14. Building the People's Health Movement[1]

The People's Health Movement is both an organisation and a network whose mission is to build a movement: the people's health movement.

Where it came from

The People's Health Movement (PHM) was formed in December 2000 following the first People's Health Assembly (PHA) in Bangladesh. PHA 2000 had been convened by eight global civil society networks concerned that the slogan 'Health for all by the year 2000' – which the World Health Organization (WHO) had promoted during the 1980s and 1990s – had not been achieved. The People's Health *Assembly*, was a reference to the annual World Health Assembly, where ministers of health gather in Geneva as the governing body of WHO. However, this was to be a *people's* health assembly.

PHA 2000 was attended by 1453 participants from 75 countries (largely developing countries) and lasted five days. It included formal speeches, workshops, cultural programs, exhibitions, films and testimonies. The program canvassed the experience of primary health care since Alma-Ata; reviewed the impact of structural adjustment and World Bank policies on health; explored a wide range of social determinants of health; and shared the experiences of the wider social movement for health around the world.

PHA 2000 was preceded by a series of events held across the world. The most dramatic of these was the mobilization in India. For nearly nine months prior to the assembly, local and regional initiatives took place, including people's health enquiries and audits; health songs and popular theatre; sub-district and district level seminars; policy dialogues and translations into regional languages of national consensus documents on health; and campaigns challenging medical professionals and the health system to become more 'health for all' oriented. Finally, over 2000 delegates travelled to Kolkata, most riding on five converging people's health trains, where they brought forth ideas from 17 state and 250 district conventions. After two days of simultaneous workshops, exhibitions, two public rallies for health and a myriad of cultural programs, the assembly endorsed *The Indian People's Health Charter.* About 300 delegates then travelled to Bangladesh, mostly by bus, to attend PHA 2000. Similar preparatory initiatives, though less intense, took place in Bangladesh, Nepal, Sri Lanka, Cambodia, Philippines, Japan and other parts of the world, including Latin America, Europe, Africa and Australia.

PHA 2000 adopted *The People's Charter for Health,* which outlined the global health situation, identified the main barriers to health for all and adopted a set of principles, priorities and strategies to guide the people's health social movement globally. The Charter (since translated into many languages) has proved to be a powerful leadership document in the years since December 2000. It expresses the commitment of PHM.

> *Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world – a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of*

1. Work in progress. Feedback to dlegge(at)phmovement.org much appreciated.

people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives.

The second People's Health Assembly (PHA 2) followed in July 2005, in Cuenca, Ecuador, with 1492 participants from 80 countries. PHA 2 was organized around nine streams, including issues of equity and people's health care; intercultural encounters on health; trade and health; health and the environment; gender, women and health sector reform; training and communicating for health; the right to health for all in an inclusive society; health in people's hands; and PHM affairs (PHM 2010d). Planning is underway for the third People's Health Assembly in South Africa in 2012.

PHM as an organisation and a network includes

- country circles (core activists plus affiliated organisations),
- affiliated networks (globally, regionally and nationally);
- regional coordinators, and
- the global structures (the Secretariat, Steering Council and Coordinating Commission or CoCo).

The Global Steering Council includes regional representatives of country circles and representatives of the various networks who are affiliated with PHM at the global level; the CoCo is the executive committee of the Steering Council.

PHM Global is not a 'legal person' and does not receive monies or enter contracts directly. Since its formation in 2000 PHM has been supported by NGOs who are part of PHM, in most cases in the country where the Global Secretariat is based. These hosting organisations have managed incoming monies, banking, contracting, auditing and reporting. In some cases they have also provided additional administrative support for the Secretariat.

PHM is part of a much wider people's health movement including activists and organisations working in many different settings, not always linked with PHM. The wider people's health movement can be defined as including all of those activists and organisations who are working in various ways to achieve the kinds of outcome which are described in the People's Charter for Health.

The need for a global people's health movement

There have been people (as individuals, organisations and networks) working towards better health care and working to address the social determinants of health in many different settings and countries and for many decades (and centuries). Until recently these were local struggles which were largely oriented around local circumstances and the 'need' to become part of a global people's health movement was not so pressing. However, with increasing globalisation it is clear that even the most 'local' issue or struggle has at least some roots in the economic and political dynamics and the policy discourses at the global level.

PHM brings to this conjunction two different values. The first of these is a clear focus on globalisation and health informed by a clear analysis of the political economy of health at the global level. However, PHM also provides inspiration and organisational support for activist engagement on local and more specific issues where there is presently little activism.

The vision of a 'global people's health movement' does not imply some kind of absorption of the huge diversity of individuals, organisations and networks who are part of this wider people's health movement into a monolithic, centrally organised PHM. These individuals and organisations have their own history, commitment and identity. To speak of strengthening the people's health movement implies stronger communication links and collaboration when appropriate. However, the diverse purposes, ways of working and identities should in no way be compromised by building closer links through the PHM with the rest of the wider people's health movement globally; indeed this rich diversity is the movement.

Critical functions in building the movement

PHM must engage of course with the contemporary politics of health development. However, a major function of PHM, as an organisation / network is movement building: building the people's health movement. The critical functions of PHM, in terms of movement building, include:

- Growing our activist base: recruitment, retention, learning, inspiration;
- Building new and stronger alliances and inter-organisational understandings; working intersectorally; working with communities; working across difference;
- Attracting resources; building our resource base;
- Projecting inspiration: we can make change happen; we are part of a collectivity which is struggling in the same broad direction; we are working on the issues that matter; we know where we are going; we are mutually supportive;
- Improving our effectiveness in practice (attracts people and resources; inspires people; generates positive feedback) including: situation analysis and planning; implementation projects and campaigns; learning from practice; communicating success and effectiveness;
- Organisational development: richer communication structures; new ways of sharing the work; new ways of sharing and participating in analysis and planning; new forms of leadership;
- Cultural development: stronger sense of collectivity, self-consciousness, of solidarity, of trust;
- Learning: richer understandings, wider repertoire of strategies; new forms of inspiration (including a strong capacity for learning, communicating and applying the political economy dimensions and globalisation dimensions).

PHM sees itself as driven by the priorities and concerns of community level activists; working in a dialogical relationship with various kinds of distributed leaderships. Thus for many of the 'critical functions' listed above, the principal drivers will be at the country level although supported by regional and global units.

How to build a PHM country circle

A PHM country circle comprises: core activists (whose main commitment is to PHM as an organisation) and affiliated organisations and networks (who see themselves as part of PHM but not to the exclusion of their own organisational purposes).

The work of a PHM country circle includes: meetings, communications, and projects (including campaigns). The building of the circle and the wider movement is effectively undertaken through these meetings, communications and projects. The style of meetings, the quality of communications and the orientation of the projects will all determine the success of the circle. However, the same pattern of work may not be appropriate in all countries or states/provinces.

For example in countries which already have a rich mix of progressive civil society organisations active in health the focus of PHM needs to be on the cross cutting issues which are not being addressed and, in particular, the global dimensions and the political economy analysis. In countries where civil society is relatively weak PHM may need to focus its attention on building local grass roots action around the priority issues.

The constitutional structures adopted by different country circles within PHM vary widely. In some cases there is a formal constitution in some cases not. Where there is a formal constitution the 'membership' varies from solely organisational members, to solely individual members, to a mix of individual and organisational members. In countries where there is no formal constitution a mix of core activists and organisational affiliates is common. There is not one size which fits all.

In many countries and provinces PHM is supported by a host organisation; usually a larger and well established NGO which is committed to the Charter and is able to provide organisational overheads for PHM, either formally or informally. In countries where PHM has a strong host the pattern of activities, communications and meetings will be different from those where this is not the case.

The heartbeat of PHM is the project or campaign at the local /country level, addressing directly the local priorities in health development. However it is in the projects and campaigns that the movement is built. A (tentative) set of criteria for selecting issues to focus on at the country level might include:

- it is a major priority in terms of health care locally and/or the social determination of health;
- the issue has a strong global dimension and calls for a strong political economy analysis;
- our approach to this issue will inspire people from various PHM-close constituencies who would then see themselves as becoming more active in PHM;
- it is not already 'owned' (and being effectively addressed) by existing NGOs in health (who are affiliates or friends of PHM);
- we have the capabilities needed to make a difference.

We can also comment in general terms on the way our style of work on such projects or campaigns might help to build the movement:

- we will use the project as a bridge for building stronger links with existing organisations and networks (whose commitment is broadly aligned with the Charter);

- we will use the project as an opportunity to reach into constituencies where there will be PHM–attracted people who may be inspired through their contact with this project;
- we will use this project as an opportunity for disseminating the PHM analysis and commitment more widely.

Style and media of communication also matter. PHM needs to use the most appropriate communication media which are available including contemporary platforms and social media. This requires developing and sharing expertise in the relevant technologies.

Building the movement also involves working to create a shared culture which supports the values and aspirations of the movement. The 'foundations of activist practice' provide a kind of checklist for thinking about some of the cultural norms which might characterise a PHM culture:

- channelling our passion; recognising how our distress, frustration and anger feed into our activism; ensuring that this engine of activism is managed constructively;
- cultural practice; celebrating the rituals, symbols and affirmations which hold us together and help us to shape whom we are becoming;
- ethical clarity; cultivating reflexivity regarding various forms of socialisation we bring and the various paradigms of 'helping' which shape our engagement;
- skills in tracing the causes of the causes;
- skills in sketching scenarios of change;
- developing a broad repertoire of forms of action;
- working on the issues that matter;
- working with communities;
- working across difference;
- working intersectorally;
- communicating effectively (includes deep listening);
- bridging the local and the global (addressing the micro and immediate issues in ways which also address the macro and longer term dimensions);
- living 'the personal is political';
- building the movement.

Range of social movement strategies

It is useful to revisit the below list of 'elements of strategy'. This provides a kind of menu for country circles to reflect upon in terms of whether increased investment in these strategies might be worthwhile. These elements of strategy include:

- Information strategies, including research, through which the forces for change may be emboldened and the dominant ideologies delegitimized;
- Cultural action which throws new light on the familiar and helps to articulate alternatives;
- Networking and dialogue leading to stronger alliances and more coherent action; for example, alliances between the health movement and the environment, women's, labour movements, etc;

- Community engagement in projects and campaigns through which people and communities gain confidence in their power to change, while addressing priority issues;
- Policy critique and advocacy;
- Service development reforms, creating health systems that address the structural determinants of health as well as the biomedical;
- Institutional reform, creating institutions that are accountable and responsive and which clear the path for progressive change;
- Personal behaviour change (eg away from patriarchy, away from materialism); changes which are both individual and collective; intentional and cultural; personal and political;
- Research advocacy and brokerage;
- Movement building.

Capacity building

PHM, through IPHU and GHW in particular, brings together a rich body of knowledge which many young, would-be health activists have not been able to access in other settings and which many find very empowering.

Country circles need to take up the challenge of providing local learning opportunities in and around these kinds of issues:

- How social change takes place
  - and the intentional drivers of change
- Political economy of health
  - political and economic environment which shapes health care and the determinants of health
  - trade policy and population health
- Health systems policy (and politics)
  - debates, evidence, experience and politics
  - principles for health system development
  - campaigns around health care policy
- Action on the determinants of health
  - tracing the causes of the causes
  - understanding change
  - strategies and forms of action
- Right to health
  - legal structures
  - struggle to enshrine new rights

There is an additional need for learning opportunities for the core activists of PHM, working through topics such as:

- Working across difference (gender, class, caste, race, etc)
- Ethical reflections
  - the mote of health professionalism
  - different paradigms of ‘helping’

- Working in groups
- Working with communities
- Practical skills in organising
- Meetings and governance
- Fund raising
- Research and evaluation

Global and regional support for movement building

One set of options for country circle development involves gaining leverage from global programs and activities including:

- Visits by PHM activists from other countries who can be featured at local workshops or meetings
- IPHU,
- WHO Watch,
- Thematic campaigns under the umbrella of the Right to Health Campaign,
- Building communications with the local constituencies of the global affiliated networks.

Sharing and learning from diverse country experiences in building PHM

PHM is committed to supporting a wider sharing of country circle experiences in movement building:

- systematically collecting the experiences of country circles and (sub national chapters);
- pooling these experiences and collectively reflecting on the lessons which can be drawn and the tools and strategies that can be shared;
- implementing such tools, strategies, best practices and principles as may be appropriate in particular settings and monitoring, reflecting upon and learning from such implementation experience.

As part of this pooling of country circle experiences, PHM could identify clearer 'outcome measures' which might help us to gauge our success in movement building. Some of these key outcomes which can be assessed implicitly include:

- richer communication structures,
- clearer divisions of labour and collaborative relationships,
- richer understandings and wider repertoires of strategies,
- stronger self-consciousness,
- cultural and institutional development,
- inspiration, and
- retention and recruitment.

Absent from this list is 'outcomes' in terms of improved health systems and healthier living conditions. Where such outcomes can be attributed to PHM's work these should of course be considered but such changes are always the consequence of a myriad of influences and it can be very hard to attribute causality.

Building relations with affiliated networks and organisations

The number of global networks affiliating with PHM Global is increasing and there are new opportunities to build links between country circles and the country-based constituencies of the various global networks.

Regional Coordination

Each region is represented in the global steering council of the PHM through a regional representative. These representatives are voluntary. Their responsibilities include providing strategic guidance and advice to country level circles; promoting communication within the region; and ensuring fluent two way communications between the global structures of PHM (including SC, CoCo, Secretariat and global programs) and the region they represent.

In addition PHM has employed one part time regional outreach coordinator in Africa. She has been employed since late 2009 and with the funding of this position, the region has shown significant progress in terms of growth and activity. According to PHM's external evaluation, completed in early 2011, "The existence of a regional outreach coordinator has proven to be successful for follow-up and movement building in the regions." We are seeking funds to be able to appoint regional outreach coordinators in the other regions.

Making the most of our resource people

PHM has within its sprawling networks some amazing resource people and links to further resource people through associated and parallel networks. However, it can be a challenge to fully utilize these resource people in building country circles.

For example we have many resource people who attend conferences and meetings in different countries as part of their work. We want to be able to offer them to local PHM circles as speakers who might attract interest to PHM.

We may also have a local group working on a project which has ramifications in other countries but the local activists might not have the connections with people working on related issues in other countries. For example the same mining company might be operating in several countries, have its home base in another and be subject to market attention in a third. PHM is a network of personal relationships (six degrees of separation); we should be able to make greater use of this networking resource.

Some of our projects are in close contact with a wide range of experts who could do more to support country circle activities. These include: the faculty members who support IPHU, the chapter writers for GHW, and the technical experts who assist with WHO Watch. Enabling wider access to these experts in support of country development calls for closer articulation with these global programs.

Right to Health Campaign

The human rights paradigm provides a powerful, persuasive and authoritative framework for mobilizing around health care and the social determinants of health. Fundamentally the rights paradigm reinforces the legitimacy of saying, 'this is wrong!'; 'we shall campaign to right this wrong'.

The legal and conceptual frameworks through which human rights are institutionalised and elaborated enshrine a consensus around what is right and what is wrong which, with the various treaties and commissions, provides strong authority around the right to health.

PHM sees the right to health therefore as an umbrella framework within which our campaigns and projects are implemented and which gives them authority. As such it plays a key role in authorizing and inspiring local groups, country circles, thematic networks in developing their campaigns and carrying out their activities.

Examples of multi-country campaigns around the right to health (the social, environmental, political and economic determinants of health) include:

- food sovereignty;
- trade and health;
- extractive industries;
- gender based violence; and
- war and occupation.

Examples of multi-country campaigns around the right to health care (health systems that work) include:

- community monitoring;
- sexual and reproductive rights;
- universal health coverage;
- community health workers; and
- against privatization and austerity.

Many of these topics overlap across these broad headings. For example, debates around intellectual property rights, in relation to trade (or economic integration) agreements, clearly concern access to medicines and health care. Sexual and reproductive rights encompasses gender based violence and maternal mortality. Food sovereignty and extractive industries both have a significant trade component.

In countries where some of these issues are on the boil there may be some benefit from joining a wider network of circles working on this topic and building an international campaign.

The idea of RTH as an umbrella within which a wide range of campaigns are developed is widely supported. However, if we are to gain maximum leverage from the rights discourse we do need to ensure that PHM activists are fully aware of the legislative, conceptual and institutional foundations (and limitations) of the RTH. We also need to put some resources into promoting the rights slogans as well as those associated with the campaigns listed above.

Democratising Global Health Governance

'Global governance' refers to the networks of national, intergovernmental and corporate power through which the rules and policies are made which govern our increasingly globalised world. Global health governance refers to the networks of national, intergovernmental and corporate power which determine the rules and policies globally which shape health care and the social determinants of health.

One way of conceiving the challenge of building a better world is to think in terms of improving the structures and dynamics of governance. PHM's Democratising Global Health Governance Initiative envisages a redistribution of power globally and a reform of the institutions and networks which at the global level shape the conditions for health.

This is a big project and we elected to start with a focus on WHO. WHO Watch is a resource for advocacy and mobilisation and an intervention in global health governance. WHO Watch has been operating since 2010. We envisage developing our monitoring and advocacy capacity so that we can participate in all WHO governing body meetings (WHA, EB and regional committees) and also hold governments accountable domestically for the policies they adopt or oppose at WHO.

We need to build closer links between global and regional watching and the work of our country circles. This would involve engaging with WHO at the country level where it has a presence and engaging with the MOH about its relations with WHO, eg how it speaks at governing body meetings. The lack of accountability of member state representatives is one of WHO's fundamental weaknesses.

One of the particular values that PHM brings to health activism is its internationalist perspective. Monitoring and advocacy around WHO is one avenue for direct engagement around the global policies which shape health care and the SDH. It gives grass roots activists direct experience of engaging at the global level.

We need to explore how engaging with global policy making through WHO can support the building of country circles and chapters. We can perhaps learn from Bolivia and El Salvador which have developed closer links between civil society and MOH policy makers in relation to issues being discussed at WHO. One strategy would be for country circles to help to disseminate the commentary and analysis of the watchers including the concurrent tweets during governing body meetings. Watchers need to prepare papers which can be used at the country level.

IPHU

The International People's Health University (IPHU) has shown itself to be a strong tool for movement building when local PHMs are involved in recruitment and when there is adequate follow up of alumni.

One learning stream within IPHU is focused on activism and movement building. We are also developing new specialist IPHU directed at the organisational activists in country circles, which will focus on country circle building. This would be organised on a regional basis.

In 2012 we ran our first IPOL course (IPHU OnLine). This has real promise in terms of getting to a larger audience and also sharpening up our selection process for face to face IPHUs. We plan for more IPOLs.

The early IPHU courses were generally seen as regional in contrast to national but in recent years we have had a number of successful national level courses. These have proved to be useful in strengthening local PHM groups. We need to encourage greater involvement of country circles in organizing, fund raising and presenting IPHU courses at the national level and in the follow up of IPHU alumni. We need to experiment with different ways of presenting IPHU content, including seminars and short courses. IPHU alumni should be encouraged to arrange and resource such. Some country circles are experimenting with webinars also.

Global Health Watch

The development of GHW4 will include collaboration between more experienced and less experienced activists as part of a process to increase capacity of the young activists. The GHW process will be extended to the regional and country level. National and regional watches will be encouraged. Chapters should propose a clear program of action which can be used as an organising tool. Further work is needed on the other products which hang off GHW: translations, primers, website, smaller documents to be used by activists.

ICT Resources for Health Activism

Information and communications technologies are evolving very fast. In view of PHM's global aspirations but parlous budgetary situation we need to use the best technology available to reduce travel and accommodation.

The development of new on line repositories and directories have been suggested to enhance access to information resources useful for strengthening country circles and establishing new country circles and to support health activists in general. These could include materials on community development, participatory organisational development and links to information and resources useful in developing advocacy activities, press releases, campaigns etc.Another technology we are starting to use is for webinars to facilitate virtual presentations and gatherings.

However, if new technologies are to be integrated within the routines and practices of a movement like PHM we need to give as much attention to the changes to routines and practices (including orientation and training) as to the technologies themselves.

Working across languages

As a global movement, multi lingual communication is essential within PHM, in building relationships, supporting local activism and strengthening country circles. Generally, PHM communication is in English, with important communications being translated into Spanish, French and Arabic as many activists in Spanish, French and Arabic speaking countries do not speak English.

PHM is most active in developing countries and as such, most of the emerging PHM groups are located in West Africa, Latin America, Asia and the Middle East. It is therefore essential to provide translation in at least French, Spanish and Arabic, to ensure participation and to broaden access of local communities in benefitting from the materials developed it is.

We have language coordinators whose job it is to coordinates the translation of official PHM communications, documents and website texts by making use of a network of professional translators familiar with language and terminology of PHM. This calls for significant funding.

Conclusions

The vision which inspires the activists and organisations who constitute the People's Health Movement is a global people's health movement working at the local, national and global levels for decent health care and living conditions which support health for all, including equity and sustainability. It is not ordained that this outcome will be achieved; it will depend at least in part on the direction and determination of the activists.