MEETING REPORT
Country meeting: Tanzanian Network on Equity in Health

TANESA, CEHPRAD and the Tanzania Public Health Association

Tanzania National Meeting on Equity in Health
Bahari Beach Hotel, Dar es Salaam, 26 February 2004

with the Southern African Regional Network on Equity in Health (EQUINET

Report produced by: TARSC
Financial support from IDRC (Canada)

Tanzanian Meeting on Equity in Health, February 26 2004

1. Background

The Southern African regional Network on Equity in Health (EQUINET) was launched by southern Africans after a 1997 seminar on 'Equity in Health' in Kasane, Botswana. EQUINET is a network of professionals, civil society members and policy makers who have come together as an equity catalyst, to promote policies for equity in health in the Southern African Development Community (SADC) region. Since late 1998 EQUINET has built a programme of research, analysis, training, publication, advocacy and policy dialogue on determinants of health equity across political, macro-economic, trade, public policy and provisioning, governance and health rights issues. Institutions in EQUINET have built programme of research and analysis that has been used to build skills, inform policy and engage with key stakeholders, including parliament and civil society (see www.EQUINETafrica.org)

This meeting was carried out by the Tanzania members of EQUINET in terms of is one of the key goals of the strategic plan, strengthening the network. Noting the critical mass of equity actors and EQUINET supported activities in Tanzania and the resolution made in 2000 to form a country network in Tanzania, the Tanzanian organisations active in EQUINET proposed to hold a one day meeting for EQUINET to review the work being done in Tanzania and to discuss plans for launching a national health equity network.

The meeting was held at the Bahari Beach Hotel in Dar es Saalam, Tanzania. Twenty-two individuals from civil society, government, academic and research institutions with an interest in Health equity in Tanzania attended the meeting (See delegates list Appendix 2). The meeting was hosted by TANESA, TEHIP, CEHPRAD and the Tanzania Public Health Association with support from EQUINET. The meeting aimed to review health equity related work being carried out in Tanzania and to discuss the launch of the Tanzania National Network for Equity in Health.

The programme is in Appendix 1. The Network for Equity in Health in Southern Africa (EQUINET) supported the meeting. This report was prepared by the EQUINET secretariat at Training and Research Support Centre (TARSC).

2. OPENING PAPERS

Ms Mwajuma Masaiganah of the Peoples Health Movement and an EQUINET Steering committee member welcomed participants to the meeting and said it was an opportunity for them to be part of a new process of promoting health equity in Tanzania. Three members of the Tanzanian Parliament were amongst the participants. Delegates introduced themselves. Members of the EQUINET Steering committee and its secretariat that had earlier attended a steering committee also attended the Tanzanian National meeting. The Global Equity Gauge Alliance was also represented at the meeting.

2.1 The health equity situation in Tanzania

Prof. Gabriel Mwaluko of TANESA and a Steering Committee member of EQUINET explained that various reform programmes aimed at strengthening the Public health delivery system had been implemented in Tanzania. He however, highlighted major shortages of human resources for health in the system and poor service delivery. This is compounded by inequitable distribution of facilities and funding. He described various areas of on-going work on equity in Tanzania.

The District Health Account (DHA) program is being conducted by the Tanzania Essential Health Intervention Project (TEHIP) as well as the Adult Morbidity and Mortality (AMMP) study. The Ministry of Health has decided to use the DHA as the blueprint for local government authorities (LGAs) to plan on resource allocation based on the burden of disease. TEHIP gave a full review of that work.

The National AIDS Control Programme (NACP) and the Tanzania Commission for AIDS (TACAIDS) are the two key public players in the area of HIV/AIDS/STIs and Antiretroviral treatment (ART). There is a policy is in place as well as a National Multi-sectoral Strategic Framework emanating from the National Policy for AIDS. The NACP/MOH has produced the HIV/AIDS Health Sector Strategy, 2003-2006. In it the fight against HIV/AIDS has been clearly defined. Guidelines for the use of ARVs have been given and it seems likely that their use could start before end of 2004. There are tensions on who should get them? How to monitor their use? Already there are pockets of the private sector, for example, Tanzania Breweries Limited that are providing ART free of charge to all their employees and their spouses.

During the period 1965-1978 Tanzania provided free primary health care. Many dispensaries were built, drugs were supplied, and health workers were trained. It did very well in immunization coverage. Yet, since the 1990s, the picture has changed. The public sector can no longer bear the cost of providing free health for all. The quality of health care has dropped and the current reforms could not come at a better time. Yet, despite the reforms there must be very clear strategies put in place to ensure equity in health and health care. The picture becomes more complicated with the HIV/AIDS/TB epidemic that has gone hand in hand with the one on stigma.

2.2 Health priorities in Tanzania

The Honorable Omar Kwangw' Chairman of the Parliamentary Social Services Committee of Tanzania noted that the mandate of the Ministry of Health is to improve the health and well being of all Tanzanians focusing on all those at most at risk. It also endeavors to provide equitable and affordable basic health services that are gender sensitive and sustainable. He outlined the Tanzania National Development Vision-2025, which has recognized the health sector as high priority to ensure that all Tanzanian have high quality livelihood. The Ministry of Health has revised the national Health Policy in 2002 to widen its scope and made it consistent with other sectorial reforms that are occurring in the country. He stated that the National Health Policy in general terms aims to ensure equity in health care provision.

The ministry of health bases its policy decisions on information and statistics obtained from the following sources, National census data, demographic and health surveys, hospitals, clinics, research findings and non governmental organizations. Key objectives of the health sector reforms that have been conducted in Tanzania are as follows,

- Improving access, quality and efficiency in primary, secondary and tertiary service delivery.
- Increasing the financial resources and management.
- Promoting private sector involvement in the delivery of health services

These objectives are inter-linked with strategies in the provision of accessible, quality, well supported cost-effective district health services with clear priorities and essential clinical and public health packages at the decentralized level with the back-up secondary and tertiary level. The health sector reforms have resulted in an increase in the share of budget resources devoted to health over the last three years.

Prof Mwaluko presented the comments from Adeline Kimambo, Tanzanian Public Health Association (TPHA) . She noted that there was poor understanding of the concept of equity in the country and there was need to disseminate information on the work being conducted by EQUINET both in Tanzania and the SADC region as a whole. She stated that EQUINET was a platform for promoting evidence based interventions at community level. She suggested a number of priorities for equity work:;

- operationalization of policies/ strategies based on evidence.
- advocacy and dissemination of EQUINET work findings in Tanzania
- Financing evidence based interventions at community level
- Community involvement approaches
- Participatory policy development to address equity issues.

3.0 Examples of Equity work currently being done in Tanzania

Delegates presented examples of the existing work underway on health equity in Tanzania. EQUINET supported work on resource allocation, policy analysis, HIV/AIDS, and community participation were reported together with programmes under TEHIP and Ifakara and the Rufiji Demographic Surveillance programme.

3.1 Allocation Formula for the Health Sector Block Grant & Health Basket Fund

A team from the ministry of Health sector reform secretariat of the Ministry of health gave an overview of the funding mechanisms that were currently being used in Tanzania. In order for the Ministry of Health to allocate Health Basket Funds more equitably there was need to develop a transparent formula that incorporated important variables that ensure that the poor areas have reasonable allocations. This formula must take into account the regional variations that exists in Tanzania and should avoid large changes to allocations to areas that traditionally received larger funding.

The formula considered the following variables, population structure, special Health Needs (burden of disease, poverty level, local cost of delivery services, distance covered by service provider, number of Health Units and geographic location (accessibility barriers). The new resources allocation formula now considers the population (70%0, poverty count (10%), vehicle route mileage (10%), vehicle route mileage (10%) and under five mortality. The cabinet of Tanzania has approved the formula based system for funding the health sector. Its implementation started on the 11th of February 2004.

3.2 Equity in health sector response to HIV/AIDS in Tanzania

Innocent Semali and Adeline Kimambo presented a paper entitled 'Equity in health sector response to HIV/AIDS in Tanzania. They stated that the Tanzanian cumulative incidence of HIV was 356.6 per 100,000 for 2001. There is marked spatial variation in the country. The HIV/AIDS pandemic has been associated with increased absenteeism at the work place, high orphan rate and excess demand on the health system. The methodology used by the authors of the paper included, review of documents, analysis of secondary data, observations and informal interviews.

HIV/AIDS has resulted in increased inequity in the following areas, school enrolment, economic productivity, poverty, communication infrastructure, health facilities and health care financing. Reforms in the health sector have also resulted in reduction of the labor force at some clinics/ hospitals as well as charge in the role of ministries. The response of the Tanzanian government has been the formation of TACAIDS, the development of the HIV/AIDS policy. However, there is no mechanism to ensure that this policy is being followed and is equitable.

Church based and non governmental organisations have advised donors to pay attention to the capacity to deliver the desired output instead of paying attention to how best an organization can write a proposal and also look at the more rural and remote areas. The focus should be at reducing the cost of drugs, increasing the capacity of the health sector to respond to the needs of patients, improving the referral system and training of health care personnel.

3.3 Tanzania Essential Health Interventions Project (TEHIP)

Harun Kasale presented the work in TEHIP, noting that the project aims to support decentralized planning with evidence on burden of disease, cost effectiveness,

community preferences and capacity of the health system to deliver. The core questions of on Decentralization TEHIP is attempting to answer are;

- How, and to what extent, can DHMTs do planning which is more evidence based?
- How, and to what extent, can DHMTs implement such evidence based plans?
- How, to what extent, and at what cost, does this reduce the burden of disease?

TEHIP uses supportive Interventions and strategies, including

- District Simulated Basket Funding,
- Strengthening Health management and administration,
- District Integrated Management Cascade, and
- Community Ownership of Health Facilities and Community Voice (PAR). .

A Lesson from the TEHIP work is that to ensure equitable use of basket funding it is important to develop decentralized planning and management capacity. This would result in the development of practical planning tools such as graphical burden of disease profiles and expenditure mapping. These tools should focus on interventions addressing the largest disease burdens e.g**.** (IMCI and malaria).

3.4 Mapping Health Inequalities in Rural Areas of Tanzania

Eleuther Mwageni presented work on mapping health inequalities in rural areas of Tanzania, particularly describing health inequalities in a rural setting, in the Rufiji Demographic Surveillance site. Its specific objectives were to describe an asset-based socio-economic index in a rural setting in Africa and to determine the relation between household socio-economic status & inequality of (i) access to health interventions and (ii) health outcomes. In rural areas there is an additional problem because planners erroneously assume that rural communities are homogenous and have equal access to health care. The paper addresses this issue with evidence from Rufiji Demographic Surveillance System (DSS). The objective of the paper was to present evidence of health inequalities in a rural setting. The methodology depended on Principal component analysis (PCA) on datasets collected from the DHSS. The PCA used the following socio-economic variables (SES) and dependent health variables. Independent SES Variables used are Assets, Housing characteristics, Water & sanitation and Socio-economic status index. The dependent Health variables used are, bed net ownership, Infant mortality, under-five mortality and Distance to health facility. This work showed that the average travel time to health facilities is 20 minutes and only 10% of population exceeds 1 hour travel time. Comparing between the least poor and the poorest, the poorest have 44% more crude mortality, 46% more infant mortality, 53% more under-five mortality and 8 times less coverage of bed nets. They also appear to have reduced access to services. Policies and programmes should attempt to reduce these inequalities.

3.5 Understanding mechanisms for integrating community preferences in health planning and quality of care

Godfrey Mubyazi presented work on mechanisms for integrating community preferences in health planning and quality of care. The authors aimed to identify health services needs of communities. Community participation became an international focus since 1978 [Alma-Ata Declaration]. The community must be won over when it comes to labor contributions e.g. building health facilities and cost sharing. They stressed that for equity

in health to be achieved there is need for an explicit policy to guide public voice in Health. There is a need to develop skills necessary for public stakeholders to fully participant in consultation processes.

The following mechanisms were used to identify community preferences in Health in Tanzania: Village and Ward Development Committees, Health Facility Committees, Local health boards, Suggestion boxes at health facilities, Operational research – community interviews and Demonstration projects – e.g. TASAF (Country-wide) and TEHIP (Rufiji, Kilombero, Morogoro Rural). Despite this there are limitations to formal community participation in health in Tanzania

- Inadequate planning skills at local level
- Low intersectoral sharing of health information e.g. budgets…
- Deliberate neglect by council health authorities to reveal to the community budgets allocated by gov't
- Low public attendance rates at local general meetings…
- Low/lack of- public trust in some local leaders
- Council health plan over-driven by national priorities with neglect of local context problems
- Low level of education of Volunteering CHWs…(e.g. school dropouts)
- Low motivation of CHWs and some local government leaders

These issues need to be addressed if community participation is to be strengthened.

3.6 Community's Voice and Preference in District Planning

S Mbuyita and Harun Kasale presented a paper on the community's voice and preference in District planning under the TEHIP project. The paper first described the Health Sector Reforms that have occurred in the Tanzanian Public Health System in the past 5 years. For these reforms to work it is central to develop community level participation, ownership and resource mobilization. Community participation is central in defining needs, identifying objectives and setting priorities in the health sector. This includes

- defining needs, identifying objectives (goals) and setting priorities
- Involvement in aspects of planning and implementation
- Furnishing resources (human and material)

The project achieves these outcomes through involvement of communities in a Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA).

The objective of the household health seeking behavior research was to work with , Council Health Management Teams (CHMTs) and other district departmental sectors to facilitate the creation of a procedural framework for communicating identified and felt needs of communities into CHMT/ District planning process. This was achieved through training, recruitment, community entry, sensitization/ awareness creation meetings and community reflective activities. In addition attempts were made to involve village governments, Council Health Management Teams (CHMT) and District Management Teams (DMT). The key lessons learnt, were that openness and transparency are central in good governance of CHMTs and DMTs. There was need to involve the youth in all community outreach initiatives.

4. Regional and global health equity work

4.1 The global equity gauge alliance (GEGA)

Dr. Alexandra Bambas presented the work being conducted by GEGA. She explained that a gauge was a programme of work that uses an active approach to monitoring inequity in health, health care, other determinants, and consequences of ill health and responsive actions to support pro-equity policy and empowered communities. The Global Equity Gauge Alliance is involved in determining intra-country inequities and on identification of the determinants of health for health development. They promote evidence-based policy and planning for health equity at national and sub-national levels.

The Equity Gauges are developed on a three-pillar model to move research to action.

- Assessing and Monitoring the current dimensions of health inequity as well as changes over time, using quantitative and qualitative methodologies and using primary or secondary data;
- Advocating for health equity through evidence-based policy recommendations, raising public awareness, capacity building, partnering with MoH and others, publications, etc.; and
- Actively supporting community empowerment in developing projects, advocacy campaigns, and interventions.

The Equity Gauges were initiated 3 years ago and are centered on government/NGO partnerships. GEGA acts as a link between the technical people (e.g. researchers) and the advocacy people (e.g. social justice organisations). Country level partners of GEGA include government, (ministries of health, planning, finance, parliamentarians, other policy makers), NGOs at the community, local, national and international levels, private and public research and policy institutions and universities.

In southern Africa Equity gauges are active in South Africa, Zambia and Zimbabwe. In South Africa the gauges are providing support to the Parliamentary Portfolio Committee on Health, through equity-analysis of the Health Sector Budget, health and other social sector policies, other issues requested by the committee and supporting and capacity building clinic committees. In Zambia Development 4 District-level Gauges have carried out sensitisation and training on health equity for community leaders, investigation into issues of user fees, access to drugs, role of NGOs, and health inequalities and stimulated debate at district and national levels with the Parliamentary Portfolio Committee on Health.

She noted that GEGA offered training and capacity building, exchange with other equity Gauges and ongoing technical support, learning of other countries' experiences.

4.2 Southern African Regional Network on Equity in Health (EQUINET)

Rene Loewenson representing EQUINET explained the formation of the network. The Southern African Regional Network in Health (EQUINET) was launched by southern Africans after a 1997 seminar on 'Equity in Health' in Kasane, Botswana. EQUINET is a network of professionals, civil society members and policy makers who have come together as an equity catalyst, to promote policies for equity in health in the Southern African Development Community (SADC) region. See www.equinetafrica.org) She

outlined the work and networking meetings already conducted. EQUINET has identified the equity concept with addressing differences in health status that are unnecessary, avoidable and unfair, noting the importance of community voice and agency in this.

EQUINET has conducted work on,

- Equity in health generally
- Economic and trade policy and health,
- Wider inputs to health – food security, water, sanitation,
- Health Services – fair financing, health personnel,
- HIV/AIDS and treatment access, surveillance ,
- Participation and governance and Health rights, values and policies.

In the past year EQUINET has for example been working on health systems approaches to antiretroviral treatment (ART), noting the need to expand ART access in the context of strengthened prevention and care of HIV and of strengthened health systems. This raises concern over policy, systems and social criteria for rationing treatment, integration of ART in district health systems and the need to invest health personnel.

She noted that EQUINET networks existing equity actors across government, civil society, academic institutions, parliament and others and formally liaises with SADC. EQUINET commissions, fund and carry out research and gather policy relevant evidence on health equity issues, exposes policy / decision makers to health equity issues and options and convenes forums for debate and review of issues. EQUINET publishes and disseminates information, analysis and debate and news through its newsletter and website. The network provides training, mobilizes resources for health equity work and builds facilitate and service alliances around specific policies and campaigns.

5. PRIORITIES FOR TANZANIA HEALTH EQUITY WORK

The key expectations and outcomes of participants of the Tanzania health equity meeting were discussed. They identified as priority areas the need for research and programme support for equity work in Tanzania, development of technical expertise, resource support and coordination of current work. Key players in promoting equity issues in Tanzania will be research institutions, the community, donors, government, ministry of health, members of parliament and civil society organizations.

5.1 Launching of the Tanzania National Network on Equity in Health, EquineTA

The Tanzanian participants agreed to form a network for promoting health Equity in Tanzania. It will be called the Tanzanian National network on Equity in Health, EQUINETA and will be a Tanzania national 'chapter' of EQUINET. It will also work with other organisations involved in health equity priorities, including GEGA. It was agreed that Prof. Mwaluko will co-ordinate/chair the Tanzanian network. The Tanzanian co-ordinating committee will be as follows:

Government: The Chief Medical Officer will nominate someone
Research: Mwele Lazoro Malecela, National Institute for Medical Research (NIMR)
Parliament : Hon. Ladiana Mafuru Mng'ong'o, Tanzania, Parliamentarians AIDS Coalition (TAPAC)
Civil society: Majumwa Masaiganah, PHM

It was agreed that EquineTA's first activity would be to meet to present equity issues in the budget review input for the health services review hosted by NIMRI. Concern was expressed by the Tanzanian delegates that a meeting be held on equity issues in treatment access. EQUINET offered to support a second activity - a meeting in late March (probably 26th of March 2004) on Health systems approaches to ART. This meeting will take place before the TAPAC Parliament meeting on AIDS. It will be supported by EQUINET and convened by EQUINETA. Collaboration was also suggested between EQUINETA and other centres in southern Africa (Chessore, MHEN, CWGH) working with Parliaments. As a chapter of EQUINET work done by EQUINETA once documented and forwarded to the EQUINET secretariat will be disseminated in the region and in the EQUINET website.

Opportunities for networking were noted in the June 8-9 2004 EQUINET Conference in Durban, South Africa and in the GEGA Research to Action course also in Durban in June 2004. It was noted that EQUINETA can write grant application proposals to get funding to support their work.

Closing remarks

Rene Loewenson and Gabriel Mwaluko gave the closing remarks. They acknowledged the importance and valuable outcomes of the meeting, and the potential for support to the newly formed Tanzanian network based on shared values and commitments to equity and to strengthening national and regional networking. Prof Mwaluko urged delegates to sustain the commitment shown in the meeting to produce a high quality of work.

Appendix 1: Programme

Tanzania National Meeting on Equity in Health

Bahari Beach Hotel, Dar es Salaam, 26 February 2004

Programme

Time	Activity	Responsible Person(s)
08.30 – 08.45	Welcome and introductions	Adeline Kimambo
08.45 – 09.30	Equity in Health issues in Tanzania: An Overview of Tanzania EQUINET	Gabriel Mwaluko
09.30 –09.50	Health Priorities in Tanzania	Parliamentary Social Services Cttee Chair, Hon, Omar Kwangw
09.50 –10.15	Plenary discussion: Priorities for work in hea Equity in Tanzania	Adeline Kimambo
10.15 –10.45	Tea/Coffee break	ALL
10.45 –12.00	Examples of EQUITY work currently underw in Tanzania: ▪ Equitable Resource Allocation ▪ Equity in Health Sector Responses to AIDS ▪ Community Participation ▪ TEHIP	 Gredelyn Minja/MOH Innocent Semali Godfrey Mubyazi Harun Kasale
12.00 – 12.45	Plenary discussion on work currently being done	Rene Loewenson
12.45 –13.00	National EQUITY Gauges	Lexi Bambas - GEGA
13.00 – 14.00	LUNCH Break	ALL
14.00 –14.30	Regional Work on EQUITY in Health	Rene Loewenson
14.30 –15.30	Group Work: ▪ Priority areas of research and programme support ▪ Strengthening alliances for Equity in health ▪ Building a National Health EQUITY Network ▪ Strengthening training and capacity development towards health equity	Break away groups
15.30 –16.30	Plenary presentation of group work	Group rapporteurs
16.30 –17.00	The way forward	Gabriel Mwaluko
17.00 – 17.30	Tea/Coffee break	ALL

APPENDIX 2: Delegates
Tanzania National Meeting on Equity in Health
Tanzania, February 26 2004

Name	Institution and address	Email address	Phone and Fax number (show fax with (f) and give country and area code please)
TANZANIAN DELEGATES			
Q S Kwaangw	Parliament of Tanzania Box 941 Dodoma or 248 Balati (home area)	Omanikwaangw@yahoo.com	255+748-396003
Mwajuma S Masaiganah	PHM East Africa Box 240 Bagamoyo	masaigana@africaonline.co.tz	255-23-2440062/2440006 255-744-281260
Lawrence Limbe	Women's Dignity Project Box 79402 PSM	wdp@cats-net.com	255-22-2152577/8
Innocent Semali	MUCHS Box 65131 Dar es Salam	isemali@muchs.ac.tz	255-744-269838
Agnes Namuhisa	Tanzania Federation of Cooperatives	Anamuhisa2001@yahoo.com	255-22-2184084 f 255-22-2184081 m 255-744-684812
E Mwageni	Sokoine University Morogoro	mwageni@hotmail.com	255-744411456
H A Kasale	TEHIP Box 78487Dar es Salaam	kasale@tehip.or.tz	255-28-2130627 255-0744334574 f 255 22 2112068
S S Mbuyita	IFAKARA Health Research and Development Centre Box 53 Ifakara	smbuyita@ifakara.mimcom.net	255-23-2625164
Godfrey M Mubyazi	MMR, Ubwani Station Box 81 Muheza Tanzania	mubyazig@hotmail.com	255-27-2643869 f 255-27-2641132 tel 255-744-389635 cell
Mary G Materu	COUNSENUTH Box 8218 Dar es Saalam	materu@ud.co.tz	Tel. 255-22-2152705 Cell:0744279145
Helene B Proba	HSRS/HSPS MoH Box 9171 Ghana Avenue Dar es Salaam	helene@acexnet.com	0744 222283
Peter Kamuzora	IDS University of Dar es Saalam Box 35169 Dar es Saalam	petkamu@udom.ac.tz	0255(022) 2410075
Mwele Malececa	National Institute for Medical Research Box 9653 Dar es	mmalelela@nimr.or.tz	255-22-21252084

	Saalam		
Ndinini Sikan	Masai Women Dev. Org	maawomen@yahoo.com	255-744695865 Fax: 255 262701 780
Hon Lediana Marufu Mugongo	Tanzania Parliamentarians AIDS Coalition (TAPAC)	ledianamafuru@lutaicul.com	255-744695865
EQUINET STEERING COMMITTEE MEMBERS			
Rene Loewenson	TARSC 47 Van Praagh Ave Milton Park Harare	rene@tarsc.org	263-4-708835 f 263-4-737220
Itai Rusike	CWGH 114 McChlery Ave Eastlea Harare	cwgh@mweb.co.zw	Tel:263-4-788100 Fax:263-4-788134 cell:263-91363991
T J Ngulube	Department of Community Health College of Medicine	chessore@zamnet.zm	260-1-228359 f 260 1 228359
Gabriel Mwaluko	TANESA Box 434 Mwanza	gmwaluko@mwanza-online.com	0748-274545
Godfrey Woelk	Dept of Community Service, University of Zimbabwe Box A178 Avondale Harare	gwoelk@medsch.uz.ac.zw	263-4-791631 f 263-4-725166
G N Musuka	EQUINET 47 Van Praagh Ave Milton Park Harare	godfreym@tarsc.org	263-4-708835 f 263-4-737220
PARTNERS			
Lexi Bambas	GEGA	lexi@gega.org.za	+27 31 3072954
Q Marmood	GEGA	granar@gega.org.za	+27 31 3072954
B Rutherford	Carleton Inventory Ottawa	Blair-rutherford@carleton.ca	