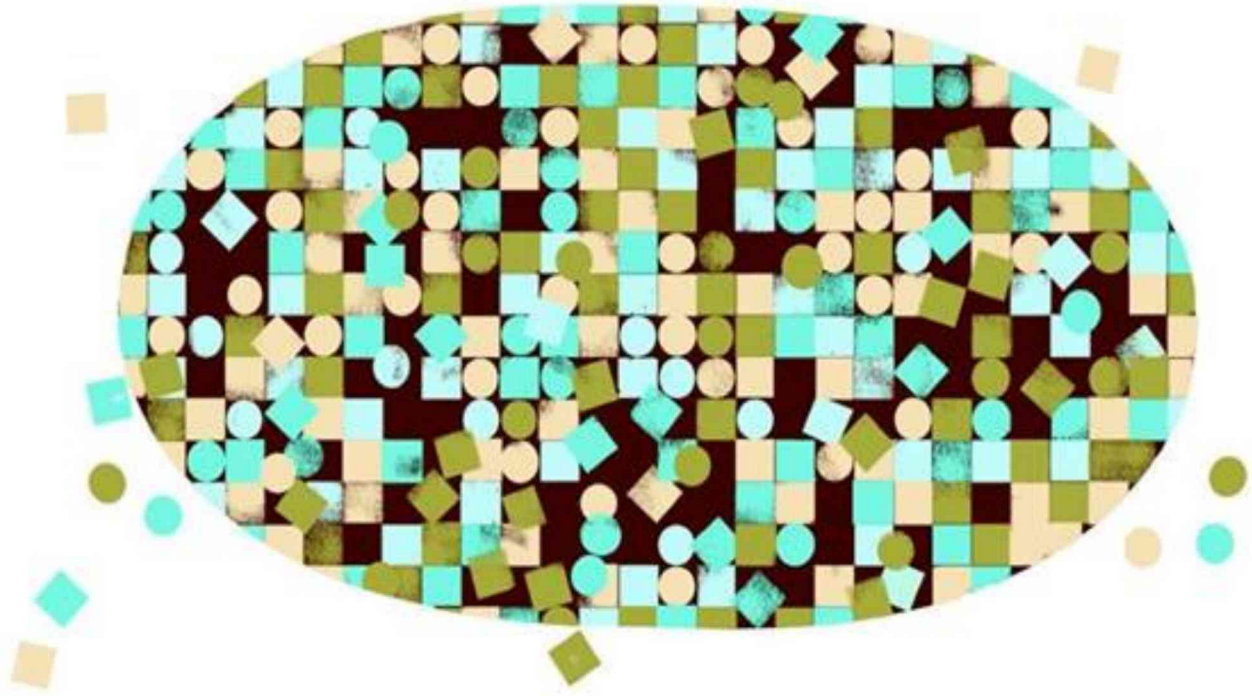


Evaluation of PHM programme "International People's Health University" (IPHU)

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1. Introduction

The evaluation of PHM programme International People’s Health University (IPHU) was undertaken by a multidisciplinary team of the Centre for International Health (CSI) of Bologna (Italy), as part of the IDRC-funded research “The contribution of civil society organisations to achieving health for all” (CSE4HFA). The activity was originally part of Phase 1 of the action-research, but it was then decided to postpone it to Phase 2.

Following a decision taken in a coordination meeting held in Vancouver (November 2016), in January 2017 the following timeline was agreed between the international research team and the CSI:

Task	Timeline
Short literature review on training evaluation + review of previous IPHU evaluations	Feb 2017
Developing the evaluation questionnaire	Feb/Mar 2017
Creating a list of IPHU alumni emails from at least the last 15 IPHUs [at least 500 recipients]	Feb/Mar 2017
Sending the questionnaire + 2 reminders [objective 30% response rate]	Mar/Apr 2017
Analysing the questionnaire	May 2017
Writing a report	Jun 2017

Table 1. Timeline of activities

The CSI team included people with medical/public health, health education, and (medical) anthropology background. With different roles at different stages, five people worked on the project: 3 with a medical background, 2 with an anthropological background. All had some knowledge of PHM, having participated in one or more IPHUs (2/5) and/or playing an active role in the national (4/5) or international (3/5) PHM activities.

The research questions

The research questions were framed into the broader CSE4HFA research, aimed at exploring and documenting the impact of civil society organisations, and PHM among them, on health for all. The IPHU falls under theme 4 of the research, i.e. capacity building. As reported in the guideline for Phase 1: *“The purpose of the inquiries under this theme is to throw new light on capacity building as part of building a global HFA movement. Suggested focus:*

1. *How are training needs identified, curriculum assembled and pedagogy developed (what principles guide educational planning within the training/capacity building program)?*
2. *How are the recruitment and selection processes for participants handled?*
3. *How do such programs affect the activist/career choices of participants, and how do they influence participants’ future engagements with PHM or other HFA movements?*

4. *How can we enhance the impact of training/capacity building courses (preparations, structure, content, dealing with language, enhancing relevancy, etc.)?*
5. *To what extent have these courses contribute to the strengthening of the PHM or other CSOs/movements at the country level?'*

Through the questionnaire, we aimed particularly at exploring points 3, 4 and 5 of the above list. The following aspects were therefore taken into account:

- who is reached (who knows about the opportunity, how it is broadcasted incl. language, routes of dissemination, support to attendance, etc.)
- how is the training (content, methodology, duration, trainers)
- what happens afterwards (follow up, opportunities of engagement, increased knowledge and awareness, engagement in PHM global programs).

Designing the questionnaire

Prior to developing the questionnaire, a short literature review was done covering both pedagogical aspects (evaluating adult learning and learning for action/activism) and aspects related to the design and delivery of web-based questionnaires. In addition, the evaluations that had been done for some IPHUs were carefully reviewed (in particular, the evaluation of the South African People's Health University - SAPHU, conducted as part of Phase 1 of the CSE4HFA project in South Africa; the narrative report of the IPHU in Cape Town in June-July 2012; the evaluation of the IPHU in Atlanta in June 2007). Reports to the PHM Steering Council on the IPHU programme were also taken into consideration, including the most recent discussions on capacity building within PHM based on Phase 1 results of the CSE4HFA project (Steering Council meeting in Bangkok, January 2017).

A thorough review of the available softwares for online surveys led to the choice of SurveyMonkey, based on multiple considerations taking into account features such as multi-lingual support, maximum number of responses allowed, readability from mobile device, statistical analysis support and possibility to access the full data, as well as cost.

In March 2017 a draft questionnaire in English was developed, and sent to 12 'experts' (key people in PHM, such as regional representatives, and those involved in running the IPHU program) and 11 alumni (identified through the PHM regional representatives). The selection was balanced both in terms of gender and of geographical representation, covering all the regions (Latin America, North America, Africa, Middle East, Europe, South Asia, India, South East Asia). Given the great deal of diversity of PHM across regions, reflected also in the IPHU program, expert respondents were asked particularly to judge the appropriateness of the questionnaire for their local/regional context. The alumni were asked if the questions and the words used were clear, if it was too hard to reply to some questions as memories had faded away, if there were questions 'out of context' compared to their experience, or others that were missing. They were also consulted on the average time of completion, estimated in 10 minutes.

12 people completed the test questionnaire. From their responses, and from the additional feedback received via email, the questionnaire was finalised. It was then translated into French and Spanish, with a 'validation' of the translation by PHM key people. Based on the observations received, time of completion was increased to 10-15 minutes. The final questionnaire (see

Annexure 1) comprises 5 sections: 1. Introduction; 2. Something about you; 3. Before the IPHU; 4. During the IPHU; 5. After the IPHU, for a total of 33 questions of which 29 multiple choice and 4 open-ended questions. No question was mandatory.

Building the alumni database

The database for sending the questionnaire was compiled through the mailing lists of IPHU participants hosted on the PHM website, as well as others that were retrieved through direct contact with the organisers. The mailing list 'IPHU alumni' on the PHM website was also included. All repetitions were excluded from the database, in order to count the number of individual recipients.

IPHU course	Source of email contacts
1. Cuenca, Ecuador (2005)	Mailing list on PHM website
2. Bhopal, India (2007)	Mailing list on PHM website
3. Vancouver, Canada (2007)	Mailing list on PHM website
4. Atlanta, Georgia, USA (2007)	Mailing list on PHM website
5. Savar, Bangladesh (2007)	Mailing list on PHM website
6. Cairo, Egypt (2008)	Mailing list on PHM website
7. Jaipur, India (2008)	Mailing list on PHM website
8. Porto Alegre, Brazil (2008)	Mailing list on PHM website
9. London, UK (2009)	Mailing list on PHM website
10. Thessaloniki, Greece (2009)	Mailing list on PHM website
11. Bangalore, India (2009)	Mailing list on PHM website
12. Havana, Cuba (2009)	Mailing list on PHM website
13. London, UK (2010)	Mailing list obtained from organisers
14. Chimaltenango, Guatemala (2010)	Mailing list on PHM website
15. Kisumu, Kenya (2010)	Mailing list on PHM website
16. Moratuwa, Sri Lanka (2010)	Mailing list on PHM website
17. Dakar, Senegal (2011)	Mailing list on PHM website
18. Bronx, USA (2011)	Not retrieved
19. London, UK (2011)	Mailing list obtained from organisers
20. El Salvador (2011)	Mailing list obtained from organisers
21. Online IPHU - IPOL (2012)	Mailing list on PHM website
22. Cape Town, South Africa (2012)	Mailing list on PHM website

23. Manila, Philippines (2012)	Mailing list obtained from organisers
24. El Salvador (2012)	Mailing list obtained from organisers
25. Los Angeles, California, USA (2013)	Mailing list on PHM website
26. El Salvador (2013)	Mailing list obtained from organisers
27. Online IPHU - IPOL (2013)	Mailing list on PHM website
28. Thessaloniki, Greece (2013)	Mailing list on PHM website
29. South African People's Health University (2013)	Mailing list obtained from organisers
30. South African People's Health University (2014)	Mailing list obtained from organisers
31. El Salvador (2015)	Mailing list obtained from organisers
32. Bruxelles, Belgium (2016)	Mailing list on PHM website
33. Seattle, USA (2016)	Mailing list obtained from organisers
34. London, UK (2016)	Mailing list obtained from organisers
35. El Salvador (2016 - April)	Mailing list obtained from organisers
36. South African People's Health University (2016)	Mailing list obtained from organisers
37. El Salvador (2016 - November)	Mailing list obtained from organisers
38. Kathmandu, Nepal (2016)	Mailing list on PHM website

Table 2. Source of email contacts per IPHU

Questionnaire collection and response rate

Overall, the first communication announcing the questionnaire (with the possibility to opt out) was sent to 1.262 individual emails. Of these, 163 were invalid addresses, 4 were institutional addresses and people were no longer working there, 1 person opted out considering that too much time had passed since his participation for a proper evaluation.

N.	Content	Date
1.262	Preliminary communication recipients	11-13 April
168	Error messages (163), impossible delivery (4), refusal (1)	
1.094	Questionnaire recipients	19-20 April 26-27 April (first remind) 3-4 May (second remind)
33	Error/blocked messages	
1.061	Valid addresses	
325	Responses collected, of which: - 169 in English - 141 in Spanish - 15 in French	19 April - 24 May ¹

Table 3. Questionnaire distribution and responses collected

Overall, 325 anonymous questionnaires were collected. Of these 6 were collected through an offline form as some people living in Cuba and El Salvador indicated that they did not have access to the internet and could not therefore complete the web based questionnaire. The forms completed offline were scanned and sent, and the responses inserted online by the research team.

Of the collected responses, 169 were completed in English, 141 in Spanish and 15 in French. For the Spanish and French surveys, there can be an approximation to the region of origin of participants (Latin America and Africa, respectively), while for the English this is not possible. In any case, in order to avoid biases the breakdown of the analysis has been done by region where the IPHU has been organised, and not by language.

If we assume, with some degree of approximation, that 325 is the number of respondents, the overall response rate would be around 30%. However, in order to properly calculate the response rate, the exact number of recipients and respondents should be known. This is difficult in our case, for two main reasons:

- the **exact number of recipients** is not known, because even when an error message was not received, we can assume that many email addresses were no longer in use, for example those related to educational institutions where participants were students at the time of the IPHU; moreover, at least for the IPHUs in El Salvador the questionnaire was circulated also through local networks, including a database of the Ministry of Health that could not be shared with the research team;
- **one person could complete more than one questionnaire**, for every IPHU he/she wished to evaluate, but this could not be recorded to keep the anonymity of the respondent.

As shown in the graph below, not all questions were answered by respondents (the graph includes only closed first level questions, as it is expected that open-ended and second level

¹ The online survey officially closed on May 5th; however, an extension period was asked to allow people without internet connection to complete it offline, scan it and send it. We therefore decided to accept also a few additional online submissions that came in the period between May 5th and when all the offline questionnaires were received (May 25th).

questions are answered only by some). As one may expect, the number of skipped questions slowly but regularly increases as the survey progresses. The one exception is question n. 30, that asked if - after the IPHU - alumni participated in other PHM activities. We assume that many of the skipped questions in this case could be taken as negative replies to the question.

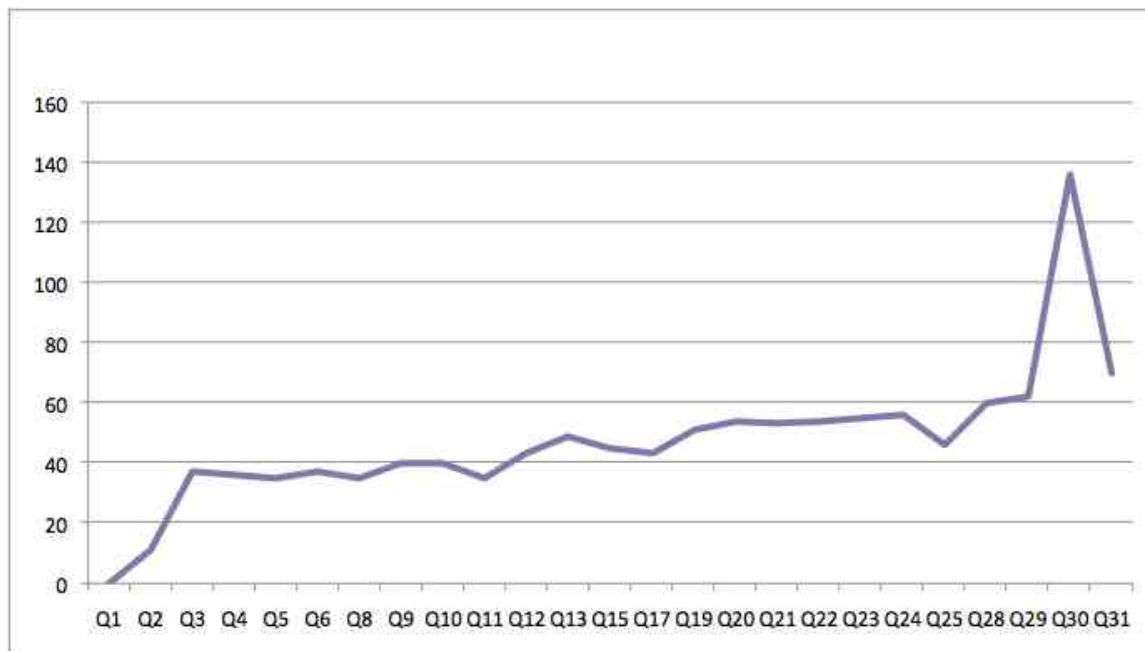


Figure 1. Number of respondents who skipped a question, per question

Analysis

In the analysis that follows, we adopted both an overall approach (summing all the replies obtained from the questionnaire in different languages and analysing the results as a whole), and - when relevant - a regional approach. This was done by coding the responses per world region (Latin America, North America, Europe, Africa, Asia) and adding a specific code for online IPHUs (IPOL). The number of responses per region/IPOL is shown in the table below:

Region	N. of responses
Latin America	155
North America	18
Europe	33
Africa	46
Asia	67
IPOL	6

Table 4. Number of respondents per region

While we are aware that the IPHUs in each region were attended also by participants from other regions, we decided to still adopt this classification as it seems more relevant considering PHM organisation and decision-making structures. Of course, other types of analytical breakdown can also be done, if considered relevant.

Another issue to highlight is that a relatively large number of responses come from alumni of the IPHUs in El Salvador, and that these courses have some distinctive features in terms of being co-organised with the Ministry of Health and targeting particularly health professionals and community leaders. When relevant (in terms of numbers or specificity), the comments on these IPHUs have been analysed separately.

Finally, in the analysis we choose to adopt a rather descriptive approach, in order to facilitate access to the data and offer the ground for a discussion within the PHM, as any interpretation should also be informed by the background, history, political vision and strategic objectives of the movement.

IPHUs evaluated

The graph below shows which IPHUs (listed in chronological order) have been evaluated, by how many people (range 0-26). The response was good in terms of overall distribution, with at least 1 response collected for 36/38 IPHUs. However, the number of responses per IPHU was in many cases rather small, with a tendency to increase for more recent courses. It should be noted that the number of participants per IPHU varied greatly, and although it was not possible to retrieve the exact figures for each course, the range of the emails collected per course went from 5 (London 2011) to 195 (IPOL 2012).

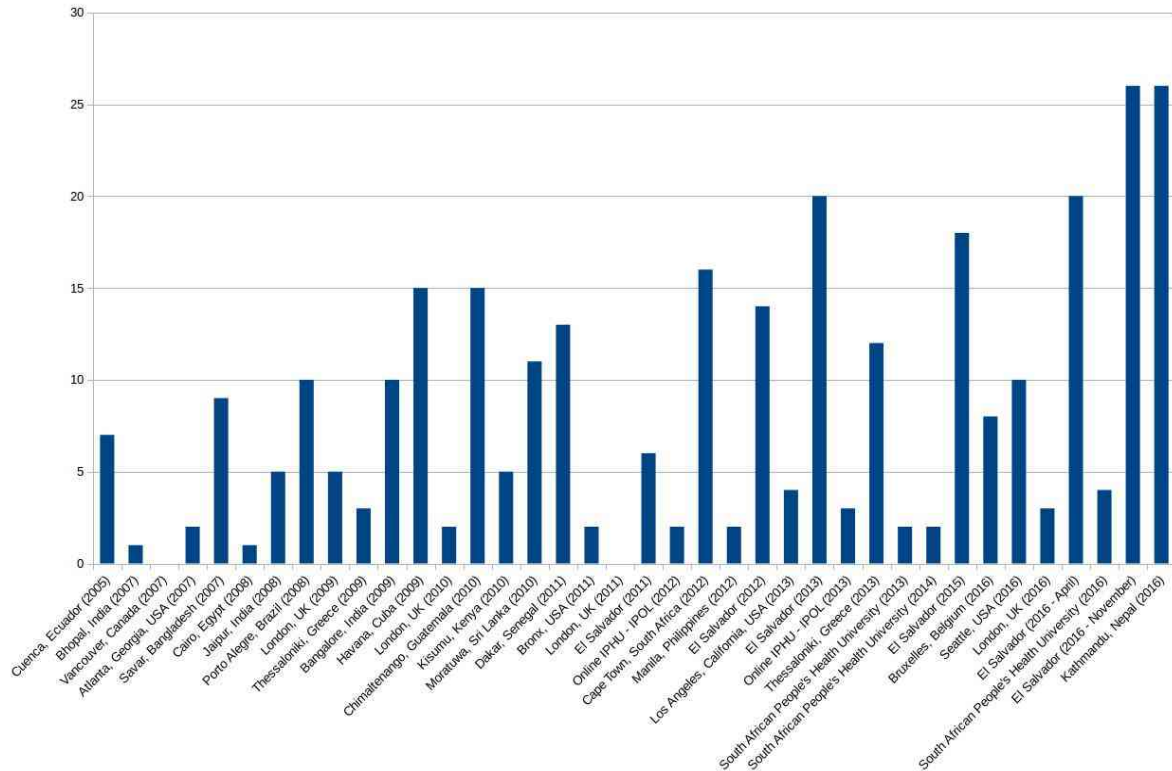


Figure 2. Number of questionnaires received per IPHU

Limitations

Before getting to the analysis, it is important to share some limitations of this work:

1. For time as well as cost-opportunity reasons, we opted for an **online survey**, aware that this may result in an exclusion of some people due to issues of internet accessibility. In some cases, it was possible to overcome this limitation by making the offline questionnaire available; however, this could only happen when people received the news of the survey and proactively reached out to let us know their problems. In the case of El Salvador, however, thanks to local collaboration there has been a proactive effort to reach out to local community leaders, who were in this way able to give their opinion.
2. The survey was available only in **three languages**, which are the main languages used for the IPHUs. However, some people may have not responded because they did not feel comfortable in expressing themselves in these languages. For example, translation to Arabic would be recommended for future researches.
3. For a more comprehensive analysis, a decision was made to **include all the IPHUs** in the survey. However this implied accepting to ask questions also on courses realised over 10 years ago. This is one of the reasons why we chose to avoid mandatory questions, and tried to encourage people to share only what they felt was more consistent and accurate. However, opinions on less recent IPHUs may be less reliable than those on more recent ones, and this is something to consider while reading the analysis.
4. Another implication of including old courses has been reducing the **reliability of the email database**. Many addresses were no longer in use, especially those related to the

workplace or the university. We preferred not to advertise the survey publicly, and to rely on personal email addresses, in order to better track the number of people reached; however this may have resulted in not being able to reach some of the alumni.

5. Choosing a **standard (online) questionnaire**, we were aware of the intrinsic limitations of this tool, particularly the impossibility to reflect, explore and document the diversity of contexts and features incorporated in the IPHU programme. To do the best within this limitation, key PHM representative from all regions were engaged in testing and revising the draft questionnaire. Moreover, the decision on the tool was shared with the international research committee of the CSE4HFA project, so the implications were known and accepted from the beginning of this activity, knowing that other approaches (interviews, focus groups, etc.) are needed in order to explore other aspects.
6. The survey was targeted **only to IPHU participants** (alumni), not to facilitators, trainers or other people involved in the organisation. Again, this decision was shared with the international research committee, and a different survey and/or other approaches are needed to explore this area of the programme.
7. Finally, as reported above we would have liked to be more accurate in calculating the response rate. This would have implied a **registration** to the online survey, with complications related to the anonymity of the responses. A registration would have allowed participants also to save the survey and complete it later one, a feature that could have reduced the number of skipped questions, and potentially increased the accuracy of the responses. However, the costs to include these features in the online survey exceeded by far the available budget (several hundreds Euro per month, as compared to the 35 Euros per month required for more basic features).

2. Who joins the IPHU

The first part of the questionnaire was aimed at understanding some individual characteristics of the IPHU participants, inquiring dimensions such as age, gender, educational qualification, field of education/employment, etc. For some questions, the choice has been to explore the self-perception of the people involved, as in the case of gender (see below for more considerations), perceived social class and being part of a minority group.

Age

As reported in the graph below, around 80% of respondents is under 45 years old, with 40% between 26 and 35 and 37% between 36 and 45 years old. 38 respondents skipped the question about age.

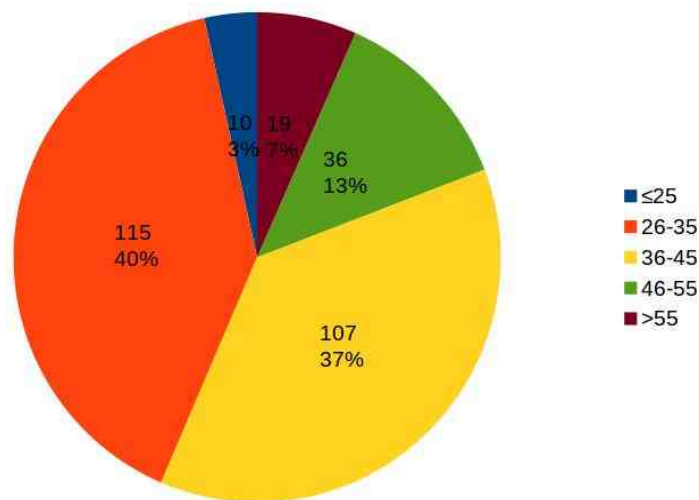


Figure 3. Age groups of respondents

The graph below illustrates the breakdown of ages per number of respondents. The most frequent age among respondents was 33 years old.

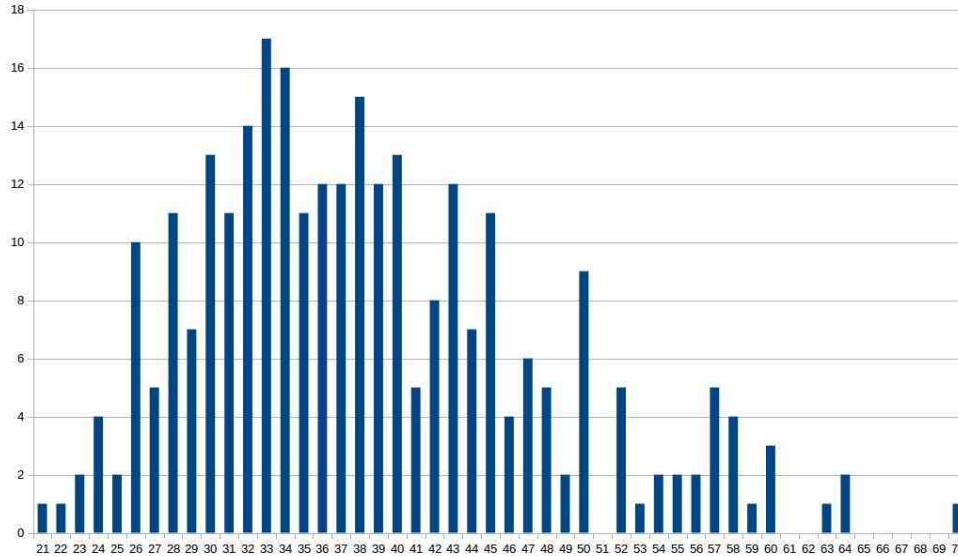


Figure 4. Number of respondents per age

Gender

In order to allow respondents to express themselves freely beyond the gender binary, the question on gender had three possible answers: M, F and other. Respondents could express more than one choice and, if they wished, also add an open comment.

37 respondents skipped the question. Among those who responded, the distribution between men and women is near 50%. It should be noted that in the 15 French questionnaires, all coming from African countries, there was a significant gender bias with 12 males (80%) and 3 females (20%).

Total answers	M	F	Other
288 (37 skipped)	141 (48,96%)	147 (51,04%)	0

Figure 5. Gender of respondents

Among the 18 open comments received under the heading “Would you like to add something?”, only one was relevant about gender, while all the others were broader considerations about the participant’s background and/or the IPHU. This is despite the fact that the gender multiple choice and the open question were all in one page, with no other question. To explain this, we could imagine that there was a problem of clarity in the question design or formulation, and/or that the respondents were not familiar with online surveys and got confused with the attribution of the open-ended question. However, it is probably also true that the perspective of going beyond the gender binary is not so shared among IPHU participants, therefore a gender attribution other than M/F is not really conceived (this is also shown by the fact that no one opted for the category “other”).

At the same time, several of the answers to the question on self-perceived minority status took into account gender-related issues (see more details below):

- female feeling part of a minority in a patriarchal context
- transgender person
- LGBTQI
- intersectionality between race and gender as source of marginalisation.

Educational qualification

The educational qualification of IPHU participants was explored using the ISCED 2011 classification, which identifies 9 level of education, from level 0 to level 8:

- ISCED 0: Early childhood education ('less than primary' for educational attainment)
- ISCED 1: Primary education
- ISCED 2: Lower secondary education
- ISCED 3: Upper secondary education
- ISCED 4: Post-secondary non-tertiary education
- ISCED 5: Short-cycle tertiary education
- ISCED 6: Bachelor's or equivalent level
- ISCED 7: Master's or equivalent level
- ISCED 8: Doctoral or equivalent level

In the question, respondents could choose among 3 levels:

- ISCED 0-2: Lower secondary (middle) or less education
- ISCED 3-4: Upper secondary education
- ISCED 5-8: Tertiary (University) or higher education

More than the 90% of respondents (n. 259) reported tertiary (university) or higher education; only 4 people, slightly more than 1%, declared lower secondary (middle) or less education, while 22 (8%) reported upper secondary education. 40 people skipped the question.

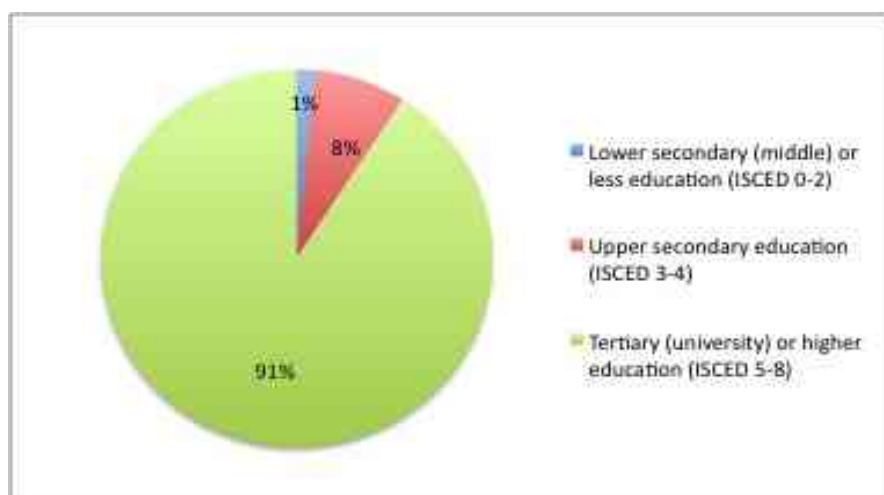


Figure 5. Educational qualification of respondents

Considering the breakdown of answers per region of IPHU, it appears that:

- all 4 people who marked ISCED 0-2 attended an IPHU in El Salvador;
- all participants in European IPHUs and IPOL have at least a tertiary level of education (ISCED 5 or higher);
- upper secondary education is reported by 22% of respondents for African IPHUs, by 6% for IPHUs in North America and by 2% for IPHUs in Asia.

	Latin America		North America		Europe		Africa		Asia		Online	
Lower secondary (middle) or less education - ISCED 0-2	4	2,96%	0	0%	0	0%	0	0%	0	0%	0	0%
Upper secondary education - ISCED 3-4	12	8,89%	1	6,25%	0	0%	8	22,22%	1	1,59%	0	0%
Tertiary (university) or higher education - ISCED 5-8	119	88,15%	15	93,75%	30	100%	28	77,78%	62	98,41%	5	100%
Answered	135		16		30		36		63		5	
Skipped	20		2		3		10		4		1	

Table 6. Educational qualification of respondents, per region

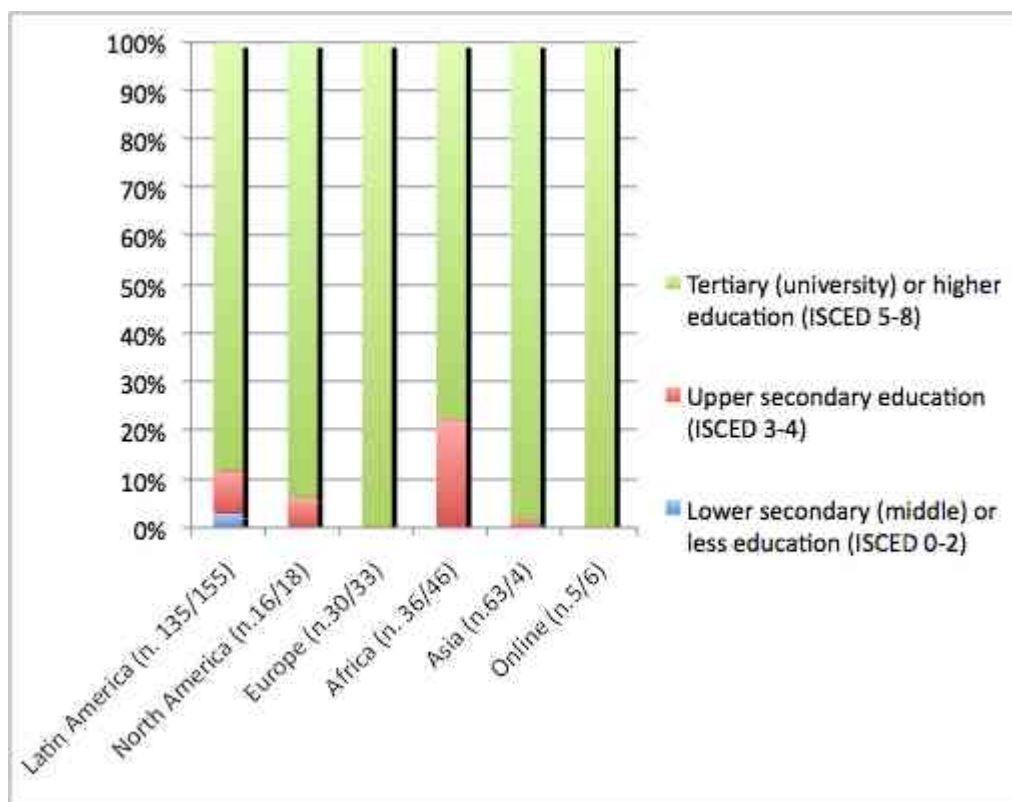


Figure 6. Educational qualification of respondents, per region

Field of education and employment

IPHU alumni were asked to state what was their main activity at the time of the IPHU, choosing one or more of the following:

- Student in the health field
- Student in a non-health field
- Health worker
- Worker in a non-health field
- Worker in an NGO / Civil society organisation (CSO)
- Academic position
- Unemployed
- Retired

290 people replied, while 35 skipped the question. 17% of respondents declared to be a student in the health field, and only 1% a student in another field. 40% was a health worker, 37% worked in an NGO/CSO, and 12% had an academic position. Finally, 3% was unemployed.

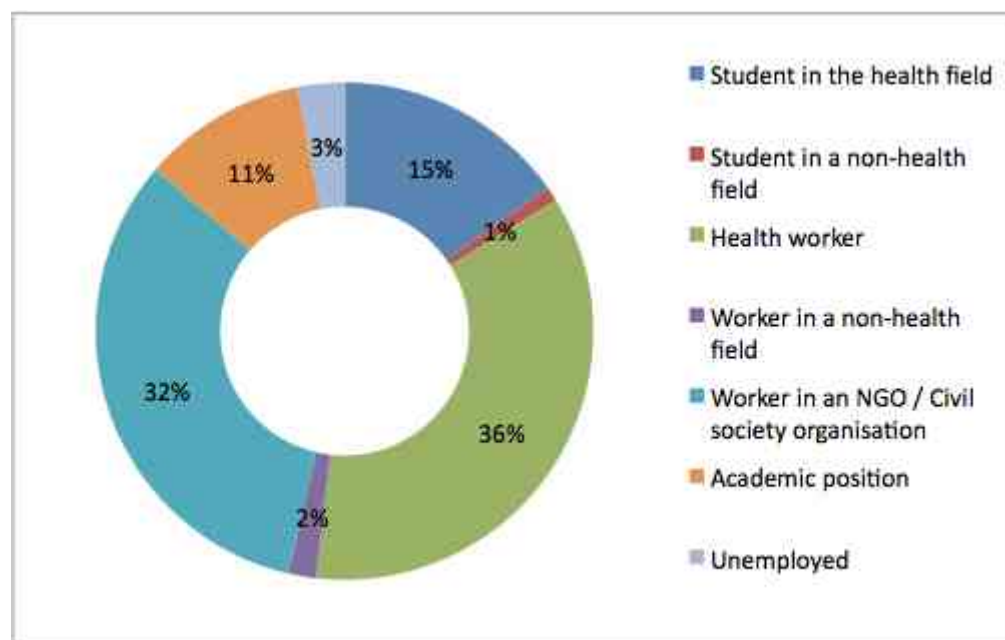


Figure 7. Occupation of respondents at the time of the IPHU

Analysing the results per region of IPHU, some differences can be highlighted:

- in **Latin America**, 68% of respondents are employed in the health field and 21% in an NGO/CSO; 11% is a student in the health field;
- in **North America** the distribution is more even, with a predominance of health students (24%), health workers (19%) and workers in NGOs/CSOs (19%);
- in **Europe** students in the health field are the largest category (37%), followed by health workers (26%), workers in an NGO/CSO (17%) and academics (17%);
- in **Africa**, an absolute majority is represented by NGO/CSO workers (59%), while 21% is a health student and 15% a health worker;
- in **Asia** the situation is similar, with 63% working for and NGO/CSO; quite remarkably, 25% has an academic position;
- Among the 6 **IPOL** respondents, 5 work for an NGO/CSO.

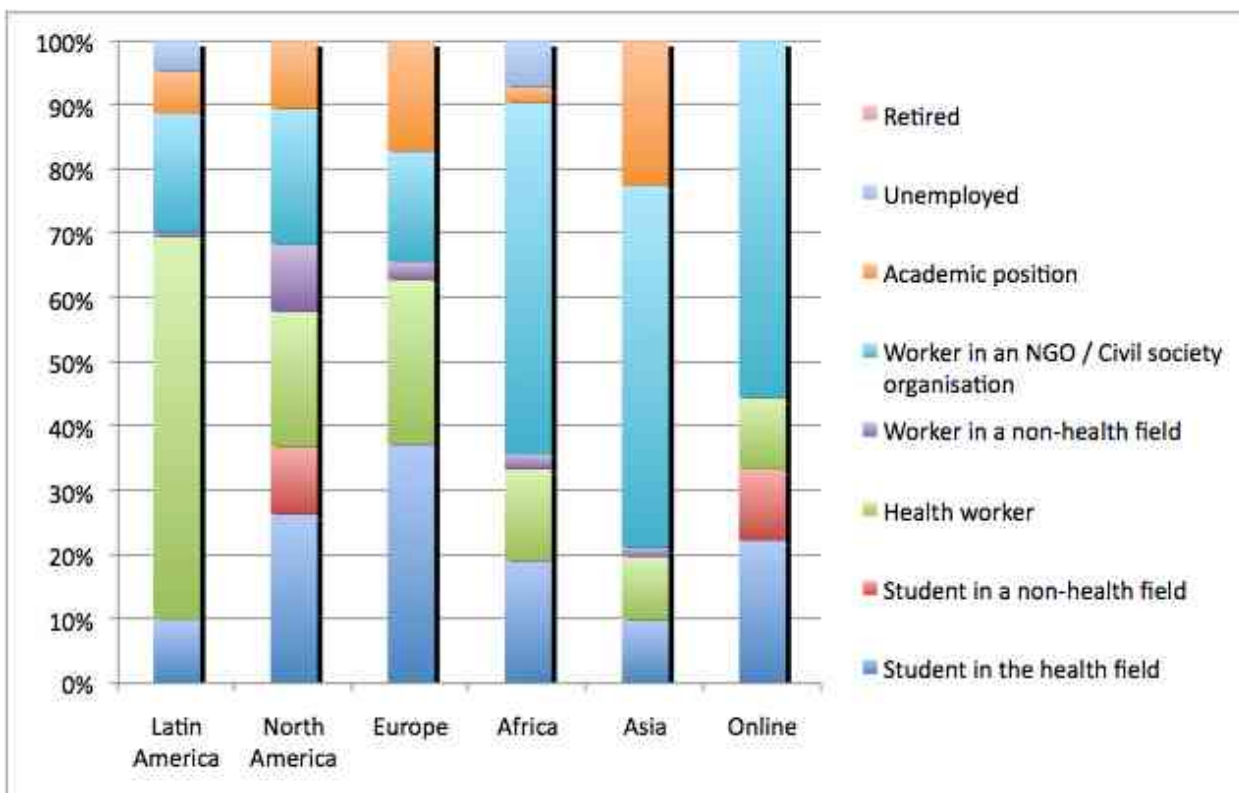


Figure 8. Occupation of respondents at the time of the IPHU, per region

Social class

Social class was explored asking alumni to rate their self-perceived social class, on a scale from 1 to 10 and referring to their community (where the persons who present the lower living standards - income, education, occupation etc. - are at the bottom of the scale, and those who present the higher living standards are at the top).

285 respondents answered the question and 40 skipped it. No one reported class n. 1, while all other classes were indicated by at least one respondent.

Social class	N. of respondents	Percentage
1	0	0,00%
2	5	1,75%
3	15	5,26%
4	26	9,12%
5	71	24,91%
6	60	21,05%

7	68	23,86%
8	28	9,82%
9	10	3,51%
10	2	0,70%

Table 7. Self-reported social class, number and percentage of respondents per class

The highest concentration is among classes 5, 6 and 7, that taken together include around 70% of respondents.

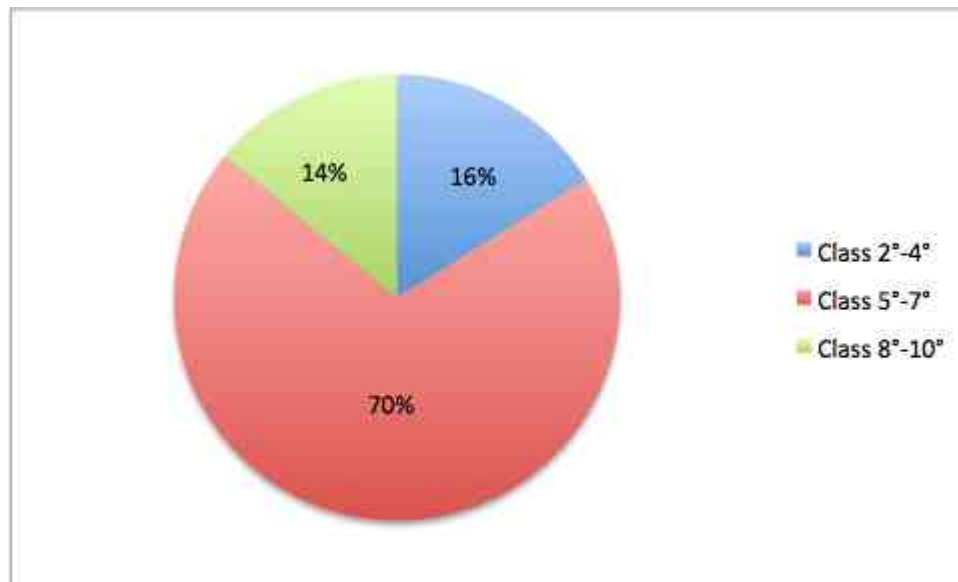


Figure 9. Self-reported social class, percentage of respondents per class groups

Analysing the results per region of IPHU, some differences emerge:

- in **Latin America** and **Asia**, classes 5-7 include respectively 72% and 62% of respondents;
- in **North America** and **Europe** there's a shift towards upper classes, with classes 6-8 including respectively 82% and 76% of respondents;
- in **Africa** classes 6-8 cover only 37% of the answers.

However, since the question explored the respondents' perception compared to the community where he/she lives, there may be multiple reasons behind these differences (e.g. that IPHUs in Africa are attended by people of lower classes, but also that inequalities in the region are bigger) and a more in-depth analysis is required in order to have a clearer picture of the situation.

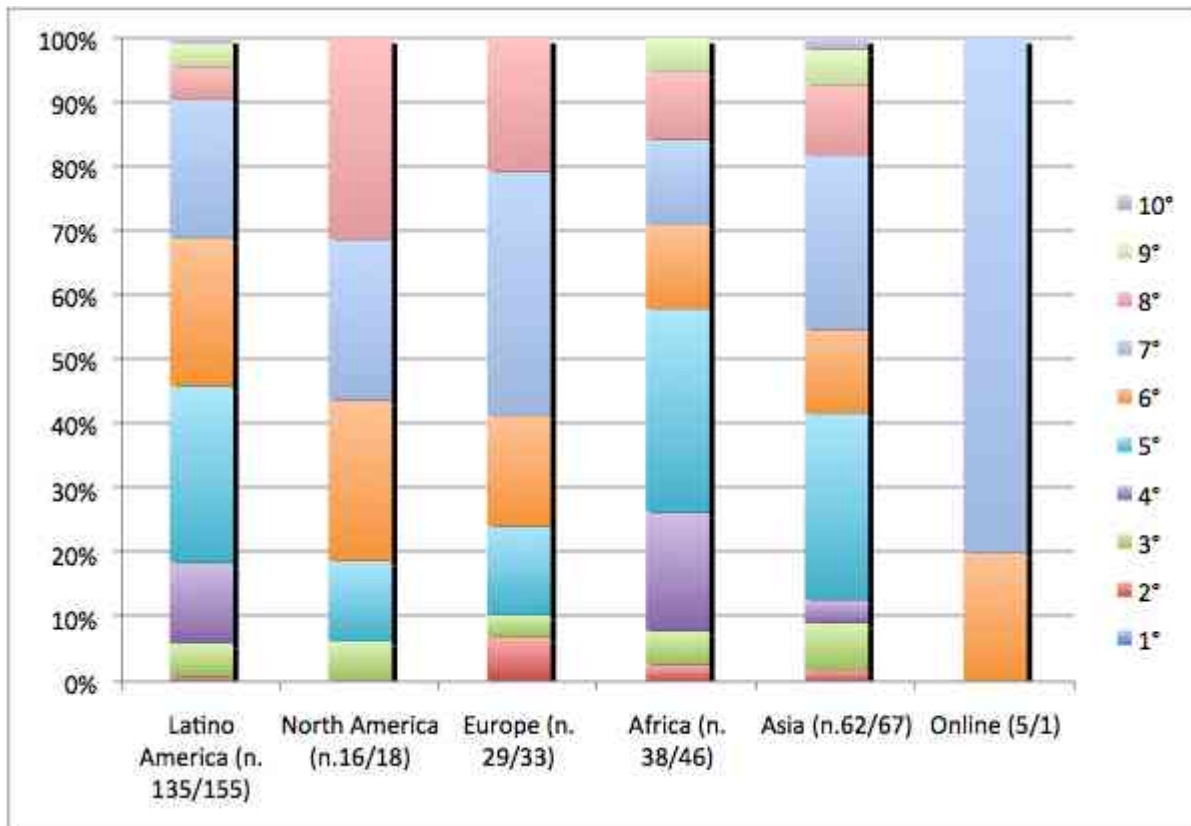


Figure 10. Self reported social class, per region

Minority group

A specific question explored whether IPHU alumni feel part of minority groups. 289 people replied, while 36 skipped the question. Among respondents, 26% feel part of a minority group, while 74% don't.

Analysing the answers per region of IPHU, it can be noted that:

- in **all the regions**, more than 20% of respondents feel part of a minority group;
- the percentage is higher in **Asia** (27%) and **North America** (38%).

	Yes	No	Yes%	No%
Latin America	34	103	24,82%	75,18%
North America	6	10	37,50%	62,50%
Europe	7	23	23,33%	76,67%
Africa	8	30	21,05%	78,95%
Asia	17	46	26,98%	73,02%

Table 8. Self-reported minority status, by region

In an open field, respondents could add free comments to explain their situation. The answers can be grouped in the following categories:

- **Ethnic or religious minority**
- **Socio-economic class**
- **Gender and/or sexual orientation**
- **Political minority**
- **Health-related issues**

In addition, 17 respondents said they feel part of a minority group without further specifying, while 6 did not feel part of a minority but commented on their situation of privilege, or said they belong to the majority of people. However, many (all from Latin America) added that this majority is somehow oppressed and exploited.

“No pues tengo un salario medio y trabajo por privado también.”²

“Me siento parte de la gran mayoría, los que por alguna razón somos explotados o afectados por las transnacionales.”³

Similar remarks are also found among the comments concerning socio-economic class, for example:

“Most of people are unemployed and are living with social grant to support their families, the working class are minority.”

“Minority privileged group.”

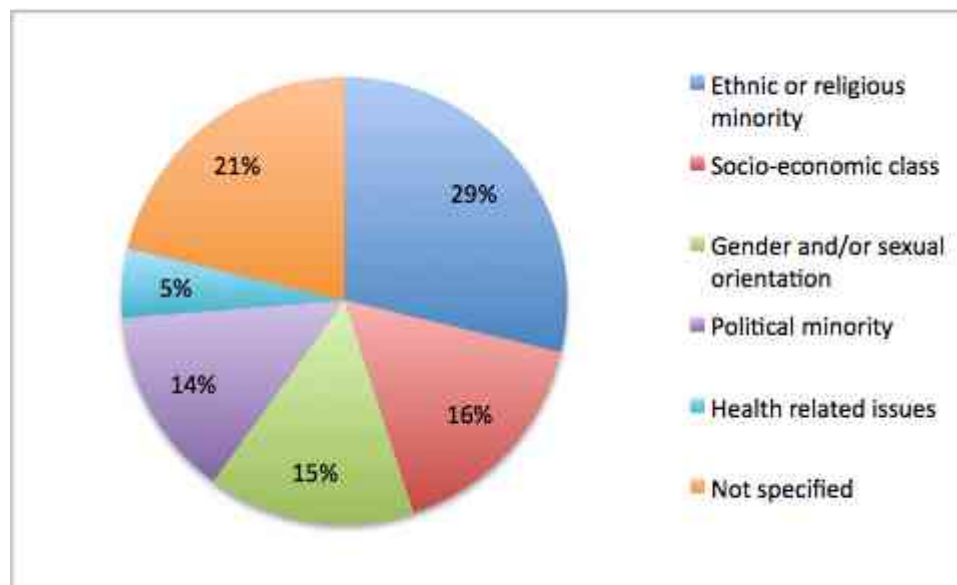


Figure 11. Self-perceived minority group

² “No, because I have an average salary and I also work in the private.”

³ “I feel part of the vast majority, those who for several reasons are exploited or affected by the transnational corporations.”

Minority group	N.	Perc.
Ethnic or religious minority	23	30,67%
Socio-economic class	13	17,33%
Gender and/or sexual orientation	12	16,00%
Political minority	11	14,67%
Health related issues	4	5,33%
Not specified	17	22,67%

Table 9. Self-perceived minority group

Of those who feel part of a minority, 30% refer to be part of **ethnic or religious groups**:

“I have different ethnic origin than majority of people around me.”

“I am an immigrant.”

“I feel invisible in groups that are dense with white majority. For example in a discussion, opinion given by me is unheard/partially heard and not valued whereas the same opinion given by a white person receives attention, appreciation and has chance of being implemented.”

17% refer to **socio-economic class** (9 out of 13 from Latin America):

“Clase obrera que sostiene la economia del pais.”⁴

“Pobre luchador.”⁵

“Clase media trabajadora, con un salario inferior a la canasta basica.”⁶

However, most of these rated their self-perceived social class between 6 and 8 (see above); in accordance, most of these comments (9/13) highlight a privileged condition, at least as working class, even if underpaid and exploited.

16% refer to **(female) gender and/or sexual orientation**:

“Woman community where women are not valued.”

“LGBTI”

“Soy mujer, en el sistema capitalista patriarcal, las mujeres somos minoría.”⁷

15% to a **political minority** (in terms of activism, ideals, views, etc.):

“My views and activism.”

10 people (13%) indicated **more than one condition** related to the feeling of belonging to a minority group, not in the sense of a numeric minority (e.g. female/male) but in terms of power relations in society. Of these 10 people, 9 reported a condition related to gender or sexual orientation, besides at least another minority condition. Furthermore, 5 of these 9 comments report a “raced” condition and a gender issue. So there is a quite strong intersection expressed between race and gender (intersectionality). For example:

4 “Working class that supports the country's economy.”

5 “Fighting poor.”

6 “Middle working class, with a salary lower than the minimum basket of goods.”

7 “I am a woman, and in the capitalistic patriarchal system we are a minority.”

“Personne vivant avec VIH/SIDA et transgenre.”⁸

“Queer, anticapitalist and intersectional political minority.”

“Issue d'un pays à faible revenu ainsi que de la communauté LGBT.”⁹

“Mujer indígena.”¹⁰

“Latin women (...).”¹¹

Looking at the distribution of comments per region of IPHU, it is important to note that:

- 22 comments out of 52 come from **Latin America**, and 13 from Asia;
- 9 comments out of 13 on socio-economic class come from **Latin America**;
- in the category of ethnic or religious minority, 4 comments out of 17 come from **Latin America**, 5 from **North America** and 6 from **Asia**;
- on gender and sexual orientation, 5 comments come from **Latin America**, 3 from **Europe** (on a total of 4 comments made from this region), 3 from **Africa**.

Knowing PHM before the IPHU

Half of respondents said they knew PHM before taking part in the IPHU. 47 people skipped the question.

The differences per region of IPHU are illustrated in the table below. Something to highlight:

- in **Europe**, **Asia** and **Africa** the majority of respondents knew PHM before attending the IPHU (in Europe more than 80%, in Asia almost 70%);
- in **Latin America** and in **North America** the situation is reversed (in North America only 13% of respondents knew PHM before attending the IPHU).

	Yes	No	Yes%	No%
Latin America	52	84	38,24%	61,76%
North America	2	13	13,33%	86,67%
Europe	23	5	82,14%	17,86%
Africa	20	17	54,05%	45,95%
Asia	40	18	68,97%	31,03%

Table 10. Knowledge of PHM prior to the IPHU

41% of those who already knew PHM were also active in PHM at some level (country circle/group; regional level; global level), and 39% were involved in an organisation affiliated to PHM (more than one choice was possible).

8 “Living with HIV and transgender.”

9 “Coming from a low income country and the LGBT community.”

10 “Indigenous woman.”

11 “Latin woman.”

Level of engagement with PHM prior to the IPHU	N.	%
Was active in PHM (country circle/group; regional level; global level)	60	40,81%
Was involved in an organisation affiliated to PHM	58	39,45%
Knew about PHM but was not involved	45	30,61%

Table 11. Level of engagement with PHM prior to the IPHU

Economic support

When asked if they received economic support to attend the IPHU (travel, accommodation, meals, fees, etc.), 81% of respondents answered yes.

280 answered the question and 45 skipped it.

The breakdown per region is illustrated in the following table; it can be highlighted that:

- in **Africa** almost 95% of respondents received economic support, in **Asia** 90%, in **Latin America** 86%;
- in **Europe** and **North America** the figure is less than 50%.

	Yes	No	Yes%	No%
Latin America	117	19	86,03%	13,97%
North America	7	8	46,67%	53,33%
Europe	12	16	42,46%	57,14%
Africa	35	2	94,59%	5,41%
Asia	54	6	90%	10%

Table 12. Economic support to attend the IPHU

Among those who received support, 68% (n. 156) declared that they would not have been able to attend the IPHU without it. Here below the answers per region.

	Yes	No	Yes%	No%
Latin America	42	75	35,90%	64,10%
North America	4	5	44,44%	55,56%
Europe	4	8	33,33%	66,67%
Africa	8	28	22,22%	77,78%
Asia	14	37	27,45%	72,55%

Table 13. Relevance of economic support for IPHU attendance

IPHUs attended and country of origin

A significant number of respondents participated in more than one IPHU: 12% attended two IPHUs, and 2,5% three.

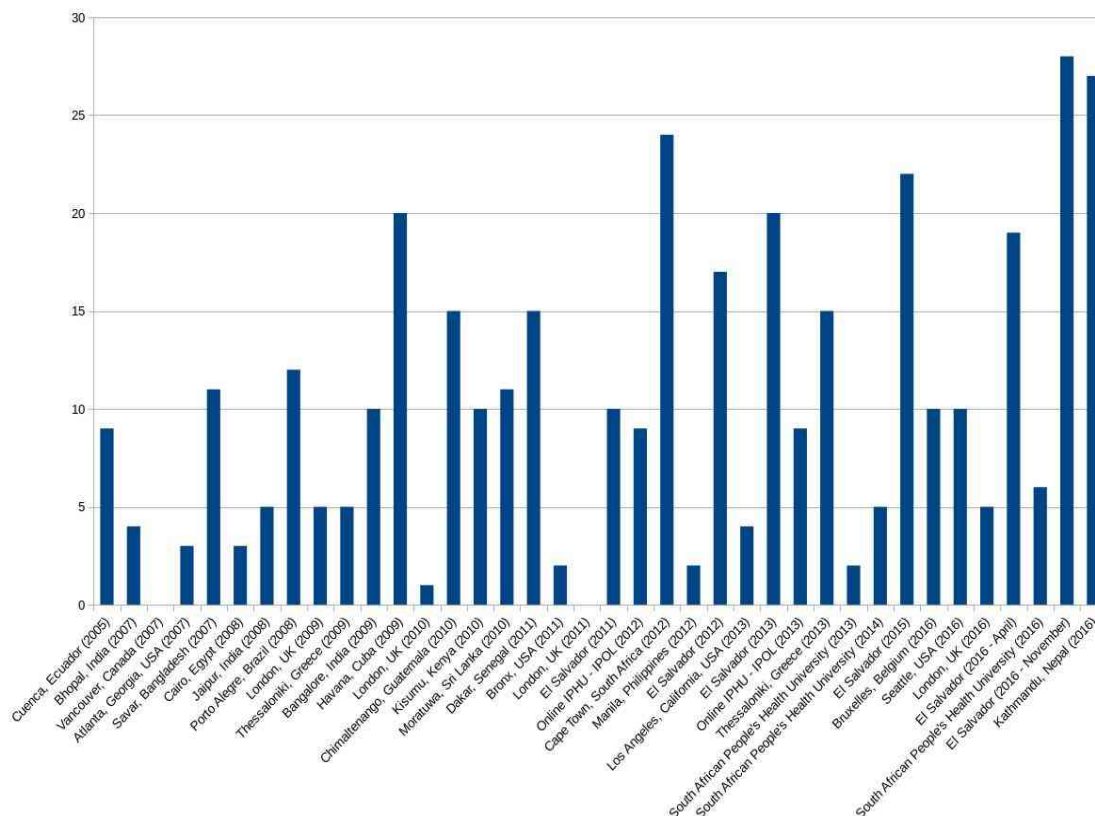


Figure 12. IPHUs attended by respondents

119 respondents attended an IPHU coming from another country or region, precisely:

- 89 coming for another country within the same region;
- 30 coming from another region.

Region	N. of participants from another country within the region	N. of participants coming from another region
Latin America	27	9
North America	0	2
Europe	14	3
Africa	23	6
Asia	25	9

Table 14. Participants from another country/region

3. How PHM shares information

IPHU alumni were asked how they found out about the IPHU. Quite significantly, almost half (46%) received the information through their activist network, while 28% were informed by a friend. 45 people skipped this question.

How did you find out about the IPHU?	N.	Perc.
I learned about it from my activist network	147	52,50%
I was informed by a friend	89	31,78%
I found the information by myself	26	9,28%
I received information at my university	20	7,14%
Other (please specify)	35	12,50%

Table 15. How participants learn about the IPHU programme

Among those who replied ‘other’, 5 people (all from El Salvador) said that they learned about the IPHU from the “Foro Nacional de Salud”; 18 (mostly from Latin America) said from their work; 8 said that they took part in the organisation; 4 through mentioned other ways.

Concerning the sources of information on the IPHU, PHM ‘traditional’ channels such as the website, the newsletter (PHM Exchange) and the mailing lists were rated among the first sources, followed - at a distance - by social media. Quite significantly, 34% of people reported personal email exchange among the main sources of information.

Where did you find the information about the IPHU?	N.	%
PHM website	94	34,30%
Personal email exchange	93	33,94%
PHM Exchange mailing list	64	23,36%
Other PHM mailing list / group	46	16,79%
Facebook	16	5,84%
Twitter	2	0,73%
Other (please specify)	49	17,88%

Table 16. Sources of information for the IPHU

Among the 49 respondents who marked “other”, 7 mentioned a connection with a PHM local group or activity, 2 said they took part in the organisation, 2 received the information through their activist network, 2 at university. As before, participants from Latin America - and particularly from El Salvador - also received information at their workplace (n. 3), from the “Foro Nacional de Salud” (n. 6) and from the Ministry of Health (n. 13).

Asking how IPHUs could be more effectively announced, the suggestions (ordered per decreasing number of relevant comments) are to use the following channels:

- Social networks (Facebook, Twitter...)
- Website and mail/ mailing list
- University, professional associations, other institutions (as the Ministry of Health)
- Social movements, health activist networks, NGOs
- Informal networks and word of mouth
- TV, radio e newspapers (LA e A)
- Alumni, through social networks and meetings.

In terms of regional distribution, the use of social networks is very high among the comments from all regions. Comments on using TV, radio and newspapers come mostly from Latin America and Asia. University channels are suggested from Latin America, but not from Africa where the preferred route are PHM communication tools and networks. From Asia there is a suggestion to also use local languages. Finally, the involvement of alumni is present in comments from Latin America, Asia and Africa.

4. Participant's satisfaction

Overall satisfaction

In order to rate the overall satisfaction, respondents were asked to state their level of agreement, on a scale from 1 to 5, to the following questions:

- Overall I really enjoyed the course
- I would recommend this course to other health activists

Both questions received high scores, with an average of 4.6 for the first one and of 4.7 for the second one. 58 people skipped the question.

When looking in depth at the responses of those who declared to be in disagreement or complete disagreement (only 3 respondents), one person was satisfied by the trainers and by other aspects of the IPHU (Sri Lanka, 2010), however noted that PHM should be more active in rural areas as *“currently it is of elite and does not provide opportunity for locals and socially oppressed class”*. The remaining two persons had a bad experiences during the IPHU (UK 2009, Cuba 2009) - see below for more details.

Duration

A question asked if the duration of IPHU was ok or too short/too long. 271 respondents answered this question and 54 skipped it.

About 74% answered that the IPHU duration was ok and slightly more than 20% that it was too short, while only 4% considered it as being too long. Among these, one specified that the days were too dense to maintain the attention all the time, and 4 said that the course could have been shorter focusing only on some topics.

Among those who answered that the IPHU was too short, 23 said that it was too dense and the topics discussed were very interesting, 5 specified it was difficult to maintain the attention all the time, and 3 that there was not enough time to share experiences. Other 3 people found the IPHU very interesting and would have continued the course some more days. 1 said he/she did not have time to rest and 1 that he/she would have liked to have more time to spend with the other participants.

Among the 201 respondents who were ok with the duration of the course, 10 underlined that there was not enough time for discussion/debate.

Analysing the answers in relation with the duration of the IPHU evaluated, this is what emerges:

- **2/3-day IPHUs** are ok for over 80% of respondents, and too short for about 18%;
- **4/7-day IPHUs** are ok for 75%, and again too short for around 18%;
- **IPHUs that last more than 7 days** (range 8-14) are ok for 75% of respondents, too long for 5% and too short for 20%.

From these data, there is no clear relation between the duration of the IPHU and the satisfaction on the duration. From the comments analysed above, probably the variable that matters most is how the days are organised and the level of interest raised by the course.

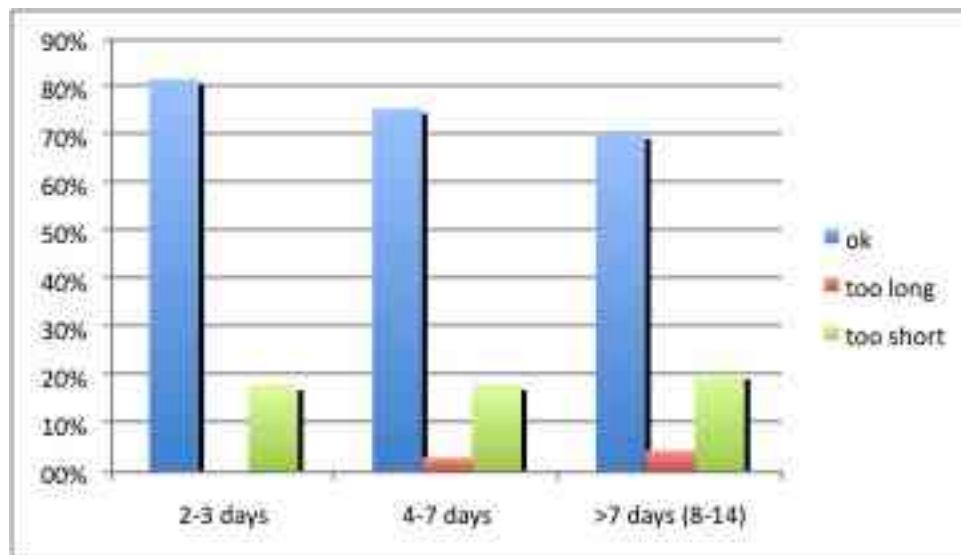


Figure 13. Opinions on the duration of the IPHU

Methodologies

When asked about the methodologies used during the IPHU:

- **lectures** and **small working groups** were indicated by 81% of respondents;
- **Field trips** and **informal opportunities** for learning and sharing were indicated by 64%;
- **Interactive and creative training** was selected by 57%.

In addition, 4 people reported use of films/documentaries, 3 had bibliographic material to study, and 1 reported the participation in traditional rituals. Overall, 271 respondents answered this questions and 54 skipped it.

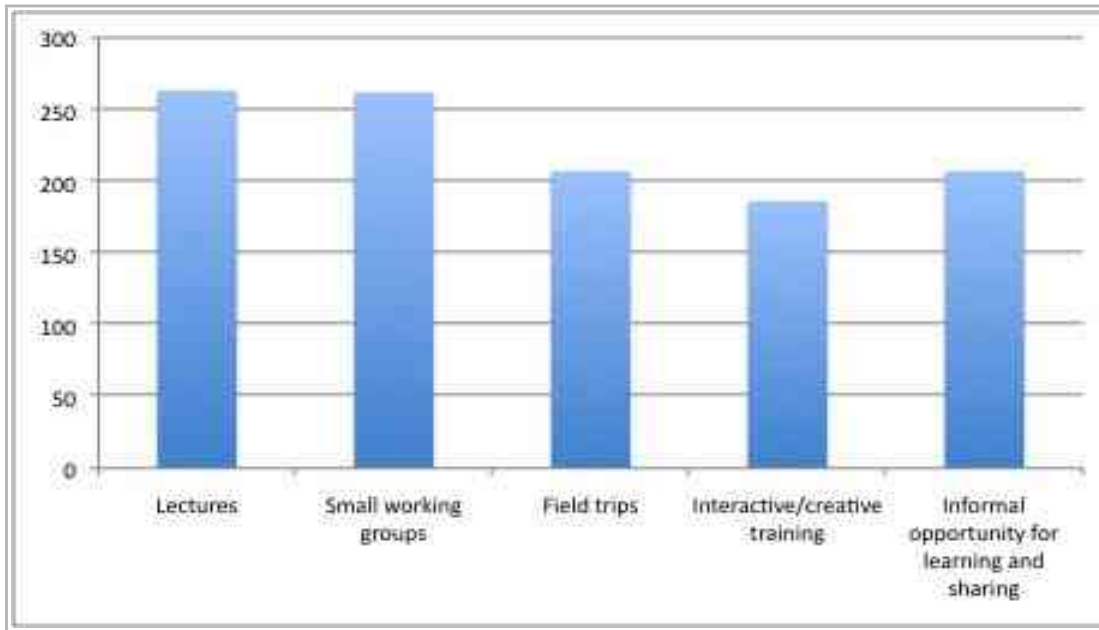
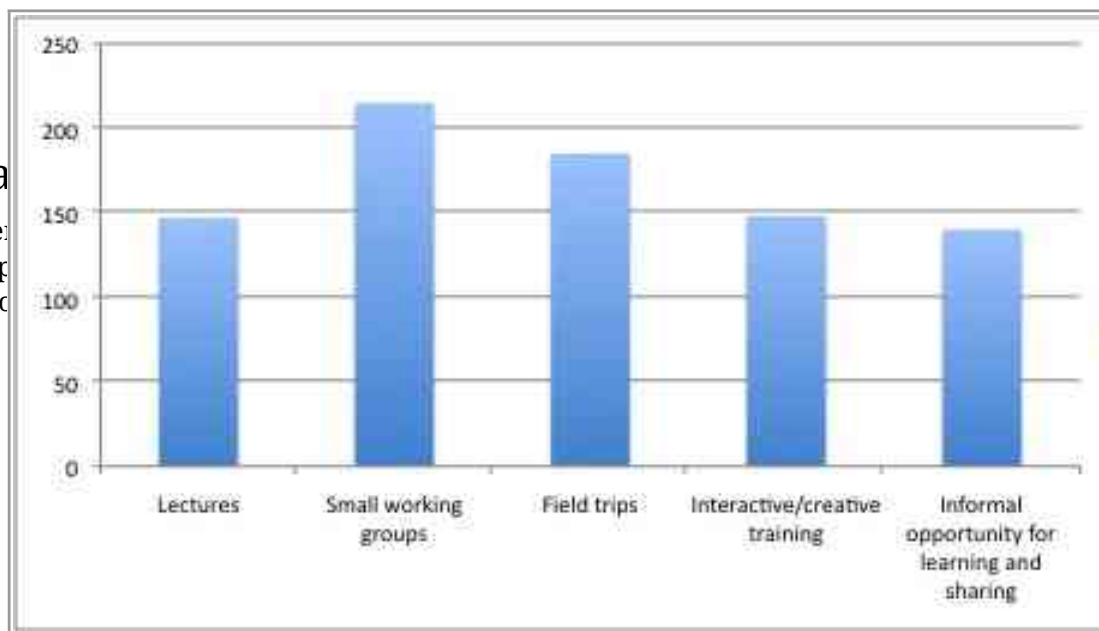


Figure 14. Methodologies used during the IPHUs

A related question was meant to explore **which methodologies were more effective, considering the goal to improve Health For All by strengthening PHM**. Respondents could indicate a maximum of three choices. The question was answered by 272 people, while 53 skipped it.

Almost 80% of respondents indicated **small working groups** as being effective, 68% **field trips** and 54% **lectures and interactive/creative training**. More than 50% reported also **informal opportunities for learning and sharing**. Finally, 3 people answered documentary/film, and 2 wrote that it would be important to create a network of alumni and feed it with continuous interaction through an exchange platform.

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Completely satisfied	80	29,63%
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* all from Latin America.

Table 17. Satisfaction about the trainers

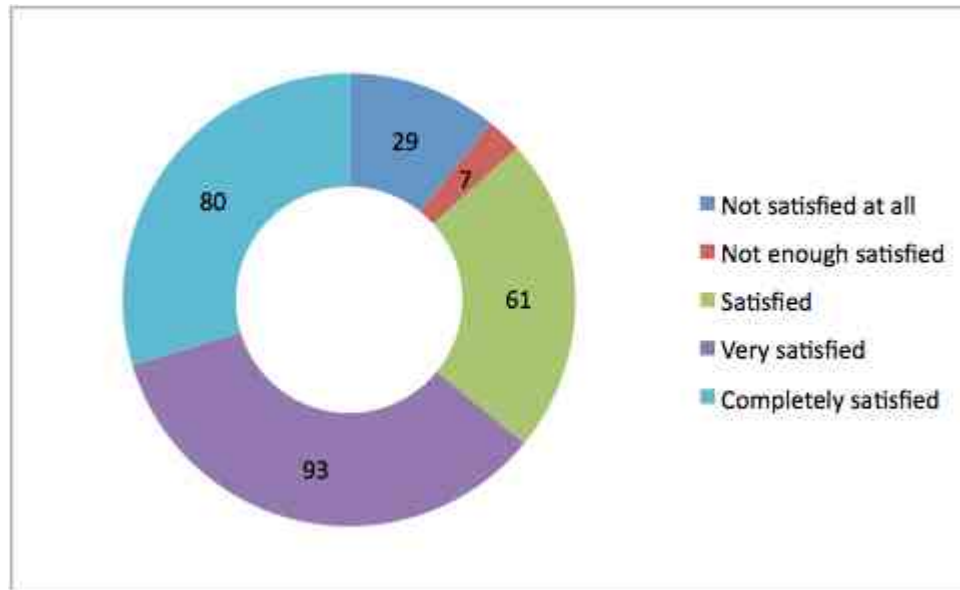


Figure 16. Overall satisfaction regarding the IPHU trainers

Respondents were also asked to state their agreement/disagreement (on a scale of 5) regarding the following sentences:

1. The trainers were competent on the content they exposed;
2. The trainers should be strengthened in communication skills;
3. In terms of relationship- and group-building, the trainers were adequately skilled;
4. The language competence of the trainers should be improved;
5. The trainers were directly engaged in movement struggles;
6. There was diversity among trainers.

94% of respondents either agreed or strongly agreed with the fact that trainers were **competent on the content** they exposed. A slightly lower - but still high - level of agreement is reported for the trainers' competence in **relationship- and group-building skills** (89%), and their **direct engagement in movement struggles** (85%).

Opinions on the trainers' **communication skills** were more evenly distributed, with roughly the same proportion of respondents agreeing (36%) and disagreeing (37%) on the need to strengthen them.

In terms of trainers' **language competence**, a relative majority of respondents (48%) did not feel that it should be improved; however, a significant proportion (28%) felt the opposite. Finally, 84% of respondents agreed that there was **diversity among trainers**.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
The trainers were competent on the content they exposed	1,50%	0,75%	3,76%	38,35%	55,64%
The trainers should be strengthened in communication skills	10,86%	25,84%	27,34%	26,59%	9,36%
In terms of relationship- and group-building, the trainers were adequately skilled	0,75%	2,25%	8,24%	46,82%	41,95%
The language competence of the trainers should be improved	13,81%	34,33%	23,51%	19,78%	8,58%
The trainers were directly engaged in movement struggles	1,13%	1,13%	12,41%	39,47%	45,86%
There was diversity among trainers	1,14%	4,17%	10,23%	40,15%	44,32%

Table 17. Opinions on the IPHU trainers

5. Problems and suggestions

Problems

In an open question, IPHU alumni were asked to report any problem they faced before, during or after the IPHU.

Before the IPHU, a few people reported problems related to unclearness on what to expect, lack of information and adequate communication.

“before when i am coming for participate i just confused and hesitate that how they are? how they treat us? many questions in my mind” (Nepal, 2016)

“I was not sure what to expect and therefore my presentation was not very good .. however I should make more effort to find out beforehand” (Belgium, 2016)

During the IPHU, several respondents highlighted logistic issues (transport and accommodation, internet connection, and thefts - reported by 3 different people in El Salvador, USA and Senegal), as well as difficulties related to language (especially where English was used as main language).

“The accommodation was poorly planned and I ended up sleeping in 4 different places within that short period.” (Senegal, 2011)

“I felt uncomfortable when our colleagues from the French speaking countries could express loneliness as if the course was structured just to suit us the Anglophones only” (South Africa, 2012)

A few respondents also highlighted ethical issues, commenting on aspects that are in contrast with PHM political vision (e.g. use of products manufactured by multinationals that should be boycotted, carbon emission for long distance flights, high organising expenditures).

“I saw Nescafe served to us for breakfast from Nestle company, while Nestle was under attack during the presentations. I was wondering why we could be served products from the same company we were discouraging people from consuming their products.” (Senegal, 2011)

“I was concerned about the expenses of the course. It was organized in a Three Star Hotel with full accommodation and fooding along with travel expenses. So, the expenditure was quite high. If we could have organized at a cheaper place and the saved funds could have been used in some other projects in the ground.” (Nepal, 2016)

Again among ethical issues, a few remarks addressed the issue of race:

“The majority of the lecturers have been elder white academics. The experience of activists and non-white academics was nearly missing on the panels.” (Cuba, 2009)

“A white person claiming native status was odd and disturbing.” (Ecuador, 2005)

“During IPHU, I was the only African participant and had to join Asians whenever we were to work in groups as per continents” (India, 2009)

Finally, respondents addressed relational issues, concerning both trainers (considered paternalistic by one person, and too academic by another one) and participants. The latter is particularly relevant in the case of the IPHU in El Salvador, where a few comments highlighted features such as intolerance for others' opinion, misogyny, rivalry among officials of the Ministry of Health, pressure to align to party's views, challenges among different roles and positions (community leaders, health professionals).

Also the IPHU organised in Havana (Cuba) in 2009 deserves a specific comment, as it received a higher number of remarks, that highlighted:

- lack of critical vision on the Cuban government and health system;
- lack of awareness/sensitivity to the context (expensive hotel, waste of fuel);
- paternalistic and judgemental attitude of trainers (labelled as “*elder white academics*”).

Concerning problems encountered **after the IPHU**, several respondents commented on the lack of follow up and the fact that no activities with shared objectives have been organised. Two people (both from Africa) also highlighted the lack of resources to engage young activists and expand the movement.

Suggestions

IPHU alumni were asked to give their suggestions on aspects to consider in order to improve the programme.

Consistent with the problems highlighted, respondents suggested to improve communication **before the IPHU**, sending material that can be used for a better preparation and/or organising online activities (meetings, videos, etc.) before the face-to-face programme.

In terms of organising process, the main comments concerned the following aspects:

- Selection: increase transparency on the criteria; select people/organisations that stay with PHM and strengthen local circles; involve local PHM circles in the selection; involve community organisations, medical students, health professionals, health officials (to facilitate changes in policy); ensure regional balance; check language competency (even self-assessed). Several comments highlighted the need to promote/increase diversity (of age - more young people; background/ideas; role/position - not only doctors; including people coming from rural areas; etc.). Specific for El Salvador: select health workers that are committed to the health reform.
- Trainers: should know very well the local context; come from different countries; present a diversity of experiences and positions (not only “white elders”); be competent in languages and/or translated by local interpreters to local languages (e.g. Urdu and Hindi); have an activist background. “...*the students must see that there is indeed a ‘PEOPLES’ MOVEMENT.’ That there is actual struggle happening on the ground. And that the people involved in those struggles are here in PHM-IPHU*” (Ecuador, 2005)

In order to improve things **during the IPHU**, respondents suggested to consider logistics more carefully (particularly accommodation). Some also suggested to increase the duration of the course (2 from El Salvador, 2 from Africa). Participants from Africa also raised the issue of funding, saying that more resources are needed in order to support people’s participation and improve the overall organisation; a specific suggestion was made to consider local fundraising to engage young people. One person suggested to provide a daily allowance for participants in order to “*encourage active participation*” (Nepal, 2016).

In terms of themes, several comments from Asia suggested to strengthen aspects related to the current situation in health systems; gender and health budgeting analysis; sexual and reproductive health and rights; culture and health, methods of motivations, social mobilisation

and behaviour change process; role of social media activism; policy implementation issues; fighting corruption; environment.

Some comments specifically pointed to the need to give priority to activism and struggles, including the history of people's struggles, the stories and experiences of those who fight for social justice and health, and local activist groups.

On methods and approaches, there were suggestions to improve the facilitation for working group discussion, increase field trips/practical activities and reduce lectures (several comments in this sense from Nepal 2016), include creative and body activities to 'balance' theoretic/academic approaches (from Latin America).

Concerning the IPHU as an opportunity for international exchange and networking, in Africa a comment highlighted the importance to get together from anglophone and francophone countries; in Latin America there were suggestions to increase the number of LA countries involved. Finally, someone highlighted that it's hard to find common grounds for exchange when participants come from very different regions (e.g. Europe and Africa).

Many comments suggested ways to improve the IPHU efficacy by organising activities **after the IPHU**. Among these, support alumni to become facilitators and trainers, including through periodic meetings at the country level. Also: do follow up IPHUs with a more specific focus. Improving follow up was a really widespread comment, coming from all the regions: respondents suggested to keep in touch with alumni, create and support alumni networks (including through dedicated meetings) and keep them in touch with country-level PHM focal points, and publish papers from the IPHUs.

"It would be better to create alumni after the course so that the alumnus remains in touch and the learning and activism continues long after the course as well." (Nepal, 2016)

"Mettre sur pied un mécanisme de pérennisation des acquis. Il est question de dire ici comment est ce qu'on déploie les personnes formées à travers le monde pour qu'ils mettent en œuvre leur connaissance. Ils peuvent former d'autres personnes, ils peuvent appuyer dans l'organisation d'une campagne etc." (Senegal, 2011)¹²

"Publicar los trabajos mas destacados de los diferentes países en cada curso y tomar esta experiencias para la formación de los estudiantes" (Guatemala, 2010)¹³

Even in the absence of structured follow up, someone noted that the learning-through-relations and exchanges that happened during the IPHU can last long; however, its potential should be more developed:

"I think that much more focus could go into movement building after the IPHU of the people who meet as part of this, to stay working and talking long after the few days of the course. I miss the people that I met and wish I were still in touch with them. There are still things we talked about in our groups that come back to me sometimes in my healthcare practice 10 years later. The lectures... forget about it. The people I met... I feel there is so much more that could happen if there were ways for us to still connect." (USA, 2007)

In order to sustain engagement after the IPHU, respondents suggested to follow up and monitor the projects that participants committed to put in place, in order to achieve the objectives. Several comments along these lines came from the IPHU in El Salvador, including one suggesting to put alumni and new participants in touch through meetings, in order to ensure continuity and consistency.

¹² "Establish a system to make the learning long lasting. How can we deploy trained people throughout the worlds so that they can apply their knowledge. They can train others, support a campaign, etc." (Senegal, 2011)

¹³ "Publish the more relevant works from different countries in each course, and use this experience to train students" (Guatemala, 2010)

Finally, respondents said that PHM should organise more programs, and strengthen the existing ones.

“Need to do more programmes to strengthen the PHM around the world, do more and more training's and information sharing will create a positive minds” (Sri Lanka, 2010)

6. Impact and follow up

The dimension of impact was analysed from multiple aspects, including learning, engagement with PHM and broader (health) activism.

Learning

Learning was evaluated through a self-perceived score that respondents had to attribute to their pre and post IPHU knowledge on the following topics, considered to be ‘standard’ for all IPHUs:

- Primary Health Care
- Social Determinants of Health
- Free Trade Agreements and health
- Global governance of health
- Structure, functioning and global programmes of PHM
- Roles that activists can play in the struggle for health
- Experiences of the struggle for health around the world

The table below illustrates the average learning, calculated as a mean difference between the knowledge after and before the IPHU, ordered from the lower to the highest level.

	Before the IPHU	After the IPHU	Average learning
Primary health care	3,14	4,41	1,26
Social determinants of health	2,94	4,5	1,56
Free trade agreements and health	2.29	3,9	1,61
Global governance of health	2,24	3,93	1,69
Roles that activists can play in the struggle for health	2,61	4,31	1,7
Experiences of the struggle for health around the world	2,34	4,24	1,9
Structure, functioning and global programmes of PHM	1,79	3,94	2,15
Total answers	271		
Skipped	54		

Table 18. Knowledge on standard topics before and after the IPHU

As shown in the table, the average knowledge after the IPHU in all fields reached at least 3.9/5. The least known subject (Structure, functioning and global programmes of PHM), is also the one that showed the greatest progress. On the opposite, participants knew already quite a lot about Primary Health Care, that consequently reported the least progress in terms of acquired learning. The subject where participants felt most strengthened after the course was the Social Determinants of Health.

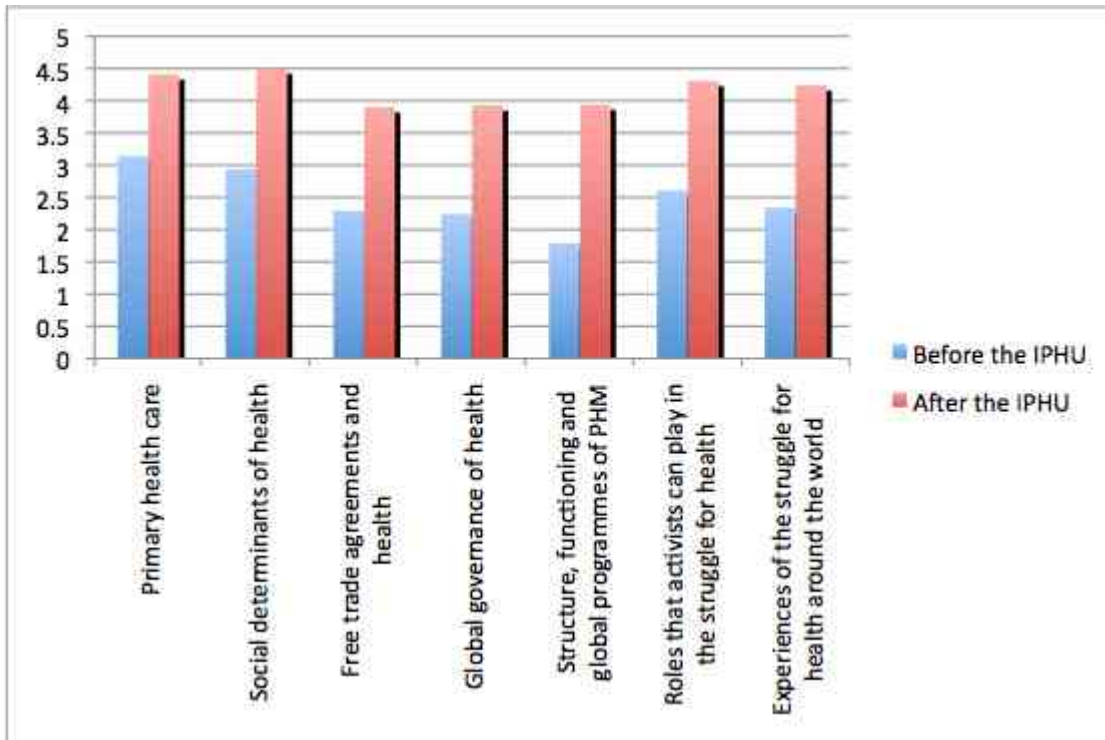


Figure 17. Knowledge on standard topics before and after the IPHU

Overall, 39 respondents declared a below-average learning (0-1) in at least one of the topics. These respondents were quite scattered throughout the IPHUs, but a concentration of 6 of them is reported for the IPHU organised in Bangalore (India) in 2009, evaluated by 10 people.

What's the IPHU more useful for

When asked about the impact of the IPHU on several life, work and activism-related aspects, over 85% of respondents declared that it improved their understanding of health problems at the local and the global level. The second most reported area of impact was that of relations and networks (almost 70% of respondents), followed by political activity (55%) and work/career (50%). 62 people skipped this question.

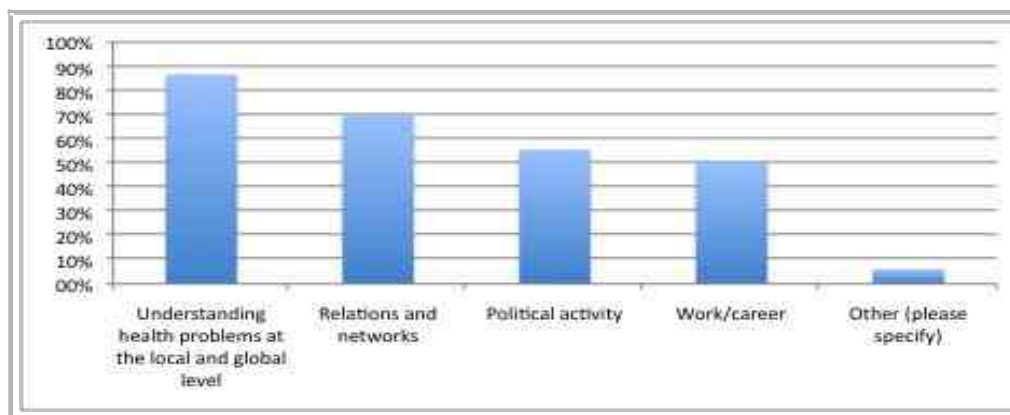


Figure 18. Impact of the IPHU on different life, work and activism-related areas

In the breakdown per region (see graph below), a few differences are significant. For example the impact on work/career was rated above average in Latin America, and this is likely due to the fact that the IPHUs in El Salvador are organised jointly with the Ministry of Health, involving several health officials and therefore probably impacting also on their formal functions and career. The impact on political activity was also reported above average in Latin America, suggesting that these work-related functions are not separate from political engagement. A situation that may be quite different in North America and Europe, where the gap between impact on political activity (70% and 60% respectively) and on work/career (around 30% for both) indicate a clear separation between the two aspects. A somehow ‘in between’ situation is represented by Africa and Asia, where again the impact on political activity and on work/career are close to each other, but below average, and in the case of Asia with a predominance of work/career over political activity.

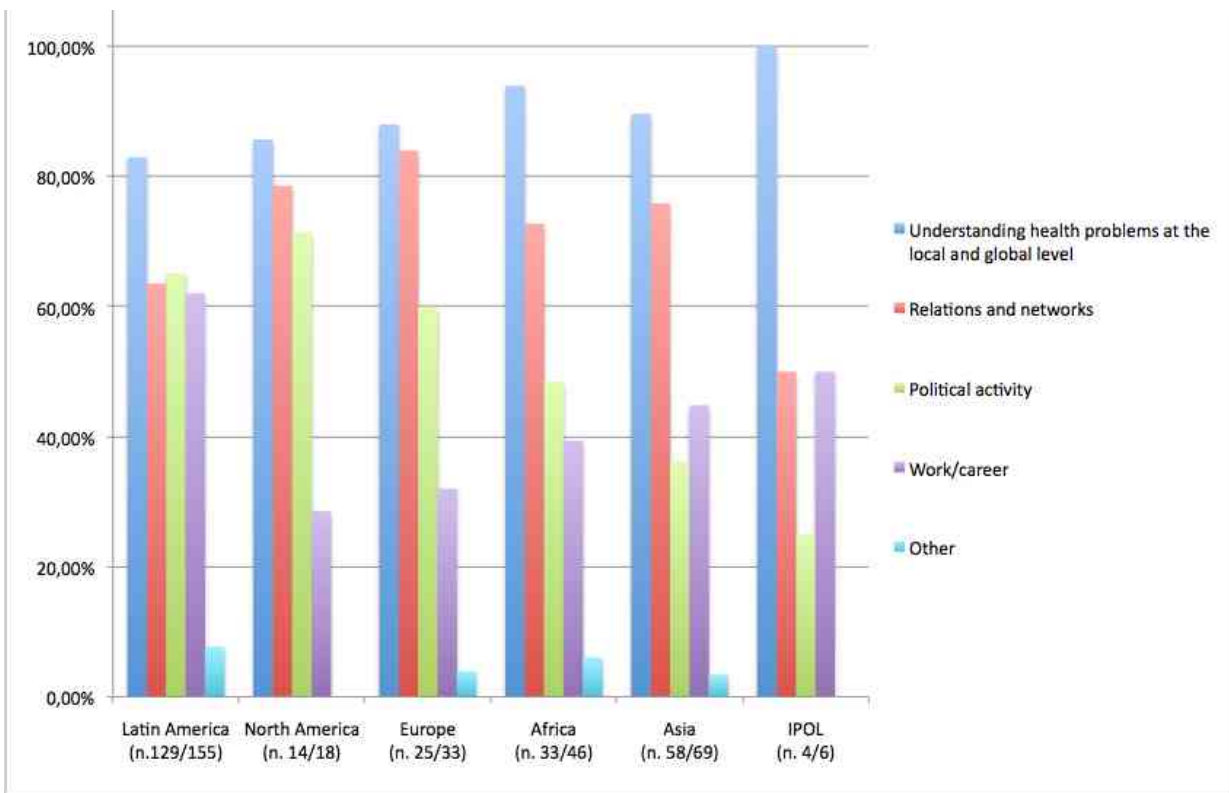


Figure 19. Impact of the IPHU on different life, work and activism-related areas, per region

The impact on relations and networks has been considered relevant in all regions, ranging from 64% in Latin America to 84% in Europe. As expected, and with all the limitations linked to numerosity, the value is lower for IPOL.

Of the 15 open comments received under the heading ‘other’, 11 were made by participants of IPHUs in Latin America and highlighted aspects such as the Latin American perspective on health and health determination (vs determinants), the health reform in El Salvador (knowledge, defense and application), strengthening PHM in countries and as a network, struggling with the

community, and the promotion of human rights. Significantly, 2 people reported an impact on their personal/family life. The remaining 4 comments were from IPHUs organised in Europe (1), Africa (2) and Asia (1), and highlighted a greater connection with the global level and the capacity to contextualise the knowledge on the political economy and the rights-based perspective. Finally, one respondent left a rather critical comment: “*I feel we were just working for the leaves of the trees that why they are not so green and healthy, actually we have to work for the roots*” (SAPHU, 2013).

Engagement on health issues

When asked if their level of engagement on health issues increased after the IPHU, 92% of respondents (n. 240) said yes. 64 people skipped the question.

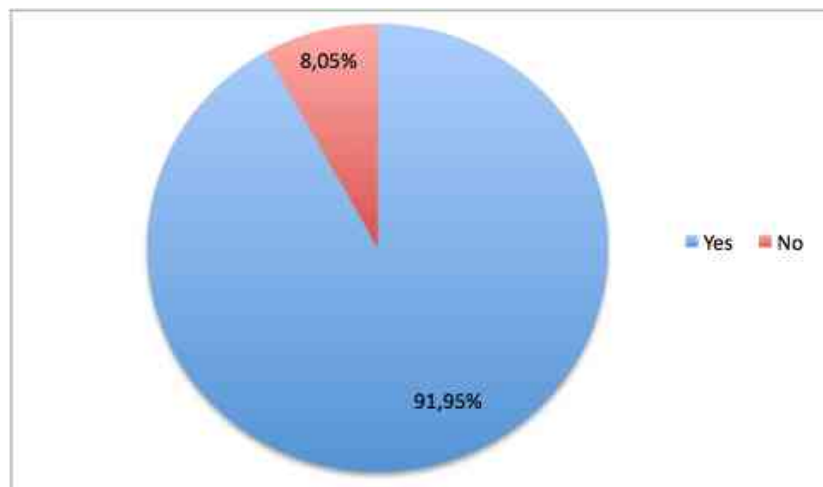


Figure 20. Increased engagement on health issues after the IPHU

In the breakdown per region of IPHU, there are differences (e.g. lower rate of affirmative responses for Europe) that are however not easy to interpret, as they could also be due to the fact that respondents were already engaged before the IPHU.

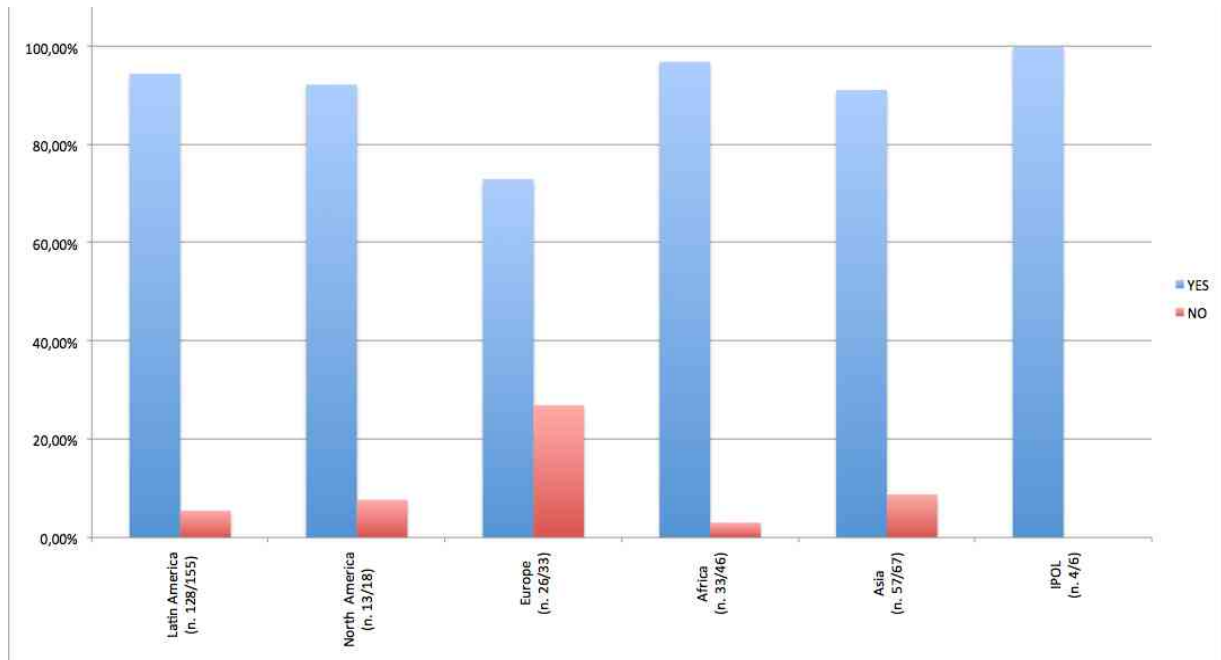


Figure 21. Increased engagement on health issues after the IPHU, per region

In overall numbers, the respondents who declared that their level of engagement did not increase were 21. 7 of these were evaluating IPHUs in **Latin America**; none of them is still active in PHM. However, 2 declare to be active in (health) education, one saying that it may be something inspired by the IPHU. Other reasons for not being active with PHM are lack of time (work-related), lack of knowledge for engagement (El Salvador), and lack of capacity of the local PHM (Ecuador).

8 of the people who said their engagement did not increase were from **Europe** (7) and **North America** (1). Of these, 2 are active in PHM at the local and regional level, while 5 have not taken part in other PHM programmes and are not active with PHM at the moment. The reasons for this include for 3 people lack of time and capacity (work- and family-related), and for 1 engagement in other (political) networks. Finally, a lack of follow up was highlighted by 2 people, with one reporting also a bad experience during the course, feeling excluded for not being from the health field (UK, 2009).

From the IPHUs in **Asia** and **Africa**, 6 people reported no increase in their engagement on health issues, of which 3 are currently active in PHM at the local level. 3 are not active for reasons linked mainly to a reported lack of follow up (India, 2008) and of knowledge on how to engage (Bangladesh, 2007).

Adjusting the original data by subtracting the number of respondents who declare to be currently active in PHM or in other political networks (13/21), the percentage of those who remained not engaged after the IPHU is slightly less than 5%.

Participation in other PHM global programmes

After the IPHU, around 50% (n. 162) of respondents took part in other PHM global programmes; 25 respondents declared that they did not take part in any other programme, and 138 skipped the question.

Among those who did take part in other programmes, almost half (49%, n. 79) were active in the Health for All campaign. This is a bit unexpected, as the campaign is the activity that was least organised at the global level. We have to assume, therefore, that respondents were active mostly in local campaigns, perceived as part of the global PHM and therefore of the Health for All campaign. IPHU was the second most common programme attended by the alumni (27%, n. 43), followed by Global Health Watch (19%, n. 31) and WHO Watch (13%, n. 21).

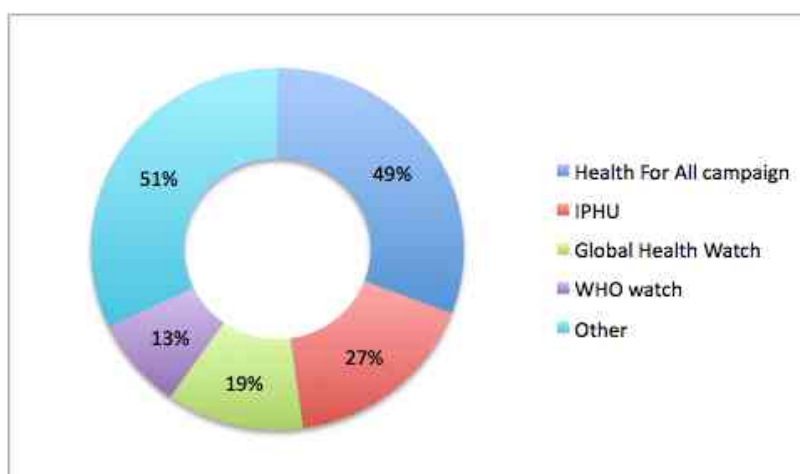


Figure 22. Participation in other PHM global programmes after the IPHU

In the open comments, 17 respondents (10%) said they are active with PHM at the local level, 5 (3%) at the regional level, 3 (2%) follow PHM through reading emails. 11 (7%) reported to have attended a People's Health Assembly.

Moreover, 22 people (14%) are active in what is sometimes referred to as the 'broader people's health movement': engaged at the community level (7; 4%), active in other organisations that work on the social determinants of health (7; 4%), engaged in health policy (8; 5%; mostly from El Salvador).

Sustained engagement with PHM

When asked whether they are still engaged with PHM, 64% (n. 161) of respondents replied yes; 72 people skipped the question.

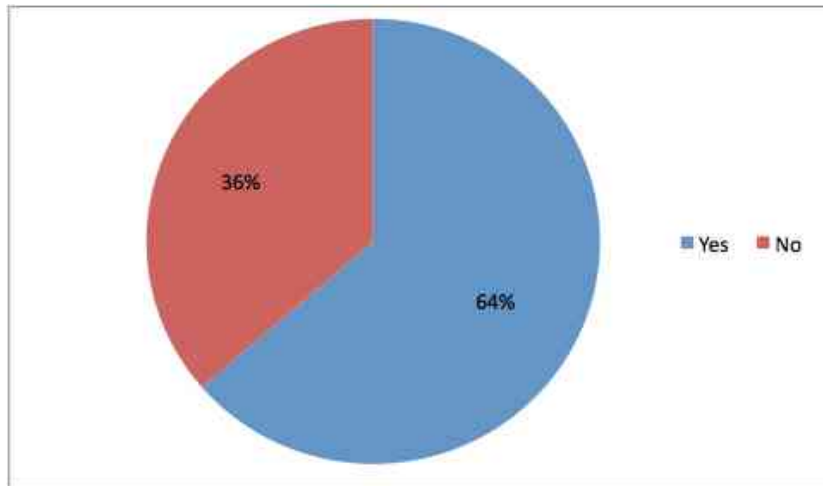


Figure 23. Respondents who are still active with PHM

In the breakdown per region, North America stands out for an opposite ratio of non engagement vs engagement of 86% to 14%. Among the other regions, the level of continued engagement is highest for Africa and Asia (73% and 72% respectively), slightly lower for Latin America (64%) and Europe (58%).

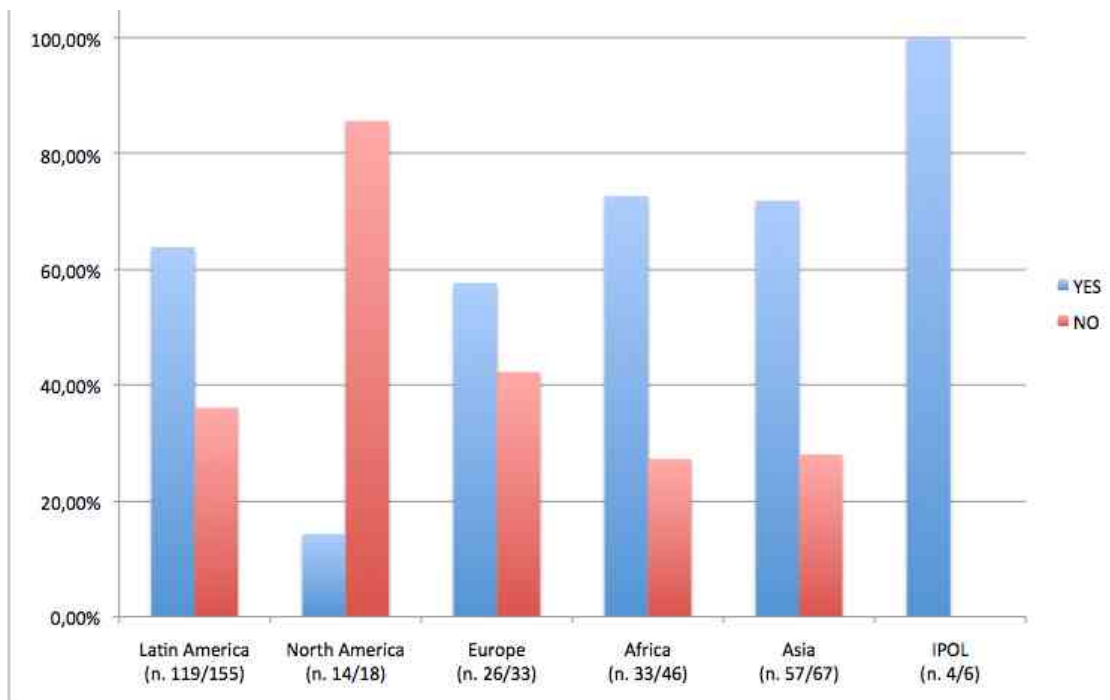


Figure 24. Respondents who are still active with PHM, per region

In terms of level of engagement within the structures of PHM, 57% of respondents declared to be active at the local level; 19% at the regional level; and 5% at the global level.

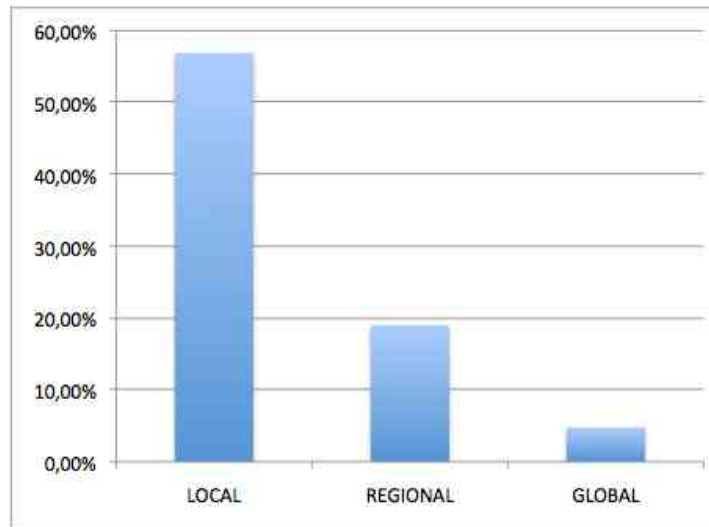


Figure 25. Level of engagement with PHM

In the breakdown per region, the ratios are similar with a greater degree of reported engagement at the regional level for Africa.

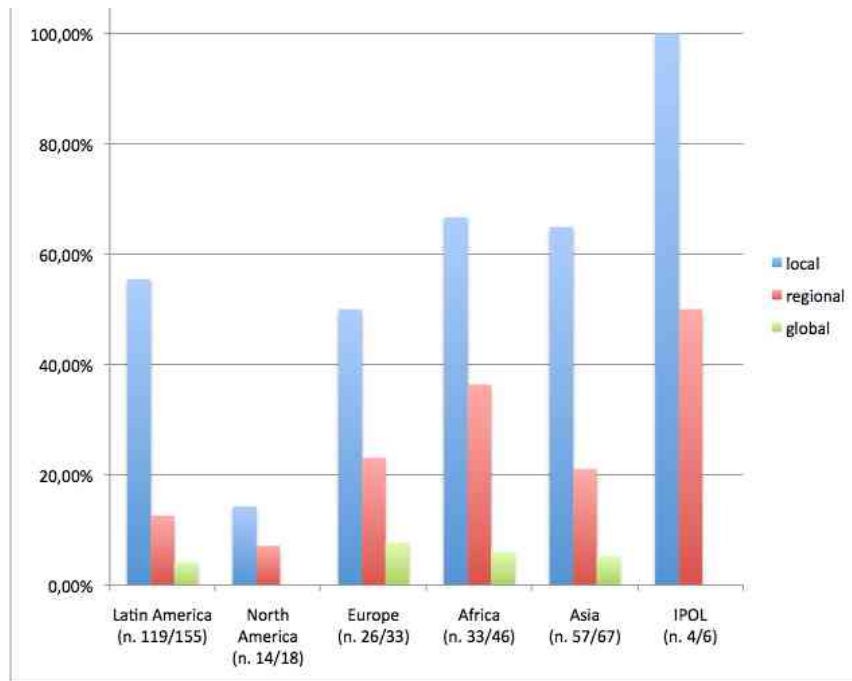


Figure 26. Level of engagement with PHM, per region

From an analysis of the overlaps between activity at the global, regional and local level, it is clear that most people active at the global and regional level are also active at the local level. The cases of ‘isolated’ engagement in supranational structures are just a few and only for the regional level.

The reasons for not/no longer being active with PHM have been explored through a final open question, to which 89 people answered (out of 92 of those who had said they are not active with PHM). The motivations can be summarised into the following categories¹⁴:

- Don't know how, no follow up or support (n. 27, 30%)
- Time, work, family/personal reasons (n. 23, 26%)
- Active in other organisation (n. 18, 20%)
- No local PHM, local PHM not active (n. 11, 12%)
- Questioning PHM approach (n. 8, 9%)
- Limited participation (n. 7, 8%)
- Other (n. 3, 3%)

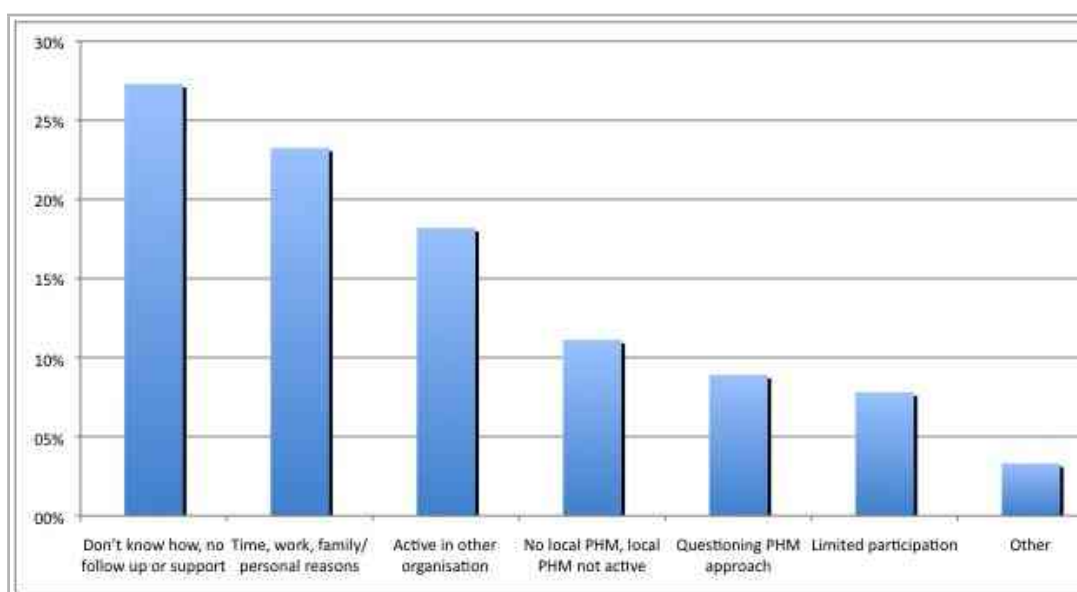


Figure 27. Reasons for not being active with PHM

Adopting a regional approach, the data show the following distribution:

	Don't know how, no follow up or support	Time, work, family/personal reasons	Active in other organisation	No local PHM, local PHM not active	Questioning PHM approach	Limited participation	Other	Tot.*
Latin America	17 (34%)	10 (20%)	10 (20%)	4 (8%)	2 (4%)	5 (10%)	2 (4%)	50 (46)
North America	4 (40%)	1 (10%)	3 (30%)	1 (10%)	1 (10%)	0	0	10
Europe	2 (14%)	5 (36%)	3 (21%)	1 (7%)	1 (7%)	1 (7%)	1 (7%)	14 (11)
Africa	1 (11%)	4 (44%)	1 (11%)	3 (33%)	0	0	0	9 (8)

¹⁴ The total number of comments (97) is higher than the number of answers (89), as one comment can fit in more than one category.

Asia	3 (21%)	3 (21%)	1 (7%)	2 (14%)	4 (29%)	1 (7%)	0	14
Tot.	27	23	18	11	8	7	3	97 (89)

*The number in parenthesis indicates the number of responses, which is lower than the total when one comment applies to more than one category.

Table 19. Reasons for not being active with PHM, per region

Lack of information, follow up or support seems particularly relevant for Latin America and North America, while time, work and personal reason impact especially in Europe and Africa. In Africa, also the lack of (active) local PHM is relevant, while in Asia there are a few critics of PHM approach.

7. Conclusion

A preliminary - obvious but necessary - observation is that the study was not based on a sample of IPHU alumni, but collected answers from those who voluntarily agreed to participate. It is important to keep this in mind as it is likely that those who did respond are ‘closer’ to PHM compared to those who did not, or have stronger reasons for sharing their opinion (that may include as well opposing PHM approach on certain matters). It is also important to note that all the considerations that follow are related to the respondents, and can not be directly generalised to the broader group of IPHU alumni.

In terms of participants' composition, the survey was completed by **male and female in a similar proportion** (with the exception of the 15 questionnaires compiled in French, all by alumni coming from African countries, of which 12 were male and only 3 female), the majority of them in the **age range 26-45, highly educated and coming from the middle-upper classes** (with some degree of difference per region, as detailed in the report). A significant proportion of respondents has a **minority background**. The aspects related to social class and minority background have just been exposed through the survey, and may deserve a greater deal of attention while rethinking the IPHU program (including the selection process).

The survey shows a **high level of appreciation for the IPHU**, that is widespread across regions, time, and characteristics of the IPHU such as duration. Alumni feel that the program is **relevant for the range of expected impacts**, including on knowledge and competences (particularly on PHM functioning and on the social determinants of health), relations and networks, political activity, but also work/career. They are generally **happy with the methodologies and with the trainers**, highlighting on the one side the need to increase practical/creative activities and field trips, and on the other to strengthen aspects related to language competence. Some comments on **logistics** seem to be related to specific IPHUs, rather than being generalised.

Alumni share **suggestions on how to improve the IPHU**, starting with better/broader announcement of the opportunities to engage, followed by improved communication before the IPHU in order to share expectations and distribute material to read in advance. Also, a strong call that comes from many a respondent highlights the **importance of follow up**, to keep in touch with the alumni and create and nurture a strong alumni network. This would increase the retention of activists and strengthen the movement at the local, regional and global level.

When trying to look at the impact, as much as **92% of respondents declared that their engagement with health issues increased after the IPHU**. Around 50% took part in other PHM programmes after the IPHU, and **64% declare to be still engaged with PHM** (mainly at the local level). Quite significantly, **30% of those who are no longer active with PHM motivate it with not knowing how, lack of follow up and support**. This shows that there is a considerable potential for growth in terms of sustained engagement of alumni and using the IPHU for the purpose of movement building.

Annexure 1 – Questionnaire

Evaluation of PHM programme "International People's Health University" (IPHU)

As former participant of the International People's Health University (IPHU), we kindly ask you to complete this online evaluation questionnaire, giving your contribution to inform a better planning for future IPHU courses and other capacity building activities organised by the People's Health Movement (PHM).

The questionnaire is anonymous and takes 10-15 minutes to complete. It is divided in 5 sections: 1. Introduction; 2. Something about you; 3. Before the IPHU; 4. During the IPHU; 5. After the IPHU.

You can skip questions that you don't want or know how to answer, but please help us by giving your full opinion on how you really experienced the IPHU!

If you attended more than one IPHU, please complete one questionnaire for each IPHU that you want to evaluate. The questionnaire will be accessible until May 5th.

Thank you!

The IPHU evaluation team

1. INTRODUCTION

1.1 Which IPHU(s) did you attend? [list; more than one choice]

1.2 Which IPHU do you want to evaluate through this questionnaire? [list; one choice]

2. SOMETHING ABOUT YOU

2.1 How old are you?

2.2 Gender [more than one choice]

M

F

Other

Would you like to add something? [open]

2.3 In what country were you living when you attended the IPHU? [list]

2.4 Was it your country of origin? [Y/N]

2.4a If NOT, what is your country of origin? [list]

2.5 What were you doing when you attended the IPHU? [more than one choice]

Student in the health field

Student in a non-health field

Health worker

Worker in a non-health field

Worker in an NGO/Civil society organisation

Academic position

Unemployed

Retired

If other, please specify [open]

2.6 What is your educational qualification? [See, if you need, the ISCED classification]

ISCED 0-2: Lower secondary (middle) or less education

ISCED 3-4: Upper secondary education

ISCED 5-8: Tertiary (University) or higher education

2.7 How would you rate your social class? [1-10]

Thinking at the community where you live in, how would you rate your social class on a scale from 1 to 10, where the persons who present the lower living standards (income, education, occupation etc.) are at the bottom of the scale, and those who present the higher living standards are at the top.

2.8 Do you feel part of a minority group? [Y/N]

2.8a If yes, would you like to specify? [open]

3. BEFORE THE IPHU

3.1 How did you find out about the IPHU? [more than one choice]

I found the information by myself

I received information at my university

I was informed by a friend

I learned about in from my activist network

Other (please specify) [open]

3.2 Where did you find the information about the IPHU? [more than one choice]

PHM website

Facebook

Twitter

PHM Exchange mailing list

Other PHM mailing list/group

Personal email exchange

Other (please specify) [open]

3.3 How could IPHUs be more effectively announced? [open]

3.4 Did you know about PHM before the IPHU? [Y/N]

3.4a If YES, in which way? [more than one choice possible]

I was active in PHM (country circle/group; regional level; global level)

I was involved in an organisation affiliated to PHM

I knew about PHM but I wasn't involved

3.5 Did you receive economic support to attend the IPHU (travel, accommodation, meals, fees...)? [Y/N]

3.5a If YES, would you have attended without the support? [Y/N]

4. DURING THE IPHU

A) Content

4.1 State your knowledge before and after the IPHU on the following topics: [on a scale from 1 to 5, where 1 is no knowledge at all and 5 the best knowledge possible]

Primary health care

Social determinants of health

Free trade agreements and health

Global governance of health

Structure, functioning and global programmes of PHM
Roles that activists can play in the struggle for health
Experiences of the struggle for health around the world

B) Methodology

4.2 What methodologies were used during the IPHU? [more than one choice]

Lectures
Small working groups
Field trips
Interactive/creative training (living sculpture, role play, theatre...)
Informal opportunities for learning and sharing
Other (please specify)

4.3 The IPHUs are meant to improve Health For All by strengthening PHM. In your experience, which methodologies were more effective to achieve this goal? [max three choices]

Lectures
Small working groups
Field trips
Interactive/creative training (living sculpture, role play, theatre...)
Informal opportunities for learning and sharing
Other (please specify)

4.4 How was the course duration?

Ok
Too short
Too long
If too long/too short, why? [open]

C) Trainers

4.5 Are you satisfied by the trainers in your IPHU?

Not satisfied at all
Not enough satisfied
Satisfied
Very satisfied
Completely satisfied

4.6 What is your opinion on the pool of trainers? [strongly disagree, disagree, neither disagree or agree, agree, strongly agree]

The trainers were competent on the content they exposed
The trainers should be strengthened in communication skills
In terms of relationship- and group-building, the trainers were adequately skilled
Neither disagree nor agree
The language competence of the trainers should be improved
The trainers were directly engaged in movement struggles
There was diversity among trainers

D) Summing up

4.7 Please, express your opinion about the following sentences:

Overall I really enjoyed the course
I would recommend this course to other health activists

4.8 Before, during or after the IPHU, did you face any problems or something that made you uncomfortable?

4.9 Do you feel that there are other aspects that we should consider to improve the IPHU? [open]

5. AFTER THE IPHU

5.1 For which aspects did you find the IPHU useful, if so? [more than one choice possible]

Political activity

Work/career

Relations and networks

Understanding health problems at the local and global level

5.2 After the IPHU, did your level of engagement on health issues increase? [Y/N]

5.3 From the IPHU to today, did you take part in any of PHM programme? [more than one choice]

IPHU

WHO watch

Global Health Watch

Health for all campaign

5.4 Are you still active with PHM? [Y/N]

5.4a If YES, at what level? [more than one choice]

Local

Regional

Global

5.4b If NOT, why? [open]

Thank you for finishing the questionnaire! We really appreciate your support!

A report will be shared through the PHM communication channels in about three months.

For more information write to iphu.bxl@gmail.com.

Annexure 2 - Reasons for not being engaged with PHM

1. DON'T KNOW HOW, NO FOLLOW UP OR (ECONOMIC) SUPPORT

Latin America

1. Acá participo en programas propios de nuestro sistema de salud, pero no he sido llamado o invitado a participar en alguno del PHM/MSP
2. Nunca más contactaron conmigo, no tuve más noticias de la organización, pero sí continué en contacto con otros participantes
3. Aparte del UISP que yo sepa no hay otro programa en el país
4. No se ha dado la oportunidad de incorporarme nuevamente en este tipo de programas.
5. No hay apoyo
6. Falta de conocimiento para inclusión
7. no me enterado de ninguna actividad.
8. No se me ha invitado o indicado como participar
9. No sabia que hay seguimiento y como puedo participar en esto.
10. falta de convocatoria por parte del msp y falta de financiamiento para concurrir a encuentros y actividades del msp
11. Probablemente no he dedicado tiempo para incorporarme al trabajo y no he buscado conocer que tipo de trabajo existe para poder participar
12. No habia tenido la oportunidad aunque mimtrabajo en mi país en la comunidad.
13. Falta de información, solo visito la pagina oficial.
14. No se como poder participar de los programas
15. No existe la posibilidad de mantenerme al tanto de las actividades que se desarrollan y poder acceder aportando economicamente al traslado a los lugares
16. Have moved countries often, which has made it hard to maintain linkages with PHM and have often lived in countries where PHM is not active. Also, at times - particularly as an early career professional - there were limited opportunities to genuinely engage in PHM activities,
17. No hay contacto hacia Perú del MSP global ni del MSP Latinoamérica. En Perú somos muy pocos que hemos pasado por la IPHU (quizá 7). En ocasiones me identifico como MSP. Quedamos a cargo como impulsores mi persona y un compañero en Cuenca 2013. Sé he colocado al PHM como como organizador de ciertas actividades en el Perú, junto a FOROSALUD.

North America

18. Wasn't sure how to connect into larger movement afterwards, I didn't feel "qualified"
19. I'm not really sure how to be! I get the e-mails but that is it.
20. I have lost touch with PHM and have no clue what it's doing now. This is the first contact I've had in who knows how long! Reach out more!
21. Don't know how to get involved

Europe

22. Not sure how

23. I am more engaged with main party politics (Green party). I think that there could have been more targeted focus / follow up on engagement after the course. I realise that this was the first London course and organisers were feeling their way.

Africa

24. Have been involved in other organizations. At some point I send an email showing interest on participating in the global Health watch but got no reply

Asia

25. No opportunity came up.....no one contacted as a follow up I didn't know who to get back to & why / when
26. Not clear about how to do it in the current circumstances
27. I felt very disappointed - I offered to support Hani, David Legge and others in lit reviews and asked how to be active, registered on site but no contact or follow up - i am still keen to be helpful or support - met up with others in Vancouver etc but not sure how to engage after offering to country circle also but not followed up.

2. TIME, WORK, FAMILY/PERSONAL REASONS

Latin America

1. My work has become to all consuming and I don't personally have enough time although other people do that I work with and it takes organizational dedication
2. Recarga laboral.
3. Tengo muchas obligaciones de trabajo que se me ha hecho difícil
4. actualmente vivo en España
5. Limitaciones familiares y personales.
6. Falta de tiempo.
7. No me autorizo mi jefa
8. No he tenido la posibilidad.
9. Por el cambio de directiva
10. No he tenido la oportunidad

North America

11. Too many commitments / competing priorities

Europe

12. Unfortunately I did not have the capacity in my daily work on the phd to also engage in PHM. This is not the fault of the PHM which received me with open arms and taught me a lot.
13. Mostly due to other work commitments. Moreover, I moved to another country and I did not find a very active country circle there. "
14. I said yes, but really I used to be much more involved in the past, when I didn't have a baby and a work
15. Per questioni legate ai tempi di lavoro e famiglia
16. No particular reason

Africa

17. unfortunately, there is a matter/difficulty of combining time x work x family x money
18. Moved to another country for postgraduate studies
19. Relocated to a new country, exploring options available including career change
20. I still participate in some of the PHM meetings but not directly to PHM activities for personal reasons.

Asia

21. work related commitment.
22. Too busy with work, family and life balance.
23. I have been very mobile and away from my country. It became difficult to continue being engaged with the country chapter.

3. ACTIVE IN OTHER ORGANISATIONS

Latin America

1. I have moved to my true vocation of spiritual formation and rehabilitating my faith community. I no longer work in public health.
2. I'm a medact member, but i'm currently active with Sustainable Healthcare Education network and Centre for Health in the Public Interest (about privatisation of UK NHS, which may be something that i was inspired to work on based on IPHU!..)
3. Aquí participo en programas propios de nuestro sistema de salud, pero no he sido llamado o invitado a participar en alguno del PHM/MSP
4. ÚNICAMENTE EN LOS COLECTIVOS DE SALUD Y A NIVEL DE TRABAJO, Y FAMILIAR
5. Por questões pessoais e também pelas formas de interação utilizadas
6. A través de las acciones del Foro Nacional de Salud
7. No trabajo con el Ministerio; sino que con el FNS
8. FNS y Comité Regional de Promoción de la Salud Comunitaria
9. Lo hago promoviendo el derecho a la salud pero ya no me fue posible articular con PHM
10. El compromiso lo vertí a través de la cátedra a los estudiantes, y en el Ecuador a pesar de existir la organización acerca de la salud de los pueblos, esta tiene dificultad de convocatoria e integración de las personas comprometidas.

North America

11. Do other health activist work and teaching now but would like to be active with PHM if there will be a chance.
12. I am not sure why not but I suppose my local community has different goals.
13. Not in a health-related field

Europe

14. no time available. However I do participate in the social solidarity clinic of thessaloniki and take part in the local struggle for health for all
15. I did not spend enough time trying to do so and thinking of how to participate. I guess I didn't yet find the way to use these skills and new relations in my political life. There are however people in my city who have started a PHM group and who I know and appreciate, maybe I will find a way to participate again

16. I am more engaged with main party politics (Green party). I think that there could have been more targeted focus / follow up on engagement after the course. I realise that this was the first London course and organisers were feeling their way.

Africa

17. Have been involved in other organizations. At some point I send an email showing interest on participating in the global Health watch but got no reply

Asia

18. I work on health issues but despite of shared perspective not able to devote time in PHM level activity at local level.

4. NO LOCAL PHM, LOCAL PHM NOT ACTIVE

Latin America

1. por distancia, en mi pais no existe promocion de PHM/MSP
2. No hay contacto hacia Perú del MSP global ni del MSP Latinoamérica. En Perú somos muy pocos que hemos pasado por la IPHU (quizá 7). En ocasiones me identifico como MSP. Quedamos a cargo como impulsores mi persona y un compañero en Cuenca 2013. Sé he colocado al PHM como organizador de ciertas actividades en el Perú, junto a FOROSALUD.
3. Have moved countries often, which has made it hard to maintain linkages with PHM and have often lived in countries where PHM is not active. Also, at times - particularly as an early career professional - there were limited opportunities to genuinely engage in PHM activities,
4. Aparte del UISP que yo sepa no hay otro programa en el país

North America

5. Lack of presence in my home community

Europe

6. Mostly due to other work commitments. Moreover, I moved to another country and I did not find a very active country circle there.

Africa

7. No local circle in my area
8. PHM Uganda is not very active, needs an organization that can bring together all PHM members to work together for the common cause
9. le cercle PHM pays n'est pas actif donc moins motivant

Asia

10. Our country circle was not active
11. There have not been such active movements here in Nepal. However, we have been planning to come up activities.

5. QUESTIONING PHM APPROACH/FOCUS

Latin America

1. Por questões pessoais e também pelas formas de interação utilizadas
2. EN EL SALVADOR SE UTILIZA EL MSP COMO UNA ESPECIE DE ESCALERA PARA LA OBTENCION DE PUESTOS DENTRO DEL MINISTERIO DE SALUD.

North America

3. It is not organized, I am active on line did start www.mebhc.org

Europe

4. I felt quite let down by the experience. It felt like I needed to be a health practitioner already for this to benefit me or already working in the area not as someone interested in being more involved.

Asia

5. The meetings were quite abstract, moved to another place
6. Time factor and in case of Nepal Government is also trying to establish health as fundamental human right so why does IPHU not try working with government instead of individual person
7. It is concentrated to specific group of individuals.
8. As PHM activities are largely focused around policy and activism, I don't find space to engage. Currently I am an entrepreneur in the field of education and I use the concepts learnt in content development and organization building.

6. LIMITED PARTICIPATION

Latin America

1. Only local level- regional level is complicated due to the progressive non progressive government support and scarce intergenerational exchange in leadership
2. Mi participación en los Cursos fue como parte del Equipo Logístico en uno y como Facilitador en otro, dada mi relación laboral con IPHC. Luego de finalizado el Proyecto IPHC quedé apoyando algunas tareas relacionadas a la Administración del sitio web PHM Español. Este rol con el tiempo ha disminuido hasta no tener ningún rol
3. Desde la organización a la que pertenezco estamos retomando el trabajo con MSP.
4. Me encuentro en la disposición de formar parte del movimiento por a salud de los pueblos y en específico en mi país El salvador, donde quisiera contribuir de manera más activa. Por el momento soy estudiante y me gustaría colaborar con lo que este en mis capacidades.
5. Estamos iniciando las pláticas para ser parte de.

Europe

6. I said yes, but really I used to be much more involved in the past, when I didn't have a baby and a work

Asia

7. I am connected with the PHM network but not directly in PHM activities.

7. OTHER

Latin America

1. enfocando los problemas locales con determinantes de la salud
2. Si porque me interesa y creo que defender el derecho a la salud es importante para subsanar necesidades de toda la población.

Europe

3. Limited internet access makes it hard to be up to date