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

The Short Version

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

Project leaders and principal investigators

David Sanders (University of the Western Cape, South Africa)

Chiara Bodini (University of Bologna, Italy)

Amit Sengupta (People's Health Movement, India)

Time period of Reporting
April 2014 – June 2018

Date of presentation:
September 1, 2018

Civil society engagement for 'Health for All'

PHM gratefully acknowledges:

Civil society engagement for 'Health for All'

"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 mobilise 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.

Contents

Preparation of this short version of the CSE4HFA Report has involved removing extended quotations from the country case studies and other reports; removing the annexes which are part of the main report; and removing the hyperlinks to various reports and references.

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 researchers in 10 countries produced 50 research reports. The main report (of which this is a short version) summarises those studies and distils out from them the key findings regarding civil society engagement for Health for All.

The main findings chapters of the full report (chapters 5-9) are structured around the five themes which have framed this whole project: Movement building, Campaigning and advocacy, Capacity building, Knowledge generation and dissemination, and Engagement with global health governance.

Chapter 2. The unfulfilled promise of Health for All

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.

Origins

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

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 NIEO was "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 with relatively high levels of industry protection.

The references to the NIEO recognized 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

The optimism of Alma-Ata, including 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'. Steep increases in official interest rates which were deployed in high-income countries to control inflation (from the early 1980s) also precipitated the Third World debt crisis, 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.

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

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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. In many countries structural adjustment had a very damaging impact on health systems and on the social determinants of health and by the late 1980s its legitimacy was being widely questioned.

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. The Bank 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. In effect the WTO agreements put in place a new framework of international law designed to entrench trade liberalization and global economic integration.

With the availability of antiretroviral drugs (ARVs) for AIDS/HIV the health implications of the WTO agreements, in particular the TRIPS Agreement[1], 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 flexibilities provided for in the TRIPS Agreement for public health objectives.

The Doha Ministerial Council is also remembered for 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. 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 trade regulation.

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 liberalisation/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 shaped by structural adjustment and locked in through the WTO agreements. However, the legitimacy of this regime took a hit with the Treatment Access Campaign from 1997-2001. The idea that pharmaceutical corporations should be allowed to set drug prices at levels which denied access to the majority of those in need, 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". The authors of the Macroeconomics and Health report were fully aware of a rising popular concern regarding neoliberal globalization. Their response was to repeat the nostrums of 'Investing in Health' and to urge a big increase in development assistance for health (DAH).

The Millennium Development Goals (MDGs) provided a broad rationale 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 over 100 in the health sector alone since 2000.

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1. The Agreement on Trade-Related Intellectual Property Rights.

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 these organizations' operational agenda. The routing of DAH through GPPPs, rather than through WHO, further marginalized WHO in setting the global health policy agenda.

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, and 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. Despite increasing resistance, 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 (from 2015) was informed by the weaknesses of the MDGs. 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 they are limited to rhetorical commitments which assume generalized good will and which fail to contemplate the power relations that need to be changed if the goals are to be achieved. The promise of the SDGs is predicated upon a dramatic increase in economic growth in the low and middle income countries. Unless economic activity in the high income countries is at the same time wound back and/or there is a dramatic reduction in material throughput of economic activity the SDGs would yield global ecological disaster. There is a fundamental and widely-recognized contradiction between the economic growth goals of the Agenda and the environmental sustainability goals.

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 rapid economic development in China. However, the promise of 'health for all' has not been delivered.

Child 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. In particular the Global Strategy highlighted global inequalities in life expectancy (LE), infant mortality (IMR) and under-fives mortality.

WHO's Global Health Observatory (GHO) provides a useful data series from history 2000-2016 for LE and from 1990 to 2016 for IMR. The trend changes from 1990 to 2016 throw some light on progress towards HFA with respect to infant and child mortality. All (WHO) regions have achieved absolute improvements in infant, neonatal and under-fives mortality over this time. However, comparing the other regions to the European region (as a rate ratio, see Table 1 in Chapter 2 of the main Report) demonstrates that Africa, South East Asia and the Eastern Mediterranean regions have all been left further behind since 1981. The rate ratio for IMR for Africa (compared with Europe) has increased from 4.3 to 6.3; for under-fives from 5.8 to 8. Significant increases in the rate ratios for IMR are also seen for South East Asia and Eastern Mediterranean region. In contrast, the Western Pacific region has achieved significant improvements in rate ratios for all three indicators.

Immunisation

The 1981 Global Strategy also highlights low levels of immunization. WHO data (cited in Chapter 2) show significant progress in immunization in all regions. The Africa region data are intriguing: relatively 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 Global Strategy also highlighted the morbidity and mortality from diarrhoeal disease in 1981 and the lack of access to safe water supply and adequate sanitation facilities. Not much has changed since 1981 on this front. By 2015 access to safe drinking water and basic sanitation in the Africa, Eastern Mediterranean and South East Asia regions remains low, particularly for people living in the rural areas (see Table 6 in Chapter 2).

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". In 2017 WHO's Director-General Dr Tedros commented that the incidence of malaria had increased from 2015-2016 and that the rate of decline in mortality had stalled and even reversed in some regions. Just over half of people at risk of malaria in sub-Saharan Africa were sleeping under an insecticide-treated mosquito net and there had been a "precipitous drop" in indoor residual spraying coverage in the WHO African Region since 2010.

Nutrition

In 1981 the Global Strategy cited undernutrition as affecting hundreds of millions of people and highlighted addition, there are great inequalities within countries; "this is catastrophic for the underprivileged in many developing countries". In 2017 one third of under-fives in WHO's Africa and South East Asia regions were stunted (more than two standard deviations below the median height-for-age of the WHO Child Growth Standards) and one quarter of children in the Eastern Mediterranean region (see Table 7 in Chapter 2). In contrast there has been striking improvement in the Western Pacific Region.

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.

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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.

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. 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.

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.

We are using the term "civil society" to denote a domain of social action, 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 engagement. We are using the term to refer to a voluntary assemblage of individuals, organizations and networks who share a core set of goals, analyses and commitments and who communicate and collaborate in various ways to achieve those goals. Under this definition 'social movements' 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 labour 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, analysing, and improving social movement practice

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

The effectiveness the 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), 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.

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 and networking (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[2] for individuals and relationships, shared culture, division of labour, and leadership for organizations);

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2. '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.

- knowledge development and dissemination (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).

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

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.

PHM's Charter for People's Health argues that global governance is largely controlled by a relatively small political, bureaucratic and corporate elite, and exercised primarily in ways that embody *the interests* of that elite. Achieving Health for All will therefore require progress towards *democratizing* global governance, including global health governance. Presently the global elite (coherent, self-conscious, well networked) 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 emergence of an 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.

However, the global elite is also empowered by the processes of globalization. The labour 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 labour market associated with dramatic increases in labour 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 labour 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.

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Research questions

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

- 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?
- 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?
- 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?
- 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?

Chapter 4. Methodology

The setting and the questions

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 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?'

The research reported here 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

The data collection and analysis have been structured around five domains of activist practice:
- movement building and networking,
- campaigning and advocacy,
- capacity building (individual and organizational),
- knowledge generation and dissemination, and
- engaging with global health governance.

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.

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 (Brazil, Colombia, the Democratic Republic of the Congo (DRC), India, Italy and South Africa. Six 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 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 was analyzed through i*nductive* 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 labour of PHM activists and colleagues and in some settings PAR was judged neither appropriate nor feasible. The Indian team, for example, prepared a detailed case study of the Indian PHM experience with wide consultation and collaborative interpretation rather than using a 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

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. It was not possible to extend these evaluations formally through two cycles of action and reflection.

Consultative synthesis: 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

In-depth interviews were conducted with a selection of experienced global health activists, from within PHM and beyond, 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 top 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 (the International People's Health University (IPHU), Global Health Watch (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;

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- 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 the 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 summarised 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.

Principles remain tethered *to the case studies*

The principles were 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. 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.

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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. The contingency of civil society engagement – the influence of unique circumstance - precludes the application of hypothetico-deductive falsificationism and limits even the application of descriptive correlational strategies. Instead, 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, in terms of usefulness in activist practice, is based upon critical reflection on the data by civil society activists and activist/researchers, and the perceived utility of our findings in ongoing practice.

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 and program evaluations, 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 this 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 for the global research project as well as the South Africa specific research 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)

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.

The implementation of the project in countries has provided opportunities for 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). In all of the country teams there were also 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 community volunteers) is summarized in Annexes 1-6 of the main report.

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:
- Queer movement in Italy
- LGBT movement in Colombia
- Women in the Asociación Campesina del Valle del Rio Cimitarra (ACVC) in Colombia
- Community health workers (CHWs), a highly gendered workforce, in South Africa
- Women's movement episodes (including long acting contraception) in India

Planning and review meetings

Several meetings of the central research team were held between 2014 and 2018. These meetings provided the opportunity of reviewing implementation of the research and discussing the implications of findings as they became available.

Case studies and sub-projects

Country case studies

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 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, all countries followed a similar process in convening PHM country groups and discussing the international research guidelines in order to: (i) learn about the research and gather general support; (ii) recruit volunteers and form research teams; (iii) adapt the guidelines to the country context and the local needs and priorities of the PHM group; and (iv) 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 research principles. All country protocols were inspired by participatory action research principles but the degree of action involved varied somewhat, as already noted. 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.

Methodological details regarding the country case studies are included in Chapter 4 of the main report and summaries of and links to the findings are included in Annexes 1-6. The following section provides a brief summary of the country case studies.

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+.

The first stage of the research in *Colombia* comprised nine case studies covering various episodes and struggles around the right to health. 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, which was structured around a '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.* This plan was subject to consultative meetings with indigenous and peasant organizations in early 2017.

Democratic Republic of Congo (DRC) held a training and planning workshop in order to adapt the international research protocol to the local context, co-construct the research tools, and build capacity within the local team. 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 enthusiasm of the DHC 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.

The *India* research team elected to document and analyze the experience of the Indian 'HFA movement' (including but going well beyond PHM) in relation to each of the five themes. 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. 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 listserve seeking suggestions of other organizations.

Organizations and movements were listed 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.

The research team in *Italy* 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 PAR 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. The group decided for the second stage of the project to organize three open workshops focusing on three key issues emerging from the project. The second stage report provides brief summaries of the discussion at these workshops but the main focus of the report is a reflection on the research experience across the two stages of the research.

Civil society engagement for 'Health for All'

The contribution to the research from *South Africa* 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. Five studies were undertaken as part of the Stage 1 Research:

- reflections on the PHM-SA's Right to Health Campaign and on the National Health Insurance Campaign;
- formal evaluation of the 2013 and 2014 South African People's Health University (SAPHU);
- a study of health activism, mobilisation and organization among community health workers; and
- an overview history of civil society engagement in health development in South Africa.

The main study undertaken as part of the second stage was based on a two day workshop held in July 2017. The workshop provided an opportunity to reflect on the experience of the projects addressed through the CSE4HFA research, the implications for the five generic domains, and lessons for the future.

Global studies

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

A literature review of research and commentary on social movements in relation to health was undertaken.

A desk top 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.

A series of personal narratives of experienced activists was collected regarding their experiences as activists and their reflections regarding the conditions for effective civil society engagement in the struggle for Health for All.

On the basis of the Stage 1 reports in 2016 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, and volunteered case studies, and was revised in consultation with advisors from across PHM.

A survey of alumni of the International People's Health University (IPHU) was undertaken by a multidisciplinary team at the Centre for International Health in Bologna. Several other reports dealing with different IPHUs or related issues have also been prepared and are considered further in Chapter 6 below.

An evaluation of the reach and impact of Global Health Watch 4 was undertaken 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 organising 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.

An evaluation of WHO Watch was undertaken in May 2015 and involved key informant interviews, focus group discussion, participant observations, and an online survey.

Five regional workshops 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.

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.

Strategic and programmatic discussion at PHM's Steering Council meetings in 2017 and 2018 has been significantly informed by the emerging findings of the project.

Chapter 5. Movement building

Chapters 5-9 of the main report present in detail our findings in relation to the five themes of the research. In this shorter version chapter we summarise the finding regarding *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 summarised 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: 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 globalisation.

Box 1. Eight principles for movement building

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

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 is discussed in more detail in Chapter 7 of the main report (and summarized below).

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 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 (referred to in the HFA history) was instrumental in driving the Framework Convention on Tobacco Control, locking into institutional form the demands of the movement. Community health entrepreneurs who demonstrate that services can be delivered differently are also HFA activists.

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.

People (as 'human resources')

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

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.

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'.

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 organised as part of this research. We discuss organizational learning further in Chapter 8 of the main Report and in summary below.

Working on the self

The reports from the Italian research group have highlighted the importance of cultivating reflexivity at the individual and collective level, and explicating the challenges of 'steering our own becoming'. We return to the issue of organizational culture below under *Leadership*.

Material resources

Many activist organizations cope with very limited resources, although self-funding for participation in meetings and actions can be inequitable and distort representation. PHM in India 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 organisations taking financial responsibility for different expenditures.

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 HFA. 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.

Civil society engagement for 'Health for All'

The organisation and the movement

The evolution of the PHM circles in India and South Africa 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 both 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 key entity within the India HFA movement but there are organisations which the India research group recognises 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 largely about capacity building through the SAPHU and policy analysis, informed by its strong political economy perspective. PHM-SA 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 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 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 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 of the main report).

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 by personal relationships. Sometimes it is about 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 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 their Stage 2 project the Colombian research team deployed 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 in some degree the subjectivity of the movement including the broad analysis and directions 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[3] mobilisation 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 perspectives, and finding common ground.

Pathways to activism

Movement building starts with the individual and needs to recognise 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 ('this is wrong!'). This transition involves three understandings: wrongs and rights, imagining difference, and agency: this is wrong; things could be different; and I/we could make a difference.

One of the Colombian studies, reflecting on the emergence of the health equity movement in Colombia, concludes that 'outrage' plays a leading role in creating a political subject who will drive the needed transformations.

Predisposition, triggers, enablers, barriers

The Nina Rodrigues case study from Brazil provides a practical illustration of the pathway to activism. This story 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 mobilising 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.

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)" 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.

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3. PHA stands for People's Health Assembly. PHA1 was the first PHA, held in Bangladesh in December 2000 – the year HFA should have been delivered.

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. 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 tell 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.

Episodic to sustainable engagement

Finally we can recognise 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' (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.

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 Hospital of San Juan 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. 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 pre-occupied with (and 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 the movement, and for thinking through organizational strategies regarding such relationships: recruitment, retention, mobilising, activating and retrieving.

The case studies 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 high profile campaigning and policy advocacy. However, several of the country case studies have highlighted low key 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 Colombian case studies from the Campesino Association of the Cimitarra River Valley highlight the scope in community enterprise to focus attention on occupational safety and to recognise, confront and reshape traditional gender roles and relationships.

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 working to deny them legitimacy.

The case study of user representation on the health councils of Brazil is a good example. 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)[4]. 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 relation to 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 reports from 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.

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4. "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".

Social movements have deep roots: know your history

The Italian report, which was prepared by cadre of young activists, tells of a meeting organised in Rome 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 study of narratives of experienced activists both suggest that there are the benefits from remembering.

Sometimes the deeper structural factors emerge with greater clarity when viewed across a longer time scale. The Nina Rodrigues story from Brazil tells of community members organising around the urban environment 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 from before and 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. 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, the Pholela health centre) in inspiring activists and in binding the wider HFA movement.

Leadership is necessary but also accountability

Leadership is important for effectiveness. The research literature 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 and a personal likability which encourages people to think that 'these are footsteps in which I might also tread'.

The concept of the learning organization, 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 recognised as offering different but complementary expertise. The emergence of women in the leadership of the ACVC in Colombia 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: 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).

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

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 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 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, decision making, and leadership.

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 is usually relatively narrow in its scope, restricted as it is to a particular issue or sector of social practice. 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 more comprehensive policy agenda is generally a feature of a political movement or party, rather than an issue focused social movement.

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.

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. There may be some benefit from 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 globalisation

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 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

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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 Mitanins);
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 1 below. Also listed are some broader indications of contemporaneous historical context and of technological development.

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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 1. An Archaeology of the Global Health for All Movement: Timelines and categories of engagement, from HFA History project (Note that some episodes appear in more than one column)

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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 mobilise (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 organisational 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 has been discussed earlier (p.20).

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 organised 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 mobilisation in India leading up to the first People's Health Assembly. 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 contextualise 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 ZRC[5] in Colombia 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.

Macro micro principle. The macro micro principle: addressing local and immediate issues in ways that also contribute to redressing the larger scale structural issues serves in this context to highlight the global influences which are common across many different settings and strengthens the logic of networking and collaboration across networks.

Identity politics and the politics of difference. The Global HFA History recognises the power of shared identity in mobilising and cohering health activism, exemplified by the women's health movement, the workers' health movement and the health oriented actions in the US civil rights movement. However, the paper also recognises various cautions about organising solely around identity where singular constructions of identity can render invisible those oppressions which are

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5. Zona de Reserva Campesina del Valle del Rio Cimitarra

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'.

Building links between the HFA movement and broader political movements. We 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 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 link, highlighted by Illiffe, between 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, IPHUs 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 PHAs always included opportunities for sharing and participating in such resources and activities.

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;
> - Networking for campaigning is empowering but requires investment and compromise;
> - Balance policy advocacy with structural critique.

Box 2. 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 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 Phase 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'.

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 provides a range of detailed case studies which describe and analyse ongoing struggles over many years.

The India Stage 1 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 mobilisation, knowledge resources, campaign strategies, enablers and barriers, campaign organisation, outcomes and challenges for the future.

The Italy Stage 1 report 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 organisations 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 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.

Similarly the South African report on the National Health Insurance (NHI) campaign lists a range of factors which hampered the success of that 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 paper, 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 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 which inform social movement campaigning are: 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 approach to migrants; in South Africa, introducing national health insurance. At the global level policy reform, as a theory of 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 form of community involvement; alternative, or perhaps complementary, to the more formal structures of the Brazilian health councils. The ACVC case study from Colombia reported on how, in the context of ongoing conflict, a range of basic community functions (e.g. health care, education, environment) had been undertaken by new structures and practices. The India report highlighted the number of stand-alone community-based health projects 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 review 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. Some of these are listed in Chapter 6 of the main report.

These forms of action 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 organised 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 conveyed 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 (e.g. long waits, stock outs). 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.

Novelty

Creative actions attract interest for their novelty. The Indian case study of the India-EU Free Trade Agreement campaign describes an action which involved delivering black coffins to the office of the delegation of the EU and asking the EU official to sign the receipt for their delivery. Later, over 2000 people living with HIV marched alongside farmers in protest of the EU-India FTA.

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 Campaign, can reinforce a rights consciousness, strengthen one's sense of agency, and provide access to information about health care provision.

The Colombian team highlight the importance of creating space for dialogue, including assemblies, public hearings, high profile reports, and the creation of observatories. The Indian RTHC Campaign 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 Phase 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 (the ASOTRECOL case). The lobbying extended to the International Labour Organization 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

Mobilising people to participate in various ways is a core element of the campaign. Several of the campaign case studies 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 mobilising those networks.

Maintaining and sustaining participation also needs attention. The Indian case study on access to health care reports on attempts to set up a campaign around urban health care which did not get off the ground despite the urgency of the issue. It seems that the resources and commitment for sustained participation were insufficient.

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 media 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

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achieved. The challenge, in any particular setting, is to integrate and find the right balance between the two approaches.

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 (in the Colombian Stage 1 case studies) 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 cites two cases where quite technical policy analysis was undertaken as part of formulating the demands of the campaigners. These were the opposition campaigns to patents and to the proposed India Europe FTA. A similar, policy-heavy example was the campaign around NHI in South Africa.

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 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 NHI campaign.

Addressing the configurations of power

In all of the campaign case studies, the strategies adopted reflect judgments about the power relations amongst key decision makers, the loci of the decision-making, and the accountability obligations of those with the power to decide. 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 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: *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 organised locally; food systems are structured globally. For organizations, like PHM, that seek to facilitate a global HFA movement, the

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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 taking place at the higher levels is aligned with 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 PHAs (national and global) that PHM has organized contribute to bridging these boundaries. Likewise various occasions for international visitors, including in association with IPHUs, can be useful.

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 involve trade-offs, such as agreement on the lowest common denominator messages in return for increasing 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. The case study of the Right to Food campaign in India highlights the important role played by the World Social Forum in Mumbai in 2004 in bringing together people and organizations who were keen to work on food issues. 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.

By way of contrast to this emphasis on linking with other civil society networks, the Indian Right to Health Care campaign emphasized the benefits of bringing low income grassroots organizations together with middle class activists and eminent people.

The case study of the occupation of the San Juan of God Hospital from Colombia instances a coalition between significantly different constituencies, in this case bringing together dismissed workers, concerned about their jobs and economic security with community activists concerned about urban renewal, access to health care, public provision, and opposition to 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 partnerships and how these might be resolved, notably in how decisions are taken when there are divergences of opinion.

The South African team describes how the NHI 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 Stage 1 Colombia report includes a case study on the People's School of Health (EPLS). The EPLS arose out of a coalition of 23 health related organizations among 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 (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 as a way of emphasising that they were not proposing a new organization which might submerge the existing peasant organisations.

The JSA experience is also useful here, inasmuch 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, the ones 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 campaign regarding long acting contraceptives. A swirl of different issues intermingled, including unethical clinical trials, undisclosed risks, a prevailing preoccupation with birth control for the poor and, conversely, the empowerment of women through control of own fertility. A concern was how widespread availability of injectable contraceptives, while improving women's control over fertility, also diluted 'efforts to challenge the basic social and economic conditions' leading to women's powerlessness. Similarly the South African NHI campaign noted difficulties in getting different organizations to agree on even a single core demand, leading to 'no focus' in the campaign.

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.

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.

Our presentation of the findings of our research regarding capacity building is structured around six 'principles' emerging from the research.

- 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.

Box 3. Six principles for capacity building

Beyond individuals, think relationships, think organization

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 kinds of capacity below.

Individual capacity

Capacity building, 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 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). 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 provides a 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, and 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 also some new information and, importantly, new relationships, through joining the local group with wider PHM networks.

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These are processes which the Colombian team refers to as the 'systematization of experience', a form of qualitative research that works with the classification, reconstruction, analysis, and critical comprehension of lived experiences. It is an exercise that seeks to understand the process and the factors that define why a process goes in one direction and not in another.

These are also learning processes that do not always need a 'teacher'. Indeed, the systematizing of experience is something that people can do both individually and in conversation, and particularly, so at the site of campaign struggle.

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 knowledge 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 of activist engagements 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. An example is the place of treatment literacy in the Treatment Action Campaign in South Africa. Given the speed with which medical science develops the training programs needed to maintain treatment literacy need to be continually revitalised.

The range and depth of these examples is 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, 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, in which the process of learning and acquiring new knowledge and skills leads to people adopting a new identity as activists.

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;

- an attitude of active inquiry and learning; and
- being trustworthy and honest.

The Italian research group use the term 'subjectivation' to describe the process of identifying as an activist, in which there is a transition of moving from discourse to praxis. 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.

The El Salvador report also speaks to the question of 'subjectivation' as a result of attending an IPHU, in which the process comprises a 'profound shock that shakes one' where people are changed; 'nobody's the same as before'.

The process of shaping and reshaping one's subjectivity (or collectively, our subjectivities) takes place mainly through operating in a community of practice where particular ways of being 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, emerging from action, reaction and reflection. It is deliberate process.

While the process of becoming an activist takes place largely in the 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 personal relationships acquired in the context of face to face training.

It is evident that individual capacity building can contribute substantially to organizational capacity, not only through numbers but also through relationship- building – the sinews of the organization.

When training programs and other learning opportunities facilitate the deepening of relationships and development of organizational culture they also contribute to individual, organizational and movement-building. It follows that organizational training and development policies in activist civil society organizations must give attention to relationship building and cultural development and not only to skills and knowledge sharing in their 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 local 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 collective identity. Stories of previous struggles can inspire contemporary activists to confront the issues of today. In facing the challenges of Nina Rodrigues, the history of the Landless People's Movement

(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. 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 was 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 quality, 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 at the individual and group level.

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. 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. A case study provided through the South African research team describes a series of workshops resourced by PHM-SA in response to requests first from a local health forum on the national government's NHI 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.

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 value of PHM's IPHU program as a movement building strategy was also borne out in the Alumni Survey and in the analysis prepared by the Indian research team of the experience of IPHUs in India.

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 older, less self-aware ways of engaging.

Taking advantage of learning opportunities which arise in campaigns and actions was 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.

The Stage 2 case study from Porto Alegre provides an instance where training in life skills (including gardening, permaculture and using 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, 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 to addressing health concerns with the TTIP with the broader public.

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.

The role of formally structured training programs

We 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, EPLS), 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, especially their contributions to informing 'the principle of interculturality'.

The South African research team similarly reported a number of instances where PHM activists were asked to contribute to health professional training programs (e.g. the 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.

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.

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 mobilisation 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 were organized through a cascade of volunteers in a campaign approach. Key outcomes of these trainings included the enhancement in public understanding on various issues around health policies and programs, and the (social, contextual) 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 India research team also note that most of these initiatives were 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 mobilising the communities for action around health rights. 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.

Under 'Training for community level health leadership and action' the Indian 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 government 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, public health, health promotion, and health care.

The People's School of Health in Medellin (see description in Annex 2) is another example of a formal training program, co-sponsored in this case 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 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. Respondents 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.

Alumni share suggestions on how to improve the IPHU, starting with better/broader announcement of the opportunities to engage, distribution of material to read in advance, and improved communication before the IPHU in order for participants to share expectations. Also, a strong call that comes from many IPHU respondent highlights the importance of follow up, for PHM to keep in touch with the alumni in order to create and nurture a strong alumni network.

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 and South African experiences 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. 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 sustained 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.

Civil society engagement for 'Health for All'

Curriculum

The 'standard' curriculum used for many IPHU courses includes 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 in general are 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/or with little or 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 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, particularly for travel, accommodation, meals, and venue hire. All of the international IPHUs have had external funding support.

Funding support for an expensive program raises questions (in theory) regarding opportunity costs. 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 for 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 is considerable and the quality of the experience for participants (particularly in terms of both relationships and the richness of the whole experience) not comparable to that of 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.

At the individual level, 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 contributes 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.

Chapter 8. Knowledge use, generation and access

Introduction

Knowledges, the plural signifying different kinds of knowledge, are critical assets in the struggle for HFA. 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 4. Three principles regarding knowledge generation and access

This chapter 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. Knowledge generation and access is a huge topic and this chapter is focused on the findings of this research; it is neither comprehensive nor exhaustive in relation to the field generally.

As previously noted there are some 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 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 Labour, 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 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.

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 about science, including both its empowering potential and how it can be misused. The People's Science Movement has employed this strategy across many issues including access to medicines and the pharmaceutical industry, and a health literacy program which educated and mobilised people around issues of health care, water, sanitation, and nutrition.

In another activist 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 report (see Annex 1 in the main Report) the research team highlights the knowledge regarding permaculture and agroecology which had been shared through the community garden project. 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 has been packaged and made more widely available.

PHM-SA brings a comprehensive political economy analysis to its activism around health systems and population health that makes it unique in South Africa. 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. Their roles range from undertaking 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; one concerning the role of nutrition in TB recovery and the other on deaths following sterilization. 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 significant 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 dominant academic paradigm. 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 criticised the epistemological roots of medical knowledge and power, and of its institutions. The movement criticised the idea that science is neutral and that medicine is a technical profession, and exposed the social control role that medical institutions (particularly hospitals and psychiatric hospitals) and doctors played, including 'the de-valuing of knowledge that originates directly from people's lived experiences'. While not denying the potential role of academics in mediating the dissemination of technical (institutional) knowledges, including to activist organizations, the Italian 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 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 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 include 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 'systematising' 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. 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. 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) also 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.

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 five books represented a shared understanding of the critique of existing policies as well as recommendations for change and possibilities for peoples' initiatives. They were published not in the names of individual authors or organizations but collectively by the entire group and thus became a binding force in themselves.

The participatory process of the development of the five initial booklets 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. 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.

Civil society engagement for 'Health for All'

The evaluation of GHW4 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 analysts 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'. 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 of 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.

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. 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 a number of 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 organisations 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. There is a wide range of possible media for such dissemination. We comment here 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. The 'kalajaths' communicate social and scientific messages

through traditional as well as modern art forms, such as songs, street theatre and poster exhibitions. 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.

Social media

There is widespread appreciation of the role that communications through social media can play in social movement activism. 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.

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. There are many knowledge sharing platforms sponsored by activist organizations including Health Action International (in relation to medicines), bilaterals.org (trade agreements) and Knowledge Ecology International (intellectual property).

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 (e.g. 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 encyclopaedias in particular fields. These can be very useful.

Many software and technology providers sponsor online 'user communities' as well as, or even instead of, 'help desks', to mobilise 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 which 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, e.g. theatre or role play (in contrast to fact and logic paradigm).

The particular challenge at the core of the Grup-pa project in Italy 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'.

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.

Chapter 9. Engaging with global governance

Introduction

Our discussion of global governance is structured around just 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 5. . Principles for civil society engagement with global governance

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 recognise the power relations within which the structures of governance operate and 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' is significant. The term encompass 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.

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 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 undertake contentious actions. In spite of the state's breaches, the indigenous groups have successfully demanded a judicial framework for important public policy initiatives including SISPI (Indigenous System of Own and Intercultural Health).

The LGBT movement in Cali in Colombia 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 Valley of the 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 organisations engaging in policy dialogue with government on domestic issues and in a few cases on issues with international ramifications.

The South Africa case study also includes 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 comment 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 globalised, 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 addresses 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 globalised 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 bivir*, 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[6] 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 at the centre of this case study.

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

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6. 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)

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. 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.

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 so 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 Labour 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. 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 engagements 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 Exchange[7], a 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 they have the capacity to engage with the global forces impacting on their communities, even if they have information about the networks of power they are facing (which can be difficult to access).

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).

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7. PHM's global email list.

Critical policy engagement with global governance

Civil society activism at the global level

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, mobilise 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, thus helping to widen public accountability around these policies.

The Indian research team comments that, although still fairly new in India, civil society engagement in global governance for health has moved beyond just the WHO to include challenging different actors that influence health outcomes, including in particular pressures around trade agreements.

As the Indian survey noted, some developing countries have a capacity problem at the global level and 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 (access to medicines is a case in point), which opens the space for civil society organizations and national governments to engage in policy discussions and advocacy.

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 well-networked civil society organizations positioned at the global level, 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) were all cited as exemplifying civil society organizations which have a significant global presence and affiliated organizations in some or many countries. IBFAN in particular illustrates a network with a strong global presence with passionate national affiliates, with the ability 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' business associations and industry-sponsored (and funded) 'patients' organizations'.

WHO Watch

About 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.

From the WHO Watch website:

As a resource for advocacy and mobilisation 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.

WHO Watch is also an intervention in global health governance. Partly this is about defending WHO which has been subject to severe stresses for several decades (more below). 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. WHO Watch aims to provide a resource which delegates to WHO governing bodies might turn to for ideas and resources.

A more detailed description of how WHO Watch operates is provided below, following an overview of the crisis of WHO that provides important background to the work of WHO Watch.

WHO in crisis

The WHO faces key challenges related to its capacity, legitimacy and resources. Its legitimacy has been seriously compromised because of its inability to secure compliance with its own decisions, formulated in the various resolutions passed at the World Health Assembly.

Nevertheless, WHO's role is appreciated as important by many countries. The WHO Watch Evaluation reports that interviewees from LMICs speak strongly of the importance of WHO for their health work. However, several interviewees also expressed concern regarding the power of the donor states (often exercised on behalf of the large corporations) and of large philanthropies. Donor influence is expressed through their tightly earmarked donations and by WHO's concern not to offend the big donors[8]. Interviewees recognised the need for a robust civil society critique of the governance of WHO, promoting transparency and challenging the control by the donors of WHO's operational priorities.

Another set of issues mentioned by several interviewees were the barriers facing smaller LMICs in preparing for and participating in governing body debates. Simply participating in informal drafting

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8. As with many other UN organizations, the WHO's core funding has remained static because of a freeze in the mandatory (assessed) contributions of member states. The bulk of WHO's revenue (about 80%) comes in the form of conditional, extra-budgetary funds that are earmarked for specific projects by donors. Its total budget amounts to a tiny fraction of the health spending of high-income member states.

committees (often several running in parallel) and remaining in the two main committees is impossible for countries with small delegations.

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 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 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 EB and WHA meetings 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 upon[9]. 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).

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9. Civil society organisations 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.

Watching (and intervening and reporting) has been established at the global governing body meetings but this kind of physical presence at WHO's 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 as about holding governments to account for implementing the principles and programs to which they have agreed 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 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. This national level does not require physical presence at governing body meetings although personal experience of watching on the part of the organizers appears to be necessary.

Theory ('hypotheses')

WHO Watch is something of an (informal) experiment. The hypotheses which it is 'testing' include:
- that the PHM commentary and policy briefs prepared by the watchers will be useful to LMIC delegates and HFA activists working at the local and national levels;
- that disseminating information about the crisis of WHO, in particular the donor chokehold, will contribute to shoring up support for a properly funded and accountable WHO;
- that being involved in tracking, commenting, watching, and policy dialogue will provide new pathways to watchers' activism;
- that participating in the various different functions associated with WHO Watch will contribute to individual and organizational capacity building;
- that working with other civil society organizations active around WHO governing body meetings will strengthen the links between PHM and other networks in the HFA movement;
- 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;
- that the benefits of WHO Watch will be judged to be cost effectiveness in terms of the human and material costs of maintaining it.

These 'hypotheses' provide some context in reviewing the findings of the WHO Watch evaluation, other relevant evaluations and the comments of various country based research teams.

Findings

Usefulness

The interviews regarding WHO Watch found that it is widely appreciated by CSO representatives and by some country delegates and 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.

A watcher's memoir from Brazil 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 viewed it favourably. 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.

WHO Watch is also valued for the quality of the analysis (knowledge generation). 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."

Capacity building

WHO Watch is also 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.

Networking

The WHO Watch workshops also provide a platform for networking among civil society organizations. 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.

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 are supported in principle by country delegates.

The report of the Ghana workshop demonstrates the model is feasible both in terms of domestic policy issues as well as Ghana's position on upcoming global issues. However, other countries 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 some ministers and senior officials are easier to access and perhaps more attuned to civil society perspectives than others.

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-silencing" due to funding influences.

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.

Several respondents who were watchers themselves 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 mobilisation and action between events.

Physical presence

WHO Watch is relatively expensive and one of the largest 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 diplomats 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.

Civil society engagement for 'Health for All'

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.

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.

Conclusions (regarding hypotheses)

At this point we return to the 'hypotheses' listed above as underpinning the strategic logic of WHO Watch.

Usefulness

We have data from the GHG survey confirming that some delegates find the PHM commentary useful. More systematic surveys are needed to develop firm conclusions.

We do not have much data to evaluate usefulness 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

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 more 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

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

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. 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. community-based organizations and local health movements.

Networking

WHO Watch provides new opportunities for networking and movement building. PHM is not the only civil society movement seeking to follow and participate in decision making through WHO's governing bodies. PHM's engagements in these processes have thrown up new opportunities to work with other international networks and to explore pathways to a stronger global Health for All movement.

Convergence

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 quite expensive as it currently operates, 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 establishing 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.

WHO Watch has been operating in its present form since 2011. As capacity building (for the watchers), as a contribution (transparency, accountability, participation) at the global level, and in terms of networking with other civil society groups, it has obvious achievements. However, in terms of strengthening the links between national advocacy and global politics, progress has been slow. The investment in capacity building for the watchers has not seen huge returns in terms of strengthening local awareness of (and engagement in) global dynamics. Ghana is an exception.

It is not clear how to interpret this. The optimist might argue that change is taking place but it is slow (perhaps inevitably so). The pessimist might argue that the slowness in strengthening the Watch at the national level reflects the neglect of more community based movement building, in part as a consequence of an over investment at the global level.

Sustainability

A third 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 organised systems (institutionalization); this is happening but slowly.

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. Several respondents have urged such an expansion.

Conclusions

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 the theoretical assumptions which 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 summarise some possible messages to policy makers and funders arising from the research presented in this report. This is an uncertain project because not all policy makers and funders would share our commitment to Health for All and/or our analysis of barriers and pathways.

Accordingly 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.

CSE can be effective in moving towards HFA but there is always scope for improving practice

Civil society organizations are making a significant contribution to improved health care and creating the social 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. 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).

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 at the global as well as the local levels

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 e.g. the impact of tax competition on fiscal resources for health care or 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. CSE at the global level needs to be closely linked to CSE at the local and national levels.

Advice for policy makers

Civil society engagement in working towards HFA at the national and global level could be greatly strengthened through greater support from national policy makers. In this section we explore 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.

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 (e.g. freedom of speech, 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 in particular, 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, dissemination and access:
- 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:
- (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 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 in funding community organizations to delivery basic health services because of the risks of 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; and

- don't impose 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 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 just a question of policy failure. It 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 advancing more rapidly towards the Health for All ideal, 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 in sustaining or accelerating progressive action towards HFA, 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 summarised 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: 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 globalisation.

Campaigning and advocacy are at the heart of social movement activism. Our findings regarding campaigning and advocacy are summarised 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)

Civil society engagement for 'Health for All'

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 recognise 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.