The **Health Systems Trust (HST)** is a dynamic independent non-profit organisation established in 1992 to support the transformation of the health system in a new democratic South Africa.

**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 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 health service users.

**CORE VALUES**

HST’s work is guided by the following:

- Transparency and accountability
- Innovation and responsiveness
- Integrity and nurturance
- Embracing diversity
- Participatory democracy
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Email: hst@hst.org.za 57
I am pleased to present this Annual Report of the Board of the Health Systems Trust for the 2006/07 financial year.

The year under review started with some good news in the South African health sector with the release of the antenatal HIV survey results, suggesting that infection rates had stabilised in youth, although they continue to rise in older women. This engendered a sense of hope, which was followed later in the year by the incredible collaboration between government, civil society and other sectors in finalising the HIV & AIDS and STI Strategic Plan for South Africa (NSP 2007-2011). Crucially, the NSP also recognised the need to strengthen the overall health system as a key requirement in order to ensure delivery on the NSP targets.

The year also saw a very strong focus on tuberculosis (TB). The increase in the rates of multi-drug resistant tuberculosis (MDR-TB) was documented, as were pockets of extensively drug-resistant tuberculosis (XDR-TB), with Tugella Ferry becoming notorious for its outbreak of XDR-TB. Even within the context of an extensive focus on diagnosis and treatment regimens, focus also shifted to health system failures in preventing the emergence of and the management of MDR-TB and XDR-TB.

The South African Human Rights Commission (HRC) held hearings on access to health and the implications of health as a human right during this year. After visiting many facilities and speaking to users and service providers, the HRC indicated concerns about poor access in many areas due to inadequate staffing and a lack of transport for patients, among others. These failures have meant that we have not as yet attained the ‘Right to Health’ as enshrined in the Constitution.

Globally there has also been a growing focus on the need to strengthen health systems in order to more effectively address global health priorities and achieve global targets, in particular the Millennium Development Goals (MDGs). HST has sought to engage pro-actively with these processes and challenges during 2006/07. Our work in these areas is extensively described in this report. The Trust’s projects have ranged from research on and development of human resources, governance, equity, community development,
nutrition, district health systems development, HIV & AIDS, research on STI and TB as well as participation in the NSP process.

I believe HST is well positioned to further contribute to national and international developments based on its 15 years of experience in researching and strengthening health systems.

HST has sadly parted with Health-e news having provided support during a difficult funding transition phase. We wish Health-e further success in their role as the leading media agency in health in South Africa.

I extend my appreciation to my fellow Trustees for the tremendous support that they have provided to HST during this year. Unfortunately, Dr Yogan Pillay, a Trustee since 2003/04 was unable to remain on the Board due to competing commitments. We thank him for his willingness to serve and the support given to HST during his tenure.

On behalf of the Board, I acknowledge and thank all funders who have generously supported the work of the organisation over this year. It is such support that has enabled HST to continue making progress with achieving the objective of health for all in southern Africa. Finally, I wish to acknowledge the outstanding role that the HST Board has played in providing stewardship to the organisation, and thank all HST staff for their hard work and dedication.
2006/07 was a year of consolidation for many HST projects, but also a time to redirect our strategy and develop new areas of work.

Key achievements and outputs from HST clusters during this year include the management of a large number of relevant Research projects. The Mother and Child research group have published extensively and expanded the original Prevention of Mother-to-Child Transmission (PMTCT) project, to include further mother and child health research projects. HST’s research into health systems components of tuberculosis control produced several sound reports and continues to grow as an important focus. In response to the need for detailed infrastructure information on Primary Health Care (PHC) facilities for planning, HST assisted the National Department of Health with two important audits; a review of available PHC infrastructure information, and an audit of health information management infrastructure in all provinces.

The District Support and Community Development cluster released a much needed Guidebook for District Hospital Managers and expanded its projects to include a new national partnership with the University Research Committee (URC) on strengthening counselling and testing (C&T) services, while continuing the Integrated Primary Health Care (IPHC) partnership in national health systems development with Management Sciences for Health (MSH). The Mpumalanga project focusing on HIV prevention and anti-retroviral treatments (ART) literacy continued to gain ground, and the Integrated Nutrition Project (INP) continues to build an effective model of a comprehensive strategy for nutrition and food security. The cluster’s collaboration with regional organisations continued through the Southern African Development Community (SADC) project on enhancement of the syndromic management of Sexually Transmitted Infections’ (STI) research on STI management in the private sector and through its partnership with the Africa Regional Sexuality Resource Centre.

HealthLink consolidated the National Health Information Systems (NHIS) and monitoring and evaluation projects, and produced a range of guidelines and tools to support the NHIS. The appointment of Ms Ronel Visser as Director has ensured that use of health information is integrated across all HST projects. The publication of the 2005/06 District Health Barometer (DHB) was well received and recognised in national and international forums and publications. The 2006 South African Health Review (SAHR) was launched in November.
2006, and work commenced on the 2007 SAHR focussing on the role of the private sector within the South African health system. Our Equity Gauge and Governance projects, as well as Global Equity Gauge Alliance and the Global Health Watch continued to play an important role in highlighting equity, and building capacity to address equity from a community to an international level. Following a review of the project, the Treatment Monitor shifted focus to researching and advocating gender related aspects of access to HIV & AIDS care and to the integration of HIV & AIDS prevention and care into comprehensive reproductive health services.

HST celebrates its 15th anniversary in 2007, and it was considered an opportune time to update our strategy following the review conducted in 2006. HST will increasingly focus on key content areas of governance of the health system, assessing and strengthening management systems, supporting the PHC approach, as well expanding research and support to priority programme areas. To enhance effectiveness in these focus areas, HST will be identifying opportunities and partners to support health systems development within the region, managing strategic relationships and partnerships more effectively, building internal capacity and systems in the organisation, and improving the communication and marketing of HST’s outputs. Planning also commenced for a national conference scheduled for October 2007 to review and share HST’s contribution to the health system as part of our 15th anniversary celebration.

Many partner organisations and grantees have continued to support HST’s work, and are thanked for their role in our success. Particular appreciation goes to HST funders, whose support often extends beyond providing financial resources for the work.

The Chairperson, Mr Patrick Masobe, and the HST Board of Trustees, have again provided wise council while continuing to ensure good governance of the organisation, and are thanked for their invaluable contribution of expertise and time to HST.

Dr. Lilian Dudley
CHIEF EXECUTIVE OFFICER
THE HEALTH SYSTEMS TRUST IN BRIEF

The Health Systems Trust’s 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 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. We support the transformation of the health system to provide better health for all and a more equitable provision of health services, especially to meet the needs of the most disadvantaged. In particular, we facilitate and support health systems interventions to strengthen primary health care and district health services. Our core activities are health systems research, health systems development, advocacy, capacity development and knowledge management through information production and dissemination, which are implemented through the three clusters of Research, District Support and Community Development and HealthLink.
HIGHLIGHTS OF HST ACHIEVEMENTS FOR 2006/07
The Research cluster focuses on innovative research to strengthen the district health system, its support system and priority programmes, in particular HIV & AIDS, tuberculosis and the special needs of vulnerable groups such as mothers and children. Our priority is getting research into policy and practice. Our key research areas are Public Health Care, District Health Systems and Decentralisation, Human Resources, Tuberculosis, Reproductive Health, Maternal and Child Health, Community Health Workers, Occupational Health and HIV & AIDS and Sexually Transmitted Infections.
MOTHER AND CHILD HEALTH RESEARCH

The Goodstart Intervention and Related Maternal & Child Health Care Projects

Description:
The Goodstart Study is a randomised control trial of the effectiveness of peer-educators in improving infant feeding practice, health outcomes and access to social grants in three sites: Paarl, Rietvlei and Umlazi (Goodstart II). Collaborating institutions include: Medical Research Council (MRC), Health Systems Trust (HST) and University of the Western Cape (UWC).

Principal Investigator: Tanya Doherty

Duration: October 2005 to September 2007; continuing thereafter with new studies.

Progress:
By June 2007 about 3 000 women were receiving peer support in the sites, of whom a third were enrolled into the study. An important study finding is that children exposed to formula feed have high risks of dying of other diseases. The HIV status of the mother should therefore not be the only consideration in choice of infant feeding. A change of practice resulting from this study could impact profoundly on the rising infant mortality rate as a result of HIV & AIDS in South Africa. The project team has published widely in peer reviewed journals, including the early transmission paper from the previous Goodstart cohort study, which was published in the Bulletin of the World Health Organisation in June 2007.

A subcomponent of the study, funded by a National Department of Health grant, is assessing progress with Maternal and Child Health based on the UN Millennium Development Goals using data gathered during the Goodstart interventions. Ten abstracts were accepted for the recent South African AIDS Conference and a policy brief focusing on infant feeding recommendations from the Goodstart study was distributed at the conference.

The team has obtained funding from Centre for Disease Control and Prevention/President’s Emergency Plan for AIDS Relief (CDC/PEPFAR) for two new studies that will begin towards the end of 2007, namely a community intervention focusing on neonatal survival and a further community intervention dealing with home-based voluntary counselling and testing (VCT) and tuberculosis (TB) case finding and emphasizing pregnant women.

Funders: European Union and CDC through PEPFAR and managed by MRC

Evaluation of the Mothers’ Programme (m2m) in KwaZulu-Natal

Description:
This longitudinal study evaluated the effectiveness of HIV positive mothers as peer educators during ante-natal and post-natal care at three sites in the Pietermaritzburg area.

Principal Investigator: Sibongile Mkhize

Duration: July 2005 to June 2007

Progress:
The project report was finalised, and a policy brief is being developed. The research revealed that the m2m project plays an important role in providing a continuum of care for HIV-positive women and infants. Compared to non-participants, m2m participants had greater psychosocial well-being, greater use of Prevention of Mother-to-Child Transmission (PMTCT) services, and better PMTCT outcomes. Postpartum participants had more positive changes than pregnant participants, suggesting that increased contact and time with the program results in a greater impact. Lastly, m2m keeps women linked to health facilities, which is especially important after delivery, which is a weakness of many PMTCT services.

Funder: Population Council’s Horizons Programme
REPRODUCTIVE HEALTH RESEARCH

Barriers to Implementation of the Choice on Termination of Pregnancy Act

Description:
A descriptive study of the implementation of the Termination of Pregnancy Act in KwaZulu-Natal.

Principal Investigator: Jaine Roberts

Progress:
This study, scheduled to be completed by July 2007, has explored some of the barriers to enhancing the Termination of Pregnancy (TOP) service in South Africa’s most populous province. KwaZulu-Natal faces numerous challenges in providing reproductive health services. The findings are of major importance to improving not only the availability of TOP, but other reproductive health services as well.

Funder: National Department of Health

Baseline Assessment of Youth Mentoring Programme

Description:
This study is a baseline assessment of reproductive services for young people in 41 facilities in eight districts of five provinces (KwaZulu-Natal, Eastern Cape, Limpopo, Mpumalanga and North West Province).

Principal Investigator: Irwin Friedman assisted by Nandy Mothibe and consultants Nhlanhla Ngomane, Refiloe Joka, Ntombi Thula, Thadeka Ntuli and Tshitshi Ngcobo.

Duration: May 2006 to July 2007

Progress:
The study found enormous inconsistency in the way that facilities collect data between as well as within provinces. Much of the data was not accessible or usable because of poor record keeping systems. The findings do however provide baseline data of services used by youth and reveal that more women than men use the service in each age cohort. The age group of 20-25 was the most frequent users of the services.

Funder: USAID through Management Sciences for Health (MSH)

TUBERCULOSIS RESEARCH

The Technical Assistance Support Contract Tuberculosis (TASC II TB) Project

Description:
TASC II TB is a large scale TB improvement programme in four provinces led by University Research Corporation (URC) in collaboration with the National TB Control Programme. HST is subcontracted to manage the operational research, monitoring and evaluation and TB programme support in the Eastern Cape.

Researchers: Team leader, Elizabeth Lutge supported by Madibata Matji, Patela Giyose and Marian Loveday.

Duration: August 2004 to September 2008

Progress:
A mid-term evaluation of this five year project was completed during 2006/07. The review concluded that TASC II TB was well-conceived and showed evidence of strengthening TB programmes at the facility level. Improvements in TB outcome results across districts and provinces were not available yet due to initial delays in the project. The review recommended ways of strengthening the programme in the areas of TB counselling and defaulter tracking, expanding tools for supervision and monitoring, strengthening evidence-based public education efforts, and modifying the approach to operations research.

Funder: USAID through the URC (TASC II TB)
Leakages in the TB Control Programme

Description:
This cross sectional study sought to understand why patients who present to facilities with TB symptoms are lost within the system.

Principal Investigator: Marian Loveday

Duration: April 2005 to March 2007

Progress:
The study revealed three major ‘leakages’ where patients were lost on their journey from diagnosis to completing treatment in the study sites. In particular, 58% of patients diagnosed with smear positive TB in the laboratory were never registered in the TB register, and did not commence treatment. Another 31% of patients referred from the hospital to the study clinics never arrived. Lastly, 39% of the patients with pulmonary tuberculosis (PTB) started treatment but failed to complete treatment. The National TB Control Program (NTCP) guidelines were not complied; resulting in unnecessary investigations, an increased workload for laboratory staff and unnecessary expenditure. System problems resulted in inadequate sputum collection, a poorly functional transport system between the wards and laboratory and results not being adequately documented. PTB was frequently diagnosed in the absence of smear microscopy and a clinical history suggestive of TB. Research results and recommendations were discussed with stakeholders at a national, provincial and local level to inform planning of appropriate interventions.

Funder: National Department of Health

HEALTH SYSTEMS RESEARCH

The Impact of Decentralisation on Reproductive Health Services (RHD) in Africa

Description:
The study was a multi-country comparative analysis of progress with the decentralisation of reproductive health services in South Africa, Uganda, Mali and Burkina Faso.

Principal Investigators: Jaine Roberts and Wendy Hall

Duration: The four year RHD project is now completed.

Progress:
This study has collated a wealth of information from the experiences of four countries on aspects of decentralisation such as health governance, financing, service organisation/delivery, logistics, human resources, capacity planning and monitoring and evaluation. The outputs are a valuable resource for planners and policy makers throughout the African continent. A meeting of all research partners (Nuffield Institute for Health and International Development, the University of Heidelberg, South Africa, Uganda, Burkina Faso and Mali) in Leeds in February 2007 finalised drafts of individual country reports, the South - Uganda (Anglophone) comparative report, the four country comparative report and a final booklet of guidelines and recommendations. The latter publication, Developing Decentralisation and Reproductive Health Services: Guidelines for Policy-makers, is available in hard copy and has been distributed to South African stakeholders. Understanding the Impact of Decentralisation on Reproductive Health Services in Africa: South Africa Report is available on the HST and Nuffield Institute’s RHD websites. Additional country reports and country comparative reports are also available.

Funder: European Union/Nuffield Institute for Health

Baseline Audit of Resources Available for Information Management at a National and Provincial Level

Description:
This rapid operational research study described the infrastructure of the health management information system, including the human resources, information technology and other relevant equipment.

Principal Investigators: Marian Loveday and Ronel Visser (HealthLink)
Duration: July 2006 to March 2007

Progress:
The study assessed the capacity of personnel in health information posts at provincial and national level, in terms of numbers, qualifications, training, experience and access to appropriate equipment. A large proportion of health information system personnel were inadequately trained for their role and/or did not have access to computers with appropriate hard/software, printers or a means of electronic communication. This information has helped to identify urgent and important actions needed to improve the health information system.

Funder: National Department of Health

**Situation Analysis of Primary Health Care Infrastructure Information**

**Description:**
The study was a baseline to describe the availability, completeness and quality of information on Primary Health Care (PHC) infrastructure for planning.

**Principal Investigators:** Elizabeth Lutge and Thokozani Mbatha

**Duration:** January 2007 to June 2007

**Progress:**
A set of required data elements agreed upon with the National Department of Health was used to construct a minimum dataset and database for essential information on PHC infrastructure needed for planning and maintenance of facilities. A review of the data available in all the provinces found that only two provinces have complete datasets of PHC facility infrastructure necessary to inform the planning and costing of upgrading and maintenance of clinics. In other provinces the amount and quality of available data varied, and several important data elements were lacking. The finding that most provinces have insufficient information about primary care facility infrastructure to enable planning and budgeting has highlighted the need for a national audit and identified areas of deficiencies.

Funder: National Department of Health

**Refugee Health in South Africa**

**Description:**
The study investigated the perceptions of health status and care received from health facilities of refugees in Durban.

**Principal Investigator:** Dr Teke Apalata

**Progress:**
Key findings are that refugees in Durban perceive the public health system as difficult to access and once accessed, hostile to their needs. Problems experienced in obtaining refugee documentation from the Home Affairs Department exacerbated this situation. The research has provided practical recommendations for improving health services to refugee communities. A combined response between the Departments of Health and Home Affairs will be necessary to address many of the issues raised. The study report has been finalised, and will be shared with key stakeholders.

Funder: National Department of Health

**Health Care Waste Management in Public Clinics in the iLembe District**

**Description:**
This study investigated current Health Care Waste (HCW) handling practices in the public clinics in the iLembe District to determine the nature and volume of HCW generated by the public clinics, and whether public clinics comply with the HCW management policy.

**Principal Investigator:** Sibusiso Gabela (a Masters student in Public Health at the University of KwaZulu-Natal, under the supervision of Dr Steven Knight).

**Progress:**
The study has been completed, and its findings are a valuable contribution to improving guidelines and practice in waste management in clinics throughout South Africa.

Funder: National Department of Health
CAPACITY DEVELOPMENT/HUMAN RESOURCES RESEARCH

Strengthening Provincial Research Committees

Description:
The project reviewed progress in the establishment of Provincial Research Committees required in terms of the National Health Act (2003) and Health Policy Research Guidelines issued in 2001. It also served as an opportunity to build institutional capacity for essential national health research initiatives at a provincial level.

Principal Investigator: Thokozani Mbatha
Duration: July 2006 to June 2007
Progress:
A situational analysis of the Provincial Research Committees was undertaken over a one year period. Committees were found to be constrained by lack of dedicated staff and funding. In spite of these limitations, some provinces have made substantial progress in setting up Committees. A follow-up review of Committees commenced in June 2007, and a final comprehensive report will be available by August 2007.

Funder: National Department of Health

Evaluation of the Learning Complexes Project of the Centre for Rural Health

Description:
The Centre for Rural Health of the University of KwaZulu-Natal has embarked on a three year project, funded by Atlantic Philanthropies, to establish a Learning Complex of health institutions in three districts of northern KwaZulu-Natal. HST will conduct an evaluation of the Learning Complexes project over a three year period.

Principal Investigator: Elizabeth Lutge
Duration: January 2006 to December 2008
Progress:
A situational analysis was completed of the target area of the project in north-eastern KwaZulu-Natal, and a comprehensive report produced describing staffing levels, formal and informal learning opportunities and barriers to learning experienced in the region. Various sub-projects are now being implemented, involving interventions to improve learning opportunities in the region, as well as further research to inform the interventions.

Funder: Atlantic Philanthropies through the Centre for Rural Health

Career Choices of School Leavers in Relation to Nursing

Description:
The cross sectional study investigated the perceptions of school leavers about nursing as a career choice and factors influencing their choices.

Principal Investigator: Sibongile Mkhize
Duration: February 2007 to July 2007
Progress:
Data was collected from eleven schools between February and April 2007. A key finding is that there is an abundance of young people who wish to do nursing, but have difficulty in securing a place at a training institution. The results suggest that marketing nursing as a career is less important than accommodating those who are interested in nurse training programmes.

Funder: National Department of Health

Baseline Study on Opportunities for Expansion of the Expanded Public Works Programme (EPWP) Social Sector. Institutional Audit and Capacity Analysis in Regards to Overcoming Obstacles in Mainstreaming the EPWP

Description:
A national audit of the Expanded Public Works Programme (EPWP) work opportunities in
the Social Sector Cluster (Health, Education and Welfare) and feasibility and cost-benefit analysis of extending the programme into new job creation categories.

**Principal Investigators:** Irwin Friedman and Nandy Mothibe assisted by consultants Lungile Bhengu, Alfred Mafuleka and Norman Reynolds.

**Progress:**
This important study reveals the potential in the social sector for vastly increasing employment using the framework of the EPWP. The results suggest that this can make a substantial impact on poverty as well as expanding human resource capacity within the health and allied social sectors of social development, education and agriculture. A series of nine provincial reports have been finalised, and provincial meetings held to discuss findings, recommendations and the use of the information to inform provincial policy and practice.

**Funder:** Development Bank of Southern Africa (DBSA)

**Community Health Workers – Moving Towards Best Practice: Documenting and Learning from Existing Community Health Workers Programmes**

**Description:**
This qualitative descriptive study of best practice activities in fifty community health worker (CHW) projects was conducted in all nine provinces.

**Principal Investigator:** Irwin Friedman

**Duration:** August 2005 to July 2007

**Progress:**
This study has provided useful information on best practices in South African non-governmental organisations (NGOs) working with CHWs that can be used to strengthen and introduce innovation in CHW programmes nationally. Provincial reports have been completed, and a final national report will be finalised by July 2007.

**Funder:** National Department of Health

**Investigating an Approach to Developing a Surveillance System for Measuring the Impact of Community Health Workers Programmes and the Implications for Social Spending**

**Description:**
Action research into the development of a surveillance system for measuring the impact of CHW programmes. The project plans to generalize the experience of developing a surveillance programme in a few sites to one that can be implemented more widely, and to develop a set of indicators that will be proposed for nation-wide adoption. It also compares the use of mobile phone technology with paper-based systems for such surveillance.

**Principal Investigator:** Marina Clarke

**Duration:** August 2006 to July 2007

**Progress:**
The research has been undertaken in two best practice sites in Limpopo and the Western Cape. The cell-phone data collection system has been designed and implemented and functions very effectively. Data from both paper-based questionnaires and cell-phones have been analysed. The findings in respect of both the acceptance of the novel method of collecting data by participants and ease of administration offer an important new advance on previous methods. The study will be completed by August 2007.

**Funder:** National Department of Health

**RESEARCH UNDER DEVELOPMENT**

Projects for which proposals and planning were finalised during 2006/07 and are due to commence in 2007/08 include: *The Adhere Project: A study on antiretroviral adherence in KwaZulu-Natal with MEASURE Evaluation; A post intervention evaluation of VCT infrastructure in KwaZulu-Natal, Eastern Cape and Mpumalanga funded through DBSA; A study on social determinants of health focusing on the role of incentives in improving TB outcomes; and A study of the occupational disease burden on the public health system.*
The District Support and Community Development cluster supports selected districts in improving the quality of health care by strengthening capacity of both clients and providers in the SADC region. The aim of Community Development is to support selected districts in developing partnerships with communities and community based organisations as part of the District Health System. While the key focus of District Support is to improve quality of care by strengthening systems through the lens of priority health conditions. Technical support and capacity building is provided to district management and staff to bridge the gap between health policy and practice.
**Integrated Nutrition Project**

**Project Manager:** Noluthando Ford-Ngomane  
**Facilitators:** Mzikazi Masuku, Hlengiwe Gumede and Pat Mhlongo

HST’s Integrated Nutrition Project (INP) is based on the recommendations of the 1994 Ministerial Nutrition Committee for an integrated approach to nutrition. Broad strategies of the project to improve the nutritional status of the target groups are:

- Nutrition support, education and counselling at the clinic and community level
- Community based Growth Monitoring and Promotion (GMP) and Integrated Management Childhood Illnesses (IMCI)
- Promotion and support of breastfeeding
- Micronutrient and macronutrient education
- Promotion of household food security

The project covers 15 clinics and clinic catchment areas (CCAs) in Umkhanyakude, Uthungulu and Zululand districts of KwaZulu-Natal and 30 clinics and CCAs in O.R. Tambo district of the Eastern Cape. The clinic is the project entry point to developing facility and community centered initiatives, using participatory approaches that encourage and empower families and individuals to take an active role in improving their livelihoods. The strength of the HST model lies in building the capacity of Community Based Organisations (CBOs) in household food security, household and community based IMCI and project and financial management skills. The CBOs are also assisted in applying for non-profit organisation (NPO) registration.

**Implementation model**

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1 CBO covers 5 PHC facilities for specific interventions

**CBO Structure - (1 CBO per 5 PHC facilities)**  
Implementing agent of the HST INP Interventions

**Executive members (5)**
- Chairperson
- Treasurer
- Secretary
- 2 Members

**Functions:**
- Manage and supervise activities
- Negotiate with funders, collaborators, stakeholders
- Submit progress and financial reports

**Operational team per facility**
- Minimum of 5 volunteers

**Functions**
- Implement interventions at community IMCI points and PHC facilities

**Interventions**
- Promote household food security
- Growth monitoring and promotion
- Nutrition education and counselling
- Referrals from community IMCI points to PHC

**Minimum of 5 IMCI points per CBO**

Community Growth Monitoring and IMCI points have been established in 28 villages in KwaZulu-Natal and 60 in the Eastern Cape that are more than 5km from the clinics; thus bringing services closer to communities. Trained CBO volunteers visit these points fortnightly to monitor the growth of infants and children under five years of age, and conduct follow
up home visits to trace defaulters. On average 40 children are weighed each month per site, ‘Road to Health’ cards are checked, and referrals made between Community Growth Monitoring and IMCI points and Primary Health Care (PHC) facilities.

Intersectoral collaboration is a critical component of the project, and the Departments of Agriculture and Social Welfare and Development provide training and support of community volunteers including aspects such as accessing grants, technical support at the clinic, demonstration gardens and seeds to communities for communal gardens. The Agricultural Research Council is piloting recently tested yellow sweet potato, found to have a high Vitamin A content, in some of the project areas.

HST also supported the Department of Health (DoH) in KwaZulu-Natal to develop nutrition advisors to increase capacity to expand community based interventions, and the project is now fully integrated within the DoH INP. The Eastern Cape DoH has also utilised the HST model to expand project activities and initiate additional activities, such as running soup kitchens in other clinics.

**Mpumalanga Antiretroviral Therapy Literacy Project**

**Project Managers:** Nonkosi Slatsha and Noluthando Ford-Ngomane

**Facilitators:** Wanda Mthembu, Mzikazi Masuku and Vikitsha Mtshali

The Antiretroviral Therapy (ART) literacy project uses community mobilisation strategies to equip individuals, families and communities to appropriately engage with treatment, care and support of those infected and affected by HIV and AIDS. The project stresses the importance of treatment adherence, benefits of knowing your status, nutrition in HIV, the role of STI’s in HIV, and the interaction of TB and HIV.

During 2006/07 the project functioned in the clinic catchment areas (CCAs) of 67 feeder clinics that support eight accredited ART sites in Mpumalanga. Key focus areas were the promotion of ART literacy, strengthening of prevention and promotion initiatives and of community support structures and networks. To strengthen community structures twelve CBOs have been established and members trained to manage project activities and provide support to the volunteers. The CBOs support and organise HIV related community meetings and workshops, and provide strategic direction for the community interventions. Twenty two community based resource centres run by trained volunteers provide health information for the community and are stocked with condoms and information on ART, HIV and AIDS, nutrition and TB in languages spoken by the local communities.

In terms of reach, 6 286 health promotion talks were given with 203 785 people in attendance, 3 638 homes were visited and 344 workplace and 57 community workshops were conducted by volunteers. A total of 5 898 individuals were referred from these sessions to the clinics for HIV counselling and testing. A total of 1 467 volunteer monitored community based condom distribution points have been set up where none existed previously in the districts.

**Strengthening HIV Counselling and Testing, and Enhancing HIV/AIDS Communication, Prevention and Care**

**Project Manager:** Noluthando Ford-Ngomane

**Technical Advisors:** Makhosazane Nyawo, Nomkita Gobodo and Nobanzi Dana

This project seeks to increase uptake of HIV counselling and testing (C&T) services, and functions in five provinces (Mpumalanga, KwaZulu-Natal, Limpopo, North West Province and the Eastern Cape). HST provides support in three (Mpumalanga, KwaZulu-Natal and the Eastern Cape) of the five provinces to introduce facility based provider-initiated C&T, and integrating HIV C&T with TB, STI, antenatal care, family planning and other general clinical services targeting both adults and youth. The University Research Cooperation (URC) is the prime grantee and HST is sub contracted in this Centre for Disease Prevention and Control (United States) funded project.

Specific project objectives are to:

- Increase the number of public and private facilities offering provider-initiated HIV testing.
- Improve the capability and skills of health workers in C&T.
• Increase the number of antenatal care, TB, STI and general clinic attendees who receive high quality C&T services.
• Increase the number of HIV positive persons referred for further care, treatment and support by C&T service providers.
• Improve the capacity of facility and district staff to collect, analyse and use monitoring and evaluation data, then plan and allocate resources for C&T and HIV care, treatment and support services based on timely and accurate information.

A baseline assessment of the operational quality of HIV voluntary counselling and testing (VCT) in the sites revealed low VCT uptake among TB, Family Planning and STI services. The quality of VCT and HIV testing data was also found to be poor in the three provinces. These results were discussed with district, sub district and facility level staff and management, who played an important role in developing strategies to address the shortcomings. The intervention uses the integrated HIV C&T expansion and continuous quality improvement model which includes implementing a quality improvement package, strengthening of capacity and skills of staff through training, mentoring and support, periodic measurement of results and reviewing and adapting the improvement package.

Integrated Primary Health Care Project under TASC II

Project Manager: Nomonde Bam

Technical Advisors: Muzi Matse, Orgrinah Nqobeni, Nonebea Languza, Frank Tlamama and Thulile Zondi

The main goal of the Integrated Primary Health Care (IPHC) Project under TASC II is to strengthen the District Health System as a vehicle for PHC service delivery. It is a project of the National Department of Health (NDoH) funded by the United States Agency for International Development (USAID), and managed by Management Sciences for Health (MSH) in partnership with HST and the University Research Committee (URC).

The project provides technical assistance to strengthen the District Health System in eight districts in five provinces of South Africa, namely Mpumalanga (Gert Sibande District), North West (Bojanala District), Limpopo (Capricorn and Sekhukhune Districts), KwaZulu-Natal (Sisonke and Uthungulu Districts) and the Eastern Cape (Chris Hani and Alfred Nzo Districts). HST coordinators work in three of the five provinces namely: North West, Limpopo and the Eastern Cape, and provides technical support for clinic supervision and health information systems across the five provinces. The project began in October 2004 and is due to end in September 2008.

The project aims to strengthen key health programmes and health systems. Programme interventions focus on Maternal Health and Family Planning, Child Survival, Nutrition, Youth Participation and Integration of HIV & AIDS Program at the PHC Level. The health systems strengthening focuses on quality improvement and supervision, district health planning and expenditure reviews, district health information systems, district development and community support and participation.

Achievements in strengthening health programmes:

• The district antenatal HIV testing rate improved from 76.6 % to 90% by July 2007.
• The weighing rate of children under five has improved from below 40% in the previous year to above 70%, with fifteen of the directly supported facilities reaching 100%.
• The immunization coverage improved from 57% to 62.1%, with ten of the directly supported facilities reaching 100% as a result of IPHC interventions.
• VCT uptake increased from below 60% in 2005/06 to 80% in 2006/07, with fifteen of the directly supported facilities reaching 85%, and provider initiated C&T was introduced in the districts.
• Sexually Transmitted Infection (STI) clients testing for HIV increased from 4% to 32%. STI patients treated according to the Syndromic Management Protocol increased from a baseline of 9% to 84% (June-July 2007).

Achievements in strengthening PHC systems and service delivery:

• Trained quality assurance teams have been established in all facilities and are able to identify quality gaps and develop quality improvement projects to address the gaps.
- Monthly reviews of PHC data allow supervisors to compare clinic performance in order to identify facilities in need of support.
- District Health Expenditure Review (DHER) Reports were successfully completed in all facilities supported by the project in May 2007.
- The District Health Plan (DHP) process has been cascaded down to facility level, with all facilities participating in monthly reviews where the DHP indicators and targets are monitored and tracked.
- Utilisation of information for planning, managing and reviewing of programmes has improved in all facilities. IPHC has supported health care workers to build competence in planning, implementation and evaluating health programmes through the use of information.

**North West Guidebook for District Hospital Managers**

**Project Manager:** Muzi Matse

The North West Department of Health commissioned HST to develop a handbook for district hospitals in 2005. HST subcontracted a team led by Professor M. de Villiers of Stellenbosch University to assist in the development of the guidebook. The aim was to provide a practical resource for district hospital managers to improve the daily management and supervision of district hospitals. The guidebook is designed to assist managers in assessing the functioning of the district hospital, and in ensuring the provision of high quality district hospital services. Following an initial literature and record review, a series of interviews were conducted with district hospital management team members, mainly in the North West, Western Cape, Limpopo and Kwazulu-Natal and with other key informants. These interviews were analysed and yielded a practical set of criteria for a successful district hospital. Drafts of the guidebook were distributed to experts in the field, including senior provincial managers and policy makers prior to finalisation. The final draft was field tested by hospital managers and HST in the North West Province. The Guidebook was officially handed over to the MEC for Health of North West Province on 2 August 2007 at a special launch function, and is available on the HST website (www.hst.org.za).

**Strengthening Primary Health Care through the Development and Improved Use of Information Systems**

**Project Manager:** Sarah Davids

**Facilitators:** Notemba Makhunga, Stiaan Byleveld and Frank Tlamama

This project, funded by Atlantic Philanthropies, was implemented jointly by HST and the School of Public Health at the University of the Western Cape (UWC). It aims to strengthen Primary Health Care (PHC) in South Africa through the development and improved use of information for programme and support systems. The project has supported selected sub-districts in Chris Hani District in the Eastern Cape and Cape Town District in the Western Cape since January 2005.

The strategies of strengthening the information health system for better PHC delivery entailed:

- Ensuring involvement and support of key stakeholders at all levels of the health system.
- Developing new or improved programme and support information systems and tools.
- Improving skills and capacity of managers to use programme and support information.

Health information tools and systems were developed and used by the target districts, and in some cases their use was extended to the provinces. Many health care staff were capacitated to develop a ‘use-of information culture’ through training, mentoring and coaching. A substantial number of PHC health professionals have been skilled in understanding the importance of information in decision-making, and have a good knowledge of the available indicators and what they are used for. Work emanating from the project has been presented at conferences and published.

New or improved information systems, lessons learnt and tools developed in Chris Hani and
Cape Town Metro were shared with provincial and national programmes, information and monitoring and evaluation managers; as well as other senior managers to support information systems strengthening and use throughout South Africa.

**Understanding Human Sexuality**

**Consultant:** Nobanzi Dana

HST is one of four partners in a continental consortium on understanding human sexuality led by the Africa Regional Sexuality Resource Centre in Lagos, Nigeria. The project was established in 2005 and is funded by the Ford Foundation. HST has held a series of seminars focusing on ‘Understanding Human Sexuality in South Africa’ to promote more informed and affirming public dialogue on human sexuality in order to engender positive changes in relevant policies, programmes and individual behaviour. During 2006/07 HST partnered with Fort Hare University and the Bower Wentzel and Partners law firm to conduct a series of seminars on the topics of Sexual Violence in the Public Sphere: Myths, Facts and Responses and Culture, Femininity and Sexuality. Seminar reports are available on the HST website (www.hst.org.za) and on the Africa Regional Sexuality Resource Centre site (www.arsrc.org).

**District Health Systems Development in Gauteng**

**Project Manager:** Sarah Davids  
**Facilitator:** Thulile Zondi

This project is funded by the Gauteng Department of Health and seeks to improve the quality of PHC in all districts of the province by supporting:

- District Health Systems (DHS) development and integration;
- the implementation of a Clinic Supervisory Policy; and
- the development and implementation of District Health Expenditure Review (DHER) and District Health Plan (DHP).

The Quality Improvement Cycle approach has been utilised to strengthen and support the DHS in bringing about quality improvements in PHC services. Clinic supervision is now entrenched in all districts with a clinic supervision rate consistently exceeding 90%, with improved use of information and a clear improvement in public health impact. Health Planning and Reporting Task Teams were set up in each district and capacity building focused on the use of the DHER and its linkages with DHP. Districts were able to comply with 95% of the District Health Planning and Reporting (DHP&R) guidelines when compared to the total package of requirements, and were able to set realistic targets and develop strategies, which supported the achievement of the targets.

**Public Health Impact: Immunisation**

**Southern Service Delivery Regions Cumulative Immunisation Coverage: 2005-2007**

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<th>Month</th>
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% Expected coverage: 7.5 15 22.5 30 37.5 45 52.5 60 67.5 75 82.5 90

Source: Ekhuruleni District Municipality
Enhancement of Syndromic Management of STI’s in Selected Cross Border/High Transmission Sites: Botswana, Lesotho, Namibia and Swaziland

Project Manager: Abdul Elgoni

HST was commissioned by the Southern African Development Community (SADC) health coordinating unit to strengthen the syndromic management of sexually transmitted infections (STIs) in selected cross border and high transmission areas (CBS/HTA) in Botswana, Lesotho, Namibia and Swaziland through a health systems development approach. The project, funded by Department of International Development (DFID), also assisted the SADC region in developing a regional response to STI control and management. Project objectives included:

- Facilitating the development of a SADC regional response to STI control through harmonisation of STI treatment guidelines and development of minimum standards of care.
- Development of a standardised regional STI training program.
- Development of comprehensive STI surveillance systems that recognise mobile population issues.
- Strengthening systems for drug procurement, stock management and delivery.
- Synchronise policies on STI’s management across the SADC countries.

Policy and framework documents developed based on local research and in collaboration with countries and regional institutions included:

- A regional framework for comprehensive STI control.
- SADC STI tool for monitoring and evaluation of Quality of Care.
- SADC STI case management clinical guidelines.
- Surveillance tools and training manual.
- Minimum norms and standards for STI quality management.

These final policy documents and guidelines were endorsed and adopted by representatives from the Departments of Health of the 14 SADC member states at a regional meeting in Swaziland in September 2006.

SADC STI Public Private Partnership Project

Researcher: Oluseyi Oyedele

The primary aim was to undertake participatory action research in three Southern African countries (Botswana, Zambia and Namibia) to assess the delivery and quality of STI treatment in the private sector to inform policy and practice on public private partnerships in STI control. The project was funded by an International Development Research Centre (IDRC) grant from 2004 to 2006.

Project objectives included:

- Assessing the quality of private general practitioners’ provision of STI services.
- Describing the policy and regulatory framework of the private health care sector.
- Determining the design and nature of existing public-private partnership for STIs.
- Developing a public-private partnerships framework that can facilitate an integrated national and regional approach to STI management and control in public and private sectors.

The project results reinforced the need for the private and public sector to work together on important public health issues such as STIs. HST built strong relationships with country STI coordinators, and involved universities and research institutions in participating countries. Links established between private practitioners and public sectors managers has allowed for sustainability of the project initiatives. The results of the research were shared at national feedback and consensus building workshops in the three countries, with participation of other countries, to allow for sharing of lessons and experiences. The workshops also discussed a proposed Private-Public Partnership (PPP) framework for STI control which has been submitted to SADC for consideration and adoption.
The HealthLink cluster facilitates the strategic use and dissemination of health and related information and is also involved in advocacy projects which serve to improve the quality and availability of reliable information. The cluster also focuses on advocating for equity in health and is actively involved in supporting the implementation of the National Strategic Plan.
Health and Management Information Systems/ Monitoring and Evaluation

Project Managers: Faith Kumalo and Stiaan Byleveld

The National Health Information Systems Strengthening (NatHIS) Project

The NatHIS Project, established in 2005 and funded by the National Department of Health, provides technical support to strengthen the national health information system, with a strong focus on the District Health Information System (DHIS). The aim of the project is to assist and support employees of national, provincial and local government health departments to access and use routine health data in the DHIS software and other data sources, in order to improve management of the health system and health programmes. A team of twenty-one professionals including ten health information facilitators, software developers and a database manager provided the support to the national and provincial departments, and were coordinated by both project managers. The Health Information Systems Programme (HISP) was subcontracted by HST for components of the project.

The key focus areas of the project for 2006/07 were improving access, data flow, data quality as well as providing training and support. The project demonstrated significant achievements in strengthening these aspects of the health information system including improving data quality, full implementation of the standard national indicator dataset in all provinces, development and implementation of Emergency Medical Services (EMS) and training and capacity development of 4,889 national, provincial and local managers. Additional outputs include a national audit of Health Information Systems (HIS) infrastructure, and the development of thirteen training manuals and resource materials including a ‘Top Ten Indicators Handbook.’

Numerous national and provincial managers confirmed the value of the project and a desire for ongoing support to address the challenges that still remain. HST is therefore seeking longer term funding in order to sustain the current interventions, and to support further improvements of the national health information system.

NatHIS Internship Programme

The aim of the programme is to build capacity in Health and Management Information Systems (HMIS) and monitoring and evaluation skills and competence through participation in a semi-structured two-year programme. Four interns were originally placed in the programme, and have been widely exposed to the National Health Information Systems (NHIS) and rapidly developed their skills in this area.

Data Manager Project

HST was contracted by the National Department of Health (Primary Health Care and District Development cluster) in 2006/07 to provide data management support to the DHIS software for the cluster. The aim of the project was to improve the monitoring and evaluation of PHC implementation by ensuring timeous availability of updated provincial data, access to and improved use of data and information by health officials, and to support the implementation of new data sets.

Key achievements have been firstly the implementation of the environmental health system (EHS) dataset, which had previously suffered from inertia for three years. HST trained EHS staff in every province and supported data collection in some provinces. Secondly, the District Quarterly Reporting System was developed and is poised for implementation as a monitoring tool of district performance. Thirdly, feedback on district and provincial performance against selected indicators was regularly provided to provinces, thus strengthening PHC monitoring and evaluation.
The District Health Barometer

Project Manager: Fiorenza Monticelli

The District Health Barometer (DHB), an annual HST publication funded by Atlantic Philanthropies since 2005, provides a snapshot of the overall performance of the public health sector across provinces and health districts in South Africa. By presenting accessible management information the DHB functions as a tool to monitor progress towards strategic health goals (including the Millennium Development Goals); to support more equitable provision of PHC, and the improvement of the quality of routinely collected health data. The DHB also promotes transparency of the performance of the South African health sector by placing the information in the public domain and encouraging greater scrutiny of the information.

The DHB 2005/06 report, released in February 2007, compares a range of health, socioeconomic and financial indicators using three years of data. Approximately 600 CDs and books of the DHB 2005/06 were disseminated, and eleven presentations made to local and international conferences, including the WHO Conference on Strengthening Management in Health in Ghana in January 2007 and the 22nd Annual Joint Scientific Conference of the National Institute for Medical Research in Tanzania in March 2007. The DHB 2005/06 has also been cited in numerous local, international and peer reviewed publications.

The DHB is guided by an advisory committee of key stakeholders from the health services, research and academic sectors. In 2007, the project hosted an intern to build capacity in the use of HMIS.

The Equity Gauge and Governance

Project Co-ordinator: Ashnie Padarath

The Equity Gauge was formed in 1999 by HST in partnership with national and provincial parliamentarians, with the objective of raising consciousness about the meaning, implications and implementation of equity in the health sector. In response to the growing need to strengthen governance of the health system, the project broadened its focus in 2006/07 to include governance at all levels. It has sought to do this by undertaking research, developing tools, and working to support health governance structures and strengthen community participation in such structures.

A key success has been the development of guidelines and training tools for governance, which have been used in training and supporting clinic committees, hospital boards and district health councils in the Free State. More than twenty training workshops throughout the province focussed on the policy and legislative frameworks for community participation in governance structures; effective and efficient management and understanding and responding to community needs. Evaluations indicate that the training has addressed a critical knowledge gap and has contributed to developing a common understanding and consensus over the role and functions of governance structures.

Research and interventions to strengthen governance also took place in the Maphumulo area of KwaZulu-Natal with a focus on facilitating the development of clinic committees and enhancing understanding of the broader determinants of health from an equity perspective. For example, the project supports clinic committees to play a role in the development of Integrated Development Plans (IDPs) where issues such as provision of sanitation, water, electricity and municipal health services (environmental health issues) can be addressed.

Funders: Free State Provincial Department of Health, the Open Society Foundation and the Raith Foundation.

Global Equity Gauge Alliance and Global Health Watch

Project Co-ordinators: Antoinette Ntuli, Bridget Lloyd and Noluthando Ford-Ngomane

The Global Equity Gauge Alliance (GEGA) network, comprising projects in Latin America, Asia and Africa, continued to support individual country initiatives designed to ameliorate inequities, build capacity for equity oriented activities and advocate for equity. Building on
its successful ‘Equity and Health’ workshop, GEGA developed and piloted an ‘Equity and Health Systems’ course developed in collaboration with Equity Gauges in South East Asia. The course has subsequently been adapted for use in the Region.

In addition to participation in various international fora, GEGA advocates for equity through the Global Health Watch (GHW). GEGA currently hosts the Secretariat for the GHW, located in HST. The impetus for an ‘alternative world health report’ arose from concerns about the widening inequities between and within countries, an increase in poverty and preventable diseases, lack of recognition of the broader social determinants of health and a predominantly disease based vertical approach to health programmes and financing dominating the global health agenda. Furthermore, civil society, and especially southern civil society, has not adequately participated in international health advocacy, especially with regards to broader public health and health systems issues.

In response, the People’s Health Movement, GEGA and Medact (organisations with expertise and experience in policy analysis, research and advocacy) decided to develop the GHW in order to mobilise stakeholders around the key challenges to improving global health. The main target groups of the GHW are health workers and people working for health around the globe including policy makers, activists, academia, the general public and people from other sectors that impact on and interrelate with health.

The second GHW will be published in 2008 and among other things, provides a critique of the dominant concept of development: what is considered to be progress, what health-harming manifestations of development have become acceptable as part of the dominant paradigm, as well as a strong emphasis on helping to hold key global health institutions to account.

The Treatment Monitor

Project Co-ordinator: Marion Stevens

Following a review of the project, a shift was made in focus from a collation of data on treatment, to exploring the quality of the continuum of HIV care, and gender related aspects of HIV & AIDS. In particular, the integration of HIV & AIDS into sexual and reproductive health services and ensuring the right to comprehensive care for women became a strong focus. It also seeks to address the rights and wellbeing of health-workers, largely female, as providers of care for HIV & AIDS.

As a founding member of the Joint Civil Society Monitoring Forum (JCSMF), the Treatment Monitor hosted the June 2007 meeting at the South African AIDS Conference where the National Strategic Plan (NSP) was discussed. The Treatment Monitor was also mandated to take the lead on Human Resources issues related to the NSP on behalf of the forum. The Monitor has since been collaborating with Democratic Nurses Organisation of South Africa (DENOSA) and the regulatory sector in reviewing legal and policy barriers in task shifting. The project has also been actively engaged in the South African National AIDS Council (SANAC) process, participating in the Women’s and Academic Sector, and providing technical assistance to the Health Regulatory Bodies sector.

In March 2007 the Treatment Monitor hosted a visit from the International Women’s Health Coalition and facilitated revitalising the Reproductive Right Alliance within the Western Cape and nationally.

The Monitor actively engaged in researching, sharing information and supporting civil society, government and other stakeholders in responding to the Choice on Termination of Pregnancy Amendment Act and making clear linkages between the need for HIV positive women to be offered a choice to terminate as part of treatment. As a result of this work, the Project Manager was sponsored to run a workshop at the Global Safe Abortion workshop in London with the International Community of Women Living with HIV/AIDS (ICW).

In partnership with MOSAIC, the project facilitated the process of consultation and led the research on assessing the sexual and reproductive health indicators for the United Nations Special Session on HIV/AIDS (UNGASS). This information was used by SANAC in the development of the country report. The projects active participation within an international network on Gender, Human Rights and HIV/AIDS (ATHENA) has resulted in the Project Manager being nominated to be on the UNAIDS UNGASS Civil Society Task team and to be a speaker within the plenary of the International Mexico AIDS Conference 2008.
South African Health Review

The South African Health Review (SAHR), an annual publication of HST since 1995, provides a South African perspective on prevailing local and international public health issues. It also seeks to provide a platform for assessing progress in the health sector and to stimulate debate and critical dialogue. Recently, the SAHR has been produced on a thematic basis with the focus of the 2006 SAHR being on Maternal, Child and Women’s Health, and the 2007 SAHR being on the Role of the Private Sector within the South African Health System.

Since the official launch of the 2006 SAHR on 30 November 2006, more than 650 copies were distributed. HST website logs for the month following the launch (December 2006) indicate more than 2000 visits to download individual chapters or the full PDF version of the 2006 SAHR. The review was also extensively covered and quoted in the national media, and has contributed to raising the profile of key public health and health systems challenges relating to maternal, child and women’s health.

Development of the 2007 SAHR

The development of the 2007 SAHR focusing on ‘The Role of the Private Sector within the South African Health System’ commenced in January 2007, with a planned launch date of November 2007. Editors of the SAHR 2007 are Stephen Harrison, Rakshika Bhana and Antoinette Ntuli, guided by an Advisory Committee of experts and sector representatives.

Critical issues covered in the 2007 SAHR include, the stewardship role of government; policy and legislation on the provision and funding of private health care; mandatory health insurance; key debates on the medical schemes industry; developments in the market and regulatory environment impacting on medicine pricing and access to medicines; public-private partnerships in health care; analysis of the private hospital industry, traditional and complementary interventions and the private sectors response to HIV & AIDS, STI’s and tuberculosis.

The SAHR can be viewed in PDF format, or CDs can be ordered on the HST website. The publication has been generously funded by Atlantic Philanthropies.

HST website and information dissemination services

The HST website (www.hst.org.za) provides a wide array of knowledge, research, links and information about health systems and PHC in southern Africa. The website, which is continuously updated showcases HST’s work across its various programmes and projects and holds an extensive database of HST and other publications, which can be freely downloaded.

The website statistics below provide a quick overview of the number of visits to HST’s website between July 2006 and June 2007. There was a monthly average of 15 224 unique visitors to the HST website during this period.
In the last year HST has also provided support to other initiatives for establishment and maintenance of ‘independent’ websites. These include:

- 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
- Global Health Watch - www.ghwatch.org
- Technical Support Facility Southern Africa of UNAIDS - www.tsfsouthernafrica.com
- Madibeng Centre for Research - www.madibeng.org.za

Health and Related Indicators

An online database of health and related indicators on the HST website includes over 17,000 items of indicator data drawn from over 200 sources over about eight years. This resource is continuously updated as new sources of data become available. Although most data are from sources in the public domain such as household surveys, the national Census and the DHIS, some indicators such as those related to health financing are calculated from raw data sources. The online indicators can be accessed at http://www.hst.org.za/healthstats/.

A selection of this data is collated, with interpretation and analysis, in the Health and Related Indicators chapter of the SAHR and provides a comprehensive overview of data available to assess the status of the national health system. The chapter also provides a synopsis of the latest research in health metrics, and principles of monitoring and evaluation to assist in interpreting and applying the health statistics appropriately.

Electronic discussion lists

HST manages 55 electronic discussion lists (http://www.hst.org.za/generic/31) of which 20 are for clients external to the organisation. The Druginfo (385 members), DHIS (576 members), Disability (161 members), Maildoc (163) and the JCSMF (204) lists are HST-hosted lists that have been the most active, with some achieving many thousands of postings during the year.

New lists include the HRH (Human Resources for Health) list, which HST hosts throughout southern Africa for a Human Resources consortium including Equinet and ECSA, and lists for the UNAIDS Technical Support Facility Southern Africa (TSF). HST uses the lists extensively to disseminate publications and relevant data to a wide audience, while keeping the health sector abreast of the latest public health sector news, views, education and support.

HealthLink Bulletin

The HealthLink Bulletin is a bi-weekly email newsletter, which provides subscribers with links to current resources, news articles, publications, events, job opportunities and the latest research on HIV & AIDS, health systems development, PHC and public health. Information is sourced from a wide variety of local and international sources. Membership is free of charge to subscribers or can be accessed on the HST website. Membership on the list has increased since it was established in March 1998, with a total of 1,694 subscribers by July 2007.
Resource Centre

The Resource Centre assists HST staff and partner organisations to access relevant information and publications. During 2006/07 the centre distributed over 4 000 HST publications. The Resource Centre also responded to approximately 350 enquiries on HST reports, publications and other information.

Human Resources for Health (HRH)

HST’s collaboration with EQUINET and ECSA in the field of Human Resources for Health (HRH) focused on the migration of HRH and its impact on equity and health in the East and Southern African (ESA) Region. An overview of current codes and protocols operational in ESA on, or affecting health worker migration, their scope and major policy content was produced together with a review paper on the distribution of costs and benefits of migration within and beyond the ESA region. These papers were discussed at a regional meeting of researchers and relevant stakeholders to inform a follow up programme of work. A presentation was also made to the plenary session of the ECSA Regional Health Ministers meeting from the work on migration undertaken by EQUINET with a view to contributing to regional responses to the HRH challenges posed by ongoing migration from the Region.

Funder: Equinet

Technical Support Facility

The Technical Support Facility Southern Africa (TSF) was established in 2005 in order to improve access to quality local technical assistance to support HIV & AIDS programmes in the southern Africa region. The project funded by UNAIDS is led by Health and Development Africa (HAD) in partnership with HST and Crown Agents. HST supports the capacity development aspects of the TSF, and organised a workshop which brought together key stakeholders including international partners, consultants, country partners (mostly representatives from National AIDS Councils) and representatives from other regional TSFs from Africa and Asia to review capacity development work to date and outline a way forward. The workshop affirmed that effective consultancy requires both technical and process skills, and that the programme should aim to build capacity both among consultants as well as among country partners to strengthen short term technical assistance on this basis. The TSF website continues to be hosted by HST, and technical support is provided by HST to the management of TSF lists.

Health-e News

HST continued to provide support to Health-e news during 2006/07. In addition to the extensive coverage of topical health issues, highlights during this period included Health-e receiving a fellowship to cover the work of hospices, while radio reporter Mabutho Ngcobo was declared the winner of the national Vodacom radio features award. Health-e had also consolidated its management and funding since joining HST in 2005, and decided to establish itself as an independent section 21 company. The company was registered in November 2006, and the transfer of all HST support and oversight was successfully concluded by the end of the 2006/07 financial year. Atlantic Philanthropies renewed Health-e funding for a further five year period.
Human Resources and Administration
The HR team provides support to staff at all levels regarding the human capital component of the organisation and the Admin team provides administrative support to all clusters.

Finance and IT
The Finance team is responsible for the design and implementation of accounting systems for the various clusters and projects and the IT team provides support to all staff allowing them to use their computers efficiently and with confidence.
Human Resources (HR)

Staffing
At the end of 2006/07, HST employed 111 staff members. HST’s staff profile remains largely female and Black, exceeding national Employment Equity profiles. Two senior staff members, Mr Ricardo Ngcobo and Ms Ronel Visser joined as HR and Administration Manager and Director: HealthLink, respectively, strengthening the management team. Staff retention strategies and HST’s status of being an employer of choice remain focus areas of the leadership.

Skills Development
HST continued to strengthen its internship programme and hosted a total of one international and 10 local interns this year. A training needs analysis of all staff members was undertaken and an application for a Levy Exempt Funding grant was made to the Health and Welfare Sector Education and Training Authority (HWSETA). Programme staff are encouraged to register for formal postgraduate studies, and several are currently undertaking Masters and PhD studies. Support has also been given to emerging consultants and sub-grants provided to support emerging young black researchers.

Key HR Policies and Practices
Remuneration and performance management are important components of the human capital management strategy of HST and are directed at making HST an organisation that cares for its people, creating an environment that allows employees to grow and recognises individual performance and contribution. To this end, HST finalised and implemented an updated Remuneration Policy, Job Evaluation Guidelines and reviewed and strengthened its Performance Management system and practices during 2006/07. Capacity of managers and staff was strengthened in these areas through workshops, training sessions and active participation in policy development.

Finance
Good governance and financial sustainability of the organisation remains a key priority of the HST leadership. The annual financial statements as at 30 June 2007 reflect assets to the value of R47m, which reinforces HST’s stability and sustainability for the foreseeable future. Both the finance and audit subcommittees of the Board play an important oversight role in the governance of the organisation and provide strategic advice and direction to the Finance team. During the year under review, external and internal audits were conducted at HST and the findings once again confirmed HST’s adherence to sound financial management systems and procedures.

Information Technology (IT)
The strategic focus for IT in 2006/07 was on ‘Communication and Connectivity’. We upgraded our Durban dedicated bandwidth from 256k to 1024k, and implemented a Virtual Private Network (VPN) connecting all HST offices and remote users. HST users can now connect at high speed to HST’s networks using cellular datacards from anywhere in the world. HST also improved the efficiency and security of its email systems and upgraded the webmail system. This has been achieved while sustaining our normal program of maintenance and upgrades for HST’s Information and Communication Technology (ICT) systems including website, mailing lists, management information systems, and individual user support.
HST STAFF

Lilian Dudley, CEO

HR and Administration
Ricardo Ngcobo, Manager
Delene King
Duduzile Zondi
Farana Bibi Khan
Joyce Mareme
Julia Elliott
Jarie Thaver
Karen Campbell
Khuphukile Nyawose
Mercia Kuhn
Monde Nyangintsimbi
Mpho Monyatsi
Nomfuneko Tsooloane
Nomzi Kalipa
Portia Ramokgolo
Primrose Mbuli
Rachel James
Salome Selebano

Finance and IT
Deenadayalan Govender, CFO
Charmaine Singh
Deon Olivier
Fazila Khan
Jonathan McKeown
Mahomed Hoosen Imam
Quintin Dreyer
Rakesh Brijlal
Rosheen Seale

Research
Irwin Friedman, Director
Amos Soxa
Andile Shandu
Babalwa Makalima, Intern
Edwill Fourie
Elizabeth Lutge
Eric Cele
Duduzile Nsibande
Jaine Roberts
Madibata Matji
Marian Loveday
Mbali Msweli
Muziwandile Ndlovu
Nandy Mothibe
Neo Mohlabane
Nokuthula Radebe
Nontombi Memela
Patela Giyose
Pumza Mbenenge
Sibongile Mkhize
Sindisiwe Hlangu
Siphiwe Hlongwane, Intern
Siyabonga Nzimande, Intern
Tanya Doherty
Thantaswa Mbenenge
Thoko Ndaba
Thokozani Mbatha, Intern
Thumeka Chasana
Wanga Zembe, Intern
Zimisele Ndlele, Intern
Zodwa Mzimela

District Support and Community Development
Nomonde Bam, Director
Abdul Elgoni
Frank Tlamama
Hlengiwe Gumede
Khosi Nyawo
Muzi Matse
Mzikazi Masuku
Nobanzani Dana
Nolutando Ford-Ngomane
Nomkita Gobodo
Nonceb A Languza
Nonkosi Slatsha
Notemb Makunga
Oluseyi Oyedeke
Orginah Ngobeni
Pat Mhlongo
Sarah Davids
Thulile Zondi
Wanda Mthembu

HealthLink
Ronel Visser, Director
Ashnie Padarath
Bridget Lloyd
Candy Day
Catherine Pagett, Intern
Christa Van Den Bergh
Crizelle Nel
Elliot Sello, Intern
Faith Kumalo
Fiorensa Monticelli
Halima Hoosen Preston
Hlengiwe Ngcobo
Imeraan Cassiem
Jacqueline Smith
Jan Baloyi, Intern
Judy Ann Caldwell
Marion Stevens
Molefe Mahlatsi, Intern
Naadira Karrim, Intern
Naomi Massyn
Nonqaba Mzana
Petrida Ijumba
Qamar Mahmood
Rakshika Bhana
Riette Venter, Intern
Ronelle Niit
Ross Haynes
Sithandiwe Nyawose
Stiaan Byleveld
Zweni Sibiya

Specialist Technical Advisors
Antoinette Ntuli
Peter Barron

Health-e
Anso Thom
Khopotso Bodibe
Kerry Cullinan
Nawaal Deane
Nina Taaibosch
Hester Olifant
Yolisa Njamela
SHARING KNOWLEDGE:
PUBLICATIONS AND CONFERENCE PRESENTATIONS

During 2006/07, HST shared its knowledge by publishing and disseminating a range of publications, which have influenced policy-making and contributed to strengthening the implementation of health services. Several staff members have also presented papers and posters at local, national and international conferences.

PUBLICATIONS

Peer-reviewed journals, bulletins and chapters in books


Doherty, T., Chopra, M., Nkonki, L., Jackson, D. and Greiner, T. Effect of the HIV epidemic on infant feeding in South Africa: “When they see me coming with the tins they laugh at me”. Bull World Health Organ 2006; 84(2):90-96.


London, L., Cooper, D. and Shongwe, B. Community Participation In Primary Care Service Development: A Case Study From The Informal Settlement Matthew Goniwe, Khayelitsha, Cape Town, South Africa, Department of Public Health, University of Cape Town, and Health Systems Trust, Durban, South Africa, International Journal of Health Services in press.


HST published and supported reports and publications


2007 SAHR chapters authored by HST staff:


MRC, HST, UWC & CADRE: HIV and Infant Feeding: A Policy brief and Summary of Findings from the Good Start Study was published by the Good Start Study Consortium, June 2007.


**CONFERENCE PRESENTATIONS**

**International conferences**


Monticelli, F. The District Health Barometer. 22nd Annual Joint Scientific Conference of the National Institute for Medical Research, Tanzania, March 2007.


**National conferences**


HST BOARD OF TRUSTEES

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

Mr Thokwa Patrick Masobe (Chairperson), is the Chief Executive and Registrar for the Council for Medical Schemes of South Africa. Mr Masobe has a background in health economics, holds an MSc in Health Policy, Planning and Financing from LSE & LSHTM, and was previously the Director for Health Policy and Planning in the National Department of Health of South Africa.

Professor Eric Buch (Deputy Chairperson), is Professor of Health Policy and Management in the School of Health Systems and Public Health at the University of Pretoria and is also Health Advisor to NEPAD. Formerly, he was Deputy Director General for Health Care in Gauteng, Executive Director for Health, Housing and Urbanisation in Johannesburg, and a founder and Director of the Centre for Health Policy at the University of the Witwatersrand.

Ms Jeanette Hunter (Deputy Chairperson), is Chief Information Officer for Gauteng Department of Health and was previously Director for 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, as well as in Health Information Systems Implementation and Maintenance.

Professor David Serwadda, is Dean of Public Health and Professor at Makerere University in Uganda. His expertise is in the fields of epidemiology, evaluation of health intervention and disease surveillance, and his specialty is infectious disease. He is a member of the International Epidemiological Association.

Ms Seadimo Chaba, is Human Resources Executive in charge of Human Capital Development for Sasol and serves on the board of Denel as a Non-Executive Director. She was previously the CEO of Creditworx (Pty) Ltd, Executive Manager for Public Works and Management Services (Gauteng) and Chief Director for HR in the office of the Premier. She brings to the Board extensive experience in management and human resources in both public and private sectors.

Dr Sagie Pillay, is Chief Executive Officer of Johannesburg Academic Hospital, and previously worked for the National Department on Hospital Management and Decentralisation. He has a Masters in Health Management, Policy and Planning from Leeds University, and has a Senior Executive qualification from Harvard Business School. He has done extensive consulting in several countries and worked in hospital management, policy and planning.

Professor John Volmink, 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.
ANNUAL FINANCIAL STATEMENTS

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES
for the year ended 30 June 2007

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 42.

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

Chairperson

Date: 2 APRIL 2008

Trustee
TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

CORPORATE GOVERNANCE STATEMENT
for the year ended 30 June 2007

The Trust for Health Systems Planning and Development confirm 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 2007 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 (Term ended: 30 June 2006)
- Barry Kistnasamy (Term ended: 30 June 2006)
- Sagie Pillay
- Ilan Lax (External Member)

The audit committee addressed its responsibilities properly in terms of the charter during the 2007 financial year. No changes to the charter were adopted during the 2007 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 2007, and of the results of its operations, changes to the charter were adopted during the 2007 financial year.

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 2007 financial year.

The personnel committee consists of the following non-executive Trustees:

- S Chaba
- J Hunter
- Y Pillay

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:

- J Volmink
- 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 involving segregation of duties, transactions authorisation, supervision, monitoring, and financial and managerial reporting.

To meet its responsibilities 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 2007 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 2007, 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 has 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 Conducts (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 South African Statements of Generally Acceptable Accounting Practice. 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 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

REPORT ON THE FINANCIAL STATEMENTS

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 2007, the income statement, the statement of changes in equity and cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 46 to 53.

Trustees’ Responsibility for the Financial Statements
The trust’s 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. 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
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 of 30 June 2007, and its financial performance and its 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.

PricewaterhouseCoopers Inc
Director: N Ramaglan
Registered Auditor
2 April 2008

C Beggs
Chief Executive Officer
M J J Kritzmann
Chief Operating Officer
S J Asfour
Director – Managing Centres, North and Eastern regions and Durban office
D A Asfour
Resident Directors
M R Miller, B K Rajaram, N Ramaglan, H Ramusser, S P Rendelhoff, M H Teller, T S White
The Company’s principal place of business is at 3 Edge Road, Sunninghill where a list of directors’ names is available for inspection.
PricewaterhouseCoopers Inc is an authorised financial services provider.
VAT reg.no. 4590149692
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 2007.

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 44 to 53 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 R3,147,532 (2006: R8,587,309).

3. Trustees

The following served as trustees during the current year:

• E Buch
• S Chaba
• J Hunter
• L Jacobs (resigned: 03/05/06)
• P Masobe
• DN Pillay
• Y Pillay
• D Serwada (Uganda)
• J Volmink

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

• C Househam
• B Kistnasamy

4. The Lovelife Trust’s assets and liabilities

With the transfer of the Lovelife division, all the assets and liabilities of the Lovelife division were to be transferred into The Lovelife Trust.

As at 30 June 2007, land and buildings comprising the remainder of Erf 5 Wierda Valley Township were still registered in the name of Trust for Health Systems Planning and Development. Management of The Lovelife Trust were informed of this matter and have taken steps to rectify this.

5. 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.

6. Reportable irregularity

As at 30 June 2006, the trust was not registered for Regional Service Council levies nor had the amount due been paid over to Ethekwini Municipality. In accordance with their responsibilities in terms of the Auditing Profession Act, our auditors reported the matter to the Independent Regulatory Board for Auditors.

In February 2007, the trust applied for registration with the Regional Services Council and paid over all amounts due to Ethekwini Municipality.

7. Auditors

PricewaterhouseCoopers Inc. will continue in office.
## BALANCE SHEET
for the year ended 30 June 2007

<table>
<thead>
<tr>
<th>Notes</th>
<th>2007</th>
<th>2006</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>3,827,722</td>
</tr>
<tr>
<td>Current assets</td>
<td>8</td>
<td>24,533,656</td>
</tr>
<tr>
<td>Receivables and prepayments</td>
<td>9</td>
<td>19,508,990</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td></td>
<td>44,042,646</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>47,870,368</td>
</tr>
<tr>
<td><strong>EQUITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust capital and funds</td>
<td></td>
<td>30,211,238</td>
</tr>
<tr>
<td>Trust capital and accumulated surplus funds</td>
<td></td>
<td>30,211,238</td>
</tr>
<tr>
<td><strong>Total equity</strong></td>
<td></td>
<td>30,211,238</td>
</tr>
<tr>
<td><strong>LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td>12</td>
<td>2,030,827</td>
</tr>
<tr>
<td>Interest bearing borrowings</td>
<td></td>
<td>2,030,827</td>
</tr>
<tr>
<td>Current liabilities</td>
<td>10</td>
<td>15,579,897</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>12</td>
<td>48,406</td>
</tr>
<tr>
<td>Current portion of interest bearing borrowings</td>
<td>12</td>
<td>48,406</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td></td>
<td>15,628,303</td>
</tr>
<tr>
<td><strong>Total equity and liabilities</strong></td>
<td></td>
<td>47,870,368</td>
</tr>
</tbody>
</table>

## INCOME STATEMENT
for the year ended 30 June 2007

<table>
<thead>
<tr>
<th>Notes</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Grant income</td>
<td>3</td>
<td>51,224,439</td>
</tr>
<tr>
<td>Other income</td>
<td></td>
<td>412,696</td>
</tr>
<tr>
<td>Project expenses</td>
<td>(31,458,159)</td>
<td>(25,973,450)</td>
</tr>
<tr>
<td>Grants paid</td>
<td>(9,284,082)</td>
<td>(9,820,868)</td>
</tr>
<tr>
<td>Administration expenses</td>
<td>(9,378,285)</td>
<td>(7,368,482)</td>
</tr>
<tr>
<td>Surplus funds</td>
<td>2</td>
<td>1,516,609</td>
</tr>
<tr>
<td>Finance costs</td>
<td>5</td>
<td>(158,605)</td>
</tr>
<tr>
<td>Finance income</td>
<td>5</td>
<td>1,789,528</td>
</tr>
<tr>
<td>Surplus funds before income tax</td>
<td>3,147,532</td>
<td>8,587,309</td>
</tr>
<tr>
<td>Income tax expense</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Surplus funds for the year</td>
<td>3,147,532</td>
<td>8,587,309</td>
</tr>
</tbody>
</table>
## STATEMENT OF CHANGES IN EQUITY
for the year ended 30 June 2007

<table>
<thead>
<tr>
<th>Notes</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Trust capital and accumulated surplus funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at beginning of year</td>
<td>27,063,706</td>
<td>18,476,397</td>
</tr>
<tr>
<td>Comprises as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District Support Community Development (DSCD)</td>
<td>14,519,187</td>
<td>5,428,251</td>
</tr>
<tr>
<td>Opening balance</td>
<td>14,936,005</td>
<td>5,428,251</td>
</tr>
<tr>
<td>Change in accounting policy</td>
<td>(416,818)</td>
<td>-</td>
</tr>
<tr>
<td>Research</td>
<td>5,702,088</td>
<td>4,631,956</td>
</tr>
<tr>
<td>Opening balance</td>
<td>7,565,555</td>
<td>-</td>
</tr>
<tr>
<td>Change in accounting policy</td>
<td>(1,374,560)</td>
<td>-</td>
</tr>
<tr>
<td>Less: Transfer</td>
<td>(488,907)</td>
<td>-</td>
</tr>
<tr>
<td>Central Administration (CORE)</td>
<td>5,675,376</td>
<td>4,477,555</td>
</tr>
<tr>
<td>Opening balance</td>
<td>5,587,461</td>
<td>-</td>
</tr>
<tr>
<td>Less: Transfer</td>
<td>87,915</td>
<td>-</td>
</tr>
<tr>
<td>Healthlink</td>
<td>307,410</td>
<td>3,938,635</td>
</tr>
<tr>
<td>Opening balance</td>
<td>4,656,770</td>
<td>-</td>
</tr>
<tr>
<td>Change in accounting policy</td>
<td>(3,890,707)</td>
<td>-</td>
</tr>
<tr>
<td>Less: Transfer</td>
<td>(458,653)</td>
<td>-</td>
</tr>
<tr>
<td>Heath-e</td>
<td>859,645</td>
<td>-</td>
</tr>
<tr>
<td>Opening balance</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Change in accounting policy</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Less: Transfer</td>
<td>859,645</td>
<td>-</td>
</tr>
<tr>
<td>Add : Net surplus for the period</td>
<td>3,147,532</td>
<td>8,587,309</td>
</tr>
<tr>
<td>District Support Community Development (DSCD)</td>
<td>151,536</td>
<td>9,090,936</td>
</tr>
<tr>
<td>As previously reported</td>
<td>151,536</td>
<td>9,507,754</td>
</tr>
<tr>
<td>Change in accounting policy</td>
<td>-</td>
<td>(416,818)</td>
</tr>
<tr>
<td>Research</td>
<td>1,180,280</td>
<td>1,753,011</td>
</tr>
<tr>
<td>As previously reported</td>
<td>1,180,280</td>
<td>2,933,599</td>
</tr>
<tr>
<td>Change in accounting policy</td>
<td>-</td>
<td>(1,374,560)</td>
</tr>
<tr>
<td>Central Administration (CORE)</td>
<td>(539,537)</td>
<td>1,109,906</td>
</tr>
<tr>
<td>Healthlink</td>
<td>1,600,751</td>
<td>(3,172,572)</td>
</tr>
<tr>
<td>As previously reported</td>
<td>1,600,751</td>
<td>718,135</td>
</tr>
<tr>
<td>Change in accounting policy</td>
<td>-</td>
<td>(3,890,707)</td>
</tr>
<tr>
<td>Health-e</td>
<td>754,502</td>
<td>-</td>
</tr>
<tr>
<td>As previously reported</td>
<td>754,502</td>
<td>-</td>
</tr>
<tr>
<td>Change in accounting policy</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>At end of year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiative for sub-district support (ISDS)/District Support Community Development (DSCD)</td>
<td>14,670,723</td>
<td>14,519,187</td>
</tr>
<tr>
<td>Research</td>
<td>6,882,368</td>
<td>6,190,995</td>
</tr>
<tr>
<td>Central Administration (CORE)</td>
<td>5,135,839</td>
<td>5,587,461</td>
</tr>
<tr>
<td>Healthlink</td>
<td>1,908,161</td>
<td>766,063</td>
</tr>
<tr>
<td>Health-e</td>
<td>1,614,147</td>
<td>-</td>
</tr>
<tr>
<td>Balance at year end</td>
<td>30,211,238</td>
<td>27,063,706</td>
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CASH FLOW STATEMENT
for the year ended 30 June 2007

<table>
<thead>
<tr>
<th>Notes</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>R</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cash flows from operating activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cash receipts from grants</td>
<td>40,459,619</td>
</tr>
<tr>
<td></td>
<td>Cash paid in respect of projects and to employees</td>
<td>(51,509,806)</td>
</tr>
<tr>
<td></td>
<td>Cash (used in)/from operations</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Net finance income</td>
<td>1,630,923</td>
</tr>
<tr>
<td></td>
<td>Net cash (used in)/from operating activities</td>
<td>(9,419,264)</td>
</tr>
<tr>
<td>R</td>
<td>Cash flows from investing activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proceeds from disposal of property, plant and equipment</td>
<td>13,776</td>
</tr>
<tr>
<td></td>
<td>Acquisition of property, plant and equipment</td>
<td>(3,286,833)</td>
</tr>
<tr>
<td></td>
<td>Net cash used in investing activities</td>
<td>(3,273,057)</td>
</tr>
<tr>
<td>R</td>
<td>Cash flows from financing activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proceeds from interest bearing borrowings</td>
<td>2,079,233</td>
</tr>
<tr>
<td></td>
<td>Net cash from financing activities</td>
<td>2,079,233</td>
</tr>
<tr>
<td>R</td>
<td>Net (decrease)/increase in cash and cash equivalents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cash and cash equivalents at beginning of year</td>
<td>(10,613,088)</td>
</tr>
<tr>
<td></td>
<td>Cash and cash equivalents at end of year</td>
<td>19,508,989</td>
</tr>
</tbody>
</table>

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 30 June 2007

1. Summary of significant accounting policies

The principle accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

1.1. 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.

1.2. Standards, Interpretations and amendments to published standards that are not yet effective

a) Standards, amendments and interpretations effective in 2007 but not relevant to the Trust

The following standards, amendments and interpretations are mandatory for accounting periods beginning on or after 1 July 2006 but are not relevant to the Trust's operations:

- IAS 19 (Amendment), Employee Benefits;
- IAS 21 (Amendment), Net Investments in a Foreign Operation;
- IAS 39 (Amendment), Cash Flow Hedge Accounting of Forecast Intragroup Transactions;
- IAS 39 (Amendment), The Fair Value Option;
- IAS 39 and IFRS 4 (Amendment), Financial Guarantee Contracts;
- IFRS 1 (Amendment), First-time Adoption of International Financial Reporting Standards and (Amendment), Exploration for and Evaluation of Mineral Resources;
- IFRS 6, Exploration for and Evaluation of Mineral Resources;
- IFRIC 5, Rights to Interest arising from Decommissioning, Restoration and Environmental Rehabilitation Funds;
- IFRIC 6, Liabilities arising from Participating in a Specific Market - Waste Electrical and Electronic Equipment.
- IFRIC 7, Applying the Restatement Approach under IAS 29, Financial Reporting in Hyperinflationary Economies

b) Standards, Amendments to existing Standards and Interpretations to existing Standards that are not yet effective and have not been early adopted by the Trust

- IFRS 7, Financial Instruments: Disclosures (Effective for annual periods beginning on or after 1 January 2007).
- IFRS 7 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, Financial Instruments: Disclosure and Presentation. The adoption of this standard will only impact the format and extent of disclosures presented.
- Amendment to IAS 1; Presentation of Financial Statements: Capital Disclosures (Effective for annual periods beginning on or after 1 January 2007). The amendment to IAS 1 introduces disclosures about the level of an entity’s capital and how it manages capital. The adoption of this standard will only impact the format and extent of disclosures presented.
- IFRIC 9, Reassessment of Embedded Derivatives (Effective for annual periods beginning on or after 1 June 2006).
- IFRIC 11, Group and Treasury Share Transactions (Effective for periods beginning on or after 1 March 2007).
c) Standards and interpretations to existing standards that are not yet effective and not relevant for the Trust’s operations.

The following interpretations to existing standards have been published that are mandatory for the Trust’s accounting periods beginning on or after 1 July 2007 or later periods but that are not relevant for the Trust’s operations:

- IFRS 8, Operating Segments (Effective for periods beginning on or after 1 January 2009)
- IFRIC 8, Scope of IFRS 2 (Effective for annual periods beginning on or after 1 May 2006).
- IFRIC 10, Interim Financial Reporting and Impairment (Effective for annual periods beginning on or after 1 November 2006).
- IFRIC 12, Service Concession Arrangements (Effective for annual periods beginning on or after 1 January 2008).
- AC 503, Accounting For Black Economic Empowerment (BEE) Transactions (Effective for periods beginning on or after 1 May 2006).

1.3. 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 reviewed, and adjusted if appropriate, at each balance sheet date.

An asset’s carrying amount is written down immediately to its recoverable amount if the asset’s carrying amount is greater than its estimated recoverable amount (refer note 1.5).

Gains and losses on disposals are determined by comparing proceeds with carrying amount and are recognised within ‘other income’/administrative and other expenses’ in the income statement.

1.4. 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.

1.5. 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.

1.6. 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.

1.7. 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 date.

1.8. Funded projects

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

1.9. Revenue recognition

Income from donations and grants, including capital grants, shall be recognised as income over the periods necessary to match them with the related costs which they are intended to compensate, on a systematic basis.

Income from donations and grants, including capital grants, is not recognised until there is reasonable assurance that the trust will comply with the conditions attaching to it, and that the grant will be received.

Donations and grants, including capital grants, that are awarded for the purpose of giving immediate financial support rather than as an incentive to undertake specific expenditures are recognised as income in the period in which the trust qualifies to receive it.

Donations and grants, including capital grants, that are receivable as compensation for expenses or losses already incurred shall be recognised as income of the period in which it becomes receivable.

Income from sale of publications is included in other income.

Other revenue earned by the trust is recognised on the following basis:

- Interest income - as it accrues

1.10. 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.

1.11. Financial risk management

Financial risk factors:
Foreign exchange risk

The trust receive donations and grants from international donors and is exposed to foreign exchange risk arising from various currency exposures. The trust do not enter into Forward Foreign Exchange Contracts to hedge their exposure to fluctuations in foreign currency exchange rates.

Interest rate risk

As the trust has no significant interest-bearing assets, except for cash and cash equivalents, the trust’s income and operating cash flows are substantially independent of changes in market interest rates.

The trust’s interest rate risk arises from long-term borrowings. Borrowings issued at variable rates expose the company to cash flow interest rate risk. Borrowings issued at fixed rates exposes the trust to fair value interest rate risk.

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.

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.

1.12. Borrowings

Borrowings are recognised initially at fair value, net of transaction costs incurred. Borrowings are subsequently stated at amortised cost; any difference between the proceeds (net of transaction costs) and the redemption value is recognised in the income statement over the period of the borrowings using the effective interest method.

Borrowings are classified as current liabilities unless the company has an unconditional right to defer settlement of the liability for at least 12 months after the balance sheet date.

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
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<td>R</td>
<td>R</td>
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<tr>
<td>2. Surplus funds</td>
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<tr>
<td>The following items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>have been</td>
<td></td>
<td></td>
</tr>
<tr>
<td>charged/(credited)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in arriving at the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surplus funds:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation on</td>
<td>375,454</td>
<td>457,820</td>
</tr>
<tr>
<td>property, plant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(for detailed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>breakdown of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>depreciation refer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to note 7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auditors’ remuneration</td>
<td>88,000</td>
<td>76,200</td>
</tr>
<tr>
<td>Audit fees -</td>
<td>5,095</td>
<td></td>
</tr>
<tr>
<td>current year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underprovision in</td>
<td>3,429</td>
<td>24,913</td>
</tr>
<tr>
<td>prior year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td>96,524</td>
<td>107,113</td>
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<tr>
<td>Profit on disposal</td>
<td>(7,263)</td>
<td>-</td>
</tr>
<tr>
<td>of property, plant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultancy fees</td>
<td>1,386,736</td>
<td>308,577</td>
</tr>
<tr>
<td>paid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating lease</td>
<td>1,416,879</td>
<td>1,278,323</td>
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<tr>
<td>rentals</td>
<td></td>
<td></td>
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<tr>
<td>Land and buildings</td>
<td>213,408</td>
<td>103,229</td>
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<tr>
<td>Other</td>
<td>1,630,287</td>
<td>1,381,552</td>
</tr>
<tr>
<td>Staff costs (see</td>
<td>24,513,095</td>
<td>19,448,154</td>
</tr>
<tr>
<td>note 4)</td>
<td></td>
<td></td>
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<tr>
<td>Expenses by nature:</td>
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<td></td>
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<tr>
<td>Advertising costs</td>
<td></td>
<td>11,543</td>
</tr>
<tr>
<td>Consulting fees paid</td>
<td>1,386,736</td>
<td>308,577</td>
</tr>
<tr>
<td>Depreciation</td>
<td>375,454</td>
<td>457,820</td>
</tr>
<tr>
<td>Staff costs</td>
<td>24,513,095</td>
<td>19,448,154</td>
</tr>
<tr>
<td>Operating lease</td>
<td>1,630,287</td>
<td>1,381,552</td>
</tr>
<tr>
<td>rentals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel and</td>
<td>5,898,252</td>
<td>4,320,729</td>
</tr>
<tr>
<td>accommodation</td>
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<td></td>
</tr>
<tr>
<td>Other expenses</td>
<td>13,073,683</td>
<td>14,516,279</td>
</tr>
<tr>
<td>Printing and</td>
<td>1,388,217</td>
<td>862,946</td>
</tr>
<tr>
<td>stationery</td>
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<td></td>
</tr>
<tr>
<td>Project facilitation</td>
<td>1,015,029</td>
<td>1,031,158</td>
</tr>
<tr>
<td>Telephone and fax</td>
<td>1,090,160</td>
<td>824,042</td>
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<tr>
<td>Total administration</td>
<td>50,370,913</td>
<td>43,162,800</td>
</tr>
<tr>
<td>and project expenses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Grant Income

**FOR THE YEAR ENDED 30 JUNE 2007**

<table>
<thead>
<tr>
<th>Health</th>
<th>Healthlink</th>
<th>DSCD</th>
<th>Research</th>
<th>Admin/CORE</th>
<th>Total Income</th>
<th>Accrued Income</th>
<th>Deferred Income</th>
<th>Prior Year Reversal</th>
<th>Total Receipts</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Atlantic Philanthropies</td>
<td>2 700 000</td>
<td>46 801</td>
<td>1 831 859</td>
<td>128 387</td>
<td>917 350</td>
<td>5 624 396</td>
<td>(1 749 232)</td>
<td>1 215 590</td>
<td>1 880 088</td>
</tr>
<tr>
<td>W K Kellogg Foundation</td>
<td>-</td>
<td>-</td>
<td>2 494 743</td>
<td>-</td>
<td>-</td>
<td>2 494 743</td>
<td>-</td>
<td>761 026</td>
<td>-</td>
</tr>
<tr>
<td>Department of Health</td>
<td>-</td>
<td>9 491 056</td>
<td>21 412 521</td>
<td>4 612 034</td>
<td>1 049 081</td>
<td>29 403 833</td>
<td>(8 669 139)</td>
<td>1 471 679</td>
<td>(9 881 787)</td>
</tr>
<tr>
<td>DBSA</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1 193 519</td>
<td>-</td>
<td>1 193 519</td>
<td>(78 208)</td>
<td>334 874</td>
<td>249 816</td>
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<tr>
<td>SADC</td>
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<td>-</td>
<td>1 490 807</td>
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<tr>
<td>SIDA</td>
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<td>2 334 382</td>
<td>-</td>
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<td>-</td>
<td>2 334 382</td>
<td>(251 972)</td>
<td>-</td>
<td>(80 452)</td>
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<td>HISP SA</td>
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<td>49 027</td>
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<tr>
<td>Charles Kendall &amp; Partners LTD</td>
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<td>216 905</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>216 905</td>
<td>-</td>
<td>386 709</td>
<td>153 433</td>
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Total: 2 700 000 13 790 541 29 637 537 9 650 783 2 606 434 51 224 439 (11 452 835) 6 370 103 (12 842 943) 40 459 623
## FOR THE YEAR ENDED 30 JUNE 2006

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|                      |       |            |       |                      | 13 909 058   | 16 849 109     | 6 871 449        | 8 493 373       | 1 878 168    | 48 001 158   | 5 375 415   | (11 057 499) | 53 683 242   |

|                      |       |            |       |                      |               |               | 48 001 158       | 5 375 415       | (11 057 499) | 53 683 242   |
4. Staff costs
Salaries and wages
Average number of employees

5. Finance income/(costs)
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>Land and buildings</th>
<th>Motor Vehicles</th>
<th>Computer Equipment</th>
<th>Computer Software</th>
<th>Furniture &amp; Fittings</th>
<th>Total</th>
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<td>Year ended 30 June 2007</td>
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<td>Opening net carrying amount</td>
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<td>926,793</td>
<td>926,793</td>
<td>133,740</td>
<td>3,717,527</td>
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<td>Additions/improvements</td>
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<td>2,544,521</td>
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<td>101,803</td>
<td>414,397</td>
<td>647,800</td>
<td>674,049</td>
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<tr>
<td>Depreciation charge (refer note 2)</td>
<td>-</td>
<td>(423,063)</td>
<td>(1,616,359)</td>
<td>(39,709)</td>
<td>(457,820)</td>
<td>(2,720,337)</td>
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<tr>
<td>Closing net carrying amount</td>
<td>2,758,031</td>
<td>926,793</td>
<td>29,149</td>
<td>113,740</td>
<td>3,827,722</td>
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<td>As at 30 June 2006</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cost</td>
<td>2,758,031</td>
<td>2,364,227</td>
<td>398,477</td>
<td>65,823</td>
<td>707,238</td>
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<tr>
<td>Accumulated depreciation</td>
<td>-</td>
<td>(150,006)</td>
<td>(154,006)</td>
<td>(225,004)</td>
<td>(454,551)</td>
<td>(2,720,337)</td>
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<tr>
<td>Closing net carrying amount</td>
<td>2,758,031</td>
<td>926,793</td>
<td>29,149</td>
<td>113,740</td>
<td>3,827,722</td>
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</table>

Year ended 30 June 2006

<table>
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<tr>
<th></th>
<th>Land and buildings</th>
<th>Motor Vehicles</th>
<th>Computer Equipment</th>
<th>Computer Software</th>
<th>Furniture &amp; Fittings</th>
<th>Total</th>
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<td>154,006</td>
<td>225,004</td>
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<td>-</td>
<td>(150,006)</td>
<td>(154,006)</td>
<td>(225,004)</td>
<td>(454,551)</td>
<td>(2,720,337)</td>
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<tr>
<td>Closing net carrying amount</td>
<td>-</td>
<td>-</td>
<td>29,149</td>
<td>113,740</td>
<td>3,827,722</td>
<td></td>
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<tr>
<td>As at 30 June 2006</td>
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<td></td>
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<tr>
<td>Cost</td>
<td>-</td>
<td>2,364,227</td>
<td>398,477</td>
<td>65,823</td>
<td>707,238</td>
<td></td>
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<tr>
<td>Accumulated depreciation</td>
<td>-</td>
<td>(150,006)</td>
<td>(154,006)</td>
<td>(225,004)</td>
<td>(454,551)</td>
<td>(2,720,337)</td>
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<tr>
<td>Closing net carrying amount</td>
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<td>29,149</td>
<td>113,740</td>
<td>3,827,722</td>
<td></td>
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</table>

Depreciation expense of R375,454 (2006: R457,820) has been charged in project expenses. Land and buildings comprise the property described as ERF 26726 Observatory, Cape Town. The property is held as security over the mortgage bond. (refer note 12)

8. Receivables and prepayments

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<td>Receivables - net</td>
<td>23,849,928</td>
<td>8,147,544</td>
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<td>Receiver of Revenue - Value added Tax</td>
<td>492,479</td>
<td>749,599</td>
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<td>PAYE</td>
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<td>27,390</td>
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<td>Deposits</td>
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<td>400,630</td>
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<td>24,533,656</td>
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9. Cash and cash equivalents

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<td>Call accounts</td>
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<td>26,441,030</td>
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<tr>
<td>Cash on hand</td>
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<td>1,285</td>
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<tr>
<td>19,508,990</td>
<td>30,122,077</td>
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For the purpose of the cash flow statement, the year end cash and cash equivalents comprise the following:

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<td>3,679,762</td>
</tr>
<tr>
<td>Call accounts</td>
<td>16,154,411</td>
<td>26,441,030</td>
</tr>
<tr>
<td>Cash on hand</td>
<td>3,000</td>
<td>1,285</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,508,990</strong></td>
<td><strong>30,122,077</strong></td>
</tr>
</tbody>
</table>

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

Lovelife (refer note 10) - 96,715
Research - 5,515,803, 6,547,201
DSCD/ISDS and Community Development - 2,813,374, 16,906,694
Health-E - 56,247
Healthlink - 7,171,871, 1,623,587
Core - 3,951,695, 4,947,880

19,508,990
30,122,077

At the 2006 balance sheet date, The Lovelife Trust bank accounts amounting to R96,715 were still registered in the name of Health Systems Planning and Development Trust.

10. Trade and other payables

Payables Accruals - 2,075,162, 1,145,267
Deferred income - 12,372,830, 11,057,499
Provision for audit fees - 88,000, 76,200
Provision for leave pay - 1,043,905, 931,305
The Lovelife Trust (refer note 9) - 96,715

15,579,897
13,306,986

11. Cash from operations

Surplus/(deficit) funds - 1,516,611, 7,565,829
Adjusted for:
(Profit)/loss on disposal of property, plant and equipment - (6,668), 14
Depreciation - 375,454, 457,820
Movement in working capital - Increase in receivables and prepayments - (15,208,493), (5,175,860)
Decrease in trade and other payables - 2,148,509, 10,066,045
Provisions - 124,400, 122,303

(11,050,187)
13,036,151

12. Borrowings

Non-current
- Mortgage bond - Standard Bank - 2,079,233
Less Short term portion transferred to current liabilities - (48,406)

2,030,827

The mortgage loan is secured by a mortgage over the property with a net book value of R2,758,031 (refer note 7). These loans bear interest at 10.85% per annum and are repayable in 228 monthly instalments of R22,434, inclusive of finance charges.

13. Operating lease commitments

The future minimum lease payments under non-cancellable operating leases are as follows:

Not later than 1 year - 1,190,486, 648,172
Between 2 and 5 years - 1,494,490, 1,249,955

2,684,976
1,898,127

14 Contingent liabilities

14.1. 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.

14.2. 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.
15. Capital commitments
Capital expenditure contracted for at balance sheet date but not recognised in the financial statements is as follows:

Property, plant and equipment 2,300,000

16. Change in accounting policy
In previous years income from donations and grants were included in income resources when such donations and grants were received. In the current year the accounting policy has changed to record income to compensate for the related costs as they are incurred. Where the related costs have been deferred to future accounting periods, the income has also been deferred. This adjustment has been accounted for in terms of IAS 8 with restatement of prior year figures where necessary.

The above adjustment, when applied retrospectively, has the following effect on opening retained earnings:

- Decrease in grant income (5,682,084)
- Decrease in deferred tax -
- Decrease in opening retained earnings (5,682,084)

The above adjustment has had the following effect on the net profit for the year:

- Decrease in grant income (5,682,084)
- Decrease in income tax expense -
- Decrease in net profit for the year (5,682,084)
Funders and Funding Partners

- Action Aid
- African Regional Sexuality Resource Centre
- Anglo Gold Ashanti
- Atlantic Philanthropies
- Canadian International Development Agency
- Centre for Disease Control
- Centre of Rural Health, University of KwaZulu Natal
- Department for International Development
- Development Bank of Southern Africa
- Eastern Cape Department of Health
- Equinet
- European Union
- Ford Foundation
- Free State Department of Health
- Gauteng Department of Health
- German Development Cooperation
- Health Development Agency (UNAIDS TSF)
- Intel
- International Development Research Centre
- Ipas
- Management Sciences for Health (USAID)
- Mpumalanga Department of Health
- Medical Research Council
- Mosaic
- National Department of Health, South Africa
- Open Society Foundation South Africa
- Population Council
- Public Health Programme, UWC
- Southern African Development Community
- Swedish International Development Agency
- Training and Research Support Centre
- University of North Carolina, Population Centre
- University of Pretoria
- University Research Co. LLC
- Western Cape Department of Health
- W.K. Kellogg Foundation
- World Health Organisation
The Health Systems Trust’s unique strength lies in its ability to add value to the critical interface between health systems research, policy development and implementation support.
Health Systems Trust

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  - Tel: +27-33-347 3968
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