HEALTH CIVIL SOCIETY IN EAST AND SOUTHERN AFRICA

MEETING REPORT

at the South African Social Forum

People's Health Movement

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Held at the CWGH offices, Harare, Zimbabwe
13 October 2005

Report produced by TARSC
Meeting held with support from
IDRC and Dag Hammerskold Foundation

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1. Welcome and introductions

The regional meeting of health civil society in east and southern Africa was planned and held by the health civil society planning group in the region. It aimed to consolidate the civil society platform developed by health civil society, link this with the regional equity analysis proposed by the regional network for equity in health in east and southern Africa (EQUINET) and take it forward within the Southern African Social Forum being hosted in Harare in the following days. It gathered delegates from health civil society in Zimbabwe and from the region. Logistic support for the meeting was given by Itai Rusike CWGH, Godfrey Musuka EQUINET, Thomas Deve SASF and Njogu Morgan of the HCSESA.

Itai Rusike welcomed everyone to the CWGH home and also to the meeting of Health Civil Society (HCS) in eastern and southern Africa. He welcomed our colleagues from elsewhere in the region and invited Njogu Morgan to briefly talk about HCS and what brings us together. The deliberations from this meeting would be input into the Southern African Social Forum (SASF) and possibly into the work with the World Health Organisation (WHO) on the Social Determinants of Health Commission.

Njogu Morgan explained that the HCSESA was a group from many different countries. He explained that the agenda for the day was not a workshop, but and opportunity to participate and interact as we are all learning. HCSESA is a network in formation, organising people's power for health. A number of organisations and people in the regional network for equity in health in east and southern Africa (EQUINET) in the People's Health Movement (PHM) and other organisations in health civil society began to understand the need to reach out to people in southern and east Africa for joint collaboration and solidarity. In trade negotiations, there have been attempts to divide and rule us; therefore the necessity for collaboration was recognised.

There was an initial mapping exercise and beginning to generate shared consensus and vision, during which there were disagreements on strategies and tactics, so we had a series of meetings to find issues that we agree on. In February this year about 30 organisations had a meeting to launch the HCSESA and developed the consensus

statement. The poster “Building national people’s health systems’ attempts to capture our consensus areas of work that our network in engaged in around the six points:

1. Values of equity, social justice and the right to health.
2. Comprehensive, universal and integrated national health system.
3. People led, people centred health systems that organise, empower, value and entitle people.
4. Fair financing with debt cancellation, 15% govt funding to health, equitable mobilisation and deployment of resources.
5. Ethical and equitable human resource policies at national, regional and international level that recognise health workers concerns, and confront perverse south-north subsidies.
6. Fair global policy (just trade, reversing unfair flows of resources) with national and regional policy flexibility to exercise policies that improve health.

We are still looking to bring other actors into the process; we are growing and we want as many CS actors as possible to be involved. EQUINET has a similar framework that HCSESA has fed into that it is using for its regional analysis, advocacy and policy engagement on health equity in the region.

2. Building a National People’s Health System

Greg Ruiters of the Municipal Services Project chaired the session. He introduced Mwajumah Masaiganah of the Tanzania People’s Health Movement.

2.1. Revitalising and building a National People’s Health System

Mwajumah Masaiganah said we are actually here to mobilise people’s power on health, by making sure that there are workable health systems. We have had health systems in place, but they are not currently workable. Therefore we need to revitalise and rebuild health systems to work for the people.

National people's systems started with primary health care (PHC) movements which started up in an autonomous manner in the 1960s and 70s. They were very rooted in communities, with voluntary sector playing a big role. In 1978 was the Alma Ata declaration calling for "Health for All" by the year 2000 – which has never been, and may never be reached without us pushing our governments.
We used to have healthy nations with good well-being, as the spirit of PHC was sustained for a period, but then parallel programs were set up and external processes and reforms being instituted by external forces, bringing down the spirit of Alma Ata and structural adjustment programmes (SAPs) tending to have detrimental effect on health systems, social justice and equity. A shift beyond doctors, drugs and diagnostic health underpinned PHC. Now people are dying in their homes as there is no one to provide proper care. Our systems are currently unworkable. In 1986 Ottawa declaration introduced basic determinants of health – peace, shelter, etc. But global health discourse is technocentric with public-private partnerships pushing vertical programs. There are worsening economically, socially and politically generated health inequalities amongst communities and competition for scarce resources, and the root causes of avoidable diseases and deaths are not effectively addressed by current programs.

"Health for All" has simply not happened and comprehensive primary care is no longer effective. Reforms are failing as commodification of health and health care is taking its toll. The MDGs are not on track and won't be achieved. Therefore, we are united around core principles and values of the fundamental right to health and life. "The right to health is a social right, an obligation on the state and on society through collective, social action" (EQUINET 2005).

We need to urgently replace dominant discourse by a process aimed at universally achieving our aims of revitalizing and building National People's Health Systems, which:

- are universal, comprehensive, equitable, participatory and publicly funded;
- initiate or support struggles related to the right to water, food security and food sovereignty, a healthy environment, dignified work, safe housing, universal education and gender equity, since people's health depends on the fulfilment of these basic rights; and
- defend health workers in their opposition to the privatization of health services by building broad multi-sectoral alliances.

In response to questions from participants, Mwajumah Masaiganah outlined the work being done to tackle problems with health care delivery in Tanzania as follows:

- We are trying to show the impact of privatisation and people failing to access health care facilities because of user fees just to see the doctors. There is a cost sharing exercise, there are mechanisms for exemption but they are difficult to access for children, poor and pregnant women and the old. We have been trying to create alliances with doctors and government to do advocacy work. Tanzania is vast and you can have to walk 12 hours to the nearest clinic; you cannot get transport, while people are transported by locker beds.
- We dialogue with government through HCS and NGO forums, organisation meetings, and the media (although this requires you to create alliances as the media is privatised; the govt media is tricky because you have to figure out how to put across the message). We have to be able to track reasons for mortality and many are dying from things that can be cured and prevented; we are trying to find out why people are dying even if they have been to the clinics; mortality is occurring on the periphery where there are not many services.
- In the PHM we have been working with communities, looking at impact of rollback malaria treatment. People feel that many of the promises are just rhetoric. At district level, health workers said they were overloaded with too many meetings and office work instead of treating patients.

She finished by highlighting the need to unify our cause towards common goals: to have one voice from different fronts to create pressure on our governments; if everyone is voicing different concerns from different perspectives it won't be easy.

3. Ensuring health systems are fairly and adequately financed

Greg Ruiters said he thought everyone understood the severe and serious challenges confronting us. We have now a presentation on finances and building fair health systems, from Vimbayi Mutyambizi who is a health economist based at the Health Economics Unit at the University of Cape Town, South Africa.

3.1. Ensuring Health Systems are adequately and fairly financed

Vimbayi Mutymabizi said a health care system is fair if payments for care are based on ability to pay. Those with higher incomes should pay more. Those with similar incomes should make similar contributions, but the benefits must be distributed according to need.

To ensure our systems are fairly financed we need to push for more public investment in health care, while for example, Tanzania is cutting its health budgets. In the face of

shrinking tax bases with increasing unemployment, what other sources of taxation can we look to? Can we tax multinationals, rather than individuals etc.? We are rich in resources, but we are not accessing those resources to increase our pool of funds for health care. Debt relief must be translated into increased health care finances.

We need to reach and go beyond the Abuja target that says countries should aim to achieve 15% of their budget on health spending: only Tanzania, DRC and Mozambique have managed to do this, but that is based on donor funding which is unreliable and unsustainable. We need to ensure the removal of user fees and the reduction of out of pocket payments, this includes getting drugs etc. Payments for transport to access health care should also be covered as out of pocket payments make up 50% of all expenditure on health care in the region.

If we increase funding and financing then we need to ensure that resource allocation is open and transparent and fairly allocated to those most in need. Increase financing must translate in delivery to the poor of a basic package of benefits based on resources that we have in the system, for example, including ART, taking into account the health needs of all the people. Another important goal is to decrease reliance on donor funding as this has conditionalities attached and can be unreliable. When we do have donor funding we should not have vertical programmes, but use these funds in sensible way, donor funding should fit into operations of system as a whole.

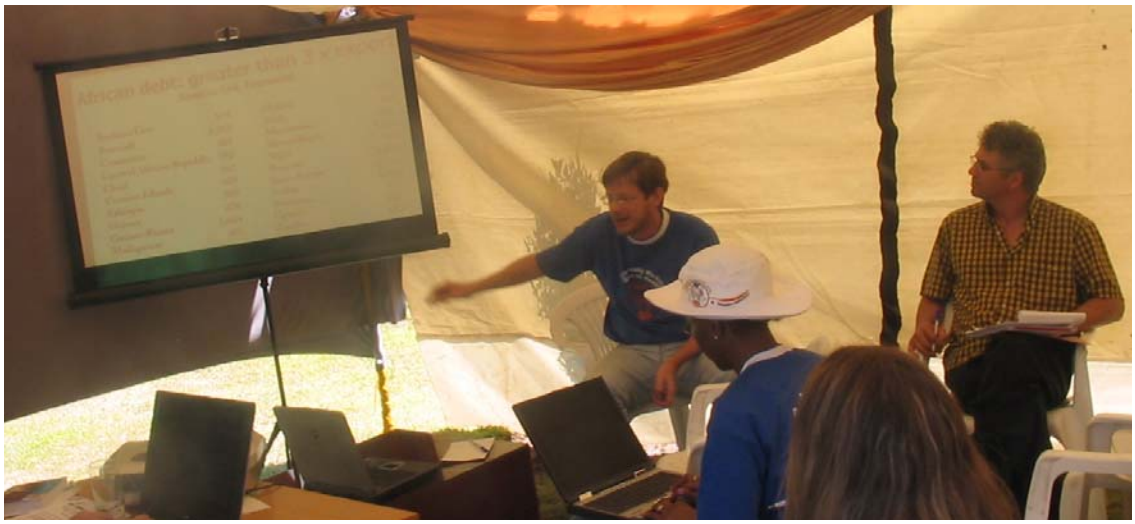
Researchers are pushing for health insurance schemes based on western models which are dangerous if they tend to fragment society. This means those are able to pay get better health care, which is not a fair system. Community based health care systems may not really generate the kind of revenues that we need; can lead to the poor subsidising each other, while the rich are subsidising no one.

In discussion participants said that in an unstable economic environment, increasing spending on health is difficult, while small incremental increases that do not take inflation into account, may actually be health cuts. The Abuja declaration of 15%, but it is difficult to ask for and achieve and in any case governments do not honour the declarations they sign. In countries honouring their Abuja commitments, health status indicators are not necessarily improving even if % of funds allocated is increasing, because it is about distribution and how to achieve equitable distribution. A poverty reduction strategy is a way of ensuring that impact is felt. We need to learn more about how increased spending improves health outcomes.

In resource poor settlements, even those with money, facilities are not available and therefore people cannot access health care. Money that is accruing from those who can pay should be distributed to those who need. A lot of the work on financing is technical, but politicians might decide against what has been technically defined, depending also on the strength of the minister and ministries of health. Therefore, while communities should rather identify their health needs and resource allocation should be based on that rather than a specific percentage of the budget, we cannot look at community health care in isolation from political context.

3.2. Accessing resources for health: Halting the outflow from Africa

Patrick Bond said the allocation of resources to health sector is linked to all the other rights, health is a compelling argument and it is linked to all other rights. But how can we challenge fiscal austerity? There is a tyranny of debt repayments based on high interest rates and repayments on debt far exceeding health budgets. Odious debts are sometimes made for example, apartheid debt - bankers who funded apartheid are now getting repaid. The elites continue to take money out to foreign countries – e.g. Nigeria $98 billion.



Aid is declining, while military spending is increasing. Some aid goes to northern technocrats in phantom aid. We have a situation of unequal trade with money being sucked out of the third as the commodity prices keep falling. Cash crops and minerals lead to crashing markets. The more you liberalise the economy the more people have less than $1 a day to live on.

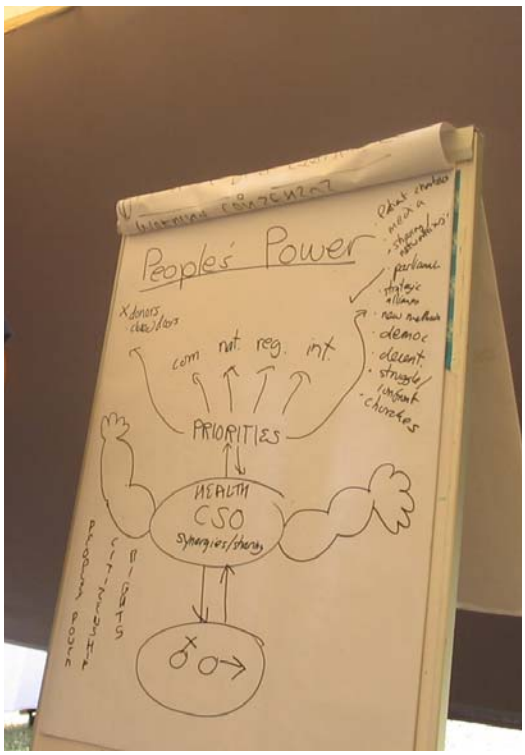
Small farmers are not receiving subsidies, but multinational corporations are. The World Bank admits there is a dramatic looting of Africa. Fiscal austerity is making life miserable, and yet fiscal austerity is making things worse. We should name and shame the phantom aiders, demand to be repaid for the looting and the suffering, impose exchange controls, stop unfair trade and create inward-oriented development, not dependent on exporting and donors. We are still fighting for our independence, but we “Don’t Owe, Won’t Pay!” In response to questions from participants, Patrick said it is not clear, given the collapse of systems and the lack of development aid, why our governments continue adopting same policies, knowing how much it is damaging us.

Greg Ruiters summarised the points for convergence from the two sessions on building a national people’s health system and fair financing as:

- we need ways of linking our struggles and unifying our voice, to overcome the isolation and segregation of health activists and health struggles.
- to build holistic and integrated health systems that talk to people’s lives; and
- find ways to pay for health and distribute resources fairly.

4. Organising people's power for health

Sally Theobold of REACH Trust in Malawi chaired and introduced the session, explaining that the presenters would discuss the features of people-led, people centred health systems that organise, empower, value and entitle people and trade liberalisation and the encroachment on health.



4.1. Organising people's power for democratic and universal health system

Caroline Mubaira of the Community Working Group on Health said that health is a human right and therefore you must demand it and contribute meaningfully through dialogue to organising people's power for health. Civil society had been affected by so many agendas confronting them, while we recognise the bankruptcy of globalisation. We are aiming for equity and justice and to realise that health is our right and our responsibility. We seek to bring power the people, and to strengthen people's voice in decision making through or ganising, uniting people and building public consciousness.

Our challenge is to:

- bring unity across civil society organisation, while ensuring autonomy;
- build an inclusive front of all stakeholders working in health and health related areas;
- demystify and link local, national and global structures to coordinate action; and
- define realistic priorities.

In Zimbabwe it is important to ensure the survival of CSOs against external attacks and challenges. Therefore, we need to involve our communities, engage the district officials and also involve national leaders. CSOs need people's backing for their demands, their work with local communities and sharing local knowledge. Incorporating traditional health systems we need to widen access to PHC which is where communities interact with providers, government and state. It is therefore important to facilitate logistical support, educate people and increase awareness of health and human rights, and strengthen health civil society at all stages (district, provincial and national).

In organising people's health our strength is our commitment to empower people for their health, and embrace diverse experience, skills, expertise and knowledge. Unfortunately, we are weak because civil society is fragmented with split efforts and the lack of joint vision; we have limited resources and are donor dependent and some CSOs are losing

focus and lack passion for the fight for the cause. She observed that there are too many meetings and no action; and capacity is weakened by too much work and too few people. Therefore, we need to mobilise communities.

Health civil society is threatened by global disasters resulting in the movement of policy attention. Donors focus on vertical programmes such as vaccination and prefer large organisations rather than smaller ones and we also face unsupportive governments and government policies which are not healthy. This may mean that we lack of finance, human resources and time. However, we should use the opportunities we have to bring young people on board, form strategic alliances across issues and across the region, and to give input to the parliament portfolio committee on health across SADC.

In discussion following the presentation, participants said that organising people's power for health is crucial and it is our right. Therefore we need to take responsibility for actions to protect our own health, by using health services, controlling our own resources and organising around the health inputs that we want. Community organisations and participation should not be taken for granted but should be planted, nurtured and protected keeping eyes open for things that erode our ability to access right to health.

4.2. The road from subject to citizenship: securing our health and fight for our existence

Alinefa Kasiya of the Malawi Health Equity Network said we are looking at a fight for our lives; if you do not have good health you will die. If we think about those who cannot reach facilities, medicines etc – it is our lives we are fighting for. Being a citizen is more than just being a recipient of programs and interventions; it means active participation in the state: being conscious of your rights and obligations plays a role to improving quality of life for other citizens.

Services in communities are not a privilege, but a right. We must claim the right to the realization of the health and healthcare as an entitlement for every individual. The trend in terms of decentralization and democracy promotes participation and makes more room for engagement with the state, accountability from the state and for popular advocacy and voices for the voiceless.

At a community level people need to engage with local health systems at a national level we need to engage with state/government departments and the private sector for policy dialogue, and at an international level we need engagement with governments/ private

sector on international policies. We also need to share our energy to give us more voice and energy.

People's power means:

- creating awareness on issues e.g. access to healthcare as a right;
- building consensus on the agenda e.g. more resources for health;
- strengthening capacity of people to engage in dialogue / advocate/ participate in state processes to promote health; and
- building alliances and networking with the like minded individuals.

The way forward lies in what we are doing to build a strong and constructive civil society movement to advance the equity and right to health agenda. This means developing strategic links with key institutions- parliaments, etc, international, keeping the momentum for the cause, being focused on the shared agenda for change/ action; and celebrating half measures, but not being satisfied by them.

In discussion, participants said that there are many avenues, strategies and alliances that we still have to explore. We often emphasise political rights rather than other rights such as social and cultural rights. We also need to be clear that health is not merely the absence of disease, but also psychological, mental and social health. We need a comprehensive definition of health and must look at health in totality. There is also a need to bring disabled people on board.

We need to develop new mobilisation tools by looking at case studies and diversify strategies. Being confrontational sometimes becomes necessary when governments fail to honour their commitments. Civil society organisations should try to mobilise and motivate the community so that community members look after their own health. Civil society is failing because people need to recognise themselves as being with us.

To ensure our efficiency we really need to forge good relationships with the media to reach people and be strategic in working with them, while understanding that the mainstream media can be manipulated.

Participants agreed that our priorities are that we need to:

- develop a shared agenda and be focussed in terms of our agenda, never losing sight of our agenda;
- fight at community level, national, regional and national levels;
- voice these needs; and
- fight for health rights linked to other rights.

5. Challenging trade liberalisation and encroachment of health

Riaz Tayob of SEATINI said that he was unashamedly biased in his presentation. Three factors are causing the encroachment of trade liberalisation on health:

- governance/ democratic factor (including national and global justice systems);
- social factor: since we achieved independence, we had a fantastic run, but once we embraced a particular neo-liberal globalisation system has impoverished us further; and
- imperial factor: external interference in our affairs; stakeholders in our region are the people, but we make decisions that hurt us.

The south is exporting $1.8 trillion to first world every year. Trade used to be the move of goods across the border with there being impediments through tariffs, but now it is also services being trade with the only thing stopping services moving are things like visa regulations.

The WTO General Agreement on Trade in Services (GATTS) is a problem because if you want to promote trade in goods, you lower tariffs; if you want to promote trade in services you remove regulations. GATTS is about removal of regulations unless they are "necessary": but WTO decides in Geneva what is necessary, therefore GATTS is a process of outsourcing government to Geneva, while "necessity" is a values judgement. GATTS will tell us it is not necessary for us to restrict trade in health services; if we want to retain our democracy, why are decisions being outsourced to Geneva when this removes our authority.

On the WTO agreement on Intellectual property rights TRIPS: these are agreements to protect ideas. Generally ideas are freely available, but increasingly ideas are being protected through patents, giving a monopoly right to the inventor – no one else can use the idea – but then you must disclose how you made it. Pharmaceutical companies spend more on marketing than they do in research and development and focus on sexy drugs like Viagra and baldness, but not malaria and TB. Our people die so that we can protect monopoly rights for inventors, making drugs expensive, while producing generics causes monopoly prices to drop. When life is threatened, that which is illegal becomes legal. The pharmaceutical companies are pushing for more regulations to make drugs scarce. Rich countries prevent us from using flexibilities. USAID tells us that we must

buy patented drugs from the USA – phantom donors – this has negative social implication.

The rich countries wanted to blur distinction between discovery and invention. 80% of drugs were sourced from indigenous knowledge sources, while those people got nothing.

It is the same as saying that Da Gama, Diaz discovered and invented southern African. Rich countries will give us money, but they won't make drugs cheaper at WTO, they say: "Die!", while they give us aid? They know they are doing unfair things to Africans that is why they publicise their so-called aid. Systemic interventions are not done. This has been going on for the last 30 years.

Therefore, we must keep our decisions as ours and not outsource them to Geneva, UK, Hong Kong, etc. The corporate agenda must be stopped; it is not the people who want illness spreading in Africa, but the corporates. Northern countries retain their health systems, while telling us to destroy ours. We must stop subsidising the rich countries every year to build a self-financed public health system Power concedes nothing without demand, so we must build people's power. Everyone with ill health is in the same boat – irrespective of who is in charge we have right to health.

In discussion it was explained that three lethal diseases (TB, malaria and HIV/AIDS) formed 18% of disease burden but only 3% of research. Is it really so expensive to provide cheap drugs? We are locked into a system that does not let us produce and export our own drugs. Zambia's health budget is only enough to cover buying malaria medicine. The northern governments are doing this and our northern partners have complicity in this.

Looking at synergy: we have people with traditional substitutes to medicines, but people are giving knowledge away for the possibility of developing stronger medicine. We have so much knowledge and potential, but valuable information is withheld to export our ideas so that they can sell finished product back to us at an exorbitant rate. The profiteers must think we are stupid – we supply them with learned people, the technical know how, the raw materials, and then they sell it back to us.

Part of imperial structure is that patent rights are individual, while knowledge is communal and collective, so how do we introduce collective ownership as the system is geared to individual ownership which makes a free for all on collective knowledge. All indigenous knowledge should be invested with the state and these flexibilities are not being explored. San people getting 1.5% of profit on diet medicine they contributed to when according to agreements they could have got 50%.

In terms of the disruption of trade discussions in Seattle, Mexico, Doha etc northern groups came together to resist these agreements being made. African ministers refused to sign in Seattle and Doha and insisted on development agreement, which was not development, then in Mexico they also refused to sign a deal. These struggles have helped building a broad consensus, with widespread condemnation of the WTO, but have hurt us in that we have been absorbed into unified agenda – controlled by northern activists -- without saying specifically what we need.

In response to participants' questions, Riaz Tayob said our key priorities and slogans should be:

1. No deal is better than a bad deal at WTO.
2. Retain national autonomy and sovereignty on issues.
3. People power is an essential part of securing health rights.

Trade and service agreements are absolutely essential to our health rights and our challenge as civil society is to find ways to make them an opportunity, to locate consensus within realities of southern African and Africa as a whole!

6. Ensuring health systems have adequate and valued health workers

TJ Ngulube of Chessore chaired the session. Introducing Godfrey Musuka of Training and Research Support Centre (TARSC) and Soraya Elloker of the South African Municipal Workers Union (SAMWU), he said human resources are our allies in our health systems and we are going to look at the current issues for health workers and the way that are treated.

6.1. Human resources for health

Godfrey Musuka of TARSC said health outcomes are influenced by the need for adequate, well trained, equitably distributed health workers who work in decent working conditions. We need to motivate health workers through training and other financial and non-financial incentives, so that we value the role of health workers: many health workers are poorly paid, they lack the basic tools they need to perform their jobs properly, those working in rural settings live in poor conditions without adequate access to services. Instead of subsidising developed countries that save on training, we need to advocate for a better response to migration of health workers from the region, as well as to take action on the relevant production of human resources for health: what numbers, what gender, what distribution, what kinds of training. We need to think about how we

can take the struggle on HRH up at the SASF and beyond; how can we inculcate the message that health outcomes are greatly influenced by HRH issues?

Activity sheet on human resources for health

Soraya Elloker of the SAMWU took participants through an activity sheet on human resources for health. She described health care as a river, with different streams of actors leading into it to create collective action –- these are:

- fair financing
- health workers
- civil society
- trade unions
- politicians
- public health system
- researchers.

She asked each person to think about what they are going to contribute on the journey of motivating health workers. Participants responded as follows:

- listen to the load that nurses are taking and I will keep myself healthy as far as possible not to overload health workers;
- action research on the needs of health workers;
- community-health worker dialogue;
- building capacity in health worker training;
- advocacy at tertiary institutions;
- providing education for health worker from community perspective;
- encouraged health workers to take up further studies to improve their skills and get better jobs; and
- advocate for more money for human resources.

There are different currents in the water – issues and conditions of work – which contribute to making health workers so weak, such as:

- The disease burden of Africa, causing staff shortages as many leave the system because of the demands being put on them.
- In South Africa, it was clear that nurses were, in many hospitals, having to make decisions about life and death; some hospitals had rats and medical waste lying around. Communities and trade unions have been raising the issue, but nothing has been done because of lack of funding because of neo-liberal policies causing conditions to worsen.

- Thirty healthy babies died in same few days in one hospital this year because conditions were bad. Workers were working without gloves -- an OH&S issue.
- The South African government has introduced for some to work in rural areas, but they have not distributed these incentives equally which causes friction between health workers. The HIV/AIDS epidemic is breaking the back of an already weak system.

Participants then reflected on how some of those currents could be neutralised, for example:

- more training and professional development for more health workers to build capacity and inter-personal skills, with an appropriate curriculum and appropriate skills mix (universities need to create health workers to tackle our priority health issues, not for work in industrialised countries);
- multi-sectoral approach to incentives, but not just money, but access to loans, full medical cover;
- lobbying government to be conscious about concerns of health workers instead of just talking about just politics;
- advocating for more resources to encourage health workers to enjoy their work with drugs, infrastructure, equipment;

- better working conditions, including protective equipment, clothing and disinfectant;
- advocate for care, support, treatment and prevention for health workers;
- full funding for home based care activities with trade unions taking up the issue;
- pharmaceutical companies should be supported to make drugs available at lower prices;
- civil society organisations need to lobby for health workers and volunteers to receive incentives;
- inter-country exchange visits with health workers to acquire models of best-practice;
- involve health workers in dialogue about issues that effect their work;
- need for CBOs to encourage community participation in health workers so that they can help each other and understand each other and develop respect for each other; and
- evaluation of achievements of health workers.

We also need to value the contribution of traditional health workers as 70% of population access traditional health workers. It would be good to incorporate them into the health sector, but by legitimisation and regularisation of traditional healers and clear

accountability. Initially there is a need for them to be trained in specific areas such as midwifery, infection control, community-based counselling, etc. We need to be supported by a good infrastructure and provide system of accreditation for their work and their medicines.

As most health workers are women, and women are carrying the whole burden of HIV/AIDS, we need to be gender sensitive in some of the following ways:

- stop violence against woman;
- protect women from their higher risk of contracting HIV/AIDS;
- men should engage is activities, even if they don't get paid and become more involved in care, share the load, provide support and sometimes exchange roles;
- tackling the increased workload on women because of home-based care;
- train men – not just women – on gender issues;
- men must be trained as home and community care givers;
- empower women in initiating relationships so that they are empowered around roles, pace of relationships and condom negotiation; and
- men should stop taking credit for work of their wives.

7. Resolutions

Delegates collectively developed the resolutions from the meeting, drawing from the platform developed and expressed on the health civil society poster and the discussions at the various sessions. The resolutions are shown below. They were presented by Mwajuma on behalf of the group to the people at the Southern African Social Forum and discussed with them. There was significant support for the resolutions and the ideas lying behind them and they were also distributed at the plenary session of the SASF.

Health civil society groups in Zimbabwe and east and southern Africa, recognising the initiative of health civil society in the region met in Harare on the 13th of October 2005 to discuss our struggles for health. We agreed on the following resolutions.

We are united, together with health civil society in the region, around the core principles and values of:

- the fundamental right to health and life
- equity and social justice
- people-led and people-centred health systems
- public over commercial interests in health (health before profits)
- people-led and grassroots-driven regional integration.

To take these values forward we are reclaiming the state in health and have identified the following priorities:
1. Building a national people's health system
2. Organising people's power for health
3. Having adequate fairly treated health workers
4. Sufficient and equitable funding of our health systems
5. Global solidarity for economic and trade justice.

Within these areas we resolve that:

Building a national people's health system
1. We are struggling to build an integrated health systems underpinned by the principles of equity that addresses of our lives, not just our illnesses and that keeps us healthy.
2. We will link, network and foster strategic alliances with partners, inside and outside the health sector, to develop a unified voice.

Organising people's power for health
3. We are organising people's power to amplify our voice, claim our right to health and control our resources for health.

Having adequate, fairly treated health workers
4. Our health systems need adequate, well-trained and fairly distributed health workers at all levels of our health systems in places where people need them most.
5. Health workers in the public sector need to be motivated through decent conditions, training, incentives, living wages and safe work environments, in a way that promotes gender-equity.

Sufficient and equitable funding of our health systems
6. We demand sustained increased investments in the public sector in health. We expect our governments to meet their Abuja commitment to spend at least 15% of government spending in health.
7. We demand an end to African wealth unfairly flowing out of the continent so that we have the resources for our health.
8. We demand an end to unfair charges on poor people for health.

Global solidarity for economic and trade justice
9. We expect our parliamentarians to ensure our countries have the independence and sovereignty to protect our right to health.
10. We remind those who go to the World Trade Organisation (WTO) that: "No deal is better than a bad deal."

We as health civil society, together with all other progressive forces in society in the region, are taking forward the struggle. We call on our global partners to support us in this struggle!

8. Closing

Rene Loewenson (TARSC/EQUINET) asked participants whether their members were enjoying the right to health. Many said no, or not fully. There were many reasons, such as the absence of the basic inputs needed like access to safe water, food. The reforms in the health system and in basic services have meant that people have to pay for these and other basic services, sometimes more than they can afford, meaning that in effect we now have to 'purchase' the right to health. This she observed is not just a technical problem but an issue of social justice. The concern for equity and social justice is high in the region when there are such big differences between those who have the resources for health, and those who don't. It is even bigger globally where the differences between 'haves' and 'have nots' is even bigger.

We need to ask who makes the decisions in the health system. How far are people and their representatives making the decisions and how far are they made by international trade and finance institutions, business and private interests? How far do we have a people driven health system? She observed the problems that arise when we lose control over our own domestic financing for health over the types of finance outflows that were described in this meeting. Our own state officials then have to spend more time with external funders that with their own people. The Global Fund for AIDS, TB and Malaria for example now provides more money per capita than some national public sector health budgets per capita. Some big multinational companies can have a bigger turnover in a year than the economies in the region. These influences can counteract a people driven health system and call for alliances between people and the state.

The system is not working for health workers either. The sessions on health workers showed us that we need to bring the health workers more into this debate. Therefore we need to engage as civil society with the state, parliament and health workers. The base for this is at primary health care and district levels, but our engagement should also go to national and regional level. Our health systems are not just a matter for health civil society or for people working in health – they are a matter for everyone.

She outlined the approach in EQUINET of taking up the six priority areas raised by health civil society that are also priorities for EQUINET. EQUINET is in 2006 going to implement a regional equity analysis and country level analyses as a way of assessing how far we are meeting our priorities, the positive experiences we can share and the actions of different organisations and people to build national people centred health systems. She asked participants to the meeting to contribute their experience- we want to hear your stories – not just the problems, but also some solutions to the problems – we want to hear the stories to improve conditions, to share across the region. Let's not keep quiet about our work – let's share our stories, spread information, so that people get new ideas. We need to start building a collective picture so that we can use it to move from resolutions and meetings to giving visibility to the real situation and actions on the ground, to support people who are taking action, and to engage at national, regional and global level. We want this work to bring us together around our shared values of equity and social justice- parliamentarians, state officials, universities, civil society and others.

By the end of 2006 we will have information from across the region on what is taking place in these major priority areas, what is being done, and where we think the gaps are. This meeting is part of a process to keep taking us forward. The ideas here will be taken to many platforms, home to your own areas, into our organisational work, to the SASF and to our regional processes, including the regional equity analysis.

TJ Ngulube of Chessore said I am very impressed with all that has taken place here and we are trying to pull the forces together that have been isolated – when we work together and work as one, we can try to build something to share with our citizens in our countries and in our region. Thanks to EQUINET for bringing us here and to CWGH for letting us find the strength within ourselves and see the potential we can generate. I am confident that our voice in SASF tomorrow will be stronger after the work today. Thanks to CWGH staff who have worked so hard to see that we are comfortable.

Delphine Chirimuuta of CWGH thanked everyone on behalf of CWGH for the great participation and collective sharing of ideas on building power for health in our respective societies.

Now we are faced with challenges to take home on how we are going to organise people's power for health. Are we going to remain passive recipients or become citizens with health rights? We all need to mobilize and revitalize our communities and have a united muscular civil society. There's need for us to control resources and not leave ourselves to the mercy of others e.g. donors and multinationals.

We need to demand for health rather than begging for it as it is our right and responsibility. From today's presentations we have learnt that globalization has impoverished our nations. There is need to work with our governments to widen access to health and productive capacities in the people and build a grassroot – led regional integration in East and Southern Africa. Another challenge is to avoid commitment of our health sectors by World Trade Organisation that would weaken our national health systems.

Adequate health systems need well trained and available health workers and we therefore need to lobby the governments to provide for that.

She commended the presence of the chair for the parliamentary committee on health in Zimbabwe and the regional delegates and was happy that the views of the meeting would be taken forward into the SASF and other processes. Most importantly she challenged people to take the issues to their own areas, health services, MPs and others in order to build and revitalize national people health systems. She wished everyone safe travel.

Appendix 1: Participants list
Health Civil Society in East and Southern Africa
Building a national people's health system
Meeting, Harare, October 13 2005

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Appendix 2: Programme






SATUCC, MHEN, CHESSORE

Health Civil Society in East and Southern Africa
Building a national people's health system
Harare, October 13 2005
Meeting Agenda

- 8.00-8.15AM Welcome, introductions I Rusike (CWGH)

  Chair, Greg Ruiters Municipal Services Project

- 8.15-9.00AM Building a national people's health system M Masaigana (PHM) N Morgan (HCS)

- 9.00-10.00AM Ensuring health systems are fairly and adequately financed V Mutyambizi (HEU/EQUINET) P Bond (CCS/ SACEJ)
  10.00-10.30 Break

  Chair, Sally Theobald REACH

- 10.30-11.30AM Organising people's power for health C Mubaira (CWGH), A Kasiya (MHEN)
- 11.30-12.30PM Challenging trade liberalisation and encroachment on health R Tayob (SEATINI), T Deve (Mwengo)

  12.30-1.30 Break
- 1.30-2.30PM Ensuring that health systems have adequate and valued health workers S Elloker (SAMWU), G Musuka (TARSC/EQUINET)

  2.30-2.45 Break

  Chair, TJ Ngulube CHESSORE

- 2.45-3.45PM Towards a unified agenda and action for people's health, equity and social justice I Rusike (CWGH) R Loewenson (TARSC/EQUINET
- 3.45PM Closing D Chirimuuta (CWGH)