

# International People's Health University (IPHU)

Nairobi 27th Nov - 2nd December 2023

On

*“Struggle for Health”*

*“Action for Equitable Health Systems – Advancing universal comprehensive primary health care in pandemic times”*

Supported by

People's Health Movement (PHM) East and Southern Africa (ESA)  
Region and other partners

in coordination with

**Equitable Health Systems Thematic Circle of PHM**



Health Activists and facilitator who attended IPHU Nairobi 2023

## Summary

The International People's Health University (IPHU) Nairobi 2023 short course on *“Action for Equitable Health Systems – Advancing universal comprehensive primary health care in pandemic times”* organized by the global People's Health Movement (PHM) in coordination with the equitable health systems Thematic circle and the concerned regional PHMs of East and Southern Africa, was organized to build the capacities of 45 young health activists from East and Southern Africa (ESA) region. The six-day IPHU short course provided the activists with knowledge and skills to enhance advocacy for health rights, promote health for all goals and strengthen public health systems in communities they work in. Participants came from nine countries, South Africa 4, Uganda 7, Tanzania 3, Malawi 3, Zambia 4, Burundi 2, Zimbabwe 1, Lesotho 1 and the host country Kenya 16, Resource Person 10 onsite plus Lauren, Hani, Leign, Unni and Elizabeth Joining online. Total Participants

Throughout the 6 days IPHU short course, activists gained the basic understanding on the equitable health systems, that included:

- Understanding the Alma Ata Declaration and People's Charter for Health, the circumstances under which these were developed and the political understandings these are based on.
- Developing a critical political economy-based understanding of why health and all of healthcare must be valued as public goods, and the implications of this for the design of health systems.
- Understanding the political, social and economic structures and dynamics (at the local, national and global levels), which frame the social and environmental determinants of health as well as influence health policies.
- Understanding the health care reforms of the nineties and the universal health coverage discourse of the recent decade and how these have affected

or are affecting progress towards universal health care built on a primary health care approach.

- Activists learned about positive examples from Low- and Middle-Income Countries (LMICs) that have been able to make substantial progress in achieving the right to health, and in delivering people centered, community-based health services. Participants gained knowledge and conceptual tools for equity sensitive health systems analysis of national health systems so as to understand the challenges they face with regard to progress towards universal health care and build a common understanding on transformation of health systems.

Participants (Activists) were also taken through to understand how policies are framed and how people's movements and civil society organizations have been able to influence policy and improve outcomes and the theories of change with which people's health movements make their contribution. Activists were armed with practical knowledge and movement building tools so they can carry out/support effective campaigns in their areas/ regions towards Health for All. The short course also emphasized on the importance of equitable health systems, community engagement, and the impact of globalization on health.

The short course discussions also covered health policies, disease control strategies, and the intersection between gender and health, emphasizing the role of community-driven programs. Participants' reflections revealed the transformative impact of the short course, with participants gaining new insights into health issues, activism, and the interconnected nature of health disparities. Most of the country's presentations focused more on common challenges in achieving Universal Health Coverage (UHC) and Primary Healthcare (PHC), stressing the need to address social determinants of health.

Participants show the logic that the struggle for equitable health systems can only succeed when they get involved as champions and activists who understand the importance of building equitable health systems around the principle that, ‘health and healthcare is an entitlement of all human beings’ and who have the skills to analyze where they are on the road map and mobilize people as well as advocate with government for an accelerated push towards health for all.

Participants of IPHU Nairobi 2023 short course stressed the urgency of ongoing collaboration, formation of country’s circles, and the establishment of accountability structures in the struggle for health for all. Participants left Nairobi very determined to get involved in various PHM campaigns in their countries and circles to achieve the PHM’s shared visions of ‘Health for all’.



## Introduction

The International People's Health University (IPHU) of the People's Health Movement (PHM) is one of PHM's global programmes of involving education and capacity building/exchange that PHM organizes for young activists/professionals who are already engaged, or seek to contribute to advocacy for health rights, promoting health for all goals and strengthening public health systems.

PHM-ESA, in coordination with PHM Equitable Health Systems Thematic Group conducted a six-day International People's Health University (IPHU) short course, "The Struggle for Health" for 45 health activists in the East and South Africa (ESA) region from 27th November to 2nd December 2023 in Nairobi, Kenya. The objective was to improve PHM's growing activism.



## Context

Today we are faced with a global health crisis characterized by inequities related to a range of social determinants of health and in access to health services within communities, countries and between countries. People are denied access to quality health services as a consequence of unfair economic structures and social

conditions that lock people into poverty and ill-health. Social injustice is killing people on a grand scale. Health inequities and injustices within and between countries rise because of the unequal distribution of power, income, goods, and services as well as the circumstances of peoples' lives including their access to health care, education, their conditions of work and leisure, their homes and their communities.

The Covid Pandemic being an unprecedented global public health crisis, caused millions of deaths, as well as economic and social deprivation and displacement across the world. It also drew the attention of the world to the importance of public health and the need for accelerating progress to universal health care. The East and Southern Africa region had also been seriously affected by the Covid crisis- but some nations were able to perform much better than others. But across countries, inequities that were already quite high worsened due to the consequences of the pandemic and the nature of covid 19 response.

The countries in the region were even earlier witnessing an increasing withdrawal of the provision of services by the State with the simultaneous promotion of privatization and corporatization. Though the private sector had a limited role and across countries it was the public health services that sustained services and led the medical response during the pandemic, the pressures to privatize continue. These pressures to privatize often come from a public discourse that is unable to conceptualize what primary health care means, the barriers to establishing primary health care as global public goods, and the strategies that are required to overcome these barriers. The discourse that has emerged around universal health coverage globally today, is often used to promote minimalist insurance packages purchased from an unregulated private sector, which more often than not offers little in the way of primary health care if not altogether excluding it.

## The struggle for health, PHM history, and global health activism

(Facilitated by Peninah Khisa, PHM-ESA Regional Coordinator, Dr. Ravi Ram)

At the commencement of the IPHU short course, participants from Kenya, Uganda, Tanzania, Zambia, Lesotho, South Africa, Malawi, Burundi, and Zimbabwe introduced themselves and putting down some of their expectations. The general expectations for the short course were shared through a collaborative activity, highlighting objectives such as networking, learning from experienced health activists, and understanding the interconnections between food systems, climate, and health.



The facilitator elaborated on the objectives of the workshop, emphasizing more on understanding equitable health systems, capacity building for change, and exploring the influence of civil society on policy through networking. Participants from each country presented detailed country reports covering geographical location, politics, population, health systems, and initiatives for change or resistance. Key highlights included challenges in healthcare access, inequality, and the impact of politics and governance on healthcare provision.

The IPHU short course happened within the “16 Days of Activism against Gender-Based Violence” an annual international campaign. Facilitators and Co-facilitators

encouraged participants to use the occasion to expand the conversation, share ideas, practical advice on how to run a successful campaign, and how to engage local leaders in discussions about primary prevention of family violence and all forms of violence against women, before it occurs. Activists were urged to the opportunity to celebrate and reflect on the 16 Days, connect with one another, share how their organizations back in their respective countries engaged with the campaign.

The participants were also made aware and explained to some the PHM policies, including the Commitment Against Sexual Harassment (CASH) that promotes mutual respect and dignity of every person. Participants collectively established ground rules, emphasizing respect for cultural diversity, time management, consent before taking photos, respect for opinions, language diversity, minimal movements, embracing mingling, and maximum participation. Participants from countries were tasked with developing creative activism ideas to be presented on the second last day of the short course.





## People's Charter for Health

(Facilitated by Dr Ravi Ram and Denis)

The session introduced the People's Charter for Health, emphasizing a call to action and recognizing health as a human right. Discussions on the broader determinants of health explored economic, social, and political challenges, environmental challenges, and the impact of war, violence, conflicts, and natural disasters. The Charter is PHM's founding document and includes the values of the movement and the core principles.

Participants shared insights on health challenges in their respective countries, highlighting issues such as privatization, intellectual property laws hindering medicine production, and budgetary allocations favoring other sectors over health.



## Milestones in Health Development

The session on "Milestones in Health Development," was led by Hani, co-chair of the PHM steering council. It provided a comprehensive overview of key historical events and paradigms shaping health systems, particularly in Africa. The presentation covered critical topics such as the definition of health, the evolution of primary healthcare, and the impact of global economic shifts on health policies.

The discussion traced health development milestones namely the establishment of WHO in 1946, the Alma-Ata Declaration in 1978, the shift to selective primary healthcare, the Washington Consensus of 1990, the Structural Adjustment Programs by IMF and World Bank in the 1990s, Millennium Development Goals on Health, and the Sustainable Development Goals on health. Further, the discussion emphasized the shift from disease-centric approaches to comprehensive primary healthcare.

### *Participants Comments on the Milestones*

1. Participants from Zambia noted that the presentation was an eye opener on the challenges in the Zambian health sector, including insufficient healthcare infrastructure, limited essential services, and inadequate human resources. The session emphasized the role of governance and the environment as social determinants of health.
2. The critique of Selective Primary Healthcare raised concerns about its appropriateness for Africa based on the fact that it caused a departure from traditional healing practices.

### **The Social Determinants of Health**

Participants were made aware of how the right to health is a fundamental part of our human rights and of our understanding of a life in dignity. That, the right to the enjoyment of the highest attainable standard of physical and mental health, was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Participants were also made aware of how right to health extends further including a wide range of factors that can help people lead a healthy life, “underlying determinants of health”. They include: Safe drinking water and adequate

sanitation; Safe food; Adequate nutrition and housing; Healthy working and environmental conditions; Health-related education and information; Gender equality. Others include the right to health contains freedoms; The right to health contains entitlements.



The facilitator’s presentation also explored more into the political, social, and economic dimensions of health. It emphasized the collective responsibility of state and non-state actors, challenging the reduction of health to merely medical issues. The session explored how power and wealth influence health, referencing the Marmot Commission's recommendations to address social determinants and reduce inequalities. Globalization challenges, particularly in intellectual property regulations during the COVID-19 pandemic, were discussed. Activists were urged to unite against global institutions negatively affecting health environments.

### **Discussion on the implementation of Primary Healthcare (PHC), Universal Health Coverage (UHC), and Africanizing PHC in Africa**

“Primary healthcare is healthy for all. If Africa had primary healthcare as was planned at the Alma Ata, health insurance would not be necessary”.

Participants were made aware that, Primary healthcare is based on the following principles; Equal access and equity; Participation for all; Involving all service sectors; Health promotion and disease prevention; Affordable, acceptable, appropriate care; Multidisciplinary teams, and, On the other hand, comprehensive care is; Health promotion; Disease prevention; Cure; Rehabilitation; Palliative (Relief of suffering); Protection from harm

UHC can be misinterpreted. Although UHC has a potential to transform the lives of millions of people by bringing life-saving health care to those who need it most without regard to ability to pay, that aspiration is denied. Instead, UHC is used to push financialization of health over primary health care. At primary care services, there should be comprehensive services. This is broader than clinical care and goes to health promotion, WASH, etc.

Each country presented its approach to PHC, UHC, and strategies for Africanization. Key issues included selective PHC dominance, gaps in implementation, and reliance on donor funds.

### *Common Themes*

1. **CHWs Across Countries:** The commonality of Community Health Workers (CHWs) sparked a question about Key Performance Areas (KPA) for CHWs in each country.
2. **Resource Challenges:** Several countries highlighted resource challenges, emphasizing the need for collaboration, Africanization, and prioritizing local knowledge.
3. **Political Economy Impact:** The team highlighted political economy challenges affecting the full implementation of PHC. The outcome has been the growth of the private sector in health resulting in unequal access to healthcare. Discussions emphasized the need for activists to rise and drive positive change in their countries and Africa as a whole.

Quality time was allocated to the evaluation of health system policies and their implementation in various African countries. The discussion delved into the challenges faced by these nations in achieving Universal Health Coverage (UHC) and the reforms needed to enhance primary healthcare. It revealed the complexity of health issues in Africa, emphasizing the need for concerted efforts and learning from successful initiatives, such as South Africa's approach.

### **Health System Policies: Readjustment Reforms and UHC Reforms**

Countries were tasked with revisiting their presentations on UHC, focusing on four prompts, which were the implementation of UHC in the countries, the gaps in the implementation of PHC, how UHC is being implemented, and ways of Africanizing PHC.

Key insights from the countries:

1. **Uganda:** Faces challenges in implementing PHC due to resistance from private health insurers, poor prioritization, overdependence on donor funds, and limited intensive care facilities. Instead, a financial-focused UHC may be pushed.
2. **South Africa:** Strives for UHC by 2030 with indicators focusing on maternal and child health, infectious diseases, non-communicable diseases, and capacity. Challenges include unclear initiatives, governance concerns, and funding uncertainties.
3. **Lesotho:** Limited clarity on national health insurance, with Private Health Insurance focusing mainly on infrastructure.
4. **Malawi:** UHC is donor-driven, leading to improved services, but domestication challenges and prioritization issues persist.
5. **Zambia:** UHC primarily benefits the elite, facing challenges in reaching rural populations and inadequate specialist services.

6. **Burundi:** Emphasizes access to primary healthcare, but faces challenges of limited financing, preference for private services, and mountainous terrain affecting hospital access.
7. **Kenya:** UHC failed in a pilot from 2018-2020, facing challenges in financing, a weak health system post-devolution, and unclear implementation strategies. The government acknowledged the failure but did not make changes. Now the government is planning to relaunch UHC under a new name of “Social Health Insurance” but with the same insurance/subscription model as the failed 2018-2020 UHC approach.
8. **Zimbabwe:** UHC incorporation planned from 2025, with donor-funded services and prioritization challenges.
9. **Tanzania:** UHC bill under discussion; challenges include resource adequacy and maternal mortality.

Based on these insights, the shared challenges include financing issues, donor influence, infrastructure gaps, and private sector distortions. Concerns were raised about the insurance-centric UHC model, questioning the focus on private sector interests and the lack of alignment with Primary Healthcare (PHC) principles. Participants also delved into discussions on Universal Health Coverage (UHC) and Primary Health Care (PHC), emphasizing the importance of making health a human right and addressing social determinants.

## Human Resources for Health

This session was presided over by a representative of Kenya Medical Practitioners and Dentists Union (KMPDU). It highlighted Kenya's shortage of medical practitioners and the challenges in accessing public healthcare due to long queues. This session advocated for political involvement, healthcare financing, and addressing human resource challenges. In groups, the Participants also discussed

the challenges related to health worker financing, victimization, skill mix, policies supporting health workers, understaffing, and inadequate support/equipment.

The training explored the role of civil society in health policymaking, emphasizing knowledge-driven decisions. It raised questions about power dynamics and disconnect between civil society and those in power.

## **Public-Private Partnerships (PPPs) and Commercialization in Healthcare**

The team watched a video on building resilient health systems by PHM, stimulating reactions and discussions on the importance of community-centered healthcare systems, accountability, and the impact of privatization on health services. Key takeaways included the need for health services to be owned by the community and concerns about the increasing gap between the rich and the poor due to privatization.

Denis made a presentation on PPPs, which led to discussions on their definition, potential benefits, and drawbacks. The debate on the role of the private sector in healthcare revealed varied opinions, with some emphasizing the profit-driven nature of private entities and concerns about affordability and accessibility. The class explored the challenges of PPPs in achieving health equity and debated the role of the private sector in providing quality healthcare. The Participants also performed a skit that highlighted the potential conflicts of interest in PPPs, especially concerning both national health insurance and private providers. Private providers will run excess charges when they can charge to insurance, even if they don't benefit the patients. And the patients have little control of what they receive, putting profits ahead of people and health.

## **Disease Control Priorities and Strategies in Sub-Saharan Africa**

This session was led by Dr. Sundar. He discussed the importance of health activists understanding disease priorities and strategies, emphasizing the impact of social

determinants on health outcomes. The class engaged in group discussions to critique disease control programs for various health issues, including mental health, tuberculosis, malaria, maternal mortality, and non-communicable diseases (NCDs).

Groups made presentations on various disease priorities, highlighting prevalence, determinants, disease control programs, issues of health equity, and proposed changes to be demanded by PHM. Common themes included the need for community-driven programs, accountability, and addressing social determinants to achieve better health outcomes.

Participants recommended continued advocacy for community-centered healthcare, increased funding for mental health services, and a focus on prevention strategies.

## **Gender: The Construction of Gender, Intersectionality, and Linkages with Health**

This session focused on the intersection between gender and health, utilizing an intersectionality approach that recognizes the multidimensional factors shaping health. Areas of discussion included gender vs sex, gender inequality, sexual orientation, gender bias, gender mainstreaming, and the role of gender on health and SDGs.

Groups were assigned topical issues to discuss. Their discussions revealed factors behind gender inequality in both men and women, linking them to health disparities. The discussion extended to the use of innovation for gender equality and ways to dismantle power in health systems.

Leigh Haynes further delved into gender, intersectionality, and health, emphasizing the social construct of gender and the overlapping impacts of various systems and structures on health. She used a video that illustrated the concept of intersectionality.



Participation is a means of challenging forms of domination that restrict people's agency. Gender can be perceived as a system of power. This power has to be unlearned so that we do not recreate it. Participation should be prioritized because it is essential to the right to health. PHM as a movement has to be organized in a way that deconcentrates power, incorporates transparency and accountability.

## **Community Participation in Health**

Community participation can be passive or active. Passive views the community as a beneficiary, community support to service delivery, community involvement in monitoring. Active means community is involved in promoting changes required for being healthy, what persons or families must do, how they should resist determinants of ill-health, and in planning and management of health services. It also means community-based health programs.

The institutions of community engagement are: local elected self-government bodies like village councils and municipalities; traditional community institutions; community based voluntary organizations; associations of working people or marginalized societies; NGO-civil society organizations; Community health worker programs. Communities are not homogenous. There are variations in power, privilege, and marginalization.

One of the health systems we are advocating for is community-based health systems that are rights-based, people-centered, and highly participatory. The role of CHWs in healthcare activities including what differentiates them from regular health workers, their rights as workers, how one organizes periodic sensitization and capacity-building of activities.

Addressing the issues of equity requires identification of the marginalized, focusing on marginalized people and their representation in the health council, ensuring the bridge between marginalized community and health services, representation of

the marginalized; and affirmative action-schemes and top ups for the marginalized community and low-income facility.

## Country Group Discussions on Community Engagement Models

Country groups presented their models of community engagement, addressing functions, institutions, and how they contribute to addressing inequality. The recurrent themes included diverse community engagement models, a focus on addressing inequality, collaboration between government and civil society, and the specific functions these models serve in their respective countries.

### 1. Addressing Inequality

- Community engagement models aim to address inequality through promoting participation, inclusion, and empowerment.
- South Africa's health forums act as watchdogs for accountability, empowerment, and sensitization.
- Models in Zimbabwe and Burundi partially address inequality, while Uganda's CLM focuses on community participation.
- Zambia incorporates equal gender representation in its neighborhood health committees to address inequality.
- Tanzania aims to reduce inequality by ensuring awareness reaches everyone.

### 2. Government and Civil Society Collaboration:

- Various models involve collaboration between government institutions and civil society organizations.
- Malawi's governance committees are not part of high-level decision-making, indicating potential for improvement in collaboration.
- Uganda highlights political interference as a challenge in community-led monitoring.

### 3. Challenges and Experiences:

- Challenges include the ineffectiveness of clinic communities in South Africa, the paper-based nature of models in Zimbabwe, and duplication of work and political interference in Uganda.
- Zambia faces challenges with vertical programs causing confusion and loyalty to the government.
- Long-distance issues affect access to healthcare facilities in Malawi.

#### 4. Functions of Models:

- Functions include community responsibility, administrative activities, and equal gender representation.
- Lesotho's models inform decision-making and policy formulation.
- Zimbabwe's health committees work only on paper, and Malawi's governance committees are not part of high-level decision-making.
- Uganda's CLM involves data collection on medicine, followed by strategy development for community participation.
- Zambia's neighborhood health committees address inequality and representation is through voting with equal gender representation.
- Tanzania's model includes provision of education and services, community capacitation, and ensuring awareness reaches everyone.

### **Building a Movement for Health**

Ravi facilitated a discussion on activism, governance, money/resources, and representation. The discussion emphasized the values and principles essential for a movement, including solidarity, transparency, accountability, diversity, and selfless service. Several discussion groups formed, with the intent to outline good practices for working together as activists in a country circle. The points were captured and are summarized, as suggestions to be forwarded to the PHM East & Southern Africa regional committee for consideration and adoption as standards.

The session concluded with a call to join PHM by signing on to the People's Charter for Health, emphasizing the importance of global solidarity in addressing health disparities.

### *Country Presentations on Future Plans*

Country representatives shared upcoming projects and campaigns for their country circles as summarized below:

- Uganda: Advancing health rights equity through collaborative action.
- Malawi: Engaging the government for CHW recruitment and better working conditions.
- Zambia: Breaking the silence on the plight of the boy child.
- Kenya: Financing the health sector campaign, prioritizing government funds for public health facilities.
- South Africa & Lesotho: Advocacy for community healthcare worker conditions.
- Zimbabwe: Addressing gender inequality, climate change, and economic challenges leading to malnutrition.
- Burundi: Report to the central government on the IPHU training.
- Tanzania: Focus on mental health awareness, collaboration with NGOs, and social media campaigns.

### **Participants Reflections on the Training**

In the final day of the IPHU, representatives of various countries shared their reflections on the learnings. Below is a summary of the reflections from each country group:

1. **Kenya:** I learned that we have charge over what happens to health in our country. We can do security and safety trainings for activists in the future.
2. **Zambia:** this was a very new platform and quite insightful. There are certain things that we take casually in terms of policies and things around

healthcare. I never went to make a critical analysis and interrogating the reason why things happen. I now will not take things casually. I understand that some good writings don't mean what they seem to mean. I would still need information on various things to learn more and have a holistic approach to things

3. **Malawi:** We have learned the disadvantages of privatization to medical health services. It is up to us to engage the government to ensure public ownership of the health system. More time should be allocated to the trainings
4. **Zimbabwe:** I learned a lot including UHC and the politics behind it. I unlearned the information and ideologies that I had. Going forward I need to understand how to do activism in volatile countries like Zimbabwe
5. **Burundi:** I understood that working with institutions requires probing to have the right information. I would request regular trainings to be more equipped with knowledge on issues around health systems
6. **South Africa:** I have learned that all countries have similar issues but at different stages. I would like to learn the strategies of activism. We should also keep in contact. There is no need to depend on PHM structures but country circles should make a point of meeting like four times a year just to catch up. This will help create accountability structures
7. **Lesotho:** I have been exposed to the importance of addressing other diseases. I have only been engaging with HIV. I have gained a perspective on the politics around healthcare systems and as activists we need to engage leaders. I would like more exposure courses like these ones either physically or online
8. **Uganda:** The health sector is interconnected in terms of the things that affect it. You cannot tackle one factor in isolation. Health is deeply affected by economic devolvement. What I want to learn more about is critical

thinking and reflectivity on how we understand. As a movement is it enough for us to simply demand? What if the demands fall on deaf ears?

9. **Tanzania:** I have learned a lot about health and the interconnection between health issues. I learned the importance of collaboration and I would like to learn more about this. Health issues are the same and I have gained a wider perspective on this. If we tackle health issues, there will be no disparity between the rich and the poor on health issues

### Final Words:

- To attain health for all, the workshop highlighted the importance of research, policy, activism, and community engagement.
- Participants were encouraged to continue learning through platforms such as the PHM website, WHO tracker, WHO resolutions, and thematic circles.
- Dr. Sundar emphasized the importance of forming or joining country circles for ongoing learning and Health for All activism.

### Closing

The learning process was encouraged to continue beyond the workshop, and participants were reminded of available resources and spaces for ongoing education. The tour to City Shamba at Mama Lucy Kibaki Level 5 Hospital provided insights into the intersection between nutrition and health. The workshop concluded with a plan for an online meeting in mid-January, urging participants to reflect on the "How and What" to bring about positive change in their respective countries.

### Conclusion

In wrapping up the six-day IPHU course, "The Struggle for Health," jointly conducted by the International People's Health University (IPHU) of the People's Health Movement (PHM) and its Thematic Group on Equitable Health Systems,

a tapestry of insights, reflections, and shared commitments emerged. The workshop not only served as a platform for diverse health activists from East and South Africa (ESA) to exchange experiences but also ignited a collective flame for transformative activism. Through an intensive exploration of health development milestones, critiques of healthcare paradigms, and in-depth discussions on community engagement models, the participants dissected the intricate web of challenges, commonalities, and potential solutions.

The training underscored the importance of understanding the political economy of health, the social determinants shaping health outcomes, and the impact of globalization challenges. Amid the rich tapestry of sessions, the participants delved into the critical topics of Primary Healthcare (PHC), Universal Health Coverage (UHC), and strategies for Africanizing PHC in the context of diverse national realities. Country presentations highlighted common themes, including the challenges of resource constraints, political economy dynamics, and the imperative of addressing social determinants for achieving health equity.

The training became a nexus for learners to share reflections on their individual and collective growth. From grasping the nuances of activism to understanding the interconnectedness of health issues, each participant brought a unique perspective to the table. The commitment to ongoing collaboration, the establishment of country circles, and the recognition of the importance of accountability structures reinforced the notion that the struggle for health extends beyond borders.

In closing, the call to action resonated as participants shared their upcoming projects and campaigns, emphasizing the urgency of addressing issues such as gender inequality, climate change, and economic challenges leading to malnutrition. The resounding message from the workshop is clear: **to attain health for all, a multifaceted activist approach encompassing research, policy, activism, and stakeholder engagement is imperative.** NGOs and even advocacy do not

adequately challenge the status quo of social structures and policies that produce health inequities. Dr. Sundar's emphasis on continued learning and the provision of resources, including online platforms and thematic circles, reinforces the commitment to an ongoing journey of empowerment and advocacy. As the participants look forward to an online meeting in mid-January, the echoes of collaboration, solidarity, and shared purpose continue to reverberate, creating a vibrant tapestry of hope for a healthier and more equitable future.



### Recommendations on country circles' governance and finance for the PHM East & Southern Africa regional committee

The IPHU participants came together and developed recommendations for the East & Southern Africa region to consider and adopt. These cover the values of PHM, governance and accountability, transparency in financial resources, representation and collaboration.



## Values & principles for a social movement (PHM)

- Solidarity
- Transparency
- Accountability
  - internal
  - external
- Respect
- Equity & diversity
- Representation
- Voluntarism
- Passion
- Sacrifice
- Selfless service

Specific recommendations for accountability and governance in country circles is provided below:

### Governance and accountability recommendations

- Leadership, governance and accountability
  - The leadership is usually a national coordinator, who is accountable to a steering committee. The steering committee should be activists who are long-standing activists in the movement.
  - Selection of all PHM country leaders should be open and transparent;
  - There must be fixed terms limited to 2 or 3 years;
  - Some countries should consider having 2 or 3 national coordinators working together, to share the burden and avoid one person dominating.
  - Rotational leadership
  - Founder syndrome to be discouraged
  - Gender inclusivity
    - Gender balance is critical, and there should be alternating men and women in leadership. The national coordinator and the chair of the steering committee should not be both men simultaneously.

- Participation
- Accountability
  - There is internal and external accountability.
  - Within the country, the national coordinator must be fully accountable to both the steering committee and the movement activists.
  - Accountability includes transparency about activities conducted, funds raised and spent in the name of the PHM movement, and any person gains whether salaries, stipends, per diems, allowances, etc.
- Conflict management and resolution
  - Solidarity, meaning that disagreement does not need to become personal, lead to factions or in-fighting. Activists can and should express differences of opinion or perspective, and use those to work together in new ways.
  - Be open and Transparent - Report conflicts in the regional meetings, don't do a cover-up, and seek outside solutions and help.
- Use the PHM Building a Movement manual

#### Finance recommendations

- (Not enough time to cover this but it is very critical to keep PHM countries and activists accountable and loyal to the movement)
- Consider the following:
  - Role of money and other resources
  - Control of funds
  - Oversight and transparency
  - Need accountable and transparent governance to avoid conflict over resources
  - Consistency of the members who access funds should be transparent and accepted by other activists
- Copy PHM global office on financial reporting, for transparency and to avoid later questions.
- Pool funds and resources from our own organizations instead of raising money as PHM, but still work together as PHM

#### Representation and collaboration in PHM

- Regular communication is extremely important. Have a PHM newsletter for the country or the region

- Need to have monthly and/or quarterly PHM meetings in country
- Join the PHM ESA regional meetings
- Hold a national health assembly every 1 or 2 years
- Don't expect to get funds from PHM. Instead, you give your time and resources to PHM, to fight for health for all!
- What you get from PHM is being part of a movement and meeting other social health activists, not money.
- Representation:
  - Deliberately reach out to minority groups/special needs groups
  - Having allies in national and international decision-making spaces pushing PHM agenda
- Identify and assess the issues of concern to be addressed
  - Through research
- Work together on agreed country priorities for health activism
- Build a network across countries and regions (on similar issues of concern)
- Collective advocacy goals within the coalition
- Build a strategy on what you want to do
  - Clarity on the advocacy issue
  - Build the advocacy message
  - Education and empower activists
  - Engage policy-makers on the advocacy issue
- Join PHA5, and request support from global PHM and from our own donors
- Come to the AHETCA conference in Uganda in February 2024 (need to register and PHM Uganda will consider waiving fees)
- Have a regional PHA
- Share experiences in case studies
- Join the PHM thematic groups.

Kenya ()



Uganda



Tanzania



Malawi



Burundi



Zimbabwe



Zambia



Lesotho



South Africa ()





## Appendices

### 1. Daily Training Notes



Day One



Day Two



Day Three



Day Four



Day Five



Day Six

### Link to Photos

[https://drive.google.com/drive/folders/1k4XlqgCMTQh2i2NjoMhEn9pImKOrGYJO?usp=drive link](https://drive.google.com/drive/folders/1k4XlqgCMTQh2i2NjoMhEn9pImKOrGYJO?usp=drive_link)



video1380260678.mp4



video1207211811.mp4

### Recordings