Health civil society in east and southern Africa: Towards a unified agenda and action for people's health, equity and justice

REPORT OF A REGIONAL MEETING
February 17-19 2005
Lusaka, Zambia

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Regional Network for Equity in Health in Southern Africa (EQUINET), People's Health Movement (PHM) Treatment Action Campaign (TAC), Southern and Eastern African Trade Information and Negotiations Initiative (SEATINI), Community Working Group on Health (CWGH), Health Action International (HAI), Southern African Social Forum, Southern African Trade Union Co-ordinating Council (SATUCC)

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1. Background

During 2002/3, EQUINET, Peoples Health Movement (PHM), International People's Health Council (IPHC) and Community Working Group on Health (CWGH) identified a need for closer dialogue and networking between health and related civil society in east and southern Africa to achieve common health goals.

Civil society in this region has built strong platforms and made progress in advancing peoples health in a number of areas, including around broad health rights, primary health care, patients rights, treatment access, corporate responsibilities to protect workers health, resisting damaging health impacts of globalisation, resistance to privatisation of essential services for health and protecting rights of people living with HIV and AIDS. Civil society has also through broad networks like EQUINET and PHM and through participation in the Social Forum processes, outlined policies for building equity and social justice in health and health care, particularly through a strong public sector health system. These wider platforms are, however, not strongly linked to the issue campaigns, while the issue campaigns are not necessarily all informed by the same analysis of the political and economic causes of ill health, of the health systems we are seeking to build or of the wider changes needed to achieve health goals.

A meeting held in Johannesburg South Africa on November 26 2003 involving 14 networks of health civil society (many of these with numerous individual health civil society members) identified a number of common goals and values informing health civil society work, namely:

- Common aim for equity and justice and to realize the right to health
- We all seek to bring power to the people and to strengthen people's voice in decision making through organising, uniting people and building public consciousness.
- We all work in areas that impact on health and on the wider health system

- We are all working for an alternative to the current neoliberal system, and our perspective and practice is for a system that is based on solidarity, equity, justice and public interest, from local to global level
- We act as a people's watchdog and monitor the performance of government and private sector against their commitments and the public interests, systems and values we are promoting.

To take forward this consensus vision we agreed to:

- consolidate and strengthen our influence and role as health civil society through building shared analysis and positions on health issues and strengthening our dialogue and networking; and
- identify strategic issues that we need to take up jointly and across health civil society as a whole to advance our common platform, while giving wider solidarity on specific campaign issues within wider civil society platforms.

This was taken forward through health civil society participation in the June 2004 EQUINET regional conference and by a planning committee made up of EQUINET (Secretariat at TARSC and SEATINI), PHM, Treatment Action Campaign (TAC) and CWGH. The planning committee was also joined by the Southern African Trade Union Co-ordinating Council (SATUCC) and Health Action International (HAI).

We developed a background document that outlined our common positions and analysis, and proposed to hold a regional meeting in February 2005 in Zambia. The planning committee proposed that the meeting bring together the leadership of health civil society organisations in east and southern Africa to:

- review our current positions and analysis, identify areas where we share perspective and analysis and debate and review areas where we differ;
- build a unified and shared analysis, perspective and goals across health civil society to inform our individual and our joint platforms, strategies and campaigns;
- identify key and critical common goals and positions and the strategies for taking these forward as health civil society in the region;
- identify and agree on mechanisms for strengthening linkages, resource sharing, solidarity action and unified campaigns across health civil society in east and southern Africa; and
- identify and agree on mechanisms and processes that will strengthen and build our capabilities for ensuring mandate from, voice and agency of and accountability to communities in this process.

This report outlines the proceedings of the meeting and the resolutions and plans for future work made by the health civil society groups at the meeting. The meeting was hosted by CHESSORE, the theme co-ordinator in EQUINET on participation in health, with support from TARSC. The meeting was supported by Rockefeller Foundation and Dag Hammerskold Foundation through EQUINET, and travel contributions were made by Peoples Health Movement and Health Action International. The delegate list for the meeting is shown in Appendix 1 and the programme in Appendix 2. The report has been compiled by Rebecca Pointer and Rene Loewenson of TARSC/EQUINET.

2. Welcome, introductions

Chosani Njobvu from CHESSORE welcomed everybody to the meeting and thanked them for attending. Mwajumah Masaigana PHM and EQUINET steering committee member facilitated the introductions and everyone introduced themselves to the group.

She noted that the delegates shared a common goal of working for health equity. The meeting was designed to bring us together to strengthen ourselves, to build cohesion and linkages, and to identify strategies for working together. We need to identify areas where we agree so that we can build capacity and ensure that we are all going in the same direction.

Therefore, we need to identify who we are, what we think of ourselves, where we are now, and where do we want to go – and how – to create a shared vision.

Mwajumah wished the meeting productive work in building a cohesive and strong movement.

Rene Loewenson TARSC/EQUINET introduced the purpose of the meeting, which was fundamentally to enhance the collective unity and purpose of health civil society around a common agenda, while enabling differences on focus in individual groups areas of action. More specifically the meeting aimed to:

- review our current positions and analysis, identify areas where we share perspective and analysis and debate and review areas where we differ;
- build a unified and shared analysis, perspective and goals across health civil society to inform our individual and our joint platforms, strategies and campaigns; and
- identify key and critical common goals and positions and the strategies for taking these forward as health civil society in the region.

Honesty, being self-critical and being mutually respectful are necessary to building trust around a shared agenda, which taps different struggle styles in working together.

The major health civil society groups hosting the process were acknowledged as present although there was still an agreed need to draw in people from the traditional health movement and land lobbies. The meeting included groups from South Africa, Zambia, Zimbabwe, Tanzania given the formative organisations noting that these networks do reach into other countries in the region, however work would now need to be done to take the dialogue to countries not represented at the meeting, including Mozambique, Namibia, Botswana, Lesotho, Swaziland, Angola and the DRC. This meeting should not be a talk-shop. We need to say what will happen differently as a result of this meeting. The follow up work that emerges from this meting should not take us out of our current areas of work, but should rather build us. This means we need to define feasible lines of work to take back with enough synergy to the organizations in which we currently work.

David Sanders, PHM, reflected on how civil society has been affected by agendas that have become more complex. We are facing the challenge of a weak civil society in the context of increasing recognition of the difficulties and bankruptcy of current forms of

globalization. It is therefore important that we strengthen our respective agendas to achieve synergy in the southern and east African region. He proposed that this meeting set the groundwork for this so we can build a larger, broader network of health civil society. Therefore, this meeting is critical to deciding to commit to a common plan of action to strengthen our organizations and the global movement, but most importantly to strengthen our own region.

3. Presentations: Current challenges, alternatives and issues for health civil society

Chair: Itai Rusike

3.1. Challenges to common goals of health equity and social justice

Riaz Tayob of SEATINI outlined where the social justice movement finds itself at present, as well as posing problems that could perhaps be solved at the meeting. He observed that there are too few people involved in the social justice movement given the huge challenges that we are facing, so it is necessary to punch above our weight.
The social justice movement has been lumped together as the "anti-globalisation movement" by the media, but we are not anti-globalisation, we are anti- neo-liberal globalization: the only winners of neo-liberal globalization are the Multi-National Corporations (MNCs) and the losers are the people in the south based on class and gender.

We are seeing the increasing formalization of the structures of inequality, with equity achievements being reversed at higher and higher levels. The criticism of Structural Adjustment Programs (SAPs) has led to "transformation" into a process which is the same, but has different names, such as Poverty-Reduction Programmes (PRPs). Meanwhile, social conditions have worsened. Most poor countries have had programmes such as the Highly Indebted Poor Countries (HIPC) applied, and these bring with them increased conditionalities in the service of multinational capital.

Public health has been attacked by agreements such as the Trade Related Aspects of Intellectual Property Rights agreement (TRIPs) and the General Agreement on Trade in Services (GATS). The World Trade Organisation (WTO) meeting in Dohar in 2001 reaffirmed rights we already have, including rights to compulsory licensing and use of patented medicines where there are public health grounds. However the problem arises in implementing this in a situation profits come before people in terms of access to drugs and protecting corporate interests. The trade agreements have the ability to invert and pervert our intentions. For example while companies in India were major champions of the generics market in 2001 we now have many Indian drug companies who were generic producers shifting to supply the US market, giving them a new vested interest in WTO agreements.

GATS limits the rights of governments to regulate and capital is able to metamorphise. Instead of multinational agreements, they go for agreements at a bilateral level – therefore high levels of vigilance are required, placing an enormous burden on us.

Change happens on a spectrum of possibility form reform to radicalism/ revolution. Organisations tend to operate on either side of the spectrum, while change happens along the spectrum. This calls for sophistication in strategy and approach. For example

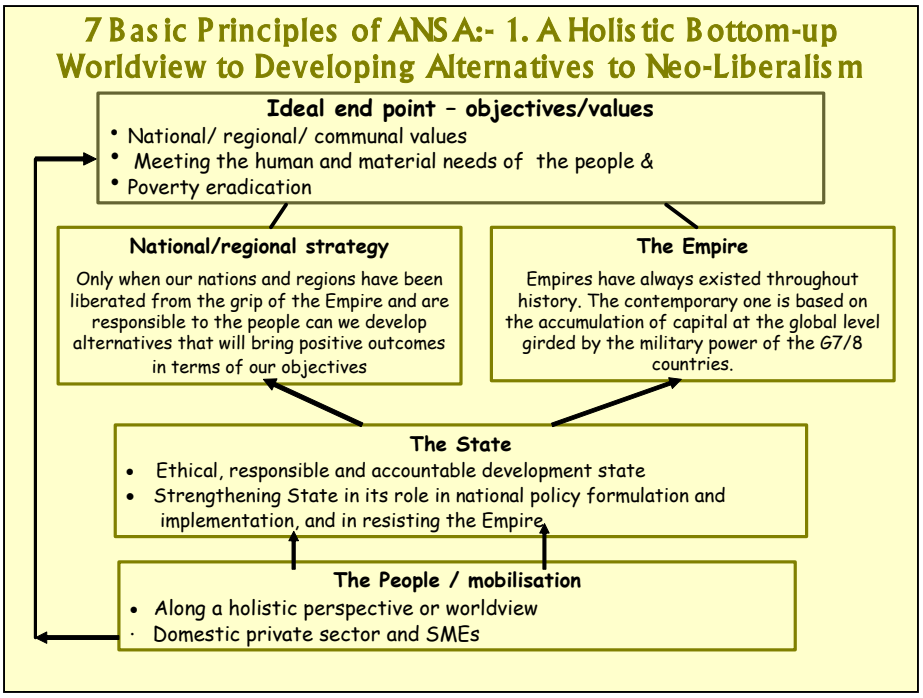
we should not be undermining each other in our campaigns, even where there are points of difference on issues.

A single-issue campaign has implications for the health sector as a whole. We have had little success with addressing weak health systems as a whole, while single-issue campaigns like the Treatment Action Campaign (TAC) have had success. This raises the issue of how we balance single-issue campaigns with a broader health systems approach?

To build solidarity, can we agree to disagree, sharpen contradictions, be tolerant of diversity and share some values? We need to identify the point beyond which there is no common ground. We also need to examine how donors determine what is done, aside from what we feel is needed, and how it polarizes civil society. For example funders often have a rights-based approach to governance, but this is in a context where investors are given more rights than people, so you end up with a perverse rights-based approach. Funders also often opt for a poverty-based approach with direct budget support. This gives donors direct access to parliamentarians, and policies can become externally determined. There is also a lot of debate with funders around debt cancellation and whether it is going to create more problems than it solves.
With regard to strategies, should the state be a primary target of radicalism, or is an anti-state approach divisive? And what is the place of indigenous knowledge systems, nutrition/ promoting food security? These issues call for us to develop a sophisticated approach to the tactics and strategy we use.

3.2. Forging an alternative in east and southern Africa

Godfrey Kanyeze of LEDRIZ observed that it is now generally agreed by wide sections of Southern African society that the neo-liberal paradigm of development has failed the people. Poverty has not only entrenched but also deepened, and the gap between the rich and the poor has increased. Members of the broad trade union movement and some intellectuals in the region have been working on an alternative paradigm, as a serious effort aimed at providing the people in the region with an alternative development programme that aims at being both visionary and at the same time practical.



He presented the seven basic principles and ten essential elements for forging an alternative in east and southern Africa.

1. A *people-led strategy*, as opposed to an IMF-WB-WTO-donor led strategy. Liberations governments have appropriated people's right to determine alternatives, seeing themselves as the voice of the people without consulting the people. People should define the agenda, not the 'experts'.

2. At an economic level, an *alternative production system*. In Africa, we have a formal economic sector, which employs about 20% of the workforce. It was created by destroying the livelihoods of the peasant sector to make men – and not women – wage earners to subsidise production. Therefore poverty is a structural issue. Peasant labour is a source of cheap labour for the formal economy and also fuels the informal economy. While current economic strategies focus on trying to grow the formal economy by selling commodities, the formal sector is actually contracting by exporting raw materials at lower and lower prices to meet the needs of imperialism, which requires declining terms of trade.

3. *Grassroots-led regional integration* (as opposed to the current fragmentation in the region by Empire). Currently regional integration – through SADC and NEPAD, etc. -- is being driven by the European Union and United States, which are trying got drive the structures and determine the configurations.

4. *Selective de-linking* with globalization by focusing on regional trade, instead of international trade.

5. An *alternative strategy of science and technology*, not just importing technology from northern countries, but using our own raw materials to develop our own products.

6. A strategy of *alliance and networking* with national, regional and global progressive forces, drawing on our previous experiences of mobilization.

7. Politically governed *redistribution on wealth and opportunities*.

The People, the State and the Empire

A holistic analysis requires us to look at all the following three factors in an *interconnected manner*: the global (or the Imperial Factor), the State (or the Governance or Democratic Factor) and the people (or the Social Factor).From this, three propositions follow:-

- **a) Ignore SF, and you have discontent and rebellion**
- **b) Ignore DF, and you have suppression and opposition.**
- **c) Ignore IF, and you have domination by the Empire, and Resistance.**

From these three, the following formula suggests itself as a *guiding principle* to achieve peace and justice. It may be written thus:

Peace and Justice = SF + DF – IF

8. A focus on *women's rights* as the basis for a healthy and productive society.

9. A strategy where *education is linked with production*.

10. A strategy of *peoples' mobilisation* and *visible demonstrations*.

The goal of all development is to enhance *human centred values and human and social welfare*. It is customary to categorise human rights at three levels – *the political or civil rights* (or "blue rights"), *economic rights* (or "red rights"), and *social and cultural rights* (or "green rights"). However, a human rights approach on its own will not be effective; there are powerful vested interests and a certain *power configurations* at the national and global levels that need to be challenged in order to bring about necessary change.

Whilst a human rights approach is a useful starting point, important issues of *distribution* of welfare and economic well being within and between nations remain as a significant aspect of the overall value system. It is important, furthermore, to take a *livelihood approach* to human rights, because human rights are not simply *individual* rights, but also community and national rights. An important ingredient of this is the *right to national self-determination*, enshrined in the United Nations Charter. Also important is the *right of communities* at the local level to determine their own life-styles and destinies, and control over the technology and norms of production and reproduction central to their livelihoods, within the broader parameters of national and global environment. A people-oriented strategy needs to *address issues of concern to the people* (such as land reform or food security or issues of sustaining livelihood) district-by-district, village-by-village.

It is important in any alternative strategy to address the question of *agency for change*. The issue of "agency", or the motive force for change, cannot be kept out of the analysis, or deferred to a later date; it has to be integrated in a holistic manner into an alternative strategy. He noted that within this the state is a *creation of history*, and it is a *product of struggles*. The state is *daily* configured. It *metamorphoses* on a daily basis. It is a *product of the struggle between people* on the one hand and the *forces that control the state at a particular point in time* on the other. The creation of a developmental or ethical state, thus, *is not an academic exercise*; nor is it one that can be postponed to some future date. *It is matter of daily struggle.* And, when everything is said and done, it is the people who are defenders of their own rights; it is they that are the agents of change

He further observed that "nations" as presently constituted are becoming inadequate political-geographic units for advancing the economic interests or security of the people within the nations. How "nations" will evolve in the future nobody knows. What we do know is that there is a powerful movement towards regionalism. He proposed a people and grassroots led regional integration, in contrast to the "perverse integration" crafted not by the people within the region, but externally imposed.

The ANSA-Strategy addresses a current challenge, the scenario that exists here and now, and not something in a distant future*. Struggle is a daily business; it is a continuous process*. The provision for example of the basic needs of the population and social services are *not battles of the future, postponed to some future date* (such as, for example, to 2015 in the MDG model) but parts of everyday battles. When these services are daily being privatised or commercialised in Southern Africa at the behest of the state or the IMF or the World Bank or individual donors, they become matters of concern to the people NOW, and not at some future date. An example can be seen, in the current negotiations for an Economic Partnership Agreement (EPA) between Africa and the European Union - *it is not tomorrow's battle. It is today's battle*. Tomorrow will already be too late.

In the **discussion** that followed delegates raised concerns about corruption undermining positions that seek to reinforce the role of the state. It was acknowledged that this is a collective problem that needs addressing, through tackling governance to ensure that our issues are addressed and articulated by the sate and providing adequate checks and balances. We also need to note that rich countries and powerful interests are involved in a lot of the corruption and expose and deal with it at this level as well.

Delegates also raised the issue of how we operationalise power to the people. It was noted that electoral and representative democracy where voting without the possibility of recall has led to depoliticisation, demobilization and reliance on the state. It is critical to reclaim the role of people who are the source of power and development for our leaders. We should institute the right to recall. Services should remain in the public domain. Let us define for ourselves what participation is, and push for participatory democracy, backed by the resources to implement it.

It was further noted that we need to examine our own relative emphasis between anti-imperialism and anti-capitalism. Many of our states have anti-imperialist sentiments, but are not anti-capitalist. This means that being anti-empire is not the end point for achieving social justice. It was however also noted that in the current environment we need to be clear about where the 'major determining contradictions are, so we focus on those and not undermine ourselves by division.

3.3. Agendas for global health

David Sanders, PHM, outlined recent decades of unequal progress in local health, with more rapid improvements for the rich than the poor:

* life expectancy increased from 46 years in the 1950s to 65 years in 1995;
* child deaths were reduced from 17.5 million a year to 11 million a year;
* there was substantial control of disease poliomyelitis, diphtheria, measles, onchocerciasis, dracunculiasis through immunisation and disease control programmes; and
* a decline in cardiovascular disease in males in industrialised countries.

Because of economic changes (e.g. SAPs) and the AIDS epidemic, we have seen massive reversals of these gains, and now, for example, we have seen an increase in child deaths since the 1990s. We have seen:

- the implementation of a selective PHC approach with money being pulled and programs not being sustained;
- inequitable globalization based on the trade liberalizations, removal of subsidies, currency devaluations and the debt crisis which escalated from 1970s through unfair trade practice and so SAPs were imposed; and
- health sector reform in the form of actions to improve the performance of the civil service, decentralization, actions to improve the functioning of national ministries of health, universal delivery of a core set of essential services, broadening health financing options, working with the private sector, and adopting sector wide approaches to aid rational planning.

While the World Bank denied the link between declining health and SAPs, it has now through the Macroeconomic Commission on Health generally been conclude that the effect of SAPs on health has been largely negative. However, the International Financial Institutions (IFIs) have never been held to account for their errors.

SAPS opened up current phase of globalization in favour of Transnational Corporations (TNCs) whose reach has expanded dramatically in the last decade, reinforced by WTO. Top companies have turnovers higher even than middle-income countries and countries in this region don't have negotiating clout. He quoted Henry Kissinger:

> *'The process of development begins by widening the gap between rich and poor in each country … What are developing countries to make of the rhetoric in favour of rapid liberalisation when rich countries with full employment and strong safety nets argue that they need to impose protection measures to help those of their own citizens adversely affected by globalisation? … The basic challenge is that what is called globalisation is really another name for the dominant role of the United States…'*

He outlined the Health sector reforms implemented in many countries and their lack of success in achieving health equity or building health systems. Efficiency measures, through more involvement of private sector and 'cost-effectiveness' has led to private health care as a parallel system drawing on resources of the public health sector, "dual practice" of public sector human resources: "moonlighting", competition for clients and time, internal migration, and so on. Decentralization may improve democratic participation, but it is under-funded and ill prepared, without the necessary resources, training and staff, so it often increases inequities. The literature on low- and middle-income countries provides little evidence that decentralisation has resulted in creation of new posts, job re-profiling, or an improved staff mix". Human resource planning responsibilities are often transferred to local managers without providing them with adequate skills for these roles. The available literature is also quite negative about the impact of decentralisation on professional development opportunities or working conditions.

He noted that cost-effectiveness approaches had led to a range of selective primary health care packages excluding areas obviously important for health, like public provision of safe water. More recently vertical programs, such as those for HIV treatment can weaken overall health systems and through this other PHC interventions like immunization. Within PHC the role of social mobilization, civil society and the need for an intersectoral focus has often been neglected.

He called in contrast for a comprehensive approach to health and outlined the work of the People's Health Movement (PHM), guided by the People's Charter for Health. PHM is a network of civil society organizations, within which organizations can retain their own integrity. The PHM "Call for action" includes demands from local to global around health as a human right, tackling the broader determinants of health, social and political challenges, macroeconomic, environmental and a people-centred health system. The second People's Health Assembly will be held in Ecuador in 2005.

3.4. Agendas for regional health

Rene Loewenson of TARSC/ EQUINET presented the outcomes from process of regional work that was consolidated at June 2004 EQUINET conference. Health is not simply and only a sector but rather an outcome of how successfully we are addressing human needs and issues of justice and equity in all other sectors and policies. Health is an expression of and tool for organizing around other basic claims of society. Liberation movements in southern Africa recognized this and delivery on health was a powerful organizing tool. There is a wide constituency for health across the region reflected in post independence policies of equity and justice in health. While there have been diversions on this platform we are staging our struggle on active, not barren ground.

A regional agenda of equity and social justice in health means giving visibility and voice to injustices in health, and building perspective and power in a purposive manner to deal with these injustices. Visibility and profile is not an end point: we need to ensure that the issues are not co-opted by other agendas – like cough medicine for a cough rather than dealing with polluting smoke. We need to use visibility of injustice to drive a deeper agenda that goes to the causes of the causes of these outcomes.

The EQUINET 2004 conference resolutions highlight areas of this agenda for the region:

i. Calling for global relations that promote equity, social justice, people's health and public interests:

Governments, realising that poverty is a security and development threat have mobilized around poverty reduction and the Millennium Development goals. It has been estimated that $50bn annually is needed to meet these goals. This is the same amount spent each year on cigarettes by Europeans and far less than the $740 billion a year spent on arms.

Box 1: International and global relations that promote equity, social justice, people's health and public interests

Basic Education for all	**$6 billion**
Cosmetics in the USA	$8 billion
Water and Sanitation for all	**$9 billion**
Ice cream in Europe	$11 billion
Reproductive Health for all Women	**$12 billion**
Perfumes in Europe and the USA	$12 billion
Basic Health and Nutrition	**$13 billion**
Pet Foods in Europe and the USA	$17 billion
Business Entertainment in Japan	$35 billion
Cigarettes in Europe	$50 billion
Alcoholic Drinks in Europe	$105 billion
Narcotic Drugs in the World	$400 billion
Military Spending in the World	$780 billion

Source: Human Development Report, 1998

ii. ***Public interest over commercial interest in health, with rising investments in the state and public sector in health***

Responding to health needs calls for rising investment in public sector in health, with collective, population-oriented strategies for health and comprehensive primary health care. Rich countries and rich communities generally choose to invest more in their public

sectors when they have the resources. Southern African public sector health systems have been seriously underfunded and need reinvestment for recovery. EQUINET has thus called for increased progressive tax-based funding of health systems as the most equitable, universal and efficient form of health financing where the rich contribute a *greater* share of their income to health than the poor. At least 15% of government spending should be spent in the public health sector, particularly to support the district and primary health care systems that address priority health needs.

iii. ***Fairer terms of trade and action around restitution for south–north flows caused by debt, unfair trade rules and human resource flows.***

We need to protect and use government authority in trade agreements to safeguard public health, such as through use of full flexibilities of TRIPS, making no health sector commitments under GATS, act as a watchdog trade agreements and ensure that the executive is accountable to parliament and public on WTO and trade agreements. This means we need democratic and accountable states, with full authority to exercise policy measures necessary to protect the health of people. We also need to identify policies that will better retain the human resource we have and shape the forms of compensation needed to meet for regressive south-north subsidies incurred through health personnel migration. Nutrition, fundamental to health and food security, calls for policies that increase household and especially women's control over food production and consumption, including land redistribution, investment in smallholder farming and confronting monopoly control of food marketing.

Driving such policies calls for powerful and effective participatory and representative mechanisms for public contribution to decision making in health backed by a concept of human rights that addresses economic and social entitlements for health and affirms the agency of communities in claiming these entitlements.

In many countries colonial health systems were largely unreformed, preserving rural-urban, public-private segmentations, even thought these were narrowed for a period and PHC programmes added. We need to make clear the deeper transformation of our health systems needed, so that we have a comprehensive national and people's health system, that addresses the health and health care needs of the whole population, backed by a unified solidarity system of funding.

In the **discussion** that followed delegates raised debate on the role of the World Health Organisation in the UN system and its ability to bring about a more radical change in health. The fact that WHO is controlled by member states is important, but the fact that some wealthy governments have withheld contributions to exert pressure on WHO weakens this potential role. We also have the contradiction that governments themselves are buying into neoliberal policies even when they rejected them while in the struggle. Can we win people to progressive health position and understand and engage the contradictions inside the state?

Delegates observed that there is a lack of understanding among health workers and communities about the role of the state, about their roles and their working conditions. Health workers largely see themselves as responsible to the state rather than to the communities they serve. Transforming the health system also means transforming the understanding of health workers.

These wider issues need to be addressed while more immediate responses take place. We cannot stop work on food relief or immediate work to bring curative relief to people, but such campaigns need to be linked to structural changes, and ensure that they operate in a way that support and do not undermine these structural changes. Hence for example relief food in school feeding projects should aim to use local suppliers.

We need to strengthen the whole health system, including tertiary level care, and ensure that the tertiary level does not become increasingly privatized and inaccessible to people, and draw funds away from PHC. It is very important to look at how health care financing happens and what impacts on this. Also we need to think about what constitutes a public health system as often churches/ faith-based organizations have too much say in public health.

4. Priorities for health and civil society action

We then organised a participatory session to bring out the priority issues that people felt needed to be the focus of our collective future work. People raised and carried out debates in small groups recording these on flip charts in different parts of the room and moving between debates. After a period of time a number of key issues emerged, with various debate points raised around these issues:

HEALTH FINANCING

How is government going to tackle the private sector and finance national health insurance?
How can government be involved in ensuring that policies are pro-poor?
World Bank etc. propose that public health services are 'inefficient' – what is the evidence base of this and what is the 'efficiency' of the private sector?
Donor co-ordination required.
Global fund and replenishment conferences = predictable financing via an equitable contributions framework
Global fund not sustainable and should not be relied upon
Establish rules for the global fund
STOP GLOBAL FUND NOW! Global funds are weakening health systems by providing a vertical system and not co-ordinating with the people and governments.
We need to monitor financial (donor money) flows.
Industries are concerned with profit, not people!
"Africa has no skilled labour, not profitable!" – Is this true?
Government commitment to Abuja declaration – 15%
Mechanisms for protecting the vulnerable (advance risk sharing):
* national social health security must reach the targeted beneficiaries
* resources should be allocated for preventive and promotion (need driven)
National health interests vs. World Bank conditionalities and health budget ceilings.
Economic revival: how do we link this to debt?
2005 presents opportunities to get more money for healthcare: how do we engage and how do we use it?

UNITY OF HEALTH CIVIL SOCIETY

Recognise that it is "one struggle with many fronts".
While there are many fronts we should not take our eyes of the long-term objective and work to achieve that.
Single-issue campaigns give us a sense of urgency! Engage: EPAs, AGOA, Bilaterals, TB, Malaria, HIV and AIDS!
Taking advantage of the health-related aspects of MDGs to advance our cause: Wait for 2015? No, take advantage of the window of opportunity provided.
Poverty related goals interrelate with health aspects.
Without debt cancellation MDGs won't be achieved.
Reduction of maternal mortality is of the MDG goals – let us use it for advocacy on health.
Advocacy for governance that puts people's demands in the priority agenda.

FOOD SOVEREIGNTY

Food is a uniting health, production, consumption, labour, etc. issue
We are talking about food not organizing around food!
The role of agriculture and health reform in promoting access to health care.
WTO on agriculture:

- increase production
- stop north subsidy
- say 'no' to GMOs

Agricultural policies contribute to healthcare problems
Elaborate what "food sovereignty" means
Give women land in their own right.
Women's access to health.

ORGANISING PEOPLE'S POWER FOR BETTER HEALTH

CSOs must start with their community, engage their district officials and move on to national leaders. CSOs should have people's backing for their demands
Work with local communities, using local knowledge, traditional health systems.
Increase access to comprehensive PHC where communities interact with providers, government and state.
CSOs role is to demystify trade agreements and other relevant policies.
Economic literacy for mass mobilization.
Communities to be informed about policy and processes where they can participate e.g. policy discussions, parliamentary hearings, etc.
CSOs can facilitate logistical support such as childcare, transport, confidence building, etc. to enable mobilization.
CSOs must increase people's awareness on health an human rights.
Are we alone where the government representatives, private hospitals and mission hospitals are present? We need to hear about the problems they face.
Strengthen health civil society at all levels (local, regional, national and international) as it is seen to be fragmented and need to explore why this is so.
CSOs have become the new elite and lost touch with the people. How do we mend that bridge and remain relevant? We need to define who we are, remain accountable and link up, respect and mobilize grassroots organizations.

HUMAN RESOURCES FOR HEALTH

The "Brain Drain" – staff exodus and human resources for health
Perverse subsidization of south to the north undermines and weakens our responses to public health and health systems.
Which health workers do we want to support and retain? (PHC & district)
Recognition and better co-ordination of community health workers (CHWs), traditional healers, etc.
Fragmented health workers organization.
Health worker organizations are not linked to other civil society organizations.
The north should put money into training in developing countries.
Private sector to channel resources to the public sector for human resources.
Campaign for compensation to poor countries whose HR is losts.
No to GATS type free movement of labour.
Lifelong education and training funded by governments.
Work with health workers within our countries to campaign for better working conditions.
Government to narrow gaps in salary among top staff and community workers.
Funding for public health services.
Retain skilled health workers and improve conditions of employment.
Transformation of international institutions.
Promote and support the public health system.
Implementation and improvement of OH&S policies, strategies and systems.
Cost-sharing mechanisms are reducing access to healthcare for rural communities.
Trade unions should broaden their discussion beyond wage agreements/ increases and focus on globalization affecting their well-being and including health.
Build solidarity with CBOs, CSOs, etc.

The review in plenary of the flip charts and the debates that took place around them as used to raise the priority issues to take forward:

1. How do we develop **one struggle with many fronts** – single-issue and broad fronts? Can we use and advance on windows of opportunity that arise from issues to advance structural and systems issues. What are those windows of opportunity and how do we use them?
2. Civil society as an **organizer of people's power** in various forms – how, where, through what forms? This also calls for a clearer analysis of the strengths and weaknesses of health civil society in these roles. We also need to strengthen the links between labour, community based and civil society organizations to build solidarity across these groups - What is the basis and processes of this solidarity?
3. **Human resources** are a strategic issue: There are parallel health service structures with little integration and links between health workers and health civil society. Social movements and civil society can only achieve goals by integrating the two. This has a ripple effect on service provision, as workers are the producers of services. We also need to tackle the internal brain drain.
4. **Health financing** is a further strategic issue to address at global level, between public and private sectors and within the public sector. We need to explore approaches and mechanisms for funding a more equitable public health care system. In this we need to engage in the debate and research the view – held by

proponents of neoliberalism - that a public health care system is inefficient. This raises focus on our positions on stopping perverse resource flows from Africa vs increasing aid flows into Africa.

5. Resisting and reversing **trade liberalization and trade encroachment** on health, through WTO and bilateral negotiations. How do we defend the public sector within trade?
6. **Food sovereignty** means addressing the role of women as producers, and issues outside the health sector like trade, land distribution, GMOs and food production and marketing.
7. **National health systems:** These areas all imply collaboration around building a national health system. What kind of health systems do we want? How do we integrate various issues and goals into this and how do we ensure the funding and workers for it?

Within these broad issues we need to explore which struggles we take up as health civil society, and how we work around these. What are our strengths and weaknesses around these key issues and what are we currently doing around them.

5. Health in Brazil

To support the discussion of the way forward, Armando de Negri of ALAMES and WSF Brazil outlined the policies and processes of health civil society in Brazil. In the 1980s Brazil was confronting many of the challenges raised at the meeting facing southern and east Africa today. Brazil had a general idea of the kind of programme we wanted to develop with a focus on the right to health. This was strongly influenced by the health reforms in Italy in the 60s and 70s. Therefore, we built a health system around a few simple ideas:

- health is a right of all citizens;
- this universal right meant a right to all healthcare, not just primary health care (PHC); with egalitarian access to health care; and
- a strong statement about social participation in health, with real decision-making power, health councils at a city level, state and national level regarding government, health providers and health workers.

This permitted us to defend the National Health System (NHS) from privatization and gave us clear ideas in managing the relationship with work in other sectors. Since health was a duty of the state, legal actions were taken when health would be affected and the state could intervene at any time that health is tread upon. If there are bed shortages in the public health system, the state can access beds in the private health system. There is absolutely no payment for services and the constitution establishes that it is forbidden to charge for health – the same laws apply to the private health sector as the public health sector.

We have local organization of the NHS, avoiding the collapse induced by more neoliberal forms of decentralization. The research and management components are decentralized, but there is a unified system, supported by 9,8% of national tax collections: 12% of the health budget goes to state governments and 15% to local governments. There were attempt to include water and sanitation in the health budget, but we successfully prevented that.

City governments have high management responsibilities in terms of tying health planning into integrated planning. We are also now developing family health programs that cover 3000 people and can tackle counseling, medication, special care for HIV and AIDS needs.

Brazil's health system is an exception in Latin America, as other Latin America countries have not been able to face and take on global systems. However, we have proved that it is possible to have a universal system, and it is much cheaper than the fragmented private sector. Therefore we must struggle for a global right to a universal health system. We need to use this example to negotiate with funders; civil society must express what they want in terms of these programmes.

There is a need for Latin American and South American countries to build alliances to support and exchange with each other and to fight to be, not just an economical block, but also have a social agenda with a right to health, so as to eliminate inequities between countries.

6. Priorities for health and civil society action, continued…

Following through on the discussion of the first day the health civil society groups identified further the major objectives and specific issues in the five major areas of common concern:

- organizing people's power, including labour;
- building a national people's health system.
- financing a more equitable health system;
- ensuring human resources for health; and
- challenging trade liberalization and encroachment.

6.1. Organising people's power for health

Objective: Building a critical mass working together towards a common vision of the right to health for all as a constitutional right.

Sites of struggle

- Bringing unity across civil society organisations, while ensuring autonomy.
- Building an inclusive front of all stakeholders working in health and related areas.
- Demystifying and linking local, national and global struggles to co-ordinate action.
- Defining realistic priorities.
- Ensuring the survival of civil society organisations against external attacks and challenges (state and donor).

6.2. Building a national people's health system

Objective: Publicly-funded comprehensive, participatory, equitable and universal health systems.

Sites of struggle

- Lobby governments to promote, finance and provide comprehensive primary care that is participatory and involves promotion, prevention, rehabilitation and curative aspects.
- Oppose privatization of public health services.

- Promote, support and engage in actions that encourage people's power and control in decision-making on health at all levels including patient and consumer rights.
- Pressure governments to adopt, implement and enforce national health and drug policies.
- Support, recognize and promote traditional and holistic healing systems and practitioners and their integration into health systems.

6.3. Financing a more equitable health system

Objective: Increased fair, sustainable and equitable financing for health at national, regional and global level in order to secure the universal right to health.
At a national level, rising investment that strengthens the national health system through the public health sector, with mechanisms that ensure universality, solidarity and transparency and that promote public over commercial interests.
Sites of struggle

- Abuja Declaration that African governments spend at least 15% of national budgets on health, (but also need our own realistic target for funding a national health service).
- Unconditional debt cancellation.
- Increased aid for health to meet short term needs ways that strengthen health systems and that are sustainable.
- Equitable allocation of national budgets for health, with promotion of tax funding for health; national debates on health insurance; and scrapping of user fees at PHC level.
- Lifting of IMF Medium Term Expenditure Frameworks (METF) caps for increased health spending.
- Ensuring these positions are adopted in WTO, MDGs, Commission for Africa, World Bank PRSPs, SADC, EAC, etc.

6.4. Ensuring the human resources for health

Objective: Adequate, well-trained, equitably distributed and motivated health workers.
Sites of struggle

- Improved working conditions for public health workers (incentives; wages, OH&S policies), with emphasis at primary and community level.
- Lifelong training of health workers to become more problem-orientated, practice-based, including management and self-evaluation skills.
- Awareness campaign around the implications of migration of health workers, (public to private health institutions; within and outside the region) and compensation issues.
- Oppose GATS commitments that promote movement of health workers to private sector and to wealthy countries, backed by positive measures to retain health workers, to compensate for perverse south-north subsidies, and to implement codes on ethical recruitment.

6.5. Challenging trade liberalization and encroachment on health

Objective: Popular participation and transparency to ensure a fair international trade system, where people are put before profits (health over commercial interests); and

where our states and governments maintain sovereignty through regulatory flexibility for development.

Sites of struggle

Access to medication

* National level: regulatory and financing frameworks.
* Regional level: make WTO powerless.
* Global level: fight against TRIPS.

Privatisation

* National level: PRSPs, GEAR and SAPs.
* Regional level: NEPAD issues and other regional trade agreements (RTAs).
* Global level: impact of GATs.

Food sovereignty

* National level: tackle GMOs, monocultures, cashcropping, and food security.
* Regional level: WTO agreements, regional agreements on national level issues.
* Global level: subsidies, commodity prices, food aid and donors, market access.

Indigenous knowledge systems and national regulation

* National level: regulation required.
* Regional level: powerlessness in Regional trade agreements.
* Global level: bio-piracy, TRIPs

Watchdog trade measures that impact on health

* National level: governments, parliaments, faith-based organizations, domestic capital, social movements and CSOs and FBOs.
* Regional level: European union EPA, United States AGOA and FTAs. Work with African social forum processes, African RTAs such as SADC and Comesa to tackle regional fragmentation.
* Global level: WTO, WIPD, WHO, WHA, UNDP, UNCTAD, WSF WEF, G8, etc.

7. Strengths, weaknesses, opportunities and threats for health civil society

David Sanders PHM outlined the motivation for doing a SWOT analysis of health civil society. He noted that those working to build and establish PHM in South Africa have found mobilization difficult. The experiences from this indicated the need to do a reality check around our strengths, weaknesses, opportunities and threats in building mobilization. This SWOT analysis should be in relation to the key issues identified and reflect on our country and organizational situations. A SWOT analysis will also help us prioritise a realistic set of collective actions.

The delegates carried out the analyses in groups and identified key strengths and weaknesses, opportunities and threats that need to be taken into account in shaping follow up work:

7.1. Organising people's power for health

The major concern is to increase the capacities of civil society organisations.
Strengths: CSOs have a commitment to the issue, and embrace diverse experience, skills, expertise and knowledge. There are many organisations working on health issues in the region, and successful single-issue campaigns, able to mount a quick response to issues.
Weaknesses: Civil society is fragmented, with splintered effort and lack of a joint vision. Organisations have limited resources and are donor dependent (and driven in some cases) with more funding for vertical than comprehensive programmes. Some CSOs are losing focus and lack the passion to fight for a cause. This leads to too many meetings and too little action. There is also too much work and too few people weakening our capacity.
Opportunities: There are windows of opportunity: the WTO Cancun victory created the possibility for alliance between NGOs and governments, the MDGs. The need to address health system decline creates a mobilizing opportunity to push for national public health system. Strategic alliances have formed across issues and across the region, such as the National and African Social forums, this fourm.
Threats: Exist in some government policies, such as the Zimbabwe NGO Bill and unsupportive governments. Global disasters result in the movement of policy attention and funds away from Africa, e.g. Tsunami, Iraq, etc. Donors are focusing on vertical programs such as vaccination, and prefer large established organizations over smaller ones. Civil society organisations lack finance, human resources and time.

7.2. Building national people's health systems

Strengths: There is analytical experience and organizations are working in these areas in the region.
Weaknesses: This is a complex area and patchy understanding of how to grapple with key issues in unions, CSOs. It needs a lot of work to get unions and communities on board. Ineffective and poorly resourced health committees, community organizations demobilize communities.
Opportunities: A common understanding, an interested media, global funds and increased resources, opportunities; opportunities for links with other organizations to build a popular movement.
Threats: Weak public understanding of how the health system functions; Disinterested media attitudes. Funds going to vertical programmes, over broader approaches. Unsupportive or repressive policies to civil society and lack of autonomy of health civil society.

7.3. Ensuring the human resources for health

The major concern is to improve the working conditions of health care worker, increase training and capacity, believing this will also impact on the brain drain and as a way of bringing health workers on board in fighting the brain drain and building health systems.
Strengths: Existing organisational capacity to build around this campaign by organizations which represent workers interests. A lot of work is being done around improving working conditions. It is an issue that is common across the region, from health workers to civil society. There is a felt need from health workers to build a campaign around this.
Weaknesses: This is a single-issue campaign that may again neglect health systems. It costs a lot of organizational resources, while capacity and energy are already stretched

in terms of capacity, resources. There is lack of co-ordination amongst the unions, and issue is not taken up at a federation level. There are also issues of sectoral organization and conflict of interests.
Opportunities: Communities are dissatisfied with current service delivery and there is a window of opportunity through engaging around treatment access. HR has achieved a higher profile with possibility of additional funds for HRH.
Threats: Conflict between communities and health workers and the impact of HIV and AIDS.

7.4. Fair financing for a national people's health system

The key goals are increased per capita spending on health, progressive tax funding for health, debt cancellation, and appropriate external funding to support national health system
Strengths: There is consensus that current spending is inadequate. There is expertise and information in this area in CSOs in the region, solidarity from Northern CSOs, e.g.: on debt cancellation and CSOs in South America have researched models that could be adapted in Africa, such as, the Brazilian model. CSOs have the ability to track health sector funding.
Weaknesses: There is a low level of civil society/ government engagement on the issue and different opinions on strategies that could be used to address the issue e.g. tax-based delivery, health insurance, debt cancellation with or without conditionalities, MDGs, etc. There is poor SADC-CSO engagement on the issue and absence of a regional combined effort that includes governments and CSOs. There is inadequate follow-up by CSOs of gains and promises made at the global level and inadequate capacity to monitor and poor monitoring and influence on use of saving created by debt cancellation. Too many unmet needs result in disagreements on what funding should be used for.
Opportunities: All African union countries signed the Abuja declarations that African governments should spend at least 15% to be sent on health. WHO has developed recommendations on per capita spending on health. World Bank has upcoming meetings with civil society, PRSP processes in countries are engaging CSOs, as is the Global Fund replenishment conference, AU, Africa Commission and the G8 is now chaired by Britain, which has been leading the push for debt. There is potential to increase awareness among CSOs on the issue.
Threats: Low levels of public sector funding and misuse of funds weakens national advocacy, reliance on external funding with conditionalities, and external influence from financiers around, such as caps on health spending. Resistance may come from the private sector, who see solidarity financing measures as some form of control. International processes such as WTO, Commision for Africa, SADC, EAC, Comesa can be used to dissipate energy, therefore we need to be careful what processes we engage in and how. Global funding is not being used to strengthen health systems.

7.5. Challenging trade liberalization and encroachment on health

The key issues were identified as access to medications, privatization and food sovereignty and security.

Strengths: There are visible movements and campaigns; Already developed strong positions against privatization in individual organizations; partners with an anti-privatisation agenda.

Weakness: Single-issue campaigns. Few organizations working specifically on TRIPs and health in the region. No regional programme of action, although PATAM, EQUINET initiating work. Don't have clear articulation, requiring additional dialogue, for example anti-privatisation is not articulated within EQUINET. Nutrition is not major issue that we are tackling and therefore we are weak in this area.

Opportunities: Can use single issues to move onto other platforms and build on victory for comprehensive health campaigns. Raise dialogue and campaigns around issues of private and public sector and take advantage of the dialogue on the new perceptions on the role of the state. Information dissemination can catalyse action. Need to get traditional healers on board.

Threats: WTO, TRIPs, FTAs, EPAs, RTAs, national development plans, donors and IFIs, etc. Control of supply impacts on trade and consumption. There is a perception that governments are not efficient in delivering services and that the public health sector is weak. There is lack of knowledge on how trade agreements such as TRIPs impact on our lives and a varied level of dialogue on privatization. We are locally in conflict with government around issues that governments are advancing that were rejected in Cancun.

8. Presentations from social movements

To give background to planning of future work delegates heard further input on three major social movement processes that impact on health

8.1. African Social Forum

Thomas Deve noted that the WSF is an open space where we throw proposals and dialogue. Anyone can participate without mandates from any organization. The entry point in Africa started at the top and one of the biggest challenges we have is to explain the open space to people who are used to more bureaucratized processes. WSF has a charter of principles and is an initiative to challenge neo-liberal corporatisation and develop alternatives. WSF is for movements and organizations that want to undermine work of Davos – and it is a parallel process with those meetings.

Since it is an open space, there are many people and agendas, and debate alone will not change the world. So there have been debates around methodology of WSF. It relies on registration of organizations and events to announce their programs, but revolves around the slogans: “Our world is not for sale”; “Not in our name" and “Another world is possible”.

There is now an African Social Forum (ASF) that has identified thematic areas for work such as labour, youth, gender, etc. Professional activists from NGOs are administering the process as social movements are resource poor. The sub-regions of the ASF are Southern Africa, Arab North, East Africa, and West Africa. The most vibrant region so far is southern Africa and it has the most organizations involved, with labour movements (except South Africa, students and AIDS activists. So SASF has a big niche in determining agenda of ASF. How do we organize to make sure we are everyone participates in it? In the Social Movements Indaba held in Johannesburg, organizations constantly demanded mandates, which is not how the Social Forum process works, so how do we interact with it, to what extent do we show solidarity and when do we break with it?

African attendance at previous WSFs has been disorganized, and you could easily get lost. We need to prepare a program and agenda before we even get to the venue otherwise we always face these challenges. Those of us involved in Trade issues have built people-to-people solidarity networks to bring alternative dialogue to the social forum. On the ground we have a challenge to hold SASF in Zimbabwe in October 2005 and in 2006 to have regional expressions of WSF (e.g. ASF – may be in Morocco).

The WSF on health was outlined by Armando De Negri., This meeting has a history at first WSF in 2001 when we identified the need to put people together to prepare health agenda for WSF as it is not a main issue of the WSF, although it was represented under neo-liberal umbrella. In 2001 we proposed the health WSF to take place 3 days before main event and it has been held for next 3 years until the 2004 international forum for people’s health.

In 2003 PHM joined the meeting, and in 2004 PHM was responsible for organizing it. This year we ran WSF on health, as it's an important space to put together main agendas of "Another world is possible". The health forum developed a group of general agreements to develop and identify terms of about how:
* the struggle for health is linked to struggle against neoliberalism and war
* health is a fundamental human right
* this can be developed into national systems for health.
The final agreement was to generate an organizational process similar to WSF with international council to generate permanent space for dialogue. We are proposing that we are identified and linked to WSF and will follow the dynamics and organize a health WSF wherever the WSF takes place to develop an exchange of information between regions.

Initial dialogue in health WSF sees the need to bring Africa on board, establish effective ways to touch the bases of social movement's etc in order to establish wider struggle and internationalise as much as possible. The health WSF is a coalition of coalitions, meant to reinforce wide coalitions to develop stronger international movement for human rights program. The Health WSF called for participation in PHA in Ecuador to achieve good South American participation around this event.

The dialogue on the format of WSF for 2006 is a confirmation of peoples' idea for expansion of the process, but organizing it is taking too much of energy when we'd rather be in the trenches and fighting. That is why a continental process was decided on for 2006. There are a number of different positions being developed on future of WSF.

It is hard for 150 000 people to reach common agreement, but with thematic divisions there were more that 300 different proposals as exchange of ideas within the forum. The main purpose of WSF is to generate a broader perspective, make friends, know you are not alone and know you have allies.

8.2. People's Health Assembly

Samuel Ochieng noted that the next PHA is in July 2005 in Ecuador. Civil society realized that objectives of World Health Assembly were not being met and therefore we needed to have an alternative forum to achieve the "Health for All" call. The first PHA was held in 2000 in Bangladesh; about 1500 people attended from 93 countries.

Since then PHA has been involved in a number of international forums and campaigns for health. After 5 years PHM will be holding PHA 2 in July 2005 in Ecuador. The process has begun and we have an international organizing committee. The main objective of this is to:

- strengthen and expand the PHM as a network that struggles for the revival of the original spirit and principles of "Health for All";
- launch a more concerted global action to achieve a full and universal recognition of the Right to Health as a fundamental Human Right;
- widen the debate leading to a more proactive resistance to all the forces that oppose and violate the right to health of the people-many of them enshrined in neoliberal reform policies and in the overwhelmingly unfair move towards globalization with its shift towards increasing militarisation; and

- share experiences and practices useful for the universalisation of our struggle to implement alternative models of people-centered and beneficiary controlled health care delivery systems.

Preliminary themes have been developed and we are busy developing a programme. We want to take people who have roots and who can make sufficient use of the knowledge and help us establish the network. We have resources and we ask for support in identifying candidates and developing process to ensure that Africa is well represented.

We are also seeking to develop a project called "African Dreams" within the PHC exchange. We are collecting stories, poems, posters, photos or other artistic works to create an exhibition. Please submit anything you have on this to Mwajuma Mwasaigana. Armando extended an invitation for the southern African delegation going to Ecuador through Johannesburg and Porte Allegre, to have a two-day stop in Brazil to find out more about Brazil's health system.

8.3. WTO Ministerial, Hong Kong December 2005

Riaz Tayob outlined the process to the WTO Ministerial conference of trade ministers meeting every two years. The specific challenges we are facing at the next WTO are to review TRIPS agreements to allow countries that do not have manufacturing capacity to import generics. This agreement comes up for review and may be held over, as rich countries want to hold it over developing countries heads. Developing countries also want to prevent patenting of discovery.

The strategy inside the WTO is that nothing is agreed until everything is agreed and the GATS negotiations are also going to be included in this agenda. Key issues in the negotiations are agriculture to limit northern countries tariffs and export rights for poor countries. We are blocking out venues for African civil society and parliamentarians so that they can call ministers to account. Because Africa is underrepresented at the parallel event trying to make sure that Africa speakers are represented. We need to promote a communications system that will work for activists in Hong Kong to organize people at home and MPs.

The WTO co-ordinating group meeting – the Hong Kong People's Alliance Against WTO --- organized by Asian people will be meeting in March. The Africa Trade Network co-ordinates around a combined assault on the WTO and we still need to work how we are going to participate in this.

9. Moving forward: Fundamental principles, values and issues for health civil society

Following these discussions Rene facilitated a session that aimed to draw together the key issues raised in the previous sessions and set the platform for defining a programme of follow up work. The summary below reflects the outcomes from the session.

9.1. Guiding values

Health civil society in the region is guided by **principles and values** of:

- the fundamental right to health and to life
- equity and social justice
- people led and people centred health systems
- public over commercial interests in health: Health before profits
- people led and grassroots driven regional integration
- anti-neoliberal policies.

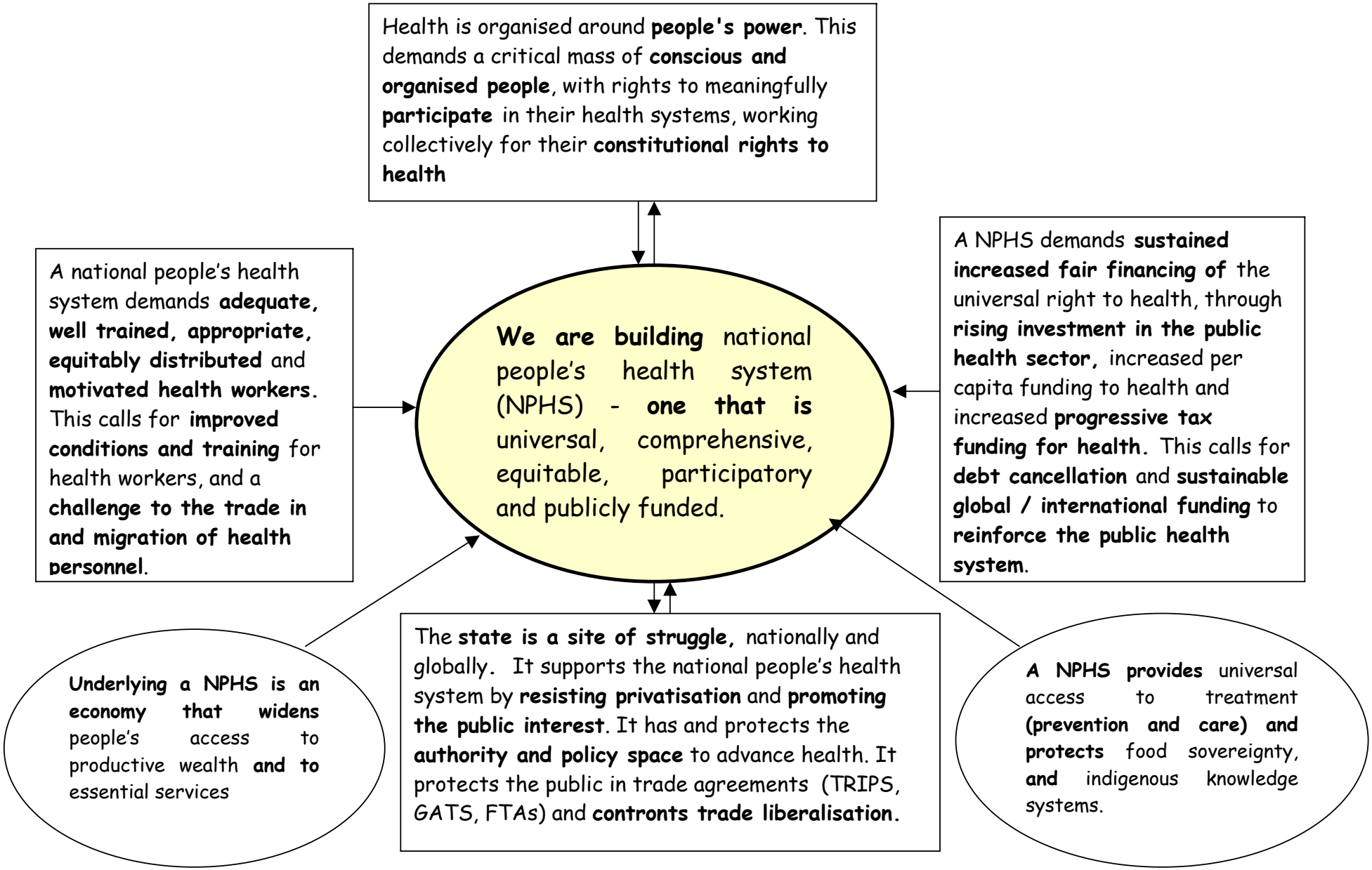
9.2. Major areas of work

We are building a national people's health system

Health civil society organisations in the region agreed that the central struggle to reflect these values and principles in 2005 is for a national people's health system.

This is the unifying goal for our various areas of struggle and the common platform around which we are all uniting, recognising the different areas of struggle around this. We understand a national people's health system to be one that is universal, comprehensive, equitable, participatory and publicly funded.

We built an understanding of how our different areas of struggle contribute and relate to this uniting goal.


Health is organised around **people's power**. This demands a critical mass of **conscious and organised people**, with rights to meaningfully **participate** in their health systems, working collectively for their **constitutional rights to health**
A national people's health system demands **adequate, well trained, appropriate, equitably distributed** and **motivated health workers**. This calls for **improved conditions and training** for health workers, and a **challenge to the trade in and migration of health personnel**.
We are building national people's health system (NPHS) - **one that is** universal, comprehensive, equitable, participatory and publicly funded.
A NPHS demands **sustained increased fair financing of** the universal right to health, through **rising investment in the public health sector,** increased per capita funding to health and increased **progressive tax funding for health.** This calls for **debt cancellation** and **sustainable global / international funding** to **reinforce the public health system**.
Underlying a NPHS is an economy that widens people's access to productive wealth **and to** essential services
The **state is a site of struggle,** nationally and globally. It supports the national people's health system by **resisting privatisation** and **promoting the public interest**. It has and protects the **authority and policy space** to advance health. It protects the public in trade agreements (TRIPS, GATS, FTAs) and **contronts trade liberalisation.**
A NPHS provides universal access to treatment **(prevention and care) and protects** food sovereignty, **and** indigenous knowledge systems.

Our different areas of struggle and issue campaigns in health civil society can be located within this wider unifying struggle. Each area demands and reinforces the other, once it is located within this unifying framework. We therefore carry the unifying platform of building a national peoples health system into all our issue platforms.

9.3. Organisational objectives

Health civil society in the region is guided in its mode of work by objectives of:

- ☑ Being people led and people-centred
- ☑ Being organised at grassroots, national and global level
- ☑ Having in one struggle with many fronts
- ☑ Linking single issues to the broader vision
- ☑ Being united organisationally across labour, community organisations and social movement
- ☑ Scaling up and advancing on victories
- ☑ Working in solidarity
- ☑ Taking advantage of windows of opportunity.

10. Moving forward: Follow up actions

With these key principles, areas of action and organizational objectives defined, we identified as groups and in plenary the major areas of follow up action. These are summarized below.

We identified several major areas of action as focus for follow up:

- strengthening peoples power in health
- improving the conditions of health workers
- ensuring fair financing for health
- advancing health in trade.

We also identified that issues such as access to treatment embed in all these areas of action and present opportunities through the gains achieved to advance our wider health interests.

10.1. Strengthening peoples power in health

Lead organisations for taking this area forward are: CWGH, EQUINET, MWENGO, MHEN, PHM.

- **Civic education for a NPHS:** We will develop, produce and with civil society organisations in countries widen the use of civic education materials on health that promote the NPHS (CWGH and EQUINET (TARSC) with national health civil society. We will training facilitators in how to use participatory health training materials (CWGH) and run an activist learning workshop open to health civil society in June 2005 (MWENGO).
- **People to people links:** We will make links with and strengthen community health workers understanding (PHM) and make links with parliamentarians in our work (EQUINET, CWGH, GEGA and local health civil society). We will strengthen national

coalitions of health civil society with a comprehensive focus on a NPHS (HEPS, MHEN, CWGH, TANGO). We will be actively brought into, supported in and participate in social movement activities of the Social Forum and the Peoples Health Movement (SaSF, PHM).

- **Communication outreach**: We will disseminate information on issues relating to the NPHS in clear, understandeable and simple terms (PHM, MWENGO, CWGH).
- We will co-ordinate out mailing lists to share information and build common issue newsletters where we send the same messages through our editorials (MWENGO, PHM, EQUINET, PATAM). We will provide training on ICTs (MWENGO, EQUINET).

10.2. Improving the conditions of health workers

Lead organisations for taking this area forward are: SATUCC and PHM.

- **Building evidence on Health worker issues:** We will gather research evidence on the conditions of health workers including norms and losses across countries and the impact of privatisation of services and analyse the policy directions from this. (MSP; PHM; EQUINET; SATUCC, PATAM).
- **Debating and developing policy options:** We will bring our evidence from different research processes into the EQUINET regional policy forum on health human resources to be held in July 2005 to develop our policy positions and take these back to our organisations and to our dialogues at national level with health workers (EQUINET, all).
- **Advancing and engaging on our policies:** We will hold a follow up meeting to discuss our advocacy positions after the EQUINET conference and secure funding for a regional campaign that we will take forward through existing campaigns and at country and regional level (MSP, SAMWU, NEHAWU, SATUCC, PHM), Our first campaign day will be on May Day 2005. We will hold meetings in SA and in the region to build capacity on health worker issues (SATUCC, SAMWU, NEHAWU).
- **Information and media outreach:** We will disseminate media statements on the issue, such as in the SAMWU/MSP/ILRIG press conference on occupational health conditions of health workers on 7 March 2005. We will use the MSP radio show on occupational health of health workers distributed through 40 radio stations in SA and the website to take up these issues. We will build solidarity with and disseminate each other's statements and positions in line with our unified platform, including in our newsletters. We will fundraise for wider radio outreach on health worker policy positions (MSP).

10.3. Ensuring fair financing

Lead organisations for taking this area forward are: EQUINET, CIN, HAI, PHM.

- **Sharing evidence and building alliances:** We will share information through our mailing lists and newsletters in fair financing issues (EQUINET) and on global funding issues (TAC/PATAM). We will hold regional policy debates: on fair financing in April 2005 (EQUINET), in March/April in SA (TAC). We will examine how GPPIs strengthen health systems (PHM, CIN, HST, CHESSORE), explore options for fair financing in Africa (EQUINET, CIN) and investigate national health insurance schemes proposals (CIN) and private sector regulation (PHM, TAC) for their impact on fair financing.

- **Monitoring and tracking health financing:** We will track how funds for AIDS are used (HEPS; MHEN) and whether G8, Abuja and other commitments are met (EQUINET, PATAM). We will track how PRSPs are operating (CIN).
- **Campaign on fair financing and debt cancellation:** We will campaign for debt cancellation and advance this at the July G8 meeting (PATAM, TAC and all). We will advocate for an increase in health financing (All) and campaign for the abolition of user fees (TANGO, all).

10.4. Advancing health in trade

Lead organisations for taking this area forward are: ATN, SEATINI.

- **Sharing information, building literacy and building alliances:** We will share information through monthly conference calls (HAI, Oxfam, MSF, TAC, AidsLaw Project); networking meetings (SATUCC); economic literacy activities (CHESSORE, ACRN, MWENGO, ATN, SEATINI) meetings with MPs (SEATINI, CHJESSORE, EQUINET, CWGH, HEPS, HAI) . We will disseminate specific papers on issues, (HAI- medicines paper re: EPAs) . We will build capacities on trade and health isues at country and regional level (SEATINI, EQUINET, CHP)
- **Campaign and engage on trade issues:** We will campaign against EPAs (early March, ATN, MWENGO, LEDRIZ, SEATINI, ACRN), against AGOA (SATUCC); and on AU-IPR medicines access (March SEATINI, ATN, HAI). We will engage the AU on TRIPS (April TAC/PATAM). We will participate in the Hong Kong ministers planning meeting (26-28 Feb, SEATINI) ; the MPs preparation workshop for Hong Kong (ATN August) and in the Hong Kong WTO Ministerial (MWENGO, LEDRIZ, SEATINI , EQUINET 13-18 Dec)
- **Promoting alternatives:** We will contribute to the building of alternatives to neoliberalism and locate the NPHS in the wider framework of economic and social policy for its achievement (LEDRIZ; before June).

10.5 Building one struggle from many fronts

These areas of struggle will be integrated through:

- a common and uniting position
- united health civil society in agreed common platforms
- common/ joint processes and materials.

Our common and uniting position is for a national people's health system.

The common platforms we will jointly aim at ensuring presence and engagement on the NPHS and the specific issues relevant to that platform are:

- **AU Ministers of Health meeting, April 2005:** lobby on the NPHS, fair financing, TRIPS, PATAM/TAC to lead in organizing.
- **World Health Day April 7 2005:** lobby on NPHS, link to mother and childcare (PHM to lead in organising).
- **May Day May 2005:** lobby on NPHS and health worker conditions, SATUCC to lead in organizing.
- **G8 July 2005:** mobilisation and social action on trade, financing and NPHS: Lead in organising MWENGO, SASF, TAC).

- **PHA2 July 2005**: plenary from the region on the NPHS. PHM to lead in organizing.
- **AU Ministers Meeting Sep-Dec 2005:** lobby on trade-health issues, ATN to lead in organizing.
- **SASF October 2005:** Zimbabwe, plenary on NPHS (Mwengo to lead in organising).
- **UNGASS September 2005:** lobby position on the NPHS and fair financing (lead to be finalised EQUINET?).
- **WTO Hong Kong Ministerial December 2005**: lobby and social action on trade and health. Lead in organising ATN, SEATINI).
- **ASF January 2006:** Morocco WSHF to lead in organizing.
- **WSF Jan 2007:** Nairobi WSHF to lead in organizing.

The points of co-ordination, planning and review for our work are:

- **April 2005, EQUINET:** A meeting of the health civil society lead institutions on 18 April after the EQUINET steering committee meeting in Johannesburg. EQUINET to ensure all organisations are present.
- **June 2005, CWGH:** A meeting of the health civil society institutions in June 2005 at the CWGH National Conference in Zimbabwe. CWGH to ensure relevant health civil society organisations are present.
- **July 2005 PHM:** A meeting of the health civil society led institutions in July 2005 at the PHA2 in Equador. PHM SA to attempt to ensure all organisations are present.
- **September 2005 SATUCC**: A meeting of the health civil society institutions at the SATUCC regional labour forum in Sept/Oct 2005. SATUCC to ensure that relevant health civil society organisations are present.

The processes we will use to strengthen our joint and common platforms are:

- Developing and producing materials for awareness and education on the NPHS.
- Producing and sharing materials for advocacy, lobbying etc.
- Ensuring organisations going to meetings take a joint mandate of the health civil society network, obtain d=solidarity from the network and feed back to the network.
- Setting up a joint mailing list for the health civil society network.

The co-ordinating committee for the health civil society network includes CWGH, EQUINET, HAI, PHM, TAC/ PATAM, SEATINI, SASF, and SATUCC. EQUINET will continue to provide secretariat support (to be reviewed in April) and will set up the mailing list. The April meeting will examine the secretariat roles and see how these can be devolved. EQUINET will gather existing materials from health civil society organisations and disseminate to the network.

PHM will give feedback in March to all organisations in the co-ordinating committee on their participation and support for attending PHA2 (PHM-SA to follow up) and to all organisations on the outcome of the plenary on Africa at PHA2.

The April co-ordinating meeting will review and finalise the joint platform on the NPHS that is integrated into issues platforms and discuss funding, proposals for cross cutting activities and work. In the meantime all groups will explore funding for the programme of work.

11. Closing

Delegates used the ideas of the past days to brainstorm banners, campaign messages and key messages for forums such as G8. While there was debate on the exact working there was evidence on common purpose and common passion across the groups - the objective of the workshop!

There is convergence across all groups of the key message of Building a national people's health system, and consensus on the key areas that this means engaging on.

Itai Rusike of CWGH thanked the delegates for their time and commitments, thanked CHESSORE for hosting the meeting and EQUINET/ TARSC for organizing it, the sponsors for their support and everyone who put work into the workshop. He wished everyone a good journey home and energy in carrying out the work we have agreed to undertake.

Appendix 1: List of Delegates

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Appendix 3: Program

Health civil society in east and southern Africa: Towards a unified agenda and action for people's health, equity and justice

Day one: Thursday February 17

Aims for the day:
To review our current positions and analysis, identify areas where we share perspective and analysis and debate and review areas where we differ, build shared analysis and joint platforms, strategies and campaigns.

830-930am	Welcome, introductions of delegates and groups represented
930-10am	Background to the meeting
1030-1150am	Current challenges, alternatives and issues for health civil society Challenges to common goals of health equity and social justice - R Tayob, SEATINI Forging an alternative in East and Southern Africa - G Kanyenze, SATUCC/LEDRIZ
1150-1pm	Agendas for global health - D Sanders PHM Agendas for regional health– R Loewenson EQUINET
1pm-2pm	Lunch
2-330pm	Group /plenary exercise on positions and priorities
345-445pm	Plenary review on priority issues

Day two: Friday February 18

Aims for the day:
To understand and review the strength, co-ordination and connection of health civil society to broader social movements nationally, regionally and globally. To assess the feasibility of significant co-ordinated regional activity.

830-930am	Plenary (facilitated) mapping of the strength of health civil society around priorities identified on day one. Where and in which issues is civil society pro-active? What is the strength of mobilisation around the identified issues.
1000-1130am	Group exercise: SWOT analysis
1130-1230pm	Plenary: report back
1230-145pm	Lunch
145-300pm	Plenary discussion: Issues from the analysis
315-415pm	Group work on issues raised in plenary
415-600pm	Plenary feedback on group discussions. Discussion and review of common positions and actions

Day three: Saturday February 19

Aims for the day:
To identify and agree on mechanisms for strengthening linkages, resource sharing, solidarity action and unified campaigns across health civil society in east and southern Africa.
To identify and agree on mechanisms and processes that will strengthen and build our capabilities for this. To map the way forward

0830-1000am	Group exercise: Development of a plan of action
1000 -1200pm	Plenary: report and discussion
1245-100pm	Closing
1pm-2pm	Lunch
200-330pm	Wrap up meeting of the planning committee

Appendix 3: Useful Websites

www.phmovement.org
www.equinetafrica.org
www.patam.org
www.mwengo.org
www.cwgh.org.zw
www.tac.org.za
sa.indymedia.org
www.haiafrica.org
www.fsms.org.br
www.samwu.org.za
www.queensu.ca/msp/