The Africa Regional Civil Society Strategy for the CSDH

1. Situation analysis of African civil society
While a more detailed diagnosis of the situation of civil society (CS) related to health in the African region will only be possible after concluding the mapping exercise (see section 4.5), it is possible at this stage to provide an overview derived from our collective experience.

During the struggle for independence and immediate post-independence (1960’s – 1980’s), African CS was in general strong, well organized and diverse and played a crucial role in achieving these victories and often provided models and infrastructure for social provision (eg. Mozambique, Zimbabwe, Tanzania, etc). Unfortunately, with few exceptions CS activity and mobilization has declined since the 1990’s as the unifying focus of liberation from colonial rule ceased to exist. Moreover, in common with general trends globally, CS, where it is active, has often become overwhelmingly focussed on single and often only technical issues and apart from the above exceptions has generally experienced a significant reduction in its funding base.

The challenges facing CS in Africa and indeed globally are now more complex. They include *inter alia* issues closely related to the focus of the CSDH, namely, increasing poverty and inequality associated with unfair globalization; economic crises and fiscal restraint causing increasing government withdrawal from social service provision; corruption and misgovernance as well as curtailment of citizens’ democratic participation and repression of their structures and organizations; weakening and collapse of institutions including universities and training institutions; and the effects of the HIV/AIDS pandemic.

The above context imposes an urgent and onerous responsibility on CS to mobilize and educate its constituencies about the nature of this crisis and to assist, and challenge where necessary, national governments and regional and global intergovernmental bodies and agencies on the need to act.

2. Methodology used in elaboration of the strategy
As the above indicates, African CS is unfortunately weak and fragmented and yet faces unprecedented challenges. It is our view that the CSDH process can serve as an important opportunity to resuscitate health and health-related CS.

In the past few years, in concert with the emergence of new social movements at a global level, some important initiatives have been taken especially in Eastern and Southern Africa. These include the formation of such networks as Equinet (Network for Equity in Health in Southern Africa), Peoples Health Movement, as well as the continued activity of several long-standing NGOs focussing often on specific aspects of SDH (eg. Health Action International (HAI) Africa, Consumer Information Network (CIN) Kenya, etc.) and several health labour unions (eg. South African Municipal Workers Union (SAMWU) and Southern Africa Trade Union Coordinating Council (SATUCC)). In February 2005, these and other organizations met in Lusaka, Zambia and created the Southern and Eastern African Health Civil Society Network which has formed the basis for the current effort to regroup and strengthen health and health-related CS in Africa.
The organization at short notice, of the first African CS regional meeting built on the above process, included nine countries (see attached list), and also involved a few newcomer organizations, including one from Central Africa and a few whose work primarily focuses on areas outside the health sector (e.g., agriculture, youth). This first regional meeting also included representation from WHO AFRO as well as two country offices (Kenya and Tanzania).

It is clear, however, that the coverage of CSOs both in terms of country representation as well as areas / sectors of activity is presently inadequate. In addition, there is insufficient involvement of grassroots organizations. We aim in the forthcoming period to address these gaps but acknowledge that this is likely to be a difficult, time-consuming and resource-intensive process.

3. How the strategy contributes to the CSDH lines of work
The draft strategy outlined in section 4 below attempts to contribute to the four main lines of work of the CSDH by utilizing resources, expertise and experience of the current group of CSOs and by involving other organizations that we believe can make a substantive contribution. It is important to recognize that at this stage this strategy is necessarily embryonic and will require for its further development greater communication, further meetings, and more resources at both national and regional levels.

4. Pillars of the strategy
Below are listed some key activities within each of the principal pillars of the proposed strategy. Since these ‘pillars’ or sets of activities are often interrelated, it was not always easy to decide where to place them. Within each of the following subsections, we list some, but not all, of the activities proposed in our recent regional strategic meeting. We envisage that additional activities will be identified through interactions with other national organizations that participants will undertake when they return to their countries. Conversely, some of the listed activities may prove to be infeasible due to resource constraints and other work imperatives. The appendices attached list a more ambitious set of activities thought to be desirable by the participants and possibly feasible in the longer term.

4.1 Dissemination of information around SDH in region and countries
- Convene regional, national and district level consultations with different stakeholders (e.g. National – South Africa, Kenya, Zimbabwe; parliamentary portfolio committee in Zimbabwe; District – CWGH review meeting in Zimbabwe)
• Using existing forums and planned events for disseminating information on SDH and the Commission (eg. country and regional social forums in Bamako, Zimbabwe, Tanzania; Youth Employment Summit September 2006 in Kenya; World Urban Forum June 2006 by UN Habitat)

4.2 Civil society country work
• Meetings with the WHO Country Representative, Focal Point in Ministry of Health, and Minister of Health and Commissioner from UN Habitat (Kenya)
• Organise press conferences by civil society activists (Kenya)
• Identify and organise campaign/s around key issues (Kenya)
• Documenting community and CSO experiences (World Vision Kenya)

4.3 Communication strategies on CSDH
• National consultative meeting (PHM South Africa)
• Use existing CS media and newsletters to inform about the CSDH (eg. devote one edition of the Critical Health Perspectives publication to CSDH and distribute it through the region by PHM-South Africa)
• Meetings with parliamentary portfolio committees (eg. Zimbabwe; Malawi - March 2006), health sector review meeting (eg. Malawi - March 2006)
• Disseminate information on regional consultation to wider base of inter-sectoral civil society organizations (eg. all participant organizations)
• Using organizational websites to disseminate information (eg. KULIMA Mozambique; TANGO; HAI Africa; CWGH)
• Utilize mainstream and alternative media (eg. print, TV, community and national radio - Malawi; Kenya; DRC)
• Meetings with the WHO Country Representative and Minister of Health (DRC)

4.4 Advocacy around SDH in region and countries
• Strengthen existing campaigns at country level (eg. Right to Health campaign South Africa; National Social Health Insurance Bill – CIN, Kenya)
• Identify and organize campaigns around key issues (Kenya)
• Develop a civil society task force to lobby government and other stakeholders (Zambia)
• Linking with existing policy forums (Tanzania)

4.5 Strengthening civil society
• Broadening the base of CS participation to include groups working on basic services and trade issues – to explore mutual campaigns including PHM’s upcoming Right to Health campaign (South Africa)
• Mapping as a tool for expanding the base of civil society participation (all participating countries)
• Conducting training courses, seminars, conferences and workshops (eg. MWENGO activist training in Zimbabwe Feb 2006; Tanzania June / Dec 2006)
• Collaborate with appropriate training institutions to develop curricula relevant to SDH (eg. International Peoples Health University)

4.6 Collection of community knowledge and civil society experience for inclusion in the KNs
• Documenting community and CSO experiences (eg. Zambia - dependant on funding from CSDH secretariat; World Vision Kenya)
• Analyse government policies and programmes (Zambia)
• Community involvement through recognition of best practice (eg. competition organized by Youth Employment Summit, Kenya, Sept 2006)

4.7 Strengthening work of CS representatives in KNs
• Develop a joint strategy with other CSFs

5. Goals, products, and examples of indicators
Given that the strategy outlined above is still preliminary, it is not possible to provide a detailed set of goals, products and indicators at this stage. However, we take the opportunity to suggest the following:

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Objectively verifiable indicators</th>
<th>Means of verification</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1</strong>: To increase the ability of CSOs to monitor the performance of the commission and its various components</td>
<td>No of position papers about the commission</td>
<td>Activity reports</td>
<td>Supportive environment from the other components of the commission</td>
</tr>
<tr>
<td></td>
<td>No of Skills development workshops, courses, seminars organized</td>
<td>Meeting reports</td>
<td></td>
</tr>
<tr>
<td><strong>Objective 2</strong>: To widen the scope CS participation according to the thematic areas of the commission at country and regional levels</td>
<td>No of CSOs actively participating in the CSDH activities at country and regional levels</td>
<td>Progress activity reports</td>
<td>CSOs are committed to the SDH</td>
</tr>
<tr>
<td><strong>Objective 3</strong>: To increase the awareness about the activities of the CSDH</td>
<td>Number of lobby and advocacy meetings held</td>
<td>Meeting reports</td>
<td>Resources are available Secretariat remains committed to CSO work</td>
</tr>
<tr>
<td></td>
<td>No. of position papers, policy briefs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Objective 4: To collect and analyze community and CSO experiences on effective interventions of Social Determinants of Health

<table>
<thead>
<tr>
<th>Number of experiences documented</th>
<th>Video recordings, Documentaries</th>
<th>CSOs are committed to SDH work</th>
</tr>
</thead>
</table>

6. Weaknesses in the region and in the CSF group
Section 1 above describes, and provides some reasons for, the weakness of CS in the Africa region. As indicated, the process of strengthening CS can be accelerated through CSDH activities but will require significant communication and interaction, networking, and capacity building.

We believe that Africa potentially possesses the resources necessary to overcome the above weaknesses eg. a rich tradition of self-organization, experienced institutions (albeit weakened) and resilient populations. However to optimize these will require sufficient time as well as significant additional inputs, including infrastructural, financial and human resources.

Furthermore, whereas the identified CSFs are committed to the implementation of the Commission’s work with CS in the region, there are structural, organizational and individual weaknesses which need to be addressed. These include:

- **Structural:** There is consensus on the concept of formalizing a reference group, drawn from CSOs and mandated to provide support to the CSFs on all critical issues, including implementation of the regional strategy.
- **Organizational:** Administrative support should be institutionalized to manage all logistics, thus reducing this particular workload of the CSF-facilitated institutions.
- **Resources:** Funds should be provided adequately, taking into consideration the unique logistical realities of the sub-Saharan Africa region (poor communications infrastructure, high cost of transport, etc)
- **Capacity building:** Besides individual capacity building needs, exchange visits among CSFs globally would be an effective method of sharing experiences, brainstorming and enhancing facilitation skills.

Association for Health and Environmental Development (AHED)