**Vision**

‘Health Systems supporting health for all in southern Africa’

---

**Mission**

The Health Systems Trust actively supports the development of comprehensive, effective, efficient and equitable national and district health systems’

---

**Approach**

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

---

**Core Values**

Our work is guided by the following key values

- Transparency and accountability
- Innovation and responsiveness
- Integrity and nurturance
- Embracing diversity
- Participatory democracy
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Message from the Chairperson</td>
<td>2</td>
</tr>
<tr>
<td>Message from the Chief Executive</td>
<td>3</td>
</tr>
<tr>
<td>Health Systems and Primary Health Care Research</td>
<td>4</td>
</tr>
<tr>
<td>Prevention of mother-to-child transmission of HIV/AIDS (PMTCT)</td>
<td></td>
</tr>
<tr>
<td>HIV mapping</td>
<td></td>
</tr>
<tr>
<td>An Evaluation of Three Home Based Care Programmes</td>
<td></td>
</tr>
<tr>
<td>The Treatment Monitor</td>
<td></td>
</tr>
<tr>
<td>The STI Initiative</td>
<td></td>
</tr>
<tr>
<td>HIV Impulse</td>
<td></td>
</tr>
<tr>
<td>PHC and District Health System Development</td>
<td></td>
</tr>
<tr>
<td>PHC facility survey</td>
<td></td>
</tr>
<tr>
<td>Local Government in Health Project</td>
<td></td>
</tr>
<tr>
<td>Environmental Health Services</td>
<td></td>
</tr>
<tr>
<td>Reproductive Health and Decentralisation</td>
<td></td>
</tr>
<tr>
<td>Strengthening Primary Care in 13 Rural Health Districts</td>
<td>7</td>
</tr>
<tr>
<td>National and provincial achievements</td>
<td></td>
</tr>
<tr>
<td>Site specific interventions</td>
<td></td>
</tr>
<tr>
<td>Lessons Learnt</td>
<td></td>
</tr>
<tr>
<td>Community Development</td>
<td>9</td>
</tr>
<tr>
<td>Integrated Nutrition</td>
<td></td>
</tr>
<tr>
<td>Male Sexuality</td>
<td></td>
</tr>
<tr>
<td>Equity, Advocacy and Information Dissemination</td>
<td>11</td>
</tr>
<tr>
<td>Equity and Advocacy</td>
<td></td>
</tr>
<tr>
<td>The Equity Gauge project</td>
<td></td>
</tr>
<tr>
<td>Community empowerment</td>
<td></td>
</tr>
<tr>
<td>HIV Gauge</td>
<td></td>
</tr>
<tr>
<td>Global Public Private initiatives</td>
<td></td>
</tr>
<tr>
<td>GEGA</td>
<td></td>
</tr>
<tr>
<td>Information Dissemination</td>
<td></td>
</tr>
<tr>
<td>SAHR</td>
<td></td>
</tr>
<tr>
<td>HST website</td>
<td></td>
</tr>
<tr>
<td>Indicators Database</td>
<td></td>
</tr>
<tr>
<td>Presentations, Papers and Publications</td>
<td>13</td>
</tr>
<tr>
<td>Our Staff</td>
<td>20</td>
</tr>
<tr>
<td>HST Board of Trustees</td>
<td>21</td>
</tr>
<tr>
<td>Grants and Acknowledgements</td>
<td>22</td>
</tr>
<tr>
<td>Financials</td>
<td>23</td>
</tr>
</tbody>
</table>
As incoming Chairperson of the Board of the Health Systems Trust, it is my pleasure to present the annual report of 2003/04.

In this year HST has operated in a very dynamic policy and legislative environment, with the promulgation of numerous pieces of legislation dealing with health professionals, the pharmaceutical industry, medical schemes and, in particular, the signing into law of the National Health bill in July 2004, establishing a clear framework for the national health system in South Africa.

In this period the National Department of Health also conducted a ten year review of the implementation of Health Sector Strategic Framework, 1999 – 2004, and defined Strategic Priorities for the National Health System for 2004 – 2009. The spotlight has increasingly focused on the challenges of ensuring adequate human resources for health, and on the implementation challenges of the Operational Plan for Comprehensive HIV & AIDS Care, Management and Treatment in South Africa approved by Cabinet in November 2003.

Within this environment HST has consistently provided support to the health system through its various activities around health systems research, district health systems development, community development, the equity gauge, and information dissemination. In addition, it has progressively expanded its focus areas to support the emerging priority needs of the health system, particularly around HIV and AIDS, and support systems such as health information and human resources development. Highlights of this year include the launch of the 2003/04 South African Health Review, the 2003 National Primary Facility Care Facility Survey, the winning of an Impumulelo Award by HST’s Integrated Nutrition Project, a successful Conference on Rural Health, and HST’s listing as one of the top Non Profit Organisation’s (all categories) in the country by Corporates.

The challenges for HST emanating from the year, are to increasingly align its activities with the National priorities, while still remaining focused on its core mandate of strengthening health systems in South Africa, and within the Southern African region.

The year has seen several changes on the HST Board. Board members who retired in the last year Dr Zola Njongwe, Dr Thabo Sibeko, and Ms Peta Qubeka, are acknowledged for the immense contribution made to HST during their term. In particular, I thank my predecessor as chairperson, Dr Zola Njongwe for the legacy she has passed on. The organisation has been extremely fortunate to attract a wealth of expertise and experience through new Board members, Professor David Serwadda, Dr Ayanda Ntsaluba, Ms Seadimo Chaba, Mr Sagie Pillay and Dr Yogan Pillay.

Lastly, as a non profit organisation HST is entirely dependent on the support of funders. The Board acknowledges and thanks all funders who have generously supported the work of the organisation over this year, and look forward to their ongoing association with HST in the future.
The 2003/04 year has been yet another challenging and rewarding one for HST. On reflection, it has been a year in which HST has shown its ability to successfully adapt to external changes and demands, while remaining true to its mission, and continuing to expand the role and influence of the organisation in South Africa and the region.

Highlights of the year include the launch of the 2003/04 edition of the South African Health Review, which provides a 10 year perspective on progress in the health system since democracy, and a data driven framework against which future achievements in the health system can be assessed. Other achievements include the release of the National Primary Health Care Facilities Survey (2003) Report, and Community Development’s Impumulelo Award for its Integrated Nutrition Project which has established a sustainable model of nutrition support in communities.

HST has also established several new projects including the ‘District Barometer’, which focuses on monitoring key indicators across districts, and shifts the focus of earlier equity work to a district level. The organisation’s expansion into regional work has continued gradually, with the strengthening of projects with SADC, and a range of new partnerships across the region.

The promulgation of the National Health Act in 2004 provided clarity on the delegations to different levels of government, and enabled planning and financing arrangements for the District Health System to proceed. Along with this, the ending of a three year European Union project supporting district health development in the 13 rural nodes, marked a watershed for the Initiative for Sub District Support (ISDS) programme, and the role it has fulfilled thus far in district health development.

ISDS, first established in six sites in 1996, to support implementation of the District Health System has over the past eight years provided direct support to district management teams and staff in more than 20 sites throughout the country. ISDS also developed a range of guidelines and tools to support district planning, management and delivery of services. These tools and lessons learnt were widely disseminated and used, and have subsequently been integrated into national policy and guidelines for district development. The ISDS model of site facilitation earned many accolades for the successes achieved.

With the wealth of experience and skills gained, ISDS continues to lead and participate in several district development projects with a range of different partner organisations. The end of the EU project has however presented an opportunity to re-examine ISDS’s role and the nature of support needed for district health systems development in the future. It also provides an opportunity to develop new strategies and appropriate skills to meet the challenges of ISDS’s changing role, and in the next year we hope to see this taking shape in HST more clearly.

I would like to thank the Programme Directors, and all HST staff for the critical role they play in enabling HST to achieve its many successes.

The important oversight role of the Board of Trustees of HST is acknowledged, and a special welcome extended to the incoming Chairperson, Patrick Masobe.

The invaluable support provided by HST’s funders is acknowledged and appreciated. In particular we acknowledge the Atlantic Philanthropies who have become a significant contributor to HST’s work over the past year.
Health Systems and Primary Health Care Research

The research programme comprises a core of skilled professionals who participate in research priority setting processes within the country, develop research proposals, undertake research and identify consultants who conduct research and provide project management. Specific areas of focus include district health systems development, primary health care, maternal and child health, PMTCT, reproductive health, TB, HIV/AIDS and STIs.

HST’s major research activities and projects over the last year included:

Prevention of mother-to-child transmission of HIV/AIDS (PMTCT)

Monitoring and Evaluation:
HST has been involved in ongoing monitoring and evaluation of the national PMTCT programme since its inception in 2001 and has provided substantial technical support for the development of guidelines, the development of a research framework and support to provincial PMTCT coordinators in terms of information management and training.

The first formal evaluation of the PMTCT programme was undertaken in 2001 and a report was released in early 2002. A second evaluation that also assessed the expansion of the programme in the provinces, was conducted in late 2003 and resulted in the following two reports.

➣ An Evaluation of the Prevention of Mother-to-Child Transmission (PMTCT) of HIV Initiative in South Africa – Lessons and Key Recommendations (2003-12-03)*

➣ Case Study Reports on Implementation and Expansion of the PMTCT Programme in the Nine Provinces of South Africa (2003-10-31)*

The National PMTCT Cohort Study investigated infant feeding patterns and behaviours of HIV+ and HIV–mothers post-natally. It described and measured the impact of the PMTCT programme on the health of infants born to HIV positive mothers. The study was a collaboration between HST, UWC and the MRC. It will be the first study to determine the effectiveness of nevirapine under routine service conditions. Future studies planned include an intervention study to improve PMTCT uptake and exclusivity of infant feeding practices, and involvement in an multi-country EU funded trial, of peer counsellor support for exclusive breastfeeding (the PROMISE study).

PMTCT Cohort Sub-studies: Two PMTCT Cohort sub-studies were built into the national cohort. These include:
1. An observational study of the quality of ante-natal counselling and education on infant feeding in all three cohort sites.
2. An in-depth sociological study of the factors determining infant feeding behaviour in all three sites which will be completed by June 2005.

PMTCT Capacity Development Tender:
HST is part of a consortium which includes the Women’s Health Project and the University of the Western Cape and which has assisted provinces in developing plans for PMTCT training. As part of this work, the consortium assisted in the development of a PMTCT training manual. The manual, funded by CDC, was field tested in KwaZulu-Natal andMpumalanga and published in October 2003: Tint K, Doherty T, Nkonki L, Witten C, Chopra M. An Evaluation of PMTCT and Infant Feeding Training in Seven Provinces of South Africa.*

* Available from the HST website
http://www.hst.org.za
HIV Mapping

This project involved mapping of HIV/AIDS services and resources in one sub-district in each of the nine provinces. An electronic database has been developed which provides a comprehensive single source of information on the resources, and the utilisation thereof, in each sub-district. It informs managers of the progress and impact of services provided, and provides district managers with a tool to monitor the performance and activities of NGOs active in their districts. The database will be useful for storing information and updating data so that temporal trends can be shown and is linked to the District Health Information System (DHIS). The database involves not only the Department of Health but also the Departments of Education and Social Development.

An Evaluation of Three Home Based Care Programmes

The Research Programme was commissioned by the Nelson Mandela Children's Fund (NMCF) to undertake an in-depth evaluation of three home-based care (HBC) projects, located in KwaZulu-Natal, Limpopo and Mpumalanga. The purpose of the evaluation is to assess the capacity to provide paediatric palliative care and to explore the possibilities of integrating this care and provision of ART to children within the current activities of HBC projects.

The Treatment Monitor

HST's Treatment Monitor supports health systems research related to the provision of antiretroviral treatment (ART) in South Africa. The initial focus of work was to develop a literature review of ARV programmes in southern Africa called 'Providing Antiretroviral Treatment in Southern Africa - A Literature Review'. Available from http://www.hst.org.za/publications/608

The Treatment Monitor dedicated significant resources in providing support to the National Department of Health in developing indicators for the monitoring and evaluation of the 'Comprehensive HIV and AIDS Care, Management and Treatment Programme for South Africa'. It has set out to develop relations with research, delivery and other involved agencies and has maintained a database of ART sites in South Africa since 2003. The data has provided valuable information on aspects of the Operational Plan such as site locations, capacity, information systems, number of patients on treatment and waiting lists and integration of ART with other essential services.

The STI Initiative

The STI programme includes two sets of projects in South Africa:

1. The Public sector work supports several sub-districts around the country working closely with ISDS facilitators and district management teams to assess quality STI care, develop remedial plans to address identified problems and then monitor progress towards improved care.

2. The Private sector initiative works through a Private Sector Consortium consisting of several research and academic institutions, independent practitioners' associations, GPs, policy makers and other regulatory bodies and individuals working in both the public and private sectors. It aims to improve access and quality of STI care in the private sector.

SADC STI Project

This is a new project which undertakes work in improving STI control in cross-border sites and developing a regional policy around STI control. The Canadian International Development Research Centre (IDRC) has also committed funding for HST to undertake work to support the evaluation and improvement of STI services in three countries (Namibia, Botswana and Zambia).

HIV Impulse

This project assessed the care of children with HIV/AIDS in South Africa. The research was undertaken in partnership with the School of Health Systems and Public Health at the University of Pretoria, as well as two European partners.

PHC and District Health Systems Development

HST's most recent National PHC Facilities Survey report was launched in July 2004, and subsequently widely disseminated. The nine provincial reports were completed by November 2004 and circulated to the NDoH and all provincial Heads of Department and are available on the HST website.

Areas covered include a description of facilities, the services provided, human resources, equipment, infrastructure, pharmaceuticals and facility and clinical management.

Can be downloaded from http://www.hst.org.za/publications/617

---

The Local Government in Health Project (LGH)

This project integrated the findings of research which monitored the health decentralisation process in South Africa between 2001 and 2003. The resulting publications were targeted at senior policy makers, health managers, as well as middle managers.

A 16-page booklet, *Decentralising Health Services in South Africa: Constraints and opportunities*, which is a brief summary of the more detailed report was printed and widely disseminated, both the summary and the detailed full report in 8 chapters are available at http://www.hst.org.za/publications/609

Assessing the Impact of Municipal Health Services Policy Decisions on Environmental Health

The National Department of Health, with funding from Danish International Assistance (DANIDA) commissioned a three part project to assess the impact of Municipal Health Services (MHS) policy decisions on the provision of Environmental Health (EH) and Primary Health Care (PHC) services. The project comprised three parts - Part A: a costing of environmental health services in the country undertaken by HST and completed in 2003; Part B: an assessment of the impact of implementing the MHS policy decisions; and Part C: developing measures to monitor equity in health services resource allocation which has been contracted out to the Health economics Unit at UCT.

Understanding the Impact of Decentralisation on Reproductive Health Services (RHD)

The RHD project is a three year study (2003 – 2005) involving four countries, coordinated by the Nuffield Institute for Health, University of Leeds, and funded by the European Union. The research compares different forms of decentralisation in two anglophone (South Africa and Uganda) and two francophone (Burkina Faso and Mali) African countries to assess their impact on the development of reproductive health services. The research methodology is mainly qualitative, with quantitative data from District Health Information Systems, financial systems and human resources. The total budget for the South African component of the research is approximately R 1.5 million.
The Initiative for Sub-District Support (ISDS) was first established in six sites in 1996 to support implementation of the District Health System and has over the past eight years provided direct support to District management teams and staff in more than 20 sites throughout the country. In this last year, the three year European Union project supporting district health development in the 13 rural nodes has ended, highlighting the valuable role ISDS has fulfilled thus far in district health development.

The Integrated Sustainable Rural Development Programme (ISRDP) is a ten-year programme driven from the President’s office emphasising the integration of planning for services. The health component of the ISRDP, the Rural District Health Support Programme (RDHSP), is funded by the European Union and focuses on district health systems development, primary health care and improvement of quality of care.

Part A of the tender was awarded to the Health Systems Trust/ISDS, for the period of October 2001 to October 2004, to assist the district and local municipalities within the thirteen nodal sites to establish relevant management and administration capacity in the delivery of good quality Primary Health Care services.

From 2001 to 2004, ISDS worked with and through management structures at national, provincial, district, sub-district and local level, taking time to build relationships, empower and capacitate different managers and ensure sustainable development.

National and Provincial achievements:

- “HST was an eye opener to us in many ways in the PHC approach”
- “So much has been done by HST . . . particularly in making health care providers (to) buy into transformation”

HST has presented several reviews of the general progress made, challenges and problems being faced as well as some of the solutions to these at the national District Health Systems Committee.

Members of the HST staff were instrumental in assisting the national DoH to produce the publication ‘Guidelines for Functional Integration: A Key Strategy Towards the full implementation of the District Health System’.

Similarly HST provided significant input and assistance to the National Department of Health to produce their publication on service level agreements and also significantly contributed to the National Department of Health’s District Health Planning Guidelines.


HST has played a large role in assisting the provincial Departments of Health to plan, organise and run a number of key workshops/Lekgotlas and has been actively involved in organising provincial and national District Health System conferences. Similarly, HST has run national seminars with national DOH managers of the STI programme.

In KwaZulu-Natal, HST was a key participant in a provincial workshop to implement the District Health Expenditure Reviews (DHERs) in the province and was responsible for DHERs being produced in Ugu, Umzinyathi, Zululand and Umkhanyakude districts.

The use of district planning guidelines has been piloted in Sekhukuneland, Limpopo. These guidelines are now being used in the whole of Limpopo province. The facilitator working in the Western Cape has used experiences in conducting the situation analysis and writing district health plans in the Central Karoo as examples to assist the four other rural districts to undertake similar interventions.

The improvement of quality of care through the use of supervision is one of the areas that received special attention. A national workshop on clinic supervision was jointly organised by HST and the national DoH in March 2004. This has given impetus to all provinces in the institutionalisation of clinic supervision for all districts. These interventions have crossed provincial borders and through HST’s support have been rolled out in the whole of Gauteng and North West supported by funding received from those provinces. Atlantic Philanthropies awarded ISDS a grant of R15 million, to work together with the University of the Western Cape, in the Eastern and Western Cape Provinces, on improving programmes and quality of care in the Eastern Cape and improving the use of information for planning and decision making, in the Western Cape.

**Site Specific Interventions**

Detailed reports of the interventions in the 13 rural districts were widely distributed to all participants at the Rural Health Conference in September 2004 and are available on a CDROM from HST, or on http://www.hst.publications/631

**Lessons Learnt**

The major lessons learnt in the process of this programme based on case studies mainly from the rural health districts are captured in an HST publication entitled *Lessons Learnt in the Implementation of Primary Health Care; Experiences from Health Districts in South Africa.*

“We are clear where we need to focus.

Without the site facilitator we would not know what to focus on. It is very difficult for us to know what to focus on as there are so many demands on us.

The workshop the site facilitator did on prioritising:

the must do:

versus the nice to do:

versus the only thing to do if we are going for the gold standard - was the most useful thing we have ever had.”

---

Community Development

The Community Development Programme, established in 2001, initiates innovative models of community involvement in key areas of male sexuality and integrated nutrition. The programme works by forging partnerships between community based organisations (CBOs) and service providers.

The Integrated Nutrition project, based on the DoH’s INP programme aims at promoting household food security by empowering communities to become self-sufficient in terms of their food and nutritional needs. Over this past year, the programme has moved beyond ‘nutrition’ into development-oriented interventions.

CBOs are the main implementing agents of these interventions. They work in close collaboration with clinic sisters. Currently 11 CBOs, each with 10 volunteers are participating in the INP. Thirty-six demonstration gardens are fully functional and are able to produce both summer and winter vegetables.

Trained volunteers at community bases use ‘Talc scales’, purchased by HST to do growth monitoring of children aged 0-5 years old. Other activities and services from these bases include; nutrition education, prenatal education, information sharing on social grants, condom distribution, communal gardens, home visits and income generating activities.

HST has facilitated the acquisition of communal garden sites, securing letters of allocation from the respective chiefs and has submitted these to the Department of Agriculture, which in turn issues a group certificate of ownership to the community.

Following a baseline assessment of the project, further evaluations will be undertaken to assess progress as well as to document important lessons.

In March 2004 the project received a silver award for the Integrated Nutrition Project from the Impumelelo Innovations Trust as recognition for its contribution to improving the health status of communities through the household food security programme.

The O R Tambo District has also provided HST substantial support for infrastructure development and promotion of homestead gardens.

The Male Sexuality Project encourages and supports the growth of a social movement which aims to promote male involvement in sexual and reproductive health with the view of mitigating the impact of the HIV/AIDS epidemic. The project also aims to develop a community empowerment model that is sustainable and strengthens the capabilities of communities to fight violence against women and children.

Current sites of programme implementation (Local Service Areas) include Jozini, Umhlabuyalingana, Umjindini, Nkomazi and Winterveldt.

HST supports CBOs in these sites to work closely with school nurses and guidance teachers and to conduct focus group discussions in schools. This School Based Peer Education Programme is aimed at training a few students in sexuality education to become peer educators, both in the school and in their communities.
Two male Imbizos (gathering of males) were hosted this year in KwaZulu-Natal and Mpumalanga by the project in partnership with other stakeholders.

Volunteers have improved access to condoms by setting up fifty-four community based condom distribution points at community level which they regularly supply with condoms.

HST facilitators and officers from the Department of Social Development and Welfare conducted workshops to train CBOs and volunteers on the guidelines for accessing social grants for the deserving.

The male sexuality project works closely with MEN IN PARTNERSHIP AGAINST AIDS (MIPAA), which is a government initiative promoting the involvement of men in HIV/AIDS initiatives. It has also recently built a partnership with the Africa Regional Sexual Resource Centre (ARSRC), an organisation which aims to build regional networks in the field of sexuality and reproductive health. HST is one of four regional partners responsible for coordinating their reproductive health interventions in southern Africa.
Equity, Advocacy, and Information Dissemination

Equity and Advocacy

The Equity Gauge Project has undertaken activities within all three pillars including monitoring and assessment, advocacy and community empowerment. The South Africa Gauge (SAfEG) has built a strong local team with diverse skills in key aspects of its work, and has strengthened its community empowerment activities and its advocacy targets to extend beyond parliamentarians to other stakeholders in civil society. It has also funded primary data collection in support of the goal of achieving equitable financing in the context of decentralisation of health care.

In response to needs expressed by the Zambian Gauge, an exchange visit in which Zambian members of the Health Portfolio committee met with their South African counterparts was organised and interaction between the two Gauges is ongoing.

The SAfEG played an important role in building regional support for health equity, through its lead role in the Programme on Parliamentary Alliances for Health Equity in coordination with GEGA and EQUINET, and in co-hosting (with GEGA and EQUINET) the 2004 International Society for Equity in Health (ISEqH) conference in Durban in June.

The SAfEG launched its publication ‘The Second Equity Gauge: Monitoring health - the role of socio-economic factors’ at the ISeQH conference. The publication is aimed primarily at assisting national and provincial legislators, councillors and civil society to understand and monitor socio-economic policies and measure their impact on equity in health.

Community Empowerment

In early 2003, the SAfEG commenced pilot work with two communities (Chesterville and Cato Manor) in the greater Durban area. The aim of these interventions was to assist health care users to interact with their local clinics and to facilitate the development of structures that enable the community to monitor their access to, and quality of care.

The HIV Gauge

As part of community empowerment, work has begun on an HIV Gauge project with communities and clinic committees in two sites: Sterkspruit and Umlazi.

The idea behind the project is to provide information and support around HIV/AIDS, in particular the Operational Plan, and to enable communities to monitor their availability and access to HIV/AIDS related services. The HIV Gauge will monitor access to HIV services including VCT, PMTCT and ARVs. In response to Community needs, the SAfEG has prepared plain language versions of the Operational Plan in English, Zulu and Xhosa and a brief literature review on existing models of community participation in ARV rollout programmes.

Global Public Private Initiatives

In August 2003, the Equity Gauge entered into a contract with the WEMOS foundation to carry out a case study into the impact of a specific Global Public Private Partnership (GPPI) in South Africa. The case study was part of a multi-country study funded by WEMOS, which sought to augment the existing body of knowledge around Global Public Private Initiatives in health.

4 The Operational Plan For Comprehensive HIV and AIDS Care, Management and Treatment in South Africa National Department of Health http://www.doh.gov.za
**GEGA**

The Global Equity Gauge Alliance includes 11 member teams, called Equity Gauges, located in 10 countries in the Americas, Africa and Asia. The Secretariat is located in Health Systems Trust, Durban, South Africa.

The function of the GEGA secretariat is to provide support to country level Gauges and contribute to the move for equity at the global level through advocacy and capacity development initiatives. To this end GEGA has developed and piloted a short course, ‘Health Equity – Research to Action’.

The Global Health Equity Watch, an emerging initiative in cooperation with the People’s Health Movement and MedAct, intends to provide a critique of the global and regional processes that contribute to health inequities, and what might done about them. The publication, intended primarily as a resource for civil society and due to be launched in mid 2005, will provide a global reflection on a range of issues that impact on health equity both within and between countries.

**Information Dissemination**

The South African Health Review 2003/04 and the National Primary Health Care Facility Survey 2003 were launched in Cape Town in July 2004. After ten years of democracy the 9th edition of the SAHR aims to measure how far the health system has moved towards providing equitable health services to all citizens. It uses different sources of information to measure and assess the health and well-being of South Africans quantitatively and can be accessed and downloaded chapter by chapter at [http://www.hst.org.za/publications/423](http://www.hst.org.za/publications/423). See section on Publications for a full list of the publications and reports published in 2003/04.

**HST Website**

HST’s website was developed in house at a fairly early stage in the organisation’s history. The revamp of the website, which has been developed in conjunction with web specialists, was completed and launched in June 2004. The new ‘architecture’ of the site means that the technology is now up to date, and enables HST to utilise the appropriate functions required for electronic information dissemination activities. The new web site hosts amongst other things the latest informative news articles, the HealthLink Bulletin, details on each of the HST programmes and projects, e-discussion groups, Events, Links, job opportunities, and public health related publications and health statistics.

**Indicators Database**

HST’s online indicators database provides the health statistical data which feeds into the South African Health Review. The data is updated on a regular basis and has the potential to contribute significantly to providing a wide range of information in an accessible and usable format. The information is easily accessible nationally and by provinces, for planning purposes as well as for monitoring equity. In future the database will be expanded to include municipal level data aggregated by for example, socio-economic status and to display district health indicators.
During this year professional staff have shared the practical experience and developments around PHC and district development and systems like health information and drug supply management at both undergraduate (medical schools) and post graduate level (MPH programmes) across the country. In addition they have provided CPD accredited programmes like TB in continuing education sessions, have done extensive training, attended and presented at numerous conferences and have run various workshops on aspects such as clinic supervision.

**National Primary Health Care Conference – Celebrating the Alma Ata 1978-2003, August 2003**

Zondi T. Factors influencing burnout amongst PHC Nurses in Gauteng Province.

Shezi S. Empowering Communities to Access their Health Rights: Lessons from a partnership between the Health Systems Trust and the communities of KwaZulu-Natal, South Africa.

**HIV Symposium University of the Witwatersrand, Johannesburg August 2003.**

Barron P. Scaling up access to anti-retroviral (ARV) therapy in South Africa.

**ICASA Conference – Nairobi Kenya, 21-26 September 2003.**


**HELINA Conference, Johannesburg, October 2003**


**23 Conference on Priorities in Perinatal Care in Southern Africa, March 2004**

Hall W. Decentralisation of Health Services and Reproductive Health – Seeking the link.

**XV International AIDS Conference, Bangkok, Thailand 2004**


Buch E, Mathambo V, Ferrinho P, Kolsteren P, van Leberghe W. The gap between the national guidelines for PMTCT and care received at a regional hospital in South Africa.*

Doherty T. Measuring the effectiveness of PMTCT training initiatives.

Doherty T. Improving the coverage of a nevirapine-based PMTCT programme in South Africa.


**International Union of Health Promotion and Education Conference, Melbourne, Australia, April 2004**

Ntuli A. The Brain Drain: A real Tale of Development and AID.

Ntuli A. The Global Equity Gauge Alliance: Critical Directions.

* Poster
HST and EQUINET Workshop on Human Resources for Health, Johannesburg, April 2004


EQUINET Conference, Durban, June 2004


International Society for Equity in Health, Durban, June 2004

Ntuli A. Measuring the Cup: Half Full or Half Empty.

Leon N. Classen J. The District Health Expenditure Review as a tool for improving District Health Planning.

Conference on Social Aspects of HIV/AIDS Research, May 2004


Stewart R. Scaling Up Antiretroviral Treatment in South Africa: Have we learnt from past initiatives?

Public Health Conference, June 2004

Stewart R. Scaling Up Antiretroviral Treatment in South Africa: Have we learnt from past initiatives? – An Update.

The Valley Trust’s 50th Anniversary Conference – Primary Health Care Learning from the Past Looking to the Future, Durban, July 2004

Shezi S. Strengthening Community Participation in Health – Lessons from a partnership between the HST and the community of Chesterville, Durban.

Baez C. Striving for Outstanding Quality of Care: An Intervention by the Health Systems Trust in collaboration with the Lejweleputswa District.


Barron P. Scaling up the use of antiretrovirals in the public sector: what are the challenges? Mail and Guardian Newspaper, 14 August 2003.


Publications

Publications and reports published and funded by HST, 2003/04 freely downloadable from www.hst.org/publications

Equity

The Second Equity Gauge – Monitoring Fairness in Access to Basic Services Essential for Health*
Khosa S, Ntuli A, Padarath A.

The second Equity Gauge seeks to place the goal of equitable health care within a broader framework that links socio-economic disparities with health outcomes. This publication highlights the fact that people do not get sick at random and that health is intimately tied up with living and working conditions.

HIV/AIDS

Governmental Relationships and HIV/AIDS Service Delivery
Blaauw D, Gilson L, Modiba P, Erasmus E, Khumalo G, Schneider H.

This research project examined inter-governmental relations in the health sector in South Africa. It focused on HIV/AIDS services but the intention was to use HIV/AIDS as a tracer or probe of broader health system functioning.

* Publications authored by HST
Providing Antiretroviral Treatment in Southern Africa – A Literature Review*  
Stewart R, Padarath A, Bamford L.

This report outlines experience with ART in a number of sub-Saharan countries. ART is provided through a number of different avenues, which include the public sector, the non-profit sector, the corporate sector and the private sector.

HST Submission to the National Task Team Charged with Developing Treatment Options to Supplement Comprehensive Care or HIV/AIDS in the Public Sector*  
HST.

HST provided input to the National Task Team on a selection of the Terms of Reference, based on its experience with research, implementation and information, communication and advocacy.

Health Sector Responses to HIV/AIDS and treatment access in southern Africa: Addressing equity  
McCoy D.

This report discusses a set of complex, inter-connecting issues related to the moral imperative to increase access to HIV care and treatment in southern Africa, with a particular focus on antiretroviral therapy (ART).

Cost-Effectiveness of Antiretroviral Treatment for HIV-Positive Adults in a South African Township  
Cleary S, Boule A, McIntyre D, Coetzee D.

This report is the product of research into the cost-effectiveness and cost-utility of treatment for HIV-positive adults. The research was conducted in three HIV-dedicated clinics in Khayelitsha, a township on the outskirts of Cape Town.

District Health and Primary Health Care

Cape Town TB Control – Progress Report 1997-2003  
Azeveda V, Caldwell J.

The Cape Town Metro TB progress report documents the progress made in the TB Control programme in the last 6 years, from 1997 to 2003. The focus of the report is on the TB programme performance indicators, but it also addresses issues of monitoring and quality assurance, the cost of TB Treatment and TB and HIV/AIDS/STI integration.

Primary Health Care Financing and Need Across Health Districts in South Africa  
Thomas S, Mbatsha S, Muirhead D, Okorafor O.

This report explores this issue by evaluating the funding of non-hospital PHC services, within the decentralised South African system, against indicators of need.

The National Primary Health Care Facilities Survey 2003  
Reagon G, Irlam J, Levin J.

The 2003 PHC Facility Survey (like earlier surveys undertaken in 1997, 1998 and 2000), contributes to this endeavour by describing the status of South Africa’s PHC services.

* Publications authored by HST
The Provision and use of Progestogen-only Contraceptives amongst Antenatal and Postpartum Women in a Rural area in the Eastern Cape*
Hani A.

The National Contraceptive Policy Guidelines, published subsequent to this study, have been amended from the original draft and recommend that women be given a choice about the timing of post-partum POC (progestogen-only contraceptives) initiation, after appropriate counselling.

Key Issues in Clinic Functioning: A case study of two clinics
Couper I, Tumbo J, Hugo J, Harvey B, Malete N.

An in-depth case study was done looking at two primary care clinics serving the same community. One clinic is a typical government-funded public sector clinic offering a comprehensive 24-hour service the other is an NGO-funded day clinic offering a range of primary care services. The aim of the research was to understand and explore key issues in the functioning of the two clinics, in order to draw out lessons for district management teams.

The role of ISDS in the Rural District Health Support Programme (RDHSP)
ISDS*

The health component of the ISRDP, the Rural District Health Support Programme (RDHSP), funded by the European Union in terms of tender RT 1397 GP, focuses on district health systems development, primary health care and improvement of quality of care. The District Health System (DHS) is the vehicle for the delivery of Primary Health Care (PHC).

Lessons Learnt in the Implementation of Primary Health Care - Experiences from health districts in South Africa*
Barron P, Monticelli F, Leon N. [eds]

The Initiative for Sub-district Support (ISDS) has grappled with the dilemma of improving the technical aspects of primary health care delivery, whilst at the same time balancing this with a developmental approach that capacitates local staff. This document is evidence of the success achieved by ISDS in this balancing act.

Prevention of Mother-to-Child Transmission of HIV/AIDS

An Evaluation of the Quality of Counselling Provided to Mothers in Three PMTCT Pilot Sites in South Africa*
Chopra M, Jackson D, Ashworth A, Doherty T.

This study assessed the quality of counselling provided to mothers through the programme to prevent mother-to-child transmission (PMTCT) of HIV in South Africa.

The Prevention of Mother-to-Child HIV Transmission - Costing the Service in Four Sites in South Africa
Desmond C, Franklin L, Steinberg M.

Data from this research were fed back to the Directorates of Financing and HIV/AIDS as soon as they became available at the end of 2002. Some of these data have already been used to inform government plans and budgets. This report is now being released to the broader public in order to help raise general awareness about the value and limitations of costing studies, and also because some of the findings have on-going relevance to current PMTCT services and provision of antiretroviral therapy (ART) on a large scale.

* Publications authored by HST
Bacterial Contamination and Nutrient Concentration of Infant Milk in South Africa: A Sub-study of the National PMTCT Cohort Study
Bergstrom E.

The aim of this study was to assess how mothers in an urban/peri-urban PMTCT area of South Africa prepare and feed commercial infant milk to their infants and to assess the safety of these feeds. The objectives were to describe the methods of preparation of commercial infant milk and to measure bacterial contamination and protein concentration in these feeds.

Infant Feeding Practices in KwaZulu-Natal - An exploratory study of current infant feeding practices of mothers with 0-6 month old infants attending PMTCT and non-PMTCT clinics in Central Durban*
Kassier S, Maunder E, Senekal M, Doherty T.

The aim of this study was to determine and compare the current infant feeding practices and some of the factors that influence these practices of Zulu mothers with 0 - 6 month old infants attending PMTCT and non-PMTCT clinics in Central Durban, KwaZulu-Natal.

An Evaluation of PMTCT and Infant Feeding Training in Seven Provinces of South Africa*
Tint K, Doherty T, Nkonki L, Witten C, Chopra M.

This report presents the results of the evaluation of the PMTCT and Infant Feeding Training carried out in seven provinces, namely Gauteng, Free State, Mpumalanga, North West, Limpopo, Eastern Cape and Northern Cape between July and September 2003.

An Evaluation of the Prevention of Mother-to-Child Transmission (PMTCT) of HIV Initiative in South Africa - Lessons and Key Recommendations
Doherty T, Besser M, Donohue S, Kamoga N, Stoops N, Williamson L, Visser R.

This second and final evaluation report on the PMTCT pilot sites builds on the report in February 2002 which covered the period January to December 2001, and describes progress made between January and December 2002 in the same 18 pilot sites. This study forms part of the national research framework for the PMTCT programme, and reference is made in sections of the report to work conducted in other components of the overall PMTCT research.

Case Study Reports on Implementation and Expansion of the PMTCT Programme in the Nine Provinces of South Africa*
Doherty T, Besser M, Donohue S, Kamoga N, Stoops N, Williamson L, Visser R.

This report presents progress in each of the nine provinces during the second year of the pilot programme, over the period January to December 2002. The provincial case studies document experiences and key challenges associated with the pilot sites, and initial attempts to expand this programme beyond the pilot sites.

District municipalities/municipal health services

Financing Environmental Health Services in South Africa*
Haynes R.

A Primary Health Care Financing Task Team (including representatives from the national and provincial Departments of Health, National Treasury, and Department of Provincial and Local Government) identified the need for data on the costs of delivering EHS in South Africa. Health Systems Trust was commissioned to conduct the costing exercise with funding from the Danish Embassy.

* Publications authored by HST
General

**South African Health Review 2003/04**

This 2003/04 SAHR, the 9th edition, consists of an overview and 24 chapters, each describing a key health concern. Unlike many of the previous Reviews, this year's is data driven. It uses different sources of information to measure and assess the health and well-being of South Africans quantitatively over the last ten years.

**How to Write a Research Proposal for Health Systems Trust**
HST.

The Health Systems Trust (HST) considers proposals to decide whether or not to fund certain projects. These are guidelines from HST on what is required in a research proposal.

**Health Research Capacity Building in South Africa: Current knowledge and practices**
Magwaza S, Mathambo V, Magongo B, Kortenbout E, Mvo N, Makhanya N.

This review describes the current experiences of capacity building in health research in South Africa by identifying recent interventions from which lessons can be drawn to inform and support the ENHR Committee in strengthening and implementing the health research policy for South Africa.

Local Government and Health

**Decentralising Health Services in South Africa: Constraints and opportunities**
LGH Consortium

This report integrates the findings of a project monitoring the health decentralisation process in South Africa between 2001 and 2003. It is targeted at senior policy makers and health managers, although the report is also intended to offer middle managers insights into the situation.

**Rapid Appraisal of the Health Content of Selected Municipal Integrated Development Plans**
Moodaley, R.

The Health Systems Trust commissioned a study to review the Integrated Development Plans (IDPs) from selected municipalities in South Africa's nine provinces. The study assessed the quantity and content of health-related information in the IDPs and the involvement of the provincial and local health officials in the IDP process.

**Public-Private Interactions in the South African Health Sector: Experience and Perspectives from National, Provincial and Local Levels**
Wadde, Haroon, Gilson L, Blaauw D, Erasmus E, Mills A.

This report is an introductory analysis and overview of Public-Private Interactions (PPIs) in the South African health system. It forms part of a broader programme of work looking at decentralisation and health.

*Publications authored by HST*
Staff

David Mametja - EXECUTIVE DIRECTOR
Lilian Dudley - MANAGING DIRECTOR
Antoinette Ntuli - DIRECTOR
Lesley Banford - DIRECTOR
Nomonde Bam - DIRECTOR
Nomusa Mmope - ASSOCIATE DIRECTOR
Peter Barron - DIRECTOR
Jaine Roberts - DEPUTY DIRECTOR
Petrida Ijumba - DEPUTY DIRECTOR
Sarah Davids - DEPUTY DIRECTOR
Nandy Mothibe - DEPUTY DIRECTOR

Durban
Alexandra Bambas
Alfred Mafuleka
Ashnie Padarath
Candy Day
Dawn McDonald
Deena Govender
Delene Tissong
Duduzile Zondi
Farana Khan
Fazila Khan
Florencia Monticelli
Halima Hoosen
Hendrick Lushaba
Hlengwe Mhlongo
Jonathan McKeown
Jurie Thaver
Khululwe Mfayela
Khuphukile Nyawose
Mahommed-Hoosen Imam
Mamra Ntsike
Mzikazi Masuku
Naomi Massyn
Noluthando Ford-Ngomane
Nunu Gumede
Qamar Mahmood
Quintin Dreyer
Rachael James
Rakshika Bhana
Robert Stewart
Ruth Grobler
Sabine Verkuijl
Sakhiwo Nombrambe
Sizwe Shezi
Solani Khosa
Vuyiswa Mathambo
Yolisa Sithela

Johannesburg
Abdul Elgoni
Carmen Baez

Cape Town Office
Julia Elliot
Lungiswa Nkonki
Mercia Kuhn
Natalie Leon
Rita Sonko
Rosheen Seale
Tanya Doherty

Pietermaritzburg
Marian Loveday
Ross Haynes
Wendy Hall

Interns
Vareshni Moonsamy
Hlengwe Gumede
Sophie Donnellan
David Barr
Lee Berthiaume
Patrick Masobe, the CEO of the Council of Medical Schemes was elected as the new Chairperson of the HST Board. He will be assisted by Barry Kistnasamy (Dean, Nelson Mandela Medical School at University of KwaZulu-Natal) as first deputy chairperson and Jeanette Hunter (Chief Director in the Department of Health in the Northwest Province). Yogan Pillay joins the Board as the formal liaison between the HST and the Department of Health.

**Patrick Masobe Chairperson** currently Chief Executive Officer of the Council for Medical Schemes. Patrick is an economist and has published widely on financing of hospitals, contracting of health services public/private mix in health care, and the economics of HIV/AIDS. He led the departmental team that drafted the new Medical Schemes Act Act 131 of 1998), and its subsequent regulations.

**Barry Kistnasamy Deputy Chairperson** Professor and Dean of Nelson Mandela School of Medicine, University of Natal and is also a specialist in Community Health with further training in Occupational Health. He brings to HST valuable experience through his involvement with health system transformation over the last 15 years.

**Jeanette Hunter Deputy Chairperson** Director Knowledge Management in the North West Province Department of Health as well as guest lecturer in Health Information Management at WITS and University of the Free State. Jeanette brings to the Board wide experience in Policy & Planning, Communication and Health Information.

**Ayanda Ntsaluba** Director-General of the Department of Foreign Affairs since September 2003. He has held various posts including that of Deputy Director-General for Policy and Planning in the national Department of Health and in 1998 was appointed Director-General of Health. He also chaired the Steering Committee of the South African AIDS Vaccine Initiative and served as a member of one of the Working Groups of the World Health Organization Commission on Macro-Economics and Health.

**Craig Househam** Head of the Department of Health in the Western Cape. He was Head of the Free State Department of Health for six years and also Head of the Department of Pediatrics and Child Health at the University of the Orange Free State for six years. Craig brings to the HST Board wide experience in health management, human resource development and clinical practice and research.

**David Serwadda** Director of the Institute of Public Health at Makerere University, Uganda. He is also an Associate Professor at the University. David’s expertise is in the fields of epidemiology, evaluation of health intervention and disease surveillance, whilst his specialty is infectious disease. He is a member of the Uganda Medical Association, New York Academy of Sciences and the International Epidemiological Association amongst others.

**Eric Buch** is Professor of Health Policy and Management in the School of Health Systems and Public Health at the University of Pretoria. He is a registered specialist in Community Health with wide experience in health policy and management, the South African health system and primary health care.

**Loretta Jacobus** member of the NCOP and also serves as a member of the Select Committee on Education. Loretta has a Diploma in Social Welfare and has worked for NUMSA and the Macro Economic Research Group. She has a strong political background and is still an active member of the Johannesburg East ANC branch.

**Sagie Pillay** Chief executive Officer of Johannesburg Academic Hospital. Sagie has worked for the National Health Department programme on Hospital Management and Decentralisation. He has extensive consulting experience in several African countries as well as in hospital management, policy and planning.

**Seadimo Chaba** Chief Executive Officer of Snyman & Vennote (Pty) Ltd, previously employed by the Gauteng Provincial Government as the Executive Manager for Public Works and Management Services. Seadimo has past experience in General Management and Human Resources Management both in the Private and Public Sectors. She has worked in the retail and chemical industries and for government. And has been an internal consultant in the areas of Organisation Development, Human Resources Development, Affirmative Action and Labour Relations.

**Yogan Pillay** Chief Director: Strategic Planning in the National Department of Health. Yogan Pillay was previously National Manager of the Equity Project for 3 years. Prior to this Director: Systems Development and Policy Coordination in the National Department of Health. He is a clinical psychologist and holds a doctorate in public health as well as qualifications in management.
Grants and Acknowledgements

<table>
<thead>
<tr>
<th>Programme</th>
<th>No of grants made</th>
<th>Value (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISDS</td>
<td>4</td>
<td>503 894</td>
</tr>
<tr>
<td>HealthLink</td>
<td>12</td>
<td>2 860 540</td>
</tr>
<tr>
<td>Community Development</td>
<td>22</td>
<td>2 045 376</td>
</tr>
<tr>
<td>Research</td>
<td>12</td>
<td>4 089 449</td>
</tr>
<tr>
<td>Business Development Unit</td>
<td>5</td>
<td>965 046</td>
</tr>
</tbody>
</table>

Acknowledgements HST Board and Advisory Committees

Executive Committee
- Patrick Masobe – Chairperson
- Barry Kistnasamy – 1st Vice Chairperson
- Jeanette Hunter – 2nd Vice Chairperson
- David Mametja – ex officio
- Lilian Dudley – ex officio

Research Sub-Committee members
- Craig Househam (Chair)
- Eric Buch

ISDS Sub-Committee
- Patrick Masobe (Chair)
- Louis Claasens
- Elise Leverdal
- Nelly Manzini

Eric Buch
- Thobekile Mjekevu
- David Power
- Yogan Pillay
- Steven Hendricks
- Shadrack Shuping
- Bennett Asia
- Refik Basmillah

SAHR Editorial Committee
- David Sanders
- Andy Gray
- Daisy Mahubelu
- Eric Buch
- Gugu Gumede
- Craig Househam

Lindwe Makubalo
- Steve Reid
- Yogan Pillay

Finance Sub-Committee
- Barry Kistnasamy (Chair)
- Patrick Masobe

Audit Sub-Committee
- Selva Govindsamy (Chair)
- Craig Househam
- Patrick Masobe

Personnel Sub-Committee
- Peta Qubeka (Chair)
- Jeanette Hunter
- Zola Njongwe

HST and loveLife Relationship

The HST participated in the formation of loveLife, since its inception in 1999 (then called Nashi). In addition to playing a key role in the formulation of loveLife, HST played a critical role as the “legal persona” for loveLife. With the expansion of loveLife, it has become impossible for the HST to provide the direct oversight and governance support required. As a result, the HST Board of Trustees has recommended to loveLife that it establish its own Board to deal with governance matters that were placed on the HST. This means that the HST will cease to be a formal partner of loveLife as soon as the loveLife Board has been established.
The 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 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 received 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 trustees believe that all representations made to the independent auditors during their audit were valid and appropriate. PricewaterhouseCoopers Inc. audit report is presented on the following pages.

The financial statements were approved by the board of trustees and are signed on its behalf.
TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

CORPORATE GOVERNANCE STATEMENT

for the year ended 30 June 2004

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 four times during the 2004 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; and
◆ Compliance with the trust’s code of ethics.

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

Selva Govindsamy (External Member and Chairperson)
Craig Househam
Patrick Masobe

The audit committee addressed its responsibilities properly in terms of the charter during the 2004 financial year. No changes to the charter were adopted during the 2004 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 2004, and of the results of its operations, changes in equivalents and cash flows for the period ended then, in accordance with statements of Generally Accepted Accounting Practice (GAAP) and the Trust Deed.
Personnel Committee

The personnel committee advises the Board of human resources and other personnel related policies including remuneration packages, and other terms of employment for senior executives. Its specific terms of reference also include recommendations to the Board on matters relating, inter alia, to general staff policy remuneration, bonuses, executive remuneration, trustees remuneration and fees and service contracts. Wherever necessary, the committee is advised by independent professional advisers. The committee met three times during the 2004 financial year.

The personnel committee consists of the following non-executive trustees: Peta Qubeka and Zola Ngongwe.

Executive Management

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

Risk management and internal control

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

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

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

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

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

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

Accordingly, even an effective internal control system can provide only reasonable assurance with respect to financial statement preparation and the safeguarding of assets. Furthermore, the effectiveness of an internal control system can change with circumstances.

A documented and tested business continuity plan exists to ensure the continuity of business-critical activities.

The trust assessed its internal control system as at 30 June 2004 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 2004, 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 audit manager, reports to the executive management 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 Statements of Generally Acceptable Accounting Practice in South Africa. In this regard, trustees shoulder responsibility for preparing financial statements that fairly present:

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

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

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

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

The audit committee set principles that were considered and accepted by the stakeholders for using external auditors for non-audit services.
We have audited the annual financial statements of the Trust for Health Systems Planning and Development set out on the following pages for the year ended 30 June 2004. These financial statements are the responsibility of the trustees. Our responsibility is to express an opinion on these financial statements based on our audit.

Scope

We conducted our audit in accordance with statements of South African Auditing Standards. Those standards require that we plan and perform the audit to obtain reasonable assurance that the financial statements are free of material misstatement. An audit includes:

- examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements,
- assessing the accounting principles used and significant estimates made by management, and
- evaluating the overall financial statement presentation.

We believe that our audit provides a reasonable basis for our opinion.

Qualification

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

Qualified audit opinion

The financial statements fairly present in all material respects, the financial position of the trust at 30 June 2004, and the results of its operations and cash flow information 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.

Supplementary information

The supplementary information set out on the following pages does not form part of the annual financial statements and is presented solely for information purposes. We have not audited this information and accordingly we do not express an opinion on them.
The trustees present their annual report, which forms part of the audited financial statements of the trust for the year ended 30 June 2004.

1 General review

The Health Systems Trust 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 11 to 24 in the attached financial statements.

2.2 As set out in the annual financial statements, the trust has incurred a net deficit for the year of R16,084,412 (2003: deficit R12,135,367).

As a result the trustees have implemented steps to maintain the annual spending of the trust below the level of grants received for the respective period to ensure the financial soundness of the trust. At the date of issue of the financial statements the trust has secured grant income of R153,230,766 for the 2005 financial year with possible further grants receivable totalling R69,230,722.

For the forthcoming 2005 financial year the trust has budgeted a net surplus in excess of R10,000,000 based upon steps to reduce spending. The trustees will continue to monitor the performance of the trust and if required implement remedial action to ensure the continued financial soundness of the trust.

2.3 During the course of the year it has come to the attention of the trustees that certain grantees of Lovelife, a division of the trust did not comply with all the financial controls required by the trust. The trustees are in the process of implementing corrective measures to ensure that all grantees comply with adequate and effective financial procedures and controls.

3 Trustees

The following served as trustees during the current year:

E Buch H Manzini
C Househam P Masobe
J Hunter Z Njongwe (Chairperson)
L Jacobus P Qubeka
B Kistnasamy T Sibeko
A Ntsaluba S Pillay
S Chaba

The following trustees were appointed during the year under review:

A Ntsaluba S Pillay
S Chaba

4 Material events after year end

4.1 Subsequent to the year-end, Lovelife, a division of the Trust for Health Systems Planning and Development, entered into an agreement to purchase property situated at 48 Wierda Road West, Sandton and described as Remaining Extent of Erf 5 Wierda Valley Township, Registration Division IR, Province of Gauteng, in extent 3 974 m², for R12,000,000 (refer note 15). This agreement is subject to the condition that a loan can be raised from a financial institution for an amount of R3,000,000. The balance of the purchase price will be financed from the sale of the property situated at 174 Oxford Road, Johannesburg and a guarantee amounting to R6,000,000 from a third party.

4.2 With effect from 31 December 2004 all the activities as well as all assets and all or any liabilities, presently existing or which may arise in future, of Lovelife, a division of the Trust for Health Systems Planning and Development, were transferred into a separate legal entity, The Lovelife Trust.

No other 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.

5 Auditors

PricewaterhouseCoopers Inc. will continue in office.
BALANCE SHEET
as at 30 June 2004

<table>
<thead>
<tr>
<th>Notes</th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
</tbody>
</table>

**ASSETS**

**Non-current assets**

Property, plant and equipment 7 8,891,702 9,896,965

**Current assets**

Receivables and prepayments 8 24,917,161 10,804,658
Cash and cash equivalents 9 14,241,539 23,399,965

**Total assets** 48,050,402 44,101,588

**EQUITY AND LIABILITIES**

**Capital and reserves**

Trust capital and accumulated surplus funds 12,961,021 29,045,433

**Current liabilities**

Trade and other payables 10 33,198,870 13,132,444
Short term borrowings 11 109,770 524,278
Provisions 12 1,780,741 1,399,433

**Total equity and liabilities** 48,050,402 44,101,588

---

INCOME STATEMENT

for the year ended 30 June 2004

<table>
<thead>
<tr>
<th>Notes</th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
</tbody>
</table>

**Grant income** 3 196,377,461 278,076,617
Other income 10,401,808 3,045,011
Refunded project expenses 347,360 2,024,000
Project expenses (152,041,839) (200,895,140)
Grants paid (65,017,537) (93,028,653)
Administration expenses (7,053,350) (5,693,624)

**Deficit funds** 2 (16,886,097) (16,471,789)
Net finance income 5 901,685 4,336,422

**Deficit funds before tax** (16,884,412) (12,135,367)
Tax 6 - -

**Deficit funds for the year** (16,884,412) (12,135,367)

---

STATEMENT OF CHANGES IN EQUITY

for the year ended 30 June 2004

<table>
<thead>
<tr>
<th>Notes</th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
</tbody>
</table>

**Trust capital and accumulated surplus funds**

At beginning of year

Research 11,884,436 10,248,030
Initiative for sub-district support (ISDS) as previously stated 2,006,809 8,516,456
Transferred to Community Development - (2,890,959)

Initiative for sub-district support (ISDS) restated 2,006,809 5,625,497
Community Development (412,557) 2,890,959
Healthlink (755,035) 2,133,290
Central Administration (CORE) (136,123) 963,138
Lovelife as restated 16,457,903 19,319,886

Net (deficit)/surplus funds for the year

Research (2,262,962) 1,636,406
Initiative for sub-district support (ISDS) (1,413,463) (3,618,688)
Community Development 2,267,670 (3,303,516)
Healthlink 2,613,033 (2,888,325)
Central Administration (CORE) 455,780 (1,099,261)
Lovelife (17,744,470) (2,861,983)

At end of year

Research (16,084,412) (12,135,367)
Initiative for sub-district support (ISDS) 593,346 2,006,809
Community Development 1,855,113 (412,557)
Healthlink 1,857,998 (755,035)
Central Administration (CORE) 319,657 (136,123)
Lovelife (1,286,567) 16,457,903

29,045,433 12,961,021
CASH FLOW STATEMENT  
for the year ended 30 June 2004

<table>
<thead>
<tr>
<th>Notes</th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
</tbody>
</table>

Cash flows from operating activities

- Cash receipts from grants: 178,842,581
- Cash paid to suppliers and employees: 186,892,594
- Cash used in operations: 8,050,013
- Net finance income: 901,685
- Net cash used in operating activities: 7,148,328

Cash flows from investment activities

- Proceeds from disposal of property, plant and equipment: 71,647
- Acquisition of property, plant and equipment: 1,667,237
- Net cash used in investment activities: 1,595,590

Net decrease in cash and cash equivalents: 8,743,918

Cash and cash equivalents at beginning of year: 22,875,687

Cash and cash equivalents at end of year: 14,131,769

NOTES TO THE FINANCIAL STATEMENTS  
for the year ended 30 June 2004

1. Basis of preparation
The annual financial statements are prepared on the historical cost basis. The following are the principal accounting policies used by the Trust, which are consistent with those of the previous year and which comply with Statements of Generally Accepted Accounting Practice in South Africa.

1.1 Property, plant and equipment
All property, plant and equipment are included at cost. Cost includes all costs directly attributable to bringing the assets to working condition for their intended use. Depreciation is recorded by a charge to income computed on a straight-line basis so as to write off the cost of the assets over their expected useful lives. The expected useful lives are as follows:
- Motor vehicles: 4 years
- Computer equipment: 4 years
- Computer software: 2 years
- Furniture and fittings: 6.667 years
- Property: 50 years

1.2 Receivables
Receivables consisting mainly of amounts to be reimbursed by funders, are carried at anticipated realisable value. An estimate is made for doubtful receivables based on a review of all outstanding amounts at the year-end. Bad debts are written off during the year in which they are identified.

1.3 Cash and cash equivalents
For the purpose of the cash flow statement, cash and cash equivalents comprise of cash on hand and deposits held at call with banks, net of bank overdrafts. For the purpose of the balance sheet bank overdrafts are included under short term borrowings.

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

1.5 Revenue recognition
Income from donations and grants, including capital grants, is included in incoming resources when these are received except as follows:
- When related costs, which grants are intended to compensate, have been deferred to future accounting
periods in terms of the conditions specified by the donors, the income is also deferred until those periods. When donors impose conditions which have to be fulfilled before the Trust becomes entitled to use such income, the income is deferred and not included in incoming resources until the pre-conditions for use have been met.

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

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

Interest income - as it accrues

1.6 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.

1.7 Provisions
Provisions are recognised when the company has a present legal or constructive obligation as a result of past events, it is probable that an outflow of resources embodying economic benefits will be required to settle the obligation, and a reliable estimate of the amount of the obligation can be made.

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

1.8 Financial instruments
1.8.1 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
The trust's income and operating cash flows are substantially independent of the changes in market interest rates. The trust has no significant interest bearing assets except for cash and cash equivalents.

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

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

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

The following items have been charged in arriving at deficit funds:

Depreciation on property, plant and equipment 2,639,332 2,445,258
(for detailed breakdown of depreciation refer to note 7)

Auditors’ remuneration
Audit fees - current year 127,200 123,000
Underprovision previous years 48,892 55,100
Other services 191,791 190,846
367,883 368,946

(Profit)/loss on disposal of property, plant and equipment (7,087) 22,605

Consultancy fees paid 1,291,154 1,389,190

Operating lease rentals
Land and buildings 993,619 556,474
Other 522,451 478,096
1,516,070 1,034,570

Staff costs (refer note 4) 28,515,691 25,591,187
### Grant income

**For the year ended 30 June 2004**

<table>
<thead>
<tr>
<th>Funders</th>
<th>ISDS</th>
<th>Healthlink</th>
<th>Community Development</th>
<th>Research</th>
<th>Lovelife</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>European Union</td>
<td>8,372,439</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8,372,439</td>
</tr>
<tr>
<td>Department of Health</td>
<td>1,675,000</td>
<td>367,971</td>
<td>-</td>
<td>2,000,000</td>
<td>23,072,020</td>
<td>27,114,991</td>
</tr>
<tr>
<td>University of Western Cape</td>
<td>178,734</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>178,734</td>
</tr>
<tr>
<td>World Health Organisation</td>
<td>100,000</td>
<td>-</td>
<td>-</td>
<td>233,162</td>
<td>-</td>
<td>333,162</td>
</tr>
<tr>
<td>Atlantic Philanthropies</td>
<td>765,000</td>
<td>1,500,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,265,000</td>
</tr>
<tr>
<td>European Union</td>
<td>-</td>
<td>1,769,512</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,769,512</td>
</tr>
<tr>
<td>Rockefeller</td>
<td>-</td>
<td>4,792,005</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4,792,005</td>
</tr>
<tr>
<td>HRH Project</td>
<td>-</td>
<td>175,510</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>175,510</td>
</tr>
<tr>
<td>Health E</td>
<td>-</td>
<td>300,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>300,000</td>
</tr>
<tr>
<td>NDA</td>
<td>-</td>
<td>-</td>
<td>799,693</td>
<td>-</td>
<td>-</td>
<td>799,693</td>
</tr>
<tr>
<td>Kellogg Foundation</td>
<td>-</td>
<td>-</td>
<td>6,481,359</td>
<td>-</td>
<td>-</td>
<td>6,481,359</td>
</tr>
<tr>
<td>Ford Foundation</td>
<td>-</td>
<td>-</td>
<td>789,575</td>
<td>-</td>
<td>-</td>
<td>789,575</td>
</tr>
<tr>
<td>Kaiser Family Foundation</td>
<td>-</td>
<td>-</td>
<td>3,337,065</td>
<td>75,615,844</td>
<td>-</td>
<td>78,952,909</td>
</tr>
<tr>
<td>DFID</td>
<td>-</td>
<td>-</td>
<td>758,565</td>
<td>-</td>
<td>-</td>
<td>758,565</td>
</tr>
<tr>
<td>Irish Aid</td>
<td>-</td>
<td>-</td>
<td>679,920</td>
<td>-</td>
<td>-</td>
<td>679,920</td>
</tr>
<tr>
<td>Womens Health Project</td>
<td>-</td>
<td>-</td>
<td>65,456</td>
<td>-</td>
<td>-</td>
<td>65,456</td>
</tr>
<tr>
<td>Sedibeng District</td>
<td>-</td>
<td>-</td>
<td>105,500</td>
<td>-</td>
<td>-</td>
<td>105,500</td>
</tr>
<tr>
<td>University of Pretoria</td>
<td>-</td>
<td>-</td>
<td>656,977</td>
<td>-</td>
<td>-</td>
<td>656,977</td>
</tr>
<tr>
<td>MSH Equity</td>
<td>-</td>
<td>-</td>
<td>255,000</td>
<td>-</td>
<td>-</td>
<td>255,000</td>
</tr>
<tr>
<td>Danish Embassy</td>
<td>-</td>
<td>-</td>
<td>290,423</td>
<td>-</td>
<td>-</td>
<td>290,423</td>
</tr>
<tr>
<td>Nelson Mandela Foundation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10,000,000</td>
<td>-</td>
<td>10,000,000</td>
</tr>
<tr>
<td>Global Fund</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>39,940,731</td>
<td>-</td>
<td>39,940,731</td>
</tr>
<tr>
<td>Anglo American</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,300,000</td>
<td>-</td>
<td>3,300,000</td>
</tr>
<tr>
<td>Department of Sports and Recreation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8,000,000</td>
<td>-</td>
<td>8,000,000</td>
</tr>
</tbody>
</table>

| Total                         | 11,091,173    | 8,904,998  | 8,070,627             | 8,382,068     | 159,928,595 | 196,377,461 |

**For the year ended 30 June 2003**

<table>
<thead>
<tr>
<th>Funders</th>
<th>Core</th>
<th>ISDS</th>
<th>Healthlink</th>
<th>Community Development</th>
<th>Research</th>
<th>Lovelife</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Kaiser Family Foundation</td>
<td>210,370</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,737,475</td>
<td>95,515,527</td>
<td>99,463,372</td>
</tr>
<tr>
<td>Department of Health</td>
<td>-</td>
<td>1,675,272</td>
<td>-</td>
<td>-</td>
<td>9,138,008</td>
<td>33,500,000</td>
<td>44,313,280</td>
</tr>
<tr>
<td>European Union</td>
<td>-</td>
<td>10,027,543</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10,027,543</td>
</tr>
<tr>
<td>Media Training Centre</td>
<td>-</td>
<td>-</td>
<td>300,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>300,000</td>
</tr>
<tr>
<td>Unicef</td>
<td>-</td>
<td>48,444</td>
<td>-</td>
<td>-</td>
<td>284,476</td>
<td>1,433,756</td>
<td>1,766,676</td>
</tr>
<tr>
<td>University of Leeds</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>612,068</td>
<td>-</td>
<td>-</td>
<td>612,068</td>
</tr>
<tr>
<td>Ford Foundation</td>
<td>-</td>
<td>-</td>
<td>1,002,513</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,002,513</td>
</tr>
<tr>
<td>Embassy of Ireland</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>584,274</td>
<td>-</td>
<td>-</td>
<td>584,274</td>
</tr>
<tr>
<td>SIDA</td>
<td>-</td>
<td>-</td>
<td>531,915</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>531,915</td>
</tr>
<tr>
<td>Rockefeller Foundation</td>
<td>-</td>
<td>-</td>
<td>862,102</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>862,102</td>
</tr>
<tr>
<td>Woodrow Wilson</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30,000</td>
<td>-</td>
<td>-</td>
<td>30,000</td>
</tr>
<tr>
<td>DFID</td>
<td>-</td>
<td>732,874</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>732,874</td>
</tr>
<tr>
<td>Bill &amp; Melinda Gates Foundation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100,850,000</td>
<td>-</td>
<td>100,850,000</td>
</tr>
<tr>
<td>Vodacom</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,000,000</td>
<td>-</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Nelson Mandela Foundation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15,000,000</td>
<td>-</td>
<td>15,000,000</td>
</tr>
</tbody>
</table>

| Total                         | 210,370       | 12,484,133 | 1,694,017  | 1,002,513             | 14,386,301   | 248,299,283 | 278,076,617 |
4 Staff costs
Salaries and wages 28,515,691 25,591,187

5 Net finance income
Interest received
Bank 1,336,131 4,595,556
Interest paid
Bank overdrafts (434,446) (259,134)
901,685 4,336,422

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

7 Property, plant and equipment

<table>
<thead>
<tr>
<th></th>
<th>Motor Vehicles</th>
<th>Computer Equipment</th>
<th>Computer Software</th>
<th>Furniture and Fittings</th>
<th>Property and Fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Year ended 30 June 2004</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening net carrying amount</td>
<td>1,399,012</td>
<td>3,061,751</td>
<td>206,587</td>
<td>1,405,016</td>
<td>3,824,599</td>
<td>9,896,965</td>
</tr>
<tr>
<td>Transfers</td>
<td>-</td>
<td>131,755</td>
<td>10,204</td>
<td>20,840</td>
<td>-</td>
<td>162,799</td>
</tr>
<tr>
<td>Additions/Improvements</td>
<td>81,000</td>
<td>843,387</td>
<td>531,108</td>
<td>48,943</td>
<td>-</td>
<td>1,504,438</td>
</tr>
<tr>
<td>Disposals</td>
<td>-</td>
<td>(33,168)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(33,168)</td>
</tr>
<tr>
<td>Depreciation charge</td>
<td>(620,201)</td>
<td>(1,395,529)</td>
<td>(225,253)</td>
<td>(318,517)</td>
<td>(79,832)</td>
<td>(2,639,332)</td>
</tr>
<tr>
<td>Net carrying amount at end of year</td>
<td>859,811</td>
<td>2,608,196</td>
<td>522,646</td>
<td>1,156,282</td>
<td>3,744,767</td>
<td>8,891,702</td>
</tr>
</tbody>
</table>

As at 30 June 2004

<table>
<thead>
<tr>
<th></th>
<th>R</th>
<th>R</th>
<th>R</th>
<th>R</th>
<th>R</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening net carrying amount</td>
<td>1,998,727</td>
<td>3,352,296</td>
<td>134,095</td>
<td>1,536,856</td>
<td>3,147,556</td>
<td>10,170,030</td>
</tr>
<tr>
<td>Additions/Improvements</td>
<td>116,489</td>
<td>1,087,258</td>
<td>200,828</td>
<td>148,665</td>
<td>750,000</td>
<td>2,303,240</td>
</tr>
<tr>
<td>Disposals</td>
<td>(67,781)</td>
<td>(60,731)</td>
<td>-</td>
<td>(2,535)</td>
<td>-</td>
<td>(131,047)</td>
</tr>
<tr>
<td>Depreciation charge</td>
<td>(648,423)</td>
<td>(1,317,572)</td>
<td>(128,336)</td>
<td>(277,970)</td>
<td>(72,957)</td>
<td>(2,445,258)</td>
</tr>
<tr>
<td>Net carrying amount at end of year</td>
<td>859,811</td>
<td>2,608,196</td>
<td>522,646</td>
<td>1,156,282</td>
<td>3,744,767</td>
<td>8,891,702</td>
</tr>
</tbody>
</table>

Year ended 30 June 2003

<table>
<thead>
<tr>
<th></th>
<th>R</th>
<th>R</th>
<th>R</th>
<th>R</th>
<th>R</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening net carrying amount</td>
<td>1,399,012</td>
<td>3,061,751</td>
<td>206,587</td>
<td>1,405,016</td>
<td>3,824,599</td>
<td>9,896,965</td>
</tr>
<tr>
<td>Additions/Improvements</td>
<td>859,811</td>
<td>2,608,196</td>
<td>522,646</td>
<td>1,156,282</td>
<td>3,744,767</td>
<td>8,891,702</td>
</tr>
<tr>
<td>Disposals</td>
<td>(434,446)</td>
<td>(259,134)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(693,577)</td>
</tr>
<tr>
<td>Depreciation charge</td>
<td>(901,685)</td>
<td>901,685</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(1,803,362)</td>
</tr>
<tr>
<td>Net carrying amount at end of year</td>
<td>1,399,012</td>
<td>3,061,751</td>
<td>206,587</td>
<td>1,405,016</td>
<td>3,824,599</td>
<td>9,896,965</td>
</tr>
</tbody>
</table>

Property consists of 174 Oxford Road, Melrose, ERF RE/119 in Johannesburg and stand No 125 Acornhoek, 212 KU.
### 8 Receivables and prepayments

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receivables</td>
<td>2,125,521</td>
<td>3,613,454</td>
</tr>
<tr>
<td>Accrued income</td>
<td>19,022,813</td>
<td>-</td>
</tr>
<tr>
<td>Receiver of Revenue - VAT</td>
<td>3,624,763</td>
<td>7,091,503</td>
</tr>
<tr>
<td>Staff Loans</td>
<td>205</td>
<td>5,962</td>
</tr>
<tr>
<td>Provision for doubtful debts</td>
<td>(27,360)</td>
<td>(74,100)</td>
</tr>
<tr>
<td>Deposits</td>
<td>171,219</td>
<td>167,839</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>24,917,161</td>
<td>10,804,658</td>
</tr>
</tbody>
</table>

### 9 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current accounts</td>
<td>4,177,387</td>
<td>12,156,841</td>
</tr>
<tr>
<td>Call accounts</td>
<td>10,063,439</td>
<td>11,242,552</td>
</tr>
<tr>
<td>Cash on hand</td>
<td>713</td>
<td>572</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14,241,539</td>
<td>23,399,965</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current accounts</td>
<td>4,177,387</td>
<td>12,156,841</td>
</tr>
<tr>
<td>Call accounts</td>
<td>10,063,439</td>
<td>11,242,552</td>
</tr>
<tr>
<td>Cash on hand</td>
<td>713</td>
<td>572</td>
</tr>
<tr>
<td>Bank overdrafts (refer note 11)</td>
<td>(109,770)</td>
<td>(524,278)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14,131,769</td>
<td>22,875,687</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Department</th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research</td>
<td>4,989,275</td>
<td>9,179,619</td>
</tr>
<tr>
<td>ISDS</td>
<td>2,101,799</td>
<td>2,132,852</td>
</tr>
<tr>
<td>Community Development</td>
<td>3,947,567</td>
<td>605,819</td>
</tr>
<tr>
<td>Healthlink</td>
<td>2,196,379</td>
<td>477,760</td>
</tr>
<tr>
<td>Core</td>
<td>842,010</td>
<td>(32,404)</td>
</tr>
<tr>
<td>Lovelife</td>
<td>54,739</td>
<td>11,037,577</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14,131,769</td>
<td>22,875,687</td>
</tr>
</tbody>
</table>

### 10 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accruals</td>
<td>33,071,670</td>
<td>13,009,444</td>
</tr>
<tr>
<td>Provision for audit fees</td>
<td>127,200</td>
<td>123,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33,198,870</td>
<td>13,132,444</td>
</tr>
</tbody>
</table>

### 11 Short term borrowings

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank overdraft</td>
<td>109,770</td>
<td>524,278</td>
</tr>
</tbody>
</table>

The bank overdraft bears interest at prime related interest rates and is payable on demand.

### 12 Provision

#### Leave pay

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>1,780,741</td>
<td>1,399,433</td>
</tr>
</tbody>
</table>

### 13 Cash used in operations

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deficit funds</td>
<td>(16,986,097)</td>
<td>(16,471,789)</td>
</tr>
<tr>
<td>Adjusted for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss on scrapping of asset</td>
<td>(38,479)</td>
<td>22,605</td>
</tr>
<tr>
<td>Depreciation</td>
<td>2,639,332</td>
<td>2,445,258</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(14,112,503)</td>
<td>(3,082,183)</td>
</tr>
<tr>
<td>Increase in accounts receivable</td>
<td>20,066,426</td>
<td>314,871</td>
</tr>
<tr>
<td>Provisions</td>
<td>381,308</td>
<td>(348,669)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(8,050,013)</td>
<td>(17,119,907)</td>
</tr>
</tbody>
</table>

### 14 Operating lease commitments

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

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not later than 1 year</td>
<td>789,116</td>
<td>720,865</td>
</tr>
<tr>
<td>Between 2-5 years</td>
<td>347,515</td>
<td>1,123,469</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,136,631</td>
<td>1,844,334</td>
</tr>
</tbody>
</table>
15 Capital commitments

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

The capital expenditure will be financed by way of a loan raised from a financial institution for an amount of R3,000,000. The balance of the expenditure will be financed from the sale of the property situated at 174 Oxford Road, Johannesburg and a guarantee from a third party for R6,000,000.

Property, plant and equipment 12,000,000 -

16 Contingent liabilities

16.1 During the current year the trust received a request from the Commissioner for the South African Revenue Services (“SARS”) regarding the payment of Regional Service Council (“RCS”) Levies. At the balance sheet date the liability is not accrued for.

16.2 At the balance sheet date a claim was made against Lovelife, a division of the Trust for Health Systems Planning and Development. This claim is being disputed and therefore no liability is accrued for.

The information regarding the claim is as follows:

<table>
<thead>
<tr>
<th>Nature</th>
<th>Estimated possible liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim 1</td>
<td>Non-payment of services rendered 2,429,665</td>
</tr>
</tbody>
</table>
Funding

HST has a range of funding partners including:

- SIDA
- Atlantic Philanthropies
- Irish Aid
- Ford Foundation Sexual and Reproductive Health Care
- The National Department of Health and Provincial Departments of Health
- DFID
- USAID/MSH
- NDA
- Kaiser Family Foundation
- Rockefeller Foundation
- Kellogg Foundation
- European Union
- DANIDA
- University of Western Cape
- World Health Organization

Design and layout by The Press Gang, Durban - Tel: 031 566 1024
For more information about HST visit

http://www.hst.org.za

e-mail us at

webmaster@hst.org.za

or contact one of our offices in:

**Durban**

401 Maritime House, Salmon Grove, Victoria Embankment, Durban 4001

Postal Address:
P.O. Box 808, Durban 4000, South Africa

Tel: +27-31-307 2954  Fax: +27-31-304 0775

**Cape Town**

1st Floor Riverside Centre, cnr of Belmont & Main Road, Rondebosch 7700

Tel: +27-21-689 3325  Fax: +27-21-689 3329

**Johannesburg**

11th Floor Devonshire House, 49 Jorrison Street, Braamfontein 2017

Postal Address:
P.O. Box 31059, Braamfontein 2017, South Africa

Tel: +27-11-403 2415  Fax:+27-11-403 2447