Southern African Regional Network on Equity in Health (EQUINET)

in co-operation with

OXFAM (GB)

REPORT OF A

Review meeting on

EQUITY ISSUES IN HIV/AIDS, HEALTH SECTOR RESPONSES AND TREATMENT ACCESS IN SOUTHERN AFRICA

February 19 2003
Harare, Zimbabwe

With support from IDRC(Canada) and Oxfam GB

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EQUINET, Oxfam GB, Harare, February 19 2003

'Securing treatment access through equitable public health approaches'

1. Background

HIV/AIDS has had a deep impact on health and health equity issues in Southern Africa, imposing challenges in mounting a response to the epidemic that cuts across its economic, social and public health dimensions. Health care systems have been stressed by increased demand for care, while themselves suffering HIV/AIDS related losses in health personnel. Household and community caring have complemented and sometimes substituted health care inputs. Where these lack adequate support they increase burdens on already poor households. As HIV/AIDS related mortality rates have fallen with new treatments available in high income countries, treatment access has become a central issue, with campaigns on this in South Africa recently widening through the Pan African HIV/AIDS Treatment Access Movement. The Global Health Fund (GHF) has added raised attention about international obligations around resourcing responses to health risks such as HIV/AIDS, and the challenges to the TRIPS agreement has focused attention on the areas of conflict between trade agreements and access to treatment, including to ARVs. Funds available from the GHF and other sources make ARVs potentially more accessible to some people in southern Africa, but there are issues to be addressed of who, on what basis, and how?

The response to HIV/AIDS is clearly inseparable from wider public policy around trade, employment, poverty, social welfare and gender equity. While equity is a central issue across these public policy responses, the changes in demand for health care, and access to resources for prevention and care and the role of treatment in mitigation of future impact have made equity in access to treatment a critical issue for prevention, caring and mitigation of impacts of HIV/AIDS.

These issues motivated the Regional Network for Equity in Health in Southern Africa (EQUINET)[1] and Oxfam GB[2] to initiate a process and work with other

[1] EQUINET has played a role over the past three years in highlighting issues of equity in health in southern Africa. It does so by networking professionals, civil society and policy makers to promote policies for equity in health, undertaking research, initiating conferences, workshops, and discussions through the internet, and providing inputs at SADC and other forums. (See www.equinetafrica.org)

[2] Oxfam GB is a development, relief, and campaigning organisation dedicated to finding lasting solutions to poverty and suffering around the world. Oxfam believes that everyone is entitled to a life of dignity and opportunity, and works with poor communities, local

partners towards exploring, documenting, analysing and identifying policy concerns on HIV/AIDS and equity in health sector responses.

The process initiated in November 2002 aimed to explore and inform policy debates that have grown around health sector responses to HIV/AIDS in the region, particularly with respect to care and treatment access and to equity dimensions of the choices being made. A review panel of people with strong experience or institutional commitment to various aspects of HIV/AIDS Equity in the health sector was established. The names and institutions of the members of the panel are shown in Appendix 1.

The members of this panel assisted to define the critical areas for commissioned work, to provide background information and to review the applications received for the review papers. The review panel identified the need to explore the evidence and values policy and advocacy on:

1. Equity issues in current health sector responses in southern Africa to HIV/AIDS and the extent to which these are associated with increased/ decreased risk of HIV infection or vulnerability to the impacts of HIV/AIDS.
2. The public policy choices now being faced and made in relation to the health sector response to the epidemic in southern Africa, with analysis of the equity implications of these policy options and of the choices currently proposed or being made. This is the primary area of focus and includes a specific focus on treatment access policies and practice.
3. Recommendations for equitable public policy within the health sector and mapping of the policy platforms and institutional agents that need to be engaged for such recommendations to be taken forward.

Three research teams were identified to contribute to the background research and work to be done for this, from Zimbabwe, Malawi and South Africa (See Appendix 2). While many more useful concept papers were received, funds limited the selection to three country studies and a regional overview[3].

A meeting was held on 19 February 2003 in Harare, Zimbabwe between the review panel, the proposed authors and further members of to the scientific, programme, advocacy and policy community. The delegates to the meeting will be included in the future work (See Appendix 2).

The meeting aimed to

- **review current knowledge and issues related to equity in health sector responses to HIV/AIDS, (including treatment access);**
- **refine further the scope and key areas for focus of the technical paper at regional and country level,**
- **identify the audiences and processes that should be targeted by the papers and the follow up work to be done**

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partner organisations, volunteers, and supporters to realise this . Oxfam GB Southern Africa has a regional programme on improving access to basic health services, with a focus on HIV/AIDS.

[3] Since the meeting further funds have been secured from DfID and further papers are being commissioned, including a further country paper from Tanzania.

This report summarises the proceedings of the meeting.

2. Current priorities in policy issues and options in health sector responses to HIV/AIDS in southern Africa

The first session of the meeting was used to explore the major issues around equity in health sector responses to HIV/ AIDS in southern Africa. Introductions were made by Sunanda Ray and Richard Laing of the leading issues triggered by the introduction of new treatments for HI/AIDS, strong public momentum for rights to treatment access, new funding arrangements for introducing treatment for some, against a background of old challenges to health equity.

Sundanda Ray highlighted that costs of treatment have come down with **reduced drug prices, making the wider costs now a more critical issue** to address, particularly costs of improving health delivery systems, training of staff, opportunity costs of applying resources to HIV/AIDFS and impact of treatment on prevention. This made it urgent to now address issues relating to **strengthening health services,** through widespread availability and access to VCT, uninterrupted supply of medications through strictly managed procurement and regulation, adequate clinical monitoring with treatment and care of complications, effective management of STIs and TB and effective provision of laboratory services to monitor ART and potential complications. She noted that the energy directed to treatment activism and the inclusion of HIV+ people in the policy debate had had enormous impact on including HIV/AIDS concerns in national, workplace and gender policies. She urged that this **activism now be directed to ensuring an equitable health system response, including building accountability on resources channelled from the Global Fund** on AIDS, TB and Malaria (GFATM). This includes **who benefits from new resources for treatment?** For example choices to channel ARVs using GFATM funds through central hospitals could be less effective in both public health and equity terms than through mission hospitals that have stronger community links, public health outreach and relations with low income communities, or through prevention of mother to child transmission during pregnancy (PTCT) which gives women greater access. Mission hospitals with PTCT programmes were observed to have usually already good infrastructure, more chance of integrated care, VCT services for PTCT already established, potential for synergy between treatment and testing for PTCT and can bring in men. Mission hospitals with PTCT programmes have already established registration, monitoring and follow up of women, community education and outreach and linkage with STI and TB programmes. They have linkages with support groups and community home based care programmes.

In contrast, introducing treatment through private sector and workplaces may increase inequity if it targets management level based on replacement costs. Treatment issues need to be factored into overall workplace policy, including issues of job security, termination, dependents, accreditation of providers. Drug choices are also important, such as procuring ARVs when essential

drugs for treatment of opportunistic infections such as diflucon are not available.

She also noted the need to **locate treatment access issues within the wider social response to HIV/AIDS**. Availability of treatment may encourage people to get tested with spin-off that many will find that they are negative, however fear is still very great and there are reports that men are sending their wives to get tested, but will not get tested themselves. The benefits of being tested need more publicity and people who benefit from treatment will need to 'display' themselves.

A recent conference in Harare on access to treatment highlighted a number of **concerns around current public policy choices:** Public education is needed that not all positive people need to be on treatment to ensure demand is relevant. Only select groups have access through present resource levels, many through research projects, certain mission hospitals or NGOs. Many people don't have food so find it difficult to take drugs on an empty stomach and many question widespread availability of ARVs when note other drugs such as pain killers and antibiotics are not available.

At global level, access needs to be underpinned by secure trade and legal agreements and financing systems, rather than aid. UNAIDS has called for tiered pricing dependent on relative income of countries, competition between drug suppliers to reduce prices, regional procurement to secure price reductions through large volume purchases and licensing agreements between patent holding companies and manufacturers in low and middle income countries. This itself calls for reinforcement of health safeguards in trade agreements such as compulsory licensing to manufacture patented medicines where HIV constitutes a national emergency and new global private and public funding mechanisms to pay for treatment for the poorest countries.

Dr Richard Laing highlighted the need for an **efficiency – equity synergy-** where ensuring efficiency in treatment access issues was equitable, while inefficient approaches generated scarcities and inequities. While 28,5 mn people in Africa are HIV+, only 1,3mn have AIDS, making treatment costs feasible in terms of drug prices. He cautioned however that new ways of assessing affordability across different socio-economic settings were needed, such as by measuring drug prices in terms average daily wages. This raises the issues of **how to organize treatment access,** in terms of defining standard treatment guidelines, procuring storing and distributing selected drugs, ensuring quality assurance and monitoring and securing financing for these costs. He noted the potential costs in drug resistance (current 75% of the virus in the US is drug resistant and 44% in Brazil).

At global level, he called for mechanisms for monitoring local use of global funds such as the GFATM, both in terms of ethical practice, efficiency and equity.

A **pro-treatment, pro-public health agenda** needs now to complement treatment activism. Using an equity lens to review current policy provides opportunities for doing this at national and global level. This does not imply that equity will be immediately achieved, but that efforts to enhance absolute coverage of treatment and that health care responses chose the most equitable options for doing this. The priorities within this were identified as:

At global level: Ensuring that international agreements (eg WTO TRIPS) and global financing mechanisms support the policies and systems for equitable access, including within national governance and public policy. Flowing from this is the need to monitor WTO agreements post Doha for their impact on treatment access and health systems and to monitor global and multilateral spending choices for the extent to which they reflect demands of equitable responses to HIV/AIDS.

In relation to national political and economic policies: Public policy decisions on HIV/AIDS are affected by the macroeconomic framework, signals and incentives sent, as well as by the extent of transparency and accountability on policy decision making. The costs and benefits of public policy decisions on HIV/AIDS, at national level and across different social groups are areas is thus important, as is the extent of public knowledge, information on policy and empowerment to claim entitlements around health care responses, like treatment access. Public perceptions – of stigma, denial or more positively of entitlement- and public confidence within social and economic processes also plays an important role.

Within health services: How can health service responses, such as treatment access, best be initiated before everything is in place. What implications do different approaches have for reversing the burden shift to communities, such as that from home based care and for enhanced prevention. To enhance equity, it is necessary to review with an equity lens the point of entry within the health system, the roles of private and public providers, the skills and interaction of health workers to provide care, the role of mushrooming pilot programmes within broader health systems, and the interface with community and home based care. A stronger evidence base is needed for standard treatment guidelines. Should health care personnel themselves be a priority group for treatment access when supplies are scarce? How can funds from the global fund (GFATM) be levered for wider health system support and essential drugs needs beyond ARVs?

On treatment access: Under conditions of scarce resources who should receive treatment and through what levels of the health service? What are the costs of this to the health service and to the client and what are the most equitable ways of meeting these costs? How can treatment be introduced in a manner that avoids resistance and thus does not limit future access? As a baseline for equity how can basic technical requirements of drug selection, quality assurance, monitoring, and support of compliance be assured?

While these issues raise immediate questions of policy on how new therapies are *introduced* they also highlight concerns that current paths do not create

longer term liabilities or reduce future treatment access –issues of intergenerational equity.

3. Terms of reference for the country and regional papers on equity in health sector responses to HIV/AIDS in southern Africa

The meeting identified that the paper should address equity concerns at the level of

i. the global and national social, economic, political, legal and institutional factors influencing decision making and societal resources for equitable health sector responses;
ii. the health system and health service options and responses, and
iii. the choices around treatments and equity dimensions of access to treatments

These areas were further discussed, and key questions and dimensions of these issues elaborated.

1. Global, regional and national policies

Equity oriented policies within the health sector demand a wider framework of macroeconomic, social policy and political and legal conditions to provide the conditions and resources for their implementation. Trade agreements, financing mechanisms and political processes within and beyond the health sector have an impact on overall health sector responses to HIV/AIDS, and on the distribution of costs and benefits of these programmes. The papers should thus examine the equity impact of relevant macroeconomic, trade and social policies at global, regional and national level on health sector responses to HIV/AIDS. They should also identify options for reducing inequities or enhancing equity outcomes of these policies and programmes. More specifically, work in this area should address:

1.1 Economic and trade policies

The extent to which (global, regional and national) trade agreements, economic and financing policies and their implementation assist or constrain the ability of SADC countries to access and provide affordable and accessible treatment.

1.2 Financing mechanisms

The extent to which global, regional or national financing mechanisms increase funding for both access to treatment *and* the forms of health service provision and access needed for equity and the trade offs and opportunity costs of current financing mechanisms (including around other inputs to health within and beyond the health sector)[4] . In particular the work should explore the impact of HIV/AIDS financing on wider equity issues in health sector financing and the distribution of costs and benefits of such financing mechanisms, particularly in terms of the current burden shift to poor households of HIV/AIDS.

[4] This includes for example food, nutrition, safe water

1.3 Governance issues

The extent to which decision making processes on health sector responses to HIV/AIDS, including proposals for use of global funds, have facilitated accountability and participation and to which there has been transparency and monitoring in administration and implementation of programmes.

2. Health System and Service issues

Health systems in southern Africa already have documented equity issues to address, and some policies towards this[5]. Against this background the papers should explore how current policies and programmes on HIV/AIDS exacerbate or reduce current inequities within the health sector. Current health sector responses to HIV/AIDS should thus be judged for their impact on ensuring that health resources are differently applied to those with different levels of need. The papers should present options for reducing inequities or enhancing equity outcomes within health sector responses to HIV/AIDS. More specifically, this implies addressing:

2.1 The overall situation

The documented distribution of HIV/AIDS, and the risks and vulnerability to the epidemic interface with major documented equity challenges within the current health system. This interface calls for broad analysis of where the HIV/AIDS epidemic itself intensifies (or reduces) existing equity challenges, such as in relation to benefit incidence, cost burdens, access to care, staffing of services, pressures for more costly curative over preventive or pro-poor services, across different communities and different levels of the health system. More specific dimensions of such analysis would then cover:

2.2 Current and projected health sector needs

How do the current patterns of resource distribution within the health sector influence HIV/AIDS responses and what gaps need to be addressed to provide for more equitable responses? What is the distribution of costs and benefits with current financing mechanisms and how do new forms of HIV/AIDS financing, including from GFATM, impact on resource distribution and cost burdens within the health sector? Equity in health sector responses demands adequate core resources, including skilled personnel at relevant levels of care – to what extent is this fulfilled across different providers (public, private, NGO, religious). What provisions exist for necessary laboratory services, drug procurement, distribution and dispensing within health services[6] and for making complex treatment regimes accessible across different levels of service and types of communities[7]. What is

[5] See for example Equinet policy series 7 at www.equinetafrica.org or the 1997 Kasane meeting report at www.equinetafrica.org

[6] At different levels and across different providers

[7] Such as using blister packs

the impact of logistic and support systems[8] on provision and access and what gaps need to be addressed. Standard treatment guidelines potentially improve efficiency and quality: do they exist, when were they last revised, through what process and how are they disseminated and used?

2.3 Access to health care

To what extent are core services such as Voluntary Counselling and Testing, STI and TB treatment, laboratory services etc accessible across different levels of health services and to different communities? Access to health care is determined by factors within and beyond the health sector. How are known barriers to access[9] impacting on access to HIV/AIDS care[10] . What role do social and community factors play in access to HIV/AIDS care generally? Have treatment or patient selection policies generated a beneficiary profile, what is the income, gender, age, location of that profile and what is its relationship to to the population and to risks groups for HIV/AIDS? What role have pilot projects played in enhancing or biasing access?

2.4 Building coherent links between prevention and treatment

To what extent do health sector policies and programmes provide a coherent framework for a prevention-treatment- care continuum? What gaps need to be addressed to enhance this? Are there positive synergies or negative impacts projected or being experienced within this[11]?

3. Treatment access issues

Equitable treatment access implies addressing a number of concerns covering choice, quality and management of treatment and beneficiary identification. It also implies addressing concerns around barriers to treatment, both in the how treatment is organised, and in factors that *disorganise* the provision of treatment. In the papers this implies addressing:

3.1 Treatment choice and conditions

How the range of options for treatment are prioritised and to what extent are they provided, from prevention, pain relief and palliative treatment to treatment of opportunistic infections to ARVs. The options for sequencing different forms of treatment and how these are being applied[12] The biases / gaps that exist in such choice and how these should be addressed[13]? The role of particular entry points for treatment, such as PTCT, use of VCT, in enhancing equity and the referral systems needed to support this? The provisions for ensuring

[8] Such as transport; supervision/ support ; physical structures; communications, training, information exchange
[9] Such as resources, scheduling, quality of care, attitudes,
[10] At different levels and across different providers
[11] eg: impacts of possible treatment access on attitudes to prevention
[12] Eg: ensuring contrimoxozole/ fluconazole access
[13] Such as for example treatment of children in policy and practice

community awareness and rights around treatment, for reducing stigma and for enhancing rational drug use, monitoring and compliance and adherence to treatment?[14] What are the projected long term effects of current capacities to provide and comply with treatment and what gaps need to be addressed[15]?

3.2 Beneficiary and access issues

What is the real and effective demand for treatment and how are beneficiaries being identified, prioritised and selected and by whom? [16] How are evidence from studies, human rights principles, advocacy, political interests, economic interests used in determining decisions on beneficiary identification? What has been the role of pilots, donations and research projects in access and beneficiary selection? How have decisions about treatment choices and regimes been made (on what evidence), with what ethical clearance and how do they impact on access across different groups? What options exist for enhancing equity, ethics and efficiency within these current processes? To what extent do current treatment policies and practices ensure sustainable supply and quality and how do pricing policies affect access? What impact has TRIPS/DOHA had on policies and practices on local production; purchase, storage and distribution?

3.6 Aspects of 'Treatment Chaos'

To what extent do aspects of treatment chaos exist, with what impact on equity in access and what measures are or could be put in place to manage this[17]? How are providers accredited and monitored and treatment standardised and what measures are in place to prevent resistance?

4. Key issues for policy and practice to enhance equity in responses to HIV/AIDS

On the basis of the findings above, what are the recommendations for changes to public policy and to practice relevant to the health sector at national, regional and global level? What policy platforms and institutional agents need to be engaged for such recommendations to be taken forward?

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[14] Such as for example the buddy and DOTS systems

[15] Such as side effects management; toxicities; structured treatment interruptions

[16] Are demographic, family, economic or employment criteria used in identifying ARV beneficiaries, if workers are identified through workplaces, are their spouses included, is there a gender bias in beneficiaries? Are factors service providers (teachers/ health care workers) prioritised and how are high risk groups such as commercial sex workers covered? How do children, orphans and other marginal groups access? Who makes this decision and how?

[17] Examples of treatment chaos include treating without testing, providing sSub optimal treatments, variable unaccredited providers, non transparent political and funding pressures influencing decision making.

These terms of reference will be carried forward into the commissioning of the papers.

The products: It was proposed that the four country studies (Malawi, Zimbabwe, South Africa and Tanzania) pursue the suggested framework as far as possible at national level, supported by district level secondary data, while identifying important global and regional influences. The regional synthesis paper should provide information on the generic policy and programme issues within the region, using national examples from the country papers, and explore further national, regional and policy and programme options for enhancing equity and access.

The intended product is one overall paper that includes relevant information from the country papers. The four country papers will also be available as stand alone papers.

The process: It was agreed that the report and terms of reference be circulated so the papers can be commissioned by 20th March with drafts of country papers submitted to the review panel through EQUINET by 1 June and of the overall paper by 30 June 2003. Feedback from reviewers will be given within 2 weeks and final papers submitted by 3 August to EQUINET.

While original field work is not intended, grey literature (reports) and key informant interviews will be used in addition to published information.

It was also agreed that further papers be commissioned on equity impacts of health sector responses to HIV/AIDS in relation to

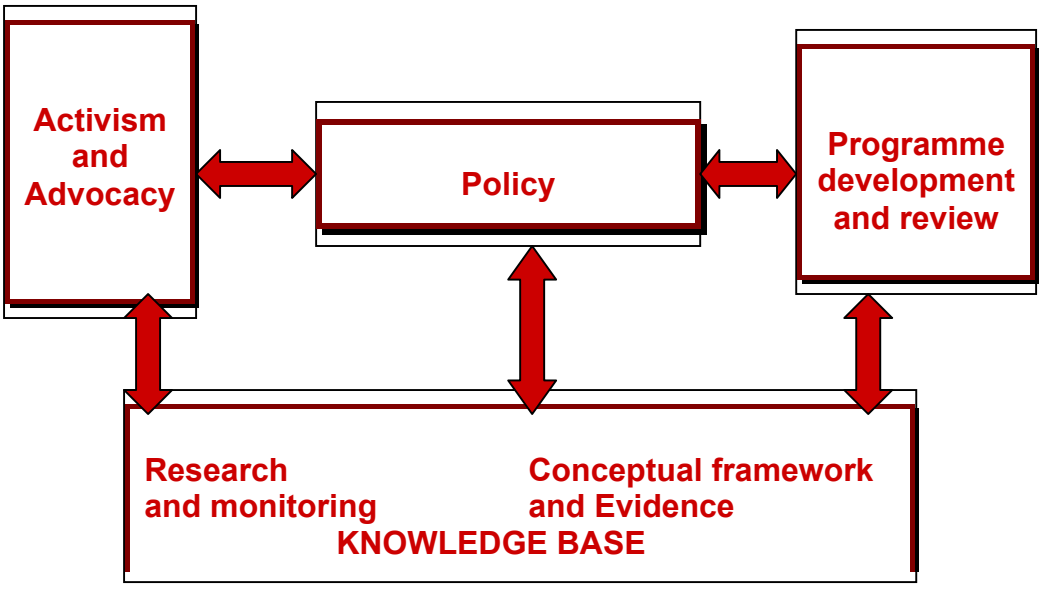
- Food and nutrition policies and programmes
- Health personnel
- Human rights and governance
- Gender equity
- Global trade and economic policies
- Essential drugs policies
- Specific distributional issues (eg urban rural, risk groups) and equity issues in responses in terms of comprehensive health system or targeted approaches

These are listed in order of priority. Terms of reference and commissioning of these papers will be done from mid-March to Mid-April 2003. DfID indicated commitment to supporting further papers.

4. Follow up actions and platforms

The review meeting identified that the information produced in the report should reach a number of targets: national, SADC and international policy makers and programme implementers to inform decision making, civic and wider activist groups to inform advocacy, and financers and donors to influence resource allocation.

Follow up processes were thus discussed to take forward an agenda of enhancing equity in health sector responses to HIV/AIDS within southern Africa. These were conceptualised within a framework of a knowledge base, supporting activism/advocacy and programme design and implementation, that informs policy.



The current process relates to building **conceptual frameworks and evidence to support policy and programme development and review.** Within this the review meeting proposed using the evidence that will be produced

- To contribute to the UNAIDS programme on scenarios for the future
- To make input at the ICASA 2003 conference on September 21 -26 2003 in Nairobi Kenya, preferably through a mini-symposium that allows for report back of papers (www.icasanairobi2003.org)
- To give feedback on the work at other conferences, such as the Durban HIV/AIDS Conference in June 2003
- To prepare summaries and briefs directed at different target groups and providing the papers on the web. (EQUINET will upload the papers to the web at www.equinetafrica.org and link to the Oxfam site and others)
- The process can also widen the inclusion of country studies and peer review by making available the terms of reference for the work so that it can be used in other protocols through web and health mailing lists.

As the evidence base is developed the work can further develop **areas for follow up research and a framework for monitoring equity and access issues in health sector responses to HIV/AIDS** that can be applied to generate new evidence, enhance policy review and advocacy and build public accountability on this. Agencies such as IDRC, WHO TDR, DfID and others would need to be engaged around support of research work.

It was proposed that follow up be made to **engage with and support a number of existing processes of activism and advocacy**, including

- Making links with NGOs involved in advocacy on equity, rights and access, including the PHM, TAC, Pan African Treatment Access movement, MSF, Medact, HAI, CWGH, African Social Forum, Poverty Forums and others
- Making or enhancing links and work with NGOs working as watchdogs of equity, rights and access around Abuja and UNGASS declarations, including Action AID, GEGA, Oxfam and EQUINET
- Developing and using indicators for monitoring access and equity to monitor the performance of the GFATM in Southern Africa

Ensuring dissemination of evidence to **programmers and planners** through

- Dissemination channels noted above
- Providing summaries and briefs highlighting operational and programme implications and experiences
- Engaging with national authorities and health providers on monitoring and review of equity and access options
- Using research to review and disseminate positive practices
- Engaging with the private sector through forums, initatives (eg the Harvard Business Forum on AIDS, World Economic forum)

Supporting and informing **policy processes with issues and options** on equity and access on HIV/AIDS and health sector responses. Some of the key policy targets highlighted that merit follow up are:

- National policy making mechanisms (stakeholder councils, executive and parliament)
- Southern African Development community (SADC) HIV/AIDS desk, social sector and other directorates
- African Union, particularly on its Abuja commitments and their implementation
- UN institutions, including UNAIDS, World Health Organisation / Assembly

Further it was noted that it is important to engage with financers, including GFATM, bilateral donors and other major new financing initiatives.

It was thus proposed that a follow up review meeting be held at the time of the ICASA conference in Nairobi to review progress and facilitate planning of this follow up work based on the papers produced. It as agreed to make a submission to present the work at ICASA symposium and hold a meeting at the time of the conference. In the interim EQUINET and Oxfam will work with the review panel to follow up on those issues that can be dealt with more immediately and to seek further funding for the planned work.

4. Closing

Equinet and Oxfam express their thanks to the review panel, delegates and authors for their valuable contributions to date, for setting the process on an extremely firm footing using their experience, perspectives and values and for the intensive exchanges in the one day of the meeting.

APPENDIX 1:
Review Panel
EQUITY ISSUES IN HIV/AIDS, HEALTH SECTOR RESPONSES AND TREATMENT ACCESS IN SOUTHERN AFRICA

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APPENDIX 2:

Review meeting on
EQUITY ISSUES IN HIV/AIDS, HEALTH SECTOR RESPONSES AND TREATMENT ACCESS IN SOUTHERN AFRICA
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[18] *Also invited but not able to attend : Other review panel members, Dr Moeti WHO, Dr Dhlakama SADC focal point, Dr Mahlangu MCAZ*

APPENDIX 3:
Review meeting on
EQUITY ISSUES IN HIV/AIDS, HEALTH SECTOR RESPONSES AND TREATMENT ACCESS IN SOUTHERN AFRICA

Bronte Hotel February 19 2003

Agenda

8.30-9.00am	Welcome, Introductions, Objectives
9.00-10.00am	Current priorities in policy issues and options in health sector responses
10.00-10.30am	Tea/ coffee
10.30-11.30am	Working groups: Equity dimensions of issues to be addressed in the paper Gp 1: Treatment access issues Gp 2: ART in the context of prevention, treatment, care continuum and other public health interventions Gp 3: Wider health infrastructure and political economy issues
11.30-12.30pm	Feedback from working groups
12.30-12.45pm	Summary of morning discussion outcomes
12.45-2.00pm	Lunch
2.00-2.30pm	Country issues, sources and institutional links
2.30-3.30pm	Policy targets and audiences, follow up processes and platforms
3.30-4.00pm	Tea/coffee
4.00-4.30pm	Next steps, closing

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[21] Noting that health 'care' includes the spectrum of promotive, preventive,- public health- curative and rehabilitative services.

[22] It is expected that these broad parameters will be developed in the concept paper that the candidates submit for their scope of work and further in the initial review meeting, to ensure that deeper questions, such as the equity issues in the vertical / disease-based versus health systems dichotomy, are adequately captured.

[23] Applicants are asked to submit a proposal for the grant that includes

i. a CV, clearly identifying previous work and documents authored in the areas of HIV/AIDS,, equity and health
ii. a sample of a paper produced by the applicant
iii. in one to two pages a conceptual outline of the paper and the major sources of evidence

[24] The paper will cover at least the SADC countries where Oxfam and Equinet have a presence (Angola, Malawi, Mozambique, South Africa, Zambia, Tanzania, Botswana and Zimbabwe and will draw information from secondary sources. The most significant data bases on these issues may be found in Zimbabwe (eg TARSC, SAfAIDS) and South Africa. Whether case exists for regional travel to access these will be explored at the regional meeting and it is suggested that a further Usd1 500 be provisionally set aside for this.

[25] (1 & 2) Costs jointly borne- suggested that Equinet manage the technical and language edit and layout costs (about Usd1 000) and Oxfam the printing charges (about Usd3 000)