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PROGRAMME PRESENTATION DOCUMENT

(Version 1)

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Abbreviations and Acronyms

PHC	primary health care
EAS	School of Health Activism
SDoH	social determinants of health
INS	National Institute of Health
MoH	Ministry of Health
CBO	community-based organisation
CSO	civil society organisation
SDG	Sustainable Development Goals
NGO	non-governmental organisation
CSO	civil society organisation
NHS	National Health System
UPF	University of Pompeu Fabra
UEM	University of Eduardo Mondlane

Why have an Alliance for Health in Mozambique?

In a context where inequality and commodification are increasing, it is essential to defend health as a right in countries such as Mozambique. Despite the advances of recent years, the vast majority of Mozambique's population continues to face many difficulties in making this right a reality (GREDS and **medicus**mundi, 2017).[i]

Many factors prevent universal and quality health care from being accessible to all people, especially the poorest and most vulnerable populations. Perhaps most significant, however, is how little importance is attributed to the social determinants of health (SDoH), with ignorance of these meaning the right to health itself is vulnerable. The SDoH are the set of variables that have the capacity to protect from or cause health problems both at individual and population levels – originating from the World Health Organisation's (WHO) definition of health as biological, psychological and social well-being. Arrival at this definition demonstrated a paradigm shift which revealed that, rather than a result of their own decisions or preferences, a person's health is the product of their interaction with the environment in which they live.

WHO defines the SDoH as the " *conditions in which people are born, grow, live, work and age"*,[ii] which includes the broadest set of forces and systems that influence everyday living conditions. These determinants account for a large part of the health inequities suffered by the world's population and, notably, Mozambique's.

Social inequalities have an enormous impact on a population's health and must therefore be a priority in public health policy and be cross cutting through all state policy, following the principle of *Health in All Policies* and the parameters set by the main international organisations and others addressing these issues.

In order to move towards greater equity in health, taking into account the parameters and recommendations proposed at international level, it is essential to: (i) create political and technical bodies that support this priority; (ii) have data and surveillance systems to study the evolution of inequalities and the impact of policies; (iii) promote health interventions, including public health, that reduce inequalities; (iv) **establish alliances to drive and promote policies that reduce the health inequalities developing outside the health sector**.

Based on these recommendations therefore, it is necessary to establish commitments and assign responsibilities among the different agents involved, placing particular importance on society as a whole.

It is, for example, known that the health system itself is a determinant and that the most effective and efficient way of providing health care to the population is through a public system based on the **principles of primary health care** (PHC).

The WHO definition of *primary health care is provided below*:

What is primary health care?

Primary health care is a whole-of-society approach to health and well-being, focussing on the needs and preferences of people, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing.

It provides whole-person care for health needs throughout the lifespan, not just for a set of specific diseases. **Primary health care** ensures people receive quality comprehensive care – ranging from promotion and prevention to treatment, rehabilitation and palliative care – as close as feasible to people's everyday environment.

According to WHO, **primary health care** is rooted in a commitment to justice and social equity and the recognition that the enjoyment of the highest attainable standard of health is a fundamental right as stated in Article 25 of the Universal Declaration of Human Rights: *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."*

WHO's definition is based on three components:

i. Meet people's health needs through comprehensive life-long promotive, protective, preventative, curative, rehabilitative and palliative care, by giving strategic priority to core health care services for individuals and families through primary care, and for populations through public health functions as central elements of integrated health services;

ii. Systematically address the wider determinants of health (including social, economic and environmental, as well as people's characteristics and behaviours), through evidence-based multi-sectoral policies and actions; and

iii. Empower individuals, families and communities to optimise their health, as advocates for policies that promote and protect health and well-being, as co-creators of health and social services and for enhanced self-care and care of others.

Why is primary health care important?

WHO states renewing **primary health care** and placing it at the centre of efforts to improve health and well-being is fundamental for three reasons:

1) **Primary health care** is well placed to respond to the rapid economic, technological and demographic changes that are occurring in the world and which all have an impact on people's health and well-being.

2) **Primary health care** has proven to be a highly effective and efficient way of addressing the main causes and risks of ill health and well-being today, as well as dealing with emerging challenges that will threaten health and well-being in the future. It is also a proven valuable investment through evidence quality **primary health care** reduces total health care costs and improves efficiency, reducing hospital admissions.

3) **Stronger primary health care** is essential to achieving the Sustainable Development Goals (SDGs) related to health and universal health coverage. It also contributes to the achievement of other objectives in addition to health (SDG 3), including those related to poverty, hunger, education, gender equality, clean water and sanitation, work and economic growth, reducing inequalities and climate action.

Source: World Health Organisation[iii]

Public health policies and the interventions of all those who play a role in public health in the country must therefore be steered in this direction. The same thing applies to gender,

environmental and economic policies, etc., all of which must consider health in their design and goals, throughout their management, implementation and evaluation, to improve the health of the population.

It is important to unite the forces of all organisations, entities, social movements, civil society, universities and scientific research institutes that consider health to be a right not a consumer good and which believe the best way to guarantee this right is through promoting public policies that address the SDoH. This requirement is the starting point for launching the **Alliance for Health**, a platform for Mozambican and international actors whose common objective is to defend the *Right to Health* using an SDoH approach.

The *Right to Health* is a fundamental right that allows us to enjoy other rights, and all other rights are equally important and irreplaceable. The Declaration of Alma-Ata that emerged from the International Conference on Primary Health Care, held from 6 to 12 September 1978, states in point IV that:

> *"The people have the right and duty to participate individually and collectively in the planning and implementation of their health care."*[iv]

The **Alliance for Health** is, in short, a network of civil society entities acting in different areas (health, education, gender, environment and others) to be established as a social movement to defend the *Right to Health* for the entire population of Mozambique, through sharing knowledge and evidence, training, and carrying out advocacy and awareness-raising activities. This purpose is partly a consequence of the obvious, significant inequities and social injustices affecting access to health and therefore, the full exercise of that right. It also partly arises from the existing opportunity and space for civil society to join forces to engage in continuous dialogue with the National Health System (NHS) as well as with other involved, accountable sectors and actors. In other words, applying a multidisciplinary and holistic perspective, based on the different social, economic, political, cultural, environmental, gender or other determinants that influence the health of the Mozambican population.

The main challenge in Mozambique (and in a large part of the world) remains making the *Human Right to Health* a reality through greater community and citizen participation i.e. harnessing collective capacity for social transformation to achieve the well-being of the whole of society. In this context, participation can be understood both as an instrument of the *Right to Health* and a human right *per se*. On the one hand it supports advocating for equity in health through fairer and more transparent processes, understood by individuals as administrative justice and by communities as the collective voice. On the other hand, it applies a *rights-based approach*, i.e. an approach that prioritises the most vulnerable, offers opportunities for agency and intrinsically speaks to an agenda that promotes equity, favouring the experiences of poor, disadvantaged and marginalised groups and the importance of collective agency.

In this respect, participatory civil society initiatives have multiplied, with the common denominator one of exerting considerable pressure on the public sector with the goal of reforming the social rights system. Social rights are no longer understood merely as the right to State-planned and delivered services, but also as a demand for greater citizen involvement in defining public policies, through increased social accountability of the State in different sectors (education, health etc.).

The availability of resources, technical training, organisational development and information, along with the ability to carry out / facilitate social accountability actions, have all influenced the increase in actors (at national and local level). This cannot, however, be taken in isolation from the general dynamics of the sector (dependency, distribution of resources among civil society organisations (CSOs) / community based organisasions (CBOs) etc.). Civic action (critical to increased social responsibility) remains in its infancy. Collective civic action has almost exclusively occurred in large cities and in response to extreme situations (for example, price rises for fuel and essential goods). In addition, CSO capacity development fails to significantly address this more demanding aspect. There remains only superficial understanding and use of the drivers and ways citizens self-mobilise and organise for action, as well as of the many environmental factors that influence their capacity to act.

Therefore, as well as needing to think and act according to what differentiates the people who participate in the processes, we must also consider the particularities of the health sector. When we refer to citizen participation in terms of public service policies and accountability in the health sector, it is not the same as working on wider issues of local governance. There are different moments in the process of understanding citizen participation and, especially in health, there are equally different vulnerabilities: patient dependence on health / health facility; perception of power; and choices that influence these power relationships. Existing health sector mechanisms for citizen participation do not empower them. With the exception of health committees, which play a role in promoting health and are chaired by a community leader, all other mechanisms are managed by service providers, thereby limiting citizens' influence on the system.[vvi]

The Vulnerability of the Right to Health in Mozambique.

Respect for human rights is enshrined in Mozambique's Constitution; this is consistent with the *Universal Declaration of Human Rights* and the *African Charter on Human and Peoples' Rights*[vii]. It therefore upholds the principle of non-discrimination before the law and equal rights, regardless of colour, race, sex, ethnic origin, place of birth, religion, education level, social position, parents' marital status, profession or political choice.

In its fifth chapter on economic, social and cultural rights and duties, the Republic of Mozambique's Constitution states, in Article 89 (*Right to Health*), that:

> *"All citizens have the right to medical and health care, in the terms of the law, as well as the duty to promote and defend public health."*

From the above, it is clear, firstly, that it is the duty of the State to provide health care to citizens, quality health care, so citizens enjoy good health. Secondly, that citizens must promote and defend public health. This means that, if citizens see their rights violated, they must fight in different ways to be able to enjoy those rights or see them restored. Therefore, it is also the duty of all citizens to defend free public health in Mozambique, accessible and

available to all, since the Constitution states in Article 35 that all citizens are equal before the law, enjoy the same rights and are subject to the same duties.[viii]

> *"Improving people's health, including health security, depends on good partnerships between communities, health care providers, implementing organisations, governments, technical agencies and international partners."*[ix]

Despite being covered by the national legal framework, these rights – in particular, the *Right to Health* - are frequently violated. Possible causes include the general public's lack of knowledge that health is a right; more specifically, a similar lack of knowedge among health personnel in the performance of their duties; as well as the need for those charged with guaranteeing and safeguarding the full exercise of this right accepting their responsibility to do so.

The low availability and accessibility of health services in Mozambique is aggravated by insufficent numbers of appropriately trained health professionals. The quantitative and qualitative lack of human resources, both in medical specialties and in the areas of planning, management, monitoring and evaluation, directly affects the quality of health service provision.

There are serious weaknesses in how the NHS plans and manages the scarce resources it has. Sufficient financing and the rational use of available resources directly influence service quantity and quality. In Mozambique, total public expenditure on health was between 7% and 9% between 2010 and 2016, dropping dramatically in 2017 to 5.4% – well under and increasingly far from the regional average and WHO recommendations.[x] Although the percentage contribution of external resources has decreased in the last decade (approximately 35.4% according to the 2019 budget execution report, known as the REO)[xi], the system remains highly dependent on external aid, directly affecting the sustainability of MoH policy and strategy.[xii] In addition, ongoing decentralisation implies geographical resource allocation should replace sectoral allocation, however the MoH lacks objective criteria for allocating resources *per capita*.

A study carried out by **medicus**mundi, UEM, INS and UPF[xiii] shows that Mozambicans living in rural areas, those with fewer economic resources and, primarily, women, face more barriers in accessing and using the services provided by the health system. The NHS itself is a determinant and, having access to it, receiving adequate care adapted to the cultural needs of users, etc., contributes to the quality of life of the population. However, this alone does not justify all the health differences different groups and social strata face in the effective exercise of the *Right to Health*.

In Mozambique, the NHS is almost exclusively responsible for meeting the health needs of the population, with little effort given to developing an integrated multidisciplinary vision with other sectors' strategies. Such integrated strategies could have a greater impact on improving the health of the population. Although health policies continue to define the health system's commitment to **PHC**, in reality this is clearly threatened by the verticalisation of public health programmes.

Any analysis of the health sector in Mozambique should therefore always take into account the weight of, and dependence on external funds, i.e. the weight of Official Development

Assistance and other targetted funds, including neo-philanthropic funds for major diseases / programmes such as malaria, HIV/AIDS, and tuberculosis. These represent the largest share of investments and have been undermining the *Agenda for a Global Health*[xiv] in relation to universal health coverage – based on the **PHC** strategy – as a *driver for equality, inclusive development and prosperity for all*[xv]*,* though today these latter seem to be only for the chosen few.[xvi]

In recent years, the country has managed to translate greater expenditure on health per capita into improved infant mortality and life expectancy indicators and made advances in the provision of health services to citizens. However, Mozambique faces major dilemmas in this sector: given the current fiscal context there are unlikely to be increases in health expenditure in the short to medium term[xvii]. In addition, users and providers still consider current quality falls significantly below requirements.

Throughout the country, systematic stockouts of medicines and other medical items in health facilities, the enormous distances users have to travel to access the closest health facility, as well as waiting times and sometimes dehumanised care, remain important concerns to the vast majority of service users.

Finally, it should be noted that the country's new economic activities (extraction of gas, oil, minerals, mega-projects, agro-industry, etc.) are impacting the regions where they occur, both in terms of environmental health and in the emergence of "new" diseases characteristic of these activities and whose prevention and treatment the system is not yet ready to adopt, either due to lack of resources or ignorance of the real risk these diseases constitute to the health of the population.

At the same time, in recent years, especially in the capital, there has been a steady growth of *private health services*, targetting a very small percentage of the population; these contribute to increasing inequality in access to services and consolidate a dual system of quality for the rich and minimal (less than minimal) for the poor. These new trends are not being studied in depth and, therefore, no critical opinions have been developed nor awareness raised to contribute to ensuring the Government meets its commitments to health.

What is the Alliance for Health?

Background

The process of creating the **Alliance for Health** began in 2015, following a carefully defined feasibility plan. Through a participatory process involving the MoH, training and research institutions and civil society, all actors agreed on the importance of promoting a platform to defend the *Right to Health* and for this to initially be led by **medicus**mundi, an international non-governmental organisation (NGO).

The **Alliance for Health**'s first institutional development plan completed the following steps: (i) aggregation of alliances, (ii) preparation of the research agenda, (iii) provision of content for this agenda and strengthening of knowledge, (iv) public presentation (I International Conference on Social Determinants of Health of Maputo, in December 2018). Having completed these steps, our purpose is now to consolidate this platform, providing the technical and human resources to finalise the Alliance's lines of action and ensure its integration and sustainability in the health sector in Mozambique.

A Social Movement

It is a social movement to defend the *Right to Health* in Mozambique. Believing a *social movement to be a form of expression of civil society, through which participating citizens seek, through collective action, to achieve various types of change in society*, this movement aims to influence changes at policy and strategy level and even to the NHS budget, focusing on ***PHC*** and a ***SDoH*** perspective.

Social movements are important and fundamental in societies as, through them, individuals act collectively and adopt strategies to fight against the inequalities they experience in order to achieve social inclusion.

Social movements are essential elements, acting as mediators between minority groups (the most disadvantaged and impoverished populations), the State and other actors. They become critical instruments in the search and exercise of rights and duties and in reducing existing and/or inflicted inequalities.

Beyond the free exercise of *rights and duties*, it is important to note this is not a question of any kind of *permanent opposition, denunciation or criticism*, but rather one of constructive collaboration to expand and help improve the responsiveness and mission of the NHS vis-à-vis the population of Mozambique.

In the **Alliance for Health**, common and collective action will be developed in order to achieve a shared objective: the effective exercise of the *Right to Health*, which translates into fairer access to health.

The expectation, therefore, is that this social movement will be formed by groups of individuals who defend, demand and fight for a common social and political cause: the *Right to Health for all people.* In other words, in addition to the needs that unite them, it is important every individual or entity joining the **Alliance for Health** passionately believes in health as a fundamental *human right*, in the broadest and fullest sense.

This social movement – the **Alliance for Health** – argues in favour of quality public health policy. This means the Alliance will fight to ensure the country invests in the *National Health System* i.e. in the capacity of the public health sector to provide quality services and care to the entire population, something that is unquestionably relevant given the current context of Mozambican society. This context is one of fragility, where the public health system frustrates the provision of quality services, and society is, for the most part, inactive and uninformed because of its level of schooling and education. This makes it difficult to monitor the performance of public policies and to demand responsibility and accountability from government structures.

The **Alliance for Health** will be a point of reference for the generation and exchange of knowledge on matters such as the *Right to Health*, ***PHC***, the ***SDoH*** in Mozambique and beyond, with the aim of continuing to integrate the collective work of national and international efforts that argue health is a right for all citizens of the world and, notably, for Mozambicans.

A network

In recent years, NGOs and other third sector (civil society) organisations have been developing and implementing the logic of networks and partnerships, leveraging their own development, role and space in an increasingly globalised and interconnected world. A world where the traditional North-South, West/Not-West and Global-Local dichotomies are being redefined, considered deficient or are questioned, and replacing them with evermore horizontal logic to meet increasingly complex challenges and problems, including health. There are multiple examples, such as the effects and inequalities generated by the predominant capitalist economic system or the consequences of climate change, aggravated by the former. These have a direct and indirect impact both on individual and collective health and on the design and organisation of the health system itself, which often has little anticipatory capacity and is slow to react.

NGOs and other civil society entities have therefore begun to build their own organisational models according to the new requirements for achieving their objectives, which are also often redefined. They are also building networks and cooperating between organisations as a means to find solutions and intervene in this increasingly complex social reality. It is worth remembering therefore that "networks are open structures capable of expanding in an unlimited way, integrating new nodes as long as they can communicate within the network, that is, as long as they share the same communication codes, such as values or performance objectives" (Castells, 2000)[xviii]. We define this network as an alliance, because we want to create a bond between people and entities with a shared mission, vision, principles and objectives.

Mission

To focus on public policies in Mozambique, through greater engagement and participation of citizens, so health can be a right within reach of the entire population.

Vision

We believe that, through cooperation in a network between civil society entities, businesses, public administration, universities and research centres etc., we can support improved public health policies in Mozambique using an **SDoH** approach, focusing on generating greater awareness of health as a fundamental human right, defending **PHC** and equitable access to it for everyone.

Principles

- People come first. We defend human life, dignity and equal rights of all citizens, independent of their origin, religion, political ideology or any other identifier, as fundamental and inviolable principles;
- Human rights and social justice are instruments for struggle and action as well as objectives of this network, especially the *Human Right to Health* and health equity, based on the principle of One Health For All;
- Policy and strategy changes should be considered a structural and gradual process;
- Actions should be taken by people and/or entities that understand health as a fundamental human right, that believe in defending **PHC** and public health focused on human rights whilst taking into consideration related social determinants (economic, cultural, political, environmental, gender etc.);
- The organisation of this network is governed by horizontal dialogue, democratic participation and willingness to cooperate between all members, regardless of the size and amount of resources any single member may contribute towards operations.

Objectives

- To establish a platform of national and international actors whose common denominator is believing and defending health as a fundamental human right and not a consumer product.
- To become a reference for research, training and defence of the *Right to Health* in Mozambique, with a focus on its principal determinants.
- To defend the public health system and **PHC** as the most equal and equitable strategy that best meets the interests and needs of the whole population.

Organisation and affiliation

The **Alliance for Health** will be organised through the combined efforts and contributions of its members, without requiring a complex structure or requiring resources that cannot be guaranteed. Rather, it should be a space for meeting and coordination that integrates with the dynamics of its members, prioritising rational and efficient use of existing resources (its own and others that may emerge) and the use of new technologies, wherever possible.

The **Alliance for Health** will be implemented through regular meetings (coordination meetings, working sessions, courses, seminars, workshops, exchange of experience etc.) in the facilities of its members or elsewhere, depending on available resources. An *online* platform, which will include a **virtual campus** of the School of Health Activism (EAS), will be created. In the future, this platform may be managed and maintained between the members, who will use it for the shared goals of the **Alliance for Health**.

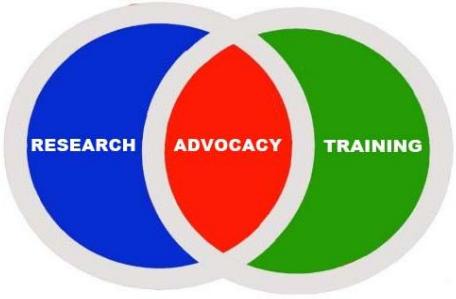
To become a member, it is only necessary to share the vision that it is possible to help build a public health system in Mozambique that supports equitable access of all citizens to health, based on the defence of **PHC** and the exercise of the *Right to Health*.

All members must engage with the same guiding principles around organisation and networking, giving priority to horizontal dialogue, democratic participation and willingness to cooperate with each other, regardless of the size and amount of resources that each can contribute to its operations.

In this sense, members and future members of the **Alliance for Health** must agree and commit to the content of this **Programme Presentation Document** and subsequently become involved in developing the strategic and operational plans that will shape it and guide its actions.

Pillars

The **Alliance for Health** rests on 3 main pillars:



Research

- *Generate and share knowledge and evidence on different subject areas related to health, based on their social determinants and with a special focus on primary health care.*
- In this component, the aim is to generate and share knowledge and evidence in a multidisciplinary way on health challenges and experiences from the perspective of social justice and based on social, economic, cultural, political, environmental and other determinants.

Training

- *Open a space for in-person and virtual training and capacity building - the School of Health Activism.*
- In this component, the aim is to increase the knowledge and capacity of Mozambican civil society (NGOs, CSOs, social movements, networks, activists, academics, artists and others) in order to be able to defend the legitimate pursuit of the *right to health* in a more effective and coordinated way.

Advocacy

- *Inform, raise awareness and influence strategies and policies through coordinated advocacy and awareness raising activities and campaigns,* based on the evidence and knowledge gained.
- In this component, the aim is to carry out work to defend and promote the right to health and defend the National Health System and Primary Health Care as the best strategy for building and strengthening a more just and equal health system in Mozambique.

Both the first and second pillars feed into the third pillar (advocacy) because the **Alliance for Health**, by generating and sharing knowledge, aims to influence changes in health behaviour and policies, thereby helping to defend the **right to health** for all citizens and to improve the quality of **PHC** in Mozambique.

1st Pillar: Research

Alliance for Health Research Agenda

The Alliance for Health Research Agenda

As outlined in the **Alliance for Health's Research Agenda**, approved and published in 2019[xix], **PHC** and health system effectiveness and efficiency are key to improving global health and reducing health expenditure. Naturally, research on **PHC** allows measurement of these attributes and provides a reference point to determining their progress towards the desired objective. In this context, Mozambique, in general, distinguishes itself through sponsoring Public Health and Health Promotion (as evidenced by NHS public policies). In recent years, the lines of research in the area of "health promotion" have included a focus on behaviour and practices, more specifically in relation to malaria, HIV / AIDS, contraception, condom use, breastfeeding, childbirth, sexual and reproductive health.

A challenge for Mozambique is the insufficient evidence on the role of research in relation to **SDoH** in policy making. Research alone requires resources such as infrastructure, specialist knowledge and financing – generally in short supply in low- and middle-income countries such as Mozambique. Thus, having strategic guidelines is crucial to optimising the scarce resources destined for research on **PHC** and **SDoH**. This necessarily involves identifying key health care issues for the population, evaluating their clinical importance and implications and, finally, aggregating them into a **research agenda** centred on the community and directed towards a specific area, such as **PHC**. This agenda is intended to serve as a platform to involve local researchers and health policy makers in the assessment, deliberation and selection of resources needed to support **PHC** research efforts in a given community.

This instrument – the **research agenda** – aims to promote research and evidence on the social determinants of health that influence the health model pursued by Mozambique in relation to **PHC**.

The **research agenda** defined some priority areas:

1.	**Territory, democracy and health.**
•	Social control in health;
•	Social inequities in health;
•	Road accidents as a space for health action;
•	Social determination of the health-disease process;
•	Health and work
•	Urban health, mobility and informal settlements;
•	Social structure and power distribution in communities affected by preventable health problems
•	Health impact from lack of access to water;
•	Socio-demographic profile and pattern of health service use for users and non-users;
•	Evolution of sanitary and environmental conditions in resettlement programmes resulting from natural disasters;
•	Per capita income and nutritional disorders in rural versus urban populations.

2.	**Gender and Health.**
	• Gender, diversity and health;
	• Gender violence and health;
	• Masculinity and health;
	• Sexual minorities and representation in the health workforce;
	• Patterns of discrimination and the participation of women in health committees, APEs, first aiders, community activists;
	• Participation and governance of public hospitals.
3.	**Health and the Environment**
	• Health, conservation and sustainable development;
	• Natural elements (such as water, air, land) within public health policies;
	• Economic interests in environmental protection and health;
	• Environmental health and toxicology;
	• Health sciences and environmental education;
	• Health, climate and ecosystem change;
	• Occupational risks and work environment;
	• Planning the use of land and water resources;
	• Hygiene, sanitation and diseases.
4.	**Health System – political, legal and institutional framework.**
	• Health history and historiography;
	• Consumer and user protection policies in health services;
	• Integrated and complementary health practices;
	• Health financing in face of the new fiscal reality: challenges and perspectives;
	• Functioning of the bodies and institutions responsible for implementing primary health care actions and services;
	• The fiscal impact of indirect public financing via tax waivers and health insurance costs for private sector employees;
	• Share of health in the public budget;
	• Share of the health programme in the State's total unfunded expenses;
	• Fiscal space possible with institutional reforms in the health sector;
	• Share (weight) of social security in the State budget;
	• Public Social Expenditure: sectoral composition.
5.	**Migratory movements and health.**
	• Development of productive forces and impacts on collective health;
	• Migration and social determination of health care;
	• The living and working conditions of workers in the mining and extractive industries from the perspective of health promotion;
	• Assessing the magnitude of the effects on the population's health after natural disasters;
	• Migration movements and health coverage challenges;
	• Informal work associated with cross-border trade and access to health care;
	• Participatory processes and organisation of health services.

6.	**Communities and social actors and health.**
•	Social determination of the health-disease process;
•	Social inequalities in health;
•	Participation and social activism for health citizenship;
•	Socio-demographic inequalities in the prevalence of chronic diseases in Mozambique;
•	Integrative and complementary health practices with a focus on the continuous provision of care;
•	Child health and nutrition;
•	Adolescents in social risk situations;
•	Percentage of provincial governments' and municipalities' own resources invested in public health.
7.	**Management and Health.**
•	Evaluation of health services;
•	Structuring of networks focusing on primary care;
•	Planning and management policies for PHC;
•	Integrated and complementary health practices focusing on health education institutions;
•	Study of the process of building research agendas for training institutions, the National Health Institute, National Health Observatory;
•	Composition of health expenditure and combating inequalities;
•	Costing of family hospital expenses.

As the **Alliance for Health** is a social movement and, as social reality is dynamic and constantly changing, the research areas proposed above may be updated according to needs or priorities, as well as research possibilities. The **Alliance for Health** and its members should therefore engage in permanent and open discussions, both to define and update the areas and sub-areas of research, as well as to agree which areas to prioritise depending on existing resources and opportunities.

2nd Pillar: Training

School of Health Activism (EAS)

School of Health Activism (EAS)

The **School of Health Activism (EAS)** will be an integral part of the **Alliance for Health**, responding to the training and knowledge sharing component. Creating the first **School of Health Activism** in the country to defend the public health system and the right to health, from an SDoH approach, will be fundamental to the process of consolidating and ensuring visibility of the **Alliance for Health**.

The proposed methodology for this component consists in designing a training space for Mozambican activists with the support and guidance of international activists and specialists in human rights related to public health, such as the People's Health Movement (PHM), **medicus**mundi, N'weti and others. The EAS will be predominantally digital/virtual, so it is accessible to interested people in Maputo and provincial capitals where access to information and communication technologies is likely to be greater and where, at least initially, greater impact can be made towards changing or fulfiling public policy.

To reach the most remote (and disadvantaged) communities and promote grassroots activism, beyond the capital and other cities of the country where a large part of the intellectual mass is concentrated, it will be necessary to use other means, such as community radios and spaces (spaces for community participation in health, existing and created), with a view to social transformation in these more isolated areas too.

Some of the courses the **EAS** aims to initiate in the first phase of implementation include:

- Course on ***Digital Activism***
- Course on ***Primary Health Care – PHC***
- Course on the ***Social Determinants of Health – SDoH***
- Course on ***Nutrition from the Perspective of the Social Determinants of Health***
- Course on ***Advocacy, Networking and Social Movements (Health)***
- Course on ***Health Communication and Behaviour Change***

These courses will be taught to groups comprising members of the **Alliance for Health** and other partners, in-person, in Maputo. Their duration, organisation, number of trainees, etc., will depend on available resources.

However, these same courses will also be taught through the **EAS** online platform, accessible via the **Alliance for Health** website. Their content will be available mainly in Portuguese, though there may be specific content in other languages i.e. English and Spanish.

Online course content structure aims to be dynamic and understandable and should include videos of lessons or other relevant, specific pedagogical materials, forums, webinairs, evaluation tools, etc.

Access to the online training sessions will be restricted to ensure the best possible management and tutoring. Students admitted to these sessions will receive a certificate of participation. Once the session has finished, anyone will be able to access the materials and on completion of the course, students will be entitled to a certificate and/or badge.

The principle of these courses is to improve the knowledge and skills of civil society activists and current / future health professionals for defending the *Right to Health* and improving health policies in Mozambique.

3rd Pillar: Advocacy

Action for Health

Action for Health

With this third pillar, the **Alliance for Health** intends to influence the transformation of social and public health policies in Mozambique through cooperation and constructive collaboration. Like the two previous pillars, this pillar requires all **Alliance for Health** members to be involved and really participate because it is the combination of individual efforts that will make the actions we aim to take visible and relevant.

While the first pillar promotes research and evidence on the SDoH that influence the health model pursued by Mozambique, the second pillar provides the training and knowledge sharing component. In this context, the third pillar on advocacy – ***Action for Health*** – will primarily be based on the evidence generated by the research conducted (pillar 1) and the training in knowledge generation (pillar 2), with the aim of carrying out concrete advocacy and awareness-raising actions to influence public policies that impact health and influence social and behaviour change to defend the *Right to Health* through a focus on the **SDoH**.

> The **advocacy component** includes a series of activities aimed at improving political dialogue and knowledge of evidence demonstrating the need to back policies that promote **PHC**, approaches based on the SDoH, equity in health, or other relevant issues impacting and enabling progress towards fully exercising the *Right to Health* in Mozambique.
>
> In the **awareness component**, public awareness will be raised on the *Right to Health* (campaigns using audiovisual as well as information, education and communication materials) and on each of the social, economic, political, cultural, environmental, gender and other determinants which influence it. In this way, the design and implementation of actions and campaigns will always assess the leadership, recognition, social relevance, experience and intrinsic knowledge in each area where member organisations (allies) work: health, education, gender, environment or others.

Health actions will generally involve advocacy and awareness raising, inspired not only by evidence from the research implemented (Pillar 1), as previously mentioned, but also necessarily with the involvement of all Alliance members.

All **health actions** will require evidence-based communication approaches through: i) appropriate and assertive messages; (ii) the use of effective communication channels within selected areas and appropriate for target audiences; and iii) involvement and training of decision-makers so they can formulate and apply necessary measures to effect positive behavior changes and defend the *Right to Health*.

In summary, advocacy and awareness-raising actions, activities and approaches, including the selection of target audiences, will always be supported by systematic documentation of data obtained through research, data provided by the NHS, programmes and lessons learned.

The **Alliance for Health**'s advocacy logic is also based on the idea of *social accountability* because we believe a singler provider, i.e. the State, has primary responsibility for providing a **public health system** based on **PHC** which factors in the **SDoH**.

There are various definitions of the concept of *social accountability*.[xx] Some writers, for example, define it as *an approach toward building accountability that relies on civic engagement, i.e., in which it is ordinary citizens and/or civil society organizations that participate directly or indirectly in exacting accountability*.[xxi]

In the context of the public sector, it refers to a wide range of actions and mechanisms which citizens, communities, CSOs and the media can consult or use to ensure service providers (in this case the State) are held accountable and influenced in order to implement public policies, as well as to define other policies according to the needs of citizens.

We will expand this debate within the **Alliance for Health**, without restricting or conditioning the **advocacy actions** (public demonstrations, campaigns, marches and protests) joint or individual (by each member), always favouring the use of participatory methods and constructive dialogue, both internally and externally. In other words, taking into account the different aspects of the health sector, meaning we will seek to work with both sides of the health system – supply and demand for health services – to create a joint commitment and advance the agenda for improving universal coverage, quality and access to health services, based on **PHC** approaches (as the best strategy to build and strengthen a fairer and more equal health system), **SDoH**, ***human rights*** and ***women's rights*** etc.

Civil society representing Mozambican people / citizens will be involved in all advocacy phases / actions (from the research phase to the implementation of campaigns). We believe this methodology will be the most effective and efficient because it presupposes the work and engagement of Mozambican society and community groups that are informed of the conditions and quality of services provided by the NHS.

However, we are aware any **advocacy action** that involves citizens also presents some challenges, such as fear of confronting or challenging abuse of the system due to dependence on it, and fear of specific reprisals. In this way, the existence of a network – an alliance – emerges as a process facilitator because actions and pressure will be exerted collectively and not by a single institution or individual, allowing greater impact on changes, both in society and public policy. This also enables a more favourable political, legal and regulatory framework in terms of access and dialogue with the Government (the Ministry of Health, in particular).

For advocacy to be effective, the **Alliance for Health** must constantly work to mobilise knowledge i.e. produce evidence. Producing evidence need not only be contextual or localised on the basis that if data are not sufficiently representative, decision and policy makers are more resistant to bringing about necessary changes.

For this reason, we reaffirm the Alliance has already proposed a guiding research agenda which all members should consider and develop. In other words, all members should contribute to this process of knowledge mobilisation through their own research as well as the dissemination and sharing of knowledge or information external to the **Alliance for Health**

including from other countries, which can strengthen stated aims. The **Alliance for Health** should learn from its members – both for its members and to engage with other stakeholders; it should also learn from what is happening outside the Alliance, bringing this learning in for members. This strategy reflects a continous process of exchange of experiences where it is possible to learn from national and international contexts and where others can learn from the **Alliance for Health**.

Thus, for the **Alliance for Health**, *learning* is a central and self-defining objective. It is a question of promoting reflexion and exchange of experience between the different actors and stakeholders involved, with the aim of coordinating specific advocacy actions. It concerns managing and systematising learning gained and knowledge produced in the heart of the **Alliance for Health**, making them accessible to other audiences so as to disseminate information, promote discussion and strengthen a community of practice in research-training-action around the defence of the *Right to Health* and **PHC** in Mozambique. An important step in this direction is the organisation of an International Conference for this purpose.

For this process it is, however, important to map and understand power relations. We have to constantly identify the actors with decision-making power in relation to our agenda and strategy so we can facilitate their achievement and the possiblity of exercising real influence. In addition to identifying power relations, it is also important to clearly identify the spaces where advocacy actions can be effected and in each space, identify the most appropriate strategies and methodologies. So as the **Alliance for Health's** learning is not lost, a lot must be invested in systematisation and documentation, through stories of change, systematised advocacy processes, six-monthly newsletters and other methodologies.

More specifically, based on key messages from research implemented by the **Alliance for Health** and other potential inputs, it involves defining advocacy and awareness-raising campaigns, including target groups and means of dissemination. Research results will be an important tool in the process of raising citizens' awareness of the barriers and facilitators to accessing **PHC** and fully exercising the *Right to Health*. For campaigns to be impactful and reach more individuals, members must publicise them via their own platforms, adopting them as their own and not just considering them a product of the **Alliance for Health**.

Constructing messages will be a joint process, through workshops where, in addition to designing messages, members are also provided learning opportunities.

For members to be better able to work in **advocacy actions** in this field, there is a need to improve understanding of a wide range of concepts: human rights, *right to health*, women's rights, environmental law, **SDoH, PHC**, health equity, and others. This alone will not be sufficient unless also accompanied by interventions to build a favourable environment and to address the very factors that influence the government's decision-making processes (referred to above) and, particularly, the gender norms and beliefs shaped by complex structures of matrilineal and patrilineal kinship aligned with underlying social and cultural constructions on the health system. To make this increased consciousness effective, we have the second pillar that includes a number of training sessions.

As a result, the third pillar is not limited just to advocacy actions such as campaigns. It will also favour other spaces and methodologies, such as round tables, workshops, marches and more

incisive actions to achieve citizen engagement and participation so health can be a right within reach of the whole population.

Advocacy actions will include interpersonal communication (e.g. informative sessions, school demonstrations, community dramas, learning through documentaries etc.) and be two-way by promoting exchange of ideas. The aim being for the target group to acquire a relatively high level of knowledge and consciousness of the *Right to Health* and other topics espoused by the **Alliance for Health**, and thereby to identify with the actions and recognise the need for change.

Interpersonal communication channels can facilitate and encourage individual action and help people discuss their beliefs and feelings as well as their ability to make the most appropriate decisions and actions. Interpersonal communication activities are also a powerful tool to strengthen the messages disseminated by mass media, campaigns and the actions we aim to undertake.

Priority will, however, be given to the use of digital platforms (www.aliancaparasaude.org, social networks etc.) both for sharing information and for training activities so as to increase coverage and inclusion of citizens. In addition to digital platforms, the **Alliance for Health** intends to work with artistic groups and use the potential art has to bring about changes within / between citizens, through edutainment and other forms of artistic expression (video art, urban art, music, theatre, etc.).

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[ii]Refer to definition at: World Health Organization, Commission on Social Determinants of Health. Closing the Gap in a Generation: Health equity through action on the social determinants of health. http://www.who.int/social_determinants/en

[iii]WHO (February 2019): *Primary health care.* https://www.who.int/world-health-day/world-health-day-2019/fact-sheets/details/primary-health-care

[iv]Declaration of the International Conference on Primary Health Care, Alma-Ata, 1978. http://cmdss2011.org/site/wp-content/uploads/2011/07/Declara%C3%A7%C3%A3o-Alma-Ata.pdf

[v]MISAU (2017): *Termos de Referência dos Comités de Qualidade e Humanização dos Cuidados de Saúde em Moçambique.* Maputo.

[vi]MISAU (2017b): *Estratégia nacional para a melhoria da qualidade e humanização dos cuidados de saúde (2017-2023).* Maputo.

[vii]African Charter on Human and Peoples' Rights (Banjul Charter): http://www.dhnet.org.br/direitos/sip/africa/banjul.htm

[viii] Ibidem.

[ix]WHO (2014): *People's health: what works: Health Report in the African Region 2014.* WHO-AFRO http://bit.ly/2vKomaz

[x]See also: FMO (2020): Orçamento da saúde: a disparidade entre o discurso político e a prática (Policy Brief). Maputo.

[xi]MISAU (2020): Relatório de Execução Orçamental (REO) Sector Saúde (Âmbito Nacional) Janeiro-Dezembro 2019 (Versão Final)

[xii]See also: FMO (2020). Idem.

[xiii]Medicus Mundi (eds.) (2018). Idem.

[xiv]Horton, R., et al (2014): *From public to planetary health: a manifesto* https://doi.org/10.1016/S0140-6736(14)60409-8

[xv]UN News (2019): *World leaders approve the health declaration to achieve universal health coverage.* https://news.un.org/es/story/2019/09/1462542

[xvi]See also: Namburete, D. (2018): *When a health system turns into a Tower of Babel: Mozambique's experience*. The Impact Initiative. November 2018. https://www.theimpactinitiative.net/blog/tower-babel-mozambique-experience

[xvii]UNICEF, 2017: *Informe Orçamental Saúde 2017.* http://budget.unicef.org.mz/briefs/2017/UNICEF_BB2017_Health_PT_Final3.pdf

[xviii]Castells, M. (2002): *A Era da Informação: Economia, Sociedade e Cultura, Vol. I, A Sociedade em Rede.* Fundação Calouste Gulbenkian. Lisbon.

[xix]Medicus Mundi (eds.) (2019): *Research Agenda of the Alliance for Primary Health Care (Aliança - CSP).* Maputo. https://medicusmundimozambique.org/files/2020/03/agenda-de-pesquisa-mm.pdf

[xx] CESC (2017): *Estudo sobre a Participação da Comunidade e Gestão Escolar.* CEP – Programa Cidadania e Participação. Maputo.

[xxi]Malena, C., Forster, R., and Singh, J., (2004): *Social Accountability: An Introduction to the Concept and Emerging Practice.* Social Development Series - Participation and Civic Engagement, No. 76. World Bank. Washington, DC. http://documents.worldbank.org/curated/en/327691468779445304/pdf/310420PAPER0So1ity0SDP0Civic0no1076.pdf