WHO WE ARE

The Health Systems Trust (HST) is a non-governmental organisation, supporting the transformation and development of health systems and services since its inception in 1992.

Our approach is to embrace a public health perspective with a focus on Primary Health Care. We support health systems development through research and disseminate information that influences both policy and practice. By facilitating supportive interventions and sharing ‘best practice’, we improve quality of care in priority health programmes. We advocate for equity, efficiency and effectiveness in health services and for empowerment of the health service users.

We are guided by an independent Board of Trustees. Board members collectively comprise a diverse group of individuals with professional standing and expertise in health systems development and public health.

VISION
Health systems supporting health for all in Southern Africa.

MISSION
To contribute to building comprehensive, effective, efficient and equitable national health systems by supporting the implementation of functional health districts in South Africa and the region.

APPROACH
- We embrace a public health perspective with a focus on the Primary Health Care approach.
- We do health systems development through research and information dissemination that influences both policy and practice.
- We improve quality of care in priority health programmes through facilitating supportive interventions and sharing ‘best practice’.
- We advocate for equity, efficiency and effectiveness in health services and for empowerment of the health service users.

CORE VALUES
Our work is guided by the following key values:
- Transparency and accountability
- Innovation and responsiveness
- Integrity and nurturance
- Embracing diversity
- Participatory democracy
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Owen Arthur, Prime Minister of Barbados, famously told the United Nations: “He (sic) who has health has hope; and he who has hope, has everything”. This observation certainly has relevance to southern Africa. Indeed, the health and well-being of southern Africans is a significant determinant of our ability to enjoy the fruits of democracy, including economic growth, international recognition and political freedom.

Health Systems Trust’s mission of actively supporting the development of comprehensive, effective, efficient and equitable national and district health systems therefore retains its relevance not only to health systems development, but also to broader societal objectives of social, political and economic stability and development in South Africa and neighbouring states. In recognition of this, during 2005/6 the HST Board focused on ensuring that the governance processes and strategic objectives of the organisation remained closely aligned to our vision and mission.

From a governance perspective, the Board put in place measures to strengthen its role in providing leadership, governance and oversight to HST. This included revisiting the founding document of the organisation, the 1992 HST Deed of Trust, to ensure its ongoing appropriateness and relevance as a framework for strategic development of HST’s role nationally and internationally.

In addition, a review of the external environment was conducted to determine whether HST’s programmes and internal processes remain sufficiently responsive to local, national and regional health system priorities. From a strategic perspective, this review confirmed the continued relevance of our focus areas, including primary health care facilities, district health system development, HIV/AIDS and sexually transmitted infections, reproductive health, maternal and child health, and support systems for health.

At the same time, the review highlighted a number of operational areas in which there is room for improvement. These areas included management of key stakeholder relationships, and the marketing and promotion of the work and outputs of the organisation. The Board is committed to increasing attention and resources to address these issues. In particular, it has geared itself to become more involved in maintaining key stakeholder relationships and in supporting the marketing of HST and its work, particularly as the organisation seeks to extend its role within the SADC region.

The review also identified the need to strengthen knowledge management within HST. This is clearly an important area, given the centrality of information generation and dissemination to our strategic objectives. As a consequence, we will be prioritising the improvement of information, communication and technology during the coming year to ensure that HST builds the necessary technical platforms to support its expanding roles and programmes.
In taking on these challenges, HST enjoys the benefits of a skilled and committed staff complement. On behalf of the Board, I would like to thank Dr Lilian Dudley and her team, whose passion and vision have ensured that HST continues to be a driving force in health system development.

I would also like to take this opportunity to express sincere appreciation to my fellow Board members for their dedication to the task during the past year, and particularly for making themselves available to serve on a range of subcommittees. Special recognition must be given to the sterling contributions of Professors Barry Kistnasamy and Craig Househam, whose tenures on the Board came to an end during 2006. Thanks to both of you for your extensive contributions to HST over the past six years.

At the same time, we are privileged to welcome Dr Busi Nyembezi and Professor John Volmink onto the Board. As current head of the KwaZulu-Natal Department of Health, and with a long history of involvement in health service delivery, Dr Nyembezi brings a wealth of experience to the Board. Professor Volmink also has much to contribute to overall governance and to the intersectoral and international collaborative initiatives of HST, given his active involvement in the education sector and his position as Chairperson of the International Partnership Network.

Finally, I would like to acknowledge and express the Board’s sincere appreciation to the various funders who have continued to support HST’s work during 2005/6. Your loyal and generous support has given us the opportunity to approach the mandate of HST with vision and creativity.

T. Patrick Masobe
Chairperson
Message from the Chief Executive Officer

The 2005/6 period has been an exciting phase in the life of the Health Systems Trust.

Key achievements include broad expansion of our work in strengthening Health Information Systems and monitoring and evaluation within the public health sector in South Africa. HST has established several projects working at all levels of the health system from district to national, and in support of a range of programmes, focusing on improving access to data, the quality of health information, and developing innovative ways of packaging and presenting the information, and training in order to strengthen the use of information by health managers and others.

The newly developed District Health Barometer (DHB) has proven to be an extremely valuable publication, allowing comparisons across districts of a range of health and socio-economic indicators. The DHB received international attention when the Global Health Metrics network invited HST to present the DHB at a meeting in Geneva as an example of an innovative tool using health information.

The 11th edition of the South African Health Review published in 2006 focused on Maternal, Child and Women’s Health (MCWH). The Review served to highlight gains made as well as many of the gaps still remaining in addressing the health of vulnerable groups in South Africa. We plan to continue to focus on the gaps and further research needs in MCWH identified by the Review in the coming year.

The South African Equity Gauge placed greater focus on researching and developing community participation for equity, as well as the role of community level governance structures. At the other end of the spectrum HST continued supporting global equity initiatives by hosting the secretariat of the Global Equity Gauge Alliance (GEGA), and supporting the establishment of and publication of the Global Health Watch in 2005/6. Antoinette Ntuli, who as Director of the Healthlink cluster for the past eight years has become synonymous with the SAHR and Equity projects of HST, changed roles in May 2006 to become a senior technical advisor to HST.

HST consolidated the ISDS and Community Development programmes into the District Support and Community Development cluster in this year under the leadership of Nomonde Bam. Through this cluster HST continues to be a key partner in national health systems development projects such as the Integrated Primary Health Care (IPHC) initiative and TB TASC with Management Sciences for Health (MSH) and University Research Corporation. HST also successfully established a provincial-wide project in Mpumulanga focusing on HIV prevention and antiretroviral therapy literacy. This work builds on several earlier community development projects in HIV prevention, Male Sexuality and Integrated Nutrition, through which HST has developed successful models of working with and building capacity of local community-based organisations to deliver effective interventions that address priority issues.

The HST Research cluster under the leadership of Irwin Friedman continued its successful and established
health systems research projects, particularly the prevention of mother to child transmission research in partnership with the Medical Research Council and University of the Western Cape, and research on the implementation of the Operational Plan for HIV and AIDS. We also initiated several new TB and TB/HIV research projects. The role of community health workers has been a strong area of focus, and HST was awarded a national contract by the Development Bank of Southern Africa to evaluate the Expanded Public Works Programme during this period.

A review of the external environment for health systems research and development helped HST to gain a deeper understanding of and align our programme with national, regional and global priorities in health systems development. Emanating from the review, key strategic questions were debated within the organisation relating to the organisation’s role within the southern African region, and to the nature and role of partnerships which have become a predominant mechanism of operation for HST. Both these changes present many opportunities for HST, but also many difficulties and challenges.

The success of current HST regional projects, in particular an SADC project within the framework of the regional HIV and AIDS strategy to review and build sexually transmitted infection control within the SADC, strengthened our commitment to working in the region. We therefore plan to build on these successes to enable HST to expand its contribution to health systems development and research, and our network of partnerships within the region.

As a learning organisation there has been a strong focus on skills development with a growing intern programme, ongoing internal skills development, and a large number of staff undertaking master’s and PhD level postgraduate studies.

We thank the Board of Trustees of HST for the sound leadership and governance role provided, and our funders for their commitment and support to HST over this year.

Dr Lilian Dudley
Chief Executive Officer
Highlights of HST achievements for 2005/06

**Research**

The Research cluster focuses on innovative research to strengthen the district health system, its support system and priority programmes, in particular HIV, TB and the special needs of vulnerable groups such as mothers and children.

**Mother and Child Health Research**

**Good Start Intervention Study and PROMISE**

The Good Start study and the PROMISE study are managed as one large randomized controlled trial (RCT). The Good Start Intervention Study has a community intervention where peer supporters counsel HIV-positive mother-child pairs to support exclusive infant feeding practices, and a facility intervention testing the new WHO integrated infant feeding counselling course. The PROMISE study is evaluating the effectiveness of peer counsellor support on exclusive breast-feeding rates and infant morbidity (diarrhoea and pneumonia) in the general population at 3 months postpartum.

The main research question of this study is 'Do community level workers improve infant feeding and child health outcomes in the context of scaling up the PMTCT programme in South Africa?' The study design is a community-cluster RCT and includes an innovative control arm which aims to improve access to social grants.

HST, University of the Western Cape, Medical Research Council, CADRE and the National DoH are the collaborating institutions. HST’s team under senior researcher Tanya Doherty manages two of the three sentinel research sites based at Paarl, Western Cape and Umlazi, Kwazulu-Natal; UWC manages Rietvlei, Eastern Cape. The project has also involved collaboration with the DoH (National and Provincial), CDC, WHO, The Africa Centre for Health and Population Studies and Tulane University in the USA, and is funded by several donors, primarily the CDC.

**Development of Infant Feeding Peer Supporter Training and Training Manuals**

An infant feeding and PMTCT expert consulted with national and international experts and resources in the field to adapt the WHO training for use with in-home, community-based peer supporters in SA. Experiences from the Africa Centre trial on exclusive breast-feeding promotion to reduce PMTCT and a recently published trial from Asia on promotion of exclusive breast-feeding, as well as SA national protocols and documents were reviewed and consulted to assist with adaptation. Consultants from the Africa Centre project also assisted. The following materials were produced and a two-week training course was developed:

1. Peer Supporter Package
2. Peer Supporter Trainers Manual
3. Peer Supporter Participants Manual
4. Field Aide for Peer Supporters
5. Assorted checklists, exercises and additional training documents and materials.

**PROMISE Peer Supporter Training**

A two week training of trainers was conducted by HST in late July 2005. This was facilitated by a consultant trainer from the Africa Centre and by Dr Ameena Goga. Each of the three participating countries sent two trainers to be prepared to train their own peer supporters for the study.
The training materials were an adaptation of the WHO Breastfeeding Counselling Course and the WHO HIV and Infant Feeding Counselling Course. During the second week the trainers trained the newly recruited peer supporters for the Umlazi site, involving classroom sessions and practicals at King Edward Hospital.

Evaluation of The Mothers’ Programme in KwaZulu-Natal
The Mothers’ Programme was introduced in the Western Cape in 2001 as a mentorship programme run by mothers to provide information, education and support to recently diagnosed HIV-positive pregnant women. HST, in collaboration with Horizons (Population Council) and the Elizabeth Glaser Paediatric AIDS Foundation, is evaluating the activities of this programme as introduced to and broadened in KwaZulu-Natal.

The research question posed by the evaluation team is “how effective has The Mothers’ Programme been in affecting the utilisation of a range of PMTCT interventions as well as a range of protective behaviours?”. The Population Council is providing the funding for the study. The impact of the programme in KwaZulu-Natal is being assessed on a range of PMTCT interventions: voluntary HIV counselling and testing during pregnancy, single-dose nevirapine, infant-feeding choices, postpartum contraception, infant testing, and medical treatment of mothers.

Evaluation sites in the Pietermaritzburg area of KwaZulu-Natal are Edendale Hospital, Imbalenhle Community Health Centre and Mpophomeni Clinic. Data will be collected from groups before and after The Mothers’ Programme.

The first phase, completed in 2005, provided baseline data prior to interventions. The second phase, to evaluate impact of the interventions, was due for completion during the second half of 2006. Results from the study will be analysed and reported on during the first half of 2007.

Barriers to implementing the Choice on Termination of Pregnancy Act
Research on barriers to implementation of the Choice on Termination of Pregnancy Act has been funded by the Research Directorate of the National DoH, and carried out at a range of facilities in KwaZulu-Natal: Lower Umfolosi War Memorial Hospital in Stanger, King Edward VIII Hospital, Wentworth Hospital and Addington Hospital in Durban, and in some facilities in northern KwaZulu-Natal designated to provide such services but which are not yet doing so.

The general objective is to examine barriers to empowerment of women in implementation of this Act within the District Health System in South Africa. The question of accessibility requires investigation of why services have not been decentralised to district level hospitals and PHC facilities, as originally intended in the policy.

The aim is to describe factors hindering the effective implementation of the CTOP Act and to: assess the knowledge of communities regarding the CTOP Act; determine whether communities and women specifically are aware of the facilities providing TOP in their areas; describe problems that women encounter while seeking TOP services; describe women’s attitudes towards TOP; describe attitudes of health care providers towards women seeking TOP; analyse availability of TOP services, especially in rural areas; and evaluate utilisation of contraceptive services.

This research was undertaken by Jaine Roberts and interviews have been undertaken with health workers and management, along with a survey of women who have been accessing the services and a survey among community members. Results will be available during the first half of 2007.
Monitoring and evaluating access to HIV and AIDS care and treatment project

‘HIV treatment optimism’ - the belief that treatments are making HIV less fatal, which may lead to less commitment to safe sex - has become a global public health concern. HST has explored perceptions of risk, safe sex and severity of HIV and AIDS among heterosexual men and women receiving antiretroviral treatment (ARV) in South Africa.

This study, undertaken by researcher Vuyiswa Mthambo, sought to understand changes in sexual risk behaviours and perceptions of risk of HIV transmission over a six-month period among people receiving ARVs. Importantly, treatment-related health improvements may also depend on and contribute to changes in risk perceptions and behaviours among those receiving this treatment. The study was part of a larger ‘Treatment Monitor’ project managed by HealthLink and funded by Atlantic Philanthropies.

Patients on ARV treatment at St Mary’s Hospital in Mari-anhill, KwaZulu-Natal, were interviewed about disclosure of HIV status, safe sex practices, support networks and more. Data were collected by November 2005 and a draft report produced; results will be published in 2007.

Overall, while patients on ARVs might show some risk reduction in terms of unprotected sex, many still resort to unsafe practices. While there has been some willingness to disclose HIV status to partners and family, a significant proportion still feel reluctant to do so because of stigma.

Health Systems Research

Impact of decentralisation on reproductive health services

Provision of appropriate reproductive health care remains one of the major health care challenges in developing countries. Development of reproductive health service delivery is continually confronted by challenges from a changing environment, an important element of which is health sector reform, particularly decentralisation, being undertaken by most governments in Africa.

The general objective of this research is to make health sector decentralisation more effective in development of appropriate reproductive health services. The general research question is ‘how does decentralisation affect reproductive health services?’. The project compares different forms of decentralisation in two anglophone (South Africa and Uganda) and francophone (Burkina Faso and Mali) African countries to assess impact on and importance for development of reproductive health services.

The Reproductive Health Decentralisation (RHD) project (2003 - 2006) is funded by the European Union and is a partnership of the co-ordinating institutions of the Nuffield Institute for Health and International Development, University of Leeds, UK and the Department of Tropical Hygiene and Public Health, University of Heidelberg, Germany, and four African countries. HST has undertaken the SA study and worked closely with researchers from the Institute of Public Health, Makerere University, Uganda. Other partners are the Centre de Recherche en Sante de Nouma, Burkina Faso and the Association Sante Commun-\nitaire de Banconi, Mali.

The SA report, Understanding the Impact of Decentralisation on Reproductive Health Services, has been completed, as well as a comparative report, Comparative Analysis of Decentralisation and Reproductive Health Services in South Africa and Uganda. All six partners will be finalising the research in a combined four-country comparative report, along with development of recommendations in February 2007.

Transport policy for public health services

Evaluation of public-private partnerships (PPP) for transport services in health was undertaken in the Eastern Cape in 2005 and completed early in 2006. This looked at the impact of privatisation of the public sector fleet on provi-
Transport is the third highest cost driver - after personnel and medicines - for health services, and hence must be provided in the most cost-effective and efficient way possible to ensure quality of health care.

Objectives were to assess impact on health service delivery at district and facility level of the change from the Government Garage (GG) system to the PPP by determining whether there had been any improvement in health service delivery; assessing availability of vehicles at service delivery level; determining what adaptations had occurred in Provincial DoH management systems for transport; determining how vehicles were allocated at service delivery level; and reporting on whether health managers and health workers were satisfied with the transport services.

Funded by the Research Directorate of the National DoH, HST researchers worked with the Eastern Cape Provincial DoH, Department of Transport and Provincial Research Committee.

A final report is available: Transport Policy for Health Services in the Public Sector: Lessons Learned from a Study of the Impact on Health Services of a Public-Private Partnership for Transport in the Eastern Cape, in hard copy from the HST Head Office in Durban, and on the HST website.

Tuberculosis Research

Improving treatment of TB and AIDS

The Technical Assistance Support Contract Tuberculosis (TASC TB) project funded by the United States Agency for International Development (USAID) started in September 2004 and will run over a period of four years. It is being implemented by a consortium led by University Research Corporation (URC), along with Management Sciences for Health (MSH) and HST in five provinces identified by government: KwaZulu-Natal, Eastern Cape, Limpopo, North West and Mpumalanga. HST is leading operational research, Monitoring and Evaluation, and coordinating the project in Eastern Cape.

TASC TB aims to assist in improving TB control and integration of TB and HIV services. The five project objectives include improving the quality, availability, demand and management of support systems within the TB Control Programme, as well as testing innovative approaches.
for expanding DOTS (Directly Observed Treatment Short Course).

‘Leakages’ of patients from TB Programme
A study is being carried out on ‘leakages’ in treatment of patients with TB at Edendale Hospital, KwaZulu-Natal, and two local primary health care clinics, and reasons for these leakages. The research question is exploring the hypothesis that patients are not being adequately treated for TB as a result of leakages from the health care system at various levels.

Possible reasons for ‘leakage’ of or losing TB patients include failure of doctors to recognise TB, poor understanding by different health care workers of how the National TB Control Programme works, patients being tested for TB but not receiving results, patients being referred to local clinics for follow-up but not going there, and patients experiencing problems in getting to clinics regularly to receive their treatment.

Funded by the National DoH, the results of this study will be available during the first quarter of 2007.

Human Resources Research

Community health workers – moving towards best practice
Many different models of community-based practice exist, some excellent, some poor. A confusing array of CHWs with various names and roles have gradually emerged over the last two decades, e.g. Onompilo, community caregivers, DOT supporters, peer educators, home-based carers and institutional caregivers, among many others. This is matched by an equivalent assortment of training programmes and support mechanisms. The result is a medley of initiatives, some excellent, but many often standing side-by-side or in competition with projects of questionable value which threaten to discredit the entire national programme.

The objective of this research is to study how programmes have evolved and are operating and investigate the ways that CHWs have been recruited, trained and supported, in order to find the characteristics of best practice among CHW projects in South Africa. The research will compile recommendations and lessons learned, and develop a more evidence-based approach for formulating national and provincial policy.

This research, supported by the National Directorate of Human Resources, has been a joint project undertaken by HST in partnership with the SEED Trust, and is supported by the National DOH. Preliminary findings entitled ‘Moving Towards Best Practice: Documenting and Learning From Case Studies of Existing CHW Programmes in the Eastern Cape’ were presented at a review of community-based lay health workers in TB and HIV/AIDS programmes in South Africa held in Cape Town in October 2005.

The study so far reveals a wide variety of CHW management structures in the country. Best results appear to be achieved when organisations use democratic and participatory processes, and show willingness to be accountable to
the communities they serve. Presence of a champion leading the organisation is often cardinal to long-term stability and success. Quality of training and especially ongoing supervision are vital. Secure funding in terms of government grants, and particularly honoraria for volunteers who have shown commitment to their work, is essential.

This research is likely to influence future policy regarding CHWs. Results will be available during the first half of 2007.

Overcoming obstacles in mainstreaming the Expanded Public Works Programme
An audit of the Expanded Public Works Programme (EPWP) work opportunities in the social sectors (Health, Education and Welfare) countrywide is currently being undertaken by HST and is funded by the Development Bank of South Africa (DBSA), after HST successfully won the tender earlier in the year.

This study is an institutional needs analysis of how to increase the scale of the EPWP, and to establish whether there is capacity to extend the EPWP. The team is led by Dr Irwin Friedman and comprises Ms Nandy Mothibe and three consultants: Dr Norman Reynolds, Dr Lungile Bhengu and Mr Alfred Mafuleka. While not a formal research project, the study seeks to assess to what extent there is capacity among the social sector Government departments to extend the EPWP. If so, what categories of work could be created and how many such workers could be employed within the programme.

This project involves developing ideas for new cadres of work opportunities in the social sectors, primarily in the Health, Education and Social Development spheres by:
- Reviewing the initiatives of the social sector departments (Health, Social Development and Education)
- Analysing how departmental structures should be re-aligned to achieve increased service delivery in EPWP
- Estimating the costs and social benefits of existing and new work opportunities.

The project commenced in May 2006 and was scheduled to be completed by November 2006. A draft report was submitted in late November 2006. It will be important to move into a phase of encouraging implementation of the findings in policy and practice.

Evaluation of the Learning Complexes project of the Centre for Rural Health
The Centre for Rural Health at the University of KwaZulu-Natal is embarking on a three-year project funded by Atlantic Philanthropies to establish a Learning Complex of health institutions in three districts of northern KwaZulu-Natal, namely Uthungulu, Umkhanyakude and Zululand. Continuous learning of staff in health facilities in these districts will be facilitated by the Centre for Rural Health, in order to both meet the educational and practical needs of these staff and the health needs of the populations they serve.

The main research question will be the extent to which the programme leads to building of human resource capacity in the intervention districts. The evaluation by HST will take place over the duration of the project. Elizabeth Lutge is the lead researcher supported by Sibongile Mkhize and Irwin Friedman.

Conference on Priority Setting for Health Research
At the request of the National DoH Research Directorate, HST provided extensive support to the 2nd National
Conference on Priority Setting for Health Research 2006, hosted by the National DoH: Health Information, Research and Evaluation Cluster on 16 and 17 March 2006. The purpose of the conference was to identify a list of priority areas for research in South Africa, and was supported by delegates from numerous research organisations, most Provincial Departments of Health and National Directorates, and funders. Irwin Friedman and Jaine Roberts assisted in the planning, and with other HST Research staff facilitated various workshop sessions.

Capacity development

Audit of Provincial Health Research Committees and establishment of research database
HST is assisting the National Research Directorate in conducting an audit of the research being overseen by Provincial Research Committees, and developing a database of ongoing research projects in each province. Work towards this end will involve establishing of a database, consisting of details of projects, and providing on-going maintenance of the database. The lead researcher for this project is Elizabeth Lutge.

Strengthening capacity in the public sector

Health care waste management in public clinics
As part of an HST strategy to help build research capacity among newly emerging researchers working in the public service, Sibusiso Gabela, a student undertaking a Masters in Public Health with the University of KwaZulu-Natal, was awarded a grant to investigate medical waste management in public clinics in the iLembe District. This appears to be a significant problem for all primary health care facilities.

The specific objectives of the research are to establish current health care waste (HCW) handling practices in public clinics in the iLembe district, to determine HCW components and volumes generated, and find out whether public clinics have the HCW management policy in place and implement it correctly.

It is anticipated that findings from this research will be useful in facilitating the development of an HCW management strategy for the iLembe district, improving HCW management practices by HCW generators in public clinics as well as influencing the design of the HCW management policy by national and provincial policymakers.

Refugee health in South Africa
Dr Teke Apalata of the African Health Provider Organisation has been awarded a grant to undertake research investigating the perceptions of refugees in Durban of their own health status, and of the care they receive from health facilities. An initial qualitative phase will inform construction of a structured self-administered questionnaire (quantitative phase). This is an under-researched area in South Africa. The results will be of value to government and other organisations involved in refugee health, as well as to refugees themselves.

Intern programme
Two full-time interns, Zimisele Ndlela and Wanga Zembe, joined research in 2006. Zimisele Ndlela worked in Pietermaritzburg with Marian Loveday on the Edendale TB project, and Wanga Zembe worked in Cape Town with Tanya Doherty on the Good Start study. In addition to attending formal courses externally, the interns participated in all internal skills development initiatives.

Research staff development
Staff development is ongoing in the form of presentations at external conferences and workshops, and internally in presenting specific research projects to colleagues. There is an additional skills training focus in expanding software use, especially of various statistical packages, and in the use of qualitative methodologies. Research staff have also been encouraged to register for PhDs that are relevant to their sphere of work.
HEALTHLINK

The HealthLink cluster covers a range of health information, information dissemination and advocacy projects which serve to improve the quality and availability of reliable information on the health system, promote the use of information by stakeholders, and advocate for equity in health.

Health Information Systems and Monitoring and Evaluation

HST was contracted by the National DoH to strengthen Health Information Systems at both national and provincial level. The project is in its second of the intended 3.5 years.

The National Health Information Systems (HIS) project was scaled-up during 2005/06, and full-time support is now provided in all provinces as well as at national level. The aim is to enhance the use of health information for management; planning and monitoring; to improve availability of health data to managers; improve data flow and quality; transfer skills to managers at all levels on the use of information; and to develop training material and user manuals.

In order to achieve this, HST conducted audits at national level and in each of the provinces of the current HIS and developed plans with the health management teams. These plans are being implemented in partnership with the NDoH and provinces. HST has contracted Health Information Systems Programme (HISP) as a partner in two provinces.

The HIS team has initiated a two-year intern development programme within HST to promote Health and Management Information Systems skills and experience in a scarce-skills environment. Four interns are currently participating.

Monitoring and Evaluation of the Operational Plan (development of training materials and training of national and provincial staff)

HST was awarded a national tender to develop capacity in the provinces on the Monitoring and Evaluation Framework of the Comprehensive HIV and AIDS Care, Management and Treatment in South Africa. This project was undertaken in partnership with HISP. The aim was to build capacity in monitoring and evaluation through training of targeted personnel at ART service points. Comprehensive training materials were developed and over 370 Department of Health personnel were trained.

Implementation of the National Minimum Dataset for Emergency Medical Services (EMS)

HST was contracted by the National DoH to develop a routine information system for Emergency Medical Services (EMS) as part of the District Health Information System Software (DHIS). The project ran from November 2005 until the end of May 2006, and was fully incorporated into the National HIS project from June 2006. A national EMS minimum data set was developed and incorporated into the DHIS as separate data files per province.
Design and implementation of a comprehensive Monitoring and Evaluation System for the KZN Department of Health

Phase 1 of this project to support the KwaZulu-Natal DoH in developing a Monitoring and Evaluation (M&E) system focused on an in-depth situation analysis of the current M&E practices and systems in the Department. A normative framework for M&E, incorporating an analysis of the reporting requirements, was developed.

Data Management, National DoH

A full-time facilitator has been appointed to support the National DoH Districts and Development and Primary Health Care Cluster in all aspects of data management.

Ronel Visser leads the health information team in HST, which has grown from 5 members at the start of this year to 14 by June 2006. She is supported by Faith Khumalo, Stiaan Byleveld and Christa Van de Berg at the National level, and HST or HISP health information facilitators in each of the provinces.

District Health Barometer

Managers at all levels of the health system need appropriate information to analyse the health situation, set relevant objectives and develop plans amenable to monitoring. The District Health Barometer (DHB), funded by Atlantic Philanthropies, contributes to improved quality and access to primary health care by presenting information in a format which managers can easily use to monitor the district health system in South Africa.

The DHB provides analyses of a carefully selected range of health and socio-economic indicators, from which comparisons between and among districts (across provinces) can be made. This information is presented graphically, and geographically using maps which enable district comparisons to be made at a glance. It is also intended to provide the public, other sectors such as Treasury, the international health community, and funders with greater access to and insight into the public health sector in South Africa.

The DHB year 1 report was finalised in November 2005, and was well received by all levels of the public health sector.

Per capita expenditure across the rural nodes, 2001.
By placing routine District Health Information in the public domain, the DHB has also highlighted the importance of improving the quality and reliability of the information. There is a slowly growing awareness by districts that if data collected at base level are not accurate, the information presented in the DHB will also be skewed. It has also accentuated awareness of the need for capacity building in information systems at all levels, especially at management level.

Editor and project manager of the DHB, Fiorenza Monticelli, was invited to present the DHB year 1 report to the WHO Health Metrics network meeting in Geneva in September 2006, as an example of innovative work in using health information. She has been supported by Peter Barron, as well as a DHB Advisory Committee constituting key stakeholders from the health services, research and academic institutions.

South African Health Review

The South African Health Review is HST's flagship publication, providing all levels of the public health sector with a current and longer-term review of health policy developments and their implementation in South Africa. It is regarded as the most comprehensive and authoritative publication on monitoring changes and challenges in provision of equitable and accessible health care in the country.

The 2006 Review, edited by Petrida Ijumba and Ashnie Padarath, focused on Maternal, Child and Women’s Health. It did so by analysing current key trends, progress made and challenges faced by the public health sector in providing health care to South African mothers, children and women. Available information indicates that despite increased access to health care, South African children and women remain vulnerable.

Key challenges include a high prevalence of HIV and TB among women, inadequate management of children infected with HIV and AIDS, and poor service delivery to vulnerable children inflicted with chronic diseases and disabilities. Gender-based violence and rape continue to fuel HIV and AIDS, and South Africa still has an unacceptably high maternal death rate.

The Review also looks at a number of core issues, including Health Management Information Systems, health legislation, health care financing, morbidity and mortality patterns, HIV and AIDS, and TB. The health and related indicators chapter provides the best available data on a wide range of important indicators, allowing both local and international comparisons of SA data, as well as providing important trend data.

The Review is available in hard copy and CD Rom from HST offices, or can be viewed on the HST website. Atlantic Philanthropies has generously funded the publication of the SAHR in 2005/6 as well as much of HST’s information dissemination activities.

HST website and online indicators database

The HST website http://www.hst.org.za provides a wide array of knowledge, research, links and information about health systems and primary health care in southern Africa. It showcases HST’s work and holds an extensive database of publications published by HST and other organisations, which can be freely downloaded. Information on the HST website is coordinated by our webmaster, Halima Hoosen-Preston.

Web log analysis shows that HST’s website received over...
1.1 million visitors over the financial year ending June 2006. Some of the most popular pages viewed include the South African Health Review, the health indicators database and news section.

The indicators database, http://www.hst.org.za/health-stats/index.php, provides a range of indicators and statistics describing the South African health system. It is one of the largest such databases making a combination of demographic, socio-economic, health status and health services data freely available.

Other websites hosted by HST include the following:
- Rural Doctors Association of southern Africa
  www.rudasa.org.za
- Global Equity Gauge Alliance
  www.gega.org.za
- Public Health Association of South Africa
  www.phasa.za.org
- National Bioproducts Institute
  www.nbi-kzn.org.za
- Global Health Watch
  www.ghwatch.org
- Technical Support Facility Southern Africa
  www.tsfsouthernafrica.com
- Madibeng Centre for Research
  www.madibeng.org.za

HealthLink Bulletin

HealthLink Bulletin is a bi-monthly electronic news summary sent free of charge via email to over 1500 subscribers from all over the world, but mainly from South Africa and the Southern Africa Development Community.

The focus is on news items related to HIV and AIDS, health systems development, primary health care and public health. It also summarises relevant conferences and other events, various current research resources and training and job opportunities.

Resource Centre

Information dissemination encompasses distribution of complimentary HST publications to HST partners, including the National and Provincial Departments of Health, health districts and local municipalities, academic institutions, NGOs and HST funders.

In 2006 close on 3000 publications were distributed. In addition, over 340 relevant news items were posted on the HST website and approximately 400 enquiries on HST research reports, publications and other information were responded to.

Sithandiwe Nyawose is HST’s librarian managing the Resource Centre and can be contacted at rc@hst.org.za or tel: 031 3072954 for publications.

Electronic discussion lists

HST manages and runs some 55 electronic discussion lists, of which 20 are for clients external to the organisation. Druginfo (393 members), DHIS (719 members), Disability (168 members) and Mailadoc (173) are the most active HST-hosted lists, some achieving many thousands of postings during the year.

These lists provide HST with a first-rate means to disseminate recent publications, research documents and important data to a wide audience, while keeping the health sector abreast of the latest public health sec-
tor news and views, education and support. For more information see E-discussion groups (http://www.hst.org.za/generic/31).

South African Equity Gauge
The Equity Gauge Project is based on a three-tier model of assessment and monitoring, advocacy and community empowerment. The assessment and monitoring tier includes ‘identifying context and processes that contribute to health inequities and tracking selected inequities over time in relation to those contexts’. The advocacy pillar involves using information strategically and acting to change policies to improve the lives of disadvantaged people. The third tier, community empowerment, involves a “bottom up” developmental approach and moves away from the notion of poor and disadvantaged groups as passive beneficiaries.

HST’s Equity Gauge work has been led by Antoinette Ntuli, who plays a key role in both the South African Equity Gauge and the Global Equity Gauge. During 2005/6 she was supported by various HealthLink staff.

HIV Gauge
This project, led by Ashnie Padarath, was designed to facilitate community participation in health care delivery and develop local responses to overcome weaknesses in health systems particularly in relation to accessing HIV and AIDS care services. The M&E aspect is represented by a community-based M&E tool which evaluates key services and resources that impact on uptake of HIV/AIDS and ARV services. Findings are used by the community to engage in advocacy at local and policy-making level.

Clinic committees are responsible for administering the monitoring tool and spearheading activities arising out of findings of the tool. The HIV Gauge intends to assist communities and clinic staff to develop local solutions to obstacles impeding take-up of HIV/ARV services, and to mount local advocacy initiatives aimed at decision- and policy makers to address broader issues hampering effective service delivery and treatment.

Challenges to effective community participation
The Equity Gauge Project has been involved in a study to understand barriers and challenges to effective community participation in the roll-out of HIV/AIDS treatment and care services. The goal is to collect data on barriers and challenges to the use of services, and on involvement of community organisations in the roll-out of ARV for use in the design and implementation of appropriate interventions.

The study was conducted in two urban and two rural sites within two provinces in order to analyse findings from an equity perspective. Some regional differences did emerge, but there were no significant differences between urban and rural areas. Results have been reported back to study participants and dissemination and planning workshops held in all sites. Further interventions are currently being designed.

Soul City
The SA Equity Gauge has been working with Soul City on their latest series, which includes issues related to equity and community participation in health care. Key messages focus on community empowerment and strategies that the community can adopt to advocate for improved equity in access to and quality of care. Some of the suggested strategies, based firmly within a human rights model, draw from community empowerment work that the Equity Gauge is doing at local level with communities and clinic committees, in particular the HIV Gauge.

The team was responsible for proposing the topic to Soul City, compiling a literature review on the subject, participating in message design workshops, and providing consultant input on both the radio and television series.

Networking
The Equity Gauge has consolidated its links with other
Equity Gauges in the African region (Zambia, Zimbabwe, Kenya and Cape Town), and been involved in sharing lessons learned and providing support in conceptualising a publication on the African Gauges.

Global Equity Gauge Alliance
The Global Equity Gauge Alliance (GEGA) is a network of groups in developing countries in Africa, Asia and Latin America. These groupings, known as Equity Gauges, undertake research to monitor and assess inequities; advocacy to influence a move towards equity within and between countries; and community empowerment to facilitate meaningful community participation in all spheres of community life, with a particular focus on the health system. This three-pronged work process, known as the three pillars, underpins the GEGA strategy.

The Secretariat is based in South Africa and includes the Coordinating Committee chair (Ms Antoinette Ntuli), a coordinator (Dr Noluthando Ford-Ngomane), an assistant coordinator (Dr Qamar Mahmood) and administrative support by Farana Khan. The Coordinating Committee provides strategic direction for the Alliance and comprises the Secretariat, a member from each Equity Gauge, and technical experts.

GEGA is one of three organisations (along with the People’s Health Movement and Medact) involved in initiating a global health advocacy tool, the Global Health Watch. The first Global Health Watch, launched in 2005, has been widely used by a range of groups including researchers, students and activists. The Global Health Watch 2 Secretariat is now located in South Africa with a full-time coordinator, Bridget Lloyd, managing the process that will culminate in publication of this report in 2008. A major challenge is to ensure increased participation and contributions by African and eastern European scholars and activists.

In an effort to strengthen equitable delivery of and access to health care, six Equity and Health Systems small grants have been awarded to Equity Gauges. The emphasis is on enabling communities to actively engage with health systems and to strengthen their role in promoting equity in health, and support the link between community initiatives and local advocacy activities.

In partnership with EQUINET, GEGA provides technical support to the Southern and East African Portfolio Committees on Health (SEAPACOH) as part of the interim working committee. Activities have included finalising: a database of parliamentary, partner and donor contacts; a work plan and funding proposal; and a draft constitution or terms of reference; and conducting visits to the parliaments of Swaziland, Lesotho, Mozambique, Namibia, Botswana and Kenya to encourage active engagement with and participation in SEAPACOH. The Secretariat is facilitating documentation of the experiences of the Africa Gauges in the use of the three pillar approach. This is intended to serve as an advocacy document to augment the health equity analysis skills development that the Africa Gauges plan to undertake in neighbouring countries, increasing the pool of technical expertise in health equity.

GEGA gave a presentation at and participated in a workshop for the CDC in Atlanta, USA, and gave a keynote address to the Community Indicators Conference in Bur-
A presentation on equity-relevant work was made in South Asia at the 5th World Congress of the International Health Economics Association.

Funders of GEGA have included the Rockefeller Foundation, International Development Research Centre (IDRC), Swedish International Development Cooperation Agency and Canadian International Development Agency.

Health-e News Service
HST has provided oversight and support to Health-e since 2005. Over the past year the five-member Health-e team - spread between the Durban, Johannesburg and Cape Town offices - has continued to be a leading team of health journalists supplying newspapers and radio stations with health news.

The team has worked on a number of themes over the past year, including TB, mental health, service delivery, HIV/AIDS and nutrition. Newspaper features and articles written by Kerry Cullinan and Anso Thom have been supplied mostly to the Independent Group and the Sunday Times.

Mabutho Ngcobo supplies SABC’s Nguni radio stations, which have the most listeners of all the radio stations in the country.

Visitors to the website www.health-e.org.za increased by a massive 20 000 this year. There are now an average of 48 000 visitors per month. The website is managed by Nina Taibosch, who has attended a number of website courses over the past year.

The highlight of the past year was when Khopotso Bodibe and Anso Thom were presented with the CNN Multi-choice African Award for Excellence in HIV/AIDS Journalism in July 2006. This is the first time that an award has been presented in this category, and the Health-e reporters were selected out of 135 entries from 29 countries.

Atlantic Philanthropies has generously supported Health-e over the past year.

DISTRICT SUPPORT AND COMMUNITY DEVELOPMENT

HIV prevention and ART literacy
Since July 2005 HST has worked with local communities in Mpumalanga on HIV and AIDS prevention and care, with a special focus on antiretroviral therapy (ART) literacy in a project funded by the Provincial DoH. The project sites are 72 feeder clinics of seven ARV-accredited hospitals in the Ehlanzeni (40 clinics), Nkangala (13 clinics) and Gert Sibande (20 clinics) districts.

Full implementation of the project took place in Ehlanzeni, highlights of which were the selection and training of 390 volunteers, establishment of 8 community-based organisations (CBOs) to manage the project, and selection and training of 39 CBO members. The volunteers established 401 Community Condom Distribution Points, 6 functional Multi-purpose Resource Centres, and 6 support groups; they gave a total of 5636 health promotion talks (clinic-, school-, workplace- and community-based), visited 215 homes, and made 725 referrals.

The volunteers have reported increased demand for condoms and voluntary counselling and testing (VCT).
Furthermore, volunteers and staff members have started disclosing their HIV-positive status. Attrition of volunteers constitutes the main challenge, although 85% have been retained. The plan for the next financial year is to implement the project in Nkangala and Gert Sibande.

Project manager Nonkosi Slatsha and programme Director Nomonde Bam and their team have made huge gains in implementing these interventions within the period of one year, which are to be consolidated over the next two years.

**Improving food security and nutritional status**

Research commissioned by HST has shown that food production and consumption from home-based and communal gardens are inadequate, and that prevalence of childhood malnutrition increases sharply during the second year of life, reaching medium to high levels of severity. These issues are exacerbated by HIV and AIDS, particularly in poor settings.

The Integrated Nutrition Programme (INP) project aims to improve food security and nutritional status in selected rural areas. It is modelled on the government’s integrated nutrition programme policies and guidelines. The target population are children aged 0-5 years, pregnant and lactating women, orphaned and vulnerable children, and all vulnerable groups facing household food insecurity, including the elderly and ill adults. Implementation sites include catchment areas of clinics in the O. R. Tambo, Alfred Nzo and Ukhahlamba districts in the Eastern Cape and Umkhanyakude and Zululand districts in KwaZulu-Natal.

The project takes an integrated, holistic view of the problems of food insecurity and malnutrition and has put into place people-centred, sustainable programmes that draw on existing social capital networks.

**Integrated PHC (IPHC): Building capacity for effective service delivery and district management**

Interventions geared towards building capacity for effective service delivery at facility level, and strengthening district management to manage and monitor service delivery as well as advocacy and lobbying at provincial levels, form the Integrated Primary Health Care (IPHC).
Project. A collaborative initiative between the National DoH and the Provincial Departments of Health in Eastern Cape, KwaZulu-Natal, Mpumalanga, Limpopo and North West, it is funded by USAID under a bilateral agreement with the NDoH. The project is led by Management Sciences for Health (MSH), with HST and URC as partners, and will run between 2004 and 2008.

This project ensures that interventions occur at community, facility, sub-district, district and provincial levels. Partnerships for community-oriented service delivery have been established through community health workers, volunteers and local CBOs.

In the past financial year the IPHC Project has been able to assist all eight districts in the five provinces to develop District Health Plans and ensure that they put in place proper mechanisms for monitoring through scheduled quarterly reviews. It has: built capacity of DHIS officers and district staff on the DHIS, quality of data and use thereof; assisted the districts to strengthen clinic supervision implementation by ensuring proper district planning, monitoring and reporting; and built capacity of PHC staff on PMTCT, Integrated Management of Childhood Illnesses (IMCI), HIV/AIDS, sexually transmitted infections (STIs), VCT and Quality of Care Improvement strategies, through training as well as on-site mentoring and coaching.

It has also trained and mentored youth volunteers for the Youth Friendly programme and supported selected facilities to attain Youth Friendly Services standards. The community component of the IMCI has been set up through involvement of community health workers, lay counsellors and volunteers, and a local CBO contracted for community-oriented service delivery for orphans and vulnerable children. Integration of STI, HIV/AIDS and TB programmes within districts has been facilitated and includes VCT, family planning and PMTCT.

The project will be handed over to the districts and provinces in 8 months’ time, having ensured transfer of skills, sharing of information and strategies by carrying out every intervention together with the relevant manager in the district. A team of HST staff led by Nomonde Bam works closely with MSH in providing technical support and coordinating work in the five provinces.

Reducing STIs and risk of HIV/AIDS in selected cross-border sites

This SADC Regional HIV/AIDS project is part of the Botswana, Lesotho, Namibia and Swaziland (BLNS) migrants STI/HIV and AIDS Control Strategy and Work Plan for 2003-2006. It aims to reduce prevalence of STIs and risk of acquiring HIV/AIDS in selected cross-border sites in BLNS through enhanced STI control and management in the public, private and NGO sectors. It also aims to assist the SADC in identifying and developing a regional response to STI control.

The STI project was implemented by HST with its partners the Center for Health Policy and the STI Reference Center of the National Institute of Communicable Diseases. Abdul Elgoni, HST project manager, successfully led the team in developing SADC minimum standards for client-friendly STI care at health facilities, paying particular attention to access to quality care for all at risk.

Curricula were developed or adapted and standardised,
and training conducted (through the cascade model) in: monitoring STI quality of care at management and service delivery levels; incorporating interpersonal communication into clinical STI management; and conducting STI surveillance and supervision. A total of 198 health public sector managers and service providers and 52 private practitioners in BLNS were trained on syndromic management of STIs. In Lesotho 45 graduating nurses attended the training course as well as class instructors.

A regional surveillance tool was developed and surveillance established in a total of 20% of health facilities in the four countries. The BLNS governments took over these surveillance systems.

The following tools, guidelines and frameworks were developed through the project and adopted by SADC member states for wider use and application:

- The WHO and BLNS national STI case management guidelines reviewed, harmonised and contextualised to SADC. A strong no-drug management aspect was added. The adapted document also contains the Quality of Care monitoring and evaluation tool, surveillance tools, STIs medicines and supplies management tool and clinic client satisfaction tool.
- SADC Norms and Standards for STI Management were developed to benchmark quality of STI service across the region - the first initiative of its kind in the SADC.
- An SADC regional framework for comprehensive STI control was developed, identifying key areas constituting a comprehensive national STI quality of care programme. This initiative is acknowledged to be the first of its kind globally.
- An SADC tool for monitoring and evaluation of quality of STI care was developed from the DISCA Tool, capacitating STI managers and service providers to monitor weaknesses and improvements in quality of care.

- An SADC regional tool for STI surveillance was tested in the four countries and harmonised for the region.
- Questionnaires for action research in mobile groups (commercial sex workers, truck drivers and seasonal farm workers) were developed to complement the normal data collected at facilities, that do not capture all needs and practices of mobile groups.

This project focused attention on STI management in the SADC region (which has been eclipsed by HIV and AIDS) as a result of lobbying and demonstration of its successes to national policy-makers, planners and managers. It enhanced sharing of lessons and experiences on STI management in the region and increased attention on migration as a determinant of the spread of STIs/HIV in the four pilot countries.

Results were shared within the BLNS and at SADC regional conferences in Maun, Botswana in May 2006 and Mbabane, Swaziland in September 2006. Two papers were presented at the PHASA Conference in May 2006, one on quality of STI services in BLNS and the other on surveillance.

Delivery and quality of private STI services in Botswana, Namibia and Zambia

This project, funded by IDRC, is aimed at implementing participatory research to describe the policy frameworks for delivery and quality of STI services in the private sector in Botswana, Namibia and Zambia.

Literature and experiences, especially from SADC countries, were reviewed, and primary research was conducted within the private sector in the three countries. STI management stakeholders including the Ministries of Health, private sector associations and individuals and training and research institutions attended feedback and consensus building workshops in Namibia and Zambia.
All stakeholders welcomed the project as an important aspect of a national STI initiative that needed urgent attention. HST has developed strong long-term working relationships with the national STI coordinators for the three countries. This project highlighted the need to forge stronger working relationships with the private sector.

National feedback and consensus building meetings in Botswana, Zambia and Namibia provided an important platform for national steering committees and working groups for STI services in both public and private sectors. This has paved the way for long-lasting working relationships between the public and private sector.

HST’s principal investigator, Dr Oluseyi Oyedele, managed the research with in-country research partners, and worked closely with the SADC STI team to ensure that the findings on the private sector were incorporated into the overall STI regional policy framework.

Outputs include three country reports, three workshop proceedings, a consolidated report and the PPP framework document.

Using health information to strengthen PHC

HST in partnership with the School of Public Health Programme of UWC completed the first year of a three-year project focusing on use of health information in improving priority programmes and support services at district level. Project sites are in Chris Hani district (Eastern Cape) and Khayelitsha sub-district (Western Cape).

In Chris Hani the focus is on improving information management capacity of district staff through available district information, as well as key programmes such as child health and nutrition, and human resources information. In the Cape Metro and Khayelitsha, priority programmes include an integrated approach to HIV, TB, STIs, human resources and pharmaceutical information systems, as well as improving use of information by managers at district level.

The project has a strong focus on capacity building to facilitate sustainability. Eighteen health service staff were identified to participate in winter school courses and included human resources staff, information officers and managers. Capacity building of sub-district information officers and facility information staff in Khayelitsha will impact positively on the quality of data received.

The project, coordinated by Sarah Davids with the UWC team, aims to build on the existing DHIS by identifying programme and support systems requiring additional information systems. Within pharmacy, a data set with agreed upon data elements was designed and implemented. A presentation was done on the development of information system for Human Resource Management at the 2006 PHASA Conference.

Gauteng District Health Systems development

Since 2002 HST has been supporting District Health Systems (DHS) development, fostering integration and decentralisation, supporting development of a clinic supervisory system and improving PHC service delivery in all six districts (three metropolitan and three district municipalities) of Gauteng. During 2005/6 Thulile Zondi successfully consolidated key areas, particularly clinic supervision in the province, under the oversight of Sarah Davids.

The clinic supervisory rate now averages 90%. HST’s support in implementation of the monthly tools of the Clinic Supervision Manual has empowered supervisors, facility managers and sub-district management teams to take responsibility for decisions within their span of control. Three papers on quality of care and the impact of supervisory practices were presented at the PHASA Conference.
in May 2006, showing how, with HST’s technical support, clinical supervisors were able to analyse, interpret and present their findings at a national public health forum.

**Understanding Human Sexuality**

The goal of the Africa Regional Sexuality Resource Centre’s (ARSRC) Understanding Human Sexuality programme is to promote more informed public dialogue on human sexuality in order to engender positive changes in relevant policies and programmes on the African continent. The programme provides a forum for exchanging ideas, lessons learned and advocacy with a view to expanding thinking and action in favour of healthy, respectful, responsible and pleasurable sexuality. It contributes to documentation of views, experiences and emerging knowledge on sexuality-related issues in Africa. During the reporting period HST hosted a week-long regional sexuality institute and two day seminars at the Universities of Cape Town and Pretoria.

*Understanding Human Sexuality Seminars*

These two seminars were a joint collaboration between HST and the Universities of Cape Town and Pretoria respectively. One focused on ‘Sexuality and Social Institutions with a focus on Religion, Beliefs and Marriage’ and the other on ‘Sexuality beyond Reproduction’. Participants at these seminars included practitioners, academics and students. The presentations are available on the HST website as well as in the ARSRC magazine *Sexuality in Africa*.

*Understanding Human Sexuality Institute*

The Institute was held in South Africa from 2 until 8 October 2005, to provide a forum for sexuality professionals, academics and activists in Africa to share ideas and update their knowledge on cutting-edge issues in adolescent sexuality, to set the agenda and devise strategies for dealing with priority issues of concern on the continent.

Participants were from the four focal countries of the project: Nigeria, Kenya, Egypt and South Africa. The theme of the Institute was ‘Sexual Violence and HIV/AIDS’, and all the presentations will be published in *Sexuality in Africa* and are available on the HST website. The next Sexuality Institute will be held in Egypt in 2006.

**SUPPORT SERVICES**

**Finance and Audit**

HST exceeded its income target for the financial year and was therefore able to successfully finance its planned programme of work. A review of the Financial Policies and Procedures commenced during this year, and will be finalised in the next period. The annual external audit of HST commended the sound financial management of the organisation. In addition, an internal risk assessment audit was undertaken to identify major risks. The risk assessment was used by HST’s management to prioritise and plan improvements in the management of the organisation, and by the Board and its Audit sub-Committee to monitor the management of any risks.

HST recognises the challenges of the fast-paced IT environment and will continue to invest in and improve IT software and infrastructure.

**Human Resources**

Staff numbers grew to 117 as HST maintained its status as an employer of choice. HST achieved its Employment Equity targets, with 95% of staff being PDI, 80% female, 80% black and 63% African (based on definitions of the EE Act). HST met all statutory requirements for reporting on Employment Equity and Skills Development. A range of skills development activities were provided within the organisation, and professional staff were encouraged to further their training at postgraduate level.
A new, simplified Performance Management System was adopted at the end of 2005, and implemented over the first 6 months of 2006. HST reviewed its Job Grading and Remuneration system and policies in this period, and commenced a process of reviewing and updating its Human Resources policy and procedure manual to keep pace with changing labour legislation and best practices in human resource management.

Sharing knowledge through publications and conferences

HST shares its knowledge by publishing and disseminating a range of publications that influence policy-making and contribute to strengthening implementation of health services, as well as by presenting papers and posters at local, national and international conferences.

Publications

Peer-reviewed journals, bulletins, and chapters in books

http://www.hst.org.za/publications/695


http://www.hst.org.za/publications/694


Publications and reports published and funded by HST

http://www.hst.org.za/publications/683

http://www.hst.org.za/publications/689

*Integrating paediatric palliative care into home-based care: An evaluation of 3 home-based care projects.* Rendall-Mko-


HST staff authored the following chapters in the South African Health Review 2006:

Chapter 4: Health Management Information Systems, Kumalo F.
Chapter 9: The Impact of Male Sexuality on Women’s and Children’s Health. Friedman I, Mthembu W, Bam N.
Chapter 13: HIV and Infant Feeding. Doherty T, Chopra M.
Chapter 22: Health and Related Indicators. Day C, Gray A.

Conference Presentations

This conference was co-hosted by HST. Jaine Roberts and Irwin Friedman were part of the Organising Committee, and the HST staff below presented posters or papers.

Kumalo F, Visser R, Bhana R. Health management information system challenges of implementing a comprehensive plan for HIV and AIDS care, management and treatment in SA’s public sector facilities (Poster).

Padarath A, Searle C, Williams E, Sibaya S, Ntsiki M. Understanding challenges to effective community participation in HIV and ARV services (Poster).

Monticelli F. The District Health Barometer.

Schneider S, Zundi T. Supervision in Primary Health Care: The Implementation of the Clinic Supervision Policy in Gauteng.


Doherty T, Chopra M, Jackson D. Appropriateness of Formula Feeding Choices Amongst HIV positive Women in South Africa.


London L. Operationalising Health as a Human Right: the Implementation of the Patients’ Rights Charter (HST-funded)

Makan B (IPHC), Barron P (IPHC & HST), Asia B (NDoH). District Health Plans.

12th Priorities in Reproductive Health and HIV Conference, Spier, Stellenbosch, 18–21 October 2005
Hall W. Monitoring availability and access to maternal health services in three health districts in South Africa.

Research, the Heartbeat for Quality Health Services: Bophirima Health District Research Conference, Vryburg, North West, 25 October 2005
Hall W, Keynote Speaker. Health Management and Health Systems Research.

Loveday M. PMTCT follow-up care: Comparison of two provincial programmes (Poster).

South African AIDS Conference, Durban, 2005
Doherty T. Preventing HIV transmission to children: Quality of counselling of mothers in South African pilot sites.
Our staff

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Imraan Cassiem
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Candy Day
Noluthando Ford-Ngomane
Ross Haynes
Halima Hoosen-Preston
Petrida Ijumba
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Faith Kumalo
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Naomi Massyn
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Mamra Ntsiki
Sithandiwe Nyawose
Ashnie Padarath
Zweni Sibiya
Jacqueline Smith
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Mzikazi Masuku
Wanda Mthembu
Yolisa Sithela
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Stiaan Byleveld
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Nonceba Lunguza
Musi Patrick Matse
Notemba Makunga
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Evangeline Shivambu
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Nandy Mothibe
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Nokuthula Radebe
Jaine Roberts
Andile Shandu
Amos Soxa
Sabine Verkuil
Wanga Zembe, Intern

Specialist Technical Advisor
Peter Barron
HST Board Members

An independent Board of Trustees guides and provides oversight of the HST. Board members collectively comprise a diverse group of individuals with professional standing and expertise in health systems development in and beyond South Africa.

The Board is led by the Chairperson, Patrick Masobe, the Chief Executive and Registrar for the Council for Medical Schemes of South Africa. Patrick has a background in health economics, holds an MSc in Health Policy, Planning and Financing from the London School of Economics and London School of Hygiene and Tropical Medicine, and was previously the Director: Health Policy and Planning in the National Department of Health of South Africa.

He is supported by Board members:

Eric Buch, Professor of Health Policy and Management in the School of Health Systems and Public Health at the University of Pretoria, Health Adviser to the New Partnership for Africa’s Development (NEPAD) and formerly Deputy Director General for Health Care in Gauteng, Executive Director for Health, Housing and Urbanisation of Johannesburg and a founder and Director of the Centre for Health Policy at the University of the Witwatersrand.

David Serwadda, Director: Institute of Public Health, Makerere University in Uganda, is also an Associate Professor at that university. David’s expertise is in the fields of epidemiology, evaluation of health interven-
tion and disease surveillance, and his specialty is infectious disease. He is a member of the International Epidemiological Association, among others.

Jeanette Hunter, Chief Information Officer for Gauteng Department of Health and previously Director - Knowledge Management, in the North West Province Department of Health. She brings to the Board wide experience in policy analysis and implementation, planning, monitoring and evaluation, and Health Information Systems Implementation and Maintenance.

Seadimo Chaba, Human Resources Executive in charge of the human capital portfolio for Sasol, who also serves on the Executive of the Black Management Forum as well as being Company Secretary. She was previously the Chief Executive Officer of Snyman & Vennote (Pty) Ltd, and Executive Manager for Public Works and Management Services, Gauteng Province, having previously served as Chief Director for HR in the Office of the Premier. She has a degree in Economics and Industrial Psychology and diplomas in Human Resources and Diagnostic Radiography. She brings to the Board her experience in management and human resources in both the public and private sectors. She has also received a number of awards as a leader, such as being the first woman to be ‘Boss of the Year’, in 2002.

Sagie Pillay, Chief Executive Officer of Johannesburg Academic Hospital, has worked for the National Department of Health Programme on Hospital Management and Decentralisation. He has a Masters in Health Management, Policy and Planning from Leeds University, UK, and has undertaken a Senior Executive Programme at Harvard Business School. He has extensive consulting experience in several African countries as well as in hospital management, policy and planning.

Yogan Pillay, Chief Director: Strategic Planning in the National Department of Health. Prior to this position he was Director: Systems Development and Policy Coordination in the same Department. He was also National Manager of the Equity Project for 3 years. A clinical psychologist, he holds a doctorate in Public Health as well as qualifications in management, and brings to the Board a wide range of experience in policy and planning and health systems development.

John Volmink, currently Principal and Chief Executive Officer of Cornerstone Christian College, started his academic career at the University of Western Cape, and completed his PhD in Mathematics Education at Cornell University, NY, in 1988. He has held various teaching positions, including at the University of Western Cape, University of Cape Town and Cornell University. As Director for the Advancement of Science and Mathematics Education in Durban he has been involved in development initiatives. He also served as Interim Pro-Vice Chancellor: Partnership, at the University of KwaZulu-Natal. He has been centrally involved in curriculum reform in post-apartheid South Africa and was asked to play a leading role in the transformation of education in the new South Africa. He is Chairperson of the International Partnership Network (IPN).

Busi Nyembezi, Head of Department for the KwaZulu-Natal Department of Health, has held various positions as Principal Medical Officer, Medical Superintendent and Regional Director. She played a pivotal role in the amalgamation of school health services and community psychiatric services by the former KwaZulu-Natal Government, Natal Provincial Administration and National Health and Population Development Departments. She introduced a Hospital and Clinic Improvement and Accreditation Programme to improve quality of care in the Provincial Health Facilities, as well as the ‘Batho Pele’
Programme. She holds a number of qualifications, including a Bachelor of Science in Chemistry and Biochemistry, a medical degree, and a postgraduate diploma in Health Management.

Professor Craig Househam and Professor Barry Kistnasamy were also Trustees during the 2005/06 financial year, and completed their tenure with HST during this period.

Mr Patrick Masobe continued his tenure as the Chairperson of the HST Board, supported by Deputy Chairpersons Professor Barry Kistnasamy and Ms Jeanette Hunter. The Board held three meetings during this period, preceded by meetings of the Audit, Finance and Personnel sub-Committees. Board members contributed to the External Review of the environment for health systems development and research, and actively engaged with management in reviewing HST strategy and plans during this period.
Annual Financial Statements

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES
for the year ended 30 June 2006

The Board of Trustees are responsible for the preparation of the financial statements of the Trust for Health Systems Planning and Development and to ensure that proper systems of internal control are employed by or on behalf of the Trust. In presenting the annual financial statements, South African Statements of Generally Accepted Accounting Practice have been followed, appropriate accounting policies have been used, while prudent judgements and estimates have been made.

The financial statements have been prepared on the going concern basis, as the Board of Trustees have no reason to believe that the Trust will not be a going concern in the foreseeable future based on reserves forecasts, available cash resources, and on the assumption that the Trust will continue to receive sufficient donor funding to meet its financial obligations.

The annual financial statements have been audited by the independent accounting firm, PricewaterhouseCoopers Inc., which was given unrestricted access to all financial records and related data, including minutes of all meetings of members, the Board of Trustees and committees of the Board. The Board of Trustees believe that all representations made to the independent auditors during their audit were valid and appropriate. PricewaterhouseCoopers Inc. audit report is presented on page 36.

The financial statements were approved by the Board of Trustees and are signed on its behalf:

____________________      ____________________
Chairperson       Trustee

Date: 27/02/2007
Trust for Health Systems Planning and Development

Corporate Governance Statement
for the year ended 30 June 2006

The Trust for Health Systems Planning and Development confirms its commitment to the principles of openness, integrity and accountability as advocated in the King II Code on Corporate Governance. Through this process stakeholders may derive assurance that the Trust is being ethically managed according to prudently determined risk parameters in compliance with generally accepted corporate practices. Monitoring the Trust’s compliance with the King Code on Corporate Governance forms part of the mandate of the Trust’s Audit Committee. The Trust has complied with the Code in all respects during the year under review.

Application

Although the Code is applied to all divisions within the Trust, it is specifically and in all respects adopted in all national operating divisions of the nature and size identified in the King Report.

Board of Trustees

Responsibilities

The Board was established on the basis of a legal Deed of Trust document, supplemented by a formally approved written charter. Its composition is balanced so that no individual or small group dominates decision-making. The Board meets regularly, at least quarterly, and is responsible for oversight and ensuring proper accountability by the Executive Management. The Executive Management attends Board meetings by invitation.

The roles of chairpersons and executives do not vest in the same persons and the chairpersons are always non-executive Trustees. The chairpersons and chief executives provide leadership and guidance to the Trust’s Board and encourage proper deliberation on all matters requiring the Board’s attention, and they obtain optimum input from the other Trustees. New appointments to the Board are submitted to the Board as a whole for approval prior to appointment.

The Board has ultimate responsibility for the management and strategic direction of the Trust, as well as for attending to legislative, regulatory, and best practice requirements. Accountability to stakeholders remains paramount in Board decisions, and this is balanced against the demands of the regulatory environment in which the Trust operates, and the concerns of its other stakeholders.

Governance structures

To assist the Board in discharging its collective responsibility for corporate governance, several committees have been established, to which certain of the Board’s responsibilities have been delegated. These committees operate with written terms of reference and comprise, in the main, non-executive Trustees. The chairman of each committee is a non-executive Trustee. The following Committees play a critical role to the governance of the Trust:

Audit Committee

The role of the Audit Committee is to assist the Board by performing an objective and independent review of the functioning of the organisation’s finance and accounting control mechanisms. It exercises its functions through close liaison and communication with corporate management and the internal and external auditors. The Committee met three times during the 2006 financial year.

The Audit Committee operates in accordance with a written charter authorised by the Board, and provides assistance to the Board with regard to:

- Ensuring compliance with applicable legislation and the requirements of regulatory authorities;
- Matters relating to financial accounting, accounting policies, reporting and disclosure;
- Internal and external audit policy;
- Activities, scope, adequacy, and effectiveness of the internal audit function and audit plans;
- Review/approval of external audit plans, findings, problems, reports, and fees;
- Compliance with the Code of Corporate Practices and Conduct;
- Review of ethics policies; and
- Risk assessment

The Audit Committee consists of the following non-executive Trustees:
Selva Govindsamy (External Member)
Craig Househam
Patrick Masobe (Chairperson) (Resigned 11/11/2004)
Barry Kistnasamy (Joined 30/11/2005)

The Audit Committee addressed its responsibilities properly in terms of the charter during the 2006 financial year. No changes to the charter were adopted during the 2006 financial year.

Management has reviewed the financial statements with the Audit Committee, and the Audit Committee has reviewed them
without management or the external auditors being present. The quality of the accounting policies was discussed with the external auditors.

The Audit Committee considers the annual financial statements of the Trust for Health Systems Planning and Development and its divisions to be a fair presentation of its financial position on 30 June 2006, and of the results of its operations, changes in equivalents and cash flows for the period ended then, in accordance with statements of Generally Accepted Accounting Practice (GAAP) and the Trust Deed.

Personnel Committee
The Personnel Committee advises the Board of human resources and other personnel related policies including remuneration packages, and other terms of employment for senior executives. Its specific terms of reference also include recommendations to the Board on matters relating, inter alia, to general staff policy remuneration, bonuses, executive remuneration, trustees’ remuneration and fees and service contracts. Wherever necessary, the Committee is advised by independent professional advisers. The Committee met three times during the 2006 financial year.

The Personnel Committee consists of the following non-executive Trustees:

- S. Chaba
- J. Hunter
- Y. Pillay (Joined 27/07/2005)

Finance Committee
The Finance Committee operates in accordance with a written charter authorised by the Board, and provides assistance to the Board in the overall management of the financial affairs in a manner that will ensure generally accepted reporting, transparency and effective use of the Trust’s resources, and to periodically review, evaluate and report on the financial affairs of the Trust.

The Finance Committee consists of the following Trustees:

- B. Kistnasamy
- E. Buch
- P. Masobe

Executive Management
Being involved with the day-to-day business activities of the Trust, these officers are responsible for ensuring that decisions, strategies, and views of the Board are implemented.

Risk management and internal control
Effective risk management is integral to the Trust’s objective of consistently adding value to the business. Management is continuously developing and enhancing its risk and control procedures to improve the mechanisms for identifying and monitoring risks.

Operating risk is the potential for loss to occur through a breakdown in control information, business processes, and compliance systems. Key policies and procedures are in place to manage operating risk involve segregation of duties, transactions authorisation, supervision, monitoring, and financial and managerial reporting.

To meet its responsibility with respect to providing reliable financial information, the Trust for Health Systems Planning and Development and its divisions maintain financial and operational systems of internal control. These controls are designed to provide reasonable assurance that transactions are concluded in accordance with management’s authority, that the assets are adequately protected against material loss or unauthorised acquisition, use, or disposal, and that transactions are properly authorised and recorded.

The system includes a documented organisational structure and division of responsibility, established policies, and procedures, including a Code of Ethics to foster a strong ethical climate, which are communicated throughout the Trust. It also includes the careful selection, training, and development of people.

Internal auditors monitor the operation of the internal control system and report findings and recommendations to management and the Board of Trustees. Corrective actions are taken to address control deficiencies and other opportunities for improving the system as they are identified. The Board, operating through its Audit Committee, provides supervision of the financial reporting process and internal control system.

There are inherent limitations in the effectiveness of any system of internal control, including the possibility of human error and the circumvention or overriding of controls.

Accordingly, even an effective internal control system can provide only reasonable assurance with respect to financial statement preparation and the safeguarding of assets. Furthermore, the effectiveness of an internal control system can change with circumstances.
A documented and tested business continuity plan exists to ensure the continuity of business-critical activities.

The Trust assessed its internal control system as at 30 June 2006 in relation to the criteria for effective internal control over financial reporting. The internal control process has been in place up to the date of approval of the annual report and financial statements. Based on its assessment, the Trust believes that, as at 30 June 2006, its system of internal control over financial reporting and over safeguarding of assets against unauthorised acquisitions, use, or disposition, met those criteria.

**Internal audit**

The Trust’s internal audit department has been outsourced to an independent auditing firm. It has a specific mandate from the Audit Committee and independently appraises the adequacy and effectiveness of the Trust’s systems, financial internal controls, and accounting records, reporting its findings to local and divisional management and the external auditors, as well as to the Audit Committee. The Trust’s internal auditors report to the Audit Committee on a functional basis and have direct access to the Chairperson of the Board.

The internal audit coverage plan is based on risk assessments performed at each operating unit. The coverage plan is updated annually, based on the risk assessment and results of the audit work performed. This ensures that the audit coverage is focused on and identifies areas of high risk.

**Sustainability**

The Trust supports the concept of “triple bottom line” reporting as set out in the King II report.

**Ethical standards**

The Trust has developed a Code of Conduct (the Code), which has been fully endorsed by the Board and applies to all trustees and employees. The Code is regularly reviewed and updated as necessary to ensure it reflects the highest standards of behaviour and professionalism.

In summary, the Code requires that, at all times, all Trust personnel act with the utmost integrity and objectivity and in compliance with the letter and the spirit of both the law and Trust policies. Failure by employees to act in terms of the Code results in disciplinary action.

The Code is discussed with each new employee as part of his or her induction training, and all employees are asked to sign an annual declaration confirming their compliance with the Code. A copy of the Code is available to interested parties upon request.

The trustees believe that ethical standards are being met and fully supported by the ethics programme.

**Accounting and auditing**

The Board places strong emphasis on achieving the highest level of financial management, accounting, and reporting to stakeholders. The Board is committed to compliance with the Statements of Generally Acceptable Accounting Practice in South Africa. In this regard, trustees shoulder responsibility for preparing financial statements that fairly present:

- The state of affairs as at the end of the financial year under review;
- Surplus or deficit for the period;
- Cash flows for the period; and
- Non-financial information.

The external auditors observe the highest level of business and professional ethics and their independence is not impaired in any way.

The external auditors were given unrestricted access to all financial records and related data, including minutes of all meetings of trustees, the Board of trustees, and committees of the Board. The trustees believe that all representations made to the independent auditors during their audit are valid and appropriate.

The external auditors provide an independent assessment of systems of internal financial control to the extent necessary for the audit, and express an independent opinion on whether the financial statements are fairly presented. The external auditors complement the work of the internal audit department and review all internal audit reports on a regular basis. The external audit function offers reasonable, but not absolute, assurance as to the accuracy of financial disclosures.

The Audit Committee set principles that were considered and accepted by the stakeholders for using external auditors for non-audit services.
INDEPENDENT AUDITOR'S REPORT TO THE TRUSTEES OF
TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

We have audited the annual financial statements of Trust for Health Systems Planning and Development, which comprise the report of the trustees and the balance sheet as at 30 June 2006, the income statement, the statement of changes in equity and the cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 9 to 25.

Trustees' Responsibility for the Financial Statements
The trustees are responsible for the preparation and fair presentation of these financial statements in accordance with South African Statements of Generally Accepted Accounting Practice, and in the manner required by the trust deed. This responsibility includes: designing, implementing and maintaining internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audit. Except as discussed below, we conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the trustees, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Qualified Opinion
In common with similar organisations, it is not feasible for the trust to institute accounting controls over cash collections from grants prior to the initial entry of the collections in the accounting records. Accordingly, it was impracticable for us to extend our examination beyond the receipts actually recorded.

Qualified Opinion
In our opinion, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph, the financial statements present fairly, in all material respects, the financial position of the trust as at 30 June 2006, and of their financial performance and their cash flows for the year then ended in accordance with South African Statements of Generally Accepted Accounting Practice, and in the manner required by the trust deed.

Emphasis of matter
Without further qualifying our opinion, we draw attention to the fact that, in accordance with our responsibilities in terms of Sections 44(2) and 44(3) of the Auditing Profession Act, we report that we have identified an omission committed by persons responsible for the management of Trust for Health Systems Planning and Development. This constitutes a reportable Irregularity in terms of the Auditing Profession Act, and we have reported such matter to the Independent Regulatory Board for Auditors. The matter pertaining to the reportable irregularity has been described in note 8 of the trustees' report.

Further we draw attention to the fact that supplementary information set out on pages 26 to 30 do not form part of the annual financial statements and is presented as additional information. We have not audited these schedules and accordingly we do not express an opinion on them.

PricewaterhouseCoopers Inc.
Director: H Ramlogan
Registered Auditor
29/3/2007

D Bugge Chief Executive Officer
M J Mabey Chief Operating Officer
S J Ashforth Director - Managing KwaZulu-Natal region and Durban office

The Company's principal place of business is at 2 Engin Road, Sunninghill where a list of directors' names is available for inspection.

PricewaterhouseCoopers Inc is an authorised financial services provider.
VAT reg no. 4950174682
TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

REPORT OF THE TRUSTEES
for the year ended 30 June 2006

The Board of Trustees present their annual report, which forms part of the audited financial statements of the Trust for the year ended 30 June 2006.

1 General review
The Trust for Health System Planning and Development is a dynamic independent non-government organisation that actively supports the current and future development of a comprehensive health care system, through strategies designed to promote equity and efficiency in health and health care delivery in South Africa.

Goals
- Facilitate and evaluate district health systems development;
- Define priorities and commission research to foster health systems development;
- Build South African capacity for health systems research, planning, development and evaluation;
- Actively disseminate information about health systems research, planning, development and evaluation; and
- Encourage the use of lessons learnt from work supported by the Trust.

2 Financial results
2.1 Full details of the financial results are set out on pages 38 to 48 in the attached financial statements.

2.2 As set out in the annual financial statements, the Trust has a net surplus for the year of R14,269,394 (2005: R5,515,376).

3 Trustees
The following served as trustees during the current year:

E. Buch   J. Volmink
C. Househam   P. Masobe (Chairperson)
J. Hunter   S. Pillay
B. Kistnasamy   Y. Pillay
B. Nyembezi   S. Chaba
D. Serwadda (Uganda)

The following trustees completed their term during the year under review:

C. Househam   B. Kistnasamy

4 The Lovelife Trust
During the 2005 year, the Lovelife division was transferred into its own stand-alone trust. This decision was made in order to facilitate ease of administration as well as to take into account that the division had grown into a sizeable fund, capable of operating independently.

As such the trustees and administrators felt that the needs of the greater public and the funders could be better served by separating Lovelife from Trust for Health Systems Planning and Development, allowing the respective trustees to refocus their efforts on their divisions and operations.

By mutual consent of both parties, with effect from 31 December 2004, all the assets and all liabilities presently existing or which may arise in future, of Lovelife were transferred into the separate legal entity, The Lovelife Trust.

5 The Lovelife Trust’s assets and liabilities
With the transfer of the Lovelife division, as noted in note 4 above, all the assets and liabilities of the Lovelife division were to be transferred into The Lovelife Trust.

As at the balance sheet date, two bank accounts (refer notes 9 and 10 of the annual financial statements), the land and buildings and the mortgage bond raised to finance a portion of the purchase price are still registered in the name of Trust for Health Systems Planning and Development. Management of The Lovelife Trust have been informed of this matter and were requested to implement corrective measures.

The detailed information is as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Balance R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheque account 40 5661 8776 (ABSA)</td>
<td>90 876</td>
</tr>
<tr>
<td>Cheque account 40 5773 0684 (ABSA)</td>
<td>5 839</td>
</tr>
<tr>
<td>Mortgage bond 80 5988 6716 (ABSA)</td>
<td>(2 613 589)</td>
</tr>
</tbody>
</table>

Property comprises the remainder of Erf 5 Wierda Valley Township.

6 Material events after year end
No matter which is material to the financial affairs of the Trust has occurred between the balance sheet date and the date of approval of the financial statements.
7 Auditors
PricewaterhouseCoopers Inc. will continue in office.

8 Reportable irregularity
As at 30 June 2006, the Trust was not registered for and has not made payments in respect of Regional Service Council (“RSC”) levies.
Subsequent to 30 June 2006, the trustees have taken measures to register and pay such levies.

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

BALANCE SHEET
for the year ended 30 June 2006

<table>
<thead>
<tr>
<th>Notes</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>7</td>
<td>923,452</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receivables and prepayments</td>
<td>8</td>
<td>3,949,749</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>9</td>
<td>30,122,077</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>34,995,278</td>
</tr>
<tr>
<td><strong>EQUITY AND LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital and reserves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust capital and accumulated surplus funds</td>
<td></td>
<td>32,745,791</td>
</tr>
<tr>
<td><strong>Total equity</strong></td>
<td></td>
<td>32,745,791</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>10</td>
<td>2,249,487</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td></td>
<td>2,249,487</td>
</tr>
<tr>
<td><strong>Total equity and liabilities</strong></td>
<td></td>
<td>34,995,278</td>
</tr>
</tbody>
</table>

INCOME STATEMENT
for the year ended 30 June 2006

<table>
<thead>
<tr>
<th>Notes</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Grant income</td>
<td>3</td>
<td>53,683,243</td>
</tr>
<tr>
<td>Proceeds from Lovelife disengagement</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Other income</td>
<td></td>
<td>2,727,471</td>
</tr>
<tr>
<td>Project expenses</td>
<td></td>
<td>(25,973,450)</td>
</tr>
<tr>
<td>Grants paid</td>
<td></td>
<td>(9,820,868)</td>
</tr>
<tr>
<td>Administration expenses</td>
<td></td>
<td>(7,368,482)</td>
</tr>
<tr>
<td><strong>Surplus funds</strong></td>
<td></td>
<td>13,247,914</td>
</tr>
<tr>
<td>Finance costs</td>
<td>5</td>
<td>(14,865)</td>
</tr>
<tr>
<td>Finance income</td>
<td>5</td>
<td>1,036,345</td>
</tr>
<tr>
<td><strong>Surplus funds before tax</strong></td>
<td></td>
<td>14,269,394</td>
</tr>
<tr>
<td>Tax</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net surplus funds for the year</strong></td>
<td></td>
<td>14,269,394</td>
</tr>
</tbody>
</table>

The comparative figures include the results of the Lovelife division for the six months ending 31 December 2004 prior to its disengagement. Refer note 4 of the Report of the Board of Trustees.
STATEMENT OF CHANGES IN EQUITY
for the year ended 30 June 2006

<table>
<thead>
<tr>
<th>Notes</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td><strong>Trust capital and accumulated surplus funds</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At beginning of year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research as previously stated</td>
<td>4,631,956</td>
<td>9,621,474</td>
</tr>
<tr>
<td>Inter-trust transfer</td>
<td>-</td>
<td>(3,574,816)</td>
</tr>
<tr>
<td>Research restated</td>
<td>4,631,956</td>
<td>6,046,658</td>
</tr>
<tr>
<td>Initiative for sub-district support (ISDS) as previously stated</td>
<td>5,769,317</td>
<td>593,346</td>
</tr>
<tr>
<td>Inter-trust transfer</td>
<td>-</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Initiative for sub-district support (ISDS)</td>
<td>5,769,317</td>
<td>2,593,346</td>
</tr>
<tr>
<td>Lovelife as restated</td>
<td>-</td>
<td>(1,286,567)</td>
</tr>
<tr>
<td>Community Development</td>
<td>(341,066)</td>
<td>1,855,113</td>
</tr>
<tr>
<td>Healthlink</td>
<td>3,938,635</td>
<td>1,857,998</td>
</tr>
<tr>
<td>Central Administration as previously stated</td>
<td>4,477,555</td>
<td>319,657</td>
</tr>
<tr>
<td>Inter-trust transfer</td>
<td>-</td>
<td>1,574,816</td>
</tr>
<tr>
<td>Central Administration restated</td>
<td>4,477,555</td>
<td>1,894,473</td>
</tr>
<tr>
<td><strong>Net surplus/(deficit) funds for the year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>2,933,599</td>
<td>(1,414,702)</td>
</tr>
<tr>
<td>Lovelife</td>
<td>-</td>
<td>1,286,567</td>
</tr>
<tr>
<td>Initiative for sub-district support (ISDS)</td>
<td>6,199,966</td>
<td>3,175,971</td>
</tr>
<tr>
<td>Community Development</td>
<td>3,307,788</td>
<td>(2,196,179)</td>
</tr>
<tr>
<td>Healthlink</td>
<td>718,135</td>
<td>2,080,637</td>
</tr>
<tr>
<td>Central Administration (CORE)</td>
<td>1,109,906</td>
<td>2,583,082</td>
</tr>
<tr>
<td><strong>At end of year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
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<td><strong>18,476,397</strong></td>
<td><strong>12,961,021</strong></td>
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CASH FLOW STATEMENT
for the year ended 30 June 2006

<table>
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<tr>
<th>Notes</th>
<th>2006</th>
<th>2005</th>
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<tbody>
<tr>
<td></td>
<td>R</td>
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</tr>
<tr>
<td>Cash flows from operating activities</td>
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<td></td>
</tr>
<tr>
<td>Cash receipts from grants</td>
<td>53,882,797</td>
<td>98,443,660</td>
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<td>Cash paid in respect of projects and to employees</td>
<td>(40,846,646)</td>
<td>(103,258,606)</td>
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<tr>
<td>Cash from/(used in) operations</td>
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<td>(4,814,946)</td>
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<td>Net finance income</td>
<td>1,021,480</td>
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<tr>
<td>Net cash from/(used in) operating activities</td>
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<tr>
<td>Cash flows from investing activities</td>
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<td></td>
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<tr>
<td>Disposal of property, plant and equipment</td>
<td>-</td>
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<td>Proceeds from disposal of property, plant and equipment</td>
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<td>207,597</td>
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<tr>
<td>Acquisition of property, plant and equipment</td>
<td>(674,049)</td>
<td>(738,378)</td>
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<tr>
<td>Net cash used in investing activities</td>
<td>(674,048)</td>
<td>6,597,968</td>
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<tr>
<td>Net increase in cash and cash equivalents</td>
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<td>2,606,725</td>
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<td>Cash and cash equivalents at beginning of year</td>
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<td>Cash and cash equivalents at end of year</td>
<td>30,122,077</td>
<td>16,738,494</td>
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NOTES TO THE FINANCIAL STATEMENTS
for the year ended 30 June 2006

1 Basis of preparation
The financial statements have been prepared in accordance with South African Statements of Generally Accepted Accounting Practice (SA GAAP). The financial statements have been prepared under the historical cost convention.

The preparation of the financial statements in conformity with SA GAAP requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period based on management’s best knowledge of current events and actions. Actual results may ultimately differ from these estimates. During the current year, there are no areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements.

1.1 Property, plant and equipment
All property, plant and equipment is stated at historical cost less accumulated depreciation and impairment losses. Historical cost includes expenditure that is directly attributable to bringing the assets to working condition for their intended use.

Subsequent costs are included in the assets carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the Trust and the cost can be measured reliably. All other repairs and maintenance are charged to the income statement during the financial period in which they are incurred.

Depreciation is calculated using the straight-line method to allocate their cost to their residual values over their estimated lives as follows:
Motor vehicles  4 years
Computer equipment  4 years
Computer software  2 years
Furniture and fittings  6 years

The assets’ residual values and useful lives are re-viewed, and adjusted if appropriate, at each balance sheet date.

1.2 Impairment of non-financial assets
Property, plant and equipment and other non-current assets that are subject to amortisation are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset’s carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset’s fair value less costs to sell and value in use. For the purposes of assessing impairment, assets are grouped at the lowest levels for which there are separately identifiable cash flows.

1.3 Receivables and prepayments
Trade receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method, less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of receivables. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation, and default or delinquency in payments are considered indicators that the trade receivable is impaired. The amount of the provision is the difference between the asset’s carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. The amount of the provision is recognised in the income statement.

1.4 Cash and cash equivalents
Cash and cash equivalents are carried in the balance sheet at cost. Cash and cash equivalents includes cash on hand, deposits held at call with banks and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities on the balance sheet.

1.5 Trade and other payables
Trade payables are carried at the fair value of the consideration to be paid in future for goods or services that have been received or supplied and invoiced or formally agreed with the supplier.

Employee entitlements to annual leave and long service leave are recognised when they accrue to employees. An accrual is made for the estimated liability for annual leave and long service leave as a result of services rendered by employees up to the balance sheet date.

1.6 Funded projects
Funds granted to approved projects are expensed as and when payments are made, even if projects are of an ongoing nature.

1.7 Revenue recognition
Income from donations and grants, including capital grants, is included in incoming resources when these are received except as follows:

• When related costs, which grants are intended to compensate, have been deferred to future accounting periods in terms of the conditions specified by the donors, the income is also deferred until those periods.
• When donors impose conditions which have to be fulfilled before the Trust becomes entitled to use such income, the income is deferred and not included in incoming resources until the pre-conditions for use have been met.

When donors specify that donations and grants, including capital grants, are for particular restricted
purposes, which do not amount to pre-conditions regarding entitlement, this income is included in incoming resources of restricted funds when received.

Other revenue earned by the Trust is recognised on the following basis:
- Interest income - as it accrues

1.8 Leased assets
Leases of assets under which all the risks and benefits of ownership are effectively retained by the lessor are classified as operating leases. Payments made under operating leases are charged to the income statement on a straight-line basis over the period of the lease. When an operating lease is terminated before the lease period has expired, any payment required to be made to the lessor by way of penalty is recognised as an expense in the period in which the termination takes place.

1.9 Financial risk management

1.9.1 Financial risk factors
Foreign exchange risk
The Trust receives donations and grants from international donors and is exposed to foreign exchange risk arising from various currency exposures. The Trust does not enter into Forward Foreign Exchange Contracts to hedge their exposure to fluctuations in foreign currency exchange rates.

Interest rate risk
The Trust’s income and operating cash flows are substantially independent of the changes in market interest rates. The Trust has no significant interest bearing assets except for cash and cash equivalents.

Credit risk
Concentrations of credit risk with respect to trade receivables are limited due to the nature of the business. At the year-end the Trust did not consider there to be any significant concentration of credit risk which had not been adequately provided for. Cash transactions are limited to high-quality financial institutions.

Liquidity risk
Prudent liquidity risk management implies maintaining sufficient cash, marketable securities and the availability of funding through credit facilities. Due to the nature of the underlying business, the Trust aims at maintaining flexibility in funding by keeping committed credit lines available.

1.9.2 Fair value estimations
The carrying amounts of the financial assets and liabilities in the balance sheet approximate fair values at the year-end. The particular recognition methods adopted are disclosed in the individual policy statements associated with each item.

1.10 Standards, interpretations and amendments to published standards that are not yet effective
Management has considered and assessed the relevance of all new Standards, Interpretations and Amendments to existing Standards that are in issue but not yet effective. The new Standards, Interpretations and Amendments that will apply for the Trust’s accounting periods beginning on or after 1 July 2006 or later periods, but which the Trust has not early adopted, are as follows:

1.10.1 IFRS 7 (AC 144) – Financial Instruments: Disclosures and a complementary Amendment to IAS 1 (AC 101) – Presentation of Financial Statements: Capital Disclosures (Effective for periods beginning 1 January 2007)
IFRS 7 (AC 144) introduces new disclosures to improve the information about financial instruments. It requires the disclosure of qualitative and quantitative information about exposure to risks arising from financial instruments, including specified minimum disclosures about credit risk, liquidity risk and market risk, including sensitivity analysis to market risk. It replaces disclosure
requirements in IAS 32 (AC 125), Financial Instruments: Disclosure and Presentation. The amendment to IAS 1 (AC 101) introduces disclosures about the level of an entity’s capital and how it manages capital. The Trust assessed the impact of IFRS 7 (AC 144) and the amendment to IAS 1 (AC 101) and concluded that this will impact the format and extent of disclosures presented. The main additional disclosures will be the sensitivity analysis to market risk and the capital disclosures required by the amendment of IAS. The Trust will apply this from the annual period beginning 1 July 2007.

Management have assessed the relevance of the following amendments and interpretations with respect to the Trust’s operations and concluded that they are not relevant to the Trust:

1.10.2 IAS 19 (AC 116) (Amendment) - Employee Benefits Actuarial Gains and Losses, Group Plans and Disclosures (Effective for periods beginning 1 January 2006)
1.10.3 IAS 39 (AC 133) and IFRS 4 (AC 141) Amendments - Financial Guarantee Contracts (Effective for periods beginning 1 January 2006)
1.10.4 IAS 39 (AC 133) (Amendment) - Cash Flow Hedge Accounting of Forecast Intragroup Transactions (Effective for periods beginning 1 January 2006)
1.10.5 IAS 39 (AC 133) (Amendment) - The Fair Value Option (Effective for periods beginning 1 January 2006)
1.10.6 IFRS 6 (AC 143) - Exploration for and Evaluation of Mineral Resources, IFRS 1 (AC 138) (Amendment) - First-time Adoption of International Financial Reporting Standards and IFRS 6 (AC 143) Exploration for and Evaluation of Mineral Resources (Effective for periods beginning 1 January 2006)
1.10.7 IAS 21 (AC 112) (Amendment) - Net Investment in a Foreign Operation (Effective for periods beginning 1 January 2006)
1.10.8 IFRIC 4 (AC 437) - Determining whether an Arrangement contains a Lease (Effective for periods beginning 1 January 2006)
1.10.9 IFRIC 5 (AC 438) - Rights to Interests arising from Decommissioning, Restoration and Environmental Rehabilitation Funds (Effective for periods beginning 1 January 2006)
1.10.10 IFRIC 7 (AC 440) - Applying the Restatement Approach under IAS 29 (AC 133) Financial Reporting in Hyperinflationary Economies (Effective for periods beginning 1 March 2006)
1.10.11 IFRIC 8 (AC 441) - Scope of IFRS 2 (Effective for periods beginning 1 May 2006)
1.10.12 IFRIC 9 (AC 442) - Reassessment of Embedded Derivatives (Effective for periods beginning 1 June 2006)
1.10.13 AC 503 Accounting For Black Economic Empowerment (BEE) Transactions (Effective for periods beginning 1 May 2006)
2. Surplus funds

Depreciation on property, plant and equipment
(for detailed breakdown of depreciation refer to note 7)

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<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
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<tr>
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<td>1,657,524</td>
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</table>

Auditors' remuneration
- Audit fees – current year
- Under/(over) provision in prior year
- Other services

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Loss/(profit) on disposal of property, plant and equipment

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Profit on transfer of division

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<td>(10,682,347)</td>
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Consultancy fees paid

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Operating lease rentals
- Land and buildings
- Other

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<th>Notes</th>
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<td>2,106,423</td>
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Staff costs (see note 4)

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</thead>
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<tr>
<td></td>
<td>19,448,154</td>
<td>20,978,919</td>
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</tbody>
</table>

Expenses by nature:
- Advertising costs
- Depreciation
- Staff costs
- Operating lease rentals
- Travel and accommodation
- Other expenses
- Total administration and project expenses

<table>
<thead>
<tr>
<th>Notes</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td>11,543</td>
<td>5,277,504</td>
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<tr>
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<td>457,820</td>
<td>1,657,528</td>
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<tr>
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<td>19,448,154</td>
<td>20,978,919</td>
</tr>
<tr>
<td></td>
<td>1,381,552</td>
<td>2,106,423</td>
</tr>
<tr>
<td></td>
<td>4,320,729</td>
<td>3,536,465</td>
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<tr>
<td></td>
<td>17,543,002</td>
<td>78,700,042</td>
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<tr>
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<td>43,162,800</td>
<td>112,257,381</td>
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</table>

The comparative figures include the results of the Lovelife division for the six months ending 31 December 2004 prior to its disengagement. Refer note 4 of the Report of the Board of Trustees.

3 Grant income

for the year ended 30 June 2006

<table>
<thead>
<tr>
<th>Funders</th>
<th>ISDS</th>
<th>Healthlink</th>
<th>Community Development</th>
<th>Research</th>
<th>Core</th>
<th>Total</th>
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<td>R</td>
<td>R</td>
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<td>SIDA</td>
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Rockefeller Foundation & 827,200 & - & - & - \\
Anglo Gold & - & - & 500,000 & - & - \\
Medical Research Council & - & - & - & 19,592 & - \\
UWC & - & - & 1,551,406 & - & 1,551,406 \\
Teache & - & - & - & 393,369 & 393,369 \\
NMCF & - & - & - & 154,330 & 154,330 \\

<table>
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<th>Community</th>
<th>Research</th>
<th>Core(Admin)</th>
<th>Lovelife</th>
<th>Total</th>
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<td>Anglo American</td>
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<td>1,029,988</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,029,988</td>
</tr>
<tr>
<td>Nelson Mandela Foundation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5,000,000</td>
<td>-</td>
<td>5,000,000</td>
</tr>
<tr>
<td>Nuffield Institute - Leeds</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>70,785</td>
<td>-</td>
<td>-</td>
<td>70,785</td>
</tr>
<tr>
<td>Nyandeni</td>
<td>-</td>
<td>-</td>
<td>187,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>187,000</td>
</tr>
<tr>
<td>Rockefeller Foundation</td>
<td>-</td>
<td>2,117,852</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,117,852</td>
</tr>
<tr>
<td>SADC</td>
<td>-</td>
<td>-</td>
<td>3,022,787</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,022,787</td>
</tr>
<tr>
<td>SIDA</td>
<td>-</td>
<td>1,750,275</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,750,275</td>
</tr>
<tr>
<td>TARSC</td>
<td>-</td>
<td>361,356</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>361,356</td>
</tr>
<tr>
<td>University of Western Cape</td>
<td>277,897</td>
<td>-</td>
<td>219,297</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>497,194</td>
</tr>
<tr>
<td>URC</td>
<td>-</td>
<td>-</td>
<td>434,324</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>434,324</td>
</tr>
<tr>
<td>World Health Organisation</td>
<td>-</td>
<td>-</td>
<td>102,374</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>102,374</td>
</tr>
</tbody>
</table>

| | | | | | | | |
| | | | | | | | |
| 12,769,699 | 8,826,358 | 3,323,710 | 10,171,088 | 1,749,000 | 62,747,134 | 99,586,989 |
4 Staff costs

Salaries and wages

5 Finance (costs)/income

5.1 Interest received
Bank

5.2 Interest paid
Bank

6 Tax

No provision for taxation has been made as the Trust has been approved as a public benefit organisation in terms of Section 30 and is exempt from income tax in terms of Section 10(1)(CN) of the South African Income Tax Act.

7 Property, plant and equipment

<table>
<thead>
<tr>
<th></th>
<th>Motor Vehicles R</th>
<th>Computer Equipment R</th>
<th>Computer Software R</th>
<th>Furniture and Fittings R</th>
<th>Total R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year ended 30 June 2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening net carrying amount</td>
<td>101,803</td>
<td>398,477</td>
<td>65,823</td>
<td>141,135</td>
<td>707,238</td>
</tr>
<tr>
<td>Additions/improvements</td>
<td>-</td>
<td>643,391</td>
<td>-</td>
<td>-</td>
<td>674,049</td>
</tr>
<tr>
<td>Disposals</td>
<td>(15)</td>
<td>(15)</td>
<td>-</td>
<td>-</td>
<td>(15)</td>
</tr>
<tr>
<td>Depreciation charge</td>
<td>(99,377)</td>
<td>(293,958)</td>
<td>(24,749)</td>
<td>(39,709)</td>
<td>(457,820)</td>
</tr>
<tr>
<td>Closing net carrying amount</td>
<td>2,426</td>
<td>747,868</td>
<td>41,074</td>
<td>132,084</td>
<td>923,452</td>
</tr>
<tr>
<td>As at 30 June 2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>423,063</td>
<td>2,364,227</td>
<td>195,080</td>
<td>542,888</td>
<td>3,525,258</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(420,637)</td>
<td>(1,616,359)</td>
<td>(154,006)</td>
<td>(410,804)</td>
<td>(2,601,806)</td>
</tr>
<tr>
<td>Closing net carrying amount</td>
<td>2,426</td>
<td>747,868</td>
<td>41,074</td>
<td>132,084</td>
<td>923,452</td>
</tr>
<tr>
<td>Year ended 30 June 2005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening net carrying amount</td>
<td>207,568</td>
<td>476,578</td>
<td>65,389</td>
<td>165,644</td>
<td>915,179</td>
</tr>
<tr>
<td>Additions/improvements</td>
<td>-</td>
<td>214,609</td>
<td>31,849</td>
<td>18,318</td>
<td>264,776</td>
</tr>
<tr>
<td>Disposals</td>
<td>(15,807)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(15,807)</td>
</tr>
<tr>
<td>Closing net carrying amount</td>
<td>101,803</td>
<td>398,477</td>
<td>65,823</td>
<td>141,135</td>
<td>707,238</td>
</tr>
<tr>
<td>As at 30 June 2005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>423,063</td>
<td>1,807,274</td>
<td>195,080</td>
<td>512,230</td>
<td>2,937,647</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(321,260)</td>
<td>(1,408,797)</td>
<td>(129,257)</td>
<td>(371,095)</td>
<td>(2,230,409)</td>
</tr>
<tr>
<td>Closing net carrying amount</td>
<td>101,803</td>
<td>398,477</td>
<td>65,823</td>
<td>141,135</td>
<td>707,238</td>
</tr>
</tbody>
</table>
8 Receivables and prepayments

<table>
<thead>
<tr>
<th>Description</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receivables</td>
<td>3,295,511</td>
<td>3,268,850</td>
</tr>
<tr>
<td>Provision for doubtful debts</td>
<td>(523,381)</td>
<td>-</td>
</tr>
<tr>
<td>Receivables - net</td>
<td>2,772,130</td>
<td>3,268,850</td>
</tr>
<tr>
<td>Receiver of Revenue - Value added Tax</td>
<td>749,599</td>
<td>766,615</td>
</tr>
<tr>
<td>PAYE</td>
<td>27,390</td>
<td>-</td>
</tr>
<tr>
<td>Deposits</td>
<td>400,630</td>
<td>113,838</td>
</tr>
<tr>
<td></td>
<td>3,949,749</td>
<td>4,149,303</td>
</tr>
</tbody>
</table>

9 Cash and cash equivalents

<table>
<thead>
<tr>
<th>Description</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current accounts</td>
<td>3,679,762</td>
<td>4,708,663</td>
</tr>
<tr>
<td>Call accounts</td>
<td>26,441,030</td>
<td>12,029,084</td>
</tr>
<tr>
<td>Cash on hand</td>
<td>1,285</td>
<td>747</td>
</tr>
<tr>
<td></td>
<td>30,122,077</td>
<td>16,738,494</td>
</tr>
</tbody>
</table>

For the purpose of the cash flow statement, the year end cash and cash equivalents comprise the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current accounts</td>
<td>3,679,762</td>
<td>4,708,663</td>
</tr>
<tr>
<td>Call accounts</td>
<td>26,441,030</td>
<td>12,029,084</td>
</tr>
<tr>
<td>Cash on hand</td>
<td>1,285</td>
<td>747</td>
</tr>
<tr>
<td></td>
<td>30,122,077</td>
<td>16,738,494</td>
</tr>
</tbody>
</table>

Cash and cash equivalents as stated above related to the various departments as follows:

<table>
<thead>
<tr>
<th>Department</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lovelife (refer note 10)</td>
<td>96,715</td>
<td>-</td>
</tr>
<tr>
<td>Research</td>
<td>6,547,201</td>
<td>4,190,905</td>
</tr>
<tr>
<td>ISDS</td>
<td>15,186,766</td>
<td>6,587,558</td>
</tr>
<tr>
<td>Community Development</td>
<td>1,719,828</td>
<td>352,229</td>
</tr>
<tr>
<td>Healthlink</td>
<td>1,623,587</td>
<td>3,335,310</td>
</tr>
<tr>
<td>Core</td>
<td>4,947,880</td>
<td>1,972,492</td>
</tr>
<tr>
<td></td>
<td>30,122,077</td>
<td>16,738,494</td>
</tr>
</tbody>
</table>

At the balance sheet date, The Lovelife Trust bank accounts amounting to R96,715 are still registered in the name of Health Systems Planning and Development Trust. Refer note 5 of the Report of the Board of Trustees.

10 Trade and other payables

<table>
<thead>
<tr>
<th>Description</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payables</td>
<td>1,145,267</td>
<td>2,233,436</td>
</tr>
<tr>
<td>Accruals</td>
<td>76,200</td>
<td>69,250</td>
</tr>
<tr>
<td>Provision for audit fees</td>
<td>931,305</td>
<td>815,952</td>
</tr>
<tr>
<td>Provision for leave pay</td>
<td>96,715</td>
<td>-</td>
</tr>
<tr>
<td>The Lovelife Trust (refer note 9)</td>
<td>2,249,487</td>
<td>3,118,638</td>
</tr>
</tbody>
</table>

11 Cash from/(used in) operations

<table>
<thead>
<tr>
<th>Description</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus funds</td>
<td>13,247,914</td>
<td>4,691,673</td>
</tr>
<tr>
<td>Adjusted for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss/(profit) on disposal of property, plant and equipment</td>
<td>14</td>
<td>(71,028)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>457,820</td>
<td>1,657,524</td>
</tr>
<tr>
<td>Movement in working capital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decrease in receivables and prepayments</td>
<td>199,554</td>
<td>20,767,858</td>
</tr>
<tr>
<td>Decrease in trade and other payables</td>
<td>(984,504)</td>
<td>(30,896,184)</td>
</tr>
<tr>
<td>Provisions</td>
<td>115,353</td>
<td>(964,789)</td>
</tr>
<tr>
<td></td>
<td>13,036,151</td>
<td>(4,814,946)</td>
</tr>
</tbody>
</table>
13 Contingent liabilities

13.1 Miles and Associate have served Summons on Trust for Health Systems Planning and Development which has been forwarded to their legal advisors for advice. Trust for Health Systems Planning and Development has the right to recourse against The Lovelife Trust for all costs and losses incurred should judgement be granted against Trust for Health Systems Planning and Development.

Management’s estimate of the Trust’s financial exposure (inclusive of costs and disbursements) amount to R3,071,211.

13.2 At the balance sheet date a claim from the ‘Sunday Times’ against Lovelife a division of the Trust for Health Systems Planning has not yet been resolved. With the disengagement of the Lovelife division into The Lovelife Trust the Trust for Health Systems Planning and Development has the right to recourse against The Lovelife Trust for all costs and losses incurred, should judgement be granted against Trust for Health Systems Planning and Development.

Management’s estimate of the Trust's financial exposure (inclusive of costs and disbursements) amount to R1,000,000.

14 Capital commitments

Capital expenditure contracted for at balance sheet date but not recognised in the financial statements is as follows:

Property, plant and equipment

The capital expenditure will be financed by way of a loan raised from a financial institution for an amount of R2,070,000.
Funders

HST has a range of funding partners, including:

- National Department of Health (South Africa)
- Department for International Development (UK)
- Commission of the European Union
- Rockefeller Foundation
- Ford Foundation
- W. K. Kellogg Foundation
- Swedish International Development Agency
- Royal Danish Embassy/DANIDA
- Southern African Development Community
- Nelson Mandela Children’s Fund
- International Development Research Centre
- National Development Agency
- World Health Organization
- Development Bank of South Africa
- Centers for Disease Control and Prevention
- University of the Western Cape
- Charles Kendall and Partners Ltd
- Department of Public Service Administration
- AFRICON
- AngloGold Ashanti
- Micronutrient Initiative
- Nuffield Institute for Health
- Training and Research Support Centre
- University Research Co., LLC/USAID
- African Regional Sexuality Resource Centre
- Canadian International Development Agency
- Population Council
- The Joint United Nations Program on HIV/AIDS
- Wemos Foundation
- Eastern Cape Department of Health
- Free State Department of Health
- Gauteng Department of Health
- Mpumalanga Department of Health
- North West Department of Health
- Western Cape Department of Health
- Chris Hani District Municipality
- University of Pretoria
- Management Science for Health/USAID
- Henry J. Kaiser Family Foundation (USA)
www.hst.org.za

Health systems supporting health for all in Southern Africa

How to contact us:

Email webmaster@hst.org.za
Via our offices. HST head office is located in Durban, KwaZulu-Natal. We also have offices in Cape Town, Johannesburg, Pretoria and Pietermaritzburg.

- **DURBAN (Head Office)**
  - **Physical Address:**
    - 401 Maritime House,
    - Salmon Grove, Victoria Embankment, Durban 4001
  - **Postal Address:**
    - PO Box 808, Durban 4000
    - Tel/Fax: +27-31-307 2954; +27-31-304 0775

- **CAPE TOWN**
  - **Physical Address:**
    - 81 Strubens Road, Observatory 7700
    - Tel/Fax: +27-21-448 3544, +27-21-447 3446

- **JOHANNESBURG**
  - **Physical Address:**
    - 11th Floor Orion House,
    - 49 Jorrrison Street, Braamfontein 2017
  - **Postal Address:**
    - PO Box 31059, Braamfontein 2017
    - Tel/Fax: +27-11-403 2415; +27-11-403 2447

- **PRETORIA**
  - **Physical Address:**
    - Boardwalk Office Park, Block 6,
    - Haymeadow Street (off Hans Strydom), Faerie Glen 0184
  - **Postal Address:**
    - PO Box 40394, Arcadia 0007
    - Tel/Fax: +27-12-991 5514; +27-12-991 5328

- **PIETERMARITZBURG**
  - **Physical Address:**
    - 1st Floor, SNA Building, Cascades Business Park,
    - 14 Cascades Crescent, Montrose, Pietermaritzburg 3200
    - Tel/Fax: +27-33-347 3968/7