People, Politics and Global Health:
Actions to change the Approach

REPORT OF THE SECOND
UK INTERNATIONAL PEOPLE'S HEALTH UNIVERSITY COURSE
HELD IN LONDON 12th – 17th April 2010

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Acknowledgements

The organisers would like to thank all those who took part in this second IPHU course in London: the presenters for the high standard of their contributions and the participants for their enthusiasm and active participation. Thanks also to the four organisations that provided stimulating site visits for the participants.

Above all thanks to Healthlink Worldwide for hosting the course, providing administrative support and stepping in to solve every logistical problem. Without this support, the course would not have been possible.

INTRODUCTION AND BACKGROUND

BACKGROUND TO THE INTERNATIONAL PEOPLE'S HEALTH UNIVERSITY (IPHU)

The IPHU is a global virtual university. It is a collaboration between health professionals, universities, grass roots health organisations and funding partners. It is coordinated by the International People's Health Council (IPHU) as part of the global People's Health Movement (PHM).

The overall goal of the IPHU is to contribute to the struggle for 'health for all' by strengthening people's health movements around the globe. It aims to do this by

- organising and resourcing opportunities for learning, sharing and planning for activists in the global people's health movement, particularly for activists from Third World countries; and
- sponsoring and coordinating research into the conditions for health for all including decent health care.

IPHU SHORT COURSES IN LONDON

IPHU has developed short courses in collaboration with local partners in several countries. This was the second course run by PHM UK – the first held in March/April 2009. It was coordinated by a planning group which included representatives from Healthlink Worldwide, Medact, Health Poverty Action and AMREF UK. While the overall approach was the same as the first course, several changes were made, based on the lessons learnt from the first course. This was enhanced by the involvement of two participants from the first course on the planning group. This meant that we were able to integrate suggestions from the participants' perspective into the revision.

Participants and presenters (See appendix 1 and 2):

Eighteen participants took part on the course. They were all health and/or development workers, and several were post graduate students. The participants came from several countries. Some (from Italy, Germany and Georgia) came especially for the course. Others, (from France, India, Pakistan and Zimbabwe) were already based in the UK, mainly as students.

The presenters were experts in their field, invited to give the participants the benefit of their experience. The day to day facilitation was undertaken by members of the PHM planning team. These facilitators were also responsible for maintaining continuity of the issues.

Through the generosity of PHM, a film maker attended the course, to document the process. This will be available online through the PHM website when completed.

Course objectives:

The overall objectives of the course were:

- To heighten awareness of the importance of developmental approach to health that focuses on social determinants, equity, social justice and the right to health
- To provide information on key documents and strategies, e.g. GHW2, the report on the Commission for Social Determinants in Health and The People's Health Charter.
- To raise awareness of the need for a long term commitment for change
- To facilitate networks for ongoing action, of people in the room, of key organisations and networks, e.g. PHM, and through literature and case studies.
- To sharpen people's skills to shift from theory to action
- To build on the experience, knowledge and skills of the participants

Desired outcome

A group of informed, enthusiastic and committed health activists, equipped with appropriate skills, ready to continue and develop the work in their own contexts.

The approach

Each day had a specific theme which, in combination, provided a comprehensive overview of what is needed for developmental approach to health. Within each theme there were presentations to provide the knowledge component, and practical sessions to enable participants to share their experience and to strengthen their skills.

A CD with the programme, readings, powerpoint presentations and other notes was given to each participants on the final day as a record of the course.

COURSE OVERVIEW

(see appendix 3 for course programme and the IPHU website for additional information)

DAY 1: MONDAY 12th APRIL
THEME: A DEVELOPMENTAL APPROACH TO HEALTH

- **Introduction (Margaret Reeves and Andrew Chetley):**
  The UK PHM coordinator, Margaret Reeves, introduced the course, providing the background to PHM and IPHU, and outlining the course objectives. This was followed by a session led by Andrew Chetley that included introductions and a discussion on the participants' expectations of the course.

- **Participatory activity: Living Sculpture exercise (Ruth Stern).**
  The first activity was designed to raise issues of relevance to the course through a participatory exercise. Participants created a 'living sculpture' based on a scenario given by the facilitator (a pregnant teenager attending a health clinic for the first time during her third trimester of pregnancy). The participants had to suggest characters - people who would be part of the scenario - and position them according to (i) their relationship with the girl (near meant a close relationship and far meant minimal to no relationship), and (ii) the amount of power they held (low – i.e. on the floor meant limited power, while high i.e. standing on a table, meant significant power). Characters selected ranged from the girl's family and local service providers, to politicians and the World Bank. The exercise was followed by a discussion on the roles of these characters and the impact they would have on the girl.

- **Presentation: Impacts of Globalisation (Mike Rowson)**
  Mike used the example of health worker migration to illustrate the challenges of globalisation for health and health policy. It is well known that health workers are unevenly distributed. Regions that spend most on health care and have the greatest number of health workers also have the lowest burden of disease. Mike described the significant increase in migration to the UK of health workers (doctors and nurses) trained in Ghana in the early 2000s. He outlined the push and the pull factors. The West, receiving trained health workers from countries such as Ghana, effectively receives a subsidy from those countries in terms of training costs saved. Meanwhile the health system in the country of departure is depleted, increasing health inequalities further. Mike raised the challenges facing policy makers simultaneously to recognise that migration is not a trend that can be halted; to respect the rights of individual health workers to migrate and so to improve their own working conditions and quality of life; and the need to not further undermine the health system in countries already at a disadvantage. He raised a variety of potential responses, including the possibility of paying compensation to the country providing the health workers, and if viewing the health systems in separate countries as part of one globalised health worker system.

- **Presentation: Human Rights and Health – Jude Mesquita**
  Jude Mesquita described the characteristics of a human rights approach. She illustrated a range of ways that a human rights framework can be used in terms of health: as a legal approach – through taking cases to court that challenge the violation of rights; as a

policy approach to strengthen those policies by setting out entitlements in terms of rights; using a human rights approach to pursue political objectives; and as a tool for advocacy. She set out the advantages of a human rights approach, and addressed some of the limitations that such an approach might bring. She also gave examples to illustrate how human rights to health can be addressed, drawing on the work of Special Rapporteur on the Right to Health: such as his role in challenging conditions for patients in psychiatric institutions and in integrating HR into health service, shifting the culture from an individual to a collective perspective. Another example cited was the Treatment Action Campaign of South Africa's legal case which resulted in the use of Nevaropine for Prevention of Mother to Child Transmission (PMTCT).

- **Human Rights Case Study: UK PHM Human Rights Report (Margaret Reeves).** Margaret reported on the PHM UK report which was prepared to coincide with the Reporting Cycle of the UN Committee on Economic, Social and Cultural Rights. The purpose was to highlight factors limiting the health rights of people living in the United Kingdom. The report resulted in the Committee making several relevant observations and recommendations to the UK Government.

- **Participatory activity. Market Place exercise: What is the issue? Who wants to know? Who are the allies? (Andrew Chetley)**
  Participants rotated around 4 tables, discussing the issues they were interested in and would therefore like to explore during the week. Each time they moved they worked with different people, but took the ideas from their earlier discussion with them. A 'host' remained at each table for continuity, informing new groups of the discussions that had come before. These ideas were also communicated through notes left by each group on flip chart paper on each table. This process culminated in a list of topics which formed the basis for the group task, worked on throughout the week as the last session of the day.


- **Small group exercise**

  Four small groups were formed according to their interest in the topics selected during the market place exercise. These were: increasing health activism at a community level; tackling health inequalities; globalisation and how it affects local health outcomes; and

climate change. The purpose was to create a forum where participants could share their interest and experience. These themes were returned to later in the week.

DAY 2: TUESDAY 13th APRIL.
THEME: SOCIAL DETERMINANTS AND EQUITY

- **Introduction to the theme (Andrew Chetley)**
  Andrew provided an overview of social determinants and the work of the WHO Social Determinants Commission, posing the question: '*what good does it do to treat people's illnesses then send them back to the conditions that made them sick*?' He noted the challenge set out by the World Health Assembly in 2009 for a global event to discuss renewed plans for addressing health inequities through the social determinants of health. He suggested that this challenge could be a rallying call for us all.

- **Presentation: Sanitation, a social determinant of health (Ruth Stern)**
  Ruth drew on her experience in South Africa to illustrate one of the most under-developed determinants of ill health – sanitation. Following a brief overview of the global situation, she described a small pilot study of dry sanitation units (that is, ecological sanitation that is not attached to the sewage system) in an informal settlement near Cape Town. The pilot study, which was small but successful, had been set up as a collaboration between local community members, environmental health practitioners, engineers and academics. The success of the pilot culminated in a larger study, led by the local government. Unfortunately this did not succeed. There were several contributing factors in this failure. Among them was the failure to involve the range of stakeholders, including the community. A general discussion explored some of the opportunities that exist, as well as constraints that make work on social determinants difficult. Lessons were drawn from both the study and the experience of the participants.

- **Presentation: London's Health Inequality Strategy (Helen Davies)**
  The presentation, while London based, was useful in raising points that can be generalised to different situations. Helen provided an overview of the role of the London Mayor's office, and the aims of objectives of the recently completed Mayor's Inequalities Strategy. By definition, the strategy had a strong equity focus. It also adopted a broad social determinant perspective, which inevitably then required the input of a range of different departments and sectors.

The focus of the presentation was on the process and challenges of developing a complex, multisectoral initiative. This was particularly challenging as the period of development spanned a local election and change of political party. The process included gathering of evidence which included: community experience gathered from outreach to small organisations; policy and programme mapping; ongoing stakeholder involvement and consultation. Helen's advice on how to succeed included finding the right partners, seeking and using evidence, commitment to using the alliances that are developed, and finally, to 'keeping the faith'.

- **Presentation: Climate Change and Health (Robin Stott)**
  Robin reminded the group that climate change is not new, but that the current changes in the climate are driven by man-made activity; namely the consumption of fossil fuels. He described the consumption of fossil fuels and the global inequalities in that consumption. He set out the threats this would bring to the planet and the global population, drawing attention to the increase in inequalities of all kinds, including health, and the growing threat of conflict. He contrasted this with the notion that what makes for a healthy society is a 'fair-shares' society. He encouraged the audience to think that knowing about their own carbon consumption is as much a responsibility for citizens as knowing other features of their own population, such as a country's infant mortality rate. He outlined things that the audience, as individuals and as health and development professionals could do, and presented the model of contraction and convergence as a potential way of coming to live sustainably on our planet.

- **Participatory session: climate change and the media (Alison Whyte)**
  After a short introduction on the way the media is tackling climate change, Alison divided the participants into small groups to explore the complexity of the issues, the campaigning potential and the challenges. The group tasks topics were (i) the development of wind farms, and (ii) how to get climate change taken up as an election priority. The feedback from all the groups included imaginative approaches for drawing in people so that they could gain from the measures taken (in this case the wind farms); in dealing with opposition; and ensuring political accountability.

DAY 3: WEDNESDAY 14th APRIL
THEME: HEALTH SYSTEMS

- **Introduction to the theme (Margaret Reeves and Marion Birch)**
  Margaret and Marion began the discussion on health systems with a discussion on the components of good comprehensive primary health care. Suggestions from the group indicated a human rights approach, which were noted, on reflection, to be the Alma Ata principles. This was then contrasted with the current situation where health is seen more as a commodity. Mechanisms for tackling inequalities in health care were raised, including risk pooling and cross subsidy. The session concluded with discussions on health systems in different countries, and presentations on three country examples by participants: Pakistan, Italy and Georgia


- **Participant presentations**
  - Pakistan (Sadiq Bhanbhro).
    Health concerns are reflective of a low income country. The health system, which operates at different levels, is predominantly funded by the Government. Health challenges include limited resources, unstable government, mismanagement, poverty and natural disasters. There is very limited community involvement in health care planning.

  - Italy (Chiara Bodini)
    The health system is funded by general taxation. Equity in access in guaranteed in theory (i.e. by law), but not always in practice. Recent health reforms (since the 1990s) have resulted in devolution of health powers to the regions. Current concerns include health inequalities, prominence of hospital based care, low community participation and limited care for vulnerable groups.

  - Georgia (Ketevan Tchelidze and Lela Kurdghelashvili)
    Prior to 1991, the health care system was centralised and fully publically owned and financed. The economic crisis resulted in health sector reform that combined social insurance, tax revenues and out- of-pocket payments. After the rose Revolution State Medical insurance company was abolished. States programs are now financed

thought private insurance companies, with vouchers to cover those living below the poverty line.

- **Presentation: Health Systems Strengthening (Gill Walt)**
  Gill compared the new agenda of Health Systems Strengthening (HSS) with the Primary Health Care agenda of Alma Alta in 1978, drawing on a case study of Mozambique. She traced the shift from what was a comprehensive PHC approach in the late 1970s to current vertical disease programmes; drawing on the local and global forces that influenced the shift. Initially health care in Mozambique was a state centric approach, supported by the WHO and NGOs, without restrictions. This was then replaced by a change in global focus, which included the shift from population groups to market economies, the influence of the World Bank, structural adjustment programmes and the growth of large funders such as GAVI and the Global Fund. The current climate includes target driven priorities such as the Millennium Development Goals, governance that focuses on privatisation and corporatisation, and a massive proliferation of actors in the health field. This also includes the shift of power from WHO to the World Bank and now to multiple global health initiatives, including the 'Health 8'. Gill concluded by pointing out that in order to increase support for HSS, lessons should be learned from the failure of PHC to build the evidence base, but also from the way PHC inspired its supporters to work towards change.

- **Presentation: National Health Service (NHS) campaigns (John Lister)**
  John's presentation focussed on the challenges facing the NHS in a period of economic crisis in the UK. He began by describing the significant increases in funding that the NHS has received under the labour government and the performance improvements that have been a consequence of this. He explained how, following the banking crisis and the bail out of the banks, the NHS is set to receive inflation-only increases in funding until 2017, despite the year on year increase in NHS costs that come from technology and workload changes. He discussed three areas which he considered to have been 'unwise spending' over the labour administration: the introduction of Private Finance contracts (PFI); spending on Independent Sector Treatment Centres (ISTCs); and the involvement of private sector consultancy in NHS management. He described some of the potential consequence of the financial squeeze on the NHS, in particular, cuts in staffing. He talked about how the forthcoming election in the UK, and the possibility of a hung parliament that could provide an opportunity for campaigners supporting the NHS.

- **Participatory activity: Site Visits**
  The afternoon was devoted to site visits. Four different organisations were selected to illustrate health care that tackled broad based issues. These were:
  - Providence Row, an organisation for homeless people that offers advice to local people and people from overseas
  - Praxis, an organisation for migrant communities in London, offering advice, training and support (including an interpreting service) for migrants and training for workers in London who work with migrants.
  - Clash (Central London Action on Sexual Health) a Camden Primary Care Trust service that provides services and support to population groups that are at high risk of HIV/AIDS. These include African communities, gay men and sex workers.
  - Health Poverty Action (formerly Health Unlimited), a development NGO that works to improve the health of the world's poorest, including marginalised and indigenous groups, using direct interventions and advocacy to empower local communities and address structural injustices.

Day 4: THURSDAY 2ND APRIL.
THEME: PARTNERHIPS AND COMMUNITY PARTICIPATION.

- **Site visit feedback (Andrew Chetley)**
  Before embarking on the theme of the day, feedback was given about the site visits. The visits were all considered excellent. They were also useful in demonstrating how different approaches can be taken to achieve similar objectives, with some organisations focusing more on client services, some building alliances and partnerships, and others including a strong advocacy focus.

- **Introduction to the theme: Ruth Stern**
  Ruth led an introductory discussion on partnerships in preparation for the next presentation, drawing on the experience of the participants. The value of partnership working was discussed, as were the many constraints and challenges of working across different sectors and organisations.

- **Presentation. Partnerships (Grace Mukasa)**
  Grace began with an overview of her extensive experience in collaborative work, mainly in Africa, and the background to AMREF and their work. AMREF is an African NGO with a long history of work on health. She used the example of the Katine project to illustrate the multifaceted aspects of partnership initiatives. The project is a joint initiative between AMREF, other NGOs, the Guardian Newspaper (UK), Barclay's Bank, the local government of Soroti district in Uganda, and the community of Katine. She described how the partnership had come about, what the different actors brought to the partnership, and some of the challenges, as well as the benefits for all parties of working in this unusual partnership. The different expectations and assumptions of each partner in the Katine Project were explored through a group task, with each groups taking on the identity, and therefore perspective, of one of the partners. Grace followed this up by describing some of the tactics they have used to deal with the tensions and dynamics within the Katine partnership. She concluded her session by outlining some of the values and challenges of partnerships in general.

- **Participatory session: Participatory approaches: (David Musendo and Andrew Chetley)**
  This was a very practical and enjoyable session exploring participatory approaches and methods. It commenced with a presentation and discussion led by Andrew on the theory and practice of participatory tools. This was followed by a discussion on community participation, exploring the importance of self awareness as well as the needs and strengths of communities, the need for effective communication that includes good listening, and the recognition of the diversity of communities. David then took the participants through a selection of participatory activities, showing the value of each approach each as they went along. He also used practical measures to demonstrate the different levels of influence and power within community participation (from none to significant power), according to a participatory ladder.


DAY 5: FRIDAY 3RD APRIL. THEME: WORKING WITH CIVIL SOCIETY

- **Introduction to the theme (Andrew Chetley)**
  Andrew introduced the topic of advocacy, providing an overview of what advocacy entails. Using their initial 'market place' groups, the participants illustrated how they would influence someone (in a position of power) about the importance of their issue through role plays.

- **Presentation: Advocacy (Sarah Edwards)**
  Sarah started by asking the group to think about what they understood by advocacy, and the tools that could be used. She suggested that a good way to think of advocacy was 'everything we do to influence others to bring about change.' She described the Jubilee 2000 Campaign which was followed by Jubilee Debt Campaign, and their impact in bringing about a cancellation of certain debts of highly indebted poor countries. She discussed some of the strengths of the campaign; in particular the popular mobilisation, the breadth of the coalition, and the success in making a complex concept into one that was accessible for people. She also drew attention to some of the potential limitations of the campaign; including a loss of focus on the broader issues about the inequities of the global political economy. She concluded with the example of a recent campaign about Vulture Funds (distressed debt companies) to illustrate the variety of tools that

can be used in advocacy, the use of parliamentarians and the media, and the importance of a timely context enabling change to be brought about.

- **PHM Panel (Margaret Reeves, Martin Drewry, Marion Birch, Andrew Chetley, Brendan Donegan)**

  The final session provided an overview of the value of PHM. Each member of the panel talked about their organisation and then the benefit of PHM to their organisations. This provided an opportunity for the participants to reflect on the relevance of PHM to their own circumstances.

  - Margaret, as UK PHM coordinator, started the discussion with an overview of PHM, its history and the different approaches being adopted in different regions and countries.
  - Martin talked about the focus of his organisation, Health Poverty Action, on poverty, social determinants of health, social justice through campaigning and advocacy. Health Poverty Action adopts a comprehensive approach within the 15 countries they work in, aiming to work with communities that are missed by others. They are involved in advocacy at a global level on issues across the board.
  - Marion described the educational, policy and campaigning approach of Medact. Their initial focus was as a campaign against nuclear weapons, and this has now extended to include the health impacts in conflict situations, such as in Iraq and Sri Lanka; and on the health and health rights of refugees and asylum seekers. Medact has also played an active role on the secretariat of Global Health Watch and Global Health Watch 2, and it will maintain this input in GHW 3.
  - Andrew gave a brief overview of Healthlink Worldwide, describing their approach of working with communities in several developing countries, strengthening their knowledge base and building their capacity to improve their health. Healthlink Worldwide was involved in the evaluation of the first People's Health Assembly, which led to the development of PHM.
  - Brendan Donegan, the final panel member, was completing his PhD on PHM India. He therefore gave an overview of how they operate, and the impact that they have had on PHM as a whole. India, comprising one sixth of the world's population, has a long history of activism, and this is reflected in their campaigns including the right to health, health care and gender equality.

    The panel members all talked about the value PHM as a network that can be drawn on as required, in particular when they work in different countries. This includes gaining support from people that they can assume will be sympathetic to their approach; seeing their own work in perspective, as part of a bigger picture; 'keeping their brains alive' and keeping them in touch with issues and debates.

    An interesting discussion followed, which included the way that PHM operates differently in different countries; the relative strength of PHM in countries with a strong community participation focus, such as in Asia, Latin America and parts of Africa; and the difficulty in measuring the success of PHM, given that PHM is a network, rather than an organisation. Being a network also makes it more difficult to determine PHM priorities or to develop a set of objectives that can be called 'PHM'. The value of PHM, therefore was not about developing a specific programme or campaign. It was described as a grouping where the core focus is its values and its local focus, and it was suggested that if we demand too much evidence and structure, we will lose the value of the PHM. The use of the People's Health Charter

was noted as a way of legitimising what we do as being part of the PHM, of achieving some uniformity of approach, and of being able to maintain our links with other PHM circles in other countries.

The discussion on the role of PHM in the UK and in Europe will be continued through future workshops and meetings organised by PHM UK, in particular in relation to the role we may have at the PHA in 2011.

EVALUATION

PARTICIPANT FEEDBACK

There were three different opportunities to get feedback during the course.

i) Different designated participants (eyes and ears) gave feedback each morning on the day before, having consulted with fellow participants to get a group view

ii) An evaluation session was held on the last day, noting what was useful, gaps and what people hoped to take away with them

iii) An evaluation questionnaire was completed at the end of each day. This included ranking of each session and of the organisation of the course. Most people considered most aspects to be 'very good' or 'good', with a few giving ratings of 'neutral'. There were very few 'poor' comments, and none were 'very poor'.

The feedback included the following:

The participants enjoyed the course. They found it stimulating, and in particularly appreciated meeting each other and having time to work together.

- *Overall the day was informative, useful and enjoyable*
- *It was wonderful. Thank you very much*
- *The overall course content, structure and timing were excellent.*

The participatory approach was welcomed, as was the mix of theory and practical sessions, although it was felt having two presentations 'back to back' was difficult.

- *Excellent mix of learning/participatory methods.*
- *Morning sessions could have been more participatory, less powerpoint please*
- *Some sessions would have benefited from more guidance*
- *Tutors/facilitators present at all times, good/excellent speakers, good learning setting, different backgrounds of participants*

Comments on specific sessions and the site visits included:

- *Possibly more time for the climate change issue, particularly thinking more thoroughly about the link between climate change and inequality*
- *Very good and interesting/engaging morning sessions [on social determinants].*
- *The GLA presentation was great*
- *A bit UK focussed*
- *Site visit excellent to see real examples of the services/approaches we've been talking about*
- *More time to discuss national case studies presented by participants. These presentations could have also been organised around specific issues that were more relevant for the course*
- *Need focus on the criticisms of participatory approaches, e.g. there have been very strong criticisms from a gender perspective. These need to be formally explored in the session*

What people found the most useful about the course.

- *Learning from others on the course*
- *Meeting other participants and sharing with them*
- *Having the space to think reflectively and discuss.*
- *Learning more about key principles in health and PHM, meeting and learning from a group of interesting people.*
- *The teaching methodologies*
- *Organised and deeper understanding of 'health activism'.*
- *Advocacy – complex – better understanding of what makes it successful, and how to make complex issues e.g. maternal mortality into successful campaigns*

What would have improved the course?

- *More discussion time*
- *How to influence/handle global players and global partnerships*
- *A bit more prior reading might have helped with getting a background to some of the theory, and allowing more time for discussion*
- *More time for organised discussions. More 'structured' moments for sharing experiences on what goes on in different countries*
- *Providing more info about PHM*

What people will try to introduce into their work:

- *Use of information and participatory tools*
- *Use PHM in health care policies*
- *Adopt examples of advocacy*
- *Organise courses in own countries*
- *Build it into existing work, through building linkages and looking at other networks and organisations to work with.*
- *Develop a network of IPHU participants and provide support for each other as appropriate*

LESSONS LEARNT

Drawing on the evaluations and the organisers' assessment, the following analysis was made:

What worked well

The course had been carefully planned, taking on board the lessons from the first course. This included more time devoted to participant experience, more focus on action, and more focus on the links between themes.

Suggested improvements for future courses

Despite the improvements there was still felt to be too much focus on presentations. This creates a dilemma for the course organisers as the presentations provided much of the substance and illustrations on which the discussions were based. Future courses will have to explore ways of providing the inputs without having participants feeling 'talked at'.

The over-riding frustration was the lack of time. The participants felt that they would not have been able to attend a longer course. Their view was that 5 days was just right. However, from the organisers' point of view, there were many issues and in particular practical skills sessions that would have benefited by more time. A solution to this would be a residential course. This would provide the opportunity for more networking, informal discussions on issues of importance raised during the day.

WHERE TO FROM HERE?

PHM UK is committed to run further courses, with the next one taking place in April 2011. Funding applications were unsuccessful for years 1 and 2. The organisers will try again, exploring different funding institutions and means of sponsorship. A priority will be to have a residential course

One day meetings and workshops will also be organised. This will start with a meeting in June 2010 exploring how best to take forward issues as PHM UK.

Links with the global IPHU

The benefit of these experiences will be fed back to the global IPHU secretariat, to be publicised on their website. The UK PHM will also maintain contact with other countries running IPHU courses to maximise the opportunities for shared learning. These opportunities will be enhanced by the film of the second IPHU course.

For more information about PHM and the IPHU, see www.phmovement.org, and for PHM UK, see www.phm-uk.org.uk, or email phmukcoordinator@yahoo.co.uk

Appendix 3

People, Politics and Global Health: Actions to Change the Approach
IPHU COURSE, 2010, PROVISIONAL PROGRAMME

START 09.00	***PARTICIPATORY SESSIONS*** ***1hour***	***TEA*** ***20 mins*** ***betw*** ***10.00 and 11.00***	***INPUT AND DISCUSSION/SPEAKERS*** ***Approx 2 hours***	***LUNCH 45 mins – 1 hour*** ***betw*** ***12.30 and 2.00***	***PRACTICAL SESSIONS/SKILLS DEVELOPMENT*** ***1.5 - 2 hours***	***TEA*** ***15 mins*** ***betw 3.30 and 4.00***	***PRACTICAL SESSION*** ***1 hour***	***CLOSE*** ***5.00***
Mon 12/4	**THEME: DEVELOPMENTAL APPROACH** 9.00 – 9.30 Introductions: Margaret Reeves/ Andrew Chetley **9.30 – 10.20** Participatory activity, Ruth Stern		10.45 – 11.45 Globalisation and health – intro session Mike Rowson 11.45 – 12.45 Human Rights and Health Jude Mesquita 12.45 – 1.15 PHM HR report, and how it was used Margaret Reeves		**2.15 - 3.30** Market place exercise, Discussion on issue and approaches for the week, building on the Market Place exercise. Andrew Chetley		3.45 – 5.00 Group activity	
Tues 13/4	**THEME: SOCIAL DETERMINANTS IN HEALTH AND EQUITY** 9.00 – 10.00 Introduction: Social Determinants Andrew Chetley		10.30 – 11.30 Social Determinants, Sanitation case study Ruth Stern 11.30 – 12.30 London Health Inequalities Strategy, Helen Davies.		1.30 – 2.30 Climate change and health Robin Stott Climate change and the media Alison Whyte		Climate change contd. 4.30 – 5.00 Preparation for site visit	

Wed 14/4	**THEME: HEALTH SYSTEMS** 9.00 – 10.00 Introduction: Health Systems Group activity, exploring different health systems Marion Birch, Margaret Reeves		Speakers: Practical applications and implications 10.30 – 11,45 Developing country experience: Mozambique case study Gill Walt 11.45 – 1.00 NHS campaigns. John Lister		Site visit 2.30 - 4.00/4.30 Praxis, Providence Row, Health Poverty Action, CLASH (Camden PCT) To look at different approaches to health care and how they are tackling social determinants and equity		Site visits, contd	
Thurs 15/4	9.00- 10.00 Feedback from site visits Andrew Chetley **THEME: PARTNERSHIPS** Working in partnership - discussion Ruth Stern		Working in partnership 10.30 – 12.30 Case studies, discussion and group work Grace Mukasa		1.30 – 3.45 Participatory approaches David Musendo, Andrew Chetley		4.15 – 5.00 Group activity	
Fri 16/4	**THEME: WORKING WITH CIVIL SOCIETY** Group discussion: What have we learnt, what do we still want to know		10.30 - 1.00 Advocacy, campaigning, Sarah Edwards, Andrew Chetley		2.00 – 3.45/4.00 Panel discussion on activism Margaret Reeves Martin Drewry Marion Birch Andrew Chetley Brendan Donegan		4.00/4.15 – 5.00 Small Group work: Practical application of how to take forward own priorities, building on lessons of the week.	