were mandated as part of the 1988 Constitution which itself was the consequence of a powerful social movement for democratic reform. However, three decades later community enthusiasm for participating in the health councils appears to be waning.

The research team contrasts the institutional structures of participation with the increasing pressures on communities and families associated with neoliberal globalization. The team suggests that if decent health care and public health are human rights and if governments are the ultimate duty bearer then perhaps more attention needs to be paid to holding governments accountable rather than focusing too much on the capacity of local communities to hold health systems to account. The need for movement building remains but these reflections point to a more political movement perhaps not identified with health per se but driving wider reforms at the national and global levels.

The research team comments on the representativeness of the users on the health councils and links this to the organic structures, expectations, relationships which comprise community as against any kind of bureaucratic measure of representativeness. They suggest that 'representativeness' also needs to be understood in terms of alienation, insecurity and fragmentation of communities and that this throws new light on 'movement building'.

The second stage research responds directly to these lessons from the first stage. The team has worked much more closely with existing structures of community including the school community and has moved from the

bureaucratic focus of the health councils to food, gardening and relations with nature which are of more immediate interest to families and communities.

It appears that the second stage project is contributing to community building as well as movement development. The project has greatly broadened PHM's field of action locally and the coming together of new activists, allies and partnerships. The strengthening of PHM locally is a dynamic outcome of the activities and relationships developed as part of the research.

Campaigning

Reflecting on the experience of the Stage 1 project the research team reviewed the role of health councils, and in particular, the user representatives, in campaigning and advocacy. They judged that renewal and strengthening of community engagement with the health councils (as members and from outside) would contribute to more effective advocacy and campaigning.

The team comments that while they did not undertake any overt campaigning during the second stage project, quite significant actions happened, like community gardening, participation in the municipal organic market, the partnership with the Alliance for Adequate and Healthy Food, and participation in the World Food Week. Attention to high profile campaigning should not discount the social change potential of such low key actions.

Capacity building

In the context of the first stage research there were references to previous training initiatives designed to support community participation on the health councils but they do not seem to have been sufficient.

No formal training or capacity building was carried out as part of the second stage project. It was understood that the training/capacity building of the people was happening in the process of development of the project and its actions. The seminar held as part of the UERGS Outreach Project and other meetings fostered a deeper study of some topics. The team comments that they also were learning from the project, both in relation to the topics that were being worked on as well as learning new ways to make things happen (see for example the methodology employed in the September 2016 workshop described in the second stage research report).

These various learnings (building of capacity) were outcomes of the aggregation of distinct people, with distinct experiences, where everything serves as input to build a joint action.

Knowledge production and dissemination

The term 'knowledge production and dissemination' in the context of the wider CSE4HFA project refers to the production and dissemination of information resources designed to address significant gaps and barriers in the availability of documentation and analyses of particular significance to the 'health for all' and 'right to health' movements.

Against this definition the research undertaken by this Porto Alegre project is the central act of knowledge production and hopefully knowledge dissemination. The first stage research has raised important questions about the role of health councils in mediating community participation. These have been documented in the internal reports prepared as part of the project but further work is under way directed at capturing and disseminating these findings.

In the context of the second stage project not only the research report regarding the project but the research and knowledge syntheses arising from the UERGS Outreach Project also constitute knowledge production in these terms.

Modes of dissemination are clearly important including both channels and media of dissemination and also the form in which knowledge is packaged. In this context the use of audio-visual materials (especially videos) in the second stage project to document the project actions and to explain the guiding concepts, is important because it will make these ideas available to a wider audience.

The research team highlights the knowledge which has been shared regarding permaculture through the actions in the school and the community garden including the principles of agroecology and *buen vivir* and the wider political economy of food systems (drawing also on contributions through the Alliance on Adequate and Healthy Food). Much

of this knowledge has been captured in documents and videos which will be packaged and made more widely available.

Policy dialogue

The fifth generic theme in the wider CSE4HFA project spans a number of related concepts ranging from 'democratising global health governance' to 'WHO Watch' to 'policy dialogue'. The following extracts from our original research proposal clarify these links.

"The broad goal of the Democratising Global Health Governance (DGHG) Initiative is to improve the global environment for health development by changing the information flows, alliances and power relations which frame global health agenda-setting, decision-making and policy/program implementation. The principal form of action here is participation in policy dialogue at multiple levels: monitoring, analysis and advocacy at the local, national, regional and global levels."

"PHM has elected to focus on WHO, as the first stage in implementing the DGHG Initiative, through our WHO Watch project which analyzes the content and functioning of the annual World Health Assembly and Executive Board meetings and lobbies country delegations. WHO is a central agent in global health governance (GHG) and provides a lens through which the wider field of global health governance can be viewed. Building our 'watching' capacity in relation to WHO provides a firm basis for extending the project to the wider field of GHG."

"The kinds of causal chains that can be studied ... include the effectiveness of different strategies for CSE in influencing global decision making relevant to achieving HFA, and the effectiveness of different strategies which aim to create advocacy linkages between local or national level struggles and the global decision making which shape those struggles."

The different research teams engaged in the country projects and the centrally organized global projects (which comprise the CSE4HFA) have focused somewhat differently on the different aspects of this theme.

The research team involved in the Porto Alegre research comment that their activities were focused on the local scope and that they were not working with the topic of global governance.

However, there are several instances where issues arising in the context of this research have important policy implications at the national and global levels. These include:

- reflections by the researchers about the waning of community interest in the health councils (and their relatively limited mandate) and the implications for health care and community health of wider tendencies to austerity, individualism and privatisation;
- reflections by the researchers on the disappointments of structured community participation as compared to the wider political environment which guarantees (or otherwise) the right to health and holds government accountable as the ultimate duty bearer;
- the political economy of global food systems and the contradictions between globalised, corporate controlled, highly processed food systems and the opposing arguments of agroecology and food sovereignty;
- access to water via publicly owned urban infrastructure compared with the privatisation of water supply through private utilities and plastic bottles.

These issues all raise challenges for the project of CSE4HFA in terms of *"advocacy linkages between local or national level struggles and the global decision making which shapes those struggles"*.

Interestingly, several of the PHM activists/researchers involved in this local project have also taken part in "WHO Watch" events around various meetings of the governing bodies of the WHO. One of the researchers has contributed a personal report and reflection ([here](#)) on participation in three such events. This researcher is presently undertaking further research on this subject under the project titled 'Stories of global health: The World Health Organization and the cooperation with non-state actors'.

It will be useful to have further reflections from the team on the barriers to making the connections both analytical and strategic between 'local or national level struggles and the global decision making which shapes those struggles'.

Grassroots rural activism for health

The research undertaken through this project was directed to describing a movement building initiative in a rural municipality (Nina Rodrigues) in the state of Maranhão (in northern Brazil) extending over a five year period and still ongoing. The description is generated in two stages. The first is a retrospective account (put together by Raimundo Cardoso) of the initiative from 2012 to 2015 drawing on contemporary documents and current key informant interviews. The second is a contemporaneous account of the project ([here](#)) as it has evolved from 2015, drawing on current records, interviews and participant observer documentation (by Marta Giane).

The context of the initiative is described by Cardoso in his retrospective account of the early phase of the initiative ([here](#)).

Maranhão (MA) is a Brazilian state with an agrarian, large estates and colonialist heritage. Its social, political and economic development was based on the slavery of African black people who, even after slavery was abolished, remained excluded from the government services and protections. Such exclusion continued for some segments of low income social classes in Maranhão, particularly those which were geographically and culturally isolated.

The presence of large estate in Maranhão is a legacy of its history of Portuguese and French colonization. The ownership of these large estates remained within the agrarian elite, transferred from generation to generation, from the colonial times to the present. Land ownership by peasants – including rural, mestizos, mixed, gypsies, indigenous and *quilombola* workers - was not recognized by the state, in contrast to the perceptions of these rural populations, who understood, in accordance with their customs and traditions, that the ownership of the land was a result of the cultural and territorial heritage left by their ancestors, transferred from generation to generation in the rural communities.

The predominance of the concentration of formal land ownership and monocultural farming directed to serving the external market is remarkable in Maranhão, not allowing the healthy development of the rural population. As a consequence there has been a growing awakening in the peasant population of ideals of organizing around agrarian reform in Brazil. This aspiration is materialized by the MST (Landless Rural Workers' Movement), which fights for the realisation of peasant's rights and identity.

Cardoso quotes a 2009 study which describes confrontations and vulnerabilities in daily lives of the rural population of Nina Rodrigues (“... the majority of the rural population doesn’t even have access to the basic rights - education, health, basic sanitation-, resulting in a contrast with these official social indicators, which disclose little on how these populations, formed in its majority by black people, live.” This reality is still the same until the current days.

Nina Rodrigues is located approximately 113 km from São Luis, the capital city of Maranhão state. It is a largely rural area made up of settlement communities (including *quilombola*, previously landless peasants and indigenous people). These settlements were achieved through the struggles for agrarian reform led by the MST. The colonial period, the resistance to slavery and the struggle for land reform are etched in the culture and memory of the people of the region.

The nearest larger municipality is Vargem Grande, located around 9 km from Nina Rodrigues seat. There is no public transportation between the two municipalities. Service is usually provided by motorcycle taxi. The transportation of the population from the municipality seat to the state capital is carried through by private vans. However, the transportation of the population in the settlements and *quilombola* communities to the municipality seat only occurs through the motorcycle taxi service.

The families are large in the settlement communities, with a large number of children under 10 years of age, living in mud dwellings, with septic tanks and tap water from artesian wells, which usually present problems, causing long-term issues to the population, living in precarious basic sanitation conditions. At the time this project started the communities of Nina Rodrigues were also facing serious problems with alcohol and other drugs, particularly among younger people, with associated violence and insecurity.

Cardoso tells the story of this popular education initiative from the perspective of Claudenir Gomes da Silva. In 2011 Claudenir was assigned responsibility for organizing training workshops for the Fraternity Campaign, an annual initiative sponsored by the local parish of the Catholic Church. For 2012 the theme was to be 'fraternity and public health'. Claudenir and his brother were both members of the local MST and they sought the advice of local MST organizers. They were advised to seek the assistance of Sister Ani (Anne Caroline Wihbey, a religious sister with the Namur Notre Dame Congregation and also a long standing member of PHM). Sister Ani had long and rich experience in grassroots education with peripheral communities and she agreed to join the team.

In March 2012 Sister Ani, with Claudenir and Father Lucas visited several settlements in Nina Rodrigues and heard stories of "... much suffering, so many medical errors, lack of service, deaths of both children and adults that could have been prevented". Sister Ani encouraged Claudenir to encourage the people in the settlements to come together to share their experiences and to discuss what they could do to address these issues.

The leading issues coming out of these workshops: closer organization of the communities for realising their health rights; requirement of transparency and monitoring of health resources; access to information on management of the health resources; acquisition of knowledge on health rights and the SUS; choice of skilled public managers; and the need for health education in the communities.

Over the next three years monthly training workshops were organized by and for the Nina Rodrigues health team (the five core members) under the mentorship of Sister Ani. Discussion topics included: self-knowledge, the SUS, health reality, working in the community, why are there diseases, the human body, grassroots education methodology, neoliberalism, *buen vivir*, the history of the *quilombolas*, human rights and reflections on the work of the team in the communities.

From late 2014 the team started discussing the possibility of their participation in the CSE4HFA project, discussing what it might involve and learning about the global PHM movement.

Cardoso ends his account of the early year of this project in the following terms:

The successful experience of training and work of the PHM health team in Nina Rodrigues - MA will make it gradually possible to the members of the settlement and peasant communities the perception and understanding of health as a universal right, thus allowing the construction of a horizontal dialogue with the local and state management, aiming to the visibility of the main health harms and the construction of an agenda of intervention. The right to grassroots participation (social control) and equity in the access of the communities to the health system services, based on the principles of SUS, will only be possible to reach with the process of grassroots education in health.

The second report from Nina Rodrigues ([here](#), prepared by Marta Giane) draws upon document review, key informant interviews and participant observation and brings the story up to September 2017.

During this time the regular meetings of the health team continued, increasingly identified as Nina Rodrigues PHM (NR/PHM) although still with strong links to the local parish. However, while the focus in the early years was on training of the health team in recent years there has been a stronger emphasis on working with the communities of Nina Rodrigues.

One of the continuing themes of the health team (NR/PHM), in its own meetings and in meetings with the communities has been how to be closer to the municipal management, aiming to demand improvements in the public infrastructure for the population. Above all, aiming to mobilize and to create strategies for the engagement of the civil society in relation to the access, the health care, the action on the social determination of health and the collective participation within the spaces that debate public policies in the local and municipal scope. From 2016 there have been two members of NR/PHM on the municipal health council.

In these later years the style of work with the communities has also changed, from relying mainly on home visits to community meetings. Giane's report includes details of several community meetings held in 2017. Some of the themes of these discussion included:

- The history of fight for land and for the good quality of public policies was reviewed, showing that the water system only exists there because it was implemented and kept by its inhabitants. It was also

mentioned the creation of the team and the arrival of PHM in the municipality, as well as its commitment with the people.

- The only health care centre that exists in Palmares was built by the community itself in partnership with the children ministry and UNICEF; the presence of the public power is quite distant from the real needs of these towns; recall the conquests happened with the land rights fight, achieving recognition of the ownership of their lands in the settlements where they live. They mentioned the importance and valuation that they assign to home remedies, healers and midwives, quite present in the community.
- The need of renewal of the community leaders, as well as the more effective participation of the youth in the collectivity. To demand for the conclusion of the multisport court of the town, that was interrupted a long time ago. That the community needs to occupy more the school space, to fight for a health centre, since there is none there. To fight also for the environmental preservation, as there is an increasing deforestation of the edges of the river, besides too much garbage in the community.

Several of the members of NR/PHM are keen gardeners and environmentalists and Giane's report includes reference to a range of environmental initiatives.

Giane's report notes some of the barriers and challenges faced by NR/PHM. These include:

- tensions between the Catholics and the Evangelicals;
- national economic difficulties and budget cuts;
- the cost of travel and transportation;
- poor internet and mobile phone coverage; and
- the ongoing work and family commitments of the volunteers in the Health Team - NR/PHM.

Implications for the five generic themes of the larger CSE4HFA project

Movement building

MST legacy. The NR/PHM Health Team is building a movement for health development in the NR municipality. The focus on health builds on the legacy of the struggle for land rights led by the MST. Cardoso comments that community experiences from the struggle for land rights are remembered in the names of the settlements of NR.

Capacity building. The training of the health team (see capacity building below) and support for the community education and mobilization undertaken by the team have been critical.

Networks of support. An important asset for the NR/PHM has been the support of elements within the Catholic Church, in particular Sister Ani and Father Lucas and the support of local academics such as Raimondo Cardoso who comes out of the NuRuNI project of the UFMA (Outreaching and Research with Rural, Black *Quilombola* and Indigenous Population and Communities Nucleus (NuRuNI), linked to the MSc in Health and Environment of the Federal University of Maranhão, UFMA). Likewise the links to PHM activists from elsewhere in Brazil, elsewhere in Latin America and elsewhere around the world (in particular through the July 2016 workshop, the visit by Dr Mariana from Bologna, and the support of Marta Giane from Belem in the second stage study) has emphasised that the NR activists are not alone.

Campaigning

High profile campaigning has not been part of this project although the NR/PHM Health Team has a clear objectives about improving the standard of health care to the communities of NR and addressing the social and environmental challenges those communities face. Rather than 'campaigning' it seems that the team has supported families and communities in thinking through and acting on their own priorities.

Capacity building

The training that Sister Ani has supported has been critical in supporting this initiative, growing confidence, knowledge, skills and relationships. She has emphasised Freirean methodology including learning centred on experience and consciousness raising. She has mentored members of the team in relation to their community work.

A particular feature of this training has been learning while doing and reflection on experience. The opportunity of sharing and reflecting with outside supporters has also been important. Members of the health team also participated in a number of meetings in São Luís including the July 2016 meeting of PHM Brazil ([report here](#)).

Knowledge production and dissemination

This research is knowledge production and in some degree builds on earlier research. The reports prepared for this research have been circulated locally and will provide a further basis for reflection and learning.

The production of knowledge resources does not have to be in academic form. The photos in the two reports also capture knowledge in practice. Sister Ani's personal notes provided key resources for the reconstruction of the history of this initiative.

Perhaps the lesson here is about documentation of activist work to support reflection, sharing and learning.

Policy dialogue

Policy dialogue has not been a central feature of this story although NR/PHM is starting to build advocacy and dialogue with local health system managers. However, the main challenges are seen as local and national and policy dialogue which addresses global issues have not been so prominent in this story.

Nevertheless, global forces are very much in evidence if the question is asked. The large estate managers are part of global supply chains which are part of corporate globalized food systems. Corporate dominated food systems do not make space for small farmers or agroecology. The global perspective is therefore clearly evident in the discourse of NR/PHM, in particular, through the repeated references to *buen vivir*, which has direct implications for food sovereignty and agroecology.

Likewise the transnational mining giant Vale is a dominant influence in Maranhão and there have been recurring clashes with indigenous and *quilombola* communities over exploration, mining and transport infrastructure. While mining does not feature prominently in this story questions about neoliberalism do appear in the reports of the health team training.

Case studies in coalition building

Two research reports have been prepared by personnel associated with ACT+ (the Brazilian Alliance for the Control of Tobacco Use and for Health Promotion). The first of these Civil Society Engagement for Tobacco Control in Brazil is a retrospective reflection on two key campaigns around tobacco control: smoke free indoor spaces and banning tobacco advertising. This report is prepared by Paula Johns and Mônica Andreis. The second report provides a chronological account of the establishment of new coalition – The Alliance for Adequate and Healthy Food in 2016 and 2017 and a summary of achievements in the first year of operation.

The work of ACT+ in tobacco control

The tobacco control case studies ([here](#)) are based on document analysis, a key informant group interview and eight key informant individual interviews.

The Framework Convention on Tobacco Control was finalised by WHO in 2003. ACT+ was formed in 2006 as a coalition of academic, professional and civil society groups with a mandate to drive the implementation of the FCTC in Brazil, in particular to counter the opposition of the powerful Brazilian tobacco industry.

In 2000 Brazil adopted legislation banning tobacco advertising in the mass media. In 2011 this advertising ban was extended to ban advertising at point of sale, except the display of products. Through the same law the Congress mandated smoke-free closed spaces.

At the time this report was prepared there were two bills before the National Congress further extending the ban to sponsorship, display and plain packaging. The ACT+ network has been actively campaigning around these issues since it was formed in 2006.

ACT+ campaigning has involved:

- networking, mobilization and the development of partnerships;
 - networking across sectors such as health, law, gender and environment;

- networking between civil society, academia, the media and government;
- conducting research and policy analysis and disseminating technical, scientific and policy-focused resource materials;
- formal advocacy training;
- direct lobbying of parliamentarians and government officials; and
- continuing media advocacy and media liaison.

The Alliance for Adequate and Healthy Food

The second report ([here](#)) provides a chronological account of the establishment of The Alliance for Adequate and Healthy Food from 2016 and a summary of achievements in the first year of operation.

A 'task force' around food had been created in 2014 but this included government representatives and a need was perceived to create a coalition outside government so that it could advocate to and put pressure on government.

The report traces the development of the Alliance through setting objectives, negotiating a manifesto, adopting a name, advocacy training, training in strategic planning, sharing and trust building, mapping (and respecting) work being undertaken by different members, developing a governance structure, priority setting (for the Alliance)

Among the priority issues for political advocacy identified were: human right to adequate and healthy food, taxation of sugary drinks, labelling, marketing, conflict of interest, the school environment and agrotoxics. It was decided to develop a program of action around the school environment.

The report does not describe the financing arrangements for the Alliance.

In conclusion the report cites the following as achievements in the first year:

- a. progress of the legislative proposals selected by Alliance
- b. level of participation of coalition members in the discussions, meetings, public hearings and other regulatory process.
- c. quality and quantity of media coverage
- d. public opinion and participation in social debate and social media campaigns
- e. higher monitoring and interference of the F&B industry in our advocacy actions

Reflecting on the five generic themes

All five of the generic themes of the CSE4HFA research are evident in the work of ACT+ and the Alliance for Adequate and Healthy Food.

Movement building

Networking was a big feature of both of these two stories; networking across academia, professional organizations, civil society and government and building understanding and trust across participating organizations. The story about the Alliance describes the processes involved in bringing different organizations together; negotiating shared objectives and agreed governance arrangements; emphasising respect for the existing programs of work (and the brand) of participating organizations; sharing and trust building.

Campaigning

Both ACT+ and the Alliance are explicitly campaigning and advocacy vehicles. They adopt specific policy targets including sometimes suggested legislative text. They develop a mixed package of strategies to achieve explicit objectives: direct lobbying, media advocacy, working at different levels, challenging the corporates.

Capacity building

Capacity building was an important part of both stories but it tends to be quite instrumental practical training including training in advocacy and strategic planning ('theory of change' methodology).

Knowledge production and dissemination

Both ACT and the Alliance are producing a range of technical and advocacy publications (drawing on academia and other organizations for science, epidemiology, and policy analysis) and making them available for download and for informing specific campaigns.

Policy dialogue

Policy dialogue has played a central role in both campaigns, both in private and through the media and at different levels, from local institutions to federal government.

In both cases, tobacco control and food, there was a clear articulation between local and national policy dialogue on the one hand and global dynamics on the other. Local global policy dialogue is not mentioned in the case studies but several of the participating organizations are active at the global as well as the local and national levels.

Participation in WHO Watch

This is a report ([Brazil WHO Watch report](#)) prepared by Mariana da Rosa Martins who as an undergraduate public health student participated in WHO Watch through a number of governing body meetings. She describes her involvement, first as part of a virtual support group for the onsite watchers in Geneva at the 67th World Health Assembly in May 2014; second, as a watcher in Washington on the occasion of the PAHO meeting (DC53) in September 2014; and third at the 136th meeting of the WHO Executive Board (EB136) in January 2015.

This report has contributed to the analysis of Policy dialogue and governance presented in Chapter 8.

Annex 2. Colombia

In Colombia five universities were involved in the Civil Society Engagement project through a formal collaboration agreement. Two research teams were created, both involving professors, graduate teaching assistants and students pursuing a masters or PhD. This strategy was adopted on the basis of the common interests between students and professors in supporting the PHM action research project and studying the relationship between civil society and health development.

The Colombia project comprised:

- a Stage 1 research phase focused on documenting nine case studies of civil society engagement in health development (summarized below);
- a Stage 1 report ([ES](#), [EN](#)) including reflections on the implications of Stage 1 findings for the five central themes of this research;
- a review and planning workshop ([ES](#), [EN\(G\)](#)) leading to
- a new Stage 2 capacity building pilot project (proposal here: [ES](#), [EN\(G\)](#)) with three consultation reports and a final Stage 2 summary report ([ES](#), [EN\(G\)](#)).

Stage 1

The Colombian Stage 1 synthesis report ([ES](#), [EN](#)) describes the research arrangements; provides a review of theoretical and methodological resources drawn upon in documenting and analysing the case studies; describes the national context within which the various struggles documented in the case studies have taken place; and provides an analysis of the lessons from the nine case studies for the five themes of the CSE4HFA project.

The conclusions of the Colombian teams regarding the five themes are not reproduced here; they are clearly set out in the Stage 1 synthesis report and are further discussed and referenced under the relevant chapters of this report.

The nine Stage 1 case studies are available in Spanish (see links below and in [Table 1](#)) and are summarized briefly in this annex in order to give non-Spanish readers a sense of the material out of which the conclusions of the synthesis report have been drawn.

Nine case studies were documented by the Colombian team:

1. [ACIN](#): *Asociación de Cabildos Indígenas del Norte – Association of Indigenous Councils of the North*,
2. [ACVC](#): *Asociación Campesina del Valle del Rio Cimitarra - Peasant's Association of Valle del Rio Cimitarra*,
3. [ASOTRECOL](#): *Association Of Extrabajadores Enfermosof Colmotores – Association of Sick Former Employees of Colmotores*,
4. [EPLS \(lite\)](#). *Escuela Popular de Salud - People's School of Health*,
5. [LGBT](#) in Cali,
6. [MNSSS](#): *Movimiento Nacional por la Salud y la Seguridad Social - National Health and Social Security Movement*, ([in press](#))
7. [ACVC \(women's direction\)](#): *Asociación Campesina del Valle del Rio Cimitarra - Peasant's Association of Valle del Rio Cimitarra*,
8. [ZRC](#). *Zona de Reserva Campesina del Valle del Rio Cimitarra - Peasant Reserve Zone of the Cimitarra River Valley*, and
9. [HSJ](#). *Trabajadores del Hospital San Juan de Dios - Workers of San Juan de Dios Hospital*.

1. ACIN: Association of Indigenous Councils of the North (in full in Spanish [here](#))

This case study provides a history of the struggles of the Nasa people in the Department of Cauca (particularly in the North of the department) for their right to health in the context of their social, cultural and political rights generally (in particular land rights).

The case study first provides a quick tour of the development of the indigenous movement and how the struggle for health came into its political platform; the second part outlines the processes and internal organization of the movement, the decision-making and forms of struggle; the third part presents the potentialities and difficulties perceived by the members of the indigenous movement for the achievement of the right to health; and finally the last part reviews the results obtained in this struggle.

The achievements are discussed in five sections:

- consolidation of a platform of unity in the struggle for indigenous rights including land rights, cultural integrity, political autonomy and the right to health;
- knowledge management and capacity building: sharing and valuing indigenous cultural heritage; communicating indigenous perspectives to other political actors, nationally and internationally; understanding the indigenous struggle in the context of the struggle for human rights in Colombia generally;
- political positioning in the national health agenda and the development of a regulatory framework: including consultative mechanisms; recognition of indigenous traditions in health and the principle of interculturality; legal guarantees of self-determination, including in health;
- the development of indigenous health care institutions (both insurer and provider) as the base for the guarantee of health in the community;
- the importance of indigenous health personnel:

Without a doubt, one of the main achievements in health is having indigenous community health personnel, who operationalized SISPI [traditional health understandings and practices and the principle of interculturality] on the ground; these are the people who day by day invigorate the health process in all the components and are recognized by the community and by the authorities.

[This struggle]... has made visible the indigenous movement of Cauca as one of the stronger movements at national and international level and that through their struggle has left their mark and their shared knowledge in different spaces have allowed other peoples to take this process as an example.

2. ACVC: Peasant's Association of Valle del Rio Cimitarra (in full in Spanish [here](#))

This case study provides a close examination of the processes of colonization, resistance and community organization over the last three decades through the experience of the Campesino Association of the Cimitarra River Valley (ACVC), a peasant organization immersed in the struggle for land and livelihood in the Middle Magdalena region of Colombia, a region which experienced one of the most bloody scenarios of economic, social, political and armed conflict in the country.

The analysis presented seeks to understand the dynamics and ways of representing the health-disease-care process within the framework of the *social determination* concept of the Latin American critical epidemiology, through the experience contributed by the organized rural community in the ACVC. Two questions are asked: first, how are the subaltern groups and classes organized around their needs in relation to the health-disease-care complex and secondly, what determines the existence or not of conscious and

strategic actions by the State, in the form of public health policies and sustained institutional actions, for Colombian rural people?

The case study provides an overview of the configuration of rurality in Colombia and in particular in the Middle Magdalena region and Valley of the River Cimitarra. Secondly the study seeks to 'systematize' the organizational experience of the ACVC; to discover within it the internal understanding of its conceptions and disputes in relation to the production and distribution of health; to understand their shapes through organization and mobilization and the lessons learned from the actions, the errors, scopes and projections after the evaluation and criticism process. (The "systematization of experiences" is a qualitative research methodology what seeks to reconstruct experiences, privileging the knowledge and the point of view of the builders of the action.)

In the first section the study locates the Cimitarra River Valley as a region where the logic of the prevailing (global) capitalist regime confronts a logic of small traditional farming communities. Colonisation and displacement is confronted by peasant resistance. As the regulatory instruments of the state are stalled by peasant resistance the displacement project is taken over by military and paramilitary forces.

The implications for health and health care of the ongoing conflict are profound. The study cites the role of traditional midwives as the only service available for birthing under pressures of violence and displacement. Likewise communities cut off from institutional public health services have had to rely on traditional knowledge regarding the vectors of malaria and leishmaniasis. In addition to the conflict other health implications arise from exposure to mining with sexually transmitted diseases, alcoholism, prostitution, destruction of peasant culture, increasing exposure to unhealthy ecosystems through the use of mercury and contamination of the aquifer, and junk food.

From here the case study moves to a chronological account of the various struggles of the peasants of the Cimitarra Valley from the 1980s onwards, including the displacements driven by the army and the paramilitaries through murders, arbitrary detention, largely directed to clearing the land for miners and ranchers. Under these circumstances the community established its own structures of governance and regulation including conservation, schools, food distribution, and self-protection.

The ACVC was formed at a large clandestine conference in 1993 and the association was active in community organizing and mobilizing around peace and security. One important outcome of engagements around human rights at this time was the Program of Development and Peace of the Middle Magdalena which included declaring the Cimitarra River Valley as a peasant reserve zone (ZRC). The program also involved community assemblies, support for small farmers and environmental initiatives.

However, by 2003 the ZRC was suspended and there was an increase in paramilitary activity directed at freeing up new territories for mining. Amidst the attacks, fear and displacement there was a coming together within the communities around production and survival. In 2005 the ACVC created a new vehicle, for demanding rights and social investment, called the Communal Platform for the Dignified Life. In the same year the ACVC promoted the establishment of a Popular Training School to support organization and mobilization and other communication modalities.

By 2009 the tide was turning and in 2011 there was a major gathering of indigenous, peasant and Afro-descended communities for land and peace and in the same year the ZRC was revived and a program was initiated to address problems in "in twelve sectors: human rights, economic development, environment, health and basic sanitation, land and territory, organization and participation, mining, rural women and gender, infrastructure, education, agroecology, culture and communication". Since 2012 there has been progress on a number of these fronts.

A major step was the establishment of COMUNALPAZ (Cooperativa Multiactiva Nacional por la Paz) directed to strengthening economic solidarity in the peasant sector including pursuing the principles of agroecology and the goal of food sovereignty.

A presentation based on the ACVC case studies is summarized in the report of the Colombian Workshop 160902 ([ES](#), [EN](#)). The synthesis report from the Colombia team draws a range of important implications from the ACVC experience for the CSE4HFA project. We return to these in the thematic chapters of this report.

3. ASOTRECOL: Association of Extrabajadores Enfermos of Colmotores – Association of Sick Former Employees of Colmotores (in full in Spanish [here](#))

This case study concerns employees of the Colombian subsidiary of General Motors, Colmotores, who have suffered musculoskeletal injuries through their work with the car manufacturer/assembler but were discounted by the company doctors, denied injury compensation payments and subject to bullying and intimidation until they resigned. The case study describes the formation of ASOTRECOL and the advocacy over several years to receive compensation entitlements. They deployed official complaints, legal action, rallies, sit-ins and hunger strikes (including at the US embassy in Bogota and on one occasion in Detroit) among other strategies. They lobbied US politicians and US unions and were successful in having workers' rights recognized in the free trade negotiations between the US and Colombia. The lobbying extended to the ILO in Geneva.

The case study documents as background the changing dynamics of global car manufacturing and assembling and the progressive speed up of these processes associated with technological and organizational change. It also traces the impact of changing employment practices with flexibilization and union busting.

The ASOTRECOL advocacy was ultimately successful and as members' entitlements were progressively realized the number of members of ASOTRECOL diminished.

A presentation based on the ASOTRECOL case studies is summarized in the report of the Colombian Workshop 160902 ([ES](#), [EN](#)). The case study provides useful reflections on the five themes of the CSE4HFA project which are further developed in the Colombia synthesis paper and have informed the relevant chapters of this report.

4. EPLS: Escuela Popular de Salud - People's School of Health (in Spanish [here](#)¹⁷)

The Medellín EPLS was first presented in 2014. The case study included in the Colombian project was prepared after the third presentation of the course in 2016. A fourth presentation was planned for 2017.

The EPLS is co-sponsored by the Antioquia Intersectoral Platform for the Fundamental Right to Health, the Guillermo Fergusson Group and the Right to Health and Social Struggles for Health in Colombia project of the National School of Public Health and the Faculty of Communications of the University of Antioquia and is presented through the University of Antioquia Extensions Department.

The purpose of the EPLS is to strengthen leaders in health of the city of Medellín drawing on popular education principles and to support research into the *systematization of experiences*. This project was called *Collective construction of the right to health: an initiative in popular education*.

The case study includes five chapters which:

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1. Present the participating organizations and the main practices of the School;
2. Describe the theoretical approaches and pedagogical practices developed;
3. Addresses the exercise of tutorials as a novel element of this version, its components and meanings;
4. Presents the achievements and limitations of the process; and
5. Collects our reflections from an exercise of lessons learned.

The experience of the EPLS is nicely presented in the case study. It is analyzed further in the Colombian synthesis paper and has informed Chapter 5 of this report on Capacity building.

5. Construction of Citizenship in Health in the Framework of the LGBT Movement in the City of Cali (in full in Spanish [here](#))

This is a study of the experience of LGBT people in the city of Cali considered in relation to different constructions of citizenship.

The study is based on in depth interviews (six leaders of LGBT activism in Cali), semi-structured interviews (five senior officials in city institutions involved in implementing policies aimed at LGBT population) and document review.

The results of the study are set within the history of activism and public policy around LGBT populations in Cali and the Department of Cauca. Major events and issues in terms of activism and public policy include:

- emergence of activist organizations in the 1970s;
- decriminalisation of homosexuality in the 1980s;
- the emergence of AID/HIV as a focus of concern for both gay men and public health officials in the early 1980s;
- the availability of treatment from the mid 1990s and the involvement of pharmaceutical companies including sponsorship of gay organizations;
- formal agreement between LGBT organizations and the Department of the Cauca Valley including a guarantee of enforceable rights of LGBT people;
- international support (from the Global Fund) for gay organizations including training opportunities;
- continuing violence against LGBT people including multiple homicides;
- continuing perception among LGBT people of discriminatory treatment by health services.

Considering these experiences against the different conceptions of citizenship and human rights highlights continuing discrimination (community and institutional) and public policy which is perceived as focused on controlling risky bodies rather than realising human rights including equal dignity.

While the authors of this case study do not address the five themes of the CSE4HFA project, the Colombian synthesis paper draws extensively on this case study in relation to several of these themes and they are further discussed in the relevant chapters of this report.

6. MNSSS. Movimiento Nacional por la Salud y la Seguridad Social - National Health and Social Security Movement¹⁸

The Colombian Stage 1 Synthesis Report provides a history of health policy reform from 1993 to the present, focusing on the debates and laws around the funding arrangements for health care (in particular the SGSSS - System General for Security Social in Health).

This paper builds upon and complements this history with a focus on civil society engagement in the policy debates and political confrontations around the development of the SGSSS. The paper is based on document analysis, informed by the familiarity of the authors with these events.

The paper identifies four periods in the development and engagement of the social movement for health; briefly summarized these are:

1. 1998-2001: The transformation of the health system under structural adjustment, health sector reform and economic crisis; the birth of the social movement for health; including the
 - a. influence of the Latin American School of Social Medicine;
 - b. National Movement for Public Health;
 - c. the Colombian Platform for Human Rights, Democracy and Development (2000);
 - d. the Campaign for the Right to Health (2000);
 - e. the National Congress for Health (October 2001);
2. 2001- 2004: Continuing crisis in health care; continuing market reforms; building the movement for health in local settings (Bogotá, Medellín, Middle Magdalena, Cali); widening use of popular education; movement building based on affection, trust and solidarity;
3. 2004-2010: Deepening health sector reform (with retrenchments, anti-union violence, political repression); deep divisions within the movement for health over whether to participate in policy debate around health financing; transiting from the period of conflict and fear to the reconstruction based on trust; then Uribe's state of emergency provokes fierce protests; beginning of coming together again of the movement for health, rebuilding trust;
4. 2010-2015: Regrouping of the movement for health; moving towards movement unity around 'Health for All' (universal, publicly funded and provided, equitable and participatory health care); governments persisting with market model; growing sense of shared identity across various organizations and movements around of health as human right.

The authors reflect on the lessons from this history. The lessons they draw include:

- the significance of outrage in stoking activism, when people realize that their misfortunes are breaches of a fundamental right to health;
- cultivating exchange and discussion across different social actors with different origins, histories and priorities;
- linking local actions to a shared unifying platform;
- need for material resources to support organization;
- importance of popular education in raising awareness, politicising the debate, building relationships;
- managing relations with opposition politicians, political parties and governments;
- recognizing the power of neoliberalism in government but that some wins are possible.

The paper ends with three challenges for movement building:

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- reveal with greater force the inequalities and iniquities existing in health, deepening outrage as a fundamental driver of mobilization;
- expand the political agenda to allow collaborations with other movements and to move into more comprehensive struggles;
- renew and innovate the repertoires of action that allow more people to feel touched and attracted by the ways in which health demands are made and that better understand the content of the proposals that are made.

These lessons and challenges are taken up in the Colombian synthesis paper and also inform the thematic chapters of this report.

7. Peasant women and their contribution to the health for their communities. The case of the Campesino Association of the Cimitarra River Valley (ACVC, *Asociación Campesina del Valle del Rio Cimitarra*) (in full in Spanish [here](#))

One of the most serious problems of the health situation of the Colombian population is that of rural populations. Women are taking an increasingly prominent role in the struggle for their rights, those of the communities and, in particular, those of health.

This case study was directed to exploring how rural women through the Campesino Association of the Cimitarra River Valley (ACVC) are contributing to the achievement of health for their communities.

The Peasant Reserve Zone of the Cimitarra River Valley (ZRC-VRC) includes the municipalities of Yondó and Remedios (Antioquia), Cantagallo and San Pablo (Sur Bolívar). Like other rural areas of the country, this area has been characterized by a serious historical health situation that coexists with a condition of structural rural poverty including lack of access to public services as housing, health and education. This reality has been grounded in an unjust structure of tenure, use and distribution of the land and in a lack of guarantees on citizens' civil, political and social rights.

Systematic violence across the territory, together with the neglect by the state, forms a panorama in which the control exercised by multinationals, landowners and other actors over natural resources and land is remarkable. The advance of the mining industry and monoculture agribusinesses destroys biodiversity and rivers, the main sources of water for human consumption in the region. According to a report by the Peace Brigades International (PBI) for the year 2011, in the Cimitarra region, the land problem is centred on the tendency toward a concentration of ownership of land. The exclusion of peasants generates a change in agriculture towards the *desagriculturización* which leads to a food crisis.

In the Reserve Zone in particular, the population suffers from the absence of, and abandonment by, the state with a weak network of services and little or no availability of medical personnel. For diseases and conditions such as leishmaniasis, malaria, dengue, tuberculosis, respiratory diseases, bites of poisonous snakes, prenatal check-ups, births and accidents to be attended by health personnel, the inhabitants of the area will face high transportation costs and the long geographical distances to reach the health centres located in the municipal capitals.

Likewise, they suffer from lack of power, housing, safe and nutritious food, drinking water and basic sanitation resulting in a high prevalence rate of parasitic diseases in the population, in addition to the fact that acute diarrheal disease continues to be a cause of mortality in the ZRC, all part of the causal chain that accounts for a context of inequality and inequity. The health and sanitation conditions in the ZRC-VRC fundamentally require a comprehensive health care and a basic sanitation program concentrated in the construction of habitat conditions and decent housing.

The peasants' stories collected through the research for this case study reveal how the communities organize themselves to respond to the lack of health infrastructure and lack of permanent medical assistance in the area. The role of women in the management of individual, family and community health is critical. The women also work in agriculture including domestic livestock and, in the area where there are gold mines, some work as scavengers from the mine tailings and / or sweepers. Women also participate in the meetings for community action and in different community organizations in the village and / or in the region, not always with complete support from their partners.

This case study of the women of the Campesino Association of the Cimitarra River valley reveals how they have been developing their own actions for health.

This is a very rich case study with implications for all of the main themes of the CSE4HFA research but the authors have not drawn out those implications in this report. However, the Colombian synthesis and overview paper has systematically reviewed all of the Colombian case studies and has drawn out their implications. These have also been transferred into the relevant chapters of this report.

8. The Peasant Reserve Zone (ZRC) of the Cimitarra River Valley, a strategy in the search for the achievement of food sovereignty and the right to food for the peasant communities of Middle Magdalena ([ES](#))

This study explores the significance of ZRC in the Cimitarra River Valley in the Colombian Middle Magdalena, a region that has been the stage of repeated mobilizations by peasants and workers in defending of their rights. The focus of this study is on the way in which this territorial order has contributed to the achievement and defence of food sovereignty for the peasant communities of the region. It is an interpretive narrative largely based on secondary sources.

The study reviews the struggles over land tenure with peasants pitted against latifundia and mining and oil companies and the several massive mobilizations of peasants which initially led to the declaration of the Peasant Reserve Zone. The study reviews also the repeated periods of conflict including the period during which the ZRC was suspended.

Nonetheless the ZRC emerges as a very significant victory for the peasant communities and one which is enabling steps towards successful small farm agriculture, food sovereignty and improved nutrition among the communities in the ZRC. The study notes the influence of agroecology principles on farming practices in the region, including taking a position against the introduction of palm plantations. The study notes the tentative links with institutions of the state providing technical advice to the farmers, although this process has a long way to go.

This study has deep implications for our generic themes including in particular campaigns (and the achievement of the ZRC) and capacity building (and the deepening of the theory and practice of agroecology). The Colombian synthesis and overview paper has drawn attention to further implications arising from this study and these have also been transferred into the relevant chapters of this report.

9. Invisible Struggles: the Resistance of the Workers of San Juan of God Hospital (in full in Spanish [here](#))

Saint Juan of God Hospital was one of the most important research, educational and medical institutions in the history of Colombia. Its closure in 2001 brought with it the "dismissal" of thousands of employees and the loss of a major source of health care for the people of Bogota. Despite its history the hospital was unable to generate the needed revenues in the marketised health insurance system and government funds to make the difference were lacking.

Over the next years, from 2001 to the present hospital workers and local community activists have occupied, defended and prevented the obliteration. In the process of this struggle they have accomplished important legal conquests and achieved local and national recognition.

This case study is the story of the resistance of the workers and community based on interviews and document analysis.

The processes of resistance and collective action involved of social and union organizations, collectives, professionals, academic institutions, ordinary citizens and activists. In the period 2012 – 2015 the local government sought to address the claims of the hospital and its employees, through the purchase by the District for a partial reopening a primary care service and to progress the payment of workers entitlements (although these initiatives were again at risk with the change of mayoralty in 2016).

The processes of struggle and resistance leave sequels which mark the activists, not only the sacrifices in social and economic terms but also for the stresses on families with separations, consumption of drugs and damages to mental health, the inability find return to their vocation, among others.

To these consequences have been added the stigmatization and rejection promoted by the media and the business sector, which have generated consequences for the San Juan workers such as the denial of new contracts, insults and comments on the streets, as well as the hurt to the good name of each of the workers and the constant threats against the life and integrity of the leaders of the groups and collectives. These attacks have not weakened the workers' persistence, but it has forced them to adapt their strategies.

The case study includes reflections on several of the generic themes of the CSE4HFA which have been picked up in the Colombian overview synthesis paper and transferred into the relevant chapters of this report.

Stage 2

Following the completion of the Stage 1 case studies the team held a three day workshop (2-4 Sept 2016) to review their findings and plan for Stage 2. Participants came from the four regions where the case studies were based, plus the participating universities, with two delegates from Brazil. The case studies (above) were reviewed with a view to identifying strategies to strengthen the movement for the right to health in Colombia.

The report of the workshop (in Spanish [here](#); in Google English [here](#)) includes brief summaries of the case study presentations (of the cases above) and an overview of the theoretical resources drawn upon in those studies.

The workshop participants recognized that the struggles for the right to health described in the case studies are ongoing and that Stage 2 of this project should be focused on supporting them.

Participants worked in regional groups (Cauca Valley, Bogota, Medellin, and Valley of the Cimitarra River) and reported in plenary on their responses to four questions:

- What are the most important regional challenges?
- What actions should we take to reduce the impact of those challenges?
- What is missing from the national movement for the defence of the health of Colombia?
- What is (or should be) the role of the global People's Health Movement (Movimiento de Salud de los Pueblos or MSP)?

The report summarizes the highlights of the final plenary discussion. There was enthusiasm for the possibility that MSP might play a role in supporting and bringing together the various struggles around the right to health. However there was concern at the prospect of forming yet another organization in the presence of so many existing organizations. Out of this discussion emerged the idea of a network, a 'political mobilizing platform', a 'permanent encounter', that would bring the different organizations together and support them in their own local works. It was proposed to work under the flag of the MSP but from the already constituted organizations.

The discussion gave close attention to the contemporary Colombian context and the processes of peace negotiations between the government and the insurgency with a view to a political solution to the long armed conflict in Colombia through the so-called Havana Agreements. This was considered to be a nodal issue. Included in the Havana Agreements was the proposed national plan for rural health which was seen as an opportunity to promote the design of an approach to health that effectively meets the needs of everyone. However, it was seen that the struggle for health could not be separated from the struggle for a more democratic and inclusive country. It was considered that a network should be promoted that can support various initiatives, that diversify the strategies for the construction of a common social and health project, that effectively allow the construction of peace in Colombia

In this context the participants recognized the importance of the existing systems of health care in the rural and contested regions and of community work around the social determination of health which had been documented so clearly in the various case studies.

Accordingly a consensus emerged around a series of local pilot meetings to explore the scope for movement building and advocacy around the emerging national rural health plan as well as the possibility of a training (and sharing) program for community health workers, for the local community members who were working around health.

Permanent encounters for the collective development of capacities among community health workers and the participatory construction of the living conditions of the communities

The next step was in March 2017 with the formalisation of a plan for Stage 2 of the 'Civil society engagement' project¹⁹. (See Anexo 1 in Spanish [here](#) and in Google English [here](#))

The plan (in Anexo 1) reviews the findings of the case studies from Stage 1 focusing on the local struggles around health care and the conditions of living and concludes from this work that a priority need would be training and capacity building among the communities around the enforceability of the right to health, support for participation in public debates and in the construction of health plans and programs, as well as in the recognition of subordinate actors for change.

It was recognized that the health personnel of the FARC-EP had a practical training resulting from their experience in the war, not limited to basic sanitary necessities of military life but, given the precariousness of the health system to serve the population in the rural territories in which they were based, they have had to assume responsibility for delivering basic health care. The 'physicians, dentists and military nurses' of the FARC-EP were, in most cases, rural people who were forced to respond by the circumstances of the war, from jungle folk medicine and from very basic training, to the needs related to the aftermath of fighting, tropical diseases, common diseases and the daily emergencies of combatants and peasants. Clearly these personnel could play a valuable role in the National Rural Health Program promised under the Havana

19. Developed by Román R. Vega R, Jairo E Luna G, Mauricio Torres T, Katherin I. Carrillo N, Patricia E Molano B, Soledad Días P, Yadira E. Borrero R and Esperanza Echeverry L

Agreements.

A particular feature of the Colombian situation during this period has been the establishment of 26 Transitional Normalisation Zones (ZVTN) and eight Transient Normalisation Points (PTN) as part of the disarmament, demobilization and reintegration processes.

Against this background it was proposed that Stage 2 of the CSE4HFA project would aim to help to build and develop collective capacities in the various communities in and around the ZVTNs and PTNs (working with peasant, Afro-descended and indigenous communities, including ex-guerrillas). The project would focus on supporting community health workers in order to ensure popular and proper forms of health care adapted to their needs and customs with full regard to the claims of autonomy of the ethnic and peasant communities, and the creation of their own, social, environmental, cultural and territorial conditions for health and food sovereignty and nutritional security. It would also explore the principles and directions to be expressed in the proposed National Rural Health Plan and help to build policy capacity to engage in that process.

The idea of a 'permanent encounter' was seen as a key strategy for building collaboration, policy dialogue and training opportunities and short, medium and long term objectives for the permanent encounter were identified. A series of meetings was planned to initiate this process with a focus on specific and current problems facing different communities and exploring the scope for more structured training opportunities for local community members engaged in various ways in health work.

Three meetings with peasant communities were planned to promote the training of community health agents and discuss the elements of a health model that meets the health needs and circumstances of the rural communities of Colombia (see Stage 2 Activity Report (in [Spanish](#), [EN\(G\)](#)). The meetings were planned in:

1. ZVTN Juan Carlos Castañeda, Carrizal-Antioquia during the days 2 to 4 of July of 2017. See [Annex 2](#) (in Spanish).
2. Lejanías-Antioquia, on July 5 and 6, 2017; see [Annex 3](#) (in Spanish, file size reduced);
3. Three communities around La Macarena-Meta: ZVTN Urías Rondón (July 2), Vereda La Cristalina (July 3), and Vereda Playa Rica (July 4). See [Annex 4](#) (in Spanish, file size reduced).

ZVTN Juan Carlos Castañeda in Carrizal-Antioquia during the days 2 to 6 of July and Lejanías-Antioquia, on July 5 and 6, 2017

This meeting was organized in association with Asociación Campesina del Valle del Rio Cimitarra ACVC-RAN, the Peoples Health Movement (MSP), Popular Processes Unit, Intersectoral Platform of Antioquia for the Right to Health (MIAS), and the Centre for Rural and Urban Studies (CeSUR).

The objectives for this first pilot meeting were to:

- exchange knowledge in health with the community and ex-combatants of the FARC;
- present the People's Health Movement as a way to articulate initiatives in health from the communities;
- promote and present the project initiative of community health agents for the community;
- systematize the experience and knowledge of the communities in order to collect tools that serve as input for the formulation of the National Rural Health Plan.

The program for the five day workshop was carefully developed with some thematic input and lots of time committed to more participatory activities. Unfortunately the planned evaluation with the participants

on the last day was swamped by the cultural event. It was also unfortunate that the planned discussion of further events and organizational commitments was likewise swamped.

The facilitation teams met in Medellin following the conclusion of the event and documented their reflections on the five days and the meetings in both Carrizal and Lejanías. The meetings were recognized as a definite success notwithstanding some difficulties. The facilitators had elected to use a rapid appraisal technique but the evaluators recalled some confusion as to whether the focus was health needs appraisal or health-related training needs appraisal. The evaluators noted that many participants had regretted that there was not more on topics of their interest; this was seen as arising from the unavoidable tension between breadth and depth. It was recognized that in future meetings there would need to be deeper exploration of the role of the community health worker and how local experience might map onto that. It was recognized that engaging with the proposed National Rural Health Plan should be based on full systematisation of previous and current local experience which will require further attention next time. Further attention to evaluation will also be required next time.

The setting up of a separate engagement with the community of Lejanías appears to have been a last minute decision following a request from that community through the peasant organization ACVC. Accordingly a group of facilitators left the ZVTN Juan Carlos Castañeda in Carrizal after the second day and travelled to the village of Lejanías where they presented a two day workshop. The Lejanías workshop was also judged a success although facilitators commented later that many of the local participants thought that they were coming to a workshop on first aid.

On the second day of the Lejanías workshop it was agreed that a second visit would be scheduled for October, including deepening coverage of a number of topics the local organizations saw as key, including training in basic first aid and primary care. The next event should have clear objectives and agreed schedule. Closer liaison with local organizations in the planning was also agreed.

La Macarena in Meta: ZVTN Urias Rondòn (July 2), Vereda La Cristalina (July 3), and Vereda Playa Rica (July 4)

A second group of facilitators travelled between June 30 and July 7 to the Macarena region in Meta. Four meetings were held, the first in the ZVTN Urias Rondòn and then in two nearby villages and finally with peasant leaders, the indigenous governor and members of the ZVTN. See [Anexo 4](#) (in Spanish) for detailed report.

An earlier visit in May 2017 had explored objectives and program with the local organizations and agreed on broad directions.

The structure of each meeting consisted of:

1. Introductions;
2. Presentation of the People's Health Movement and the Civil Society Engagement project;
3. Contextualization in relation to the peace agreement of the national rural health plan;
4. Identification of problems regarding health situation;
5. Memories of the struggles in the territory;
6. Actions to advance;
7. Commitments between the parties involved.

The meetings alternated between small group work and plenary discussion.

The meeting report lists in rich detail the health care and health-related needs facing the local peasant and indigenous communities, including the members of the ZVTN. There was a presentation about the People's Health Movement which helped to broaden the horizons from medical care to the social and

environmental circumstances which shape community health. There was appreciation of the proposals for capacity building for community health workers and for policy engagement regarding the National Rural Health Plan.

In looking towards building the Rural Health plan across the region it was agreed to refer to it as "Health without borders" in order to generate a positive impact on problems that affect the population. The meetings agreed to:

1. Participate collectively in the construction of the Rural Health Plan of the territories;
2. Coordinate the work towards the rural health plan among the different organizations of the territory (ZVTN Urías Rondón, CORPOAYAR, ASOPREPROC, ASCAL-G and the Embera-Chamí indigenous council);
3. Strengthen, and establish where there are none, the health committees of the community action boards in the villages, the health coordinations of the peasant associations, the Transition Zone and the indigenous council;
4. Select the personnel (know how to read and write) for the training that allows the collection of information by sidewalk and other community spaces as input of knowledge of reality for the construction of health plans;
5. Develop the training to carry out the work of gathering information;
6. Collection of information by the trained teams of the communities;
7. Sending information to the community team for processing and analysis;
8. Processing and analysis of information by the university support team;
9. Meetings for socialization of the results of the processing and analysis of information in each of the territories and construction of objectives and strategies of the Rural Health Plan by territories;
10. Meeting for the socialization of the plans by territories and their integration into a more general plan of the common territory of the various organizations;
11. Work to change the obstacles in the general health social security system that hinder the implementation of the rural health plan of the territories; and
12. Train community health agents to promote community participation in the preparation of the rural health plan and to help address the basic health needs of the communities.

Timelines were proposed to progress the ideas presented; these were discussed in the following meetings and validated in the final meeting, with the peasant leaders and the indigenous governor:

- a) Training: October 13 to 16, 2017 simultaneously the three processes;
- b) Collection of information: October - November 2017;
- c) Sending the information to Bogotá: November 25;
- d) Analysis of information: January - February 2018;
- e) Socialization of the information collected in each path: first week of March 2018;
- f) Encounters for the preparation of the Plan in the territory: Holy Week of 2018;
- g) Regional meeting of the three associations (ASOPREPRO, CORPOAYAR and ASCALG): mid-year vacations in 2018.

The meetings in Vereda La Cristalina and Playa Rica which followed identified similar problems in those villages and adopted similar commitments and timelines.

Implications of the Colombia Stage2 reports for the main themes of the project

The report of Stage 1 of the Colombian project (in [Spanish](#); and in [English](#)) includes a detailed analysis of the thematic implications of the nine case studies (which has been incorporated into the relevant chapters above).

However, the Stage 1 commentary was prepared before the Stage 2 planning workshop (late 2016) and the pilot meetings (for the permanent encounter) of July 2017.

These Stage 2 materials point to a number of new issues and illustrative cases in relation to Movement building, Capacity building, and Knowledge generation, dissemination and access (below).

Movement building

The MSP project team has adopted some quite ambitious objectives for Stage 2 (and beyond). The mid term objectives have to do with CHW training and engaging in the development of the National Rural Health Program. However, these objectives are located within a much broader goal which is about citizenship (equality, dignity, safe and healthy living) and social development (freedom, peace, human rights, *buen vivir*). The project is located in the first instance in relation to the ZVTNs and PTNs

The 'movement' which the MSP is seeking to build in this Stage 2 project will in the first instance bring together the largely professional and academic membership of the MSP in Colombia with the organizations and activists of the peasants, Afro-descended, indigenous communities of the ZVTNs and PTNs including the ex-guerrillas. This will be a movement which recognizes 'health' and the responsibilities of the 'health system' as much more than medical care; which recognizes the social and political determination of health; which recognizes *buen vivir* as a condition for community health.

However, it is evident that there is some distance between the consciousness of the MSP activists and that of the communities of the zones and points. The MSP activists may have a challenge in sharing their enthusiasm for the 'social view of health' and the concept of the CHW as an agent for operationalising that view. There may be challenges in other areas also such as gender relations. On the other hand the peasants are facing very practical challenges associated with water, agriculture, building, artisanal mining, and dispossession; these are areas where they are the experts and building policy dialogue around rural health may require that the theoretical wealth of the MSP activists is blended with the realities of local praxis.

The local peasant and indigenous organizations are clearly keen to work with the MSP activists but they are also concerned that the identity and work programs of their organizations not be subsumed into some larger umbrella body. The MSP activists are seeking to address this concern with the idea of a 'permanent encounter' which suggests a network which sustains a continuing and evolving engagement. It is a nice metaphor for the concept of a 'social movement', bringing together individuals, organizations and networks. Likewise engaging in the development of the rural health plan under the slogan of 'Health without borders' suggests both, an inclusiveness regarding access to care, and looks beyond arbitrary institutional boundaries which points towards an awareness of the social and political determination of health.

It is evident that both the MSP activists and the local leaderships are aware of these challenges and are committed to reaching out across this divide. However, success will depend on very practical decisions as well as commitments. Mistakes were made in planning for the Stage 2 meetings and both the local organizations and the MSP activists are clearly committed to learning from those mistakes.

Ultimately the building of this movement will depend on a certain mutuality of drive. The MSP activists have initiated this present engagement. However, the peasants, indigenous and Afro-descendants have been struggling (and fighting) for their health, land, food and dignity for many years. The MSP initiative is offering not just a different approach to health but the power which comes from being part of a wider struggle and the solidarity of brothers and sisters. The building of this movement will involve and depend upon a deep transformation of the individuals and organizations who constitute the 'Health without borders' movement.

Capacity building

Capacity building was central to the conception of the Stage 2 project and it is evident that the local communities of the zones and points were very keen to develop their individual and organizational capacities.

The MSP activists deployed a wide range of facilitative methodologies in the planning and conduct of the July meetings. They were certainly conscious of the need to blend thematic presentations with playful activities.

However, the reports of the July meetings underscore the challenges of negotiating training needs and of building policy on the basis of systematising the experience of the peasants, indigenous, and Afro-descended, and the ex FARC military.

In the Carrizal meeting there was some confusion as to whether the rapid appraisal method was directed to rapid appraisal of health needs or of training needs. On reflection it is self-evident that training needs are in a sense defined by health needs and perhaps the debate points to the complexity of this kind of capacity building initiative.

Likewise it was recognized that input into the development of the National Rural Health Plan should reflect the lived experience of local communities. However, the process of 'systematising'; bringing lived experience into discourse and articulating its meaning, is not simple.

Knowledge generation, storage, dissemination and access

Superficially the knowledge transfer envisaged in the Stage 2 project was from the academics to the peasants. Both the capacitation of ex FARC medics as CHWs and the engagement in policy dialogue around the National Rural Health Plan would involve the local activists and organizations accessing information to which the largely professional and academics have privileged access. Evidently there was also a thirst among the peasant activists for access to this kind of knowledge as evidenced in the call for 'primers' to be developed and circulated prior to future meetings. However, this image of one-way knowledge flow would bode poorly for respect and equality within the movement.

The issues of food and agriculture take us past this unfortunate scenario. The city based MSP activists are quite persuaded of the importance of agroecology in principle. They are aware of the structural pressures at the national and global levels which are driving the domination of industrial intensive, input-rich agriculture. However, the peasants know their soil. The implementation of high level principles regarding agroecology is totally dependent on local knowledge as well as the cultural and historical basis of local practice. Food looms large as a determinant of health for the MSP activists and agriculture looms large as the basis of life for the peasants. If food and agriculture are to be part of the National Rural Health Plan and to be part of the work of the CHWs then the building and sharing of useful knowledge will have to be more sharing than transmitting.

Annex 3. Democratic Republic of the Congo

DRC participation in the CSE4HFA project was canvassed with the PHM circle in the DRC during early planning and following the launch of the project three junior researchers were recruited and a planning workshop was organized in January 2015. A project steering committee comprising four members of the PHM DRC circle; a research mentor (M3M²⁰ staff in Kinshasa). SC and mentor responsible for supporting junior researchers and for facilitating relations with members of the PHM circle.

An interview study was planned with a view to eliciting experiences and opinions from civil society organizations affiliated with or close to PHM regarding each of the five generic themes. The interviews were carried out and transcribed and a report prepared (May 2016). The report of this study is [here](#).

The findings of this research are structured around the five generic themes and have been included in the material analyzed for the thematic chapters of this report.

Unfortunately the enthusiasm of the PHM circle was somewhat depleted following the completion of the report and planned research for Stage 2 did not proceed.

However, a lively bilingual regional meeting was held in Kinshasa in early 2018 with participation from West and Central Africa (EN report [here](#); FR [here](#)).

²⁰ M3M is a PHM affiliated NGO, based in Belgium and with activities in DRC, Palestine and the Philippines.

Annex 4. India

The India research group, assembled under the aegis of PHM India (Jan Swasthya Abhiyan or JSA) elected to undertake a substantive review of the Indian experience in relation to the five generic themes deploying literature review, document analysis, key informant interviews and case study documentation and analysis. The group elected not to include an action research component into their research but to focus on a formative evaluation of Indian experience. See [India report](#), Methodology, from p. 4.

The literature review of social movements and the Health for All movement in India (from p. 7) provides a rich coverage of the theoretical discussions of social movements in India and an overview of the 'movement for health' in India. The material in this literature review has informed the empirical theme-focused research including the selection of case studies. This literature review also complements the review presented in Annex 7 of this report.

The empirical research undertaken for the India study is reported under each of the five themes and will not be summarized here. The findings and commentary are extensive and rich and need to be read in the original. These sections are drawn upon in chapters 5-10 of this report.

Movement building

Campaigning and advocacy

The India report includes case studies of eight campaigns undertaken by JSA affiliates and some non-JSA organizations. The case studies deal with:

1. Wielding the 'Right to Health' approach,
2. Access to healthcare with JSA,
3. Opposing privatisation of diagnostics,
4. Environmental issues (JSA Karnataka),
5. Right to food,
6. Campaign against long-acting hormonal contraceptives,
7. Patent oppositions, and
8. EU-India FTA.

The analysis of the interviews regarding campaigning comment upon the following.

Resource mobilization

Wide range of approaches reported from 'friends and neighbours' to friendly funders to self-funding. Comment on the value of funders who trust the organization, show flexibility and provide untied funds (or allow retention of surplus).

Knowledge resources

Importance of research to underpin campaigns.

Importance to give attention to developing resource materials (including technical material as well as cultural media) before launching the campaign.

Forms of action

Wide range of actions reported:

- street action, protests, research, fact finding, legal action, policy advocacy, public hearings about the violations that had ensued, endorsed letters and memorandums, press conferences;
- using the courts, policy advocacy, mass mobilization;
- direct actions, media advocacy, legislative advocacy, legal action, and international advocacy;
- post card campaigns, street protests, letters, research, fact finding, public hearings and mobilization
- social media (useful in leveraging international support);
- working with particular journalists;
- litigation;
- sting operations;
- working with trade unions;

Enablers and barriers

Importance of internal organization of the campaign

Networking is foundational

Lack of driving will within the campaign

Disagreements about messages within the campaign (leading example being injectable contraceptive campaign)

Magnitude of oppositional forces

Clamp downs on free speech and increase detentions and arrests

Knowledge generation, dissemination and use

New information flows

Wider social acceptance of health rights is an essential pre-condition for the realization of HFA. Successes of such initiatives are realized only when the civil society initiated dialogues are relevant to people's daily lives and show them the glimpse of the world without injustice and structural violence. The mass contact programmes began by the science movements are good examples of such initiatives. The 'kalajaths' as they are widely known, communicates the social and scientific messages through traditional as well as modern art forms, such as songs, street theatre and poster exhibitions.

Learning from activist practice

The democratic social engagements of civil society often seek to understand the world by trying to change it. By thinking, acting and learning collaboratively with community that they work with, CSOs reclaim the vast knowledgebase of the marginalised communities.

"On the links between TB and nutrition for example there just wasn't much evidence. But we published evidence in PLOS and were then able to successfully campaign in Chhattisgarh for the provision of food for TB patients. We did operational research with action including on what the food should be and how it should be delivered. We worked with other research groups." [Respondent 6]

"For example, along with other groups, we undertook a fact-finding on the deaths that took place following sterilizations in one state. The fact finding provided important information and documentation of what had transpired and contributed to the campaign against such violations, policy level advocacy as well as towards justice for those who experienced morbidities or for the families of those who died.

Academic networks

there are also significant body of knowledge created through established means of formal research. Such initiatives are carried out by sympathetic 'activists communities' within the academia as well as selected resource organizations within the civil society movements.

Knowledge sharing

The five booklets

A major driver of the year and half long process in India before the first National Health Assembly in Kolkata and the first Peoples Health Assembly in Dhaka was what came to be known as the magic of the 'five booklets'. These five booklets (on globalization and Health, Health Systems, Child Health, Women and Health and Confronting Commercialization), written in a popular style formed the bedrock of the massive mobilizational campaign in 1999 and 2000.

The participatory process of the development of the 5 initial booklets has never been duplicated, at that scale however. Which JSA developing a more organized institutional structure, somehow the participatory process of the 1999-2000 have not been subsequently captured to the same extent.

GHW in local languages

It was recognized that the use value would increase if 'readers' on important issues could be created in local languages. As one JSA respondent said:

"I use GHW extensively and it is extraordinarily useful. It has the evidence I want to use and am able to quote from it in my advocacy and research work. I want both what GHW is now, and make it available to activists in different forms. Peoples movements have to promote changes in discourse at macro and academic level and

GHW dissemination

The need to disseminate the contents of GHW more extensively was also articulated.

"Global PHM is also an alternate to the bleak scenario of global governance. The coming out of GHW is an important global event, though dissemination should be much more". (JSA respondent 1)

Annex 5. Italy

The research in Italy was undertaken through a network of young health activists which has been meeting since 2006 and comprising medical students, medical graduates, public health professionals and others. Many of PHM's Italian activists have been members of this network and have participated in its meetings. For the purposes of this research the volunteer researchers constituted themselves as "Grup-pa" (permanently open group). The research collective included people from different cities in Italy and the mode of communications and collaboration included face to face meetings, Skype meetings, and various forms of digital collaboration.

The first phase of the research is reported here: [IT](#), [EN](#), (32 MB each) and here [EN-lite](#) (1 MB). The research collective decided to focus on the social determination of population health rather than on activism around health care. For the purposes of defining their fields of work and undertaking (and transcribing) interviews the volunteers organized themselves into nine working groups. Seven of these (Education and disability; Environment, health, work; Land and food sovereignty; Imposed mega projects; Queer; Arts and culture; Alternative economy) undertook interviews with key informants in civil society organizations and networks centred on these different fields of work.

The interview transcripts were reviewed in small groups and analyzed in accordance with the five project themes. In a second round analysis a series of 'conceptual maps' were developed structured around a further set of seven topics: Structural context; Non-identitary processes; Organization and functioning; Sustainability; Training and education; Direct action; and Interaction. Further analysis of the findings was undertaken in relation to these topics which were notionally mapped to the five project themes.

In their study of Campaigns the research team documented twelve health-related campaigns in Italy, largely from the last decade.

1. Due Sì per l'Acqua Bene Comune ("Two 'yes' for water as a commons")
2. Citizens' initiative for a law on water as a commons
3. deLIBERIAMO Roma (petition supporting four initiatives concerning water, finance, schooling and urban spaces)
4. Access to land
5. Terra Bene Comune - TerrABC ("Land as a commons")
6. Citizens' initiative for a law on a guaranteed minimum income
7. Stop TTIP
8. Sbilanciamoci! (alternative economic and development policies)
9. Noi non segnaliamo! ("we will not report") (resisting requirement for health care practitioners to report unauthorised migrants needing health care)
10. No Alaco (opposing the Alaco dam)
11. Yo decido - El tren de la libertad (I decide - The train of freedom) (opposition to Spanish anti-abortion legislation)
12. Gender strike (supporting the struggles of queer movements and of precarious workers, students, unemployed, migrants, etc)

Two of these (#9 and #1, above) were selected for more detailed case studies.

The working group on Critical medicine prepared a brief history of Critical medicine in Italy (and Europe more broadly) and sponsored a two day workshop on 'Health and social movements: 1978-2015' in Bologna in April 2015. A key feature of this meeting was hearing the personal narratives of the people who had lived the years of the critical medicine and healthcare reform movement. The different experiences came

together in a collective narrative, but a very heterogeneous one and rich of diversity. The personal motivations of those involved were also shared and discussed.

At the end of the first stage of the project the research collective formulated three priorities:

- to repoliticise the discourse on health, challenging the hegemonic biomedical perspective while proposing different approaches (“what is health?”);
- to share, experiment and put into practice different ways to “make health”, taking into account also the aspects of decision-making, organization, sustainability (“what makes health, and how?”); and
- to promote and sustain the process of building a movement for health in Italy.

The group decided, for the second stage of the project (see report: [IT](#), [EN](#)), to organize three open workshops focusing on three key issues emerging from the project. The organization of these three workshops constituted the main focus of the second stage of the project. The titles of the workshops were:

- “Social movements and welfare: which practices between defending public institutions and social transformation?” (Bologna, 1-3 April 2016); video report [here](#);
- “Building healthy spaces and communities. Practices of collective reappropriation and self-organization” (Naples, 10-12 June 2016); video report [here](#); and
- “Commons. Between the personal and the collective: new forms of community and sustainability” (Rome, 19-21 May 2017); video report [here](#).

The second stage report provides brief summaries of the discussion at each of these workshops (and links to the video reports, above) but the main focus of the report is a reflection on the research experience across the two stages of the research. This summative overview includes reflections on the five (main) project themes, constructed largely around the experience of the research collective during the first and second stages of the research.

Participatory action research *and* descriptive research: researching our own practice *and* movement experience

The approach taken by the Italian collective to this research needs to be explicated in more detail as part of drawing out the lessons for the wider CSE4HFA research. In effect the Italian collective has conducted two different research projects simultaneously although the boundaries between the two are quite blurred.

At one level the focus of the research was on *activist thinking, practices and relationships* as expressed in the work of the research collective. This focus arose from a sense of alienation from orthodox medicine and research and a degree of scepticism regarding conventional forms of social movement activism. In this frame the project themes (movement building, campaigning, etc) were interpreted in relation to *activist thinking, practices and relationships*. This is particularly clear in the analysis presented in Chapter five of the first report and the seven themes around which this chapter is structured. It is at this level that the research was conceived of as participatory action research (PAR). The PAR cycle of act, observe, reflect and re-engage was applied to the thinking, practices and relationships of the research collective. Both the first and second reports include detailed descriptions of the organization and carrying through of the research including a strong emphasis on the workings of the collective. The planning and conduct of the three public meetings in 2016 and 2017 were informed by systematic participatory reflection on the experience of the first stage of the research, in accordance with the principles of PAR.

At another level the research was about learning from the wider experience of civil society organizations in various health-relevant engagements in accordance with the brief from the global CSE4HFA project which was to learn from the wider field of social movements and activist organizations in Italy about the five

(global project) themes. In accordance with this brief the Italian collective undertook 29 interviews with activists from a range of activist organizations and networks and the theme lists and prompts were derived from the templates around these five themes developed through the global research team. However, the analysis of the data derived from these interviews was largely centred on the issues which were the focus of the action research, the *thinking, practices and relationships* of activism. This is not entirely so; the collection of campaigns and the two case studies of campaigns provide very useful descriptions of the structures and strategies of those campaigns and the broad conditions for their achievements. Another illustration of the intersection (and congruence) of these two frameworks is the participation of members of the research collective in two major mobilizations in 2016, the Women's Strike in Bologna and the Europe wide People's Health Day (April 7).

Reflections on the five generic themes

The reflections on the main generic themes presented from p7 in the second report ([IT](#), [EN](#)) need to be understood as lessons learned about the thinking, the practices and the relationships of activist groups working towards social change. They are about the micro practice rather than the macro strategy of activism.

Movement building

Under this heading, the research collective highlights the contradiction between individual autonomy and collective responsibility in voluntary activist organization ('what is the relationship between freedom, responsibility and participation?'). Clearly there is no simple answer to the question but the experience of this collective underlines the importance of bringing the issue into the open and trying to build consensus around how the contradiction might be managed.

The second question identified under this heading is how to maintain dynamism, energy and creativity. The collective notes a reduction in participation from the first to the second stages of the research. The collective reflects that the engagement with other organizations and networks through the interviews during the first stage brought a lot of energy into the group whereas the organizing of three public workshops in the second stage felt more like hard work.

The importance of personal relationships in shaping the trajectory of the group (organization or network) was an assumption which fed into the way the Italian research was implemented, reflecting long standing discussions in the wider network out of which the research collective was formed. In its planning, organization, data analysis, report writing and meeting practices, relational dynamics were closely considered and a wide array of creative tools and methods adopted to facilitate good practice. However, in the final evaluation workshop 'several people reported negative feelings that, in different moments, made the collective work harder and heavier to sustain'. In this context the report recognizes '...the risk to improperly force the personal and even intimate way in which different people choose/are able to express themselves in collective and relational processes'.

Campaigning

In relation to campaigning the (second) report reflects upon the group's participation in the Europe-wide mobilization on 'People's Health Day' on April 7 in 2016 (actually an appropriation of WHO's World Health Day). Despite a certain lack of enthusiasm across the Grup-pa network there were actions in Bologna and Naples.

In both cases the participation of Grup-pa activists was structured around alternative modes of demonstration; in Bologna involving the public in games and in Naples through 'theatre of the oppressed'

performances. Both of these reflect the interest of Grup-pa in experiential knowledge (see below) and both appear to have been well received.

Knowledge generation and dissemination

The challenge of knowledge generation and dissemination was considered in the final evaluation workshop, in particular, experiential knowledge. The group's approach to experiential knowledge was shaped by a concern regarding the power relations associated with possession of 'officially endorsed knowledge' linked to a confident facility with speech. At the micro level such powerful speech can render others silent; at the macro level such powerful speech can project an understanding of the world shaped in the interests of the powerful. Accordingly the group's practices were often directed to non-verbal expression and emotionally informed modes of expression, eg theatre or role play (in contrast to fact and logic paradigm). Experiential knowledge in this context involves valuing people's lived experience as a source of knowledge, validating such knowledge, bringing it into discourse and drawing on it to inform practice.

The particular challenge at the core of the Grup-pa project is how this perspective may be used to inform a counter-hegemonic approach to health. In this context the group is committed to working with groups who are already experimenting with alternative approaches to health and its determinants. The group is working towards a project directed to the co-construction of experiential knowledge under the name of 'health commons practice'.

The group draws significant lessons for this enterprise from its experience in both stages of the CSE4HFA project. The view was expressed in the final evaluation that while deploying various creative methodologies for supporting open discussion in its public meetings were appreciated it was much harder to convey the deep political logic of such practices, particularly in communities who were more familiar with more conventional activist practice. Even within the Grup-pa the political logic of experiential knowledge generation was not always fully appreciated.

Annex 6. South Africa

The South African contribution to the CSE4HFA was coordinated by the People's Health Movement South Africa (PHM SA) Steering Group. The research activities were carried out by PHM members supported by two professional researchers.

The Stage 1 report opens with a very useful historical review and commentary on health activism in South Africa including the impact of democratisation in 1994.

The key events around which the South African projects have been implemented are as follows:

- **November 2014.** PHM SA held a planning workshop to align the research with PHM SA's priorities and commence planning for Stage 1 activities;
- **December 2014.** South African People's Health University (SAPHU) course;
- **June 2016.** Africa CSE4HFA Regional Workshop in Cape Town in Aug 2016 ([report here](#));
- **June 2016.** 2016 SAPHU (focused on community health workers or CHWs);
- **June 24-6 2016.** National Health Assembly (NHA, see description in SA Stage 2 report); and
- **July 2017.** Day 1. Consultative workshop with NHA partners. Day 2. PHM SA Reflections and planning workshop (see Report of workshop findings and decisions in SA Stage 2 Report)

The main streams of health activism which have been addressed by the South African team include:

- PHM's Right to Health (RTH) project, from 2007;
- The National Health Insurance (NHI) Campaign (from 2010), co-sponsored by PHM SA, TAC and Section 27;
- SAPHUs in 2014, 2016 and 2017 (two courses);
- SA NHA in June 2016 and campaign proposals emerging:
 - Community Health Workers: The foundation of primary health care
 - Clinic Health Committees: One clinic - One committee - One policy
 - Health Financing and Tax Justice: Stop subsidising the private health sector
 - Stop Stock-Outs: Medicines when we need them
 - Human Resources for Better Health: People make the health system

Five studies were undertaken as part of the Stage 1 Research (see [South Africa Stage 1 Report](#)):

- SA RTH Campaign. Reflections on the PHM SA's RTH Campaign (see Stage 1 Report)
- NHI Campaign Reflections. Reflections on the NHI Campaign, co-sponsored with Section 27, TAC, and others from 2010 (see report: [South Africa NHI Campaign Case Study](#));
- SAPHU Evaluation. Formal evaluation of the 2013 and 2014 South African People's Health University (SAPHU) (See overview of evaluation in Stage 1 report);
- CHW study. Health activism, mobilization and organization among community health workers (see report dated May 2016, [South Africa CHW Case Study](#)); and

- Overview history of civil society engagement in health development in South Africa (included in the body of the Stage 1 report, from page 1).

The main study undertaken as part of the second stage was based on a two day workshop held in July 2017. This workshop involved PHM researchers and members, several SPHU alumni and representatives of some of PHM's main partners in the 2016 National Health Assembly. The workshop provided an opportunity to reflect on the experience of the projects addressed through the CSE4HFA research, the implications for the five generic themes, and lessons for the future. The report of the workshop forms part of the Stage 2 Report ([South Africa Stage 2 Report](#)).

In both the South Africa Stage 1 Report (from page 10) and the South Africa Stage 2 Report (from page 15) there are extended sections where the South African team have drawn out the implications of their research for the five generic themes. These passages have informed the analyses presented in the relevant chapters of this final report.

Movement building

Section 10 of the Stage 1 report includes a thoughtful reflection on the place of PHM SA in the South African landscape and on what has worked well and not so well with respect to movement building to this point. It concludes:

Since the advent of democracy in 1994 progressive civil society in South Africa has declined in strength and focus, with the notable exception of the treatment action movement, spawned by a dramatic public health crisis and based in a mass movement predominantly composed of HIV-affected youth.

PHM SA emerged in the early 2000s globally and in South Africa it began as a small organization with a comprehensive political economy analysis that makes it unique. It is the only organization with a socialist analysis of health and health systems.

PH-MSA has been consistently active in analyzing and publicizing infringements of the right to health – including inequities in the social determinants of health. It has been consistent and vocal in promoting comprehensive primary health care as the core strategy for health development and applied this understanding in its critical support for various national and local health policies. This critical approach has been promoted in its capacity building and knowledge generation activities and has informed its campaigns.

However, its ability to convey this framework and translate it into broad-based action/a mass movement for health is weak. This has been partly a result of weak capacity but also because its message is often seen as too complex. Nonetheless, there is evidence that PHM SA has influenced the thinking and actions of numerous individuals and even of other civil society and mass organizations.

This raises the question of whether PHM should position itself as an organization that politicizes and animates health activists who don't necessarily identify as PHM SA members, rather than trying to build a mass movement, which it may have limited capacity to do in a sustained manner.

Campaigning

The South Africa reports describe two major campaigns that PHM SA was involved in (Right to Health and National Health Insurance) and five campaign proposals that were launched with enthusiasm but which did

not bloom. The reports include critical reflection on successes and failures as well as detailed commentary on campaigning and networking.

Major lessons learned during the RTH campaign (from [Stage 1 report](#)):

- campaigns should be developed in light of local circumstances and should speak to issues that will mobilize support from communities and other civil society organizations.
- it is important to have a campaign plan mapped out. A successful launch is no indication of a successful campaign.
- single issue campaigns tend to generate more support but don't necessarily address systemic issues well.

In the [Stage 2 report](#) the researchers summarize the learnings from the NHI Campaign, concluding that the efficacy of the campaign was undermined by:

1. Limited financial and human resources capacity to coordinate the initiative;
2. The lack of a focus to mobilize around, i.e. the government delayed releasing the NHI White Paper, which would have been a focus of the campaign;
3. The consequent lack of urgency with which civil society partners viewed this campaign, given that they had to prioritise ongoing work with the limited resources that they had; and
4. The NGO-isation of South African civil society, which has created an expectation amongst potential health activists that they can and should be paid for their participation in campaigns; this makes voluntarism rare.

Stage 2 conclusions on Campaigning

The main findings in relation to campaigning from the [Stage 2 report](#) are that they are often strained – and sometimes ultimately undermined – by a mix of “hard” and “soft” factors. Important “soft” factors that sustain campaigns, but are routinely neglected, include building good interpersonal relations, managing conflicts productively, and maintaining meaningful contact and respectful working relationships between organizations and between comrades with radically different financial, racial, and language privileges. The “hard” factors that undermine campaigns and coalitions include inadequate resources, poor management of resources, unclear and/or ineffective processes and institutional structures for managing ongoing campaign work – particularly in contexts where activists cannot afford to work on a voluntary basis.

The discussions on Day 1 suggested that health activists can be politicised and mobilized under both repressive and politically “open” conditions, that voluntary work can be sustained in either context, and that campaigns often provide a crucial “institutional home” for newly politicised activists, i.e. it offers them a political home where they can do activist work on the “personal” issue that led to their conscientisation (e.g. a routine inability to access medicine at a public health facility). As such, campaigns can be a key tool for movement building.

The discussion on Day 1 also suggested that a more “open” political climate enables activists to focus on socioeconomic issues rather than prioritising more urgent issues like avoiding criminalisation or demanding political rights before “also” demanding the right to health. A more open political context, however, can also be demobilizing in cases where activists adopt a posture of waiting for/responding to government initiatives (e.g. waiting for the publication of a key piece of legislation in order to take up campaign work in response to it can cause a campaign to dissipate if the legislation is not published in a timely manner).

Knowledge generation

Stage 1 report

PHM SA has a comprehensive political economy analysis that makes it unique in SA. It is the only organization with a socialist analysis of health and health systems. However, its ability to convey this frame and translate it into broad-based action/a mass movement for health is weak.

PHM SA's knowledge generation and dissemination activities are aimed at raising public awareness about the local and global dimensions of the political economy of health and health systems in South Africa. Globally PHM SA members do this by contributing to Global Health Watch.

The South African team comment that knowledge generation takes place in many of the different activities of the organization including providing feedback on government policies e.g. through submissions to parliamentary committees, meetings with government officials or letters in the press; writing articles for academic journals and popular publications and in projects such as in the CHW survey.

PHM SA has commented on policies such as the NHI White and Green Papers, the National Sanitation Policy, and the Draft Amendment Regulations on the Consumer Protection Act Regulations (which defined the permissible use of GMO foodstuffs and labelling requirements in this regard). One of the interviewees mentioned that collaborating on policy feedback not only generated new information, but also offered health civil society organizations the chance to build (and in some cases, rebuild) working relations with each other,

Some members of PHM SA work as academics and researchers and have contributed articles to peer-reviewed journals (e.g. articles on global governance for health in the Lancet) and to popular publications aimed at a broader readership (e.g. articles on the NHI in Amandla magazine, a local publication distributed nation-wide). For many years PHM SA also published a journal, Critical Health Perspectives, which used a political economy of health lens and covered topics such as the health impact of climate change, globalization and health, health financing, and the history of the primary health care approach.

Annex 7. Review of Research and Commentary on Social Movements Generally²¹

We have reviewed the social movement literature focusing on some selected reports which are particularly relevant to our research objectives. The full review is here: [Review Social Movements Research and Commentary](#).

The most useful outcomes of this review of research and commentary is that it provides a vocabulary and snippets of theory which can help to extend discussion and deepen reflexivity within the movement. It certainly does not yield simple guidelines or principles.

In relation to movement building there are useful resources regarding:

- shared grievances, identity and solidarity;
- organizational forms and resources;
- contingency and leadership and organizational culture;
- diffusion and convergence.

In relation to campaigning and advocacy there are useful resources regarding:

- forms of action and sources of power;
- delegitimation and framing.

In relation to capacity building, we can draw out some useful implications about objectives and methods:

- learning from, and about, each other (and ourselves) are conditions for solidarity and movement building;
- reflecting on practice, learning about our movement, developing a culture of reflexivity and commitment, are part of movement building and leadership development;
- learning about other struggles and movements beyond our boundaries speak to the possibilities of learning from and working with a wider range of allies and friends,
- learning about the wider configurations and dynamics of power within which we are working, are core resources for strategy;
- acquiring the knowledge and skills needed to reframe grievances into policy proposals, locally, nationally and globally; are core resources for policy dialogue;
- methods of teaching and learning must balance sharing and relationship building with skills and knowledge sharing.

In relation to knowledge building and dissemination Carroll's eight 'modes of cognitive practice' provide a particularly useful framework.

In relation to policy dialogue and governance we can draw some useful implications:

- addressing the local and immediate challenges in ways that also impact on the larger scale structures and longer term dynamics which reflect and reproduce those challenges;
- outrage about injustice and critiques of existing power relations must sometimes be translated into specific policy proposals to be advanced through existing structures of governance.

The literature review summarized in this annex was supplemented by the note on social movement theory in the Colombian Overview and Synthesis Report ([ES](#), [EN](#)) and the literature review prepared for the Indian

21. Prepared by David G Legge, Melbourne

Report ([here](#)). Both of these reviews draw upon theoretical materials which are only briefly touched upon in this review.

Annex 8. Historical development of the global Health for All movement: continuity and convergence²²

The focus of this study was on the conditions for the emergence of a stronger globalized movement for health equity. The researcher has assembled a collection of ‘episodes’ or ‘streams’ of civil society action around health with a view to learning about enabling conditions for movement building and in particular the patterns of influence through which different currents are coming together (or not) as a global social movement. See full report of this study [here](#).

The highlights of this study with respect to the five generic themes of this project are as follows.

Movement building

Within particular episodes/currents

Highlights include:

- organizing around and building a sense of collectivity, a sense of identity, is always part of movement building, strengthening the sense of ‘we’; however, activists need to be aware of the limits of identity politics and give full attention to working across difference, in particular, listening across difference; this principal points to the importance of interpersonal skills, group work practices and opportunities within which personal relationships across boundaries can develop and flourish
- our review highlights the potential of social entrepreneurship and leadership but the political and institutional challenges of ‘scaling up’ to system-wide implementation;
- small scale community initiatives can be insulated from or aligned with the wider political challenges arising from inequalities and breaches of human rights;
- it is important to recognize both the potential and the limitations of health ‘movements’ which are largely restricted to health professionals;
- learning from previous and parallel experiences (eg in group work, popular education methodologies) should be part of movement building.

Convergence across different currents

Highlights include:

- building organizational relationships, building networks, cannot be done by correspondence alone, or even digital communication; personal contact and the opportunities to develop strong personal relationships are also critical;
- inspirational writings, songs, movies and other cultural activities and resources can contribute to building solidarity and collectivity across boundaries; and
- strengthening organizational networks which span different countries and currents is clearly a fundamental part of the convergence project.

Campaigning and advocacy

Highlights include:

- the potential for learning from previous and parallel experiences in campaigning and advocacy;

22. Prepared by David G Legge, Melbourne

- the significance of articulations between the social movement for health and the political movements (including parties) which are engaged in mainstream politics; in many instances securing improved health care and social conditions for health may depend on such articulations.

Capacity development

Highlights include:

- recognize the role of inspiration and organizational culture in nurturing agency and solidarity;
- accumulate and demystify technical knowledges (eg access to medicines, fair trade activism, tax justice);
- cultivate story telling as carriers of history and theory;
- model transgression; and
- cultivate leadership.

Knowledge building and dissemination

The main highlight emerging under this heading is the importance of documenting movement building and campaigning experience and making it accessible. It is useful to note the limits of the 'gray literature' and other evanescent modes of communication (videos, websites, and even books) which may disappear within a few years. Note the benefits of the indexed literature and the importance of progressive academic as vehicles for publishing activist experience.

Policy dialogue and governance

The main highlights include:

- attention to the articulations between the social movement for health and the various political movements (including parties) upon which improved health care and social conditions for health may depend;
- the challenges of aligning local activism with the dynamics of global power are many:
 - acquiring a sense of agency in relation to big picture issues;
 - accessing arcane technical knowledges; and
 - building collectivity and solidarity across difference and distance.

Annex 9: Personal narratives of experienced activists

The aim of this project was to document the narratives of long term People's Health Movement activists, in order to understand in a detailed way the motivations, dilemmas, experiences and learnings of activists and how they impact on the strategies and achievements of health activism.

Fifteen interviews were conducted; eight men and seven women from different countries across the world. All participants had long involvement in the global People's Health Movement.

The methodology and detailed analysis are presented in the full report [here](#).

This annex summarizes some of the main implications of this analysis for the five generic themes at the centre of this research.

Movement building

Social movements have long histories and deep roots.

Social movements are rooted in the lives of ordinary people: their hopes and aspirations; frustrations and denials. Aspirations and grievances are shaped by cultural expectations, discourses of what is right, and by political structures, the power relations of privilege. The explicit issues change with time and circumstance but building and steering the movement to address new issues may benefit from an understanding of the historical continuities, from an alignment with the legacies of earlier struggles.

Pathways to activism

There are many pathways to activism. Facilitating such pathways can contribute to movement building. Activism builds on a sense of right and wrong and a sense of responsibility for others. Moving to active political engagement - criticising, discussing, urging, joining, refusing, demanding, organizing - may be driven by personal injustice or exposure to other wrongs; particularly being required to be complicit in such wrongs.

But understanding, hope and resilience are also needed to support political engagement. Understanding of causalities points to the way things might be different. Hope, that struggle may yield outcomes, drives engagement. Resilience is the ability to return after disappointment. Movement building strategies can work on these dynamics: exposing wrongs, clarifying causes, articulating alternatives, inspiring hope, and nourishing resilience.

Several interviewees pointed to ways in which PHM's global programs (IPHU, GHW, WHO Watch, etc) were contributing to movement building through such dynamics.

Leadership and accountability

The social movement depends on mass mobilization: people power in the face of money power. However, popular anger can manifest in many different ways. Leadership provides a coherent narrative and inspiration with respect to directions. But leadership can be corrupted by ego. What kinds of accountability can discipline leadership ego but grow the narrative and fire the inspiration?

The most obvious form of accountability is refusal to follow, either because of ego or failure to resonate. However, our interviewees also spoke of their personal participation in grass roots organizations; of organizational accountability to grass roots organizations; and of being so embedded in grass roots communities that the passion of the leadership is aligned with the aspirations of the masses.

Campaigning and advocacy

Projecting alternatives

Projecting alternatives must be more than simply denouncing the status quo:

“This outburst of energy that we see in street protests that are denouncing the things that are wrong in this world have to be followed by an organized preparation of announcing in terms of what alternatives we are going to propose. This is absolutely key for activism.”

But where to land between the utopian generalities and policy specifics?

Policy alternatives are important but they must be contained within a larger narrative which problematizes the prevailing structures of power and points towards strategies which both address immediate needs and contribute to changing the prevailing structures of power.

Addressing the immediate issues in ways which also contribute to addressing the structural issues

There is a dialectic between campaigning around specific issues (eg access to medicines) and working on the structural underpinnings of such issues (eg neoliberalism, imperialism).

Nearly all of our interviewees described ways in which they been involved in both working to improve curative services and working to address the underlying determinants of health. One described how a food relief effort in an African country had been implemented alongside a program to provide longer term food security. “We selected the foods on the basis of what people said that they wanted to grow, what we knew were nutritious foods and would comprise a child-friendly nutritious diet.”

PHM emphasises the political economy perspective on health, at both the national and global levels, and generally seeks to give attention to such structural issues even while joining forces around quite specific sufferings and injustices. Sometimes the immediate issues are so pressing that structural change necessarily takes a back seat. All agreed with the sentiment expressed by one that while conducting reactive campaigns *“At the same time, one should still have and fight for a much more radical vision.”*

Campaigning around access to treatment has led to massive increases in donor funding to ensure that the ‘immediate needs’ are being addressed. However, less progress has been achieved in addressing the poverty which produces tuberculosis and stunting or bringing the economic development needed so that countries can afford decent comprehensive health care.

Several of our interviewees acknowledged being sometimes overwhelmed by the magnitude of those large scale structural forces and the power of entrenched privilege. Taming global capitalism is a different project from access to medicines or food relief. It deals with a different architecture, different dynamics of change, different strategies. Progress in this struggle needs to be judged in that context.

Maintaining commitment in the face of overwhelming power is in part an ethical issue for our interviewees but it also depends on continued questioning and the elaboration of a narrative which explains, points to strategy and provides benchmarks against which progress on the structural issues can be assessed.

One interviewee pointed out how the concepts *health equity, social determinants of health, and health for all* have entered the mainstream consciousness. “Some of the things we were saying and we were rejected 25-30 years ago because we were hot headed activists are now mainstream.”

Organizing campaigns

Effective campaigns depend on behind-the-scenes organizational work which is not glamorous: photocopying, arranging chairs, keeping accounts, booking accommodation, etc.:

“a lot of organizing is actually mundane, day to day stuff, it is not glamorous. It is not about an ideolog putting down her or his ideas on paper, and everybody starts following. A lot of it is really nitty, gritty, hard work at the lowest levels, including, as I said, arranging chairs, making sure that the room has been booked, that the trains is all scheduled, and stuff like that... The devil lies in the detail. Activism is not glamorous. If you're looking for glamour, join a corporate bank.”

Activist organizations need to create pathways through which volunteers can find their ways to participate in organizational work and enjoy it.

Linking with other organizations

Campaigns contribute to building the movement as well as addressing particular objectives. However, the idea of a movement encompasses different organizations as well as unaffiliated individuals. Campaigns can easily become diluted without solidarity between organizations and networks: *“So you create the space and then the trade union does it's own and a small political party does its own, the other association does its own, so it's very fragmented.”*

Accordingly the processes of campaigning depend on building networks of relationships and communication across different organizations so that the campaign reflects and builds the movement as well as achieving agreed objectives.

Health activism in the Global North

Much of PHM's campaigning has been oriented around the structural injustices associated with globalization and the impact of such injustices in the Global South. In parts of the Global North, particularly in Europe, there are constituencies which are campaigning passionately about debt or unfair trade or tax justice and their impact in the Global South but have ignored domestic issues (such as unemployment, austerity and privatisation of health care); many of which reflect the same dynamics of neoliberal globalization.

One of our interviewees emphasised the necessity of engaging in domestic activism as well as international solidarity. She cited the changes in PHM-Europe which have seen it move from doing very little campaigning to spearheading PHM's action on World Health Day against the commercialisation of health and relabelling the day People's Health Day. Activists believed that they need to balance the tension between acting locally and globally consciously:

“But that's a balance that's not always very easy to maintain, and global work, in itself, can suck people into a long-term commitment which often draws them away from their connection to work at the national and local level”

Participants voiced concerns that not maintaining links to the local community and grass roots activism would lead to a disconnection with the people who they are supposed to be representing at the national and global levels. As Sammy pointed out, remaining connected to the local is about accountability - *“If you don't have constituency - you're not accountable to anybody, even ethically”*. If they were not working at the local,

the discussion often then turned to how and in what ways were they then able to act as a “*tool for a broader community*” (Irene).

Capacity building

Building the capacity of individuals and organizations

Several of our interviewees emphasised that capacity building is not just about individual skills. It is also about relationships which hold organizations together and about organizational culture.

Formal training programs and informal learning opportunities

Participants commented that while formal training programs are important many of them attributed their own capacity development to learning opportunities that arose informally in the context of their activist work.

One interviewee described how his work as a GP in a working class community taught him about communities and had led to his activist career:

“After graduation I went to work as a GP, a general practitioner, in a workers’ community, and that was a – I was working there in a medical centre off some progressive organization, group of progressive doctors. It’s called Doctors for the People, and they were working in this – they set up some medical centres in workers’ neighbourhoods. So, for me, that was my first encounter with trade union activism, with local activism, with the community activists, and so this is how I got involved in what we can call health activism.”

Structured learning programs and opportunities for activist engagement

PHM has been running short courses in the political economy of health since 2005 but while alumni are often very excited by what they have learned they often return to communities or work settings in which there seem to be few opportunities for engaging at the structural level.

More work is needed in following up and working with IPHU alumni if they are to find ways of putting the political economy perspective to work.

Kate recalls a training program she had previously been involved in which was directed at providing training for community health workers, not just health care skills but also creating an organizational culture of solidarity within the organization and with marginalised community members. Kate explained “*we were training the community health workers, we were supporting them but we were also supporting programs of action to improve the conditions within which the community lived and to lobby for better services*”.

Organizational culture and capacity development

Irene emphasised the importance of creating spaces within civil society organizations which strengthen relationships, solidarity, reflection and learning. Irene argued this can lead to accepting and accommodating peoples’ differences and strengths, and building a greater diversity of skills.

Reflexivity and openness to learning about the self and others are key tools for developing an organizational culture which nurtures capacity building: “*It helps you to adjust because in this activism you need to adjust a lot, you need to ... it’s a high relational activity.*”

Reflexivity as a tool for capacity development

The activists' narratives pointed to *reflexivity* as a tool for capacity building. Reflexivity was described by many of the participants as an essential skill for activism, as it helps to manage tensions which arise in the self and the group, build relationships and support continual learning. Rohit described how reflexive practice guides his activism and his approach to mentoring younger activists:

“But as you do in life, and try to change the world around you, please remember you have to change the world inside you... And every activist and everybody who comes here knows that you’ve got an inside learning and an outside learning. So when you go and even an activist will do something, it works, it doesn’t work, doesn’t matter. We have to understand why it worked, why it didn’t work. But you sit back and reflect: have you learned something about yourself?”

Activism as a paid job

Many young activists contemplate an ‘activist career’ but there are very few jobs. A few activists get paid for their activist work but they are generally underpaid, over-worked and their employment is often quite insecure. Relations between volunteers and paid activists can sometimes get difficult.

There are career paths in the NGO sector; often providing services on contract to large donors; contracts which often fragment service delivery and take the pressure off governments to deliver comprehensive health care programs. Another possible (well paid) career path lies with large intergovernmental organizations.

Our interviewees emphasised that activist organizations investing in capacity building (like PHM’s IPHU program) should try to ensure that their limited resources are directed at supporting young people who are passionate about working for structural change as well as addressing immediate health needs.

Self care

Throughout their activist careers the participants had been challenged by personal, professional and political dilemmas. They discussed strategies for managing the pressures of activism. Many of the activists highlighted the importance of self-care and in engaging in healthy activities, balancing personal and activist responsibilities and looking after your mental health:

“So you must give time on to that’s another thing which we have done is always find a little time for quiet reflection, for a little holiday. And not to feel guilty. But that’s I find a problem with activists. You start feeling guilty about the nice things of life. The comfortable things of life. But, you see, they’re all human beings, and you need some time to recover. After all, even a mobile needs a few - ours have been put into a little plug and get charged. And it’s safer not to be using the mobile while you’re charging it, because you could get a shock also, they say ... So I think that’s a very important strategy is to have - to know that your batter needs charging.”

Knowledge generation, storage, dissemination and access

The health activists’ in this study collected, generated and deployed knowledge in numerous ways to challenge hegemonic discourses of health and society which they understood as creating and sustaining health inequities.

Accessing scientific, technical, institutional, legal information to strengthen movement strategy and policy dialogue

Most of our interviewees spoke about the role of knowledge in their activism; examining, researching, synthesising and deploying technical, scientific and legal information. This occurred through advocacy work, writing policy proposals, interacting with government and community organizations, academic research and writing, and speaking at conferences and meetings in local and global spaces.

Over his activist career Indra has participated in many knowledge generating activities to disrupt and challenge inequitable systems, including through the People's Science Movement in India. In 1984 a Union Carbide gas leak caused the death of thousands of people at Bhopal. Questioning how scientific knowledge was being misused and silenced by the Indian government and big industries became central to the group's activism. The group focused on researching and educating through science, *"not just in the context of its potential as a liberator, but also its context of how it's misused under capitalism, and the kind of social control that you require over science"*. The People's Science Movement employed this strategy across many issues including access to medicines and the pharmaceutical industry, and a health literacy program which educated and mobilized people around issues of health care, water, sanitation and nutrition.

Knowledge as power

In the 1970s Angela worked in a coastal village in Central America delivering a community-based health program, training community leaders as part of a joint project with a government department and an NGO. Angela used her position in the community to empower local leaders with legal knowledge that was being withheld from them by their government. In this example Angela highlights the value of assisting marginalised people to understand their situations through sharing knowledge, and also how knowledge is tied to power relations which in this instance eventuated in her having to leave the country.

"We taught the people the constitution of (name of country), but it was written in mestizo and so it was a subversive document. That was my crime, teaching the people the constitution. My crime was having subversive literature... We taught the constitution to local people who are the Justice Department in a little village. They don't have judges and things like that, but they helped to solve the problem locally, and these are isolated villages up and down the river, no highways and nothing like that. The river is the only way of communicating."

Empowerment of the dispossessed through bringing lived experience into discourse and reshaping world views

Emma drew on her many years of experience working as doctor in disadvantaged communities delivering health services, training and popular education programs. She stated:

"I think always learn from the masses because they will always tell you what their needs are ... you have the knowledge and the skills, but they should be the ones who really work, you work with them but not you work for them. You work with them because they should be part of this development work, it's not you alone, and you have to listen to them. I think that's the learning there, to listen to the people and learning, analyze with them what is happening; and together you can come up with a course of action that will really lead towards a positive development because you're with them."

Conscientization

Angela discussed how through employing popular education techniques and engaging in Paulo Freire's (1968) theories of 'conscientization', she learnt how to engage with local people to develop their political consciousness; making them aware of the social and political contradictions of their social worlds, initiating a desire to take action against the oppressive elements impacting their lives.

Cosmovision

Angela described how the People's Health Movement in Latin America had decided to incorporate the cosmovision philosophy of indigenous people into their program and culture. This is an example of valuing experiential knowledges that are alternate to the mainstream and incorporating them into discourse to construct new ways of viewing and experiencing the world.

"The People's Health Movement in Latin America has made some pretty important decisions. We have taken the philosophy of the cosmovision of native peoples to be the driving force for the People's Health Movement in Latin America and that's the whole concept of buen vivir.

We are in a crisis of civilisation and the model is not working and so what model can work. The concept of buen vivir provides us with a model that is not exploitive of our planet; that recognizes that we have to take care of water and we have to source this water"

Knowledge dissemination and access; role of social media

In the narratives the activists shared their concerns about new forms of communication and collective action. There was some debate over whether social media and online activities such as "clicktivism" were a hindrance to activism or whether they represented another mode of communication.

On the one hand concerns centred on whether social media has eroded collective action practices in activism, and that the power of people coming together in person, learning from each other and organizing activities has deteriorated.

While Ivan presented a quite different perspective while commenting on the role of social media in campaigning:

"So it plays a very important role. Many older activists were distributing leaflets in the street when they were younger activists, and the equivalent today is tweets on Twitter...

... it's just another tool, and it doesn't change the way activism works. It's just another medium. It's just another way of communicating."

Policy dialogue and governance

Making policy dialogue accountable to communities

Some interviewees emphasised that activists whose main focus is on participation in policy debate need to share their analyses with the communities whose interests are at stake in such debates.

Policy dialogue should complement other forms of activism such as working with communities and campaigning and advocacy.

Some interviewees spoke of the risk of people seeing community work as more 'authentic' activism than engaging in policy dialogue, that community work was "rooted in a context that is real, that is made of

people” (Irene).

Engaging in policy dialogue can be dangerous

In many cases, policy dialogue involves challenging vested interests, including commercial interests. Sami reflected: “You’re challenging interests. And don’t be naïve to think that sitting on the same table with a pharmaceutical company is going to lead to a fair game. They are more powerful than you and me.”

There were in some cases extreme costs and risks associated with policy dialogue activism, ranging from activists who had been assassinated, injured, arrested, or exiled by oppressive regimes, through to NGOs losing government funding for advocacy.

Don’t let engagement in policy dialogue obscure structural power relationships

Rohit commented that structural power relationships and inequities that are evident in community work risk being hidden in policy dialogue work, and thus policy dialogue work requires vigilance and reflection to guard against reinforcing these power inequities:

In participating in policy dialogue and seeking to influence policy, activists often work with government bodies and thus have to balance competing interests:

“Even in the health sector, we do work with the government. Many of us, including me, are part of government task forces. But at the same time, we retain our independence, and I’m often very, very critical of the government on many issues.” (Indra)

WHO Watch and Global Health Watch

WHO Watch, a program of sending activists to report on and advocate on the World Health Organization, and Global Health Watch, a public health book now in its fifth edition, were noted by some interviews as good examples of global work that was important for civil society to engage in. Interviewees were positive about the success of these strategies – that WHO Watch had gone from struggling to engage young activists to receiving more applications than they could include, and that the Global Health Watch publication had “*a position now which is established in the activist/academic community of Public Health*” as a “*useful publication*”. Another interviewee noted that “*a lot of people give us very positive feedback about it.*”

In both WHO Watch and Global Health Watch policy analysis and policy advocacy are explicitly embedded in a wider structural analysis of governance.

Suggestions for policy makers and funders

Funding for core infrastructure costs rather than projects

A number of activists highlighted the problem that increasingly funding is only available to cover costs of projects but not basic infrastructures costs for a network like PHM which does not have a membership structure to produce annual fees.

Funders who appreciate the work that PHM does should consider funding infrastructure rather than defined limited projects. One activist recalled that from its foundation in 2000 to the global financial crisis in 2009 PHM had benefited from core funding from a number of progress

“PHM, from about after 2000 through ‘til probably the global financial crisis, we did have organizations, particularly in Europe, who would fund and we could have quite a strong secretariat but that’s been whittled away now and it’s much, much harder. You really do

need a sort of society that's prepared to pay for an international movement because either someone has to give their time or someone has to pay for time. You can do so much on volunteer effort but at some point you do need societal support for the movement.” (Elaine)

Furthermore, as described in the discussion on global local relations, the world has become more globalized and local issues are intrinsically linked with global issues. Therefore, there is increased need for policy makers and funders to support international activities and organizations such as PHM whose work is centred on advocacy and analysis. Funding must be considered for activities beyond projects and services.

Universities and academic freedom

Some activists in PHM combine their activism with an academic career. They have been fortunate to work in Universities that respect the tenets of academic freedom and this means that they do not have to be fearful of repercussions for their activism:

“I've been able to manage both careers in academic and been a very – what's the word? Overt and open activist. Political activist, and I've been able to continue to be successful in an academic career whilst continuing a track of activism and hopefully I've helped to make activism respectable and something that you shouldn't be fearful of. Consequently, trying to encourage people to not be worried about the impacts of being socially and politically active on their careers. That it is possible to manage both things, although there is a risk, and that you have to be prepared to take a risk at the same time.”

However, in some settings academic freedom may be compromised and university staff may be persecuted for their activity as happened recently in relation to Turkish academics. Universities need to protect and maintain academic freedom so that their staff are able to engage freely in civil society activity including social movement activism.

Annex 10. Manual on movement building

A manual on movement building was developed during the CSE4HFA research and published in April 2017. Its development was based on wide consultation across PHM, including a wide range of case studies (summarized in the appendix), and was also informed by the emerging findings of CSE4HFA research. See Manual in full here: [Movement Building Manual \(2017\)](#).

In this annex we abstract from the Manual some of the main 'principles' for movement building highlighted in the manual.

The preface summarizes 'why we need a (global) movement for health'. This preface covers some of the same ground which is covered in Chapters 1 and 2 of this report.

Chapter 1 is entitled 'Relationships, wellbeing, pleasure in doing things together, values'. The implications of this title are elaborated in the chapter; exploring the forces which keep people together in movements; the shared identity, shared values and vision for change. The cultural environment created within the movement should make people feel better and enjoy working together! The chapter highlights respect for diversity and care for each other and for Mother Earth.

Chapter 2 deals with decision making, organizational structure and process and sustainability. The chapter starts with a discussion of power within organizations and the need to be aware of the reproduction within the activist organization of the hierarchies of power which characterise the regime that the movement aims to change. This awareness of power has implications for group work and decision making.

Chapter 3 deals with advocacy, campaigns and communication. The chapter highlights the importance of combining winnable short-term localised objectives within a framework of longer term larger scale change and cites a number of case studies which illustrate this in various ways. The chapter also discusses the practical issues involved in mobilizing resources for action; action that is visible, attracts people and makes an impact. The chapter highlights the importance of good communication, the message, the media and the channels.

Chapter 4 deals with participation and community action. Sometimes the focus is needs assessment and prioritisation. This leads to new partnerships and the acquisition of new understandings and finally joint action.

Chapter 5 discusses networking (at local, national and international levels) and cooperation and resource sharing across networks. Networks need to be nourished with continuing engagement and shared activities.

Chapter 6 discusses mutual learning, knowledge generation and participatory action research. The chapter emphasises collaborative processes, shared learning rather than transferred learning.

Chapter 7 develops some of these ideas further, focusing on popular education and creative and interactive training. The chapter focuses on learning from PHM's experience with the various IPHU courses.

Do we need to say the manual will be revised every two-three years based on evolving experience ie not intended as a static document??

Annex 11. Evaluation survey of the International People's Health University (IPHU)

This study was a questionnaire survey evaluation of IPHU alumni conducted by a multidisciplinary team at the Centre for International Health in Bologna. The full report of the research is [here](#).

See also the report of the 2016 IPHU course in Nepal ([report here](#), summarized in Annex 14 below) and the report of the sequence of courses in El Salvador ([report here](#), summarized in Annex 12 below) and the Study Guide for the Online IPHU course (IPOL) on global health governance ([here](#), discussed further in Annex 16 below).

In this annex we highlight the implications for capacity building generally arising from the IPHU evaluation. These propositions are oriented around PHM's capacity building program including IPHU but are cast more generally.

Capacity building matters

The survey shows that the responding alumni reported a high level of appreciation for the IPHU, appreciation that is widespread across regions, time, and characteristics of the IPHU such as duration. Alumni think that the program is relevant for the range of expected impacts, including on knowledge and competences (particularly on PHM functioning and on the social determinants of health), relations and networks, political activity, but also work/career. They are generally happy with the methodologies and with the trainers, highlighting on the one side the need to increase practical/creative activities and field trips, and on the other to strengthen aspects related to language competence.

As many as 92% of respondents declared that their engagement with health issues increased after the IPHU. Around 50% took part in other PHM programs after the IPHU, and 64% declare to be still engaged with PHM (mainly at the local level). Quite significantly, 30% of those who are no longer active with PHM explain it in terms of not knowing how, lack of follow up and support.

Content and 'level'

With some important exceptions IPHU courses have assumed a knowledge and academic skills level which corresponds broadly to graduate level training if not higher. This is reflected in the profile of participants. Less effort (at the global level) has been put into presenting courses which are accessible to participants without graduate qualifications. The SAPHU courses ([here](#)) and the El Salvador courses ([here](#)) provide precedents for such training.

Clearly social movement organizations need to think in terms of a suite of programs, not just pitched at different levels of prior training, but also addressing different technical areas and issues.

There may have been an assumption of some kind of cascade training; that IPHU alumni would be immediately empowered, resourced and equipped to present more targeted courses in their own countries and localities, oriented around the learning needs of local activists and current priorities (as with the SAPHU courses).

PHM's IPHU program has presented a number of 'specialist' courses, in particular on medicines policy and on global health governance. These courses point to a much wider range of specialist courses which could be presented (assuming need and resources).

Teaching methods need to be appropriate for content and aligned to the expectations of participants. There are important learning objectives which are dense with facts and logic. These call for particular pedagogical styles. There are also learning objectives which are more about relationships and listening. These may call for different pedagogical approaches. Participants vary in their taste and tolerance for facts and logic and vary in their prior exposure to more experiential ways of learning.

Marketing and selection

The broader the range of course/opportunities on offer, the more important it is that organizers target and select for those who correspond to their purposes and that potential participants are able to target the kind of courses which meet their needs.

Most of the IPHU courses that PHM has presented were directed to movement building. This has implications for the organizers in relation to marketing. However, many applicants are thirsty for the knowledge and skills that the courses offer, not always for reasons of activism. This also points to questions of selection.

Language and identity

There are benefits from running bilingual or multilingual courses in terms of learning across difference and building solidarity. However in the absence of high quality simultaneous translation and facilitation these benefits can be lost and even overshadowed by the experience of linguistic exclusion. Extremely heterogeneous classes, even with good translation resources, can make listening across difference more difficult.

People want to learn from people they trust. A perception that a course is organized by and taught by *our* experts strengthens trust. IPHU alumni want to know about the activist credentials of people who are presented as teachers.

Annex 12. International People's Health University: El Salvador, A transformational experience in El Salvador

In 2016 was held the sixth El Salvador IPHU, bringing together government officials and civil society activists to reflect on health development issues in EL Salvador, to learn together about policy options and the science and logic behind those options, to undertake field visits to learn together about the realities facing different segments of the El Salvador people.

This annex draws from a case study of the six IPHU courses held in El Salvador between 2009 and 2016. The case study, [here](#), starts with some history, including PHM and IPHU but also recounts the election to government of the Farabundo Martí National Liberation Movement (FMLN) in 2009 with a platform in health which corresponded to many of the principles discussed in IPHUs and within PHM LA.

The case study is a rich description of a unique initiative with a significance which goes way beyond El Salvador. This annex provides a brief summary by way of supporting the relevant chapters in the main report.

The new government's health policy 'Building Hope' was based on primary health care principles including not just health care delivery but concerted action around the social determination of health, in particular through creating substantive avenues for community participation in policy, in management and in action for better health.

The new vice-minister for health and the coordinator of the NHF had both participated in previous IPHU courses and were keenly aware of the potential of this kind of structured training to support the implementation of the new policy 'Building Hope'.

In putting together the first course in 2011 the organizers were able to draw upon the experience and expertise of members of the Latin American Association of Social Medicine (ALAMES), including its El Salvador chapter, many of whom had attended and resourced previous IPHU courses. Maria Hamlin Zuniga, the author of this case study, was a key player in coordinating the development of the course and all of the subsequent courses.

The case study reviews the arrangements for curriculum planning, marketing and selection. One of the unique features of this sequence of courses is the bringing together of government officials including medical doctors with representatives of the National Health Forum (NHF), a coalition of civil society organizations.

In the preparation of this case study a number of key actors were interviewed and focus groups were held with both health professionals and NHF leaders. Qualitative assessment exercises using the "most significant change" method were conducted with facilitators of different generations of courses, as well as with foreign students and several international teachers.

The remainder of the case study summarizes the findings of this evaluation. This synthesis is structured around a number of direct quotes:

"The IPHU produces an intense shock that shakes one. The contents are profound, very strong, and unveil 'real reality.' There's a break between before and after the IPHU. We're changed; nobody's the same as before."

"The greatest benefit I received from IPHU is to have generated friendships with all the participants whose dream is to transform and create a better world."

“The course made me get out of that non-existent space of being in the system as ‘a professional’ (colonized) and anchored me to a mooring that keeps me closer to reality, as one who is critical and feels others’ pain. It’s an eye opener that sensitizes and humanizes a person.”

“IPHU in El Salvador marks people’s lives because they encounter reality itself, with explanations that provide elements to judge their own behaviour, to understand the class struggle and why people act as they do, and finally to understand life itself. The course forms lifelong activists to strengthen the struggle for health based on social determination and to advocate for health reform.”

“We realized Salvadorans have lost their identification with the indigenous population. We not only have the right to territories, to water, and to restore forests and preserve the air, but also to recover and promote their traditional, ancestral knowledge.”

“More than former participants, we are militants in the struggle for health”

“It is fundamental that people from other countries of the region and the world recognize the Salvadoran revolutionary process and the struggle for health.”

Some intellectuals and academics who have participated as teachers/tutors in IPHU courses have shared their reflections for this study.

“The strategic alliance generated between the PHM-IPHU and MINSAL of El Salvador is of vital importance. On the one hand, the PHM-IPHU makes available to the ministry a teaching methodology and a group of facilitators trained in a pedagogy for liberation, while MINSAL assumes as a priority the formation of political and technical cadres as a central element to advance the health reform. Today, it can be said that the leaders in charge of the Salvadoran health system are the IPHU graduates who consider the struggle for the right to health their fundamental objective.”

Oscar Feo, Venezuela.

“The IPHU in El Salvador has allowed the creation of a critical mass of health professionals, trained to [translate and interpret] the underlying reality in the public health and health systems environment. Tools of a certain complexity are acquired, given the self-interested ‘wrappings’ that conceal reality. This group of professionals is essential to support the country's current health reform. In the future, from the opposition, they will be guarantors of non-regression of achievements. The ‘transversality’ of the participants’ origin and especially the NHF’s participation are important factors. The constant presence of the teachers insures the exchange of opinions, from diverse sanitary environments, at different moments.”

Txema Ostolaza, Basque Country.

“There is no health reform that will survive in time if not defended by its professionals, its workers and the organized population. That is precisely what the issues discussed in El Salvador’s IPHU are affecting.”

“In the reforms of health systems, in addition to the political will of the government to prioritize social policies and specifically health policies and citizen's right to health, the socioeconomic context and the attitude of the population and the leadership in support and defense of the reforms are important. The ideological position of the professionals working in the central health structures, health centres and hospitals is key.”

“The role of health professionals and workers is fundamental in the defense of a democratic public health system, with efficient and effective citizen participation and control of scientific and technical quality in accord with the objectives of the health plan.”

Juan Luis Uría, Basque Country.

Conclusions

IPHU has formed a critical mass of sensitized health workers and NHF leaders with tools to defend health reform. They are a strategic generational replacement group in the public health system, many of whom have management-level positions in the institutions and organizations to which they belong.

Implementing IPHU in a single country over time, with the majority of participants coming from that country, helps strengthen territorial organization.

The major obstacle to developing the course was the deep-rootedness of the biomedical model among the majority of health professionals, attributable to their formal education and to the traditional organization and functioning of the health system. Another obstacle is the lack of follow-up, institutional support and funding for the projects proposed in IPHU.

El Salvador’s experience with health reform and the value of IPHU to that effort is neatly summed up in this MINSAL (Ministry of Health) document titled *“Diagnostico Nacional de Promocion de la Salud”* (National Health Promotion Assessment), jointly prepared by representatives of both NHF and MINSAL (an accomplishment that in itself is of historical symbolic importance):

Today, in addition to the hegemonic [risk and social determinants] approaches, there is another more progressive approach to health at a global level: one that speaks of the social determination of health. MINSAL has made a commitment to implement that social determination of health approach. Participation in IPHU in El Salvador has allowed for that transformation in ideological, theoretical and practical terms. It is not simply a matter of semantics, but an understanding of the social determination of health approach, a fairly recent conception for approaching and understanding the process of health and disease.

A major achievement and lesson for the global PHM is the involvement of a critical mass of participants in this debate, as well as their importance at the national, regional and global levels.

Annex 13. Evaluation of reach and impact of Global Health Watch 4

This annex draws upon an evaluation of PHM's engagement with *knowledge creation and dissemination* towards Health for All, with a focus on Global Health Watch 4 (GHW4). See full evaluation report [GHW4 Reach and Impact](#).

About GHW

Global Health Watch was first published in 2005 ([here](#)) and subsequently in 2008 ([here](#)) and 2011 ([here](#)). GHW4 was published in 2014 ([here](#)). GHW5 was published in late 2017.

From the introduction to GHW4:

The Global Health Watch, now in its fourth edition, is perceived widely as the definitive voice for an alternative discourse on health. It integrates rigorous analysis, alternative proposals and stories of struggles and change to present a compelling case for the imperative to work for a radical transformation of the way we approach actions and policies on health. It was conceived in 2003 as a collaborative effort by activists and academics from across the world, and is designed to question present policies on health and to propose alternatives. Global Health Watch 4 has been coordinated by six civil society organizations – the People's Health Movement, ALAMES, Health Action International, Medico International, Third World Network and Medact.

Global Health Watch 4, like the preceding volumes published in 2005, 2008 and 2011, provides analysis of contemporary issues that impact on health. It provides policy analysis, debates technical issues, and provides perspectives on current global processes. The GHW does not limit itself to the 'health sector' but extends its scrutiny to all those areas that determine whether people are able to live healthy and fulfilling lives. We hope the contents will be of use to a wide range of readers – activists, academics, developmental agencies and policy-makers. Global Health Watch 4 provides information and analysis, but it also takes sides. The analysis and alternatives that we present are embodied in a vision of a society that is more just, more equal and more humane. Many of the stories that we include inspire hope that change can happen, and is actually happening in many parts of the world.

As in the case of the previous editions, the contents of Global Health Watch 4 are divided into five interlinked sections. The section on the 'The Global political and economic architecture' locates the decisions and choices that impact on health in the present structure of global power relations and economic governance. The section 'Health systems: current issues and debates' looks at contemporary debates on health systems in different parts of the world, to draw appropriate lessons and propose concrete actions. The third section, 'Beyond healthcare', engages with multiple social and structural determinants of health. The section on 'Watching' scrutinizes global processes and institutions which have significant impact on global health. The final section foregrounds stories of action and resistance, from different parts of the world.

The introduction to GHW4 provides a summary of the sections and chapters, [here](#).

Methodology

The evaluation was based on a survey of anonymous respondents recruited through PHM's Newsletter and collected through the PHM website and an anonymous survey of PHM activists who had been involved in organizing launches of GHW4 in their countries at various different events.

Findings

Respondents valued GHW, partly for its content but also as a tool for disseminating PHM's analysis and as a focus for movement building. The respondents believed that the main audience being reached are academicians and students and policy officials and health activists perhaps to a lesser extent.

Respondents were asked to identify the content they found most useful. The responses were quite varied and spanned all of the sections of the book. Several respondents noted that they found many chapters useful.

There was broad agreement among the respondents regarding limitations on the usefulness of GHW. The main limitations were the restriction to English and the relatively dense language of the text.

Respondents suggested producing primers in simpler language, and which use of infographics and more detailed case studies. It was also suggested that PHM organize speaking tours elaborating on particular sections or chapters. One respondent suggested GHW explore methods for promoting an ongoing discussion, perhaps focused on one or a few chapters but including digital communications and local events.

Most respondents accessed GHW because they are already affiliated with PHM (which is not surprising in view of the samples being surveyed). Most advised that they have suggested GHW to others. Most respondents do not purchase GHW in hard copy but rely on the internet access. Several respondents indicated that price was a barrier to purchasing hard copy.

Implications for generic themes

Movement building

It is interesting that several respondents cited, under the usefulness of GHW, the fact that it helps to build PHM first as a focus for local PHM activity and second as a unique source of useful information.

Campaigning

The suggestion that GHW pay more attention to follow up and create a conversation could be pursued by encouraging campaigning around the issues covered by particular chapters. Conversely, the content of these chapters also often describes local (or global) campaigns in which PHM is often involved.

Capacity building

Whilst not mentioned in this evaluation it is worth noting that online GHW chapters have commonly been used as references for IPHUs, and frequently are included in university course references (confirmed by anecdotal reports from Canada, Mexico, Brazil, Australia and the UK).

Knowledge creation and dissemination

It is apparent that resources like GHW (as currently produced) have a key role in knowledge creation and dissemination to support civil society engagement in Health for All. Some of the suggestions for improving GHW would also be more widely applicable, including more case studies, multilingual versions, products at different levels, more follow up (a continuing conversation) and more effective dissemination.

While the intellectual content of GHW is generated free, largely by academics and researchers from many countries, it is worrying that the price (printing and distribution) is seen as a barrier.

However, there are other forms of knowledge creation and other forms in which GHW content could be packaged. For example PHM does not have a repository in which selected books, reports and journal articles might be listed and annotated and made available to activists who spend less time monitoring the flow of publications.

Several other studies undertaken under the CSE4HFA banner and linked from elsewhere in this report have highlighted other approaches to knowledge production including participatory action research and popular education.

Policy dialogue and governance

The chapters of GHW are highly policy relevant. However, they are necessarily set at a relatively general level for an international publication. For this kind of resource to usefully support local and national policy dialogue there would need to be further activities and/or resources directed to applying the more general resources and perhaps generating more locally relevant knowledges. This is an area where using certain GHW chapters as a starting point for local dialogues on more contextually specific policies or campaign actions could be considered.

Annex 14. “The Struggle for Health in South Asia: An Alternative Thinking for Solutions” Report of IPHU short course, November 2016, Kathmandu, Nepal

The study linked from this annex provides a detailed report of the IPHU conducted in November 2016 in Kathmandu, Nepal. The full report of the course is [here](#).

This report provides an excellent window into the style, content and atmosphere of the ‘standard IPHU’.

Annex 15. Civil Society Engagement with Global Health Governance (GHG)

The research reported in [CSE and GHG](#) was conducted to evaluate PHM's WHO Watch initiative in the context of the wider Democratising Global Health Governance (DGHG) project.

In this annex we provide some further background to WHO Watch and the DGHG project; we outline the methodology used in the CSE and GHG project; and finally bring together the conclusions in relation to the five generic themes of the larger project.

Background

The Democratising Global Health Governance project was launched in 2010 by PHM in association with a number of other civil society organizations. WHO Watch is a first step in implementing the objectives of the DGHG project.

From the webpage, 'About WHO Watch' ([here](#)):

The structures and dynamics of Global Health Governance (GHG) are dominated by the big powers (in particular, USA and Europe) and by large transnational pharmaceutical corporations. The big players operate through the UN system, the Bretton Woods system and a plethora of global public private partnerships. They also operate directly through bilateral and regional trade agreements; through the operations of bilateral health-related assistance; and through direct advice and pressure. The operating paradigm of this regime is strongly influenced by the ideology of neoliberalism which is promoted through a much wider range of channels including the commercial media and various corporate peak bodies (such as at the World Economic Forum).

In many respects the regulatory, financing and policy outcomes of this system reflect the interests of the elites of the rich world. This bias is reflected in:

- continuing unimpeded brain drain, in part because the rich countries do not train enough of their own professionals (it is much cheaper to import professionals trained in the developing countries);
- an intellectual property rights regime which is largely focused on maintaining the profits of transnational pharmaceutical companies and discounts the urgent need of millions of people in developing countries for affordable medicines;
- trade policies which sanction the dumping of agricultural produce on developing country markets (which jeopardises the livelihoods of small farmers);
- trade policies which pressure developing countries to cut tariff protection and export duties without regard to the consequent unemployment and loss of government revenues (and public services);
- health system policy models which are oriented to stratified health care delivery with private care for the rich, social insurance for the middle and safety nets for the poor;
- resistance to the kinds of sectoral policies suggested by the WHO Commission on the Social Determinants of Health which could greatly improve population health.

The Democratising Global Health Governance Initiative, of which WHO Watch is a project, is designed to contribute to improved population health by changing the power relations around global decision-making through new alliances and new information flows.

WHO Watch is a project undertaken under the broad umbrella of the DGHG initiative:

WHO Watch is a resource for advocacy and mobilization and an intervention in global health governance.

As a resource for advocacy and mobilization WHO Watch provides a current account of global policy dynamics in relation to a wide and growing range of health issues. While the focus is on issues being considered through the WHO the background documentation provides a more broadly based account of these issues.

We aim to strengthen various streams in the Health for All movement (IP and access to medicines, trade and health, health systems, PHC, quality use of medicines, amongst other topics) by ensuring that activists whose concerns arise from their grass roots involvements can learn about the global dimensions of the problems they are facing and reshape their advocacy and mobilizing accordingly.

WHO Watch is also an intervention in global health governance.

Partly WHO Watch is about defending WHO as the global health policy voice, a voice that has been subject to very bad stresses for several decades. WHO is the paramount health authority at the global level and needs to be strengthened and reformed and properly funded to play this role. WHO Watch seeks to generate support for a reformed WHO restored to its proper place in global health governance.

WHO Watch also aims to democratise the decision making within WHO, in particular supporting delegations from smaller countries who are seeking to know more about particular issues or are looking for resources regarding issues that they are concerned about. Many delegates from small countries are over-stretched trying to cover a very wide range of issues. We aim to have a resource here which delegates to WHO governing bodies might turn to for ideas and resources. Our objective in resourcing this constituency is largely about better decision making in WHO.

Finally, WHO Watch aims to support wider knowledge of, and participation in, the various engagements across the broader field of GHG. We are aiming to change the balance of power framing global decisions which impact on health. WHO Watch is the first phase of broader ambition, the Democratising of Global Health Governance.

How WHO Watch works

Tracking and commenting

In advance of the global governing body meetings of the WHO (the Executive Board (EB) meeting in January and May and the World Health Assembly (WHA) in May) PHM prepares a detailed commentary on the entire agenda of the meeting. This is a collaborative effort that harnesses the expertise of activists and subject experts from across the world. The commentary provides a detailed background for each agenda item to be discussed at the governing board meetings, an analysis of the documents circulated in advance and articulation of a PHM policy position in relation to most agenda items. The detailed commentary is circulated to all the delegations prior to the meetings.

The PHM commentary is linked from the WHO Tracker (who-track.phmovement.org) which is an internet platform for tracking governing body meetings, the consideration of particular issues, and the implementation of resolutions.

PHM's commentary and advocacy documents are now being utilized by a number of CSOs to support their analysis and by a number of country delegates (especially from LMICs) who find the documentation and analysis useful in formulating their own interventions.

Tracking and commenting is now routine for global governing bodies (EB and WHA). The regional committees are tracked but not routinely commented upon at this stage. Tracking and commenting does not require physical presence at the meetings.

Watching, intervening and reporting

The 'Watchers' presently attending the EB and the WHA are young health activists from around the world, who are selected through a 'call for applications from volunteers' sent out before each governing body meeting. The 'watchers' are mentored by 2-3 senior PHM activists and they prepare for the meeting by familiarizing themselves with PHM's commentary and with documents circulated for each agenda item by the WHO Secretariat. A 4-5 day orientation workshop, prior to the meeting, is organized in which the 'watchers' with the support of the mentors develop an understanding of the wider picture of Global Governance for Health, as well as of the specific agenda documents and proposals that are to be discussed at the EB or the WHA. The workshop, thus, is designed to build capacity of young activists on global health, and also prepares them to intervene during the governing board meetings.

During the EB or the WHA the watchers document discussions taking place inside and relay this, in real time, through a Skype channel to a large network of interested people, including PHM activists in countries, interested CSOs, and academics following the debates in the WHO. The watchers are encouraged to liaise directly with official delegates during breaks and advocate on PHM's positions on important agenda items. An advocacy document containing key issues and PHM's positions regarding these is produced as a tool for advocacy with delegates. The watchers also make statements within the meetings on issues that PHM thinks are important to focus upon²³. Towards the end of the governing body meetings the watchers prepare reports on particular agenda items which are then circulated via PHM Exchange (PHM's global email list).

Watching (and intervening and reporting) has been established at the global governing body meetings but this kind of physical presence at regional committees has been somewhat sporadic.

Policy dialogue at the national level

It is part of the design of WHO Watch that PHM circles might develop policy briefs on agenda items for forthcoming governing body meetings (global governing bodies or regional committees) and might engage in some level of policy dialogue with health ministers or departmental officials regarding the position to be adopted by that country at the forthcoming meeting. This process generally needs to be led by local activists who have attended governing body meetings as watchers and have a strong sense of how WHO works and how WHO Watch works.

National level policy dialogue may also deal with the implementation in the country of WHO resolutions and programs. This is not so much about helping the government prepare for its participation at the governing body meetings but more about holding governments account for implementing the principles and programs which they have agreed to at those meetings.

These provisions for policy dialogue at the national level are envisaged as creating new links between the 'watching' processes and the various struggles around health in different parts of the world. These links enable local activists to keep in touch with the trajectory of global policies which shape the context for such

23. Civil society organizations which are recognized by WHO as having 'official relations' with WHO are entitled to make brief statements to the governing bodies during the discussion. PHM does not have 'official relations' with WHO but participates under the aegis of Medicus Mundi International.

local struggles. They also help to ensure that policy analysis and policy advocacy at the regional and global levels is informed by the reality of grass roots activism.

Engagement in this kind of policy dialogue at the national level has been implemented in several countries and it is expected to be adopted more widely. The PHM Ghana circle has pioneered this process and the report of the [Ghana Workshop](#) provides a sense of how it works.

Methodology

The research reported in [CSE and GHG](#) involved an evaluation of WHO Watch undertaken in May 2015 and involving key informant interviews, focus group discussion, participant observations, and an online survey. See full report for more details.

Attached as an appendix to the research report are reports of three episodes of WHO watching:

- The 138th Executive Board meeting,
- the 69th World Health Assembly, and
- the 140th Executive Board meeting.

The detailed findings are presented in the full research report ([CSE and GHG](#)). In the remainder of this annex we draw out the implications for the five generic themes of this research, in particular for the fifth theme regarding policy dialogue and global health governance.

Implications for the five generic themes

In extracting implications from the evaluation report for the five generic themes we are aiming to generalise to ‘civil society engagement’ more broadly and not to restrict the learnings to PHM and WHO Watch alone. However, it needs to be kept in mind that WHO Watch is unique in its comprehensiveness (most CSOs involved in advocacy at the global level are generally single issue organizations) and its reliance on a relatively high turnover of young activists (most CSOs are represented by paid staff or more senior and experienced volunteers). This limits somewhat the transferability of our lessons to other civil society or social movement groups.

Movement building

WHO Watch is an excellent opportunity to build relationships with other civil society actors. This is of particular significance in terms of converging towards a more broadly based Health for All movement.

However, concern has been expressed within PHM and from some of the activists interviewed that the opportunity costs of WHO Watch, measured in terms of other uses to which donor money might be put (movement building or grass roots campaigning), may be significant.

Campaigning and advocacy

The material generated through WHO Watch should in theory feed into campaigning and advocacy at the local and national levels. Likewise the systems in place for engaging with global decision making should in theory provide new strategies for local struggles which are in various ways shaped by global dynamics.

These possibilities have not proved easy to realize in practice.

Capacity building

The participants in the Watch have reported that their involvement in the Watch process had been a very significant boost to their development as activists. This includes their understanding of health issues, their appreciation of the structures, power relations and dynamics of global health governance, and the friendships and networks that were forged.

Similarly civil society respondents also commented on the value of the both the workshop and participation in the governing body discussions, as capacity building.

Knowledge development and dissemination

The development of the commentary and in particular the ability to trace the evolution of particular issues through time (assisted by the functionality of the [WHO Tracker](#)) is an important form of knowledge creation. However, constructing such longitudinal narratives requires a certain amount of work and needs an appropriate platform for access and dissemination.

Policy dialogue and global health governance

WHO's role is appreciated as important by many countries

Respondents from LMICs interviewed for this evaluation spoke strongly of the importance of WHO for their health work.

WHO needs civil society support including more radical critiques such as PHM's

Several respondents expressed concern regarding the power of the donor states (often exercised on behalf of the large corporations) and of large philanthropies, particularly Gates, often exercised behind closed doors.

Donor dependence and a totally inadequate budget (through the freeze on assessed contributions and tightly earmarked donor funding) imposes serious limitations on what WHO can do and exposes the Secretariat to pressures to serve the wishes of the donors rather than implement governing body resolutions.

There is a widely recognized need to hold WHO – Secretariat and member states – accountable. These involve different questions. The Secretariat is under intense pressure to bend to the wishes of the donors; occasionally they bend too far. Civil society has an important role in challenging such concessions. Member states need to be accountable for implementing Assembly resolutions which generally they are not. More worrying are the member states who provide Trojan Horse facilities for commercial interests. Civil society has a key role in holding member states accountable on both counts.

However, beyond this there is also a recognition of the usefulness of civil society advice and statements, including draft resolutions, speaking points, influential side events.

Oxfam, MSF, DiNDI, IBFAN, NCD Alliance are cited by respondents by way of illustrating the contribution that CSOs can make, highlighting high level policy analysis and close awareness of what is going on, on the ground.

However, several respondents voiced warnings about the heterogeneity of 'civil society' and the emergence in recent years of 'front organizations', dressed up as civil society but pursuing quite commercial interests.

WHO Watch, as it presently works is widely appreciated

WHO Watch is widely appreciated, by CSO representatives, some country delegates and some WHO staff. It is appreciated for the quality of the analysis, for the comprehensive coverage, and for the real time broadcasting including through the Twitter and Skype feeds and the daily reports.

However, there were a few criticisms of the Twitter and Skype feed. Some respondents recalled comments that might not have been fully informed or highly nuanced.

Respondents suggested a number of possible improvements to WHO Watch including developing a stronger capacity for real time comments on particular issues arising during the governing body meetings. Several respondents urged PHM to reach out more effectively to WHO staff as well as country delegates based in the country mission in Geneva and government officials based at home. One suggestion was to create stronger links through the Communications Office of WHO and perhaps spend more time in Geneva visiting Secretariat staff, including senior managers as well as technical officials.

There are alternative models for civil society input to global structures

Respondents noted that there are other models for civil society participation in global decision-making, citing the role of civil society representatives at UNAIDS and at the Global Fund. These are semi-permanent representatives who acquire a high level of expertise.

Engaging effectively with the governing body deliberations

The strength of the WHO Watch team is an important element of effectiveness of the Watch. Likewise the use of digital technologies.

However, respondents recognized that the Watch could be more effective in influencing outcomes, for example as a vehicle for including on the WHO agenda items which reflected the needs and challenges faced by grass roots communities and their health workers.

Several respondents urged year round engagement rather than parachuting into Geneva for the governing body meetings. This would facilitate the building of personal relations with Geneva missions and Secretariat staff which is difficult without a permanent presence in Geneva. Likewise developing ongoing relations with delegates based at home is difficult because of the continuing turnover of our watchers.

Training through the pre watch workshop highly appreciated (and highly necessary)

The pre-watch workshop is highly valued by participants and appreciated by other CSO folk who participate. Some watchers suggest that deeper pre-workshop orientation would be useful, perhaps a short online orientation (such as the IPOL on GHG, see [Annex 16](#)).

Communication from the Watch to the wider PHM constituency and beyond

Several respondents have suggested better dissemination of information and analysis, including better use of social media. This could include more regular information sharing (outside governing body meetings), including new policy directions, progress in the funding of WHO, etc.

Links between engagement at the global level and action at the national and local levels

A core assumption underpinning the development of WHO Watch was the expectation that it would contribute to linking local advocacy to global decision-making. Participation in WHO governing bodies provides information, insights and relationships not otherwise easy to access. Information and insights from participation in WHO Watch and access to the materials flowing from it could support policy dialogue at the national level and more locally

It is part of the WHO Watch concept that local activists, drawing on WHO Watch experience and information, are able to liaise with government officials before the assembly and to influence the policy positions adopted by those countries. Likewise that grass roots activists might be able to gain leverage from information and insights from the global level in their local and national policy dialogue. There are some early signs that such engagements are feasible and the ideas were supported in principle by country delegates. However, it has proved slow to develop.

Several respondents from among the watchers have urged more effort to support dialogue between activism at the global level and at the local and national levels. After each watch there should be a realistic project for mobilization and action in between events.

One suggestion which emerged was that PHM should be encouraging progressive governments to include civil society representatives (including PHM activists) in their delegations to Geneva.

WHO Watch is quite expensive to maintain

WHO Watch is quite expensive as it currently operates, largely because of the cost of travel and accommodation in Geneva for teams of 8-12 watchers.

Strengthening the watching of regional committees would add significantly to this cost.

A permanent Geneva presence, urged by several respondents, would further add to the costs of this project.

Stepping up engagement between PHM's country circles and their governments regarding issues coming before the governing bodies would also have resource implications.

Annex 16. Study Guide for the online course on Democratising Global Health Governance and WHO Watch (IPOL GHG)

The first online IPHU (IPOL) focusing specifically on global health governance was held in April and May 2014 before the watching of WHA67 (study guide [here](#)).

The IPOL comprised four units:

1. WHO: structures, functions, governance
2. History of WHO
3. WHO Watch
4. Policy skills

Each unit included:

- a set of learning objectives,
- a reading program,
- a webinar discussion,
- one on-line small group discussion, and
- one written exercise (with email feedback).

The Study Guide ([here](#)) is included in this report simply to convey the approach we are adopting in terms of preparation for watching WHO's governing bodies.

Feedback from the participants was positive although there were bandwidth problems for some participants and the one week turnaround for each unit was too short to allow full exploration of the materials covered in the readings and the webinars.

Implications for generic themes

The main implications are for capacity building and policy dialogue and governance.

Capacity building

In terms of capacity building the Study Guide illustrates the potential for online training. There have been three IPOLs:

- the first was presented by way of preparation for the full, face to face IPHU which was held in Cape Town before the Third People's Health Assembly in 2012;
- the second was a stand-alone IPOL covering the 'standard' curriculum over four months; and
- the third was the short IPOL in GHG presented in 2014.

All of the IPOLs have followed the same broad format.

The main advantage of the IPOL approach is that they are very cheap (recognizing that they depend on the voluntary participation of teachers and tutors). For motivated students they have been very successful. However, the disciplines involved in the reading, viewing videos, writing (and commenting on) exercises are onerous for both participants and tutors. In addition many participants (and tutors) faced bandwidth issues and lack of technical capacity.

Policy dialogue and governance

In terms of policy dialogue the IPOL (GHG) demonstrates the potential of this kind of online training in relation to global health governance. There is no strong reason why this stream of IPOLs should wait until watchers are selected just before the governing body meetings. Indeed participation in an IPOL (GHG) could be a precondition for being selected to participate in the Watch.

Annex 17. Ghana workshop

As noted earlier ([Annex 15](#)) it has been part of the WHO Watch concept that as well as watching WHO governing bodies the program would include activities at the national level: reporting back to local PHM circles; liaising with government officials before governing body meetings.

The Ghana circle of PHM has had several members participate in watching episodes and has taken the lead in organizing dialogue with local officials and consulting with other civil society organizations.

Linked from this Annex is the report ([here](#)) of a two day civil society consultation held Accra in May 2017 before the 70th WHA.

In preparation for the 70th World Health Assembly to be held in Geneva from 22 - 31 May 2017, People's Health Movement (PHM) in Ghana convened a two-day national civil society consultation to review in detail items that will be coming up for consideration and prepare a civil society position paper on the key items. PHM/Ghana is fast establishing a distinctive niche as the lead network that mobilizes civil society actors on issues of global governance for health in the country. PHM/Ghana is committed to a strong WHO, and a strong MoH/Ghana that is well positioned to effectively contribute and influence Ghana's preparations and positions in international health decision making.

PHM/Ghana has been involved in the WHO-Watch initiative since 2011, with three active members having previously participated and served as WHO-watchers (see Table 1 below). Furthermore, PHM/Ghana has previously convened similar civil society consultations ahead of WHA, the WHO Executive Board meeting and/or the WHO Regional Committee meeting for the Africa region. The engagement therefore offered the opportunity to build on previous experiences and leverage new partnerships with other civil society organizations such as the Health Services Workers' Union of TUC Ghana for greater voice and reach.

The report provides a full account of the program and the photographs give a very good picture of the nature of the engagement.

Implications for generic themes

The main significance of this report is that it illustrates the potential of domestic policy dialogue linked to participation in global watching. It should be noted that the discussion covered domestic policy issues as well as Ghana's position on upcoming global issues.

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