African Civil Society (CS) regional meeting to develop a strategy of work with WHO Commission on Social Determinants of Health (CSDH)

10 – 11 January 2006
Nairobi, Kenya
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DAYS ONE 10 January 2006: SETTING THE SCENE

Participants
The 24 participants were of diverse representation from nine African countries. While many were already members of the Eastern and Southern Africa Health Civil Society Network, there were some newcomers from organizations that came from outside the health sector specifically.

Meeting objectives
Mr P Mubangizi, Regional Coordinator, Health Action International (HAI) Africa
The Civil Society Facilitators (CSFs) for CSDH in Africa are Equinet, HAI Africa, Health Civil Society Network of Eastern and Southern Africa, and People’s Health Movement. On behalf of the CSFs, Mr Mubangizi presented the agenda (see Annex 1) and the meeting objectives:

- To identify and further expand the health CSO network, and to sensitize the network about CSDH
- To identify regional and country level agendas addressing SDH
- To develop a regional strategy for CSO engagement with the Commission
- To draft the regional workplan

Welcoming remarks
Dr H Karamagi, National Professional Officer, Health Systems, WHO Kenya Country Office
(representing the WHO country representative (WR), Kenya)
Dr H Karamagi gave the welcoming remarks on behalf of the WR. He reiterated that health issues need to be addressed in a wider perspective than the WHO traditionally has. Using the example of child survival, he noted that significant health gains have been achieved often not through direct interventions in the health sector, but rather through interventions in social aspects. Health should be viewed as an interplay between SDH, diseases, and the proximate determinants (maternal, environmental factors, etc).

He noted the Ministry of Health’s strategic plan in Kenya 2005 – 2010 uses such a reoriented approach in a number of ways: the health sector is moving away from disease prevention and becoming more focused on ensuring individuals are healthy by looking at all the conditions which make people unhealthy.

Furthermore, the health sector is attempting to get a more collaborative effort with other actors in heath, so there is also a collective responsibility for outcomes. Presently CS is meeting with the MOH, also together
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with donors and implementing partners to decide how to move forward. This has opened an opportunity to start a focus on the social and economic impacts on health.

WHO is coordinating all the actors in the collaboration, and they view CSOs as a key resource due to their firm grasp on the issues affecting households and communities. WHO and the MOH have recognized they cannot alone address these issues and they strongly welcome this kind of cross-work and linkages with CS.
Background and overview of the CSDH

Dr A Mawaya, Focal Point for CSDH, WHO AFRO Regional Office

Dr Mawaya reviewed a general CSDH presentation which had been prepared by the Secretariat. The SDH are defined as the social conditions in which people live and work, reflecting their different positions in hierarchies of power, prestige and resources.

He reviewed the desired outcomes of the CSDH to be achieved by May 2008:
- SDH incorporated in debates and policy processes in growing number of countries
- CSDH "lead countries" implementing comprehensive multi-sectoral policies on SDH
- Scientific knowledge on SDH consolidated, gaps clarified
- Civil society mobilized for action on SDH
- SDH incorporated into WHO policy and technical work

In general, he noted a change was necessary to view health in a social paradigm and finally, he encouraged CS to remain active as regards the CSDH, as CS is key to each of its phases of work.

He gave an overview of the first consultative meeting on CSDH in the Africa region, held in Brazzaville, July 2005. The meeting was well attended by WHO HQ, CSDH Commissioners, MOHs from 13 countries, WHO country offices, WHO collaborating research and training institutions, and various WHO National Professional Officers. Countries presented what they are doing on SDH and whether they have policy to support the work, especially in the area of health inequalities (eg. access to health) but also in programs such as HIV, TB, child health, maternal health, health promotion, and urban settings.

He agreed that a comprehensive matrix is needed, showing the action plan, actors and concrete outcomes for what WHO wants to achieve from this Commission. The concepts are not new; rather the new focus would be to outline what is “value added” from all this work.

He reiterated that the root cause of inequality is poverty, hence any meaningful scheme to make an impact at grassroots level must take into account mechanisms to assist the poor. Policymakers must be convinced to address health through poverty reduction strategies.

The conclusions of the Brazzaville meeting will be shared with CSFs when the report is finalized. In general, they include the following:
- The need to ensure social programs are addressing health; such programs need scaling up
- Poverty reduction strategies as entry points / need to engage with CS
- Use of partnership, including with communities
- SDH are diverse and countries are at different levels of addressing social and health indicators. This needs to be taken into account when the CSDH is doing its work

SDH and challenges in Africa

Prof D Sanders, Director of School of Public Health, UWC and member of international steering group of the Peoples Health Movement

Prof Sanders gave a comprehensive overview of Social Determinants of Health in the African context. Tellingly, he presented the factor of “underweight” as the single leading global cause of health loss – due to low quality and low quantity of food. The conceptual framework on the various SD-related causes of childhood malnutrition gives a useful model for identifying other SDH.

His view on the reasons for Africa’s health crises were threefold, all of which result in slow progress and reversals:
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- Increasing poverty and inequality worsened by inequitable globalization
- Selective Primary Health Care (PHC) and health sector “reform” (HSR)
- HIV / AIDS

He pointed out specifically how HSR impacts on public sector health systems and their human resources through at least three of its strategies:

- Quest for efficiency through delivery of a core set of essential services: the cost effectiveness approach increasingly influences health policy, leading to this “package” approach
- Greater involvement of the private sector
- Decentralization

Prof Sanders outlined the strategies for health development, which include the following:

- Equitable development is the key (eg. ‘Good Health and Low Cost’ countries)
- Value of investment in health and social sectors must be emphasized
- ‘Strong’ community participation and participatory democracy key to achieving political commitment to health
- Complementary strategies needed:
  - Bottom-up community-based programme development
  - Top-down policy development and planning
- Promoting healthy policies and plans
- Implementing comprehensive and decentralised health systems
- Success of these strategies depends upon the creation of a facilitatory environment through such actions as advocacy, community mobilisation, capacity-building, organisational change, financing and legislation

He challenged the Public Health Community to the following actions:

- Challenge unfair globalisation and ill-considered health sector reforms through research and advocacy
- Advocate for increased investment in enhancing capacity, and reorientation, of African institutions (incl. equitable collaboration/partnerships with Northern institutions)
- Develop capacity through health systems research, practice-based and problem-oriented training.
- Improve quality of interventions and develop well-managed comprehensive programmes
- Involve other sectors and communities
- Support with better management systems
- Focus on health centres
- Rapidly (re)train Community Health Workers
- Provide resources to and develop partnerships with progressive civil society

Finally, he encouraged the participants to read the “alternative health report” from the Global Health Watch at www.GHWatch.org

Comments, Discussion and Questions

General Comments on the presentations

- Only small percentages of budgets are allocated to SDH, since the focus has traditionally been on curative aspects of health. More money needs to be allocated to the preventive side.
- Need to consider the MDGs within the CSDH. It was noted that Tanzania might not achieve MDGs by 2015 because of HIV, through its effect on labour forces, etc.
- Structural Adjustment Programs have resulted in some good economic growth in the region, but the unfair distribution of that income is the problem. From the social and human development
perspective, SAPs are purely negative. Health is a human right, and anything done to it to help achieve “growth” can be called a disaster. Health shouldn’t be equated to growth rate; the trade-off between economic growth and inequality is not acceptable. (An example of SA was shared: the Ministry of Finance is currently achieving hero status because SA’s economic indicators are strong…but to what end? There is more poverty in SA than there was ten years ago.)

- As inequities in wealth and health grow bigger (“the champagne glass” of Prof Sander’s presentation), it is the responsibility of people working in SDH to campaign together on the various determinants. If the “glass falls over” there is great risk of violent eruptions in poor countries.
- We cannot address SDH from within the health sector, so we need to break through the “medical consciousness” to involve relevant ministries (eg. Gender, Economic Planning, Education, etc). Health receives all the intersectoral failures: the victims of poor housing, food insecurity, etc. But before there will be sustained policy change, what is needed first is a strong CS movement on the ground. Examples from Zimbabwe and Nicaragua show that good social policies are often the result of pressure from below.

Comments / Concerns on the CSDH Process

- The phases of CSDH reflect its long term vision (by May 2008). The tendency of improving health problems in the world is to develop such long term visions. In the interim, people die.
- It appears the Knowledge Hubs are based mostly in rich countries. It seems this was one of the mistakes the CSDH made when it began. The hubs (and the accompanying resources) should be going to poor countries, where there are reputable universities and research institutions.
- There should be CS involvement in all the KN hubs – this is one way to ensure that the Northern bias does not dominate, and that the South has a say. It is hoped that the two vacant hubs will be awarded to Southern groups. It appears, however, that there is a closed policy decision-making system within the Secretariat regarding how the hubs are chosen.
- There is a concern about an apparent verticalization within the hubs. Rather, they should be integrated so the result is not nine different programs at the end of progress.
- It is generally disappointing that there is no representative here from the Secretariat, nor any Commissioner. In the overview presentation, it appears that CS has an important role but it is necessary to see the support of CS by WHO.
- The mission of the Commissioners is not well understood. If CS is going to constructively engage with CSDH, who is in charge? What is the decision making process? What is the way for consensus? The Commissioners come from obvious diverse political backgrounds – republicans and liberals – does one have veto power? Who drives the CS – CSDH engagement: CS or WHO? (eg. Is it a real process, does CS really have a voice or will it follow a pre-arranged agenda by WHO?) It was agreed that CS needs to remain autonomous.
- Most WHO departments sit outside the Commission and thus it is difficult to follow what is happening in the Commission, even for Regional CSDH Focal Points.
- It was noted that all the above process issues should be taken to Iran, in order to have the best possibility of influencing the Commission.

Group Work I: Current strategies, policies, activities positively or negatively affecting SDH – Government and CSOs / NGOs

Chair: M Masaiganah, PHM / Equinet

Ms Masaiganah gave an overview of the CS engagement with the CSDH to date, and the potential benefits this opportunity offers to CS. The CSFs have developed some guiding principals for CS engagement in the CSDH and the Secretariat: to maintain autonomy, to demand that CS participation be real and not only as a token, and to demand transparency in the whole process. It was noted that one further value driving CS in this process is that of the recognition of health as a fundamental human right.
GROUP WORK I OUTCOMES: The participants met in country groups and brainstormed on the current polices, programs, and strategies / actions addressing the SDH, both from governments and CSOs / NGOs. They produced those which affected the SDH both positively and negatively.

The groups further discussed and documented experiences / narrative stories from their work which illustrate addressed or unaddressed SDH issues and were asked to consider the following questions during the strategizing session:

- Which of the country level programmes involve the active participation of CSOs?
- How can the engagement of CS with governments be enhanced to improve health inequities?
- How can CSOs participate while maintaining their own autonomy?
- What are the key opportunities that exist today at country level or could arise later to facilitate the participation of CSOs in action on SDH?
- Who are the other actors at country level that are involved in the SDH and how can CSOs effectively engage them using the opportunity of CSDH?

<table>
<thead>
<tr>
<th>Government programs positively affecting SDH</th>
<th>Government programs negatively affecting SDH</th>
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<tr>
<td>- subsidies on agriculture inputs</td>
<td>- health sector reform programs – health insurance law / withdrawal from service</td>
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<td>- fumigation of residential areas with antimalarial and</td>
<td>- provision cut on budgets deterioration – less utilized</td>
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<td>cockroach fumigants</td>
<td>- food when grown sometimes lies uncollected</td>
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<td>- stable gain of local currency against the dollar</td>
<td>- high bank interests on people intending to borrow for their entrepreneurship</td>
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<td>after attaining the HIPC completion point</td>
<td>- tax holidays to investors, hence burden on a small working population</td>
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<td>- opening up of new mines, creating employment</td>
<td>- poor remuneration to medical staff, hence the brain drain through migration</td>
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<td>- social health insurance scheme</td>
<td>- bilateral agreement with USA</td>
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<td>- improvement of salaries of doctors</td>
<td>- privatization of water and sanitation services</td>
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<td>- free primary education</td>
<td>- poor working conditions of nurses</td>
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<td>- re-introduction of community partnership for health</td>
<td>- marginalization of women in key decision making</td>
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<td>- exemption categories for user fees</td>
<td>- poor coverage of national health insurance scheme – for formally employed /</td>
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<td>- recognition of role of NGOs in policy development and</td>
<td>cater for bed and food</td>
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<td>implementations</td>
<td>- SWAP governance structure</td>
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<td>- increased investment in water and sanitation programs in</td>
<td>- limited participation of NGO roles within restrictive confines or definition</td>
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<td>rural areas</td>
<td>of health</td>
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<td>- slum upgrading program</td>
<td>- user fees for health with increased capacity of users to pay</td>
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<td>- AIDS levy</td>
<td>- commercialization of water and sanitation and services in urban areas – cholera</td>
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<td>- abolition of user fees for vulnerable groups</td>
<td>- the Essential Health Care package – guiding the SWAP</td>
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<td>- improving human resource base; primary health care</td>
<td>- government diverting funding from CBOs / NGOs – withdrawal from CWH programs</td>
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<td>nurse</td>
<td>and CPHC</td>
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<td>- development of the health sector-wide approach (SWAP)</td>
<td>- introduction of health services fee</td>
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<td>- stabilizing the currency</td>
<td>- NGOs Act contradicts the policy</td>
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<td>- peace (eg DRC)</td>
<td>- operation Restore Order (attack on poor</td>
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<td>- child support grant – increased age limit… <em>but</em></td>
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<td>problems accessing as not increased social infrastructure to deliver</td>
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<td>- water policy and provision</td>
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<td>- no taxes on agricultural inputs</td>
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<td>- nutrition program at schools… <em>but</em> approach taken was</td>
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<tr>
<td>not developmental or promotive of agriculture / small</td>
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<td>retail sectors</td>
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<td>- decentralization policy – brings all sectors</td>
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- together at district level
- all government programs with Poverty Eradication Action Plan
- NGO Policy in place
- NACP and TACAIDS (Tzn)
- plan for modernization of agriculture
- National Social Security Fund
- establishment of national councils
- gender mainstreaming
- some effective vertical programs in health system
- quota relief on agricultural inputs / implements (import tax relief)
- development of the Poverty Reduction Growth Facility
- agricultural inputs subsidy in the Southern Region
- plan for modernization of agriculture

**CSO / NGO programs positively affecting SDH**

- mobilization of CS around issues such as access to water, privatization, etc
- awareness creation on women rights
- Faith Based Organizations contribute over 40% of health care delivery
- community awareness and empowerment on health as human right
- NGOs and food programs – health centers and free food and medication
- agriculture programs
- strong linkage with grassroots
- pressure on government for accountability in terms of delivery
- NGOs have managed to organize themselves in thematic groups to engage with government
- trade issues
- presence of strong sector networks (eg MHEN, MEJN, CISAWET, etc)
- cross fertilization and multi-stakeholder consultations
- community mobilization and awareness-raising (eg. on MDGs)
- visible and meaningful evidence-based advocacy with government ministries, parliament
- Treatment Action Campaign (SA) and civil society – put HIV and access to medicines higher on agenda
- increased numbers and networking of CSOs

**CSO / NGO programs negatively affecting SDH**

- lacking resources to reach out to most rural places
- being easily intimidated by parliament
- lacking follow-ups on issues
- weak and disorganized and no lobbying of minimum wages
- no policies / governance
- unsupported by appropriate legal framework
- some fragmented and uncoordinated
- some blindly peddle donor-driven agendas
- treatment access lobbies have moved focus away from health systems issues
- tension between single issue campaigns and broader health movements
- donor driven programs ++++ funding for ARVs
- NGOs not well coordinated
- mostly specific HP short term – up to 3 years
- lack of a strong national level for a for CSO / NGO (fragmentation)
- coordination and coherence of programs lacking
- working on donor determined programs
- state / CSO relations -- NGO Bill
Further questions for discussion in Group Work I:

**Which of these programmes involve the active participation of CSOs?**
- control and management of HIV / AIDS through TACAIDS and NACIP (Tz)
- maternal health (eg. Women’s Dignity, SHIRDEPHA)
- health policy planning and development
- human rights
- education development (participatory education development programmes)
- National Social Security Fund (NSSF)
- Gender – equal opportunities for women; Domestic Relations Bill (Ug)
- National Health Policy – community health promotion; health consumers organization (eg. HEPS)
- environment – policy, community participation
- trade issues – IP Bill, Negotiations
- but in Uganda, level of engagement is still low (rubber-stamping is common)

**How can the engagement of CS with governments be enhanced to improve health inequities?**
- by enacting clear cut legislation that would wholly embrace the CSO as partners with governments in improving health inequities
- by advocating, sharing information and knowledge
- promote the engagement of the parliament
- reinforce the capacity of the CS to talk about the budget (to influence the MOH budget)
- participation in government dialogue and consultations
- to be conversant with research reports so may raise evidence-based arguments
- policies to recognize SDH
- “watchdogging” / monitoring role of the NGOs (hold to account)
- in a true democracy, transparency and accountability could facilitate the participation of CSOs in action on SDH
- CSO can recommend successful strategies, experiences, best practices especially at communities
- CSO can be strengthened to be alternative in implementation of programs that address SDH eg. Health Insurance Schemes, Health Service delivery, fighting corruption
- M&E of government (eg. National budget)

**How can CSOs participate while maintaining their autonomy?**
- educate CSO on SDH
- separate audit of plans and policies by government but done by CS
- build networks
- CSO identify trends of inequities, generate evidence, present it to governments
- CSO empower communities so that communities can hold NGO and government accountable to them
- partnerships with academia
- if they were empowered with the resources to sensitize communities (e.g with financial resources and implements)
- building capacities and leadership for NGOs who are operating in disadvantaged areas
- CSO should have their own framework and internal cohesion
- CS should be self-reliant; not depend on governments
- CS needs capacity to develop and analyze policies
- mechanisms for accountability within CS (reporting, selecting, consulting)
- clarify role of CSO (not partners in implementation; rather advocacy, watchdogging the Commission and governments and regional policies)
- if the CSDH appears to be off-track or useless, we need to decide whether to remain in or disengage
- establish “non-negotiables” / benchmarks to clarify the above point
- functional structure needs focal points in countries or regions that are accountable to CS or CSDH
- there are dangers when the funders are calling the meeting, setting timeframes and setting the parameters of engagement. WHO is like a global government
- not all in the Commission are keen to engage CS – we need to be careful that we don’t jump when WHO says jump (e.g. to hold meetings at short notice)
- the IPHU has proposed to monitor in a rigorous way the work of CSDH, by playing a strong watchdogging role. This group could be a part of the proposal if agreed.
- establish CSO parallel or separate process to feedback to the CSDH
- monitor and submit regular reports to CSDH (e.g. by PHM, HAI Africa)
- linkage with other groups / movements
- look at own accountability
- assess where the funding for the CSDH is coming from

What the key opportunities that exist today at country level or could arise later to facilitate the participation of CS in actions on SDH?
- In SA, MOH wants to be involved in CSDH, but not with CS (PHM, TAC)
- Commissioners are not all attending relevant CSDH meetings (including this one)
- putting promises into practice (e.g. National Poverty Eradication Programs)
- increasing consciousness of failure of programs (e.g. SAPS, HSR, HIV / AIDS interventions) – opportunity for change / refocus
- increasing recognition of health as a Human Right
- growing health movement atmosphere (e.g. Trade)
- MDGs
- Parliamentary Committees on Social Services
- social clubs, schools, colleges / universities and traditional gatherings (royal establishments)
- there is political will to implement SDH
- two Commissioners are residing in Kenya
- WHO Country office is supportive to SDH processes
- NGOs are willing to network and partner on SDH processes and implementation
- the existence of National Strategy for Growth and Poverty Reduction
- annual NSGPR and sectoral review
- participation in annual consultative group meetings (government and donors)

Who are the other actors at country level that are involved in the SDH and how can CSOs effectively engage them using the opportunity of CSDH?
- development partners (JICA, DFID, DANIDA, etc)
- MPs (Committee on Social Services; Orphans and Vulnerable Children)
- National Council for Population and Development
- ministries (Health, Finance, Trade, Education)
- women parliamentarians
- international organizations (UN System)
- health provider associations
- academia and media linkage
- local communities
- not-for-profit sector
- Public Private Partnerships (?)
DAY TWO 11 January 2006: DEVELOPMENT OF STRATEGY FOR CSO WORK WITH CSDH

CSO and the CSDH, the East Mediterranean experience

Dr H Serag, Director AHED and CSDH Civil Society Facilitator for AMRO region

Dr Serag presented the Association for Health and Environmental Development’s experience of facilitating the East Mediterranean CS work with the CSDH. He noted one of the main challenges was that of the diversity of both the countries in the region, and also of the “space” CS has within these countries.

Proposal to re-orient WHO towards achieving “Health for All”

Dr H Serag

Dr Serag presented a proposal document based on a project by one of the working groups during the first short course of the International People’s Health University (IPHU) which was convened 11 – 16 July 2005, prior to the Second People’s Health Assembly in Cuenca, Ecuador. A summary of the proposal is included here.

The overall objective of the proposal is to re-orient the WHO to take all possible measures towards achieving “Health for All”. This can be partially realized through influencing the WHO’s Commission on Social Determinants of Health. The specific objectives are:

- To identify and properly address solutions to the key social determinants leading to poor health
- To assist in the eradication of all forms of disparities, inequalities and discrimination in health and health-related issues among people all over the globe
- To assist in democratizing the global health decision-making process by creating channels through which people can express themselves and participate actively in reforming the global health systems
- To promote the participation of people and people’s organizations in expressing their understanding and knowledge about the social determinants of their health as well as in expressing their own alternatives for addressing these determinants

The proposed strategies include:

- Mobilizing the PHM thematic and geographical circles and networks, inclusive of associated grassroots communities, to participate in the process. This includes the active participation of the PHM in the Commission’s planned process of engagement with civil society
- Assisting the process of the work of the “Commission on Social Determinants on Health” through: providing the Commission as well as the knowledge networks with evidence-based reliable information and analysis about key determinants of people’s health and ill-health from all over the world, focusing on the most marginalized and most disadvantaged groups and communities
- Monitoring closely the direction of the work of the Commission and the knowledge networks to ensure that they are not influenced by the dominant neo-liberal trend, represented by the international monetary organizations, that affects the WHO itself
- Lobbying the commissioners and the knowledge networks to ensure their objectiveness as well as to ensure that they appropriately relate the social determinants to the political and economic contexts
- Advocating the WHO to ensure that the reports of the Commission succeed in influencing the political, structural and programmatic reform needed within the WHO as a whole

By establishing a PHM thematic circle or working group that focuses on the SDH, PHM members, people’s organizations, civil society organizations, health activists and health workers will be called upon to actively...
participate. This global circle can include geographical and thematic sub-circles. Geographical ones can be established as country or regional-based. Thematic sub-circles would be of specific concern (e.g. sub-circles around people’s working conditions, environmental health, indigenous communities, etc.). The work of sub-circles will be facilitated by a focal point (preferably an active organization) and the global circle will be hosted and coordinated by one or more of the PHM member organizations to ensure the common pool.

The functions / activities of the circle are proposed to be:
1) Developing and publishing a periodical electronic newsletter hosted by the PHM global website
2) Producing, publishing and disseminating awareness-raising materials in the form of leaflets, pamphlets, booklets, etc. to discuss the social determinants and their implications on people’s health
3) Developing and continuously updating a data-base for local, regional and global events concerning the social determinants of health
4) Convening special events on the social determinants of health as PHM events
5) Collecting / generating reliable evidence-based information
6) Exposing the Commission and the knowledge networks to different local experiences
7) Producing and publishing monitoring reports on the Commission’s work
8) Coordinating with all PHM campaigns

Discussion and Conclusions
Although knowledge generation is a function of the KNs, it was agreed that CS should be active in generating knowledge. Creating knowledge and generating research can be influenced by ideology. Thus this should not only be a function of the KNs, given their Northern bias. CS needs more influence overall, since they have only a small representation on KNs. Evidence shouldn’t only be taken from research work, but also can be taken from successful models at community levels and by documenting testimonies, etc. In general, CS proposes to be involved in KNs but to also generate knowledge outside the KNs.

Letter to the Secretariat and CSF budget overview

P Mubangizi
The proposed letter outlining the CS participants’ process concerns was presented for discussion and approval. It was agreed the CSFs would sign on behalf of all participants, and that it would be sent to the CSDH Secretariat, and cc’d to the Commissioners.

The CSF budget was presented. The shortfalls were pointed out by the participants, and concerns rose about the ability to take this process forward effectively at country level with such limited financial resources.

Group Work II: Developing the African region CS strategy of work with the CSDH

Chair: B Lloyd, PHM
The objective of the strategy is to build health and health / SDH-related CS in the region. The participants split into groups to consider the following areas of strategy: communication and dissemination of information, capacity development, advocacy and lobbying and generation of knowledge.

The groups were to consider the following questions during the strategizing session:
- What do we need to do within these key areas?
- What parallel processes are required by CS (e.g. monitoring)?
- What is the minimum you can commit to in achieving this?
- What constituency will you report to when you return?
- What forums and processes are already in place?
- What are your expectations from the secretariat?
What are your expectations from your CSFs?

**GROUP WORK II OUTCOMES**

Brainstorming on the four areas of strategy:

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<tr>
<th>1. Communicating and disseminating information</th>
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<tr>
<td>- Use existing web sites: HAI Africa to collate and edit inputs into the website; others in the network to develop and update links to the HAI website</td>
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<td>- Develop country focal points: define roles and responsibilities of focal point contacts; focal point contacts to be channels for linkage with CSF</td>
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<td>- Audience analysis</td>
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<td>- Formulate messages and communicate the same</td>
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<td>- Networking: divide the thematic areas for each CSO</td>
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<td>- PHM / IPHU to strengthen health organizations and CS through the region of E and S Africa.</td>
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<tr>
<td>- Strengthen CSOs through trainings on communications (eg. tailoring the message as per the audience, using appropriate media)</td>
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<td>- Train figure heads in local communities to disseminate information</td>
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<td>- Use of representatives of local government structures</td>
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<td>- Obligating governments to use public funded infrastructures</td>
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<td>- Enhance existing networks (widening the constituency)</td>
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<th>2. Capacity building / development</th>
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<tr>
<td>- Several capacities needed: public speaking, writing / communication skills, presentation skills for dissemination; contextualizing issues at country level; adapting information for wider dissemination and reach to elicit feedback and input from the grassroots</td>
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<td>- Tools / mechanisms: use both formal and informal mechanisms (exchange visits; attachments; mentoring; short courses (UNISA, UWC SoPH, TARSC / EQUINET, etc); collaboration with Northern-based institutions; volunteer / studentship programmes. It was noted that the spirit of voluntarism becomes difficult as socio-economic circumstances become difficult, and could this be factored in?</td>
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<td>- Develop a strategy to create a general understanding of CSDH, with focal points at national level</td>
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<td>- Hold an IPHU course this year: current CSO participants could attend (or at least the country focal points)</td>
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<td>- Fundraising to facilitate training, networking and office running-costs, including IEC materials</td>
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<td>- Exchange programs / meetings between networks (e.g. HAI and PHM)</td>
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<td>- Training on SDH and peer education to enhance dissemination aspect</td>
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<td>- Engagement and training of methods of engagement CSOs with the Commission and CSOs with the government</td>
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<th>3. Advocacy and lobbying</th>
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<td>- Parliamentarians (Health and Social Services Committees)</td>
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<td>o briefings on relevant issues; user friendly formats</td>
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<td>o develop databases of working with parliamentarians (strong linkages and relationships</td>
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<tr>
<td>o be mindful of high turnover at election time (in developing/evolving democracies)</td>
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<td>- Local authorities (live and work locally and have powers to make appropriate by-laws (for SDH?))</td>
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<tr>
<td>- Media – aim for active involvement to become part of the challenge. (But it was noted that the issues of CSDH are political and political biases in reporting may misrepresent or distort key messages)</td>
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<th>4. Generation of (relevant) knowledge</th>
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<td>- Identify knowledge that is needed and necessary for furthering SDH</td>
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<td>- Monitor whether the knowledge being generated is appropriate and addresses issues on the ground</td>
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<tr>
<td>- Tools: oral testimonies, pictorial formats, short stories</td>
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<tr>
<td>- Lessons learned documented for dissemination: map onto existing focus</td>
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Identify existing structures and avenues to generate and document information from the grassroots
- Documented reports from KN should be circulated for review
- Identify the kind of knowledge needed
  Dissemination of the knowledge through case studies, involving the affected communities to speak for themselves

Further questions considered during the strategizing process:

**What parallel processes are required by CSOs?**
- Malawi and Kenya: engage with PRSPs and HSR program
- Zambia: trade unions that cover diverse areas
- Health desks at EAC as well as SADC
- WV Kenya has linkage with government; need to engage MOH Kenya and other Commissioners
- TZ breakfast session brings together CS and UNICEF
- Global Youth Employment Summit in Kenya
- Malawi Users and Provider Group
- SA PHM forum
- Bamako SF
- PHM General Assembly
- World Urban Forum (at which CS advises UN Habitat)
- Shadow reports (parallel reports presented by the watchdogs; retaining independence)
- CS position papers (open letters, petitions) to each Commission meeting
- Diversification of funding for CS meetings

**Minimum commitments to achieve the above**
- Use existing spaces to advocate and inform on SDH (e.g. use the social forums in the sub-regions)
  - HAI Africa to use its website to collate and edit network information
  - Country point focal contacts volunteers (e.g. CWGH – Zimbabwe; TANGO – Tanzania; CHESSORE – Zambia)
  - Dissemination to constituencies on SDH (newsletters, materials, etc)
- Task force to produce a report by 13th Jan (of this meeting)
- Participation in next edition of Global Health Watch
- MWENGO can run thematic social forums in SA
- All can participate in national consultations for CSDH processes

**Which constituencies to report to**
- HAI reports to network members at regular intervals (suggested monthly)
- CWGH reports to membership; disseminates to NANGO umbrella NGO; disseminates to MoHCW; disseminates to Parliamentary Committee on Health)
- TANGO disseminates to member organizations (700+ NGOs)
- CHESSORE reports to network members groups; feeds into existing NGO/CSO groups
- Undertake a consultative process to bring together Zambian CSOs around the SDH process (perhaps form a new CSO grouping)
- SA: Social and Economic Justice Network
- In general: community service organization networks; consumer movements; national NGO associations

**What forums and process are already in place**
- WTO CSO networks
- PHM
- Africa Trade Network
- Global Call for Action Against Poverty
- Common Market for East and Southern Africa
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- SADC
- EAC
- AU

**Expectations from the Secretariat**
- Offer a sustainable commitment to the CSO process and work; be available when needed
- Ensure sustainability of the commitments of / by the Secretariat – going beyond the report into desired actions and interventions
- Provide resources (financial and others as needed; help to mobilize resources)
- Disseminate relevant information
- Facilitate links with CSOs
- Be accountable

**Expectations from the CSFs**
- Give regular feedback / consultation
- Ensure accountability / transparency to network members
- Take up collective views and perspectives (e.g. not selective or own views)
- Use the mandate wisely to cultivate trust in the CSO CSDH process among network members
- Function as links between the broader CSOs and the local networks – ensure flow of information
- Facilitate interactions between CSDH and CSOs and Commissioners
- Present position papers
- Maintain continuity
- Link different regions together

*Specific commitments from each organization and country, for use in the workplan development*

**CS mapping exercise for CSDH**

*P Mubangizi*

The draft mapping methodology and questionnaire were presented. It was agreed that most CSOs would need more information on CSDH before this becomes something with which they would want to be involved. All felt that many won’t complete the questionnaire because of its length and / or because of its medium (email).

Within one month, the mapping questionnaire will be amended and resent to all participants for final comments.

**Conclusions and next steps**

*P Mubangizi*

On behalf of the CSFs, Patrick thanked all the participants. The draft report will be circulated as soon as possible for comments, and it will be taken to Iran specifically as a draft.

Given their mandate to develop the workplan based on the above strategy development sessions, the reference group (Equinet, HAI Africa, PHM) will meet tomorrow to develop a first draft. The draft will be taken to Iran as per the requirements of the CSDH Secretariat.

The workplan with specific activities will be circulated to all participants for their organizational endorsement. Attached will be a form to sign, indicating the CSO’s commitment to work within the workplan and future CSDH processes. Those who do not reply in the specified time will cease to be active members of the network.
January 2006

Annexes

Annex 1 – Agenda
Annex 2 – Group work I: full text / testimonies
Annex 3 – Group work II: full text of proposed activities within CSDH (per country)