CSE4HFA – Phase 2 Report
PHM South Africa
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Introduction

This report sets out the research activities undertaken during Phase 2 of the CSE4HFA project, and findings emerging from the activities. The first section of the report gives a brief overview of Phase 1 of the research project, and explains how it has shaped the research questions and activities undertaken during Phase 2. This is followed by Section 2, which describes the research activities undertaken during Phase 2 of the research process. Section 3 highlights the main lessons learned during Phase 2 with respect to Movement Building, Capacity Building, Knowledge Generation, Campaigns, and Global Governance.

The fourth and final section of the report focuses on a key finding from the research process: while PHM-SA maintains a consistent and distinctive ideological and political position, it is insufficiently able to influence significant constituencies or animate the emergence of a mass movement for health equity. These weaknesses derive from the national political context where there has been a demobilisation of civil society, the resource constraints (human and financial faced by PHM and other civil society organisations advocating for the right to health), and insufficient organisational focus and follow-up of contacts and partners.

It was agreed that some of these constraints could be addressed through improved structuring of PHM's work. This will involve strengthening the role of the executive, forming action groups on key campaign/capacity building activities, strengthening the capacity of the secretariat by improving communication platforms, and by raising more resources for PHM.

Section 1
Phase 1 of the CSE4HFA Research Project: Identifying the Limitations of the NHI Coalition and the Campaign for a "People's NHI"

Phase 1

Phase 1 of the research project was aimed at identifying factors that contribute to or undermine the efficacy of health activism. During Phase 2 country teams have to reflect on lessons learned during Phase 1 and use them to improve health activism currently under way.

In South Africa, Phase 1 of the research focused on assessing the strengths and weaknesses of the NHI campaign that PHM undertook in conjunction with Section 27, TAC, and others after 2010 TAC and Section 27 were key members of the NHI Coalition that led the NHI Campaign.

Our findings from Phase 1 suggested that the efficacy of the campaign was

undermined by:

1. Limited financial and human resources capacity to coordinate the initiative;
2. The lack of a focus to mobilise around, i.e. the government delayed releasing the NHI White Paper, which would have been a focus of the campaign;
3. The consequent lack of urgency with which civil society partners viewed this campaign, given that they had to prioritise ongoing work with the limited resources that they had; and
4. The NGO-isation of South African civil society, which has created an expectation amongst potential health activists that they can and should be paid for their participation in campaigns; this makes voluntarism rare.

Section 2
Phase 2 of the Research Project: Disseminating the Findings from Phase 1 and Reflecting on Lessons Learned During Previous Coalitions and Campaigns

Phase 2

Phase 2 of the research focused on applying the lessons from Phase 1 to a new set of campaigns that PHM embarked on in 2016, in the wake of the National Health Assembly (NHA).

In 2016 PHM again joined forces with TAC and Section 27 to plan and co-host the NHA. The assembly took place in Cape Town from 24 to 26 June 2016. It was organised around 6 themes, each pointing to a crisis characterising the South African (SA) health system. These were:

1. Lack of meaningful community participation in primary health care, and more specifically, the marginalisation of health committees – the primary formal mechanism for community participation in decision-making at the health facility level – that has taken place in recent years.

2. Human resources for health, and more specifically, the poorly defined role and exploitative working conditions of community health workers, who are required to serve as the "foot soldiers" of the government's primary health care strategy.

3. A lack of responsive, equitable and effective leadership and management within the health sector, particularly at the level of health facilities.

4. Unreliable access to HIV/AIDS and TB treatment for public sector patients, particularly due to stock-outs of essential medicines and difficulties accessing treatment facilities in rural areas.

5. The disproportionate resources and influence of the private health sector in the SA health system. The possibility that efforts to implement a National Health Insurance (NHI) scheme would further entrench this dynamic through increasing the role of private sector providers in the national health system, as

well as the amount of public funding they receive through reimbursements claimed from the NHI fund for services performed, is particularly worrisome.

6. The need for sustained civil society mobilisation to address the social determinants of ill-health.

The NHA was preceded by three types of activities, which were all designed at generating empirical information, and political education and debate about the key themes of the Assembly in the months leading up to it. Each co-host (PHM, TAC, S27) took responsibility for organising activities in specific provinces. These activities entailed:

1. Provincial health assemblies, which were aimed at documenting the main health problems and activities that health activists were engaged with at provincial level.

2. An IDRC regional workshop, which brought together PHM and health activists from across sub-Saharan Africa. The workshop was held in the days immediately preceding the NHA and was aimed at:
   a. introducing the IDRC study's research questions, methodology and initial findings to activists;
   b. building networks amongst health activists on the continent;
   c. sharing PHM-SA's political economy of health approach with health activists; and
   d. receiving political reports on the state of health activism in the countries represented and engaging collectively in identifying actions to address challenges.

3. A South African People's Health University (SAPHU), which is an activist school hosted by PHM-SA. The 2016 SAPHU was specifically aimed at training community health workers (in previous years activists from other sectors, e.g. unions, were also involved) and was held immediately preceding the NHA.

Delegates from each of these forums were present at the NHA, as were health activists from other civil society organisations, including an activist from PHM-India. In total, 156 delegates from 31 organisations attended the Assembly.

At the Assembly the delegates decided to launch five national health campaigns (briefly described below). In planning the NHA, and implementing the resolutions emerging from it, PHM-SA (including SAPHU graduates), TAC and S27 committed to working as a coalition in leading these national campaigns. As with the NHI Campaign and Coalition, the NHA work was supposed to be led by a Secretariat located within PHM-SA. This was similar to the organisational structure of the earlier NHI Campaign.

A number of other campaigns were discussed at the NHA, e.g. provincial campaigns. However, for the purposes of this report we focus on the five national campaigns, which are led by the same three organisations – TAC, S27 and PHM-SA – the leading partners during the NHI campaign that was the focus of Phase I of the research. We presumed this would allow for greater comparability between the two cases (both involving national campaigns and led by the same organisations), and thus highlight

the "lessons learned" during Phase 1 for the health activism informed by these findings during the participatory action research (PAR) oriented Phase 2

The five campaigns that were supposed to be taken up by these three organisations in the wake of the NHA were focused on:

COMMUNITY HEALTH WORKERS: The foundation of primary health care

This campaign focuses on two categories of workers, i.e. CHWs and community care workers (CCWs), and "health staff in general". With respect to CHWs and CCWs, the NHA decided to launch a campaign to "[d]evelop an evidence base around the cost/benefit of CHW/CCWs to take to Treasury" and to "Mobilize CHW/CCWs, NGOs and social movements, to push forward a national campaign for one appropriately trained, remunerated and resourced CHW/CCW per 250 households". A broader HRH campaign aims to "fill vacant posts", oppose "freezing of posts", and "prioritise rural … and frontline worker posts".[1]

CLINIC HEALTH COMMITTEES: One clinic - One committee - One policy

At the NHA the lack of a national legislative and/or policy framework regulating clinic health committees was identified as a major problem. Consequently, a campaign was launched that advocates for establishing such a framework, ensuring that activist community members join these committees, that health forums exist at district, province and national level, and that these committees play an active role in monitoring health services.

HEALTH FINANCING and TAX JUSTICE: Stop subsidising the private health sector

This campaign is premised on the assumption that health care financing is central to the provision of health care services. It is aimed at ensuring greater citizen participation in the work of the National Treasury, the recovery of public funds used to train staff that who subsequently decide to work in the private sector, and stopping medical aid subsidies to the private health care sector.

STOP STOCK-OUTS: Medicines when we need them

This campaign is focused on addressing four broad problems, i.e. poor access to medicines, difficulties in adhering to chronic treatment regimens, poor integration of HIV/AIDS and TB care, and a lack of appropriate, accurate and easily accessible HIV/AIDS and sex education. One of the major initiatives of this campaign will be to create adherence clubs that support adherence, assist patients in avoiding long queues when filling prescriptions, and breaking the stigma associated with HIV/AIDS and TB.

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[1]
  Report of the NHA, pg.6
https://drive.google.com/file/d/0B51omkzVbFRSUmtZWVBILVhhQUZOd1hwU2kzektyeWVSMUZJ/view

HUMAN RESOURCES FOR BETTER HEALTH: People make the health system

This campaign was launched as a result of some of the concerns listed under campaign 1 (above), as well as a concern with the poor quality of leadership and health care services provided at health facilities. It is aimed at filling vacant posts in the public sector, providing better training to medical students and health care workers, unionisation of health workers, and civic education aimed at ensuring that citizens are able to hold health facility managers accountable for their actions.

Implementing Lessons Learned from Phase 1 during Phase 2

The South African IDRC country research team proposed that the PHM-SA Steering Council ("the SC") host a two-day workshop on 15 and 16 July 2017. The workshop had four aims. The research team wanted to:

1. Explain the IDRC project, particularly its rationale and objectives: the workshop would familiarise PHM-SC members with the status and findings of the IDRC research project. PHM-SA had elected a new SC in December 2016. Newly elected SC members had no knowledge of the IDRC research project. The re-elected SC members had some knowledge of the project – mainly that the research was ongoing, funded by the IDRC, and aimed at assessing how to improve the efficacy of health activism. However, even longstanding SC members had limited direct involvement in the project during Phase 1 and did not have detailed knowledge of the findings.

2. Share the findings from Round 1, particularly the findings from South Africa: the second aim of the workshop was to share the findings of Phase 1 of the research with partner organisations and research participants. These were mainly TAC, Section-27 and SAPHU-trained activists.

3. Gain additional data on how the experienced activists attending the workshop became politicised, what factors sustained their activism and organisational affiliations, how their activism had changed over the years, and how they understood the opportunities and pitfalls of working in coalition with other organisations.

4. Encourage reflection on the "afterlife" of the 2016 NHA and SAPHU: the workshop was aimed at bringing the PAR methodology of the IDRC research project to life. It was designed with a view to collectively reflecting on how the findings of Phase 1 could be used to ensure more successful mobilisation around the programme of action set out at the NHA in 2016, and that the SAPHU graduates remain engaged health activists. This was organised around four questions:

   o What NHA processes or resolutions have been taken up since June 2016?

- o What forms of health activism have TAC, PHM, S27 and SAPHU graduates been engaged in since June 2016 and how do they fit into/diverge from the NHA campaigns?

- o What organisational practices and structures undermine and/or facilitate PHM-SA's ability to "do" and "facilitate" effective health activism, i.e. to create and sustain a broad-based people's movement for health.

- o How might the lessons from Round 1 help us to explain the dynamics that inform our answers to these two questions, and how should we amend our programmes of work in light of this?

Participants in Phase 2 Activities

The workshop was the main research and planning activity initiated by the IDRC research team during Phase 2. The IDRC research funds remaining in the PHM-SA budget were used to transport and/or house the delegates, purchase workshop materials, and pay for transcription documenting the discussion that took place during the two days of the workshop. All facilitation and reporting work was voluntary (i.e. unpaid), and use of the venue was "donated" to PHM-SA by AIDC.

Invitations to the workshop were sent out by PHM-SA to partner organisations that had participated in the NHA, in SAPHUs, and/or organisations that have an ongoing working relationship with PHM (i.e. PHM "allies") but may or may not self-identify as working on "health" issues. Founding members of PHM-SA and previous SC members were also invited.

All of the organisations invited to the workshop were either members of the NHI campaign (the focus of Phase 1 of the IDRC research) and/or participated in the 2016 NHA. Organisational invitations were extended to: Section 27, Women on Farms Project, Alternative Information & Development Centre (AIDC), Health Enabled, the Wellness Foundation, and TAC. Unfortunately, no representatives of Women on Farms Project and AIDC were present at the workshop. All the other organisations sent representatives. The entire PHM-SC (2017) was invited and PHM members from the Western Cape, Eastern Cape, and Gauteng were in attendance.

As already mentioned, the NHA was a major focus of the workshop. The NHA was co-hosted by TAC and Section 27 and it was thus particularly important that representatives from these organisations attend the workshop. Unfortunately, TAC sent only one representative to the workshop. However, this was a very senior member of their executive leadership group and a longstanding health activist who made many thoughtful and well-informed contributions to the discussion. Section 27 also sent one representative. However, this representative was a newly appointed staff member at S27 and had not attended the NHA. However, they had been briefed about that organisation's NHA work prior to the workshop. Whereas the TAC representative at numerous moments suggested potential areas of work where TAC and PHM could collaborate, as well as strategies and structures for doing so, the S27 representative participated in the discussion without identifying future areas of collaboration or forms of health activism that could animate the NHA campaigns.

Two SAPHU 2016 graduates attended the workshop. They had attended the 2016 NHA and it was important to include them in the meeting as they represent the core groups of "new" activists PHM has trained in the hope of building a stronger mass movement for health.

Workshop Activities and Practices

Day 1 of the workshop (15 July) focused on how alliances and working relations between PHM-SA and its civil society allies could be strengthened, particularly those allies working on health issues. All invitees were present on Day 1.

Day 2 of the workshop (16 July) focused on how PHM-SA's internal structure and programme of work should be rethought in light of findings from Phase 1 of the IDRC research and discussions that took place during Day 1 of the workshop. Participation in the second day of the workshop was limited to members of PHM-SA.

There was a fairly equal balance between male and female activists, and participants ranged in age from activists their 20s through to those in their 60s. Day 1 involved about 20 participants, while a smaller group of 14 participants were present on Day 2.

The workshop was designed to enable frank, inclusive, and critical discussion. The agenda for each day was shared at the start of the workshop and posted on a large sheet in the front of the room. Before the start of the meeting and throughout the course of the day, participants offered feedback on the agenda. The daily programme of work would then be amended to make time for new or urgent items.

On both days two IDRC researchers – David Sanders (DS) and Lauren Paremoer (LP) – were responsible for designing the agenda, doing facilitation, and scribing. Anneleen de Keukelaere (AdK) captured additional notes on both days and shared these with the IDRC researchers after the workshop.

Discussions were conducted in English, though this was not the first language of all workshop participants. No translator was present, though workshop participants helped with translation at times. The lack of translation may have impacted the quality of the discussion or the willingness of some activists to contribute to the conversation, and is a potential limitation.

On both days, a voice recorder was used to capture the exchanges. Verbal consent for doing so was obtained at the start of each day's work. A scribe and/or facilitator captured notes of the main points and decisions made during the course of the day. This was displayed at the front of the room so that participants could offer corrections or additions if needed. These transcripts, as well as notes captured by AdK, and a questionnaire filled out during the workshop serve as the main data sources for this

report.

Themes and Key Questions Emerging from Day 1

Day 1 was divided into five areas of work, each of which is describe below.

1. *Describing the IDRC research project and reporting on Phase 1 findings.*

2. *Gathering data through brief personal narratives on why and how the workshop participants first became health activists, and how their work has changed over time.*

   Workshop participants were asked to introduce themselves by briefly explaining (a) why they became a health activist, (b) what the first issue was that they worked on, (c) what issues they are working on now, and (d) how and why their work has changed.

   a. In explanations of why participants became *activists* four themes emerged. They were politicised as a result of:

      i. personal experiences (e.g. by difficulties family or community members had in accessing good quality public sector health care when they became sick);
      ii. the poor living conditions and inequalities that defined their everyday lives;
      iii. the disjuncture between the training they got at medical school and the needs of the communities they served; and
      iv. a broader political conflict that had inspired conflict and/or mass mobilisation e.g. human rights activism within the context of the anti-apartheid movement, repressive and authoritarian government practices in SA and Zimbabwe, attempts to dismantle national health care systems such as the NHS.

   b. The specific issues that participants first took up as *health* activists seem to be issues that both constituted immediate crises facing their communities and were, at the time, the focus of national government interventions or civil society campaigns. These include issues such as HIV/AIDS deaths and medicines stock-outs, chronic hunger amongst school-aged children and orphans, high rates of infant mortality in hospitals, the exploitative working conditions of community care workers, medicines stock-outs, doctors' complicity in political repression (e.g. deaths of political activists in detention), and inadequate access to care as a result of privatisation or sub-contracting of health care services.

   c. Many of the issues activists currently work on also exist at this intersection of personal and political but they touch on new thematics, and often ones that are framed more broadly than their initial entry points into

health activism. These include the importance of:

    i. improving the quality of leadership, governance and citizen participation within public health institutions and health activist organisations (including strengthening thee organisations' capacity to do political education at the grassroots level and amongst youth);

    ii. addressing the ecological crisis as a foundational step towards securing health for all (opposing the use of nuclear energy was a particular concern in this regard);

    iii. better working conditions for health workers;

    iv. protecting and promoting migrants' health rights;

    v. devising policies governing how technologies can be used to promote access to health services; and

    vi. universal health care (UHC) and primary health care (PHC) in ensuring health equity.

d. In reflecting on how their work had changed over the years many activists mentioned that structural factors had shaped how, when and why they do their health activism. The most important of these factors were:

    i. The adoption of a neoliberal macroeconomic policy in SA, which had undermined the strength of the public health system, and the quality of public services more generally. One delegate mentioned that there was a need to be more "aggressive" as a health activist, given the "radical" context of neoliberalism in which they were now organising.

    ii. The change from apartheid to a constitutional democracy. This has had a number of consequences. First, it facilitated capacity-building amongst activists, who are now allowed to organise more freely. This has built the confidence of activists "over the years" and has allowed them to develop leadership skills. Some participants mentioned SAPHU and PHM solidarity with/support for community-based health activism as particularly important in bolstering their skills and confidence. Secondly, this political opening has given activists more access to government decision-making processes and "stakeholder" consultations, and they feel more entitled to be part of these processes. Third, there has been a shift from mobilising for political rights to an emphasis on claiming socioeconomic rights such as health – and others rights (e.g. to housing, sanitation, education, food and land) that shape the social determinants of health.

    iii. Some activists also mentioned the fact that over the years their voluntary work as health activists has translated into paid work within the health sector, i.e. for some activism has become "a part of work". Academia was mentioned as one sector that was particularly amenable to people who wanted to do waged work that contributed to or constituted a form of health activism.

3. *Conducting a survey, completed in the room before the lunch break, aimed*

at gathering information about the work participants and their organisations had done on NHA campaigns since the NHA a year earlier in June 2016.

The survey was completed before lunch and the two facilitators analysed the data over the lunch break. The report-back occurred immediately after lunch. The survey indicated that most delegates and their organisations had worked on the NHA campaign themes in their meetings between June 2016 and July 2017. For example, many respondents said they had worked on issues surrounding community health workers (14 out of 20 respondents), clinic health committees (14/20), and human resources for health (11/20). Work on stockouts (9/20) and financing and tax justice (5/20) was less frequently undertaken over the course of the year. Significantly, coalition members primarily undertook this work as part of their intra-organisational work; it was not explicitly conceived of as being done under the banner of an NHA Campaign. The forms of "collective" campaign work that had been undertaken since June 2016 mainly involved administrative and communications work that required coordination amongst coalition partners, e.g. publishing the NHA report, doing follow-up calls on NHA related issues, or jointly hosting meetings.

4. *Doing group work reflecting on the challenges, pitfalls, and importance of using coalitions to do health activism, and in particular, to lead and organise campaigns.*

The survey findings, together with the Phase 1 findings, were used to initiate a discussion about the successes and challenges of the NHA campaigns during their first year. Participants broke into sub-groups to discuss the strengths, weaknesses and political importance of making use of coalitions and campaigns as forms of health activism. The group discussions were then reported back to the plenary.

Workshop participants reported that coalitions were *politically important* because they "consolidated people's power and voices", allowed for resources to be pooled and for work to be shared, and that coalition partners' diverse political perspectives served as a resource for political education and expanding activists' repertoire of strategies and tactics.

As regards the latter, it was acknowledged that this could also introduce conflicts and tensions amongst coalition partners, and risks resulting in "unfocused" actions. Other *difficulties* of working in coalitions included that:
   a. coalitions are not always quick to respond to changes in the political context;
   b. they are overly focused on national level issues and neglect opportunities for building locally;
   c. it is more difficult to hold activists accountable within the context of a coalition;
   d. a lack of clarity amongst coalition partners about the strategies and broader goals they share, and, more importantly, those they do not share – i.e. coalition work can be difficult when coalition partners lack clarity about the parts of the activist journey they

want to share, and those sections where they choose to part ways, and when coalition work is informed primarily by reacting to external events.

e. the difficulties of the emotional labour involved in building and sustaining coalitions and interpersonal comradeship are underestimated. Participants mentioned that coalitions require a lot of emotional work in order to sustain interpersonal and inter-organisational relationships, and that not all activists are equally adept at this or willing to take on this labour. This was mentioned as something that not only makes coalition work difficult, but sometimes contributes to them breaking down entirely.

In participants' experience, other factors contributing to the breakdown or "*failure*" of coalitions include:

a. insufficient leadership (defined as a lack of coordination and communication amongst coalition partners);
b. a lack of finances or conflict around the administration and use of finances (i.e. a lack of transparency and accountability in the use of organisational resources;
c. inequalities in the power wielded by coalition members who occupy different class positions);
d. tension between organisational and coalition priorities;
e. the decreased relevance of coalitions during moments when more urgent organisational or political crises emerge (i.e. this seems to suggest that working with allies is perceived as cumbersome during moments when issues become very pressing or urgent);
f. a lack of capacity building amongst junior members of the coalition;
g. no processes for managing conflicts between organisations or personalities within the coalition (or even an acknowledgement that this may be necessary);
h. class, language and cultural differences can contribute to creating a hierarchy within coalitions where some members become more influential because these characteristics give them "upward" mobility within coalition structures (gender and sexuality were not mentioned as such markers of difference – it is unclear why).
i. pursuing party-political issues within coalitions; and
j. a lack of clarity about the strengths of each coalition partner and what issues they should therefore "lead" on, even if they are much smaller or less resourced than other coalition members.

5. *To decide on how to proceed with the NHA coalition and campaigns in light of the day's discussion.*

In light of the discussion the workshop participants felt that it was important to continue working on the NHA campaigns as a coalition. However, they felt that there needed to be an explicit agreement on how the coalition would work

particularly with regard to fundraising, when/how to consult non-coalition partners on issues, and its media strategy, and who its mandated organisational representatives would be. It was also felt that the coalition should "not just be reactive", i.e. that it should have a proactive vision and that this should be translated into an ongoing working practice/style.

In terms of thematic issues, the participants felt that the coalition needed to decide as a matter of priority what its position would be on the NHI, as this was identified as a potential area of work that could be used to animate the various NHA campaigns going forward but it was not explicitly formulated as an autonomous NHA campaign.

The NHI, participants felt, could be used to create momentum on the ground and develop a working practice amongst the coalition partners. It was proposed that this could be done, for example, by conducting a survey of NHI pilot sites that draws on the strength of each of the lead coalition members (e.g. PHM could contribute by developing a survey instrument and doing training, TAC could mobilise its members to conduct the survey and participate in data analysis, and S27 could develop a legal strategy on the basis of the data collected). All of this could be preceded by a national workshop of all the coalition partners that is aimed at developing a common position on the NHI and possible actions around it. It was felt that the PHM's articulation of a "people's NHI" would be an important resource in this process, and that it should be used as the "glue" with which to bring together the five NHA campaigns into the broader objective of securing a people's NHI.

Participants did feel that PHM-SA should take the lead in "driving" any NHI-related campaign, and that it had not done sufficient work in coordinating communications between itself, S27 and TAC on the NHA campaigns in the wake of the NHA.

This course of action was tentatively embraced at the workshop, subject to further discussion within the organisations leading the NHA campaigns, i.e. PHM-SA, S27 and TAC. Day 1 ended with organisational representatives agreeing to take up this proposed course of action within their structures and to commit to a follow-up meeting that includes at least TAC, PHM-SA and S27.

Day 2 of the Workshop

Day 2 of the workshop involved PHM-SA members reflecting on how the country circle's organisational structure and practices should be amended in light of the IDRC findings from Phase 1 and the workshop discussions on Day 1 in order to make it a more effective activist organisation.

The Big Unanswered Question

The meeting agreed that it was politically important for PHM-SA to build coalitions with other organisations. It also acknowledged that this was a complicated process and that coalition-building work has not always been consistent, given the resource constraints within PHM-SA. The hope was expressed that coalition-building would be

improved if the roles and responsibilities of different sub-structures within PHM-SA were spelled out more clearly. This document tries to summarise some of the discussion that took place at the workshop about how to allocate roles and responsibilities. However, it remains unclear whether there will ultimately be one or two "point people" within PHM-SA who are ultimately responsible for driving coalition-building work across the thematic areas and sub-structures discussed below.

Responsibilities of the Steering Committee (SC)

The meeting decided that the SC would take primary responsibility for the areas of work below. Concerns were raised about the fact that the SC was not being very effective in doing this work or communicating internally, and that more attention needed to be given to the following areas that could be improved.
1. Strategic decision-making about PHM-SA's role in health activism in SA
2. Collating and sharing information about the activities of working groups
3. Sharing information about PHM-SA with the broader public

Responsibilities of the Executive Committee (EC)

It was decided that the EC should take primary responsibility for fundraising and budgeting, particularly for identifying funding opportunities and/or calls and for submitting funding applications. The meeting decided that the EC should meet more regularly in order to do this work effectively.

Responsibilities of the Secretariat

The Secretariat will be responsible for:
1. Maintaining an accurate membership database.
2. Doing a "skills audit" of the membership database in order to identify ordinary PHM-SA members that could be pulled into ad hoc work, or into the work of the working groups.
3. Share the membership database with regional SC members.
4. Build a database of organisations and contacts in those organisations that PHM can build alliances with.
5. Facilitating in-person meetings.
6. Assisting in budgeting and fundraising work.

Establishment of Working Groups

The meeting recommended that working groups be established on the thematic areas listed below. The idea is that the working groups will be led by SC members, but that members will extend invitations to ordinary PHM-SA members to join these groups and support their work. This will offer an opportunity to expand the number of PHM-SA members who are active in the work of the organisation throughout South Africa. The meeting indicated that working groups should not be "reactive", but should have a plan of work that it executes over the course of each year.

1. *Tax Justice and the NHI*
   Next steps: make contact with individuals and organisations that could form

part of a Coalition for a People's NHI.

2. *South African People's Health University (SAPHU)*
   Next steps: there was a suggestion that an effort should be made to produce materials that are easily accessible to community members (e.g. pamphlets) that explain what SAPHU is and how one can participate, and that the SAPHU team should think about strategies that can be used to help other organisations to undertake the kind of activist training that is done at SAPHU.

3. *Health Committees*
   Next steps: there is a proposal that the upcoming National Colloquium be used as an opportunity to refine the work plan of this working group in collaboration with other health activists and health activist organisations.

4. *Knowledge Making & Sharing*
   Next steps: there was a suggestion that this group could be responsible for thinking about how the Y-Mobilise platform can be used by PHM-SA to record "best practices" and case studies of activism in communities, and the production and dissemination of popular education materials and other resources on the right to health as well as PHM-SA activities and analyses of the political economy of health.

5. *Fundraising*
   This committee would be responsible for identifying funding opportunities, submitting funding applications and ensuring compliance with funders' requirements.

There was also a discussion of the areas of work PHM-SA had been most active in over the preceding year. The discussion was aimed at teasing out how the "successes" in these areas of work could be translated into actions that strengthen the five dimensions of health activism explored in the IDRC research. The three areas of work are discussed below.

SAPHU: this is one of PHM-SA's most successful areas of work and participants felt it could be used in movement-building by including new partners in the NHA Coalition in the SAPHU process, and by building relationships between coalition partners and alumni that share areas of work. SAPHU was also seen as an important opportunity for knowledge generation and capacity-building for a mass movement for health, i.e. the SC felt that there was potential for developing popular education materials based on the SAPHU curriculum and that alumni could use this in building capacity for health activism within their own communities. This process, it was felt, would probably be one that was more aimed at information sharing – e.g. sharing information about patients' rights to care – rather than serving as "training" of health activists/replicating the SAPHU model. These materials could be distributed via the PHM-SA website and social media accounts, which SC members felt were being underutilised as tools for knowledge-sharing and capacity building.

Health Committees: PHM-SA's work on health committees mainly involves training and mobilisation of health committee members and was undertaken as a result of another civil society organisation – The Learning Network – reaching out to PHM to assist with

this. Much of the work has focused on critiquing and improving legislation governing the role, powers, and functioning of health committees. Health committee members are on PHM-SA's governing structure, which has enabled ongoing collaboration and support between PHM and the committees, and this has aided with movement and capacity building. It has also contributed to knowledge generation, as health committee members often have up-to-date information on the kinds of systemic problems patients and workers encounter at public health facilities. In turn, PHM-SA sometimes organises actions (e.g. meetings, letters, workshops) that speak to these issues and their connection to the broader political economy of health in SA, thereby building solidarity between community health activists and PHM. However, it was felt that more could be done to formalise health committees' involvement in the NHA campaigns.

Knowledge Sharing: The SC felt that it needed to do more thinking about what PHM-SA's unique contribution is as a fairly small organisation that does not have the mass membership or resources of a health activist organisations such as TAC. It felt that PHM-SA could make a big contribution to health activism in SA by building health activists' understanding of the political economy of health in SA and globally. This way of framing health and health activism is relatively unique to PHM-SA in the SA context, and it was felt the organisation could do more to use its connections, coalitions and social media platforms to popularise this analysis. There was also a feeling that knowledge sharing needed to be strengthened by producing materials in more than one national language rather than predominantly working and publishing in English as PHM-SA typically does, and that materials should be targeted at different age groups.

Section 3
Lessons Learned during Phase 2 of the CSE4HFA Research Project

Movement Building & Capacity Building

One of the primary constraints to movement building in SA has been the scarce resources of the PHM-SA country circle. This came up on Day 2, during the discussion about the need to establish a financing/fundraising committee. The country circle is mainly run by volunteers (the SC members work on a voluntary basis and there are two support start who are paid) and it is not a mass membership organisation. PHM activists tend to split their time between their PHM work and other (sometimes paid) work. This has limited the time that they have been able to spend on movement building: most SC members contribute to movement building through the thematic work that they focus on (e.g. SAPHU, health committee work, arranging or speaking at public meetings, etc.).

During the workshop a consensus seemed to be emerging that PHM-SA could be an effective "movement builder" without being a mass membership organisation, i.e. it could help build a people's movement for health by focusing on sharing its expertise – particularly on the political economy of health, the right to health, and health governance – with mass based movements that are political allies of PHM-SA.

Within PHM-SA the most successful capacity building tool seems to be SAPHU. This was

a finding that emerged during the workshop, but also during Phase 1 of the research. Neither this workshop (focused on the NHA campaigns) nor Phase (focused on the NHI campaign) suggested that campaigning worked very effectively in building capacity amongst activists – particularly new activists.

Knowledge Generation

Knowledge *sharing* emerged as somewhat of a weakness during the workshop. On Day 2 in particular participants emphasised that PHM could make a unique contribution by emphasising the importance of adopting a political economy of health approach in promoting health equity, and that the organisation was not doing enough to share existing knowledge and to do so in a manner that was easily accessible and took cognisance of the diverse audiences (i.e. the diversity of languages and ages) that it should be engaging with.

The issue of knowledge *generation* was primarily discussed in terms of applying the lessons from Phase 1 to the NHA activities, i.e. to take a proactive approach to the NHA campaigns and to organise them around a coalition-led activity rather than in response to the publication of a government policy. This involved the proposal that PHM-SA, S27, and TAC jointly undertake a survey of NHI pilot sites which would not only generate knowledge about what the piloting exercise had achieved, but would also assist the organisations in developing a collaborative activist practice, and mobilisation of activists responsible for conducting the research. The activity thus also has the potential to contribute to campaigning, movement building and capacity building. This work could also contribute to activities at the global level (e.g. a chapter in the Global Health Watch, data for ongoing debates about how to "operationalise" UHC).

Campaigns

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

The discussions on Day 1 suggested that health activists can be politicised and mobilised under both repressive and politically "open" conditions, that voluntary work can be sustained in either context, and that campaigns often provide a crucial "institutional home" for newly politicised activists, i.e. it offers them a political home where they can do activist work on the "personal" issue that led to their conscientisation (e.g. a routine inability to access medicine at a public health facility).

As such, campaigns can be a key tool for movement building.

The discussion on Day 1 also suggested that a more "open" political climate enables activists to focus on socioeconomic issues rather than prioritising more urgent issues like avoiding criminalisation or demanding political rights before "also" demanding the right to health. A more open political context, however, can also be demobilising in cases where activists adopt a posture of waiting for/responding to government initiatives (e.g. waiting for the publication of a key piece of legislation in order to take up campaign work in response to it can cause a campaign to dissipate if the legislation is not published in a timely manner).

Global Governance

The workshop contained no discussion of issues related to the global governance of health. The role of the Global Secretariat in securing funding for the IDRC research project was acknowledged, but other global-level PHM initiatives – the Watchers Programme, the Global Health Watch publication, PHUs in other regions – were not mentioned. In short, there seems to be no clear consensus at the country circle level about whether health activism locally would (and should) involve a more routine relationship with PHM Global – or other global movements for health.

Section 4
Challenges to Building More Effective Civil Society Engagement for Health for All in PHM-SA: Tentative Conclusions

Key Challenges

Phase 2 enabled sharper focus on factors that facilitate or undermine PHM's work. However, phase 2 illustrated the considerable resource constraints that operate, in that even participation in the research process was sub-optimal and only very intermittent on the part of the core members of the PHM circle. The focus was on difficulties PHM experiences in maintaining momentum in its campaign work, and even greater challenges in sustaining active coalitions. While PHM maintains a consistent and distinctive ideological and political position, it is insufficiently able to influence significant constituencies or animate the emergence of a mass movement for health equity. These weaknesses derive from the national political context where there has been a demobilisation of civil society, the resource constraints (human and financial faced by PHM), and insufficient organisational focus and follow-up of contacts and partners. It was agreed that more energy and attention needs to be directed to improved structuring of PHM's work through strengthening the role of the executive and forming action groups on key campaign/capacity building activities, strengthening capacity of the secretariat by improving communication platforms, and raising more resources for PHM.

The Impact of Resource Constraints on the Action-Research Process

The main lesson learned from the action-research process was that delayed and insufficient reporting of phase 1 findings, combined with lengthy gaps between undertaking activities decided upon at a coalition event (NHA) led to sub-optimal

application of lessons learned. These shortcomings reflect the larger problems that face PHM – namely its resource constraints which affect both the functioning of its structures as well as the secretariat's organising ability. However, partner organisations with which PHM has attempted to collaborate, are also affected by the same constraints, and they, understandably, contribute only to those agreed upon campaigns that coincide with their own priorities.

Next Steps

PHM developed more focussed but still ambitious plans as a result of this process. However, implementation of the structural and organisational changes agreed upon after the process of reflection have only partially (and very slowly) been operationalised. There is however, now an improved database of contacts, the beginnings of a multi-faceted communications platform and a recent re-invigoration of the 'People's NHI Campaign' – largely as a reaction to government's proposed implementation of a fundamentally changed NHI. Furthermore, the SAPHU continues and has been successful in raising awareness amongst CHWs of the social determinants of health. The ongoing challenge is to maintain and enhance organisational strengthening, communicate our positions and achievements much more effectively and thus to recruit more (especially young) activists to PHM.