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From Savar to Cuenca via Bangalore - Experience of Sochara's PHM Global Secretariat Team: Reflections on PHM Realities & Future Challenges - 2003-2006

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12.1 Preamble

This background note is based on the experience of the PHM Secretariat team (hosted by the Community Health Cell (CHC), Bangalore, on behalf of the *Jan Swasthya Abhiyan* –PHM India) from January 2003 till December 2005. For three years, we were the coordination, organizational and communication hub of the PHM wheel with spokes spreading out in different directions linking us to the founding networks and institutions; the regional and country level focal points; the conveners of various PHM circles, initiatives and campaigns. We were also in touch with all the individuals, organizations, networks and campaign groups who wished to join or be associated with the PHM or wished to seek PHM's inputs, perspectives or partnership with their specific event, initiative, campaign or document.

This linkage was established primarily by receipt and processing of over 100 emails per day, supplemented by telephone calls, personal visits to the Secretariat, and by discussions with PHM secretariat team members during PHM and other events at country, regional and international levels.

To operationalise the challenges of these evolving linkages with their own agenda's, needs, requests and initiatives, the Secretariat team facilitated processes using governance and decision making structures evolved by the PHM before January 2003. These included the global steering group; geographical and issue based circles; PHM news brief, exchange and website; and an evolving PHM funding group.

In the process of this direct involvement, the secretariat team developed a first hand understanding of the reality of these structures, links, initiatives, campaigns. We also experienced the strengths, weaknesses, opportunities, threats, cross cultural and regional diversities and dynamics of the evolution of PHM globally. This note tries to identify and highlight some of the challenges and

options and was a background contribution to the PHM transition process and strategy meeting held in Frankfurt hosted by Medico International from 6-9th of February 2006.

To stimulate discussion, this note does make some unavoidable generalizations and some provocative judgements – but all these are to be taken as a contribution to our current efforts at strengthening and sustaining the growth and evolution of PHM. We have enjoyed greatly this unique opportunity and responsibility and have appreciated the trust, solidarity and support received from so many from all over the world. However, we also realize how privileged we have been to shoulder this responsibility so early in the evolution of the post PHA-1 movement building process. Recognising the importance of documenting this experience of the early organizational history of this global movement, we have evolved this short paper as a constructive contribution to the further development of PHM.

12.2 PHM AS A MOVEMENT!

a) A movement is not an international NGO or an international health institution or foundation. It is not just a network or coalition; a campaign or issue raising group; an event or project organizer. Neither is it a travel agency for resource persons to move from conferences, seminars or workshops from one region to another; a coordinator of meetings and or field initiatives at local, national, regional or international levels; a community based or community oriented project or organization or just a fraternal group of friendly people and organizations coming together for a good cause. **What is it then?**

b) Our three year experience with PHM helped us to learn, that a movement was more than all these put together, even if some of our time during these years, was spent on activities that fitted into one or more of the above categories.

c) The movement, as we understood it, was a growing and diverse collective process of evolving circles at community, country, regional and international levels of individuals, groups, organizations, networks and campaigns, linked by a commitment to the Health for All strategy, and to addressing the deeper determinants of health with communities and marginalized peoples through health action. The circles were linked by geographical closeness (country and region) or by a common concern leading to action regarding specific issues from the large 'Health for All' agenda.

d) The movement was circles not pyramids of decision making and common action, that were inclusive and not exclusive or ideologically straitjacketed; that built on trust, mutual respect, with an ethos of debate and dialogue; identifying common, shared concerns while accepting diversity and plurality of interpretation and strategy. These intersecting PHM linked country, regional and issue or campaign based circles were further woven together by a series of evolving charters and declarations that symbolized this growing consensus of shared concern and evolving collectivity, particularly focused on impoverished people and communities.

e) If PHM has to grow strong in any region, and develop in a healthy and sustained way, then country focal contact points and their groups or committees need to:

i. be inclusive in their networking;
ii. work with trust, mutual respect and a sense of responsibility for the movement;
iii. appreciate cross cultural diversity;
iv. be non-hierarchical and participatory in decision making ;
v. be patient and constructive in their circle building efforts ;
vi. develop their concerns and activities with people and communities.

Capacity building for the above is a necessary and important challenge for strengthening the movement further.

f) Some problems possibly due to a lack of these approaches were seen in Switzerland (PHM Geneva group), PHM Mauritius, some situations in PHM Latin America and PHM Middle East. The lack of capacity to network was seen in some countries of Africa and Asia, where circle building has sometimes failed to take off. Part of the problem included leadership styles; social skills; sometimes local political or ideological differences; but often members of founding networks were not necessarily inclusive, and had difficulty in donning the more inclusive PHM cap. Being inclusive, without being ideologically vague, is one of the biggest challenges for the PHM.

g) The movement was a new experience with no direct parallel for comparison and hence is a very exciting development.

Internal Audit

If the PHM has to grow in different countries and regions, then selection of contact points and focal points who have these and other skills and capacities are crucial. Alternatively strategies that help chosen contact/focal points at country and regional level to develop these capacities and attitudes may also be necessary. An internal review of existing contact points would be useful

In some countries and regions ad-hoc, hasty selection of contact points without taking some of these capacities into consideration has led to a lot of time wasted, adversely affecting human relationship and bridge building. While the human relations challenge is inevitable in collective efforts, problems are not always unavoidable. A small internal audit cum support group within the evolving PHM global or regional governance system will ensure that these issues can be addressed, without distracting or sidetracking the work of ongoing coordination, planning and movement building.

Auditors could be senior PHM activists or members who have shown these capacities in the past

12.3 PHM VISION AND STRATEGY – WHAT AND HOW?

h) The PHM Vision: The Movement must have a Vision! The People's Charter for Health (PCH) 2000, and its two updates the Mumbai Declaration of January 2004 and the Cuenca Declaration of July 2005 articulate this vision quite comprehensively. The People's Charter for HIV / AIDS released in Bangkok in July 2004; statements on Macro-Economics and Health, Public Private Partnerships, Trade and Health, Primary Health Care, Health Systems Research, Disasters (Tsunami) and the Politics and Power of Aid, the Researchers for Health Statement (PHA 2),; and a series of press statements by the PHM media group articulate evolving perspectives, responding to new international developments and challenges in health.

A ' Vision' Booklet

A small booklet or a section of the PHM website or both Should be planned to increase ready access to PHM vision and perspective statements

A Strategy Review

A small PHM Strategy circle or perhaps the Research Circle should undertake an exercise to review the Charter, declarations, statements and press releases to evolve this booklet and to indentify and respond to dialectics and perhaps inconsistencies if any. Vision clarity and its communication to various constituencies is important, and consensus can be is built up through democratic debate

Strategic Options – what does the Charter offer?

i) The real challenge to PHM is not vision but strategy and action. The challenge is to convert vision into meaningful strategic options at different levels to symbolize the content, direction, role, function and responsiveness of the movement.

An overview of the Charter highlights key strategic directions. In order of their appearance in the body of the Charter these include.

Health for All means:

1. "Challenge powerful interests and political and economic priorities of globalisation.
2. Encourage people to develop their own solutions.
3. Hold accountable local authorities, national governments, international organizations and corporations.
4. Demand that governments and international organizations reformulate, implement and enforce policies and practices which respect the right to health.
5. Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.

6. Demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
7. Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalized groups.
8. Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
9. Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
10. Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.
11. Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.
12. Oppose international and national politics that privatize health care and turn it into a commodity.
13. Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organizing public health services so as to ensure free and universal access.
14. Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organizations in the World Health Assembly, and ensures independence from corporate interests.
15. Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.
16. Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people and public health-oriented, respecting universal ethical principles.
17. Build and strengthen people's organizations to create a basis for analysis and action.
18. Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
19. Demand that people's organizations be represented in local, national and international fora that are relevant to health.

20. Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world".

This list is a selection from a much larger one in the Charters and represents those on which PHM has taken action or needs to do something urgently

12.4 PHM Current Strategies (2003-2006)

By trial and error, through the steering group and in response to situations, PHM has evolved the following major strategic priorities over the last three years. Examples mentioned are those with which the secretariat has been more closely involved. There are other examples at regional and country level which are in the same genre.

1. Building country circles around community and national needs, challenges and opportunities

i. These are ongoing in some countries by proactive country contact / focal points e.g., Bangladesh, India, Italy, Sri Lanka, Philippines, South Africa, Egypt, Palestine, Australia and many countries of Central and South America such as Ecuador, Guatemala, Argentina, etc. This should be enhanced by further recognition, involvement and capacity building of well selected country contact points.

ii. Some country circles have been supported by visits of the global secretariat coordinator, steering group members and resource persons from the PHM who facilitated dialogue and workshops with potential PHM country circle partners, NGOs, academics, researchers and sometimes policy makers. In some countries, there have been more than one such visit – a PHM relay. These PHM relays have been effective in giving a boost or stimulus to country PHM circle mobilization. In USA, Iran and Pakistan, these have been primarily responsible for the establishment of the circle. This approach could continue as capacity building activities in the future. During the past four years visits were made to:

2002 - Kenya, Uganda, Tanzania, UK, Switzerland.

2003 - USA, Sri Lanka, Norway, Sweden, Netherlands, Germany, Iran, Italy.

2004 - Pakistan, Thailand, Mexico, Mauritius, Australia, Lebanon, Germany.

> The outgoing coordinator, some steering group members and resource persons who have shown an aptitude and skill to undertake this inspiration/mobilization task at country and regional capacity building circle, and supported to do the same in coordination with country and regional contact point in the future

2005 - Chile, Ecuador.

iii. PHM India, PHM Bangladesh have very strong, ongoing movement building experiences that need to be more widely shared. The collective effort of over 20 national networks learning to work together as PHM India; people's health tribunals; strong engagement, health policy work and health watch efforts with government health programmes; and

decentralized district level PHM mobilization in Bangladesh are all inspiring examples of relevance to other countries.

2. Building Regional Circles around regional needs, challenges and opportunities

- Some efforts have been made in East Africa; Latin America and Middle East, and in Asia.
- These need to be strengthened and could be an important adjunct to the process of increasing PHM participation in World Social Forum and Regional Social Forum processes. The opportunities to PHM provided by WHO-CSDH for facilitating dialogue with civil society can also be used to strengthen regional circles.

3. Facilitating PHM representation, participation in local, national, regional and international fora and meetings

There is regular input/involvement in the:

- World Social Forum,
- Regional Social Forum,
- World Health Assembly,
- Annual Forum of Global Forum for Health Research,
- Health Promotion conferences at regional / international levels,
- Canadian Society of International Health meetings,
- Meetings of National Public Health Associations,
- National, regional, international HIV-AIDS conferences and meetings.

In many of these conferences PHM resource persons have been on specific panels providing opportunities to raise PHM concerns and perspectives.

In several of these meetings PHM related participants have taken the initiative to organize special lunch time seminars or informal meetings for those interested in PHM so that they get an opportunity to meet the PHM participants, learn about the movement and join the movement if they are interested.

These proactive efforts need to be strengthened and increased so that PHM concerns and perspectives are more widely shared and the movement grows increasing its outreach and impact. Some mechanism and guidelines by which organizers / panelists participating in these events report back to PHM through short reports featured in the PHM exchange and the PHM website are crucial to ensure that the learning experiences are more widely shared. Regular reporting will also inspire more PHM related participants at such meetings to take the initiative to promote PHM concerns and perspectives.

4. Evolving an advocacy strategy to bring WHO back to Health for All perspective and goals and to focus action on health determinants.

The WHO-WHA advocacy circle in close coordination with the Research circle and the Global Health Watch group have very effectively advocated with WHO at different levels and through different strategies making them more open, responsive and keen to engage with Health for All goals and PHM concerns in particular. As of today, this strategy includes:

i. Regular and increasing proactive participation and advocacy in the annual World Health Assembly,

ii. Regular and increasingly proactive participation in the Annual Research Forum of Global Forum for Health Research

iii. Involvement with WHO Commission on Social Determinants on Health at all levels. PHM has a full Commissioner as well.

iv. Informal and formal advocacy including submission of position papers / policy briefs on areas of WHO concern and PHM interest.

v. Participation in WHO meetings including more recently the consultation on WHO General Programme of Work (2006-2015) and the earlier Madrid consultation on Primary Health Care Policy, etc.

vi. Participation by WHO team members at HQ and regional levels in PHM workshops and meetings including the Second People's Health Assembly.

vii. Increasing dialogue by PHM at regional levels with PAHO, EMRO, AFRO, WPRO and SEARO. All are beginning to show interest, with PAHO leading the way with excellent examples of dialogue and partnership.

PHM Advocacy with UNICEF / World Bank/ Global

Similar to the PHM WHO Circle efforts with WHO which are beginning to bear some results – PHM should actively evolve advocacy strategies with UNICEF and World Bank and perhaps the Global fund as well. The Save UNICEF campaign was starting point vis-à-vis UNICEF but this could now be converted to a PHM UNICEF watch. Similarly a group or circle that will monitor, watch and engage if required with World Bank. Health activities and Global Fund as well should be urgently considered.

5. Building Global Solidarity through regular participation in the World Social Forum (WSF) and Regional Social Forums

The WSF processes (both global and regional) provide a unique opportunity for PHM to dialogue with larger global social movements and apart from supporting them also adding or strengthening the health related agenda in their movements. The People's Charter for Health has calls for action that are so comprehensive that they very easily allow this form of linkage or complementary relationship

- PHM participation in the main events with two or three workshops or creative events have become a regular feature of the WSF and regional and country forum's that precede the global event.
- In 2002, 2003 and 2005 PHM also participated in the International Health Forum in Defence of Peoples Health in Porto Alegre, Brazil and in 2004 at Mumbai – it hosted the Third International Health Forum (see Mumbai Declaration, January 2004)
- In 2006, PHM is participating in all the three policy centric WSF in Caracas, Mali and Karachi.

PHM links to the Social Movement

A Circle to enhance this linkage and dialogue of PHM with the events and the culture of the WSF process. Some groups and could be involved to operationalise the PHM - WSF circle and its activities

6. Global Right to Health Campaign (since 2004)

This has evolved through consultation at various levels, an extensive campaign with People's Tribunals organized by PHM India, and meetings at WHA and other fora with the UN Special Rapporteur on Human Rights. At PHA-2, after extensive discussion the global campaign was launched. Efforts are on now to get around 20 country PHM circles involved, adapting the campaign to local opportunities.

7. Disaster and Humanitarian Responses

- The PHM War, Disaster and Humanitarian Circle has been active raising issues and promoting collective initiatives during the build up to the Iraq war, and during the tsunami (South Asia), earthquake (Iran) and some Latin America disasters.
- The Tsunami statement on the politics and power of aid (April 2005), several press statements, the post BAM earthquake initiative, the Tsunami Watch project etc., are examples of practical initiatives that have greatly helped to enhance the visibility of PHM and also symbolize a responsiveness of the movement.

8. The active participation in the Annual Research Forum organized by Global Forum for Health Research (GFHR)

The WHO-WHA Advocacy Circle and the PHM Research Circle have been very effective in raising the profile of PHM in issues of relevant research important for People's Health in the annual forum's organized by the GFHR.

These have included:

- Presentation and participation in panel discussions at Annual Forum on Research priorities and issues from a PHM point of view.

- Facilitation of a NGO Civil Society Dialogue on Health Systems Research
- Articles and view points in Lancet and BMJ and other key journals.
- Very strong participation and inputs in the Mexico Health Research Summit, November 2004 (18 participants from PHM) which also impacted on the Mexico Declaration and led to PHM now being represented on the GFHR Foundation Council.
- GFHR also supported a Researchers Forum (dialogue with researchers) as a pre PHA2 satellite event which resulted in a small booklet released in Forum

9. The International People's Health University (since 2005)

- From January 2004, PHM has been seriously considering a proposal for regional capacity building and training of younger generations of activists for PHM involvement in the future.
- In 2004, IPHC – one of the founding networks initiated a process towards evolving an International People's Health University Project which will facilitate such perspective/ capacity building processes linked to international and regional events associated with PHM.
- At PHA-2, the IPHC facilitated the first IPHU session from 10-16th July 2005, with 60 participants from around the world (2/3rd from Latin America).
- The Frankfurt meeting will also be an opportunity to review this initiative further and plan its future content and strategy.
- The challenge to the IPHU initiative is to harness and involve all potential academic, research and training centres within the global and regional PHM circles in this international training initiative.

10. Communications and Campaigns

PHM has evolved a communication strategy to keep all its members informed about all that is happening within PHM circles at country, regional and international levels.

This includes:

a) PHM Website;

b) PHM Exchange

c) Regular News-briefs every 3-6 months (we are now moving towards a double bumper issue News-brief 16-17 - which will cover PHA-2 at Cuenca and the transition process),

d) A set of increasing PHM publications at national, regional, and global levels,

e) A set of audio visuals –video cassettes and CDs (see separate list).

It has also evolved campaigns from time to time which include:

a) The Million Signature Campaign (January 2003 Asia Social Forum), Hyderabad

b) No War, No WTO, Health for All Campaign, January 2004, IHF / world Social Forum, Mumbai

c) Save UNICEF campaign – March 2005

d) Women's Access to Health Campaign – Annual campaign of Hesperian, WGNRR of which PHM is a co-sponsor.

(see section on Issue circles as well)

Other campaigns and smaller initiatives have been initiated from time to time because of the enthusiasm of some PHM members but it is necessary to review them and decide on the following as a PHM campaign policy.

12.5 GLOBAL GOVERNANCE AND DECISION MAKING IN PHM

a. The Global governance and decision making process in PHM includes three components:

I. A global steering group which consists of

i. A group of founding networks and organizations

ii. A group of regional focal points

II. A Global Secretariat with a coordinator and a secretariat support group.

I) Global Founding Networks and Organizations

Issues of Governance in the context of Founding Networks and Institutions

1. All founding networks and institutions have played a crucial role in mobilization for and organization of PHA-1, in the formation of the concept of PHM and early governance, structure and initiatives of PHM

2. Now in 6th year of the Movement and based on the experience of 2001-2005, there is need for clarity in each of these eight networks on

a) Areas of support and focus

Technical - What issues of interest

Regional – What regions; Where strong

Membership , Who could be involved

Organisational (support to secretariat function) –

Which function if any of secretariat global/ regional contacts will they support?

b) Need to move beyond individuals/ icons of these networks to more institutional/ network policy linkages

c) Need to build PHM projects/ related initiatives including funding support into their annual/ perspective plans of action and budget of each of these networks

d) Clarity of identity with PHM at all levels- national, regional and global

3. Larger issue for policy review

a) Should founding networks or organizations continue to be represented in the Steering Group separately or should they merge into regional & country level coordination and representation?

If they continue then for how long? Till PHA 3 or permanently

b) What should be the PHM governance response be to inclusion of other global networks like IBFAN, IFMSA, WSHE

ii) Regional Focal Points and Coordination

Apart from the eight member, representatives of the founding networks and organizations the global steering group in the last few years 2002-05 has also consisted of 9-13 additional members who were representing the thirteen regions into which all the original 75 countries (represented at PHA1) were divided. A SWOT of this component of the steering group membership and contribution is as follows:

i. The regions which had a representative (focal point) where South East Asia, India, Southern Africa, East and Central Africa, Middle East, Europe, Central America and Caribbean's, South America and Australia, New Zealand & the Pacific.

ii. North America had two US representatives and PHM USA was facilitated jointly by the Hesperian Foundation and Doctors for Global Health and the absence of a representative from Canada was an additional factor. Further West Africa and China had no representative even though we tried to get WGNRR, (Cameroon) to stand in as a contact point. South Asia had Qasem, even though he was also ex-officio because he was the outgoing coordinator.

iii. Efforts were made to specify the countries allotted to each region and help the focal points initiate regional networking among the contact points of the countries in the region so that they would enhance their representativeness on the Steering Group. This representativeness was enhanced in East and Central Africa, Southern Africa, Europe, India, Australia-New Zealand and the Pacific and Central America and Caribbean's. This was less successful in South Asia, South East Asia, South America and in the absence of focal points not possible in China and West Africa region. However, the efforts in the Middle East region were probably the most effective.

iv. Apart from representativeness, the real problem experienced was responsiveness. In spite of setting up a steering group – yahoo. Group for governance and decision making convenience, that was efficiently moderated by Maria – many SG members neither acknowledged the communication nor provided responses to decision making options or queries on matters of PHM planning and policy. Some complained that the secretariat sent too much mail and too often but any changes in size or number or even labelling them as alerts; needing priority attention; just communication etc., failed to enhance adequate participation. The few who did were mostly representatives of other networks and hence were sympathetic and responsive to the process of communication.

v. We included all the members of the secretariat support group on this yahoo group. They were not steering group members officially but were volunteers who had offered to support the secretariat in specific functional areas and some others who were convenors of issue circles. On the whole, these volunteers were more responsive than most of the steering group and this was very supportive of the secretariat team's morale.

Evolving strategies for organizational communications in concentric circles

There is need to have concentric circles of e-group listing to enhance various levels and degrees of decision making and or enhance internal communication in PHM. This may involve the following circles

- a core for decision making; a core +secretariat support group;
- a core +secretariat support group + country contacts;
- a core + secretariat support group + country contacts + campaign issue circle convenors

vi. Most regional focal points with the exception of Latin America / Australia and North America did not evolve any mechanism to communicate with country contact points in their region so this responsibility became an additional burden on the secretariat team and often we had to send it to everyone directly with no amplification or support from the regional focal point. Hence, potential strengthening of regional level communication strategies did not take place as widely as we had hoped.

vii. Enhancing regional coordination is an important organizational imperative not only to reduce the overall burden on the inevitably small global secretariat team but also to enhance responsiveness, regional decision making, regional capacitation and regional communication. With the exception of Middle East and Central America which were good even before PHA2 and probably North America and Australia and Pacific after PHA2 this capacity will take some time to build in the different regions. Hence, while a collective regional coordination (a horizontal structure of equal regional coordinators) who work complementary to each other such as in HAI or other networks is an excellent proposition and definitely the way ahead, the presence of very unequal regional capacity at present will require some proactive global coordination or convenorship for some time to come. In the absence of such global coordinatorship – often proactive, bridge building, linkage promoting and opportunity exploring, the movement will just disappear or collapse in some regions today.

viii. The choice is not simply global –vs- regional coordination but an active regional capacity building strategy by a global coordination council / secretariat as pro-requisite to a more horizontal governance structure in the future perhaps operationalised before PHA3.

ix. The number of regions (original 13 of November 2001 proposal) has been found to very unrealistic and unwieldy in terms of organizational efficiency and support to decision making processes.

x. Eight or Nine would probably be more feasible and practical especially if we are also going to consider finding more full time regional coordinators who have an NGO in the region backing them up with supportive services as hosts of regional secretariats.

xi. Finally, while deciding on the number of regions and distribution of countries – the transition team must recognize some regional processes that have been strengthened particularly in the mobilization phase towards PHA2. These should be recognized, respected and strengthened further. Key among these ongoing are:

a) **Africa region**: The regional meeting of Civil Society in Health organized in Lusaka, Zambia in February 2005 brought together many Africa based networks including PHM Africa. The group helped the mobilization process for PHA2 and helped evolve the special plenary on Africa at PHA2. A five member group facilitated this and at PHA2 and thereafter two members have continued to support the process including the interaction with WHO-CSDH in the region. It is important to take this process forward after reviewing the experience of 2005. This is particularly important because several efforts in 2002, 2003 and 2004 of PHM resource persons trying to facilitate regional and country level meetings as promoters / visitors from other regions failed to take off. The more local effort in 2005 seemed more feasible.

b) **Middle East in Region** – the region has been mobilizing as a regional group for many years but their efforts got a boost with preparations for PHA2 and the WHO-CSDH process thereafter the proposal for hosting the secretariat that evolved from the region after PHA2 had a very good regional process / movement building plan. While coming to terms with inclusion of Iranian PHM and perhaps people's health group in Israel as well in an inclusive way as also North Africa, the regional process needs to be strengthened with focus on PHM circles at country level. Perhaps hosting the global secretariat will enhance the regional capacity as well. There is a lot of country level potential particularly simultaneously is Egypt and Lebanon that can be tapped.

c) **North America** – PHA2 mobilization and the actual event has led to great strengthening of PHM mobilization in USA and Canada and much greater potential for a North American regional dialogue and joint planning. At Forum 9 in Mumbai –PHM Canada organized an informal meeting as well and PHM USA has also been moving from strength to strength. There is great scope for the North American region of PHM becoming a strong resource group for International Health Advocacy as also a funding support partner for PHM especially supporting regional initiatives.

d) **Europe Region** – the paradox of PHM Europe has been that it is among the strongest resource groups of PHM – the funding operations are facilitated there; the Charter translations are tracked; the Global Health Watch 1 secretariat was based there; the annual Women and Access to Health Care campaigns are facilitated / coordinated from there; the early communication efforts were supported from there; PHM members in Netherlands, Germany, Switzerland and Italy are strong supporters / participants of all PHM events and initiatives etc., etc. But country circles focused on local Health for All challenges are not yet getting established. More recently, the evolving network regarding the movement against privatization of health care with strong trade union roots and European, Social

Forum linkages is a good step to shift focus from international solidarity effort to local country level health action. The discussions among PHM Europe region contacts has also led to the identification of language and cross-cultural challenges in the European region. The North and South of Europe and perhaps East and West have their own challenges and PHM Europe region has to tackle the challenge of bringing together nearly 46 countries with all their diversity. A growing link between international solidarity group and local HFA action groups especially among the trade unions and radical professional groups may be a good way ahead to strengthen further the PHM in the region.

e) **Australia, New Zealand and Pacific** – the Australia PHM has been steadily evolving for the last few years with a boost following the interactions by the PHM resource group from other regions before the Melbourne conference in 2004. The mobilization for PHA2 further strengthened the links with indigenous people and some extension of linkages with New Zealand also took place. Other island country contacts need to be identified and the regional activity further strengthened. The PHM OZ website has been an inspiration. It could be a vehicle for stronger regional networking.

f) **Asia** – originally divided into four regions (South Asia, India, South East Asia and China) Asia has had a mixed regional development. The presence of HAI-AP, ACHAN, CIROAP and TWN and the strong PHM movements in Bangladesh and India have meant that Asian PHM circles have been meeting quite often at various network meetings and regional workshops and at the Asia Social Forum and other key meetings. Country circles have developed to varying extents in Nepal, Pakistan, Sri Lanka, Philippines and are evolving in Malaysia, Indonesia, Cambodia and Thailand. Progress in Vietnam, Myanmar, China and Japan is poor. Regional UN organisations like UNESCAP and WPRO and SEARO have been slowly beginning to recognize the PHM in Asia as a resource. UNESCAP involved PHM in orienting its new health unit team and also in evolving its health policy for Asia.

However, a regional identity of PHM as PHM Asia or even PHM South Asia and PHM South East Asia is yet to emerge. This needs to be constantly worked upon building the resources and opportunities provided by various Asian Networks already interested in and supporting PHM. The enthusiasm of evolving the People's Charter for HIV / AIDS and the evolution of APPACHA was a good initiative but like many others lost some steam along the way. WHO-CSDH-CSO Initiative in India and Bangkok and WSF Karachi (March 2006) offer good opportunities.

ACHAN which has been dormant for a while, but now recently, more involved with Tsunami Watch and also PHA2, should be revived to play a much more significant role with probably younger leadership. A concerted effort by all the five networks in Asia – HAI-AP, CIROAP, ACHAN, TWN, ASF and supported by strong PHM country resources in India and Bangladesh could lead to a region strengthening strategy. This is urgently required. The WSF in Karachi in March 2006 and the next National Health Assemblies in Thailand 2006 and India 2007 may be opportunities for such cross regional efforts.

g) **Latin America** – these includes the PHM regions of Central America and the Caribbean's and South America. The regional mobilization has been historical and strong even before PHA1 and now recently for PHA2. But the region faces some important challenges

- the language diversity – Spanish and Portuguese is a challenge
- the high degree of political awareness and complexity provides a challenge for the issue of PHM inclusiveness and the secretariat has received in the last few years the largest amount of feedback on this matter and has found it not an easy matter to address.
- the region is one of the most inspiring of the PHM regions for the wealth of movement experience including the growing indigenous people's empowerment, and the phenomenally creative culture of protest and celebration, as was evident at PHA2.
- Latin America has so much to offer other regions if some of these complexities could be transcended and the global coordinatorship which was already available for the PHA2 organisation further extended for the next phase.
- The recent political changes with a growing axis of good – Cuba, Venezuela, Bolivia, Chile, Uruguay, Argentina offers a larger regional context of change that makes PHM more meaningful and viable in the region.

In conclusion, there is great potential and possibilities in enhancing regional coordinating both as a concept and thrust of PHM in the next two years building on the ongoing processes discussed above. This should be done however with a specific focus of regional capacity building by a catalyst team which can do it in a participatory, facilitatory way enhancing local effort and local creativity. It will not happen spontaneously so some global planning even to facilitate a group of people who will do this activity in a focused committed way must be operationalized fairly soon.

c) Global / Regional Secretariats and steering group

Guidelines relevant to a PHM global secretariat were evolved in November 2002 at Gonoshasthaya Kendra, Savar – Bangladesh, (PHM steering group) before the shift of PHM secretariat to CHC, Bangalore. These have been circulated (January 2003). Also, how these guidelines were operationalised by the Bangalore has also been circulated (to help Middle East and Latin America understand the dynamics / challenges of global coordination while they were evolving proposals to host the global secretariat.

In this report, we shall not go through these points once again since those documents can be referred to suffice to. A few general points relevant to global or even regional secretariats are included here.

The concept of a global secretariat with a full time coordinator and a small team of communication officer, secretariat assistant etc., was a necessary aspect of the phase 2002-05 because the PHM was an evolving concept and movement. However as the movement has grown rather unexpectedly both in visibility and in terms of demands on global secretariat teams this is not a viable proposition now.

a) A large number of activities / responses / functions presently carried out by the global secretariat and coordinator can be better done perhaps more effectively by regional coordinators if they have the capacity and aptitude to be inclusive, representative and responsive. Funding a larger number of regional NGOs who will support regional secretariats and perhaps even provide a senior team member to do the temporary (part time job) of a regional coordinator may be easier than trying to identify a global coordinator in a region to do the job the Bangalore team did.

b) CHC Bangalore had a rather unique history of networking and movement building in India and later South Asia for over 2 decades, resulting in facilitation of some significant aspects of PHM India mobilization. They also had a senior team member like Ravi Narayan available to be full time on this global assignment. The coordinator of the global secretariat had the full support of CHC team since support to PHM secretariat and process was one of its key initiatives for the phase. So its funding partners were also supportive, as were PHM resource persons from the region. This led to an unusual combination of supportive factors not easy to find in every hosting region willing to host the secretariat.

c) So new approaches may be required. One of this enhancing is regional coordination with supportive NGOs hosting regional secretariats and providing at least part time coordinator who can work together as a global coordination council.

d) Whether global or regional secretariats some factors need to be looked into as we evolve responsive governance structures at all these levels including steering groups or coordination council

e) All global or regional steering groups or coordination groups or coordination councils or (whatever the new nomenclature) must have chairpersons so that coordinators are not expected to do both executive and convening roles, which can be conflicting.

f) As a general rule, steering groups should not consist of icons or very famous or well known resource persons. These should be on advisory groups. Efforts should be made in a concerted way to identify and foster younger leadership in all regions who can be more responsive and creative to the current situations.

g) All councils or steering group members should have limited periods on the group / council – never more than 2 years so that there can be rotation of responsibilities and 'new blood' all the time.

h) Some watch on 'representativeness' and 'responsiveness' of council or steering group members must be maintained to enhance the potential of PHM mobilization at every level.

i) While funds and other forms of resource support may be provided from the global budget of PHM to support, kick start or facilitate regional mobilization and capacity building – regionalisation should also focus on regional capacity building which should ultimately lead to regional capacity to plan, organize, raise own resources and evolve local governance and advisory structures without too much reliance or dependence on global effort / coordination.

12.6. ISSUE CIRCLES

The experience of the secretariat in supporting / facilitating issue based circles and campaigns have been very diverse.

Only three circles the WHO-WHA Advocacy Circle; the Research Circle and the War and Disaster Circle have been consistently active and responding to requests, events and evolving some collective initiatives around World Health

i. Assembly; Global Forums for Health Research and Natural and man-made disasters respectively helping greatly to enhance PHM visibility, relevance, contribution and to some extent impact as well. The membership of these circles has been varying, some events / initiatives linked to the circle activities getting more responses and participation than others. However, even these three circles need to plan their communications on the PHM Exchange and PHM website in a more coordinated way to interest new members in their activities.

ii. Efforts to facilitate a PHM – HIV/AIDS circle after the UNAIDS request for a dialogue in 2002 and the interest shown by WHO with its 3 x 5 initiative to dialogue with PHM around IHF/WSF Mumbai, January 2004 saw some activity leading to the development of the People's Charter for HIV / AIDS before the Bangkok World AIDS Conference. However, this circle has been somewhat dormant since.

iii. A Macro-economics and Health Circle worked on a statement / PHM position on Jeff Sachs report. This was circulated at the WHO regional dialogue with Civil Society in Colombo (SEARO and HQ initiative).

iv. Politics of Health – IPHC had offered to host this circle since it was central to their contribution to HFA before PHA1 and as PHM evolved. But there has been a lack of clarity about this circle and how it differs from IPHC itself.

v. Disability and Economics Circle – a meeting was organized at one of the GFHR fora and there was some interest in many.

vi. **PHA2 – An international organizing committee (IOC**): This was set up to help with PHA2 organisation and mobilization. After an initial well planned meeting between IOC and the local /national committee in September 2004, the PHA2 Organising Circle / IOC failed to work as an effective supportive circle. Hopefully, the PHA2 review that is expected soon will try to explore and establish factors and learning experiences for this inadequacy, which greatly affected the pre PHA2 developments and increased the load on a few people left to handle the responsibility.

vii. More recently, Global Health Watch, Global Right to Health Campaign and WHO-CSDH dialogue with PHM are three PHM related activities which are evolving into relevant and perhaps effective circles of PHM members working together.

The presence of an efficient secretariat team in the GHW1 context; the presence of consistent interest and initiative in GRHC context and the presence of a full time PHM Commissioner on the WHO-CSDH and strong PHM supporters in the CSDH Commission have been responsible for the evolution of effective circle like developments.

PHM Communication Circle: The idea of bringing together PHM resource persons and secretariat support group members who help with communication, Website, News Brief, PHM Exchange, PHM Charters translation and Media have failed consistently in spite of efforts in 2002

viii. through a paper on communications as if people mattered and efforts in January 2004 (IHF) to circulate a paper on communication challenges.

Recently however after Cuenca PHA2 due to the enthusiastic young Bangalore based website volunteers, a website linked communications circle has been established bringing together all the website managers and editors of an increasing number of global and regional and country level websites which have a strong PHM linkage or content.

ix. IPHU at PHA2 has resulted in three potential circles of IPHU student volunteers in the areas of Trade and Health; PHM experiments; and Social Determinants of Health. These are evolving slowly.

Policy on Issue Circles/ Campaigns

- A time has come to move beyond this sort of adhoc circle formations that wax and wane with activities to the evolution of certain guidelines or framework for issue circle convenors in terms of communication/organizations/links to exchange/ website and other structural /functional imperatives so that issue circles become a more visible and a more effective form of PHM growth and evolution.
- The website and the PHM Exchange should be the key vehicles through which issue based activities in PHM are communicated and new members are constantly invited/encouraged to join in. This will greatly increase the value and meaning of PHM membership
- Another important policy guideline is to decide when an issue circle becomes a campaign? A campaign must have some core objectives, methodology, an advisory and decision making structure, a time schedule and perhaps some funds of its own

12.7 SOME STRATEGIC THRUSTS

The Bangalore phase of PHM movement evolution has seen six strategic thrusts that go beyond governance, vision, action, funding and communications. These thrusts were seen as crucial to long term sustainability and to the celebration of diversity and plurality of this unique movement.

a) Rebuilding Bridges

The first People's health Assembly had been a great experience of organizing a multi cultural, multi-regional, people's dialogue effort with creativity, competence and a solidarity building ethos. Inevitably however the organizing group and many of the supportive members had experienced the stresses and stains of such a multi dimensional decision making effort leading

to breakdown in some post PHA1 communications, reduction in enthusiasm levels of many participants and supportive networks and NGOs, crossed communication and some degrees of exhaustion, and unmet expectations. As a relatively new member in the global planning group, CHC had the unique experience of not being easily identifiable as linked to these past conflicts and dimensions. As we discovered them along the way, accidentally or through participant feedback and communication, we took very personal and proactive steps to help heal these feelings by encouraging participants of PHA1 with such mixed or negative feelings or experiences to appreciate the larger inspiring reality of the evolving PHM and to get involved with the movement in newer and more creative ways transcending the negative experiences of the past. Without listing such individuals / groups for obvious reasons – one of the nicest experiences of the secretariat team was to see nearly all such people back to work with PHM and strongly involved in PHA2 (healed, enthusiastic and actively contributing at local, national, regional or even global level). We believe that this was a crucial contribution and a lesson for the future as well as we track the post PHA2 scenario which would have had similar experiences.

b) Mobilizing newer and more youthful leadership

Another effort on our part was to identify and support / facilitate newer and often younger leadership in PHM so that the movement was more sustainable and not over dependent on the 'networkers' and 'activists' of the pre 2000 AD era. While respecting the contribution of these elders and their radical perspectives and recognizing the need to keep them involved as advisors, 'perspective builders' and 'inspirers', efforts were made to give newer resource persons (who were less well known globally / regionally but showed great potential capacity and enthusiasm greater opportunity to get more involved with PHM initiatives and take more focused responsibility for management and action. This was not an easy task because many of the 'activists' of the past are not always ready for this shift and have not always been developing younger leadership in their own areas of focus and influence.

However, our experience was very positive and we are very glad that as we transit to the next phase of global coordination, a large number of younger leaders are visible in all aspects of PHM activities. They need to be supported and encouraged in the next phase as well.

The presence of youth in all aspects of PHA2 organization and the effective IPHU experience bringing nearly 60 mostly younger activists were also symbolic of this trend. Efforts were also made to keep in touch with IFMSA, IPSA and other groups focussing on younger potential leadership. This whole process needs to be maintained.

c) Engagement with mainstream not only confrontation

Another major thrust in the PHM Secretariat's efforts since 2003 was to shift the focus of PHM initiatives from only confronting the main stream through protests, street actions and other modes of democratic dissenting – (which are very necessary because of the over dominance

and cancerous spread of neo liberal economic and political determinism) to a more confident and more strategic process of engagement with the mainstream using strategic openings and opportunities (what may be called chinks in the armour) so that we built hope, enthusiasm and 'space for alternative thinking' even within mainstream institutions and the public health system. It was important not to remained confined to pre 2000 AD strategies of 'talking to the converted' or being preoccupied with micro level community based alternatives (the romantics of PHC / HFA) or becoming hopelessly cynical because of our perceived weakness, lack of resources or lack of recognition by the system.

Whether it was the advocacy with WHO, active involvement with WHA or the active participation in the GFHR fora or whether it was the PHM country relays that included meetings in the universities and with policy makers in every country visited, we consciously promoted the presentation PHM concerns, perspectives and Charters in mainstream institution and to policymakers with the confidence that 'evidence' was on our side. It worked to some extent at least especially in events related to WHA, GFHR, GHW releases, WHO-Health Systems Task Force and WHO-CSDH where we saw some results and impact.

d) Inspiring and informing 'evidence gatherers'

During the current phase, we have also attempted to take the PHM Charter to academic and research institutions so that mainstream institutions orient / inform their students about these perspectives and help to build up greater awareness among the future academic and researchers on the social determinants of health and the alternative socio-epidemiological analysis that is central to the People's Charter. Surprisingly, this effort has been more successful than earlier envisaged. The Charter is now recommended to students at the London School of Hygiene and Tropical Medicine, some of the Scandinavian Schools and other institutions. Mainstream journals have run articles by PHM resource persons. The presentations at the Annual Researchers Forum of GFHR and the Research Forum on People's Health preceding PHA2 are good examples of increasing interest in academics and 'evidence gatherers' in PHM concerns and analysis. The Global Health Watch report has been another such linking effort. Over 125 contributors to GHW1 included only 25 with a direct PHM linkage and similarly the Latin American GHW brought together over 30 resource persons from the region in a collective evidence gathering exercise. The IPHU and the WHO-CSDH knowledge hubs in which PHM is very involved are all additional opportunities. If demand creators (activists) and system builders (academics and researchers) can begin to work together with respect and trust and a mutually acceptable alternative perspective, the movement would be strengthened at all levels.

e) PHM as Generic not Brand

This has been the most difficult but challenging proposition. To help PHM recognize all potential partners focusing on PHM as a generic process rather than getting too carried away by

establishing PHM as an overarching brand. This has meant a policy of increasingly recognizing network and campaign groups at local, national, regional and international level as natural partners of PHM and not trying to make them members. This has been done by exploring linkages, common activities, co-sponsorship and collective action. PHM has met and worked with Oxfam, MDM, SCF, IBFAN, Environmental groups, IFMSA, various formations within the WSF arena and other groups at WHA, WSF and other events without too much hassle, encouraging groups to recognize PHM as a partner. This has also helped PHM visibility and outreach. A similar policy could be more actively followed at local, national and even regional levels. The challenge for maintaining this clarity between recognizing lower case – phm as spontaneous movements at every level and higher case PHM, which are initiatives / events sponsored by Global PHM will continue to be a healthy impetus for the growth and evolution of PHM.

f) Some Continuing Challenges

While all the above thrusts began to make some impact and be accepted slowly by the PHM members at different levels, there were some areas in which the secretariat team remained disappointed because not much headway could be made. Perhaps this will continue to remain challenges to be addressed in the next phase.

i. The PHM website, communication and media efforts continue to be dominated by English and the English speaking world continue to be more involved in PHM because of this dominance. While a concerted effort was made to break this language divide by more Spanish-English efforts for PHA2 the language divide remains a challenge. It’s not just a matter of communication but much more so the loss to PHM from the absence of cross cultural fertilization of ideas and creativity.

ii. There is much more people/ community level PHM efforts often termed grass roots mobilization taking place at the initiative of local, community, district and sub-national PHM circles and members many parts of the world. However, the communication of these efforts at local / community level are not reflected adequately in our website, publication, reports – these appearing to be thereby focussed only on national and even more so with regional / international events and global levels of activity. Much more effort must be made to record / document the grass roots level of initiative especially by harnessing younger volunteers to document them and perhaps more creative media efforts to focus on reporting them.

iii. Enhancing responsiveness of the PHM participants in governance structures at all levels and enhancing representativeness of those participants will continue to be a great challenge. For PHM to be a more effective movement this internal democracy has to be constantly strengthened at all levels.

12.8 IN CONCLUSION

The next phase of PHM evolution and development post PHA2 will hopefully be a phase marked by greater representativeness and responsiveness of PHM structures, for governance, action and communication

i. A phase of greater rationalization, decentralization and regional and country level capacity building.

ii. A phase of greater maturity and strategy in our PHM initiatives for engagement and confrontation with the mainstream policy and system building efforts.

> As Harris and Seid in their latest Book on Perspectives on Global Development and Technology (Bril, 2004) have noted.
>
> *"the People's Health Movement (PHM) is clear evidence that the existing linkages between globalization and health are contestable………….*
>
> *……The People's Health Movent and the People's Charter for Health provide a significant expression of alternatives 'from below' to the present globalization, privatization and commercialization of health among 'from above'.*
>
> *…The People's Charter for Health lays out a blueprint for the transformation of the existing global circles through democrazation at all levels of the existing system and through what some people in the global social justice movement call 'globalization from below.*
>
> *…It is based on the assumption that global decisions must be demonstrated and that people's organizations and organized grass roots action can bring about an alternative vision of development – one that promote human and environmental well being. To achieve this vision, the PHM is pursuing the democratization of health decision and outcomes at all levels.*
>
> *…One of the most strategic assumptions held by the PHM is that it will take organized grassroots action as well as concerted action at the global level to bring about the profound social changes that are needed to achieve the sweeping vision and radical goal of the movement."*

The increasing recognition by the non-PHM world of the PHM world is a challenge to us as well as a great responsibility. Are we building the movement adequately to be responsive to such expectations? That is the continuing challenge before us.