People's Health Movement (PHM) and
Regional Network for Equity in Health in East and Southern Africa (EQUINET)

REPORT of the East and Southern Africa Regional People's Health University

Theme: Past, present and future struggles for Health equity

29 July to 12 November 2021

Online

Table of Contents

Cite as: EQUINET, PHM (2021) REPORT of the East and Southern Africa Regional People's Health University, PHM, EQUINET, East and Southern Africa

Acknowledgements: The course was largely self-funded by the participating EQUINET and PHM organisations and voluntary work by the convenors and leads, with some complementary support from Open Society Foundation to EQUINET and from PHM funders that is gratefully acknowledged. This report summarises the proceedings of the ESA RPHU. It has been compiled by B Ncube with input from R Loewenson and with review input from the PHM and EQUINET members of the ESA RPHU planning group and by course participants.

1. Background and aims

The first East and Southern Africa Regional People's Health University (ESA RPHU) jointly convened by the People's Health Movement (PHM) and Regional Network for Equity in Health in East and Southern Africa (EQUINET) was held virtually between 29 July and 12 November 2021 with the theme 'Past, present and future struggles for Health equity'. The course aimed to build and share evidence, experience, analysis, and knowledge on the drivers of health equity to support efforts and activism within countries, as new and existing members of PHM and EQUINET, and in regional co-operation and joint engagement, from local to global level, on shared priorities. The course further aimed to link key areas of evidence and knowledge to practical experiences and action to share insights and build learning from action.

As this was the first ESA RPHU and was being held virtually, it also involved a steep learning curve for the organisers! A planning group, a programme working group and an IT and process working group were set up, each involving EQUINET and PHM people. Support was also provided by separately contracted people from TARSC and Belinda Ncube a consultant. RPHU pages, an online application form and resource pages were developed by EQUINET on the EQUINET site and then mirrored on the PHM website.

The course took place in closed, interactive sessions, with presentations, group activities and discussions throughout the 18 sessions that covered the key issues affecting and responses applied to advance health equity in the ESA region. The sessions covered the political economy and social determinants of health and wellbeing, the organization of comprehensive public health, primary health care and health systems, commodification of health and equity in health technology, and the social power, rights and laws, organisation and activism that drives health equity. The course addressed past trends, current realities and future challenges, and integrated learning on the implications of the COVID-19 pandemic and preparedness for future epidemics, pandemics and public health 'emergencies'. The final sessions integrated discussions of follow up work and participant evaluation of the course. Between sessions, there was time for engagement within and feedback from participant organisations/constituencies and discussions on how future work can connect across organisations and regionally within EQUINET and PHM. The programme is shown in *Appendix 1.* To widen uptake in the region, background readings were made available by PHM and EQUINET Resource people and uploaded online before sessions. Presentations from sessions were clipped and uploaded by EQUINET and made available open access following each session on the ESA RPHU Resources page.

The selection of the applicants followed the commitment to balance gender, age, countries, organisations, and roles of participants, with consideration to applicants under 35 years and persons with disabilities. There were 100 applicants, from which the planning group selected 40 course participants representing a diversity of countries from the ESA region, various disciplines affecting health equity, organisations and areas of focus. Applicants were working or with a role within organisations/associations/ networks that engage with grassroots communities and at district and or national and international level, to be in a position to amplify outreach of information from the course to others through their work. During the course, applicants demonstrated their experience in activism/action in social justice, health and wellbeing and a commitment to using the course for follow up action and activism. To be selected applicants needed to confirm their organisations' support, access to the internet and commitment to attend the full RPHU. However, the first session had 29 participants and across the course there were an average of 23 participants per session attending or catching up using a record of the online session. Some sessions had higher and some lower numbers. Any fallout from the average of 23 participants was largely due to internet and electricity challenges, competing time commitments, and illness. The applicants and their organisations are shown in *Appendix 2* and the RPHU faculty in *Appendix 3.*

Before the course started, resource people and participants were given training in using the zoom platform used for the course. Draft sessions provided by course leads were reviewed and feedback given. This together with an online reporting of course outcomes between sessions and period planning group meetings were used to enable continuity across the course.

2. Course proceedings

2.1 Introduction and overview

The first session was held on the 29th of July 2021 and the convenors were Rene Loewenson, Barbara Kaim, EQUINET, Melanie Alperstein and Peninah Khisa, PHM ESA. The session aimed to introduce PHM, EQUINET and their goals, organisations and work. It also aimed to facilitate participant introductions, experiences on health equity, and expectations; and to introduce the course programme and process.

Rene Loewenson introduced EQUINET. Founded in 1998, the Regional Network on Equity in Health in east and southern Africa (EQUINET) is a network of professionals, civil society members, policy makers, state officials and others within the region who have come together as an equity catalyst, to promote and realise shared values of equity and social justice in health. EQUINET brief 2016.pdf (equinetafrica.org). Peninah gave an introduction to PHM. The PHM is a global network bringing together grassroots health activists, civil society organizations and academic institutions from around the world, particularly from low and middle income countries (L&MIC). We currently have a presence in around 70 countries. Guided by the People's Charter for Health (PCH), PHM works on various programmes and activities and is committed to Comprehensive Primary Health Care and addressing the Social, Environmental and Economic Determinants of Health. About the People's Health Movement - People's Health Movement (phmovement.org)

Rene led the conversation on the meaning of equity. Equity in health implies addressing differences in health and wellbeing that are unnecessary, avoidable and unfair. In our region, these typically relate to disparities by race, residence, socio-economic, cultural and political status, gender, age, ecological conditions and region that have both current and intergenerational impact. They arise from living, working and social conditions, but also deeper factors in past and current political economies. It calls for states, policies, services and interventions that allocate and distribute social and economic resources to improve health and wellbeing, that act on t, and that regulate interests and practices that are harmful to health. For this, equity also implies people having the values, power, agency and voice to make and use choices over resources to realise collective health rights and social justice, to improve their wellbeing and that of future generations.

In the discussion that followed key messages shared on the key challenges for health equity in the region included:

- Equity in access to primary health care
- Irresponsive governments failing to prioritize investing in the core health needs of the most vulnerable and underserved people especially in rural areas.
- Health governance, archaic laws, health illiteracy and lack of confidence in the public health facilities
- A lack of political will in countries, lack of well-coordinated civil societies activism in the health system
- Often more division within the left than there is between the left and the right.

On the type of activism most needed for equity in the region, participants raised:

- Activism that is grassroots led and empowers those who are marginalized to voice their issues.
- Evidence-based activism where research and evidence are used to advocate for solutions that work
- Demand for political accountability through strengthening regional organisations, and civil society and community involvement in decisions.
- Connections made between the grassroots, national and regional levels to engage globally.

Participants suggested that we need many activists located in multiple different institutions: from generating evidence to demonstrate inequality, to folks working in the public sectors, to those focusing on specific issues. We need to be connected to each other and find ways to build on the work done before. we need to build a critical mass at grassroots level to champion the agenda for successful advocacy.

An overview was given of the programme for the RPHU and the resources available before and after sessions and participants were warmly welcomed to this first ESA RPHU!

Graphic: ESA RPHU Zoom session

2.2 Political economy and reclaiming resources for health

Week 2 was convened by Rene Loewenson, TARSC/ EQUINET and two sessions were held. Session one was facilitated by Firoze Manji, Daraja Press and Patrick Bond, University of the Western Cape School of Government, who discussed a political-economic analysis of health and wellbeing in the region. Session 2 was with Mariam Mayet, African Centre for Biodiversity (ACBio) on biodiversity and ecological resources for health, political economy of malaria and transnationals in industrial agriculture, gene technologies and key struggles locally to globally on them; and David van Wyk, Benchmarks Foundation on transnational extractives, particularly in mining, and the struggles in the region around health and wellbeing in the extractive sector.

Prior to the session participants were asked what they saw as the resources for health, and a wordcloud was generated from the responses.

The word cloud was generated from participants' views of the resources for health:

In the discussion, we explored the different forms and levels of resources, noting that while health care was commonly noted, it is living, working and social conditions that have high impact on health and that it does not make sense to keep treating people and then sending them back to the conditions that make them ill. Underlying this, we then pointed to the policies and services and the political and economic conditions that generate the conditions that affect health. Evidence shows that the further upstream you act, the deeper and more sustained the impact on addressing inequities. This led us to the panel discussion on the political economy.

The panel discussion Rene moderated using participant questions with Firoze Manji and Patrick Bond is available as a clip on the RPHU resources page https://www.youtube.com/watch?v=L-JL54PU3bg%C2%A0%C2%A0. Key messages from the discussions were:

1. In the same way as colonialism and a racist liberalism created 'sacred' and 'sacrifice' spaces where lives and rights were cultivated or denied, neoliberalism and neo-colonialism is doing the same, and in recent decades has reversed gains won by struggle, with support from those in the 'sacred' zones of our region.
2. Neoliberal global and country economies have reproduced this inequity by commodifying and stratifying what should be global commons- water, health, education services, communications, ecological resources, and key state institutions, reproducing features of colonial states and undermining their role in transformation.
3. COVID has intensified this, given legitimacy to unaccountable power, privatisation, and intensified inequality, but has also exposed injustices and opened opportunities in challenges, expectations of the state, and demands for change across many regions globally. It has raised calls for public goods and like climate change has provoked a 'globalisation of people', such as in demands around vaccine equity, rather than of capital.
4. There are many forms of social organisation and struggles, but we need to move from oppositional to propositional struggle, driven by clear ideas of 'commoning', (or decommodifying and destratification) and universalism, and not by appeals but by claims to rights, equity, and self-determination.
5. Health is a critical site of grievances and struggle, and the health sector and health workers should be playing a key role in these propositions, but we need to overcome its disconnect from wider struggles and resist its privatisation and commodification.

In the discussion that followed participants noted their own experiences of how COVID has impacted their political economy context. Firstly, as threats in terms of privatisation and weakness in the state response, secondly, as growing inequity in impacts and wealth because of the responses to the pandemic, and thirdly, as rights deprivations, and conflict. However, it was noted that people can generate solidarity through networks, such as the Community Action Networks (CANS) in Cape Town, local alliances organising around responses, in some cases building on what was already experienced from Ebola.

A key challenge noted was states often opposed local initiative and were silent in the face of or enabled privatisation. In relation to COVID, we discussed that the biological virus may be harmful, but it is these political economy conditions that lead it to generate growing inequalities and violations in health rights in its impact on people. The response equally demands wider alliances and activism that also engages health workers around these deeper political economy challenges, around communing and around resisting privatisation of the public sector.

During session 2, we explored the general themes raised in the first session in relation to two key areas- health and wellbeing in the extractive sectors, firstly in mining and secondly in the extraction of biodiversity. We started with a summary of the previous session. Two participants presented their experiences of extractives and health - one on engaging the mining sector in Botswana and one on agro-industrial extraction and food in Uganda available on https://youtu.be/LTxKYfurUiQ.

The presentation by David van Wyk showed how the lifecycle of a mine raises different issues and entry points for engagement at different stages, how mine underinvestment in social wellbeing for workers and communities has left a legacy of social deficits that then become difficult to manage when mineral prices fall, and how the pollution of air and water generates health and environmental consequences for communities that are not met by mines. https://youtu.be/IrsBvhT1Dng.

Mariam Mayet noted in her presentation that in addition to resource extractivism from the region and the destruction of ecosystems that has taken place in a neoliberal globalisation, there is now a new challenge of transnationals investing in gene technologies in health. As production systems have generated pest and drug resistances and escalated disease levels, rather than tackle the underlying ecological causes, the solution being offered is a new form of genetic manipulation of species such as in the case of malaria. These technologies are controlled by corporates outside the region, driven by large funders like Gates Foundation, Facebook, who also have significant financial influence in global health agencies, and who use these developments to fund the entry of private capital in the health sector. Mariam's presentation is available on https://youtu.be/Ip-eFJvRFm8%C2%A0 .

The two group discussions exploring these issues further raised some points of follow up action and activism:

On extractives and health, especially in the mining sector

- Provide information on the sector to those affected- workers, communities, ex mineworkers- to engage at key stages of the mine lifecycle (eg. on issues of prior informed consent before mines start through to ensuring post-closure liabilities after they end)
- We should be organising across the different communities in and around the mines and break organisational silos
- There should be advocacy and monitoring to ensure mines are not exempt from taxes
- Vaccination campaigns by mines should include and cover the surrounding community
- We can link across groups in with the Extractives and health group in the region.

On biodiversity and ecological integrity

- Community-led information, engagement and advocacy is critical, including for engaging the state on policies that undermine ecological wellbeing
- The state is not homogenous, so we need to engage state actors that share concerns with communities
- Research and engagement needs to aim at building transparency and accountability on decisions on key natural resources
- We need to shift the paradigm driving decisions in health from one that is focused on disease and the products of a medical industrial complex to a comprehensive public health that provides for key social needs in a manner that protects ecological and human wellbeing.

2.3 Social determinants of health and reclaiming comprehensive public health

Week 3 had two sessions convened by Masuma Mamdani, EQUINET and Peter Binyaruka, Ifakara Health Institute (IHI) / EQUINET; with Shakira Choonara and Sue Godt, introducing the social and commercial determinants of health, and gender equity. These convenors introduced the social determinants of health and equity over four individual powerpoint presentations.

- **An overview on SDH and wellbeing**. Using various examples (inequities in life expectancies, adult literacy and maternal health between and within countries; global inequities in covid vaccine distribution - global governance and common goods; and consequences of climate change and unplanned urbanization on people's wellbeing), Masuma introduced key SDH concepts. She discussed three conceptual frameworks (WHO SDH conceptual framework, Dahlgren and Whitehead framework, PHM modified framework on determinants of health), underscoring the need for responding to the immediate as well as the long-term global health challenges- the causes behind the causes; and for an integrated intersectoral approach towards improved health outcomes and well-being. Masuma's presentation is available online on https://youtu.be/jGHLJaJp3oQ.

- **An intersectional lens to health inequities (gender, race and class)**: Shakira's presentation drew on some theoretical elements and also the practicalities, with insights into the realities of vulnerable and marginalized populations. She explored intersectional realities and health outcomes, the gender and geography divide, impact on culture and tradition, and the state of systems for health. Shakira's presentation is available online on https://youtu.be/Miq1aFMe_WU.
- **A presentation on commercial determinants of health (CDoH) in the region**: Focusing on the Philips community life centre public-private-partnership (PPP) model being rolled out in Kenya, Sue Godt's presentation examined emerging issues related to skewing of health systems away from comprehensive primary health care approaches; control of data collection and its use and impact on governance of health delivery. Sue defined the CdoH, explored the growth of global corporate health and PPPs across the region, and raised several concerns linked to emerging vision of health, big data analytics, innovation and IPR, manipulative partnerships, and the dominance of corporate over national priorities amidst weakened governance and accountability, highlighting the need for exploring regional innovation systems. Sue Godt concluded by reiterating the call made in Week 2 to be propositional, decommodify and destratify, and counter neoliberalism. She argued that PPPs & austerity are not the solution. Sue's presentation is available online on https://youtu.be/XlhVz9X4zvA.
- **A review of co-financing to address SDH**: Using three very interesting cases and examples from the STRIVE project [Malawi 2008-09 cash transfer programme to keep girls in school demonstrating multi-sectoral impacts; potential co-financing of Opioid Substitution Therapy (OST) programmes; and financing structural/upstream social determinants of health (http://strive.lshtm.ac.uk/drivers/co-financing)], Peter's presentation highlighted and discussed the roles, economic rationales, challenges, and potential benefits of inter-sectoral co-financing of structural interventions with multiple benefits as a way to address SDH. Peter explored the equity, efficiency and cost-saving concerns that policy makers have in addressing SDH; highlighting some of the potential barriers, the requirements and the political buy-in required for co-financing. Peter's presentation is available online on https://youtu.be/M2hMr9DmKWM.

In groups in session 2, participants shared their own context specific experiences, current determinants and identified areas for individual and collective advocacy to address SDH within areas such as urban wellbeing for young people; intersection of gender, race, class; and financing and PPPs, including the implications for equity lens to their discussions. In plenary discussions, a Jamboard was used for participants top give feedback on questions and issues arising. These are pasted below:

The problems and realities have been outlined, the question is, what can we do about these issues, individually, collectively?

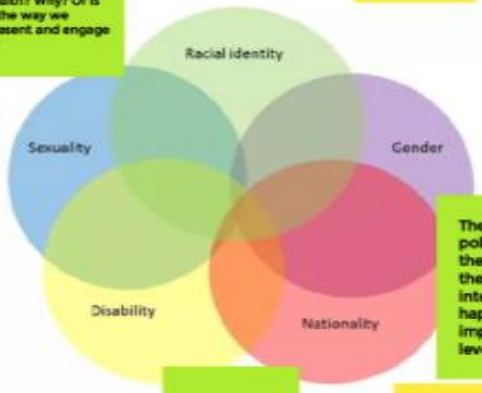
Intersectional Realities

In Uganda for example whereas government is promoting girl child education, it also placed a ban on teaching of sexuality education

There are few people who speak out about their own health? Why? Or is it the way we present and engage it?

Do Governments and our individuals actually really value their health?

You can add your thoughts/ reflections via a sticky note, shape or even text box on the left side! The space is yours!



The influence of global factors on our health, especially in our region is very profound, complex architecture is in place to sustain it. It requires a multi-layered approach to tackle it, ideological tuffs.

There are so many policies in SA, but the problem is that these intersectionality happen at the implementation level

Vulnerabilities

Governments are there to prioritise our individual needs, why is this not happening?

Plenty of good policies, but which ones get implemented and which don't?

How have you tackled corporate power in your work and community?

What lessons? (what works? what obstacles and how to overcome?)

You can add your thoughts/ reflections via a sticky note, shape or even text box on the left side! The space is yours!

Commercial Determinants of Health

Tried to take on Nestle on baby food products, and especially milk powder as substitute for breast milk. Very difficult.Multinationals often forge strong and strategic alliances with powerful national actors...

Yes, working on obesity prevention and NCDs, we implemented the Sugary Beverage Tax (SSB), the role of industry and power is shocking, similarly when it comes to food products and marketing regulations

Yes,community level asking a production company to reduce pollution, or a large industrial farming company to ensure equitable access to water..BUT companies are politically connected, the ordinary poor people's plights are ignored..

Action is required on multiple fronts: nationally and globally, with increasing broad based support

We consume products of MNCs what is our role?

Tobacco companies are predatory

What are the investments we need to make to bolster health equity?

Inter-sectoral Co-financing

Here is a devil's advocate question, LMICs donor-dependent or co-financing

HRH housing in rural setups

I like this intervention Peter it shows the impact of investing in gender transformative programming

Doing away with TRIPS policies, to ensure access to medicines

Infrastructure

You can add your thoughts/ reflections via a sticky note, shape or even text box on the left side! The space is yours!

we need to improve the living conditions of the communities to improve health standards of inhabitants that way we will be getting to the root problems and then compliment that with improved infrastructure of health care facilities

Medicines

I suspect this calls for transparency in various sectors i.e. available funds? Governance, oversight?

Do these three concepts - value for money, efficiency and EQUITY- speak to each other? Or does it result in tensions?

Investment in Energy- has potential multiple effects on health and wellbeing

transparency issues

2.4 Health Systems and Comprehensive Primary Health Care

Week 4 had two sessions convened by Melanie Alperstein, PHMSA and Louis Reynolds, PHMSA/Paedatrics and Child Health Advocacy Committee, UCT, with Vera Scott, UWC/PHMSA and Denis Bukenya PHMUganda/ CEHURD. The sessions aimed to help participants to gain a critical understanding of the issues in strengthening universal equitable health systems underpinned by a Comprehensive Primary Health Care approach, and its related philosophy for equity and social solidarity and justice.

Vera Scott (UWC and PHMSA) focused on 'What is meant by a health system'? See her presentation at https://youtu.be/GgeMr27gOPg. The discussions covered who makes up the health system, and that despite good policies for comprehensive services, implementation was limited. A mainly western curative approach was being practiced, with a public and private divide. Traditional and faith-based and community-based services such as the elderly especially grandmothers, and mothers are not regarded as part of the system. Louis Reynolds and Melanie Alperstein gave overviews of Comprehensive Primary Health Care (CPHC) as developed in the Alma-Ata Declaration of 1978, what led to it and the social justice and equity dimensions of CPHC. See https://youtu.be/yD08ZLJXiGc. Louis Reynolds (PHMA and UCT) underscored that social participation and intersectoral action for health have economic implications that demand political activism and support will. See https://youtu.be/Q6MtOnOnwBQ.

In the plenary discussions, participants said that *social solidarity should spread faster than the virus* and noted that:

- More resources are put into curative care than prevention.
- Health professional education needs to be addressed for CPHC
- Community participation maybe slower but more sustainable
- Community Health Workers are essential for PHC approach and for enabling community partnerships. In most countries, however, they are exploited and because most are women, it is gendered exploitation.
- Health Committees are a useful vehicle for participation if elected by community. Some are appointed by politicians, or services, raising questions of who they are accountable to and their potential to support community participation.

The second session focussed on implementing Universal Health Care (UHC) in Uganda and South Africa and the connection between PHC, UHC and the SDGs. The presentation on Approaches to Universal health coverage and equity: Uganda's approach by Denis Bukenya, CEHURD and PHM Uganda and South Africa's approach through National Health Insurance by Louis Reynolds, PHMSA is found online on https://youtu.be/jVOxicu0Vfs.

Denis Bukenya explained that the Ugandan approach is to achieve improved PHC and UHC through community led approaches by empowering communities. There needs to be community led action to demand. The government is concerned about what communities want, understanding that UHC has to start with communities, but this will be a gradual process. UHC will be financed through health insurance which collects money and health care is provided through solidarity of the healthy subsidising the ill, the young, the old etc. through a risk pool. He reiterated that only social participation and mobilisation will achieve an equitable system.

Louis Reynolds explored the lessons from the South African experience that have taught us that health needs to be looked at from a political - economy lens, with focus on who has power over decision making. He highlighted the centrality of economics and its definition as 'good house-keeping' with reference to management of household resources and who decides what to spend money on? Louis compared health systems before and after apartheid and concluded that health services are still segregated, not ostensibly by race, but we now have hospitals for the rich and poor which exacerbates inequality. In South Africa, the rich pay for medical schemes (about 14% of the population), the poor pay tax for the public health system (86%). The health system is unequal between the private and public sector, with the public sector being inefficient and fragmented.
Participants identified the following points for further discussion:

- UHC is differently understood and interpreted.
- In the Astana Declaration, PHC is seen as the cornerstone of UHC, which makes PHC just a part of health system and not as broad and comprehensive as it intended to be.
- PHC needs public finances in the form of progressive taxation, creating one pool through solidarity. This however is challenged by strong groupings with vested interests, with those who benefit from their profits giving strong opposition.

In the group discussions, participants flagged the following issues and these were also discussed through the chat forum:

- Our health systems and related sectors, such as water supplies and food security, were not prepared for COVID-19.
- Corruption, lack of transparency and accountability in the COVID-19 response affected countries' ability to deal with COVID-19. In Kenya and SA misuse of funds for PPE for health workers exposed frontline workers.
- Political interference in regard to CHWs doing their job being deemed as anti-government resulting in whistle blowers of corruption and mismanagement of funds being murdered or silenced in other ways.
- Some of the initial preventive measures for COVID-19 such as curfews, lockdowns contained the first wave of COVID-19, but some used brute force to enforce lockdowns.
- There were very few supportive measures to maintain behaviour change leading to 2nd, 3rd and 4th waves.
- Civil Society organisations played a big role in pushing government and there is still need for substantial civil society representation on government committees.
- Communication between the state and the people was lacking. There was obscurity about vaccines and distribution with vaccine nationalism growing and the big pharma determining which countries get vaccines and when.
- Botswana raised pertinent issues of treatment of non-citizens, which is possibly relevant in more countries, definitely SA. Testing for corona virus has been difficult because of the migrants being undocumented and their unchecked mobility.

2.5 Power, values, rights, law and reclaiming collective agency

Week 5 had two sessions. Session 1 was convened by Peninah Khisa, PHM ESA with Eunice Awino from Centre for Women Empowerment in Technology (CWE-TECH) /PHM and Ravi Ram, PHM. Conveners discussed the role of power, values, norms and rights in health equity, and built a common understanding of some of the key concepts necessary to develop a gendered perspective. Eunice's presentation was on Gender equity issues and responses, gender inequalities in power, in the access and control over resources, the sexual division of labor and gender socialization. Eunice's presentation is accessible online https://youtu.be/Vu9wx7h0ci8. Peninah's presentation is available on https://youtu.be/WNkCN9C6CZs and Ravi's presentation on https://youtu.be/Mv1RwBQOpCo on power, values and norms.

Moses Mulumba, CEHURD/EQUINET presented in the second session on how constitutional framings and laws provide for health as rights and equity issues. Moses showed how such legal provisions enable equity, and he explored the challenges to their implementation in the ESA countries. He further discussed the learning from COVID-19 on the options for and challenges in implementing rights in 'emergencies' and in using rights to claim collective agency and solidarity. See Moses Mulumba's presentation https://youtu.be/EEZnVteQF_M

2.6 Commodification, privatization in health and reclaiming the role of the state in health and health services

Week 6 had one session which was convened by Denis Bukenya with Ausi Kibowa, SEATINI, on forms of and national and regional forces driving privatisation in the ESA region. See https://youtu.be/b9QGhMmBfUY. Ausi Kibowa analysed privatization, commercialisation and corporate takeover of the public service sector and set the pace for the discussion. Some points that were highlighted included:

- That a number of policies and agreements like Trade agreements; Public-Private Partnerships (PPPs) and the New Aid Architecture which are being fronted in the health sector and other public service sectors are turning healthcare from being a fundamental human right to big business. This has resulted in limited access to quality care services especially by the marginalized communities.
- There is a need to rethink the commoditization of health if the Sustainable Development Goals are to be achieved.
- The PPP model in its current mode leaves a lot to be desired. This is because PPPs often give private individuals and entities the largest share of profits, while government is expected to absorb all costs of negative issues. Thus, there is need to challenge the narrative that the private sector in health is more efficient than the public sector.
- Given the limited capacity of government institutions to negotiate, implement and monitor PPPs in the public service sector, there is a need to develop this capacity so as to ensure that the government regulates PPPs, for people's access to better services. This should be supported by research and analysis of deeper analysis of the implications of key PPPs in health and their implications to the right to health.
- On WTO reforms, there is an ongoing discourse on reforming the World Trade Organization (WTO), including the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement and these conversations are supported by the UN High Level Panel on Access to Medicines. These reforms seek a solution to situations where patented pharmaceuticals which are not available in a country with no or insufficient manufacturing capacity can be supplied by a foreign provider. However, there is a need to inform the process so that the rules streamline the procedures and ensure access to pharmaceutical products in a timely manner.

Participant discussions further highlighted evidence from different countries with emphasis on the challenges of corporate takeover of the public service system as highlighted in below:

- That this causes discrimination according to social status.
- It deprives poor people of service delivery by the government.
- The SDGs are not attainable with the inequity caused.
- Kenya has tried to introduce cost sharing with the government subsidising treatment but it is not effective because it still requires total facilitation of care from the taxes.
- Uganda has unending stock-outs and infrastructural challenges in the public health facilities. This causes an imbalance in care when the private sector has everything at the expense of the public sector.

2.7 Equity in health technology

Week 7 had two sessions convened by Rangarirai Machemedze, SEATINI/EQUINET and Leslie London, UCT/EQUINET/PHM who equipped participants with advocacy skills based on an in-depth knowledge and understanding on the WTO and the TRIPs agreement, how intellectual property rights affect the production, availability and affordability of health technologies, medicines, and vaccines. The sessions explored the political economy of local production in the ESA region, the role of south-south and south-north cooperation and key local, regional and global debates and engagement in health technologies, including in engaging on COVID-19 vaccines.

In session one, Leslie London, UCT/EQUINET/PHM discussed implications of recent developments regarding TRIPs and the WHO global strategy on Public health for the region and the right to health. See https://youtu.be/JG7z5iyLLtk and Rangarirai Machemedze, SEATINI/EQUINET gave an overview of World Trade Organisation agreements and the factors affecting access to health technologies in the region. See https://youtu.be/WVmvedL8Hsg.

The presentations highlighted that the WTO has tremendous influence over international trade policy and no other agreement has been as much of a driving force behind the globalization and liberalization of trade as the WTO agreements, particularly TRIPs. The TRIPs agreement has flexibilities that country must use to access essential health technologies for African populations advocated for at national, regional and global levels. African countries have had to lobby for

transition periods for laws to become TRIPS compliant. This includes compulsory licensing or the right to grant a licence, without permission from the licence holder, on various grounds including public health. It also includes parallel importation or the right to import products patented in one country from another country where the price is lower; and early working, known as the Bolar Provision, allowing generic producers to conduct tests and obtain health authority approvals before a patent expires. This makes cheaper generic medicines and health products available more quickly at that time. These flexibilities give countries the policy space for local production.

Leslie's intervention was on the global landscape on TRIPS, public health and the WHO global strategy & plan of action on public health innovation and intellectual property, focusing on challenges faced by countries in using TRIPs flexibilities. Some of the challenges included weak or absent national laws, big pharma backlash which deterred use of compulsory licences and that the process was generally cumbersome.

In session two, Leslie London, UCT/EQUINET, PHM looked at the case for progressing local production of essential health technologies in the region, available on https://youtu.be/YMFyuqpAQ0c. The presentation raised issues around access to vaccines through the COVAX facility and the debate around the TRIPs waiver. The presentation noted that the COVID-19 Accelerator was established to speed up the response to COVID19 and COVAX was to "advance purchasing" through pre-payments for vaccines. Under COVAX, Low Income Countries get free vaccines while Middle Income Countries purchase at market prices. However, the target population coverage is not 100%.

A number of weaknesses on COVAX were noted, including:

- Intervention is underfunded by higher-income countries.
- There are not enough doses for everyone. Countries must develop criteria to decide who gets the vaccine.
- Big Pharma still maintains patents.
- Rollout relies on the markets. Companies decide who to sell to.
- Vaccine pricing is opaque and not fixed beforehand.
- COVAX does not prevent countries from cutting their own deals.
- There are no guarantees that countries get the most suitable vaccines (e.g. super cold chain may not be appropriate in all contexts).

Rangarirai Machemedze, SEATINI/EQUINET shared case studies of local production in the ESA region https://youtu.be/KkDdwcVQ9EM. The case studies covered what other countries were doing on local production and key to the presentation were obstacles to local production and how countries like Uganda were overcoming these through partnerships between CIPLA of India and Quality chemicals of Uganda. The presentation noted that the problem of local production did not lie on policies since these were in place across the ESA countries but in their implementation.

From these interventions, the plenary participants in groups proposed that taking forward the issues raised meant building this network of participants in the RPHU beyond the training and forming a community of practice that:

- Develops IEC materials for use in our advocacy on TRIPs, local production and EHP issues that is easy to understand- make these material relevant such as how TRIPS affects medicine access or right to health.
- Engage in regional campaign that targets regional bodies raising awareness on TRIPs and the right to health.
- Training of cadres and civil society and beyond on geopolitics and foreign interests.
- Advocate for the integration of TRIPs and the right to health and other relevant matters in school curriculum as part of civic education- Crucial to work with civil society in the education sector.
- EQUINET and PHM should strengthen national structures in government and civil society through building effective leaders.
- Advocacy for domestic laws to incorporate and operationalise TRIPs flexibilities

- Regional cooperation and integration as a conduit for allocating resources for establishing local production.
- Consolidate lessons learnt from CIPLA/Quality Chemicals ARV plant in Uganda and use these to apply to other potential similar investments in the ESA region.

2.8 Social participation and organizing activism for health

Week 8 had two sessions. It was convened by Tinashe Njanji, PHM and Melanie Alperstein, PHM with Damaris Kiewiets UWC, Pelagia Nziramwoyo, CFYDDI Uganda/ EQUINET. The sessions built on previous understanding on social participation in health in different sectors and constitutions and how this is relevant to health equity in the region and explored how emergencies enable/disable social organisation, participation, and activism. Damaris' presentation https://youtu.be/OdfBygPOy84 and Pelagia' s presentation https://youtu.be/WH1UuF3E_oI are online.

In session 1, participants highlighted the need work across the region, strengthening networks. Exchange visits either virtually or face to face could be utilised to build solidarity. It was emphasised that the region needs to look into the Open Government Partnership and TUFH (Towards Unity for Health) to strengthen networks. There is a need to also consider and explore language as a barrier to communication so that in information dissemination, the IEC materials are made accessible to everyone. As activists, participants underlined the need to connect and move with communities emphasizing that activists are not above communities.

In session 2, Pelagia Nziramwoyo explored how Uganda developed their own COVID-19 response equipment including isolation tents for health services and ventilators, using local materials. Considering challenges of Intellectual Property, access to technologies and barriers placed by the commercialisation of health and privatisation, Uganda showed that local production and innovation can help African countries advance. In her presentation, Pelagia also spoke to increase in GBV and child abuse during the COVID-19 emergency. She recommended that the discussions on power and values need to be taken forward by activists as they impact on poor people and access to health care.

2.9 Building a movement for health equity

Week 9 had two sessions and was convened by Nathan Banda, Mavis Koogotsitse, SATUCC/EQUINET; Linda Shuro, Ravi Ram PHM with Anneleen De Keukelaere, PHMSA. The sessions discussed and exchanged experiences on advocacy work in consortium building and led to increased appreciation and lessons from best practices in the region on movement building. Participants developed strategies in countries, regionally and in engaging globally to promote health equity.

In session 1, Anneleen De Keukelaere shared experiences of the South African C19 Coalition - Health Working Group, see https://youtu.be/s6qt92D4zAQ. Participants observed that the road to change requires several strategies. It is not a one-fit-all approach, hence the need to domesticate policies to respective environments. There is need for solidarity. There is also need for convergence on key issues on group level rather than working in silos. This should be coupled with a mindset shift to appreciate activism and advocacy.

Participants further noted the PHM coalitions in country and EQUINET at regional level as basis for building solidarity forums. The importance of connecting local sites to regional networks was highlighted as critical as many challenges arise locally but with regional or even global implications.

The discussions on Week 9 session 2 that related to next steps are captured with the general discussion on moving forward in week 10 in *Section 3.*

3. Moving forward

A number of areas were identified from the sessions in weeks 2-8. Taking the information from sessions, groups discussions and chats, Rene Loewenson, TARSC, identified 6 key areas as

- Building a propositional narrative and breaking organisational silos to connect health workers/activists to wider organisations/struggles challenging (mining, biodiversity) resource extraction and state capture
- Engaging, building alliances on corporate/commercial practices and influences that undermine health
- Building and engaging on a clear, shared vision on what we expect from our health systems (more comprehensive PHC, prevention, promotion…)
- Regional platform on activism in, experiences of community voice in health systems
- Challenging privatisation of public services
- Advocacy, information outreach, engagement on tech transfer, local production of health technology including vaccines

These areas were emailed to delegates to find out the areas that they were interested in for follow up, that also align well to where their organisations are already engaging. Based on the delegate feedback we revised the six areas to five. Participants identified their interest in the different areas through email feedback and in Sessions 1 and 2 in week 9, as show below. Where participants indicated more than one area of interest they were allocated to one group for the discussions. This did not negate that participants may also be involved in work in another area.

1. GROUP 1: Challenging resource extraction and state capture; building alliances on corporate/commercial practices that undermine health; Sekatuka Abubakar; Seabata Makoe, Connie Walyaro, Vama Jele

2. GROUP 2: Building and engaging on a clear, shared vision on what we expect from our health systems; Leanne Brady, Job Komakech, Prisca Mhlanga, Linda Nkuna, Mercy Wanjala, Ronald Chikwenhere

3. GROUP 3: Regional platform on activism in, experiences of community voice in health systems; Harriet Kamashanyu, Danny Gotto, Jokonia Mawopa, Daniel Onyango, Poleen Kyakunzire
4. GROUP 4: Challenging privatisation of public services; Peter Eceru, Florence Khonyongwa, Kedibone Mdolo, Kenneth Ochwer, Boitumelo Molete, Artwell Kadungure

5. GROUP 5: Advocacy, information outreach, engagement on tech transfer, local production of health technology including vaccines; Regina Kamoga, Lucky Mbewe, Mevice Makandwa, Francina Nkosi

In week 9 session 2, the five groups discussed the three questions below (not all were present in session 2).

1. What are you/ your organisation already doing in relation to the area your group is discussing?
2. What specific aspects of the area do you want to focus on?
3. What do you think would be the most important actions to take forward on this area of work? Within countries? As a region?

Rapporteurs captured the discussions and their feedback during the session is captured below and was taken for follow up discussion in week 10 on regional follow up and connections with / support from ongoing work in PHM and EQUINET. Week 10 was convened by Rene Loewenson, Barbara Kaim, EQUINET; and Melanie Alperstein, Denis Bukenya, PHM.

The feedback from the week 9 session is captured as provided.

GROUP 1: Challenging resource extraction and state capture; building alliances on corporate / commercial practices that undermine health

Current organization actions

Seabata noted that in Lesotho digging of artificial dams has resulted in an influx of migrant workers and an increase in HIV cases. Some companies are using technology to violate human rights and promote gender based violence. We are lobbying companies to support local CSOs/NGOs to mitigate increasing HIV cases as part of their CSR. Abubaker also pointed out that logging has been penetrated by 'big wigs' that have prevented monitoring and accountability. Activists are using nonviolent resistance, taking pictures of damage and perpetrators and sharing on social media and also sharing corruption cases. Since government officials are involved, legal action has been long and unfruitful, but exposing them has been effective. We are using resources from Rhize, a US-based organization to train grassroots activists to mobilize around issues affecting communities including on the impact of climate change on community health. We have also identified allies for each group working on a social issue and connected them together to amplify their activities and advocacy work. Diversion of resources meant to be used by the environment monitoring body is also avoided since corruption cases are exposed. Commie reported that some corporate/commercial practices that undermine health include production and increased consumption of unhealthy foods and products; interference in trade process that are set up to promote health equity (TRIPS plus); commodifying/privatising health care making it less accessible for all, and generally undermining the right to health. We are promoting and protecting the right to health by engaging and empowering stakeholders from the grassroots to the global level, from children to policy makers - using a One Health approach - to move from awareness to action using a 4-pronged approach: i) capacity building and technical assistance, ii) networking and sharing of best practices; iii) political advocacy and review and iv) creation and engagement on platforms for action. We are also building disease resilience among vulnerable and marginalized communities regionally/LMICs by exploring and addressing the nexus between Antibiotic/Antimicrobial Resistance [ABR/AMR], Covid19 and Mental Health

Specific aspect of the area to focus on:

Promoting and protecting the right to health in corporate and commercial practices

Most important actions to take forward within countries and as a region:

- Build coalitions/alliances for lobbying/advocacy at regional level.
- Awareness campaigns, training of grassroots leaders for more impact from grassroots upwards.
- Lobby corporates to carry out health impact assessments and mitigate harmful effects and invest more in local CSOs.
- Lobby for greater budgetary allocation to healthcare; member states to fulfil Abuja Declaration.
- Invest in/incentivize local production of health tools and resources including PPEs, vaccines/medicines, ventilators.
- Use human rights as a tool to reduce TRIPs+ conditionalities in bilateral and multilateral agreements - ensure low income countries can make use of TRIPs flexibilities that allow them to produce generic versions of patented medicines in public health crises.
- Use IPC as a tool to increase disease resilience and enable vulnerable communities to be able to better cope with current and future pandemics and health crises.
- Empower communities to better understand the right to health, what it looks like/what to expect, how to lobby for transparency, accountability and action.

GROUP 2: Building and engaging on a clear, shared vision on what we expect from our health systems

Current organization actions

In Botswana a consortium of twenty community-based organizations, formed in November 2019 is looking at various themes including access to health, protection and promotion of human rights in general, migration governance, etc. They have contributed to a larger extend on climate justice advocacy, access to ART services for migrant communities, disseminating critical Covid-19 information, gender justice and vaccination sites available in Botswana. In Zimbabwe, trade unions at Country level are setting up an OSH network were every affiliate of ZCTU is represented and efforts are made to integrate Public Health issue in OSH. We also focus on

vaccines availability and uptake of it though with caution as we appreciate different cultural social and religious beliefs around vaccines

Specific aspect of the area to focus on:

Awareness raising and information sharing and in-country collaboration

Most important actions to take forward within countries and as a region

- Strengthening / building of networks to avoid having so many struggles from individual corners.
- Extend solidarity to the countries facing extreme health crises.

GROUP 3: Regional platform on activism in, experiences of community voice in health systems

Current organization actions

- Community-based activism, such as community Barraza's where people are able to identify a community that's struggling with particular issues and it helps communities to express their needs.
- Involving community leaders, health workers and policy makers in online activism activities like webinars to address community issues.
- Conducting patient health care trainings, public awareness, needs assessment to facilitate re- alignment of health service delivery.
- Bringing every stakeholder on board.

Specific aspect of the area to focus on:

Active advocacy and engagement, to address inequity, colonialism and politics.

Most important actions to take forward within countries and as a region

- Formation of people centred platforms that do not depend on funding so that they can be sustainable at community level, district level and national level.
- Strengthening community awareness, advocacy, challenging politics and colonialism in countries.

GROUP 4: Challenging privatisation of public services

Current organization actions

As a knowledge and learning organization, TARSC is doing research, skills building and technical support and a commitment to long-term capacity building in civil society and in public sector. In this area covering cost of health and access to health monitoring; national dialogue processes around health funding: advocacy on and monitoring of funding and healthcare for all people irrespective of their social economic and political backgrounds; partnership with other organisations to explore how the state can raise funds for health sector; implementing the Equity Watch process within EQUINET and training parliamentarians on public health law and issues around health services privatization. From TJNA, Kenneth reported that as different countries around the world strive to cope with the social and economic effects of the current Covid pandemic, debt burdens and budget deficits have continued to widen. This is especially the case in the African continent where the post-Covid-19 recovery is projected to cost more than 150 billion dollars and a yearly funding gap of about 200 billion dollars to attain the Sustainable Development Goals. As the budget deficit of the poorer African states increases, their ability to mobilize the local fiscal resources becomes merely a dream. Yet Illicit Financial Flows and unprogressive tax regimes have continued to erode the African countries' tax base and their potential to mobilize domestic resources to fund basic services like health care. The Kenyan government introduced the UHC and Linda Mama programme to enhance healthcare services' access by poor people. However, the packages are inefficient as the Linda Mama does not carter for any birth-related complications including the caesarean birth. Some level 2 and 3 hospitals are poorly equipped with no basic supplies like surgical gloves. Notably, there is both a direct and indirect relationship between IFFs and unprogressive tax systems and the government's inability to provide quality and affordable healthcare to its citizens. When the government becomes unable to provide for its citizens, it leaves them in the hands of donors and private players, and this is where healthcare becomes commercialized and marketized. Tax Justice Network Africa, in collaboration with other CSOs and partners across Africa, works to curb IFFs and promote equitable and progressive taxation policies and systems. It encourages African

countries to develop pro-poor tax policies and strong tax systems to curb ilicit outflows and promote resource mobilization.

Specific aspect of the area to focus on:

- Strengthen actions in advocating for pro-poor (public sector) healthcare policies
- Harmonise civil society organizations operations, working together within our regional blocs.

Most important actions to take forward within countries and as a region:

- Keep what we are doing and strengthen our actions.
- Focus more on financial flows and taxation and their impact on governments' ability to provide affordable and quality healthcare.
- Harmonizing operations at regional level such as SADC.
- Follow up on the implementation of proposed policies.
- Building capacity around the state: looking at the state's capacity to implement progressive healthcare policies and whether the state agencies have the capability to implement progressive policies around healthcare privatization and access.

GROUP 5: Advocacy, information outreach, engagement on tech transfer, local production of health technology including vaccines

Current organization actions

- Carrying out awareness campaigns on Covid-19 Vaccine to sensitize people on the availability of the vaccine.
- Engaging government and private sector to provide accessible Covid-19 vaccine.
- We have been working in coalitions and networks to build voices to present a strong voice on the gaps and challenges in access to Covid-19 and others.
- Some have been advocating on the need for increasing access to medicines and other health services using Technological Transfer to address the challenges of Supply chain issues.
- Some are engaging government on improving the working environment for Health Workers in the face of Covid-19.
- Some are conducting Training of Trainers for Service Providers in the provision of Covid-19 vaccine to ensure reaching out to all people.

Most important actions to take forward within countries and as a region:

- Establishing Regional Advocacy Committees/groups to lobby for access to Covid-19 vaccines and other health supplies at a reduced cost to increase reach.
- Training in advocacy at regional level to have capacity to engage regional blocks like SADC, AU etc..
- Build the capacity of the communities for community-oriented advocacy through Civil Society Monitoring (CSM) using scorecards on existing gaps and challenges.
- Lobby with governments in the region for subsidized health services to reach even the most marginalized communities.
- Door-to-door awareness on Covid-19 vaccines information to dispel misconceptions around the vaccine and provide answers to questions that people may have.

Following these discussions in week 10, Peninah Khisa presented PHM SA work and Rene Loewenson EQUINET's work in the region.

Peninah presented on PHM reminding participants that **PHM** is a global network which comprises grassroot health activists, civil society organizations, academic researchers and activists from a low middle and high income. PHM activities are conducted through country circles and globally through a range of campaigns. PHM activities and work are based on six thematic areas in order to achieve health for All! The **six thematic areas** were articulated as:

- **Equitable Health Systems - i**ts work in these broad areas has been divided into six sub-themes: privatisation, resistance to privatization, corporate watch, innovative attempts in PHC, UHC, and health rights. PHM puts pressure on governments to accept their responsibility and keep their commitment to finance and organise health systems that deliver equitable and good quality health services with decent work and act on SDH.

Governments are encouraged to ensure community participation, based on primary health care as defined in the Alma Ata Declaration.

- **Environment and Ecosystem Health** - Activism on extractivism has the most momentum and is especially strong in the Latin and North American regions, though activists in other regions are also involved in extractivism issues and thematic areas generally. PHM is concerned with addressing the climate crisis. The vision of the thematic area is the recovery of the natural environment and ecosystem and its contribution to health. This work includes activism on land rights, impact of mining and workers' rights and the conditions they work in.
- **Nutrition and Food Sovereignty -** The vision is the creation of an equitable and fair food system based on the inalienable people's right to food and adequate nutrition. PHM challenges the politicization of food and nutrition issues by raising broad awareness and activism about the negative links between food and financial systems.
- **Gender Justice and Health -** PHM calls for the creation of accountable and equitable health policies and health systems in the context of intersectional justice, and to enhance access to quality public healthcare, including sexual and reproductive healthcare that is premised on intersectional justice.
- **Trade and Health-**The EACT (Equitable Access to Essential Health Technologies) Project is currently one of the main engagements of PHM. The Covid pandemic has brought into focus the barriers to ensuring equitable access to essential health technologies i.e. PPE, ICU capacity, diagnostics, medicines and vaccines. PHM has facilitated webinars on TRIPS flexibilities, and other trade agreements, intellectual rights.
- **War and Conflict, Occupation and Forced Migration and Health -** PHM believes that War and Conflict, Occupation and Forced Migration is a priority, not only as a determinant of health and the vulnerability of those affected, but also due to the level of conflict and displacement occurring around the world. The vision for the War and Migration and Health Thematic Area is that migrants' and refugees' health rights are upheld.

These themes frame the campaign of PHM within country circles and globally. Within each theme there are issues that are relevant globally and they can have local impacts. PHM brings together knowledge from both perspectives. Additional campaigns and groups may evolve as new challenges and insights emerge. These themes do not exclude the development of campaigns on pressing national health challenges. Peninah also spoke to the major **Global** Campaigns of the Movement as highlighted:

- WHO Watch - watching and providing critical support to efforts at democratizing the World Health Organization (WHO) and providing a critical analysis of global health policy. The watchers tend to be younger members and so the process is a great training ground and recruitment vehicle for PHM.
- IPHU - (A short course) Building capacities to address health inequalities. IPHU contributes to 'Health for all' by strengthening people's health movements around the globe, by organising and resourcing learning, sharing and planning opportunities for people's health activists.
- Global Health Watch- Alternative world health report that is published every five years. Five of these reports have been published and the sixth is planned for 2022.

More details on PHM work are found on the PHM Website on www.phmovement.org.

For EQUINET, Rene noted the connection to the definition of equity in the different areas of work, including in

- **Tackling health injustice:** addressing differences in health and wellbeing that are unnecessary, avoidable and unfair
- **Closing the gap:** addressing social disparities on conditions that impact on health and wellbeing (today and tomorrow).
- **Redistributive, beyond equality:** Allocating resources in line with health need and to overcome the causes of social inequities (laws, rights, funds, policies, services, capacities)
- **Tackling deeper causes:** In the political economy (extractive, neocolonial, political), ideas and impact on what is public / commons

- **Asserting voice and agency:** the collective values and power, and the voice in political, socio-economic and civil society processes to influence, produce and learn from change

She showed how the different areas participants were interested in related to EQUINET's agendas and ongoing areas of work, as shown below with an asterix next to areas that participants were raising that EQUINET is also working in:

- **Reclaiming the resources for health**
  Extractive sectors, biodiversity and climate *
  Commercial practices, illicit flows *
  Urban health wellbeing
  Local production and trade issues in health technology *
- **Reclaiming the state**
  Challenging commodification/privatisation of public services *
  Fair health financing
- **Reclaiming collective agency and solidarity**
  Collective rights and social participation in health *
  Reclaiming participatory knowledge systems

Rene highlighted that EQUINET implements work on these areas in a range of ways:

- Producing information, discussion papers, policy briefs and other publications
- Holding Reviews and forums
- Through research, providing grants, holding research meetings, and in participatory action research
- Taking evidence to national/ regional /global engagement
- Through training activities
- And on the EQUINET website www.equinetafrica.org, the quarterly newsletter and the various searchable databases and portals on the website to give voice to evidence from and on the region.

After the presentations in Week 10, delegates went to their same groups on follow up actions as in week 9, but with resource people from PHM and EQUINET, to further discuss and identify specific areas of follow up work. This document provides the proposals made in those group discussions as kindly provided by the rapporteurs *shown in italics*

GROUP 1: Challenging resource extraction and state capture; building alliances on corporate / commercial practices that undermine health

Abubakar; Seabata, *Connie,* Vama with Rene, TARSC/EQUINET

Specific focus identified in week 9

Promoting and protecting the right to health in corporate and commercial practices

Two areas of follow up work were identified:

a. **Preventing corporate violations of health rights with training and involvement in health impact assessments**

- Organizing HIA trainings to build communities' capacity to undertake their own HIAs in areas of interest/need/important e.g. health projects, logging, mining, large dam projects, (Ethiopia), dumping of waste etc. EQUINET's work on extractives already involves HIA training and they are interested in widening capacities. EQUINET has supported independent HIAs with trade unions and communities and used that information to negotiate/advocate/argue/ campaign for improved health conditions/ for health rights /demand prior informed consent using legal frameworks.
- Building the capacity of local/grassroots leaders, providing the effective tools and resources so that they will be able to carry out their own HIAs and also enable them to more effectively engage/monitor/assess corporate/government facilitated HIA processes, to ensure that affected communities do get included in state HIA processes, avoid corporate/investors' interests being prioritized above health violations or issues identified being ignored or hidden from the public and as many of those HIAs only look at the immediate workplace and surroundings and not the broader environment/community.

- Ideally HIAs should be done before corporates are given licenses to prevent violations, however this is not always the case and some HIAs are done after operations begin.

b. **Tracking and taking action on violations of health rights by corporates:**

- Consider the ways corporates violate the right to health - focusing on particular industries or sectors, collecting information and evidence to show those violations, bringing those issues to the fore and engaging/advocating around them with environment authorities when air, water, or land is polluted. Use participatory research and photovoice, narratives.
- Type of violations - environmental pollution: release of toxic fumes/radiation/residues into the air, dumping of untreated sewage, radioactive effluent, and other industrial toxins/pollutants into/near water bodies, in landfills in unsafe/unsecure manner, and near community land and facilities - results in increased sicknesses, birth defects, deformities; contaminated water and food supplies, destroyed animal habitats, job/livelihood loses. Examples include coal burning tile factory, and dead fish in contaminated waterways consumed by local communities
- Choose areas that have impact and that could expose corporate practices, as well as areas that are visible and easy to mobilize the community around and that can provide a big win to boost motivation and build confidence to take on bigger violations. Examples include: tax evasion, food safety issues, tobacco advertising or other practices that breach existing laws.
- Work with others in international networks we connect with, including through , EQUINET and PHM, to expose, name and shame rights and legal breaches by corporates in their country of origin/registration and bring evidence and issues to regional platforms (EAC, SADC), and as shadow reports to UN committees and bodies to hold states accountable to their obligations.

The group participants agreed to form a steering group to take this work forward with EQUINET, given its existing work with HIAs in the extractives and health group and with PAR in the region

GROUP 2: Building and engaging on a clear, shared vision on what we expect from our health systems

Leanne, Job, Prisca, Linda, *Mercy,* Ronald, with Melanie and Louis PHM

Specific aspect of the area to focus on identified in week 9

Awareness raising and information sharing and in-country collaboration

The group identified that follow up work needs to frame and communicate the elements that are as essential towards envisioning and creating sustainable health systems, ie:

- Health systems that take care of everyone both the sick and the healthy with no exclusion
- A system that addresses the socioeconomic determinants of health including the provision of promotive and preventive services
- A system that protects the right to health and health care including the right to education, water and sanitation and other social socioeconomic determinants of health (SDH)
- Thinking broadly about health policy, so each policy addressing the SDH should have health as a central theme and addressing where every component in all other systems impacts on health positively or negatively

As actions to take this forward they proposed

- A first and crucial step is an in-depth analysis of the status of our health systems online with the elements above
- Correctly identifying the problems within the system and coming up with the correct solution
- Assessing if health care is considered an essential service
- Building intersectoral collaboration in advocacy since we are all advocating for an issue that directly or indirectly impacts health

GROUP 3: Regional platform on activism in, experiences of community voice in health systems

Harriet, *Danny*, Jokonia, Daniel, Poleen with Peninah, PHM

Specific aspect of the area to focus on identified in week 9

Advocacy and engagement to address inequity, colonialism and politics.

The group saw a priority in countries and as a region to form people centred platforms that do not depend on funding so that they can be sustainable at community level, district level and national level; and to strength community awareness, advocacy, challenging politics and colonialism in countries.

As actions to progress this, involving EQUINET and PHM, they proposed to

- Build capacity of community level actors/organizational staffs/CSOs/CBOs in participatory evidence collection, community engagement, activism and other means of social mobilization.
- Explore avenues to carry out participatory evidence collection and documentation of health inequities. Drawing on the expertise/resources (grants/human) opportunities from EQUINET.
- Disseminate collected research evidence to wider platforms exploit the EQUINET platforms and activities to reach wider audiences.
- Use the evidence generated to identify issues of most priorities to the people as informed by peoples' voices through research.
- Communicate the identified priorities to wider audiences to encourage participation, exploit the PHM country circles to widen reach, collaboration, partnerships and join engagement.
- Using the identified priorities, establish/generate an advocacy plan (engagement action plan) that aggregates communities' voices to inform country level and or regional advocacy.
- Create avenues for replicating learning at lower levels (community level) taking advantage of the learning resources/training opportunities from EQUINET. Link local activists to these resources and learning opportunity.
- Package the evidence generated into easy-to-understand formats and make it available to communities, CSOs, CBOs, networks and allied agencies to catalyse activism.
- Explore EQUINET & PHM online resources to benchmark from other regions on community mass mobilization efforts and how they can be contextualized to local realities.
- Scale engagements by taking advantage and nurturing relations and collaboration with PHM country, regional and global networks.
- Create avenues that tracks community/regional level issues as prioritized by the communities and regularly inform the networks/activists on progress/trends etc.

GROUP 4: Challenging privatisation of public services

Peter, Florence, Kedibone, Kenneth, Boitumelo, *Artwell* with Denis, PHM and Barbara TARSC/EQUINET

Specific aspect of the area to focus on identified in week 9

Strengthen actions in advocating for pro-poor (public sector) healthcare policies

Participants in the group saw specific areas for possible collaboration with PHM and EQUINET to strengthen what they are already doing. For example, the UGANDA PHM is creating coalitions (national level) to better and collectively articulate challenges in health equity and begin to act together to drive changes in policies and demonstrate innovative solutions in addressing the challenges. They see EQUINET's strength in having a 'local to global linked methodology', and in social participation and analysis as important, and the link with EQUINET work will help strengthen their work in decolonising health. Colleagues within health-related trade union in South Africa (also a member of COSATU) working on gender justice and equitable health systems, carry out advocacy in many areas are sometimes 'all over the show'. The course had helped to be more focused on specific impacts on their members and communities. In this regard, the work within EQUINET on reclaiming resources for health is very important for them, including in the debates on the national health insurance in S.A. As members of COSATU, they are against privatisation, and more recent challenges with electricity seem likely to lead to privatisation of energy provision in South Africa, and there is a possibility for learning from EQUINET in this area to resist privatisation of energy in South Africa. EQUINET and PHM are seen as having complementary capacities that can be synergised and used in advocacy work in the region and to global level. This training is an example of a joint partnership that can be escalated: both organisations could collaborate more in challenging the forces shaping privatisation. The group observed that digitalisation has influenced privatisation and state capacities to provide public goods, through illicit financial flows, but has also brought access to the information. In some cases this means that private organisations are now custodians of people's information with implications for privacy and who can access the information.

As key steps to advance the area, the group proposed:

a. *RESEARCH AND ANALYSE*: As a starting point, we agreed that we need jointly (as EQUINET and PHM and members) to carry out rigorous research work to understand what is happening, and how it is taking place. EQUINET research methodology allows for analysis of

the causes of causes, the research work would thus us to dig deep and look at the drivers and underlying causes of the phenomenon (at all the different levels) and impacts they are causing. EQUINET has started working on this but this needs strengthening and widening of the evidence base to cover current areas in more detail and expand to other areas not currently covered. Both EQUINET and PHM bring unique strategic capacities in this area- eg. PHM through its organisation around country circles and EQUINET through its community, state, regional and global connections. The capacities of the two organisations could be synergised for this research work.

b. *DECIDE ON CHANGE YOU WANT TO SEE AFTER GETTING THE EVIDENCE*: After building on the evidence, there need to be discussions at the various levels on what aspects do we want to change. Besides looking or fighting at the private sector, our work should also look at what happens within the state itself around these areas- need to look for issues such as capacities within the state to regulate the private sector and if capacities are weak or not available, options on how this could be strengthened
c. *ACTION PLANNING, IMPLEMENTATION*: After the discussions on the change, we want to see, then we can move towards strategising towards the actions and advocacy work

GROUP 5: Advocacy, information outreach, engagement on tech transfer, local production of health technology including vaccines

Regina, Lucky, Mevice, Francina with Ranga, SEATINI/EQUINET

Specific aspect of the area to focus on identified in week 9

Regional Advocacy on access to Covid-19 vaccines and other health technologies

The COVID 19 pandemic has more than ever before exposed health system challenges in Africa and beyond. Access to safe quality health products including vaccines production is an issue of great concern as has been witnessed during this pandemic. The need for advocacy around local production of quality health technologies and technological transfer is quite urgent. It was noted that quite a number of challenges exist. These include human resource capacity, skills mix, technology, finances and infrastructure. The issue of an enabling environment in terms of legal and regulatory was also highlighted. Advocacy to increase investment into local production of health medical products including vaccines is urgently needed. This will require bringing all actors on board at national, regional and international level.

As actions moving forward the group proposed:

- Research for evidence-based advocacy (what are issues and what needs to be done).
- Building the capacity of members to be able to advocate for the identified issues.
- Mapping of key actors to ensure targeted advocacy.
- Engaging key actors e.g governments, African Union, NEPAD, supply chain organisations and pharmaceutical industry.
- Building partnerships with likeminded individuals organisations –public and private.
- Identifying and take advantage of opportunities such as the TRIPS waiver.
- Information sharing to enhance learning
    - Sharing experiences to identify best practices on local pharmaceutical production of health technologies.
    - Take advantage of learning platforms, e.g how have countries like India gotten where they are in local production?
- Engaging EQUINET and PHM and other organisations for guidance and strategy.

As an overall summary, it was noted that **t**here are complementary ways in which PHM and EQUINET work. PHM can benefit from EQUINET's experience in doing rigorous evidence-based research and EQUINET's source materials/bibliography will be of great use to PHM and to all. PHM country circles and global engagement provide important platforms for sharing and using knowledge. Denis Bukenya pointed out that both PHM and EQUINET are working on privatisation of health and that this would be a good theme both networks could collaborate on. There is a lot that PHM and EQUINET can do together in tackling privatisation. It was also noted that EQUINET can provide an entry point for the work outlined by Groups 1 and 5; while PHM is well situated to support work in Groups 2 and 3. As next steps, PHM and EQUINET will get back to participants with follow up on identified thematic areas and participants were encouraged to reach out to PHM and EQUINET as well.

4. Evaluation of the RPHU and conclusion

Participants were asked to respond during the session to questions in an online questionnaire of the RPHU. After this, there was a general discussion on their evaluation of the RPHU facilitated by Barbara and Melanie.

In terms of what was seen as the most valuable aspect of the RPHU, participants observed:

- Meeting others in the region w potential for networking both nationally and at regional level, seeing the commonality of our problems at regional level.
- Varied lenses in understanding health equity were important in deepening my understanding of the issues.
- Appreciated that after 10 weeks of learning, it all came together w tangible actions.
- Good that we were able to catch up on sessions missed through the recordings.
- Website provides opportunities for further learning - material will be useful for future reference.
- Course reminded me that we can't implement policies at higher level without listening to the voice of those at community level.
- Group discussions/breakout sessions and assignments were great in sharing experiences from different people - created an interest in me to work w others in this group across countries.
- Great support from organising team.

In terms of suggestions for improvement, participants raised:

- Find ways for participants to get to know each other better - through short presentations;
- Each of the themes addressed were so large that there just wasn't enough time to delve into them in depth. Suggest focusing on only 1 or 2 themes in future RPHUs;
- We needed more time to contribute and share;
- While participants were aware of and appreciated the resources given to them through the website, when asked whether they used these resources more than twice during the 10 weeks, less than 50% raised their hands. Some indicated that they would be reading and sharing these resources after the course as they needed more time.

"For me, this course has been a journey in self growth, as a health care professional, looking at health through a different lens. Thank you to EQUINET, PHM and especially to my colleagues for being so open, honest and dedicated in sharing all their experiences" Comment from a participant.

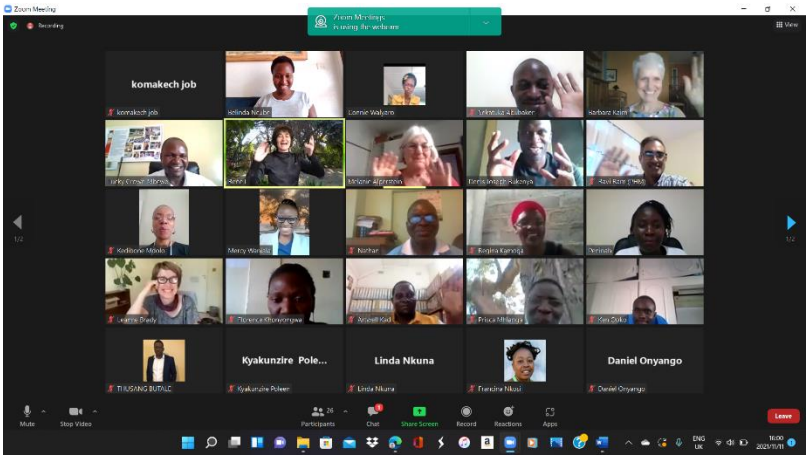
In closing Peninah and Rene gave closing remarks.

Peninah expressed gratitude to the joint PHM and EQUINET planning group and the various working groups who organised the training. She thanked participants for remaining on the course despite various challenges which included poor internet connectivity. Peninah invited participants to join EQUINET and PHM in their various countries as the struggles continues. The combination of forces strengthened through the training will help activists to fight for health for All! Participants can also visit the PHM website for more opportunities such as trainings and webinars. Peninah thanked participants and wished them well.

Rene thanked all participants and thanked Belinda Ncube, the IT support consultant. Rene also thanked other people in the background who have provided support ensuring successful holding of the ESA RPHU. Rene explained that this course was initially planned as a physical training and when COVID-19 struck, the organisers decided to adapt to new interactive platforms and continue with a virtual training. The RPHU showed complementarity between PHM and EQUINET. Rene underscored the need for joint action in the face of worsening conditions under COVID-19 and climate change. She encouraged the participants to remain committed, connected, strong and to share the online RPHU resources with others in their organisation and networks, and to use them in their own training. Participants were encouraged to keep engaging through being propositional, and negotiating and petitioning for alternatives that promote equity in

claiming rights to have a say into health. She hoped the RPHU was a fruitful experience for everyone.

With these remarks participants gave their own thanks, waved goodbye online and the ESARPHU closed.



Waving goodbye in the final session

.

Appendix 1: Programme

WEEK 1: Introduction and overview Thursday 29 July

Convenors: R Loewenson, B Kaim, EQUINET, M Alperstein, P Khisa, PHM ESA
Aims: Introduction to PHM, EQUINET and their goals, organisation and work; Participant introductions, experiences on health equity, and expectations; Introduction to the course

SESSION	Facilitation/ input
Brief welcome and participant introductions	Barbara Kaim, TARSC/EQUINET +participants
Brief introduction to why we are holding this course (its purpose	Denis Bukenya, PHM
How we understand equity	Rene Loewenson, TARSC/ EQUINET +participants
PHM and EQUINET introduction on goals, work and organisation and how each connects with the health equity agenda	Peninah Khisa PHM +participants
BREAK (5 min)	
Participant experiences on health equity, and social activism and PHM and EQUINET panel input on how their work addresses these equity issues	Denis Bukenya, Barbara Kaim Rene Loewenson + participants
Course overview and conclusion	Melanie Alperstein PHM and all

WEEK 2: Political economy and reclaiming resources

Convenor: R Loewenson, TARSC/ EQUINET
Tuesday 3rd August
Aims: With Firoze Manji, Daraja Press and Patrick Bond Professor, University of the Western Cape School of Government we will discuss a political-economic analysis of health and wellbeing in the region, what it implies for divergent framings of health and wellbeing, and sites of struggle against neoliberal globalisation both regarding resources available for health as well as the impact of COVID.

SESSION	Facilitator/ Resource inputs
Brief welcome and week introduction	Rene Loewenson, TARSC/EQUINET Patrick Bond, UWC, Firoze Manji, Daraja
Reclaiming the resources for health- what are the resources for health and who controls them?	Rene Loewenson + participants
How does neoliberal globalisation affect our health? Firoze on "The state, politics and the wretched of the earth" Patrick on "Neoliberal globalisation, neocolonialism and the capitalist crisis in the region Panel discussion and response to participant questions: Impacts and sites of struggle around political economy of health	Rene Loewenson moderating Patrick Bond, Firoze Manji, as panelists +participants
Panel and participant discussion: Equity issues and COVID Impacts on political- economic issues raised	Rene Loewenson moderating Patrick Bond, Firoze Manji, as panelists +participants
Consolidating the session; introduction to session 2 and goodbyes	Rene Loewenson and all

SESSION 2: Thursday 5th August
Aims: With Mariam Mayet, African Centre for Biodiversity (ACBio) on biodiversity and ecological resources for health, political economy of malaria and transnationals in industrial agriculture, gene technologies and key struggles locally to globally on them; and David van Wyk, Benchmarks Foundation on transnational extractives, particularly in mining, and the struggles in the region around health and wellbeing in the extractive sector.

SESSION	Facilitator/ Resource inputs
Brief welcome, recap of Session 1, and introduction to the session and resource people	Rene Loewenson EQUINET; Mariam Mayet, African Centre for Biodiversity, David van Wyk, Benchmarks
Participant experiences of acting on political economy drivers	Rene Loewenson + Participants
Introduction to ecological resources, extractives and health	Rene Loewenson + Participants
Transnational extractives in mining, and the struggles in the region around health and wellbeing in the extractive sector.	David van Wyk

SESSION	Facilitator/ Resource inputs
Political economy of biodiversity and ecological resources for health, with a focus on malaria,	Mariam Mayet
BREAK (5 min)	
2 breakaway group discussions Room 1: Extractives with David Room 2: Biodiversity and Malaria with Mariam Dialogue with resource people and how COVID has affected the situation; Key messages on implications for health equity activism	Rene introducing David van Wyk, Mariam Mayet + participants
Plenary feedback: Activism on health equity around extractives and ecological resources Issues for further work and advocacy from Week 2 and conclusion	Rene Loewenson + All

WEEK 3: Social determinants of health and reclaiming comprehensive public health

Convenors: Masuma Mamdani, EQUINET Peter Binyaruka, Ifakara Health Institute (IHI)/EQUINET
Aims: With Shakira Choonara and Sue Godt, we will introduce the social determinants of health and equity - the idea, the framing of, and inter-sectoral approach to addressing health inequities, ideas of commercial determinants and the reality in the region, and of inter-sectoral co-financing of structural interventions. It will encourage participants to explore and share experiences based on their context, current challenges in global health (structural determinants) and to identify and advance advocacy

SESSION 1: Tuesday 17th August

SESSION	Facilitator/ Resource inputs
Brief welcome and week introduction Overview of SDH and wellbeing	Masuma Mamdani, EQUINET
Intersectional Lens to Health Inequities, looking at gender, race and class	Shakira Choonara
BREAK and networking icebreaker (10 min)	Shakira Choonara
Emerging commercial determinants of health and the reality in the region	Sue Godt
Session-de-brief, closing and goodbyes	Peter Binyaruka and all

SESSION 2: Thursday 19th August

SESSION	Facilitator/ Resource inputs
Brief welcome Co-financing to address SDH	Peter Binyaruka, IHI/EQUINET
3 group reflective Sessions: Identifying areas for individual and collective advocacy to address the structural determinants of health 1. Urban wellbeing: a focus on young people. 2. Intersectional challenges, gender, race, class. 3. Financing and PPPs – equity implications/ implications of data and ownership. (Questions will be introduced by the facilitators)	Peter Binyaruka + Participants Masuma Mamdani Shakira Choonara Sue Godt
BREAK (5 min)	
Plenary feedback: areas for individual and collective advocacy to address the structural determinants of health Issues for further work and advocacy from Week 3 and conclusion	Shakira Choonara + All

WEEK 4: Health Systems and Comprehensive Primary Health Care

Convenors: Melanie Alperstein, PHMSA and Louis Reynolds, PHMSA /Paedatrics and Child Health Advocacy Committee, UCT
Aims: With Vera Scott, UWC/PHMSA and Denis Bukenya PHMUganda/ CEHURD, we aim for participants to gain a critical understanding of the issues in strengthening universal equitable health systems underpinned by a Comprehensive Primary Health Care approach, and its related philosophy for equity and social solidarity and justice. Emphasis is placed on the principles of social participation and Intersectoral Action in Health (IAH) and Health in All Policies (HiAP). We will explore the debates regarding UHC, its goals, status and health equity issues within the relevant SDGs and share experiences of comprehensive PHC responses to COVID-19 and the related challenges.

SESSION 1: Tuesday 31st August

SESSION	Facilitator/ Resource inputs
Brief welcome and introductions Overview of the week 3 session aims, content and process	Melanie Alperstein, PHMSA and all
Understanding the issues in strengthening health systems for equity and social justice	Melanie Alperstein Vera Scott, UWC,PHMSA + participants
Comprehensive Primary Health Care as an organising strategy for universal health systems Group discussions (4-5) on the PHC system in their country	Melanie Alperstein + participants
BREAK (5 min)	
Social participation and intersectoral action in health (IAH) and health in all policy (HiAP) – Presentation Group discussion on social participation, IAH and HiAP in participant countries	Louis Reynolds, UCT, PHMSA +participants
Conclusion- Summing up and preparation for Session 2	Melanie Alperstein

SESSION 2: Thursday 2nd September

SESSION	Facilitator/ Resource inputs
Welcome. UHC goals for health equity: presentation and discussion of case studies. South Africa's approach – the NHI Uganda's approach to UHC	 Louis Reynolds, UWC Denis Bukenya, CEHURD
Group work: Experiences of comprehensive PHC responses to COVID-19 and challenges	Melanie Alperstein, Denis Bukenya, Louis Reaynolds, Tinashe Nanji + participants
BREAK (5 min)	
Plenary feedback of group discussions	Melanie Alperstein +participants
Interactive Quizz on the week content Conclusion- Issues for further work and advocacy from Week 4 and participant drawings of their PHC systems	Melanie Alperstein +participants

WEEK 5: Power, values, rights, law and reclaiming collective agency

SESSION 1: Wednesday 15th September

Convenor: Peninah Khisa, PHM ESA

Aims: With Eunice Awino Centre for Women Empowerment in Technology (CWE-TECH) /PHM, Ravi Ram, PHM we will discuss the role of power, values, norms and rights in health equity, and build a common understanding of some of the key concepts necessary to develop a gendered perspective

SESSION	Facilitator/ Resource inputs
Welcome and introductions Roles of power, values, norms and rights in health equity	Peninah Khisa, PHM ESA Ravi Ram, PHM
Gender Equity and responses: Case study "Spike on sexual and gender-based violence Amidst Covid-19 Pandemic in Kenya Group discussions and plenary feedback • Gp1: How can we equip girls to hold governments accountable on the delivery of youth- friendly health services? • Gp2 How can we help women in ESA understand and manage contraception side effects once they start a method?	Eunice Awino CWE-TECH/PHM + participants
BREAK (5 min)	
The roles of social power and social activism in health as a way for 'people-centered' health systems and 'a culture of health', Group discussions and plenary feedback • Gp 1: How do we bring active participation, informed engagement, in the 'Integration of health services/systems? • Gp 2: How do we raise the profile of our community needs and build literacy and social inclusion to strengthen 'Healthier, more equitable communities'? • Gp 3: How do we build shared values in health?	Peninah Khisa + Participants
Consolidating the session; key issues for follow up work in the region.and goodbyes	Peninah Khisa

SESSION 2: Thursday 16th September
Convenor: Moses Mulumba, CEHURD/EQUINET
Aims: we will outline how constitutional framings and laws provide for health as rights and equity issues; show how such legal provisions enable equity, and the challenges to their implementation in the ESA countries; and discuss the learning from COVID-19 on the options for and challenges in implementing rights in 'emergencies' and in using rights to claim collective agency and solidarity.

SESSION	Facilitator/ Resource inputs
Welcome. Outline of how constitutional framings and laws provide for health rights and the way such legal provisions enable equity, and the challenges to their implementation Brief case study example from Uganda on using legal processes for maternal health rights and discussion	Mulumba Moses, CEHURD/EQUINET + participants
BREAK (5 min)	
4 group discussions on the learning from COVID-19 on options for and challenges in implementing rights in 'emergencies' and in claiming collective agency and solidarity – questions to be provided in the session Plenary feedback and discussion of areas for activism and engagement using rights based approaches for equity in emergencies	Mulumba Moses + participants
Summary of key issues and areas for activism using the law and right to health for health equity, and goodbyes	Mulumba Moses

WEEK 6: Commodification, privatization in health and reclaiming the role of the state in health and health services

SESSION: Thursday 30th September
Convenors: Denis Joseph Bukenya, PHM
Aims: With Ausi Kibowa, SEATINI PHMUGA, we aim to explore and understand the meaning, drivers, modalities and effects of privatisation in health and health systems and the national, regional and global forces that sustain it. We will explore existing actions and processes for social transformation that may reverse this trend and state policies on privatization of healthcare systems.

SESSION	Facilitation/ input
Welcome and introductions Overview of the session	Denis Bukenya, PHM +participants
impact of Privatization, commodification of the healthcare system and essential services in pandemic times and reclaiming public health services	Ausi Kibowa, SEATINI PHMUGA
Meaning and effect of privatization and commercialization of health National and regional forces driving privatization and commercialization of health	
BREAK (5 min)	
Participant experiences on commodification, privatization in health, social activism to reclaim the state- 4 group discussions with guidance introduced in the session Plenary feedback on a one message on the key challenge for health commodification and privatization of health in the region and one message on what type of activism is most needed for reclaiming the state from commodification and privatization of health in the region	Denis Bukenya + participants
Participant 'survey', conclusion; key issues for follow up work in the region.and goodbyes	Denis Bukenya + participants

WEEK 7: Equity in health technology

Convenors: Rangarirai Machemedze, SEATINI/EQUINET, Leslie London, UCT/EQUINET/PHM
Aims: this session aims to provide participants with advocacy skills acquired from an in depth knowledge and understanding on the WTO and the TRIPs agreement, how intellectual property rights affect the production, availability and affordability of health technologies, medicines and vaccines. It

will explore the political economy of local production in the ESA region, the role of south-south and south north cooperation in this and key local, regional and global debates and engagement in health technologies, including in engaging on COVID-19 vaccines

SESSION 1: Tuesday 5th October

SESSION	Facilitator/ Resource inputs
Brief welcome and introductions Overview of The WTO TRIPs Agreement and local production and access to health technologies Developments regarding TRIPs and public health and the WHO global strategy and plan of action on Public health, innovation and IP	 Rangarirai Machemedze, SEATINI/EQUINET Leslie London, UCT/PHM/EQUINET
BREAK (5 min)	
Interactive plenary session on The WTO TRIPs Agreement and the impact on local production and access to health technologies	Rangarirai Machemedze
Conclusion- Summary of the key issues for follow up	Rangarirai Machemedze

SESSION 2: Wednesday 6th October

SESSION	Facilitator/ Resource inputs
Welcome. Overview of local, regional and global debates on ensuring access to health technologies Case studies from the ESA region on local production.	Leslie London, UCT/PHM/EQUINET Rangarirai Machemedze, SEATINI/EQUINET
Group work: 4 groups on key issues in progressing local production of essential health technologies in the ESA region	Linda Shuro, PHM, Rangarirai Machemedze + participants
BREAK (5 min)	
Plenary feedback of group discussions	Leslie London + participants
Conclusion- Issues for further work and advocacy from Week 7	Rangarirai Machemedze

WEEK 8: Social Participation and Organizing activism for health

Convenors: Tinashe Njanji, Melanie Alperstein, PHM

Aims: With Damaris Kiewiets UWC, Pelagia Nziramwoyo, CFYDDI Uganda/ EQUINET this session aims to on build on previous weeks understanding on social participation in health in different sectors and constitutions and how this is relevant to health equity in the region and to explore how emergencies enable / disable social organisation, participation and activism.

SESSION 1: Tuesday 12th October

SESSION	Facilitator/ Resource inputs
Welcome and introductions Overview of week	 Tinashe Njanji, PHM
Social Participation in health, processes, experiences and benefits	Damaris Kiewiets UWC
4 groups sharing experiences in social participation through health committees, VHTs, CHWs, and activists	Tinashe Nanji + Participants
BREAK (5 min)	
Plenary report back from groups session and key points for follow up and discussion	Tinashe Nanji, Damaris Kiewiets + Participants
Conclusion- Summary of the key issues for follow up	Tinashe Nanji, Damaris Kiewiets

SESSION 2: Wednesday 14th October

SESSION	Facilitator/ Resource inputs
Welcome and recap from Session 1	Tinashe Njanji, PHM
Activism in the time of emergencies: Organization and social participation in health equity in the emergencies - Uganda experience	Pelagia Nziramwoyo CFYDDI Uganda/EQUINET
Groups: From your experiences, how do emergencies (COVID. Ebola, other) enable/disable social organization, participation and activism?	Tinashe Nanji + Participants
BREAK (5 min)	
Plenary feedback of group discussions	Tinashe Nanji + Participants
Conclusion- Issues for further work and advocacy from Week 8	Pelagia Nziramwoyo, Tinashe Njanji

WEEK 9: Building a movement for health equity: Consortium building, organization and advocacy

Convenors: Nathan Banda, Mavis Koogotsitse, SATUCC/EQUINET; Linda Shuro, Ravi Ram PHM

Aims: With Anneleen De Keukelaere, PHMSA this session aims to discuss and exchange experiences on advocacy work in consortium building, to appreciate and learn from best practices in

the region on movement building and develop strategies in countries, regionally and in engaging globally that promote health equity.

SESSION 1: Tuesday 26th October

SESSION	Facilitator/ Resource inputs
Welcome and introductions Recap of week 8	Mavis Koogotsitse, SATUCC Melanie Alperstein, PHM
Consortium building, organization and advocacy: 4 groups on • Success stories to share on building health movements • Challenges faced in building a health movement Plenary feedback and issues for further discussion	Nathan Banda ZCTU/EQUINET, Linda Shuro, PHM + participants
BREAK (5 min)	
Moving forward - Summary of priority areas of work raised for participants to discuss with their organisations before session 2	Mavis Koogotsitse, SATUCC; Rene Loewenson, TARSC

SESSION 2: Thursday 28th October

SESSION	Facilitator/ Resource inputs
Welcome and recap from Session 1 Feedback from discussion with organisations on areas of interest.	Rene Loewenson EQUINET
C19 Coalition -Health Working Group	Anneleen De Keukelaere, PHMSA
Drawing from the case study experiences 2 group discussions on key points to consider / act on when building a social movement for health and plenary feedback	Anneleen De Keukelaere, Linda Shuro + participants
BREAK (5 min)	
Strengthening the regional movement for health equity- 5 groups on the follow up work for the prioritised areas and plenary feedback	Linda Shuro, Rene Loewenson
Conclusion- Issues for further work and advocacy from Week 9	Linda Shuro+ participants

WEEK 10: Recap, future steps and evaluation

Convenors: Rene Loewenson, Barbara Kaim, EQUINET; Melanie Alperstein, Denis Bukenya, PHM

Aims: In this week we will recap what we have covered in the course, and discuss and present what we see as key areas of follow up work (drawing on issues and discussions from the prior weeks) both for how participants will use the course in their own work and organisations work and regionally with EQUINET, PHM and others. We will also evaluate the course.

SESSION 1: Tuesday 9th November

SESSION	Facilitator/ Resource inputs
Welcomes and aims of Week 10 session 1 Review of the RPHU 'journey' Summary of what this means for understanding of health equity	Denis Bukenya, PHM Melanie Alperstein, PHM, Rene Loewenson,TARSC/EQUINET
Recap of possible key areas of focus / issues for follow up action on health equity, drawing from the concluding sessions in WEEK 9, and their relevance to equity and implications of COVID	Participants
BREAK (5 min)	
How the key areas of follow up relate to ongoing EQUINET and PHM work Introduction to groups	Peninah Khisa PHMESA Rene, EQUINET Barbara Kaim, TARSC/EQUINET
Working groups on follow up work and links to PHM and EQUINET	Participants with PHM, EQUINET,
Plenary feedback and discussion (2 groups)	Participants with Barbara, Denis

SESSION 2: Thursday 11th November

SESSION	Facilitator/ Resource inputs
Welcome, session 2 aims Recap from Session 1	Denis Bukenya, PHM Rene Loewenson, TARSC/EQUINET
Plenary feedback and discussion (3 groups) Wrap up discussion of the follow up work Areas for involvement in joint EQUINET and PHM work	Rene, EQUINET Melanie, PHM Denis, PHM
BREAK (5 min)	
Course evaluation form	Ravi Ram, PHM
Reflections and evaluation discussion on the course aims, content, process, participation and experience	Barbara Kaim, TARSC/EQUINET, Melanie Alperstein, PHM
Conclusion, thanks, Closing of the RPHU and goodbyes	EQUINET, PHM ESA + participants

Appendix 2: RPHU Participants

(based on accepted applicants. Those that did not attend any sessions are shown with an asterix)

1. **Sekatuka Abubakar** is the Community Engagement lead in the Love to Love Organisation in Uganda (www.LTLORGUG.com)
2. **Amuda Baba** is the CEO of the Institut Panafricain de Santé Communautaire, based in Kinshasa in the Democratic Republic of the Congo.(www.ipasc.net).
3. **Leanne Brady** is a researcher and activist at the Western Cape Department of Health, South Africa and part of the Cape Town Together Community Action Network (CAN).
4. **Victoria Bungane** is a health advisor working at the British High Commission, South Africa (www.fcdo.gov.uk)
5. **Thusang Butale** is the Secretary General of the Botswana Federation of Trade Unions (www.bftu.org.bw).
6. **Ronald Chikwenhere** is the Research and Advocacy Officer of Bridging the Gap Botswana, a human rights Advocacy organisation.
7. **Peter Eceru** is Program Specialist for Health and Human Rights Advocacy for the Center for Health, Human Rights and Development (CEHURD) (www.cehurd.org) in Uganda.
8. **Denise Ferris (*)** is a research fellow for the international NGO Bangladesh Rural Advancement Committee (BRAC) in Uganda (www.Brac.net).
9. **Danny Gotto** is Executive Director of the Uganda-based Innovations for Development (I4DEV) (www.i4dev.or.ug).
10. **Esther Harzel** is a program officer in the Kenya LBQT & SG Western Kenya Initiative working with LBQT people living with HIV and with disabilities and LBQT parents in rural areas.
11. **Choolwe Jacobs (*)** is a lecturer and researcher at the University of Zambia, School of Public Health in Zambia (https://www.unza.zm/).
12. **Vama Jele** is regional coordinator for advocacy and social mobilisation for Southern Africa Miners Association (SAMA) in Eswatini.
13. **Artwell Kadungure** is a programme officer at the Training and Research Support Centre (TARSC) (www.tarsc.org), a not for profit research and training Institution.
14. **Harriet Kamashanyu** is the Founder and Executive Director for Rhythm of Life – Uganda (www.rhythmoflifeuganda.org).
15. **Regina Mariam Kamoga** is the Executive Director for Community Health and Information Network (CHAIN) (www.chainproject.co.ug) that engages communities through health literacy and sustainable livelihoods and advocates for patient-centered health care and safety, and strengthened community systems and community owned resources.
16. **Florence Khonyongwa** is Monitoring and Evaluation Officer for Malawi Health Equity Network (www.mhen.org), a health advocacy NGO.
17. **Job Komakech** works for the law firm, Walemi & Co. Advocates and is a legal associate of the Legal Support Network, Uganda providing legal support to sexual and reproductive health providers, to female sex workers during COVID-19 and to health workers, such as after arrest for providing post abortion care services.
18. **Cecilia Taonga Kwalira** is a young leader in the Malawi Girls Guidance Association (www.mgga.mw) that works to develop youth to their fullest potential.
19. **Seabata Makoae** is a Lesotho-based social worker, working for She-Hive Association (www.shehive.org.ls), a civil society organization.
20. **Jorge Matine** is Country Director for Observatorio Cidadão para Saúde (https://observatoriodesaude.org/), a civil society organization promoting good governance in health sector in Mozambique.
21. **Samuel Matsikure** is Programme Manager for GALZ, an association of LGBTI people in Zimbabwe (www.galz.org), working for the protection and promotion of LGBTI rights, access to health, HIV and SRHR, social and LGBTI services in Zimbabwe
22. **Mevice Makandwa** is an Information Officer for Training and Research Support Centre (TARSC) a not for profit research and training institution based in Zimbabwe and working in the region and internationally (www.tarsc.org)

23. **Jokonia Mawopa** is Health and Safety Officer of the Food Federation Allied Worker Union of Zimbabwe (www.ffawuz.co.zw) a trade union organization.
24. **Lucky Kalauni Crown Mbewe** is Executive Director of the Malawi Centre for Youth Empowerment and Civic Education (CYECE) www.cyecemw.org, working with youth, SRHR, child rights and youth empowerment and participation issues
25. **Slindile Mbhele** is a Union Researcher in the trade union for health workers, NEHAWU in South Africa (www.nehawu.org.za).
26. **Kedibone Mdolo** is North West Acting Provincial Secretary for the Democratic Nursing Association of South Africa (DENOSA).
27. **Prisca Mhlanga** is Project Coordinator in the Zimbabwe Catering and Hotel Workers Union, a trade union organization.
28. **Boitumelo Molete** is Social Development Policy Coordinator for Congress of South African Trade Unions (COSATU) (www.cosatu.org.za)
29. **Linda Nkuna** works for the Chiawelo Community Practice in South Africa as a health and NHI Advocate.
30. **Davies Mwachumu** is a Programs Manager in the Malawi Health Equity Network (www.mhen.org), a civil society organisation.
31. **Zindaba Ngwenyama** is Assistant Coordinator for civil society organisations for the Zambia Medicines Research and Access Platform (www.medrapzambia.org) that advocates for equitable access to affordable essential medicines.
32. **Francina Nkosi** is the Provincial Coordinator for Women Affected by Mining United in Action (Macua), based in Braamfontein, Gauteng, South Africa. She is a member of the clinic committee.
33. **Kenneth Ochwer** is a Finance Intern for the Kenya Tax Justice Network Africa (https://taxjusticeafrica.net/) that advocates for tax policies with pro-poor outcomes and tax systems that curb public resource leakages and enhance domestic resource mobilisation.
34. **Easter Okech** works for Kenya Female Advisory Organization (KEFEADO) (www.kefeado.org) as the Executive Director and Programs Coordinator.
35. **Daniel Onyango** is a medical practitioner and the Executive Director for the Kenya-based "Let Good Be Told In Us" NYARWEK NETWORK (www.nyarwek.net), a network of 17 LGBT member organisations advocating for human rights of marginalised people
36. **Kitso Phillip Phiri** is Executive Secretary of the Botswana Mine Workers Union, a trade union in Botswana's mining sector.
37. **Kyakunzire Poleen** is a Public relations officer for the Ugandan-based Youth Led Initiative for Sustainable Health as an activist for WASH promotion, public awareness on non communicable diseases, in climate change mitigation, and gender equality.
38. **Rose Wakikona** is the Senior Program Officer for the Uganda based Center for Health, Human Rights and Development (CEHURD) (www.cehurd.org), a civil society organisation advocating for the right to health.
39. **Constance Georgina Walyaro** - is the Executive Director of Talk AB[M]R in Kenya (www.talkabr.org) and Leadership Council Member and External Affairs & Advocacy Committee Member for the International Society for Infectious Diseases (ISID) (https://isid.org).
40. **Mercy Wanjala**- Family Medicine Resident at Thika Level V Hospital (https://thika-hospital.business.site), providing healthcare services to Kiambu and surrounding counties in Kenya.

Appendix 3: Faculty List

Name	Institution
Dr Rene Loewenson	Training and Research Support Centre (TARSC) and cluster lead, EQUINET
Ms Melanie Alperstein	People's health movement (PHM) South Africa Steering Committee member, Rep PHM East and Southern Africa,
Ms Barbara Kaim	TARSC and cluster lead, EQUINET
Ms Peninah Khisa	PHM ESA,
Mr Denis Bukenya	CEHURD and PHM
Ms Linda Shuro	PHM SA
Mr Tinashe Njanji	PHM SA
Mr Rangarirai Machemedze	Southern and East African Trade Information and negotiations Institute (SEATINI) and EQUINET
Mr Ravi Ram	PHM Kenya
Dr Firoze Manji	Daraja Press
Prof Patrick Bond	University of Western Cape
Ms Mariam Mayet	African Centre for Biodiversity (ACBio)
Mr David van Wyk	Benchmarks Foundation
Ms Masuma Mamdani	EQUINET
Mr Peter Binyaruka	Ifakara Health Institute (IHI)/EQUINET
Ms Shakira Choonara	Independent
Ms Sue Godt	Independent
Dr Louis Reynolds	PHM and UCT
Mr Moses Mulumba	CEHURD/EQUINET
Ms Eunice Awino	Centre for Women Empowerment in Technology (CWE-TECH)
Prof Leslie London	University of Cape Town (UCT)/PHM/EQUINET
Ms Damaris Kiewiets	University of Western Cape (UWC)
Ms Pelagia Nziramwoyo	CFYDDI Uganda/ EQUINET
Dr Vera Scott	UWC/PHM SA
Mr Nathan Banda	Health Dept, Zimbabwe Congress of Trade Unions (ZCTU)
Ms Mavis Koogotsitse	Southern African Trade Union Co-ordinating Council, SATUCC/EQUINET
Ms Anneleen De Keukelaere	PHM SA